Special Commission of Inquiry

into Healthcare Funding

Before: The Commissioner,
Mr Richard Beasley SC

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

Wednesday, 24 July 2024 at 10.04am

(Day 038)

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

Also present:

Mr Richard Cheney SC with Mr Hilbert Chiu for NSW Health

THE COMMISSIONER: Good morning.

MR FULLER: Good morning, Commissioner. Commissioner, first this morning we have two witnesses from the Australian and New Zealand College of Anaesthetists who will be giving their evidence concurrently.

I call Dr Frances Page, who is via AVL, and Dr Michelle Moyle, who is here in person.

THE COMMISSIONER: All right. Dr Page, can you hear me?

DR PAGE: Loud and clear, thank you very much.

<FRANCES PAGE, sworn: [10.04am]

THE COMMISSIONER: And Dr Moyle, I'm going to believe you, whether you give an affirmation or an oath, but you have to choose which one.

<MICHELLE MOYLE, affirmed: [10.05am]

THE COMMISSIONER: Are you going to refer to the document that's 0181.0001; is that what we're --

MR FULLER: Yes.

THE COMMISSIONER: I've got that.

MR FULLER: Thank you, Commissioner.

<EXAMINATION BY MR FULLER:

MR FULLER: Starting with you, Dr Moyle, you are one of the signatories to a statement that has been given by four individuals from the Australian and New Zealand College of Anaesthetists; that's right?

DR MOYLE: That's correct.

MR FULLER: And you have a copy of that statement there with you?

DR MOYLE: I do.

MR FULLER: Have you had an opportunity to review the statement recently?

DR MOYLE: I have.

MR FULLER: Is everything in that true and correct, to the best of your knowledge and belief?

DR MOYLE: Yes.

MR FULLER: Dr Page, I'll ask you the same questions. You are one of the signatories to the statement provided 15 July 2024 by the college; that's right?

DR PAGE: That's correct.

MR FULLER: Have you got a copy there with you?

DR PAGE: I do.

MR FULLER: Have you had the opportunity to review that recently?

DR PAGE: Yes, I have.

MR FULLER: Is everything in it true and correct to the best of your knowledge and belief?

DR PAGE: It is.

MR FULLER: Dr Page, can I start by asking you, please, to describe your current role in the college?

DR PAGE: So I'm a member of the college. I'm the chair of the New South Wales regional committee and, you know, I will undertake various sort of teaching roles in conferences and that kind of thing that the college will run.

MR FULLER: Am I right in understanding that you are also safety and quality officer?

DR PAGE: So within the regional committee, yes, I currently hold the safety and quality portfolio.

MR FULLER: And how does the regional committee, the New South Wales regional committee, relate to the broader ANZCA council?

DR PAGE: The regional committees across the states and territories are designed to be a conduit of information to and from central ANZCA, particularly regarding training in the states and territories.

MR FULLER: And, Dr Page, have you previously held any leadership roles within the college before your current role?

DR PAGE: I was involved in the authorship of the current curriculum of the college. So that was a process that ran over about three years, and I was one of the members of the authoring team. That would be it.

MR FULLER: Dr Moyle, can you tell the Commission your current position within the college?

DR MOYLE: I'm just the most recent chair of the New South Wales regional committee. I stepped down in June. I was the chair for about a year, the deputy chair for two years before that, and I held - the most substantive role that I held whilst on the regional committee for 12 years was that of the education officer for New South Wales.

That role involves direct liaison with the trainees themselves across New South Wales, tends to - and provides assistance and expert advice or guidance for supervisors of training. So every hospital has supervisors of training that look after the trainees within those individual hospitals and the EO basically is the sort of source of information and a conduit to the higher echelons, if you like, of the college, so the central office. So I had frequent conversation and discussion with the chair of the ANZCA, of the national body.

MR FULLER: And that was specifically in relation to training; is that right?

DR MOYLE: Correct. So when I had that role it was the beginning - it was quite a significant moment in the college's history in that our trainees had the first online training portfolio system, which is essentially an electronic platform for everybody to record all manner of performance review and training milestones. So that obviously raised a few issues and identified trainees that weren't meeting certain requirements.

MR FULLER: Around what year was that?

DR MOYLE: 2013.

MR FULLER: Are you still a member of the regional committee?

DR MOYLE: I am not, no. I've stepped down - you can only stay on the regional committee for a maximum of 12 years. I'm head of department of anaesthetics at St Vincent's, and there's a lot of communication between heads of departments and supervisors of training with the college on a regular basis. So I am invited on occasion to participate at regional committee as a co-chair of a working party that we put together to look at centralised recruitment for training in New South Wales.

MR FULLER: When did your term as chair end?

DR MOYLE: June this year.

MR FULLER: Dr Page, can you just tell us what is your clinical role?

DR PAGE: Sure. I'm the head of anaesthetics at Gosford Hospital, which is part of the Central Coast LHD, and prior to that for about 15 years I was the supervisor of training, rotational supervisor of training here.

MR FULLER: Thank you. Staying with you, Dr Page, in paragraph 1 of your statement you've told us some of the responsibilities of the college in relation to training, assessment, examination and so on. Do you see that?

DR PAGE: Yes.

MR FULLER: So point 1 on the first page of the statement.

DR PAGE: Yes.

MR FULLER: Do you view the college as also having an advocacy role in relation to its fellows?

DR PAGE: It will advocate for fellows, absolutely. That's a challenging - I think it depends on the context in which you're asking about advocacy. If you're talking about advocacy within the workplace, it doesn't employ - it

doesn't employ me or any of the trainees, and so whilst it does have statements around how trainees should be treated, how fellows should be treated and how departments should deal with disputes and that sort of thing, it is very difficult for the college to get involved in that. If you are talking about advocacy on a wider level in terms of employment terms and that sort of thing, that's not really a core role of the college.

MR FULLER: So would I be right in thinking that the college does view itself as having a general role in advocating around the health and wellbeing --

DR PAGE: Absolutely.

MR FULLER: -- equity and diversity and so on of its fellows; that's right?

DR PAGE: Correct. And it has a whole department that deals with health and wellbeing. If we're not healthy it's difficult for us to provide proper health care to our patients.

MR FULLER: It is the case that from time to time the college will get involved at the local or site level if fellows or trainees raise issues, for example, around culture, safety and so on.

DR PAGE: Correct, absolutely. And as part of the training and accreditation requirements, any hospital that has ANZCA trainees is required to undertake an accreditation process with the college on a five-yearly basis, or more frequently if there are issues. And one of the particular issues that the training and accreditation team that visit that hospital will be interested in is to hear from the trainees, and from the senior staff in the department as well, but especially from the trainees, that they are being treated appropriately, that there aren't any issues with bullying, harassment and that kind of thing, that they have appropriate access to their training needs et cetera.

MR FULLER: I'll come back to that a bit later.

Dr Moyle, for the moment, do you have anything to add to what Dr Page has said on that issue?

DR MOYLE: No. My experience, the college has been a strong advocate for anaesthetists and anaesthetic departments.

MR FULLER: In what ways?

DR MOYLE: Just in terms of certainly from an accreditation perspective, it's a reasonably powerful tool in terms of if a department feels that it's unable to provide safe anaesthesia for patients because of staffing issues.

There was an accreditation visit in a hospital in New South Wales where there were significant staffing issues and the college threatened - well, "threatened" might be a strong word but discussed with the executive of that hospital the issues that it saw from a patient safety perspective and that was met with an appropriate solution, which that particular department had been struggling with for some time. So I do think it does become - it is a strong tool in terms of maintaining patient safety and staff safety.

MR FULLER: It's a strong tool - why do you say it is a strong tool?

DR MOYLE: I think it's really important that there is an external body that can maintain and determine clinical governance of maintenance of standards, for example. You know, nearly every person will require an anaesthetic at some point in time and if you don't have something to be able - something of substance to go to executive of hospitals and wider, then it's hard to argue, really.

MR FULLER: Is it right, then, that you see the role of the college as including setting and maintaining broader professional standards for the anaesthesia profession?

DR MOYLE: Yes, I think so. Certainly there's a new - I think it's called a chapter, we're not allowed to call it a - what was the - I can't remember the name of the perioperative medicine --

DR PAGE: No, chapter is right, Michelle, yes.

DR MOYLE: It is now a chapter because of, I don't know, university regulations, and that is around perioperative

medicine.

I think certainly the profession of anaesthesia has advanced significantly. You know, in the early 1990s we were a faculty of the college of surgeons and now we're - you know, we've been a college of our own for a long time. We're much more involved in the perioperative care rather than just intraoperative care of patients, and I think as a specialist group of people we see things that can be improved in health care across the board and we have quite a unique - I think we have a unique view of that because we see patients before their surgery, we have the opportunity to optimise and choose, perhaps, you know, influence, what procedure goes on, how that patient's care is implemented.

THE COMMISSIONER: I was going to ask you, I think you are getting there, what are the benefits of anaesthetists becoming involved in perioperative medicine?

DR MOYLE: Look, this is perhaps a bit of personal opinion mixed in with the college, but --

THE COMMISSIONER: That's all right, it's expert opinion, so go ahead.

DR MOYLE: Patients present to hospital for surgical services, generally speaking through the lens of the surgeon, so patients are referred to surgeons for a surgical problem and, you know, as is their - they will recommend surgery. I don't think - I think we've kind of lost the generalised nature of patient care in that things are - you know, patients come in on the day of surgery, things are managed outside the acute care hospital, and so I'm not sure - the surgeon will always choose the surgical pathway and I don't think that patients - the general health literacy of the population is broad enough to understand that there are other alternatives. So patients aren't always --

THE COMMISSIONER: This is about providing options. One option might be - for a particular patient, might actually be surgery.

DR MOYLE: Correct, yes.

THE COMMISSIONER: But your involvement provides the options for something other than surgery?

DR MOYLE: Yes, absolutely. I mean, once upon a time, anaesthesia was sort of the - it would determine whether surgery went ahead or not, whether you thought somebody was going to survive. You know, the mortality rate from anaesthesia these days is exceptionally low and I think we're much more - we're in a position where we can actually see - like, we accept patients on the basis of their fitness for anaesthesia that once upon a time we would not have chosen.

So I think the peri - anaesthetists are in a very good position to help with that perioperative care because the individual specialists that, say, look after a patient's heart or their lungs or their kidneys are not necessarily skilled in what happens in the operating room itself, and so whereas we see all of that.

And then obviously there is the postoperative recovery as well. So there is an increasing emphasis within the college on encompassing perioperative care rather than just the actual time that the anaesthetic is being given to the patient.

MR FULLER: Am I right in thinking that when you said the college is in a "unique" position, that's because its fellows are the ones involved in that clinical work; is that right?

DR MOYLE: Yes, I think so. I think anaesthetists are - obviously are the membership of the college and in our workplaces we are being called much more frequently to attend to all sorts of issues around the hospital beyond the operating room. So the expansion of services for anaesthetists is much greater than just the operating room now.

MR FULLER: In terms of accreditation being a powerful tool, as you've described it, I take it you'd agree that withdrawing accreditation, for example, is something that may have serious consequences for the delivery of anaesthesia services in a hospital?

DR MOYLE: Absolutely, yes.

MR FULLER: Dr Page, do you have anything you want to add to what Dr Moyle has just said?

DR PAGE: I think Michelle's comment about the wider work of anaesthetists beyond simply providing anaesthesia care in the operating theatre is really important. It gives us an opportunity to interface with almost every other discipline in the hospital. So we see our physician colleagues when we provide supportive care for interventional procedures that they undertake; we provide pain interventions for patients across the hospital from ED to palliative care and pretty much everywhere in between.

I think that that gives us a unique insight into the nuanced working of the wider hospital, which is why I think that we're well placed to then offer suggestions or ideas as to alternative appropriate pathways for care for patients, more than simply surgery. Surgery is appropriate for very many people, but sometimes, alternative options need to be considered and the nature of our work means that we're able to do that.

Accreditation is a powerful tool. If hospitals are accredited with the college for training, their positions are desirable, as far as trainees are concerned, so they attract better quality of application of junior doctors to the hospital. The college does not undertake withdrawal of accreditation lightly. It understands that it has a huge impact on the trainees, which is detrimental to the trainees; on the department and on patient care and it would far rather work with the hospital to see, you know, the appropriate standards met.

I guess one of the things that maybe I didn't mention or didn't well articulate when you were asking earlier about standards, you know, there are standards for accreditation but there are also the professional documents that the college has which set standards for care across many different, you know, aspects of care. Those are there for reference for all hospitals, for all departments, and they are used by other disciplines as well, you know, so physicians providing sedation may actually use some of those documents as well, may refer to those.

MR FULLER: Those documents you're referring to are things like the college's professional guidelines in --

DR PAGE: Correct, yes.

MR FULLER: Is that right?

DR PAGE: Yes.

MR FULLER: Am I right in understanding that some of the accreditation standards that the college requires sites to meet require, in turn, that sites comply with those professional guidelines?

DR PAGE: Where those guidelines are relevant. I mean, obviously each hospital has different services that it offers, but yes, you know, the standard, for example, on the anaesthesia machine and on where emergency drugs should be available for emergencies associated commonly with anaesthesia practice and those sorts of things would be across the board, and so an accreditation team, when visiting the hospital, would be making sure that the anaesthesia machines were of the appropriate standard, that those emergency drugs were freely available for when life-threatening emergencies happened, and that would be an expectation everywhere, yes.

MR FULLER: And would we be right in thinking that part of the reason for linking the professional guidelines with accreditation standards is again to try to set a level of broader professional --

DR PAGE: It's safety. It's patient safety. Yes. The principal driving force behind accreditation is standards of training and patient safety, and I put them that way around but they could be the other way around. I think they sit on a par with one another.

MR FULLER: I'll come back to the accreditation standards shortly.

Just going back to your statement, Dr Page, I will ask you this: in paragraph 6, you have referred to the Australian Society of Anaesthetists. Do you see that?.

DR PAGE: Yes.

MR FULLER: Does the society have any role in accreditation of anaesthesia training programs?

DR PAGE: No.

MR FULLER: Dr Moyle, completion of the training program accredited by your college is the only way for a doctor to obtain registration as a specialist anaesthetist in Australia; that's right?

DR MOYLE: Correct.

MR FULLER: Do you agree that the lack of competition makes it important for colleges, such as yours and others, to have fair, effective and transparent processes for governance and administration of training programs?

DR MOYLE: I don't think so. I mean, the college doesn't actually employ anybody. It sets the standards, the performance standards, and so I think - I'm not sure that another competitor, if you like, in terms - to ANZCA, like the ASA, for example, might be - I mean, the ASA is generally a professional body that's grown because of more support for practitioners in private practice. That was their original missive, and so they don't tend to get involved in accreditation.

I think the whole - like, accreditation of facilities only occurs from an ANZCA perspective when there are actually trainees in that facility. So ANZCA, for example, doesn't accredit a private hospital that doesn't have current trainees in it.

THE COMMISSIONER: Sorry to interrupt. I think there's perhaps a disconnect between your question and the answer.

This isn't a criticism, but what Mr Fuller asked you was:

Do you agree that the lack of competition makes it important for colleges, such as yours and others, to have fair, effective and transparent processes for governance and administration of training programs?

And you said, "I don't think so". Leaving aside the competition aspect --

DR MOYLE: Yes.

THE COMMISSIONER: -- I would be surprised if you had the view that your college shouldn't have fair, effective and

transparent processes for governance and administration.

DR MOYLE: Oh, no, I think that absolutely --

THE COMMISSIONER: So you agree with that?

DR MOYLE: Yes, I definitely agree with that.

THE COMMISSIONER: The issue I think Mr Fuller is trying to get at is: is competition needed for that or is your college able to do that --

DR MOYLE: I don't think competition is needed.

THE COMMISSIONER: -- and desires to do that in any event?

DR MOYLE: Yes, no, I think the college achieves that, yes.

MR FULLER: Thank you, Commissioner.

Dr Moyle, do you think that the lack of competition, that is the college being the only pathway, makes it particularly important for there to be fair and transparent processes?

DR MOYLE: Yes.

MR FULLER: Dr Page, do you agree with that?

DR PAGE: Absolutely. And I think they are, and those standards are freely available to everybody.

MR FULLER: Yes. Dr Page, as we understand it, the training program in anaesthesia includes a requirement for trainees to complete subspecialised training.

DR PAGE: Yes.

MR FULLER: Is that right?

DR PAGE: Yes.

MR FULLER: That's in three areas, cardiac --

DR PAGE: No. It's actually in more than three areas. It's in 12 areas. But the three areas that I think you are

about to refer to, cardiac, neuro and paediatrics, are the three bottleneck areas. So those are the areas that are not provided in every hospital.

Other specialised study units - there is one in ophthalmic surgery, one in orthopaedics, et cetera, et cetera, there's a number of them. But those obstetrics, et cetera, are much more widely available and therefore the opportunity for trainees to get access to the experience that they need to meet the training requirements in those specialty areas is not problematic. Because neuro anaesthesia, cardiac anaesthesia and paediatric anaesthesia is performed in limited quantities and in limited locations, that's what makes it tricky for the trainees to get the required experience and to meet the required standards.

MR FULLER: Just to be clear, the 12 subspecialties that you have referred to, are they the same as the specialised study units or --

DR PAGE: Study units, that's correct.

MR FULLER: -- the SSUs?

DR PAGE: The SSUs, yes.

MR FULLER: So paragraph 42, for example, of your statement, when we see that reference we can understand that as meaning the 12 areas of specialisation?

DR PAGE: Correct.

MR FULLER: You refer later in paragraph 42 to the roadblocks to access subspecialised training in the three areas that we've just mentioned.

DR PAGE: Correct.

MR FULLER: I see. Is it the college's view that subspecialised training in each of those 12 areas is an essential requirement for someone to become a competent anaesthetist?

DR PAGE: Yes. And it's not because we view that any trainee who has done their four years of core training, who has completed all of these SSUs - that doesn't qualify

anybody to be a neuro anaesthetist or a cardiac anaesthetist, or what have you, but it's more about understanding the nuanced difference, the requirements for safe anaesthesia for patients in those circumstances, as much as anything, to understand why you just don't merrily plough on ahead when you're not in an appropriate facility with the appropriate staff and with the appropriate level of training for yourself to do that.

So it's about giving people a minimum exposure to have a baseline understanding of what is involved in those subspecialty areas, so that if that's an area of interest to them, they can explore it further through their provisional fellow year and on into their consultant practice, so that we can actually get people to sort of continue in those subspecialty areas, but also so that the rest of us who aren't cardiac anaesthetists, neuro anaesthetists, et cetera, kind of know why there are boundaries that we would be sensible to not cross.

MR FULLER: Dr Moyle, do you have anything to add as to why it's important in the college's view for those subspecialties to form part of the training program?

DR MOYLE: So there are a whole bunch of procedural skills, technical skills that all anaesthetists need to have, and some of those skills are - there are more on offer in some of those specialised study units than others. I think, as Frances has said, Dr Page has said, some of - the expectation is not that you become a specialist in any of those particular specialised areas but that you observe and actually get to practise that within the skilled environment so that you can understand nuances of aspects that you see more in those specialised study areas, just in the general population at any time. So it's just really - it's about identifying, you know, and experiencing the types of conditions that can occur in a general population in any hospital that you might work at.

MR FULLER: So in circumstances where the college sees there being roadblocks in paediatric, cardiac and neuro in particular, nevertheless you don't see any room to move on those being essential parts of the curriculum; is that right?

DR MOYLE: No, I think the college has always maintained some flexibility in adjusting volume of practice targets,

for example. It's pretty widely accepted by all anaesthetists that it is very important to have minimum amount of exposure to paediatrics, obviously, in those hospitals - so most people tend to not go very far from the place that they trained in terms of their specialist practice, so paediatric anaesthetists, you know - there are more generalist paediatric anaesthetists, for example, in Newcastle, where paediatrics is part and parcel of their everyday work than, say, in a specialist centre in Sydney that doesn't have paediatrics, but it is considered important.

Obstetrics is obviously important.

The neurosurgical is - it's sort of the changing face of where these procedures are actually done has made it more difficult to achieve those volumes of practice targets for everybody. Cardiac, you know, there's actually a decline in the number of cardiac surgical procedures but more work in cath labs, for example, where anaesthetists are involved across the state. So it is still - you know, we're constantly arguing whether we should be insisting that trainees do those specialised study units. I think at the moment it's the right mix, yes.

MR FULLER: You mentioned the college having had some flexibility in the volume of practice targets. Can you just elaborate on that, please?

DR MOYLE: Okay, so back when the curriculum first started, in 2013 when it changed, there was a volume of practice for neonates, for example, and it was actually really difficult for all trainees to get that volume of practice, and so the working party that looks after education and training and curriculum looked at what was the benefit in insisting on that target. I think it was 20 under 2, or something like that, that had to include a certain number of neonates, and so it was adjusted.

So now the numbers are much more reflective of what the general anaesthetist in a general hospital would be expected to know, and it's really - sometimes it's not so much - it's more, as you get further on in your specialist career, you tend to subspecialise, but you may still have a patient come through the ED, for example, with a specialist problem that it would be expected that everyone could handle. So you may not be a super expert at

it, but at least you understand the basics of what you need to do to keep that patient safe until a specialist can be brought in.

THE COMMISSIONER: Do I understand "20 under 2" to mean 20 procedures on a child under 2 years of age?

DR MOYLE: Yes, 20 cases, yes.

THE COMMISSIONER: Thanks.

MR FULLER: So is this a fair summary of your view, that despite what the college has identified as the roadblocks in those three particular areas in the statement, in your statement, at the moment, you think that the balance is right in terms of the subspecialty areas, but it's a matter that the college is keeping under review; is that fair?

DR MOYLE: Yes, I think that's fair, yes.

MR FULLER: Dr Page, do you have anything to add on that issue?

DR PAGE: No, I think that's a pretty fair summary of it. I mean, medicine changes over time, so we should expect that the curriculum for anaesthesia training and for any other discipline in medicine should similarly change over time, and it's about getting that balance right - what is the minimum amount of experience that somebody needs to be able to practise safely, versus, you know, what is so much that it is so onerous that it's not achievable.

I think the college is very cognisant of that problem and is really working hard to find the right balance, and I don't think that there's too many fellows, supervisors of training, or actually trainees, that think that the numbers where they are at the moment are fundamentally wrong.

MR FULLER: Thank you. Dr Page, as we understand it, the college accredits sites rather than individual positions; that's right?

DR PAGE: Yes, that's correct.

MR FULLER: What's the reason for the college taking that approach?

DR PAGE: My understanding - and this pre-dates my coming to live and work in Australia, but my understanding is that, at the time that the decision was taken, there was concern that if you accredited individual positions and that you potentially had trainees who were accredited working alongside trainees who were not accredited, yet both individuals were essentially doing the same job, the same expectations of them, that that potentially was a source of industrial litigation and that that was felt to be a move that people didn't want to - a door that people didn't want to open up. So the answer to that was rather to accredit the site and then all of those individuals employed in anaesthesia training in that site could be accredited and if the site wasn't accredited then the individuals wouldn't be accredited for their training time at that site.

MR FULLER: Dr Moyle, do you have anything to add on that sort of historical issue.

DR MOYLE: That background is correct. So all trainees who participate in an anaesthetic roster, for example, in an accredited facility, will be in an accredited position. The college decided to accredit - so in its accreditation of facilities, it will determine how many years that facility can provide training for. So that number of years - so how do I - okay, so St Vincent's Hospital is full accreditation of 156 weeks, because we can provide all of the SSUs. If a hospital is only able to provide two SSUs, then they will get one-year accreditation. So the accreditation is for the number of years of training.

I think that that's reasonable. It's very difficult for - and what was your second part of your question again?

MR FULLER: I think you've answered my question.

DR MOYLE: Did that answer it?

MR FULLER: Yes, thank you, Dr Moyle. It's the case that there may be individuals at PGY3 plus performing similar work to anaesthesia trainees at sites that are not accredited by the college; is that your understanding of the reality?

DR MOYLE: I don't think - I don't think that occurs.

MR FULLER: Not in anaesthesia, to your knowledge?

DR MOYLE: No. I mean, the problem we have is that the number of - because we have different facilities that can offer a four-year contract, an all-training requirement, and we have a lot of other hospitals that can only provide one or two years of training, there is a backlog of people in those non-scheme hospitals, and so they can't get through their training without access to scheme hospitals.

So the problem is actually the pathway from the independent hospitals to the scheme hospitals. I think that there has been - it is a much bigger problem in New South Wales than any other state in the country, although it is - the problem is increasing in other states. Part of that problem has arisen because of the huge increase in the amount of service provision required at each hospital and anaesthetics is a popular choice of specialty and a very skilled workforce, and so often it's the anaesthetic component of that job is offered as a carrot to get people to fill intensive care rosters, for example.

MR FULLER: When you referred to "scheme hospitals" in that answer, can you describe what you mean by that phrase?

DR MOYLE: Okay. So there are 12 scheme hospitals in New South Wales. So a scheme hospital is one that can offer access to all specialised study units, and so NSW Health has an agreement that we - when we recruit for scheme hospitals, trainees are given a four-year contract so that they can get through their first four years of training, and in that time, the hospital will commit to get them exposure and access and completion of their SSUs. That's what a scheme hospital is.

MR FULLER: Is it also the case that the college requires all of its accredited sites to be part of a rotation?

DR MOYLE: No. The college will accredit sites - okay, it's a bit tricky to explain. I will use my own hospital as an example. So St Vincent's Hospital obviously doesn't have paediatrics or obstetrics, so we send our trainees on rotation to Children's Hospital for paediatrics and to women's hospital for obstetrics. But they go there on secondment from us, from our scheme hospital. So they are considered a rotation.

The college, when they come to accredit St Vincent's, they just accredit St Vincent's. Because our trainees are rotating to other accredited facilities, those facilities are accredited on their own. So if we were to send our trainees to a non-accredited hospital, they would not have their training accredited. So clearly we don't do that.

There are some hospitals in New South Wales that are accredited as satellites, where they don't necessarily have their own accredited anaesthetic trainees but they accept trainees from their parent hospital for a specified period of time. So, for example, Ryde Hospital is not accredited for anaesthetic training but it has now just been accredited as a satellite of North Shore, so North Shore will send their accredited trainees there and that time there will be accredited despite the hospital not being accredited in its own right.

MR FULLER: Thank you. Do you have an appendix A to your statement there with you? It might be easier just to look at an example.

DR MOYLE: Yes.

THE COMMISSIONER: Can that go on the screen, because I don't have it?

MR FULLER: I think so. The number is [SCI.0011.0196.0001]. Thank you.

So as I understand it, and tell me if this is wrong, this appendix sets out each of the accredited sites in New South Wales?

DR MOYLE: Correct.

MR FULLER: And it also identifies for each site, rotations --

DR MOYLE: Yes.

MR FULLER: -- and any satellite that the site has, which you have just described what that is? So if we have a look on page 0009, at St Vincent's Hospital, we see that - tell me if this is right: St Vincent's Hospital itself is an accredited site?

DR MOYLE: It is.

MR FULLER: Is what is what is set out in that row not quite correct?

DR MOYLE: "Central Gold Coast" is not correct. I'm not sure if that's a typo from the college.

MR FULLER: In terms of the rotations --

DR MOYLE: As a rotation, yes.

MR FULLER: -- St George is a rotation from St Vincent's; is that right?

DR MOYLE: Yes, actually we have a number of rotations that aren't listed there. So there is St George, Wollongong, Wagga Wagga, Royal Hospital for Women, the Children's Hospital Westmead.

MR FULLER: Focusing on St George as an example, St George is itself an accredited hospital?

DR MOYLE: An accredited hospital, correct.

MR FULLER: But St Vincent's Private Hospital, which is listed as a satellite, is not itself accredited; is that right?

DR MOYLE: That's correct. So St Vincent's Private Hospital is a satellite technically because it doesn't employ its own accredited trainees because it's not accredited of itself. So we have - we actually send trainees there on a different funding model. There's a specialist training program which is run through - it's a federal funded program that allows hospitals to send trainees to private facilities, so those private facilities generally would be accredited as a satellite of that hospital, and that is to - the main reason for that is to improve access to those roadblocks such as cardiac. So we use that for cardiac at St Vincent's, because at the private hospital we have outstanding cardiac services offered by the same team that do it at the public hospital, so we have trainees that come from Wollongong and also from Gosford, who come there specifically for cardiac.

MR FULLER: Is that the only situation where a hospital might have a satellite or are there other reasons why the college might use the satellite model?

DR MOYLE: The main reason for satellites is to increase exposure to - or, yes, for those sort of hard - the SSUs that are hard to get or, in our case obviously, it's not difficult for us to get cardiac SSUs at St Vincent's, but we don't have enough work in the public hospital, for example, to bring other people to us, but if we combine with the private hospital, then we have enough cases across the campus that we can accommodate trainees from other centres to get - help them get their cardiac training.

MR FULLER: Are the satellites ever used by the college to help trainees get exposure in rural and regional areas?

DR MOYLE: Yes. There they can use the STP process. They also use a thing called IRTP, which is - I can't remember what it stands for, but it's for rural trainees where the federal government - it's a federal government initiative and they fund a specific rural trainee and then that rural trainee takes their funding with them to wherever they need to go. So that's a very attractive option for most public hospitals in New South Wales because they're not paying for that trainee and that trainee is actually contributing to the hospital in terms of helping with service provision but also getting their SSUs.

MR FULLER: Does the college have any systematic process for working out whether hospitals either form part of the same rotation or have a satellite?

DR MOYLE: Yes. So I'm not exactly sure where you are driving but for example we've just had Albury hospital and Wagga Wagga hospital have come to the college and said "We'd like to combine our services", and so then we can create a rural training network. So then trainees don't need to come to the city for most of their training, they can get it between Wagga and Albury, but they do spend one year in a metropolitan hospital. So the college is very active - as a regional committee, quite active in helping achieve that. So, for example, Albury and Wagga, they spend either one year in one, two years in the other, so that gives them the three years, and then their fourth year, there's an arrangement that they will come to Westmead for that year. So then they get all their SSUs.

MR FULLER: So that's an example of a situation where hospitals approach you about - that is, the college - about setting up that structure?

DR MOYLE: Yes.

MR FULLER: Does the college do anything proactively to encourage those sorts of structures, particularly in rural and - involving rural and regional sites?

DR MOYLE: The college is the main driver for managing the STP and IRTP process.

MR FULLER: Sorry, just pausing there, can you just explain STP and IRTP?

DR MOYLE: So that's a federal source of funding. So they manage - so individual hospitals in New South Wales will apply to the college to receive funding through this federal model. So the college will put out an expression of interest amongst all hospitals and then, you know, there's a wait list of hospitals who would like to be considered for STP or IRTP, and then the college actually does the leg work in terms of putting those hospitals up for consideration.

So St Vincent's - so we have an STP position; Westmead and Westmead private have an STP position; I think there's also one in Dubbo, maybe, that came through last year. And there is a wait list of mainly rural and regional places.

MR FULLER: The availability of those positions is based on Commonwealth funding; is that right?

DR MOYLE: Correct.

MR FULLER: Does the college apply to the Commonwealth for that?

DR MOYLE: Yes.

MR FULLER: Dr Page, do you have anything to add on the question of - on the issue of rotations and satellites?

DR PAGE: I was just - yes. It's a challenging one because the college doesn't have easy vision of the service

development of individual hospitals. The college really has no way of knowing what services hospitals need to grow and how the hospitals best view that growth to be achieved. So the college is very much dependent upon the hospital making that assessment of its own needs, and then where that growth is going to involve further growth of anaesthesia services, then contemplating how they would do that, and then approaching the college where growth of trainee numbers is necessary or where development of training programs is necessary to facilitate the service development that the hospitals want.

So I suppose in answer to your question, how does the college drive that process, it can't really because it doesn't have the information to be able to know who is needing what growth of services where.

In terms of the STP and IRTP funding, the STP funding is for a position in a hospital, and it seems that probably the best use of that is to fund positions where bottlenecks exist.

For example, the STP application at St Vincent's private was something that Gosford Hospital was very involved with, because at that time we were seeking additional accreditation, we were seeking to move from a two-year accredited site to being a three-year accredited site and the roadblock for us in achieving that was having a mechanism to get cardiac experience for our trainees. The ability to get a position at St Vincent's private then offered us the opportunity to work with St Vincent's to get our trainees down there and then that kind of got us over the line as far as three years of accreditation goes.

So there is a lot of working out that happens between anaesthetists in individual hospitals, and in all honesty, the college keeping tabs on all of these conversations, developments, et cetera, is really hard work, and is very much dependent on us remembering to tell the college where things are at. So I can look at this document and I can just see, oh, yes, that's changed or that's not quite right as Michelle has just said to you. The suggestion that St Vincent's somehow has a link with the Gold Coast hospital is a little bit fanciful. I know that that's not the case. But I think that's just representative probably of us failing to tell the college in a timely fashion of what's changed and what's not changed, because it does on

a frequent basis.

MR FULLER: Thank you. That document can be removed from the screen.

Dr Page, you have used the acronyms STP and IRTP.

DR PAGE: Yes. So the integrated rural training pipeline is IRTP, and that's what Michelle just described is an aliquot of funding that follows a trainee through all of the different sites that they might go to. That's a relatively new source of federal funding and is designed to try and promote training in rural locations, but recognises the fact that most of the rural locations will not have tertiary cardiac, neuro and paeds, so there will need to be some mechanism to get those trainees through those disciplines such that they can get back to, hopefully, a long-term working in a rural location. So it's a mechanism to try and improve or increase the service provision in rural and remote locations.

The specialist training pathway, the STP funding, funds a position rather than an individual, at a given site. When that first started there were lots of sites applying for it. I think that they were viewing that as a way of deflecting costs back on to the federal government to pay for workforce.

I think that we've ended up with some STP-funded positions in rural hospitals that have only one year of accreditation and it funds a year of training, but it doesn't really then provide forward movement for that trainee through the rest of their training. And I think by using the regional committee, we're understanding better that probably the use of that money to fund positions where we can ease some of the bottleneck is probably the best opportunity for all trainees because it increases that capacity in those bottleneck SSUs, which benefits all trainees.

MR FULLER: Can you just describe how the college either is or plans to use that funding to relieve the bottlenecks that you have just described?

DR PAGE: So where departments make an application for STP funding, for example, that comes through the regional committee, and the regional committee will look at that

application and will sort of say, "Yes, this makes sense", or, "They need to do a bit more work in this area."

What we would look at is what they want the funding for, so what the particular position is that they want the funding for, and what they have thought about in terms of who is going to use that funding. So where applications have come through to say, you know, "We would like to fund" - for example - "a position at St Vincent's private to do cardiac", that will then enable us to get Central Coast trainees through their cardiac and neuro specialised study units so that that site can become a three-year accredited - a fully accredited scheme training hospital, and we can then complete the training process for a bunch of trainees on an ongoing basis. That is advantageous to those individual trainees, but it's advantageous to the system, because it actually stops people getting partway through training and then not being able to complete it, and it actually allows people to get all the way through their training and for us to create more specialist anaesthetists.

THE COMMISSIONER: Can I just ask about the integrated rural training program you have mentioned?

DR PAGE: Yes.

THE COMMISSIONER: How should I understand that? So that's funding provided by the Commonwealth to a particular trainee?

DR PAGE: Yes.

THE COMMISSIONER: So that they do some of their anaesthetic training in a regional centre, obviously at a hospital that has accreditation?

DR PAGE: Correct.

THE COMMISSIONER: But because most, I suppose, of those regional hospitals that have accreditation don't do cardiac or paediatrics, part of that training for that trainee that is on the integrated rural training program, they have to go back to the city --

DR PAGE: Correct.

THE COMMISSIONER: -- to complete their --

DR PAGE: So we reviewed recently a couple of hospitals that were wanting to apply for IRTP funding for a position at their site. These were rural hospitals in New South Wales. One site had got a well-articulated pathway that it had worked out with the tertiary hospitals in Sydney and they said yes, they had capacity to take an additional trainee, and so they had articulated a year of time at the rural - sorry, two years of time at the rural site, a year of time in the city to do the bottleneck SSUs, and then a further year of time at a nearby rural site.

So the first site - the two rural sites both had two years of accreditation, so the trainee couldn't do more than two of their four core years of accreditation at either one of the sites but the proposal was two years at one site, one year at the other site, and then their fourth year of training at accredited sites in the city. So that was easy to support because the pathway was well worked out for the trainee.

THE COMMISSIONER: Just pausing there, I assume this IRTP, at the risk of using an acronym, is - the theory behind it is that it's at least hoped that it will address the maldistribution of anaesthetists that you have talked about in your statement.

DR PAGE: Correct.

THE COMMISSIONER: Is the theory or the hope behind it that - tell me if I've got this wrong. Does the particular trainee under this program do some training in a regional centre, come back to do the cardiac paediatrics, et cetera, in the city, but then do they complete their training in a regional hospital?

DR PAGE: That's the idea, that's right.

THE COMMISSIONER: So that they actually finish up and get in a position where they can be admitted as a fellow, whilst they are in a regional hospital --

DR PAGE: A rural site - yes, or a regional site.

THE COMMISSIONER: -- with the hope that they might stay there and live and work there?

DR PAGE: Exactly right. And those regional/rural sites have also been accredited for a further provisional fellow year, which is the final year of training, so that those trainees that have gone on the IRTP pathway have the option to stay for their final year of training in that regional site, very much with the hope that they will then have put down enough roots that they want to stay there long term.

THE COMMISSIONER: And I assume the data behind the theory, as with other specialties or branches of medicine, is that whilst it's no guarantee, people that are trained in regional New South Wales are more likely to stay and work --

DR PAGE: Yes.

THE COMMISSIONER: -- in regional New South Wales than someone that's been trained entirely or largely in a metropolitan area?

DR PAGE: Yes. So my understanding is that, to date, the only strategy that's really borne any fruit in terms of easing that maldistribution is to actually get trainees out to those regional and rural sites during training, so that they can see that these are nice places to work with nice colleagues to work with and interesting, challenging, you know, anaesthesia to provide, such that they actually see that as a realistic option for their future career.

THE COMMISSIONER: Yes. And how long has this program been funded by the Commonwealth? How long has it been up and running?

DR PAGE: I think - Michelle please jump in and correct me - IRTP is reasonably recent, I think maybe over the last three to four years. STP pre-dated IRTP.

THE COMMISSIONER: Would I be right then - and either of you can answer this - in saying given it's relatively new, is there any data, sort of evaluation data, available about whether it's actually achieving what the hope --

DR PAGE: None that I have seen.

DR MOYLE: There is a problem with it.

THE COMMISSIONER: All right. Well, you tell me what the problem is.

DR MOYLE: It's been around for about five or six years. The first trainee that had it - in fact, I don't think there have been very many trainees at all who have actually had that type of funding.

THE COMMISSIONER: It would be good to know the numbers, actually.

DR MOYLE: It's pretty small. The first trainee had difficulty passing their primary exam. So there are two exams within your training. The first one's a primary exam after - you can't enter your third year of training until you have passed it. And then there is a final exam, which you can't sit until 150 weeks, or something, of training have gone by.

THE COMMISSIONER: Right.

DR MOYLE: So he couldn't pass the primary, and was in the city in a job but couldn't do his SSUs because he didn't have his primary and so then it became a huge issue because the problem is the funding is only for four years and he required six years, because of delays.

THE COMMISSIONER: I see, yes.

DR MOYLE: So the funding didn't follow him. So then he had to try and get a job. So I think he did eventually finish, but it was not a smooth process.

THE COMMISSIONER: I guess we can find this out and you can take the question on notice, but how many positions are funded under the - I'm going to call it the integrated rural training program.

DR MOYLE: Yes, it sounds better.

THE COMMISSIONER: Do you know? Ballpark?

DR MOYLE: I can take that on notice.

THE COMMISSIONER: You don't think it is large numbers, though?

DR MOYLE: It's not large, no.

DR PAGE: I think it would be single figures.

DR MOYLE. Yes.

THE COMMISSIONER: Tell me if I'm wrong but that doesn't sound - if it's single figures, I don't know how many anaesthetists you need, but that doesn't sound like, on those numbers, that even if it's largely successful, it may not address the maldistribution of anaesthetists in New South Wales.

DR PAGE: No.

DR MOYLE: I think the best --

THE COMMISSIONER: Perhaps it was done as a trial, was it?

DR MOYLE: I think it may have worked in other specialties but it didn't work in - or it hasn't worked very well. I think the gold is in the rural network training groups getting together. That's really only just started. I think the Wagga/Albury training network is probably - they've got their first scheme trainees in first year and they're very organised, they'll be producing two people every year, hopefully within a couple of years, and they generally have - their trainees are locals and they will stay in the country.

THE COMMISSIONER: When you say "locals", you mean people that were actually born or raised in that --

DR MOYLE: Yes, yes.

THE COMMISSIONER: Okay, which is another - I think there's some data that that assists, too, in terms of keeping medical professionals, medical workers, health care workers, in regional/rural settings.

DR MOYLE: Yes.

THE COMMISSIONER: Just on this topic, I might just complete what I wanted to ask and you can pick it up.

MR FULLER: Yes.

THE COMMISSIONER: In paragraph 21 of the statement - my questions are for either of you to answer and both of you can chip in - you talk about the longstanding maldistribution we've just been talking about of anaesthetists. Are the reasons for the maldistribution, in your opinion, covered in the rest of paragraph 21 or is there anything you'd like to add in relation to why there is a maldistribution? You've mentioned COVID didn't help, but, you know, you've talked about work/life balance issues and other things. Is there anything you want to add to 21, either of you?

DR MOYLE: I think one of the big problems with - as we said, with maldistribution, is that trainees come to the city and they have - had come to the city for most of their training, and so not all of them --

THE COMMISSIONER: There is no way of avoiding that, unless a regional hospital starts doing cardiac surgery or neurosurgery or paediatrics, which is --

DR MOYLE: It's very difficult in the rural centres because there's generally only one or two people there and they take on a very large after-hours load, and it's a very lonely existence, and anaesthesia, it's always nice to have some friends around, because when things go wrong, they go wrong very quickly. So it becomes a very - it's very hard. So it is not very attractive and there are plenty of jobs in the city, so people tend to stay here. I think one of the --

THE COMMISSIONER: But the reality is - it doesn't matter whether it's anaesthetics - the big training hospitals are in the metropolitan --

DR MOYLE: In the city. ANZCA has been very actively involved, though, in the rural generalist program. Our president of our college a few years ago is a real activist for rural training and generalist training.

Queensland has about - I think they've got 60 rural generalists who have - not all of those have completed their anaesthetic years --

THE COMMISSIONER: So this is general practitioners who are doing training?

DR MOYLE: Anaesthesia, yes. So they do a specialist year of anaesthesia in a city hospital and then they go out and they also do some other critical care stuff and then they go out and practice as rural generalists, but predominantly, anaesthesia. Queensland has a lot. New South Wales has about four or five rural generalists but almost all of those rural generalists trained in Queensland.

THE COMMISSIONER: I see. Why is that?

DR MOYLE: It's not as - it's not really - the networks aren't set up for that here. I think it's because of the recruitment process, it's difficult to get funding for - so in Queensland, the generalist is included in sort of service roles, if you like, sort of what might have once been unaccredited jobs in New South Wales. Like, that's what it would have looked like. But we don't really have that. I think the competition for anaesthetic places is such in New South Wales that people either get a scheme job and they - and so the recruitment teams are looking for people who want to be anaesthetists rather than facilitating a year of a rural generalist program.

THE COMMISSIONER: Just to clarify, I'm right, your college doesn't actually select the trainees?

DR MOYLE: They do not, no.

THE COMMISSIONER: You have mentioned in 22 that ANZCA is looking to increase the number of regionally based training programs, and you mentioned Wagga --

DR MOYLE: Yes.

THE COMMISSIONER: -- having recently commenced a comprehensive anaesthetic training scheme in 2023. By "comprehensive anaesthetic training scheme", what should I understand that to mean exactly?

DR MOYLE: So it can provide all of the SSUs, and three of the four --

THE COMMISSIONER: So you could actually train there for the entire period of your training to become a fellow?

DR MOYLE: Three out of the four - three of four of the

core training years.

THE COMMISSIONER: Right. What would you have to do in the city?

DR MOYLE: For Wagga, they will get enough paediatrics there, but they will need neurosurgery and cardiac.

THE COMMISSIONER: That's what I thought, all right. You also say "and other centres are likely to follow within the next two years".

DR MOYLE: So Dubbo and Orange have put forward a proposal. It's a little in its infancy. It needs a little bit more, you know --

DR PAGE: It needs a bit more working out, doesn't it, yes.

DR MOYLE: A better description of how they're actually going to manage it. They will get there.

THE COMMISSIONER: We've been to Dubbo and we've been to Wagga so I should know that, but is the main Dubbo public hospital and the Orange public hospital of similar size? They are slightly smaller than Wagga, would that be right, than the Wagga Base Hospital.

DR MOYLE: Yes, I think Wagga is bigger.

THE COMMISSIONER: But they are still doing similar procedures?

DR MOYLE: Yes they are doing good volume of practice. Again it's very general. They may struggle a little more for paediatrics than Wagga and Albury do.

THE COMMISSIONER: Looking at - again for either of you - 23 of your statement where you're talking about the nature of the recruitment process hindering workforce --

DR MOYLE: You've got the two co-chairs of the centralised recruitment working party here.

DR PAGE: How long have you got?

THE COMMISSIONER: I was going to ask you can you expand

upon what you see as the problem there including what you say is this massive duplication of work? Either of you, feel free.

DR PAGE: I was going to chip in earlier, sorry, Commissioner --

THE COMMISSIONER: No, please do.

DR PAGE: -- and just sort of say that you were asking a question about why does Queensland train more GP anaesthetists than New South Wales does. I think part of the problem that New South Wales has is its size, and over time, everybody's kind of grown and done their own thing individually, whereas if you look at all of the other states and territories in Australia, the total number of trainees is much smaller and the total number of training sites and schemes is much smaller, and therefore, it's just much easier, when you've only got two or three or four, or in some instances only one scheme, to organise, it's much easier to then organise training within that one or two schemes.

When you look at 12 in New South Wales - and they've all, over time, developed their own affiliations and training rotations and who they send where for what - trying to bring them all together on the same page makes herding cats seem like child's play. It really is very, very challenging and the numbers are just absolutely --

THE COMMISSIONER: That's an organisational problem you're identifying?

DR PAGE: It is, and that's what you see with annual recruitment. So each year you will have, you know, of the order of 350, up to 400, people applying for an anaesthesia training position in New South Wales. Each one of those individuals can only obviously occupy one job. But they know the competition is fierce, so they apply to every single tree and lamp post across the state, and interstate as well. So each year, the hospitals - each individual training site receives an application from almost all of the applicants. So, you know, to get 300, 320, 350 applications is not at all unusual.

So each training site then has to go through the CVs and the written applications of all of those applicants,

but we all know that they've all applied everywhere.

So if we have 10 jobs arbitrarily, we can't just interview 10 people, because we know that those 10 people will want to go elsewhere. So the law of averages tells us that we need to interview roughly four people per position that we have. So you have this frenetic amount of work to shortlist a number that is going to give you enough people that want to come to your hospital that so you can fill your training jobs. So there is this huge shortlisting process, this huge interview process. Everybody's interviewing everybody else, the workload for the applicants is insane, you know, they're putting in 20, 25, 30 applications, because they will apply to the scheme hospitals and then they'll apply to all of those hospitals that just offer an independent 12-month position as a back-up in case they don't get a scheme job and then they'll apply interstate as well. And we have really tried, Michelle and I, to get this whole process centralised so it's --

THE COMMISSIONER: I've got to say, I think where you're going now is paragraph 29 of your statement where you're suggesting a centralised recruitment process would massively --

DR PAGE: Absolutely.

THE COMMISSIONER: How would that work? Tell me.

DR PAGE: So the sticking point that we've got to is the administrative burden. So in the conversations that we've had with NSW Health, they've been very keen to go down the avenue of centralised recruitment and have been very keen to show us examples of where that's worked and worked really well, and the problem is that they've shown us examples of subspecialty disciplines where they've maybe had a total number of 20 or 25 applicants per year across the state. So they say, "It's really easy. You just give all of the admin role to a workforce department in a hospital, and they hold that admin role for three years and then they hand the baton on to somebody else." And we've been saying, "You can't do that when the number of applicants is of the order of 350 to 400. You will break hospitals." It's just that simple. You cannot expect that amount of organisational effort.

THE COMMISSIONER: Have you had that conversation with health? When you say, "You can't do that because the so numbers are so much greater", what's the response from NSW Health?

DR PAGE: "Oh, but it's worked brilliantly in the past", and we're going, "Yes, but it has worked brilliantly when you have got 20 to 25 applicants." I think that they were beginning to see that that was what was necessary.

We've then had the post-COVID rush to catch up all of the elective cases; we've just not been able to get to this piece of work. I've tried reaching out a couple of times in the last few months to New South Wales to the workforce department that we were speaking to before, but I'm just getting radio silence. I'm not sure if the people that we were talking to previously have moved on into other roles. But I'm trying to get in touch with them again to restart this conversation.

THE COMMISSIONER: All right. Is there anything you want to add?

DR MOYLE: Yes, I think there are a number of issues with centralised recruitment. It's a difficult process. There's no clear obvious way to do it. Frances and I have discussions with our colleagues in the NHS because they have a centralised process for anaesthesia for their entire country. They actually have a separate recruitment agency that manages all of that. That's not - that also is not perfect because they've just stuffed up the - there's industrial litigation because they made some mistakes with the data entry.

THE COMMISSIONER: I'm sure the new government will fix that.

DR MOYLE: So, you know, it's very complex, it requires separate dedicated funding and a unit that's motivated and knows what they're doing, I think, and that's a really big job.

There doesn't - even though the people that we spoke to in medical workforce at ministry, they were very keen to help, but they didn't have any authority to determine either a location for these processes to occur or a funding source.

I think it is a really big problem in terms of lack of transparency to the actual candidates who are applying, and I think that there's growing frustration amongst those young people who are trying to get specialty positions.

THE COMMISSIONER: The lack of a centralised agency or body is part of the problem for a lack of transparency; is that --

DR MOYLE: I think so. I think because it's individual hospitals that are doing their own recruitment, everyone's drawing from the same pool of 300 - 300 plus, and so clearly no individual hospital can interview the number of people that truly deserve to get an interview.

THE COMMISSIONER: Yes.

DR MOYLE: So there's a lot of creative culling that goes on and, you know, you can have people - so at the moment there is a preference matching of sorts, but it's overseen by the heads of department at a meeting, in a dedicated meeting, which is next Monday. So we're all exhausted because we're trying to do our clinical work, we're trying to do this, we're --

THE COMMISSIONER: Would a centralised body aid the consistency of approach?

DR MOYLE: I think so. I think all of the candidates who are eligible for consideration should be offered an interview and that currently doesn't occur. Also we did a survey of hospitals looking at how many individual hospitals actually advertise - how many people they interviewed and how many trainees were offered whatever number of interviews. So there were a large number of people who were offered an enormous number of interviews, and those people tended to be the trainees who actually didn't get a scheme job or offer in the first round, and then had to apply to more hospitals, multiple hospitals, and they had multiple interviews but didn't get a spot. So there were some people who only had one interview and got a job. Clearly, you know, they are outstanding candidates probably in the hospital that they applied. And so you have applicants with very similar CVs, very similar experience, probably very similar ability, and one may get a job and one might not even get an interview.

THE COMMISSIONER: Is there anything you wanted to add to that response?

DR PAGE: Sorry, who is that question - is that question addressed to me?

THE COMMISSIONER: Yes, sorry.

DR PAGE: Yes, look, I think that the lack of transparency is a problem for the regional and rural hospitals that have accreditation for mostly one year. So they will appoint somebody for a year, they get a year of accredited training, but because that individual is not personally known, because they've worked outside one of the metro scheme centres, it is - you know, there is unconscious bias that comes into the selection process.

We try to be as non-biased as possible. That's not possible for human beings, and I think the way the system is contrived makes it disadvantageous for those individuals who have done an independent year at a rural or remote site. And that then becomes a bit of a vicious cycle, because if those trainees can't progress in their training because of the biases within the system, then word gets around very quickly and those hospitals are not preferenced very highly because the trainees want to go somewhere where they can be more assured of training completion.

THE COMMISSIONER: It's defeating the purpose of having this sort of scheme of doing some rural training.

DR PAGE: That's right. And therefore the trainees who end up at these rural and remote hospitals tend to be the ones who, you know, are just not the strongest performers and so we go round and around and around the loop. I think that's where a lot of the lack of transparency, lack of clarity, lack of openness comes in. There's all sorts of urban myths that then get generated out of that which are just fanciful.

THE COMMISSIONER: All right. If you want to pick this up, are you going to ask some questions about the award?

MR FULLER: I'm happy for you to ask your questions about that, Commissioner.

THE COMMISSIONER: It's just that it's mentioned in paragraph 30.

MR FULLER: I will come to it.

THE COMMISSIONER: Okay. I'll let you go. You go ahead now.

MR FULLER: Thank you, Commissioner.

Just on that answer you just gave, Dr Page, you referred to independent positions or trainees, can you just explain for us what that means?

DR PAGE: Sure. So it's a term that we use to describe somebody who is not in a four-year scheme position. So if you have applied for a position in a hospital that can offer all of the core training and you're given a four-year contract, that contract - the hospital is saying to the applicant that they can provide access to all of the experience required to complete core training.

If the hospital is accredited for less than three years and doesn't have the ability to offer the applicant access to all of the training requirements for core training, we would term them an independent trainee. So they can continue and complete all of their requirements with a one-year contract here and another one-year contract there and so on and so on, but it gets progressively more difficult the further into training they get because there are very, very few, if any, independent jobs that would cover the bottleneck SSUs.

MR FULLER: Just coming back to paragraph 29 of your statement, which the Commissioner asked you about, you say in there as well that a centralised recruitment process could be contrived to incentivise independent positions. Can you just elaborate on what you mean by that, please?

DR PAGE: So the last meeting that we had, we had sort of talked about how we might use a centralised process to encourage progression of independent trainees into completion of their training, and one way that we could do that is by requiring, for example, six months of anaesthesia training prior to getting a scheme job. What that would mean is that, all of a sudden, all of the independent jobs across the state would be very, very

popular with everybody, because that would be the clear stepping stone into anaesthesia training. So that would be a way that we could do it, if we had a centralised process that everybody subscribed to.

MR FULLER: Does the college otherwise have any influence over the number or distribution of independent training positions?

DR PAGE: No, and it has very little oversight or very little vision on where those jobs are, so that - and they have grown up as a consequence of workforce needs locally, so that if a site is accredited and it's got need for expansion of its workforce, it just expands the numbers, but the college has no vision of what those numbers actually are.

MR FULLER: You've mentioned having very little vision and I think in one of your earlier answers you also mentioned the college not having easy vision of the service development needs throughout New South Wales, for example. I take it you see that as a significant issue?

DR PAGE: Well, I guess it depends on what the college wants to do or what people think the college should be doing. There's lots of questions around the college's role in the better distribution of workforce, the better distribution of trainees across the state, but that's not really what the college is for, and the college, even if it took a view that it should step into that space, it doesn't have the information that it needs to be able to do that. So it's a little bit of a moot point. Does that answer your question?

MR FULLER: Yes. Dr Moyle, do you have anything to add on that topic?

DR MOYLE: No.

MR FULLER: Commissioner, I'm about to move on to another topic and I note the time.

THE COMMISSIONER: That would be a convenient time.

Dr Page, we're going to have a break now, a mid-morning break. You don't have to sit in front of your screen while that occurs. So if you could just come

back to your screen at 11.50, that's when we're going to resume.

DR PAGE: 11.50, no problems, thank you.

THE COMMISSIONER: We'll adjourn until 11.50.

DR PAGE: Thank you.

SHORT ADJOURNMENT

THE COMMISSIONER: Yes, Mr Fuller.

MR FULLER: Thank you, Commissioner.

Dr Moyle and Dr Page, I'm going to move on now to ask you a few questions about the college's accreditation process. Starting with you, Dr Moyle, is it right to say that the accreditation standards are developed by the college?

DR MOYLE: Mmm-hmm.

MR FULLER: Who within the college develops them?

DR MOYLE: So you might be best to direct this question to Frances, because Frances is actually on the trainee accreditation committee.

MR FULLER: Thank you.

Dr Page, do I take it from Dr Moyle's answer there's a training and accreditation committee that's responsible for the standards?

DR PAGE: There is a training and accreditation committee and I've done some accreditation work on behalf of that committee. So the committee exists and it applies the accreditation standards that you would have seen in the handbook.

MR FULLER: What do you view as being the function of the accreditation standards?

DR PAGE: It's to provide a benchmark of safety and quality training to ensure that those minimum standards are met across all of the training jurisdictions in

Australasia.

MR FULLER: In terms of providing a benchmark for safety, does that go beyond the issue of whether a site is an appropriate one for a trainee to be able to receive their specialist training? In other words, does it include setting broader professional standards for the operation of anaesthesia departments in New South Wales, in your view?

DR PAGE: That's a difficult question to answer because it's a little bit chicken and egg. If you're not providing anaesthesia in a safe, appropriate environment, it's probably not a good place to have trainees in the first place. You don't want to be teaching people how to provide unsafe anaesthesia; you want to be able to teach people what is a good way of providing anaesthesia that you achieve adequate anaesthesia for the procedure to be undertaken and the patient receives their - the most appropriate quality care that they can for whatever their particular needs are. So I'm not sure I can answer that question, you know, sort of categorically. They're hand in hand with one another.

MR FULLER: Dr Moyle, do you have anything to add on that?

DR MOYLE: Yes, look, I think if you're an individual department about to undertake accreditation, this occurs on a five-year cycle and it's fairly clear the sorts of things that you have to achieve, benchmarks that you have to achieve. I think it is a very good opportunity for people to stop and make sure that the various requirements are in place.

You know, in an operating theatre, for example, there are a lot of people outside of - not just anaesthetists, obviously, and they are involved in ensuring that facilities meet the standards. Just, for example, the availability of cognitive aids, for example, for emergencies. So these are things that don't - you know, they're always set up in good faith, but pilfering occurs from various areas and so occasionally you might not - you go to find the box for treatment of malignant hyperthermia, for example, and some of the required pieces might not be there. So although checks and balances occur on a regular basis within a hospital, I think the accreditation visits are an opportunity just to take stock and make sure that everything is up to date and as it should be.

So I think it's also a reminder about trainees and your teaching and training programs. During the pandemic, for example, it was - you know, everything sort of fell apart, really, and the emphasis was on direct patient care rather than - I think trainees started to miss out a little bit so it's another moment to stop and recollect and reset.

MR FULLER: Do you think it's appropriate for the college as the entity that's responsible for accrediting training, effectively, accrediting in the context of training, to use the accreditation process to look at broader issues of safety and professional standards?

DR MOYLE: I do. Although that's not formalised, that does occur in practice. For example, as I said earlier, anaesthetists are involved in much more than just the operating room, so our reach extends well beyond that, and there's been an explosion - the pandemic made it worse - of, say, patients who are waiting for elective endoscopy, you know, bowel screening programs are in place, and those endoscopy centres are often separating from operating rooms, and so it's been an opportunity for many hospitals for their anaesthetic departments and the gastroenterology departments to get together to determine what is the minimum safe staffing requirement, for example.

With more and more patients having deep sedation or full anaesthetics in the endoscopy room, you know, there is a requirement, a high-level requirement for equipment, for example, and resources. So I know that that has been a big issue in many hospitals. So yes, in an informal way, it does extend into other areas.

MR FULLER: And your view is that it is appropriate to be done --

DR MOYLE: Absolutely.

MR FULLER: -- by way of the accreditation standards for training, effectively; is that right?

DR MOYLE: Yes, I think the accreditation is a mandated thing, and so we have to meet - and it becomes - the thing that I'm thinking of in my own head is, you know, just the allocation of anaesthetic nurses, dedicated anaesthetic nurses to the anaesthetists in the endoscopy room, for

example. You know, when you've got resource shortages and funding shortages, there is a - you know, people interpret the guidelines in many different ways and the college accreditation standards have been very helpful in ensuring that the appropriate staffing is dedicated to that area.

MR FULLER: We might just have a look at the college's accreditation standards on that particular --

DR PAGE: Can I just - sorry, may I just add in one other comment?

MR FULLER: Yes, please.

DR PAGE: Just to make the observation that I think any healthy organisation would welcome the opportunity for a little bit of self-reflection, whether that's an individual department or whether that's the whole of the hospital or whether it's completely outside of health, and I think that that's one of the things that TAC, the training and accreditation committee or the training and accreditation process offers.

I think also informally it offers the opportunity for anaesthetists to talk with one another, from different hospitals. So in anaesthesia we very much work in silos of single individuals. I very rarely get to see what any of my consultant colleagues are doing, because if I'm in theatre, they're not with me, and vice versa. Whereas the groups of accreditors, usually three or four, so small groups of people who come to an individual hospital on a planned basis, they are dealing with the same real world issues in their own hospitals as the site being accredited is managing. So you can just have informal conversations with the accreditors about "How do you manage this?" You know, "What are your workarounds for this particular problem?" And I think those can actually be incredibly supportive and incredibly helpful to heads of departments, supervisors of training, trainees and just the wider anaesthesia department. Sorry to interrupt.

MR FULLER: No, thank you. In practice, though, it is the case that sometimes those informal conversations or usages of the accreditation standards can rise to the level of, for example, withdrawing accreditation or imposing conditions on accreditation?

DR PAGE: No. No, so the way the report comes back to the individual hospital, TAC talks about above and below the line recommendations, so that something which is considered above the line is something which is a clear breach of one of the accreditation standards and is problematic and is something that TAC will pursue with that accredited department to try and find a resolution to it.

Something that is below the line is something that is of recommendation to the hospital, recommendation to the particular department, but is not something that TAC is going to mandate or pursue. And then during the course of the visit, the day, the two days, however long TAC is actually at that particular site, there will be other conversations that will happen with the various different people that TAC meets with, which will never make it to a piece of paper, but are just offered in the spirit of collegiality, "You might want to try this", or "We've had some success with ... "

MR FULLER: But if, for example, on a site visit, the college inspection team observed what it thought was a significant breach of safety in a particular - in the department, is it the case that the college may take some sort of accreditation-related action in relation to that, even if it didn't have a direct impact on the training of trainees in that department?

DR PAGE: Ultimately, that's the final stick that the college has got to wield, but in practice, that doesn't very commonly happen, and it certainly doesn't happen without plenty of lead notice. So, for example, I went to New Zealand for a three-day visit, to three different sites in New Zealand, last month. One of those particular sites has been having an annual visit, every year.

Next year will be the start of their new five-year cycle and it's an unusual situation because they've still not signed off all the problems that were identified five years ago. So the college has gone back every year and is still talking to them about the same above the line issues that they're not managing to resolve, but is still working with them to try and get resolution to those issues, but hasn't taken - hasn't withdrawn accreditation.

So it could do it, but it chooses not to because it's more beneficial for everybody to try and fix the problems

rather than just chuck the whole sort of system out.

DR MOYLE: Within the last 25 years there's been no hospital that's lost its accreditation from the college of anaesthetists, in New South Wales. There has been one in Victoria and there was one in New Zealand.

MR FULLER: Yes. Thank you.

Before I move to the standards themselves, Dr Page, do you agree, as a general proposition, that the accreditation standards should be outcomes based and evidence informed?

DR PAGE: In an ideal world, yes.

MR FULLER: When you say that --

DR PAGE: It can be difficult to get that evidence and information but yes, in an ideal world.

MR FULLER: What's the cause of those difficulties?

DR PAGE: Sometimes it's the mechanisms that we have. If you look at hospitals globally, I think, but any hospital in New South Wales, we're all awash with data but very little information in any of them, and so some of the processes that we have for collecting the data and some of the particular data points that we collect don't necessarily give us a lot of information in terms of how we move forward.

MR FULLER: Do you see there being any conflict or potential conflict in the fact that accreditation standards are developed by the fellows whose sites are, in turn, going to be subject to those standards?

DR PAGE: I can see why somebody might argue that but I think in practice that's not the case. Of course it would be the case if I was accrediting my own department, that would clearly be a nonsense. But I don't accredit my own department. I can't. I can only go and accredit other people's departments, and I can't go and do that in isolation. So I go with a couple of other colleagues, and there is a discussion throughout the time that we are at the site that we're accrediting and there is a requirement to reference any issue that we raise with the particular accreditation standards. So I can't unilaterally just take

a dislike to somebody or somewhere and create a problem for them.

MR FULLER: The requirement that you can't participate in accrediting your own department, is that a guideline or policy that the college has put in place?

DR PAGE: Yes. Yes.

MR FULLER: Am I right in thinking that the college's accreditation standards, they need to comply with standards that are developed by the Australian Medical Council; that's right?

DR PAGE: Yes, to the best of my knowledge, that is. Clearly the college can't have standards that conflict with national health standards, no.

MR FULLER: Are you familiar with the Australian Medical Council standards for accreditation for colleges such as yours?

DR PAGE: Not in detail.

MR FULLER: Your college's accreditation standards don't need to be approved by any external body; that's right?

DR PAGE: I'm not sure that I can answer that question.

MR FULLER: When the committee, the training - sorry, let me step back. The training and accreditation committee that you're part of, is it involved in developing the college's accreditation standards as well as overseeing the inspections?

DR PAGE: Yes, I should be clear, I volunteer, offer my services, to be a training and accreditation visitor. I am not actually on TAC; I'm not actually on the committee. I can attend their meetings if I request and they agree, but I'm not part of their committee. My understanding is that they will work with the wider college to develop the training and accreditation standards, and I'm sure somewhere along the line those will be reviewed by the process that reviews the whole of ANZCA's existence and execution of its business, but the detail of that I'm not familiar with.

MR FULLER: Dr Moyle, are you --

DR MOYLE: There was a review of the college's - certainly the training, I'm not sure if the accreditation standards were part of that or not, but certainly the training program and trainee selection - everything to do with trainees, basically - within the last two to three years, AMC, I know that Frances and I were both involved in that from - because they interviewed members of the New South Wales regional committee. There were no issues identified.

MR FULLER: Are you familiar with the National Health Practitioner Ombudsman report at all?

DR MOYLE: I have skimmed it. I can't say that I could Remember it.

MR FULLER: One of the recommendations of that report was that the --

DR MOYLE: The Kruk report? No, a different one?

MR FULLER: Yes, a different report. But leaving aside the report, you can take it from me that it's been recommended that the AMC develops a procedure for colleges to follow when developing their accreditation standards. Do you think that is a good idea?

DR MOYLE: Yes, I think a national body that oversees all colleges is - that's got to be a good idea. I know that the executive of ANZCA are in constant contact with the AMC and - yes.

MR FULLER: That's not something you're involved in?

DR MOYLE: We don't get involved in that aspect.

MR FULLER: Dr Page, do you agree that, in principle, it would be a good idea for a body such as the AMC to have a procedure in place for colleges to follow when developing their own accreditation standards?

DR PAGE: It makes sense to have that sort of consistency across the board, absolutely. I guess it just depends on the detail in that process and exactly how much the AMC would be controlling of that process. I mean, clearly ANZCA knows more about anaesthesia training than the AMC

does, so it's just about where you set that balance point, I think.

MR FULLER: So your concern there is that ANZCA is the one with the specialised knowledge about how anaesthesia training should be delivered; is that right?

DR PAGE: I think it's got much more knowledge and experience for the nuance that's required in there, and because I'm not familiar with the detail of what the AMC procedure is, it sounds like a sensible idea but I would be sort of loath to sort of say, "Yes, go right ahead" until I've actually seen the detail of it.

THE COMMISSIONER: Would this be - again for both of you, Dr Page and Dr Moyle - a fair summary of your opinions, and please tell me if it's not, or if you want to clarify or elaborate or disagree: regardless of the exact processes for accreditation, including withdrawal of accreditation, you would both, I think, agree - tell me if you don't, but I would imagine you would both agree - that, and by "processes" I mean a form of natural justice where the site has the right to know the issue or the problem; that there's a period to respond, that there's appropriate time and protocols to give a proper response and appropriate protocols and time to address any issue.

DR PAGE: Mmm-hmm.

THE COMMISSIONER: But leaving that aside as to the exact mechanics of that process, your opinion is, is it not, that the involvement of your college in an accreditation process, one, adds a layer of expertise that you hold?

DR PAGE: Mmm-hmm.

THE COMMISSIONER: And, two, for want of a better expression, avoids a site marking its own homework.

DR PAGE: Yes.

DR MOYLE: Yes.

THE COMMISSIONER: And therefore provides a mechanism, through your involvement, of the maintenance of proper standards. And by "proper standards", I mean safety standards as well as a safe and hospitable workplace. Is

that --

DR PAGE: Yes.

DR MOYLE: Yes.

THE COMMISSIONER: -- a fair summary, all of that? Is there anything you want to add, either of you? Dr Page first, anything you want to add?

DR PAGE: No, I think that's a very fair summary and I think that's a pretty accurate description of what currently happens with TAC.

MR FULLER: Dr Moyle?

DR MOYLE: Yes, I agree.

MR FULLER: Are either of you familiar with the way in which the college system operates in the UK at the moment?

DR PAGE: I trained in the UK but I left there 20 years ago. So are you talking about accreditation in the UK?

MR FULLER: Yes. Please, go on.

DR PAGE: There is an accreditation process but I left the UK as my training had completed and I was just becoming a consultant. So I would not have had any opportunity as a trainee to be involved in accreditation in the UK. But I've experienced accreditation in the UK and it's not wildly dissimilar to the experience in Australia in terms of a nuclear group of consultants from different hospital sites coming to visit, talking to staff members, seeing the facilities and then having conversations with supervisors of training, heads of department and presumably the executive of the hospital, though I would have never seen that in the UK.

THE COMMISSIONER: For all I know, what you've just said might well be right. There was evidence given yesterday by Professor Hockey, I think, that suggested there was a reform about 10 years ago. I have to admit I'm not up to speed as to what that reform is. I have requested something be done. I don't know whether Mr Fuller has a better idea.

MR FULLER: Can I maybe ask the question in this way, Dr Page: at the time you were subject to the accreditation process in the UK, do you know whether that process was performed by the colleges or by some central body?

DR PAGE: By the colleges, to the best of my knowledge.

MR FULLER: Thank you.

THE COMMISSIONER: That was what Professor Hockey suggested might have changed about 10 years ago.

DR PAGE: Yes, and that may be consistent with centralisation of recruitment and quite a lot of organisational change that has happened in the UK. But that's all happened since I have left there, so please take what I'm saying with a large grain of salt.

THE COMMISSIONER: I mean, I don't know what this reform is. I doubt very much, though, that it just involves a site deciding whether it will be accredited or not.

DR PAGE: No, no.

THE COMMISSIONER: I'm sure there's a more in-depth process than that, but we'll find out what it is in due course.

DR PAGE: The UK has moved very much more centrally organised rather than individual hospitals doing their own thing across all of the training. I'm absolutely sure that they wouldn't have individual sites ticking themselves off, marking their own homework.

MR FULLER: Dr Page, what would be your reaction to a proposal that the colleges' roles in Australia should be limited to setting curriculum, standards - curriculum and standards for training programs and examining trainees, with the accreditation function instead performed by some central body, separate from the colleges?

DR PAGE: I would worry that there would be a lot of support lost. Accreditation visits are principally designed to support departments and to support the trainees within those departments and offer an opportunity, as I say, for feedback and for working out local issues. I think if you've got a separate accreditation body that

has got, if you like, a tick sheet, you know, "Is this particular device in place, is this particular process in place", that side of things can be very easily achieved, but some of the nuance will get lost. "How do you find the quality of the teaching that you receive in your department? Does it happen when it should? Is it pitched at the level that you need it to be pitched at? Can you get workplace based assessments achieved when you need to?" Some of those much less discrete questions that accreditors spend a lot of time asking I think would be very difficult to achieve with an external body that really doesn't understand what training is and what training looks like.

MR FULLER: Do you think those problems could be addressed by the external body receiving expert advice from, for example, anaesthetists who are fellows of the college, but ultimately the accreditation decision is made externally not at the college level?

DR PAGE: I actually think that would be incredibly difficult. One of the - probably the most important meeting of any accreditation visit is with the trainees and we try incredibly hard to sit face-to-face in the room with them. I'm cognisant of the loss or fidelity of our conversation by me being online and we do try and read the room as much as possible, and we'll go on a - you know, a digging exercise. You know, we'll sort of try and ask a very kind of open-ended question and then we'll pick up on themes that the trainees bring up, and normally that meeting with the trainees goes on for an hour, and you can really start to see a change in - you know, there's an anxiety within the trainees, "Who are the strangers that have come to the hospital?" "Are we in trouble?"

Then as they see, "No, they're actually here for our benefit", they tend to relax a bit and then they're actually much more forthcoming with information, and it's often in that second half of the meeting that they may become willing to share issues with us that they simply wouldn't have shared at the start of the meeting, issues around individual members of the department who might be bullying in their behaviour; issues around the quality of some of the training; issues around the timetabling of rosters - you know, all sorts of things come up in the conversations that then enable us to sort of have those conversations back with the head of the department, the director of medical services, the executive of the

hospital, in a de-identified way to say, "This issue has been raised", you know, "How do we move forward with it?" I think that would be really difficult to do with an external body.

MR FULLER: Why, if at all, do you think it's important for the college to be involved or mediate in that process rather than, for example, specialist anaesthetists being engaged by an external body to perform that inspection function? Why does the college need to be involved?

DR PAGE: Okay, so you're sort of saying could we take the college out of the equation --

MR FULLER: Yes.

DR PAGE: -- could you have some kind of external body that would just - you could do that. You could do that, absolutely. I guess there is a sense of I am part of ANZCA, I feel a sense of loyalty and obligation to ANZCA. I am prepared to give up some of my time to help facilitate that role, and now you are sort of saying there is another body that wants another chunk of your time and, you know, it's just how many people want how much of you. There is only so much of any of us individually that we can spread around over all of the different wants that exist. It could be done, I'm sure it could be done.

DR MOYLE: I think that's a very interesting question. Obviously our facilities, there are accreditation teams that occur across the wider facility. I think they focus on very different things to what our specialist colleges focus on. I think it's important that the college remains involved in terms of the oversight and setting of standards for training, and with accreditation, it's kind of part and parcel of that whole process. So I think when the college - the college's processes, when I was a trainee, were much less formalised, and I think that there was a huge difference between hospitals, because once the college became involved, it sort of set the bar, really, the minimum standard.

I think what that managed to do was elevate the performance of those hospitals that maybe weren't so great, in terms of what they had on offer for training and patient safety. I think that the college has definitely added to the patient safety aspect in a broader sense.

So yes, I agree that you probably could have one accreditation body, but I think it would be a very large group that would need to visit every hospital, and I'm not sure that's - like, the nature of anaesthesia is very specialised, and I'm not sure that that would necessarily serve us so well.

MR FULLER: Dr Moyle, just coming to the accreditation standards themselves, and I'll try to do this without showing them to you, some of the standards relate to the supervision of trainees. Are you familiar with that?

DR MOYLE: Yes, yes.

MR FULLER: Do you accept that those standards may have the practical effect of imposing minimum staffing specialist staffing levels for a particular site?

DR MOYLE: Not so much setting the number of minimum staff. I think more the - what I find that it does is that it makes it very - you know, there is no argument about which trainees need full supervision. So I think senior doctors are frequently on multiple after-hours rosters and, you know, they're busy people and there is a tendency to let trainees do their own thing. I think when you have very junior trainees, it's - when you have someone in their first six months of training, it's a really powerful tool to make people - like, there's no questions entered into. It's not up to the trainee to determine whether seniors come - get called in or not. So that doesn't affect the number of - the minimum number of senior staff. It does - and I think the number of junior staff should be set by the rosters that are in place. So I think the supervision levels actually are really helpful.

MR FULLER: It would be the case, wouldn't it, that if there was an inadequate number of supervisors for the number of trainees at a particular site, then the site wouldn't be able to be accredited; is that right?

DR MOYLE: You would - that's a tricky question. I think every site has to have an on-call, after-hours roster, with a nominated supervisor. I think, in practice, if there were fewer people in that site than would be ideal, the people who are there generally step up to cover more. So, yes - no, I mean, I'm not aware - actually, I am aware of

one site in New South Wales who didn't have enough people. I think it was not that they didn't have enough people; they didn't have enough people who were willing to come in.

DR PAGE: Can I --

MR FULLER: Does the college have - sorry, Dr Page.

DR PAGE: May I just make a contribution in that? In the handbook for accreditation there is a recommended ratio of the number of supervisors to the number of trainees. So there is a suggestion that an individual supervisor of training shouldn't be supervising - shouldn't have overarching supervision of more than five trainees.

I'm not talking about the day-by-day, one-on-one supervision whilst you're providing anaesthesia care, but a supervisor of training will have responsibility for ensuring that, over time, trainees meet their training requirements and don't fall behind on collecting the items of evidence that they need to suggest that they've got the experience that they should have got.

So in that sense, there is a ratio that's recommended, and that's partly to make sure that there is somebody that each trainee can talk to, if they're struggling with their training in some way, and partly to make sure that the burden of training responsibility isn't excessive on the seniors. I'm not sure if that was answering part of your question.

MR FULLER: It might be easier if I just go to the document. The document number is [ACA.0011.0007.0001]. I think we have a hard copy available for Dr Moyle and I think Dr Page --

DR PAGE: I can see it online. I've got a soft copy here.

THE COMMISSIONER: Can you tell me what volume of the materials it is in?

MR FULLER: I might just ask you to be provided with a hard copy at the moment. I'm not sure that it is --

THE COMMISSIONER: It may not even be in there yet. Okay, thanks.

DR MOYLE: Sorry, what number was it?

THE COMMISSIONER: It's on the screen.

MR FULLER: It's on the screen as well but I might just start at page 13 in appendix 1.

THE COMMISSIONER: So this is not in the tender bundle yet?

MR FULLER: I don't believe it is.

DR PAGE: Are you talking about "Summary of the criteria underpinning each ANZCA accreditation standard"?

THE COMMISSIONER: Mr Fuller is just engaged with one of the staff at the moment, Dr Page.

DR PAGE: No problems. My apologies.

THE COMMISSIONER: That's all right.

MR FULLER: I'm told it should be in H1.53.1.2.

THE COMMISSIONER: So it already is, all right. Yes, thank you.

MR FULLER: So it is. I'm sorry about that.

THE COMMISSIONER: Anyway, I've got it.

MR FULLER: Thank you, Commissioner.

Page 13, appendix 1. I might just ask - so there are seven standards for accreditation; that's right?

DR PAGE: Yes.

MR FULLER: And standard 1, "Quality patient care". You see on that page - and this standard is an example, isn't it, of what we were discussing earlier where some of the accreditation standards require compliance with relevant professional statements --

DR PAGE: Yes.

MR FULLER: -- and guidelines that the college has

established?

DR PAGE: Yes.

MR FULLER: Those professional standards and guidelines include ones relating to the general operations of the anaesthesia department?

DR MOYLE: Mmm-hmm.

MR FULLER: Is that fair to say?

DR PAGE: Yes.

DR MOYLE: Mmm-hmm.

MR FULLER: For example, if we have a look on page 14, one of the accreditation criteria is "adequate assistance for the anaesthetist", and that refers to a position statement?

DR PAGE: Correct.

MR FULLER: Dr Moyle, is this the standard that you were referring to earlier in relation to the assistant?

DR MOYLE: For endoscopy, yes, correct.

MR FULLER: It would be fair to say, wouldn't it, that standards such as these that we see in this document relate not only to the capacity for the site to deliver adequate training to a trainee, but also to setting broader standards about how anaesthesia departments operate in a hospital; is that - do you agree with that, Dr Moyle?

DR MOYLE: Yes.

MR FULLER: Dr Page, do you agree with that?

DR PAGE: Yes, that's right. It's about safety and it's about training.

MR FULLER: Thank you. Just going down, then, to standards 3 and 4, these are the ones that relate to supervision.

DR PAGE: Mmm-hmm.

MR FULLER: Standard 3, as I read it - tell me if I'm wrong about this - doesn't impose or require a specific ratio, it just requires sufficient full-time equivalent anaesthesia specialists; is that right?

DR MOYLE: Yes, yes.

DR PAGE: Correct. But the ratio that I was referring to I think is in the handbook for training, which is not a document that you're currently looking at.

MR FULLER: I see.

DR PAGE: So there's a handbook for training that would help inform departments about how they deliver training, what the different roles are within the department, so what a rotational supervisor would do, a supervisor of training, a departmental scholar role, a tutor, a fundamental tutor, et cetera, et cetera, and it also talks about, in there, a suggested ratio of trainees to supervisors of training and, as I say, that's to make sure that there's access - that the trainee has access to somebody that they can talk to about any issues related to their training and that appropriate sign-offs for particular chunks of time, so clinical placement reviews and so forth, can be done in a timely fashion, and to make sure that the supervisors themselves are not overloaded. It's not an inconsiderable amount of work that the supervisors of training undertake. And if you're trying to do it for 20 or 30 trainees, it's nigh-on impossible.

MR FULLER: And it's fair to say that the practical effect of limiting - of imposing these requirements for supervision - and this is not a criticism but just practical reality - is to limit the number of trainees who might be able to take up training positions at a particular accredited --

DR PAGE: No. No.

DR MOYLE: No.

DR PAGE: No, that's not true. You're not limited to the number of trainees that you put on at your hospital site. It's just that for every extra trainee that you choose to employ, you have to think about, meaningfully, how you're going to provide the training requirements for that

individual. So it's not simply about giving them a contract of employment, but you also have to think about how you're going to support them through their training, how you're going to support them on the floor, provide them with adequate supervision in theatre, how you're going to support them through exams, how you're going to provide appropriate classroom-style training as well as practical hands-on training, and how you're going to support them if they have a problem somewhere along the line.

MR FULLER: But just to understand it practically, the number of supervisors available at a given site would limit the number of trainees --

DR PAGE: I see it the other way round. I see it the other way round. The number of trainees would then tell a site how many more supervisors of training they needed to find. I don't think that the number of supervisors is the rate-limiting step. The more trainees that you have, the more people that you want to see involved with the supervision process. If you're a site that's got one or two trainees, you only need one supervisor of training. If you're a site that's got 30 trainees, from a practical perspective, you just can't do it with one or two supervisors; you want to have more so that, you know, when one's on leave you've got somebody else that can step in and just to sort of share the load.

MR FULLER: But if the site's position, rightly or wrongly, is that they either can't or don't want to engage any more supervisors, then the college's position would be that, well, that limits the number of trainees who should properly be able to be trained at that site?

DR PAGE: Yes, I don't think that that would ever occur. If you've got a hospital anaesthetic department, for example, that's got five specialists in it, you would never imagine that a hospital that is that small, that has that smaller need for anaesthesia service delivery, would ever be employing, you know, 20 trainees. The anaesthesia department in any hospital anywhere is the largest single department within that hospital, by far.

DR MOYLE: For medical workforce.

DR PAGE: There are 70 consultants in my workforce.

MR FULLER: Dr Moyle, do you have anything to add to that answer?

DR MOYLE: Yes. My interpretation of it, in a nutshell, the number of senior supervisors - so every senior doctor in any given hospital is - in a teaching hospital, is a supervisor by virtue of their position there, and the number of anaesthetising sites within that hospital, generally that will determine the number of senior staff that you would allocate on a daily. So there are usually far more supervisors within the remit of that department who actually aren't on site on any given day. So, you know, it would be very uncommon to have a lack of supervisors for the number of trainees.

In terms of the number of junior trainees that are in any given site, it is the - the minimum number would be those required to sustain an after-hours roster in the hospital. Some of maybe the smaller rural hospitals might not have anaesthetic registrars on site, but every city hospital would have at least one anaesthetic registrar on site 24/7, and that determines the minimum number of trainees.

There is greater scope for more junior trainees within each individual hospital on most occasions, because there's just plenty of work to do, but as Frances said, the anaesthetic department of any hospital is the largest medical workforce unit within that hospital, so, you know, the staffing costs, for example, of an anaesthetic department is about a third of the overall staffing costs. It's a lot.

So in terms of the college's supervision rules, they will have - there are, from a training perspective in terms of looking after the administration components of a trainee's experience, there will be five trainees to one supervisor of training. That's essentially an admin role.

On a day-to-day basis, the trainees require different levels of supervision depending on their seniority and their experience levels, and the nature of the patients that they are anaesthetising. So somebody in their first six months' training would have one to one supervision. There must be a senior member of staff with them at all times whenever they are delivering any patient care. And then, as they progress, it goes down a little bit.

The college has rules around the number of cases that any trainee can do, which are supervised. So as you get up to more seniors - obviously, 100 per cent of all cases are supervised for introductory trainees - by the time you get to your final year, the recommendation is that you have a maximum of 50 per cent of the cases that you do should be supervised. So really encouraging independent practice. In reality, the vast majority of provisional fellows would probably - well, you know, maybe 70 per cent of their cases, they would do independently, with a supervisor remote, not allocated to them in that theatre at any given time.

MR FULLER: Thank you. We can put that document aside, thank you. Finally on accreditation, in relation to monitoring compliance with these standards, Dr Moyle, I understand there are routine site inspections done as part of the reaccreditation process; is that right?

DR MOYLE: Yes.

MR FULLER: There might also be ad hoc inspections done from time to time of particular sites?

DR MOYLE: Rarely. If somebody - if a department is given a five-year tick of approval, the visit will be in five years' time. Usually it stretches out to that five years because of the vast number of departments that need to be accredited. If a site has an issue above the line, as Frances described before, that hospital will have a return visit within a year to see how progression is --

MR FULLER: It might be the case if a fellow or trainee at a particular site raises an issue, that the college will come in and conduct an inspection? Does that happen from time to time?

DR MOYLE: It's possible, it doesn't - from a practical perspective, it doesn't really happen that often. Yes, no, it doesn't really happen that often.

MR FULLER: I see. If a fellow or trainee does raise a concern with the college, what's the usual process of the college?

DR MOYLE: Generally it will go through training, the

training ANZCA team, and then it will get - depending on the nature of the complaint, it will be elevated usually to a director of professional - DPA, professional --

DR PAGE: Affairs.

DR MOYLE: Affairs, thank you. So there are a number of DPAs and they tend to specialise in either trainees or facilities or whatever, and when I was - certainly when I was the EO, they introduced the college policy on bullying and at that time any complaints that came in about bullying were directly referred to a DPA, who then liaised with the trainee who had made the complaint.

THE COMMISSIONER: Just tell me what DPA is?

DR MOYLE: Director of professional affairs, sorry.

THE COMMISSIONER: Thanks.

DR MOYLE: Then the CEO was actually informed as well. So it was recognised that perhaps the CEO was not the ideal person to be handling bullying complaints, because the trainees didn't feel comfortable with that, but I'm not sure how - when they get involved now.

MR FULLER: In terms of taking a bullying complaint as an example, is it possible for that sort of complaint to ultimately have consequences for a site's accreditation?

DR MOYLE: Definitely. Bullying and harassment are one of the top two things that TAC visitors will look for. The college makes inquiries of trainees directly to the trainee of any reports of that. I'm not aware of - well, I mean, heads of department would be involved only after there was an initial investigation by a DPA, for example.

MR FULLER: When the college is receiving complaints about things like bullying and harassment or other cultural issues, am I right in thinking that those complaints are usually being - are being received from its trainees and usually its own fellows; is that right?

DR MOYLE: Yes, the trainees and fellows are members of ANZCA. Yes.

MR FULLER: What process, if any, does the college follow

when it receives that sort of complaint to make sure that the site is given a fair opportunity to address it before any adverse action is taken?

DR MOYLE: I have no personal experience of what they do in reality, so I would refer you to - there's a policy there which was developed in association with the college of surgeons.

MR FULLER: Dr Page, are you able to assist us with that?

DR PAGE: I can speak to it from the perspective of a TAC visit that I did a couple of years ago when it became apparent through discussions with the trainees and with the senior medical workforce that there was an individual who was the deputy director of that particular department who was perceived as being quite bullying and controlling of many members of the department, senior and junior, and it was known that that individual was a close personal friend to the director of the department, so there was quite a lot of, you know, difficulty with how that was addressed.

The normal process with any TAC visit is any issue of concern that would be one of the so-called above the line issues is discussed with the director of the department, in the first instance, on the day of the visit, and is then discussed with the hospital executive subsequent to that, offering both an opportunity to correct any misunderstandings that the visiting team might have. The report is then discussed with the training and accreditation committee back at ANZCA before a letter is issued to the hospital. The hospital has an opportunity to address issues of factual inaccuracy with that letter before it becomes binding and the hospital is then given a time period in which to respond to whatever the issues are.

So the issue of bullying was raised with the head of department and with the director of medical services. It became formalised in a letter to the hospital with a requirement that the college received assurances, written assurances, from the hospital that the appropriate workforce processes had been executed to deal with that issue.

So it wasn't seeking, you know, blood or, you know, anybody's sacking, but just an acknowledgment and an

assurance that that had appropriately been dealt with through workforce, and that was what happened.

MR FULLER: Do you agree that in a context where the college is hearing these sorts of concerns from its own members, it is important for the site to be given a fair opportunity to respond to those concerns?

DR PAGE: Absolutely. I think natural justice is very important and I think everybody would support that. And I think that that's why the TAC process is contrived as it is, so that when the letter arrives, there should be no surprises in that.

MR FULLER: Can I come then finally to the issues of workforce shortages that you've raised in your statement. I will start with you again, Dr Page. In paragraph 15 of your statement you've referred to there being a severe statewide workforce shortage since 2021. Do you see that?

DR PAGE: Yes.

MR FULLER: I take it you mean workforce shortage of anaesthetists; is that right?

DR PAGE: Correct, yes. Well, there are probably other workforce shortages. I'm aware of the workforce shortage of anaesthetists. It seems apparent to me that there is a similar shortage in anaesthesia nurses, but that's not really something I've got full oversight on.

MR FULLER: Are you able to quantify "severe" in any way?

DR PAGE: I can only quantify it by the number of sessions that we're cancelling. I've been working here on the coast for the last two decades. I can recall one session that we cancelled due to lack of anaesthesia workforce prior to the COVID pandemic. We're regularly cancelling two, three, four sessions a week as a result of having insufficient numbers of anaesthetists to cover the lists.

THE COMMISSIONER: Is that what you've referred to in paragraphs 110 and on?

DR PAGE: Sorry, I'll have to find paragraph 110.

THE COMMISSIONER: That's all right. It's on page 17 of

29. Is that what you were referring to?

DR PAGE: Yes.

DR MOYLE: That's one of the aspects.

DR PAGE: Yes.

THE COMMISSIONER: Sorry, I interrupted. Go ahead.

MR FULLER: Thank you, Commissioner.

Do you have a sense, Dr Page, of what's changed since 2021 to give rise to the shortage?

DR PAGE: I think lots of things. I mean, obviously during the pandemic we stopped doing elective surgery and so there was a large build-up of elective surgical cases that the state government's been very keen to see brought back under control again, and has been very keen to see that happen in a very short time frame, and the hospitals are struggling with capacity to do that.

I think what we're also seeing is there's definitely been an increase in presentations to emergency departments across the state. There's been roughly a 15 per cent upkick in emergency departments, which has been persistent even after we've all got back to work again, and the thinking is that there are probably a significant proportion of the community who have chronic health problems, who maybe haven't looked after themselves as well as they possibly might have during the pandemic, who might not have seen their GPs as regularly or in that kind of face-to-face capacity that they might otherwise have seen their GPs, and so those chronic health conditions might have spiralled a little bit out of control and some of what we're seeing might be the complications or the progression of those disease processes.

I think we're also seeing patients who are presenting later, and that's probably a similar effect, that patients may or may not have noticed symptoms but haven't addressed those with their general practitioner and are therefore presenting later, so we're seeing patients presenting with more advanced forms of disease, more advanced cancers, more, you know, cardiac and respiratory disease. So I think all of that is creating a significant increased

burden of work. If your cancer has grown bigger and has spread further by the time it is addressed, the intervention that you need both medical and surgical is more aggressive and takes longer to achieve.

THE COMMISSIONER: Is what you're identifying there, at least in part, a problem at the level of primary care, which then has repercussions for the care provided in the public hospitals?

DR PAGE: Some of it is, yes. Some of it is, absolutely, a problem with primary care. I have an impression that it is more difficult to see a GP now than it was before the pandemic; that GPs may be in shorter supply than they were beforehand. That's not really something that I'm qualified to pass judgment on, but that's what it seems as a consumer.

THE COMMISSIONER: I know, but as a specialist, your impressions may not be precisely supported by a peer-reviewed academic analysis, but they might also have a degree of accuracy that's sufficient for our purposes.

DR PAGE: That's certainly what it feels like.

THE COMMISSIONER: That's the impression you're getting?

DR PAGE: Yes, very much so. I think there has also been a change in the workforce. I think some people have chosen to step back a little bit, have chosen maybe to retire earlier than they thought they would. So I think, on that side of things, there's also been a diminution, you know, of the available numbers of hours that anaesthetists have - in some instances, not in all.

MR FULLER: Dr Page, given what you perceive as being the --

THE COMMISSIONER: Sorry, can I just - my apologies.

The impression that you just talked about, I assume - and I'd like to hear from you, Dr Moyle, about this as well. The impression that you were just talking about, Dr Page, I assume - tell me if I'm wrong - it's not just informed by your own experience and what I'll call your own practice; I imagine it's an impression that's also informed by discussions with your colleagues?

DR PAGE: Absolutely. And there was a heads of department survey that was conducted by NSW Health February time this year, and we're still waiting to see the detail of that come out to those of us that answered the report, but many of us have discussed our answers that we put in that report and it feels that there's a pretty uniform sentiment across the board.

THE COMMISSIONER: Is there anything you wanted to add to that, Dr Moyle?

DR MOYLE: Can I just clarify, was the question about why the increased demand or why the shortages?

THE COMMISSIONER: It was why the increased demand, whether primary care or lack of availability or lack of use of primary care has a role in that.

DR MOYLE: So I think I agree with what Frances said about the increased demand of services. Certainly I think it's all sectors have been affected.

From the point of view of the number of anaesthetists available to provide services, I was involved with the team at central ANZCA in Melbourne about looking at the number of people who actually retired during or as a result of the pandemic, and there was a small uptick in the number of people who retired. But certainly not enough to explain the shortages that we were all feeling across the city.

There has probably - there has been a big - possibly those retirements that did occur were predominantly in the private, and so it appears that the floodgates in the private hospital sector have opened quite widely and there was a lot of work directed to the private, which resulted in basically mass exodus from the public sector.

So the people who are left to work in the public sector, essentially staff specialists or VMOs, the award reform, or lack of award reform, or change, has certainly decreased the FTE of staff specialists within each department. You know, my source for that is heads of department group that we all meet regularly and we talk to each other and every single hospital has experienced exactly the same decrease in FTE. So it's the people who - the staff specialists who are there are leaving and there

is no - like, no-one is putting their hand up to become a staff specialist.

So a lot of those staff specialists are still within the system but now employed as VMOs, and so they're contracted work. So I know that in every other hospital, and my own, the number of VMOs that we actually have on the books has, like, exponentially increased, but that hasn't resulted in more people being in the public hospital. So there's plenty of work outside of the public hospital sector and the remuneration for that work is much higher in the private sector and as VMOs.

So it's a real problem. I know that there are - as we talked about before, anaesthetists' presence in other places other than the operating theatre has meant that, you know, we're pulling people into the operating theatre to deliver anaesthetic care who would otherwise - may have been involved in out of theatre care, including, you know, representation on multiple committees across the hospital, I think training and teaching are in danger of being, you know, severely affected. It certainly seems to have - anecdotally it seems to have improved, but that change in what the workforce looks like has been very significant.

THE COMMISSIONER: You used the term "award reform" during the course of that answer.

DR MOYLE: Yes.

THE COMMISSIONER: We're obviously well aware, as an example, of the staff specialists award. Staff specialists in New South Wales don't appear to have salary parity with colleagues interstate, and whether that's sensible or not, is something that this Inquiry will address at some stage.

DR MOYLE: That would be good.

THE COMMISSIONER: But beyond that, beyond salary parity, is there anything else you want to refer to in relation to award reform?

DR MOYLE: There's been no significant changes to the award in well over 34 years. I think fatigue management - obviously the base rates of pay, et cetera, paid on call, paid after hours attendances for anaesthesia, we really feel that, because when we get called in, we're in there

for a long time. I think that would make a significant difference.

I think also in other states the conditions of that, so if you've been on call overnight you get - you know, your next day is allocated at home. At the moment, the shortages mean that we - you know, if you're there until 4 o'clock in the morning you stay on and you start your list at 8 o'clock in the morning. So clearly that's not in the best interests of patient safety. Each individual department has to manage that in whatever way it can.

So sometimes, that means the list gets cancelled. Sometimes, it means that you maybe have to move the deck chairs a little, and sometimes, you know, it just means that it just flows on and everybody feels it and the rates of burnout, et cetera, are much higher.

THE COMMISSIONER: Is there anything you wanted to add to that, Dr Page?

DR PAGE: Yes. I just would say that in the absence of award reform and with the dwindling numbers of people wanting to take up staff specialist positions, it really undervalues what we can bring in the clinical - sorry, in the non-clinical sphere or the clinical support sphere, whatever you want to describe it as.

The involvement that anaesthetists can have in the wider working of the hospital developing services, ensuring the smooth running of services, the efficient running of services, developments in techniques and so forth, because of the involvement that we have with so many other departments, we're actually really well placed to do that.

In a VMO model, because it's a fee for service model, there is relatively little involvement of VMOs in that administrative workload of the hospital. There simply aren't enough staff specialists on the ground to have involvement of staff specialists in all of the areas that a hospital would want. And so over time you just see that fracturing of the service, because the problems aren't identified and addressed early on. And I think that that's where we're at at the moment.

MR FULLER: Dr Page, when you referred to "award reform" --

THE COMMISSIONER: Sorry, can I interrupt you again? It's not for a question, but I'm not rushing you, but are we going to need to ask the doctors to come back after lunch?

MR FULLER: I only have about five minutes left. So if it is convenient --

THE COMMISSIONER: I'm conscious about where the witnesses are clinicians that have got other things to do, so we might run over the lunch break so that we can let them go back to what they usually do. Of course, it's partly dependent on Mr Cheney, but we'll see how we go. You finish. We'll just go beyond 1 o'clock.

MR FULLER: Thank you, Commissioner.

Dr Page, in your answer to the Commissioner, you referred to "award reform"?

DR PAGE: Yes.

MR FULLER: What do you have in mind? When you say "award reform", is it just salaries or other things as well?

DR PAGE: No, I think it's - you know, it's salaries, it's working conditions, it's actually sort of understanding or creating a sense that being a staff specialist is something that people want to do. I think on many levels, lots of clinicians want to have involvement in the operational side of how hospitals and departments work. I think we have a lot to contribute in that space. But if it's viewed as something that you do completely in your own time and that there's no value that is ascribed to that, then people very quickly burn out and when there are fewer bodies to share the load, the load becomes unwieldy.

What I'd like to see with award reform is some sort of parity with other states and territories that actually creates a sense of new fellows coming into anaesthesia, and any other discipline for that matter, who actually want to take up staff specialist positions. It's almost impossible to find a suitable applicant for a staff specialist position if you advertise one.

MR FULLER: Do you have a sense of whether there is an overall shortage of anaesthetists in Australia or whether

it's more an issue of imbalance between public and private sector or between jurisdictions?

DR PAGE: It feels like there's an overall shortage. The demand seems to have increased everywhere. If we - yes, it does feel like there's an overall shortage.

MR FULLER: Dr Moyle?

DR MOYLE: So there is definitely a global shortage of anaesthetists and I think every country is seeing similar sorts of movement of staff out of the public sector. The Australian Society of Anaesthetists, the ASA, are doing some workforce modelling on this. The college hasn't really done any workforce modelling of any significance, certainly not in New South Wales. Other states - we do know that other states are short too. But the ASA is trying to do workforce modelling.

Back in 2019 they did produce some data, pre-pandemic, to suggest that the workforce was in balance. Certainly we were hearing that newly minted senior - like, specialists were struggling to get as much work as they wanted. At the moment, if you look at the number of - I mean, the rural sector is crying out for help. No-one wants to go there. But even big centres are also struggling. I know that, you know, Prince Alfred, St Vincent's, the coast, Westmead, are still cancelling the occasional list because they can't find suitable staff. So if that's affecting metropolitan areas, there's clearly still a shortage.

MR FULLER: Do you think there's a need to increase funding for training positions for trainees and, if so, why?

DR MOYLE: I think it's very hard to predict without any real - without any good data or modelling, how many anaesthetists we need. Certainly as we have mentioned, there has been an increase in the need or the demand for anaesthetists in hospitals. I think at the moment we probably could have more trainees. I think that there are so many different factors that don't work so well that make the system very inefficient, that if - like, we would need to address a few different areas.

I think maldistribution is a major issue and that needs to be part and parcel of it, and you could argue that

increasing numbers should improve that, but that's never really been the case in the past. I think we need to be smarter about who we recruit and how we recruit them to fill those vacant slots.

MR FULLER: Dr Page, do you have anything to add to that?

DR PAGE: No. I think Michelle has covered that pretty well. There was some increased funding for positions in the paediatric tertiary centres, I think that came through three years ago now, and for a couple of extra positions, that's actually created a significant capacity in improvement for getting trainees through the paediatric bottleneck. So if we needed to fund more positions purely for training, I think that it wouldn't be large numbers that were needed to ease the burden.

I guess I'm concerned by reports that I hear from hospitals, you know, major metro teaching hospitals, who are financially under the pump, as everywhere is, but have made decisions to reduce entry numbers into the training program at a time when we're talking about how can we ease the pathway of specialist international medical graduates into Australia and how can we improve the numbers of trainees that - home-grown anaesthetists that we're bringing through. If the parlous financial state of major metro teaching hospitals is so bad that they can't afford to put on the same number of anaesthesia trainees that they did last year, I'm not quite sure how we resolve that problem.

MR FULLER: Thank you. Dr Page, Dr Moyle, those are my questions.

THE COMMISSIONER: Can I just ask one more series of questions.

Please tell me - this is just so I understand it. If you could both turn to paragraph 110, of the statement, at page 17, where you have given the case study.

DR PAGE: Yes.

THE COMMISSIONER: Who should I address questions to, just so I understand this?

DR PAGE: Well, I can answer anything that's relevant to

Central Coast.

THE COMMISSIONER: I will try you, Dr Page, first. This is an example regarding obviously Central Coast LHD.

DR PAGE: Yes.

THE COMMISSIONER: The first bullet point is six staff specialists to 64 VMOs. What should I take from that - that there's a disparity in the numbers or something else?

DR PAGE: Yes. And there's a --

THE COMMISSIONER: Disparity in the ratio or something else?

DR PAGE: There's a significant disparity in the ratio. Staff specialists generally spend the bulk of their working time in the public system. Of the VMOs that I have, six of them have no regular sessions within the department. Some have significant numbers of regular sessions, but most - most contribute relatively little to the non-clinical workload of the department.

DR MOYLE: I could give an example at St Vincent's.

THE COMMISSIONER: Yes, please, go ahead.

DR MOYLE: So in 2017 I became director. I had 19 FTE staff specialists and about 33 VMOs. Today I have 8 FTE staff specialists, and most of the staff specialists are still there, they've just reduced their fraction a lot, and I've got 70 VMOs.

THE COMMISSIONER: And you are obviously talking about St Vincent's public?

DR MOYLE: I'm talking about St Vincent's public. We had no issues with filling our required slots when I started, and now every day we're really struggling to have the appropriate seniority in every anaesthetising location.

THE COMMISSIONER: The reason for that is all the reasons we've discussed throughout the course of your evidence?

DR MOYLE: Correct.

THE COMMISSIONER: Then the second bullet point is:

> *Recent staff specialist appointments only because they are still under section 19AB requirements.*

What should I understand by that?

DR PAGE: So if you're under section 19AB or the so-called 10-year moratorium, it means that you cannot get a provider number for working in the private sector until you have provided 10 years of service to the public sector. And so those recent staff specialist appointments that we have been able to make were individuals who had chosen to come to Australia at some point in time and were still under that 10-year moratorium.

THE COMMISSIONER: So it's linked - it's part of international medical graduates?

DR PAGE: Correct, yes.

THE COMMISSIONER: And then flowing on from that, I guess, is the two international medical graduate staff specialist appointments, both of whom are now fellows, but only want to be VMOs.

DR PAGE: Correct. That's right. They wouldn't apply for a staff specialist position, and they would have gone and been locums rather than taking up a staff specialist position.

THE COMMISSIONER: And the last five staff specialist appointments converted to VMO within 12 months.

DR PAGE: Yes.

THE COMMISSIONER: Do you have any direct or indirect knowledge as to why they did that?

DR PAGE: Because they could get paid better and it was more flexible and they could do what they wanted and they didn't want to be - you know, they could do what they wanted within the public system without having to, you know - be better paid for it and without having to do any of the additional non-clinical work. So they were individuals who probably decided that they didn't really

have a strong wish to be involved in the clinical support stuff, or those that did are still able to do that as VMOs. But those five individuals have chosen not to.

THE COMMISSIONER: All right. Did you want to add anything?

DR MOYLE: No, I'd be boasting, but St Vincent's has a pretty damn good academic record from exam perspective, and we track loads of trainees who really are committed to the public sector, and they all come to me, "I'd love to be a staff specialist but I can't afford to pay my mortgage, so I'm going to become a VMO."

THE COMMISSIONER: Okay. And that's something that's consistent feedback to you?

DR PAGE: Mmm.

DR MOYLE: Yes. Oh, yes.

THE COMMISSIONER: I think I understand the rest of the bullet points. Can I just ask in relation to the first bullet point in 111, the "regularly cancelled lists", should I take from that that that has been a problem from the time of the pandemic, but is still an ongoing problem?

DR PAGE: It is an ongoing problem, that's right, due to workforce shortages. Those would be lists specifically cancelled because of lack of anaesthesia workforce, whereas, as I say, there was only the single session prior to the pandemic.

THE COMMISSIONER: Yes, all right. Did anything flow from anything I asked?

MR FULLER: No, thank you, Commissioner.

THE COMMISSIONER: Mr Cheney, do you have any questions?

MR CHENEY: Commissioner, may I just take up one short topic with Dr Moyle.

THE COMMISSIONER: Of course you can, yes.

<EXAMINATION BY MR CHENEY:

MR CHENEY: Dr Moyle, you gave some evidence earlier about how at St Vincent's complaints of bullying were handled, and I think you said that they were referred to the director of professional affairs; is that --

DR MOYLE: No, no. So I was actually in the role as education officer for New South Wales at the time and we had a - I actually had two trainees who made complaints of bullying - they were at different hospitals, they were not at my hospital - about supervisors of training, which were - they came to me. Both of those trainees were on a program at the time called "trainee in difficulty", now referred to as "trainee experiencing difficulty", where trainees who are maybe failing to meet milestones or who have clinical issues are on a sort of formalised plan for how to address their shortcomings, and so they felt like they were being bullied. I was contacted directly by them as the representative, as the EO, and then they were - their complaints were referred on to the director of professional affairs at ANZCA.

At the time, the bullying process - the bullying policy was in process but not yet published, and the CEO made it a rule, basically, that any bullying complaints went to him.

So then that was referred on to - so I basically was the intermediary and then the DPA and CEO addressed that independently with - they actually appointed a psychologist from, I can't remember the name of the group, who worked with - who happened to also work with the College of Surgeons in Melbourne.

MR CHENEY: But the process of which you speak, did it involve speaking to the alleged perpetrator of the bullying, where that perpetrator was a member of the college?

DR MOYLE: No, no. Not from me, but they were - it was addressed. So basically I was not aware of what happened after that, except that the matter was dealt with by the college and they resolved to speak to the supervisor of training.

MR CHENEY: And does the since-formalised policy, to your

knowledge, deal with how a complaint of bullying about a member of the college is to be handled by the college?

DR MOYLE: It was - so I was - because of all of these things that were all starting out at the time, it was very topical at the time. I was involved in - there was a pretty large scale project that spoke to many people about recommendations for how the policy should be developed, and part of that policy was that there should be confidential - you know, there were issues of privacy and confidentiality for the trainee, and it was made very clear that - in discussion with the trainee, as to whether the person who was the alleged perpetrator would be contacted or not. So I don't know whether - how that all panned out at the time, but generally speaking, I found that - anaesthesia is a pretty small world and generally speaking, these things are - the people who are involved are aware of complaints at local levels.

MR CHENEY: In part, they glean that awareness because the topic is taken up with them by the college; is that right?

DR MOYLE: I think it's - you know, it's sort of local hospital policies come into play. The trainees are always advised that they should contact their local HR. There are frequent education sessions for supervisors of training - generally that's the most organised group and the most invested in the trainees - about what to do in the case of a bullying complaint

MR CHENEY: And are the trainees also advised that they are welcome to contact the college about such complaints? .

DR MOYLE: They are. At the time I did say that I thought - and the CEO acknowledged - that it might be perceived to be difficult for a trainee to contact the CEO of the college, so that's - there are well-documented avenues of what to do.

I think the other thing that has happened in that intervening time is that there has been a rise - the college strongly recommends formal mentoring programs in each department, and it is much more of a feature at accreditation visits that bullying and harassment is actively sought - any reports are sought out.

MR CHENEY: Including - I think you mentioned that one of the top two priorities of the training and accreditation committee visits was to ask trainees about bullying experiences; is that right?

DR MOYLE: Yes

MR CHENEY: Presumably that's to inform the college as to the extent to which this is happening to its members?

DR MOYLE: I think so. I think this came about more as a trainee advocacy piece and trying to ensure that trainees were being given fair and just access to resources and training and - but yes.

MR CHENEY: Because the problem --

THE COMMISSIONER: Can I just ask - sorry to interrupt - this will be me just not getting it, but the reason you are asking these questions is to establish what?

MR CHENEY: Largely it deals with something that has been asserted in another college's submission, Commissioner. I'm just trying to draw a distinction between how this college deals with it and the position taken by others.

THE COMMISSIONER: Okay, all right. Go ahead.

MR CHENEY: I will leave it there, Commissioner.

THE COMMISSIONER: All right. Thank you. Nothing arising out of that?

MR FULLER: No, thank you.

THE COMMISSIONER: Dr Page and Dr Moyle, first of all, thank you very much for the statement you prepared and, secondly, thank you for your time today, we're very grateful, and you are excused.

DR MOYLE: Thank you.

DR PAGE: Thank you so much for hearing us.

THE COMMISSIONER: All right. We'll come back at 2.20.

<THE WITNESSES WITHDREW

LUNCHEON ADJOURNMENT

THE COMMISSIONER: Yes, Mr Fuller.

MR FULLER: Thank you, Commissioner. The next witness is Dr Angelo Virgona from the Royal Australian and New Zealand College of Psychiatrists. I call the doctor.

THE COMMISSIONER: Doctor, can you hear me?

DR VIRGONA: Yes, I can.

<ANGELO VIRGONA, affirmed: [2.22pm]

<EXAMINATION BY MR FULLER:

MR FULLER: Q. Doctor, my name's Dan Fuller. I'm one of the counsel assisting the Commission. I'm going to be asking you some questions this afternoon. I understand you are the chair of the New South Wales branch committee of the college; is that right?
A. No. I'm the immediate past chair of the college in New South Wales. My term ended in May, and this is one of my leftover responsibilities, but I now serve on the board of our binational college and maintain a potential on the New South Wales committee because of that and have an enduring interest in matters workforce and training in New South Wales.

Q. What's your position on the board?
A. I am the elected board member. There are five elected board members of the binational college and I am one of those.

Q. What's the relationship between the New South Wales branch committee and the board, if any?
A. Oh, well, the New South Wales branch committee represents the membership in New South Wales and relates to what we call our members advisory council, which is the broadest council of the college incorporating all the committees of the college, and that committee reports to the board. The board is ultimately responsible for all the activities of the college.

Q. For how long were you the chair of the New South Wales branch committee?

A. Six years.

Q. And did you hold any leadership roles in the college before that time?
A. No. I served on the branch committee but not in a leadership role before that, and I've served on the branch training committee decades before that, so I had a hiatus and I've been more engaged with college affairs the last 10 years.

Q. You have helpfully provided a statement to the Commission dated 18 July 2024. Do you have a copy of that there with you?
A. I do. I'll just get it up on the screen, thanks. Yep.

MR FULLER: I should say, that's exhibit H6.5 in the tender bundle.

Q. Have you had the opportunity to read over that statement recently?
A. Yes, I have done.

Q. Is everything in it true and correct to the best of your knowledge and belief?
A. Yeah. It's very - it's extensive. Yes, I will say yes.

Q. All right. Well, if there's anything that comes up to your mind or in the course of my questions that you want to correct, please just let us know.
A. Will do.

Q. Starting at paragraph 3 of your statement, you say that the college is the principal organisation representing the medical specialty of psychiatry in Australia and New Zealand; you see that?
A. Yes.

Q. Do you see part of that role as being to advocate for the interests of the college's fellows?
A. Oh, absolutely.

Q. And as a matter of fact, the college does engage in general advocacy in relation to, for example, resourcing of mental health services in New South Wales?
A. Yes. Yes, resourcing of mental health services, the

workforce issues that involve our junior medical workforce and the senior medical workforce, whether they be in the employed workforce of the state or whether they be in the private sector, yes.

Q. I will come to some of those issues shortly but I'll just start by asking you some questions about the college's role in accreditation.
A. Yes.

Q. The college offers a training program in the specialty of psychiatry; that's right?
A. Correct.

Q. And completing that program is the only way to become a specialist psychiatrist in Australia?
A. Yes. I mean, you can be an internationally trained specialist and those specialists can be accredited by the Health Insurance Commission to provide psychiatric services, but to become a psychiatrist in Australia, this is the only pathway to train and achieve psychiatric specialty status.

Q. So in terms of a doctor who wants to complete their training in Australia, they complete the training through your college and there's no other pathway for them; is that right?
A. There is no other pathway for them within Australia, no.

Q. Do you agree that that lack of competition makes it important for colleges like yours to have fair, effective and transparent governance and administration processes?
A. Absolutely.

Q. Are we right in understanding that the college of psychiatrists accredits training posts and programs rather than sites?
A. Yes.

Q. And posts are individual training positions; is that right?
A. Yes, correct.

Q. How do the posts relate to the training program?
A. How do they relate to the training program? Well, they - a post will be accredited by the branch training

committee and depending on the location of the post, the post will be managed by the director of training for that training zone - so there are five training zones in New South Wales. So director of training will be responsible for the progress of that post, and essentially the director of training is part of the branch training committee in New South Wales, as well as being part of a network governance committee, and there's also a psychiatric training council in New South Wales. We have a very complicated arrangement, you probably would have seen, in New South Wales, which has evolved over time and probably is due for reconsideration and a refit, I think, and we've made that point to the department. But, yes, at the moment it's reasonably complicated but it's also - you know, if you can find your way through it, it's reasonably transparent, I think.

Q. Just in terms of the current system, are you able to help us with - is there a reason why posts and programs are separately accredited? In other words, the college accredits both posts and programs. Is there a particular reason for that?

A. I can't - I don't quite know - essentially what happens is - I suppose if I take it back, essentially what happens is, if I give you an example, funding will be made available, for example, by NSW Health for an expanded service, for example, they've built a new hospital, they've got new wards, they need registrars to work in those wards, and so the local health district will then come to us, come to the branch training committee, with an application to approve a training post in that facility, and the training post, as long as they fulfil the criteria, which aren't terribly difficult to fulfil - you basically need, you know, basic essential infrastructure, the term has to sort of fit with the training experiences that we expect our trainees to undertake and there has to be supervision available - the position will be approved.

Then the position will be then, as I said before, under the auspices of the local director of training. Then the local director of training will be responsible for filling that position and rotating people through that position within their jurisdiction.

Q. And the broader program that we've been discussing, is that associated with the five zones that you mentioned, so each zone has a program?

A. No, the zones don't have a program. There's a sort of a formal education course, right? So there's a formal education course in the first three years of training. That's D? Didactic teaching course, if you like. That's the curriculum that you've got to get under your belt and everybody has to do one of those courses, and there are several available to the trainees in New South Wales, the main ones being the one run by HETI. There's one conducted by the Brain and Mind Centre at Sydney University, and there's also the Newcastle training - the Hunter training program for their local trainees. But people in New South Wales can also go online and get that education experience from, I think, Monash and Melbourne universities in Victoria. So there's the basic curriculum that's delivered that people have to participate in.

Then there's the training program. We have, as a college - there are certain compulsory rotations that need to be provided within a training zone, right? So you've got to be able to provide your acute adult experiences in hospital; you've also got to be able to provide consultation liaison psychiatry terms and a child psychiatry term in your first three years of training, essentially, or the first two to three years of training. So those compulsory rotations have to be able to be delivered by a training zone, and the person has to be participating in a formal education program.

Q. Just picking up on something you said about the online training, if I'm a doctor sitting in New South Wales, is it possible for me to complete some of my training program online through Monash; is that the idea?
A. Yes, yes. Yes, the formal education. That is the lectures, the stuff that, you know - the stuff that you've got to commit to memory and the hard data of didactic teaching. So that stuff can be done online.

Q. Do I have to be sitting in an accredited post in New South Wales --
A. Yes.

Q. -- for that experience to count?
A. Yes.

Q. Is that right?
A. Yes.

Q. So it's an alternative way of delivering the training that is otherwise delivered to people who have to - who sit in accredited training posts?
A. Yes, yes, that's right, the context.

Q. The zones that you have referred to, are they also called networks, training networks?
A. Yes, sorry - yes, sorry, I mix up my terms, sorry. Yes. Networks.

Q. I might just show you a document so we're on the same page. It's [SCI.0011.0204.0001] I will see if I can identify that in the tender bundle. It is H1.84 in the tender bundle.
A. Yes. Yes.

THE COMMISSIONER: Where is that page from? What document is that? Is it a webpage?

MR FULLER: This is a webpage. That's part of HETI's website.

THE WITNESS: That's HETI'S. Yes, that's part of HETI a website, correct, yes.

MR FULLER: Q. It's just a way of trying to get this information on one page. If I just ask the operator to scroll down.
A. Yes.

Q. We see in the orange headings, are they the names of the five training networks or zones in New South Wales?
A. Yes, correct.

Q. We see underneath each of those headings quite a number of different health services; is that right?
A. Correct. Yep.

Q. And each of those health services forms part of the network --
A. Correct.

Q. -- the relevant network? And there will be presumably accredited posts distributed at those sites throughout each network?
A. Yes.

Q. And they include metropolitan, as well as rural and regional sites?
A. Yes, they do.

Q. Does the college have anything to do with the establishment of these networks, or is that a matter for NSW Health?
A. That was a NSW Health matter. I will take that on notice a little but I mean, my understanding is that these were NSW Health designed and implemented, you know, over a decade ago.

Q. Is the structure similar in other jurisdictions or is this a New South Wales specific thing?
A. No, we are unique, and - but partly it's because of our, you know, the size in New South Wales, the geography. Also, partly because NSW Health required trainees to do rural rotations as part of their experience. That was partly a workforce distribution issue, so that was a historical thing as well. So you'll see the link between metropolitan and rural/regional locations.

That has become - and I think we put this in our submission - less of an issue. We think that things have changed over time as our regional centres have become much better at becoming standalone training zones with people living and working in the bush now, and we've got over 50 registrars working in - training and working in rural - living, training and working in rural New South Wales. So we think that this sort of model, which was developed to, I think, essentially support the bush, could be revisited because we're seeing things sort of happening in a positive way in the bush now, compared to the way it was 10, 15 years ago.

Q. At a high level, and just jumping forward a bit, am I right in thinking that the college's concern with workforce is more with the overall numbers of psychiatrists who are available rather than the distribution between rural and regional and metro?
A. Listen, we're concerned about everything, you know? And we're concerned about distribution. But really it's not within our remit to do anything about it. These are really state-based - state-government-based issues. So it's very difficult for us to - I mean, we will not make decisions or anything that we can do in a coherent way that's going to make any difference to what happens to the

workforce distribution really. These are government decisions, yes.

Q. Just in terms of accrediting posts, obviously in that way, the college has some control over the number of training positions that may, in theory, be available in New South Wales. Do you accept that as a theoretical proposition?
A. Yes. I accept that.

Q. Is the issue that, in practice, you just don't have enough people to fill the training posts that the college could potentially make available?
A. Well, the college makes available posts in reaction to funding, essentially. I mean, we don't decide, "Oh, we think we need more posts in Wagga Wagga or Tamworth so we're going to create them"; really, these things come from the ground up, really, and so the services will have an enhancement and say, "We're opening up a training position", as I have sort of alluded to earlier, and then they'll come to the college and say, "Well, we think we can provide a good training experience for this person and we would like you to approve it and monitor it, thank you very much", and we will do so. I mean, it's very rare - I can't give you any specific examples, there probably have been but it would be quite rare - that we have knocked any applications back.

THE COMMISSIONER: Q. So I should understand that to mean that - and let's forget the exact numbers, they're not important for the purpose of this question.
A. Yes.

Q. But it's not the college dictating to the New South Wales health system "There will be 50 psychiatric trainees"; it's the New South Wales health system saying, "There will be funding for 50 psychiatric trainees", and then the college finding the posts?
A. Yes - well, the college approving the posts.

Q. Approving the posts, yes.
A. Approving the posts, as long as you can provide those basic things that you need to be able to conduct a training experience appropriately according to our standards.

Q. But it would be wrong to assume that the New South Wales health system is saying, "We have funding for

100 psychiatric trainees", with the college saying, "Oh, no, there are only going to be 50"?
A. Yeah, yeah, we're not dermatologists here, we're sort of - you know, we're different.

Q. We haven't heard from them yet. We'll mark that page of the transcript, though.
A. You can redact that, thanks. But we are not trying - no, we are not trying to restrict numbers at all.

Q. I'm in charge of redactions.
A. We are not trying to restrict numbers at all.

Q. Understood.
A. We don't have any role in that.

Q. Understood.
A. Yes.

MR FULLER: Q. Doctor, you told us earlier, and you say it in your statement as well, that you think the network model at least in New South Wales is due for reconsideration and refit, I think those were your words earlier?
A. Yes.

Q. Can you just tell us what you have in mind, what you think could be done in terms of restructuring?
A. It's a big thing. Like, I think it takes greater minds than mine, because I'm sort of one step removed from training, I must admit. So I don't want to give you sort of, you know, the Virgona view of how the world should operate. But certainly - so in other jurisdictions they have a metropolitan zone and they will have a rural zone, for example. I mean, you know, it's a lot easier in South Australia or Western Australia where you've got much smaller numbers. So it's easier to sort of configure things that way.

We are developing, but on the rural piece I will say this much, I mean, within the college we are developing - we have developed a rural training pathway, which has been aimed at being able to provide the entire training experience in the bush, whereas previously, people who wanted to work and train in the bush, they would have to come down to Sydney or to a major regional centre to be able to do those compulsory rotations that I spoke to you

about before, child and adolescent or consultation and liaison, and that was quite - it made it very difficult for people. Whereas now, we are finding that they're much better in the bush at being able to provide these rotations on site, and so that sort of need to come to the city is becoming redundant.

We think that being able to sort of develop just pure rural training zone is something that should be considered in New South Wales. We've had the experience - the federal government provided funding, and this was in response to our rural training pathway, the federal government provided funding through the FATES program, which I think we put in our submission a link to.

So what that did was ask for expressions of interest around Australia for the establishment of rural directors of training positions. So we don't have a rural director of training in New South Wales. The directors of training are in these five networks that you have seen up on the screen.

So we didn't apply for one in New South Wales because our - because we're so complicated here, and how would you do it and we were sort of scratching our heads, "Oh, we would have to liaise with HETI and with the ministry", because one of the provisos of this FATES-funded directors of training positions was they were only to be for two years, I think the funding was available, and there had to be agreement from the states that they would then take on the funding thereafter. So we had to get a lot of people to sort of tick the boxes to make it happen. We didn't have enough time.

However, in northern New South Wales, they decided, the local health district decided, to put in an application for one of these positions, and they have got their own director of training, it's a rural director of training, and it has been a very, very, very successful position. They have doubled the number of trainees in a very short space of time, less than two years. They've doubled the number of locally based trainees. The experience that people are having is quite extraordinary. So we are thinking that this does provide something of a model.

In our pre-budget submission to the New South Wales Government, we asked for four such positions for rural

New South Wales, based in the mainly regional centres, like Orange, Wagga, Tamworth, and perhaps Coffs. But looking at having that level of support makes it much more attractive and a much greater training experience for the people locally. So we see that as something for the future.

So in its broad sense, I would say that - how could it look in the future? An entire rural training network or split rural training networks, and then the metropolitan networks could be reimagined. So that would be a simplification of things.

We also put in there an extract from our internal review of the administrative requirements for supporting our branch training committee and our directors of training. There's been no change to the amount of money provided by the college or NSW Health to support the administrative - administration needs for trainees, and despite the fact that there has been a doubling in the number of trainees over the time period.

So we were looking to see, you know, looking at how things worked in New South Wales compared to other jurisdictions, and certainly Victoria's is a much simpler arrangement that they have - fewer committees, greater delegation of responsibility to local zone committees rather than at the branch training committees. There are a whole range of issues that we identified there, and we saw this as perhaps being a first step in this idea of a review of how we do things in New South Wales, and perhaps we could do things differently. So we think it is high time for a review of the network structure in New South Wales.

Q. I think you tell us about all this from paragraph 53 of your statement?
A. Yes.

Q. Just in terms of the rural director of training, is it right that the reason why you think that's been successful is because you've got a dedicated person who is responsible for trying to attract and support trainees in that area; is that right?
A. Exactly. Before that, the person who is responsible for the trainees in that place sits at St George Hospital, right? So in Sydney. So the ability to sort of be able to have connection with the trainees, to understand what their

real needs are working and training in the bush is really difficult for these metropolitan-based directors of training, and they are all metropolitan based, all these network directors of training. So we think that it makes much greater sense that rural trainees need their own director of training that understands the - you know, the specific issues that they're sort of confronted with, working and training in the bush.

Q. Do you think the sort of restructuring that you've described would help in any way with the general workforce shortages that you've described?
A. Well, I think it would be a step in the right direction, because anything that you do that sort of enhances, you know, the quality of support provided to trainees - I mean, things spread, you know, by word of mouth, you know, particularly in this sort of social media age. I mean, people are sort of connecting up with each other in all sorts of ways and finding out all sorts of information about what a training experience is like.

I think that anything that enhances the quality of a training experience for people is a good thing for training and a good thing for attracting people to train in New South Wales. As I highlighted, you know, on a number of occasions in the documents, we are really struggling in New South Wales across the board with attracting people and retaining people.

Q. I'll come back to that in a moment, if I might.
A. Yes.

Q. Just coming back to accreditation briefly, does your college have a role in selecting trainees at all?
A. Oh, yes, yes, of course. So we have this combined statewide recruitment exercise. I've forgotten the acronym for it, but anyway, but we're combined with HETI. So HETI and the college do this together and - where there are representatives from the college and representatives from the local health districts, and we have this annual recruitment exercise, which is good. It's efficient. You know, it works. It works quite well, yes.

THE COMMISSIONER: Q. This is in paragraph 39, I think, of your statement, you have set out - you have provided some links to the committees and what-not?
A. Yes, I'm just going to go down there. Hang on, sorry.

Q. It's 39 on page 6.
A. Yes. I mean, it sort of talks about the role of HETI with us, yep. Yep.

MR FULLER: Q. The recruitment process is, you've said, a combined one with the college and HETI; that's right?
A. Yes.

Q. You said that you thought that was efficient and worked quite well. Why do you think that is?
A. Oh, well, it saves trainees having to sort of have an interview with each local health district, if you like, and - or each network, and saying - so it's a combined effort and people are sort of accredited for - approved for entering training, so that's our job, you know, "Yeah, you tick the box for being an appropriate person to start training in psychiatry", and then there is a process by which people I think - and I might take this on notice - I think people can sort of put down their priorities in terms of which local health district they would like to work, and then it is worked out from there.

So I think it's a system that works, it's efficient. I don't think people have a problem - I don't think across the board that people have expressed an issue with that. It's one of the things that we think works quite well.

Q. So is the college's role in that process effectively to provide the expertise for working out whether someone's a suitable trainee or not?
A. Yes. Yes.

Q. Are you able to give us a ballpark of how many applicants for training positions you'd get each year in New South Wales?
A. Yes, I think I put it in our submission, but we had about 135 applicants for about 135 positions, give or take, you know, four or five. So that's what it was in New South Wales this year, which is, you know - it doesn't - it's not good, you know? So you get a lot of attrition and we may have found that the people had gone - taken up other postings interstate. So there's not only - this isn't the only opportunity to enter training; there are other opportunities where local health districts or networks will then - local health districts will then have their own separate ads during the course of the year to fill gaps in

their systems, so - and we will be involved in those processes with them. But this is the mass recruitment exercise.

So, yes, we're doing poorly in New South Wales on that score. In Victoria, as I think I mentioned, they had 200 applicants for about 115 positions. Psychiatry training is popular. We do know that people who were PGY1 and 2 doctors in New South Wales looking to train in psychiatry went to Victoria. So I don't have specific numbers to be able to give you on that, but we know from our intelligence that people are looking interstate because, you know, there are a whole lot of - there are a whole stack of reasons, which you'll probably get to when you ask me about workforce.

Q. I'll come to that in a moment. Just when you say we're doing not good, or poorly, in New South Wales, that's because the numbers of applicants, in your view, are not sufficient to meet either current or future demand for psychiatry services; is that right?
A. Yes. Yes, absolutely. Yes, definitely, yes.

Q. I might come directly to the issue of workforce shortages. In paragraph 12 of your statement you've told us that New South Wales has a 25 per cent vacancy rate in staff specialist positions.
A. Yes.

Q. I take it that means staff specialist psychiatrists; is that right?
A. Yes, yes. Yes, staff specialist psychiatrists. So you've got - they are the employed psychiatrists in New South Wales, and some of those are filled by locums and some are just vacant, they haven't been able to fill them at all.

Q. So this is a situation where there are positions that exist, they've been created by LHDs --
A. Yes.

Q. -- but they're not filled?
A. Yes, they've been filled for decades and they're no longer filled because people have left and they have not been able to fill the positions. Or, you know, when I say "decades", that's obviously not all of them, but there will be a number of positions. You know, these are due to

people just leaving the system.

THE COMMISSIONER: Q. Is that vacancy rate evenly spread between metropolitan and regional LHDs or is there - does one have greater vacancy rates than the other?
A. Well, I think historically - I mean, historically the regional areas have relied - other than Newcastle, which is an aberration, and I'll talk about them in a minute, but historically the regions have relied on visiting medical officer workforce, so whether locally living people or fly-in fly-outs, so most - Wagga, Coffs Harbour, Tamworth, Orange have relied on fly-in - and Bathurst relied on fly-in fly-outs, for a couple of decades, really.

Now, the situation has improved in some locations like Orange, for example, and it has some locally grown staff specialist and VMO workforce, but it's a big centre. It's got a big facility. And there is some improvement, you know, with locally grown, if you like, specialists staying put in places like Wagga and Tamworth but, you know, this is - it's a work in progress, yes.

THE COMMISSIONER: Yes.

MR FULLER: Q. I think you told us you were going to come back to Newcastle, and sorry if I missed it, but what were you going to say about that?
A. Well, I think historically Newcastle is just a bit weird compared to the rest of New South Wales. I mean, historically, it's had - it's a beautiful place, on the beach, with affordable real estate, so that's the first thing that may be the most important factor. No, but it's had an excellent medical school. It had two mental health hospitals, if you like, in its region, at Morisset and at James Fletcher in town in Newcastle itself. So it had a very solid infrastructure of psychiatric staffing and mental health, other mental health workers, and also it's got the Hunter Institute of Mental Health Research arm, as well. So it's a very, you know, well-resourced.

Now, the other thing that they did very well from about 20 years ago is that they recruited very well from overseas, and they've had a series of overseas trained specialists who got their Australian fellowship, and they stayed on board as staff specialists predominantly in the Newcastle system. So they've got probably the highest proportion of staff specialists in their staffing profile

of any place in New South Wales.

Q. The 25 per cent figure, where does that come from?
A. NSW Health. So we've been engaged in quite detailed deliberations and meetings with the department, the mental health branch of the department and the workforce branch of the department. We've been highlighting, at the college, along with industrial organisations like ASMOF and the AMA - have been highlighting to the department and the minister's offices how parlous the workforce situation is in New South Wales, and particularly both the junior medical workforce and the staff specialist workforce, and we have bemoaned the fact that it is very difficult to get solid data.

We're not in a good position to get solid data because, you know, any surveys that are conducted by organisations like ourselves are going to miss a lot of people, we're not going to capture everything, and really all the data sits there in NSW Health. They know where all the bodies are and where they're sitting and how they are being paid. So we, you know, put some pressure on them via the minister to really start to deliver some information and as a result it --

THE COMMISSIONER: Q. There might be some data that's harder to find, but vacancy rates shouldn't be difficult, should they?
A. Yes - no, it's not - no, it shouldn't be difficult. But they had to mine - they really had to mine each local health district to do this, right? This is - like they had to go out and speak to each clinical director and say, "Tell us what your substantive positions are; what are your substantive FTE; how many vacancies have you got; what sort of vacancies; are they long service leave, are they retired", et cetera, et cetera, and also the same for the junior medical workforce. So it becomes - it is difficult when things - at that level.

Then you've got - as well as that, I suppose the other piece of the pie is that you've got a visiting medical officer workforce, so you've got the VMO contractors, and then you've got the locums who are different. So you've got VMOs on contract and they might be on short-term contracts, three or six months; they might be on quinquennial contracts for five years; and then you've got locums who might be on a locum contract for a couple of

weeks coming in. And how they pay those within the New South Wales finance system can vary a lot across the joint.

And sometimes they don't separate out in their locum data, you know, what's a psychiatrist locum and what's an emergency department locum, for example. So it becomes - it can be quite messy. So they're not paid out of the cost centre sitting under the mental health service, but they may be coming out of this locum VMO cost centre. So it's a bit of a dog's breakfast to be honest with you.

NSW Health have tried their best in these meetings that we've had to deliver information. That's why we said - I think there was some request made of, "Can you clarify, can you clarify", and we came back to you and said "Just ask NSW Health. They've got the data", you know, "They should be able to provide this data." Particularly, workforce should be able to give it to you.

So in these meetings, that was the rough figure, was the 25 per cent vacancy rate for staff specialists in New South Wales. We've got over 50 locums, full time equivalent locums that are sort of working in New South Wales at the moment, as far as we can figure out, there may be considerably more than that, and - at any one time, we're talking about, which is a lot of people, and then there are a lot of positions that are just plain vacant, they just can't fill them.

MR FULLER: Q. Do you have a sense of why there is in your view such a high number of locums in New South Wales, that's locum psychiatrists?
A. Yeah, because - well, it's because - well, it's not a perfect storm, it's been more like climate change that's been building up over years and years and years really, and that we've had - you know, we've had the salary cap, which didn't help things, obviously for a long period of time. We've had awards moving forward in our competitor states, so Queensland and Victoria, you know, the staff specialists are doing 25 per cent better than they are in New South Wales - at least. Up to 30 per cent. So they're our main competitors and that's where we're losing people to in the junior workforce and the senior workforce.

We have - what else has been happening? The underinvestment in New South Wales mental health services

has seen the workforce becoming increasingly demoralised. People working harder. People not being able to do the clinical support activities that are so important in being a staff specialist - you know, time for education, training, research, participation in quality improvement, participation in service planning, et cetera. So it makes these positions less and less attractive because it's more like, you know, day in, day out, hard clinical - hard clinical work.

There's also been an increase in the sort of - the demands placed on the system, obviously, we've got emergency department data which has shown things going through the roof, and a lot of pressure to turn people over very quickly, like moving people out of the emergency department as quickly as possible into the ward and then, when they're in the ward, getting them out of there as quickly as possible, and people are finding - and I think, you know, we've had survey results of our members, our fellows, sorry, who have shown an increasingly demoralised workforce, disenchanted, they don't feel valued, their skills don't feel appreciated - they don't feel appreciated for their skills. So I think that's been a factor.

I think cost of living in New South Wales is obviously a factor. Sydney is, you know, a very, very difficult place to try to buy a house for psychiatrists, like everybody else. And we've seen, I think in the last few years, the options that are available in the private sector are sort of much more attractive. I think telehealth has had a role to play in this because, you know, people are able to see - well, it's very attractive, being able to get your letters as a young psychiatrist, you know, and you've got a young family and you can sit at home and work with practice software, you know, you'll have a full load of books because people will be able to provide you with lots of patients to be able to assess and review from the comfort of your own home, and you'll be well remunerated earning twice as much as a staff specialist, you know, without a huge amount of effort.

So when you add all those factors together - and I think I also made the point that there has been, we feel, an erosion in the status of psychiatry in NSW Health. You know, we've seen Sydney Local Health District and Sydney West - I don't know if it's called Sydney West still, but now they've created executive director of mental health

positions and you can't be a psychiatrist if you want to apply for one. You know, we've got a really rich tradition of, you know, high-quality leadership provided by psychiatrists in our health district.

I know I've worked in health districts where I've been the leader, the clinical and operational leader, but I've also worked in those where I've had, you know, the executive director has been a non-psychiatrist and they have been fantastic people and very good, but I'm saying to exclude psychiatry from the possibility of being in such a role is not a good move and it's a sign, we feel, of, you know, a move toward - a move away from psychiatry in leadership positions per se.

THE COMMISSIONER: Q. Can I just interrupt you there?
A. Yes.

Q. This isn't a criticism, but the picture you have just painted is one where it's almost surprising there would be a single staff specialist psychiatrist in New South Wales. I'm not suggesting you are wrong. The reason I interrupted you was because first I didn't want you to break the record for the longest answer in this Inquiry, which belongs to Mr Spittal from Western New South Wales.

I understood all of what you were saying, but I just wanted to hear a bit more from you where you said there'd been - these are my words - a diminution in the status of psychiatry that concerns you. You mentioned the executive director of mental health roles and that you can't be a psychiatrist to apply for them. What was the reasoning behind that, if you know?
A. I don't know. You'll have to ask the chief executive of those local health districts. But, yes, I don't understand. I don't understand the reason behind it. Whether it - I mean, we were - paying a staff specialist - you'll probably pay a staff specialist more than you will pay a health service manager, you know. It may be financial. I have no idea why they would do such a thing. And I've worked with those people before and they've been - they have been, I thought, well disposed towards psychiatry, those managers. But anyway, I think - I mean, we've also - you know, we're involved in "industrial discussions" with the ministry, and the minister's offices, around the situation in New South Wales and how parlous it is, and I've done a survey. I will tell you the results

are that 70 per cent of the respondents - and I had, like, a 75 per cent response rate from staff specialists in New South Wales - 70 per cent of the respondents said that they would be leaving NSW Health in the next 12 months if there wasn't an improvement in pay and conditions.

Q. Yes, okay.
A. That's an extraordinary number. Just - whether they're going to do it or not is another thing, but the fact is that, you know, these are people who are rusted on, you know? You can walk out tomorrow, and I could say I'm a staff specialist at Royal Prince Alfred and I'll say, "Listen I'm not doing this anymore. I want to be a - I'm walking away or you pay me as a VMO." Well, they will pay you as a VMO. So they will keep you and pay you as a VMO the next day. But these --

Q. By "rusted on", you mean these are people that are voicing these concerns that otherwise have a record of being - a history of public service psychiatry?
A. Absolute. Absolutely. Dedicated, committed public servants, these people. I mean, the fact that they're still there, you know, speaks volumes. But they're at their wits end now. And they've got plenty of other options. They don't have to do this anymore.

MR FULLER: Q. Doctor, is there an overall shortage of psychiatrists in Australia to meet the demand for psychiatry services or is it a particular issue with New South Wales public sector?
A. Well, in New South Wales public sector is certainly a big one. But, I mean, the data - and don't ask me how they came up with this, but I think the Australian Institute of Health and Welfare say that we meet 56 per cent, currently, with the number of psychiatrists we've got in Australia. (Internet interruption). So we can have a whole lot more psychiatrists. We're not going to get double the number of psychiatrists in this country, and we have to think about - oh, my internet connection is a bit unstable, I've just been told. We have to think about how you get the best bang for your buck out of the psychiatrists in the future in this country.

That's one of the challenges that I think we have as a profession, and I think with the national mental health workforce strategy, there has to be some thought given to that, and that involves not only state governments and the

services that they run, but obviously federal government and the MBS and how services are delivered via that. So yes, there is a shortage across the nation, but it's most acute in this sector.

THE COMMISSIONER: Q. In raising the federal government and the MBS, should I take that to mean that at least one aspect of the provision of mental health services to the public, and perhaps the first line, is primary care, and if we want to reduce the number of presentations, for example, in emergency departments, which I think everyone agrees aren't a great place for people suffering some form of mental health episode or condition --
A. Yes.

Q. -- that the Commonwealth has to ensure that general practitioners can be funded to provide that initial primary level of care for people that are suffering mental health conditions so that there's proper remuneration for the kind of clinical time that might be required for what might be an early intervention that might prevent something more serious later on; is that a reasonable - is that what you were referring to?
A. Yes, that's very reasonable. I am referring to that in part, and I think the college has - in our federal government budget submission, we have - we are developing a postgraduate qualification in mental health, a certificate in mental health for GPs, and this has been funded by the federal government, and so we are developing that and we are taking enrolments for that course for people to do.

But that course is only going to be as good as the MBS item number that goes with it. So the federal government's got to get real and remunerate people appropriately for sitting down with someone for longer than the 11-minute consultation, which is about the average it is for a general practice consultation nowadays. So the longer the consultation --

Q. Just stop. Just stopping you there, that sort of time frame you're talking about, you're the expert not me, that, I assume, is just an inadequate period of time to have a discussion with someone, or provide treatment --
A. Oh, of course.

Q. -- at a primary level, that's suffering some form of

even low-grade mental health problem or issue?
A. Yes, of course. Yes, of course. I mean, they've got to be able to see people for 30 to 45 minutes and be able to get an adequate amount of remuneration. I don't know what number the division of GPs puts on this in terms of time period, what they see is ideal, but, you know, sensibly, you need a reasonable period of time to be able to do a comprehensive assessment to make sure that you're able to build a rapport with someone, to be able to get them to tell their story and make the appropriate inquiries to figure out what the main issues are and how you are going to address them.

So, yes, I mean that is a federal government responsibility, there is no doubt about it, and more work needs to happen on that score. We did ask for that. We asked for appropriate item numbers for GPs in our federal budget submission, and we will continue to advocate for that. I mean, it's going to be - that's going to be very important, I think, into the future, because we're never going to have enough psychiatrists to be able to deliver all the services that are required by the Australian population.

MR FULLER: Q. Doctor, the figure you gave us of 70 per cent of psychiatrists in the New South Wales public sector saying they will leave if pay and conditions don't improve, have the results of that survey been published anywhere?
A. No.

Q. Is that something that you're able to provide?
A. Well, I just told you. So what it was - I mean, what it was was just a simple, literally, a very simple survey that we conducted during a Zoom meeting of all our psychiatrists a few months ago. I provided that data to the Minister for Health and the Minister for Mental Health and the department. So they've seen all of - they've seen all of that data. I mean, I could give you - I could send you the SurveyMonkey slides, the summary slides if you wish.

Q. I'm happy for you to have given me that context.
A. Yes.

Q. I just have a couple of other questions from particular issues you've raised in your statement.

Firstly, paragraph 17, you talk about locums - I'm sorry. Paragraphs 16 and 17 you talk about locums. Paragraph 16 you say that relying on locums, the unprecedented reliance on locums, is unsustainable and invariably leads to poorer outcomes. Is that for the reasons you've put in paragraph 17, if you could just have a look at that?
A. My apologies, but can you read that, because I closed my - because of my signal, I closed - trying to close down all the windows on my computer. So could you just tell me what reasons I quoted in 17.

Q. You say this:

Locums can deliver quality clinical services, but they do not provide continuity or service/team leadership, affecting patient outcomes and training experiences for registrars.

A. Yeah, I think that's a fair comment. I don't think any locums would argue with that.

THE COMMISSIONER: Q. Tell me if I'm wrong, but if locums are turning over, is psychiatry one of those disciplines less suited for locums because it's better for the patient to be seeing the same practitioner, or am I wildly wrong about that?
A. Well, you're probably - you're not wildly wrong. I mean, you're right in terms of it's better for people to be seen by the same practitioner, but the high turnover, in terms of the length of stay some New South Wales public hospitals, I think, is average length of stay in a general hospital unit is - I think it's between 11 and 14 days, I think. So you've got a locum in there who is going to be there for a couple of weeks, they're going to see the person for the entirety of their admission. So I don't think it affects that so much.

Q. Understood.
A. Certainly in the community mental health setting, which is the most under-resourced part of our mental health system, when you are putting locums in the community mental health teams, I mean, they don't have the opportunity to develop relationships, and it is building relationships with people that have got really chronic severe disorder --

THE COMMISSIONER: Q. When I asked the question, that was

more what I had in mind than a public hospital ward?
A. Yes, yes, certainly. I mean, it does impact on - when you know your patients and you've got to know them over a long period of time, you know, you can be much more efficient in the care that you can deliver to people and then --

Q. So there is an advantage for the clinician and an advantage for the patient, in continuity?
A. Oh, absolutely. Absolutely.

MR FULLER: Q. In paragraph 23, Doctor - I will just tell you, so you don't have to look at it --
A. Thanks.

Q. You talk about a contraction in clinical variety and deskilling in the public sector. Can you just elaborate on what you meant by that?
A. So what we see increasingly is that the patient populations are becoming narrower and narrower, to people with acute behavioural disturbance related to psychosis, which, you know, is often going to be a drug-related issue, so it's either a drug-precipitated or drug-aggravated situation. So there's that population.

I don't want to be one of these people who say, "In my day", but in my day, you would have people in your units across the diagnostic spectrum. You would have people that had had severe mood disorder, severe depression; you would have people with acute mania; you'd have people with chronic schizophrenia and people with early psychosis; you would have people with perhaps severe anxiety disorder. And so nowadays, we're seeing less and less of that broad spectrum and seeing more and more of this narrow acute behavioural disturbance, or those people that are in acute sort of suicidal crisis associated with a trauma/personality disorder, who stay on wards for brief periods of time.

So the opportunity - and in the community mental health setting, the community teams are seeing, again, the people with chronic severe mental illness, often on community treatment orders, often with chronic psychosis, more often. More often than not, they're seeing that population or they're seeing a population of people who have been referred for brief follow-up after emergency department presentation with deliberate self-harm or

suicidal ideation. And so - and those people are sort of seen briefly.

There are some people in a personality disorder category who they will see in an ongoing way because they may be people who present frequently, often to the emergency departments, and they require a closer follow up. But generally speaking, again, we've got a narrower range of diagnostic problems that people are presenting with, and so the opportunity for exercising skills as a psychiatrist or as a trainee becomes more and more limited.

You know, for example, when I was a trainee, or when I was a psychiatrist working in a community health centre, I could carry a small number of patients who were psychotherapy patients, you know, with severe psychological or trauma related disorders, as well as looking after people with other disorders like anxiety disorders, mood disorders and psychosis.

So you had that sort of range of experience where you're using all your skills, and it becomes - yes, it gets harder to exercise those skills really in these sorts of environments so you're just sort of tackling the same sorts of problems over and over again.

Q. Is the issue that, in your view, that makes practice of psychiatry in the public sector less attractive?
A. Yes, I think it does make it less attractive and less attractive for trainees. Whenever I mention to trainees, you know, the possibility of working in the private sector as a trainee, having that, they all want to jump at the opportunity to sort of see a broader range of problems that people present with, and I think, yes, that makes it - it is more attractive, I think.

Q. Is there anything, in your view, that can be done about that issue?
A. Well, I think - I mean, we have been pushing, you know, over the last two years with this government and the previous government, for - you know, what does - everybody wants everything and our big ticket item is that we asked for - the Royal Commission in Victoria resulted in a major investment in mental health services in Victoria. Queensland had an upper house inquiry which resulted in major investment in mental health services in those states. So those states have gone ahead of New South Wales in terms

of the amount of - the proportion of the health budget that is spent on mental health, and they're making significant inroads - not easy but they're doing it, despite sort of working in a significant workforce complicated environment.

In New South Wales, we've asked the state government to do the same thing, and the first step in that is doing an analysis of the gap - the gap between what we have and what we should have according to the formulas. There are planning formulas that you could use that tell you New South Wales should have this many child psychiatry beds in Wagga; you know, this many old persons' beds in Tamworth; this many community mental health staff in Camperdown. So it gives you - for population, it tells you how many staff and how many beds you need essentially to meet the need.

So we've asked for this gap analysis and the government has committed to it and I know the department is working on it at the moment, and we're trying to get them to be as transparent as possible with that information so that, you know, we can be part of a conversation about it and be able to, you know, put political pressure on, because it was only in Queensland and Victoria where they got - where they used special levies on businesses with payrolls of over $10 million a year, they put a special levy on those payrolls to fund this enhancement of mental health services, both in Victoria and Queensland.

Well, we've been pushing this argument a lot with the government over the last two years and we'll continue to prosecute the argument. You know, it's going to take that sort of level of investment, particularly in the community mental health space. That's the space which is really lacking. When they talk about the missing middle, everybody talks about the missing middle, I call them the missing severe, because they don't have middling problems, they've got severe mental health problems, moderate to severe mental health problems and these people fall through the gaps between primary care and the state government services. There's nothing for them.

Q. So is the idea that if we invest more in the provision of public mental health services, that will naturally increase the clinical variety and give public sector psychiatrists the opportunity to exercise those skills in a wider range of settings?

A. Yes, yes.

Q. Is that how the two ideas tie together?
A. Yes, I suppose. I mean, that's not the reason. The reason is we need these services. I'm not trying to make psychiatrists' lives happier, but trying to increase these services. But a natural byproduct of that is that these jobs are going to be more interesting, I think, for people, and more attractive for people.

Q. In paragraph 43 you've told us that the supply of international medical graduates dried up during COVID and hasn't recovered. Do you have any sense of the reasons for that?
A. Well, I think we just couldn't get people into the country, was the big reason. I actually think - and I'm a bit removed and I'll take this on notice, I'm sorry, but I have other intelligence that says that things sort of slowed down in that space before COVID and that because we - those of us who had worked in sort of outer metropolitan and rural areas sort of have relied on international medical graduates. I mean, they provide a really substantial part of the public sector workforce in New South Wales.

I was mentioning Newcastle, before but, you know, in South West Sydney when I was involved there, I mean, it was an international medical graduate workforce that was the backbone of that workforce, and I know there's a similar situation in Western Sydney as well.

So I think these are - that probably has played a role. I can't tell you - again, workforce would have to be able to provide some data for us on that. But I'm certain that that's been something.

Now, the Kruk Inquiry and the trying to sort of streamline getting people into the country - and we know that there's a workforce ready and waiting in the UK, because things have been falling apart there for some time. You know, how quickly NSW Health can sort of tap into that and how quickly we can sort of get through visa requirements, satisfy the AMC, the Australian Medical Council, and also the college. Now, they want to - the Kruk inquiry and the federal government recommend sort of bypassing the colleges to some extent, and we're sort of trying to remind people that we're in the best position to

be able to judge whether people have equivalent qualifications, whether they've got the right stuff to be able to operate as a psychiatrist in Australia here and now.

So we're engaged in an active process of - an active job of streamlining our own processes as a college to make things as efficient as possible to bring people into the country because we want people to be engaged with the college and not be operating under some sort of separate pathway independent of our college.

It's not only because of our, you know - we don't see this as an existential threat, or anything, but we see it as really, you know, we are the keepers of the skills and the processes, you know, we have them, you know, no point reinventing the wheel, but if we can do it faster and better, we will.

Q. Aside from implementing the Kruk recommendations and streamlining your own processes, do you have any views about other things that could be done to help address the international medical graduates not coming back into Australia?
A. Oh, no, I mean, I think that will do the trick. I mean, I think - you know, I think there is a workforce that's willing to move to Australia and we're a very attractive destination for people, and - so yes, we've just got to get better at it. But by the same token, you know, it's only got - it's yet one piece of the puzzle. It's not going to solve all the problems. That's just one piece that's going to help in some ways.

So we have to - we can do that, but look at these other issues that are affecting the specific issues in New South Wales, particularly about the lowest remuneration in the country. I've got to get that plug in there somewhere, you know, for both the junior medical --

THE COMMISSIONER: Q. You're not the first, it's all right.
A. For the junior and the senior medical workforce, I mean, really. I mean, come on, you know? We've been trying - I mean, we need some action here. I mean, I know it's up to the industrial organisations to do it, I'm not going to spruik the industrial line but it's pretty obvious that something has to happen here. We can't have

Queensland and Victoria earning, you know, a third as much more.

MR FULLER: Q. Just on that particular issue of pay and conditions is it, in your view - sorry, is the issue the pay, from your perspective, or are there other conditions as well that you think need to be reformed just looking at it from the perspective of psychiatrists?
A. Yeah, well, we've got a couple of issues. I suppose the clinical support time is that - you know, that is often not - I've forgotten the term - quarantined so that, you know, as I said earlier, people are just sort of, you know, running around dealing with, you know, urgent clinical issues all the time and not that time for - and psychiatry is one of those places where you need to sit, think, reflect, you know? You need time to - and you need to be able to have those experiences with your colleagues, with your - with the other members of the multidisciplinary team, with your trainees, you know?

Research - all those other factors, all those other things that are sort of alluded to earlier on. I mean, people talk about access to TESL and how variable that is across the state and how they made it much more difficult recently because CEOs had to sign off on it, chief executives, sorry, had to sign off on it, making it another step in the process to make it more difficult to get TESL, and that's one of the - you know, that's one of the most attractive things for specialists in New South Wales. So making sure that those - we can grease the wheels, you know, with TESL, not have issues obstructing.

And the other thing, the other big thing in New South Wales, I think, is the on call. So on call for staff specialists is really difficult. We don't get any call-backs so much because people do not come in, most of it is done by remotely, so - but when the registrar is calling you from the emergency department or the clinical nurse consultant is calling you or the ED registrar, well then, you know, you can be up for half the night or all the night and people regularly report that the on call is the hardest thing to deal with for them, and - because in some services, and I don't quite know why they organised it this way, they just decided that people would be on call for one week at a time. So for that week, most people think, "I'm just not going to - plan on not sleeping." I mean, that's just ridiculous.

So there are a couple of ways in which you can look at this and we've taken it to the new psychiatric workforce group that the department and workforce branch have set up, reinvigorated, we were on this group previously, so we're talking about a dedicated on-call service for the state, is one option.

Another option is to remunerate appropriately for, you know, the work that you do. So you're working at night, all night, and you're not coming in to do an emergency operation but you're on the phone for half an hour or 45 minutes talking to staff and then you go back to bed and then you are up again for another 45 minutes or half an hour and then how do you - people aren't remunerated for that at all at the moment. It's just built in to the award and it's just inadequate.

So building something into the award like a digital on-call, because people will be providing notes into the electronic records, for example, I mean, that would be something that should be sort of entertained. I know that they're talking about it from - in a log of claims.

Q. Paragraph 46 of your statement, you tell us, we know that exposure to a psychiatry rotation pre-vocationally is the most significant factor in people choosing a career in psychiatry?
A. Yes.

Q. Firstly, how do you know that? Is that survey evidence?
A. Yes, that's survey evidence. I can't tell you the survey. I can get it for you from - we know it from Melbourne. But we - so in Victoria, they actually mandated that everybody in - about five years ago - that every PGY1 and 2 had to do a psychiatry rotation.

Now, they weren't able to actually implement it, I mean, it was logistically too difficult for them, I think, but certainly the number of PGY1 and 2 rotations in psychiatry did increase quite significantly, and we think that that's one of the reasons why it is a much more attractive training experience for them.

In New South Wales, we've got very patchy PGY1 and 2 terms, some places have very little, other places like the

Hunter, for example, that's another Hunter tick, they have a lot of PGY1 and 2 rotations. So it's probably a key to its success.

We see this as very important. We put it in our pre-budget submission asking for an increase in rotations year on year over the next three years, and we didn't get any this time. But anyway, we'll keep prosecuting that argument.

Q. In your pre-budget submission you had some particular numbers for increased rotations?
A. Yes.

Q. So year 1, 50 positions; year 2, 100 positions; year 3, 150 positions.
A. Yes.

Q. Were those numbers based on some internal modelling that you'd done at the college?
A. We got some idea of numbers from Victoria and we're trying to sort of increase them in a gradual fashion; rather than just saying okay, we've got to do this all overnight, but increase by 50 a year over the course of three years, yes.

Q. Finally, in paragraph 50 you tell us that there has been a 60 per cent increase in trainees over the last decade but no change in the level of administrative support. Can you just elaborate on what you mean by that point?
A. Well, so the college in New South Wales funds 1.4FTE admin staff to look after our branch training committee and really look after the recruitment side from the college perspective, look after all sort of administrative stuff pertaining to trainees that the college is engaged in, and the directors of training are provided with administrative support by the state government. So they are provided with - I can't tell you the FTE for each director of training, but they get a little bit as well. But there's been no increase in that FTE, that's admin support, over this period of time and there has been a dramatic increase in the number of trainees.

We are thinking that now is the time that we have to look at this, what the college does and what the - you know, we obviously have to speak to the state government

about it and HETI and see what can be done. It's very difficult, we know everything's difficult in the current circumstances, and we know that there are things that we can do more efficiently, and that we will try to do, but certainly how we are positioned compared with Victoria isn't great. We always talk about Victoria, and I'm sick of talking about Victoria, but they have got their house in order a little bit more than we have.

Q. Doctor, I'm sorry, said I was finished but I'm not. Are we right in understanding that registrars in psychiatry can start earlier than in some other specialties; is that right?
A. Yes. Well, it was PGY1 and now it's going back to PGY2. So it has fluctuated over the years. So when I trained, you could start as a PGY1. So after your intern year you could start as a psychiatry registrar. Then some time later it became two years - you needed two years out in your PGY experience. But now - and it went back to 1 again and now it's back to 2. So it's PGY2.

Q. Do you have a view about whether that's a good thing, bad thing or the impact of it?
A. I don't have a view about whether it is good or bad, really, because I haven't given it any thought, really. You know, we've got many more graduate medical schools now than we had. So my day, you came straight out of school, you went straight to university, straight into your job, and you were pretty wet behind the ears. Now we've got graduates - many more graduates coming to medicine and they've got more experience and life experience and perhaps, you know, they only need a PGY1 before they move - an internship before they move in. But it's been determined that two years is now required.

I can't - I must take that on notice. I don't know the extent to which this is a college thing or an AMC thing, whether they have made this requirement, but yeah, we can get back to you on that.

MR FULLER: Thank you, Doctor.

Commissioner, those are my questions for this witness.

THE COMMISSIONER: Dr Virgona, given you are here, can I just ask you some questions about this: the upper house of New South Wales parliament just produced a report --

A. Yes.

Q. -- called "Equity, access and appropriate delivery of outpatient community mental health care in New South Wales", which --
A. Yes.

Q. You knew about the inquiry, the report was published on the 4th - only last month, on 4 June 2024.
A. June.

Q. Have you read that report?
A. Yeah. I went through it.

Q. Anything I want to ask you about it - and I'm not going to take you through the whole report because that would be crazy, but if there's anything about it you want to take on notice you can.
A. Yes.

Q. Because we can get the college's feedback on it, given it's really relatively recent. But some of the key findings and recommendations, can I just get your view on, and again, I won't take you through all of them, but in some of the key findings, key finding 5 was:

> *Safe workloads for clinicians working in public mental health services, as well as remuneration that reflects their skills and the challenges of their roles, can assist in recruitment and retention of staff.*

I assume you would endorse that finding?
A. Yes. Yes.

Q. I think we touched on this when we had our discussion about the Commonwealth and the MBS, but the finding that:

> *Integration between primary care and mental health services is not well supported.*

Is that something you agree with currently?
A. The integration is not - it's not happening.

Q. Integration between primary care and mental health services is not well supported?
A. Well, it's not happening. I mean - is that what you

mean? Yes, I mean, I think, yes, it's --

Q. It's not what I mean. One thing you can't hang me is this isn't my report, so --
A. No, no, but I think the --

Q. -- for example, I won't be making recommendations that government should consider anything.
A. I mean, we've made, like - the interaction between - I mean, integration - I mean, you've got - it's a no-brainer really that in this fragmented system the more we can integrate the better we're going to have in terms of outcomes for everybody. The more efficient things - the more efficient things are going to be.

Q. This was certainly touched upon in your evidence, but one of the findings is:

> *There is currently insufficient information and data on workforce, which prevents effective workforce allocation.*

Do you agree with that?
A. Yeah, yeah. Absolutely. I mean, we're in a - I won't say an argument but we're sort of seeking to get workforce data from the federal government about distribution of psychiatrists, about what sort of work they're doing. Because all that data is - all the data in the private sector is collected by Medicare and also by AHPRA, who do an extensive survey of us every year, everybody's got to fill in an extensive survey before they pay for their medical registration. But that data is never released or made available and we're really trying hard to get access to it so we can be part of the solution to the workforce issues.

Q. I imagine this may not be controversial but I'm not a clinician so I'm going to ask you anyway. One of the findings is:

> *Emergency departments are not an appropriate setting to provide mental health care in the majority of presentations.*

Do you agree with that?
A. Yes. Absolutely. Yes.

Q. I won't take you through all of the recommendations, in part because I don't - this isn't a criticism - I don't yet fully understand them all.
A. Sure.

Q. Based on some of your evidence, recommendation 10 is:

> *The NSW Government [should] immediately increase pay for New South Wales public mental health clinicians, including staff specialists, junior doctors, nurses ...*

Et cetera. I imagine that's not something you would disagree with?
A. Yeah, we're not going to disagree with that.

Q. In fact, it would be something you would agree with, I assume?
A. Yes, it's absolutely critical.

Q. Yes, correct, okay
A. I mean, it would have to be - this is critical. I'm not talking about only our craft group; you know, across all the specialty craft groups it's really critical.

Q. Recommendation 19 is this:

> *The NSW Government immediately commit to increase and maintain funding across the entire mental health system to support both the workforce and consumers, with a priority investment in community-based mental health services.*

Do you agree with that?
A. I do. I mean - so the - as I said earlier, we formed an alliance of all the peak bodies in mental health before the last election in New South Wales, and this was our key point, that there had to be a commitment, there had to be this gap analysis with a focus on the community mental health sector. The beds in New South Wales, we spend more on beds than the other states do, in terms of proportion of the mental health budget. So we - so the beds are less of an issue in New South Wales than it is in other states. Certainly beds - the beds outside of hospital, like step-down beds, and beds - and accommodation for people

with chronic mental illness who require higher levels of care, I mean, that's an area of investment that has to happen in New South Wales. But in terms of pure hospital beds, we're not as badly off as some of the other states and we really wanted to focus attention --

Q. But going back --
A. We really want to focus attention on community.

Q. But going back to the community, and I think in your evidence - I will have to paraphrase because I haven't got the transcript right in front of me - you yourself said, in the course of answering a question from Mr Fuller, that there is an underinvestment in community health - community mental health centres.

Can I ask you this about that recommendation 19 that you support, and again, I need your views as a clinician: would I be right that if there was an extra investment in primary care of the kind we've discussed, like GPs being better funded to deal with patients with mental health conditions, and also a greater investment in the community mental health centres, can that potentially lead to patients - a reduction in the number of patients with mental health conditions needing admission to public hospitals, as inpatients?
A. Well that - yeah, that's the idea. Fewer presentations to the emergency department, keeping people out of the ED, being able to sort of get people - getting in early for people when they've got a problem. People languish. They don't know where to go, who to see or how to get in to see them, you know, and then the crisis escalates and they end up in the ED, and I mean this is a story that happens day in, day out in New South Wales and across Australia, really. But I mean, you know, it's particularly pertinent here.

I think, you know, building up the capacity of the GP sector, building up the capacity of the community mental health sector will make a big difference. Instead of people being discharged too early from community mental health follow-up - we know that if you've got a case manager and we know that if you are having regular contact with the community mental health team and seeing a psychiatrist, then, you know, your admission rate's going to be lower. Once you remove those things, then you are likely that your condition is going to deteriorate and the

need for hospitalisation is going to increase.

Q. One of the things your college has done that I'm sure you are familiar with is prepare a report in 2023 called "NSW mental health care system on the brink: Evidence from the frontline". You would be familiar with that report?
A. Very much so, yes.

Q. All I wanted to ask, without going through the report with you, I note it's dated March 2023, a number of the things in it are things you've actually said in your evidence today.
A. Sure.

Q. I assume that report is still the current view of the college in terms of its contents?
A. Yes, yes, absolutely. If anything, since that time things have got worse. I mean, I think in terms of the workforce issues that we were sort of talking about in that, we've had more - we've got together more evidence since that time, which only indicates that things are sort off - that things are deteriorating. I'll just --

Q. All right, well, I'll --
A. Yeah.

Q. No, sorry, you were about to say something else, so you feel free.
A. I just wanted to say you know when you go to a meeting with ministers and with the ministry, and you represent an organisation --

Q. Occasionally I do.
A. Yes, and you represent an organisation like mine and they're used to hearing my voice and they're used to hearing my story, and they say, "Virgona's come back with the same old story, he just sings the same tune every time." But we - but in response to our advocacy, they did re-establish the psychiatric workforce group, which involves the mental health branch, the workforce branch and our organisations.

What was fantastic when we had our first meeting was that every clinical director in the state - psychiatrist clinical director in the state - came to that meeting and they all painted the picture which I have - we had been articulating. Myself, ASMOF, AMA, we had all been singing

the same song. But it came from the coalface, from these people. So it was really important, I think, for the ministry to hear it from, you know, voices outside of mine. So they know exactly: this is true. We're not - this isn't a beat-up. This is a real crisis.

Q. I'm sure you're familiar with it, but did you have a role in the preparation of the submission that your college made to the upper house inquiry?
A. Yeah, I did have a role in that, and we - I took the view that I didn't want to keep saying the same things over and over, because we've already got the gap analysis, the state government was doing the gap analysis, they'd asked me to participate in one of the committees that was looking at it, and so we thought that that was sort of happening, and I didn't want to go over, "We need to keep - we need to do this", blah, blah, blah, because something was happening, there was something in train. We said, "Okay, we'll wait. Things are bad. We'll wait for the outcome of that, let's focus on a couple of other things", which is what we did in our submission.

Q. Two of the recommendations the college made in its submission - well, I'll break them up. One of the recommendations was for the government to invest in what's described as a "centre of excellence in trauma-related disorders" --
A. Yes.

Q. -- "with the broad aims of education, training and supervision of health and sector staff, as well as tertiary level clinical service provisions to those with the most severe disorders". What resulted - the recommendation that seems to have resulted in that is for the government to "consider establishing a centre of excellence for research, training, et cetera. Can I just ask you to elaborate what the college had in mind in relation to that centre of excellence in a bit more detail?
A. Well, I think it's --

Q. And why it would be useful?
A. Yes, why it would be useful. We - oh, this is very big. How much time have we got? But there's an argument within the mental health sector around two different conditions, if you like. One is called borderline personality disorder and one is called complex post-traumatic stress disorder. Now, borderline

personality disorder and complex post-traumatic stress disorder share a lot of characteristics, and, in fact, some will say that those with borderline personality disorder all have a complex post-traumatic stress disorder. So the symptoms that we see that lead to them coming to the attention of mental health services have their origins in cumulative trauma during the course of their lives.

Now, with borderline, I've been active in this space for quite some time and I think I was, I might say, one of the advocates for a borderline personality service for the state, and that occurred about a decade ago, where the government put up some money for a statewide service to educate and train staff around borderline personality disorder. That is the Project Air at Wollongong University, they won the tender for that and they've been running the programs in this space since.

Some of their programs, they're education programs that they run for staff and for consumers and carers, but they also have been rolling out - were commissioned to roll out a gold card program. I think it is a gold card or a green card. But anyway, these are programs where people that present to emergency departments with deliberate self-harm, overdoses or cutting, for example, and who are deemed fit for discharge, they will be given a card and they'll be given follow-up assessment by a psychologist. I don't know how many appointments they get but it's a small number of appointments.

There is some evidence to suggest that just doing something very simple like that will diminish the - reduce the number of presentations to the emergency department for this sort of group of people.

Q. Right.
A. What we see in this state and across the country is that we've developed - the National Health and Medical Research Council have developed guidelines for the management of borderline personality disorder and most of it revolves around long-term psychological therapy. So you need to have a big chunk of therapy. You're not going to - these people have got severe trust issues, severe attachment issues, they've had terrible lives, they've had terrible things happen to them, been treated terribly by people. It's going to take them time to build a relationship with a trusted clinician over time and to be

able to work through the issues and help them to achieve much better symptom stability, right?

But, however, there's no - nothing in our system, you know, either through the Medicare system or the state government system, that provides this treatment. You get bits and pieces of it delivered. So separate community teams, and I set these up in the teams that I was involved in a decade ago or so, where we had therapy programs, which were outpatient therapy programs for a certain number of people that could squeeze into them.

Then there are other programs that have been run via university clinics, et cetera. But really there's no - this is a big chunk of people in the population, and they can't access regular psychological therapy. Through the MBS, they can get 10 sessions that are going to be subsidised through Medicare, you know, but most psychologists charge half as much or twice as much and it's very difficult to pay for those, but that's only 10 sessions, you know, and these people need 40 or 50 sessions at least.

So there's also, within the community, within the mental health sector, pejorative connotations around people with borderline personality disorder because they present frequently in a dramatic way to emergency departments, they can be difficult, they can be cranky, they can be irritable, they can be dismissive. So people get pretty burnt out and frustrated by dealing with them, and that was part of the reason why we need to educate staff around this issue.

Now, I don't think, over time, that there has been much of a shift in attitudes toward people as a result of this investment. That's not a massive investment, it was like 900,000 or a million dollars a year that Project Air was getting from the state government, I think. I can't remember the exact numbers. It's really hard to run a big program that's going to get statewide reach.

So we wanted to shift the focus, and part of what's happened over the course of the last decade has been a shift more to considering the problems that these people present with as being rooted in trauma, and that we - I think that if people have an idea about this person being traumatised, and repeatedly traumatised in their life - and

that's the root of their problems - that they're going to have - there's a shift in attitude toward them, rather than seeing them as just someone with a personality disorder who is - you know, they're difficult and impossible to treat, and there's a lot of therapeutic nihilism associated with them.

Plus, there are some therapeutic programs associated with complex post-traumatic stress disorder which are quite beneficial and, you know, looking good. So it was to sort of shift that sort of appreciation of the sorts of problems that these people have and the different approach to dealing with them. So there was going to be a lot of education and training around that.

In Victoria, they've got a statewide personality disorder service, which is now a personality and trauma service. They've thrown trauma into the mix because they know that trauma must be - it's got to be included as part of the picture. Now, that's a service that gets $5 million a year funding.

There's also another service down there, which is a university based service and provides Australia-wide reach, however, most of the activities occur in Victoria, again, and that's a service with a much bigger budget again. So the people in Victoria are getting access to these sorts of services and I think not only access to the services, it's more the access to the education and training for staff, carers and consumers around these things, and that's what I was trying to get to happen in New South Wales.

Q. So the benefit of that personality disorder service is what? It's twofold. It's the training that you are talking about - it might be threefold: the training that you are talking about for the clinicians; it's the treatment for the patient; but also, I imagine, with the aim or actually the outcome that those patients are seen somewhere other than an ED?
A. Yes. Exactly. You keep them out of ED.

Now, of course, you know, you're going to be limited. We could do - we can train up our clinicians in this way so the people in ED are geared up and they're much more empathic and attuned and, you know, not making things worse and dealing better with patients, and we can train up

our community mental health team staff, but unless we can actually deliver some therapy to these people, you know - and you know, you need bums on seats of psychologists who are going to be able to see these people week in and week out over long periods of time, unless we do that, you know, it will make some impact but it's not going to have a huge impact.

Whether that's delivered by the MBS, because the MBS - weird things happen with the MBS. For example, the eating disorders people, through the Butterfly Foundation, got into the ear of the federal government and, all of a sudden, if you had an eating disorder, all of a sudden, you could get access to 40 sessions with a psychologist, right?

So the eating disorder people are sort of, you know, in a way, looked after, although the impact of that I guess has yet to be seen. We've got a - I don't know that there's been a dramatic improvement in the outcome for people with eating disorders but we'll - I don't know the data. But why the MBS can't be used in that way I don't know, and why - but I also think the state government has a role in this area as well.

Q. Well, it will be money.
A. Of course it is, yes.

Q. It will be money.
A. Of course it's money, yes.

Q. Can I just ask you this, and I think this is linked to what you were telling me about personality disorder service in Victoria. On page - I'll read it out to you. On page 5 of your college's submission to the upper house --
A. Yes.

Q. -- one of the topics is "A commitment to major investment", and the submission says this:

Other states have seen unprecedented new investment in mental health services over the last two years (Queensland, Victoria, SA and WA). The New South Wales Government will need to look beyond business as usual requests to treasury for enhancements to new sources of revenue to meet these

> *requirements. Nothing short of historical investment will stem the tide of sector fragmentation where gaps are becoming chasms.*

Just pausing there, leaving aside the reference to the government having to look beyond business as usual or treasury having to look beyond business as usual, which I think means it might have to provide extra funding than it has in previous years, the unprecedented new investment in mental health services by the other states you've referred to, I take it one might be this personality disorder service in Victoria, or are there other things and, if so, can you tell me what they are?
A. Oh, no, I meant - sorry, no, the personality disorder service has been there for over a decade.

Q. Right, okay.
A. No, I'm referring to the outcomes of the Royal Commission and the outcomes of the upper house inquiry in Queensland, leading to the big investment. So what they did in Queensland was they did the gap analysis that we're wanting to do in New South Wales, and they came up with a list of priorities, they looked at the gaps, viewed the gaps in child and adolescent services, the gaps in older person services, et cetera, prioritised what they were going to do and they committed half a billion dollars worth of new money to enhance services in those parts of the business. So I mean, that's big money. And we've never given big money to things in New South Wales, it's always been this sort of incremental game in New South Wales. It's not going to cut the mustard.

Q. Can I just conclude by asking this, and I think this is entirely consistent with the evidence you've given, particularly when we were discussing extra funding from the Commonwealth in terms of primary care for people with mental health conditions, but tell me whether you agree or not with this - I'm just reading now from the AMA's submission to the upper house Inquiry, where they said:

> *AMA (NSW) is calling on the government to review the current Medicare remuneration model to better support general practitioners managing mental health conditions.*

A. Yes.

Q. That's consistent with your view, I take it?
A. Absolutely consistent, yes. Yes.

THE COMMISSIONER: Did anything emerge out of any of that for you?

MR FULLER: It didn't, Commissioner. I just wondered whether some of the documents might be marked for identification for the transcript.

THE COMMISSIONER: It's my fault that they are not in the bundle, but what we will do is MFI 11 will be the legislative council report number 64, 4 June 2024, titled "Equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales"

MFI # LEGISLATIVE COUNCIL REPORT NUMBER 64, 4 JUNE 2024, TITLED "EQUITY, ACCESSIBILITY AND APPROPRIATE DELIVERY OF OUTPATIENT AND COMMUNITY MENTAL HEALTH CARE IN NEW SOUTH WALES"

THE COMMISSIONER: MFI 12 can be the Royal Australian and New Zealand College of Psychiatrists report titled "The New South Wales mental health care system on the brink: Evidence from the frontline"

MFI #12 ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS REPORT TITLED "THE NEW SOUTH WALES MENTAL HEALTH CARE SYSTEM ON THE BRINK: EVIDENCE FROM THE FRONTLINE"

THE COMMISSIONER: MFI 13 will be the submission of the Royal Australian and New Zealand College of Psychiatrists to that upper house inquiry, which was dated 13 September 2023

MFI #13 SUBMISSION OF THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS TO AN UPPER HOUSE INQUIRY, DATED 13 SEPTEMBER 2023

THE COMMISSIONER: I also read from the AMA's submission, which will be - what am I up to? MFI 14? MFI 14 will be submission of the AMA (NSW) Limited dated 6 September 2023

also to that upper house inquiry.

MFI #14 SUBMISSION OF THE AMA (NSW) LIMITED DATED 6 SEPTEMBER 2023 TO THE SAME UPPER HOUSE INQUIRY

THE COMMISSIONER: They were all the documents I referred to, weren't they?

MR FULLER: Yes. Can I just note for the transcript that the College of Psychiatrists - MFI 13 - is in the tender bundle at H1.117.

THE COMMISSIONER: Excellent. Thank you. You don't have any further questions?

MR FULLER: No, I don't, thank you.

THE COMMISSIONER: Mr Cheney?

MR CHENEY: Just a couple of things.

THE COMMISSIONER: This is Mr Cheney, senior counsel for NSW Health, Dr Virgona.

<EXAMINATION BY MR CHENEY:

MR CHENEY: Q. Dr Virgona, can you hear me?
A. Yes, yes, good day.

Q. Good day. You gave some evidence earlier about your experience of the Sydney LHD and the Western Sydney LHD and in particular the position of executive director of mental health?
A. Yes.

Q. I think you said it was your experience that psychiatrists were ineligible to apply for that role?
A. That was my - that's it. That's my understanding, yes.

Q. Was that an understanding gleaned from your own involvement in those LHDs or from --
A. No, no, no. Just from people passing the information on to me. I don't --

Q. Can I suggest to you, sir, that the position, in fact, is that far from there being an ineligibility in

psychiatrists for applying for those positions, that psychiatrists are indeed eligible to apply for those positions?
A. All right. I mean --

THE COMMISSIONER: Q. If that's the case, you would accept that, Doctor?
A. If I'm mistaken, I'm mistaken. But that was the information - if that's the case, yes, sure.

THE COMMISSIONER: Are there psychiatrists employed in those positions?

MR CHENEY: Indeed there are, Commissioner. The clinical directors of both LHDs are psychiatrists.

THE WITNESS: But clinical directors are not executive - excuse me, clinical directors are not executive directors.

MR CHENEY: Q. Well, what is --
A. A clinical director - a clinical director is a psychiatrist who has a sort of role in the clinical governance of the service, not in the operational management of the service, right? So the executive director is a person that is responsible for the overall running of the service, like a chief executive --

Q. Well, if I asked you to assume there's no such position --
A. -- of the mental health service, if you like.

Q. -- in either LHD - that is, no position known as executive director of mental health or psychiatry in either LHD, can you help us with what position you have in mind?
A. Well, I mean (internet interruption) --

THE COMMISSIONER: I think he might be breaking up.

THE WITNESS: I will take it on notice and I will find out the - sorry, can you hear me?

THE COMMISSIONER: We can now. You did break off.

THE WITNESS: Yes, sorry, no, I will take it on notice, but the (internet interruption).

THE COMMISSIONER: He's obviously having trouble. How

many more questions do you have?

MR CHENEY: One.

THE COMMISSIONER: Let's just see what happens.

THE WITNESS: Because I don't quite know the exact titles or positions that I'm referring to.

THE COMMISSIONER: We just lost you for a minute, Dr Virgona.

THE WITNESS: Sorry about that.

THE COMMISSIONER: Did you say anything important?

THE WITNESS: No worries.

THE COMMISSIONER: There's just one more question, Mr Cheney tells me, so let's see if we can get it done.

MR CHENEY: Q. Was it your evidence earlier - and forgive me, I can't find it in the transcript - to the effect that, to your perception --
A. No, no. (Internet interruption)

THE COMMISSIONER: Just wait, it might be a problem with the audio link at the moment, but Mr Cheney hadn't quite finished that question.

MR CHENEY: Can you hear me, Dr Virgona?

THE COMMISSIONER: Can you hear us?

THE WITNESS: Okay I can hear you. I can hear you. I can hear you.

THE COMMISSIONER: Thank you. Mr Cheney will have another go now.

MR CHENEY: Q. Dr Virgona, was it your evidence that, to your perception, the psychiatry workforce within the public health system in New South Wales has declined in the past few years - that is, the number of people operating in that field?
A. I don't think the total number of people has declined. The total number of staff specialists has declined. The

total number of VMOs increased and the number of locums has increased.

Q. Is that your anecdotal understanding or the product of any research on that topic?
A. That was the - my recollection of meetings with the department this year --

Q. If the data demonstrates that --
A. -- involving workforce branch.

Q. If the data demonstrates that in 2019 there were 336.6 FTE staff specialist positions and in 2024, 416.4, would you accept that position?
A. No, I wouldn't accept it. So I think there we'll have to - we'll have to drill down, we'd have to drill down into that data, because I don't think that that's consistent with the evidence that has been presented by health to us or with the anecdotal evidence that we've put together.

THE COMMISSIONER: How come it is so easy for you to get these figures and so hard for the colleges? You don't have to answer that straightaway. You can answer it later.

MR CHENEY: I'm not sure it is that hard. I will leave it at that, Commissioner.

THE COMMISSIONER: Dr Virgona, can you hear me?

THE WITNESS: Yes.

THE COMMISSIONER: Thank you very much for the written documents that you supplied and also thank you very much for your time today. We're very grateful.

THE WITNESS: Good on you. Thank you very much for the opportunity. Appreciate it.

<THE WITNESS WITHDREW

MR FULLER: That's all for today, Commissioner.

THE COMMISSIONER: Tomorrow, it's Professor Haq at 10 and the rest of the witnesses that are out there, 13, 14 and 15, so we just adjourn until 10 tomorrow?

MR FULLER: Yes, thank you.

MR CHENEY: Commissioner, could I raise one matter about tomorrow?

THE COMMISSIONER: Yes.

MR CHENEY: One of the witnesses that was scheduled for today but put back to tomorrow is Mr Findley from the college of radiologists.

THE COMMISSIONER: Yes. You want some further time, I'm told, to consider what, if any, questions you might want to ask?

MR CHENEY: And I also want it to be put on the transcript that my client does reject much of what Mr Findley has said, and that is something that informs our request for some more time so we can marshal that.

THE COMMISSIONER: I'm not sure, I have probably been told and I have either forgotten or not listened properly, but is there an agreement? I have no problem with acceding to a request for further time from Mr Cheney, and I doubt whether anyone else does, but does that mean it's better to have Mr Findley at another time or not? Because otherwise he will have to come back, won't he?

MR MUSTON: He may. I think at the moment it is impractical to get him at another time having regard to his extremely limited availability.

THE COMMISSIONER: I see. So the preference is to have him but reserve another time for Mr Cheney to ask some questions - it sounds like he's going to want to, if he rejects - I don't care the way this is done, but is the current thinking that he will give evidence tomorrow and we'll find another time for Mr Cheney to ask some questions?

MR MUSTON: Until a few moments ago, at least my understanding - which I don't pretend is everyone on my side of the Bar table's understanding - was that his evidence was going to be given tomorrow and that was it.

THE COMMISSIONER: When you say "his evidence" --

MR MUSTON: Including his cross-examination.

THE COMMISSIONER: -- are you meaning his evidence in full including any examination by Mr Cheney? That's not Mr Cheney's understanding.

MR MUSTON: I do understand this morning, I think, an issue was raised with others on my side of the ledger about the possibility of deferring perhaps some or perhaps all. I'm not sure, of the cross-examination of this witness. I think some correspondence was going to be forthcoming. It may have been. I haven't seen it. But I would have thought we could attend to the cross-examination of this witness at least to the extent that it's practicable, and if it does turn out that, having regard to further instructions that are obtained, there are further things that might need to be put to this witness, then we'll seek to make arrangements to bring him back, and it will be an inconvenience to him but that's life in the big city.

THE COMMISSIONER: I haven't got it here, I left it in my room - Mr Findley's statement was provided to you when?

MR CHENEY: It was received in incomplete form on Friday afternoon. It was received in a more complete form on Friday evening.

THE COMMISSIONER: You don't need to say anything further. What I will do, provisionally we will have Mr Findley tomorrow, and I will grant time - in other words, I won't release the witness and we'll find time later on for Mr Cheney, at a later date, to ask any questions he wants to, save for, if you have a discussion when I leave about whether it's better to have Mr Findley entirely on another date, we'll also do that. But for the moment, what I'm hearing is it is convenient to have at least what I will call his evidence-in-chief tomorrow, and see what we need to do on another day.

MR MUSTON: Yes.

THE COMMISSIONER: All right. Okay. We'll do that and we'll adjourn until 10 tomorrow.

AT 4.13PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED TO THURSDAY, 25 JULY 2024 AT 10AM

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