

**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)**

<b>Mr Ed Muston SC</b>	<b>(Senior Counsel Assisting)</b>
<b>Mr Ross Glover</b>	<b>(Counsel Assisting)</b>
<b>Dr Tamsin Waterhouse</b>	<b>(Counsel Assisting)</b>
<b>Mr Ian Fraser</b>	<b>(Counsel Assisting)</b>
<b>Mr Daniel Fuller</b>	<b>(Counsel Assisting)</b>

**Also present:**

**Mr Richard Cheney SC with Mr Hilbert Chiu for NSW Health**

1 THE COMMISSIONER: Good morning.

2

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

7

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

10

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

12

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

14

15 <FRANCES PAGE, sworn: [10.04am]

16

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

20

21 <MICHELLE MOYLE, affirmed: [10.05am]

22

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

25

26 MR FULLER: Yes.

27

28 THE COMMISSIONER: I've got that.

29

30 MR FULLER: Thank you, Commissioner.

31

32 <EXAMINATION BY MR FULLER:

33

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

38

39 DR MOYLE: That's correct.

40

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

43

44 DR MOYLE: I do.

45

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

1  
2 DR MOYLE: I have.  
3  
4 MR FULLER: Is everything in that true and correct, to the  
5 best of your knowledge and belief?  
6  
7 DR MOYLE: Yes.  
8  
9 MR FULLER: Dr Page, I'll ask you the same questions. You  
10 are one of the signatories to the statement provided  
11 15 July 2024 by the college; that's right?  
12  
13 DR PAGE: That's correct.  
14  
15 MR FULLER: Have you got a copy there with you?  
16  
17 DR PAGE: I do.  
18  
19 MR FULLER: Have you had the opportunity to review that  
20 recently?  
21  
22 DR PAGE: Yes, I have.  
23  
24 MR FULLER: Is everything in it true and correct to the  
25 best of your knowledge and belief?  
26  
27 DR PAGE: It is.  
28  
29 MR FULLER: Dr Page, can I start by asking you, please, to  
30 describe your current role in the college?  
31  
32 DR PAGE: So I'm a member of the college. I'm the chair  
33 of the New South Wales regional committee and, you know,  
34 I will undertake various sort of teaching roles in  
35 conferences and that kind of thing that the college will  
36 run.  
37  
38 MR FULLER: Am I right in understanding that you are also  
39 safety and quality officer?  
40  
41 DR PAGE: So within the regional committee, yes,  
42 I currently hold the safety and quality portfolio.  
43  
44 MR FULLER: And how does the regional committee, the  
45 New South Wales regional committee, relate to the broader  
46 ANZCA council?  
47

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

5

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

9

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

14

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

17

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

24

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

35

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

38

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

47

1 MR FULLER: Around what year was that?  
2  
3 DR MOYLE: 2013.  
4  
5 MR FULLER: Are you still a member of the regional  
6 committee?  
7  
8 DR MOYLE: I am not, no. I've stepped down - you can only  
9 stay on the regional committee for a maximum of 12 years.  
10 I'm head of department of anaesthetics at St Vincent's, and  
11 there's a lot of communication between heads of departments  
12 and supervisors of training with the college on a regular  
13 basis. So I am invited on occasion to participate at  
14 regional committee as a co-chair of a working party that we  
15 put together to look at centralised recruitment for  
16 training in New South Wales.  
17  
18 MR FULLER: When did your term as chair end?  
19  
20 DR MOYLE: June this year.  
21  
22 MR FULLER: Dr Page, can you just tell us what is your  
23 clinical role?  
24  
25 DR PAGE: Sure. I'm the head of anaesthetics at Gosford  
26 Hospital, which is part of the Central Coast LHD, and prior  
27 to that for about 15 years I was the supervisor of  
28 training, rotational supervisor of training here.  
29  
30 MR FULLER: Thank you. Staying with you, Dr Page, in  
31 paragraph 1 of your statement you've told us some of the  
32 responsibilities of the college in relation to training,  
33 assessment, examination and so on. Do you see that?  
34  
35 DR PAGE: Yes.  
36  
37 MR FULLER: So point 1 on the first page of the statement.  
38  
39 DR PAGE: Yes.  
40  
41 MR FULLER: Do you view the college as also having an  
42 advocacy role in relation to its fellows?  
43  
44 DR PAGE: It will advocate for fellows, absolutely.  
45 That's a challenging - I think it depends on the context in  
46 which you're asking about advocacy. If you're talking  
47 about advocacy within the workplace, it doesn't employ - it

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

9  
10 MR FULLER: So would I be right in thinking that the  
11 college does view itself as having a general role in  
12 advocating around the health and wellbeing --

13  
14 DR PAGE: Absolutely.

15  
16 MR FULLER: -- equity and diversity and so on of its  
17 fellows; that's right?

18  
19 DR PAGE: Correct. And it has a whole department that  
20 deals with health and wellbeing. If we're not healthy it's  
21 difficult for us to provide proper health care to our  
22 patients.

23  
24 MR FULLER: It is the case that from time to time the  
25 college will get involved at the local or site level if  
26 fellows or trainees raise issues, for example, around  
27 culture, safety and so on.

28  
29 DR PAGE: Correct, absolutely. And as part of the  
30 training and accreditation requirements, any hospital that  
31 has ANZCA trainees is required to undertake an  
32 accreditation process with the college on a five-yearly  
33 basis, or more frequently if there are issues. And one of  
34 the particular issues that the training and accreditation  
35 team that visit that hospital will be interested in is to  
36 hear from the trainees, and from the senior staff in the  
37 department as well, but especially from the trainees, that  
38 they are being treated appropriately, that there aren't any  
39 issues with bullying, harassment and that kind of thing,  
40 that they have appropriate access to their training needs  
41 et cetera.

42  
43 MR FULLER: I'll come back to that a bit later.

44  
45 Dr Moyle, for the moment, do you have anything to add  
46 to what Dr Page has said on that issue?  
47

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

4  
5 MR FULLER: In what ways?

6  
7 DR MOYLE: Just in terms of certainly from an  
8 accreditation perspective, it's a reasonably powerful tool  
9 in terms of if a department feels that it's unable to  
10 provide safe anaesthesia for patients because of staffing  
11 issues.

12  
13 There was an accreditation visit in a hospital in  
14 New South Wales where there were significant staffing  
15 issues and the college threatened - well, "threatened"  
16 might be a strong word but discussed with the executive of  
17 that hospital the issues that it saw from a patient safety  
18 perspective and that was met with an appropriate solution,  
19 which that particular department had been struggling with  
20 for some time. So I do think it does become - it is  
21 a strong tool in terms of maintaining patient safety and  
22 staff safety.

23  
24 MR FULLER: It's a strong tool - why do you say it is  
25 a strong tool?

26  
27 DR MOYLE: I think it's really important that there is an  
28 external body that can maintain and determine clinical  
29 governance of maintenance of standards, for example. You  
30 know, nearly every person will require an anaesthetic at  
31 some point in time and if you don't have something to be  
32 able - something of substance to go to executive of  
33 hospitals and wider, then it's hard to argue, really.

34  
35 MR FULLER: Is it right, then, that you see the role of  
36 the college as including setting and maintaining broader  
37 professional standards for the anaesthesia profession?

38  
39 DR MOYLE: Yes, I think so. Certainly there's a new -  
40 I think it's called a chapter, we're not allowed to call it  
41 a - what was the - I can't remember the name of  
42 the perioperative medicine --

43  
44 DR PAGE: No, chapter is right, Michelle, yes.

45  
46 DR MOYLE: It is now a chapter because of, I don't know,  
47 university regulations, and that is around perioperative

1 medicine.

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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?



1  
2 DR MOYLE: Yes, absolutely. I mean, once upon a time,  
3 anaesthesia was sort of the - it would determine whether  
4 surgery went ahead or not, whether you thought somebody was  
5 going to survive. You know, the mortality rate from  
6 anaesthesia these days is exceptionally low and I think  
7 we're much more - we're in a position where we can actually  
8 see - like, we accept patients on the basis of their  
9 fitness for anaesthesia that once upon a time we would not  
10 have chosen.

11  
12 So I think the peri - anaesthetists are in a very good  
13 position to help with that perioperative care because the  
14 individual specialists that, say, look after a patient's  
15 heart or their lungs or their kidneys are not necessarily  
16 skilled in what happens in the operating room itself, and  
17 so whereas we see all of that.

18  
19 And then obviously there is the postoperative recovery  
20 as well. So there is an increasing emphasis within the  
21 college on encompassing perioperative care rather than just  
22 the actual time that the anaesthetic is being given to the  
23 patient.

24  
25 MR FULLER: Am I right in thinking that when you said the  
26 college is in a "unique" position, that's because its  
27 fellows are the ones involved in that clinical work; is  
28 that right?

29  
30 DR MOYLE: Yes, I think so. I think anaesthetists are -  
31 obviously are the membership of the college and in our  
32 workplaces we are being called much more frequently to  
33 attend to all sorts of issues around the hospital beyond  
34 the operating room. So the expansion of services for  
35 anaesthetists is much greater than just the operating room  
36 now.

37  
38 MR FULLER: In terms of accreditation being a powerful  
39 tool, as you've described it, I take it you'd agree that  
40 withdrawing accreditation, for example, is something that  
41 may have serious consequences for the delivery of  
42 anaesthesia services in a hospital?

43  
44 DR MOYLE: Absolutely, yes.

45  
46 MR FULLER: Dr Page, do you have anything you want to add  
47 to what Dr Moyle has just said?

1  
2 DR PAGE: I think Michelle's comment about the wider work  
3 of anaesthetists beyond simply providing anaesthesia care  
4 in the operating theatre is really important. It gives us  
5 an opportunity to interface with almost every other  
6 discipline in the hospital. So we see our physician  
7 colleagues when we provide supportive care for  
8 interventional procedures that they undertake; we provide  
9 pain interventions for patients across the hospital from ED  
10 to palliative care and pretty much everywhere in between.

11  
12 I think that that gives us a unique insight into the  
13 nuanced working of the wider hospital, which is why I think  
14 that we're well placed to then offer suggestions or ideas  
15 as to alternative appropriate pathways for care for  
16 patients, more than simply surgery. Surgery is appropriate  
17 for very many people, but sometimes, alternative options  
18 need to be considered and the nature of our work means that  
19 we're able to do that.

20  
21 Accreditation is a powerful tool. If hospitals are  
22 accredited with the college for training, their positions  
23 are desirable, as far as trainees are concerned, so they  
24 attract better quality of application of junior doctors to  
25 the hospital. The college does not undertake withdrawal of  
26 accreditation lightly. It understands that it has a huge  
27 impact on the trainees, which is detrimental to the  
28 trainees; on the department and on patient care and it  
29 would far rather work with the hospital to see, you know,  
30 the appropriate standards met.

31  
32 I guess one of the things that maybe I didn't mention  
33 or didn't well articulate when you were asking earlier  
34 about standards, you know, there are standards for  
35 accreditation but there are also the professional documents  
36 that the college has which set standards for care across  
37 many different, you know, aspects of care. Those are there  
38 for reference for all hospitals, for all departments, and  
39 they are used by other disciplines as well, you know, so  
40 physicians providing sedation may actually use some of  
41 those documents as well, may refer to those.

42  
43 MR FULLER: Those documents you're referring to are things  
44 like the college's professional guidelines in --

45  
46 DR PAGE: Correct, yes.  
47

1 MR FULLER: Is that right?

2

3 DR PAGE: Yes.

4

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

9

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

22

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

27

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

33

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

36

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

40

41 DR PAGE: Yes.

42

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

45

46 DR PAGE: No.

47

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

5  
6 DR MOYLE: Correct.

7  
8 MR FULLER: Do you agree that the lack of competition  
9 makes it important for colleges, such as yours and others,  
10 to have fair, effective and transparent processes for  
11 governance and administration of training programs?  
12

13 DR MOYLE: I don't think so. I mean, the college doesn't  
14 actually employ anybody. It sets the standards, the  
15 performance standards, and so I think - I'm not sure that  
16 another competitor, if you like, in terms - to ANZCA, like  
17 the ASA, for example, might be - I mean, the ASA is  
18 generally a professional body that's grown because of more  
19 support for practitioners in private practice. That was  
20 their original missive, and so they don't tend to get  
21 involved in accreditation.  
22

23 I think the whole - like, accreditation of facilities  
24 only occurs from an ANZCA perspective when there are  
25 actually trainees in that facility. So ANZCA, for example,  
26 doesn't accredit a private hospital that doesn't have  
27 current trainees in it.  
28

29 THE COMMISSIONER: Sorry to interrupt. I think there's  
30 perhaps a disconnect between your question and the answer.  
31

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

34  
35 *Do you agree that the lack of competition*  
36 *makes it important for colleges, such as*  
37 *yours and others, to have fair, effective*  
38 *and transparent processes for governance*  
39 *and administration of training programs?*  
40

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

43  
44 DR MOYLE: Yes.

45  
46 THE COMMISSIONER: -- I would be surprised if you had the  
47 view that your college shouldn't have fair, effective and

1 transparent processes for governance and administration.  
2  
3 DR MOYLE: Oh, no, I think that absolutely --  
4  
5 THE COMMISSIONER: So you agree with that?  
6  
7 DR MOYLE: Yes, I definitely agree with that.  
8  
9 THE COMMISSIONER: The issue I think Mr Fuller is trying  
10 to get at is: is competition needed for that or is your  
11 college able to do that --  
12  
13 DR MOYLE: I don't think competition is needed.  
14  
15 THE COMMISSIONER: -- and desires to do that in any event?  
16  
17 DR MOYLE: Yes, no, I think the college achieves that,  
18 yes.  
19  
20 MR FULLER: Thank you, Commissioner.  
21  
22 Dr Moyle, do you think that the lack of competition,  
23 that is the college being the only pathway, makes it  
24 particularly important for there to be fair and transparent  
25 processes?  
26  
27 DR MOYLE: Yes.  
28  
29 MR FULLER: Dr Page, do you agree with that?  
30  
31 DR PAGE: Absolutely. And I think they are, and those  
32 standards are freely available to everybody.  
33  
34 MR FULLER: Yes. Dr Page, as we understand it, the  
35 training program in anaesthesia includes a requirement for  
36 trainees to complete subspecialised training.  
37  
38 DR PAGE: Yes.  
39  
40 MR FULLER: Is that right?  
41  
42 DR PAGE: Yes.  
43  
44 MR FULLER: That's in three areas, cardiac --  
45  
46 DR PAGE: No. It's actually in more than three areas.  
47 It's in 12 areas. But the three areas that I think you are

1 about to refer to, cardiac, neuro and paediatrics, are the  
2 three bottleneck areas. So those are the areas that are  
3 not provided in every hospital.  
4

5 Other specialised study units - there is one in  
6 ophthalmic surgery, one in orthopaedics, et cetera,  
7 et cetera, there's a number of them. But those obstetrics,  
8 et cetera, are much more widely available and therefore the  
9 opportunity for trainees to get access to the experience  
10 that they need to meet the training requirements in those  
11 specialty areas is not problematic. Because neuro  
12 anaesthesia, cardiac anaesthesia and paediatric anaesthesia  
13 is performed in limited quantities and in limited  
14 locations, that's what makes it tricky for the trainees to  
15 get the required experience and to meet the required  
16 standards.  
17

18 MR FULLER: Just to be clear, the 12 subspecialties that  
19 you have referred to, are they the same as the specialised  
20 study units or --  
21

22 DR PAGE: Study units, that's correct.  
23

24 MR FULLER: -- the SSUs?  
25

26 DR PAGE: The SSUs, yes.  
27

28 MR FULLER: So paragraph 42, for example, of your  
29 statement, when we see that reference we can understand  
30 that as meaning the 12 areas of specialisation?  
31

32 DR PAGE: Correct.  
33

34 MR FULLER: You refer later in paragraph 42 to the  
35 roadblocks to access subspecialised training in the three  
36 areas that we've just mentioned.  
37

38 DR PAGE: Correct.  
39

40 MR FULLER: I see. Is it the college's view that  
41 subspecialised training in each of those 12 areas is an  
42 essential requirement for someone to become a competent  
43 anaesthetist?  
44

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

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

9  
10 So it's about giving people a minimum exposure to have  
11 a baseline understanding of what is involved in those  
12 subspecialty areas, so that if that's an area of interest  
13 to them, they can explore it further through their  
14 provisional fellow year and on into their consultant  
15 practice, so that we can actually get people to sort of  
16 continue in those subspecialty areas, but also so that the  
17 rest of us who aren't cardiac anaesthetists, neuro  
18 anaesthetists, et cetera, kind of know why there are  
19 boundaries that we would be sensible to not cross.

20  
21 MR FULLER: Dr Moyle, do you have anything to add as to  
22 why it's important in the college's view for those  
23 subspecialties to form part of the training program?

24  
25 DR MOYLE: So there are a whole bunch of procedural  
26 skills, technical skills that all anaesthetists need to  
27 have, and some of those skills are - there are more on  
28 offer in some of those specialised study units than others.  
29 I think, as Frances has said, Dr Page has said, some of -  
30 the expectation is not that you become a specialist in any  
31 of those particular specialised areas but that you observe  
32 and actually get to practise that within the skilled  
33 environment so that you can understand nuances of aspects  
34 that you see more in those specialised study areas, just in  
35 the general population at any time. So it's just really -  
36 it's about identifying, you know, and experiencing the  
37 types of conditions that can occur in a general population  
38 in any hospital that you might work at.

39  
40 MR FULLER: So in circumstances where the college sees  
41 there being roadblocks in paediatric, cardiac and neuro in  
42 particular, nevertheless you don't see any room to move on  
43 those being essential parts of the curriculum; is that  
44 right?

45  
46 DR MOYLE: No, I think the college has always maintained  
47 some flexibility in adjusting volume of practice targets,

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

12  
13           Obstetrics is obviously important.

14  
15           The neurosurgical is - it's sort of the changing face  
16 of where these procedures are actually done has made it  
17 more difficult to achieve those volumes of practice targets  
18 for everybody. Cardiac, you know, there's actually  
19 a decline in the number of cardiac surgical procedures but  
20 more work in cath labs, for example, where anaesthetists  
21 are involved across the state. So it is still - you know,  
22 we're constantly arguing whether we should be insisting  
23 that trainees do those specialised study units. I think at  
24 the moment it's the right mix, yes.

25  
26 MR FULLER: You mentioned the college having had some  
27 flexibility in the volume of practice targets. Can you  
28 just elaborate on that, please?

29  
30 DR MOYLE: Okay, so back when the curriculum first  
31 started, in 2013 when it changed, there was a volume of  
32 practice for neonates, for example, and it was actually  
33 really difficult for all trainees to get that volume of  
34 practice, and so the working party that looks after  
35 education and training and curriculum looked at what was  
36 the benefit in insisting on that target. I think it was  
37 20 under 2, or something like that, that had to include  
38 a certain number of neonates, and so it was adjusted.

39  
40           So now the numbers are much more reflective of what  
41 the general anaesthetist in a general hospital would be  
42 expected to know, and it's really - sometimes it's not so  
43 much - it's more, as you get further on in your specialist  
44 career, you tend to subspecialise, but you may still have  
45 a patient come through the ED, for example, with  
46 a specialist problem that it would be expected that  
47 everyone could handle. So you may not be a super expert at



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

4  
5 THE COMMISSIONER: Do I understand "20 under 2" to mean 20  
6 procedures on a child under 2 years of age?

7  
8 DR MOYLE: Yes, 20 cases, yes.

9  
10 THE COMMISSIONER: Thanks.

11  
12 MR FULLER: So is this a fair summary of your view, that  
13 despite what the college has identified as the roadblocks  
14 in those three particular areas in the statement, in your  
15 statement, at the moment, you think that the balance is  
16 right in terms of the subspecialty areas, but it's a matter  
17 that the college is keeping under review; is that fair?

18  
19 DR MOYLE: Yes, I think that's fair, yes.

20  
21 MR FULLER: Dr Page, do you have anything to add on that  
22 issue?

23  
24 DR PAGE: No, I think that's a pretty fair summary of it.  
25 I mean, medicine changes over time, so we should expect  
26 that the curriculum for anaesthesia training and for any  
27 other discipline in medicine should similarly change over  
28 time, and it's about getting that balance right - what is  
29 the minimum amount of experience that somebody needs to be  
30 able to practise safely, versus, you know, what is so much  
31 that it is so onerous that it's not achievable.

32  
33 I think the college is very cognisant of that problem  
34 and is really working hard to find the right balance, and  
35 I don't think that there's too many fellows, supervisors of  
36 training, or actually trainees, that think that the numbers  
37 where they are at the moment are fundamentally wrong.

38  
39 MR FULLER: Thank you. Dr Page, as we understand it, the  
40 college accredits sites rather than individual positions;  
41 that's right?

42  
43 DR PAGE: Yes, that's correct.

44  
45 MR FULLER: What's the reason for the college taking that  
46 approach?

47

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

17  
18 MR FULLER: Dr Moyle, do you have anything to add on that  
19 sort of historical issue.

20  
21 DR MOYLE: That background is correct. So all trainees  
22 who participate in an anaesthetic roster, for example, in  
23 an accredited facility, will be in an accredited position.  
24 The college decided to accredit - so in its accreditation  
25 of facilities, it will determine how many years that  
26 facility can provide training for. So that number of  
27 years - so how do I - okay, so St Vincent's Hospital is  
28 full accreditation of 156 weeks, because we can provide all  
29 of the SSUs. If a hospital is only able to provide two  
30 SSUs, then they will get one-year accreditation. So the  
31 accreditation is for the number of years of training.

32  
33 I think that that's reasonable. It's very difficult  
34 for - and what was your second part of your question again?

35  
36 MR FULLER: I think you've answered my question.

37  
38 DR MOYLE: Did that answer it?

39  
40 MR FULLER: Yes, thank you, Dr Moyle. It's the case that  
41 there may be individuals at PGY3 plus performing similar  
42 work to anaesthesia trainees at sites that are not  
43 accredited by the college; is that your understanding of  
44 the reality?

45  
46 DR MOYLE: I don't think - I don't think that occurs.  
47

1 MR FULLER: Not in anaesthesia, to your knowledge?

2

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

10

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

23

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

26

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

36

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

39

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

1  
2           The college, when they come to accredit St Vincent's,  
3 they just accredit St Vincent's. Because our trainees are  
4 rotating to other accredited facilities, those facilities  
5 are accredited on their own. So if we were to send our  
6 trainees to a non-accredited hospital, they would not have  
7 their training accredited. So clearly we don't do that.

8  
9           There are some hospitals in New South Wales that are  
10 accredited as satellites, where they don't necessarily have  
11 their own accredited anaesthetic trainees but they accept  
12 trainees from their parent hospital for a specified period  
13 of time. So, for example, Ryde Hospital is not accredited  
14 for anaesthetic training but it has now just been  
15 accredited as a satellite of North Shore, so North Shore  
16 will send their accredited trainees there and that time  
17 there will be accredited despite the hospital not being  
18 accredited in its own right.

19  
20 MR FULLER: Thank you. Do you have an appendix A to your  
21 statement there with you? It might be easier just to look  
22 at an example.

23  
24 DR MOYLE: Yes.

25  
26 THE COMMISSIONER: Can that go on the screen, because  
27 I don't have it?

28  
29 MR FULLER: I think so. The number is  
30 [SCI.0011.0196.0001]. Thank you.

31  
32           So as I understand it, and tell me if this is wrong,  
33 this appendix sets out each of the accredited sites in  
34 New South Wales?

35  
36 DR MOYLE: Correct.

37  
38 MR FULLER: And it also identifies for each site,  
39 rotations --

40  
41 DR MOYLE: Yes.

42  
43 MR FULLER: -- and any satellite that the site has, which  
44 you have just described what that is? So if we have a look  
45 on page 0009, at St Vincent's Hospital, we see that - tell  
46 me if this is right: St Vincent's Hospital itself is an  
47 accredited site?

1  
2 DR MOYLE: It is.  
3  
4 MR FULLER: Is what is what is set out in that row not  
5 quite correct?  
6  
7 DR MOYLE: "Central Gold Coast" is not correct. I'm not  
8 sure if that's a typo from the college.  
9  
10 MR FULLER: In terms of the rotations --  
11  
12 DR MOYLE: As a rotation, yes.  
13  
14 MR FULLER: -- St George is a rotation from St Vincent's;  
15 is that right?  
16  
17 DR MOYLE: Yes, actually we have a number of rotations  
18 that aren't listed there. So there is St George,  
19 Wollongong, Wagga Wagga, Royal Hospital for Women, the  
20 Children's Hospital Westmead.  
21  
22 MR FULLER: Focusing on St George as an example, St George  
23 is itself an accredited hospital?  
24  
25 DR MOYLE: An accredited hospital, correct.  
26  
27 MR FULLER: But St Vincent's Private Hospital, which is  
28 listed as a satellite, is not itself accredited; is that  
29 right?  
30  
31 DR MOYLE: That's correct. So St Vincent's Private  
32 Hospital is a satellite technically because it doesn't  
33 employ its own accredited trainees because it's not  
34 accredited of itself. So we have - we actually send  
35 trainees there on a different funding model. There's  
36 a specialist training program which is run through - it's  
37 a federal funded program that allows hospitals to send  
38 trainees to private facilities, so those private facilities  
39 generally would be accredited as a satellite of that  
40 hospital, and that is to - the main reason for that is to  
41 improve access to those roadblocks such as cardiac. So we  
42 use that for cardiac at St Vincent's, because at the  
43 private hospital we have outstanding cardiac services  
44 offered by the same team that do it at the public hospital,  
45 so we have trainees that come from Wollongong and also from  
46 Gosford, who come there specifically for cardiac.  
47

1 MR FULLER: Is that the only situation where a hospital  
2 might have a satellite or are there other reasons why the  
3 college might use the satellite model?  
4

5 DR MOYLE: The main reason for satellites is to increase  
6 exposure to - or, yes, for those sort of hard - the SSUs  
7 that are hard to get or, in our case obviously, it's not  
8 difficult for us to get cardiac SSUs at St Vincent's, but  
9 we don't have enough work in the public hospital, for  
10 example, to bring other people to us, but if we combine  
11 with the private hospital, then we have enough cases across  
12 the campus that we can accommodate trainees from other  
13 centres to get - help them get their cardiac training.  
14

15 MR FULLER: Are the satellites ever used by the college to  
16 help trainees get exposure in rural and regional areas?  
17

18 DR MOYLE: Yes. There they can use the STP process. They  
19 also use a thing called IRTP, which is - I can't remember  
20 what it stands for, but it's for rural trainees where the  
21 federal government - it's a federal government initiative  
22 and they fund a specific rural trainee and then that rural  
23 trainee takes their funding with them to wherever they need  
24 to go. So that's a very attractive option for most public  
25 hospitals in New South Wales because they're not paying for  
26 that trainee and that trainee is actually contributing to  
27 the hospital in terms of helping with service provision but  
28 also getting their SSUs.  
29

30 MR FULLER: Does the college have any systematic process  
31 for working out whether hospitals either form part of the  
32 same rotation or have a satellite?  
33

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

1  
2 MR FULLER: So that's an example of a situation where  
3 hospitals approach you about - that is, the college - about  
4 setting up that structure?  
5  
6 DR MOYLE: Yes.  
7  
8 MR FULLER: Does the college do anything proactively to  
9 encourage those sorts of structures, particularly in rural  
10 and - involving rural and regional sites?  
11  
12 DR MOYLE: The college is the main driver for managing the  
13 STP and IRTP process.  
14  
15 MR FULLER: Sorry, just pausing there, can you just  
16 explain STP and IRTP?  
17  
18 DR MOYLE: So that's a federal source of funding. So they  
19 manage - so individual hospitals in New South Wales will  
20 apply to the college to receive funding through this  
21 federal model. So the college will put out an expression  
22 of interest amongst all hospitals and then, you know,  
23 there's a wait list of hospitals who would like to be  
24 considered for STP or IRTP, and then the college actually  
25 does the leg work in terms of putting those hospitals up  
26 for consideration.  
27  
28 So St Vincent's - so we have an STP position; Westmead  
29 and Westmead private have an STP position; I think there's  
30 also one in Dubbo, maybe, that came through last year. And  
31 there is a wait list of mainly rural and regional places.  
32  
33 MR FULLER: The availability of those positions is based  
34 on Commonwealth funding; is that right?  
35  
36 DR MOYLE: Correct.  
37  
38 MR FULLER: Does the college apply to the Commonwealth for  
39 that?  
40  
41 DR MOYLE: Yes.  
42  
43 MR FULLER: Dr Page, do you have anything to add on the  
44 question of - on the issue of rotations and satellites?  
45  
46 DR PAGE: I was just - yes. It's a challenging one  
47 because the college doesn't have easy vision of the service

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

12  
13 So I suppose in answer to your question, how does the  
14 college drive that process, it can't really because it  
15 doesn't have the information to be able to know who is  
16 needing what growth of services where.

17  
18 In terms of the STP and IRTP funding, the STP funding  
19 is for a position in a hospital, and it seems that probably  
20 the best use of that is to fund positions where bottlenecks  
21 exist.

22  
23 For example, the STP application at St Vincent's  
24 private was something that Gosford Hospital was very  
25 involved with, because at that time we were seeking  
26 additional accreditation, we were seeking to move from a  
27 two-year accredited site to being a three-year accredited  
28 site and the roadblock for us in achieving that was having  
29 a mechanism to get cardiac experience for our trainees.  
30 The ability to get a position at St Vincent's private then  
31 offered us the opportunity to work with St Vincent's to get  
32 our trainees down there and then that kind of got us over  
33 the line as far as three years of accreditation goes.

34  
35 So there is a lot of working out that happens between  
36 anaesthetists in individual hospitals, and in all honesty,  
37 the college keeping tabs on all of these conversations,  
38 developments, et cetera, is really hard work, and is very  
39 much dependent on us remembering to tell the college where  
40 things are at. So I can look at this document and I can  
41 just see, oh, yes, that's changed or that's not quite right  
42 as Michelle has just said to you. The suggestion that  
43 St Vincent's somehow has a link with the Gold Coast  
44 hospital is a little bit fanciful. I know that that's not  
45 the case. But I think that's just representative probably  
46 of us failing to tell the college in a timely fashion of  
47 what's changed and what's not changed, because it does on



1 a frequent basis.

2

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

5

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

7

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

21

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

28

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

40

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

44

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

1 application and will sort of say, "Yes, this makes sense",  
2 or, "They need to do a bit more work in this area."  
3

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

22  
23 THE COMMISSIONER: Can I just ask about the integrated  
24 rural training program you have mentioned?  
25

26 DR PAGE: Yes.  
27

28 THE COMMISSIONER: How should I understand that? So  
29 that's funding provided by the Commonwealth to a particular  
30 trainee?  
31

32 DR PAGE: Yes.  
33

34 THE COMMISSIONER: So that they do some of their  
35 anaesthetic training in a regional centre, obviously at  
36 a hospital that has accreditation?  
37

38 DR PAGE: Correct.  
39

40 THE COMMISSIONER: But because most, I suppose, of those  
41 regional hospitals that have accreditation don't do cardiac  
42 or paediatrics, part of that training for that trainee that  
43 is on the integrated rural training program, they have to  
44 go back to the city --  
45

46 DR PAGE: Correct.  
47

1 THE COMMISSIONER: -- to complete their --

2

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

13

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

22

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

28

29 DR PAGE: Correct.

30

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

37

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

39

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

43

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

45

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

1  
2 DR PAGE: Exactly right. And those regional/rural sites  
3 have also been accredited for a further provisional fellow  
4 year, which is the final year of training, so that those  
5 trainees that have gone on the IRTP pathway have the option  
6 to stay for their final year of training in that regional  
7 site, very much with the hope that they will then have put  
8 down enough roots that they want to stay there long term.

9  
10 THE COMMISSIONER: And I assume the data behind the  
11 theory, as with other specialties or branches of medicine,  
12 is that whilst it's no guarantee, people that are trained  
13 in regional New South Wales are more likely to stay and  
14 work --

15  
16 DR PAGE: Yes.

17  
18 THE COMMISSIONER: -- in regional New South Wales than  
19 someone that's been trained entirely or largely in a  
20 metropolitan area?

21  
22 DR PAGE: Yes. So my understanding is that, to date, the  
23 only strategy that's really borne any fruit in terms of  
24 easing that maldistribution is to actually get trainees out  
25 to those regional and rural sites during training, so that  
26 they can see that these are nice places to work with nice  
27 colleagues to work with and interesting, challenging, you  
28 know, anaesthesia to provide, such that they actually see  
29 that as a realistic option for their future career.

30  
31 THE COMMISSIONER: Yes. And how long has this program  
32 been funded by the Commonwealth? How long has it been up  
33 and running?

34  
35 DR PAGE: I think - Michelle please jump in and correct  
36 me - IRTP is reasonably recent, I think maybe over the last  
37 three to four years. STP pre-dated IRTP.

38  
39 THE COMMISSIONER: Would I be right then - and either of  
40 you can answer this - in saying given it's relatively new,  
41 is there any data, sort of evaluation data, available about  
42 whether it's actually achieving what the hope --

43  
44 DR PAGE: None that I have seen.

45  
46 DR MOYLE: There is a problem with it.

47

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

3  
4 DR MOYLE: It's been around for about five or six years.  
5 The first trainee that had it - in fact, I don't think  
6 there have been very many trainees at all who have actually  
7 had that type of funding.

8  
9 THE COMMISSIONER: It would be good to know the numbers,  
10 actually.

11  
12 DR MOYLE: It's pretty small. The first trainee had  
13 difficulty passing their primary exam. So there are two  
14 exams within your training. The first one's a primary exam  
15 after - you can't enter your third year of training until  
16 you have passed it. And then there is a final exam, which  
17 you can't sit until 150 weeks, or something, of training  
18 have gone by.

19  
20 THE COMMISSIONER: Right.

21  
22 DR MOYLE: So he couldn't pass the primary, and was in the  
23 city in a job but couldn't do his SSUs because he didn't  
24 have his primary and so then it became a huge issue because  
25 the problem is the funding is only for four years and he  
26 required six years, because of delays.

27  
28 THE COMMISSIONER: I see, yes.

29  
30 DR MOYLE: So the funding didn't follow him. So then he  
31 had to try and get a job. So I think he did eventually  
32 finish, but it was not a smooth process.

33  
34 THE COMMISSIONER: I guess we can find this out and you  
35 can take the question on notice, but how many positions are  
36 funded under the - I'm going to call it the integrated  
37 rural training program.

38  
39 DR MOYLE: Yes, it sounds better.

40  
41 THE COMMISSIONER: Do you know? Ballpark?

42  
43 DR MOYLE: I can take that on notice.

44  
45 THE COMMISSIONER: You don't think it is large numbers,  
46 though?

47

1 DR MOYLE: It's not large, no.  
2  
3 DR PAGE: I think it would be single figures.  
4  
5 DR MOYLE. Yes.  
6  
7 THE COMMISSIONER: Tell me if I'm wrong but that doesn't  
8 sound - if it's single figures, I don't know how many  
9 anaesthetists you need, but that doesn't sound like, on  
10 those numbers, that even if it's largely successful, it may  
11 not address the maldistribution of anaesthetists in  
12 New South Wales.  
13  
14 DR PAGE: No.  
15  
16 DR MOYLE: I think the best --  
17  
18 THE COMMISSIONER: Perhaps it was done as a trial, was it?  
19  
20 DR MOYLE: I think it may have worked in other specialties  
21 but it didn't work in - or it hasn't worked very well.  
22 I think the gold is in the rural network training groups  
23 getting together. That's really only just started.  
24 I think the Wagga/Albury training network is probably -  
25 they've got their first scheme trainees in first year and  
26 they're very organised, they'll be producing two people  
27 every year, hopefully within a couple of years, and they  
28 generally have - their trainees are locals and they will  
29 stay in the country.  
30  
31 THE COMMISSIONER: When you say "locals", you mean people  
32 that were actually born or raised in that --  
33  
34 DR MOYLE: Yes, yes.  
35  
36 THE COMMISSIONER: Okay, which is another - I think  
37 there's some data that that assists, too, in terms of  
38 keeping medical professionals, medical workers, health care  
39 workers, in regional/rural settings.  
40  
41 DR MOYLE: Yes.  
42  
43 THE COMMISSIONER: Just on this topic, I might just  
44 complete what I wanted to ask and you can pick it up.  
45  
46 MR FULLER: Yes.  
47

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

12  
13 DR MOYLE: I think one of the big problems with - as we  
14 said, with maldistribution, is that trainees come to the  
15 city and they have - had come to the city for most of their  
16 training, and so not all of them --

17  
18 THE COMMISSIONER: There is no way of avoiding that,  
19 unless a regional hospital starts doing cardiac surgery or  
20 neurosurgery or paediatrics, which is --

21  
22 DR MOYLE: It's very difficult in the rural centres  
23 because there's generally only one or two people there and  
24 they take on a very large after-hours load, and it's a very  
25 lonely existence, and anaesthesia, it's always nice to have  
26 some friends around, because when things go wrong, they go  
27 wrong very quickly. So it becomes a very - it's very hard.  
28 So it is not very attractive and there are plenty of jobs  
29 in the city, so people tend to stay here. I think one of  
30 the --

31  
32 THE COMMISSIONER: But the reality is - it doesn't matter  
33 whether it's anaesthetics - the big training hospitals are  
34 in the metropolitan --

35  
36 DR MOYLE: In the city. ANZCA has been very actively  
37 involved, though, in the rural generalist program. Our  
38 president of our college a few years ago is a real activist  
39 for rural training and generalist training.

40  
41 Queensland has about - I think they've got 60 rural  
42 generalists who have - not all of those have completed  
43 their anaesthetic years --

44  
45 THE COMMISSIONER: So this is general practitioners who  
46 are doing training?

47

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

9

10 THE COMMISSIONER: I see. Why is that?

11

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

24

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

27

28 DR MOYLE: They do not, no.

29

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

33

34 DR MOYLE: Yes.

35

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

40

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

43

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

46

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



1 core training years.  
2  
3 THE COMMISSIONER: Right. What would you have to do in  
4 the city?  
5  
6 DR MOYLE: For Wagga, they will get enough paediatrics  
7 there, but they will need neurosurgery and cardiac.  
8  
9 THE COMMISSIONER: That's what I thought, all right. You  
10 also say "and other centres are likely to follow within the  
11 next two years".  
12  
13 DR MOYLE: So Dubbo and Orange have put forward a  
14 proposal. It's a little in its infancy. It needs a little  
15 bit more, you know --  
16  
17 DR PAGE: It needs a bit more working out, doesn't it,  
18 yes.  
19  
20 DR MOYLE: A better description of how they're actually  
21 going to manage it. They will get there.  
22  
23 THE COMMISSIONER: We've been to Dubbo and we've been to  
24 Wagga so I should know that, but is the main Dubbo public  
25 hospital and the Orange public hospital of similar size?  
26 They are slightly smaller than Wagga, would that be right,  
27 than the Wagga Base Hospital.  
28  
29 DR MOYLE: Yes, I think Wagga is bigger.  
30  
31 THE COMMISSIONER: But they are still doing similar  
32 procedures?  
33  
34 DR MOYLE: Yes they are doing good volume of practice.  
35 Again it's very general. They may struggle a little more  
36 for paediatrics than Wagga and Albury do.  
37  
38 THE COMMISSIONER: Looking at - again for either of you -  
39 23 of your statement where you're talking about the nature  
40 of the recruitment process hindering workforce --  
41  
42 DR MOYLE: You've got the two co-chairs of the centralised  
43 recruitment working party here.  
44  
45 DR PAGE: How long have you got?  
46  
47 THE COMMISSIONER: I was going to ask you can you expand

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

4  
5 DR PAGE: I was going to chip in earlier, sorry,  
6 Commissioner --

7  
8 THE COMMISSIONER: No, please do.

9  
10 DR PAGE: -- and just sort of say that you were asking  
11 a question about why does Queensland train more GP  
12 anaesthetists than New South Wales does. I think part of  
13 the problem that New South Wales has is its size, and over  
14 time, everybody's kind of grown and done their own thing  
15 individually, whereas if you look at all of the other  
16 states and territories in Australia, the total number of  
17 trainees is much smaller and the total number of training  
18 sites and schemes is much smaller, and therefore, it's just  
19 much easier, when you've only got two or three or four, or  
20 in some instances only one scheme, to organise, it's much  
21 easier to then organise training within that one or two  
22 schemes.

23  
24 When you look at 12 in New South Wales - and they've  
25 all, over time, developed their own affiliations and  
26 training rotations and who they send where for what -  
27 trying to bring them all together on the same page makes  
28 herding cats seem like child's play. It really is very,  
29 very challenging and the numbers are just absolutely --

30  
31 THE COMMISSIONER: That's an organisational problem you're  
32 identifying?

33  
34 DR PAGE: It is, and that's what you see with annual  
35 recruitment. So each year you will have, you know, of the  
36 order of 350, up to 400, people applying for an anaesthesia  
37 training position in New South Wales. Each one of those  
38 individuals can only obviously occupy one job. But they  
39 know the competition is fierce, so they apply to every  
40 single tree and lamp post across the state, and interstate  
41 as well. So each year, the hospitals - each individual  
42 training site receives an application from almost all of  
43 the applicants. So, you know, to get 300, 320, 350  
44 applications is not at all unusual.

45  
46 So each training site then has to go through the CVs  
47 and the written applications of all of those applicants,

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

2  
3 So if we have 10 jobs arbitrarily, we can't just  
4 interview 10 people, because we know that those 10 people  
5 will want to go elsewhere. So the law of averages tells us  
6 that we need to interview roughly four people per position  
7 that we have. So you have this frenetic amount of work to  
8 shortlist a number that is going to give you enough people  
9 that want to come to your hospital that so you can fill  
10 your training jobs. So there is this huge shortlisting  
11 process, this huge interview process. Everybody's  
12 interviewing everybody else, the workload for the  
13 applicants is insane, you know, they're putting in 20, 25,  
14 30 applications, because they will apply to the scheme  
15 hospitals and then they'll apply to all of those hospitals  
16 that just offer an independent 12-month position as  
17 a back-up in case they don't get a scheme job and then  
18 they'll apply interstate as well. And we have really  
19 tried, Michelle and I, to get this whole process  
20 centralised so it's --

21  
22 THE COMMISSIONER: I've got to say, I think where you're  
23 going now is paragraph 29 of your statement where you're  
24 suggesting a centralised recruitment process would  
25 massively --

26  
27 DR PAGE: Absolutely.

28  
29 THE COMMISSIONER: How would that work? Tell me.

30  
31 DR PAGE: So the sticking point that we've got to is the  
32 administrative burden. So in the conversations that we've  
33 had with NSW Health, they've been very keen to go down the  
34 avenue of centralised recruitment and have been very keen  
35 to show us examples of where that's worked and worked  
36 really well, and the problem is that they've shown us  
37 examples of subspecialty disciplines where they've maybe  
38 had a total number of 20 or 25 applicants per year across  
39 the state. So they say, "It's really easy. You just give  
40 all of the admin role to a workforce department in a  
41 hospital, and they hold that admin role for three years and  
42 then they hand the baton on to somebody else." And we've  
43 been saying, "You can't do that when the number of  
44 applicants is of the order of 350 to 400. You will break  
45 hospitals." It's just that simple. You cannot expect that  
46 amount of organisational effort.

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

5  
6 DR PAGE: "Oh, but it's worked brilliantly in the past",  
7 and we're going, "Yes, but it has worked brilliantly when  
8 you have got 20 to 25 applicants." I think that they were  
9 beginning to see that that was what was necessary.

10  
11 We've then had the post-COVID rush to catch up all of  
12 the elective cases; we've just not been able to get to this  
13 piece of work. I've tried reaching out a couple of times  
14 in the last few months to New South Wales to the workforce  
15 department that we were speaking to before, but I'm just  
16 getting radio silence. I'm not sure if the people that we  
17 were talking to previously have moved on into other roles.  
18 But I'm trying to get in touch with them again to restart  
19 this conversation.

20  
21 THE COMMISSIONER: All right. Is there anything you want  
22 to add?

23  
24 DR MOYLE: Yes, I think there are a number of issues with  
25 centralised recruitment. It's a difficult process.  
26 There's no clear obvious way to do it. Frances and I have  
27 discussions with our colleagues in the NHS because they  
28 have a centralised process for anaesthesia for their entire  
29 country. They actually have a separate recruitment agency  
30 that manages all of that. That's not - that also is not  
31 perfect because they've just stuffed up the - there's  
32 industrial litigation because they made some mistakes with  
33 the data entry.

34  
35 THE COMMISSIONER: I'm sure the new government will fix  
36 that.

37  
38 DR MOYLE: So, you know, it's very complex, it requires  
39 separate dedicated funding and a unit that's motivated and  
40 knows what they're doing, I think, and that's a really big  
41 job.

42  
43 There doesn't - even though the people that we spoke  
44 to in medical workforce at ministry, they were very keen to  
45 help, but they didn't have any authority to determine  
46 either a location for these processes to occur or a funding  
47 source.

1  
2 I think it is a really big problem in terms of lack of  
3 transparency to the actual candidates who are applying, and  
4 I think that there's growing frustration amongst those  
5 young people who are trying to get specialty positions.  
6

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

10  
11 DR MOYLE: I think so. I think because it's individual  
12 hospitals that are doing their own recruitment, everyone's  
13 drawing from the same pool of 300 - 300 plus, and so  
14 clearly no individual hospital can interview the number of  
15 people that truly deserve to get an interview.  
16

17 THE COMMISSIONER: Yes.  
18

19 DR MOYLE: So there's a lot of creative culling that goes  
20 on and, you know, you can have people - so at the moment  
21 there is a preference matching of sorts, but it's overseen  
22 by the heads of department at a meeting, in a dedicated  
23 meeting, which is next Monday. So we're all exhausted  
24 because we're trying to do our clinical work, we're trying  
25 to do this, we're --  
26

27 THE COMMISSIONER: Would a centralised body aid the  
28 consistency of approach?  
29

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

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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.

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

3  
4 MR FULLER: I will come to it.

5  
6 THE COMMISSIONER: Okay. I'll let you go. You go ahead  
7 now.

8  
9 MR FULLER: Thank you, Commissioner.

10  
11 Just on that answer you just gave, Dr Page, you  
12 referred to independent positions or trainees, can you just  
13 explain for us what that means?

14  
15 DR PAGE: Sure. So it's a term that we use to describe  
16 somebody who is not in a four-year scheme position. So if  
17 you have applied for a position in a hospital that can  
18 offer all of the core training and you're given a four-year  
19 contract, that contract - the hospital is saying to the  
20 applicant that they can provide access to all of the  
21 experience required to complete core training.

22  
23 If the hospital is accredited for less than three  
24 years and doesn't have the ability to offer the applicant  
25 access to all of the training requirements for core  
26 training, we would term them an independent trainee. So  
27 they can continue and complete all of their requirements  
28 with a one-year contract here and another one-year contract  
29 there and so on and so on, but it gets progressively more  
30 difficult the further into training they get because there  
31 are very, very few, if any, independent jobs that would  
32 cover the bottleneck SSUs.

33  
34 MR FULLER: Just coming back to paragraph 29 of your  
35 statement, which the Commissioner asked you about, you say  
36 in there as well that a centralised recruitment process  
37 could be contrived to incentivise independent positions.  
38 Can you just elaborate on what you mean by that, please?

39  
40 DR PAGE: So the last meeting that we had, we had sort of  
41 talked about how we might use a centralised process to  
42 encourage progression of independent trainees into  
43 completion of their training, and one way that we could do  
44 that is by requiring, for example, six months of  
45 anaesthesia training prior to getting a scheme job. What  
46 that would mean is that, all of a sudden, all of the  
47 independent jobs across the state would be very, very

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

5  
6 MR FULLER: Does the college otherwise have any influence  
7 over the number or distribution of independent training  
8 positions?

9  
10 DR PAGE: No, and it has very little oversight or very  
11 little vision on where those jobs are, so that - and they  
12 have grown up as a consequence of workforce needs locally,  
13 so that if a site is accredited and it's got need for  
14 expansion of its workforce, it just expands the numbers,  
15 but the college has no vision of what those numbers  
16 actually are.

17  
18 MR FULLER: You've mentioned having very little vision and  
19 I think in one of your earlier answers you also mentioned  
20 the college not having easy vision of the service  
21 development needs throughout New South Wales, for example.  
22 I take it you see that as a significant issue?

23  
24 DR PAGE: Well, I guess it depends on what the college  
25 wants to do or what people think the college should be  
26 doing. There's lots of questions around the college's role  
27 in the better distribution of workforce, the better  
28 distribution of trainees across the state, but that's not  
29 really what the college is for, and the college, even if it  
30 took a view that it should step into that space, it doesn't  
31 have the information that it needs to be able to do that.  
32 So it's a little bit of a moot point. Does that answer  
33 your question?

34  
35 MR FULLER: Yes. Dr Moyle, do you have anything to add on  
36 that topic?

37  
38 DR MOYLE: No.

39  
40 MR FULLER: Commissioner, I'm about to move on to another  
41 topic and I note the time.

42  
43 THE COMMISSIONER: That would be a convenient time.

44  
45 Dr Page, we're going to have a break now,  
46 a mid-morning break. You don't have to sit in front of  
47 your screen while that occurs. So if you could just come



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

3  
4 DR PAGE: 11.50, no problems, thank you.

5  
6 THE COMMISSIONER: We'll adjourn until 11.50.

7  
8 DR PAGE: Thank you.

9  
10 **SHORT ADJOURNMENT**

11  
12 THE COMMISSIONER: Yes, Mr Fuller.

13  
14 MR FULLER: Thank you, Commissioner.

15  
16 Dr Moyle and Dr Page, I'm going to move on now to ask  
17 you a few questions about the college's accreditation  
18 process. Starting with you, Dr Moyle, is it right to say  
19 that the accreditation standards are developed by the  
20 college?

21  
22 DR MOYLE: Mmm-hmm.

23  
24 MR FULLER: Who within the college develops them?

25  
26 DR MOYLE: So you might be best to direct this question to  
27 Frances, because Frances is actually on the trainee  
28 accreditation committee.

29  
30 MR FULLER: Thank you.

31  
32 Dr Page, do I take it from Dr Moyle's answer there's  
33 a training and accreditation committee that's responsible  
34 for the standards?

35  
36 DR PAGE: There is a training and accreditation committee  
37 and I've done some accreditation work on behalf of that  
38 committee. So the committee exists and it applies the  
39 accreditation standards that you would have seen in the  
40 handbook.

41  
42 MR FULLER: What do you view as being the function of the  
43 accreditation standards?

44  
45 DR PAGE: It's to provide a benchmark of safety and  
46 quality training to ensure that those minimum standards are  
47 met across all of the training jurisdictions in

1 Australasia.

2

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

9

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

23

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

25

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

33

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

1  
2           So I think it's also a reminder about trainees and  
3 your teaching and training programs. During the pandemic,  
4 for example, it was - you know, everything sort of fell  
5 apart, really, and the emphasis was on direct patient care  
6 rather than - I think trainees started to miss out a little  
7 bit so it's another moment to stop and recollect and reset.

8  
9           MR FULLER: Do you think it's appropriate for the college  
10 as the entity that's responsible for accrediting training,  
11 effectively, accrediting in the context of training, to use  
12 the accreditation process to look at broader issues of  
13 safety and professional standards?

14  
15           DR MOYLE: I do. Although that's not formalised, that  
16 does occur in practice. For example, as I said earlier,  
17 anaesthetists are involved in much more than just the  
18 operating room, so our reach extends well beyond that, and  
19 there's been an explosion - the pandemic made it worse -  
20 of, say, patients who are waiting for elective endoscopy,  
21 you know, bowel screening programs are in place, and those  
22 endoscopy centres are often separating from operating  
23 rooms, and so it's been an opportunity for many hospitals  
24 for their anaesthetic departments and the gastroenterology  
25 departments to get together to determine what is the  
26 minimum safe staffing requirement, for example.

27  
28           With more and more patients having deep sedation or  
29 full anaesthetics in the endoscopy room, you know, there is  
30 a requirement, a high-level requirement for equipment, for  
31 example, and resources. So I know that that has been a big  
32 issue in many hospitals. So yes, in an informal way, it  
33 does extend into other areas.

34  
35           MR FULLER: And your view is that it is appropriate to be  
36 done --

37  
38           DR MOYLE: Absolutely.

39  
40           MR FULLER: -- by way of the accreditation standards for  
41 training, effectively; is that right?

42  
43           DR MOYLE: Yes, I think the accreditation is a mandated  
44 thing, and so we have to meet - and it becomes - the thing  
45 that I'm thinking of in my own head is, you know, just the  
46 allocation of anaesthetic nurses, dedicated anaesthetic  
47 nurses to the anaesthetists in the endoscopy room, for

1 example. You know, when you've got resource shortages and  
2 funding shortages, there is a - you know, people interpret  
3 the guidelines in many different ways and the college  
4 accreditation standards have been very helpful in ensuring  
5 that the appropriate staffing is dedicated to that area.  
6

7 MR FULLER: We might just have a look at the college's  
8 accreditation standards on that particular --  
9

10 DR PAGE: Can I just - sorry, may I just add in one other  
11 comment?  
12

13 MR FULLER: Yes, please.  
14

15 DR PAGE: Just to make the observation that I think any  
16 healthy organisation would welcome the opportunity for a  
17 little bit of self-reflection, whether that's an individual  
18 department or whether that's the whole of the hospital or  
19 whether it's completely outside of health, and I think that  
20 that's one of the things that TAC, the training and  
21 accreditation committee or the training and accreditation  
22 process offers.  
23

24 I think also informally it offers the opportunity for  
25 anaesthetists to talk with one another, from different  
26 hospitals. So in anaesthesia we very much work in silos of  
27 single individuals. I very rarely get to see what any of  
28 my consultant colleagues are doing, because if I'm in  
29 theatre, they're not with me, and vice versa. Whereas the  
30 groups of accreditors, usually three or four, so small  
31 groups of people who come to an individual hospital on  
32 a planned basis, they are dealing with the same real world  
33 issues in their own hospitals as the site being accredited  
34 is managing. So you can just have informal conversations  
35 with the accreditors about "How do you manage this?" You  
36 know, "What are your workarounds for this particular  
37 problem?" And I think those can actually be incredibly  
38 supportive and incredibly helpful to heads of departments,  
39 supervisors of training, trainees and just the wider  
40 anaesthesia department. Sorry to interrupt.  
41

42 MR FULLER: No, thank you. In practice, though, it is the  
43 case that sometimes those informal conversations or usages  
44 of the accreditation standards can rise to the level of,  
45 for example, withdrawing accreditation or imposing  
46 conditions on accreditation?  
47

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

8  
9 Something that is below the line is something that is  
10 of recommendation to the hospital, recommendation to the  
11 particular department, but is not something that TAC is  
12 going to mandate or pursue. And then during the course of  
13 the visit, the day, the two days, however long TAC is  
14 actually at that particular site, there will be other  
15 conversations that will happen with the various different  
16 people that TAC meets with, which will never make it to  
17 a piece of paper, but are just offered in the spirit of  
18 collegiality, "You might want to try this", or "We've had  
19 some success with ... "

20  
21 MR FULLER: But if, for example, on a site visit, the  
22 college inspection team observed what it thought was  
23 a significant breach of safety in a particular - in the  
24 department, is it the case that the college may take some  
25 sort of accreditation-related action in relation to that,  
26 even if it didn't have a direct impact on the training of  
27 trainees in that department?

28  
29 DR PAGE: Ultimately, that's the final stick that the  
30 college has got to wield, but in practice, that doesn't  
31 very commonly happen, and it certainly doesn't happen  
32 without plenty of lead notice. So, for example, I went to  
33 New Zealand for a three-day visit, to three different sites  
34 in New Zealand, last month. One of those particular sites  
35 has been having an annual visit, every year.

36  
37 Next year will be the start of their new five-year  
38 cycle and it's an unusual situation because they've still  
39 not signed off all the problems that were identified five  
40 years ago. So the college has gone back every year and is  
41 still talking to them about the same above the line issues  
42 that they're not managing to resolve, but is still working  
43 with them to try and get resolution to those issues, but  
44 hasn't taken - hasn't withdrawn accreditation.

45  
46 So it could do it, but it chooses not to because it's  
47 more beneficial for everybody to try and fix the problems

1 rather than just chuck the whole sort of system out.

2

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

7

8 MR FULLER: Yes. Thank you.

9

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

13

14 DR PAGE: In an ideal world, yes.

15

16 MR FULLER: When you say that --

17

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

20

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

22

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

31

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

36

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

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

3

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

7

8 DR PAGE: Yes. Yes.

9

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

14

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

18

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

22

23 DR PAGE: Not in detail.

24

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

27

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

29

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

35

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

47

1 MR FULLER: Dr Moyle, are you --  
2  
3 DR MOYLE: There was a review of the college's - certainly  
4 the training, I'm not sure if the accreditation standards  
5 were part of that or not, but certainly the training  
6 program and trainee selection - everything to do with  
7 trainees, basically - within the last two to three years,  
8 AMC, I know that Frances and I were both involved in that  
9 from - because they interviewed members of the New South  
10 Wales regional committee. There were no issues identified.  
11  
12 MR FULLER: Are you familiar with the National Health  
13 Practitioner Ombudsman report at all?  
14  
15 DR MOYLE: I have skimmed it. I can't say that I could  
16 Remember it.  
17  
18 MR FULLER: One of the recommendations of that report was  
19 that the --  
20  
21 DR MOYLE: The Kruk report? No, a different one?  
22  
23 MR FULLER: Yes, a different report. But leaving aside  
24 the report, you can take it from me that it's been  
25 recommended that the AMC develops a procedure for colleges  
26 to follow when developing their accreditation standards.  
27 Do you think that is a good idea?  
28  
29 DR MOYLE: Yes, I think a national body that oversees all  
30 colleges is - that's got to be a good idea. I know that  
31 the executive of ANZCA are in constant contact with the AMC  
32 and - yes.  
33  
34 MR FULLER: That's not something you're involved in?  
35  
36 DR MOYLE: We don't get involved in that aspect.  
37  
38 MR FULLER: Dr Page, do you agree that, in principle, it  
39 would be a good idea for a body such as the AMC to have  
40 a procedure in place for colleges to follow when developing  
41 their own accreditation standards?  
42  
43 DR PAGE: It makes sense to have that sort of consistency  
44 across the board, absolutely. I guess it just depends on  
45 the detail in that process and exactly how much the AMC  
46 would be controlling of that process. I mean, clearly  
47 ANZCA knows more about anaesthesia training than the AMC



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

3

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

7

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

14

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

27

28 DR PAGE: Mmm-hmm.

29

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

34

35 DR PAGE: Mmm-hmm.

36

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

39

40 DR PAGE: Yes.

41

42 DR MOYLE: Yes.

43

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

1           that --  
2  
3           DR PAGE:    Yes.  
4  
5           DR MOYLE:   Yes.  
6  
7           THE COMMISSIONER:   -- a fair summary, all of that?  Is  
8           there anything you want to add, either of you?  Dr Page  
9           first, anything you want to add?  
10  
11          DR PAGE:    No, I think that's a very fair summary and  
12          I think that's a pretty accurate description of what  
13          currently happens with TAC.  
14  
15          MR FULLER:   Dr Moyle?  
16  
17          DR MOYLE:    Yes, I agree.  
18  
19          MR FULLER:   Are either of you familiar with the way in  
20          which the college system operates in the UK at the moment?  
21  
22          DR PAGE:    I trained in the UK but I left there 20 years  
23          ago.  So are you talking about accreditation in the UK?  
24  
25          MR FULLER:   Yes.  Please, go on.  
26  
27          DR PAGE:    There is an accreditation process but I left the  
28          UK as my training had completed and I was just becoming  
29          a consultant.  So I would not have had any opportunity as  
30          a trainee to be involved in accreditation in the UK.  But  
31          I've experienced accreditation in the UK and it's not  
32          wildly dissimilar to the experience in Australia in terms  
33          of a nuclear group of consultants from different hospital  
34          sites coming to visit, talking to staff members, seeing the  
35          facilities and then having conversations with supervisors  
36          of training, heads of department and presumably the  
37          executive of the hospital, though I would have never seen  
38          that in the UK.  
39  
40          THE COMMISSIONER:   For all I know, what you've just said  
41          might well be right.  There was evidence given yesterday by  
42          Professor Hockey, I think, that suggested there was  
43          a reform about 10 years ago.  I have to admit I'm not up to  
44          speed as to what that reform is.  I have requested  
45          something be done.  I don't know whether Mr Fuller has  
46          a better idea.  
47

1 MR FULLER: Can I maybe ask the question in this way,  
2 Dr Page: at the time you were subject to the accreditation  
3 process in the UK, do you know whether that process was  
4 performed by the colleges or by some central body?  
5  
6 DR PAGE: By the colleges, to the best of my knowledge.  
7  
8 MR FULLER: Thank you.  
9  
10 THE COMMISSIONER: That was what Professor Hockey  
11 suggested might have changed about 10 years ago.  
12  
13 DR PAGE: Yes, and that may be consistent with  
14 centralisation of recruitment and quite a lot of  
15 organisational change that has happened in the UK. But  
16 that's all happened since I have left there, so please take  
17 what I'm saying with a large grain of salt.  
18  
19 THE COMMISSIONER: I mean, I don't know what this reform  
20 is. I doubt very much, though, that it just involves  
21 a site deciding whether it will be accredited or not.  
22  
23 DR PAGE: No, no.  
24  
25 THE COMMISSIONER: I'm sure there's a more in-depth  
26 process than that, but we'll find out what it is in due  
27 course.  
28  
29 DR PAGE: The UK has moved very much more centrally  
30 organised rather than individual hospitals doing their own  
31 thing across all of the training. I'm absolutely sure that  
32 they wouldn't have individual sites ticking themselves off,  
33 marking their own homework.  
34  
35 MR FULLER: Dr Page, what would be your reaction to  
36 a proposal that the colleges' roles in Australia should be  
37 limited to setting curriculum, standards - curriculum and  
38 standards for training programs and examining trainees,  
39 with the accreditation function instead performed by some  
40 central body, separate from the colleges?  
41  
42 DR PAGE: I would worry that there would be a lot of  
43 support lost. Accreditation visits are principally  
44 designed to support departments and to support the trainees  
45 within those departments and offer an opportunity, as  
46 I say, for feedback and for working out local issues.  
47 I think if you've got a separate accreditation body that

1 has got, if you like, a tick sheet, you know, "Is this  
2 particular device in place, is this particular process in  
3 place", that side of things can be very easily achieved,  
4 but some of the nuance will get lost. "How do you find the  
5 quality of the teaching that you receive in your  
6 department? Does it happen when it should? Is it pitched  
7 at the level that you need it to be pitched at? Can you  
8 get workplace based assessments achieved when you need to?"  
9 Some of those much less discrete questions that accreditors  
10 spend a lot of time asking I think would be very difficult  
11 to achieve with an external body that really doesn't  
12 understand what training is and what training looks like.  
13

14 MR FULLER: Do you think those problems could be addressed  
15 by the external body receiving expert advice from, for  
16 example, anaesthetists who are fellows of the college, but  
17 ultimately the accreditation decision is made externally  
18 not at the college level?  
19

20 DR PAGE: I actually think that would be incredibly  
21 difficult. One of the - probably the most important  
22 meeting of any accreditation visit is with the trainees and  
23 we try incredibly hard to sit face-to-face in the room with  
24 them. I'm cognisant of the loss or fidelity of our  
25 conversation by me being online and we do try and read the  
26 room as much as possible, and we'll go on a - you know,  
27 a digging exercise. You know, we'll sort of try and ask a  
28 very kind of open-ended question and then we'll pick up on  
29 themes that the trainees bring up, and normally that  
30 meeting with the trainees goes on for an hour, and you can  
31 really start to see a change in - you know, there's an  
32 anxiety within the trainees, "Who are the strangers that  
33 have come to the hospital?" "Are we in trouble?"  
34

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

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

5  
6 MR FULLER: Why, if at all, do you think it's important  
7 for the college to be involved or mediate in that process  
8 rather than, for example, specialist anaesthetists being  
9 engaged by an external body to perform that inspection  
10 function? Why does the college need to be involved?

11  
12 DR PAGE: Okay, so you're sort of saying could we take the  
13 college out of the equation --

14  
15 MR FULLER: Yes.

16  
17 DR PAGE: -- could you have some kind of external body  
18 that would just - you could do that. You could do that,  
19 absolutely. I guess there is a sense of I am part of  
20 ANZCA, I feel a sense of loyalty and obligation to ANZCA.  
21 I am prepared to give up some of my time to help facilitate  
22 that role, and now you are sort of saying there is another  
23 body that wants another chunk of your time and, you know,  
24 it's just how many people want how much of you. There is  
25 only so much of any of us individually that we can spread  
26 around over all of the different wants that exist. It  
27 could be done, I'm sure it could be done.

28  
29 DR MOYLE: I think that's a very interesting question.  
30 Obviously our facilities, there are accreditation teams  
31 that occur across the wider facility. I think they focus  
32 on very different things to what our specialist colleges  
33 focus on. I think it's important that the college remains  
34 involved in terms of the oversight and setting of standards  
35 for training, and with accreditation, it's kind of part and  
36 parcel of that whole process. So I think when the  
37 college - the college's processes, when I was a trainee,  
38 were much less formalised, and I think that there was  
39 a huge difference between hospitals, because once the  
40 college became involved, it sort of set the bar, really,  
41 the minimum standard.

42  
43 I think what that managed to do was elevate the  
44 performance of those hospitals that maybe weren't so great,  
45 in terms of what they had on offer for training and patient  
46 safety. I think that the college has definitely added to  
47 the patient safety aspect in a broader sense.

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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

1 one site in New South Wales who didn't have enough people.  
2 I think it was not that they didn't have enough people;  
3 they didn't have enough people who were willing to come in.  
4

5 DR PAGE: Can I --

6  
7 MR FULLER: Does the college have - sorry, Dr Page.

8  
9 DR PAGE: May I just make a contribution in that? In the  
10 handbook for accreditation there is a recommended ratio of  
11 the number of supervisors to the number of trainees. So  
12 there is a suggestion that an individual supervisor of  
13 training shouldn't be supervising - shouldn't have  
14 overarching supervision of more than five trainees.  
15

16 I'm not talking about the day-by-day, one-on-one  
17 supervision whilst you're providing anaesthesia care, but  
18 a supervisor of training will have responsibility for  
19 ensuring that, over time, trainees meet their training  
20 requirements and don't fall behind on collecting the items  
21 of evidence that they need to suggest that they've got the  
22 experience that they should have got.  
23

24 So in that sense, there is a ratio that's recommended,  
25 and that's partly to make sure that there is somebody that  
26 each trainee can talk to, if they're struggling with their  
27 training in some way, and partly to make sure that the  
28 burden of training responsibility isn't excessive on the  
29 seniors. I'm not sure if that was answering part of your  
30 question.  
31

32 MR FULLER: It might be easier if I just go to the  
33 document. The document number is [ACA.0011.0007.0001].  
34 I think we have a hard copy available for Dr Moyle and  
35 I think Dr Page --  
36

37 DR PAGE: I can see it online. I've got a soft copy here.  
38

39 THE COMMISSIONER: Can you tell me what volume of the  
40 materials it is in?  
41

42 MR FULLER: I might just ask you to be provided with  
43 a hard copy at the moment. I'm not sure that it is --  
44

45 THE COMMISSIONER: It may not even be in there yet. Okay,  
46 thanks.  
47

1 DR MOYLE: Sorry, what number was it?  
2  
3 THE COMMISSIONER: It's on the screen.  
4  
5 MR FULLER: It's on the screen as well but I might just  
6 start at page 13 in appendix 1.  
7  
8 THE COMMISSIONER: So this is not in the tender bundle  
9 yet?  
10  
11 MR FULLER: I don't believe it is.  
12  
13 DR PAGE: Are you talking about "Summary of the criteria  
14 underpinning each ANZCA accreditation standard"?  
15  
16 THE COMMISSIONER: Mr Fuller is just engaged with one of  
17 the staff at the moment, Dr Page.  
18  
19 DR PAGE: No problems. My apologies.  
20  
21 THE COMMISSIONER: That's all right.  
22  
23 MR FULLER: I'm told it should be in H1.53.1.2.  
24  
25 THE COMMISSIONER: So it already is, all right. Yes,  
26 thank you.  
27  
28 MR FULLER: So it is. I'm sorry about that.  
29  
30 THE COMMISSIONER: Anyway, I've got it.  
31  
32 MR FULLER: Thank you, Commissioner.  
33  
34 Page 13, appendix 1. I might just ask - so there are  
35 seven standards for accreditation; that's right?  
36  
37 DR PAGE: Yes.  
38  
39 MR FULLER: And standard 1, "Quality patient care". You  
40 see on that page - and this standard is an example, isn't  
41 it, of what we were discussing earlier where some of the  
42 accreditation standards require compliance with relevant  
43 professional statements --  
44  
45 DR PAGE: Yes.  
46  
47 MR FULLER: -- and guidelines that the college has



1 established?  
2  
3 DR PAGE: Yes.  
4  
5 MR FULLER: Those professional standards and guidelines  
6 include ones relating to the general operations of the  
7 anaesthesia department?  
8  
9 DR MOYLE: Mmm-hmm.  
10  
11 MR FULLER: Is that fair to say?  
12  
13 DR PAGE: Yes.  
14  
15 DR MOYLE: Mmm-hmm.  
16  
17 MR FULLER: For example, if we have a look on page 14, one  
18 of the accreditation criteria is "adequate assistance for  
19 the anaesthetist", and that refers to a position statement?  
20  
21 DR PAGE: Correct.  
22  
23 MR FULLER: Dr Moyle, is this the standard that you were  
24 referring to earlier in relation to the assistant?  
25  
26 DR MOYLE: For endoscopy, yes, correct.  
27  
28 MR FULLER: It would be fair to say, wouldn't it, that  
29 standards such as these that we see in this document relate  
30 not only to the capacity for the site to deliver adequate  
31 training to a trainee, but also to setting broader  
32 standards about how anaesthesia departments operate in a  
33 hospital; is that - do you agree with that, Dr Moyle?  
34  
35 DR MOYLE: Yes.  
36  
37 MR FULLER: Dr Page, do you agree with that?  
38  
39 DR PAGE: Yes, that's right. It's about safety and it's  
40 about training.  
41  
42 MR FULLER: Thank you. Just going down, then, to  
43 standards 3 and 4, these are the ones that relate to  
44 supervision.  
45  
46 DR PAGE: Mmm-hmm.  
47

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

5  
6 DR MOYLE: Yes, yes.

7  
8 DR PAGE: Correct. But the ratio that I was referring to  
9 I think is in the handbook for training, which is not  
10 a document that you're currently looking at.

11  
12 MR FULLER: I see.

13  
14 DR PAGE: So there's a handbook for training that would  
15 help inform departments about how they deliver training,  
16 what the different roles are within the department, so what  
17 a rotational supervisor would do, a supervisor of training,  
18 a departmental scholar role, a tutor, a fundamental tutor,  
19 et cetera, et cetera, and it also talks about, in there,  
20 a suggested ratio of trainees to supervisors of training  
21 and, as I say, that's to make sure that there's access -  
22 that the trainee has access to somebody that they can talk  
23 to about any issues related to their training and that  
24 appropriate sign-offs for particular chunks of time, so  
25 clinical placement reviews and so forth, can be done in a  
26 timely fashion, and to make sure that the supervisors  
27 themselves are not overloaded. It's not an inconsiderable  
28 amount of work that the supervisors of training undertake.  
29 And if you're trying to do it for 20 or 30 trainees, it's  
30 nigh-on impossible.

31  
32 MR FULLER: And it's fair to say that the practical effect  
33 of limiting - of imposing these requirements for  
34 supervision - and this is not a criticism but just  
35 practical reality - is to limit the number of trainees who  
36 might be able to take up training positions at a particular  
37 accredited --

38  
39 DR PAGE: No. No.

40  
41 DR MOYLE: No.

42  
43 DR PAGE: No, that's not true. You're not limited to the  
44 number of trainees that you put on at your hospital site.  
45 It's just that for every extra trainee that you choose to  
46 employ, you have to think about, meaningfully, how you're  
47 going to provide the training requirements for that

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

10  
11 MR FULLER: But just to understand it practically, the  
12 number of supervisors available at a given site would limit  
13 the number of trainees --

14  
15 DR PAGE: I see it the other way round. I see it the  
16 other way round. The number of trainees would then tell  
17 a site how many more supervisors of training they needed to  
18 find. I don't think that the number of supervisors is the  
19 rate-limiting step. The more trainees that you have, the  
20 more people that you want to see involved with the  
21 supervision process. If you're a site that's got one or  
22 two trainees, you only need one supervisor of training. If  
23 you're a site that's got 30 trainees, from a practical  
24 perspective, you just can't do it with one or two  
25 supervisors; you want to have more so that, you know, when  
26 one's on leave you've got somebody else that can step in  
27 and just to sort of share the load.

28  
29 MR FULLER: But if the site's position, rightly or  
30 wrongly, is that they either can't or don't want to engage  
31 any more supervisors, then the college's position would be  
32 that, well, that limits the number of trainees who should  
33 properly be able to be trained at that site?

34  
35 DR PAGE: Yes, I don't think that that would ever occur.  
36 If you've got a hospital anaesthetic department, for  
37 example, that's got five specialists in it, you would never  
38 imagine that a hospital that is that small, that has that  
39 smaller need for anaesthesia service delivery, would ever  
40 be employing, you know, 20 trainees. The anaesthesia  
41 department in any hospital anywhere is the largest single  
42 department within that hospital, by far.

43  
44 DR MOYLE: For medical workforce.

45  
46 DR PAGE: There are 70 consultants in my workforce.

47

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

3  
4 DR MOYLE: Yes. My interpretation of it, in a nutshell,  
5 the number of senior supervisors - so every senior doctor  
6 in any given hospital is - in a teaching hospital, is  
7 a supervisor by virtue of their position there, and the  
8 number of anaesthetising sites within that hospital,  
9 generally that will determine the number of senior staff  
10 that you would allocate on a daily. So there are usually  
11 far more supervisors within the remit of that department  
12 who actually aren't on site on any given day. So, you  
13 know, it would be very uncommon to have a lack of  
14 supervisors for the number of trainees.

15  
16 In terms of the number of junior trainees that are in  
17 any given site, it is the - the minimum number would be  
18 those required to sustain an after-hours roster in the  
19 hospital. Some of maybe the smaller rural hospitals might  
20 not have anaesthetic registrars on site, but every city  
21 hospital would have at least one anaesthetic registrar on  
22 site 24/7, and that determines the minimum number of  
23 trainees.

24  
25 There is greater scope for more junior trainees within  
26 each individual hospital on most occasions, because there's  
27 just plenty of work to do, but as Frances said, the  
28 anaesthetic department of any hospital is the largest  
29 medical workforce unit within that hospital, so, you know,  
30 the staffing costs, for example, of an anaesthetic  
31 department is about a third of the overall staffing costs.  
32 It's a lot.

33  
34 So in terms of the college's supervision rules, they  
35 will have - there are, from a training perspective in terms  
36 of looking after the administration components of  
37 a trainee's experience, there will be five trainees to one  
38 supervisor of training. That's essentially an admin role.

39  
40 On a day-to-day basis, the trainees require different  
41 levels of supervision depending on their seniority and  
42 their experience levels, and the nature of the patients  
43 that they are anaesthetising. So somebody in their first  
44 six months' training would have one to one supervision.  
45 There must be a senior member of staff with them at all  
46 times whenever they are delivering any patient care. And  
47 then, as they progress, it goes down a little bit.

1  
2           The college has rules around the number of cases that  
3 any trainee can do, which are supervised. So as you get up  
4 to more seniors - obviously, 100 per cent of all cases are  
5 supervised for introductory trainees - by the time you get  
6 to your final year, the recommendation is that you have  
7 a maximum of 50 per cent of the cases that you do should be  
8 supervised. So really encouraging independent practice.  
9 In reality, the vast majority of provisional fellows would  
10 probably - well, you know, maybe 70 per cent of their  
11 cases, they would do independently, with a supervisor  
12 remote, not allocated to them in that theatre at any given  
13 time.

14  
15 MR FULLER: Thank you. We can put that document aside,  
16 thank you. Finally on accreditation, in relation to  
17 monitoring compliance with these standards, Dr Moyle,  
18 I understand there are routine site inspections done as  
19 part of the reaccreditation process; is that right?

20  
21 DR MOYLE: Yes.

22  
23 MR FULLER: There might also be ad hoc inspections done  
24 from time to time of particular sites?

25  
26 DR MOYLE: Rarely. If somebody - if a department is given  
27 a five-year tick of approval, the visit will be in five  
28 years' time. Usually it stretches out to that five years  
29 because of the vast number of departments that need to be  
30 accredited. If a site has an issue above the line, as  
31 Frances described before, that hospital will have a return  
32 visit within a year to see how progression is --

33  
34 MR FULLER: It might be the case if a fellow or trainee at  
35 a particular site raises an issue, that the college will  
36 come in and conduct an inspection? Does that happen from  
37 time to time?

38  
39 DR MOYLE: It's possible, it doesn't - from a practical  
40 perspective, it doesn't really happen that often. Yes, no,  
41 it doesn't really happen that often.

42  
43 MR FULLER: I see. If a fellow or trainee does raise  
44 a concern with the college, what's the usual process of the  
45 college?

46  
47 DR MOYLE: Generally it will go through training, the

1 training ANZCA team, and then it will get - depending on  
2 the nature of the complaint, it will be elevated usually to  
3 a director of professional - DPA, professional --  
4

5 DR PAGE: Affairs.  
6

7 DR MOYLE: Affairs, thank you. So there are a number of  
8 DPAs and they tend to specialise in either trainees or  
9 facilities or whatever, and when I was - certainly when  
10 I was the EO, they introduced the college policy on  
11 bullying and at that time any complaints that came in about  
12 bullying were directly referred to a DPA, who then liaised  
13 with the trainee who had made the complaint.  
14

15 THE COMMISSIONER: Just tell me what DPA is?  
16

17 DR MOYLE: Director of professional affairs, sorry.  
18

19 THE COMMISSIONER: Thanks.  
20

21 DR MOYLE: Then the CEO was actually informed as well. So  
22 it was recognised that perhaps the CEO was not the ideal  
23 person to be handling bullying complaints, because the  
24 trainees didn't feel comfortable with that, but I'm not  
25 sure how - when they get involved now.  
26

27 MR FULLER: In terms of taking a bullying complaint as an  
28 example, is it possible for that sort of complaint to  
29 ultimately have consequences for a site's accreditation?  
30

31 DR MOYLE: Definitely. Bullying and harassment are one of  
32 the top two things that TAC visitors will look for. The  
33 college makes inquiries of trainees directly to the trainee  
34 of any reports of that. I'm not aware of - well, I mean,  
35 heads of department would be involved only after there was  
36 an initial investigation by a DPA, for example.  
37

38 MR FULLER: When the college is receiving complaints about  
39 things like bullying and harassment or other cultural  
40 issues, am I right in thinking that those complaints are  
41 usually being - are being received from its trainees and  
42 usually its own fellows; is that right?  
43

44 DR MOYLE: Yes, the trainees and fellows are members of  
45 ANZCA. Yes.  
46

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

1 when it receives that sort of complaint to make sure that  
2 the site is given a fair opportunity to address it before  
3 any adverse action is taken?  
4

5 DR MOYLE: I have no personal experience of what they do  
6 in reality, so I would refer you to - there's a policy  
7 there which was developed in association with the college  
8 of surgeons.  
9

10 MR FULLER: Dr Page, are you able to assist us with that?  
11

12 DR PAGE: I can speak to it from the perspective of a TAC  
13 visit that I did a couple of years ago when it became  
14 apparent through discussions with the trainees and with the  
15 senior medical workforce that there was an individual who  
16 was the deputy director of that particular department who  
17 was perceived as being quite bullying and controlling of  
18 many members of the department, senior and junior, and it  
19 was known that that individual was a close personal friend  
20 to the director of the department, so there was quite a lot  
21 of, you know, difficulty with how that was addressed.  
22

23 The normal process with any TAC visit is any issue of  
24 concern that would be one of the so-called above the line  
25 issues is discussed with the director of the department, in  
26 the first instance, on the day of the visit, and is then  
27 discussed with the hospital executive subsequent to that,  
28 offering both an opportunity to correct any  
29 misunderstandings that the visiting team might have. The  
30 report is then discussed with the training and  
31 accreditation committee back at ANZCA before a letter is  
32 issued to the hospital. The hospital has an opportunity to  
33 address issues of factual inaccuracy with that letter  
34 before it becomes binding and the hospital is then given  
35 a time period in which to respond to whatever the issues  
36 are.  
37

38 So the issue of bullying was raised with the head of  
39 department and with the director of medical services. It  
40 became formalised in a letter to the hospital with  
41 a requirement that the college received assurances, written  
42 assurances, from the hospital that the appropriate  
43 workforce processes had been executed to deal with that  
44 issue.  
45

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

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

3

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

8

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

14

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

20

21 DR PAGE: Yes.

22

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

25

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

31

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

33

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

41

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

44

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

46

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



1 29. Is that what you were referring to?

2

3 DR PAGE: Yes.

4

5 DR MOYLE: That's one of the aspects.

6

7 DR PAGE: Yes.

8

9 THE COMMISSIONER: Sorry, I interrupted. Go ahead.

10

11 MR FULLER: Thank you, Commissioner.

12

13 Do you have a sense, Dr Page, of what's changed since  
14 2021 to give rise to the shortage?

15

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

23

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

39

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

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

5  
6       THE COMMISSIONER: Is what you're identifying there, at  
7       least in part, a problem at the level of primary care,  
8       which then has repercussions for the care provided in the  
9       public hospitals?

10  
11       DR PAGE: Some of it is, yes. Some of it is, absolutely,  
12       a problem with primary care. I have an impression that it  
13       is more difficult to see a GP now than it was before the  
14       pandemic; that GPs may be in shorter supply than they were  
15       beforehand. That's not really something that I'm qualified  
16       to pass judgment on, but that's what it seems as  
17       a consumer.

18  
19       THE COMMISSIONER: I know, but as a specialist, your  
20       impressions may not be precisely supported by  
21       a peer-reviewed academic analysis, but they might also have  
22       a degree of accuracy that's sufficient for our purposes.

23  
24       DR PAGE: That's certainly what it feels like.

25  
26       THE COMMISSIONER: That's the impression you're getting?

27  
28       DR PAGE: Yes, very much so. I think there has also been  
29       a change in the workforce. I think some people have chosen  
30       to step back a little bit, have chosen maybe to retire  
31       earlier than they thought they would. So I think, on that  
32       side of things, there's also been a diminution, you know,  
33       of the available numbers of hours that anaesthetists have -  
34       in some instances, not in all.

35  
36       MR FULLER: Dr Page, given what you perceive as  
37       being the --

38  
39       THE COMMISSIONER: Sorry, can I just - my apologies.

40  
41       The impression that you just talked about, I assume -  
42       and I'd like to hear from you, Dr Moyle, about this as  
43       well. The impression that you were just talking about,  
44       Dr Page, I assume - tell me if I'm wrong - it's not just  
45       informed by your own experience and what I'll call your own  
46       practice; I imagine it's an impression that's also informed  
47       by discussions with your colleagues?

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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

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

3  
4 So a lot of those staff specialists are still within  
5 the system but now employed as VMOs, and so they're  
6 contracted work. So I know that in every other hospital,  
7 and my own, the number of VMOs that we actually have on the  
8 books has, like, exponentially increased, but that hasn't  
9 resulted in more people being in the public hospital. So  
10 there's plenty of work outside of the public hospital  
11 sector and the remuneration for that work is much higher in  
12 the private sector and as VMOs.

13  
14 So it's a real problem. I know that there are - as we  
15 talked about before, anaesthetists' presence in other  
16 places other than the operating theatre has meant that, you  
17 know, we're pulling people into the operating theatre to  
18 deliver anaesthetic care who would otherwise - may have  
19 been involved in out of theatre care, including, you know,  
20 representation on multiple committees across the hospital,  
21 I think training and teaching are in danger of being, you  
22 know, severely affected. It certainly seems to have -  
23 anecdotally it seems to have improved, but that change in  
24 what the workforce looks like has been very significant.

25  
26 THE COMMISSIONER: You used the term "award reform" during  
27 the course of that answer.

28  
29 DR MOYLE: Yes.

30  
31 THE COMMISSIONER: We're obviously well aware, as an  
32 example, of the staff specialists award. Staff specialists  
33 in New South Wales don't appear to have salary parity with  
34 colleagues interstate, and whether that's sensible or not,  
35 is something that this Inquiry will address at some stage.

36  
37 DR MOYLE: That would be good.

38  
39 THE COMMISSIONER: But beyond that, beyond salary parity,  
40 is there anything else you want to refer to in relation to  
41 award reform?

42  
43 DR MOYLE: There's been no significant changes to the  
44 award in well over 34 years. I think fatigue management -  
45 obviously the base rates of pay, et cetera, paid on call,  
46 paid after hours attendances for anaesthesia, we really  
47 feel that, because when we get called in, we're in there

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

3  
4 I think also in other states the conditions of that,  
5 so if you've been on call overnight you get - you know,  
6 your next day is allocated at home. At the moment, the  
7 shortages mean that we - you know, if you're there until  
8 4 o'clock in the morning you stay on and you start your  
9 list at 8 o'clock in the morning. So clearly that's not in  
10 the best interests of patient safety. Each individual  
11 department has to manage that in whatever way it can.  
12

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

18  
19 THE COMMISSIONER: Is there anything you wanted to add to  
20 that, Dr Page?

21  
22 DR PAGE: Yes. I just would say that in the absence of  
23 award reform and with the dwindling numbers of people  
24 wanting to take up staff specialist positions, it really  
25 undervalues what we can bring in the clinical - sorry, in  
26 the non-clinical sphere or the clinical support sphere,  
27 whatever you want to describe it as.  
28

29 The involvement that anaesthetists can have in the  
30 wider working of the hospital developing services, ensuring  
31 the smooth running of services, the efficient running of  
32 services, developments in techniques and so forth, because  
33 of the involvement that we have with so many other  
34 departments, we're actually really well placed to do that.  
35

36 In a VMO model, because it's a fee for service model,  
37 there is relatively little involvement of VMOs in that  
38 administrative workload of the hospital. There simply  
39 aren't enough staff specialists on the ground to have  
40 involvement of staff specialists in all of the areas that  
41 a hospital would want. And so over time you just see that  
42 fracturing of the service, because the problems aren't  
43 identified and addressed early on. And I think that that's  
44 where we're at at the moment.  
45

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

1  
2 THE COMMISSIONER: Sorry, can I interrupt you again? It's  
3 not for a question, but I'm not rushing you, but are we  
4 going to need to ask the doctors to come back after lunch?

5  
6 MR FULLER: I only have about five minutes left. So if it  
7 is convenient --

8  
9 THE COMMISSIONER: I'm conscious about where the witnesses  
10 are clinicians that have got other things to do, so we  
11 might run over the lunch break so that we can let them go  
12 back to what they usually do. Of course, it's partly  
13 dependent on Mr Cheney, but we'll see how we go. You  
14 finish. We'll just go beyond 1 o'clock.

15  
16 MR FULLER: Thank you, Commissioner.

17  
18 Dr Page, in your answer to the Commissioner, you  
19 referred to "award reform"?

20  
21 DR PAGE: Yes.

22  
23 MR FULLER: What do you have in mind? When you say "award  
24 reform", is it just salaries or other things as well?

25  
26 DR PAGE: No, I think it's - you know, it's salaries, it's  
27 working conditions, it's actually sort of understanding or  
28 creating a sense that being a staff specialist is something  
29 that people want to do. I think on many levels, lots of  
30 clinicians want to have involvement in the operational side  
31 of how hospitals and departments work. I think we have  
32 a lot to contribute in that space. But if it's viewed as  
33 something that you do completely in your own time and that  
34 there's no value that is ascribed to that, then people very  
35 quickly burn out and when there are fewer bodies to share  
36 the load, the load becomes unwieldy.

37  
38 What I'd like to see with award reform is some sort of  
39 parity with other states and territories that actually  
40 creates a sense of new fellows coming into anaesthesia, and  
41 any other discipline for that matter, who actually want to  
42 take up staff specialist positions. It's almost impossible  
43 to find a suitable applicant for a staff specialist  
44 position if you advertise one.

45  
46 MR FULLER: Do you have a sense of whether there is an  
47 overall shortage of anaesthetists in Australia or whether

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

3  
4 DR PAGE: It feels like there's an overall shortage. The  
5 demand seems to have increased everywhere. If we - yes, it  
6 does feel like there's an overall shortage.

7  
8 MR FULLER: Dr Moyle?

9  
10 DR MOYLE: So there is definitely a global shortage of  
11 anaesthetists and I think every country is seeing similar  
12 sorts of movement of staff out of the public sector. The  
13 Australian Society of Anaesthetists, the ASA, are doing  
14 some workforce modelling on this. The college hasn't  
15 really done any workforce modelling of any significance,  
16 certainly not in New South Wales. Other states - we do  
17 know that other states are short too. But the ASA is  
18 trying to do workforce modelling.

19  
20 Back in 2019 they did produce some data, pre-pandemic,  
21 to suggest that the workforce was in balance. Certainly we  
22 were hearing that newly minted senior - like, specialists  
23 were struggling to get as much work as they wanted. At the  
24 moment, if you look at the number of - I mean, the rural  
25 sector is crying out for help. No-one wants to go there.  
26 But even big centres are also struggling. I know that, you  
27 know, Prince Alfred, St Vincent's, the coast, Westmead, are  
28 still cancelling the occasional list because they can't  
29 find suitable staff. So if that's affecting metropolitan  
30 areas, there's clearly still a shortage.

31  
32 MR FULLER: Do you think there's a need to increase  
33 funding for training positions for trainees and, if so,  
34 why?

35  
36 DR MOYLE: I think it's very hard to predict without any  
37 real - without any good data or modelling, how many  
38 anaesthetists we need. Certainly as we have mentioned,  
39 there has been an increase in the need or the demand for  
40 anaesthetists in hospitals. I think at the moment we  
41 probably could have more trainees. I think that there are  
42 so many different factors that don't work so well that make  
43 the system very inefficient, that if - like, we would need  
44 to address a few different areas.

45  
46 I think maldistribution is a major issue and that  
47 needs to be part and parcel of it, and you could argue that

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

5  
6 MR FULLER: Dr Page, do you have anything to add to that?

7  
8 DR PAGE: No. I think Michelle has covered that pretty  
9 well. There was some increased funding for positions in  
10 the paediatric tertiary centres, I think that came through  
11 three years ago now, and for a couple of extra positions,  
12 that's actually created a significant capacity in  
13 improvement for getting trainees through the paediatric  
14 bottleneck. So if we needed to fund more positions purely  
15 for training, I think that it wouldn't be large numbers  
16 that were needed to ease the burden.

17  
18 I guess I'm concerned by reports that I hear from  
19 hospitals, you know, major metro teaching hospitals, who  
20 are financially under the pump, as everywhere is, but have  
21 made decisions to reduce entry numbers into the training  
22 program at a time when we're talking about how can we ease  
23 the pathway of specialist international medical graduates  
24 into Australia and how can we improve the numbers of  
25 trainees that - home-grown anaesthetists that we're  
26 bringing through. If the parlous financial state of major  
27 metro teaching hospitals is so bad that they can't afford  
28 to put on the same number of anaesthesia trainees that they  
29 did last year, I'm not quite sure how we resolve that  
30 problem.

31  
32 MR FULLER: Thank you. Dr Page, Dr Moyle, those are my  
33 questions.

34  
35 THE COMMISSIONER: Can I just ask one more series of  
36 questions.

37  
38 Please tell me - this is just so I understand it. If  
39 you could both turn to paragraph 110, of the statement, at  
40 page 17, where you have given the case study.

41  
42 DR PAGE: Yes.

43  
44 THE COMMISSIONER: Who should I address questions to, just  
45 so I understand this?

46  
47 DR PAGE: Well, I can answer anything that's relevant to



1 Central Coast.  
2  
3 THE COMMISSIONER: I will try you, Dr Page, first. This  
4 is an example regarding obviously Central Coast LHD.  
5  
6 DR PAGE: Yes.  
7  
8 THE COMMISSIONER: The first bullet point is six staff  
9 specialists to 64 VMOs. What should I take from that -  
10 that there's a disparity in the numbers or something else?  
11  
12 DR PAGE: Yes. And there's a --  
13  
14 THE COMMISSIONER: Disparity in the ratio or something  
15 else?  
16  
17 DR PAGE: There's a significant disparity in the ratio.  
18 Staff specialists generally spend the bulk of their working  
19 time in the public system. Of the VMOs that I have, six of  
20 them have no regular sessions within the department. Some  
21 have significant numbers of regular sessions, but most -  
22 most contribute relatively little to the non-clinical  
23 workload of the department.  
24  
25 DR MOYLE: I could give an example at St Vincent's.  
26  
27 THE COMMISSIONER: Yes, please, go ahead.  
28  
29 DR MOYLE: So in 2017 I became director. I had 19 FTE  
30 staff specialists and about 33 VMOs. Today I have 8 FTE  
31 staff specialists, and most of the staff specialists are  
32 still there, they've just reduced their fraction a lot, and  
33 I've got 70 VMOs.  
34  
35 THE COMMISSIONER: And you are obviously talking about  
36 St Vincent's public?  
37  
38 DR MOYLE: I'm talking about St Vincent's public. We had  
39 no issues with filling our required slots when I started,  
40 and now every day we're really struggling to have the  
41 appropriate seniority in every anaesthetising location.  
42  
43 THE COMMISSIONER: The reason for that is all the reasons  
44 we've discussed throughout the course of your evidence?  
45  
46 DR MOYLE: Correct.  
47

1 THE COMMISSIONER: Then the second bullet point is:

2

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

6

7 What should I understand by that?

8

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

17

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

20

21 DR PAGE: Correct, yes.

22

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

27

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

32

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

35

36 DR PAGE: Yes.

37

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

40

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

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

4  
5 THE COMMISSIONER: All right. Did you want to add  
6 anything?

7  
8 DR MOYLE: No, I'd be boasting, but St Vincent's has  
9 a pretty damn good academic record from exam perspective,  
10 and we track loads of trainees who really are committed to  
11 the public sector, and they all come to me, "I'd love to be  
12 a staff specialist but I can't afford to pay my mortgage,  
13 so I'm going to become a VMO."

14  
15 THE COMMISSIONER: Okay. And that's something that's  
16 consistent feedback to you?

17  
18 DR PAGE: Mmm.

19  
20 DR MOYLE: Yes. Oh, yes.

21  
22 THE COMMISSIONER: I think I understand the rest of the  
23 bullet points. Can I just ask in relation to the first  
24 bullet point in 111, the "regularly cancelled lists",  
25 should I take from that that that has been a problem from  
26 the time of the pandemic, but is still an ongoing problem?

27  
28 DR PAGE: It is an ongoing problem, that's right, due to  
29 workforce shortages. Those would be lists specifically  
30 cancelled because of lack of anaesthesia workforce,  
31 whereas, as I say, there was only the single session prior  
32 to the pandemic.

33  
34 THE COMMISSIONER: Yes, all right. Did anything flow from  
35 anything I asked?

36  
37 MR FULLER: No, thank you, Commissioner.

38  
39 THE COMMISSIONER: Mr Cheney, do you have any questions?

40  
41 MR CHENEY: Commissioner, may I just take up one short  
42 topic with Dr Moyle.

43  
44 THE COMMISSIONER: Of course you can, yes.  
45  
46  
47

1 <EXAMINATION BY MR CHENEY:  
2

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

7  
8 DR MOYLE: No, no. So I was actually in the role as  
9 education officer for New South Wales at the time and we  
10 had a - I actually had two trainees who made complaints of  
11 bullying - they were at different hospitals, they were not  
12 at my hospital - about supervisors of training, which  
13 were - they came to me. Both of those trainees were on  
14 a program at the time called "trainee in difficulty", now  
15 referred to as "trainee experiencing difficulty", where  
16 trainees who are maybe failing to meet milestones or who  
17 have clinical issues are on a sort of formalised plan for  
18 how to address their shortcomings, and so they felt like  
19 they were being bullied. I was contacted directly by them  
20 as the representative, as the EO, and then they were -  
21 their complaints were referred on to the director of  
22 professional affairs at ANZCA.  
23

24 At the time, the bullying process - the bullying  
25 policy was in process but not yet published, and the CEO  
26 made it a rule, basically, that any bullying complaints  
27 went to him.  
28

29 So then that was referred on to - so I basically was  
30 the intermediary and then the DPA and CEO addressed that  
31 independently with - they actually appointed a psychologist  
32 from, I can't remember the name of the group, who worked  
33 with - who happened to also work with the College of  
34 Surgeons in Melbourne.  
35

36 MR CHENEY: But the process of which you speak, did it  
37 involve speaking to the alleged perpetrator of the  
38 bullying, where that perpetrator was a member of the  
39 college?  
40

41 DR MOYLE: No, no. Not from me, but they were - it was  
42 addressed. So basically I was not aware of what happened  
43 after that, except that the matter was dealt with by the  
44 college and they resolved to speak to the supervisor of  
45 training.  
46

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

1 knowledge, deal with how a complaint of bullying about  
2 a member of the college is to be handled by the college?  
3

4 DR MOYLE: It was - so I was - because of all of these  
5 things that were all starting out at the time, it was very  
6 topical at the time. I was involved in - there was  
7 a pretty large scale project that spoke to many people  
8 about recommendations for how the policy should be  
9 developed, and part of that policy was that there should be  
10 confidential - you know, there were issues of privacy and  
11 confidentiality for the trainee, and it was made very clear  
12 that - in discussion with the trainee, as to whether the  
13 person who was the alleged perpetrator would be contacted  
14 or not. So I don't know whether - how that all panned out  
15 at the time, but generally speaking, I found that -  
16 anaesthesia is a pretty small world and generally speaking,  
17 these things are - the people who are involved are aware of  
18 complaints at local levels.  
19

20 MR CHENEY: In part, they glean that awareness because the  
21 topic is taken up with them by the college; is that right?  
22

23 DR MOYLE: I think it's - you know, it's sort of local  
24 hospital policies come into play. The trainees are always  
25 advised that they should contact their local HR. There are  
26 frequent education sessions for supervisors of training -  
27 generally that's the most organised group and the most  
28 invested in the trainees - about what to do in the case of  
29 a bullying complaint  
30

31 MR CHENEY: And are the trainees also advised that they  
32 are welcome to contact the college about such complaints?  
33  
34

35 DR MOYLE: They are. At the time I did say that  
36 I thought - and the CEO acknowledged - that it might be  
37 perceived to be difficult for a trainee to contact the CEO  
38 of the college, so that's - there are well-documented  
39 avenues of what to do.  
40

41 I think the other thing that has happened in that  
42 intervening time is that there has been a rise - the  
43 college strongly recommends formal mentoring programs in  
44 each department, and it is much more of a feature at  
45 accreditation visits that bullying and harassment is  
46 actively sought - any reports are sought out.  
47

1 MR CHENEY: Including - I think you mentioned that one of  
2 the top two priorities of the training and accreditation  
3 committee visits was to ask trainees about bullying  
4 experiences; is that right?  
5  
6 DR MOYLE: Yes  
7  
8 MR CHENEY: Presumably that's to inform the college as to  
9 the extent to which this is happening to its members?  
10  
11 DR MOYLE: I think so. I think this came about more as  
12 a trainee advocacy piece and trying to ensure that trainees  
13 were being given fair and just access to resources and  
14 training and - but yes.  
15  
16 MR CHENEY: Because the problem --  
17  
18 THE COMMISSIONER: Can I just ask - sorry to interrupt -  
19 this will be me just not getting it, but the reason you are  
20 asking these questions is to establish what?  
21  
22 MR CHENEY: Largely it deals with something that has been  
23 asserted in another college's submission, Commissioner.  
24 I'm just trying to draw a distinction between how this  
25 college deals with it and the position taken by others.  
26  
27 THE COMMISSIONER: Okay, all right. Go ahead.  
28  
29 MR CHENEY: I will leave it there, Commissioner.  
30  
31 THE COMMISSIONER: All right. Thank you. Nothing arising  
32 out of that?  
33  
34 MR FULLER: No, thank you.  
35  
36 THE COMMISSIONER: Dr Page and Dr Moyle, first of all,  
37 thank you very much for the statement you prepared and,  
38 secondly, thank you for your time today, we're very  
39 grateful, and you are excused.  
40  
41 DR MOYLE: Thank you.  
42  
43 DR PAGE: Thank you so much for hearing us.  
44  
45 THE COMMISSIONER: All right. We'll come back at 2.20.  
46  
47 <THE WITNESSES WITHDREW

1  
2 **LUNCHEON ADJOURNMENT**  
3

4 THE COMMISSIONER: Yes, Mr Fuller.  
5

6 MR FULLER: Thank you, Commissioner. The next witness is  
7 Dr Angelo Virgona from the Royal Australian and New Zealand  
8 College of Psychiatrists. I call the doctor.  
9

10 THE COMMISSIONER: Doctor, can you hear me?  
11

12 DR VIRGONA: Yes, I can.  
13

14 **<ANGELO VIRGONA, affirmed: [2.22pm]**  
15

16 **<EXAMINATION BY MR FULLER:**  
17

18 MR FULLER: Q. Doctor, my name's Dan Fuller. I'm one of  
19 the counsel assisting the Commission. I'm going to be  
20 asking you some questions this afternoon. I understand you  
21 are the chair of the New South Wales branch committee of  
22 the college; is that right?

23 A. No. I'm the immediate past chair of the college in  
24 New South Wales. My term ended in May, and this is one of  
25 my leftover responsibilities, but I now serve on the board  
26 of our binational college and maintain a potential on the  
27 New South Wales committee because of that and have an  
28 enduring interest in matters workforce and training in  
29 New South Wales.  
30

31 Q. What's your position on the board?

32 A. I am the elected board member. There are five elected  
33 board members of the binational college and I am one of  
34 those.  
35

36 Q. What's the relationship between the New South Wales  
37 branch committee and the board, if any?

38 A. Oh, well, the New South Wales branch committee  
39 represents the membership in New South Wales and relates to  
40 what we call our members advisory council, which is the  
41 broadest council of the college incorporating all the  
42 committees of the college, and that committee reports to  
43 the board. The board is ultimately responsible for all the  
44 activities of the college.  
45

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

1 A. Six years.

2

3 Q. And did you hold any leadership roles in the college  
4 before that time?

5 A. No. I served on the branch committee but not in a  
6 leadership role before that, and I've served on the branch  
7 training committee decades before that, so I had a hiatus  
8 and I've been more engaged with college affairs the last  
9 10 years.

10

11 Q. You have helpfully provided a statement to the  
12 Commission dated 18 July 2024. Do you have a copy of that  
13 there with you?

14 A. I do. I'll just get it up on the screen, thanks.  
15 Yep.

16

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

19

20 Q. Have you had the opportunity to read over that  
21 statement recently?

22 A. Yes, I have done.

23

24 Q. Is everything in it true and correct to the best of  
25 your knowledge and belief?

26 A. Yeah. It's very - it's extensive. Yes, I will say  
27 yes.

28

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

32 A. Will do.

33

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

38 A. Yes.

39

40 Q. Do you see part of that role as being to advocate for  
41 the interests of the college's fellows?

42 A. Oh, absolutely.

43

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

47 A. Yes. Yes, resourcing of mental health services, the



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

5  
6 Q. I will come to some of those issues shortly but I'll  
7 just start by asking you some questions about the college's  
8 role in accreditation.

9 A. Yes.

10  
11 Q. The college offers a training program in the specialty  
12 of psychiatry; that's right?

13 A. Correct.

14  
15 Q. And completing that program is the only way to become  
16 a specialist psychiatrist in Australia?

17 A. Yes. I mean, you can be an internationally trained  
18 specialist and those specialists can be accredited by the  
19 Health Insurance Commission to provide psychiatric  
20 services, but to become a psychiatrist in Australia, this  
21 is the only pathway to train and achieve psychiatric  
22 specialty status.

23  
24 Q. So in terms of a doctor who wants to complete their  
25 training in Australia, they complete the training through  
26 your college and there's no other pathway for them; is that  
27 right?

28 A. There is no other pathway for them within Australia,  
29 no.

30  
31 Q. Do you agree that that lack of competition makes it  
32 important for colleges like yours to have fair, effective  
33 and transparent governance and administration processes?

34 A. Absolutely.

35  
36 Q. Are we right in understanding that the college of  
37 psychiatrists accredits training posts and programs rather  
38 than sites?

39 A. Yes.

40  
41 Q. And posts are individual training positions; is that  
42 right?

43 A. Yes, correct.

44  
45 Q. How do the posts relate to the training program?

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

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

17  
18 Q. Just in terms of the current system, are you able to  
19 help us with - is there a reason why posts and programs are  
20 separately accredited? In other words, the college  
21 accredits both posts and programs. Is there a particular  
22 reason for that?

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

38  
39 Then the position will be then, as I said before,  
40 under the auspices of the local director of training. Then  
41 the local director of training will be responsible for  
42 filling that position and rotating people through that  
43 position within their jurisdiction.

44  
45 Q. And the broader program that we've been discussing, is  
46 that associated with the five zones that you mentioned, so  
47 each zone has a program?

1 A. No, the zones don't have a program. There's a sort of  
2 a formal education course, right? So there's a formal  
3 education course in the first three years of training.  
4 That's D? Didactic teaching course, if you like. That's  
5 the curriculum that you've got to get under your belt and  
6 everybody has to do one of those courses, and there are  
7 several available to the trainees in New South Wales, the  
8 main ones being the one run by HETI. There's one conducted  
9 by the Brain and Mind Centre at Sydney University, and  
10 there's also the Newcastle training - the Hunter training  
11 program for their local trainees. But people in New South  
12 Wales can also go online and get that education experience  
13 from, I think, Monash and Melbourne universities in  
14 Victoria. So there's the basic curriculum that's delivered  
15 that people have to participate in.  
16

17 Then there's the training program. We have, as  
18 a college - there are certain compulsory rotations that  
19 need to be provided within a training zone, right? So  
20 you've got to be able to provide your acute adult  
21 experiences in hospital; you've also got to be able to  
22 provide consultation liaison psychiatry terms and a child  
23 psychiatry term in your first three years of training,  
24 essentially, or the first two to three years of training.  
25 So those compulsory rotations have to be able to be  
26 delivered by a training zone, and the person has to be  
27 participating in a formal education program.  
28

29 Q. Just picking up on something you said about the online  
30 training, if I'm a doctor sitting in New South Wales, is it  
31 possible for me to complete some of my training program  
32 online through Monash; is that the idea?

33 A. Yes, yes. Yes, the formal education. That is the  
34 lectures, the stuff that, you know - the stuff that you've  
35 got to commit to memory and the hard data of didactic  
36 teaching. So that stuff can be done online.  
37

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

40 A. Yes.

41

42 Q. -- for that experience to count?

43 A. Yes.

44

45 Q. Is that right?

46 A. Yes.

47

1 Q. So it's an alternative way of delivering the training  
2 that is otherwise delivered to people who have to - who sit  
3 in accredited training posts?  
4 A. Yes, yes, that's right, the context.  
5  
6 Q. The zones that you have referred to, are they also  
7 called networks, training networks?  
8 A. Yes, sorry - yes, sorry, I mix up my terms, sorry.  
9 Yes. Networks.  
10  
11 Q. I might just show you a document so we're on the same  
12 page. It's [SCI.0011.0204.0001] I will see if I can  
13 identify that in the tender bundle. It is H1.84 in the  
14 tender bundle.  
15 A. Yes. Yes.  
16  
17 THE COMMISSIONER: Where is that page from? What document  
18 is that? Is it a webpage?  
19  
20 MR FULLER: This is a webpage. That's part of HETI's  
21 website.  
22  
23 THE WITNESS: That's HETI'S. Yes, that's part of HETI  
24 a website, correct, yes.  
25  
26 MR FULLER: Q. It's just a way of trying to get this  
27 information on one page. If I just ask the operator to  
28 scroll down.  
29 A. Yes.  
30  
31 Q. We see in the orange headings, are they the names of  
32 the five training networks or zones in New South Wales?  
33 A. Yes, correct.  
34  
35 Q. We see underneath each of those headings quite  
36 a number of different health services; is that right?  
37 A. Correct. Yep.  
38  
39 Q. And each of those health services forms part of the  
40 network --  
41 A. Correct.  
42  
43 Q. -- the relevant network? And there will be presumably  
44 accredited posts distributed at those sites throughout each  
45 network?  
46 A. Yes.  
47

1 Q. And they include metropolitan, as well as rural and  
2 regional sites?

3 A. Yes, they do.  
4

5 Q. Does the college have anything to do with the  
6 establishment of these networks, or is that a matter for  
7 NSW Health?

8 A. That was a NSW Health matter. I will take that on  
9 notice a little but I mean, my understanding is that these  
10 were NSW Health designed and implemented, you know, over  
11 a decade ago.  
12

13 Q. Is the structure similar in other jurisdictions or is  
14 this a New South Wales specific thing?

15 A. No, we are unique, and - but partly it's because of  
16 our, you know, the size in New South Wales, the geography.  
17 Also, partly because NSW Health required trainees to do  
18 rural rotations as part of their experience. That was  
19 partly a workforce distribution issue, so that was  
20 a historical thing as well. So you'll see the link between  
21 metropolitan and rural/regional locations.  
22

23 That has become - and I think we put this in our  
24 submission - less of an issue. We think that things have  
25 changed over time as our regional centres have become much  
26 better at becoming standalone training zones with people  
27 living and working in the bush now, and we've got over  
28 50 registrars working in - training and working in rural -  
29 living, training and working in rural New South Wales. So  
30 we think that this sort of model, which was developed to,  
31 I think, essentially support the bush, could be revisited  
32 because we're seeing things sort of happening in a positive  
33 way in the bush now, compared to the way it was 10, 15  
34 years ago.  
35

36 Q. At a high level, and just jumping forward a bit, am  
37 I right in thinking that the college's concern with  
38 workforce is more with the overall numbers of psychiatrists  
39 who are available rather than the distribution between  
40 rural and regional and metro?

41 A. Listen, we're concerned about everything, you know?  
42 And we're concerned about distribution. But really it's  
43 not within our remit to do anything about it. These are  
44 really state-based - state-government-based issues. So  
45 it's very difficult for us to - I mean, we will not make  
46 decisions or anything that we can do in a coherent way  
47 that's going to make any difference to what happens to the

1 workforce distribution really. These are government  
2 decisions, yes.

3

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

9 A. Yes. I accept that.

10

11 Q. Is the issue that, in practice, you just don't have  
12 enough people to fill the training posts that the college  
13 could potentially make available?

14 A. Well, the college makes available posts in reaction to  
15 funding, essentially. I mean, we don't decide, "Oh, we  
16 think we need more posts in Wagga Wagga or Tamworth so  
17 we're going to create them"; really, these things come from  
18 the ground up, really, and so the services will have an  
19 enhancement and say, "We're opening up a training  
20 position", as I have sort of alluded to earlier, and then  
21 they'll come to the college and say, "Well, we think we can  
22 provide a good training experience for this person and we  
23 would like you to approve it and monitor it, thank you very  
24 much", and we will do so. I mean, it's very rare - I can't  
25 give you any specific examples, there probably have been  
26 but it would be quite rare - that we have knocked any  
27 applications back.

28

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

32 A. Yes.

33

34 Q. But it's not the college dictating to the New South  
35 Wales health system "There will be 50 psychiatric  
36 trainees"; it's the New South Wales health system saying,  
37 "There will be funding for 50 psychiatric trainees", and  
38 then the college finding the posts?

39 A. Yes - well, the college approving the posts.

40

41 Q. Approving the posts, yes.

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

45

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

1 100 psychiatric trainees", with the college saying, "Oh,  
2 no, there are only going to be 50"?

3 A. Yeah, yeah, we're not dermatologists here, we're sort  
4 of - you know, we're different.

5  
6 Q. We haven't heard from them yet. We'll mark that  
7 page of the transcript, though.

8 A. You can redact that, thanks. But we are not trying -  
9 no, we are not trying to restrict numbers at all.

10  
11 Q. I'm in charge of redactions.

12 A. We are not trying to restrict numbers at all.

13  
14 Q. Understood.

15 A. We don't have any role in that.

16  
17 Q. Understood.

18 A. Yes.

19  
20 MR FULLER: Q. Doctor, you told us earlier, and you say  
21 it in your statement as well, that you think the network  
22 model at least in New South Wales is due for  
23 reconsideration and refit, I think those were your words  
24 earlier?

25 A. Yes.

26  
27 Q. Can you just tell us what you have in mind, what you  
28 think could be done in terms of restructuring?

29 A. It's a big thing. Like, I think it takes greater  
30 minds than mine, because I'm sort of one step removed from  
31 training, I must admit. So I don't want to give you sort  
32 of, you know, the Virgona view of how the world should  
33 operate. But certainly - so in other jurisdictions they  
34 have a metropolitan zone and they will have a rural zone,  
35 for example. I mean, you know, it's a lot easier in South  
36 Australia or Western Australia where you've got much  
37 smaller numbers. So it's easier to sort of configure  
38 things that way.

39  
40 We are developing, but on the rural piece I will say  
41 this much, I mean, within the college we are developing -  
42 we have developed a rural training pathway, which has been  
43 aimed at being able to provide the entire training  
44 experience in the bush, whereas previously, people who  
45 wanted to work and train in the bush, they would have to  
46 come down to Sydney or to a major regional centre to be  
47 able to do those compulsory rotations that I spoke to you

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

7  
8 We think that being able to sort of develop just pure  
9 rural training zone is something that should be considered  
10 in New South Wales. We've had the experience - the federal  
11 government provided funding, and this was in response to  
12 our rural training pathway, the federal government provided  
13 funding through the FATES program, which I think we put in  
14 our submission a link to.

15  
16 So what that did was ask for expressions of interest  
17 around Australia for the establishment of rural directors  
18 of training positions. So we don't have a rural director  
19 of training in New South Wales. The directors of training  
20 are in these five networks that you have seen up on the  
21 screen.

22  
23 So we didn't apply for one in New South Wales because  
24 our - because we're so complicated here, and how would you  
25 do it and we were sort of scratching our heads, "Oh, we  
26 would have to liaise with HETI and with the ministry",  
27 because one of the provisos of this FATES-funded directors  
28 of training positions was they were only to be for two  
29 years, I think the funding was available, and there had to  
30 be agreement from the states that they would then take on  
31 the funding thereafter. So we had to get a lot of people  
32 to sort of tick the boxes to make it happen. We didn't  
33 have enough time.

34  
35 However, in northern New South Wales, they decided,  
36 the local health district decided, to put in an application  
37 for one of these positions, and they have got their own  
38 director of training, it's a rural director of training,  
39 and it has been a very, very, very successful position.  
40 They have doubled the number of trainees in a very short  
41 space of time, less than two years. They've doubled the  
42 number of locally based trainees. The experience that  
43 people are having is quite extraordinary. So we are  
44 thinking that this does provide something of a model.

45  
46 In our pre-budget submission to the New South Wales  
47 Government, we asked for four such positions for rural



1 New South Wales, based in the mainly regional centres, like  
2 Orange, Wagga, Tamworth, and perhaps Coffs. But looking at  
3 having that level of support makes it much more attractive  
4 and a much greater training experience for the people  
5 locally. So we see that as something for the future.  
6

7 So in its broad sense, I would say that - how could it  
8 look in the future? An entire rural training network or  
9 split rural training networks, and then the metropolitan  
10 networks could be reimagined. So that would be  
11 a simplification of things.  
12

13 We also put in there an extract from our internal  
14 review of the administrative requirements for supporting  
15 our branch training committee and our directors of  
16 training. There's been no change to the amount of money  
17 provided by the college or NSW Health to support the  
18 administrative - administration needs for trainees, and  
19 despite the fact that there has been a doubling in the  
20 number of trainees over the time period.  
21

22 So we were looking to see, you know, looking at how  
23 things worked in New South Wales compared to other  
24 jurisdictions, and certainly Victoria's is a much simpler  
25 arrangement that they have - fewer committees, greater  
26 delegation of responsibility to local zone committees  
27 rather than at the branch training committees. There are  
28 a whole range of issues that we identified there, and we  
29 saw this as perhaps being a first step in this idea of  
30 a review of how we do things in New South Wales, and  
31 perhaps we could do things differently. So we think it is  
32 high time for a review of the network structure in  
33 New South Wales.  
34

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

37 A. Yes.  
38

39 Q. Just in terms of the rural director of training, is it  
40 right that the reason why you think that's been successful  
41 is because you've got a dedicated person who is responsible  
42 for trying to attract and support trainees in that area; is  
43 that right?

44 A. Exactly. Before that, the person who is responsible  
45 for the trainees in that place sits at St George Hospital,  
46 right? So in Sydney. So the ability to sort of be able to  
47 have connection with the trainees, to understand what their

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

9  
10 Q. Do you think the sort of restructuring that you've  
11 described would help in any way with the general workforce  
12 shortages that you've described?

13 A. Well, I think it would be a step in the right  
14 direction, because anything that you do that sort of  
15 enhances, you know, the quality of support provided to  
16 trainees - I mean, things spread, you know, by word of  
17 mouth, you know, particularly in this sort of social media  
18 age. I mean, people are sort of connecting up with each  
19 other in all sorts of ways and finding out all sorts of  
20 information about what a training experience is like.

21  
22 I think that anything that enhances the quality of  
23 a training experience for people is a good thing for  
24 training and a good thing for attracting people to train in  
25 New South Wales. As I highlighted, you know, on a number  
26 of occasions in the documents, we are really struggling in  
27 New South Wales across the board with attracting people and  
28 retaining people.

29  
30 Q. I'll come back to that in a moment, if I might.

31 A. Yes.

32  
33 Q. Just coming back to accreditation briefly, does your  
34 college have a role in selecting trainees at all?

35 A. Oh, yes, yes, of course. So we have this combined  
36 statewide recruitment exercise. I've forgotten the acronym  
37 for it, but anyway, but we're combined with HETI. So HETI  
38 and the college do this together and - where there are  
39 representatives from the college and representatives from  
40 the local health districts, and we have this annual  
41 recruitment exercise, which is good. It's efficient. You  
42 know, it works. It works quite well, yes.

43  
44 THE COMMISSIONER: Q. This is in paragraph 39, I think,  
45 of your statement, you have set out - you have provided  
46 some links to the committees and what-not?

47 A. Yes, I'm just going to go down there. Hang on, sorry.

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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

1 their systems, so - and we will be involved in those  
2 processes with them. But this is the mass recruitment  
3 exercise.  
4

5 So, yes, we're doing poorly in New South Wales on  
6 that score. In Victoria, as I think I mentioned, they had  
7 200 applicants for about 115 positions. Psychiatry  
8 training is popular. We do know that people who were PGY1  
9 and 2 doctors in New South Wales looking to train in  
10 psychiatry went to Victoria. So I don't have specific  
11 numbers to be able to give you on that, but we know from  
12 our intelligence that people are looking interstate  
13 because, you know, there are a whole lot of - there are  
14 a whole stack of reasons, which you'll probably get to when  
15 you ask me about workforce.  
16

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

22 A. Yes. Yes, absolutely. Yes, definitely, yes.  
23

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

28 A. Yes.  
29

30 Q. I take it that means staff specialist psychiatrists;  
31 is that right?

32 A. Yes, yes. Yes, staff specialist psychiatrists. So  
33 you've got - they are the employed psychiatrists in  
34 New South Wales, and some of those are filled by locums and  
35 some are just vacant, they haven't been able to fill them  
36 at all.  
37

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

40 A. Yes.  
41

42 Q. -- but they're not filled?

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

1 people just leaving the system.

2

3 THE COMMISSIONER: Q. Is that vacancy rate evenly spread  
4 between metropolitan and regional LHDs or is there - does  
5 one have greater vacancy rates than the other?

6 A. Well, I think historically - I mean, historically the  
7 regional areas have relied - other than Newcastle, which is  
8 an aberration, and I'll talk about them in a minute, but  
9 historically the regions have relied on visiting medical  
10 officer workforce, so whether locally living people or  
11 fly-in fly-outs, so most - Wagga, Coffs Harbour, Tamworth,  
12 Orange have relied on fly-in - and Bathurst relied on  
13 fly-in fly-outs, for a couple of decades, really.

14

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

22

23 THE COMMISSIONER: Yes.

24

25 MR FULLER: Q. I think you told us you were going to  
26 come back to Newcastle, and sorry if I missed it, but what  
27 were you going to say about that?

28 A. Well, I think historically Newcastle is just a bit  
29 weird compared to the rest of New South Wales. I mean,  
30 historically, it's had - it's a beautiful place, on the  
31 beach, with affordable real estate, so that's the first  
32 thing that may be the most important factor. No, but it's  
33 had an excellent medical school. It had two mental health  
34 hospitals, if you like, in its region, at Morisset and at  
35 James Fletcher in town in Newcastle itself. So it had  
36 a very solid infrastructure of psychiatric staffing and  
37 mental health, other mental health workers, and also it's  
38 got the Hunter Institute of Mental Health Research arm, as  
39 well. So it's a very, you know, well-resourced.

40

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

1 of any place in New South Wales.

2

3 Q. The 25 per cent figure, where does that come from?

4 A. NSW Health. So we've been engaged in quite detailed  
5 deliberations and meetings with the department, the mental  
6 health branch of the department and the workforce branch of  
7 the department. We've been highlighting, at the college,  
8 along with industrial organisations like ASMOF and the  
9 AMA - have been highlighting to the department and the  
10 minister's offices how parlous the workforce situation is  
11 in New South Wales, and particularly both the junior  
12 medical workforce and the staff specialist workforce, and  
13 we have bemoaned the fact that it is very difficult to get  
14 solid data.

15

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

25

26 THE COMMISSIONER: Q. There might be some data that's  
27 harder to find, but vacancy rates shouldn't be difficult,  
28 should they?

29 A. Yes - no, it's not - no, it shouldn't be difficult.  
30 But they had to mine - they really had to mine each local  
31 health district to do this, right? This is - like they had  
32 to go out and speak to each clinical director and say,  
33 "Tell us what your substantive positions are; what are your  
34 substantive FTE; how many vacancies have you got; what sort  
35 of vacancies; are they long service leave, are they  
36 retired", et cetera, et cetera, and also the same for the  
37 junior medical workforce. So it becomes - it is difficult  
38 when things - at that level.

39

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

1 weeks coming in. And how they pay those within the  
2 New South Wales finance system can vary a lot across the  
3 joint.  
4

5 And sometimes they don't separate out in their locum  
6 data, you know, what's a psychiatrist locum and what's an  
7 emergency department locum, for example. So it becomes -  
8 it can be quite messy. So they're not paid out of the cost  
9 centre sitting under the mental health service, but they  
10 may be coming out of this locum VMO cost centre. So it's  
11 a bit of a dog's breakfast to be honest with you.  
12

13 NSW Health have tried their best in these meetings  
14 that we've had to deliver information. That's why we  
15 said - I think there was some request made of, "Can you  
16 clarify, can you clarify", and we came back to you and said  
17 "Just ask NSW Health. They've got the data", you know,  
18 "They should be able to provide this data." Particularly,  
19 workforce should be able to give it to you.  
20

21 So in these meetings, that was the rough figure, was  
22 the 25 per cent vacancy rate for staff specialists in  
23 New South Wales. We've got over 50 locums, full time  
24 equivalent locums that are sort of working in New South  
25 Wales at the moment, as far as we can figure out, there may  
26 be considerably more than that, and - at any one time,  
27 we're talking about, which is a lot of people, and then  
28 there are a lot of positions that are just plain vacant,  
29 they just can't fill them.  
30

31 MR FULLER: Q. Do you have a sense of why there is in  
32 your view such a high number of locums in New South Wales,  
33 that's locum psychiatrists?

34 A. Yeah, because - well, it's because - well, it's not  
35 a perfect storm, it's been more like climate change that's  
36 been building up over years and years and years really, and  
37 that we've had - you know, we've had the salary cap, which  
38 didn't help things, obviously for a long period of time.  
39 We've had awards moving forward in our competitor states,  
40 so Queensland and Victoria, you know, the staff specialists  
41 are doing 25 per cent better than they are in New South  
42 Wales - at least. Up to 30 per cent. So they're our main  
43 competitors and that's where we're losing people to in the  
44 junior workforce and the senior workforce.  
45

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

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

10  
11 There's also been an increase in the sort of - the  
12 demands placed on the system, obviously, we've got  
13 emergency department data which has shown things going  
14 through the roof, and a lot of pressure to turn people over  
15 very quickly, like moving people out of the emergency  
16 department as quickly as possible into the ward and then,  
17 when they're in the ward, getting them out of there as  
18 quickly as possible, and people are finding - and I think,  
19 you know, we've had survey results of our members, our  
20 fellows, sorry, who have shown an increasingly demoralised  
21 workforce, disenchanted, they don't feel valued, their  
22 skills don't feel appreciated - they don't feel appreciated  
23 for their skills. So I think that's been a factor.

24  
25 I think cost of living in New South Wales is obviously  
26 a factor. Sydney is, you know, a very, very difficult  
27 place to try to buy a house for psychiatrists, like  
28 everybody else. And we've seen, I think in the last few  
29 years, the options that are available in the private sector  
30 are sort of much more attractive. I think telehealth has  
31 had a role to play in this because, you know, people are  
32 able to see - well, it's very attractive, being able to get  
33 your letters as a young psychiatrist, you know, and you've  
34 got a young family and you can sit at home and work with  
35 practice software, you know, you'll have a full load of  
36 books because people will be able to provide you with lots  
37 of patients to be able to assess and review from the  
38 comfort of your own home, and you'll be well remunerated  
39 earning twice as much as a staff specialist, you know,  
40 without a huge amount of effort.

41  
42 So when you add all those factors together - and  
43 I think I also made the point that there has been, we feel,  
44 an erosion in the status of psychiatry in NSW Health. You  
45 know, we've seen Sydney Local Health District and Sydney  
46 West - I don't know if it's called Sydney West still, but  
47 now they've created executive director of mental health



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

5  
6 I know I've worked in health districts where I've been  
7 the leader, the clinical and operational leader, but I've  
8 also worked in those where I've had, you know, the  
9 executive director has been a non-psychiatrist and they  
10 have been fantastic people and very good, but I'm saying to  
11 exclude psychiatry from the possibility of being in such  
12 a role is not a good move and it's a sign, we feel, of, you  
13 know, a move toward - a move away from psychiatry in  
14 leadership positions per se.

15  
16 THE COMMISSIONER: Q. Can I just interrupt you there?

17 A. Yes.

18  
19 Q. This isn't a criticism, but the picture you have just  
20 painted is one where it's almost surprising there would be  
21 a single staff specialist psychiatrist in New South Wales.  
22 I'm not suggesting you are wrong. The reason I interrupted  
23 you was because first I didn't want you to break the record  
24 for the longest answer in this Inquiry, which belongs to  
25 Mr Spittal from Western New South Wales.

26  
27 I understood all of what you were saying, but I just  
28 wanted to hear a bit more from you where you said there'd  
29 been - these are my words - a diminution in the status of  
30 psychiatry that concerns you. You mentioned the executive  
31 director of mental health roles and that you can't be  
32 a psychiatrist to apply for them. What was the reasoning  
33 behind that, if you know?

34 A. I don't know. You'll have to ask the chief executive  
35 of those local health districts. But, yes, I don't  
36 understand. I don't understand the reason behind it.  
37 Whether it - I mean, we were - paying a staff specialist -  
38 you'll probably pay a staff specialist more than you will  
39 pay a health service manager, you know. It may be  
40 financial. I have no idea why they would do such a thing.  
41 And I've worked with those people before and they've been -  
42 they have been, I thought, well disposed towards  
43 psychiatry, those managers. But anyway, I think - I mean,  
44 we've also - you know, we're involved in "industrial  
45 discussions" with the ministry, and the minister's offices,  
46 around the situation in New South Wales and how parlous it  
47 is, and I've done a survey. I will tell you the results

1 are that 70 per cent of the respondents - and I had, like,  
2 a 75 per cent response rate from staff specialists in  
3 New South Wales - 70 per cent of the respondents said that  
4 they would be leaving NSW Health in the next 12 months if  
5 there wasn't an improvement in pay and conditions.  
6

7 Q. Yes, okay.

8 A. That's an extraordinary number. Just - whether  
9 they're going to do it or not is another thing, but the  
10 fact is that, you know, these are people who are rusted on,  
11 you know? You can walk out tomorrow, and I could say I'm  
12 a staff specialist at Royal Prince Alfred and I'll say,  
13 "Listen I'm not doing this anymore. I want to be a - I'm  
14 walking away or you pay me as a VMO." Well, they will pay  
15 you as a VMO. So they will keep you and pay you as a VMO  
16 the next day. But these --  
17

18 Q. By "rusted on", you mean these are people that are  
19 voicing these concerns that otherwise have a record of  
20 being - a history of public service psychiatry?

21 A. Absolute. Absolutely. Dedicated, committed public  
22 servants, these people. I mean, the fact that they're  
23 still there, you know, speaks volumes. But they're at  
24 their wits end now. And they've got plenty of other  
25 options. They don't have to do this anymore.  
26

27 MR FULLER: Q. Doctor, is there an overall shortage of  
28 psychiatrists in Australia to meet the demand for  
29 psychiatry services or is it a particular issue with  
30 New South Wales public sector?

31 A. Well, in New South Wales public sector is certainly  
32 a big one. But, I mean, the data - and don't ask me how  
33 they came up with this, but I think the Australian  
34 Institute of Health and Welfare say that we meet  
35 56 per cent, currently, with the number of psychiatrists  
36 we've got in Australia. (Internet interruption). So we  
37 can have a whole lot more psychiatrists. We're not going  
38 to get double the number of psychiatrists in this country,  
39 and we have to think about - oh, my internet connection is  
40 a bit unstable, I've just been told. We have to think  
41 about how you get the best bang for your buck out of the  
42 psychiatrists in the future in this country.  
43

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

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

5  
6 THE COMMISSIONER: Q. In raising the federal government  
7 and the MBS, should I take that to mean that at least one  
8 aspect of the provision of mental health services to the  
9 public, and perhaps the first line, is primary care, and if  
10 we want to reduce the number of presentations, for example,  
11 in emergency departments, which I think everyone agrees  
12 aren't a great place for people suffering some form of  
13 mental health episode or condition --

14 A. Yes.

15  
16 Q. -- that the Commonwealth has to ensure that general  
17 practitioners can be funded to provide that initial primary  
18 level of care for people that are suffering mental health  
19 conditions so that there's proper remuneration for the kind  
20 of clinical time that might be required for what might be  
21 an early intervention that might prevent something more  
22 serious later on; is that a reasonable - is that what you  
23 were referring to?

24 A. Yes, that's very reasonable. I am referring to that  
25 in part, and I think the college has - in our federal  
26 government budget submission, we have - we are developing  
27 a postgraduate qualification in mental health,  
28 a certificate in mental health for GPs, and this has been  
29 funded by the federal government, and so we are developing  
30 that and we are taking enrolments for that course for  
31 people to do.

32  
33 But that course is only going to be as good as the MBS  
34 item number that goes with it. So the federal government's  
35 got to get real and remunerate people appropriately for  
36 sitting down with someone for longer than the 11-minute  
37 consultation, which is about the average it is for  
38 a general practice consultation nowadays. So the longer  
39 the consultation --

40  
41 Q. Just stop. Just stopping you there, that sort of time  
42 frame you're talking about, you're the expert not me, that,  
43 I assume, is just an inadequate period of time to have  
44 a discussion with someone, or provide treatment --

45 A. Oh, of course.

46  
47 Q. -- at a primary level, that's suffering some form of

1 even low-grade mental health problem or issue?

2 A. Yes, of course. Yes, of course. I mean, they've got  
3 to be able to see people for 30 to 45 minutes and be able  
4 to get an adequate amount of remuneration. I don't know  
5 what number the division of GPs puts on this in terms of  
6 time period, what they see is ideal, but, you know,  
7 sensibly, you need a reasonable period of time to be able  
8 to do a comprehensive assessment to make sure that you're  
9 able to build a rapport with someone, to be able to get  
10 them to tell their story and make the appropriate inquiries  
11 to figure out what the main issues are and how you are  
12 going to address them.

13

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

24

25 MR FULLER: Q. Doctor, the figure you gave us of  
26 70 per cent of psychiatrists in the New South Wales public  
27 sector saying they will leave if pay and conditions don't  
28 improve, have the results of that survey been published  
29 anywhere?

30 A. No.

31

32 Q. Is that something that you're able to provide?

33 A. Well, I just told you. So what it was - I mean, what  
34 it was was just a simple, literally, a very simple survey  
35 that we conducted during a Zoom meeting of all our  
36 psychiatrists a few months ago. I provided that data to  
37 the Minister for Health and the Minister for Mental Health  
38 and the department. So they've seen all of - they've seen  
39 all of that data. I mean, I could give you - I could send  
40 you the SurveyMonkey slides, the summary slides if you  
41 wish.

42

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

44 A. Yes.

45

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

1 Firstly, paragraph 17, you talk about locums - I'm sorry.  
2 Paragraphs 16 and 17 you talk about locums. Paragraph 16  
3 you say that relying on locums, the unprecedented reliance  
4 on locums, is unsustainable and invariably leads to poorer  
5 outcomes. Is that for the reasons you've put in  
6 paragraph 17, if you could just have a look at that?

7 A. My apologies, but can you read that, because I closed  
8 my - because of my signal, I closed - trying to close down  
9 all the windows on my computer. So could you just tell me  
10 what reasons I quoted in 17.

11  
12 Q. You say this:

13  
14 *Locums can deliver quality clinical*  
15 *services, but they do not provide*  
16 *continuity or service/team leadership,*  
17 *affecting patient outcomes and training*  
18 *experiences for registrars.*

19  
20 A. Yeah, I think that's a fair comment. I don't think  
21 any locums would argue with that.

22  
23 THE COMMISSIONER: Q. Tell me if I'm wrong, but if  
24 locums are turning over, is psychiatry one of those  
25 disciplines less suited for locums because it's better for  
26 the patient to be seeing the same practitioner, or am  
27 I wildly wrong about that?

28 A. Well, you're probably - you're not wildly wrong.  
29 I mean, you're right in terms of it's better for people to  
30 be seen by the same practitioner, but the high turnover, in  
31 terms of the length of stay some New South Wales public  
32 hospitals, I think, is average length of stay in a general  
33 hospital unit is - I think it's between 11 and 14 days,  
34 I think. So you've got a locum in there who is going to be  
35 there for a couple of weeks, they're going to see the  
36 person for the entirety of their admission. So I don't  
37 think it affects that so much.

38  
39 Q. Understood.

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

46  
47 THE COMMISSIONER: Q. When I asked the question, that was

1 more what I had in mind than a public hospital ward?

2 A. Yes, yes, certainly. I mean, it does impact on - when  
3 you know your patients and you've got to know them over  
4 a long period of time, you know, you can be much more  
5 efficient in the care that you can deliver to people and  
6 then --

7

8 Q. So there is an advantage for the clinician and an  
9 advantage for the patient, in continuity?

10 A. Oh, absolutely. Absolutely.

11

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

14 A. Thanks.

15

16 Q. You talk about a contraction in clinical variety and  
17 deskilling in the public sector. Can you just elaborate on  
18 what you meant by that?

19 A. So what we see increasingly is that the patient  
20 populations are becoming narrower and narrower, to people  
21 with acute behavioural disturbance related to psychosis,  
22 which, you know, is often going to be a drug-related issue,  
23 so it's either a drug-precipitated or drug-aggravated  
24 situation. So there's that population.

25

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

39

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

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

3  
4 There are some people in a personality disorder  
5 category who they will see in an ongoing way because they  
6 may be people who present frequently, often to the  
7 emergency departments, and they require a closer follow up.  
8 But generally speaking, again, we've got a narrower range  
9 of diagnostic problems that people are presenting with, and  
10 so the opportunity for exercising skills as a psychiatrist  
11 or as a trainee becomes more and more limited.

12  
13 You know, for example, when I was a trainee, or when  
14 I was a psychiatrist working in a community health centre,  
15 I could carry a small number of patients who were  
16 psychotherapy patients, you know, with severe psychological  
17 or trauma related disorders, as well as looking after  
18 people with other disorders like anxiety disorders, mood  
19 disorders and psychosis.

20  
21 So you had that sort of range of experience where  
22 you're using all your skills, and it becomes - yes, it gets  
23 harder to exercise those skills really in these sorts of  
24 environments so you're just sort of tackling the same sorts  
25 of problems over and over again.

26  
27 Q. Is the issue that, in your view, that makes practice  
28 of psychiatry in the public sector less attractive?

29 A. Yes, I think it does make it less attractive and less  
30 attractive for trainees. Whenever I mention to trainees,  
31 you know, the possibility of working in the private sector  
32 as a trainee, having that, they all want to jump at the  
33 opportunity to sort of see a broader range of problems that  
34 people present with, and I think, yes, that makes it - it  
35 is more attractive, I think.

36  
37 Q. Is there anything, in your view, that can be done  
38 about that issue?

39 A. Well, I think - I mean, we have been pushing, you  
40 know, over the last two years with this government and the  
41 previous government, for - you know, what does - everybody  
42 wants everything and our big ticket item is that we asked  
43 for - the Royal Commission in Victoria resulted in a major  
44 investment in mental health services in Victoria.  
45 Queensland had an upper house inquiry which resulted in  
46 major investment in mental health services in those states.  
47 So those states have gone ahead of New South Wales in terms

1 of the amount of - the proportion of the health budget that  
2 is spent on mental health, and they're making significant  
3 inroads - not easy but they're doing it, despite sort of  
4 working in a significant workforce complicated environment.  
5

6 In New South Wales, we've asked the state government  
7 to do the same thing, and the first step in that is doing  
8 an analysis of the gap - the gap between what we have and  
9 what we should have according to the formulas. There are  
10 planning formulas that you could use that tell you  
11 New South Wales should have this many child psychiatry beds  
12 in Wagga; you know, this many old persons' beds in  
13 Tamworth; this many community mental health staff in  
14 Camperdown. So it gives you - for population, it tells you  
15 how many staff and how many beds you need essentially to  
16 meet the need.  
17

18 So we've asked for this gap analysis and the  
19 government has committed to it and I know the department is  
20 working on it at the moment, and we're trying to get them  
21 to be as transparent as possible with that information so  
22 that, you know, we can be part of a conversation about it  
23 and be able to, you know, put political pressure on,  
24 because it was only in Queensland and Victoria where they  
25 got - where they used special levies on businesses with  
26 payrolls of over \$10 million a year, they put a special  
27 levy on those payrolls to fund this enhancement of mental  
28 health services, both in Victoria and Queensland.  
29

30 Well, we've been pushing this argument a lot with the  
31 government over the last two years and we'll continue to  
32 prosecute the argument. You know, it's going to take that  
33 sort of level of investment, particularly in the community  
34 mental health space. That's the space which is really  
35 lacking. When they talk about the missing middle,  
36 everybody talks about the missing middle, I call them the  
37 missing severe, because they don't have middling problems,  
38 they've got severe mental health problems, moderate to  
39 severe mental health problems and these people fall through  
40 the gaps between primary care and the state government  
41 services. There's nothing for them.  
42

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



1 A. Yes, yes.

2

3 Q. Is that how the two ideas tie together?

4 A. Yes, I suppose. I mean, that's not the reason. The  
5 reason is we need these services. I'm not trying to make  
6 psychiatrists' lives happier, but trying to increase these  
7 services. But a natural byproduct of that is that these  
8 jobs are going to be more interesting, I think, for people,  
9 and more attractive for people.

10

11 Q. In paragraph 43 you've told us that the supply of  
12 international medical graduates dried up during COVID and  
13 hasn't recovered. Do you have any sense of the reasons for  
14 that?

15 A. Well, I think we just couldn't get people into the  
16 country, was the big reason. I actually think - and I'm  
17 a bit removed and I'll take this on notice, I'm sorry, but  
18 I have other intelligence that says that things sort of  
19 slowed down in that space before COVID and that because  
20 we - those of us who had worked in sort of outer  
21 metropolitan and rural areas sort of have relied on  
22 international medical graduates. I mean, they provide  
23 a really substantial part of the public sector workforce in  
24 New South Wales.

25

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

31

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

36

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

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

5  
6 So we're engaged in an active process of - an active  
7 job of streamlining our own processes as a college to make  
8 things as efficient as possible to bring people into the  
9 country because we want people to be engaged with the  
10 college and not be operating under some sort of separate  
11 pathway independent of our college.

12  
13 It's not only because of our, you know - we don't see  
14 this as an existential threat, or anything, but we see it  
15 as really, you know, we are the keepers of the skills and  
16 the processes, you know, we have them, you know, no point  
17 reinventing the wheel, but if we can do it faster and  
18 better, we will.

19  
20 Q. Aside from implementing the Kruk recommendations and  
21 streamlining your own processes, do you have any views  
22 about other things that could be done to help address the  
23 international medical graduates not coming back into  
24 Australia?

25 A. Oh, no, I mean, I think that will do the trick.  
26 I mean, I think - you know, I think there is a workforce  
27 that's willing to move to Australia and we're a very  
28 attractive destination for people, and - so yes, we've just  
29 got to get better at it. But by the same token, you know,  
30 it's only got - it's yet one piece of the puzzle. It's not  
31 going to solve all the problems. That's just one piece  
32 that's going to help in some ways.

33  
34 So we have to - we can do that, but look at these  
35 other issues that are affecting the specific issues in  
36 New South Wales, particularly about the lowest remuneration  
37 in the country. I've got to get that plug in there  
38 somewhere, you know, for both the junior medical --

39  
40 THE COMMISSIONER: Q. You're not the first, it's all  
41 right.

42 A. For the junior and the senior medical workforce,  
43 I mean, really. I mean, come on, you know? We've been  
44 trying - I mean, we need some action here. I mean, I know  
45 it's up to the industrial organisations to do it, I'm not  
46 going to spruik the industrial line but it's pretty obvious  
47 that something has to happen here. We can't have

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

3  
4 MR FULLER: Q. Just on that particular issue of pay and  
5 conditions is it, in your view - sorry, is the issue the  
6 pay, from your perspective, or are there other conditions  
7 as well that you think need to be reformed just looking at  
8 it from the perspective of psychiatrists?

9 A. Yeah, well, we've got a couple of issues. I suppose  
10 the clinical support time is that - you know, that is often  
11 not - I've forgotten the term - quarantined so that, you  
12 know, as I said earlier, people are just sort of, you know,  
13 running around dealing with, you know, urgent clinical  
14 issues all the time and not that time for - and psychiatry  
15 is one of those places where you need to sit, think,  
16 reflect, you know? You need time to - and you need to be  
17 able to have those experiences with your colleagues, with  
18 your - with the other members of the multidisciplinary  
19 team, with your trainees, you know?  
20

21 Research - all those other factors, all those other  
22 things that are sort of alluded to earlier on. I mean,  
23 people talk about access to TESL and how variable that is  
24 across the state and how they made it much more difficult  
25 recently because CEOs had to sign off on it, chief  
26 executives, sorry, had to sign off on it, making it another  
27 step in the process to make it more difficult to get TESL,  
28 and that's one of the - you know, that's one of the most  
29 attractive things for specialists in New South Wales. So  
30 making sure that those - we can grease the wheels, you  
31 know, with TESL, not have issues obstructing.  
32

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

1  
2           So there are a couple of ways in which you can look at  
3 this and we've taken it to the new psychiatric workforce  
4 group that the department and workforce branch have set up,  
5 reinvigorated, we were on this group previously, so we're  
6 talking about a dedicated on-call service for the state, is  
7 one option.

8  
9           Another option is to remunerate appropriately for, you  
10 know, the work that you do. So you're working at night,  
11 all night, and you're not coming in to do an emergency  
12 operation but you're on the phone for half an hour or 45  
13 minutes talking to staff and then you go back to bed and  
14 then you are up again for another 45 minutes or half an  
15 hour and then how do you - people aren't remunerated for  
16 that at all at the moment. It's just built in to the award  
17 and it's just inadequate.

18  
19           So building something into the award like a digital  
20 on-call, because people will be providing notes into the  
21 electronic records, for example, I mean, that would be  
22 something that should be sort of entertained. I know that  
23 they're talking about it from - in a log of claims.

24  
25 Q.   Paragraph 46 of your statement, you tell us, we know  
26 that exposure to a psychiatry rotation pre-vocationally is  
27 the most significant factor in people choosing a career in  
28 psychiatry?

29 A.   Yes.

30  
31 Q.   Firstly, how do you know that? Is that survey  
32 evidence?

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

38  
39           Now, they weren't able to actually implement it,  
40 I mean, it was logistically too difficult for them,  
41 I think, but certainly the number of PGY1 and 2 rotations  
42 in psychiatry did increase quite significantly, and we  
43 think that that's one of the reasons why it is a much more  
44 attractive training experience for them.

45  
46           In New South Wales, we've got very patchy PGY1 and 2  
47 terms, some places have very little, other places like the

1 Hunter, for example, that's another Hunter tick, they have  
2 a lot of PGY1 and 2 rotations. So it's probably a key to  
3 its success.  
4

5 We see this as very important. We put it in our  
6 pre-budget submission asking for an increase in rotations  
7 year on year over the next three years, and we didn't get  
8 any this time. But anyway, we'll keep prosecuting that  
9 argument.  
10

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

13 A. Yes.  
14

15 Q. So year 1, 50 positions; year 2, 100 positions; year  
16 3, 150 positions.

17 A. Yes.  
18

19 Q. Were those numbers based on some internal modelling  
20 that you'd done at the college?

21 A. We got some idea of numbers from Victoria and we're  
22 trying to sort of increase them in a gradual fashion;  
23 rather than just saying okay, we've got to do this all  
24 overnight, but increase by 50 a year over the course of  
25 three years, yes.  
26

27 Q. Finally, in paragraph 50 you tell us that there has  
28 been a 60 per cent increase in trainees over the last  
29 decade but no change in the level of administrative  
30 support. Can you just elaborate on what you mean by that  
31 point?

32 A. Well, so the college in New South Wales funds 1.4FTE  
33 admin staff to look after our branch training committee and  
34 really look after the recruitment side from the college  
35 perspective, look after all sort of administrative stuff  
36 pertaining to trainees that the college is engaged in, and  
37 the directors of training are provided with administrative  
38 support by the state government. So they are provided  
39 with - I can't tell you the FTE for each director of  
40 training, but they get a little bit as well. But there's  
41 been no increase in that FTE, that's admin support, over  
42 this period of time and there has been a dramatic increase  
43 in the number of trainees.  
44

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

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

9  
10 Q. Doctor, I'm sorry, said I was finished but I'm not.  
11 Are we right in understanding that registrars in psychiatry  
12 can start earlier than in some other specialties; is that  
13 right?

14 A. Yes. Well, it was PGY1 and now it's going back to  
15 PGY2. So it has fluctuated over the years. So when  
16 I trained, you could start as a PGY1. So after your intern  
17 year you could start as a psychiatry registrar. Then some  
18 time later it became two years - you needed two years out  
19 in your PGY experience. But now - and it went back to 1  
20 again and now it's back to 2. So it's PGY2.

21  
22 Q. Do you have a view about whether that's a good thing,  
23 bad thing or the impact of it?

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

35  
36 I can't - I must take that on notice. I don't know  
37 the extent to which this is a college thing or an AMC  
38 thing, whether they have made this requirement, but yeah,  
39 we can get back to you on that.

40  
41 MR FULLER: Thank you, Doctor.

42  
43 Commissioner, those are my questions for this witness.

44  
45 THE COMMISSIONER: Dr Virgona, given you are here, can  
46 I just ask you some questions about this: the upper house  
47 of New South Wales parliament just produced a report --

1 A. Yes.

2

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

6 A. Yes.

7

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

10 A. June.

11

12 Q. Have you read that report?

13 A. Yeah. I went through it.

14

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

19 A. Yes.

20

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

26

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

32

33 I assume you would endorse that finding?

34 A. Yes. Yes.

35

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

38

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

41

42 Is that something you agree with currently?

43 A. The integration is not - it's not happening.

44

45 Q. Integration between primary care and mental health  
46 services is not well supported?

47 A. Well, it's not happening. I mean - is that what you

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

2

3 Q. It's not what I mean. One thing you can't hang me is  
4 this isn't my report, so --

5 A. No, no, but I think the --

6

7 Q. -- for example, I won't be making recommendations that  
8 government should consider anything.

9 A. I mean, we've made, like - the interaction between -  
10 I mean, integration - I mean, you've got - it's  
11 a no-brainer really that in this fragmented system the more  
12 we can integrate the better we're going to have in terms of  
13 outcomes for everybody. The more efficient things - the  
14 more efficient things are going to be.

15

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

18

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

22

23 Do you agree with that?

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

36

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

40

41 *Emergency departments are not an*  
42 *appropriate setting to provide mental*  
43 *health care in the majority of*  
44 *presentations.*

45

46 Do you agree with that?

47 A. Yes. Absolutely. Yes.



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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

1 with chronic mental illness who require higher levels of  
2 care, I mean, that's an area of investment that has to  
3 happen in New South Wales. But in terms of pure hospital  
4 beds, we're not as badly off as some of the other states  
5 and we really wanted to focus attention --  
6

7 Q. But going back --

8 A. We really want to focus attention on community.  
9

10 Q. But going back to the community, and I think in your  
11 evidence - I will have to paraphrase because I haven't got  
12 the transcript right in front of me - you yourself said, in  
13 the course of answering a question from Mr Fuller, that  
14 there is an underinvestment in community health - community  
15 mental health centres.  
16

17 Can I ask you this about that recommendation 19 that  
18 you support, and again, I need your views as a clinician:  
19 would I be right that if there was an extra investment in  
20 primary care of the kind we've discussed, like GPs being  
21 better funded to deal with patients with mental health  
22 conditions, and also a greater investment in the community  
23 mental health centres, can that potentially lead to  
24 patients - a reduction in the number of patients with  
25 mental health conditions needing admission to public  
26 hospitals, as inpatients?

27 A. Well that - yeah, that's the idea. Fewer  
28 presentations to the emergency department, keeping people  
29 out of the ED, being able to sort of get people - getting  
30 in early for people when they've got a problem. People  
31 languish. They don't know where to go, who to see or how  
32 to get in to see them, you know, and then the crisis  
33 escalates and they end up in the ED, and I mean this is  
34 a story that happens day in, day out in New South Wales and  
35 across Australia, really. But I mean, you know, it's  
36 particularly pertinent here.  
37

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

1 need for hospitalisation is going to increase.

2

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

7 A. Very much so, yes.

8

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

13 A. Sure.

14

15 Q. I assume that report is still the current view of the  
16 college in terms of its contents?

17 A. Yes, yes, absolutely. If anything, since that time  
18 things have got worse. I mean, I think in terms of the  
19 workforce issues that we were sort of talking about in  
20 that, we've had more - we've got together more evidence  
21 since that time, which only indicates that things are sort  
22 off - that things are deteriorating. I'll just --

23

24 Q. All right, well, I'll --

25 A. Yeah.

26

27 Q. No, sorry, you were about to say something else, so  
28 you feel free.

29 A. I just wanted to say you know when you go to a meeting  
30 with ministers and with the ministry, and you represent an  
31 organisation --

32

33 Q. Occasionally I do.

34 A. Yes, and you represent an organisation like mine and  
35 they're used to hearing my voice and they're used to  
36 hearing my story, and they say, "Virgona's come back with  
37 the same old story, he just sings the same tune every  
38 time." But we - but in response to our advocacy, they did  
39 re-establish the psychiatric workforce group, which  
40 involves the mental health branch, the workforce branch and  
41 our organisations.

42

43 What was fantastic when we had our first meeting was  
44 that every clinical director in the state - psychiatrist  
45 clinical director in the state - came to that meeting and  
46 they all painted the picture which I have - we had been  
47 articulating. Myself, ASMOF, AMA, we had all been singing

1 the same song. But it came from the coalface, from these  
2 people. So it was really important, I think, for the  
3 ministry to hear it from, you know, voices outside of mine.  
4 So they know exactly: this is true. We're not - this  
5 isn't a beat-up. This is a real crisis.  
6

7 Q. I'm sure you're familiar with it, but did you have  
8 a role in the preparation of the submission that your  
9 college made to the upper house inquiry?

10 A. Yeah, I did have a role in that, and we - I took the  
11 view that I didn't want to keep saying the same things over  
12 and over, because we've already got the gap analysis, the  
13 state government was doing the gap analysis, they'd asked  
14 me to participate in one of the committees that was looking  
15 at it, and so we thought that that was sort of happening,  
16 and I didn't want to go over, "We need to keep - we need  
17 to do this", blah, blah, blah, because something was  
18 happening, there was something in train. We said, "Okay,  
19 we'll wait. Things are bad. We'll wait for the outcome of  
20 that, let's focus on a couple of other things", which is  
21 what we did in our submission.  
22

23 Q. Two of the recommendations the college made in its  
24 submission - well, I'll break them up. One of the  
25 recommendations was for the government to invest in what's  
26 described as a "centre of excellence in trauma-related  
27 disorders" --

28 A. Yes.  
29

30 Q. -- "with the broad aims of education, training and  
31 supervision of health and sector staff, as well as tertiary  
32 level clinical service provisions to those with the most  
33 severe disorders". What resulted - the recommendation that  
34 seems to have resulted in that is for the government to  
35 "consider establishing a centre of excellence for research,  
36 training, et cetera. Can I just ask you to elaborate what  
37 the college had in mind in relation to that centre of  
38 excellence in a bit more detail?

39 A. Well, I think it's --  
40

41 Q. And why it would be useful?

42 A. Yes, why it would be useful. We - oh, this is very  
43 big. How much time have we got? But there's an argument  
44 within the mental health sector around two different  
45 conditions, if you like. One is called borderline  
46 personality disorder and one is called complex  
47 post-traumatic stress disorder. Now, borderline

1 personality disorder and complex post-traumatic stress  
2 disorder share a lot of characteristics, and, in fact, some  
3 will say that those with borderline personality disorder  
4 all have a complex post-traumatic stress disorder. So the  
5 symptoms that we see that lead to them coming to the  
6 attention of mental health services have their origins in  
7 cumulative trauma during the course of their lives.

8  
9 Now, with borderline, I've been active in this space  
10 for quite some time and I think I was, I might say, one of  
11 the advocates for a borderline personality service for the  
12 state, and that occurred about a decade ago, where the  
13 government put up some money for a statewide service to  
14 educate and train staff around borderline personality  
15 disorder. That is the Project Air at Wollongong  
16 University, they won the tender for that and they've been  
17 running the programs in this space since.

18  
19 Some of their programs, they're education programs  
20 that they run for staff and for consumers and carers, but  
21 they also have been rolling out - were commissioned to roll  
22 out a gold card program. I think it is a gold card or  
23 a green card. But anyway, these are programs where people  
24 that present to emergency departments with deliberate  
25 self-harm, overdoses or cutting, for example, and who are  
26 deemed fit for discharge, they will be given a card and  
27 they'll be given follow-up assessment by a psychologist.  
28 I don't know how many appointments they get but it's  
29 a small number of appointments.

30  
31 There is some evidence to suggest that just doing  
32 something very simple like that will diminish the - reduce  
33 the number of presentations to the emergency department for  
34 this sort of group of people.

35  
36 Q. Right.

37 A. What we see in this state and across the country is  
38 that we've developed - the National Health and Medical  
39 Research Council have developed guidelines for the  
40 management of borderline personality disorder and most of  
41 it revolves around long-term psychological therapy. So you  
42 need to have a big chunk of therapy. You're not going to -  
43 these people have got severe trust issues, severe  
44 attachment issues, they've had terrible lives, they've had  
45 terrible things happen to them, been treated terribly by  
46 people. It's going to take them time to build  
47 a relationship with a trusted clinician over time and to be

1 able to work through the issues and help them to achieve  
2 much better symptom stability, right?

3  
4 But, however, there's no - nothing in our system, you  
5 know, either through the Medicare system or the state  
6 government system, that provides this treatment. You get  
7 bits and pieces of it delivered. So separate community  
8 teams, and I set these up in the teams that I was involved  
9 in a decade ago or so, where we had therapy programs, which  
10 were outpatient therapy programs for a certain number of  
11 people that could squeeze into them.

12  
13 Then there are other programs that have been run via  
14 university clinics, et cetera. But really there's no -  
15 this is a big chunk of people in the population, and they  
16 can't access regular psychological therapy. Through the  
17 MBS, they can get 10 sessions that are going to be  
18 subsidised through Medicare, you know, but most  
19 psychologists charge half as much or twice as much and it's  
20 very difficult to pay for those, but that's only 10  
21 sessions, you know, and these people need 40 or 50 sessions  
22 at least.

23  
24 So there's also, within the community, within the  
25 mental health sector, pejorative connotations around people  
26 with borderline personality disorder because they present  
27 frequently in a dramatic way to emergency departments, they  
28 can be difficult, they can be cranky, they can be  
29 irritable, they can be dismissive. So people get pretty  
30 burnt out and frustrated by dealing with them, and that was  
31 part of the reason why we need to educate staff around this  
32 issue.

33  
34 Now, I don't think, over time, that there has been  
35 much of a shift in attitudes toward people as a result of  
36 this investment. That's not a massive investment, it was  
37 like 900,000 or a million dollars a year that Project Air  
38 was getting from the state government, I think. I can't  
39 remember the exact numbers. It's really hard to run a big  
40 program that's going to get statewide reach.

41  
42 So we wanted to shift the focus, and part of what's  
43 happened over the course of the last decade has been  
44 a shift more to considering the problems that these people  
45 present with as being rooted in trauma, and that we -  
46 I think that if people have an idea about this person being  
47 traumatised, and repeatedly traumatised in their life - and

1 that's the root of their problems - that they're going to  
2 have - there's a shift in attitude toward them, rather than  
3 seeing them as just someone with a personality disorder who  
4 is - you know, they're difficult and impossible to treat,  
5 and there's a lot of therapeutic nihilism associated with  
6 them.

7  
8 Plus, there are some therapeutic programs associated  
9 with complex post-traumatic stress disorder which are quite  
10 beneficial and, you know, looking good. So it was to sort  
11 of shift that sort of appreciation of the sorts of problems  
12 that these people have and the different approach to  
13 dealing with them. So there was going to be a lot of  
14 education and training around that.

15  
16 In Victoria, they've got a statewide personality  
17 disorder service, which is now a personality and trauma  
18 service. They've thrown trauma into the mix because they  
19 know that trauma must be - it's got to be included as part  
20 of the picture. Now, that's a service that gets \$5 million  
21 a year funding.

22  
23 There's also another service down there, which is  
24 a university based service and provides Australia-wide  
25 reach, however, most of the activities occur in Victoria,  
26 again, and that's a service with a much bigger budget  
27 again. So the people in Victoria are getting access to  
28 these sorts of services and I think not only access to the  
29 services, it's more the access to the education and  
30 training for staff, carers and consumers around these  
31 things, and that's what I was trying to get to happen in  
32 New South Wales.

33  
34 Q. So the benefit of that personality disorder service is  
35 what? It's twofold. It's the training that you are  
36 talking about - it might be threefold: the training that  
37 you are talking about for the clinicians; it's the  
38 treatment for the patient; but also, I imagine, with the  
39 aim or actually the outcome that those patients are seen  
40 somewhere other than an ED?

41 A. Yes. Exactly. You keep them out of ED.

42  
43 Now, of course, you know, you're going to be limited.  
44 We could do - we can train up our clinicians in this way so  
45 the people in ED are geared up and they're much more  
46 empathic and attuned and, you know, not making things  
47 worse and dealing better with patients, and we can train up

1 our community mental health team staff, but unless we can  
2 actually deliver some therapy to these people, you know -  
3 and you know, you need bums on seats of psychologists who  
4 are going to be able to see these people week in and week  
5 out over long periods of time, unless we do that, you know,  
6 it will make some impact but it's not going to have a huge  
7 impact.

8  
9 Whether that's delivered by the MBS, because the MBS -  
10 weird things happen with the MBS. For example, the eating  
11 disorders people, through the Butterfly Foundation, got  
12 into the ear of the federal government and, all of  
13 a sudden, if you had an eating disorder, all of a sudden,  
14 you could get access to 40 sessions with a psychologist,  
15 right?

16  
17 So the eating disorder people are sort of, you know,  
18 in a way, looked after, although the impact of that I guess  
19 has yet to be seen. We've got a - I don't know that  
20 there's been a dramatic improvement in the outcome for  
21 people with eating disorders but we'll - I don't know the  
22 data. But why the MBS can't be used in that way I don't  
23 know, and why - but I also think the state government has  
24 a role in this area as well.

25  
26 Q. Well, it will be money.

27 A. Of course it is, yes.

28  
29 Q. It will be money.

30 A. Of course it's money, yes.

31  
32 Q. Can I just ask you this, and I think this is linked to  
33 what you were telling me about personality disorder service  
34 in Victoria. On page - I'll read it out to you. On page 5  
35 of your college's submission to the upper house --

36 A. Yes.

37  
38 Q. -- one of the topics is "A commitment to major  
39 investment", and the submission says this:

40  
41 *Other states have seen unprecedented new*  
42 *investment in mental health services over*  
43 *the last two years (Queensland, Victoria,*  
44 *SA and WA). The New South Wales Government*  
45 *will need to look beyond business as usual*  
46 *requests to treasury for enhancements to*  
47 *new sources of revenue to meet these*



1           *requirements. Nothing short of historical*  
2           *investment will stem the tide of sector*  
3           *fragmentation where gaps are becoming*  
4           *chasms.*

5  
6           Just pausing there, leaving aside the reference to the  
7           government having to look beyond business as usual or  
8           treasury having to look beyond business as usual, which  
9           I think means it might have to provide extra funding than  
10          it has in previous years, the unprecedented new investment  
11          in mental health services by the other states you've  
12          referred to, I take it one might be this personality  
13          disorder service in Victoria, or are there other things  
14          and, if so, can you tell me what they are?

15          A. Oh, no, I meant - sorry, no, the personality disorder  
16          service has been there for over a decade.

17  
18          Q. Right, okay.

19          A. No, I'm referring to the outcomes of the Royal  
20          Commission and the outcomes of the upper house inquiry in  
21          Queensland, leading to the big investment. So what they  
22          did in Queensland was they did the gap analysis that we're  
23          wanting to do in New South Wales, and they came up with  
24          a list of priorities, they looked at the gaps, viewed the  
25          gaps in child and adolescent services, the gaps in older  
26          person services, et cetera, prioritised what they were  
27          going to do and they committed half a billion dollars worth  
28          of new money to enhance services in those parts of the  
29          business. So I mean, that's big money. And we've never  
30          given big money to things in New South Wales, it's always  
31          been this sort of incremental game in New South Wales.  
32          It's not going to cut the mustard.

33  
34          Q. Can I just conclude by asking this, and I think this  
35          is entirely consistent with the evidence you've given,  
36          particularly when we were discussing extra funding from the  
37          Commonwealth in terms of primary care for people with  
38          mental health conditions, but tell me whether you agree or  
39          not with this - I'm just reading now from the AMA's  
40          submission to the upper house Inquiry, where they said:

41  
42                 *AMA (NSW) is calling on the government to*  
43                 *review the current Medicare remuneration*  
44                 *model to better support general*  
45                 *practitioners managing mental health*  
46                 *conditions.*

1 A. Yes.

2

3 Q. That's consistent with your view, I take it?

4 A. Absolutely consistent, yes. Yes.

5

6 THE COMMISSIONER: Did anything emerge out of any of that  
7 for you?

8

9 MR FULLER: It didn't, Commissioner. I just wondered  
10 whether some of the documents might be marked for  
11 identification for the transcript.

12

13 THE COMMISSIONER: It's my fault that they are not in the  
14 bundle, but what we will do is MFI 11 will be the  
15 legislative council report number 64, 4 June 2024, titled  
16 "Equity, accessibility and appropriate delivery of  
17 outpatient and community mental health care in New South  
18 Wales"

19

20 **MFI # LEGISLATIVE COUNCIL REPORT NUMBER 64, 4 JUNE 2024,**  
21 **TITLED "EQUITY, ACCESSIBILITY AND APPROPRIATE DELIVERY OF**  
22 **OUTPATIENT AND COMMUNITY MENTAL HEALTH CARE IN NEW SOUTH**  
23 **WALES"**

24

25

26 THE COMMISSIONER: MFI 12 can be the Royal Australian and  
27 New Zealand College of Psychiatrists report titled "The  
28 New South Wales mental health care system on the brink:  
29 Evidence from the frontline"

30

31 **MFI #12 ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF**  
32 **PSYCHIATRISTS REPORT TITLED "THE NEW SOUTH WALES MENTAL**  
33 **HEALTH CARE SYSTEM ON THE BRINK: EVIDENCE FROM THE**  
34 **FRONTLINE"**

35

36 THE COMMISSIONER: MFI 13 will be the submission of the  
37 Royal Australian and New Zealand College of Psychiatrists  
38 to that upper house inquiry, which was dated 13 September  
39 2023

40

41 **MFI #13 SUBMISSION OF THE ROYAL AUSTRALIAN AND NEW ZEALAND**  
42 **COLLEGE OF PSYCHIATRISTS TO AN UPPER HOUSE INQUIRY, DATED**  
43 **13 SEPTEMBER 2023**

44

45 THE COMMISSIONER: I also read from the AMA's submission,  
46 which will be - what am I up to? MFI 14? MFI 14 will be  
47 submission of the AMA (NSW) Limited dated 6 September 2023

1 also to that upper house inquiry.

2

3 **MFI #14 SUBMISSION OF THE AMA (NSW) LIMITED DATED**  
4 **6 SEPTEMBER 2023 TO THE SAME UPPER HOUSE INQUIRY**

5

6 THE COMMISSIONER: They were all the documents I referred  
7 to, weren't they?

8

9 MR FULLER: Yes. Can I just note for the transcript that  
10 the College of Psychiatrists - MFI 13 - is in the tender  
11 bundle at H1.117.

12

13 THE COMMISSIONER: Excellent. Thank you. You don't have  
14 any further questions?

15

16 MR FULLER: No, I don't, thank you.

17

18 THE COMMISSIONER: Mr Cheney?

19

20 MR CHENEY: Just a couple of things.

21

22 THE COMMISSIONER: This is Mr Cheney, senior counsel for  
23 NSW Health, Dr Virgona.

24

25 **<EXAMINATION BY MR CHENEY:**

26

27 MR CHENEY: Q. Dr Virgona, can you hear me?

28

29 A. Yes, yes, good day.

30

31 Q. Good day. You gave some evidence earlier about your  
32 experience of the Sydney LHD and the Western Sydney LHD and  
33 in particular the position of executive director of mental  
34 health?

35

36 A. Yes.

37

38 Q. I think you said it was your experience that  
39 psychiatrists were ineligible to apply for that role?

40

41 A. That was my - that's it. That's my understanding,  
42 yes.

43

44 Q. Was that an understanding gleaned from your own  
45 involvement in those LHDs or from --

46

47 A. No, no, no. Just from people passing the information  
on to me. I don't --

48

49 Q. Can I suggest to you, sir, that the position, in fact,  
is that far from there being an ineligibility in

1 psychiatrists for applying for those positions, that  
2 psychiatrists are indeed eligible to apply for those  
3 positions?  
4 A. All right. I mean --  
5  
6 THE COMMISSIONER: Q. If that's the case, you would  
7 accept that, Doctor?  
8 A. If I'm mistaken, I'm mistaken. But that was the  
9 information - if that's the case, yes, sure.  
10  
11 THE COMMISSIONER: Are there psychiatrists employed in  
12 those positions?  
13  
14 MR CHENEY: Indeed there are, Commissioner. The clinical  
15 directors of both LHDs are psychiatrists.  
16  
17 THE WITNESS: But clinical directors are not executive -  
18 excuse me, clinical directors are not executive directors.  
19  
20 MR CHENEY: Q. Well, what is --  
21 A. A clinical director - a clinical director is  
22 a psychiatrist who has a sort of role in the clinical  
23 governance of the service, not in the operational  
24 management of the service, right? So the executive  
25 director is a person that is responsible for the overall  
26 running of the service, like a chief executive --  
27  
28 Q. Well, if I asked you to assume there's no such  
29 position --  
30 A. -- of the mental health service, if you like.  
31  
32 Q. -- in either LHD - that is, no position known as  
33 executive director of mental health or psychiatry in either  
34 LHD, can you help us with what position you have in mind?  
35 A. Well, I mean (internet interruption) --  
36  
37 THE COMMISSIONER: I think he might be breaking up.  
38  
39 THE WITNESS: I will take it on notice and I will find  
40 out the - sorry, can you hear me?  
41  
42 THE COMMISSIONER: We can now. You did break off.  
43  
44 THE WITNESS: Yes, sorry, no, I will take it on notice,  
45 but the (internet interruption).  
46  
47 THE COMMISSIONER: He's obviously having trouble. How

1 many more questions do you have?  
2  
3 MR CHENEY: One.  
4  
5 THE COMMISSIONER: Let's just see what happens.  
6  
7 THE WITNESS: Because I don't quite know the exact titles  
8 or positions that I'm referring to.  
9  
10 THE COMMISSIONER: We just lost you for a minute,  
11 Dr Virgona.  
12  
13 THE WITNESS: Sorry about that.  
14  
15 THE COMMISSIONER: Did you say anything important?  
16  
17 THE WITNESS: No worries.  
18  
19 THE COMMISSIONER: There's just one more question,  
20 Mr Cheney tells me, so let's see if we can get it done.  
21  
22 MR CHENEY: Q. Was it your evidence earlier - and  
23 forgive me, I can't find it in the transcript - to the  
24 effect that, to your perception --  
25 A. No, no. (Internet interruption)  
26  
27 THE COMMISSIONER: Just wait, it might be a problem with  
28 the audio link at the moment, but Mr Cheney hadn't quite  
29 finished that question.  
30  
31 MR CHENEY: Can you hear me, Dr Virgona?  
32  
33 THE COMMISSIONER: Can you hear us?  
34  
35 THE WITNESS: Okay I can hear you. I can hear you.  
36 I can hear you.  
37  
38 THE COMMISSIONER: Thank you. Mr Cheney will have another  
39 go now.  
40  
41 MR CHENEY: Q. Dr Virgona, was it your evidence that, to  
42 your perception, the psychiatry workforce within the public  
43 health system in New South Wales has declined in the past  
44 few years - that is, the number of people operating in that  
45 field?  
46 A. I don't think the total number of people has declined.  
47 The total number of staff specialists has declined. The

1 total number of VMOs increased and the number of locums has  
2 increased.  
3  
4 Q. Is that your anecdotal understanding or the product of  
5 any research on that topic?  
6 A. That was the - my recollection of meetings with the  
7 department this year --  
8  
9 Q. If the data demonstrates that --  
10 A. -- involving workforce branch.  
11  
12 Q. If the data demonstrates that in 2019 there were  
13 336.6 FTE staff specialist positions and in 2024, 416.4,  
14 would you accept that position?  
15 A. No, I wouldn't accept it. So I think there we'll have  
16 to - we'll have to drill down, we'd have to drill down into  
17 that data, because I don't think that that's consistent  
18 with the evidence that has been presented by health to us  
19 or with the anecdotal evidence that we've put together.  
20  
21 THE COMMISSIONER: How come it is so easy for you to get  
22 these figures and so hard for the colleges? You don't have  
23 to answer that straightaway. You can answer it later.  
24  
25 MR CHENEY: I'm not sure it is that hard. I will leave it  
26 at that, Commissioner.  
27  
28 THE COMMISSIONER: Dr Virgona, can you hear me?  
29  
30 THE WITNESS: Yes.  
31  
32 THE COMMISSIONER: Thank you very much for the written  
33 documents that you supplied and also thank you very much  
34 for your time today. We're very grateful.  
35  
36 THE WITNESS: Good on you. Thank you very much for the  
37 opportunity. Appreciate it.  
38  
39 **<THE WITNESS WITHDREW**  
40  
41 MR FULLER: That's all for today, Commissioner.  
42  
43 THE COMMISSIONER: Tomorrow, it's Professor Haq at 10 and  
44 the rest of the witnesses that are out there, 13, 14 and  
45 15, so we just adjourn until 10 tomorrow?  
46  
47 MR FULLER: Yes, thank you.

1  
2 MR CHENEY: Commissioner, could I raise one matter about  
3 tomorrow?

4  
5 THE COMMISSIONER: Yes.

6  
7 MR CHENEY: One of the witnesses that was scheduled for  
8 today but put back to tomorrow is Mr Findley from the  
9 college of radiologists.

10  
11 THE COMMISSIONER: Yes. You want some further time, I'm  
12 told, to consider what, if any, questions you might want to  
13 ask?

14  
15 MR CHENEY: And I also want it to be put on the transcript  
16 that my client does reject much of what Mr Findley has  
17 said, and that is something that informs our request for  
18 some more time so we can marshal that.

19  
20 THE COMMISSIONER: I'm not sure, I have probably been told  
21 and I have either forgotten or not listened properly, but  
22 is there an agreement? I have no problem with acceding to  
23 a request for further time from Mr Cheney, and I doubt  
24 whether anyone else does, but does that mean it's better to  
25 have Mr Findley at another time or not? Because otherwise  
26 he will have to come back, won't he?

27  
28 MR MUSTON: He may. I think at the moment it is  
29 impractical to get him at another time having regard to his  
30 extremely limited availability.

31  
32 THE COMMISSIONER: I see. So the preference is to have  
33 him but reserve another time for Mr Cheney to ask some  
34 questions - it sounds like he's going to want to, if he  
35 rejects - I don't care the way this is done, but is the  
36 current thinking that he will give evidence tomorrow and  
37 we'll find another time for Mr Cheney to ask some  
38 questions?

39  
40 MR MUSTON: Until a few moments ago, at least my  
41 understanding - which I don't pretend is everyone on my  
42 side of the Bar table's understanding - was that his  
43 evidence was going to be given tomorrow and that was it.

44  
45 THE COMMISSIONER: When you say "his evidence" --

46  
47 MR MUSTON: Including his cross-examination.

1  
2 THE COMMISSIONER: -- are you meaning his evidence in full  
3 including any examination by Mr Cheney? That's not  
4 Mr Cheney's understanding.

5  
6 MR MUSTON: I do understand this morning, I think, an  
7 issue was raised with others on my side of the ledger about  
8 the possibility of deferring perhaps some or perhaps all.  
9 I'm not sure, of the cross-examination of this witness.  
10 I think some correspondence was going to be forthcoming.  
11 It may have been. I haven't seen it. But I would have  
12 thought we could attend to the cross-examination of this  
13 witness at least to the extent that it's practicable, and  
14 if it does turn out that, having regard to further  
15 instructions that are obtained, there are further things  
16 that might need to be put to this witness, then we'll seek  
17 to make arrangements to bring him back, and it will be an  
18 inconvenience to him but that's life in the big city.

19  
20 THE COMMISSIONER: I haven't got it here, I left it in my  
21 room - Mr Findley's statement was provided to you when?

22  
23 MR CHENEY: It was received in incomplete form on Friday  
24 afternoon. It was received in a more complete form on  
25 Friday evening.

26  
27 THE COMMISSIONER: You don't need to say anything further.  
28 What I will do, provisionally we will have Mr Findley  
29 tomorrow, and I will grant time - in other words, I won't  
30 release the witness and we'll find time later on for  
31 Mr Cheney, at a later date, to ask any questions he wants  
32 to, save for, if you have a discussion when I leave about  
33 whether it's better to have Mr Findley entirely on another  
34 date, we'll also do that. But for the moment, what I'm  
35 hearing is it is convenient to have at least what I will  
36 call his evidence-in-chief tomorrow, and see what we need  
37 to do on another day.

38  
39 MR MUSTON: Yes.

40  
41 THE COMMISSIONER: All right. Okay. We'll do that and  
42 we'll adjourn until 10 tomorrow.

43  
44 **AT 4.13PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED**  
45 **TO THURSDAY, 25 JULY 2024 AT 10AM**  
46  
47





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