

**Special Commission of Inquiry
into Healthcare Funding**

**Before: The Commissioner,
Mr Richard Beasley SC**

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

Thursday, 25 July 2024 at 10.00am

(Day 039)

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

Also present:

Mr Richard Cheney SC with Mr Hilbert Chiu for NSW Health

1 THE COMMISSIONER: Good morning.

2

3 MR FULLER: Good morning, Commissioner. First this
4 morning we have two witnesses being called concurrently
5 from the Royal Australasian College of Physicians,
6 Professor Inam Haq and Associate Professor Kudzai Kanhutu,
7 who are both online. I call those two witnesses.

8

9 <INAM HAQ, affirmed: [10.00am]

10

11 <KUDZAI KANHUTU, affirmed: [10.01am]

12

13 <EXAMINATION BY MR FULLER:

14

15 MR FULLER: Professor Haq and Associate Professor Kanhutu,
16 my name is Dan Fuller, I'm one of the counsel assisting the
17 Commission and I'm going to be asking you some questions
18 this morning.

19

20 Firstly, each of you have signed off on a witness
21 statement dated 12 July 2024. Do you have each a copy of
22 that statement with you?

23

24 A/PROFESSOR KANHUTU: Yes.

25

26 PROFESSOR HAQ: Yes.

27

28 MR FULLER: That's exhibit H6.1 in the tender bundle.

29

30 Professor Haq, starting with you, have you had the
31 opportunity to review that statement recently?

32

33 PROFESSOR HAQ: Yes.

34

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

37

38 PROFESSOR HAQ: To the best of my knowledge and belief,
39 yes.

40

41 MR FULLER: Thank you.

42

43 Associate Professor Kanhutu, have you had the
44 opportunity to review the statement recently?

45

46 A/PROFESSOR KANHUTU: Yes, I have.

47

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

3
4 A/PROFESSOR KANHUTU: Yes, it is.

5
6 MR FULLER: Thank you. Each of you have helpfully
7 identified in the statement which of you will speak to
8 particular topics, so I will try to address my questions to
9 the appropriate person, but please, if either of you have
10 anything to add on any of the questions that I've directed
11 to the other witness, please feel free to let me know.

12
13 PROFESSOR HAQ: Sure.

14
15 MR FULLER: Just starting with some background,
16 Professor Haq, can you describe your current role in the
17 college, please?

18
19 PROFESSOR HAQ: Sure. So I'm the executive general
20 manager of education, learning and assessment and my
21 portfolio is trainees and their training up and to
22 fellowship, from entry to basic training to exit as
23 fellows.

24
25 MR FULLER: For how long have you held that role?

26
27 PROFESSOR HAQ: Since January 2023.

28
29 MR FULLER: Have you previously held any leadership roles
30 within the college?

31
32 PROFESSOR HAQ: No.

33
34 MR FULLER: Associate Professor Kanhutu, can you please
35 describe your role?

36
37 A/PROFESSOR KANHUTU: Yes. I'm the dean of the College of
38 Physicians. My work portfolio encompasses workforce
39 planning, data research, and I also have leadership of the
40 research foundation that provides philanthropic grants to
41 our members.

42
43 MR FULLER: For how long have you held the role of dean?

44
45 A/PROFESSOR KANHUTU: I commenced in September 2022.

46
47 MR FULLER: And did you hold any leadership role within

1 the college before that time?

2

3 A/PROFESSOR KANHUTU: Nothing that was paid. I did hold
4 some advisory roles and leadership roles as
5 a representative of the college on other bodies, but
6 non-college bodies.

7

8 MR FULLER: Do you also have a clinical role outside of
9 the college?

10

11 A/PROFESSOR KANHUTU: I do. I still retain 0.3 clinical
12 work outside of the college of physicians but that's based
13 in Melbourne.

14

15 MR FULLER: Can you just tell us what that clinical role
16 is?

17

18 A/PROFESSOR KANHUTU: Yes, so I'm an infectious diseases
19 physician so I work in the hospital setting as well as
20 community-based care and refugee and migrant health.

21

22 MR FULLER: Thank you.

23

24 Professor Haq, do you have a clinical role as well?

25

26 PROFESSOR HAQ: Yes. I continue clinics at the Redfern
27 Aboriginal Medical Service in rheumatology, which is my
28 clinic.

29

30 MR FULLER: Thank you.

31

32 Associate Professor Kanhutu, starting with you, in
33 lines 68 and 69 of the statement, if you can just have
34 a look at those, you have described the college's remit as
35 being a "specialist education provider". Do you see that?

36

37 A/PROFESSOR KANHUTU: Yes. I do, yes, I see that.

38

39 MR FULLER: Do you see being a specialist education
40 provider as being the limit of the college's role?

41

42 A/PROFESSOR KANHUTU: No, it's not, and I think what
43 I refer to, or what I refer to in terms of my understanding
44 of what the college remit is, is what is within our
45 constitution, which really clearly sets out our role as an
46 education provider as well as a steward of ethics for
47 physicianly practice within both Australian and

1 New Zealand. So my source of - my frame of reference
2 really is what's bound within the constitution, and which
3 is extensive, but really focused closely on education,
4 maintenance of professional standards for the specialties
5 that we have care of.
6

7 MR FULLER: Do you see part of the college's role as being
8 to advocate for the interests of its fellows?
9

10 A/PROFESSOR KANHUTU: The advocacy that is stepped out in
11 the constitution mainly relates to advocacy for work that
12 relates to promoting good health and good health outcomes
13 for community and to the extent that revolves around
14 advocacy for certain groups of physicianly, I guess, craft
15 groups, yes, there is some overlap there for direct
16 advocacy for craft groups, for example, where we identify
17 that there are community care needs that aren't being met
18 due to either inadequacies in the way that our workforce is
19 being deployed to address those needs.
20

21 MR FULLER: Do you see it as being any part of the
22 college's role to advocate for individual fellows or groups
23 of fellows in relation to workplace disputes?
24

25 A/PROFESSOR KANHUTU: No. We have traditionally not
26 engaged in any industrial matters. Our focus for advocacy
27 tends to be around topic areas or areas of community need,
28 where we can potentially provide support or can help
29 contribute to better outcomes for community. So the
30 advocacy lens is usually focused on community care needs
31 and gaps or perceived gaps there.
32

33 MR FULLER: Professor Haq, do you agree with that
34 description of the remit of the college?
35

36 PROFESSOR HAQ: Yes, yes.
37

38 MR FULLER: Professor Haq, I understand - tell me if I'm
39 wrong - that you previously worked in the UK; is that
40 right?
41

42 PROFESSOR HAQ: That's right.
43

44 MR FULLER: Did you complete your training in the UK as
45 well?
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47 PROFESSOR HAQ: I did.

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MR FULLER: Are you familiar with the current way in which accreditation, specialist accreditation works in the UK?

PROFESSOR HAQ: Yes.

MR FULLER: Are we right in understanding that, at the moment, at least, accreditation is not performed by colleges but instead is performed by a central body?

PROFESSOR HAQ: I think it's by the GMC and their work, yes, as I understand it.

MR FULLER: So not by individual colleges as it is in Australia?

PROFESSOR HAQ: No, no, not in - not certainly the college of physicians, anyway.

MR FULLER: Do you have a view as to the advantages or disadvantages of that sort of model, where accreditation is not performed by the colleges, compared with the model in Australia?

PROFESSOR HAQ: Yes, I think they're two very different health systems and populations and I think the current set-up is that the colleges have worked through accreditation. I think there's always room for continuous improvement there and working together. However, I feel that, at the moment, the direction of travel that we're going on with accreditation through the work of the AMC and the National Health Practitioner Ombudsman has been really helpful in bringing us all together to a common understanding, working much more closely with the health jurisdictions.

I think that the benefits of it being managed by the colleges are that you have the subject matter experts as fellows within the college, who understand the local context, and are able to make informed decisions based on that local context and understanding of the specialty field as required.

I think it also is excellent as a peer review, as much as anything else, and that, I think, engenders trust between those being reviewed and those asking the questions to allow, I think, a safe space for issues to be raised,

1 knowing that they will be dealt with in a manner that's
2 professional and appropriate.

3
4 So to answer your question, I think there is always
5 room for improvement but I think there are benefits of it
6 being managed at a college level. I think there - and
7 there are improvements in communication. If it was to be
8 a third party, let's say, who manages this, I think that
9 the process and procedures would have to be duplicated. It
10 may lead to a complexity in the system and communication
11 and decision-making, which, you know, health systems are
12 already very complex. Do we want to add complexity? And
13 it may take away some of that sort of positive constructive
14 approach of peer review and make it much more of a sort of
15 a top-down assessment.

16
17 MR FULLER: Associate Professor Kanhutu, did you have
18 anything that you wanted to say on that topic?

19
20 A/PROFESSOR KANHUTU: Look, I definitely concur with what
21 Professor Haq has articulated there. My experience of
22 accreditation has been there is so much to be gained from
23 the nuance and the understanding of context that we have.
24 So for Australia, being a very large country
25 geographically, a lot of the challenge that we find in
26 terms of accreditation really relates to local and
27 contextual factors and it's that benefit of having local
28 people and people who understand both the craft group and
29 the skill group from within the college who are there doing
30 the accreditation that I think makes it a really valuable
31 experience for both the accreditors themselves and also the
32 sites, and that understanding that it is truly a peer
33 review that's backed by a shared knowledge and a shared
34 appreciation of a framework that has been developed over
35 time.

36
37 So I think there is really benefit for having people
38 who are doing the accreditation having a close working
39 understanding of what it's like to work in various areas,
40 whether it's, you know, urban settings versus small or
41 outer metropolitan or even very small rural/regional remote
42 settings as well.

43
44 MR FULLER: When you refer to "craft group" and "skill
45 group" in that answer, can you just explain what you mean
46 by those groups, please?

47

1 A/PROFESSOR KANHUTU: Yes, so what I mean, both of them,
2 basically it's a synonym for the different specialties that
3 we have under our banner. We have, you know, 33
4 specialties and then we also have some legacy specialties
5 as well, and each of them can have very different needs and
6 very different ways of meeting their professional needs.

7
8 So for some of the specialties they're very clinically
9 oriented and are very much hospital based, and then we also
10 have specialties there, for example, public health, where
11 there is a really vast array of places and contexts where
12 those training needs can be met. I think that's the true
13 value of the way that we have accreditation running within
14 our colleges, that we're able to bring in subject matter
15 experts who are able to make that assessment on the ground
16 and understand is this setting fit for purpose and does it
17 actually meet the outcomes that have been set up for
18 a particular curriculum stream?

19
20 MR FULLER: In relation to those 33 specialties, they're
21 the ones we see in table 1 of the statement, which I think
22 starts at line 33; is that right?

23
24 A/PROFESSOR KANHUTU: I will go back to that. Line 33?

25
26 PROFESSOR HAQ: Yes, that's right, they're the training
27 programs, yes.

28
29 A/PROFESSOR KANHUTU: Yes. Yes, correct.

30
31 MR FULLER: Thank you. Professor Haq, I think this is in
32 your section, so I'll ask you these questions. Are we
33 correct in understanding that a trainee with your college
34 will first undertake basic training in either adult
35 medicine or paediatrics and child health; is that right?

36
37 PROFESSOR HAQ: Yes, the majority will enter that way and
38 then enter into advanced training, but the chapters and
39 faculties may allow a trainee from other areas as well,
40 they're slightly more diverse in nature. But yes, the
41 adult and paediatric internal medicine route is usually
42 three years of basic training. You complete your
43 examinations and then you enter your chosen advanced
44 training stream.

45
46 MR FULLER: The chapters and faculties that you mention,
47 I think we see from line 11 of your, statement, they deal

1 with a subset of the 33 specialties; is that right?

2

3 PROFESSOR HAQ: No, they are separate. They are separate.
4 Yes, absolutely.

5

6 MR FULLER: In terms of the 33 specialties, after the
7 trainee, generally at least, has completed basic training,
8 then they undertake advanced training in one of those
9 specialties; is that right?

10

11 PROFESSOR HAQ: Yes, that's right.

12

13 MR FULLER: The only way to become a specialist in one of
14 the what I will call "physician specialties" is to complete
15 a training program through your college; that's right?

16

17 PROFESSOR HAQ: Yes, yes.

18

19 MR FULLER: As a consequence, you would agree that there
20 is no competition between your college and any other
21 training provider for specialist training in those fields;
22 that's fair?

23

24 PROFESSOR HAQ: I would say that we are the trusted
25 provider, as in the UK. You know, you alluded to the UK.
26 The college of physicians would be the provider of
27 physician training programs in the UK. We're similar,
28 yes..

29

30 MR FULLER: You would agree that because you are the
31 trusted provider, the only trusted provider of those
32 programs, it's important for your college to have fair,
33 effective and transparent processes for governance and
34 administering training programs?

35

36 PROFESSOR HAQ: Absolutely right.

37

38 MR FULLER: Professor, can you just explain to us what is
39 it that your college accredits? Is it sites or positions
40 or a combination? Can you just explain that, please?

41

42 PROFESSOR HAQ: Yes. So it is sites, and within that
43 there will be the number of positions that are within the
44 capacity to train of that site, dependent on the facilities
45 and the number of medical personnel there to supervise. So
46 it will be a mixture of the two. And that could be an
47 individual site or it could be a network of sites as well.

1
2 MR FULLER: Let me ask you first, why is it that the
3 college takes that approach to accreditation rather than,
4 for example, accrediting individual positions?
5
6 PROFESSOR HAQ: We don't cap, at the moment. I know some
7 colleges do, and we allow training sites to define what
8 they feel they need for training - in training based on
9 their infrastructure and resources. Then we would - you
10 know, then there would be a decision about whether that
11 number is correct based on the resources that have been
12 available and the guidance that the college gives. But we
13 do not cap positions at this stage.
14
15 MR FULLER: You mentioned the capacity to train guidance.
16 I might just show you that document so we're on the same
17 page. It's exhibit H1.36, [SCI.0011.0259.0001]. You'll
18 see it come up on the screen, Professor, in a moment.
19
20 PROFESSOR HAQ: Oh, yes.
21
22 MR FULLER: You don't need to worry about that.
23
24 PROFESSOR HAQ: Yes.
25
26 MR FULLER: Do you see the document there on the screen?
27
28 PROFESSOR HAQ: I do.
29
30 MR FULLER: Is that the capacity to train guidance that
31 you were referring to?
32
33 PROFESSOR HAQ: It is, yes.
34
35 MR FULLER: Can we just scroll to page 2, please.
36
37 We see under the heading "How does the RACP assess
38 Capacity to Train".
39
40 PROFESSOR HAQ: Yes.
41
42 MR FULLER: In the first sentence, I think we see what you
43 have just told us that the RACP doesn't cap the number of
44 trainees; is that right?
45
46 PROFESSOR HAQ: Yes, yes.
47

1 MR FULLER: And then it goes on to say that the college
2 monitors numbers of trainees and where required modifies
3 the number when training provider accreditation standards
4 are not met. Can you just elaborate on what that means,
5 please?
6

7 PROFESSOR HAQ: I think that would be as part of the
8 ordinary accreditation cycle. If a place is accredited for
9 X trainees then the normal reaccreditation would be four
10 years or so and then that - the numbers would be reviewed.
11 If there was an issue with accreditation or conditions
12 applied to a site, then those numbers would be reviewed,
13 perhaps more on an interim basis, depending on the nature
14 of the conditions and the nature of any concerns that have
15 been raised.
16

17 MR FULLER: Just looking about halfway down this page, we
18 see a reference to the basic training accreditation
19 requirements and standard 5.2.1 --
20

21 PROFESSOR HAQ: Yes.
22

23 MR FULLER: -- which starts with a rotation supervisor.
24

25 PROFESSOR HAQ: Yes.
26

27 MR FULLER: Are we right in understanding that that is
28 effectively a ratio of the maximum number of trainees per
29 supervisor at a given site? Is that the right way of
30 understanding?
31

32 PROFESSOR HAQ: Yes, that is guidance - that is guidance
33 on a ratio, yes.
34

35 MR FULLER: I see. So it's guidance. It's not the case
36 that if a site doesn't strictly meet that ratio, then it
37 will be denied accreditation?
38

39 PROFESSOR HAQ: No. No, I think at that point there would
40 be a decision based on in practice how does it work, and we
41 would triangulate data from the supervisors and the
42 trainees, and if there was an issue and actually it was
43 felt that more supervision was required that could then be
44 included in accreditation conditions or similar.
45

46 MR FULLER: Is there a similar requirement for advanced
47 training?

1
2 PROFESSOR HAQ: Those would vary according to - as you can
3 imagine, the very different number of specialties, and the
4 number of trainees is much smaller there per site, so
5 that's viewed - yes, there would be a view on that as well,
6 done through advanced training at a particular site.

7
8 MR FULLER: Who determines that view or position?

9
10 PROFESSOR HAQ: So it would be the advanced
11 training committee. There would be an accreditation visit.
12 There would be accreditation criteria for each specialty
13 that would be looked at and then the report would go to the
14 advanced training committee and there would be a decision
15 made there.

16
17 MR FULLER: Are there individual committees for each of
18 the 33 specialties?

19
20 PROFESSOR HAQ: So there would be - the advanced training
21 committee covers lots of or all aspects of training, but
22 also includes accreditation as well, as a decision-making
23 and review, yes.

24
25 MR FULLER: Associate Professor Kanhutu, was there
26 anything that you wanted to add on the matters I've just
27 been discussing with Professor Haq?

28
29 A/PROFESSOR KANHUTU: No, nothing. Nothing extra.

30
31 MR FULLER: Thank you. We can take that document down,
32 thank you.

33
34 Professor Haq, you also mentioned the training
35 networks and, as we understand it, basic training, at least
36 basic physician training, is delivered within training
37 networks at least in New South Wales; is that right.

38
39 PROFESSOR HAQ: Mmm-hmm.

40
41 MR FULLER: Can you just explain how that works, please?

42
43 PROFESSOR HAQ: Yes. So that is - there would be like a
44 hub and spoke model, so there would be a sort of main
45 hospital that would be running the network and there would
46 be a mixture of metropolitan, regional and rural sites
47 assigned to that network and then trainees would move

1 around those sites during their training.

2

3 MR FULLER: Does the college have any role in developing
4 that network structure?

5

6 PROFESSOR HAQ: So that's where we work with HETI on that,
7 very closely, and I'm a member of their adult and - both
8 the adult council and the paediatric council, and we have
9 representation on the network group as well. So that's
10 where there's collaboration between the college and
11 external bodies.

12

13 MR FULLER: What do you see as being the advantages of
14 that structure for basic training in New South Wales?

15

16 PROFESSOR HAQ: Experience in different settings, yet
17 still under sort of a home network, so to speak, so they
18 understand where they sit. There is opportunity for more
19 than - you know, for communities of practice with the
20 trainees so they're not siloed on their own in particular
21 areas and I think it allows training to occur, as
22 I probably said, in different sort of areas, with different
23 areas of specialism, different population, so the trainees
24 can meet the curriculum requirements.

25

26 MR FULLER: I think we just missed the start of your
27 answer but I think you were referring to experience in
28 different settings.

29

30 PROFESSOR HAQ: Yes, in different settings --

31

32 MR FULLER: Does that have to do with --

33

34 PROFESSOR HAQ: In different settings in sort of you know,
35 very specialist hospitals, with tertiary referrals maybe,
36 versus more regional and rural hospitals as well. So
37 a whole mix, yes.

38

39 MR FULLER: Is it the case that trainees are required to
40 rotate into, for example, rural and regional settings as
41 well as metropolitan settings? Is that right?

42

43 PROFESSOR HAQ: I think - with basic training I think
44 that's often a discussion for the network director of
45 physician education, to have with the trainee, as to where
46 they would be going on an annual basis to do their training
47 and if there are, you know, reasons why a trainee cannot go

1 to a particular place - and they may be family or personal
2 reasons - those would be taken into account. There's no
3 mandatory requirement for us at the moment to have
4 experience in one particular place but we see it as
5 desirable and part of our regional/rural (internet
6 interruption) - the longer a trainee - or a medical student
7 or trainee has experience in a non-specialist city centre,
8 the more likely they are to sort of stay there, and that's
9 part of managing workforce distribution, it is really
10 important.

11

12 MR FULLER: Is the college doing anything in particular to
13 help facilitate that?

14

15 PROFESSOR HAQ: Yes. So across - so we are, through our
16 regional and remote strategy we will be working on - I
17 mean, New South Wales is probably, you know, sort of a bit
18 ahead of the game here. Through federal funding, FATES
19 funding, we are working on network models in other areas of
20 the country, particularly Western Australia in adults and
21 paediatrics, and Associate Professor Kanhutu is working on
22 those as well.

23

24 We actually very much want to facilitate working with
25 other health jurisdictions to ensure that trainees have
26 well-supervised experience rurally, because we now have
27 medical schools that are end-to-end rural training, we have
28 integrated training hubs for prevocational training, so
29 there's lots of opportunities now to ensure that we retain
30 that rural workforce in the appropriate places. And for
31 vocational training, networks, rural networks either purely
32 rural networks or networks that involve metropolitan and
33 urban settings as well is I think the way forward, and
34 New South Wales obviously is developed in that, well
35 developed in that regard. There are other areas that we're
36 working on to ensure that we can manage that as well.
37 Professor Kanhutu may want to speak to the FATES projects,
38 if you require.

39

40 MR FULLER: That would be helpful, Associate
41 Professor Kanhutu. Do you want to comment on that?

42

43 A/PROFESSOR KANHUTU: Sure. So we have two projects that
44 revolve around networked models. The first one is
45 a college-driven one, which is a project running in Western
46 Australia where they're looking to establish essentially
47 end-to-end training for adult medicine in rural, regional

1 and remote areas with a very brief period spent at a larger
2 site at the time that someone's performing their
3 examination. So the whole ambition there is to do as
4 Professor Haq alluded to, to allow people to spend as much
5 time as possible in a rural setting whereas traditionally
6 they would have had to rotate out or spend extensive
7 periods in metropolitan sites in order to meet their
8 training requirements.

9
10 So what we are enabling there is the ability to see
11 that we can actually allow people to develop all of their
12 core skills and competencies largely within a rural
13 setting, and then encourage them to stay there as well, and
14 that has been very well received for that Western
15 Australian cohort.

16
17 The other project we're working with is a consortium
18 project that involves a host of other colleges, including
19 college of surgeons and the medical administrators, which
20 is looking to establish what are the key components of
21 a successful network model, and then one of the outcomes
22 for the surgeons is to actually establish a rural network
23 in the Northern Territory.

24
25 If I can perhaps reflect on some of the comments
26 Professor Haq has made, one of the real benefits that we've
27 seen with the networked models is it's not only about
28 exposure to different context, it's the efficiencies that
29 it also allows and delivers for the sites individually.

30
31 One of the things that we've had as reflections from
32 the rural sites is the real challenge of recruiting, if you
33 are a stand-alone rural site. Often there is a sense of
34 prestige or allure for the larger metropolitan sites
35 because they often have access to research partnerships and
36 research linkages that can be a real drawback, especially
37 for those specialties where there is an expectation that
38 there will be potentially an academic pathway or further
39 academic study as part of, you know, career progression.

40
41 There's also huge benefits at that basic training and
42 the advanced training level of having networks because then
43 people are able to share the same educational resources,
44 tutorials, and it really builds a sense of not feeling as
45 though, you know, they're a second-tier or third-tier site,
46 because people have an expectation that working within this
47 network, I will have access to exactly the - you know, as

1 many opportunities as I like, particularly if there are
2 some who are wanting to subspecialise. For example, some
3 of the cardiology specialties have subspecialties within
4 them, and it can be a bit of a challenge if people are
5 working in certain settings if they feel that they won't
6 actually have access or exposure to certain areas of
7 subspecialisation if they are locked into a single site.
8

9 So there are huge, I think, benefits to be gained from
10 those networked models, particularly as we're now working
11 to build them proactively and to design them, because many
12 of the existing networks, my observation has been, are
13 often legacy networks or networks that are built on
14 historical relationships and now what we're looking at, for
15 example, with the Western Australian example is to actually
16 say, "Look, if we're to start from scratch, how would we
17 build a network that is mutually reinforcing, that doesn't
18 have unnecessary duplication and also is networked in a
19 geographic way that potentially doesn't draw people that
20 still have to travel six hours or work in a network that's
21 actually unworkable for the individual and forcing them to
22 have to move house or move their families?"
23

24 That's really important that in this moment in time,
25 because we have so many of our trainees who are coming
26 through who are already postgraduate, have significant
27 commitments and often have had previous careers as well
28 that have bound them to particular geographies and giving
29 them that confidence that they can work in a network, still
30 have great exposure but aren't having to then recommit to
31 having to move extensively or disrupt that - I think that
32 sense of work/life balance that people increasingly value
33 and should really have access to, if we're serious about
34 wellbeing.
35

36 PROFESSOR HAQ: Yes, and I --
37

38 MR FULLER: Can I ask you - I'm sorry, Professor Haq.
39

40 PROFESSOR HAQ: Sorry, no, you finish your train of
41 thought with Professor Kanhutu.
42

43 MR FULLER: Thank you. Professor Kanhutu, can I just ask
44 you a few follow-up questions. Firstly, we've been talking
45 about FATES. That's a Commonwealth funding initiative
46 that's "flexible approach to training in expanded
47 settings"; is that right?

1
2 A/PROFESSOR KANHUTU: Yes, correct.

3
4 MR FULLER: Do you see any impediments to implementing
5 a similar model in New South Wales compared with Western
6 Australia?

7
8 A/PROFESSOR KANHUTU: You mean a FATES funding model or --

9
10 MR FULLER: A similar networked structure to the one that
11 you've described in Western Australia that has been
12 implemented using the FATES funding?

13
14 A/PROFESSOR KANHUTU: Look, I think there's - I want to
15 say not "impediments", but barriers and enablers. I can
16 speak to the enablers and what we've seen is often the real
17 driver is having a committed group of clinicians who are
18 focused in understanding what is it that they're trying to
19 build and also have the support and buy-in of local
20 trainees who are saying, "Yes, that is exactly what we
21 need."

22
23 Where I think things can fall apart is when there
24 aren't those, I guess, relationship built bridges that
25 allow people to then wrap around that network and actually
26 formalise it and provide the governance structures. I feel
27 that that's the role that our college can play, is really
28 helping people to shape those connections and then make
29 sure that the accreditation model that is drawn up for that
30 network supports that to remain rigorous and balanced,
31 because a lot of this work, for better or worse, often
32 happen in its early phases through goodwill, and I think
33 what we'd like to see is that we support people to develop
34 networks where, firstly, there's a real recognition of the
35 amount of work that goes into building a robust and fit for
36 purpose network, because often the downfall is that, you
37 know, organically formed networks can suffer from having
38 individual or individual dependency as to, you know, there
39 is somebody who drove the beginning of the network, they
40 disappear or leave and then it falters.

41
42 I think what we would like to see is to give people
43 some of those guide ropes of how do you set up a network
44 for success, and that's one of the real outcomes that we
45 hope to achieve from that FATES project, the consortium
46 one, is: what does it take to do it right from start to
47 finish', what sort of resourcing is required; what sort of

1 background work do you need to do; and who do you need to
2 have over the lifetime of the development to make it
3 successful?
4

5 So I don't think there are any - you know, there will
6 be as part of this project, and one of them will be
7 a catalogue list or a summation of what are the barriers
8 and enablers for establishing a network. So absolutely
9 doable and there will always be those context dependent
10 considerations. For example, if you're trying to build one
11 in far western New South Wales, it might be very different
12 from trying to build one, for example, in northern New
13 South Wales, or hinterland.
14

15 So I think the fundamentals will become clearer as we
16 develop, but there's nothing that I would say would
17 absolutely preclude setting up or working to establish
18 something like that in New South Wales.
19

20 PROFESSOR HAQ: I think the work that Professor Kanhutu is
21 doing will allow us to enhance what's going on in New South
22 Wales, I think, already.
23

24 I won't mention the site name but we've had at least
25 one site, rural/regional site, that has applied to us for
26 accreditation, that has been given, and then we have worked
27 with HETI, who will then help find a network place for
28 that, so there is a procedure in place at the moment.
29

30 Now, I think there's work to do through the work that
31 Professor Kanhutu has done, I think, to make that an easier
32 proposition.
33

34 I do think that the other thing I would like to say,
35 there is also one more project in palliative medicine,
36 looking at fully rural networking across the country. So
37 I think the college is leading this in a significant way
38 through Commonwealth funding, which is a great enabler for
39 us, and we're very engaged with the upcoming review of this
40 portfolio with the Commonwealth Government.
41

42 Another couple of things to say, I think that
43 supervision is really, really important here, either remote
44 or in person. And the nature of that supervision across
45 the network, that's something I think that we'll be having
46 to work through as well. What does that mean, particularly
47 for potentially smaller sites? And also a facilitation and

1 accreditation of smaller sites. We are currently going
2 through a review of our standards and, I think up until now
3 it would be fair to say that our standards have been a
4 little metro-centric and it's been more complex and
5 difficult for smaller - well not necessarily smaller, but
6 regional and rural sites to gain accreditation. That is
7 absolutely not our intention, and the current review of our
8 training standards will actually - much more of a
9 risk-based framework and allow regional/rural sites to get
10 accredited where, at the moment, it's been more complex for
11 them. So I think that will also be a great advantage to
12 networking.

13

14 MR FULLER: Does the college currently take into account,
15 for example, the fact that a rural or regional site will be
16 part of a network when it's deciding whether the site meets
17 the accreditation standards?

18

19 PROFESSOR HAQ: They would be on the basis that - you
20 know, accreditation would be given on the basis that
21 a network is found, yes.

22

23 MR FULLER: I see. So it's provisional, effectively?

24

25 PROFESSOR HAQ. And that's where we work with HETI on
26 finding the network, yes.

27

28 MR FULLER: Professor Haq, you mentioned considering the
29 idea of remote supervision. Is that something that you
30 think is workable for your college's specialties?

31

32 PROFESSOR HAQ: I don't think - I think it's not
33 a one-size-fits all here. I think it depends on the nature
34 of the specialty, the nature of the acuity of the specialty
35 and the sort of geographic location of that particular
36 site. So I think that's something we need to investigate
37 and it will be very different for each of the specialties,
38 I think, as to what they will feel is there to the benefit
39 of patient safety and community safety as well as the
40 trainees' safety.

41

42 MR FULLER: Associate Professor Kanhutu, do you see any
43 barriers in New South Wales to implementing a networked
44 model arising from the sheer size of the system and the
45 number of players, for example, or districts, versus the
46 ministry? Do you see any barriers in that area?

47

1 A/PROFESSOR KANHUTU: Again it goes - it boils down to the
2 governance and how you design it for success. We already
3 have some excellent examples of networks that are working.
4 So how we tend to work in that spirit of peer review is to
5 look at what's working and then try and structure models
6 that will, I guess, replicate the same foci of success.

7
8 Where you're trying to build a completely new network
9 and bridging completely new relationships, I think it's
10 always going to be a lot harder to do that and often that
11 groundwork is actually seeing where there are potentially
12 some already existing relationships that would facilitate
13 a smoother transition to a formalised network.

14
15 MR FULLER: Are we right in understanding that currently
16 in New South Wales there is no network structure for
17 advanced training?

18
19 PROFESSOR HAQ: I think it probably depends on the
20 specialty. I wouldn't know for each specialty.

21
22 A/PROFESSOR KANHUTU: Yes.

23
24 MR FULLER: So there may be some specialties that work
25 within a networked structure; is that --

26
27 PROFESSOR HAQ: Yes. I mean, certainly rheumatology,
28 I think - and whether they are networks or sort of
29 de facto, I think, is probably to be discussed, but I think
30 there are probably informal ways in which that is done in
31 some areas, yes. But I couldn't speak for each of the
32 specialties.

33
34 MR FULLER: Associate Professor Kanhutu, I think this is
35 in your section of the statement, if you go down, please,
36 to line 470 on page 17.

37
38 A/PROFESSOR KANHUTU: Yes.

39
40 MR FULLER: There's a dot point there that starts "A goal
41 of the RACP's Accreditation Renewal Program". Do you see
42 that?

43
44 A/PROFESSOR KANHUTU: Yes.

45
46 MR FULLER: Halfway down line 475, you say:
47

1 *In NSW, most Basic Physician training*
2 *occurs within HETI's network structures.*

3
4 Which we have discussed. Then you say:

5
6 *There is an opportunity to expand this*
7 *throughout Advanced Training.*

8
9 Can you just explain what you had in mind by that
10 opportunity?

11
12 A/PROFESSOR KANHUTU: I'm having a look at that. I'm not
13 sure that that was --

14
15 PROFESSOR HAQ: Maybe it's me.

16
17 A/PROFESSOR KANHUTU: -- my area of response.

18
19 MR FULLER: I'm sorry.

20
21 PROFESSOR HAQ: No, it's fine. I'm happy to look at that.
22 Look, I think again it's - the issue is, I think, the sheer
23 number and complexity of the number of sites and
24 specialties. I think there are opportunities there. And
25 again some of these may exist already, you know, around
26 trainees moving from metro to regional places. I think we
27 probably need to get a better idea of that across all the
28 specialties and see how we can create, you know, sort of
29 structures that support that.

30
31 I mean, there are also, of course, you know, as
32 Professor Kanhutu has alluded to, in WA and the NT, fully
33 rural networks as well that we need to think about
34 potentially as well as options or ways to gain the
35 requisite experience.

36
37 MR FULLER: Does your college have a role in selecting
38 trainees?

39
40 PROFESSOR HAQ: At the moment we have - that's done in the
41 workplace. We have a selection into training guidance that
42 we provide and the workplaces then manage that at a local
43 level and there are different ways in which that works.
44 There's no one way in which it works. Either the - there
45 are - different models could be that the site will work
46 with, or a network will work with, a specialist society, as
47 occurs in something like rheumatology, to select and then

1 match, or there's often in other areas, for example,
2 endocrinology, where the specialty will work with NSW
3 Health across the whole state on matching. So there are
4 different models but all are needing to align with the
5 college selection into training guidance.
6

7 MR FULLER: So the college doesn't have a direct role in,
8 for example, recruitment processes?
9

10 PROFESSOR HAQ: No.
11

12 MR FULLER: Is that right?
13

14 PROFESSOR HAQ: No. No, ,that's right. So we provide the
15 guidance and then it's down to the workplace to enact
16 those.
17

18 MR FULLER: That's the case for both what I'll call basic
19 trainees and advanced trainees?
20

21 PROFESSOR HAQ: Yes, yes, yes.
22

23 MR FULLER: Do you see that as an appropriate level or
24 scope of the college's role?
25

26 PROFESSOR HAQ: So I think we're actually looking at that
27 at the moment. We're going to be auditing our - with
28 sites, as to how they meet those selection to training
29 guidance, to ensure that they are, you know, equitable
30 across an equitable process.
31

32 The question then arises as to whether we, you know,
33 wish to maintain the local recruitment or would there be
34 some sort of centralisation and what would that mean?
35 I think that is - we haven't got there yet. That's
36 a question to be answered but we are in the first stages of
37 getting the data to understand how workplaces are currently
38 enacting the selection to training guidance.
39

40 MR FULLER: Why do you think it's important for the
41 college to at least be providing guidance on the selection
42 of trainees?
43

44 PROFESSOR HAQ: I think there is - and appropriately so,
45 I think we need to be transparent and open with trainees,
46 our members and the public, that we are recruiting in a
47 fair and equitable way, independent of personal

1 characteristics or location.

2

3 MR FULLER: Associate Professor Kanhutu, do you have any
4 comments you want to make on the issue of selecting
5 trainees?

6

7 A/PROFESSOR KANHUTU: Look, I think it's - if I reflect on
8 my pathway or entry into training, there is always
9 a spectre if you've worked somewhere, you're more likely to
10 be known, you're more likely to be welcomed into or
11 accepted on to a training program, and that was certainly
12 my experience coming into advanced training.

13

14 So I think I concur with what Professor Haq has said,
15 that we do have a role to play in trying to provide some of
16 that guidance around how do you actually manage and
17 maintain a governance process and a selection process that
18 gives people a fair opportunity based on the skills that
19 they've had rather than, you know, having people, you know,
20 feel as though they must train in a particular location in
21 order to get on to a training pathway.

22

23 MR FULLER: Associate Professor Kanhutu, do you agree with
24 the general proposition that colleges' accreditation
25 standards should be outcomes based and evidence informed?

26

27 A/PROFESSOR KANHUTU: Yes, that is a fair and a reasonable
28 way to manage things that I think is in line with both
29 trainee and community expectations.

30

31 MR FULLER: Professor Haq, do you agree with that?

32

33 PROFESSOR HAQ: Absolutely, and we're working very well
34 with the Australian Medical Council and their group and the
35 NHPO exactly on this.

36

37 MR FULLER: Referring to the Australian Medical Council
38 and the NHPO, I take it you're familiar with the
39 recommendations of the NHPO report?

40

41 PROFESSOR HAQ: Yes.

42

43 MR FULLER: Does your college, at a general level, support
44 those recommendations?

45

46 PROFESSOR HAQ: Yes, absolutely.

47

1 MR FULLER: And Associate Professor Kanhutu, I take it you
2 agree with that?

3
4 A/PROFESSOR KANHUTU: Yes.

5
6 MR FULLER: Associate Professor Kanhutu, I think,
7 hopefully, this is in your section of the report, and
8 I think within the scope of your role that you described to
9 us earlier: from line 67 of the statement on page 6, you
10 talk about supply versus demand evaluations and say that
11 the college does not routinely provide commentary or advice
12 on that issue, it's beyond the scope of your organisation's
13 remit. Is that a policy decision that the college has made
14 about the scope of its remit or it's a matter that comes
15 back to the constitution that you described to us earlier?

16
17 A/PROFESSOR KANHUTU: It comes back to the constitution,
18 which is very much embedded in that educating and providing
19 stewardship of professional practice and standards.
20 However, I think in my time in this role, it's become
21 apparent that there's a real desire from other stakeholders
22 for us to share and contribute to the conversation around
23 supply and demand.

24
25 I think where we've often found it difficult to
26 contribute more is that - it's a recurring question, it's
27 a million dollar question: how many doctors do we need in
28 order to provide care in location X or in jurisdiction X?
29 What has been hard is that there are many people who hold
30 data that would help to inform a reasoned answer to that
31 question and there are still - but in saying that there are
32 still lots of aspects of determining what is adequate
33 supply and demand that are also un-agreed or areas of
34 contest.

35
36 For example, there is a concept of what is called
37 a medical care desert. There is still some disagreement
38 about exactly what constitutes a care desert or an area
39 where community needs are either partially met or
40 completely unmet, and that can be due to a lack of access,
41 long wait times or even sociodemographic factors that mean
42 that you can have a specialist in a region but people can't
43 actually access them because of financial barriers to care
44 and access.

45
46 So when I say the college - I think we've tried to
47 work where we can, so we now publish an annual member

1 insights report that steps out how many people do we have
2 in various training pathways, how many fellows, and in
3 which states, and that, I think, is our contribution at
4 this point in time to helping people to draw some of those.

5
6 Any modelling will always have some measure of error
7 because you've had to make a lot of assumptions and some of
8 the assumptions we just can't reasonably make, and we also
9 are not in a position, for example, to conscript people to
10 work in particular areas or to bulk bill or to work in
11 particular ways.

12
13 So when I say it's beyond our remit, I think it truly
14 is functionally, but it's not something that we are shying
15 away from in terms of finding ways that we can contribute
16 to the conversation and share our data with other
17 stakeholders. For example, the federal government has now
18 committed to building supply and demand models for all of
19 the medical specialties across the next 12 months, and we
20 are part of that conversation, to test some of those models
21 and the assumptions that underlie them, and also to feed
22 in, I think - the other part of the supply/demand is
23 feeding in the qualitative aspects, because the numbers can
24 only tell you so much. It's also what we're hearing from
25 trainees about how they would like to work or how they
26 would like to carry out their professional scopes once
27 they've actually become fellows.

28
29 So, yes, the big picture pieces of are we going to
30 build all the supply/demand, I think that is a huge task
31 and one that we're not frankly resourced for at the moment,
32 but can we contribute to the conversation and provide both
33 quantitative and qualitative data to inform that dialogue?
34 Absolutely, and that's what we're working to try and do.

35
36 MR FULLER: Would it be the college's preference to have
37 more access to data about workforce numbers and
38 distribution?

39
40 A/PROFESSOR KANHUTU: Yes.

41
42 PROFESSOR HAQ: Yes.

43
44 MR FULLER: What would the college - what do you think -
45 why do you think that would be useful for the college?

46
47 A/PROFESSOR KANHUTU: Look, one of the - so if you look

1 at the trainee or the fellow outcome survey, the new
2 fellows outcome survey, one of the things that comes out is
3 people do still have that sense of anxiety about "Where am
4 I going to work?" "What does working look like?" "What
5 are the options for me?" And if I think about our role in
6 also supporting people to be - you know, to have thriving
7 careers, having information around what is the lived
8 experience of being a new fellow going to be like, I think
9 would be really instructive to guide people and to help
10 them, because there is still a real sense of being on your
11 own when you first fellow, as opposed to when you're in a
12 training pathway and are surrounded by people who are at
13 the same stage of career.

14
15 Once you have become a fellow I think that information
16 about where the opportunities might be for you would help
17 us to also have more, I think, personalised conversations
18 with individual fellows around how we can guide or direct
19 them in a way that will allow them to fulfil their own
20 career aspirations, acknowledging that, at that point,
21 they've invested literally decades of education and work
22 and effort to get to that point, and that sort of data
23 around workforce dynamics would be really useful and useful
24 evidence base for having a productive conversation with
25 people.

26
27 MR FULLER: Professor Haq, is there any you want to add on
28 the question of data?

29
30 PROFESSOR HAQ: Yes, I absolutely agree with everything
31 Professor Kanhutu said and I think it's really that
32 longitudinal data that's going to be so interesting because
33 we have the data on our medical schools, from the medical
34 schools outcomes database, that Medical Deans ANZ collate,
35 together with the data that Ahpra collect. That's gold to
36 enable any health system and the colleges and all sectors
37 to make better informed decisions.

38
39 MR FULLER: That's, I take it, data that currently the
40 college does not have access to?

41
42 PROFESSOR HAQ: We do have access to the - Kudzai may be
43 able to answer.

44
45 A/PROFESSOR KANHUTU: Yes, so we have access to medical
46 training survey and we contribute to that. We also have
47 access to the Medical Deans of Australia and New Zealand

1 dashboards, which are really at that prevocational stage of
2 where are people training in the medical schools and where
3 would they like to train. Some of their statistics are
4 really phenomenal in terms of guiding us as to career
5 aspirations at that really early phase and showing us that
6 that physician pathway is still very appealing.

7
8 The problem is, as you said, Professor Haq, that
9 longitudinal piece of seeing where someone begins, how long
10 it takes them to transit through training, where there are
11 stops, starting points, people who may be stopped to locum,
12 and then where they end up within the workforce and how
13 permanent their existence in that work space is or if they
14 are then going on to do academic work and what is
15 happening. And it's joining the dots of those multiple
16 sort of currently very siloed data points to build a really
17 clear picture of what we can expect to see as people who
18 are actually available to work and not necessarily
19 full-time, either.

20
21 I think historically the models were based on you're
22 going to be coming out working full time and that's just
23 not the reality for, I think, the majority of people that
24 we're interacting with as new fellows. They're not
25 entering into full-time work.

26
27 MR FULLER: Do you know whether the data that would be
28 needed to do that sort of longitudinal analysis - is that
29 being collected across the system?

30
31 A/PROFESSOR KANHUTU: I think that it's a great question
32 you've asked because what we've - the conversation that
33 we've had within a lot of those data forums, so the federal
34 ones and the jurisdiction ones and also the ones with
35 Aotearoa New Zealand, is that there isn't a clearly defined
36 minimum dataset for workforce. We have unified data points
37 that would allow us to link people - for example, your
38 Ahpra ID you do get very early on in your career, and that
39 would allow you to identify individuals.

40
41 But as far as making sure that each section of that
42 longitudinal pipeline is collecting exactly the same data,
43 we've not been doing that. So what you might find is
44 you'll be able to build some aspects of a longitudinal
45 pipeline, but then there will be some points where,
46 unfortunately, an organisation hasn't collected
47 a particular piece of information and you won't actually be

1 able to build a consistent picture. But there's certainly
2 enough there, and if I look - as a binational organisation,
3 if I look at the work that the Aotearoa New Zealand
4 colleagues have done, they are, I think, very advanced with
5 respect to some of their specialty mapping, and they are
6 able to not only see the individual, they're able to see
7 time points when somebody has stopped working, they're able
8 to see geographically exactly where someone is working,
9 their fractional appointment as well, and then able to
10 match that with community demand trends as well. So it's
11 possible, but I think we suffer from having often
12 a fragmented governance approach to how the data is
13 stewarded to allow us to build a consistent picture across
14 somebody's career and then across an entire specialty
15 cohort.

16
17 MR FULLER: So am I right in thinking - is this a fair
18 summary - that there are two issues: one is that there may
19 be some gaps in the data that's needed to perform the
20 longitudinal analysis; but then the second is the issue of
21 pulling the data that does exist out of the silos and
22 bringing it together to perform that analysis? Is that
23 a fair summary?

24
25 A/PROFESSOR KANHUTU: Yes, absolutely. So no agreed
26 minimum dataset, and then no governance framework to allow
27 us to share data safely, and also, I think with the consent
28 of our members as well. I know when we think about the
29 data governance framework for our Indigenous fellows and
30 members, there is a real sense that we have to get that
31 right. We can't be in a position where we're sharing data
32 where there hasn't been that deep conversation around
33 consent and also identifiability of certain specialties.

34
35 I know at our recent graduation ceremony we had the
36 first ever female Aboriginal fellow paediatrician. If you
37 published data on that, she will know exactly who she is.
38 So there are some real, I think, pauses for thought around
39 how we actually build some of those data-sharing governance
40 frameworks to make sure that they're safe and fair whilst
41 still achieving that goal of giving people an evidence base
42 to understand where are the areas of need and where can
43 someone hope to have a thriving career where they're able
44 to exercise their full scope and skill set.

45
46 MR FULLER: Did I understand you correctly to be saying
47 that there is currently some work being done in this area?

1 I think you mentioned participating in data forums or
2 something like that; is that right?

3

4 A/PROFESSOR KANHUTU: So there are a few data forums. So
5 Medical Deans Australia and New Zealand have been very
6 proactive in trying to reach out, for example, to Ahpra and
7 link their data and have been very successful in that.
8 They hold periodic data forums, so there's one coming up
9 next week which I'll be participating in.

10

11 There's also the medical workforce advisory council,
12 which is a federal body which looks at data as well and
13 brings in stakeholders including Ahpra. Then there are
14 a few things that are happening in academic space as well.
15 So if you look at the ACT, they have enlisted ANU to build
16 out some supply/demand - or stock and flow models for their
17 workforce.

18

19 So it is happening in a lot of different places and
20 what I have struggled to find is a single place I can go
21 and feed into a consistent conversation around what does
22 modelling look like for specialty workforce?

23

24 MR FULLER: In terms of if we were to imagine a world
25 where there was that single place, do you have a view as to
26 whose responsibility that needs to be, or group of people
27 whose responsibility that is?

28

29 A/PROFESSOR KANHUTU: No. I think it comes down to
30 building the foundations for if we were to even recruit
31 somebody to do it periodically as a report, whether it's
32 a census or other existing way of measuring it, is
33 everybody clear on what they need to be collecting now and
34 are they resourced to be able to collect it? So the
35 minimum dataset piece is, I think, important and something
36 that you could start to communicate to organisations now.
37 If you're not already collecting information around, you
38 know, absences of leave due to family leave, please start
39 doing that because at some point it will help to inform
40 models that will be created.

41

42 As to who fundamentally owns it, I think it is a - it
43 would be a great if it sat at the level of almost
44 a jurisdiction and federal collaboration that allows us to
45 feed data in so that people can also see a consistently
46 measured approach for all of the jurisdictions, as opposed
47 to what I see emerging now, which is each state has

1 a different level of evolution or development as to what
2 they're telling people the numbers look like, just some
3 consistency and for that to sit really at the level of
4 state and federal, to pull together that information,
5 because it sits in so many different pots. But I think if
6 we had the confidence that it was being held at that level,
7 people would also feel a lot more comfortable to contribute
8 or share their information in that space.

9
10 MR FULLER: Professor Haq, did you have any comments on
11 this issue?

12
13 PROFESSOR HAQ: No, absolutely agree with all that has
14 been said. It's working together, you know, we're all here
15 for the same reason, we all want to serve our communities,
16 and have the right number of people in the right
17 specialties in the right place, and I think by working
18 together and being comfortable with sharing our data in the
19 right circumstances with the appropriate governance, that
20 can only benefit all parties.

21
22 MR FULLER: Thank you. Associate Professor Kanhutu, can
23 you please have a look at line 448 of the witness statement
24 on page 16. I think this is in your section.

25
26 A/PROFESSOR KANHUTU: Yes.

27
28 MR FULLER: You have identified here some what you
29 describe as general "impediments/obstacles/challenges to
30 training specialists" which can occur in New South Wales
31 but are not limited to New South Wales. Do you see that?.

32
33 A/PROFESSOR KANHUTU: Yes.

34
35 MR FULLER: I just wanted to ask you to elaborate on
36 a couple of points. Firstly, in the first dot point, as
37 I understand it - and tell me if I'm wrong - the point
38 you're making here is, or the issue is, that some training
39 programs require specialist training that can only be
40 delivered in certain locations because of facilities and
41 the like; is that right?

42
43 A/PROFESSOR KANHUTU: Yes.

44
45 MR FULLER: Are there particular specialties where that is
46 an issue?

1 A/PROFESSOR KANHUTU: I think - my impression is, and I'm
2 sure Professor Haq will also be able to reference, it can
3 tend to be the procedural specialties. Whenever you have
4 procedures or a skill set that requires expensive equipment
5 or very technical equipment, you will almost always find
6 that that ends up being in a tertiary metropolitan setting.
7 For example neonatal intensive care is a good example; in
8 cardiology, ECMO, or extra corporeal membrane, you know,
9 circuit care. Really advanced - highly advanced or
10 technical skills always tend to centre on large
11 metropolitan settings and there's almost no way to get
12 around that because there's not that critical mass or the
13 resource intensity to support that to happen in regions
14 or in smaller settings.

15
16 So I think for most of those, yes, technical or
17 procedural based specialties you will find that there is
18 a heavy concentration or almost sequestration of that skill
19 set only being able to be achieved in a single setting.

20
21 MR FULLER: Would we be right in thinking that some of the
22 things we've discussed earlier today around networks and
23 the like are what the college sees as potential ways of
24 ensuring that that need for specialist facilities doesn't
25 impede specialists from moving out into, for example, rural
26 and regional areas; is that fair?

27
28 A/PROFESSOR KANHUTU: Yes, I think it's fair, but I think
29 the other part of the conversation as well, which is still
30 in evolution, is what do people want to be doing when they
31 finish? I think one of the areas of dialogue we've had for
32 some of the specialties is, "Well, if I'm going to - if my
33 intention is to work outside of a large metropolitan
34 setting, should I actually have to go and do a certain
35 period of training in this location", or are there other
36 ways that we can finesse someone's career progress or their
37 training journey so that they can stay where they are and,
38 I guess, emerge with the skill set that they feel they need
39 for the career that they intend to pursue.

40
41 I think that's an area that's still unresolved, but
42 one that, I think, is definitely in play as far as - when
43 we look at some of the specialty areas who have
44 traditionally had, as, I think, Professor Haq has alluded,
45 a very metro-centric or a metro-leaning approach to that
46 accreditation or that sign-off of competency and skills.

47

1 MR FULLER: Is that flexibility you have just described
2 something that the college is looking at at the moment in
3 terms of its curricula and so on?
4

5 PROFESSOR HAQ: Yes, absolutely. I think what we're
6 creating with our new curriculum is outcomes, called
7 entrustable professional activities, EPAs for short. Those
8 are discrete sets of skills often collated into one - well,
9 one domain that trainees can demonstrate anywhere. It
10 doesn't have to be in a particular setting. So that,
11 I think, will absolutely enable them to be developed,
12 delivered, in different areas.
13

14 The other thing is, of course, you know, the continuum
15 of medical education and health education, we're always all
16 learning and the moment you gain fellowship is not the end
17 of your learning journey. You may decide that actually
18 what you're going to do for the first part of your career
19 is work in a more generalist area, fantastic, and that can
20 be in a regional or remote area, and then you credential
21 up, if you wish to get sub-specialty skills or
22 super-specialty skills, then you would credential those at
23 a later date and then perhaps employ those skills in
24 another setting with the appropriate environment.
25

26 So I think we need to be more flexible about trainees.
27 We don't expect them to have all the skills all the time,
28 because we're all learning new skills throughout our 30- to
29 40-year working life. So I think we need to be cognisant
30 of that. People are now working longer and they're having
31 more - as Professor Kanhutu alluded to, quite a lot of
32 portfolio careers. So multiple jobs that are less than
33 full time, often mixed with research or academia or working
34 in government or, you know, health management, for example.
35 So we need to actually be aware of those and allow that
36 flexibility as part of our curricula as well. So
37 absolutely that's something we need to work towards. It's
38 complex and, of course, it's dependent again on some of
39 that workforce data that we need to enable them to make the
40 right decisions there.
41

42 MR FULLER: Associate Professor Kanhutu, coming down to
43 the third dot point, so starting at line 461 on the next
44 page, you've described there - tell me if I've understood
45 this correctly - a change in the eligibility requirement
46 for basic physician trainees so that they now have to have
47 done two years rather than one year before they can enter

1 basic physician training; is that a fair summary?

2

3 A/PROFESSOR KANHUTU: Yes, it is.

4

5 MR FULLER: What, if any, do you see as being the
6 impediments, obstacles or challenges arising from that?

7

8 A/PROFESSOR KANHUTU: This is something Professor Haq and
9 I have discussed previously. I think one of the challenges
10 in all the feedback we've had from members is that it
11 really extends people's training time. You know, some of
12 these people in postgraduate have been working as
13 clinicians, whether it's a nursing background or
14 physiotherapy or other allied health area, where they
15 actually have a really solid foundation and grounding in
16 terms of understanding how the health care settings work,
17 and the idea that you just mandatorily have to have someone
18 spend two years before they can start a training pathway
19 doesn't actually allow that flexibility and the nuance that
20 someone would expect as a postgraduate or, you know,
21 a late-career individual.

22

23 So one of the - the bigger challenge, I think, is just
24 the extended time and that has implications for people in
25 terms of other aspirations they have for work/life balance
26 or other stages of life, and I think that that's probably
27 the main theme that has come out there, is that it's
28 a rubber stamp and it's actually at odds with how the
29 current curriculum renewal has been structured - I know
30 Professor Haq can certainly speak to this - where we're
31 looking at competency rather than time-based requirements
32 for demonstrating that you're actually progressing on
33 a career path.

34

35 Actually it's moving away from where we're trying to
36 go, which is that if you have the competency and the
37 skills, you should be able to start the training program
38 and progress on it, rather than just saying, "You must do X
39 amount of time before you move on to the next stage."

40

41 MR FULLER: So to your knowledge, there is no flexibility,
42 for example, recognition of prior learning or experience in
43 that current policy; is that right?

44

45 A/PROFESSOR KANHUTU: My understanding has been that it's
46 to be deployed as a fixed two years, without any
47 negotiation. That's my understanding. I'm happy to stand

1 corrected.

2

3 PROFESSOR HAQ: That's my understanding, that there isn't
4 room for nuance in it. And I think that I understand some
5 of the reasoning for that, in the networks and health
6 districts wanting to have two- and three-year contracts to
7 give surety for trainees, so I do understand that aspect of
8 it, but I think, as a consequence of the AMC-led
9 prevocational framework, this has led to perhaps an
10 increasing training time and then delay in people getting
11 out to where the communities need them and perhaps, you
12 know, could be up for further discussion between us and the
13 relevant parties.

14

15 MR FULLER: Associate Professor Kanhutu, coming down
16 to page 20, line 564, you give a number of case studies
17 here about what you describe as "workforce
18 challenges/issues/obstacles". I just want to ask you about
19 two of these. Firstly, case study 1, where you describe
20 members reporting working beyond their capacity or
21 experiencing burnout. Can you just elaborate on what
22 you're hearing from members on those issues?

23

24 A/PROFESSOR KANHUTU: What we're hearing is that relative
25 to people's expectations of what their working lives would
26 be - ie, "I'll be at patient bedsides working with patients
27 all day long", which is where the joy and the passion comes
28 - people are increasingly finding, and this was really
29 apparent during COVID, that a lot of their work is being
30 drawn towards administrative tasks and leadership-type work
31 that really places - extends their day and extends their
32 bandwidth far beyond what they had expected.

33

34 Then, on top of that, you lay the responsibilities of
35 doing good quality supervision where you may be dealing
36 with people, you know, a cohort who are extremely strained
37 and are needing additional supports and a real sense that
38 people just don't feel as though they're able to do justice
39 to anything very well.

40

41 If you're then thinking about somebody who then has -
42 no longer has, I guess, the simplicity of having, you know,
43 "I'm 0.9 clinical and I've got a tiny fraction of something
44 else", you have people who are constantly context shifting.
45 One minute I'm a supervisor; the next minute I'm in a
46 director of medical service meeting with a governance team
47 trying to decide on things like, in the hospital setting,

1 bed flow or patient flow, and it's just a real sense that
2 people feel like they don't have enough time to do what
3 they need to do well across all of the multiple areas that
4 they have to try and cover and be competent and effective
5 in.

6
7 MR FULLER: Do you have a sense from your members of the
8 causes of that situation?

9
10 A/PROFESSOR KANHUTU: The causes are - if I look at -
11 I guess my experiences as well is that your people are
12 straddling multiple roles. They are no longer just
13 a single role based requirement and there is an increasing
14 requirement that if you hold, for example, a leadership
15 role within an organisation, that will not only be clinical
16 leadership, it will also be hospital level governance
17 leadership requirements and attendance at meetings.

18
19 So there are lots of drivers and it depends on the
20 site and the setting as to the relative burden or the
21 weight of that, and it's generally a sense that there
22 aren't enough people to do the work, although the work
23 needs to be done. And I think I'll say a lot of people
24 often feel a certain measure of compulsion to just help,
25 even though it's not actually resourced within their work
26 contract or the agreements that have been made. So there
27 are a lot of informal stressors that come on top of what
28 looks like a very sort of straightforward week, they're
29 then finding themselves really drawn and stretched across
30 multiple responsibilities, where there just isn't enough
31 time to do it justice.

32
33 That certainly came out in one accreditation visit
34 I did where a fellow was saying - a relatively new director
35 of physician education saying - "I just don't feel like",
36 with the training or the cohort that they had, "that there
37 was enough time to really sit with those people as
38 individuals and work with them to support them with the
39 level of supervision and the care that they required."

40
41 That, I think, sort of extends us into that - we can
42 make recommendations in the accreditation around the sorts
43 of ratios that we think do allow someone to do that, but
44 then the real lived experience can be very different from
45 site to site and location to location, and also dependent
46 on the, I guess, stage at which someone enters into that
47 role as well and what other things they're having to

1 juggle.

2

3 PROFESSOR HAQ: I might add that I think there is
4 allocated time, notionally, for non-clinical activities.
5 Those have to cover all the things that Professor Kanhutu
6 has said. I don't think there's enough time, and what we
7 would really want to advocate for is protected time for
8 supervision, to do it well, because we know that by doing
9 it well, you benefit the supervisor, you benefit the
10 trainee and you benefit the patient and their carers and
11 families.

12

13 So I think at the moment it's being squeezed in as an
14 additional part of things to do in the evenings, at the
15 weekends, particularly if you have larger numbers of
16 trainees, and I think we must do better to support our
17 supervisors at all levels, at the college level, but also
18 the jurisdiction and health district level, to ensure they
19 can do their job properly and effectively, supported, with
20 the appropriate time.

21

22 MR FULLER: Is there anything else that you or the college
23 has a position should be done to address the issues that
24 we've just been talking about?

25

26 PROFESSOR HAQ: I mean, advocacy is within our role here
27 and Professor Kanhutu may or may not want to talk about
28 some of that. We're seeing that we have more of a place
29 now in some of this advocacy on behalf of our members, as
30 you were alluding to earlier, counsel, so that's something
31 I think will be a focus for us next year.

32

33 Again, it's a collaboration between us and our health
34 partners as to how we do this to the best of ability. It's
35 not an "us versus them" approach, because that way nobody
36 will win. We've got to work together for the benefit of
37 our community. So I hope that we can continue those
38 conversations.

39

40 But there is increasing - the clinical work is
41 increasing, clinical management work is increasing, and
42 supervision requirements are increasing, and all of that
43 cannot be done in the current sort of contractual and
44 workload arrangements, I think.

45

46 MR FULLER: Associate Professor Kanhutu, do you have
47 a view about anything else that could be done to try to

1 address the issues that you were describing for us earlier.

2

3 A/PROFESSOR KANHUTU: I think it is really repositioning
4 ourselves from a position of wellbeing and acknowledging
5 that these people are often people who have been trained in
6 cultures where there's a deep culture of volunteerism and
7 expectation that you'll just do things, and we need to
8 start moving beyond that and that's why we're looking to
9 try and formalise some of these expectations of what should
10 a working environment be like as a supervisor; what is
11 a reasonable ratio; and that those can become shared
12 understandings and ones that are adopted by people.

13

14 That's, I think, the advocacy piece that we would like
15 to see be embraced as a common or a shared value, that we
16 do care to look after people and that we also have the
17 metrics and the tools to evaluate when things are not going
18 well, which is the data piece, that you should be able to
19 compare yourself to another site and say, "Oh, hang on
20 a minute. That's actually why I'm not - that's why I'm
21 struggling". Because numbers-wise, it's a new metric that,
22 I think, looks at ways to really embed that sense of
23 wellbeing and safe working environments for people so that
24 they can do the work that they need to do, which is around,
25 you know, stewarding the profession and looking after
26 themselves and also looking after the trainees under their
27 charge.

28

29 MR FULLER: Does the college have a position on the
30 adequacy of pay for its specialists in New South Wales?

31

32 PROFESSOR HAQ: I don't think that's within our remit,
33 to - it's probably more of an industrial arrangement that
34 we would not sort of get involved and I think - related to
35 our constitution, I think, again.

36

37 A/PROFESSOR KANHUTU: Yes.

38

39 MR FULLER: Associate Professor Kanhutu, the other case
40 study I wanted to ask you about was case study 5, where you
41 mention some particular specialties that seem to be at risk
42 because of low trainee numbers and then attrition of more
43 senior specialists.

44

45 A/PROFESSOR KANHUTU: Yes.

46

47 MR FULLER: Other than what we have already discussed, is

1 there anything else that you think can be done to address
2 that issue?

3
4 A/PROFESSOR KANHUTU: One of the challenges that some of
5 those specialties have is really advocating for the value
6 of their contributions, and I'll take occupational
7 environmental medicine as one.

8
9 When you do have a specialty that is smaller in
10 numbers, often it can be difficult for them to communicate
11 how they work to contribute to better outcomes within the
12 community, and the same goes for public health. Public
13 health had a great, you know, renaissance in COVID, but
14 then, once that flash point has moved on, it can be a real
15 challenge for them as a small group to then say, "Look, we
16 still need to be here and we have work that needs to be
17 done and this is how we fit in."

18
19 So I think one of the other aspects that I'd like to
20 see is that rather than seeing us as, you know, siloed
21 specialties, is to start to really, I think, get the health
22 service and the community outcomes perspective, start to
23 see how we actually work together to deliver the outcomes
24 because I, as an infectious diseases physician, can't do
25 all of the things. It's actually about how it's connected
26 and starting to get a sense of that multidisciplinary
27 network of care and how even these smaller number
28 specialties are part of that network, so that we can start
29 to see the mutuality and the complementarity of the
30 different specialties and the craft groups as opposed to
31 just sort of tracking what looks like a dire trend for some
32 of them, and it's because we, I think, haven't been able to
33 articulate what is the value that they bring and how do
34 they work across specialties and, you know, within their
35 own specialty, to help our communities to be healthier.

36
37 MR FULLER: Do you think the college has an important role
38 to play in relation to that issue?

39
40 A/PROFESSOR KANHUTU: Well, absolutely we do, and it's
41 a common request from those specialties, is, you know, how
42 do we help to communicate that? I think I would say from
43 a cultural perspective, we're not - I don't think we're
44 a skill group that like to get out there and say, "We're
45 amazing and we're doing all of these things". So it's
46 about also finding ways to do it that are - that feel
47 authentic for those groups as opposed to sort of launching

1 some big branding campaign. It really needs to be embedded
2 in. We know why these people have trained in these areas
3 and these skills areas, and we can see how they fit in to
4 supporting better community outcomes and communicating that
5 in a way that feels true - true to them and true to the
6 outcome that we desire. So yes, there is a role.

7
8 MR FULLER: Professor Haq, did you want to add anything to
9 that?

10
11 PROFESSOR HAQ: I think also it's around being innovative
12 with training pathways as well, that I think we're also
13 going to be looking at, so that it's less siloed and could
14 be done as part of other training, maybe. You know,
15 nothing has been confirmed in any way, but could you sort
16 of do other things together?

17
18 Also I think, you know, these groups are mainly
19 non-hospital based, if I can, with a completely different
20 set of requirements, cultures, contexts that we need to be
21 aware of and appreciate, because they do contribute so much
22 to overall health, community health and wellbeing.
23 I think, you know, you can focus a lot on the public
24 hospital, let's say, as an example, as the only way of
25 delivering health care. There are many other ways, and
26 that's something I think we could work very closely with
27 other colleges but also state and federal governments on
28 ensuring these key enablers of health and wellbeing are
29 supported.

30
31 MR FULLER: Finally, Professor Haq, on page 22, from
32 line 639, you have identified some other initiatives and
33 recommendations that you think should be considered.
34 I just wanted to ask you about some of those. Firstly, in
35 the first dot point under "In general", you'll see "Adopt
36 an ecosystems approach". Can you explain what you mean by
37 that?

38
39 PROFESSOR HAQ: I think it's related back to the data
40 issue, and that longitudinal data issue to allow us to make
41 evidence-informed decisions around current requirements,
42 future requirements, what's coming through the training
43 pipeline to enable us to get the right people in the right
44 place and in the right areas, and inform our trainees about
45 where they may wish to work and in what context.

46
47 I think culture is really, really important. We know

1 from the medical training surveys that there is a - there
2 are high rates of either having the sharp end or witnessing
3 bullying, discrimination, harassment, and that is something
4 I think we as a college really have a key place in, dealing
5 with all aspects of the health system, to ensure that those
6 issues are raised and dealt with and not hidden. Because
7 none of us - you know, all of us want equity of health care
8 but we also want good workplaces with good wellbeing of our
9 staff to enable them to do their best work.

10
11 Collaboration, absolutely, yes, I think that's going
12 to be really important. We're doing that really well as
13 part of the accreditation work with the NHPO, and I think,
14 you know, the confederation of colleges, the CPMC, are
15 also, I think, seeing that there's strength in working
16 together on key strategic issues.

17
18 I think again, if we do move into networking models
19 and rural and regional remote areas, then adequate - and
20 even in metropolitan - appropriate time for supervision
21 must be given and supported and seen as valuable, and it's
22 not an add-on, it's the key part of your, you know, medical
23 sort of persona and contribution to the health system and
24 should be managed accordingly.

25
26 MR FULLER: Can I, Professor, just pause you there and go
27 back to something you mentioned about culture and what you
28 said was the college's, I think, important role in relation
29 to bullying and discrimination and harassment and so on.

30
31 PROFESSOR HAQ: Yes.

32
33 MR FULLER: Can you just explain what you view as the
34 appropriate scope of the college's role in relation to
35 those issues?

36
37 PROFESSOR HAQ: Yes. So I think we're not the employer.
38 So, you know, I think there are sort of employer/employee
39 related mechanisms that are clearly in place, but we want
40 to be able to support our members and trainees in these
41 times. I think through accreditation, I think there are
42 ways we can sort of help lever to ensure that sites, you
43 know, work towards the right culture and there may be
44 outcome measures and metrics that we can use to help - to
45 help that. Again, that's not a stick, but I think it's
46 sort of a continuous improvement approach.

1 I think we can work through training, again, of all
2 our members and fellows, you know, in unconscious bias
3 issues, current issues in recognising and responding to
4 bullying, discrimination and harassment, intimidation and
5 by standard training and so on and so forth. So I think
6 there's a massive training opportunity we have with our
7 supervisors potentially as a first port of call. I think
8 then, through accreditation, we can work to sort of lever
9 to sort of get continuous improvement in culture and then
10 policy and position statements as well, on, you know, zero
11 tolerance approach, but --

12
13 MR FULLER: Sorry to interrupt you. Just in terms of the
14 idea of leveraging through accreditation, is your college one
15 that either has or would take effectively adverse
16 accreditation action against a site because of what are
17 identified as cultural or workplace issues?

18
19 PROFESSOR HAQ: I think we would - so we have an active
20 management pathway and if we got notice through an
21 expression of potential breach of standards of cultural,
22 you know, bullying, harassment, we would investigate those
23 and triangulate that evidence and there would be a decision
24 made by the relevant committee on that. But it could be to
25 impose conditions or requirements, and that site would then
26 enter an active management process of ongoing monitoring.

27
28 MR FULLER: In terms of investigating, does the college
29 have a particular policy or procedure as to how it would go
30 about conducting such an investigation?

31
32 PROFESSOR HAQ: As part of our active management process,
33 that highlights, you know, what we would do. That's not
34 just for bullying and discrimination, it could be for any
35 concern raised, there is an active management process. We
36 would work closely with the jurisdictions and with the site
37 on that.

38
39 MR FULLER: You understand that one of the recommendations
40 from the NHPO report was around making sure there are
41 transparent policies and processes for how colleges, in
42 particular, deal with those sorts of issues of bullying,
43 harassment and discrimination?

44
45 PROFESSOR HAQ: Yes.

46
47 MR FULLER: I take it from your earlier answer that you

1 agree with that approach?

2

3 PROFESSOR HAQ: Absolutely. We're here to work with those
4 recommendations, not against them.

5

6 MR FULLER: Associate Professor Kanhutu, is there anything
7 you wanted to add on that particular issue about bullying,
8 discrimination and harassment?

9

10 A/PROFESSOR KANHUTU: Nothing further to add.

11

12 MR FULLER: Just finally, Professor Haq, at line 663, you
13 have suggested a recommendation that starts with "Support
14 the sustainability of work-based medical education." Can
15 I just ask you to explain what specifically you have in
16 mind by that?

17

18 PROFESSOR HAQ: Really this is, as we've alluded to
19 earlier, giving supervisors the protected time to do their
20 role. That's really what that alludes to. Because it is
21 getting increasingly complex, with the increasing numbers
22 of trainees but also the requirements for workplace
23 assessment, which we see as being of high value and the
24 best sort of - one of the best markers of trainee
25 performance. That does require time and engagement to do
26 properly, to make the right decisions, so that's why we
27 would really much want to advocate for that.

28

29 MR FULLER: Thank you very much to you both.

30

31 Commissioner, those are my questions for these
32 witnesses.

33

34 THE COMMISSIONER: Thank you.

35

36 Can I just ask both of you for your assistance just on
37 one further matter. Early on in your evidence, Mr Fuller
38 asked you about a model where accreditation was not
39 performed by colleges.

40

41 PROFESSOR HAQ: Mmm.

42

43 THE COMMISSIONER: You both gave answers about the
44 advantages of the colleges having that responsibility.
45 I don't want to go back to the transcript, but I want you
46 to assume for the purposes of my question that I accept the
47 advantages that you both indicated to me concerning the

1 college's role in accreditation. Please don't think I'm
2 wedded to this, I'm only asking you this for your opinion
3 purely out of curiosity, but imagine a model where there
4 was a statutory body which included some people appointed
5 by the ministry that had great expertise and knowledge of
6 the health system, demographics, those sorts of things, but
7 where the colleges could also nominate relevant people -
8 and these are obviously part-time appointments and they
9 would be transitory depending upon the site that was being
10 looked at. So nominations from the ministry, nominations
11 from the colleges, and with that body having the power to
12 accredit or withdraw accreditation. Would that be a model
13 that might work?

14
15 And please, in answering that, feel free to tell me,
16 "Look, it might work but we still prefer the colleges to
17 have control of this." If you go first, Professor Haq, in
18 relation to that.

19
20 PROFESSOR HAQ: Sure. Look, I suppose technically,
21 Professor Kanhutu and I have discussed this, I suppose, you
22 know, any sort of external model could work. I think that
23 it would be more complex. It's adding a layer of
24 complexity to the system. I think there's a lot - I think
25 the cost of it could blow out significantly, because
26 there's a lot of work that is not costed --

27
28 THE COMMISSIONER: It would be a public body, they
29 wouldn't be paid that much, the people on it. Leaving that
30 aside.

31
32 PROFESSOR HAQ: I think the resourcing side of it is not
33 to be underestimated. I just think at the moment it is -
34 it's seen as a peer review, it's seen as colleague to
35 colleague, and I think if it's a hierarchical approach,
36 I think that reduces the value of it and I think you may
37 not get the quality of information that you require.

38
39 I think perhaps with the NHPO, that's maybe the best
40 of both worlds, that there is an opportunity for an
41 external review, and we hope - you know, most places don't
42 get to that position but I think, you know, the bulk of the
43 work - and the bulk of the places that are absolutely fine,
44 you know, if we could put that - the problems with
45 accreditation are not the majority in any way. We mustn't
46 get the wrong idea. The vast majority of places are doing
47 really fine. It's a small number that have concerns and

1 even smaller number that get to sort of the pointy end,
2 single figures, really. So is that worth setting up
3 a statutory body to do that? To me, I'm not sure the
4 benefits outweigh the risks.

5
6 THE COMMISSIONER: Okay. Professor Kanhutu, do you have
7 anything you wanted to add to that?

8
9 A/PROFESSOR KANHUTU: I would say again I think the
10 biggest - one of the potential outcomes would be you'd end
11 up with a statutory body that would still need to come back
12 to the college to ask for questions and for clarification,
13 and then you find yourself - you're still doing the work
14 but then have actually lost the ability to have the close
15 dialogue and the close working understanding of how people
16 are navigating what can be very disparate work
17 environments.

18
19 For example, an investigation of bullying - you know,
20 bullying and harassment in one context - what would it take
21 to build that sort of relationship, and sometimes having
22 a third party or a higher-level body can actually move you
23 so far away from the coalface that you actually lose that
24 ability to detect what the problems are, but yes, to
25 actually detect what is going really well and what are the
26 key factors that are allowing a site to work very
27 functionally. So there potentially is a space there for
28 that.

29
30 You know, a collaborative space where everybody comes
31 together, like the CPMC, could be a place where we come
32 together and compare notes so that there is that level of
33 calibration, and I think that is something that could help,
34 a sense of calibration across the system. But to have the
35 weight of all of that effort placed in a single location,
36 I struggle to see how you'd get good representation and
37 also be able to respond meaningfully and with deep
38 understanding of the different contexts and the different
39 specialty streams in the one location. It is not something
40 that I would want to be on, for example, as a practitioner.
41 I would find it really difficult to navigate a space like
42 that with that sort of demand on it.

43
44 THE COMMISSIONER: Thank you. Was there anything, first
45 of all, to you, Mr Fuller, that came out of that?

46
47 MR FULLER: Just one thing. Associate Professor Kanhutu,

1 can you just tell us what CPMC is?
2
3 A/PROFESSOR KANHUTU: The Council of Presidents of
4 Medical Colleges.
5
6 THE COMMISSIONER: Thank you.
7
8 Mr Cheney, do you have any questions?
9
10 MR CHENEY: No questions, Commissioner.
11
12 THE COMMISSIONER: To both of you, thank you very much
13 first of all for the written statement but secondly for
14 your time today. We're very grateful. You are excused.
15 Thank you.
16
17 PROFESSOR HAQ: Thank you very much.
18
19 A/PROFESSOR KANHUTU: Thank you. Bye.
20
21 **<THE WITNESSES WITHDREW**
22
23 THE COMMISSIONER: We might as well take morning tea.
24 Okay, we will come back at 10 to 12, 11.50.
25
26 **SHORT ADJOURNMENT**
27
28 THE COMMISSIONER: Yes, Mr Glover.
29
30 MR GLOVER: Thank you, Commissioner. The next witness is
31 Jacqueline Dominish, who is in the witness box.
32
33 **<JACQUELINE ANNE DOMINISH, affirmed: [11.58am]**
34
35 **<EXAMINATION BY MR GLOVER:**
36
37 MR GLOVER: Q. Ms Dominish, can you state your full name
38 for us, please?
39 A. Jacqueline Anne Dominish.
40
41 Q. And you are the director of health professional
42 workforce within the ministry?
43 A. Yes.
44
45 Q. Does that sit in the workforce planning and talent
46 development branch?
47 A. Yes, it does.

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Q. Is that branch headed by Mr Griffiths?

A. Yes.

Q. And to assist the Commission in its work, you made a statement on 5 July; correct?

A. Correct.

Q. I'll just have it brought up on the screen. It is [MOH.0010.0243.0001].

It will come up on the screen to your right but if you have a hard copy, feel free to use what's most convenient to you. Have you had a chance to read it before giving evidence today?

A. Yes, I have.

Q. Is it true and correct, to the best of your knowledge and belief.

A. Yes.

Q. Would you go to paragraph 2, please. In paragraph 2 you tell us about some of the responsibilities of your role?

A. Yes.

Q. I just want to go through a few aspects of it and ask you to expand on some things.

A. Mmm-hmm.

Q. In 2(a) you tell us that in your role you are responsible for leading and advising on the scope of the health professional workforces, workforce modelling and monitoring. First of all, by way of clarification, what do you put within the term "health professional workforces"?

A. So the health professional workforces that my unit is responsible for are the clinicians and the primary groups of medical, nursing and midwifery, allied health. We're increasingly doing work with paramedicine with Ambulance New South Wales; Aboriginal workforce, in particular clinicians in that workforce; and I'm also responsible for the workforce modelling team as well.

Q. In relation to the workforce modelling team, what is their remit?

A. So their remit is to undertake workforce modelling for the health professional workforces, so the clinical

1 workforces, and their focus has been allied health,
2 medicine, nursing and midwifery.

3

4 Q. When you say "focus", by that do you mean a recent
5 focus of their work?

6 A. That's the scope of their work. That has been
7 historically the scope of their work.

8

9 Q. What sort of modelling do they do?

10 A. So they do long-term modelling to look at the
11 projected behaviour of workforces into the future and how
12 that might relate to our ability as New South Wales health
13 system to deliver the care that we need to.

14

15 Q. When you say "projected behaviour of workforces into
16 the future", what do you mean by that?

17 A. I'm going to answer this just by saying, firstly, I'm
18 not a data scientist or a mathematician, so in general
19 terms I'll be talking to the best of my ability in that
20 regard.

21

22 Q. Yes.

23 A. So the behaviour of workforces - workforce modelling
24 looks at a - so we look at, they look at, the current
25 workforce, which they call the stock, and then apply flows
26 to that stock. And it's based on supply and demand. So
27 the supply side is what's actually flowing into our current
28 assets or workforce, and that will include things like
29 graduate numbers, people re-entering the workforce, people
30 immigrating from overseas, flowing in, and then flows out
31 will be people retiring, dying, leaving the sector, moving
32 overseas, those kinds of things.

33

34 They will also apply other datasets such as national
35 health workforce datasets or data from the Commonwealth
36 Department of Education to inform the information going in.
37 And then the demand side is far more complex in that that
38 requires much more engagement with stakeholders and the
39 system to understand the nuances of what happens in our
40 business in NSW Health, and therefore, what is likely to
41 put pressure on that workforce and its ability to meet the
42 demands in the system.

43

44 Q. What is done with this modelling, once it's
45 undertaken?

46 A. So the modelling is finally published online, so it is
47 available publicly. It is used to provide guidance to

1 local health districts and specialty networks so that they
2 have a more evidence-based tool to signal what's going on
3 with certain workforces that they're responsible for, and
4 then they can use that as one of the sources of evidence to
5 inform their local workforce planning and service planning.
6

7 Q. Is this an ongoing process?

8 A. Yes.

9
10 Q. Is the modelling constantly being updated?

11 A. Yes.

12
13 Q. When you say it is "published online", is the current
14 up-to-date modelling for each of these practice areas
15 online now, for example?

16 A. So the current - the up-to-date modelling that is
17 online is for the allied health professions. That was
18 recently done. The medical professions now need to be
19 redone. I believe the last time they were done was
20 2018/2019, and we've just commenced nursing and midwifery.
21

22 Q. Part also of that role is monitoring the workforce?

23 A. Mmm-hmm.

24
25 Q. Correct?

26 A. Yes.

27
28 Q. To the extent that it differs from the answers you've
29 just given, in what way?

30 A. So the role of my unit is to have a very real-time
31 connection with stakeholders in local health districts and
32 external to NSW Health that have interest in our health
33 professional workforces. So we get a lot of intelligence
34 on a day-to-day, week-to-week basis from people like tier 2
35 executive directors that are responsible for medicine,
36 nursing, allied health, Aboriginal workforce.
37

38 We also have close relationships with universities and
39 the deans of the universities. We have a relationship with
40 the Australian Health Practitioner Regulation Agency. We
41 also have relationships with professional associations and
42 from time to time, depending on what's happening,
43 industrial associations as well. So we have a steady
44 stream of intel that comes in to us through our normal
45 business, that then assists us to identify whether things
46 are changing or if there are issues we need to be cognisant
47 of.

1
2 Q. And is that intel, as you put it, utilised in the
3 modelling process that you described earlier?

4 A. Yes.

5
6 Q. In what way?

7 A. So when the modelling projects are initiated, when
8 we're actually reviewing the modelling, what will happen is
9 the team, at a high level, will look at the quantitative
10 data sources that they have, and as I described before,
11 what's going into the supply side in particular, and then
12 there will be a process by which stakeholders will be
13 spoken to and engaged with to gather qualitative
14 information from a variety of places, such as - like,
15 definitely within NSW Health and what's going on on the
16 ground in our business; but also what we know that might be
17 happening in the university sector - for example, whether
18 a course is about to close or has closed, that's obviously
19 going to affect the supply calculations or projections.

20
21 Then the team will treat the data in a way that is
22 informed by the qualitative information that is provided by
23 the stakeholders with the expertise, that have real-world
24 understanding of what's going on with that particular
25 clinical workforce.

26
27 Q. So that's on the supply side?

28 A. No, that's on the demand side.

29
30 Q. The demand side?

31
32 THE COMMISSIONER: Q. Can you just define for me what is
33 the supply side and what is the demand side?

34 A. So at a very high level, the supply is where are we
35 getting the work - where is the workforce coming from and
36 what is influencing where they're coming from? That's at
37 a very basic level, yes.

38
39 Q. And the demand?

40 A. And demand is what is creating the demand for that
41 workforce? So what's changing in the community or the way
42 we provide services or change in the population? So as
43 a very general example --

44
45 Q. It's the demand for healthcare services that you're
46 talking about?

47 A. Demand for healthcare services, yes, which will be

1 influenced by a variety of things.

2

3 Q. Like ageing, for example?

4 A. Like ageing, chronic disease, population growth,
5 immigration, socioeconomic determinants, and that will
6 differ from district to district. So whilst there will be
7 trends that will be looked at at a state level, things will
8 differ from district to district because populations are
9 different, demands are different. For example, from
10 a metropolitan to a rural.

11

12 Q. And how far in advance does the modelling look? Are
13 the models producing predictions for, "This is likely to be
14 the workforce required in two years' time"; "This is what
15 it's likely to be in 10 years' time"? How does it work?

16 A. So currently the modelling is being done to 2040, so
17 about 15 years ahead.

18

19 MR GLOVER: Q. What sort of data goes into the modelling
20 for projections out to 2040?

21 A. That's a question I can't confidently answer for you.
22 So either - we could gather that information, or Richard
23 Griffiths is appearing later in the hearing and he may be
24 better placed to give that.

25

26 THE COMMISSIONER: Q. The uncertainty in the inputs in
27 the model not so much the supply side, because you
28 currently know who is doing what courses and what the
29 numbers are; the greater analysis perhaps and the more
30 difficult inputs is what is going to be the demand?

31 A. Yes, that is the most complex part of it. So the
32 supply side, for an example, if we were looking at nursing
33 and midwifery, things like fertility and birth rates would
34 be important in considering that workforce, where that
35 might not be so important with other workforces, and so
36 it's a bit more - it's a bit easier to identify what's
37 coming in to that side of the model.

38

39 The demand side is definitely the most complex, and as
40 an example, we might model for 15 years to 2040, but there
41 might be events that occur that we can't predict, such as
42 a global pandemic, such as the introduction of the NDIS,
43 and really understanding the full impact of that policy
44 over time, and so when --

45

46 Q. Also, I suppose, if there are different new models of
47 care?

- 1 A. Correct.
- 2
- 3 Q. They might compress periods of morbidity?
- 4 A. Yes.
- 5
- 6 Q. And if, worst case scenario, we might have longer
- 7 periods of morbidity --
- 8 A. Yes.
- 9
- 10 Q. -- and that creates an uncertainty, I suppose, in
- 11 terms of your modelling out to 2040 or beyond?
- 12 A. Correct.
- 13
- 14 MR GLOVER: Q. Can I take you to paragraph 2(b), please?
- 15 There you tell us part of your role is responding to
- 16 education, training and accreditation impacts on workforce
- 17 availability. You gave one example in an earlier answer if
- 18 a university ceases a particular course, it might have an
- 19 impact on workforce availability. What are the others?
- 20 A. So at a high level - and I know this has been covered
- 21 in other submissions - one of the portfolios I'm
- 22 responsible for is medical, and I have the chief medical
- 23 workforce adviser who reports to me, and with the
- 24 accreditation of hospitals or sites, or districts as they
- 25 relate to, for example, medical training, if there's
- 26 a situation where accreditation is lost or at risk of being
- 27 lost from a particular facility or district, then that's
- 28 important for us to know about.
- 29
- 30 And also, Justine Harris, Dr Justine Harris, who is
- 31 the adviser, will often be involved in liaising with
- 32 organisations like HETI, the district, and potentially the
- 33 college, depending on what's going on, to either try and
- 34 address or resolve that, but also consider what the impact
- 35 of that loss of accreditation might be on the workforce.
- 36
- 37 Q. So this is doctors undertaking specialist medical
- 38 training that you're speaking of?
- 39 A. Correct.
- 40
- 41 Q. And I take it from that answer that a member of your
- 42 team might liaise with the interested parties to try and
- 43 resolve the issue that is leading to the accreditation
- 44 concern - have I understood you correctly?
- 45 A. That can be possible, yes.
- 46
- 47 Q. As well as looking at what a loss of accreditation

1 might mean for the training pathway for those particular
2 clinicians?

3 A. Correct.

4
5 Q. Are there any other education or training or
6 accreditation impacts on the workforce that your team might
7 be responsible for responding to?

8 A. Yes, I can give an example that happened some time ago
9 but it's a relevant one currently. So with clinical
10 psychology, the board changed the requirements for who was
11 able to supervise registrars and interns, and so what
12 occurred was the psychology board determined that anyone
13 supervising a registrar or an intern had to undertake an
14 accredited supervisor training program, which is something
15 very unique and different to psychology and doesn't apply
16 to any other profession.

17
18 That then had a significant impact on local health
19 districts at the time in the viability of them to continue
20 to train registrars and also to take interns on board,
21 because it meant that supervisors had to undergo that
22 training, which was expensive and time intensive, and there
23 was no sort of funding source centrally to support that.

24
25 So the unit, for example, would look at that, liaise
26 perhaps with HETI and local health districts to negotiate
27 ways of ensuring that we could support the supervisors to
28 remain or become accredited, so they can continue to train
29 the future workforce for psychology and clinical
30 psychology.

31
32 Q. Can I take you to paragraph 2(c), the last of the
33 three categories that you identify is the identification of
34 opportunities to influence innovation in education and
35 training and models of care. In what way does your team do
36 that?

37 A. So that's probably the reason for the establishment of
38 the unit and noting that I've been in this role for about
39 11 months now, is - I'm just thinking of a succinct way to
40 answer this. So on commencement in the role, the health
41 system in response to the future health strategy and the
42 health professionals workforce plan identified, via chief
43 executives, top priorities that needed to be looked at
44 where there were innovative models of care that had been
45 developed and evaluated or the opportunity for pilots to be
46 developed and scaled. There were seven areas that were
47 identified as a priority, and my unit leads some of those

1 or is involved in most of those areas and those projects.

2
3 Q. In what way?

4 A. So my team has the central expertise around the health
5 professional workforces at the state level. We engage with
6 other stakeholders, including the Agency for Clinical
7 Innovation, Health Education and Training Institute,
8 Clinical Excellence Commission and other internal branches
9 within the ministry like the nursing and midwifery office,
10 and we have a very close, ongoing relationship with local
11 health districts which I described before in our
12 stakeholder engagement.

13
14 So the unit and my role is like a bit like a broker
15 but also knits or stitches together and creates traction
16 between those various groups that have particular focus,
17 but really, the workforce model and what the workforce is
18 doing is a critical element of operationalising any changes
19 to models of care or service delivery, and particularly
20 when you're looking at it from a state scaling perspective.

21
22 So we don't just look at numbers and what's where;
23 it's who are the people and what are they doing and what do
24 we need them to do and therefore, are there different ways
25 we can do that or are there areas of red tape or barriers
26 we have to unlock that will then allow districts to just
27 get on with it and implement the changes they need to?

28
29 Q. And under that umbrella, is one of the pieces of work
30 that your team has been involved in looking at what is
31 described as "scopes of practice"?

32 A. Yes.

33
34 Q. If we go ahead to paragraph 43 of your statement,
35 please. By way of introduction to this topic, you tell us
36 that there is no universal definition for scope of
37 practice, with professions applying it differently.
38 Appreciating that there might be many variations, what are
39 the general differences between the way it is utilised?

40 A. So just going back to the term "scope of practice",
41 that term and the way it's applied, as you have just said,
42 is bandied around differently in different conversations,
43 and often people think they're all talking about the same
44 thing and they're not.

45
46 So, for example, one profession might talk about
47 advanced scope; another profession might talk about top of

1 scope; another profession may talk about extended scope.
2 Often they think they're all talking about the same thing
3 or they're all talking about different things and sometimes
4 it's hard to tell.

5
6 For this Inquiry, we did prepare some briefings to try
7 and simplify the use of those terms, and that's one of the
8 things that our unit is doing in our engagement with
9 stakeholders, so we can have meaningful conversations.
10 Because it's like speaking five different languages, and
11 I feel like I've moved to Switzerland in this job at times,
12 to try and have a conversation with people that come from
13 very different frames of reference, and even at the
14 national level in my engagement with AHPRA, it's something
15 that's acknowledged that different boards and professions
16 will categorise things differently and apply it to how
17 their professions have evolved over time, yes.

18
19 Q. So that we make sure we are understanding each other,
20 when you use "top of scope", what do you mean?

21 A. So if we look at scope, which broadly would be things
22 like the training someone's done, the registration they
23 need to have, the legislation or licences they need to
24 operate with or within, and then the context of where they
25 work - so those are the kind of, just roughly, things that
26 would make up a scope of practice.

27
28 When we talk about "within scope", it means that that
29 professional person might have a broader range of things
30 that they could do, but in the context of this role or our
31 discussion, we're talking about things that are within
32 scope. If we're talking about "full scope", which is also
33 a term that's used a lot, that means the person can or is
34 operating across the entire spectrum of what they're able
35 to do in that context, and that might be, for example,
36 someone working in a rural area or in a generalist role
37 where they need to do all the bottom and top end of that
38 job because they don't have other people to do it or that's
39 just the way it's designed.

40
41 "Top of scope" is where everyone wants to be, which is
42 as a health professional, I have been trained to do lots of
43 things, but I really like to do what I'm really good at,
44 what I'm really expert at and what the patients really
45 need, and that's where you move up into the top of scope,
46 but this bit in the bottom may be where an assistant or
47 a piece of technology or a decision-making framework or

1 something else has been put into place to take that, let's
2 call it, lower-value work or work that doesn't require that
3 higher level expertise; or it could be that, in that
4 context, you have multiple professions working together,
5 there's an overlap in what is at that bottom, but by
6 recognising that and not duplicating that work, you're
7 allowing people to push their effort to the top of scope in
8 that model.

9
10 Then, finally, if we're looking at what's "out of
11 scope" or what we're trying to look at, whether it's
12 advancing or extending, but I'll use the term "out of
13 scope", that's where there's the opportunities to go: is
14 there some low-hanging fruit there because of some kind of
15 regulatory licensing, training, whatever issue it might be,
16 it's not currently in scope, but if we do something, we can
17 put it in there; like, it's not unachievable.

18
19 Q. And if a plan referred to "examining opportunities to
20 extend scope", would that be in that third category that
21 you have just described?

22 A. Yes, so I've probably - again, I've fallen into that
23 trap, used that word. "Extended scope" is probably a word
24 a probably need to stay away from. But really, it's about
25 at a foundational basis, top of scope, out of scope, and
26 then different professions will use those terms as it
27 applies to their individual practice. So as an OT, you
28 know, my normal scope is this, but as a profession, the
29 profession might be looking at how they could advance or
30 extend the scope of the profession. Does that make sense?

31
32 Q. Yes. In an earlier answer you said that everybody
33 wants to be at top of scope?

34 A. Mmm-hmm.

35
36 Q. Why?

37 A. Anecdotally from engagement?

38
39 Q. Your understanding and experience?

40 A. From my understanding? That provides a higher level
41 of satisfaction for clinicians. They enjoy being well
42 utilised. They're highly trained people. Generally they
43 come into health care because they want to help people,
44 they want to do the best that they can and it allows them
45 to operate in a more autonomous way, where they feel like
46 they're using all their muscles and their capability on
47 a daily basis, and therefore feel more valued.

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Q. Accepting that those principles are important from a system perspective, are there other system advantages to having clinicians operate at the top of scope?

A. Yes. So I think it's minimising duplication and maximising your bang for buck. So if you're paying for someone who has a higher level of capability than you're using then you are not getting value for money in what you're asking that person to do.

Q. In paragraph 44 of your statement you tell us that there are a number of barriers, however, which impact on the ability of clinicians to operate at their top of scope, and you give some examples. If we just start with the example in paragraph 44(a), "Workplace culture and attitudes of individual clinicians and managers which can prevent collaborative and transdisciplinary working", how might the culture and those attitudes manifest to create a barrier to clinicians operating at top of scope?

A. In many ways. So it could be as simple as people working in a service or a team where there is an individual or a group of individuals that is very comfortable with the way things are working, they don't want to change the way things are working and, therefore, might behave in a manner that is recalcitrant or not collaborative in the efforts of other clinicians and/or leaders, managers, executives, to improve or change a service for the benefit of patients.

You can talk about things like, you know, let's assume that the evidence says it's a good idea that scopes of practice say it's fine that there's no legal impairment, that we can unlock all the red tape, so let's say we can fix all those things. If there's someone who's senior enough, powerful enough and with a loud enough voice that says, "This is unsafe", and they say it repeatedly enough, then people will believe that. And that's one of the things clinicians will often first say when they are uncomfortable, "This is unsafe. This is unsafe." And that happens a lot, or, "No, I don't think that person can do that, I don't think that's in their scope of practice". So where you've got other professions commenting on what another profession is trained to do or capable of doing. And that may be because that's that person's genuine belief or that they're not informed or that they're scared because they don't know what they don't know or there's a genuine safety concern that we're not aware of that hasn't been properly articulated or explained.

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Q. How prevalent is culture and attitudes of the kind that you've just described across the system, to your observation?

A. So I would say there are pockets of outstanding excellence, and where you get particularly a senior medical clinician that is really on board, focused on the community and really empowering and valuing the multidisciplinary team they work with - and that is allied health, that is nursing/midwifery - it can be amazing accelerator. It's like magic, it just unlocks all of the barriers and they just focus on the outcome and get it done, and there are pockets of that all over the place.

However, I would say that it is definitely a massive challenge and is quite prevalent across the state, and that makes it difficult for particularly our next generation of clinicians that are coming through, that are coming out of university and are very excited and they're innovative and they've got ideas and they're obviously tech savvy and they want to do amazing things, and that can be a real challenge to come up against when they suddenly enter a system like NSW Health. So - yes, I'll stop there.

Q. I will just pass over 44(b) for the moment and come back to it, but touching on part of the answer you just gave, in 44(c), you raise as one of the potential barriers concerns about patient safety, real or perceived, et cetera.

A. Mmm.

Q. You gave some examples in that last answer. Is there anything further that you would add to that by way of example for these types of concerns operating as a barrier to clinicians operating at top of scope of practice?

A. Yes. I'm just trying to think of which one. Can I just read the paragraph again?

Q. Of course you can. Take your time.

A. Could you just ask me the question again, sorry?

Q. Yes. So in the answer you just gave, you mentioned as part of the description of cultural and attitudinal barriers clinicians raising a concern about patient safety, once a clinician of a particular seniority might raise an issue of patient safety, that spreads through the system and operates as a barrier?

1 A. Mmm-hmm.

2

3 Q. What I was just inviting you to do, in relation to
4 what's in subparagraph (c), are there any other examples of
5 concerns about patient safety, real or perceived, as you've
6 described it, operating as a barrier to or hindering
7 clinicians operating at the top of scope of practice?

8 A. So again I'll talk about - so real or perceived, so
9 from a cultural perspective - I will just give two
10 different examples, if that's okay.

11

12 Q. Of course.

13 A. So from a perceived perspective, I can talk about
14 a conversation I was perhaps having the other day around
15 governance. So if we're going to put in a new model and we
16 decide that we want to put in a different type of health
17 professional than we've put in before, we need to make sure
18 there's a good governance of that person to make sure that
19 they have good clinical support, they know who their
20 operational manager is and they know who their professional
21 line is.

22

23 So with health professions, best practice requires
24 that you have an operational manager so you know who you
25 report to; you might have a clinical line, which is who's
26 responsible for the overarching care of the patients in
27 that setting; and then a professional line, which is
28 someone from your own discipline. The way those three
29 lines behave is different across professional groups.

30

31 So, for example, in nursing/midwifery, they're
32 normally all the same person. In medical, there might be
33 a combination of that. In allied health, we're very used
34 to - and I say "we", because my background is occupational
35 therapy - used to working in a matrix structure. So if
36 we're putting someone into a model of care that is an
37 autonomous clinician that can work really well without
38 being, you know, high degrees of supervision, and another
39 professional group might find that very concerning because
40 the three lines of governance are not aligned to the one
41 person, or they find it difficult to understand that,
42 therefore, they will raise concerns about, "Well, what
43 happens if there's an incident or a root cause analysis or
44 if there's a concern with that person's performance?" So
45 that's an example of perceived.

46

47 There are real - we do need to always be concerned

1 about are there real risks, and so, therefore, the role of
2 my unit, in looking at models we might be trialling at
3 a state level, is involving organisations like the Clinical
4 Excellence Commission, the chief health officers unit, as
5 well as the local clinical governance groups in the
6 district, to make sure that there are not real issues that
7 bee haven't considered in the design of the models, which
8 therefore we can confidently respond to any concerns people
9 might raise, whether they are real or perceived, about
10 safety.

11

12 Q. If I just take you ahead on this topic to paragraph 78
13 of your statement, please, and just invite you briefly to
14 refresh your memory about what you've said in paragraphs 78
15 through to 81 and just let me know when you've had an
16 opportunity to do that.

17 A. Mmm. Yes.

18

19 Q. Do we understand that in these paragraphs you set out
20 some of the measures that need to be implemented to
21 overcome some of those cultural and attitudinal beliefs?

22 A. Mmm-hmm. Yes.

23

24 Q. And do you perceive any challenges in implementing
25 those responses themselves?

26 A. Sorry, for all of them? I'm just --

27

28 Q. The answer might be different. I'm just trying to do
29 it in a general way, but, for example, you say in
30 paragraph 78 that there's a need to introduce a narrative
31 across New South Wales health system --

32 A. Mmm.

33

34 Q. -- about what is understood, working to the top,
35 et cetera. And then in 79 you go on to tell us about
36 attitudes, professional guarding behaviour between the
37 professions is a major barrier. As part of introducing the
38 narrative and the dialogue to overcome those challenges,
39 will that itself present a challenge to you and your team
40 in rolling that out?

41 A. Yes.

42

43 Q. In what way?

44 A. Because it's uncomfortable for people and we're at
45 a time where matters around workforce are very highly
46 emotive issues, for good reason, and we're also, in
47 New South Wales, going through a period where there's a lot

1 of industrial reform and it's for, you know, various
2 reasons, and the roles of unions around ensuring that the
3 are doing what they need to do for their members.
4

5 So there's a lot of activity occurring in each of the
6 individual professional groups around matters that are very
7 important to them - whether it's industrial issues or
8 whether it's professional issues or whether it's workforce
9 supply and demand issues - and people have very strong
10 attachment to their identity as a clinician in their
11 professions, for good reason. They've worked hard to
12 develop that. There's, you know, a history around
13 medicine, nursing, midwifery, paramedicine, how that has
14 evolved in Australia.
15

16 So in that context where people are really trying to
17 advocate for their individual professional issues, trying
18 to then have a conversation to lift people up and say,
19 "Hang on a minute. What are we doing here? The focus is
20 the patient and the community and that is what we need to,
21 firstly, think about and talk about", when we're analysing
22 what is the service they need, who's got the skills
23 required to deliver that service, and then how do we design
24 a model where there may be overlap in skills and
25 capability, where there may be a need for certain
26 professions to operate at top of scope, and it's about
27 meeting the need of the community not trying to take away
28 people's identity or erode their practice or minimise their
29 role, and that's a genuine fear of people.
30

31 So there may be perverse incentives, in some way, from
32 some people. But people do genuinely have that concern
33 about, again, real or perceived: does that mean I won't
34 have a role? Does that mean I won't have a job? Does that
35 mean I'll be less valued than a new person coming in? So
36 they're real concerns. But it is challenging and it
37 continues to be challenging and I recognise that that's
38 a key component of my role in the unit and with our
39 stakeholders, is to have those - start having those
40 conversations, as uncomfortable as they are, yes.
41

42 Q. Has work commenced to start having those difficult
43 conversations?

44 A. Yes.
45

46 Q. And how has it gone so far?

47 A. Interesting. It's robust. I mean, it depends on what

1 context, but I think, reflecting on just the last 11 months
2 where we've started to have conversations in a variety of
3 forums for different reasons, generally, when you give
4 people the time to ask questions and be curious and you
5 listen to them - and I think that's the key, we've got to
6 listen to people and what their concerns are; however, then
7 have a robust conversation in an evidence-based manner
8 about genuine concerns versus just poor attitude, and then
9 to be able to distil, well, what is it that we need to
10 genuinely address and what is it that's another issue?
11 So - yes. It's robust and it's challenging but people are
12 engaging in the dialogue.

13

14 Q. Can I take you back to 44, and this time to
15 subparagraph (b), please, where you tell us that policy and
16 legislative requirements such as regulation of drugs have
17 not kept pace with the changing landscape, et cetera. We
18 heard some evidence earlier in the week about legislation
19 review undertaken in the context of nurse practitioners?

20 A. Mmm-hmm.

21

22 Q. Is there any other work being undertaken in relation
23 to the barrier that you identify in paragraph 44(b)?

24 A. Yes, I can give a couple of examples.

25

26 Q. Please do.

27 A. So one is, in my portfolio I'm responsible for the
28 Aboriginal health workforce, and that includes Aboriginal
29 health practitioners and growing the number of places that
30 they can work in multidisciplinary teams across the state.
31 So one of the pieces of work is where Aboriginal health
32 practitioners are trained and able to do things like
33 administer intramuscular injections, but because of the way
34 they're employed within NSW Health, they may not
35 necessarily be doing that all the time - sorry, let me just
36 take a step back. This is about Aboriginal health
37 practitioners and enabling them to vaccinate the Aboriginal
38 community.

39

40 So with the current legislative framework, that was
41 not possible, so we've worked with the immunisation unit
42 and Western New South Wales, who had raised that they
43 wanted a group of their Aboriginal health practitioners to
44 start vaccinating the community this year with Fluvax -
45 under 5s have a good vaccination rate, over 65s do, but
46 between 5 and 65 the Aboriginal population has a very poor
47 vaccination rate compared to the rest of the population.

1
2 So in partnership with the chief health officer and
3 the immunisation unit, they put in place an authorising
4 instrument to enable Aboriginal health practitioners to
5 vaccinate with the flu vaccine and also have a state
6 standing order to administer adrenaline, so that in the
7 case of an anaphylactic reaction they could administer
8 that, and that would mean that they could do that
9 independently without having to get a direction repeatedly
10 from a medical officer. Again, if you don't need to have
11 that person in the team, if there's an instrument that
12 allows you to just get on with it with the appropriate
13 governance in place, that makes it --

14
15 Q. So just from that answer, do I understand that there
16 have been some reviews undertaken of a range of legislative
17 barriers to particular clinicians performing particular
18 services, with a view to removing them?

19 A. Correct.

20
21 Q. Can I take you ahead to paragraph 44(d), please.
22 There you tell us that in some cases, employment conditions
23 arising from industrial instruments may be a barrier?

24 A. Yes.

25
26 Q. What work is being done to overcome those barriers?

27 A. So NSW Health, as well as the industrial associations,
28 are commencing a process of award reform and members of my
29 team are involved in each of the various working parties
30 around medical awards, allied health awards and Aboriginal
31 health practitioner awards, and other awards that may
32 affect our health professional workforces. So that work is
33 occurring. Yes.

34
35 Q. So what type of barriers are created by the industrial
36 instruments to permitting clinicians to operate at the top
37 of their scope?

38 A. Two brief examples. So one that I've mentioned there
39 is the work we're doing with paramedics. Currently,
40 there's no industrial instrument that allows local health
41 districts to employ a paramedic. So even if they wanted to
42 create a role, they can't employ them.

43
44 The second example is the health professionals award,
45 which currently encompasses 18 allied health professions,
46 treats things like on-call allowances differently between
47 professions, and then the other five professions are

1 employed under different awards again, so if you're trying
2 to look at designing a model of care where you're wanting
3 professions to behave in a similar way, it can make it
4 difficult, as a manager, to do that and it may then
5 influence your choices about whether or not you would
6 include certain professions in your service model.

7
8 Q. And that's why you tell us in your statement that
9 those instruments are operating as a barrier to the
10 implementation of the innovative model?

11 A. Correct.

12
13 Q. In paragraph 45 you refer to the scope of practice
14 review.

15 A. Mmm-hmm.

16
17 Q. Then in paragraph 46 you tell us that your unit is
18 coordinating the statewide response, and that, in doing so,
19 it has been a significant opportunity for NSW Health to
20 contribute to the process of identifying and addressing
21 barriers experienced by primary health care professionals.

22 A. Mmm-hmm.

23
24 Q. What barriers have you identified to primary health
25 care professionals in operating to their optimum scope of
26 practice?

27 A. So as far as the review is at, and noting that the
28 outcomes have not been finalised, the barriers that have
29 been identified are very similar - so are things like
30 access to training and education; the existing regulatory
31 policy and legislative requirements. So they operate
32 under, obviously, federal policy, largely, but also
33 state-based policy will be influencing what they can and
34 can't do. The way that work is arranged and funding is
35 applied to particularly professions that are not general
36 practitioners, in being able to deliver care to the
37 community, and that's obviously out of our scope; and
38 technology and the availability and use of technology in
39 being able to deliver care, and particularly whether or not
40 that attracts funding.

41
42 So noting that some of those things are out of our
43 scope, however, the principles are also applicable to the
44 work that we do in NSW Health.

45
46 Q. In that answer you referred to professions other than
47 general practitioners. Who did you have in mind?

1 A. Physiotherapists, occupational therapists, speech
2 pathologists, even nursing, midwifery. So people who would
3 be considered as members of the multidisciplinary team that
4 are required to deliver care to populations that have
5 chronic and complex issues, so where the general
6 practitioner might have a short - you know, may coordinate
7 care or identify issues that need to be addressed, the
8 ability of that patient to then be able to go and access
9 things like podiatry, speech pathology, dietetics can be
10 limited by the things that I have just outlined.

11

12 Q. In paragraph 47 - and you touched on this in an
13 earlier answer - you tell us that the general findings from
14 that review are expected to be transferrable to the
15 New South Wales public health system and will likely assist
16 in informing ongoing statewide reforms. Why do you hold
17 that view?

18 A. So looking at the early themes that have come out of
19 that review and through our work in coordinating the
20 responses for New South Wales health system, the items that
21 I just listed around training and education being a barrier
22 or an enabler; policy and regulatory legislative reform,
23 technology; the way that employers use health professions,
24 their practices and work settings, while that might be the
25 themes coming out related to the primary healthcare work
26 force, they're just as relevant to the work that we're
27 doing in NSW Health, and we have the ability to look at
28 those things as part of our response to workforce
29 challenges here.

30

31 Q. Could I take you ahead to paragraph 50 of your
32 statement, please. There you --

33

34 THE COMMISSIONER: Q. Can I ask just on the scope of
35 practice review you've just mentioned, the second issues
36 paper came out in April this year, which had some options
37 for reform, amongst other matters. Has NSW Health made
38 a submission in relation to that issues paper? I think
39 there was a call for submissions in relation to it.

40 A. Yes. So we have responded to the latest call for
41 submissions.

42

43 Q. You have, right?

44 A. Which was some early - I think as you said, I think,
45 early request. Yes.

46

47 THE COMMISSIONER: I'll need to follow that up later.

1 Yes.

2

3 MR GLOVER: Q. Can I take you ahead to paragraph 50.
4 There you refer to the future health strategy and the
5 NSW Health workforce plan.

6 A. Mmm-hmm.

7

8 Q. In paragraph 51 you identify four key opportunities,
9 and they're the opportunities that are drawn from the
10 NSW Health workforce plan; correct?

11 A. Correct.

12

13 Q. I just want to ask you about a few elements of the
14 plan, and I'm going to do it by reference to the
15 supplementary guide. Are you familiar with that document?

16 A. I am familiar with it, yes.

17

18 MR GLOVER: I will have it brought up on the screen
19 [MOH.0010.0275.0001]. Commissioner, it's H2.36.

20

21 Q. We'll go ahead in that document to internal page 19,
22 please. This refers to priority 3 of the plan, empowering
23 staff to work to their full potential around the future
24 health care needs. Do you see that?

25 A. Yes.

26

27 Q. Under 3.1 there are two columns, "Future state" and
28 "Practical applications". I'll just invite you to read
29 what is attributable to the ministry under "Practical
30 applications", and let me know when you have done that.

31 A. Yes.

32

33 Q. So in this context, the supplementary guide uses the
34 phrase "expanded scope of practice". What work, if any,
35 does your team do in furthering this initiative?

36 A. So 3.1 applies to the work that we're doing related to
37 those seven key priority areas that I mentioned earlier in
38 the submission, around looking at new roles or expansion of
39 existing roles, and whilst it states "expanded scope of
40 practice" there, as I mentioned earlier, the simplification
41 of the terms that we just talked through, such as "within
42 scope", "full scope", "top of scope", or "currently out of
43 scope" potentially could be in - is the language we're
44 currently using on a day-to-day basis.

45

46 But the way my team does that, so those seven priority
47 areas include looking at paramedics and the other settings

1 that they potentially work in outside of ambulance New
2 South Wales. I've talked about Aboriginal health
3 practitioners; looking at allied health and nursing and
4 their role in what's called criteria led discharge, and
5 some of this is in partnership with the Agency for Clinical
6 Innovation; the expansion of well-piloted and evaluated
7 multidisciplinary teams, such as the rapid access
8 intervention and discharge service in the emergency
9 department, which is a multidisciplinary allied health
10 model, and some other models; and then there's the
11 partnered pharmacist medication charting, which the chief
12 allied health officer is leading our --

13

14 Q. Just pausing there, are these initiatives those which
15 are set out - I won't take you to it on the screen, but if
16 you've got your hard copy there - from paragraphs 53 and
17 following in your statement?

18 A. Most of them are set out there, yes, in detail.

19

20 Q. In general, in advancing the work for priority 3, are
21 they the pieces of work that your team undertakes to drive
22 priority 3 of the workforce plan?

23 A. Correct. They're the current priority focus.

24

25 Q. Thank you. If I go to internal page 21, please, this
26 relates to priority 4. I want to ask you about, firstly,
27 4.2 --

28 A. Mmm-hmm.

29

30 Q. -- in particular, the practical application
31 attributable to the ministry, which is "Exploring new and
32 emerging capabilities to support a future-ready workforce
33 and to work with health education providers to support
34 capabilities", and so on. Is that part of the role of your
35 team to advance that initiative?

36 A. So 4.2?

37

38 Q. Yes.

39 A. Yes, it will be, in partnership with other teams
40 within the branch and in the ministry.

41

42 Q. When you say, "will be", is it a piece of work that
43 has commenced as of now?

44 A. There has been some work that was commenced in that
45 space, particularly looking at capabilities around the
46 virtual care manager role, which is not a specific clinical
47 role but looking at what, if districts are wanting to

1 establish or modify how they're leading virtual care or in
2 putting that infrastructure in place, there is some work
3 around a standardised position description and a capability
4 document that is in the stage of being finalised, and that
5 will be distributed across the state for local health
6 districts to be able to use.

7
8 Q. Can we come to 4.3, "Graduates entering the workforce
9 are appropriately prepared for contemporary health care
10 delivery", and then the supplementary guide tells us that
11 the ministry, and in particular your branch, will play
12 a lead role in implementing programs to support the
13 development of the workforce pipeline. How does your
14 branch do that?

15 A. So I can partially answer this, but this question
16 would be worth putting to Richard Griffiths when he
17 provides his evidence, because there's other parts of our
18 branch that do this work around pipelines and student
19 pipelines. But as to how my team works, we have an ongoing
20 relationship with the universities and the deans of each of
21 the core groups for medicine, allied health, and in
22 partnership with the nursing and midwifery office, for
23 nursing and midwifery, where we meet with those groups on
24 at least a biannual basis and we have dialogue as required,
25 to have conversations about what are the current challenges
26 we're seeing, what is the work they're doing to improve
27 their work readiness of their graduates, and how we can
28 work together to ensure that what is coming through is fit
29 for purpose with the challenges we've got on the horizon?
30

31 Q. And is that work also related to 4.4 on that same
32 page?

33 A. Yes.

34
35 Q. As part of that work in assessing curriculum and
36 training pathways to current and future workforce needs and
37 competencies, is the modelling that you spoke of earlier in
38 your evidence utilised to progress that initiative?

39 A. Yes. So we do socialise the outcomes of the modelling
40 in those meetings with the deans and have conversations
41 about - hang on, let me just look at that again.

42 Apologies. Yes. So an example of where we're doing that
43 at the moment for radiation therapy, where the modelling
44 showed we do have a critical problem with the supply of
45 radiation therapists, not just in New South Wales but
46 nationally, part of that has been due to the closure of
47 courses, so we have university representatives on

1 a time-limited radiation therapy action group to discuss
2 how we're going to address these challenges moving forward
3 and what they're thinking about in how they might be
4 modifying even their existing courses and the impact that
5 that's likely to have on our supply.
6

7 Q. Are similar conversations had with the specialist
8 medical colleges?

9 A. I can't probably answer that question confidently.
10 I think it might be best to ask Richard Griffiths in his --
11

12 Q. In that answer you gave earlier, you referred to
13 socialising the workforce modelling data with the
14 universities?

15 A. Mmm-hmm.
16

17 Q. Tell me if you don't know the answer to this question,
18 but is the same process undertaken with the specialist
19 medical colleges?

20 A. I believe so, because it's - the data is published, so
21 it's available. So it forms part of the conversations,
22 it's one piece of evidence or information that informs what
23 is likely to be needed around training positions or - so
24 I would say yes to that question.
25

26 Q. The data that is published in relation to the medical
27 workforce relates to the 2018/19 period, did I understand
28 you earlier?

29 A. Yes, yes.
30

31 Q. So is data post that period being, to use your phrase,
32 "socialised" with the specialist medical colleges?

33 A. Once it's updated, yes, it will be.
34

35 Q. Once it's updated and published on the website, it
36 will be; is that what you mean?

37 A. Correct, yes.
38

39 Q. Jumping ahead, finally, to priority 5 on page 23,
40 please, and 5.1 --

41 A. Twenty-three?
42

43 Q. Sorry, on the screen, not your statement. That was my
44 fault entirely. The supplementary guide, internal page 23,
45 5.1, the guide tells us that the ministry will "play a lead
46 role in progressing the availability, quality and usability
47 of the workforce data"; do you see that?

- 1 A. Yes.
- 2
- 3 Q. Is there a need to improve the availability, quality
4 and usability of the workforce data, in your view?
- 5 A. I think that's been - in my view, personally?
- 6
- 7 Q. Mmm.
- 8 A. I think that when we have access to information and
9 accurate information, it informs what we do as a result of
10 that information, and I think it's been recognised within
11 the health professional workforce plan as one of those four
12 key unlockers around workforce data transparency, access
13 and utilisation. So yes, I think that's an important
14 enabler to the work that we're doing to improve workforce
15 development across the state.
- 16
- 17 Q. Are you aware of concerns expressed by, for example,
18 the specialist medical colleges about a lack of access to
19 up-to-date workforce data?
- 20 A. I'm not specifically. Yes.
- 21
- 22 Q. Are you aware of concerns expressed within different
23 arms of NSW Health about lack of availability of up-to-date
24 workforce data?
- 25 A. So from the previous submissions or the hearings that
26 I've watched, I have seen some reference to that, yes.
- 27
- 28 Q. And would you accept that there's a need to improve
29 the availability, quality and usability of workforce data
30 in general terms?
- 31 A. Yes, in general terms.
- 32
- 33 Q. That then feeds in to point 5.2, in which your branch
34 will develop an organised and strategic approach to
35 monitoring workforce trends and data-driven
36 decision-making. Do you see that?
- 37 A. Sorry, I keep getting confused between - there's a 5.2
38 on the left and a 5.2 on the right. But there are two
39 different - for each one there are two different --
- 40
- 41 Q. I'm using the columns, not the yellow. I'm Sorry,
42 I should have made that clear to you.
- 43 A. Thank you. Yes.
- 44
- 45 Q. What work is being done by your branch to achieve
46 that aim?
- 47 A. Aside from the information I've already provided

1 you about modelling, I can't answer that question.
2 Richard Griffiths, though, would be able to answer that
3 for.
4 You.

5
6 Q. And if we just go over the page to internal page 24,
7 this is in relation to priority 6, and do you see the
8 right-hand column, there are four bullet points. I just
9 want to ask you about the second one:

10
11 *Updating award structures to reflect modern*
12 *operational situations ...*
13

14 You referred to this in your earlier evidence. I'm just
15 going to invite you to review that dot point and let me
16 know if there's anything else you would wish to add in
17 relation to the work being done to further that aim?

18 A. No, I think I've covered that.
19

20 MR GLOVER: Thank you.
21

22 Thank you, Commissioner. Those are all the questions
23 I have.
24

25 THE COMMISSIONER: Do you have any questions, Mr Cheney?
26

27 MR CHENEY: No, Commissioner.
28

29 THE COMMISSIONER: Thank you very much for your time.
30 We're very grateful.
31

32 THE WITNESS: Thank you.
33

34 THE COMMISSIONER: You are excused. We'll adjourn until
35 2 o'clock.
36

37 <THE WITNESS WITHDREW
38

39 LUNCHEON ADJOURNMENT
40

41 THE COMMISSIONER: Yes, good afternoon.
42

43 MR FULLER: Good afternoon, Commissioner. I call Duane
44 Findley of the Royal Australian and New Zealand College of
45 Radiologists, who is on the screen.
46

47 <DUANE FINDLEY, sworn: [2.00pm]

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<EXAMINATION BY MR FULLER:

MR FULLER: Q. Mr Findley, my name is Dan Fuller, I'm one of the counsel assisting the Commission. I'm going to be asking you some questions this afternoon. Firstly, am I right in thinking you are not a medical doctor?

A. No, I'm not, I am a CEO, yes.

Q. So you're the CEO of the Royal Australian and New Zealand College of Radiologists; that's right?

A. That's correct, yes.

Q. You've assisted the Commission by providing a statement. Do you have a copy of that there with you?

A. Yes, I do.

Q. It's dated 15 July 2024; that's right?

A. Well, I believe so.

Q. It's on the last page. And have you had the opportunity to read over that statement recently?

A. Yes, I have.

Q. Is everything in the statement true and correct, to the best of your knowledge and belief?

A. Yes, it is.

Q. Mr Findley, can you describe your role as CEO of the college, please?

A. Certainly. My role, in a nutshell, is to ensure the long-term financial viability of the college, so that it exists well into the future; to ensure that the training and education of our trainees and our fellows is conducted to an appropriately high standard; to run our policy and advocacy program for the benefit of our members; and to otherwise be a home for our members the same as any other normal member association would be.

Q. You've been in that role since September 2021; is that right?

A. Correct.

Q. Did you hold any role in the college before that time?

A. No, but I was interim CEO of the Royal Australasian College of Physicians, I think it was 2019, 2020, around there. So that was a period of about 12 or 15 months.

- 1
2 Q. In around 2019 and 2020; is that your memory of it?
3 A. Yes, I finished just as the COVID pandemic hit, so --
4
5 Q. The only way to become a specialist radiologist in
6 Australia, if you want to complete your training in
7 Australia, is to complete one of your college's training
8 programs; is that right?
9 A. That's my understanding, yes.
10
11 Q. And your college has two training programs, one in
12 clinical radiology and one in radiation oncology; is that
13 right?
14 A. That's correct.
15
16 Q. As a consequence, you would agree there's no
17 competition between your college and any other training
18 provider for specialist radiology training in Australia?
19 A. I'd say that's a fair call, yes.
20
21 Q. And you would agree that the lack of competition makes
22 it important for colleges such as yours to have fair,
23 effective and transparent processes for the governance and
24 administration of their training programs?
25 A. Yes.
26
27 Q. Am I right in understanding that your college
28 accredits sites?
29 A. For the accreditation program for our trainees, yes,
30 we do.
31
32 Q. Does it also accredit individual positions or training
33 places?
34 A. Not to my knowledge. We only accredit sites.
35
36 Q. We also understand that the college accredits at
37 various levels, A to D; is that correct?
38 A. Under the current program which we're about to
39 change - there will be a new program that starts on
40 1 January 2025. Under the current program, the assessment,
41 when it's first carried out, is an assessment: is the site
42 acceptable for accreditation? When it's reviewed, it is
43 given a rating of A through to D.
44
45 Q. I see. And what does that rating mean?
46 A. Essentially it's a quality rating as to whether
47 they're across all the accreditation standards we have set,

1 all the way down to they're an unacceptable standard at the
2 moment and they need to improve substantially.

3

4 Q. So D is effectively a fail rating; is that right?

5 A. D means that you are an unacceptable level at the
6 moment and we need to work with you to try and improve
7 where you are.

8

9 Q. And if a college is either - is rated or downgraded to
10 a D rating, that may have a future consequence that its
11 accreditation is withdrawn? Would that be correct?

12 A. That's a potential, unless they take steps to move
13 themselves back up again, yes.

14

15 Q. Are you able to help us with whether there's
16 a particular reason for your college taking the approach of
17 accrediting sites rather than individual training
18 positions?

19 A. I will have to take it on notice. I'm not, I'm
20 afraid.

21

22 Q. Can you just describe to us what your role, if any, in
23 the accreditation process is?

24 A. I take a very small role in the accreditation process.
25 It is handled mainly by clinicians, so it's designed by the
26 clinicians for clinicians. They also run the accreditation
27 scheme with support from our training unit. My role, where
28 I do get involved in the accreditation, is primarily as
29 a review role, if they're saying that a site's coming down
30 to a D, they may talk to me about what they're seeing is
31 the issue.

32

33 Within the college, if they are looking to withdraw
34 accreditation, it needs to go through the faculty council
35 and also to the board, so I become involved in that piece
36 to make sure that the information going to the board is
37 correct. And if the department is showing some sort of -
38 or the site is showing some sort of reluctance to engage
39 in a rehabilitation scheme, they may call me in to try
40 and negotiate with those groups at a higher level. As far
41 as --

42

43 Q. And that's - I'm sorry, you finish.

44 A. As far as the mechanics and the actual understanding
45 of the scheme itself, I don't become involved in that.

46

47 Q. So what you've just told us would explain why we see

1 some letters with your name on them relating to situations
2 where the college has either withdrawn accreditation or
3 downgraded accreditation; is that right?

4 A. Correct.

5

6 Q. In those circumstances, can you just explain what your
7 role is as CEO?

8 A. It depends on the site. For many sites around
9 Australia, if we go to a D level, the site will, of its
10 own, wish to be rehabilitated and work with our team.
11 I don't get involved in those at all. I'm only told that
12 such and such a site is at a D level and I'll say, "Just
13 keep me informed to where we're going with it." Soon
14 you'll hear they're back up to a B or C or even an A, and
15 that's not a problem.

16

17 It's where the site goes down to a D level and it
18 continues at D level and they start to warn me that it's
19 a longer period of time, they're not showing any signs of
20 coming up, they're resisting, they want to argue about the
21 piece, I come - I get involved then to find out what their
22 issues are and why they're resisting, try and talk a way
23 through that, and then also preparing that for the board
24 level as well so if we need to go to the board I can say,
25 "This is where the process has gotten to."

26

27 Q. So it is commonly, if issues are raised with the
28 process of either downgrading or withdrawing accreditation,
29 then that's the sort of situation where you'll become
30 involved as CEO; is that right?

31 A. Yes, and again, when the site is fairly actively
32 resisting the process.

33

34 Q. Tell me if you don't know the answer to these
35 questions, but as we understand it, radiology training in
36 both clinical radiology and radiation oncology is delivered
37 in a network structure in New South Wales?

38 A. That's my understanding, yes.

39

40 Q. Do you understand there to be three what are called
41 local area networks in New South Wales?

42 A. I can't answer that, I'm sorry.

43

44 Q. Are we right in understanding that the networks
45 include both metropolitan and non-metropolitan sites?

46 A. Yes, that's my understanding.

47

1 Q. Do you know whether the college either has had or
2 continues to have any involvement in developing that
3 network structure?

4 A. I do know that we are trying to develop a regional
5 network structure, and there is a case study in the witness
6 statement around Dubbo and what we were trying to do with
7 Dubbo. So we are doing that.

8

9 Usually we are looking at expanding sites out, so we
10 will look at trying to work with regional, we'll talk to
11 the private sector about trying to get private and public
12 together as well. Usually with the metropolitan area, we
13 don't.

14

15 Q. Just taking Dubbo as an example while we're on it, do
16 you know whether that was an initiative of Dubbo or the LHD
17 or, on the other hand, an initiative of the college to try
18 to develop a network or an accredited site with Dubbo?

19 A. I'm not certain. I believe it was RANZCR that started
20 that up.

21

22 Q. Sorry, I just missed that.

23 A. I'm not certain but I believe it was RANZCR that
24 started the discussion around that.

25

26 A. RANZCR, okay.

27 A. Yes, apologies.

28

29 Q. And ultimately that didn't proceed; is that right?

30 A. That's correct.

31

32 Q. Can I just take you to paragraph 155 of your statement
33 on page 22. You've described some what you describe as
34 "bureaucratic hurdles" in that paragraph. Are you able to
35 elaborate for us on what specifically those hurdles were
36 from the college's perspective?

37 A. Yes. As we've put into the witness statement, there
38 were issues around insurances, superannuation, length of
39 service - pardon me. I must apologise, I've got a bit of
40 a sore throat so occasionally I will clear my throat. I do
41 apologise.

42

43 So there were a range of employment-type issues that
44 our team were trying to move forward and it seemed to be
45 too hard for the NSW Health department to get over some of
46 these hurdles.

47

1 Q. So when you say, for example, "employment-type
2 issues", you've identified some issues here around --

3
4 THE COMMISSIONER: Q. Yes, what was the issue, for
5 example, whether the trainee was employed by NSW Health or
6 the individual hospital or the LHD?

7 A. I'll have to take that question on notice. I didn't
8 get down to that level of detail. I was being reported up
9 to that these were the issues they were facing.

10
11 Q. Okay. And the other complications that you've
12 mentioned, leave allowances, super, salary packaging,
13 et cetera, what was the detail of the difficulty there?

14 A. Again, I was only getting a report up to me, so
15 I didn't actually get involved in the negotiations of that.

16
17 THE COMMISSIONER: We might need to follow that up to make
18 sense of that paragraph, I think.

19
20 MR FULLER: Q. Mr Findley, do you have any observations
21 about the advantages or disadvantages of radiology training
22 being delivered in a network structure generally?

23 A. What we find is that rarely any one site will give
24 a trainee the full spectrum of skills and experiences that
25 they require to be, frankly, one of the best trained
26 radiologists in the world when they come out and a good
27 general radiologist.

28
29 We also wish them to have more than one hospital
30 experience as well. So even in the best hospitals, I think
31 it's four years' maximum in one hospital site we have, we
32 find that when you have different experiences and different
33 circumstances, different population areas, you gain more,
34 you learn more, you learn different things. So it's a core
35 part of our development that they do experience different
36 areas.

37
38 Q. Would we be right in understanding that the network
39 structure is actually a requirement that your college has;
40 in other words, it's not just, in the case of your college,
41 something that's being implemented at the NSW Health level,
42 but you actually require radiology training to be completed
43 within a network; is that right?

44 A. I'm not certain that that's always the case. I know
45 that we have people inside networks, occasionally they will
46 leave and get jobs elsewhere or they'll move, and they'll
47 move networks. Does that answer your question? I'm not

1 sure I got it all.

2

3 Q. Sure. Do you know whether radiology training is
4 delivered in networks outside of New South Wales?

5 A. Yes, it is.

6

7 Q. Can you have a look, please, at paragraph 62 of your
8 statement, which is on page 11.

9 A. I'm just getting there. Yes, 62, yes.

10

11 Q. In the first sentence of that paragraph you say:

12

13 *Traditionally RANZCR trainees were selected*
14 *by the local network with no involvement by*
15 *RANZCR.*

16

17 Then you go on to describe RANZCR introducing a selection
18 into training program. Are you able to elaborate on what
19 that program is?

20 A. Certainly. This is something that traditionally we
21 didn't have a selection into training program managed
22 centrally across the country by the college, and the
23 Australian Medical Council, the AMC, who are the regulators
24 of our college, insisted as one of our conditions, or one
25 of our standards and conditions, that we introduce
26 a selection into training.

27

28 So what we have done, starting this year, is we are
29 doing a - we're building a program where the college takes
30 the first step and looks at the resumes from the people
31 coming in and grades them, and then sends them back out to
32 the local area network for final interviews and selection.
33 And the AMC wanted that to happen to make sure there was
34 fairness in process and that under-represented groups were
35 being given a fair assessment piece and there were no
36 adverse or unanticipated differences between the various
37 networks.

38

39 Q. Do you have a view as to whether it's a positive
40 development that the college is now involved in that part
41 of the selection process?

42 A. From the point of view of ensuring consistency and
43 ensuring that the very best candidates get through to the
44 interview, yes, I do. I believe that's a good thing,
45 a positive thing.

46

47 Q. Do you see any role or reason for the college's role

1 in selecting trainees to expand in the future?

2 A. That would be a bit of speculation. I think it's
3 important, at least at the moment, that the networks have
4 a say in who gets selected into their network because they
5 will be the ones that have to work with them for the next
6 five years, develop them, grow them.

7

8 Q. Coming now to the accreditation standards, those
9 standards are - so the college's accreditation standards
10 for sites are developed by the college; that's right?

11 A. Correct.

12

13 Q. You've told us in your statement that the college
14 standards need to meet the Australian Medical Council's
15 standards; that's right?

16 A. Correct.

17

18 Q. They aren't approved by the Australian Medical
19 Council; that's correct?

20 A. The Australian Medical Council provides standards and
21 conditions for us to operate under and then they come and -
22 they're not prescriptive so much, they'll give you
23 a boundary to work within, and then they'll review us on
24 a regular basis. They'll come out and they'll assess it.
25 They'll tell us whether they believe that the accreditation
26 program we're working on and the standards we're setting
27 are an appropriate match with them.

28

29 Q. Are we right in understanding that, in effect, your
30 college is, from time to time, accredited by the Australian
31 Medical Council to deliver its training program; is that
32 a fair understanding?

33 A. That's correct.

34

35 Q. And do you know how often that accreditation process
36 at the medical council level happens?

37 A. It depends on how you are performing as a college. My
38 understanding is they could - the AMC could review you and
39 only give you a six-month leeway before they come back and
40 investigate again. At the moment, RANZCR's been given out
41 to 2027 as an accreditation, and we've been told that if we
42 continue the way we are, we are potentially likely to go
43 out to 2030. The maximum that they can allow between full
44 reviews is 10 years, and that would be our 10 years.

45

46 I think it's fair to say we were last investigated -
47 sorry, not investigated, reviewed last year, that was

1 called a mid-tender review. I say in the witness
2 statement, it's a user-pay system, they charge us about
3 \$100,000 for that review, so you can sort of get an idea of
4 how thorough the review was, and that's where we were given
5 approval to continue forward.
6

7 Q. And did that review process include the Australian
8 Medical Council reviewing the college's accreditation
9 standards for training sites, do you know?

10 A. It covers that as well. There's 10 standards in all,
11 and one of those is CPD Homes that they've pulled out, so
12 yes, it includes the whole gamut.
13

14 Q. At the moment, the Australian Medical Council doesn't
15 require colleges to follow any particular procedure for
16 developing their own accreditation standards; is that
17 correct?

18 A. Again, they operate within a framework that they
19 allow - understanding that different colleges operate in
20 different ways and it would be very difficult to get all
21 16 colleges to operate exactly the same, they allow you the
22 flexibility to produce the standards as best set for your
23 sector and then they will have a look at that and assess it
24 against their standards to make sure it meets.
25

26 Q. Are you familiar with the National Health Practitioner
27 Ombudsman report?

28 A. Yes, I am.
29

30 Q. Are you aware that one of the recommendations from
31 that report was that the Australian Medical Council develop
32 a procedure for colleges to develop their own - to follow
33 in developing their own accreditation standards?

34 A. Yes, I am.
35

36 Q. Do you think that's a good idea or not?

37 A. My understanding of that recommendation is it will not
38 be a prescriptive, "You must follow this", you know, tick
39 box (a), tick box (b), tick box (c). It will still be
40 a framework in which the colleges can develop their
41 standards. I can say we are developing a new accreditation
42 program which will be launched officially on 1 January
43 2025. We have presented that to the Health Workforce
44 Taskforce and the team under that are implementing the NHPO
45 report. They've had a look at it and they are telling us
46 at the first level that it is entirely acceptable, so
47 they're actually mapping exercises across to it.

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Q. If the AMC were to develop a prescriptive procedure for colleges to prepare their own accreditation standards, would you think that would be a good idea or not?

A. I think it would be an idea fraught with danger and it would be a very difficult thing to implement. I believe you're better off with your - any accreditation program, of looking to be outcomes generated and to allow the flexibility for differences to allow.

Q. At a general level, though, would you agree that consistency in accreditation standards across colleges is desirable?

A. Within the differences that operate within each of the colleges, yes, and that's what the AMC is attempting to achieve with its standards as they currently work.

Q. I think you said a moment ago that you thought accreditation standards should be outcomes based. Did I understand that correctly?

A. Yes, you did.

Q. What do you mean by that?

A. I mean that, again, you can say, for example, "You will enter in the front door, you will paint this wall black and you will paint that wall blue and that will be everything you need." It may not give you the outcome you need. If you say that the outcome is that the trainees in a site are learning and they're growing and their surveys back to us are high quality and we're seeing that the ratios are in place and it's working well, that's more of an outcomes focus. So you can, I believe, become too prescriptive and miss the intent of what you're trying to achieve by trying to tick the boxes.

Q. Just thinking about the idea of ratios for a moment, that's more a process-based measure, isn't it, rather than an outcomes-based measure?

A. It's set, as I understand it, working with similar colleges around the globe and what they find their training works and how it operates effectively and efficiently, and with a good deal of experience in outcome. I can't go any further than that.

Q. What do you view as being the function of the college's accreditation standards generally?

A. We wish to see very high quality radiation oncologists

1 and clinical radiologists trained and graduated to
2 basically serve the population of the country that they're
3 serving in, and what we want is great outcomes for all of
4 the local health of the nation and so we put a lot of time
5 and effort into making sure our people are amongst the best
6 in the world at that, and I should say, they're also
7 generalists when they come out.

8
9 Q. Do you view the accreditation standards or
10 accreditation process as a way of establishing and
11 upholding more general professional standards for the
12 practice of radiology going beyond the delivery of training
13 programs?

14 A. I'm sorry, could you say that again? Something just
15 dropped out.

16
17 Q. Do you view the accreditation standards or process as
18 a way of establishing and upholding more general
19 professional standards for the practice of radiology going
20 beyond the delivery of training programs?

21 A. I would say that when we're looking at the
22 accreditation standards, we wish to make sure that the
23 sites that the trainees are in are operating to an
24 acceptable standard for them to experience what they need
25 to become top-class graduates. I think that answers your
26 question, sorry.

27
28 Q. Thank you. Do you view it being any function of the
29 accreditation process for the college to try to achieve
30 better working conditions for its fellows?

31 A. The college doesn't get involved in industrial
32 relations matters. That tends to be the remit of the AMA
33 or of groups of the fellows on their own. So we don't
34 advocate for pay and conditions.

35
36 Q. Are you aware that one of the accreditation standards
37 for clinical radiology is a maximum number of examinations
38 per consultant?

39 A. Do you mean exam attempts or --

40
41 Q. No. Let me show you the document. It's not in the
42 tender bundle. The document number is
43 [COR.0002.0006.0001]. Mr Findley, you will see it come up
44 on the screen shortly. Can we scroll to page 0021,
45 page 21, I think.

46
47 Mr Findley, I'm referring to about halfway down the

1 page, criterion 2.2.6. Can you read that at all?

2 A. Yes, slowly.

3

4 Q. Just let me know when you have --

5 A. Yes, I can see it now. I mentioned to Elizabeth from
6 your team, she told me that you may be referring to this
7 document today. I told her before the meeting, I've never
8 seen this document before or read this document before,
9 anything in the document I'd have to take on notice.

10

11 Q. That's fine. Just looking at it now, though - and
12 tell me if you can't answer this, sitting here now -
13 a criterion about the maximum number of examinations per
14 consultant that's really about achieving what the college
15 regards as an appropriate workload for its fellows, isn't
16 it?

17 A. I don't believe I can answer that at the moment.
18 I may need to take that on notice and come back to you.

19

20 Q. All right. Thank you. That document can be taken
21 down.

22

23 Mr Findley, can you go to paragraph 76 of your
24 statement.

25 A. Sure.

26

27 Q. You see in that paragraph you've told us that the
28 college has required ratios of consultants to trainees.
29 Have I understood that correctly?

30 A. That's correct.

31

32 Q. Do you accept that this will have the practical
33 consequence of limiting the number of trainees who may be
34 engaged at a given site?

35 A. It could be seen that way, yes.

36

37 Q. In that way, it would be right to say that the college
38 does have a practical influence on trainee and consultant
39 numbers - that's not being critical, but just as a matter
40 of practical reality?

41 A. No, I would disagree with that. What I would say is
42 our interest is in having trainees put into a site where
43 they've got a great chance of learning and being able to
44 complete their course. So what we say is, "If you've got
45 those conditions, these are the numbers that we believe
46 you'll have that will enable you to train them properly to
47 get them out the other end." Any more trainees than that,

1 you risk potentially losing all of them.

2

3 Q. Accepting that rationale, but just as a matter of
4 practical reality, the ratio will limit the number of
5 trainees who can be trained at a given site, assuming there
6 are a given number of consultants at that site; that's
7 right, isn't it?

8 A. If the site chooses to only put one consultant on,
9 then the trainees - yes, it will be a function of the
10 choices they make, yes.

11

12 Q. So there are two ways that a site might achieve the
13 ratio that the college requires. One is by increasing the
14 number of consultants; that's right?

15 A. Certainly.

16

17 Q. And the other is by reducing the number of training
18 positions at the site?

19 A. That's correct.

20

21 Q. Do you also accept that - or do you accept that rural
22 and regional sites might find it harder to meet the
23 college's accreditation standards than metropolitan sites?

24 A. There will be sites where it will be tougher to take
25 the numbers - yes, you're right. I mean, a huge hospital,
26 teaching hospital site, in central Sydney, it is going to
27 have the resources, the departments, the people on call.
28 It's one of the reasons we try to use networks is to give
29 the trainees an optional round, and so if we could have
30 broader networks, networks covering private/public,
31 networks covering interstate, that would help.

32

33 Q. Tell me if you can't answer this, but would we be
34 right in thinking that Dubbo is an example of a site that
35 was not able to meet the college's accreditation standards
36 as they stood?

37 A. My understanding was it was more issues to do with the
38 employment conditions rather than the clinical side that
39 precluded Dubbo moving forward, was my understanding.

40

41 Q. And is that employment conditions in the sense of the
42 number of supervisors who are available?

43 A. What we said in the case study was things like
44 superannuation, length of service, yeah, those sorts of -
45 the employment pieces underneath. The clinical - it was a
46 different priority, different --

47

1 THE COMMISSIONER: The answer the witness just gave
2 relates to employment conditions for the particular
3 employee. You were asking about accreditation standards,
4 which I think are different. Was there an accreditation
5 standard you had in mind that it was difficult for Dubbo to
6 achieve or meet?

7
8 MR FULLER: Maybe I'll try to approach it in a different
9 way, if I might, Commissioner.

10
11 THE COMMISSIONER: Yes.

12
13 MR FULLER: Q. Mr Findley, is it the case that Dubbo was
14 a site seeking to be accredited with the college but not --
15 A. I can't answer whether they stood to be accredited or
16 we started that process. I don't have that information.

17
18 Q. But either way, they're a site that is not currently
19 accredited by the college and, by some mechanism, the
20 college was considering whether or not they should be
21 accredited; is that right?

22 A. That's correct.

23
24 Q. And then it was in that context that the college and
25 management at the Dubbo site were communicating about
26 whether the Dubbo site was able to be accredited; is that
27 the effect of what was happening?

28 A. That's correct. The information I have is it was the
29 employment conditions that precluded that moving ahead.

30
31 THE COMMISSIONER: Q. The statement tells us that RANZCR
32 faced challenges in setting up Dubbo, which, to me, I read
33 that as they wanted to do it but they had challenges, and
34 that the Commonwealth had provided funding for it to be
35 done. That's in 154 I'm reading from?

36 A. Yes, that's --

37
38 Q. And then 155, which you've already been taken to, sets
39 out, without perhaps all the detail which you said you'd
40 want to take on notice, the employment conditions.

41 A. Sure.

42
43 Q. I mean, I'm not criticising anyone, but that doesn't
44 tell me what the accreditation issue might have been prior
45 to this, before this funding. To try and get a - and
46 I don't even know whether it is important, either.

47 A. Yes, I will have to come back to you, if you like, and

1 take it on notice about whether the clinical side was
2 appropriate.

3

4 Q. Yes, okay.

5 A. Yes, I would say if they're in negotiations with
6 Dubbo, then the clinical side is likely not to have been
7 the issue, if it was people's employment condition had
8 stopped it. So we'll come back and we'll confirm that for
9 you.

10

11 MR FULLER: Q. Can I just ask you this today, and again
12 tell me if you can't answer it, but setting up Dubbo as
13 a regional and rural training program site, even if that
14 was funded by the Commonwealth, your college still had to
15 accredit Dubbo in order for it to deliver the training;
16 isn't that right?

17 A. That's correct.

18

19 Q. And that was where the issue arose?

20 A. The issue wasn't us accrediting; it was whether they
21 met the standards that needed to be met.

22

23 Q. The college's accreditation standards, that is?

24 A. Sure.

25

26 Q. Perhaps you can come back to us on that. I'll just
27 leave it for the moment.

28 A. Okay.

29

30 Q. Would we be right in understanding that, from time to
31 time, trainees and fellows of the college might raise
32 concerns with the college about their working conditions?

33 A. That's correct.

34

35 Q. Those might include concerns about matters such as
36 staffing levels?

37 A. I haven't directly heard it but I would assume that
38 they would be amongst what they've - they could complain
39 about, yeah.

40

41 Q. Have you heard of trainees or fellows raising concerns
42 about workload with the college?

43 A. I haven't directly but me team may have.

44

45 Q. But you're personally not aware of that?

46 A. I can't point to an example. Again, I tend not to
47 hear about things until they're escalated up, so if the

1 survey is coming back and saying, "We're not happy about
2 this", "Not happy about" - oh, sorry, I should say, can
3 I modify that answer? There was one I'm aware of, there
4 was one hospital in Sydney. Where NSW Health were pushing
5 back on the accreditation piece and saying they had
6 a different model of operating and we had told them that
7 they were without a consultant on a number of days but
8 I don't know whether that was the trainees complaining
9 about that or we had assessed that ourselves.

10
11 Q. I think this is one of the case studies that you have
12 told --

13 A. It's in one of the case studies.

14
15 Q. -- us about. Perhaps if you have a look at
16 paragraph 167 on page 23.

17
18 THE COMMISSIONER: Which paragraph, sorry?

19
20 MR FINDLEY: I'm sorry, 167 on page 23.

21
22 THE WITNESS: Mmm-hmm.

23
24 MR FULLER: Q. Perhaps just familiarise yourself with
25 that paragraph, and then read, please, 169.

26 A. Yes.

27
28 Q. Is that the example you were referring to?

29 A. Yes, it was. Paragraph 170 talks about no consultants
30 on sites for different periods and only one consultant on
31 site for other periods. This was a debate about the ratio
32 of consultants to trainees. The hospital site was saying
33 "Well, we had a backlog. We had people working on the
34 backlog. They're still consultants and you should be more
35 flexible in your model because they're out there." But
36 they were basically ploughing through the backlog of images
37 to get those through rather than helping trainees and being
38 available to help trainees and work with trainees.

39
40 Q. Is that one of the situations where you became
41 involved as the CEO?

42 A. Yes.

43
44 Q. Are you aware of situations where trainees or fellows
45 of the college have raised concerns with the college about
46 matters of bullying or harassment or broader cultural
47 issues at the site?

1 A. Yes, I am.

2

3 Q. If the trainee or fellow raises those kinds of issues
4 with the college, are we right in thinking that the college
5 will generally take up those issues on behalf of the
6 trainee or fellow with the relevant health organisation?

7 A. What the college would do is, depending on how the
8 issue is raised with us, if it's a survey, if it's an
9 anonymous complaint, if it - that's one way. If it's
10 a trainee that has complained to one of our people, we will
11 actually advise the trainee on the processes that are
12 available to them, which may be the EAP, it may be internal
13 systems in NSW Health as the employer, that they should
14 follow. We will raise it with the site itself and it will
15 feed its way into the accreditation at some point in time,
16 and particularly if it's multiple complaints and over
17 a period of time.

18

19 Q. And in terms of feeding in to the accreditation, it's
20 the case that, from time to time, the college will rely on
21 those sorts of bullying or harassment or cultural issues
22 raised by trainees or fellows as a basis for either
23 withdrawing accreditation, downgrading accreditation or
24 taking some other action in relation to a site's
25 accreditation?

26 A. It will form part of the decision.

27

28 Q. Do you appreciate that where these sorts of what I'll
29 call cultural issues are raised, that may be in the context
30 of a broader workplace dispute at the particular site?

31 A. It could potentially be so.

32

33 Q. Do you accept that there's a risk that if the college
34 were to make an adverse decision about accreditation based
35 only on the information provided to it by its trainees or
36 fellows, it might, unwittingly, become a participant in a
37 workplace dispute?

38 A. We rely on a range of factors when we assess a site
39 and accredit a site. There is rarely one thing that would
40 tell us to come down to a D level, and usually it's a range
41 of things that are happening and it's - things like this
42 come from multiple sources. So it's - when you see a site
43 like this, it's usually ratios aren't right, the culture is
44 not right, training outcomes aren't where they need to be -
45 there's a whole range of things. So it forms part of the
46 general pattern.

47

1 It's much more sophisticated and complex in the way
2 it's looked at. Rather than a trainee complains or
3 a fellow complains and the college says, "Well, there's
4 a complaint, you're down to a D." Again, it's over a time
5 period as well, and it's a number of complaints as well.
6 And often, when we talk to NSW Health - if it is
7 NSW Health - when we talk to NSW Health about it, they will
8 acknowledge that those issues are there and, in the case
9 study I provided, they acknowledged those issues were there
10 but they said it was our responsibility, not theirs, to
11 resolve.

12
13 Q. When you say that the issues may be raised by multiple
14 sources, those sources are usually the college's trainees
15 or fellows, aren't they?

16 A. Correct. Sometimes, they might be network training
17 directors, they might be directors of training, they could
18 be the consultants on site, they could be the trainees,
19 yes, but they're all RANZCR members or fellows.

20
21 Q. Do you agree that to the extent that those sorts of
22 issues are raised with the college, it's important for the
23 college to use its best efforts to verify the allegations,
24 and when I say those sorts of allegations, I'm talking
25 about allegations of bullying, harassment, discrimination
26 or what I've called cultural issues?

27 A. Certainly, and we work with the site, we inform the
28 site that we're hearing this. I know that on different
29 sites we've actually had - the site has had independent
30 studies done into it which proves or reinforces the
31 bullying allegations.

32
33 We don't unilaterally hear a bullying complaint and
34 straightaway drop you down to a D or say we've withdrawn
35 accreditation. We work with the site. We work to see what
36 is happening and what could be improved. Again, it's when
37 the site declines to engage or refuses to engage or resists
38 over a period of time and these complaints continue to come
39 up, and they're usually one of a number of different
40 categories of things that happen, that we start to take
41 a stronger view.

42
43 I will also say that we actively fight to not withdraw
44 accreditation, and if you look at some of the case studies,
45 where we should have withdrawn, we continued to try and
46 bring that site back to be on again.

47

1 THE COMMISSIONER: Just before your next question, just so
2 it is clear, I think that Mr Findley covered this in his
3 answer, but your question was:

4
5 *Do you agree that to the extent that those*
6 *sorts of issues --*

7
8 the bullying and what not you were talking about --

9
10 *are raised with the college, it's important*
11 *for the college to use its best efforts to*
12 *verify the allegations, and when I say*
13 *those sorts of allegations, I'm talking*
14 *about allegations of bullying, harassment,*
15 *discrimination or what I've called cultural*
16 *issues?*

17
18 Your question was in the context of accreditation, was it?

19
20 MR FULLER: Yes, I think that's right, Commissioner, yes.

21
22 THE COMMISSIONER: Okay. I think the witness answered
23 from the point of view of accreditation.

24
25 MR FULLER: Thank you, Commissioner.

26
27 THE WITNESS: Thank you, Commissioner.

28
29 MR FULLER: Q. Do you also accept, Mr Findley, that in
30 relation to those sorts of cultural issues being raised
31 with the college, it's important for the college to ensure
32 that management at the site has a fair opportunity to
33 respond before the college takes any action adverse to the
34 site's accreditation?

35 A. Certainly, and we do inform the management of those
36 when we see them.

37
38 Q. Does the college have a particular policy or procedure
39 dealing with - a policy or procedure for dealing with those
40 kinds of allegations?

41 A. I may have to take that on notice. I'm not sure of
42 the exact answer on that one, I apologise.

43
44 THE COMMISSIONER: Can I just go back to accreditation
45 generally, just so that it's clear what the college's
46 position is.

47

1 Q. Mr Findley, I think in one of your answers to
2 Mr Fuller about the ombudsman's report, you said you didn't
3 view, or the college didn't view, it as being prescriptive
4 in relation to standards and I certainly think that's
5 right. Is it your understanding, firstly, that amongst all
6 of the recommendations the ombudsman made, the first was
7 that there should at least be agreement between the AMC and
8 the various colleges about what the procedure should be for
9 developing standards - that's your understanding, as
10 a first step?

11 A. Yes. Yes. Yes.

12

13 Q. And then perhaps what might be the only prescriptive
14 thing is that when those standards are developed, they have
15 to be - and Mr Fuller has used these words and I think you
16 have agreed. Whatever those standards are, they should be
17 outcome centric and evidence based, which is what the
18 ombudsman's language is?

19 A. Correct.

20

21 Q. That doesn't mean they have to be particular
22 standards, but they have to at least be of the kind that
23 can be said to be outcome centric, which I take to mean
24 those standards will produce well-trained, in your case,
25 radiologists, and that they will be evidence based in the
26 sense that they will be based on some form of proof that
27 those standards produce well-trained fellows; correct?

28 A. The other thing the NHPO says - and I'm paraphrasing
29 that --

30

31 Q. But forgetting that, just before, you --

32 A. Oh, sorry.

33

34 Q. Do you agree that that is a perfectly reasonable
35 recommendation?

36 A. I believe the outcomes-based recommendations are fine.
37 That's what we would prefer.

38

39 Q. And in terms, I think, of how standards are set or
40 what the standards should be, and again, I agree they're
41 not prescriptive and it would be hard to know how they
42 could be, but I think the recommendation is, or the
43 commentary is, there should be minimum standards, like,
44 these are the minimum standards that should be met; then
45 there is what are referred to as normative standards, these
46 are the ones that should be there to ensure we get good
47 training; and then there's the aspirational, this is what

1 we should work towards to achieve something even better
2 than the minimum or well-trained graduates. Is that
3 a reasonable framework, in your view, as well?

4 A. The NHPO report talks about - and I'm paraphrasing -
5 it's making the minimum possible standards essentially
6 focused on the outcomes that you need. So what you've just
7 said I think is right, and we believe that is a good way
8 for all the regulators to operate.

9

10 THE COMMISSIONER: Okay, great.

11

12 MR FULLER: Thank you, Commissioner.

13

14 Q. Mr Findley, can you have a look, please, at
15 paragraph 166 of your statement on page 23.

16

17

18 Q. You've extracted there another recommendation of the
19 NHPO report which relates - and feel free to read it - to
20 developing a framework for managing concerns about
21 accredited specialist training sites and then also dealing
22 in that framework with how to deal with bullying,
23 harassment, racism, discrimination and similar kinds of
24 concerns. Do you see that?

25

26

27 Q. Do you disagree with that recommendation or do you
28 agree with that recommendation?

29

30 THE COMMISSIONER: Q. Well, perhaps, why do you say it
31 was disappointing, in 166? What's disappointing to you and
32 your college about recommendation 13?

33

34 A. What was disappointing to me was the meeting we had
35 with NSW Health where they told us it was our
36 responsibility to deal with bullying complaints on one of
37 their sites because they were RANZCR members. We very
38 clearly said to them at the time, "We don't have the power
39 to go on to your site to investigate. We don't have the
40 power to compel people to speak and we can't find against
41 any of those people or put sanctions on."

41

42 Q. Pausing there, then, is the disappointment - tell me
43 if I'm wrong - that you wanted the ombudsman to clarify
44 that there's a role for the employer here as well?

45

46 A. I was more disappointed that we knew the NSW Health
47 people involved in that conversation had strong input into
47 the NHPO, and then this has come up as a recommendation.

1 We saw that as within the law, the law is fairly blunt on
2 this one, as much as the law can ever be, about the role --

3
4 Q. You mean workplace laws, you're talking about?

5 A. Workplace law. And that the role of the employer was
6 there. We saw this recommendation as seeking to re-examine
7 that and we just - when you look at the other
8 recommendations of the NHPO report and the quality and the
9 advancement that it takes, we saw this as something that
10 wasn't the same standard as the other pieces.

11
12 Q. I have to say from my perspective, I would read the
13 report and that recommendation as not involving any
14 derogation from the employer's duties in relation to any
15 workforce laws, but I at least understand where you're
16 coming from in relation to what you've said there in that
17 paragraph, in any event.

18 A. Thank you, Commissioner.

19
20 MR FULLER: Q. Mr Findley, leaving aside your
21 disappointment about how the recommendation may have come
22 about, do you disagree with the recommendation itself,
23 which is - and tell me if you think I have got this wrong -
24 really about the college developing a framework for how it
25 approaches concerns of bullying and harassment,
26 discrimination and similar matters?

27 A. I believe that there is a framework that already
28 exists within the workplace law and that the college should
29 follow the workplace law, and I suspect when this is
30 investigated and produced, that's probably what will come
31 out of it.

32
33 Q. It's the case, though - tell me if I've misunderstood
34 you but you've told us that from time to time, the college
35 will take accreditation action against a site on the basis
36 of issues of bullying, harassment and other cultural
37 matters that are raised by trainees and fellows? I have
38 understood that correctly?

39 A. Once we have told the site and asked the site to take
40 action and the site has declined to or it hasn't been able
41 to, for whatever reason, that may form part of the future
42 decision as to their accreditation level, yes.

43
44 Q. And I think you agreed with me earlier that the
45 college - it was important for the college to use its best
46 efforts to verify any of those sorts of allegations that it
47 might rely on?

1 A. We do this by going back through the site and asking
2 the site to conduct their investigation.

3

4 Q. And you agree with me, I think, that it's important
5 for the college to ensure that management at the site has
6 a fair opportunity to respond before you take any
7 accreditation action? I think you've told us of the ways
8 that your college does that?

9 A. That's correct.

10

11 Q. Have I understood that correctly?

12 A. That's correct.

13

14 Q. Is there anything wrong, then, with those sorts of
15 steps being reflected in a policy, procedure or other
16 framework developed by the college?

17 A. I - sorry, could you say that again?

18

19 Q. Is there anything wrong with - assuming I have
20 understood, just take it from me that the NHPO
21 recommendation is that the college has a fair and
22 transparent framework for dealing with concerns about
23 bullying, harassment and similar matters that are raised
24 with it. Assume that I'm right about what that means. Is
25 there anything wrong with that?

26 A. The issue we have with that is it needs to be
27 consistent with current law. So if we see something, we go
28 back to the employer and we ask the employer to
29 investigate. That's the process, if you like.

30

31 Q. But if that's the case, in circumstances where, as you
32 say on the college's view, the college can't make
33 determinations about these sorts of bullying and similar
34 issues itself, do you think it's appropriate for the
35 college to rely on those sorts of matters to take
36 accreditation action against a site?

37 A. Again, it's rarely one thing, almost never one thing
38 that says a site is not performing where it needs to. It
39 tends to be a whole combination of things. This could be
40 one of them.

41

42 What we are saying is not that, "If we hear an
43 allegation of bullying we will withdraw your
44 accreditation"; what we are saying to the sites is "We are
45 hearing credible statements from your people that there's
46 some sort of cultural issues on your site. You need to
47 address those and tell us how you're addressing those and

1 make sure that they're being proved for your site to lift
2 its accreditation standard beyond the D". So they have the
3 opportunity to rectify, they have the opportunity to come
4 back and talk to us, they have an opportunity to show how
5 they are addressing those issues.
6

7 Q. Is it the case that the college will always wait for
8 the employer to have investigated and resolved those issues
9 at the employer level before it takes any accreditation
10 action against the site?

11 A. My understanding in my time, at least, we've never
12 taken immediate accreditation withdrawal on a site.
13

14 Q. In circumstances where, as I understand your evidence,
15 you say the college isn't in a position to investigate or
16 take action in relation to these sorts of bullying and
17 similar allegations, do you think it's appropriate for the
18 college to wait for the employer to deal with those matters
19 before taking any accreditation action in reliance on those
20 matters, perhaps, among other things?

21 A. The college will always reserve its right on
22 withdrawal of accreditation. I can't think of an incident
23 at the moment, but if we ever came across an incident that,
24 for the safety of our trainees, meant we had to withdraw
25 accreditation immediately, we would do so. I cannot think
26 of a time that we would, and we haven't. So we always try
27 and work with the jurisdiction to try and improve and to
28 work and to bring them back up again. It really is not in
29 our interest to withdraw accreditation on a site.
30

31 Q. Would you agree that it would, at least leaving aside
32 circumstances of urgency, not be appropriate for the
33 college to withdraw or downgrade accreditation on the basis
34 of bullying or similar allegations that have not been fully
35 investigated and dealt with at the site level?

36 A. No, I wouldn't say that. Two things. There is
37 a difference between "downgrade" and "withdraw" - a very
38 big difference. And again, if a site refuses to
39 investigate and we continually ask them and we continually
40 hear that there's something going on and the site tells us,
41 "There's nothing wrong, we're fine. No, we don't need to
42 investigate", we may decide to - as a package of a whole
43 range of things probably going on, we could potentially
44 withdraw after a period of time. So we reserve that right.
45

46 Q. If, for example, on the other hand, the college saw
47 that the site was investigating the allegations, even

1 though they hadn't yet finished that investigation, would
2 the college give them the opportunity to do that before
3 taking action?

4 A. The college has and does work with sites that have
5 done that and we do work with them where we hear they're
6 trying to make changes. I think I mentioned before, there
7 is normally a limited period of time they can sit on a D
8 level before they lose accreditation. We have extended
9 that because we have seen that they are making efforts to
10 try to improve, so we work with them.

11
12 Q. You have provided several case studies from
13 paragraph 154 of your statement, which you've mentioned
14 earlier. You see those? You know what I'm talking about
15 there?

16 A. Yes.

17
18 Q. Without getting into the details of those case
19 studies, is it fair to say that these are situations where
20 the relationship between the college and the district or
21 the ministry, as the case may be, became strained?

22 A. I think they're at a point where there has been some
23 discord or there's been some debate about whether the
24 accreditation process has been where it needed to be or
25 whether they're trying something different and they should
26 be given credit of it. It's often not a - it's not
27 a breakdown of a relationship, it's a testing of different
28 viewpoints oftentimes.

29
30 Q. Would it be right to say it's a robust dialogue
31 between the college and individuals in the relevant health
32 organisation from time to time?

33 A. I would say that would be correct, yes.

34
35 Q. Several of the case studies you've identified were
36 situations where the college became - well, it took action
37 on the basis of matters including bullying, harassment and
38 similar cultural issues; would you agree with that?

39 A. Yes.

40
41 Q. And tell me if you don't know, but they include, don't
42 they, occasions where the college at least downgraded
43 accreditation without itself having been able to verify
44 allegations that had been made by trainees?

45 A. I can't give you the reasons why downgrades happen.

46
47 Q. Were there any - are you aware of this - situations

1 where the college withdrew accreditation on the basis of
2 allegations that it had not been able to verify?

3 A. No, if you're talking about the case study where we
4 said that continued cultural issues were happening inside
5 the site and then it was withdrawn, there were more things
6 happening than that, and it was including trainee outcomes
7 were not where they needed to be. It's where - and I will
8 say, too, if we believe trainees are in danger, we have an
9 overriding obligation for the safety of those trainees
10 under the AMC and that is one area we would withdraw
11 accreditation, so - but again, it tends to be a mixture of
12 things rather than one single issue.

13
14 Q. Do you think anything could have been done at
15 a systems level to avoid or mitigate the, as you have
16 described it, discord in the relationship that occurred in
17 these situations?

18 A. Maybe if I put it to you this way: we operate across
19 Australia and New Zealand. I'm brought in only when things
20 get difficult. In my three years here, I've had one
21 situation in Adelaide, which was resolved with one meeting;
22 one situation in Victoria, which was resolved with one
23 phone call; and the rest are all New South Wales.

24
25 Q. And how many would "the rest" be?

26 A. Well, the ones I've given you.

27
28 THE COMMISSIONER: The case studies.

29
30 MR FULLER: So six case studies.

31
32 THE WITNESS: The case studies. Well, sorry, some of
33 those case studies refer to the same site, different people
34 coming at us about the same site, so --

35
36 MR FULLER: Q. Do you have any reflections on why the
37 college has experienced that different situation in
38 New South Wales?

39 A. This is not a formal RANZCR position, this is
40 a personal CEO position. We tend to find most other sites
41 want to work with us to try and resolve the issue and when
42 we approach them they say, "What can we do? How can we do
43 this." "This is a problem we can't resolve, we're not sure
44 how to." And we will work with them on a fairly intensive
45 basis to try and bring them across.

46
47 Even within New South Wales, I should say, we had

1 a meeting with St George Hospital on Monday and they've got
2 a new CEO there, Graeme Loy, and the meeting with him was
3 just a joy, and I've worked with Graeme, against Graeme, if
4 you like, on some very tense times in the past, and one of
5 the things he said was, "Look, we're getting better now.
6 We've addressed 10 of your 14 conditions. What else can we
7 do to help you as a college?" We walked away from the
8 meeting going, "We can work with him. This is fantastic.
9 How wonderful is this." We're confident now that that
10 hospital will move up.

11
12 So it tends to be the attitude of the person there or
13 the people in there, and if they're willing to help -
14 again, we don't want to shut anyone down, we don't want to
15 withdraw accreditation, we want our trainees to have
16 a great experience, we want the health population of
17 New South Wales to have proper health care. We try
18 everything we can to continue that on. So I'm on my
19 soapbox a little bit there, I'm sorry about it, but did
20 that answer your question?

21
22 Q. Can you just tell us, since you've mentioned it,
23 St George, is that one of the case studies you've provided?

24 A. Yes, it is.

25
26 Q. Are you able to identify which one it is?

27 A. Yes, case study 3 and it was also case study 4.

28
29 Q. Do you have any reflections on things, just sitting
30 here now and looking back on these case studies, on things
31 that the college might have done differently in managing
32 those situations?

33 A. Look, I'll say up-front, this is rarely one side - all
34 fault sits on one side. There are things that we can do
35 and will do better, and whenever we have one of these
36 situations we have an internal discussion and decide what
37 we could have done differently, what we could have done
38 better. We are very much an organisation with that
39 continual learning piece and we really do sit down and do
40 that. We do talk about the personalities that we may face
41 in these areas and how we best can connect with them to try
42 and get them over the line. So we do reflect on that.

43
44 With the St George situation, and now I'll name it,
45 there were some accusations made against our visitation
46 team. We actually brought our visitation team in. We
47 talked to them about it. We put those to them. We worked

1 through what they said and how they said it. We
2 acknowledged that there may have been different ways to say
3 what we had said, and we will improve in the future. So we
4 do that on a regular basis.

5
6 Q. Is there any systematic process within the college for
7 reviewing these sorts of situations and trying to take on
8 board lessons from them?

9 A. I just described what we did.

10
11 Q. Do you have any policy or procedure for dealing with
12 that or it's something that you do when you recognise that
13 a situation perhaps deteriorated in a way that it might not
14 have?

15 A. Whenever we have a difficult - if it's a great
16 situation and there's no outcomes, we don't really have any
17 debrief session on it. It's where there's an issue, where
18 things may not have gone the way we wanted them to and we
19 talk through that to make sure that we are trying to
20 operate as best we can be, recognising again that no-one's
21 perfect. We do make mistakes. We have a saying inside our
22 organisation that mistakes shouldn't define you, it's the
23 way you address your mistakes.

24
25 Q. Just one other thing on the case studies, Mr Findley,
26 are you aware that you referred to some handwritten notes
27 in the statement?

28 A. Yes, I do.

29
30 Q. Whose notes are those?

31 A. They're mine.

32
33 Q. What, if anything, would be wrong with a system where
34 the college is responsible for developing curriculum,
35 training standards and administering examinations, but the
36 accreditation function was instead performed by a separate
37 central body on expert advice?

38 A. That is another valid model.

39
40 Q. But do you have any other comments about that, whether
41 it is a good or a bad - whether it would be a good or a bad
42 model?

43 A. Oh, that's speculation. I would have to see the
44 model. I would have to see what it looks like. It
45 probably has advantages and disadvantages. You would need
46 to look at things like cost, who you were using to do it.
47 As I say, the state - NSW Health at the moment is provided

1 the accreditation process for free. It costs us about
2 \$700,000 a year across all states and New Zealand to
3 provide that for the states. A central body is probably
4 going to have to be costed somewhere else. We also use
5 a lot of volunteer members for our services. I doubt they
6 would go for a central body. It's another model.

7
8 THE COMMISSIONER: Q. Any central body, I take it you
9 would agree, would need to have people appointed to it that
10 weren't just nominees, for example, of the ministry but
11 also there was a capacity for nominees from the various
12 colleges to have that sort of expert input into it as well?

13 A. I do believe that in that model you would need
14 experienced clinicians trained in accreditation who can
15 look at a site and know and understand what was going on
16 inside that site.

17
18 THE COMMISSIONER: Yes.

19
20 MR FULLER: Q. Mr Findley, can you have a look, please,
21 at paragraph 13 of your statement on page 3.

22 A. Yes.

23
24 Q. In that paragraph you say that the capacity of
25 clinical radiologists and radiation oncologists faces
26 significant challenges and limitations, some of which you
27 go on to describe. You refer then about a third of the way
28 down the paragraph to surge in demand for services. Do you
29 see that?

30 A. Yes, I do.

31
32 Q. When you're referring to "a surge", over what period
33 have you observed that occurring?

34 A. We are seeing, over the last few years, demand for
35 radiology or diagnostic imaging services lifting by about
36 12 to 14 per cent per annum, and that tends to be
37 a First-World-wide phenomenon, and our workforce is growing
38 by about 1 per cent a year, and so - when I say "surge",
39 I mean, you know, the surge is a trend.

40
41 Q. Those figures that you have given, where do they come
42 from?

43 A. They're comments that we've talked to when we go to
44 the Americans, RSNA, people like that, they will talk about
45 those sorts of numbers and that seems to be where the
46 global is. I don't have a written quote in front of me.

47

1 Q. Sorry, I just missed it, who do you say it came from?
2 A. Sorry, when we talk to the sister colleges around the
3 globe, when we meet with those, that tends to be the figure
4 that's discussed around that area. I don't have --

5
6 Q. Sorry, please finish. Please finish?
7 A. No, it is all right. Sorry, there is a bit of a lag,
8 my apologies. I don't have a number in front of me at the
9 moment.

10
11 Q. Those figures you've mentioned are global figures, as
12 in around-the-world figures?

13 A. Tend to be First World.

14
15 Q. For the First World, did you say?
16 A. Yes. We talk to the Americans, the Canadians, the
17 English, the Europeans, that's the sort of numbers they're
18 talking about.

19
20 Q. Does the college have data about demand in New South
21 Wales?

22 A. I don't believe we do, not a coordinated data in
23 New South Wales, no.

24
25 Q. To what extent does the college have access to data
26 about the supply - the number and distribution of
27 radiologists in New South Wales?

28 A. We know where the radiologists are on the accredited
29 sites because we see those. We don't have data on the rest
30 of those.

31
32 Q. Is that data that it would assist the college to have
33 visibility of?

34 A. It would be nice to have data. We would certainly
35 like that data, and, yes, it - yes, I'll leave it there,
36 but it would be good data to have.

37
38 THE COMMISSIONER: Q. Can I just ask, do you know, the
39 lifting by about 12 to 14 per cent per annum that you
40 mentioned, of the demand for radiology and medical imaging
41 services, do you know what's driving that increased demand?

42 A. Yes, certainly. There's a number of factors. There
43 is more of a drive towards preventative health and
44 screening programs. There is an increasing tendency in the
45 First World countries for people to want to be seen earlier
46 and quicker. There are new technologies which are making
47 imaging things you couldn't image clearly 10 years ago, you

1 can now. Contrast dyes, things like that, and
2 interventional work as well. So this sector is the highest
3 technology impact sector of any of the medical professions.
4 So yes, that explodes.

5
6 Q. For all those reasons. Yes, okay.

7 A. Yes.

8
9 MR FULLER: Q. Is the college's perception that there's
10 a shortage of radiologists in the New South Wales public
11 system?

12 A. The New South Wales public health people tell me there
13 are, and when we talk to them about the numbers, and
14 particularly where they might have more trainees than they
15 have people to supervise them, we've heard complaints from
16 them before where they're saying, "Well, we train them, and
17 then the private sector take them as soon as we've gone, we
18 can't get them."

19
20 We understand that the rate of pay for New South Wales
21 radiologists and radiation oncologists is less than other
22 state systems, most other state systems, and definitely
23 less than the private, and I do also say in our witness
24 statement, we do recognise NSW Health - they've got
25 a dreadful job, we wouldn't want to do it, and they're
26 putting all the money, and all the time and all the effort
27 into the training. So at the end of the training, they're
28 open slather for the private sector, public sector,
29 interstate, overseas. So, yeah.

30
31 Q. You mentioned lower - your understanding of lower pay.
32 Does the college have a position on whether that and
33 anything else are reasons for the shortage of radiologists
34 in the public system?

35 A. Anecdotally our members sometimes say that, for
36 instance, being put on to call on the Saturday night, you
37 may not get that with the private sector, and so the
38 lifestyle is a bit different. They may get better
39 conditions that suit them better around lifestyle and
40 travel and other things, so that it's seen as not only
41 a significant increase in the remuneration but there are
42 other conditions that I'm being told can attach to the
43 private sector as well that the public can't match.

44
45 Q. Are there any other things that you're aware of that
46 may be reasons for there being a shortfall of radiologists
47 in the public system in New South Wales?

1 A. I think there's two things. There's the overall
2 number in the public service, but there's also the mix
3 between regional and rural and the metropolitan systems as
4 well, and they are two different areas to look at. Again,
5 what I understand is the remuneration and conditions tend
6 to bring in people into the private sector. Definitely it
7 would be pay, if they were moving interstate to another
8 public sector. But there is also - we witness, even with
9 IMGs, international medical graduates, coming into the
10 country, they tend to do their time in an area of need and
11 then they tend to gravitate towards the big cities, and we
12 believe, from the anecdotal evidence we have, that there
13 are a number of factors there. One is being closer to
14 their own community, if there's a number of their own
15 community; another one is the opportunity to learn, to
16 develop their careers, to be at the cutting edge of what
17 they're doing, and you can really only get that in the big
18 cities, and to really explore if they are generalists and
19 they want to specialise, to come up and specialise in an
20 area.

21
22 THE COMMISSIONER: Q. Are the things you've just
23 mentioned, including pay, lifestyle, wanting to be in the
24 city for certain kinds of career progression, et cetera -
25 are they similar reasons in relation to the maldistribution
26 that you've talked about in paragraph 133 of the statement?

27 A. Let me look at 133.

28
29 Q. You talked about a significant issue of
30 "maldistribution of clinical radiology resources extends
31 beyond the urban areas", et cetera, and you expand on that,
32 134, 135. What are the issues that are causing that
33 maldistribution, as far as you are aware?

34 A. I do believe, from the anecdotal evidence we have,
35 that there is a remuneration element to it, certainly. If
36 you're an IMG, an international medical graduate, you would
37 tend to want to move closer to where more of your own
38 cultural group are, because, you know, we would all want
39 that, I would imagine, and then there are opportunities to
40 specialise, to do more interesting things, to do different
41 things.

42
43 A lot of that sort of information is contained in our
44 census data that we put in as one of the packets as well.
45 It's a difficult one. We also suggest, I believe, in the
46 census data, that people who come from the region and are
47 trained in their region are more likely to stay in their

1 region. So that's one of the reasons that we would like to
2 see more regional networks actually operational.

3

4 MR FULLER: Q. In terms of the census data that you just
5 mentioned, Mr Findley, we're right in thinking that the
6 last - firstly, that's a census conducted by the college;
7 is that right?

8 A. Mmm-hmm.

9

10 Q. Of its fellows?

11 A. That's my understanding, yes.

12

13 Q. The last one was conducted in 2020?

14 A. That's my understanding, yes.

15

16 Q. Do you know whether another census is going to be
17 conducted this year?

18 A. I don't have that information I'm afraid, I'm sorry.

19

20 Q. In paragraph 63 - I'm sorry to jump you around your
21 statement - on page 11 --

22 A. Yes.

23

24 Q. -- you say there that RANZCR typically has more
25 qualified candidates than available trainee positions. So
26 there is an oversupply of candidates; is that right?

27 A. That's correct.

28

29 Q. And so, from the college's perspective, the issue is
30 whether there are available positions?

31 A. That's correct.

32

33 Q. Available training positions, that is?

34 A. Yes. That's absolutely correct. If we had more
35 positions, we'd gladly fill them.

36

37 Q. Are you able to comment on whether - you say that
38 you'd gladly fill them, but whether there is sufficient
39 supervision available throughout New South Wales to meet
40 the college's ratios?

41 A. Anywhere where there is suitable conditions for
42 a trainee to be placed, we would be glad to place them. If
43 NSW Health magically tomorrow had another 200 radiologists
44 and they opened up another 100 spots for us, we would race
45 to fill those.

46

47 Q. Do you know, sitting here now, whether there is any

1 sort of gap or flex in the system as it is at the moment
2 with the number of consultants who could supervise trainees
3 in New South Wales in radiology?

4 A. I'm not certain. I don't believe so in the public
5 system.

6
7 Q. Finally, in paragraph 80, if you can have a look at
8 that on page 14, please?

9 A. Yes.

10
11 Q. In that paragraph you say that a significant influence
12 on the accreditation is the availability of consultants,
13 and then you go on to contrast salaried radiologists with
14 visiting medical officers or VMOs. Can you just explain
15 the issue you're identifying there with VMOs?

16 A. Certainly. In some sites, we've found in the past,
17 when a visiting medical officer turns up there, they're
18 there at a higher rate for, say, two days a week or three
19 days a week and the hospital is very - or the site is very
20 keen on getting the most out of that expensive resource as
21 it can while they're there, and even though the site will
22 say, "I have a VMO here for two days a week", when the
23 trainees approach to talk to them or try and get some
24 information out of them or some assistance, they will say
25 things like, "The site's got me doing this, this, this
26 today. I haven't got time for you, I'm sorry. I've got to
27 get this out because they're using me to the most of my
28 ability"; whereas a salaried radiologist has that time
29 built into their program that they can actually help the
30 trainees and work with the trainees through the week. So
31 it's not in every site, but we do see sites where they may
32 be under pressure where the VMOs are tending to be pushed
33 very much for an output that may preclude great training of
34 trainees.

35
36 Q. So the issue with VMOs, from your perspective, is not
37 with the idea or principle of there being VMOs but whether
38 the VMOs who are in the system have sufficient time
39 available to supervise trainees; is that right?

40 A. Yes, correct. RANZCR current care whether they are
41 a VMO or a salaried person that's doing the training as
42 long as the trainee is receiving the appropriate training
43 for what they do.

44
45 MR FULLER: Thank you, Mr Findley. Those are my questions
46 for this witness.

47

1 THE COMMISSIONER: Q. Can I just ask a question about
2 152 on page 21, where you say:

3
4 *RANZCR is concerned with the proliferation*
5 *of unaccredited training positions ...*
6

7 et cetera. Do you have data about what the numbers are for
8 unaccredited training positions?

9 A. No, I don't, I'm sorry.

10
11 THE COMMISSIONER: All right. That's the answer to that;

12
13 Do you - sorry, I'm now talking to Mr Cheney.
14 Mr Cheney, do you still have the difficulty you mentioned
15 yesterday?
16

17 MR CHENEY: I do, Commissioner, if I could renew that
18 request.
19

20 THE COMMISSIONER: All right.
21

22 Mr Findley, Mr Cheney, who is the senior counsel for
23 NSW Health, has told me he hasn't had full time to get
24 complete instructions on your outline, and it was a fairly
25 short time frame, so I've agreed to give him some further
26 time. As I understand it, a time of Tuesday, 6 August at
27 2pm, has been agreed for you to come back.
28

29 THE WITNESS: No.
30

31 THE COMMISSIONER: It hasn't?
32

33 THE WITNESS: No.
34

35 THE COMMISSIONER: That's what I've been told.
36

37 THE WITNESS: If I can say, Commissioner, this has been
38 a really difficult process of "last-minutism" and changing
39 of dates and times and I've had to rearrange my diary
40 a number of times on this, and I even had an offsider that
41 could have answered some of your questions today but he was
42 required and he wasn't required, then he had somewhere else
43 to go today. It's been very difficult, and we usually plan
44 our diaries six to eight weeks out.
45

46 THE COMMISSIONER: I am completely sympathetic to what you
47 have just said to me. There's also, of course, a whole

1 range of clinicians that are giving evidence at this
2 Inquiry that have very busy diaries and have to treat
3 patients and - but we manage. What I'm going to have to
4 say to you, though, is, first of all, we're very grateful
5 for your statement and for your time today. I can't
6 release you from your summons yet, though, because in
7 fairness, I've got to give Mr Cheney some time and an
8 opportunity to ask you some questions, as he sees fit and
9 as I see fit as well. Having obviously been misinformed
10 about that date, though, we'll just adjourn your evidence
11 to a time to be fixed --

12
13 THE WITNESS: Sure.

14
15 THE COMMISSIONER: -- that we'll make sure is convenient
16 to everyone. Can I just ask, though, Mr Cheney,
17 I obviously don't want a list of your questions, but just
18 to help me, what are the general topics you want to explore
19 with the witness? I can probably guess, but you tell me.

20
21 MR CHENEY: There are aspects of the case studies and most
22 of the six case studies. It's a bit hard to go much
23 further than that at the moment because I don't have the --

24
25 THE COMMISSIONER: That's in the main, what you want to
26 explore, is it?

27
28 MR CHENEY: Yes.

29
30 THE COMMISSIONER: All right. That will do. We'll talk
31 after I let the witness go.

32
33 For the time being, Mr Findley, we will say goodbye,
34 but you're still under your summons and we'll come back to
35 you to reach a convenient date for you to come back and
36 complete your evidence. For the time being, though,
37 thank you for your time today.

38
39 THE WITNESS: Okay, thank you very much.

40
41 <THE WITNESS WITHDREW

42
43 MR CHENEY: We had not, for what it's worth, heard of
44 6 August as being the projected date either.

45
46 THE COMMISSIONER: I got a message on Teams because I sent
47 a message saying, "Has Mr Findley been advised that he has

1 to come back?" Unless I misread what I was sent, I thought
2 I was told - well, I was:

3
4 *Confirmed available 6 Aug from 2pm.*

5
6 Obviously that's not quite right, based on the witness's
7 surprise. But we'll find another time.

8
9 Can I just say this, though, generally, the terms of
10 reference are role and scope of accreditation and education
11 and training generally. Do I have to make findings on
12 these case studies?

13
14 MR MUSTON: I don't think so.

15
16 THE COMMISSIONER: Do you want to think about that,
17 because if I don't have to make findings, the whole thing
18 would go away. I mean, clearly, there have been some
19 issues that are raised in the case studies where people
20 have points of view. There is some correspondence that is
21 referred to that I haven't seen. The correspondence will
22 speak for itself and it might contain some evidence that
23 you might draw an inference from, but you might not as
24 well, but unless I have to make findings on the case
25 studies, I mean, you know, some of them - the discussion
26 between the director of training at Prince of Wales,
27 et cetera, and whether they made unprofessional comments
28 doesn't seem to me to be something that I have to make
29 a finding about in this Inquiry.

30
31 MR MUSTON: It seems quite unlikely. There are
32 potentially two steps. The first is working out what the
33 contest is, and it may well be that once we reach that
34 point and we get one side saying "Unprofessional language
35 was used in a meeting" and the other side saying, "No, it
36 wasn't", it seems most unlikely, in the context of this
37 Inquiry, it will be necessary to work out whether
38 unprofessional language was used.

39
40 THE COMMISSIONER: There is an aspect of "who cares" to
41 that, without being flippant about it.

42
43 MR MUSTON: But, equally, it might be important at
44 a systemic level just to understand that a personality
45 clash during a meeting where two people walk away with
46 conflicting views, neither of which might be --
47

1 THE COMMISSIONER: That's why good frameworks might be
2 important for things like accreditation.

3

4 MR MUSTON: That might be enough.

5

6 THE COMMISSIONER: Can I suggest this: that counsel
7 explore what it is that, first of all, counsel assisting
8 thinks I should make a finding about, and if a lot of that
9 disappears, in terms of those case studies, that that can
10 be discussed with Mr Cheney. It may well be that
11 Mr Findley doesn't have to come back in those circumstances
12 because I can give an assurance that I'm not going to pay
13 any attention to those aspects that are probably troubling
14 NSW Health about this statement, and that will be one way
15 of dealing with it.

16

17 But if you think there are, perhaps, some findings
18 that I should make that are relevant to the terms of
19 reference, then we'll obviously get him back. Does that
20 make sense?

21

22 MR CHENEY: Commissioner, I was going to volunteer that
23 the question whether fairness dictated that we put these
24 propositions to Mr Findley could only be determined after
25 we had served the responsive evidence, and if you are not
26 minded to make factual findings about the case studies,
27 then that might bear on whether fairness dictates that
28 he --

29

30 THE COMMISSIONER: There would be no need for you to
31 respond.

32

33 MR CHENEY: We certainly want to respond.

34

35 THE COMMISSIONER: There is a whole lot of procedural
36 fairness issues with some of these people that are
37 identified, too, who aren't here.

38

39 MR CHENEY: My client certainly wants to respond to the
40 pejorative allegations against it in respect of those
41 various --

42

43 THE COMMISSIONER: You could probably do that by way of
44 a submission unless - look, let's just see how we go with
45 your discussion and then you can come back to me and we'll
46 work out - I will withdraw what I said about "you can
47 probably do that by submission", because I will let you

1 deal with it in the way you want to, and it might be that
2 you want to put some evidence on.

3
4 MR CHENEY: Yes.

5
6 THE COMMISSIONER: I will leave it at that for the time
7 being.

8
9 MR CHENEY: Thank you, Commissioner.

10
11 THE COMMISSIONER: All right. So we adjourn until
12 Tuesday, do we, at 10 o'clock? You are getting a note.

13
14 MR MUSTON: Yes. Mr Fuller has just raised with me that
15 I think during the course of Mr Findley's evidence there
16 was a document that needed to be marked for identification,
17 I think it was [COR.0002.0006.0001].

18
19 THE COMMISSIONER: What's the title of it though?

20
21 MR MUSTON: While that is being discovered, we're up to
22 MFI 15. It is the "RANZCR Accreditation Standards For
23 Education, Training and Supervision of Clinical Radiology
24 Trainees".

25
26 THE COMMISSIONER: Does it have a date?

27
28 MR MUSTON: As I turn over the page, it looks like "July
29 2012, amended December 2018".

30
31 THE COMMISSIONER: All right. That document, as per those
32 dates, is MFI 15.

33
34 **MFI #15 RANZCR ACCREDITATION STANDARDS FOR EDUCATION,
35 TRAINING AND SUPERVISION OF CLINICAL RADIOLOGY TRAINEES
36 DATED JULY 2012, AMENDED DECEMBER 2018**

37
38 THE COMMISSIONER: Thank you. Sorry, does that mean
39 adjourned until Tuesday at 10am?

40
41 MR MUSTON: Yes, at 10.

42
43 THE COMMISSIONER: All right. We will adjourn until
44 Tuesday at 10am. Thank you.

45
46 **AT 3.36PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED
47 TO TUESDAY, 30 JULY 2024 AT 10AM**

<p>#</p> <hr/> <p>#15 [1] - 4181:34</p> <hr/> <p>\$</p> <hr/> <p>\$100,000 [1] - 4151:3 \$700,000 [1] - 4171:2</p> <hr/> <p>0</p> <hr/> <p>0.3 [1] - 4076:11 0.9 [1] - 4106:43 0021 [1] - 4153:44 039 [1] - 4073:24</p> <hr/> <p>1</p> <hr/> <p>1 [5] - 4080:21, 4106:19, 4144:40, 4151:42, 4171:38 10 [9] - 4117:24, 4122:15, 4150:44, 4151:10, 4169:6, 4172:47, 4181:12, 4181:41 10.00am [2] - 4073:22, 4074:9 10.01am [1] - 4074:11 100 [1] - 4175:44 10am [2] - 4181:39, 4181:44 10AM [1] - 4181:47 11 [5] - 4080:47, 4124:39, 4133:1, 4149:8, 4175:21 11.50 [1] - 4117:24 11.58am [1] - 4117:33 12 [6] - 4074:21, 4097:19, 4117:24, 4143:47, 4171:36, 4172:39 121 [1] - 4073:18 13 [2] - 4163:32, 4171:21 133 [2] - 4174:26, 4174:27 134 [1] - 4174:32 135 [1] - 4174:32 14 [4] - 4169:6, 4171:36, 4172:39, 4176:8 15 [6] - 4122:17, 4122:40, 4143:18, 4143:47, 4181:22, 4181:32 152 [1] - 4177:2 154 [2] - 4156:35, 4167:13 155 [2] - 4147:32,</p>	<p>4156:38 16 [2] - 4102:24, 4151:21 166 [2] - 4163:15, 4163:31 167 [2] - 4158:16, 4158:20 169 [1] - 4158:25 17 [1] - 4092:36 170 [1] - 4158:29 18 [1] - 4134:45 19 [1] - 4137:21</p> <hr/> <p>2</p> <hr/> <p>2 [6] - 4073:18, 4082:35, 4118:22, 4120:34, 4142:35 2(a) [1] - 4118:31 2(b) [1] - 4123:14 2(c) [1] - 4124:32 2.00pm [1] - 4142:47 2.2.6 [1] - 4154:1 20 [1] - 4106:16 200 [1] - 4175:43 2012 [2] - 4181:29, 4181:36 2018 [1] - 4181:36 2018" [1] - 4181:29 2018/19 [1] - 4140:27 2018/2019 [1] - 4120:20 2019 [2] - 4143:46, 4144:2 2020 [3] - 4143:46, 4144:2, 4175:13 2021 [1] - 4143:40 2022 [1] - 4075:45 2023 [1] - 4075:27 2024 [4] - 4073:22, 4074:21, 4143:18, 4181:47 2025 [2] - 4144:40, 4151:43 2027 [1] - 4150:41 2030 [1] - 4150:43 2040 [4] - 4122:16, 4122:20, 4122:40, 4123:11 21 [3] - 4138:25, 4153:45, 4177:2 22 [2] - 4111:31, 4147:33 23 [5] - 4140:39, 4140:44, 4158:16, 4158:20, 4163:15 24 [1] - 4142:6 25 [1] - 4073:22 2pm [2] - 4177:27, 4179:4</p>	<p>3</p> <hr/> <p>3 [5] - 4137:22, 4138:20, 4138:22, 4169:27, 4171:21 3.1 [2] - 4137:27, 4137:36 3.36PM [1] - 4181:46 30 [2] - 4104:28, 4181:47 33 [7] - 4080:3, 4080:20, 4080:22, 4080:24, 4081:1, 4081:6, 4084:18</p> <hr/> <p>4</p> <hr/> <p>4 [2] - 4138:26, 4169:27 4.2 [2] - 4138:27, 4138:36 4.3 [1] - 4139:8 4.4 [1] - 4139:31 40-year [1] - 4104:29 43 [1] - 4125:34 44 [2] - 4128:11, 4133:14 44(a) [1] - 4128:15 44(b) [2] - 4129:25, 4133:23 44(c) [1] - 4129:27 44(d) [1] - 4134:21 448 [1] - 4102:23 45 [1] - 4135:13 46 [1] - 4135:17 461 [1] - 4104:43 47 [1] - 4136:12 470 [1] - 4092:36 475 [1] - 4092:46</p> <hr/> <p>5</p> <hr/> <p>5 [4] - 4109:40, 4118:6, 4133:46, 4140:39 5.1 [2] - 4140:40, 4140:45 5.2 [3] - 4141:33, 4141:37, 4141:38 5.2.1 [1] - 4083:19 50 [2] - 4136:31, 4137:3 51 [1] - 4137:8 53 [1] - 4138:16 564 [1] - 4106:16 5s [1] - 4133:45</p> <hr/> <p>6</p> <hr/> <p>6 [5] - 4096:9, 4142:7,</p>	<p>4177:26, 4178:44, 4179:4 62 [2] - 4149:7, 4149:9 63 [1] - 4175:20 639 [1] - 4111:32 65 [1] - 4133:46 65s [1] - 4133:45 663 [1] - 4114:12 67 [1] - 4096:9 68 [1] - 4076:33 69 [1] - 4076:33</p> <hr/> <p>7</p> <hr/> <p>76 [1] - 4154:23 78 [3] - 4131:12, 4131:14, 4131:30 79 [1] - 4131:35</p> <hr/> <p>8</p> <hr/> <p>80 [1] - 4176:7 81 [1] - 4131:15</p> <hr/> <p>A</p> <hr/> <p>A/PROFESSOR [57] - 4074:24, 4074:46, 4075:4, 4075:37, 4075:45, 4076:3, 4076:11, 4076:18, 4076:37, 4076:42, 4077:10, 4077:25, 4079:20, 4080:1, 4080:24, 4080:29, 4084:29, 4086:43, 4089:2, 4089:8, 4089:14, 4092:1, 4092:22, 4092:38, 4092:44, 4093:12, 4093:17, 4095:7, 4095:27, 4096:4, 4096:17, 4097:40, 4097:47, 4098:45, 4099:31, 4100:25, 4101:4, 4101:29, 4102:26, 4102:33, 4102:43, 4103:1, 4103:28, 4105:3, 4105:8, 4105:45, 4106:24, 4107:10, 4109:3, 4109:37, 4109:45, 4110:4, 4110:40, 4114:10, 4116:9, 4117:3, 4117:19 ability [11] - 4087:10, 4108:34, 4116:14, 4116:24, 4119:12, 4119:19, 4119:41,</p>	<p>4128:13, 4136:8, 4136:27, 4176:28 able [41] - 4078:40, 4080:14, 4080:15, 4087:43, 4098:43, 4099:44, 4100:1, 4100:6, 4100:7, 4100:9, 4100:43, 4101:34, 4103:2, 4103:19, 4105:37, 4106:38, 4109:18, 4110:32, 4112:40, 4116:37, 4124:11, 4126:34, 4133:9, 4133:32, 4135:36, 4135:39, 4136:8, 4139:6, 4142:2, 4145:15, 4147:34, 4149:18, 4154:43, 4155:35, 4156:26, 4164:40, 4167:43, 4168:2, 4169:26, 4175:37 Aboriginal [14] - 4076:27, 4100:36, 4118:40, 4120:36, 4133:28, 4133:31, 4133:36, 4133:37, 4133:43, 4133:46, 4134:4, 4134:30, 4138:2 absences [1] - 4101:38 absolutely [19] - 4081:4, 4081:36, 4090:8, 4090:17, 4091:7, 4095:33, 4095:46, 4097:34, 4098:30, 4100:25, 4102:13, 4104:5, 4104:11, 4104:37, 4110:40, 4112:11, 4114:3, 4115:43, 4175:34 academia [1] - 4104:33 academic [4] - 4087:38, 4087:39, 4099:14, 4101:14 accelerator [1] - 4129:10 accept [7] - 4114:46, 4141:28, 4154:32, 4155:21, 4159:33, 4161:29 acceptable [3] - 4144:42, 4151:46, 4153:24 accepted [1] - 4095:11 accepting [2] -</p>
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