

**Special Commission of Inquiry
into Healthcare Funding**

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

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

Tuesday, 30 July 2024 at 10.06m

(Day 040)

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 are two witnesses from the Royal Australian College
5 of Surgeons who will be giving their evidence concurrently
6 by AVL. I call Associate Professor Kerin Fielding and
7 Ms Stephanie Clota.
8
9 THE COMMISSIONER: Thank you.
10
11 <KERIN FIELDING, sworn: [10.06am]
12
13 <STEPHANIE CLOTA, sworn: [10.06am]
14
15 <EXAMINATION BY MR FULLER:
16
17 MR FULLER: My name is Dan Fuller, I'm one of the counsel
18 assisting the Commission, and I'm going to be asking you
19 some questions this morning.
20
21 Firstly, can I ask each of you, starting with you,
22 Associate Professor Fielding, the college has provided
23 a statement to assist the Commission. Do you have a copy
24 of that with you?
25
26 A/PROFESSOR FIELDING: Yes, I do.
27
28 MR FULLER: It's under the cover of a letter from
29 Professor Owen Ung dated 12 July 2024; is that the copy you
30 have?
31
32 A/PROFESSOR FIELDING: That's correct.
33
34 MR FULLER: Associate Professor, you are not a signatory
35 to the statement but have you had the opportunity to review
36 it recently?
37
38 A/PROFESSOR FIELDING: Yes, I have.
39
40 MR FULLER: Is everything in it true and correct to the
41 best of your knowledge and belief?
42
43 A/PROFESSOR FIELDING: Yes, it is, with a few minor
44 adjustments which I'm happy to tell you as we go.
45
46 MR FULLER: All right. Unless there is anything you want
47 to raise now you can raise those as we go through and if

1 I miss anything please tell me at the end.

2

3 A/PROFESSOR FIELDING: Absolutely.

4

5 MR FULLER: Ms Clota, do you also have a copy of the
6 statement with you there?

7

8 MS CLOTA: Yes, I do.

9

10 MR FULLER: Again, you are not a signatory to it, but have
11 you had the opportunity to review it recently?

12

13 MS CLOTA: Yes, I have.

14

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

17

18 MS CLOTA: Yes, it is true and correct and as
19 Professor Fielding, the president, has articulated, we have
20 some additional information to provide as well through this
21 process.

22

23 MR FULLER: Thank you. Associate Professor Fielding, you
24 are the president of RACS; is that correct?

25

26 A/PROFESSOR FIELDING: That's correct.

27

28 MR FULLER: Can you just describe for the Commission what
29 that role involves, please?

30

31 A/PROFESSOR FIELDING: Right. So I have been a councillor
32 on the board of RACS for eight years and was voted in as
33 president last year, so this is my second year as
34 president. President is the overarching leader, if you
35 like, of the college, of the council, which is a 28-member
36 board, and is the chair of the council and of the council
37 executive that works as a board running the day-to-day
38 business of the college in association with Ms Clota, who
39 is our CEO.

40

41 MR FULLER: And Ms Clota - and I do apologise if I'm
42 mispronouncing your name - can you please describe your
43 role as chief executive officer of the college?

44

45 MS CLOTA: Thank you. So as chief executive officer, my
46 role is to implement the strategy as approved by the
47 council, deliver the operations of the organisation, which

1 is our core purpose, to deliver education, training,
2 advocacy, research and setting the standard for surgery in
3 Australia and Aotearoa New Zealand. I'm also responsible
4 for the risk management and financial oversight of the
5 organisation.
6

7 MR FULLER: You've described just then your view as to the
8 role of the college. Do you also see it as being part of
9 the college's role to advocate for the interests of its
10 fellows?
11

12 A/PROFESSOR FIELDING: Is that directed to me?
13

14 MR FULLER: I'm sorry, that was directed to Ms Clota.
15

16 MS CLOTA: It is to advocate for the interests of - the
17 core purpose of the college is for the benefit of the
18 community, so I think that's the key overarching purpose.
19 There is an advocacy for the profession as opposed to
20 individual fellows, if I can describe that nuance, but
21 perhaps the president would like to add to that purpose of
22 the college.
23

24 MR FULLER: Yes, Associate Professor Fielding, do you have
25 any comment you want to make about that?
26

27 A/PROFESSOR FIELDING: Yes. So I mean it is a membership
28 organisation, granted, but the purpose of the college is
29 really to uphold and maintain the professionalism of the
30 profession to support members with ongoing professional
31 development throughout their careers of lifelong learning,
32 to withhold [sic] the standards and quality of surgery that
33 is provided to our communities. That obviously involves,
34 you know, training and oversight of complaints, et cetera,
35 that we may get, so it's really a professional development
36 and skills oversight, if you like.
37

38 MR FULLER: Thank you. The college offers training
39 programs - I will direct this to Associate Professor
40 Fielding - in nine surgical specialties; is that correct?
41

42 A/PROFESSOR FIELDING: That's correct.
43

44 MR FULLER: And we see those specialties listed on page 2
45 of the statement, about halfway down; is that correct?
46

47 A/PROFESSOR FIELDING: That's correct.

1
2 MR FULLER: I should say, sorry, about a third of the way
3 down, and then we see about halfway down a reference to
4 "surgical societies", which I will come back to in a
5 moment; that's right?
6
7 A/PROFESSOR FIELDING: Yes, yes.
8
9 MR FULLER: The completion of a training program
10 accredited by your college is the only pathway available in
11 Australia for a doctor to be registered in any of your
12 college's specialties; is that right?
13
14 A/PROFESSOR FIELDING: No. You can come to Australia as
15 an international medical graduate and apply through the
16 college for recognition and there are pathways for
17 specialist recognition through the SIMG process, so they're
18 the two processes.
19
20 MR FULLER: Leaving aside international medical graduates,
21 if I'm a doctor in Australia and I want to obtain
22 registration in one of the surgical specialties, to use
23 that language, I need to complete a training program
24 through your college; is that right?
25
26 A/PROFESSOR FIELDING: Correct. That's correct.
27
28 MR FULLER: You would agree that means, in substance,
29 there is no competition for the training programs that are
30 offered in surgical specialties in Australia?
31
32 A/PROFESSOR FIELDING: No, that's correct. That's
33 correct.
34
35 MR FULLER: Do you agree that the lack of competition -
36 which doesn't just apply to your college but also applies
37 to other specialist medical colleges - makes it important
38 for colleges to have fair, effective and transparent
39 processes for the governance and administration of their
40 training programs?
41
42 A/PROFESSOR FIELDING: Absolutely. Absolutely.
43
44 MR FULLER: Ms Clota, do you agree with that?
45
46 MS CLOTA: Agree, yes.
47

1 MR FULLER: Thank you.

2

3 Associate Professor Fielding, are we right in
4 understanding that the responsibility for administering the
5 college's training programs is divided between the college
6 and the specialists or specialty societies that we see
7 listed on page 2 of the statement?

8

9 A/PROFESSOR FIELDING: The college has the overall
10 responsibility for training. The societies exist because
11 of the medical and technical expertise that is required for
12 each specialty. However, the training committees of each
13 of those - the training committees for each specialty are
14 actually committees of RACS. So RACS is the governing body
15 of the training program throughout the country.

16

17 MR FULLER: I see. So when you say the training
18 committees are actually committees of RACS, does that
19 mean - maybe I'll ask it this way: can you turn to page 10
20 of the statement, please?

21

22 A/PROFESSOR FIELDING: Yes.

23

24 MR FULLER: Do you see under item 6, about halfway down
25 the page, the statement says:

26

27 *Broadly, the College is responsible for*
28 *administering ...*

29

30 and then there are six dot points.

31

32 A/PROFESSOR FIELDING: Yes.

33

34 MR FULLER: Then:

35

36 *With specialty societies responsible for*
37 *administering --*

38

39 and three dot points.

40

41 A/PROFESSOR FIELDING: Yes.

42

43 MR FULLER: Those three dot points, is it right that those
44 are administered by the specialty societies or are they, in
45 fact, administered by training committees which are
46 committees of the college?

47

1 A/PROFESSOR FIELDING: Yes, they are actually administered
2 by the training committees, rather than the societies. So
3 that is not completely correct.

4
5 MR FULLER: Okay. And do the societies themselves,
6 leaving aside the training committees, have any role in the
7 delivery of training programs, or is it all through the
8 training committees?

9
10 A/PROFESSOR FIELDING: No, it's all through the training
11 committees, yes.

12
13 MR FULLER: What's the relationship between the specialty
14 societies and the training committees?

15
16 A/PROFESSOR FIELDING: The training committee chairs sit
17 on the boards of the societies. So there is a very close
18 link between the societies and the training committees, and
19 again, that's to do with the delivery of technical and
20 medical expertise in those particular specialties and the
21 need for that, you know, cross-fertilisation, if you like.
22 So there is a close connection. But the training committee
23 really is in charge of the delivery of training.

24
25 MR FULLER: Do the specialty societies nominate the
26 members of the training committees?

27
28 A/PROFESSOR FIELDING: They do, yes.

29
30 MR FULLER: All of the members of the training committees;
31 is that right?

32
33 A/PROFESSOR FIELDING: Yes, yes.

34
35 MR FULLER: I understand that the college's training
36 programs need to be accredited by the Australian Medical
37 Council in order for doctors who complete those programs to
38 be entitled to specialist registration?

39
40 A/PROFESSOR FIELDING: Correct.

41
42 MR FULLER: And it's the college that holds the
43 accreditation, not the specialty societies; that's correct?

44
45 A/PROFESSOR FIELDING: That's correct.

46
47 MR FULLER: And do we take it that that's why it's

1 committees of the college that are responsible for the
2 training functions; is that right?

3
4 A/PROFESSOR FIELDING: Yes, and the training committees
5 report to RACS and that's the governance of the program, so
6 the training committees report to a higher-level
7 educational group at the college so that, you know,
8 everybody is collaborating and working together and trying
9 to share, you know, information and ideas. So those
10 functions all happen within RACS.

11
12 MR FULLER: Are you able to describe in a bit more detail
13 how that reporting function works between the training
14 committees and the higher level committee that you have
15 mentioned?

16
17 A/PROFESSOR FIELDING: Yes, so the training committees all
18 report to a group called CSET the Committee of Surgical
19 Education and Training, so all the chairs of those training
20 committees of the nine specialties sit on CSET. On CSET we
21 have the senior education chairs and leaders of the
22 college, the censor in chief, the chair of CSET, who is a
23 councillor, so there's oversight from council of that
24 committee so that council's directly involved and
25 understanding what's going on in the training committees at
26 all times.

27
28 So those training committee chairs come into the
29 college, sit on this CSET board, and that's overseen by the
30 college and then that CSET will also have regular workshops
31 where all the training committee chairs are brought
32 together, some with their managers and with other members
33 of their committees, to, you know, cross-fertilise
34 information and talk about selection, accreditation,
35 different issues that arise.

36
37 MR FULLER: Ms Clota, is there anything you wanted to add
38 on the topic of specialty societies and their role?

39
40 MS CLOTA: I think just to provide, I guess, information
41 with regards to the nature of the relationship, it is, in
42 addition to what the president has just outlined in terms
43 of the governance, and in particular of the training boards
44 and training committees, so there is that nomenclature
45 there, there is an instrument, the partnering agreement,
46 that is in place between the college and the specialty
47 societies to provide services in relation to the support of

1 those training committees, which is primarily
2 administrative support, so that it can deliver those three
3 functions that are listed in the submission with regards to
4 applications, selection, training support, training post
5 accreditation.
6

7 So there is some administrative function that is
8 delivered by society staff that is governed by an
9 instrument between the college and the specialty society.
10 But the decision-making is all done at the training board
11 or - they're called training boards or training committees
12 depending on the different society. And I think just to -
13 and the governance is as the president has just outlined.
14

15 And I think just in addition, the CSET reports to our
16 education committee and that is a subcommittee of our
17 council and the council are the - the council members are
18 the directors of the organisation. So it is part of that
19 governance of - and high-level reporting and oversight of
20 those functions at each of those levels.
21

22 MR FULLER: And are there, for example, standing agenda
23 items at the council level that relate to training
24 functions exercised at the committee level?
25

26 MS CLOTA: Yes.
27

28 MR FULLER: Just to clarify in relation to the
29 administrative functions that you've just mentioned being
30 performed, did I understand correctly that that is staff of
31 the specialty societies performing administrative functions
32 to effectively support the relevant committee or board and
33 that occurs pursuant to an agreement between the college
34 and the specialty society; is that right?
35

36 MS CLOTA: That is correct.
37

38 MR FULLER: But the decision-making function is performed
39 by that committee which sits under the governance of the
40 college?
41

42 MS CLOTA: That is correct. There is a - one of the
43 specialty societies, there is a different arrangement with
44 regards to that governance, and that is the Australian
45 Orthopaedic Association, and whilst the governance of the
46 training boards and training committees remains the same,
47 so the chair of the training board is a part of CSET, the

1 actual training committee itself is not a RACS committee,
2 it's an AOA committee. So that's a slight nuance. But
3 there is certainly sufficient responsibility and
4 accountability for RACS to perform the obligations as the
5 accredited organisation to deliver surgical education and
6 training as per the AMC standard for that to occur, if that
7 makes sense. So that's the only outlier that I think is
8 worth acknowledging.

9
10 MR FULLER: Is there a reason why there's a different
11 structure in place for that society?

12
13 MS CLOTA: That arrangement does pre-date my tenure with
14 the college so I'm not aware of the reason why that
15 variation exists.

16
17 MR FULLER: Associate Professor Fielding, do you know why
18 that situation, that different structure exists for the
19 orthopaedics society?

20
21 A/PROFESSOR FIELDING: Yes, it's rather difficult, since
22 I'm an orthopaedic surgeon, but look, it pre-dates my time
23 in the college as well, which is eight years, but the
24 orthopaedic association has, you know, over the years been
25 very forward-thinking about their training program. They
26 have probably, in many aspects, been quite a leader in
27 training, not in all, and so I think it's historical and
28 dates back to a time when they were moving to
29 a competency-based training program or even before that,
30 which was well ahead of many of the other specialty groups.
31 So it's really a bit more about the maturity of the
32 organisation. But saying that, there are still, you know,
33 areas where the oversight is absolutely required.

34
35 MR FULLER: Can you just elaborate on those areas, please?

36
37 A/PROFESSOR FIELDING: Okay. Well, you know, the reason
38 to have CSET is to make sure that we're trying to get all
39 the specialties to look at best practice, to think about,
40 you know, the community that we serve, look at diversity,
41 look at rural health, look at all those issues that come up
42 later on in the paperwork, and so it's extremely important
43 to have the groups working together so that, when one group
44 is ahead of the pack and doing really amazing things with
45 diversity, with Indigenous health, with rural training,
46 et cetera, they bring the rest of the group along.

1 So working as a collective is very important, and,
2 I mean, you may be aware, orthopaedic surgery has been
3 a very male-dominated specialty for a very long time. As
4 the first female orthopod in New South Wales and the second
5 in Australia, and we're only still 4.9 per cent, whereas in
6 general surgery, for example, we're well into the
7 30 per cent female representation in general surgery. So
8 it's extremely important that they're involved in the
9 collective and that they are brought along.

10
11 Saying that, the program itself has had some very
12 excellent changes and the competency-based program is
13 producing excellent orthopaedic surgeons, but, you know,
14 not always the diversity and the other things that we need
15 to do to make orthopaedics attractive to, you know,
16 a diverse group of people have happened in the past. So
17 that's a really important part about making sure that they
18 stay part of the group. I'm not sure if I've answered the
19 question, sorry.

20
21 MR FULLER: Thank you. Is it right that the chair or
22 a member of the training committee or board for the
23 orthopaedic society still sits on the education
24 subcommittee that Ms Clota described earlier; is that
25 right?

26
27 A/PROFESSOR FIELDING: The chair of the orthopaedic
28 training board sits on CSET. Is that what you mean?

29
30 MR FULLER: Yes.

31
32 A/PROFESSOR FIELDING: The college's governing body, yes.
33 No, no, the chair of orthopaedics absolutely sits on that
34 CSET. That's a requirement of training, that the chairs of
35 every training committee sit on that CSET group.

36
37 MR FULLER: So is there any difference in the governance
38 of the orthopaedic training committee or board compared
39 with the other training committees or boards that do, in
40 fact, sit under the college?

41
42 A/PROFESSOR FIELDING: Not really, no. They are expected
43 to, you know, be involved in everything, just like all the
44 other committees. Stephanie, I don't think there's really
45 any significant difference from our point of view.

46
47 MS CLOTA: I think just if I - yes, we've just gone

1 through an AMC accreditation process so all of the requests
2 for information were consistent across the societies and
3 all of the regulations apply equally across the societies,
4 and so practically, there isn't any difference in terms of
5 that nuance in terms of the governance of that particular
6 society.

7
8 MR FULLER: Do you see any need or reason to depart from
9 that historical structure or change the historical
10 structure for the orthopaedic society in particular?

11
12 A/PROFESSOR FIELDING: Difficult question. Well, I think
13 they would like to do it all on their own, and as an
14 orthopaedic surgeon, having been in rural and female for
15 the whole of my career, I think that would be a disaster
16 because I think the - you know, working in the collective
17 with the diversity and the other things that we've achieved
18 at RACS would be lost if they moved aside and went off on
19 their own. That's the first thing.

20
21 The second thing is - so I think that, you know, the
22 value of the collective is that kind of pressure that comes
23 from other people to think about your social contract,
24 think about what you need to provide for society. So
25 I think that orthopaedic surgeons, if they did move away,
26 would be bad.

27
28 In an ideal world I would quite like them to have the
29 same kind of instrument, as Ms Clota was talking about,
30 that the other societies have so that everyone's on an
31 equal playing field, and I think that is a slight issue.

32
33 MR FULLER: Is there a reason why that hasn't happened?
34 Would it be fair to say that that's a political reason?

35
36 A/PROFESSOR FIELDING: Yes, probably.

37
38 MR FULLER: Ms Clota, do you have anything you want to add
39 on those topics?

40
41 MS CLOTA: No. I think, as I mentioned earlier, it does
42 pre-date my arrival with the college, but it is something,
43 you know, I think that we are currently looking at in terms
44 of the relationship between the college and each of the
45 societies, so it's very contemporary in terms of the topic.

46
47 MR FULLER: Thank you. And Ms Clota, I'm sorry if we've

1 covered this already, but you started in your role
2 in January 2024 - that is this year; is that right?

3
4 MS CLOTA: Correct.

5
6 MR FULLER: Thank you.

7
8 Associate Professor Fielding, just coming now to the
9 accreditation standards for the college's training
10 programs, we're right in understanding that there are
11 central accreditation standards developed by the college
12 and then there are also accreditation standards that are
13 overseen by each of the training committees or boards for
14 the individual subspecialties; that's correct?

15
16 A/PROFESSOR FIELDING: That's correct.

17
18 MR FULLER: What do you view as being the function of
19 those accreditation standards.

20
21 A/PROFESSOR FIELDING: Well, accreditation standards are
22 set up so that, you know, excellent surgical training can
23 be delivered. So they're looking at each individual site
24 to make sure that the site has got the appropriate
25 infrastructure, you know, supervisory capacity,
26 administrative capacity, et cetera, to support training.
27 All of our training is pro bono. So we have a massive pro
28 bono workforce that looks after all the trainees in the
29 country, and the cost of that, if you wanted to pay for it,
30 would be enormous, and we need to make sure that our
31 trainers and our supervisors get some support, that they
32 can perform their normal activities as surgeons looking
33 after their communities as well as the training in their
34 sites.

35
36 But also it's about looking after the trainees. So,
37 you know, we've had issues, as you know, with culture in
38 medicine in Australia for a very long time and the college
39 did really make a big effort quite a few years ago looking
40 at the bullying and harassment that had been reported and
41 we've got some very strict guidelines now about our
42 supervisors and our trainers and courses that they need to
43 do and a complaints mechanism for bad behaviour. So we've
44 taken that feedback extremely seriously and we have
45 mandated training that our trainers have to do.

46
47 So the accreditation is all about looking at the

1 safety of the site for the quality of the training but also
2 for the protection of the trainees. And so, you know,
3 people will hear about dis-accreditation or a loss of
4 accreditation, but generally, that is related to cultural
5 issues in the site, not so much infrastructure or other
6 issues; it usually tends to be a cultural problem so we do
7 take that extremely seriously.

8
9 MR FULLER: I'll come back to that issue in a moment, if
10 I may. Can I just pick up on your reference to the
11 training being delivered pro bono? Can you just explain
12 what you mean by that?

13
14 A/PROFESSOR FIELDING: Yes. Well, all the supervisors and
15 trainers across the country do all the training, you know,
16 supervise registrars, do reports on registrars, you know,
17 teaching them for no financial gain. So that is part of
18 our remit and oath, if you like, as a surgeon, that when
19 you become a surgeon and you pass your fellowship, that
20 part of your professionalism is - education and training is
21 part of being a professional surgeon, if you like.

22
23 So the workforce - all the workforce across the
24 country - is pro bono. There's no remuneration for
25 teaching and training surgeons. Most of that work is
26 carried out in the public sector. There is a little bit in
27 the private sector. There are a proportion of surgeons -
28 I think it's about 40 per cent - that work in the private
29 sector and are probably not involved in training but, as
30 I said, the majority of our workforce, our surgeons in the
31 country, are providing training for no remuneration.

32
33 MR FULLER: Associate Professor Fielding, are you or have
34 you been a staff specialist in the New South Wales health
35 system?

36
37 A/PROFESSOR FIELDING: There are very few staff
38 specialists in surgery in the New South Wales health
39 system. If you're a staff specialist, then you do get time
40 for training in your package, but it's very rare in surgery
41 to have staff specialists. So I've been training
42 registrars my whole career, for 32 years, and I have them
43 in my office, I get no remuneration for doing that. I have
44 them across the spectrum from medical school right through,
45 and that's pretty standard in New South Wales.

46
47 MR FULLER: Am I right in understanding that you, in your

1 clinical role, are at Wagga Wagga hospital, among other
2 things?

3
4 A/PROFESSOR FIELDING: Yes, yes.

5
6 MR FULLER: Are you a VMO, visiting medical officer?

7
8 A/PROFESSOR FIELDING: VMO, yes. Yes, VMO. We don't have
9 any staff specialists in surgery in Wagga.

10
11 MR FULLER: As part of your VMO contract, is it the case
12 that you are not paid for or - I mean, let me take a step
13 back. As part of your VMO contract, are you engaged to
14 provide training at all under your understanding?

15
16 A/PROFESSOR FIELDING: It is part of your contract that
17 you're supposed to be involved in training. It's not
18 specifically documented, the time, and there's no - like
19 I said, there's no admin support, there's no back-up for
20 any, you know, paperwork that might need to do, meetings,
21 anything like that.

22
23 So, yes, it is in your VMO contract but, you know,
24 bearing in mind that we have surgeons across the state who
25 are working beyond capacity, if you like, because of the
26 stretched system, it is hugely onerous to be doing this
27 work as well and it is the goodwill of the surgeons
28 involved and that's sadly been quite stretched since COVID.

29
30 THE COMMISSIONER: Is that provision of the contract that
31 you just mentioned regarding training - are you aware of it
32 having ever been enforced, in other words, someone from
33 the LHD, or whatever, saying, "You've got a contract with
34 us. It's got a requirement for teaching. You're not doing
35 it"?

36
37 A/PROFESSOR FIELDING: No.

38
39 THE COMMISSIONER: Has that ever happened to you or any of
40 your colleagues that you know of?

41
42 A/PROFESSOR FIELDING: Never heard of that happening.
43 Never heard of that happening, no.

44
45 THE COMMISSIONER: Thank you.

46
47 MR FULLER: Are you, Associate Professor, engaged on

1 a sessional basis or a fee for service basis?

2

3 A/PROFESSOR FIELDING: No, so in rural New South Wales we
4 have a special arrangement on a fee for service basis. So
5 unfortunately if the hospital is bed-blocked and there's
6 nothing happening you can go for weeks without any money,
7 any pay, but you're still teaching, you're still looking
8 after your trainees, you're still doing ward rounds, for no
9 remuneration.

10

11 MR FULLER: Just so we understand, being engaged on a fee
12 for service basis, you are paid by reference to surgical
13 services?

14

15 A/PROFESSOR FIELDING: So you're only paid for the cases
16 that you operate on. So you're not paid for - if you don't
17 operate. So you might go in and do ward rounds, you might
18 go in and see, you know, quite a number of patients for
19 consultations, or you might get \$40 or something for seeing
20 a consultation, but you can spend days doing that kind of
21 work when all your elective work has been cancelled and
22 actually make no income for that week or two or whatever.
23 Which is what happened in COVID, and a lot of the surgeons,
24 particularly orthopaedics, took the brunt of that. We
25 didn't have any income for more than a year.

26

27 MR FULLER: Do you, from your position, see that issue -
28 that is, not being paid specifically to deliver training -
29 as impacting the capacity to deliver surgical training in
30 New South Wales?

31

32 A/PROFESSOR FIELDING: Look, I think particularly in
33 rural, where, you know - so there's discussion in the
34 papers about the fact that we have a workforce
35 maldistribution and that, you know, we've got this
36 increasing waiting time for surgery.

37

38 The hospitals are running at capacity at the moment,
39 and so, for example, if I had a couple of sessions where
40 I could teach and train and run a clinic and impart, you
41 know, 32 years of orthopaedic knowledge to my trainees,
42 then another surgeon could actually use my list or do
43 something else.

44

45 So there's been a real - the problem is that education
46 and training has not been remunerated in this state for
47 forever and it's not valued, you know, there's no value put

1 on education and training. We've got lots of surgeons
2 around who would be very happy to stay beyond their
3 retirement time to teach and train, run clinics, do all
4 sorts of things where you could have increased capacity for
5 training - not just operating, I mean, surgery is not just
6 about operating, it's everything else, perioperative care
7 and so on - and that would be a lot better if we had
8 capacity to do that.

9
10 At the moment, there's no arrangements for that and
11 the bottom line is, you know, your caseload, how many
12 elective cases are there getting done by the end of
13 12 months, is what NSW Health looks at. So, yeah, I think
14 the system is very mismatched.

15
16 MR FULLER: Coming back to accreditation standards for
17 a moment, do you agree that accreditation standards should
18 be outcomes based and evidence informed?

19
20 A/PROFESSOR FIELDING: Yes. Yes.

21
22 MR FULLER: Ms Clota?

23
24 THE COMMISSIONER: Do we perfectly understand what
25 "outcomes based and evidence informed" is? What do you
26 mean in your question by "outcomes based"?

27
28 A/PROFESSOR FIELDING: Yes, what do you mean. That's a
29 good - that's good.

30
31 THE COMMISSIONER: I think I know but we should get it on
32 the record.

33
34 MR FULLER: Let me ask it this way: do you agree that
35 accreditation standards should be focused on the outcomes
36 for trainees - that is, achieved by trainees - rather than
37 the process by which training is delivered?

38
39 THE COMMISSIONER: By that do you mean, more specifically,
40 perhaps, that the accreditation standards should aim to be
41 outcome based in the sense of producing very well-trained
42 doctors?

43
44 MR FULLER: Yes. Thank you.

45
46 THE COMMISSIONER: You would agree that the accreditation
47 standards should be aimed at producing very well-trained

1 doctors, I imagine, as a guess?

2

3 A/PROFESSOR FIELDING: Yes, no, absolutely and it would be
4 really good if it was also involved - if we also thought
5 about, you know, workforce planning in that.

6

7 THE COMMISSIONER: And in terms of being evidence based,
8 accreditation standards should be based on some form of
9 proof that they achieve the training - the good training of
10 specialist doctors?

11

12 A/PROFESSOR FIELDING: Yes. Yes. And how about also
13 related to, you know, the needs of the community, because
14 we can train good surgeons in the city, and we can continue
15 to do that, but we're not going to fix the problem.

16

17 THE COMMISSIONER: The maldistribution problem?

18

19 A/PROFESSOR FIELDING: Correct, correct.

20

21 THE COMMISSIONER: Sure.

22

23 A/PROFESSOR FIELDING: So I think, you know, if we just
24 purely have excellent - although, we do actually have
25 evidence that rural training is often better than
26 metropolitan training. But I think, you know, evidence
27 based but linked to the needs of the community is what you
28 really need to do if you want to have the system working
29 properly.

30

31 THE COMMISSIONER: Yes, understood.

32

33 A/PROFESSOR FIELDING: Rather than everything in the
34 eastern suburbs, you know?

35

36 MR FULLER: In terms of being evidence based, do you also
37 agree that accreditation standards should strive to be
38 based on objective rather than subjective criteria wherever
39 possible?

40

41 A/PROFESSOR FIELDING: Yes. Yes, absolutely, yes.

42

43 MR FULLER: Ms Clota, is there anything you want to add on
44 the function of accreditation standards?

45

46 MS CLOTA: I completely agree with the need for
47 outcomes-based standards and evidence-informed standards

1 and processes. I think there is a need at times for inputs
2 as well through that process, in terms of often protected
3 teaching time or protected and safe working hours and those
4 sorts of things. So there is a requirement for some of
5 those inputs which are often - you know, I think when we
6 talk about outcomes-based standards, there is sometimes
7 a move to remove some of those inputs. I think there is
8 that balance around making sure that we have controls in
9 place for the high quality teaching and education and
10 safety of the trainee, the system, the service and also the
11 patient. So, you know, I think it is perhaps more nuanced
12 in terms of that position.

13

14 MR FULLER: So is the point there that in order to achieve
15 trainees who are competent in surgical training, it's also
16 necessary to consider, as you say, the inputs or procedures
17 by which training is delivered, at least in some
18 circumstances?

19

20 MS CLOTA: That's correct.

21

22 MR FULLER: But you'd agree with the general principle or
23 philosophy that the standards should be developed with an
24 eye to achieving the outcome of competent trainees rather
25 than anything else; do you agree with that?

26

27 MS CLOTA: That is correct. So competent trainees to meet
28 the needs of the community, absolutely.

29

30 MR FULLER: And Associate Professor Fielding, I think you
31 agree with that based on --

32

33 A/PROFESSOR FIELDING: Absolutely, yes.

34

35 MR FULLER: Does the college support - firstly, are both
36 of you familiar with the National Health Practitioner
37 Ombudsman report and its recommendations?

38

39 A/PROFESSOR FIELDING: Yes, yes.

40

41 MR FULLER: Does the college, starting with you, Associate
42 Professor Fielding, support the recommendation that the
43 Australian Medical Council develop a procedure for colleges
44 to follow in developing their own accreditation standards?

45

46 A/PROFESSOR FIELDING: Yes, we do.

47

1 MR FULLER: And Ms Clota, I take it you agree with that?

2

3 MS CLOTA: Yes, we do.

4

5 A/PROFESSOR FIELDING: Could I mention something here? Is
6 that okay?

7

8 MR FULLER: Yes.

9

10 A/PROFESSOR FIELDING: So the college had actually - we
11 have spent several years working with all the specialty
12 training boards to develop a new accreditation process
13 where we divided the accreditation into two phases, one
14 being the overall accreditation of sites, which was the
15 kind of generic accreditation things, you know, has
16 the hospital got a library, do they have a CT scanner, you
17 know, is the admin functioning well, et cetera, and then
18 just the specialty requirements for each different
19 specialty.

20

21 So we had developed that well before the NHPO came out
22 with its recommendations. That had been presented to the
23 CPMC, the council of medical presidents, and actually was
24 being looked as a model that could be used across all
25 colleges and also that model has been referred to by the
26 AMC.

27

28 So we had done that work prior to the NHPO coming out,
29 and so we're absolutely on board with having, you know,
30 a generic accreditation across the board to reduce the
31 onerous part of the - the onerous work of accrediting every
32 site, and a lot of the reason that we had developed that
33 was because we're in a very - we're in the middle or
34 towards the last term of a very big rural health equity
35 strategy at RACS, to try and improve our rural training and
36 start working on regional training for general surgery and
37 orthopaedics, and to do that, we actually needed to reduce
38 the administrative burden that was put onto the individual
39 departments for accreditation.

40

41 MR FULLER: And can you just describe what the college has
42 proposed or has a view to reducing the administrative
43 burden?

44

45 A/PROFESSOR FIELDING: So at the moment, each specialty
46 will go in to do the accreditation and that amount of work
47 is repeated for each specialty. So you've got one - you

1 might have one director of medical services in Wagga, for
2 example, and we want to try and get orthopaedics, general
3 surgery, urology, vascular surgery, ENT, all accredited in
4 Wagga, and there's an enormous amount of bureaucratic, you
5 know, paperwork that needs to be done for each
6 accreditation. So the idea was to reduce that and have one
7 generic accreditation across the hospital, and then all
8 that the specialty needed to do was to come in and have
9 a look at, okay, what's orthopaedics doing, what does it
10 need to run an orthopaedic department, do you have this,
11 this, this and this, tick the box.

12
13 So you didn't need to go through does the hospital
14 have, you know, cultural competency training, does the
15 hospital have an outpatients clinic, does the hospital have
16 a CT scanner, et cetera. So it was to significantly reduce
17 the administrative burden, and it's particularly important
18 in rural where we have workforce shortages, where we often
19 don't have a regular DMS and we have fly-in/fly-out admin
20 services who really don't know what's happening here and
21 that was ready to go and then the NHPO came along. So
22 unfortunately that's actually slowed us down in starting up
23 our new accreditation program, but hopefully what the AMC
24 produces will be very similar.

25
26 MR FULLER: Can I ask you then, firstly, about how you
27 accredit at the moment and then you can tell me about the
28 plan for the future as well. At the moment, are we right
29 in understanding that the college or the training
30 committees accredit training posts rather than at the site
31 level or another level?

32
33 A/PROFESSOR FIELDING: Yes. So it's the site and post
34 accreditation, and there's a - so the sites are accredited
35 for all the generic things, as I've explained, but then you
36 need to look at each department. So, for example, you're
37 coming to Wagga, you want to look at whether or not we
38 could support an extra trainee in orthopaedics, we already
39 have four, so do we have the caseload and the case mix to
40 support training another orthopaedic surgeon?

41
42 And it's actually quite important in surgery, because
43 if you want to have a surgeon that can, you know, come back
44 to Wagga or go to somewhere even more rural or remote, they
45 need to have that broad mix of case mix as well as the
46 numbers to make sure that they're competent and capable.
47 So in surgery, there are some nuances about the individual

1 post to make sure that you've got - we've got multiple.

2

3 So, for example, in orthopaedics, you've got foot and
4 ankle, upper limb, hip and knee, spine, so you've got to
5 cover multiple specialties within the training and you've
6 got to make sure that that trainee is capable of being able
7 to offer a service somewhere else in the whole range.

8

9 Now, obviously, as time goes by and we get more senior
10 in our careers, we do tend to narrow our scope of practice,
11 but you don't always know at the beginning of your
12 specialty practice what you will need to do.

13

14 I trained as a hand and paediatric surgeon but now
15 I basically do spine and joints and trauma. So, you know,
16 things change depending on where you're going to work. So
17 we need to make sure that the trainees have a good
18 grounding of generalist training and then they can hone
19 down into a more specialised area as they go through their
20 career.

21

22 MR FULLER: And then the alternative or the new approach
23 that the college was developing before the NHP0 report, am
24 I right in understanding that the idea of that was to wrap
25 up multiple specialties so that they could be looked at
26 together or through a --

27

28 A/PROFESSOR FIELDING: Yes, so that all the specialty had
29 to do was to go in and look at that case mix, caseload and
30 the department. It didn't have to look at the whole
31 hospital and the library and the accommodation and, you
32 know, the parking or whatever. It just had to go in and
33 look at the department and check the caseload, check the
34 case mix and make sure that they could deliver a good
35 general training for that particular trainee's position.

36

37 MR FULLER: So would the idea be to basically divide the
38 current accreditation standards between things that are
39 specific to the individual specialty like case mix and
40 caseload?

41

42 A/PROFESSOR FIELDING: Yes, correct.

43

44 MR FULLER: And then broader accreditation standards that
45 relate to the site and could just be looked at once rather
46 than for every specialty?

47

1 A/PROFESSOR FIELDING: Yes, yes, exactly. And we actually
2 had offered to share that with the other specialties so
3 that, for example, we could have had a portal where - so
4 Wagga gets looked at, it's got the generic stuff done and
5 that could be shared across multiple other colleges even,
6 you know, to make sure this hospital's providing all the
7 standard things that you need and then all you just need to
8 go in and look at is your own specialty.

9
10 MR FULLER: Is it the case that the college may revisit
11 that model depending on what the AMC comes up with?

12
13 A/PROFESSOR FIELDING: Well, that's what we hope. We
14 spent a lot of money on it and a lot of time on it and we
15 really, really wanted to kick off our rural training
16 program. So yes, hopefully that's what - the AMC will come
17 up with something very similar or they'll let us do what we
18 had planned.

19
20 MR FULLER: Ms Clota, do you have anything you wanted to
21 comment on this issue?

22
23 MS CLOTA: Nothing further but just to, I guess, highlight
24 that we have been asked by the ombudsman to pause the
25 implementation of that revised model that the president
26 just outlined to wait for the NHPO - to catch up to the
27 NHPO process, so that's at the direction of the ombudsman
28 that we pause, wait for the outcomes of that process and
29 then review and proceed in terms of implementation with or
30 without change.

31
32 MR FULLER: Do you have a sense at the moment of what the
33 time frame for that may be?

34
35 MS CLOTA: Our current understanding is that there will be
36 an outcome of that project, that accreditation project,
37 in October of this year. So that's what we're working
38 towards in terms of review of the process that we've just
39 outlined.

40
41 MR FULLER: One of the functions that you've mentioned -
42 in the statement it says, "performed by the surgical
43 societies", but based on the evidence today it sounds like
44 is performed by the training committees - is applications
45 and selection. That's on page 10, about halfway down.
46 Associate Professor Fielding, can you just describe what
47 the committee's involvement in applications and selection

1 is?

2

3 A/PROFESSOR FIELDING: So the applications are actually
4 made through RACS but then - well, the initial application
5 is made through RACS and then there is a second phase which
6 goes through the societies. So the societies organise the
7 interviews, they organise the review of the referee checks,
8 they organise the CV marking. So they will bring - you
9 know, they will organise a very large group of their
10 members who are RACS fellows to come in and assist with all
11 of those functions.

12

13 They will organise the questions for their interviews.
14 They will do all the marking. But again, there'll be
15 guidelines from RACS about, you know, things that we would
16 like them to do, those things are discussed at the CSET
17 meeting, so, you know, multi-interviews. So the interview
18 process is multiple stations where they might have eight or
19 10 mini interviews, when they're going through selection,
20 was a collective decision made several years ago with all
21 of the committees working together, because we looked at
22 best practice internationally. So, you know, that
23 collaboration of the societies working together tries to
24 bring everybody on board with best practice. But they
25 actually will administer those interviews and do all the
26 marking and so on.

27

28 MR FULLER: So in New South Wales, for example, the
29 recruitment and selection of surgical trainees is done by
30 the surgical societies under the oversight of the college;
31 is that a fair summary?

32

33 A/PROFESSOR FIELDING: Yes. I mean, it's kind of
34 coordinated by the training committee, by the chair of the
35 training committee, but with the assistance of the
36 societies, yes.

37

38 MR FULLER: And to what extent is the local health
39 district or NSW Health which will be employing the trainees
40 involved in that process?

41

42 A/PROFESSOR FIELDING: NSW Health is quite involved
43 because the interview process does require that you have
44 three people for each interview, and one of those people
45 will be a jurisdictional representative, and they're
46 usually - well, pretty much always DMSs or deputy DMSs from
47 the hospitals, you know, senior members of NSW Health -

1 well, probably mid-tier, you know, experts that come along
2 and help out with people from HETI, for example, Health
3 Education and Training Institute, they will be involved in
4 the interview process. So they're involved at that level.
5

6 Our selection is a national selection program, so even
7 though each state runs its own interviews, there's a
8 national ranking and that relates back to the guidelines
9 that we were asked to work under from the ACCC when we
10 first had our first review by the ACCC.
11

12 Now, we have made some adjustments to that with
13 Department of Health approval, if you like, that, you know,
14 we've been trying to increase our numbers of trainees in
15 areas of need, for example, in Northern Territory, for
16 rural, et cetera, and certainly the national selection
17 program that we were asked to use, we don't think has
18 helped with our maldistribution issues.
19

20 So we've been - we have been assured that we won't be
21 in breach of our ACCC guidelines if we do try and select
22 for site, which I recently had confirmed when I was talking
23 at CPMC to the representatives of DOHA that for areas of
24 need, you know, we can't run national selection and get
25 people into areas of need. It just doesn't work, you know,
26 because the rural people often get knocked out. So we've
27 been assured that we can recruit and select for areas of
28 need. So we will be doing that in the future for rural.
29

30 MR FULLER: You used an acronym, I think, CPMC. What does
31 that stand for?
32

33 A/PROFESSOR FIELDING: That's the council of medical
34 presidents. The council of medical presidents of all the
35 colleges meet regularly and we meet with, you know, senior
36 leaders from the AMC, Ahpra, DOHA, NSW Health, the
37 jurisdictions, all of the major national bodies involved in
38 health.
39

40 MR FULLER: So that's CPM - for "medical" - C; is that
41 right?
42

43 A/PROFESSOR FIELDING: Yes, yes
44

45 MR FULLER: Just so we're clear on the ACCC guidelines
46 that you raised, and tell me if you don't know the answer
47 to this, the college was investigated by the ACCC in around

1 2000 in relation to its training and assessment processes;
2 that's right?

3
4 A/PROFESSOR FIELDING: Yes, yes.

5
6 MR FULLER: As a consequence, the college sought an
7 authorisation from the ACCC to engage in the sort of
8 training and selection processes that you've described for
9 us?

10
11 A/PROFESSOR FIELDING: Yes.

12
13 MR FULLER: And the ACCC granted that authorisation on
14 a number of conditions?

15
16 A/PROFESSOR FIELDING: Yes.

17
18 MR FULLER: And that authorisation has been ongoing since
19 around 2003 or so?

20
21 A/PROFESSOR FIELDING: Yes, that's correct.

22
23 MR FULLER: In terms of the college's and societies'
24 involvement in recruitment and selection, is it fair to say
25 that, in those ways, the college and the societies exercise
26 a significant practical influence over the composition of
27 the trainee workforce, the surgical trainee workforce in
28 Australia?

29
30 A/PROFESSOR FIELDING: Can you - yes, how do you mean?
31 Like, I mean, obviously, you know, they're apprenticeship
32 kind of models so there is a lot of - you know, there is
33 a lot of connection between the people that are applying
34 and the people that are involved in the process of
35 selection and training and so on. So unfortunately, there
36 are a lot of relationships and, you know, it's a small
37 program, if you like, really, if you look at the numbers,
38 there is not many people often. So I'm not quite sure what
39 you're wanting.

40
41 MR FULLER: Can I ask it --

42
43 THE COMMISSIONER: Maybe "significant practical influence"
44 could be slightly more direct.

45
46 MR FULLER: Can I ask it in a different way.

47

1 A/PROFESSOR FIELDING: Yes.

2

3 MR FULLER: Obviously, by being involved in recruitment
4 and selection, the college and the societies are really the
5 ones determining who receives training positions in
6 surgical specialties throughout Australia; that's right,
7 isn't it?

8

9 A/PROFESSOR FIELDING: Yes, yes.

10

11 MR FULLER: Tell me if you don't know this, but that is in
12 contrast to some other colleges which just allow
13 recruitment and selection to be done by the jurisdictional
14 health organisations rather than being involved in it
15 themselves, or would you not know that?

16

17 A/PROFESSOR FIELDING: I - yeah, I'm not sure how the
18 other colleges recruit, but Stephanie may know, having
19 worked in another college.

20

21 MR FULLER: That's okay. Leaving that aside, why do you
22 think it's desirable for the college of surgeons and the
23 surgical societies to be involved in recruitment and
24 selection?

25

26 A/PROFESSOR FIELDING: Why do I think it's desirable?
27 Well, I think it's very difficult to judge the technical
28 skills of a surgeon if you're not a surgeon. It's
29 a pretty, you know, sort of highly specialised thing that
30 we do and, you know, I have certainly tried to train lots
31 of people that really don't have the practical skills to
32 become a surgeon, and so I do think that there is a need
33 for surgeons to be involved in the process. However, it's
34 difficult, because it's a very competitive market and our
35 trainees are all very good, and there's a certain number of
36 positions.

37

38 Now, you know, when we get on to talking about
39 workforce, I think we all agree that we could train more
40 and we could certainly train more in areas that are needing
41 surgeons, like in rural. That's a conversation that needs
42 to be had with the jurisdictions and with NSW Health,
43 because we don't know what we don't know. We would like to
44 train more if we know where they're needed, and that's
45 something that we've been asking NSW Health for quite
46 a while. There are a lot of unaccredited registrars out
47 there that definitely would have the skills. So because

1 it's very competitive to do surgery, you know, there's
2 a lot of people that would be perfectly capable of becoming
3 surgeons that don't get on because of the numbers of
4 positions that we have. And the positions that we have are
5 really there historically, because, you know, you come and
6 work in a site and you realise you could train a registrar
7 so you apply to get a post, and you get one, but there
8 hasn't been a very good coordinated approach to the numbers
9 of trainees and positions in the state for the workforce.
10 So, you know, we're all operating in silos here and that
11 needs to be something that we do together with the health
12 department, and we've offered and we want to help and, you
13 know, we could easily train another orthopod in Wagga,
14 I can tell you now.

15
16 MR FULLER: Does the college cap the number of trainees in
17 particular surgical specialties?

18
19 A/PROFESSOR FIELDING: No. No, we don't have caps on
20 training. We would look at - every application, we look at
21 to see if there's enough caseload and case mix in that site
22 and if, you know, the site's capable of having a trainee
23 and usually if they are, they get approval.

24
25 MR FULLER: When you say "every application", that would
26 be a situation where a hospital or a local health district
27 is approaching the college and saying, "Can we be
28 accredited for X number of training posts at this
29 particular site"; is that right?

30
31 A/PROFESSOR FIELDING: Yes. Absolutely, yes, yes.

32
33 MR FULLER: Does the college have any initiatives at the
34 college level to try to promote or increase the number of
35 accredited training posts at sites where they may be
36 needed?

37
38 A/PROFESSOR FIELDING: Yes, so we have been working with
39 the national workforce task force, which is being led by
40 NSW Health, for over a year now, to try and, you know, do
41 a lot more work in workforce. Actually it's been very
42 difficult to get any data out of them about where they want
43 more surgeons and where we could train.

44
45 We have, you know, reached out several times and we
46 haven't had anything back from them as of yet. So we're
47 still waiting to talk to them. We have identified quite

1 a few sites where there were - where there was a potential
2 for what was once called STP funding, which is specialist
3 training program funding provided by the federal
4 government, and to date, many of those sites that had been
5 identified as possible sites still haven't had
6 accreditation applications.

7
8 Now, we know a lot of that's to do with the
9 bureaucratic process and that there are a lot of rural
10 sites that don't even have, you know, live-in, if you like,
11 DMSs, so there's a real problem in the medical workforce
12 with regards to medical admin. So if you don't have an
13 administrator in your site that can do the paperwork, then
14 it's very difficult for the individual surgeon. As I said,
15 their work is very onerous. So we have asked NSW Health if
16 they can help with this process and that we would - we're
17 only too happy to help with, you know, with the work, to
18 get some of the unaccredited positions around the state
19 accredited but, yes, nothing much has happened yet.

20
21 THE COMMISSIONER: Can I just ask, so that I understand
22 all of that answer, you began by saying "We have been
23 working with the national workforce task force" --

24
25 A/PROFESSOR FIELDING: Yes.

26
27 THE COMMISSIONER: -- "which is being led by
28 NSW Health" --

29
30 A/PROFESSOR FIELDING: Yes.

31
32 THE COMMISSIONER: -- "for over a year".

33
34 A/PROFESSOR FIELDING: Yes.

35
36 THE COMMISSIONER: You then said: "It's been very
37 difficult to get any data out of them." Does "them" refer
38 to the task force or NSW Health?

39
40 A/PROFESSOR FIELDING: Well, specifically to NSW Health
41 because NSW Health leads that task force and we've been -
42 we have been - I mean, we would like to know all around the
43 country where we can provide more training and we have had
44 contact with Department of Health and Ageing and they're
45 doing a lot of work on the data nationally, but
46 specifically New South Wales because New South Wales
47 did actually reach out to us last year and complained

1 because we had a slight reduction in general surgical
2 trainees last year due to a change in our program going to
3 competency-based training. And NSW Health reached out to
4 us, they were very upset that we were going to have this
5 slight reduction in numbers and we said, "Look, we'll work
6 with you and we will increase the number of posts, but we
7 need to know where you want them. We need to know where
8 you need them", and, yes, as I said --

9

10 THE COMMISSIONER: Can I just ask you, Associate
11 Professor, are these requests made in writing, you know,
12 these requests that --

13

14 A/PROFESSOR FIELDING: Yes.

15

16 THE COMMISSIONER: They are?

17

18 A/PROFESSOR FIELDING: Yes.

19

20 THE COMMISSIONER: All right. And have you --

21

22 A/PROFESSOR FIELDING: And they're minuted - and they're
23 minuted at meetings as well.

24

25 THE COMMISSIONER: Okay. So there are meetings where
26 there are minutes taken and there is correspondence
27 exchanged on the general topic?

28

29 A/PROFESSOR FIELDING: Yes.

30

31 THE COMMISSIONER: Have you been told why it's difficult
32 to get this data? Has NSW Health said, "We would like to
33 give it to you but we can't because we don't have it or we
34 don't want to give it to you"? Has there been any reason
35 given?

36

37 A/PROFESSOR FIELDING: No. I mean, the --

38

39 THE COMMISSIONER: You're shaking your head, but I'll take
40 that as a no.

41

42 A/PROFESSOR FIELDING: I mean, it doesn't make any sense,
43 because they pay everybody, they should know who they're
44 paying. They have a statewide pay system, so it doesn't
45 make any sense to me. But no, they haven't given me any
46 reason. Stephanie, not that you are aware of?

47

1 MS CLOTA: No.

2

3 THE COMMISSIONER: I think I know this, but I'll ask it
4 anyway: what would be the benefit to the college and
5 perhaps to the community if you did have that data?

6

7 A/PROFESSOR FIELDING: We could have a look at where we
8 can start increasing the number of training posts tomorrow.
9 We've said we would expedite them. We've said to the
10 NSW Health department, "We're happy to expedite some
11 accreditation particularly for areas of need in
12 rural/regional if you can tell us where you need them."
13 But we can't do anything if we don't know.

14

15 THE COMMISSIONER: All right. And when you told us about
16 the slight reduction in general surgical trainees last
17 year, and NSW Health being upset about that, using your
18 words --

19

20 A/PROFESSOR FIELDING: Yes.

21

22 THE COMMISSIONER: -- again, was that interaction in
23 correspondence as well?

24

25 A/PROFESSOR FIELDING: Yes.

26

27 THE COMMISSIONER: Okay.

28

29 A/PROFESSOR FIELDING: And we respond as appropriately and
30 quickly as we could and we certainly got our general
31 surgical society to reduce - well, we actually filled all
32 the positions, we got them to do a review of the selection
33 process and the interviews, and we got them to actually
34 fill all the posts that they were actually not going to
35 fill. So we responded immediately to NSW Health, and
36 that's kind of the presidential role, getting on to the
37 society, talking to them, collaborating with the group and
38 making sure that we filled the positions. So we acted in
39 good faith, and we did that in accordance with NSW Health,
40 and at the same time is when we said, "Look, you know, we
41 don't want this to happen again, so please can you help us
42 to identify some more posts so we can increase the number
43 of positions so this won't happen again?" And as I said,
44 nothing's happened.

45

46 THE COMMISSIONER: And what should I understand as "slight
47 reduction in numbers", what does that --

1
2 A/PROFESSOR FIELDING: I think there were 11 posts that we
3 didn't think we would be able to fill last year, and then
4 when I went back to the general surgeons and said, "Look,
5 we can't do this, this is not right, this is going to cause
6 a pipeline problem", and so then they went - so they
7 normally have a kind of a cut-off for selection of the -
8 it's not a quota but it's about the scoring, so they
9 normally have a cut-off and they went back to their
10 selection and they looked at it and then they filled all
11 the positions. So - which was good.

12
13 I mean, we did sort that problem out last year, but,
14 you know, there is the risk of another pipeline problem in
15 the future. We have a different workforce, we have people
16 taking leave for family, people taking leave for research,
17 people wanting to work part time and have work/life
18 balance. So this is going to happen more and more in all
19 medical specialties, because the workforce is changing, and
20 if we can't work together with the department, it makes it
21 quite difficult.

22
23 THE COMMISSIONER: Thank you.

24
25 MR FULLER: Ms Clota, was there anything that you wanted
26 to add on these topics around recruitment and selection?

27
28 MS CLOTA: Yes, I think just to make the point that whilst
29 the college has the influence at the individual level in
30 terms of selecting somebody that would be appropriate for
31 surgical training and to be a surgeon in the future, there
32 is a significant amount of influence that the jurisdiction
33 has in terms of both the quantum and distribution, and so
34 those are - that's where there is a partnership that's
35 required.

36
37 MR FULLER: And is that influence because the jurisdiction
38 is funding the positions?

39
40 MS CLOTA: The training places, correct. As the president
41 has just outlined, we could train more.

42
43 MR FULLER: Is it also because, as we've just been
44 discussing, the jurisdiction at the moment holds the data
45 that you would need to make a further contribution on
46 issues of workforce and distribution?

47

1 MS CLOTA: So there is a conversation about data sharing.
2 There's also information about workforce planning and where
3 the jobs of the future will be, but there is that initial
4 application of accreditation of the post as well, which is
5 done by the jurisdiction in order to create the training
6 place.

7
8 MR FULLER: Just coming to the issue of withdrawal of
9 accreditation, can I ask you both, please, to have a look
10 at page 11 of the statement, item E on that page. You tell
11 us there that the status of an accredited training post may
12 be reviewed at any time during the accreditation period,
13 particularly where there are concerns that the educational
14 standard of the post has been compromised. Associate
15 Professor Fielding, who performed that review?

16
17 A/PROFESSOR FIELDING: So that's the training committee
18 that is involved in the initial review of a post.

19
20 MR FULLER: You would accept that withdrawing the
21 accreditation of a training post may have a significant
22 impact on the provision of surgical services at a site?

23
24 A/PROFESSOR FIELDING: Absolutely. But what we do know is
25 that, you know, a department that has poor culture, usually
26 goes with that poor outcomes for patient care. So we're
27 very mindful of, you know, significant complaints regarding
28 the culture of a department having a direct effect on
29 patient outcomes and so we take this very seriously. It's
30 not just about the trainee, it's about patient outcomes and
31 the evidence internationally for that is very strong.

32
33 MR FULLER: You've mentioned culture on a couple of
34 occasions. How does the college go about assessing or
35 evaluating the culture of a site?

36
37 A/PROFESSOR FIELDING: So do you mean when there's
38 a complaint or normally?

39
40 MR FULLER: Well, in a circumstance where you've mentioned
41 that the college might have a concern about the culture of
42 a site, whatever the source of that concern is, how does
43 the college then go about assessing or evaluating the
44 culture of the site in order to make an accreditation
45 decision about the site?

46
47 A/PROFESSOR FIELDING: So, you know, we'll listen to the

1 complaint; interviews will take place with the trainee,
2 with different members of the department, with other
3 trainees; we'll go back and have a look and see if this is
4 a repeat offender, this department, if there's been
5 complaints in the past; we'll sometimes interview
6 registrars that have been there before to find out about,
7 you know, what the culture was like when they were there.
8

9 Usually, these positions, it's not just a one-off, you
10 know; it's a group of complaints that have occurred over
11 a period of time to bring it to a head. Very unusual for
12 there to be one complaint about a department that's got
13 a major cultural problem; it's usually a cluster.
14

15 MR FULLER: So is it the case that the college itself or
16 the committee will go about trying to investigate the
17 complaint?
18

19 A/PROFESSOR FIELDING: Yes, so the committee itself will
20 start off and then we have a surgical adviser that they can
21 pass information past and ask for assistance, and that
22 surgical adviser will often go out to the site and do
23 a site visit and do what we call these "Vanderbilt coffee
24 cup" conversations and talk to people and find out what's
25 going on. So it does depend, as I say, on the nature of
26 the complaint and what's happened. We will speak to the
27 DMS, we will speak to the CEO of the site, depending on the
28 nature of the complaint again.
29

30 So we do - we have tried to work with the
31 jurisdiction, depending again on the level of the
32 complaint, but there has to be - I mean, that can be
33 difficult and sometimes there's a lack of understanding of
34 the importance of the culture and patient outcomes as well
35 as trainee, you know, effects on trainees. So that's part
36 of the reason why we've had the recent discussion
37 nationally, after the NHPO - no, sorry, after the review by
38 Deborah Frew for the government, looking at the complaints
39 process and accreditation and the communication protocol
40 that was set up with all the colleges so that we can try to
41 have a more central kind of repository for complaints and
42 so that we can get some high-level assistance from the
43 departments earlier on rather than sometimes these things
44 going on for quite a while with lack of understanding by
45 the local people.
46

47 MR FULLER: Obviously if complaints of bullying,

1 harassment, discrimination or similar matters are raised
2 with the college, would you agree that those are also
3 matters of workplace management?
4

5 A/PROFESSOR FIELDING: Yes, yes.
6

7 MR FULLER: How does the college process interact, if at
8 all, with the processes that the jurisdictions would have
9 in place for managing those sorts of matters at the
10 workplace level?
11

12 A/PROFESSOR FIELDING: So, you know, when we started our
13 bullying and respect program several years ago, five, six
14 years ago, I think it was, our college went out and made
15 a big effort to set up MOUs with many different hospitals
16 and sites and with the jurisdictions around the country and
17 my hospital was one of the first, in Wagga.
18

19 But can I tell you, it's been quite a difficult
20 process to work with the administration on some of these
21 issues, and we do find it quite difficult, and then the
22 department will complain that, you know, we didn't report
23 it up the line. So I do think that the communication
24 protocol that was set up nationally will help us a lot;
25 that there is a better reporting process and hopefully some
26 more seniority from the departments will come down into -
27 I mean, the hospitals are, you know, just dealing with
28 day-to-day business and they're all very stretched and
29 people are really, you know - the workforce issues are big
30 and the hospitals are all, you know, 117 per cent occupancy
31 and things like that.
32

33 So I do think that there is a problem, you know, these
34 issues are not the most crucial issues for the medical
35 administrators. So I think having the more overarching
36 process where we report it up the line and then we can get
37 some help from the departments down at the grassroots level
38 will make a big difference, and that's really just started.
39 So we haven't been able to do that before, but - yes.
40

41 MR FULLER: Why do you think the college has a role to
42 play at all in investigating matters of bullying and
43 harassment, discrimination and similar issues, rather than
44 leaving it to the workplace to investigate those issues?
45

46 A/PROFESSOR FIELDING: Well, first of all, the workplace
47 hasn't been great at doing it, or we wouldn't have

1 a cultural problem, and we have a cultural problem across
2 health, it's not just surgeons, it's everybody, nurses and
3 everybody, and that's just because the system's, you know,
4 under strain 24/7 and much, much worse since COVID.

5
6 But also it's part of our remit as a profession. You
7 know, it's part of our remit as a profession to uphold
8 standards with our members. It's a really important part
9 of training that we role model good behaviour, because we
10 know that good behaviour directly impacts patient outcomes.
11 If we're going to be quite a good standard setter in
12 surgery, or in any kind of medical training, then culture
13 is part of that. You know, good behaviour, good team work,
14 good collaboration, good role modelling is part of our
15 training, it's part of our everyday work. You cannot do
16 good work if you don't behave appropriately. So it's an
17 integral part of our function.

18
19 MR FULLER: Do you agree that where the college does
20 become involved in considering complaints of bullying,
21 harassment and the like, it's important to ensure that
22 management at the site level has a fair opportunity to
23 respond before the college takes any adverse action in
24 relation to its accreditation?

25
26 A/PROFESSOR FIELDING: Yes, absolutely. Absolutely. And
27 pulling accreditation is a last-ditch, you know, event, and
28 I've been involved in overseeing a few of these in the last
29 couple of years in this leadership role and I can tell you
30 that removing accreditation, it's a 12-month process; it
31 doesn't happen overnight. This has been going on for quite
32 a long time, and for some reason, the jurisdictions at
33 a state level have not been aware, which is why I welcome
34 the new regulations.

35
36 MR FULLER: Is the communications protocol that you
37 mentioned part of how the college ensures that the
38 jurisdiction has a fair opportunity to respond before
39 action is taken?

40
41 A/PROFESSOR FIELDING: Yes. And this was only implemented
42 in - I think it was November last year, Stephanie?

43
44 MS CLOTA: Correct, November 2023, yes.

45
46 A/PROFESSOR FIELDING: It is very new.

47

1 MR FULLER: You would agree with the general proposition
2 that colleges should have a clear framework for dealing
3 with concerns of bullying, harassment and similar cultural
4 matters?

5
6 A/PROFESSOR FIELDING: Absolutely. Yes, absolutely.

7
8 MR FULLER: Ms Clota, do you have any comments to make on
9 how the college does and should address concerns and
10 complaints about bullying, harassment, discrimination and
11 other cultural matters?

12
13 MS CLOTA: Nothing further to add other than that there is
14 a policy and that that policy is part of our AMC
15 accreditation, thank you.

16
17 MR FULLER: From the college's perspective - I will start
18 with you, Associate Professor Fielding - is there anything
19 wrong with a model in which the college would be
20 responsible for developing the training curriculum and
21 standards and administering examinations, but the
22 accreditation function was instead performed by a separate
23 central body on expert advice? Is there anything wrong
24 with that model?

25
26 A/PROFESSOR FIELDING: No, I think if we were involved in
27 it, particularly with, you know, the specialty requirements
28 for the different specialties, there are some things that
29 you really need to run some particular services. So no,
30 I think if there was - you know, if there was input from
31 the college, from the societies over - under our
32 jurisdiction, that would be certainly something we could
33 look at.

34
35 MR FULLER: Ms Clota, I think we've lost your video. Are
36 you still there?

37
38 A/PROFESSOR FIELDING: I don't know what has happened to
39 her.

40
41 MS CLOTA: I am here, sorry. I've got an unstable
42 connection. Nothing further to add, thank you.

43
44 MR FULLER: Thank you. Associate Professor Fielding, can
45 I ask you a few further questions about the issue of
46 workforce shortages?

47

1 A/PROFESSOR FIELDING: Sure.

2

3 MR FULLER: On page 8 of your statement under item 3,
4 you've referred to long and growing waiting times for
5 elective surgery, and then you go on to say that the number
6 of specialists appears inadequate given the known elective
7 wait times in the public sector. The elective wait times,
8 is that the only evidence or information you have as to the
9 adequacy or inadequacy of the number of specialists in --

10

11 A/PROFESSOR FIELDING: No, no, that's - frankly, I don't
12 believe myself it's a very good measure, but unfortunately,
13 it's the measure that the health department uses for
14 service delivery, is the elective wait times, and it's
15 incredibly --

16

17 THE COMMISSIONER: What is a better measure or what are
18 other measures that you think are appropriate?

19

20 A/PROFESSOR FIELDING: For example, there's no great
21 measures on trauma wait times. So as a rural trauma
22 surgeon, I can tell you, you know, we can wait several days
23 to get a case into hospital, with someone with an emergency
24 trauma case. If you ask a clinician, that's completely
25 inadequate, because the health department runs on elective
26 surgical wait times as their benchmark for, you know, good
27 practice, and elective surgery should be elective surgery,
28 it's not urgent.

29

30 You know, if you've got 30 cases waiting to be done
31 for trauma, then it makes sense to clinicians that that
32 gets done ahead of elective surgery, because it's urgent
33 and it needs to be done, and we know that the longer you
34 wait with emergency surgery, the increase in complications
35 and comorbidities for the patient.

36

37 So it's a very frustrating environment to work in when
38 you've got a mountain of emergency surgery banking up and
39 your hospital will not do anything to help you get it done
40 because their funding is based on their elective surgery
41 wait times.

42

43 THE COMMISSIONER: Can I just get you to pause there.
44 I want to pick that up with you, but just so we understand,
45 where Mr Fuller was reading from in page 8 of your
46 submission --

47

1 A/PROFESSOR FIELDING: Number 3, yes.
2
3 THE COMMISSIONER: -- the wording used is "long and
4 growing wait times for elective surgery in Australia's
5 public hospitals".
6
7 A/PROFESSOR FIELDING: Yes.
8
9 THE COMMISSIONER: Then you say that the number of
10 specialists appears inadequate given the known elective
11 wait times in the public sector.
12
13 A/PROFESSOR FIELDING: Yes.
14
15 THE COMMISSIONER: Does that statement also relate to - is
16 that a national-wide opinion, as distinct --
17
18 A/PROFESSOR FIELDING: Yes, it is. Yes, it is.
19
20 THE COMMISSIONER: And can I ask you, though, do you still
21 hold the same opinion in relation to New South Wales? Let
22 me give you some context for that, though. You've, quite
23 appropriately, used the Australian Institute of Health and
24 Welfare. I haven't gone back and done a long analysis, but
25 the last quarterly report from the Bureau of Health
26 Information in New South Wales tells me - tells everyone -
27 that in the last quarter, we still had 3,419 patients
28 waiting longer than clinically recommended for elective
29 surgery --
30
31 A/PROFESSOR FIELDING: Mmm-hmm.
32
33 THE COMMISSIONER: -- which is up from the December
34 quarter but it's about 10,000 down from March 2023, which
35 I assume would mean some correction following the pandemic.
36 Would that be how you would understand it?
37
38 A/PROFESSOR FIELDING: Yes, absolutely. Yes, that's what
39 happened, yes.
40
41 THE COMMISSIONER: Now, 3,419 people waiting longer than
42 is clinically recommended for elective surgery, I guess in
43 an ideal world that figure would be zero, and it doesn't
44 tell me, I don't think, how in excess of the clinically
45 recommended period those surgeries are being performed.
46 Just help me, I'm actually scanning this document as we
47 speak. I don't think there is anything reported in these

1 quarterly reports about the trauma surgery you're talking
2 about, the wait times for that?

3
4 A/PROFESSOR FIELDING: No.

5
6 THE COMMISSIONER: Where would - is there any place - do
7 you know that simply because you're doing trauma surgery,
8 you know what the wait times are at least for your
9 hospital?

10
11 A/PROFESSOR FIELDING: Yes.

12
13 THE COMMISSIONER: I can ask other people, but is there
14 any public source of data for that?

15
16 A/PROFESSOR FIELDING: I'll have to take that on notice
17 and - there are some, there are some. There's waiting
18 times in the emergency department, there is published data
19 on that.

20
21 THE COMMISSIONER: Yes, emergency department wait times,
22 there's some information about that, but you were talking
23 more specifically about waiting for surgery, which sounds
24 like --

25
26 A/PROFESSOR FIELDING: Yes, that's right.

27
28 THE COMMISSIONER: -- if it's emergency surgery, it
29 doesn't sound like, to me as a non-clinician, you want to
30 be waiting very long.

31
32 A/PROFESSOR FIELDING: No. It's pretty terrible when
33 you've got a broken arm and you've got to wait four days or
34 five days to get it fixed because you've got to get the
35 elective knee replacements done. That's what happens.

36
37 THE COMMISSIONER: Is that typical for your hospital?

38
39 A/PROFESSOR FIELDING: Yes, absolutely. Yes, that's
40 typical. That's not just in Wagga, Commissioner, that's
41 a national problem, statewide problem, because it's not one
42 of those benchmarks that they use. And the problem is that
43 the hospitals are all full, you know, all this stuff is all
44 about theatre availability, about beds --

45
46 THE COMMISSIONER: Just pausing there so I know. In your
47 opinion, to your knowledge - and it can be also based on

1 discussions with your colleagues --

2

3 A/PROFESSOR FIELDING: Yes.

4

5 THE COMMISSIONER: -- what's causing that undesirable
6 delay in emergency or trauma surgery? What are the
7 factors?

8

9 A/PROFESSOR FIELDING: So we have a system that's become
10 dependent on the public hospitals, we have a reduced number
11 of people in private insurance, you know, where we have
12 this increasing dependency on the public sector for health
13 care. We have an ageing population. We have workforce
14 issues. It's multifactorial. You know, our primary care
15 has broken down, we need more primary care.

16

17 THE COMMISSIONER: Stop there. Stop there. "Primary care
18 has broken down", what do you mean?

19

20 A/PROFESSOR FIELDING: We're just not producing enough
21 GPs, there is a shortage in the sector, so people go to the
22 ED to get looked at when they really should be in a general
23 practice. They can't afford to go to general practice
24 because the funding support for general practice is not
25 commensurate to the cost. I mean, the ED waiting times are
26 terrible. The hospital's now developed this thing called
27 a rapid access clinic, which is like another kind of ED,
28 you know, so there's all these --

29

30 THE COMMISSIONER: Just stopping there, those rapid or
31 urgent care clinics, do you view them as a substitution for
32 primary care or are they just a bandaid over emergency
33 departments?

34

35 A/PROFESSOR FIELDING: I think it's both, you know?

36

37 THE COMMISSIONER: And with the breaking down of primary
38 care you mentioned, is that your experience or knowledge of
39 your LHD or are you talking --

40

41 A/PROFESSOR FIELDING: Absolutely, absolutely.

42

43 THE COMMISSIONER: -- more broadly?

44

45 A/PROFESSOR FIELDING: It's broad. It's a binational
46 problem, national problem, talking to everybody around,
47 listening at CPMC to the colleges and GPs, but you know, in

1 our jurisdiction, absolutely. I mean, I have patients
2 ringing my office to get a script because they can't get
3 into their GP.

4
5 THE COMMISSIONER: Just explain to me the process by which
6 having more people than need to be in emergency
7 departments - by that I mean people in there that could be
8 seen by a general practitioner or by primary care, but
9 they're in the ED so the ED is stretched - how does that
10 have a flow-on to extending the wait time for trauma or
11 emergency surgery?

12
13 A/PROFESSOR FIELDING: Well, look, it goes back a long
14 way, because if you've got people that are accessing the ED
15 because their, you know, asthma is bad or they're short of
16 breath or they've got COVID and they haven't seen a doctor,
17 they usually present late, so they present when they're
18 sicker, so then they often need a bed, they need to be
19 admitted to hospital.

20
21 So that's part of the problem. Because of the lack of
22 availability of primary care, the lack of preventative
23 health that's happening, because people go to the doctor as
24 a last resort these days and then they end up in the ED
25 because they're sicker - so we're not sorting stuff out
26 earlier, we're not preventing, you know, the worsening of
27 disease, if you like, so then you've got people in the ED
28 waiting.

29
30 So you've got the wait times generally for stuff that
31 needs admissions and stuff that doesn't need admission, but
32 for the stuff that needs admission, I think there's more of
33 that. It's well known there's more, you know, pneumonias
34 and people coming into hospital with multiple
35 comorbidities, obesity and respiratory disease and so on,
36 so then the hospital is filling up with those patients.

37
38 From my jurisdiction, you know, osteoporosis is not
39 managed in the community and then they've got a fracture
40 in their spine and then they're admitted because there's
41 no family support and nothing happening in the community.
42 So we've got stuff in hospital now that we didn't have 10
43 years ago because we haven't got good primary care
44 happening and good preventative medicine happening.

45
46 THE COMMISSIONER: You tell me if I'm wrong, but if I was
47 to sum up everything you just said - and it needs to have

1 the detail, but if I was to sum it up in a very short and
2 concise way, tell me if you disagree, but it sounds like
3 when primary care has either failed or is failing or is
4 inadequate - and by "primary care", I mean general
5 practitioners, allied health, prevention, all of that - it
6 ultimately puts the strain on the public hospitals?

7
8 A/PROFESSOR FIELDING: Absolutely correct.

9
10 THE COMMISSIONER: Can I ask one further related question
11 before we might have a break, depending on - it might be
12 a related question but I want to go back to something you
13 said at 4208, and it was just almost an aside in one of
14 your answers, but you said - you were having a general
15 discussion with Mr Fuller about workforce and trainees and
16 you said, "We could easily train another orthopod in Wagga,
17 I can tell you that now." Can you help me, does that mean
18 there is the capacity to train another orthopaedic surgeon
19 or there's the capacity to train another orthopaedic
20 surgeon and it's clinically - demand is there that we
21 should be training another surgeon?

22
23 A/PROFESSOR FIELDING: So the demand is there for rural,
24 but what we need to be doing is we need to be training - we
25 need to train rural people for rural in rural, because we
26 know internationally, from all the work that has been done
27 around the world, that the way to keep people in rural is
28 to train rural people. People that are connected to rural
29 want to stay in rural. At the moment, we have
30 a metro-centric training program, all the colleges do. We
31 have a metro-centric health system, where everybody thinks
32 that it's better if you're in the city, because we
33 obviously aren't very good in the country.

34
35 Actually, the research does not support that. I have
36 been training for 35 years in rural, but everyone I have
37 trained has gone and worked in the city. So we need to
38 keep these people in the country, from medical school right
39 through. We have programs running in other specialties at
40 the moment, in anaesthetics and in general medicine to name
41 a couple, psychiatry has started, where we have regional
42 trainee hubs and the trainees are settled in the country,
43 they're rural trainees from medical school, they go right
44 through, about 70 per cent of their training, in a rural
45 site and they're the people who want to stay here, okay?
46 So we can do that but --

47

1 THE COMMISSIONER: What's preventing another orthopaedic
2 surgeon being trained in Wagga? What's preventing it?

3

4 A/PROFESSOR FIELDING: Well, part of that's us. Part of
5 that's us but it's also - there's no point training
6 someone if we don't have another position, you know? So at
7 the moment we've got 10 orthopods running the department
8 here and we need to have buy-in from the health department
9 to make more positions to succession plan the workforce, so
10 that --

11

12 THE COMMISSIONER: So that's a funding issue; you need the
13 funding?

14

15 A/PROFESSOR FIELDING: That's a funding issue, that's
16 right. And you know, the problem is the infrastructure is
17 not there for any more theatre lists to do any more
18 surgery, but like I said very early on in the discussion,
19 if you were using your surgeons at both ends, the young
20 ones and the old ones, to do some other things, you could
21 have surgeons working in clinics to look at does this
22 person really need to be on the elective waiting list? Can
23 we do better perioperative care?

24

25 NSW Health, through ACI, has done some amazing work
26 in, for example, osteoarthritis and do people really all
27 need a knee replacement? No, they don't; sometimes they
28 need to just lose some wait and do exercise. So there are
29 programs running but they're not really supported by
30 clinicians because, you know, the funding models haven't
31 supported that. So we can do what we do better and we can
32 probably reduce the load on our operating theatres if we
33 have surgeons working in more clinical roles, we have
34 better teaching, but we need to be coordinating what we're
35 doing with the department, with the health department.
36 That coordination is not happening.

37

38 THE COMMISSIONER: All right, okay, thank you. Just
39 pausing there. Have we lost Ms Clota? We have.

40

41 A/PROFESSOR FIELDING: I think we have.

42

43 THE COMMISSIONER: You've got a few questions to go?

44

45 MR FULLER: I've probably got another 10 minutes or so.

46

47 THE COMMISSIONER: I think what we'll do, Associate

1 Professor, is we'll have the morning tea break.

2

3 A/PROFESSOR FIELDING: Sure.

4

5 THE COMMISSIONER: Don't feel as though you've got to stay
6 in front of the screen, but could you come back at 12 noon,
7 that's when we will resume?

8

9 A/PROFESSOR FIELDING: Okay.

10

11 THE COMMISSIONER: And Mr Fuller has a few questions after
12 that, and in the interim hopefully we'll get your colleague
13 back.

14

15 A/PROFESSOR FIELDING: She's actually jumping on a plane
16 to go to Melbourne. I'm sorry about that. I think I can
17 probably answer your questions if you are happy.

18

19 THE COMMISSIONER: If she has to go to Melbourne, I will
20 say she is excused.

21

22 **<MS CLOTA WITHDREW**

23

24 A/PROFESSOR FIELDING: Okay, thank you. Could you give me
25 an idea how much longer we will go? I've just got --

26

27 THE COMMISSIONER: Mr Fuller said he will be 10 minutes
28 and Mr Cheney, who is the senior counsel for NSW Health,
29 might be 5 to 10 minutes. So hopefully you will be
30 finished by 12.20 or thereabouts.

31

32 A/PROFESSOR FIELDING: Okay, and we'll reconvene, did you
33 say, reconvene at 12 o'clock?

34

35 THE COMMISSIONER: 12 noon. Thank you very much.

36

37 **SHORT ADJOURNMENT**

38

39 THE COMMISSIONER: Yes, please proceed, Mr Fuller.

40

41 MR FULLER: Thank you, Commissioner.

42

43 Associate Professor, can I take you back to page 8 of
44 your statement, please.

45

46 A/PROFESSOR FIELDING: Yes.

47

1 MR FULLER: Under item 3, the second paragraph, in the
2 last you see it says:

3

4

*RACS also understands the pipeline issues
5 for qualifying more FRACS surgeons ...*

6

7

Do you see that sentence?

8

9

A/PROFESSOR FIELDING: Yes.

10

11

MR FULLER: Can you just elaborate on those issues,
12 please?

13

14

A/PROFESSOR FIELDING: Yes. So like I said, we're well
15 aware of the fact that the health department feel they need
16 more surgeons, particularly general surgery and
17 orthopaedics. And like I said, we have been talking to
18 them about, you know, can they help us to identify sites
19 where they want more, and we would be happy to accredit,
20 and that hasn't happened.

21

22

The other thing we have been in consultation with the
23 rural GPs and the GPs, so ACCRM and RACGP, about starting
24 to increase training and to develop some modules for the
25 GPs for procedural work. So already the GPs in rural do
26 some scoping work - you know, gastroscopy, colonoscopy -
27 but we want to extend that to several modules.

28

29

We have agreement across our societies for several
30 modules, kind of hand trauma, some fracture work, some, you
31 know, skin cancer work, different - we've been talking to
32 the dermatologists to sort of cross specialty run some
33 training. So as the GPs - sorry, as the anaesthetists have
34 done, we're really keen to get into that space and help the
35 rural GPs increase their education and training so they can
36 provide this care.

37

38

MR FULLER: Is that what you mean in the second part of
39 the sentence where you say.

40

41

*... [the college] is open to discussions
42 around scope of practice ...*

43

44

A/PROFESSOR FIELDING: Yes, "for procedural non FRACS
45 practitioners". So for the GPs and the rural GPs, that's
46 what we're trying to work on through our rural health
47 equity strategy.

1
2 MR FULLER: Can I ask you to go to page 15 of the
3 statement, please. You should see there a heading "Case
4 studies"; do you see that?

5
6 A/PROFESSOR FIELDING: Yes.

7
8 MR FULLER: Can I just ask you about the two case studies.
9 The first one relates to "NSW Grafton Aboriginal Care". Do
10 you see that in italics?

11
12 A/PROFESSOR FIELDING: Yes.

13
14 MR FULLER: Are you able to elaborate on what you're
15 describing in relation to that case study?

16
17 A/PROFESSOR FIELDING: So that was a - so that's an
18 initiative that was set up in Grafton for primary care, for
19 Indigenous health, is my understanding, and the funding has
20 been pulled or reduced.

21
22 Apparently the model was working extremely well, it
23 was an excellent service for the region, was reducing the
24 requirement of people accessing hospital-based care because
25 of really good, you know, community services, and, you
26 know, reducing a primary care facility like that providing
27 good service is a travesty and certainly is going to lead
28 to huge issues in the hospital system, because obviously
29 that's where people will need to go if they can't access
30 primary care. So it's basically a primary care model, but
31 for a particular population of underprivileged people who
32 really need it, to have lost that service which had an
33 excellent reputation, and I think had won awards, is
34 a travesty.

35
36 MR FULLER: Your knowledge about that case study, where
37 does that come from?

38
39 A/PROFESSOR FIELDING: Well, I have to admit it comes from
40 my association with the member for parliament, Dr Joe
41 McGirr, independent member for Wagga, who happens to be my
42 husband. He's also a medical practitioner. He's a medical
43 administrator, was an emergency physician. We've worked in
44 rural our whole careers together in partnership, in the
45 local hospital, local health district, running education,
46 training at Notre Dame University for medical students, so
47 we've both worked together, and so we do collaborate

1 together about rural issues, we've worked on many rural
2 health committees together. So it's not really a conflict
3 but --

4
5 MR FULLER: So is this information that came to him
6 through a constituent that has made its way to you; is
7 that --

8
9 A/PROFESSOR FIELDING: No, he's actually done a visit to
10 Grafton to look at that service because of the pulling of
11 funding, and he was telling me about that, so I reiterated
12 that information to my team at the college. But that's an
13 example of, you know, the lack of support of primary care
14 which is actually a big part of the reason we're in this
15 problem with the hospital systems being overrun.

16
17 MR FULLER: Do you know if that funding was provided by
18 the Commonwealth or New South Wales?

19
20 A/PROFESSOR FIELDING: I don't know.

21
22 MR FULLER: Then the next case study you give is in
23 relation to Wagga, which I assume comes from your personal
24 experience; is that right?

25
26 A/PROFESSOR FIELDING: Yes, absolutely.

27
28 MR FULLER: Are you able to just explain - where you say
29 that Wagga only succeeds due to their relatively small
30 size, close collaborations and so on, can you just explain
31 what you mean by that?

32
33 A/PROFESSOR FIELDING: I'll just have to read it.

34
35 MR FULLER: Can I perhaps put it this way: do you have
36 anything to add to what's already in there about the Wagga
37 case study?

38
39 A/PROFESSOR FIELDING: Well, I suppose the most important
40 thing to say about it is that when you have local
41 champions, when you have, you know, people in a rural area
42 that are willing to work closely, you know, you can
43 actually do really good things. We actually do have one of
44 the lowest bed stays in the state for joint replacement
45 surgery, for example, and that's been led by our
46 department, not so much by our hospital.

47

1 So there are models around the state of things that
2 can be done that can really make a big change to what's
3 happening in your service. But these models should be
4 shared across the state and there should be better
5 collaboration between - you know, but the health department
6 should be looking at areas of excellence and then sharing
7 those models across the state.

8
9 MR FULLER: Are there any particular - or is there
10 a particular model you have in mind that you think could
11 provide a lesson for other health services across the
12 state, from Wagga?

13
14 A/PROFESSOR FIELDING: So that was one of the ones that
15 I thought of when I was preparing the statement. So we did
16 this work on short stay joint replacement, which is - it's
17 a big thing in the states, you know, get people in, get
18 them out. In Wagga, we have a hotel that's right next to
19 the hospital so when the hospital's really full, we often
20 use that for overflow and patients can stay an extra day or
21 two, because a lot of our patients come from a long way
22 away, two, three, four hours' drive from Wagga, and we do
23 know that people going back to very remote places after big
24 surgery do have a higher risk of complications after the
25 surgery. So to keep them nearby is a good thing. To keep
26 them in hospital is extremely expensive. So the hospital
27 has developed this model in the hotel next door where we do
28 kind of have our overflow, if you like.

29
30 Now, that's sort of an ad hoc arrangement, but
31 arrangements like that where you put people in a lower-cost
32 accommodation for a couple of days, particularly in rural,
33 where - you know, there is no service in their local
34 hospital or their local area health service out in, you
35 know, Hillston, for example, there is very little there for
36 them to access - to keep them close by, we have
37 a community-led hotel that is for people having cancer
38 treatment, but again, we use that for some of our joint
39 replacements and overflow. So that's one way we've managed
40 to keep the bed occupation rate a bit lower. So, look,
41 they're very small little vignettes, if you like, but
42 they're things that should be looked at that could be done
43 across the sector.

44
45 The other idea, which I know has happened in other
46 hospitals not ours, is, you know, dividing up the day
47 surgery from the big case surgery. So having the day

1 surgery separate and in a different location so that, you
2 know, the little tiny cases are not, you know, compounding
3 the lists in the major centre, works really well if you can
4 do that - so models of care like that where you're
5 separating things out or you're doing them in a different
6 site.

7
8 We did that during COVID, we did all our day surgery
9 in the private hospital and that really meant that we could
10 continue doing the big surgery. In fact, our trauma
11 surgery delivery was excellent during COVID because we
12 weren't battling with the electives, but part of it was
13 because we had all the little day cases being done in the
14 private when the government was happy to pay for that. So
15 different models like that. So I just think that the
16 system needs to be reviewed so that we can use best
17 practice across the board rather than just in tiny little
18 pockets.

19
20 MR FULLER: Those sorts of models or "vignettes", as
21 you've described them, is there currently any systematic
22 process for people like - for doctors like you to share
23 those experiences across the health system?

24
25 A/PROFESSOR FIELDING: Not that I'm aware of, not unless
26 you're lucky enough to get involved in a project, say, with
27 ACI, but no, not - as far as theatre utilisation and beds,
28 I haven't heard of any group working on that.

29
30 MR FULLER: Back on page 13, under item 12, you say, in
31 the second paragraph, that the college is advocating for
32 the expansion and creation of rural training networks and
33 corridors of training between metro and rural. I think
34 this touches on your answers to the Commissioner earlier,
35 but can you just explain what you see the expansion and
36 creation of rural training networks involving and why that
37 would be beneficial?

38
39 A/PROFESSOR FIELDING: So the Commonwealth Government has
40 funded 28 regional training hubs across the country. We
41 have, I think, five in New South Wales, or maybe more -
42 maybe more, probably more. They're regional training hubs
43 which are connecting hospitals and university rural
44 clinical schools together so that rural training can be
45 based in rural sites, and then some of those - some of the
46 rural sites are connected to the clinical schools.

1 So, for example, I think there's one in Orange and
2 that includes Dubbo and Bathurst, for example, those three
3 hospitals. Wagga's quite a big site so we would only be
4 connected, probably, to Griffith. Griffith is our only -
5 I think it's our only other hospital, major hospital,
6 that's attached to the Wagga regional training hub.

7
8 So regional training hubs are where the medical
9 students are looked after from medical student time right
10 through the whole continuum of training through internship,
11 residency and then into vocational training by a team,
12 a managerial team, if you like, at the rural training hub,
13 which is usually a connection between whatever the clinical
14 schools are and the region.

15
16 So here in Wagga it's New South Wales uni and Notre
17 Dame. They work together. They look after the students
18 from student days right through their training program, to
19 help them to get on to the training program because again
20 rural people are often a bit more disadvantaged, they
21 haven't got the same background, they can't get PhDs and
22 masters and whatever you need to do to do training.

23
24 They often come from financially disadvantaged
25 backgrounds, so, you know, understanding and paying for
26 advanced education is difficult for them. Our trainees do
27 need to access courses throughout their pre-vocational
28 time. Through those internship and junior doctor years,
29 they need to do courses which cost money, but there are
30 lots of scholarships available to them but they often don't
31 know about them.

32
33 So these managerial people are there to support them,
34 to help them through the pathway of training and we want to
35 do that for surgery. We want to set up surgery in all
36 those regional training sites throughout the country.
37 Obviously keen to do that in New South Wales as well and,
38 like I said, we could do that in Wagga yesterday, but that
39 requires - it requires support from the government, from -
40 you know, for training positions, but also support for the
41 trainers, because obviously if you're going to have
42 trainees here for extended periods of time, then they're
43 probably going to need more coaching, more support than
44 someone who is just fly-in/fly-out, if you like.

45
46 As well as that, we've recommended to national
47 government, to the jurisdictions, to state governments,

1 that, you know, to support rural workforce you've got an
2 oversupply of specialists in the city, and it would make
3 a lot of sense for those city doctors, when they apply for
4 a position in a hospital, to have links with rural and to
5 help rural with bi-directional appointments.
6

7 And the same for your rural workforce - if you really
8 want to make a rural career, you know, you really want to
9 make that a good job for a surgeon to come to a rural
10 place, particularly a place that's smaller than perhaps
11 something like Wagga, a smaller site where you've got less
12 support, less clinical governance, less, you know, ability
13 to run proper audit and M&M, you want to do that in a rural
14 site, one way to do that is to link it to a metropolitan
15 site.
16

17 So putting the onus on to some of the metropolitan
18 sites who have a really large number of specialists working
19 there, a large number of registrars, a large number of
20 fellows, they've got great infrastructure, they've got all
21 the PET scans and whatever they need, getting them to work
22 in rural as well. And some of them do that already on kind
23 of an kind of ad hoc fly-in/fly-out service, but if you
24 link it to an appointment, that's what we really have been
25 advocating, you get someone in St Vincent's who comes to
26 Wagga on a 0.1 or 0.2 and they make a commitment, they make
27 a commitment to come to Wagga regularly, it's supported by
28 the public sector.
29

30 At the moment, most of those ad hoc arrangements are
31 actually in the private sector, which actually devalues the
32 public sector even more. People are sent off into the
33 private sector, the surgeons are working in the private
34 only, patients have to pay more, and it also creates this
35 geographical narcissism or this anti-rural culture that the
36 super specialist from the city, who is fly-in/fly-out
37 private only is much better than the rural doctor who's
38 working their bottom off in the public, if you like.
39

40 So we really want to change the culture and we need
41 help to do that. So having people with appointments - so
42 if I had an appointment 0.1 in the city, I'm flying in,
43 flying out, that supports my practice, it gives me good
44 clinical governance, M&M and audit, and then you've got
45 a surgeon from the city coming to me for 0.1, I've set that
46 up organically just throughout my clear career, I have
47 surgeons who come to Wagga and help me out and I go to

1 Sydney and help them, but it's actually onerous to get the
2 surgeon, independent surgeon, working in rural to do that
3 on their own.
4

5 We've suggested to the government that this should be
6 something they do regularly. So far that has happened in
7 Victoria, with the Alfred, and that's working in Ballarat,
8 they've got some bi-directional appointments, they've been
9 working with us and they've actually started some of those
10 appointments, and I think they've got three surgeons
11 working in Ballarat on bi-directional appointments. So
12 it's just starting but, you know, we could do a lot more.
13

14 MR FULLER: When you say you "suggested to the
15 government", does that include to the New South Wales
16 Government or NSW Health?
17

18 A/PROFESSOR FIELDING: All of them, yes.
19

20 MR FULLER: Just finally, do you have with you appendix 2
21 to the college's statement, which is a document called -
22 I might just ask for it to go on the screen. It's
23 [SCI.0011.0178.0001], exhibit H6.2.2. It's a document
24 entitled "National rural surgeons training and retention
25 workshop February 2024. Issues and outcomes paper".
26

27 A/PROFESSOR FIELDING: Yes, which I wrote.
28

29 MR FULLER: I'm not going to ask you detailed questions
30 about it, but can you just explain how this document came
31 about, or how did the workshop come about, I'm sorry.
32

33 A/PROFESSOR FIELDING: Yes, okay. So I --
34

35 THE COMMISSIONER: Sorry to interrupt, while it's not on
36 the screen, can you tell me what the volume is?
37

38 MR FULLER: Volume 6, 6.2.2. I have a hard copy if that
39 would assist.
40

41 THE COMMISSIONER: H6?
42

43 MR FULLER: I think we've got it on the screen.
44

45 THE COMMISSIONER: I'll just look there. Thanks, sorry.
46

47 MR FULLER: Sorry, Associate Professor, how did the

1 workshop come about?

2

3 A/PROFESSOR FIELDING: Okay, so you know about the
4 national workforce paper that Brendan Murphy worked on for
5 many years, just - I can't quite think of the title at the
6 moment, but it is mentioned, I think, at the end of that.
7 Anyway, Brendan Murphy has been working nationally on
8 a strategic plan for national medical workforce, looking at
9 rural workforce, and I've been chair of a rural health
10 equity strategic action plan at RACS for the last three
11 years as senior rural leader in surgery, and we've been
12 working with Ruth Stewart, the National Rural Health
13 Commissioner. She's been on my committee for rural
14 strategy at RACS for those three years.

15

16 We have been working with our societies and senior
17 leaders across several colleges, and we have \$3 million
18 worth of FATES funding from the federal government working
19 on barriers to rural training and several projects that
20 we're running at RACS in coordination with multiple other
21 medical colleges.

22

23 That work's been ongoing for three years and we've
24 sort of come to a little bit of a standstill of trying to
25 get our societies across the line with rural training, and
26 it's not just the societies, it's also the jurisdictions,
27 looking at where we need people, and so we kind of decided
28 to have this workshop with the jurisdictional
29 representation, with representation of the AMC, from Ahpra,
30 from the specialty societies, to produce this outcomes
31 paper which was really a call to arms. A call to arms to,
32 come on, we've done all the work, we know what we need to
33 do, let's get on with it. So we produced this paper out of
34 the workshop that we ran in February at the college, with
35 this broad group of stakeholders.

36

37 MR FULLER: The paper goes on to set out a number of
38 problems, learnings, considerations and opportunities in a
39 number of themes?

40

41 A/PROFESSOR FIELDING: Yes.

42

43 MR FULLER: I take it the college agrees with those
44 matters that are identified in the paper?

45

46 A/PROFESSOR FIELDING: Yes, we do.

47

1 MR FULLER: The paper also sets out a number of agreed
2 actions on each theme, which are actions for the college
3 and, in some cases, the specialty training boards or
4 committees to take?

5
6 A/PROFESSOR FIELDING: Yes.

7
8 MR FULLER: I take it, because they're described as
9 "agreed actions", that the college and the boards, where
10 relevant, have agreed to implement each of those?

11
12 A/PROFESSOR FIELDING: No, so the agreed actions are from
13 the working group, not by the societies, yes. So this
14 paper has just gone to our council and will be presented
15 to - so we've presented the draft to the training boards
16 but we haven't actually asked them to sign off on it yet
17 because it was in draft form, and the plan was to take that
18 to CSET in October for sign-off.

19
20 MR FULLER: Is that still the college's plan?

21
22 A/PROFESSOR FIELDING: Yes.

23
24 MR FULLER: Will it be the case that to the extent that
25 the agreed actions are accepted or adopted, the college
26 will report on its progress against those?

27
28 A/PROFESSOR FIELDING: Yes.

29
30 MR FULLER: Do you have a sense at the moment of when that
31 will start to happen? I take it after October this year?

32
33 A/PROFESSOR FIELDING: Yes, after October. So our plan is
34 to commence regional training in 2026. That's the timeline
35 that we're working on. We obviously need to get some posts
36 accredited that we haven't got accredited so far. We do
37 have some already that we can work on. But, yes, by then,
38 the FATES funding timelines will be finished, the projects
39 will have been completed that we're doing. We're doing
40 projects on rural and remote supervision, barriers to
41 accreditation of rural and to, you know, the sort of
42 bureaucratic overload to surgeons in rural and some video
43 support, video support for kind of counselling, video
44 counselling, video training, if you like, for surgeons in
45 remote and isolated positions.

46
47 So yes, we've got several projects running at the

1 moment, with RACMA, with the college of obstetrics and with
2 the college of physicians, so they're multi-college
3 projects. So, yes, everything should be finished next year
4 and our plan is for - to commence that rural training for
5 2026 in orthopaedics and general surgery.

6
7 MR FULLER: Thank you, Commissioner. Those are my
8 questions for this witness.

9
10 THE COMMISSIONER: Yes. Mr Cheney, do you have any
11 questions?

12
13 MR CHENEY: Just a couple, Commissioner, if I may.

14
15 **<EXAMINATION BY MR CHENEY:**

16
17 MR CHENEY: Q. Associate Professor Fielding you, in your
18 statement, canvass, among other things, the role of
19 unaccredited trainees in the system?

20 A. Yes.

21
22 Q. If you go to your answer to question 13 on page 13 of
23 the document, do you see there --

24 A. Number 13?

25
26 Q. Yes.

27 A. Yes.

28
29 Q. Are we right to think of unaccredited trainees as
30 those who have been unsuccessful in obtaining a training
31 place in an accredited college training scheme?

32 A. Not usually. Unaccredited trainees are usually on
33 a pathway to training. So in some states there are a lot
34 more unaccredited trainees than we believe there should
35 be - for example, in Queensland. New South Wales has
36 a much closer relationship between the numbers of
37 unaccredited and the numbers of accredited, which is,
38 I think, a much more balanced position.

39
40 Unaccredited trainees are often used for service
41 delivery. They should be people on a pathway to training.
42 It should be that the majority of unaccredited actually
43 get into a program. Unfortunately, that has changed in
44 some of the states around the country. But in New South
45 Wales in general, there's a reasonable match. We have
46 a few more unaccrediteds, because they're not all going to
47 make it and they're not all going to decide to stay in

1 surgery. But, yes, there shouldn't be a huge number of
2 unaccrediteds and a very small number of accrediteds.

3
4 But they are on a pathway to training, so they do need
5 to learn some skills before getting on to the training
6 program and also it's a way we can assess them to see
7 whether they are developing the required skills to be
8 a surgeon.

9
10 Q. And over the page on page 14, about the fourth
11 paragraph, you refer to the college recommending that there
12 be a focus on increasing the conversion of unaccredited
13 registrars to trainees?

14 A. Yes.

15
16 Q. Can you help with us that?

17 A. So we have said that we are very happy to look at
18 a lot of those positions, where hospitals have a lot of
19 unaccrediteds, to see if we can convert some of them to
20 accredited positions, if there's enough caseload, case mix.
21 It depends on the role of the unaccredited registrar. In a
22 lot of hospitals they will be used for service delivery,
23 for example, for shifts overnight.

24
25 In the big city teaching hospitals they're often used
26 for service delivery for overnight shifts, for example, in
27 general surgery, so that there's always a registrar in the
28 hospital. That's not a particularly good training position
29 if they're on their own at night in a hospital without
30 supervision. We wouldn't be comfortable with some of those
31 positions becoming accredited, so again, they would have to
32 be looked at. But they are often used for service
33 provision. But if they're doing a similar kind of role to
34 an accredited registrar, then absolutely, they need to be
35 looked at for conversion.

36
37 Q. And where you refer to seeing an opportunity to
38 explore a career medical officer as part of the surgical
39 team - do you see that?

40 A. Yes.

41
42 Q. Are you contemplating that such a career medical
43 officer would play a surgical role in the surgical team,
44 or are you --

45 A. Yes. So in a lot of the teaching hospitals, there's
46 a large number of registrars in a unit, particularly if you
47 are dealing with a lot of complex caseloads, there's a lot

1 of ward work, you know, reviewing patients, ward rounds,
2 things like that, that often will be done by the
3 unaccredited registrar workforce. One of our suggestions
4 is - there are people that like working in hospitals that
5 want to make a career of becoming - we used to call it
6 a career hospitalist, if you like, or a career medical
7 officer, one or the other.

8
9 So we're actually quite willing to discuss forming
10 a special role as a surgical career medical officer,
11 someone who's part of a team, might not be a surgeon, but
12 like a surgical assistant, helps out on the ward, helps the
13 team. I think it would be a more efficient than having new
14 doctors as interns having to do a term in surgery or a term
15 in orthopaedics when they're not even interested in it and
16 they're changing over every eight weeks and having to learn
17 what the team requires. So we think there can be some
18 significant efficiencies in the system by having these
19 people trained as more permanent members of departments.

20
21 Q. You speak about that as an opportunity that should be
22 explored. Is that something that would be typically raised
23 by you through your membership of the Health Workforce
24 Taskforce?

25 A. Yes, we have mentioned it with that group and also
26 directly to the health department and I, prior to this
27 role, had a senior role in HETI, the Health Education and
28 Training Institute for NSW Health, for many years and it's
29 something we've been talking for a long time.

30
31 So now I've got the college agreeing to talk about
32 that, and that was a bit of a stumbling block in the past
33 but having had the previous role in HETI, I've now been
34 able to take that to the college. So yes, we're very keen
35 to - we've already opened up a CPD Home - a continuing
36 professional development home - which is AMC accredited.
37 CPD Home is now available to PGY3-plus doctors and we are
38 looking at a membership category of RACS so that people
39 could have a post nominal and make them look, you know,
40 more professional in surgery without having to do the full
41 training.

42
43 Q. You spoke earlier about the college's need for some
44 data on --

45 A. Yes.

46
47 Q. -- where there could be more accredited posts needed

1 to meet service needs?
2 A. Yes.
3
4 Q. I think, to use your term, you described it as wanting
5 to know where health wants more surgeons and where we could
6 be training them?
7 A. Yes.
8
9 Q. The Commissioner, I think, asked you about whether you
10 had had any success in obtaining that data from NSW Health?
11 A. Yes.
12
13 Q. Or from the task force; is that right?
14 A. Yes, yes.
15
16 Q. Did you mean to convey by your answers to those
17 questions that you had not received any response from
18 NSW Health about --
19 A. Oh, they said they would help us. They've said they
20 would help us.
21
22 Q. Indeed, you raised it formally I think for the first
23 time, did you not, with the Health Workforce Taskforce -
24 that is, raised this need for data - by a letter to the
25 task force head, Ms Pearce --
26 A. So it was first raised --
27
28 Q. Just bear with me. Could you just bear with me?
29 A. Sorry, sorry.
30
31 Q. Did you raise it via a letter to Ms Pearce, who is the
32 chairwoman of the task force, a letter you sent on 4 April
33 this year requesting that data?
34 A. Yes.
35
36 Q. And you received a response from Ms Pearce, did you
37 not, to the effect that the data was being assembled for
38 you?
39 A. Yes.
40
41 Q. Did you not think that would be relevant to answering
42 the Commissioner's questions about what the response --
43 A. No, it should have been in the response, you are
44 absolutely right.
45
46 Q. In any event, the good news is, I think, is it, that
47 the task force meets again tomorrow, does it not?

1 A. Tomorrow, yes, it does. Yes. I've got several
2 meetings tomorrow. Yes, it does.
3
4 Q. The topic is on the agenda for that meeting, as you
5 understand it?
6 A. Yes.
7
8 Q. And the letter that was sent to you in response to
9 your 4 April letter, a letter that I suggest was dated
10 15 May from Ms Pearce, reported, among other things, that
11 the data was expected to be to you, to the college, by
12 late July? Do you recall that?
13 A. Yes, that's right.
14
15 Q. And it's likely you'll be discussing that tomorrow?
16 A. Yes, we haven't had any data.
17
18 MR CHENEY: Nothing further, Commissioner.
19
20 THE COMMISSIONER: Thank you. Did anything emerge from
21 that?
22
23 MR FULLER: No, thank you, Commissioner.
24
25 THE COMMISSIONER: Associate Professor, thank you very
26 much for your time and for the statement you have provided.
27 We are very grateful.
28
29 THE WITNESS: Thank you.
30
31 THE COMMISSIONER: Please pass on our thanks to Ms Clota
32 as well.
33
34 THE WITNESS: I will, thank you very much.
35
36 THE COMMISSIONER: You're excused, thank you.
37
38 THE WITNESS: Thank you.
39
40 **<THE WITNESS WITHDREW**
41
42 MR MUSTON: I think the next witness is Dr Linda
43 MacPherson, Commissioner.
44
45
46
47

1 <LINDA MacPHERSON, sworn: [12.36pm]
2
3 <EXAMINATION BY MR MUSTON:
4
5 MR MUSTON: Q. Dr MacPherson could you state your full
6 name for the record, please?
7 A. Linda MacPherson.
8
9 Q. You are the director workforce reform, within the
10 workforce planning and talent development branch of the
11 New South Wales Ministry of Health?
12 A. Yes.
13
14 Q. You have held that role I think since October 2023.
15 A. Yes.
16
17 Q. Prior to that date, you were a medical adviser to
18 NSW Health?
19 A. Yes, and the workforce planning and talent development
20 branch.
21
22 Q. That's a role that you held for almost or around
23 20 years, I think?
24 A. Yes.
25
26 Q. And in that role, you traversed many of the same
27 issues, as we understand it, to those which you have
28 covered in your statement?
29 A. Yes.
30
31 Q. You have prepared two statements, in fact, to assist
32 the Commission with its work, the first dated 12 July 2024?
33 A. Yes.
34
35 Q. Do you have a copy of that statement with you?
36 A. Yes, I do.
37
38 Q. Have you had an opportunity to read that before giving
39 your evidence today?
40 A. Yes.
41
42 Q. Are you comfortable that the contents of it are true
43 and correct to the best of your knowledge?
44 A. Yes.
45
46 MR MUSTON: That will be tendered in due course,
47 Commissioner.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47

THE COMMISSIONER: Yes.

MR MUSTON: Q. You prepared a second statement dated 29 July 2024?

A. Yes.

Q. I'd ask you whether you've had an opportunity to read that before giving your evidence, but given its date, you probably wrote it very shortly before giving your evidence?

A. Yes.

Q. Are you confident that that statement also to the best of your belief is true and correct?

A. Yes.

MR MUSTON: That will also be tendered.

I think someone has handed us a stamped copy of that. For the benefit of the operators, that is [MOH.0011.0032.0001]. The first statement, which is the one we'll probably deal with first, is [MOH.0011.0020.0001].

Q. In your statement, you tell us a little bit about the number of graduate and undergraduate medical student places at universities and describe the way in which they're funded through the Commonwealth.

A. Yes.

Q. I don't really need to get into too much detail with you about that process, but what I would be interested to hear from you is whether you think, at the moment, there are sufficient undergraduate and graduate medical training positions at universities to meet current and future workforce needs?

A. I note that last year across Australia, there were more intern positions than eligible applicants for the positions. There hasn't been a significant growth in Commonwealth supported places over - since about, you know, 2007. Therefore, there might be some need to have some additional Commonwealth-supported places.

Q. Do you know, at least from a NSW Health perspective, what, if anything, is done to try and negotiate with the Commonwealth the funding of sufficient undergraduate and graduate medical places at universities to meet what is

1 perceived to be future workforce needs within the health
2 sector?

3 A. I would have to take that on notice.

4

5 Q. So it's not to say that it doesn't happen, but you're
6 not aware of any particular process whereby there's
7 discussion between the state and the Commonwealth about
8 projected workforce needs over the next, say, five to 10
9 years, probably 10 to 20 years, within the medical sector?

10 A. Through the national Health Workforce Taskforce,
11 there's a discussion by all jurisdictions about what
12 workforce, so through that mechanism there is engagement
13 with the Commonwealth.

14

15 Q. A moment ago in your answer you referred to the fact
16 that there were more intern placements than there were
17 graduates, at least within New South Wales?

18 A. No, across the country.

19

20 Q. So within New South Wales, what's the position - last
21 year?

22 A. Again, we exhausted the number of people who had
23 applied. There were no people left on the list to appoint
24 to positions, therefore, at the end of intern recruitment
25 there were vacancies.

26

27 Q. To what extent, if at all, is the number of intern
28 positions reflective of, say, the needs of the workforce?

29 A. Local health districts determine the number of intern
30 positions they need. They - intern positions are part of
31 the workforce that provides service, therefore, that is one
32 factor that will be considered when establishing intern
33 positions. The other factors are whether they can provide
34 the supervision and the training that is required for
35 interns to meet the Medical Board of Australia requirements
36 for general registration at the completion of internship.

37

38 Q. I might come back to that. Just to set a bit of
39 a map, the rough trajectory of one of the graduates from
40 one of these funded or self-funded medical university
41 positions is they graduate, they then do a year or two as
42 an intern?

43 A. The first year is internship. They have to complete
44 internship to be eligible for general registration with the
45 Medical Board of Australia. And then they will usually do
46 another second postgraduate year, and those two first years
47 are called prevocational years, and then they will look at

- 1 entering specialty training.
2
- 3 Q. So PGY1 is the intern year where you don't yet have
4 registration, your general registration?
5 A. You have provisional registration.
6
- 7 Q. You've got get through your PGY1 in order to get your
8 general registration?
9 A. Correct.
10
- 11 Q. At which point most people, but not all, will go on
12 and do their PGY2 which is a further period of training
13 delivered by the public health system --
14 A. Correct.
15
- 16 Q. -- within the hospital setting?
17 A. Correct, and the two-year capability framework that
18 has been implemented supports that.
19
- 20 Q. In terms of the appointment of people to intern
21 positions, that's a process which is, as we understand it,
22 managed by HETI or administered by HETI?
23 A. It's coordinated by HETI, yes.
24
- 25 Q. At the end of the PGY2 year, these graduates, now
26 generally accredited doctors, have a decision to make about
27 whether or not they want to become a specialist or continue
28 to work as a non-specialist, or a career hospitalist; is
29 that right?
30 A. Yes. It's usually from the postgraduate 3 year that
31 a lot of college programs will look at selecting people
32 into specialty training. It does vary across the different
33 college programs.
34
- 35 Q. Could I ask you to go to paragraphs 36 and 37 of your
36 statement on page 8, just to make sure we're talking about
37 the same thing. Once one gets to the end of their PGY2
38 year, the decision that they're making is this decision
39 that effectively you've referred to in 36 and 37; is that
40 right?
41 A. Yes.
42
- 43 Q. In terms of 37, the doctors who choose not to apply
44 for specialist training, what is the career trajectory for
45 them?
46 A. They might not choose immediately to apply for
47 specialist training because they might be seeking further

1 experiences before applying for specialist training later
2 on.

3

4 Q. Why might they do that?

5 A. Some colleges, as selection criteria, perhaps will
6 require certain experiences in addition to those undertaken
7 as an intern to be selected into training.

8

9 Q. In terms of the colleges that have those additional
10 experiential requirements as selection criteria for
11 training, what impact does that have on workforce from the
12 ministry's perspective or from the LHDs' perspective?

13 A. Those doctors will then be seeking those experiences
14 through unaccredited positions. It does mean that they
15 will be entering training later in their careers and
16 therefore how long they perhaps work as a specialist might
17 be less than somebody entering earlier.

18

19 Q. So I think I interrupted you. There are the
20 candidates who are seeking that additional experience
21 before applying for vocational training as a specialist.
22 Are there candidates who are not seeking to undertake
23 vocational training as a specialist at all?

24 A. My experience is that probably the majority - it's
25 a heterogeneous group. There are some people perhaps who
26 know right from medical school what career they want, what
27 specialty they want to pursue; there are others who perhaps
28 are still not sure and therefore will take the opportunity
29 to work in unaccredited positions to identify where they
30 want to go down the track; and there are some people who
31 perhaps immediately might not want to enter specialty
32 training for personal reasons, you know, looking for a bit
33 of work/life balance or perhaps parental responsibility.
34 So it's a really heterogeneous group.

35

36 Q. Is there a cohort amongst that heterogeneous group
37 who, at least for a period of their career, leave the
38 public health sector to pursue what might be seen as more
39 lucrative career in locuming?

40 A. I understand there would be some doctors in that
41 position, yes.

42

43 Q. Does the ministry, or at least the part of the
44 ministry that you work in, have any sense of how large that
45 cohort is?

46 A. I would have to take that question on notice. It's
47 a flexible group.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47

Q. Has any assessment been made by your group within the ministry of some of the push and pull factors that might be driving people into that - driving people to make that decision and pursue locuming as opposed to vocational training?

A. Yes. I think some of the factors are looking for greater flexibility, of not being - having greater autonomy about where and when you work is one factor.

Q. Is that reflective of just those individuals' desires, or do you think that there's a shift in the working preferences of younger people in this day and age towards that more flexible approach?

A. I understand that I think perhaps there are different work/life expectations for people younger than myself.

Q. In terms of perhaps grappling with that as an approaching reality from a workforce perspective, is there anything that's being done by the ministry to try and perhaps adjust the way in which people are employed and workforce planning type considerations to take into account the reality that people might not want to work in the way that people of my vintage, our vintage, did?

A. I think there are two parts to your question. Certainly there are options for part-time training and colleges - it is up to each individual college of the ability to undertake part-time or less than full-time training with a college. The workforce modelling is not my area of expertise and I can't provide detail on the assumptions made.

Q. So just continuing to step through the trajectory of the medical graduate, those who do wish to become specialists are trying to secure a position or an accredited training position with a college of their choice or in the discipline of their choice?

A. Correct.

Q. That vocational training takes several years, in most cases?

A. It depends on the college. Three to five years, full time.

Q. At the end of that three- to five-year period, those who have managed to secure the training position, pass the exams and satisfy any other requirements of the college,

1 become fellows of the college and are specialists?

2 A. Correct.

3

4 Q. Can I then just take us back very briefly to the start
5 of that journey, to the university side of it. In
6 paragraphs 46 and 47 you tell us a little bit about the
7 bonded positions within medical programs. In relation to
8 that, the first question is: do you think the
9 28.5 per cent of all commencing CSPs in medicine as a slice
10 of the overall graduates is a sufficient number of bonded
11 positions to achieve the outcome, the distribution
12 outcomes, workforce distribution outcomes, that I assume
13 that program is intended to achieve?

14 A. To support - it's a Commonwealth program and it's
15 looking to reflect what the population and distribution
16 needs are. So I think it is a good start, yes.

17

18 Q. It contemplates three years' worth of bonded service
19 post graduation. On the basis that, on the little timeline
20 that we've just walked through, that probably comes to an
21 end before someone has commenced their vocational training,
22 do you think three years is long enough to actually achieve
23 outcomes in terms of adjusting the distribution of the
24 workforce through this mechanism?

25 A. There is evidence that having people train in a rural
26 location allows them to develop those roots, therefore,
27 I think three years gives those people time to work and
28 establish themselves in a rural location. It is
29 a Commonwealth program and it has changed over time.

30

31 Q. We've heard some evidence about challenges faced by
32 a number of colleges, programs, insofar as training,
33 vocational training within rural areas is concerned, in
34 that they are not, they feel, able to provide the full
35 suite of training opportunities to vocational trainees
36 within a wholly rural setting. Is that something which
37 generally reflects your understanding of that vocational
38 training process?

39 A. Yes. There also has been a view that perhaps some
40 college training requirements or accreditation requirements
41 are metro-centric so that they perhaps limit the
42 opportunities to fully take advantage of rural training
43 opportunities, yes.

44

45 Q. Accepting for present purposes that that might be
46 a problem, does that mean that the students who have done
47 their three years' worth of bonded service in a rural

1 setting, if they are students who choose to pursue
2 vocational training, are then effectively forced to spend
3 some fairly important years of their lives, in terms of
4 laying down roots, in a metro area?

5 A. It depends on which specialty pathway they choose.
6 For example, something like neurosurgery, you will not have
7 many rural opportunities, but if you, for example, choose
8 to do general practice training, there are a lot of rural
9 GP training opportunities. So it does vary on the
10 specialty, and it also will vary on if you can't do - you
11 might not be able to do the full training in a rural
12 location, but you can do part of your training in a rural
13 location.

14
15 Q. So coming to the next step for the graduate, which is
16 this intern process that you've told us about, could I take
17 you to paragraph 62 of your statement. You tell us that
18 intern positions are funded by the LHDs, and it's the LHDs
19 that are responsible for determining the number of intern
20 positions they require. In making those decisions, do you
21 have a view about whether, in addition to the factors that
22 you've identified there in paragraph 62, the funding
23 available to LHDs is another one?

24 A. Certainly funding will be another factor - how many
25 positions they can support and the funding for those
26 positions.

27
28 Q. I gather from what you tell us in paragraphs 63 and 64
29 about the ministry funding of the 45 intern positions and
30 the competition amongst rural LHDs to try and secure some
31 of those positions, that it might be inferred if the rural
32 LHDs had more funding they would be delighted to take more
33 interns?

34 A. If they can support the supervision and training
35 requirements.

36
37 Q. Would it be fair to infer that at least those rural
38 LHDs that were competing for the 45 intern positions
39 referred to in paragraph 63, that each of them had
40 satisfied themselves that they had that capability?

41 A. Yes.

42
43 Q. Other than in relation to the building and sustaining
44 the rural health workforce initiative that you've referred
45 to in those paragraphs, is there any other central - that
46 is to say ministry - consideration given to the number and
47 distribution of interns across the system from a longer

1 term workforce planning perspective?

2 A. How - can you please clarify? How do you mean?

3

4 Q. So as I understand the process that you've identified
5 there, when it comes to working out how many intern
6 positions there are to be in New South Wales in a given
7 cycle and the way in which they're distributed across the
8 state, the LHDs are the driving force?

9 A. Yes.

10

11 Q. The LHDs, based on the factors that you've identified
12 and funding considerations, say, "We think we can take X
13 interns, and this is how we would like to spread them
14 across our network of hospitals and facilities"?

15 A. Yes.

16

17 Q. In relation to the 45 positions that you've referred
18 to in paragraph 63 through the building and sustaining the
19 rural health workforce initiative, there is some,
20 presumably, central consideration given to how those
21 45 positions should be distributed across the state, or
22 rural portions of the state?

23 A. Yes.

24

25 Q. And presumably, but correct me if I'm wrong, that
26 consideration about the distribution of the intern
27 positions has some regard to things like longer term
28 workforce planning and where a wider distribution of
29 interns within rural and regional settings might, from
30 a longer-term perspective, be useful?

31 A. The focus has been to increase rural and regional
32 overall and to ask the districts where - you know, where
33 their focus is and the needs of the positions, yes.

34

35 Q. My question is: other than those 45 positions, is
36 there any consideration being given at ministry level about
37 how many interns there should be in any given cycle and the
38 way that they should be distributed across the system from
39 a longer term workforce planning perspective?

40 A. If I can go back, over the last perhaps more than
41 10 years, we have been monitoring the number of intern
42 positions to see that we are able to meet our guarantee for
43 the intern positions, so that has been close focus on
44 monitoring of positions overall to see that that guarantee
45 has been met.

46

47 Q. But in terms of that, do I take it that that

1 monitoring involves communicating with the LHDs to ensure
2 that each of them is able to maintain a particular level of
3 interns in coming cycles?

4 A. It has over the previous years, yes.

5

6 Q. I might take you to paragraph 135 of your statement,
7 which might provide an answer to my next question, but in
8 paragraph 135 you tell us the ministry does not manage or
9 distribute, amongst other things, intern positions
10 centrally.

11 A. Correct, except for when there are special funding,
12 such as those 45, yes.

13

14 Q. The 45. And so other than the monitoring of the
15 state's ability to maintain its guarantee to the
16 Commonwealth about the number of intern positions that it
17 might offer in coming cycles, is it the case that there is
18 no central planning being undertaken by the ministry based
19 on the data, the workforce data, that it has at its
20 disposal, about how best to allocate and distribute interns
21 across the system with a view to achieving long-term
22 workforce planning outcomes?

23 A. Correct.

24

25 Q. Do you think that there might be some utility,
26 recognising that it would have to be a collaboration with
27 the LHDs, in a process of that type being undertaken by the
28 ministry?

29 A. Yes.

30

31 MR MUSTON: I note the time, Commissioner.

32

33 THE COMMISSIONER: Can I just ask, this is of course not
34 hurrying you, but just a question, we've still got
35 Dr Murphy and Professor Chan. Will we reach Associate
36 Professor Ridley?

37

38 MR MUSTON: We may.

39

40 THE COMMISSIONER: If we reach him, that's fine. We don't
41 have to finish him, but I just wanted to know whether he
42 should --

43

44 MR MUSTON: I think Professor Murphy will be relatively
45 short.

46

47 THE COMMISSIONER: Let's not worry about it now we'll

1 adjourn until 2 o'clock.

2

3 MR MUSTON: I can indicate that in terms of
4 Professor Ridley, I'm a little bit in my friend's hands,
5 I intend to ask him whether his statement is true and
6 correct and tender it.

7

8 THE COMMISSIONER: Yes, sure. I was only asking in case
9 there was no point - you know, some message to him. But if
10 not, we will leave it there and adjourn until 2.

11

12 MR MUSTON: Thank you.

13

14 **LUNCHEON ADJOURNMENT**

15

16 THE COMMISSIONER: Yes, Mr Muston.

17

18 MR MUSTON: Q. Can I ask you some questions now about
19 the specialist vocational training. It is essentially -
20 there is a two-step process. The first step is funding
21 needs to be provided by the LHD to stand up a JMO position
22 within one of its facilities?

23

A. Correct.

24

25 Q. The second step is that facility or that position
26 needs to have been accredited by the relevant college?

27

A. Correct.

28

29 Q. Whether it's the position or the facility that is
30 being accredited will vary depending upon which particular
31 college is being dealt with?

32

A. Correct.

33

34 Q. In terms of decisions about whether to stand up
35 a particular JMO position and, if so, where, that's
36 something which sits wholly within the control of the LHD?

37

A. Correct, yes.

38

39 Q. Are there any future workforce planning operations
40 happening at a ministry level there, so far as you are
41 aware, to inform what the LHDs are doing in terms of
42 decision-making around where and when to try and stand up
43 JMO placements for vocational training?

44

45 A. The ministry - as I say, it's not my area that I work
46 in, but I understand workforce modelling - workforce
47 modelling has been done and continues to be done. Fact
48 sheets are published, have been published, that identify

1 specialties that are considered we need to train more in,
2 so they are published on the website and information
3 provided to districts.
4

5 Q. So the number of a particular type of specialist is
6 one issue. Another issue is where those specialists are
7 being trained; is that right?

8 A. Yes, the modelling fact sheets do provide information
9 on the distribution of specialists, yes.
10

11 Q. Do you know what sort of collaboration, if any, is
12 happening between ministry and colleges about those
13 workforce planning type issues - that is to say, where
14 training positions should be, how many training positions
15 there should be, et cetera?

16 A. I would have to take that on notice.
17

18 Q. Who within your group or department deals with that?

19 A. I think Mr Richard Griffiths would be able to provide
20 advice on that.
21

22 Q. Could I take you to paragraph 128 of your statement.
23 Again, this might have been dealt with in that last answer,
24 but do you see there you explain your understanding of the
25 process whereby the positions are stood up - that is, the
26 training positions?

27 A. Yes.
28

29 Q. And you refer to the possibility of a mismatch between
30 specialist training positions and workforce requirements?

31 A. Based on, yes, that they will consider also the number
32 of positions that they need junior positions to support
33 management of the roster, and that can sometimes result in
34 a mismatch between the number of positions required to meet
35 future specialist needs versus the number of positions
36 required to meet roster requirements, particularly in
37 specialties where there is a 24/7 roster.
38

39 Q. So when you say the "mismatch", are you inferring or
40 seeking to convey there that it may well be that there are
41 more JMO positions being created and potentially training
42 positions being created than are required to meet the
43 future workforce needs in certain areas of specialisation?

44 A. In some specialties there may be overall more
45 accredited training positions than required to meet future
46 requirements for specialist workforce.
47

1 Q. Are there any in particular that you have in mind that
2 would fall into that category?

3 A. So the specialties that require 24/7 rosters,
4 emergency medicine in past modelling has indicated perhaps
5 that there might be - the Commonwealth modelling indicated
6 that we might have more accredited positions than required,
7 of the emergency medicine specialists. However, I think
8 that is not borne out by experience. There is certainly
9 a maldistribution of emergency medicine specialists between
10 metro and rural.

11
12 Q. You tell us in paragraph 130 of your statement about
13 the networking positions and rotations that exist in
14 relation to some vocational training?

15 A. Yes.

16
17 Q. Could you just perhaps, from the perspective of
18 a trainee, explain how those network positions operate?

19 A. So when they are recruited to a training position,
20 they will be recruited to a training network, and so they
21 will know which are the group of hospitals that the - that
22 constitute their network and where they may be required to
23 rotate to. It is then within the network will determine
24 the rotations across the network, and I understand that
25 that would - the factors that would be considered are where
26 the trainee is up to in their training, what they need to
27 achieve, the experiences and trainee preferences.

28
29 Q. And is that something which is managed by the colleges
30 or managed by HETI or does it depend on which specialty
31 we're talking about?

32 A. It depends on which specialty. So, for example, the
33 Royal Australasian College of Surgeons and the
34 sub-specialty organisations such as General Surgeons
35 Australia manages general - determine where the general
36 surgeon trainees go and the Australian Orthopaedic
37 Association determine where the orthopaedic trainees go.
38 For other specialties such as the basic physician training,
39 that we have 11 basic physician training networks, where
40 the trainees go will be managed by the network director of
41 training for that network.

42
43 Q. So coming back to the surgeons, is it the case that
44 LHDs will stand up positions for JMOs within their budgets,
45 essentially, and then the person who occupies that position
46 from time to time is essentially determined by the college
47 of surgeons by reference to whoever it is they have

1 permitted into one of their training programs?

2 A. Correct.

3

4 Q. Whereas with the physicians, a slightly different
5 situation, that decision about movement through the
6 networks and who goes where is being made more by HETI, the
7 LHDs and the ministry - no doubt in collaboration with the
8 physicians - than by the physicians merely parachuting
9 somebody in?

10 A. Correct.

11

12 Q. Do you see there to be potential benefit in an
13 expanded role of either HETI or the ministry to try and
14 create or take a greater involvement in that networking and
15 the movement of people through those networks than - across
16 all areas of specialisation than it currently has?

17 A. Can you clarify, you mean in broader than just the
18 training networks that we have established now?

19

20 Q. Yes. So for all specialty training pathways, do you
21 think there would be utility in the ministry, perhaps HETI,
22 having a wider role in terms of identifying, in
23 collaboration with the colleges, who should go into those
24 positions and moving trainees through the networks and
25 through their training in a way that maximises efficiency
26 within that area?

27 A. And if I can break it down into two parts - there's,
28 first of all, obviously the actual selection into a college
29 training program, and then the management of those
30 rotations.

31

32 Q. Yes.

33 A. At the moment, there are different ways of selecting.
34 I think we want to make sure that the selection process
35 identifies - supports people, supports distribution of
36 positions and certainly supports making sure that people,
37 for example, have a rural intent, are selected into
38 suitable positions. So I think we do need to look at the
39 best way of making - managing those processes.

40

41 Q. Coming back to what you tell us in paragraph 131 about
42 the bottlenecks in training, one example of that that we
43 were given in some evidence last week was bottlenecks in
44 the training of anaesthetists needing to go through, say,
45 paediatric training. Is there a role for the ministry in
46 collaborating with the college in a slightly more organised
47 way to push people through those bottlenecks as efficiently

1 as possible?

2 A. There is certainly, first of all, to look at how we
3 can ensure that we get people through training as quickly
4 as possible, and I think there is also a role to look at
5 how we can support wider training opportunities for
6 paediatrics, if we're talking about paediatrics.
7 Currently, one of the issues, my understanding, is the main
8 paediatric training is done in the children's hospitals and
9 there is a finite number that can get through there. So
10 I think there is opportunities in looking at how we can
11 expand the opportunities for paediatric training, and
12 certainly having a more coordinated approach - we don't
13 have formal networks in anaesthetics - may assist in
14 ensuring that people can get through those - their pathway.

15

16 Q. Just looking at that anaesthetics example, as we
17 understand it, the way in which people are pushed through
18 that narrow bottleneck of paediatrics is they do a term at
19 the Children's Hospital and it's assumed, no doubt based on
20 some assessment of the case mix, that during that term they
21 will cover off all of the things that they are required to
22 cover off in terms of the gained experience through that,
23 for example, the number of children under 2 that are
24 anaesthetised. Is that your broad understanding of the way
25 that works?

26 A. Correct. My understanding is, yes, the term rotation
27 to look at what they can achieve, but there are anaesthetic
28 services provided for children outside of the children's
29 hospitals as well, but obviously the case mix may be
30 different.

31

32 Q. If, for example, the ministry or some part of the
33 ministry was involved in moving trainees through these
34 networks, there might be an ability to have trainees
35 exposed to each of the things that they're required by the
36 college to be exposed to, in less time than the standard
37 term that the college, under current arrangements, might
38 rotate them through?

39 A. I can't speak to what the college would accept as, you
40 know, suitable time experience, but certainly the
41 advantages of a network, it does allow a more coordinated
42 way of managing training.

43

44 Q. Insofar as you're aware, does the ministry have any
45 plans to expand the number of networks that it seeks to be
46 involved in from those that it currently is involved in?
47 So basic physicians training you have told us about, and

1 I know there are others, but anaesthetists are not. Is
2 there some --

3 A. As I refer to in my statement, one of the final
4 paragraphs, there is, my understanding, no identified
5 funding for new networks or expanding the networks we have.
6

7 Q. So do I take from that that the reason, at least at
8 the moment, that more networks and the potential training
9 benefits that they might secure has not been explored is
10 because there is no funding allocated to that by the
11 ministry?

12 A. I'm not aware of funding for them.
13

14 Q. Can I take you forward to paragraph 137 of your
15 statement. It's part of a group of two paragraphs
16 commencing at 136, and you see the table in the middle
17 there, where you set out some information in relation to
18 medical specialty trainees. In paragraph 137, you tell us,
19 due to the award classifications, that it's not easy for
20 the ministry to differentiate between different training
21 pathways.

22 A. Correct.
23

24 Q. So do we take it from that that whilst the ministry
25 knows how many JMOs of a particular vintage - that is, to
26 say PGY4, PGY5, might be out there in the system, you
27 don't, based on that payroll data, have any sense of
28 whether that PGY4 is training to be a physician as opposed
29 to training to be a surgeon or an anaesthetist?

30 A. As I set out in my statement there, that the coding of
31 positions has been a process to try to identify that, but
32 it is not as accurate as it could be.
33

34 Q. Can I ask you, in relation to that problem, does that
35 extend also to staff specialists, in the sense that staff
36 specialists are all on the same award?

37 A. Staff specialists are all on the same award? I'd have
38 to take that on notice, yes.
39

40 Q. But insofar as you are aware, there is no ready way,
41 based on at least the payroll data, to work out whether
42 staff specialists in a particular facility are an
43 endocrinologist or a dermatologist or a rheumatologist?

44 A. I'd have to take it on notice.
45

46 Q. Can I just ask you to go back now to paragraph 110 of
47 your statement, where you tell us about the ministerial

1 policy direction. In relation to the ministerial policy
2 direction, what has, insofar as you're aware, actually
3 happened or changed in terms of the ministry's dealing at
4 the LHDs and the ministry's dealings with the colleges
5 since that policy direction was issued?

6 A. Since the ministerial policy direction has been
7 issued, the communication protocol has been developed by
8 the Australian Medical Council and it has been implemented.
9 One of the key requirements of the communication protocol
10 has been to ensure that all stakeholders develop a generic
11 contact point to contact each other.

12
13 One of the feedbacks has been received that often
14 colleges were not clear who to relay information to in
15 local health districts or they would relay it directly to
16 directors of training and not to management, and so that
17 has - everybody now has a generic contact email address to
18 make sure that information is received by the relevant
19 people in the appropriate time frame.

20
21 Also, the communication protocol has set out that
22 colleges should be contacting health departments if they
23 have concerns about issues at a site that could lead to
24 potentially withdrawal of accreditation.

25
26 Q. So it's early days --

27 A. Yes.

28
29 Q. -- but do you have any sense of making sure whether
30 the right people are speaking to one another and
31 appropriate advance warning of withdrawal of accreditation
32 has actually resulted in any material changes in the way
33 that the accreditation system is operating?

34 A. As you say, it is early days. In addition to that,
35 there is the work that the Australian Medical Council is
36 also undertaking on implementing the National Health
37 Practitioner Ombudsman recommendations to improve
38 processes, so I think a combination of things there
39 is looking to make improvements, yes.

40
41 Q. In relation to the implementation of the ombudsman's
42 recommendation, what progress has been made on that front?

43 A. As I say, the Australian Medical Council is leading
44 the work and they are working with colleges to develop
45 a model accreditation standard that would be used by all
46 colleges. So work is progressing on the recommendations.
47 Work will be under way, too, around recommendation 13 to

1 develop a framework of how to manage complaints and
2 concerns about a training site. So the work is
3 progressing.
4

5 Q. So would it be fair to say work is progressing in
6 terms of the way in which colleges and jurisdictions such
7 as New South Wales might go about implementing those
8 recommendations, but as matters currently stand, the
9 recommendations have not been implemented?

10 A. They are being - work is progressing to implement
11 them, and they will be around college processes, yes.
12

13 Q. From the ministry's perspective, do you see any reason
14 why the recommendations made by the Ombudsman ought not be
15 implemented?

16 A. No.
17

18 Q. Could I take you very quickly forward to
19 paragraph 124. That comes at the end of a discussion in
20 your statement about the selection process for training
21 programs?

22 A. Yes.
23

24 Q. In paragraph 124, you make the observation that all
25 health services are competing for the same limited pool of
26 applicants to fill the positions and that, in those
27 circumstances, where there are more positions than
28 applicants, some locations find it difficult to fill those
29 positions. Firstly, is it right to say that the
30 differentiation between number of applicants and number of
31 positions, will vary from college to college?

32 A. Correct, yes.
33

34 Q. So some areas of specialisation are very popular?

35 A. (Witness nods).
36

37 Q. And perhaps have a limited number of training
38 positions?

39 A. Yes.
40

41 Q. And in those cases, those training positions are
42 likely to be oversubscribed?

43 A. Correct. Particularly perhaps in metropolitan
44 regions, so there's sometimes a balance between positions
45 filled perhaps in the metro area and for the same specialty
46 perhaps not filled in an outer metro or rural and regional.
47

1 Q. But in relation to a very popular area of
2 specialisation with a very limited number of training
3 positions, the distribution issue is less acute - that is
4 to say, some candidates, whilst it might not be their first
5 preference, will happily go to a regional or rural location
6 if it means getting on to the program?

7 A. They certainly have those opportunities. One thing
8 that, through the work that I'm doing supporting the
9 national task force and one of the projects that we are
10 undertaking of looking at streamlined or opportunities to
11 improve recruitment processes and coordination is that we
12 perhaps do not have good consolidated data as to, you know,
13 applicants if they don't get into their first preference,
14 do they take their second preference or not.

15

16 Q. Do you see an opportunity for the ministry to have
17 a greater role in the allocation of those training
18 positions across all of the colleges?

19 A. Sorry, how do you mean, "allocation"?

20

21 Q. So let's just take it step-wise. LHDs have funded
22 positions within their various facilities for a training
23 position?

24 A. Yes.

25

26 Q. I think you've indicated in an answer that you've
27 already given that there might be some scope for the
28 ministry to have a greater role in identifying where those
29 positions should be from a longer term workforce planning
30 perspective?

31 A. (Witness nods).

32

33 Q. You've got to say it out loud --

34 A. Yes, yes.

35

36 Q. -- so the very patient lady next to us can take it
37 down.

38 A. Yes.

39

40 Q. Obviously that would have to occur in collaboration
41 with the LHDs?

42 A. Correct, yes.

43

44 Q. The question is, of course, the colleges then go about
45 accrediting those positions?

46 A. Yes.

47

1 Q. The colleges themselves don't have a wealth, we're
2 told, of workforce data which would enable them to make
3 decisions of a longer term workforce planning type?

4 A. Although when they accredit positions, they should be
5 accrediting the positions on the merit of the position, of
6 whether it meets the requirements or not.

7
8 Q. Colleges are accrediting a position based on the merit
9 of whether, from a training perspective, it meets the
10 relevant criteria?

11 A. Correct.

12
13 Q. Colleges are not making decisions about whether to
14 accredit position informed by data that is relevant to
15 longer term workforce planning considerations? For
16 example, do we need another - in 10 years' time are we
17 going to need, as part of our succession planning, another
18 surgeon in Wagga Wagga, or another endocrinologist in
19 Dubbo?

20 A. They're accrediting against the accreditation
21 standards, yes.

22
23 Q. Having established the existence of positions and the
24 accreditation of the hospitals' facilities in which those
25 positions are to be placed, do you see any role for the
26 ministry, perhaps akin to the role played by HETI in
27 relation to the distribution of the intern workforce, in
28 filling those positions and distributing them across the
29 network in a way which best meets the needs of the health
30 service as opposed to best secures the training
31 opportunities in the locations which are popular?

32 A. Just to clarify, my understanding is that HETI
33 coordinates the recruitment process and manages the match
34 of applicants based on their preferences. But I'm not
35 quite sure the way you mean - they're not sort of - they're
36 matching people to the positions based on applicant
37 preferences.

38
39 Q. But every position - just dealing with the HETI intern
40 situation, every candidate is not getting their first
41 preference?

42 A. The algorithm, my understanding of the algorithm is
43 that it matches people to their best - to their best match,
44 yes.

45
46 Q. I think we've been told in some evidence the way the
47 algorithm works is it works out a distribution of interns

1 which gives as many of them their highest preference as is
2 feasible?

3 A. Correct. And in the annual junior medical officer
4 recruitment, that is undertaken, there are preference
5 matches also undertaken, for example, for basic physician
6 training. But one of the differences is that the networks
7 interview the applicants and then, based on applicant
8 preferences and the rankings by the network, again, there
9 is a match done and one offer is made, and certainly
10 preference matching reduces the churn of positions, of
11 people getting multiple offers and then accepting one and
12 declining.

13

14 Q. And for that reason, would there be utility, do you
15 think, in expanding, perhaps even the basic physician
16 training type model, out to the vocational training
17 referable to other colleges within the wider network?

18 A. To undertake preference matching for other
19 specialties?

20

21 Q. Yes.

22 A. Yes. I think there is certain utility both from an
23 applicant and, as I say, a site perspective in that you
24 reduce the churn, as I say, of multiple offers being made
25 and then, you know, only one offer being accepted, yes.

26

27 Q. As part of that process, with the benefit of the
28 workforce data that the ministry has, no doubt in
29 collaboration with the LHDs and the colleges, training
30 positions could be distributed across the network in a way
31 which best meets or hopefully best meets future workforce
32 needs?

33 A. So as well as just doing the match, you're suggesting
34 first of all determine where the positions are and then run
35 the match?

36

37 Q. Yes. Because as I think you have told us a moment
38 ago, there tends to be a weighting towards metropolitan
39 training positions?

40 A. That is my - in some specialties, yes, there would be
41 more likely to perhaps have a metropolitan site filled
42 rather than the --

43

44 Q. Easy to create, given the population of staff
45 specialists and VMOs in a wide array of areas in
46 metropolitan hospitals?

47 A. Correct, yes.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47

Q. Easy to fill because people, maybe by preference, like to live closer to the coast than not?

A. That - one of the factors. I think we also recognise that, as I said in my statement, medical graduates are older than when I graduated, and they often already have partners and families and therefore, those other factors determine where people want to live and work as well.

Q. Just quickly, in relation to the training positions that are there, we've heard evidence from a number of the colleges where issues are raised in relation to the quarantining or isolation of training time for both trainees and trainers. Is that a concern that you have heard expressed before in the context of vocational training?

A. I have heard - accreditation standards do make reference to what is called "protected time" for both supervisors and trainees.

Q. So from an accreditation point of view, there's the concept of protected time, which is important to at least the colleges?

A. Yes, in the colleges, and again because we have 16 colleges with their standards, the requirements are slightly different across each college.

Q. And so the conceptual protection of that time is one thing, but practical protection of that time is another. In the context of a system which - and correct me if you have a different view - is often under strain, given limited resources required to deliver a level of care to the population, it is said that it's sometimes not easy to protect that time and, in fact, keep it quarantined?

A. I have certainly heard that feedback, yes.

Q. Is the need to, in a practical sense as well as a theoretical sense, protect that time a factor which is considered, at least insofar as you're aware, in decisions about the number of FTE to employ in different departments across different facilities in the network?

A. It's not something that I'm aware of, but I can't speak with authority on that.

Q. Can I quickly ask you about international medical graduates. They form an important part of the medical workforce of New South Wales?

1 A. Correct. And nationally.

2

3 Q. You've told us at paragraph 159 of your statement that
4 one of the challenges presented by the deployment of
5 international medical graduates is they're often used to
6 fill positions in areas of workforce shortage, which means
7 they have more limited mentoring and supervision than might
8 be ideal. Do you have a view about what could be done to
9 deal with that problem, that challenge?

10 A. So certainly, as I indicated in my statement, the
11 ministry has run the IMG program there to support people
12 becoming familiar with the system. I think we also do need
13 to look at different types of supervision, and it has been
14 raised by the Kruk review as well, that we need to look at
15 innovative models of supervision, whether supervision can
16 be provided remotely or can be provided by different health
17 professionals.

18

19 From a college perspective, the requirement is that
20 college fellows have to be supervisors, if we're looking
21 at, for example, the specialist international medical
22 graduates, but it is certainly a challenge, but I think we
23 do need to look at innovative supervision models as one
24 option.

25

26 Q. Could you move forward to paragraph 166 of your
27 statement where you tell us about some challenges. You
28 tell us that it's difficult for the ministry to have
29 a significant role in determining the distribution of
30 specialist training positions as they are not discretely
31 funded by the ministry, so no mechanism to redistribute
32 medical training positions across the districts. That's
33 problem one. Can I ask you about that? All of the
34 specialist trainees - that is, the JMOs - are, in fact,
35 employed by the secretary; that's correct, isn't it?

36 A. They are employed by the secretary, delegated to local
37 health districts. So my understanding is that the
38 decisions, as I said, and the funding, is from local health
39 district budgets.

40

41 Q. But it would be the case, wouldn't it, that through
42 the distribution of funding or through adjustments to the
43 budgets of LHDs, the ministry certainly would have it
44 within its capacity to make decisions about the
45 distribution of training positions if, centrally, a view
46 was reached that that particular training position should
47 be stood up in particular LHDs or facilities?

1 A. I would have to defer to the chief financial officer
2 about that. As I say, currently a district is - my
3 understanding is funded to provide a service, therefore,
4 that's what I meant by that we - unlike the 45 positions
5 that we have funded for internships where we say to
6 a district, "Here is funding for this PGY1 position", we're
7 currently not saying, "Here is funding for an accredited
8 cardiology position."
9

10 Q. I understand you're not saying that. My question
11 really was: in exactly the same way as you do with the
12 45 intern positions across the system, it would be possible
13 for the ministry to say, "We have determined that we need
14 cardiologists as part of the future workforce planning in
15 the following locations as part of some 10-year horizon
16 planning, and we are going to provide funding to an LHD to
17 conduct training of cardiologists in that location, with
18 a view to hoping that one or more of them might stick?"

19 A. Correct.
20

21 Q. As to the second challenge that you raise there, being
22 a lack of accurate specialist training position data, that
23 we've already discussed, is there a way you can see that
24 collection of that data could be better incentivised
25 through the LHDs or achieved centrally - that is to say
26 a better understanding of how training positions and
27 staff specialist positions across the system more generally
28 are --

29 A. As I say, I can't speak to the staff specialists, but
30 the training positions, obviously, as I've indicated in my
31 statement with the specialty coding, there is no incentive
32 to maintain the specialty coding.
33

34 Q. It could be incentivised, say, through the addition of
35 a KPI?

36 A. Possibly, yes.
37

38 Q. KPIs seem to be quite an effective incentive in the
39 hands of LHDs?

40 A. Yes.
41

42 Q. Is that your observation?

43 A. Possibly, yes.
44

45 Q. Could I take you finally to paragraph 19 of your
46 second statement, where you tell us a little bit about the
47 Central Coast Cancer Centre radiation oncology department

1 accreditation. In paragraph 19 you refer to a role that
2 RANZCR has to play, together with employers, to improve the
3 culture of supervisors. I am just wanting to explore with
4 you, what do you see the role of the colleges as being
5 insofar as dealing with, say, behavioural issues by staff
6 specialists employed who happen also to be their fellows,
7 of concern?

8 A. Obviously the term "culture" is quite broad and
9 I think we acknowledge that there are unacceptable
10 behaviours where there is a complaint made that has to be
11 dealt with with the employer.

12
13 But when we talk about training and supervision, there
14 is the culture of providing appropriate feedback to
15 trainees, mentoring of trainees, and I think the college,
16 together with employers, has a role in providing that
17 training to supervisors about things such as, you know,
18 what is - how to provide appropriate feedback; how to
19 manage a trainee in difficulty; looking at how they can
20 support supervisors in their role.

21
22 I understand some colleges do collect feedback from
23 trainees about supervisor performance, and I think we all
24 know that getting feedback, both good and bad feedback, can
25 help performance, so I think it's that broader how can we
26 support that excellence in training and education and that
27 supportive environment, and that is as a collaboration, and
28 colleges have a role in providing support to their
29 supervisors in that way.

30
31 Q. To the extent, though, that supervisors or staff
32 specialists within particular departments who may happen to
33 be fellows of a college engage in behaviour which is of
34 a bullying character or unacceptable workplace behaviour of
35 any type, I gather you're not telling us in paragraph 19
36 that you think it's the colleges who have a role to bring
37 them into line but --

38 A. No, that's the role for the employer to investigate
39 and deal with that.

40
41 Q. Appropriately as the case may be?

42 A. Yes.

43
44 MR MUSTON: I have no further questions for this witness,
45 Commissioner.

46
47 THE COMMISSIONER: Q. Can I just ask you, Doctor,

1 in that paragraph that Mr Muston was just discussing, where
2 you've already said at paragraph 18 RANZCR doesn't have the
3 authority to investigate a bullying complaint, et cetera,
4 and then in 19, just on that part of the statement where
5 Mr Muston was asking you that RANZCR has a role to play,
6 together with employers, to improve the culture of their
7 supervisors, to your knowledge, is that a role that RANZCR
8 accepts, that it does have a role to play in relation to
9 that? Has that emerged out of your discussions with the
10 colleges or elsewhere?

11 A. I'd say more broadly. I speak to a lot of colleges,
12 as I say, and certainly the Australian Medical Council's
13 standards, too make it clear that they see that colleges
14 and employers have a role in working together in
15 collaborating to support - to have that supportive
16 environment for training.

17
18 Q. And whilst I don't know that it's going to be
19 particularly important for me to exactly resolve what was
20 said at the meeting that you're responding to, was that
21 issue of having a role in relation to addressing a cultural
22 issue or improving culture, was that discussed at that
23 meeting?

24 A. My recollection is that the broad role that - as
25 I said, broadly, that colleges have a role. When we -
26 culture is a very broad term. One is the unacceptable
27 behaviour, but more that the culture of that training --
28

29 Q. This meeting was in the context of some complaints
30 about bullying, wasn't it?

31 A. It was about a poor culture in the department, I
32 understand.

33
34 Q. Specifically related to that or was it broader than
35 that?

36 A. I understand there was also, as well, concerns about
37 training - perhaps supervisors not providing, you know,
38 appropriate number of tutorials or things like that, yes.
39

40 Q. I see. All right. Okay. Did I cut you off, part of
41 your answer?

42 A. No.

43

44 THE COMMISSIONER: All right. Thank you.

45

46 Yes, Mr Cheney, do you have any questions?

47

1 MR CHENEY: No, Commissioner.

2

3 THE COMMISSIONER: Thank you very much for your
4 attendance. We're very grateful. You are excused.

5

6 <THE WITNESS WITHDREW

7

8 MR GLOVER: The next witness is Dr Murphy.

9

10 <KAREN HELEN MURPHY, affirmed: [2.42pm]

11

12 <EXAMINATION BY MR GLOVER:

13

14 MR GLOVER: Q. Dr Murphy, could you tell us your full
15 name, please?

16 A. It is Karen Helen Murphy.

17

18 Q. You are the acting executive director medical services
19 and clinical governance, for the Illawarra Shoalhaven Local
20 Health District?

21 A. I am.

22

23 Q. You have been in that role since about September '22;
24 is that right?

25 A. No. I started in the role 'December 23 formally, and
26 I covered the role for around six weeks August '23 and
27 a few weeks before that as well.

28

29 Q. Thank you. To assist the Commission in its work,
30 you've prepared a statement dated 12 July 2024; correct?

31 A. I did.

32

33 Q. I will have it brought up on the screen. It's
34 [MOH.0011.0019.0001]. It will come up on the screen to
35 your right but I see you have a hard copy with you. Feel
36 free to use whichever is convenient to you.

37 A. Thank you.

38

39 Q. Have you had a chance to read it again before giving
40 your evidence today?

41 A. I have.

42

43 Q. Is it true and correct to the best of your knowledge
44 and belief?

45 A. It is.

46

47 Q. Can I take you directly to paragraph 7, please. In

1 fact, I'll go back a paragraph. Commencing at paragraph 6,
2 you deal with the topic of the number and distribution of
3 medical specialists. Do we understand that in this section
4 of your statement, you're dealing with that topic in the
5 context of your LHD?

6 A. That's correct.

7
8 Q. In paragraph 7, you tell us that determining the
9 adequate number of specialist training positions is based
10 on the needs of a local population, and then you go on to
11 tell us that it's managed at a national level based on
12 population data, et cetera. Do you see that?

13 A. Yes, I do.

14
15 Q. Would you just describe in practical terms what that
16 process is, as you understand it?

17 A. Yes. The numbers of specialists required to provide
18 the level of health care that's expected in this country is
19 determined through comparators around the world but also
20 best practice and benchmarking, and then the definition of
21 requirement of those specialists per population head is
22 what is defined in the Australian Institute of Health and
23 Welfare and in some of the other documents provided.

24
25 Q. So when you say "the numbers of specialists required
26 to provide the level of health care that's expected in this
27 country is determined through comparators", who is
28 undertaking that process?

29 A. It would be through the federal government, I would
30 imagine, and then other organisations. That's not
31 something that I participate in.

32
33 Q. So how is that analysis or work used by your LHD?

34 A. So we look at our population demographics. We look at
35 the predicted population demographics, because we're always
36 forward planning, and then we look at the requirements of
37 our population, the health determinants of the population
38 and then decide what would be suitable to provide the
39 health care at that level publicly.

40
41 Q. When you go on in that paragraph to say that, as
42 a result of the process that you've just described, the
43 district cannot influence the number of specialists and the
44 services to be provided based on the population
45 determinants in the district, why is it that you consider
46 the district cannot influence the number of specialists
47 that are to be retained by the district?

- 1 A. Because it's a personal choice of the doctors, often.
2
- 3 Q. Right, but the district can deploy its resources to at
4 least attempt to recruit and retain the number of
5 specialists that it considers that it needs to provide the
6 level of services, as you put it, that's expected in the
7 country; correct?
8 A. Which we do, on a regular basis and a constant basis.
9
- 10 Q. So is it simply the case that because one can't compel
11 a doctor to come and work in the district, that you say the
12 district can't influence the number of specialists in its
13 region, or is there something more to it than that?
14 A. No, it's mainly that. At times it's also about the
15 level of service that we can provide in the area. So, for
16 example, we may not have an interoperative MRI theatre in
17 Shoalhaven and a specific surgeon only works using an
18 interoperative MRI when you're in theatre, therefore, that
19 surgeon wouldn't choose to come and work in Shoalhaven.
20 That would be an example.
21
- 22 Q. But that is something that the district could, if it
23 chose to, influence by making that equipment, facility,
24 what have you, available, could it not?
25 A. Not necessarily, because the way that you would define
26 how services are required is also around the governance
27 practice and process. So if you were only doing four of
28 those operations a year in Shoalhaven, the clinical
29 governance - so the ability of the surgeon to be able to
30 maintain their skills level by only doing four of those
31 operations a year - would not provide safe effective care
32 for that patient nor would it be cost effective.
33
- 34 Q. These are particular examples of particular
35 procedures, though --
36 A. They are.
37
- 38 Q. -- are they not?
39 A. They are. But that would apply to quite a number of
40 procedures.
41
- 42 Q. But taking it out of the micro level into the macro,
43 there are things that the district can do to influence the
44 number of specialists that it might be able to retain for
45 its services, are there not?
46 A. There are very specific needs for clinicians in
47 specific areas. So we can, for example, employ a surgeon

1 or a consultant physician to work across the district. We
2 can look at offering opportunities of them providing
3 telehealth services that would reach the other ends of our
4 district as well as the top end of the district, where the
5 biggest hospital centre is. So, yes, there's a number of
6 incentives that we can use.

7
8 Q. You tell us some of them in paragraph 25 and following
9 of your statement; correct?

10 A. Correct.

11
12 Q. Can I take you ahead to paragraph 9 of your statement,
13 please. Just before I do, I'm sorry, operator, before
14 I leave paragraph 7, in that passage that I was just taking
15 you to where you say that the district cannot influence the
16 number of specialists, you reference the impact of the
17 district service agreement with the secretary?

18 A. (Witness nods).

19
20 Q. Do you say it's a case that the district has no input
21 into the parameters of that service agreement?

22 A. No.

23
24 Q. So in what way does the district service agreement
25 with the secretary provide a barrier to the influence that
26 the district can have on the number of specialists that are
27 retained by it?

28 A. I don't believe there's a barrier, there's
29 a discussion that is carried out every year to determine
30 the requirements of the service provision in the Illawarra,
31 and that then becomes part of the service level agreement
32 that the health district works with.

33
34 Q. But the district can have influence and input into
35 that process?

36 A. Yes, it can.

37
38 Q. Would you go ahead to paragraph 9, please. In the
39 first line of that paragraph, you tell us that the number
40 of specialist training positions is highly dependent on the
41 medical colleges. Do you see that?

42 A. It is.

43
44 Q. In what way?

45 A. The colleges, as you have heard this morning, can
46 define the number of trainees that they can support going
47 through their service; they will also define the

1 appropriate training capacity for the services to be
2 provided by those health districts.

3

4 Q. Is this the accreditation process that you're
5 referring to?

6 A. It's the accreditation process and also the assessment
7 of what the skills and abilities and exposure to training
8 capacity that the districts can provide to college
9 trainees.

10

11 Q. When you refer to the "assessment of what the skills
12 and abilities and exposure of the training capacity that
13 the districts can provide", is that something that is
14 separate to the accreditation process, to your
15 understanding?

16 A. No, it's aligned with the accreditation process.

17

18 Q. So do we understand in paragraph 9 you to be referring
19 to the influence the college has in imposing standards on
20 facilities for the training of specialist clinicians within
21 the relevant program?

22 A. The colleges do influence that significantly, but in
23 the appropriate way.

24

25 Q. Does the district have any influence over the number
26 of specialist training positions, in your view?

27 A. Yes. The district can also consider whether they want
28 to approach a college to request an accredited position.
29 They can approach a college to expand and enhance that
30 training position. We can also look at enhancing the
31 opportunities that we can provide to trainees, so looking
32 at perhaps more of a district approach in some of those
33 training positions. So, yes, there's a - it's not a fixed
34 relationship; it's a very flexible relationship.

35

36 Q. There is input and influence on both sides?

37 A. There is.

38

39 Q. And the district can, if it identifies a need for
40 further trainees, deploy its resources to attempt to meet
41 some of those college standards; correct?

42 A. Correct.

43

44 Q. And your district does that from time to time, does it
45 not?

46 A. It does.

47

1 Q. In paragraph 12, you tell us that you're aware of some
2 of the colleges working with ministry and other
3 jurisdictions to develop alternative training
4 opportunities. Do you see that?

5 A. Yes.

6
7 Q. Can you just describe some of your observations in
8 that area, please?

9 A. Yes. There's a number of more flexible opportunities
10 that are being developed now, understanding that trainees
11 may need specific support if they're working outside of the
12 metro-centric areas. The colleges are being a lot more
13 flexible and understanding that the provision of
14 a supervisor may not necessarily be a physical supervisor
15 that's there all the time; it may be done through a variety
16 of modes, so it could be done remotely at times, it could
17 be done through a fly-in/fly-out assessment and
18 accreditation of supervision. So the modalities of being
19 able to provide that level of training in the less
20 metro-centric areas are really increasing significantly.

21
22 Q. And is some of that work being done in conjunction
23 with your LHD?

24 A. It is. We are looking at the colleges that would
25 enhance and support us providing trainees access to skills
26 and abilities in some of our more rural areas.

27
28 Q. There are a number of colleges, as we've heard
29 about --

30 A. There are.

31
32 Q. -- during this Inquiry. Are there any in particular
33 that are engaging with your LHD in this process?

34 A. Certainly both of the general practice training
35 colleges are really engaged with our organisation,
36 particularly at the southern end of our district. We've
37 got some really positive support from the Royal college of
38 physicians as well, again, looking at how we can support
39 trainees across both ends of our district and make sure
40 that they get the experience they need.

41
42 We - I, interestingly, had a conversation with the
43 Royal college of surgeons president a few weeks ago about
44 how we can move forward to look at offering more
45 opportunities there. The Royal College of Anaesthetists is
46 also supporting the development of more training positions
47 in the - particularly in the southern end of the state

1 where our population has significant challenges.

2

3 Q. I take it that you see benefit in specialists training
4 in more rural and remote areas, do you?

5 A. Absolutely, and previously in other experiences, there
6 is a significant benefit to trainees in working in the
7 non-metro areas, for sure.

8

9 Q. In general terms, what are they?

10 A. You work in an area where some of the health care is
11 often more challenging, particularly if you're in an area
12 of discrete Indigenous population, if you're in an area
13 where there are the challenges of demographics. You get to
14 support, as a trainee, the health care of those patients in
15 a really significant way in the smaller areas. You often
16 get more exposure to training opportunities. So in a big
17 city centre hospital you might have 10 trainees in
18 gastroenterology that work with four consultants. Those
19 trainees are always trying to get exposure to the practical
20 procedural skills, to the professional skills that you need
21 to become a gastroenterologist. In a smaller,
22 less-populated area, there are less trainees so you
23 actually get to do more work, which is really good for the
24 trainees.

25

26 Q. And are there benefits to recruiting and retaining
27 specialists in rural and remote areas, having trained in
28 those areas?

29 A. Absolutely. The communities are incredibly supportive
30 of all of the clinical trainees that move into those areas,
31 so medical nursing, allied health and some non-clinical
32 staff as well, because the communities have experienced,
33 sometimes, the struggle of not having enough staff in their
34 facilities at times. So often the staff that go there and
35 experience what it's like working in these rural areas, as
36 well as the interesting medicine and surgery that they get
37 to be exposed to, they're often made part of the community
38 really quickly and if we can get the trainees into these
39 areas more readily but also earlier in their career
40 pathways, there's often the, you know, quid pro quo that
41 you get them to stay in those areas, which is fantastic.

42

43 Q. The matters that you have been describing in your
44 answers to these few questions, are they things that you
45 have observed during your time within the district?

46 A. Within the district and outside of the district.

47

1 Q. When you say "outside of the district", you've worked
2 in health systems in other jurisdictions; correct?

3 A. I have.

4

5 Q. Including Queensland and Western Australia?

6 A. And Victoria.

7

8 Q. And the observations that you've just described are
9 things you have seen in those jurisdictions as well?

10 A. Absolutely. It makes a huge difference.

11

12 Q. In terms of the work being done with the colleges to
13 bring some flexibility, I'll describe it as, to the
14 supervision requirements, does that work also involve the
15 ministry?

16 A. Yes, absolutely.

17

18 Q. In what way is the ministry involved in that work, to
19 your observation?

20 A. I'm aware that HETI has taken a very active part in
21 that, as well as the workforce team at the ministry as
22 well, to develop those relationships with the colleges and
23 help promote that level of interaction and then
24 flexibility.

25

26 Q. I'll take you ahead to paragraph 14, please. We've
27 touched on the issue of accreditation earlier. I just want
28 to clarify a couple of things with you. In paragraph 14
29 you give a general description of accreditation processes;
30 correct?

31 A. That's correct.

32

33 Q. There are some variances between the colleges, but
34 what you've set out there is a general description of how
35 that process might play out; is that right?

36 A. It is.

37

38 Q. I just want to ask you about the last sentence, this
39 is assuming that accreditation has been given to
40 a particular facility, and then you say:

41

42 *... the college would provide the LHD with*
43 *an agreement to recruit trainees. The LHD*
44 *can then recruit trainees directly or, in*
45 *some cases, is a site provider for a larger*
46 *training process.*

47

1 Do you see that?

2 A. That's correct.

3

4 Q. Can you just explain what the process that you're
5 referring to there is, please?

6 A. I can. There are really two ways of doing that. Some
7 of the bigger colleges will allocate trainees across
8 a broad district area, so it may be across four or five
9 districts, it may be across the state, in some instances
10 it's almost a national allocation.

11

12 Q. Just pausing there, which colleges do you have in
13 mind?

14 A. The college of anaesthetists, for example, they will
15 direct and dictate where the trainees need to go to fulfil
16 their requirements.

17

18 Q. As part of what has been described to us as a "network
19 approach"?

20 A. Correct. That's correct. And then some other
21 colleges will look at the support that you can provide to
22 trainees, look at the things that they can be exposed to,
23 so those are requirements to be exposed, for example, with
24 the Royal college of obstetricians and gynaecologists,
25 a number of caesarean sections that trainees have to
26 fulfil. So you would look at how many births, how many are
27 done by caesarean section.

28

29 So the colleges would then say, "We believe you could
30 sustain three trainees", and so then you go out to advert
31 and can recruit three trainees who are registered on the
32 training program to come and work in your district.

33

34 Q. Can I take you to paragraph 17, please. In an earlier
35 answer you mentioned the role of HETI. In this paragraph,
36 you tell us that HETI provides a positive oversight
37 function in advance of accreditation processes, and
38 enhancing clinical schools of trainees. Do you see that?

39 A. I do.

40

41 Q. Is this a process that HETI delivers prior to
42 a particular facility going through an accreditation
43 process?

44 A. It can - it does on a regular basis and will help
45 pre-empt some of those accreditation journeys. Not in
46 every case.

47

1 Q. Well, let's take that example first. So let's just
2 take a hypothetical example in your district. A facility
3 is about to undergo an accreditation process to stand up
4 a training position for one of the colleges, how would HETI
5 become involved and what would the process be that you're
6 referring to in paragraph 17?

7 A. So we have directors of education who are clinicians
8 who provide the support to our juniors in their training
9 pathways. HETI works directly with those directors of
10 education and they have regular meetings, conversations
11 about trainees and the experience of the trainees.
12

13 The HETI staff also engage and involve conversations
14 with representatives of the training doctors, as well as
15 the directors of medical services, as well as the other
16 executives within the organisation, to look at all aspects.
17 So not just the training experience but the experiential
18 responses from the training doctors; looks at the
19 facilities, what we can provide them - for example, access
20 to computers, access to information around medical results
21 and records, all of those things are taken into
22 consideration by HETI.
23

24 They then support our training directors to make sure
25 that our organisation is providing the adequate things that
26 are required for those trainees, and then we go through
27 a preparative pre-accreditation conversation to make sure
28 that we've got a way forward. So if there were issues that
29 were raised by trainees, we would have a way of addressing
30 them prior to the accreditation.
31

32 Q. So to summarise that, it's really a preparation
33 process to get the facility into a position where it is
34 likely to pass, for want of a better term, the
35 accreditation process?

36 A. It is a supportive process, yes.
37

38 Q. You indicated at the commencement of that answer that
39 that is not the only time HETI would become involved in
40 accreditation issues; correct?

41 A. Correct.
42

43 Q. In what other way, to your observation?

44 A. So if there were reported issues, we would be in -
45 HETI would be in contact with us to discuss what those
46 issues were, what we can do to mitigate those issues and
47 what the opportunities are to change, improve, enhance or

1 otherwise the accreditation processes.

2

3 Q. As part of this, does HETI liaise with the colleges as
4 well?

5 A. They do.

6

7 Q. And in both scenarios, how does HETI become involved?
8 Are they drawn into that process by the relevant LHD?

9 A. They can be. They also have a standard process where
10 they will always be in contact with the directors of
11 physician education and surgical education. They have
12 regular meetings with the representatives of the LHDs and
13 the representatives of the trainees.

14

15 Q. Can I ask you about the example you give in
16 paragraph 17, and in the last sentence you tell us that:

17

18 *HETI oversaw and approved a process whereby*
19 *cardiology trainees employed by [the*
20 *district] could work in that private*
21 *hospital to get exposure ...*

22

23 et cetera. First of all, how did that process arise and
24 then play out?

25

26 A. The accreditation for the cardiology training
27 positions was carried out in the local health district and
28 one of the recommendations was that the training doctors
29 required further exposure to certain cardiology procedures
30 that were not provided in the Wollongong Hospital, but that
31 were provided by the same cardiologists in the private
32 hospital next door. So we looked at the - how we could
33 actually work with our partners next door, and also the
34 cardiologists, to permit the training registrars to move
35 into the private hospital next door to gain that experience
36 in that particular modality.

36

37 Q. So when you say "we", that was the district?

38

39 A. It was the district.

40

41 Q. The college?
42 A. It was HETI, it was the college and the private health
43 provider next door.

43

44 Q. Do you see there being scope for further opportunities
45 of that kind to provide trainees with exposure that they
46 may not be able to get within the LHD, perhaps within
47 private facilities within the LHD?

1 A. Absolutely. It's a really good example of how we can
2 be more dynamic in supporting the trainees to get all of
3 the experience that they need across that district by
4 having those relationships.

5

6 Q. And you've used the cardiologists as one example. Are
7 you aware of other similar examples for other trainee
8 groups?

9 A. Yes, specialist GP trainees. So there are GP trainees
10 who may also want to get experience working in an emergency
11 department in a tertiary site, for example, or obstetrics
12 and gynaecology in a tertiary site, and so we work locally
13 with the general practitioner trainees and then we can work
14 with our own in-house emergency departments and obstetrics
15 units to be able to provide exposure to those trainees to
16 gain skills.

17

18 Q. Can I take you ahead finally, please, to paragraph 23.
19 There you tell us that, at a high level, there's quite
20 a siloed approach across health services in New South
21 Wales. Do you see that?

22 A. Yes.

23

24 Q. Can you just describe what you mean by "siloed
25 approach across health services in New South Wales"?

26 A. I think that the examples that we've just discussed,
27 where a private facility and a public facility and HETI and
28 a college work together for the benefit of the patients to
29 have access to exposing the training professionals to be
30 able to provide that care is still in its - probably in its
31 infancy in New South Wales, and I think that that's more
32 about the custom and practice and I think the more we can
33 break down those barriers or perceived barriers about doing
34 that, I think that will help us with that development of
35 a not so siloed approach.

36

37 Q. Do you also see the collaboration of the kind that you
38 described a moment ago in relation to cardiology training
39 as being one method to perhaps overcome the challenges in
40 delivering training in rural and regional areas to be
41 specialties?

42 A. Potentially. It could be. And certainly where there
43 are multiple facilities that can offer different
44 experiences to training doctors and training nurses and
45 training allied health staff, it could be done to encourage
46 that rurality.

47

1 Q. In paragraph 23, you also refer to silos between
2 clinical and non-clinical staff and across disciplines. Do
3 you see that?

4 A. Correct.

5

6 Q. Are you there referring to silos within NSW Health
7 agencies?

8 A. In some instances, yes.

9

10 Q. Can you just describe what they are?

11 A. There is still a tendency in health generally, not
12 just in New South Wales, that health systems work in
13 specific silos. So it's still not the norm that whilst you
14 would have clinicians who may work across a private
15 facility, a public facility and provide a service in
16 another state, those organisations don't necessarily work
17 closely together and that can be through the clinical or
18 non-clinical staff not working closely together.

19

20 Q. What about different arms within NSW Health itself?
21 Do you see a similar issue there?

22 A. It is reflective of the process that is health and the
23 complexities of health, and it can be around communication
24 links. So there may be a system that allows us to report
25 patient care in one health area that doesn't talk to the
26 system availability in another health area. So those are
27 some of the barriers that we continue to work on.

28

29 Q. And what effect, in your view, does the siloed
30 approach that you've just described have on delivery of
31 health care, firstly, within the New South Wales public
32 system?

33 A. It can present challenges to ensuring that a patient's
34 journey through health care is absolutely optimum

35

36 Q. In a practical sense, how?

37 A. If you were to look at patients who seek support from
38 a community clinician, they would go to a community
39 pharmacist for a particular ailment and gain treatment
40 there, that treatment that was given in a pharmacy may not
41 be recorded anywhere to allow a hospital and health service
42 to recognise that a patient had sought treatment there.
43 Patients and their families, when they come to health
44 services, are understandably out of their depth and
45 stressed. The nature of being in a hospital facility or
46 a health facility is that you don't choose to go there
47 unless you work there and feel comfortable there, so when

1 we ask patients and their families, "How have you been in
2 the last three months", "Fine, nothing major", but they may
3 have presented to a community pharmacist five times, we
4 don't currently have a way of knowing that or seeing that
5 and that would help the patient journey significantly.
6

7 Q. By that example, it is at a very basic level sharing
8 data and information about the patient's condition --

9 A. Correct.

10
11 Q. -- between health providers across the spectrum of the
12 facility?

13 A. It's very challenging that way.

14
15 Q. It's an example of the silo that you refer to?

16 A. That's right.

17
18 Q. Are there any others?

19 A. The same could apply for general practice into - from
20 primary care into secondary, tertiary and quaternary care.
21 The systems that the general practitioners use, the
22 electronic systems for their medical information, don't
23 link in to the electronic systems that sit with primary
24 and - with secondary and tertiary and quaternary care
25 systems. Patients - there's no single identifier of
26 a patient, so a patient can go to see somebody in a Sydney
27 city centre hospital and register there, but there wouldn't
28 necessarily be a way of accessing that information if that
29 patient re-presented at Wollongong Hospital.
30

31 MR GLOVER: Thank you, Doctor.

32
33 I have no further questions for this witness,
34 Commissioner.

35
36 THE COMMISSIONER: Mr Cheney, do you have any questions?
37

38 MR CHENEY: No questions.

39
40 THE COMMISSIONER: Thank you very much, Doctor, for your
41 time. We're very grateful. You're excused.

42
43 THE WITNESS: It's a pleasure, thank you.
44

45 <THE WITNESS WITHDREW

46
47 MR FRASER: Commissioner, the next witness is

1 Professor Steevie Chan, and I understand Professor Chan is
2 hopefully outside.

3
4 <STEEVIE SIU WEI CHAN, sworn: [3.13pm]

5
6 <EXAMINATION BY MR FRASER:

7
8 MR FRASER: Q. Professor, please give your full name?
9 A. Steevie Siu Wei Chan.

10
11 Q. And that's Steevie, S-T-E-E-V-I-E; is that correct?
12 A. Correct.

13
14 Q. And we understand you are the district director of
15 medical services at the Central Coast Local Health
16 District; is that right?
17 A. Yes.

18
19 Q. And you are a fellow of the Royal Australian College
20 of Medical Administrators; is that correct?
21 A. Yes.

22
23 Q. In relation to your position at the Central Coast
24 Local Health District, is it right that you've held that
25 position since April of 2021?
26 A. Correct.

27
28 Q. Professor, you provided the Inquiry with a statement.
29 Do you have a copy of that with you?
30 A. Yes, I do.

31
32 Q. That's a statement which is dated 29 July of this
33 year?
34 A. Yes.

35
36 Q. Presumably, you've read it before coming to give
37 evidence today?
38 A. Yes.

39
40 Q. And it's only one day old, but despite that, is
41 anything in there incorrect --
42 A. No.

43
44 Q. -- that you wish to update?
45 A. No.

46
47 Q. So it's true and correct to the best of your

1 knowledge; is that right?

2 A. Yes.

3

4 MR FRASER: That will form part of the bulk tender,
5 Commissioner.

6

7 THE COMMISSIONER: Yes.

8

9 MR FRASER: Q. I just want to ask you a few questions
10 arising out of your statement. You've provided an
11 overview, from paragraph 5 onwards, of the current
12 workforce within the local health district. Thank you for
13 that. It is said to be a medical staffing head count?

14 A. Yes.

15

16 Q. So that's total number of individuals as opposed to
17 full-time equivalent positions; is that correct?

18 A. Correct.

19

20 Q. Thank you. Just at a high level, you've touched on,
21 at paragraphs 8 and 9, issues to do with locums; is that
22 correct?

23 A. (Witness nods).

24

25 Q. Can I ask, is there any - to your knowledge, do you
26 have, at the Central Coast Local Health District,
27 difficulty in attracting locums?

28 A. There's no difficulty attracting locums. We usually
29 have advance notice when we see that there are gaps in the
30 rosters, and with adequate notice there's usually no
31 difficulty in finding locums through the various agencies
32 that we have a contract with.

33

34 Q. I'm not sure if you've been told of some earlier
35 evidence the Inquiry heard last week from Dr Spooner, who
36 is, we understand, the director of emergency medicine at
37 Wyong Hospital --

38 A. Yes.

39

40 Q. -- in your local health district. His evidence was
41 that there is sometimes difficulty in filling all the
42 available slots on the roster, even with locums. Do you
43 disagree with that?

44 A. That statement in itself is true as well, because
45 there are actually many shifts to be filled on a daily
46 basis. At Wyong, for example, there are more than 40
47 shifts medically per day to be filled. So there are

1 certain times when shifts are not filled. But not every
2 single shift needs to be filled by a locum. Sometimes,
3 there are local arrangements for redeployment of staff
4 using overtime, using other staff to assist in order to
5 fill the vacancy they might be experiencing for that day.
6 So locum is not the only answer to any shift vacancies.

7
8 Q. His evidence was that, using all the different
9 methods, often there were still shifts that were unable to
10 be filled each day. Is that consistent with your
11 experience?

12 A. I would not say each day, no.

13
14 Q. You disagree with that?

15 A. (Witness nods). Not every day.

16
17 Q. In paragraph 17 of your statement, you talk about
18 workforce capacity and capability planning and you've
19 annexed the current LHD clinical services plan for the
20 years 2023 to 2028. I don't propose to take you to the
21 plan, but presumably having annexed it you're familiar with
22 it, and just at a high level, it contains an examination of
23 the health needs of the local health district, or at least
24 the population of the local health district; you agree with
25 that?

26 A. Yes.

27
28 Q. And it includes modelling in relation to future needs
29 over various periods of different types of services and the
30 different demographics?

31 A. Yes.

32
33 Q. And I am summarising this in a very high level --

34 A. (Witness nods).

35
36 Q. -- would you agree with that? Are you, in your role,
37 involved in that preparation of the plan?

38 A. So the plan was conducted over a many months period of
39 time.

40
41 Q. No doubt?

42 A. It was done by the planning unit of the LHD and it
43 involved consultation of more than 100 members of staff,
44 including the executive and including myself in various
45 workshops and iterations of the draft plan. There were
46 presentations done as part of the consultation process to
47 display the information, the data, and some of the

1 directions and suggestions of the plan. So yes, it was
2 done over an extensive period of time.

3

4 Q. And as an observation, it would seem that it draws
5 upon, not insignificantly, some information gathered by the
6 primary health network; is that right?

7 A. Yes.

8

9 Q. Are they consulted as well as part of the formulation
10 of the --

11 A. Yes.

12

13 Q. -- clinical services plan? Thank you. And in terms
14 of the modelling that is undertaken, is that within the
15 planning unit --

16 A. Yes.

17

18 Q. -- that you've just referred to --

19 A. Yes.

20

21 Q. -- which is within the central administration of the
22 district; is that right?

23 A. Yes.

24

25 Q. Thank you. Just as a separate area, I want to ask you
26 about workforce models arising out of what the health needs
27 or projected health needs are. How does one arrive at what
28 the required staffing levels for a particular service in
29 the future will be, ie, you might know or expect there to
30 be 45 births per day, for instance. How does one arrive at
31 how many obstetricians you need, for instance?

32 A. In general you use the existing activity as a guide
33 for the future, so you would assess your needs based on
34 projected activity for the future, in general. Obviously
35 different specialties have different ways of assessing the
36 future. Some specialties might indeed predict or plan for
37 a change in model of care or change in service. They may
38 need different types of staff in different combination of
39 staff. So in terms of workforce planning there's really
40 a combination of dynamic factors at play to arrive at
41 a future number.

42

43 But to use existing activity as a start would be
44 probably the best way, and if we project future growth,
45 then we'll have an expected growth in the medical staffing
46 numbers, ideally, to match the number of increased
47 activity. So if we were to increase operating theatre

1 sessions for particular procedures or a particular
2 condition in the future, we would want to make sure that
3 there's enough staff in the future to meet that requirement
4 and therefore commence any recruitment process for the
5 future if needed.

6
7 Q. I'll just come back to the emergency department. We
8 heard some evidence from Dr Spooner in relation to
9 workforce models in emergency medicine. I'll just take you
10 to a document and ask if you're familiar with it. He
11 referenced the Australian College of Emergency Medicine
12 document, "Constructing a sustainable emergency department
13 medical workforce", I'll just have that brought up on the
14 screen. It's [SCI.0011.0242.0001]. I will just ask, is
15 that a document you have seen before?

16 A. Yes, I have.

17
18 Q. I'll just take you to page 7. Without going through
19 it laboriously, it contains a model with suggested
20 workforce staffing levels for emergency departments per
21 shift, depending on the number of presentations on an
22 annual basis at the facility or at the site. You'd agree
23 with that?

24 A. Yes.

25
26 Q. And Dr Spooner's evidence is that this is not how
27 their staffing levels have been arrived at. Do you agree
28 with that?

29 A. Yes.

30
31 Q. And his evidence was that the staffing levels, at
32 least at Wyong, were lower than recommended in this
33 document. Is that something --

34 A. Staffing levels generally are based on historic
35 allocation of the department's FTE. It wasn't invented
36 from scratch. So this table would not have been around
37 several years ago when Wyong emergency department
38 commenced.

39
40 On this table, I do want to comment that it provides
41 one model of an ED which is not necessarily standardised
42 across all the nation.

43
44 Q. Of course.

45 A. Different EDs have different complexity, different
46 types of patients presenting, age groups. So Wyong may or
47 may not be identical to the model ED that is used in this

1 projection. Wyong ED would not be as complex, for example,
2 as a quaternary emergency department like RPA or
3 St Vincent's.

4
5 Q. I'll just ask you this question, though: the primary
6 factor in determining future staffing levels is effectively
7 activity or projected activity growth, presumably; is that
8 right?

9 A. That's one key factor, but I would also say evolving
10 and emerging models of care would also be important,
11 because medicine and health care do evolve and change and
12 there are better ways of delivering health care in the
13 future that we may not know yet, and one number alone may
14 not be the answer to the way future health care is
15 delivered.

16
17 Q. And that was what I was coming to. So it's not
18 solely, you had 10 staff last year and a 10 per cent growth
19 so we give you one more - that's right, isn't it?

20 A. That's correct.

21
22 Q. Because that presumes that that is the correct model
23 of care and forever more?

24 A. And there's also workforce substitution, an
25 alternative workforce available to provide care that
26 previously was not provided by that particular group. So
27 nurse practitioners in Wyong ED is one example of how that
28 has assisted in meeting the demand of presentations to
29 Wyong ED.

30
31 Q. Thank you. In paragraphs 10 through to 16 of your
32 statement you've given an overview of the use of nurse
33 practitioners in the Wyong ED?

34 A. Yes.

35
36 Q. Which I think, to summarise, is a model of care that
37 is evolving at Wyong; is that right?

38 A. It started last year so it's still evolving.

39
40 Q. And I think you have indicated at paragraph 16, the
41 goal is to further expand it in the future?

42 A. Yes.

43
44 Q. And just to clarify, in those paragraphs you talk
45 about endorsed nurse practitioners and transitional nurse
46 practitioners. Just to be clear, an endorsed nurse
47 practitioner is one who has obtained the endorsement as

- 1 a nurse practitioner?
2 A. Correct.
3
4 Q. And a transitional nurse practitioner?
5 A. On the way to becoming one.
6
7 Q. Indeed, thank you. Lastly in relation to service
8 planning, the clinical services plan that you have annexed,
9 which is for a five-year period, is that a five yearly
10 cycle of review or is it a continuous process?
11 A. It is continuous every five years.
12
13 Q. So we should expect another one some time before the
14 expiry of 2028; is that right?
15 A. Yes.
16
17 Q. In your statement you've helpfully set out a number of
18 things relating to the training of the local health
19 district's workforce. I'd just like to ask you some
20 questions, particularly arising from paragraph 26, which
21 relates to the nature and adequacy of planning regarding
22 the number and distribution of doctors. Firstly, you've
23 spoken in that paragraph about the centralised training
24 networks?
25 A. (Witness nods).
26
27 Q. Do they apply for all specialties?
28 A. Most specialties at Central Coast, yes.
29
30 Q. And you've indicated that, just looking four lines
31 from the bottom - I see we don't have it on the screen, but
32 in any event - for example:
33
34 *When medicine and surgery networks allocate*
35 *registrars to CCLHD, the LHD has no direct*
36 *influence over who and how many will be*
37 *allocated.*
38
39 Just on that, is what you are saying no influence at all or
40 no influence on whether you get the numbers that you have
41 set --
42 A. It's the latter.
43
44 Q. It's the latter?
45 A. So we make a request of number of positions.
46
47 Q. Yes.

- 1 A. But there's no guarantee and no influence that I can
2 make that that number will actually eventuate.
3
- 4 Q. Because the local health district has control over how
5 many training positions it offers?
6 A. Yes.
7
- 8 Q. On an annual basis --
9 A. Correct.
10
- 11 Q. -- on each cycle? Is it the case that often you
12 don't receive the full allocation of training positions
13 that you're offering?
14 A. It's specialty dependent. In the case of this year,
15 the examples I used were neurology and medical oncology,
16 and that has been the case for neurology last year as well.
17
- 18 Q. And generally in other specialties, you have been
19 receiving your full complement of available spots?
20 A. Usually. Usually.
21
- 22 Q. In terms of opportunities for offering additional
23 training opportunities, in your local health district, is
24 that something that is looked at across the district,
25 whether there are opportunities to establish an additional
26 training position, say, at Wyong in a particular specialty
27 or at Gosford?
28 A. Yes. The example I can use is recently we were
29 looking at establishing a gastroenterology training
30 position at Wyong Hospital and we made an application to
31 HETI for that to start the assessment.
32
- 33 Q. What about training positions that have to be
34 accredited individually by --
35 A. So that would be one. That's the example, yes.
36
- 37 Q. In paragraph 27, just over the page, you have
38 indicated that currently, for vacant training positions,
39 the biggest challenge is recruiting to a number of areas,
40 and you referred to the table that you set out at
41 paragraph 30. It would assist if we had the statement up
42 on the screen. Can we get paragraph 30 up on the screen?
43 In any event, we will keep going. In that table you've
44 referred to JMOs.
45 A. Yes.
46
- 47 Q. Does that take in registrars as well?

1 A. So that includes registrars and residents, but not
2 interns.
3
4 Q. So it includes people on specialty training programs?
5 A. Yes.
6
7 Q. As well as the general PGY1?
8 A. Not PGY1.
9
10 Q. Not PGY1?
11 A. PGY2 or above.
12
13 Q. Thank you. And all up, according to that table,
14 you're short 66?
15 A. As of that date.
16
17 Q. As of the date that you obtained the figures. Is that
18 representative of the shortfall that you generally have?
19 A. So that represents the amount of vacant positions we
20 have that we failed to recruit. So these are examples of
21 situations where we have advertised and failed to recruit.
22
23 Q. We'll come to some of what can be done about that in a
24 moment. According to your table, there are only a few,
25 only four staff specialist positions currently vacant
26 across the district, two in obstetrics and gynaecology, one
27 in psychiatry, and one in the sexual assault service,
28 presumably?
29 A. So these are positions where we advertised repeatedly
30 over time and have not been successful in recruiting.
31
32 Q. Again, I'll just ask you about Dr Spooner's evidence.
33 His evidence was that there were, I think, four or five
34 staff specialist positions FTE vacant in the emergency
35 department.
36 A. Yes, I'm not sure I understand his context. So at the
37 moment, between Gosford and Wyong hospitals, there are more
38 than 65 staff specialists appointed, as well as about eight
39 VMOs in emergency medicine. We've had rounds of
40 recruitment for emergency specialists regularly throughout
41 the last year or two and we usually appoint people as
42 a result of the recruitment campaigns. So I'm not sure
43 I understand Dr Spooner's context. Maybe he's referring to
44 days where he's unable to fill shifts of staff specialists
45 where his own staff are not available to work. I'm not
46 sure.
47

1 Q. His evidence was that there were four or five FTE
2 vacancies within his established positions. In any event,
3 that's perhaps a or discussion that --

4 A. The hospital recruits based on their needs and, yes,
5 I'm not truly understanding what he was saying there, yes.
6

7 Q. Where there seems to be some agreement is, at that
8 junior level, that there's a significant particular
9 shortfall in emergency medicine according to your table --

10 A. Yes.

11
12 Q. -- and also according to his evidence?

13 A. Yes.
14

15 Q. How does that impact, on your understanding, on the
16 ability to --

17 A. I think I started talking about that earlier. So
18 there are more than 40 shifts of medical officers being
19 filled across both Gosford and Wyong hospitals every day,
20 and in situations where shifts can't be filled, there are
21 other ways of ensuring that services can be provided,
22 including the use of other staff, workforce substitution,
23 changes in the way you provide services.
24

25 We have expanded our primary care service through the
26 establishment of the urgent care centre at Long Jetty, also
27 with the aim of trying to use general practitioners to
28 assist with seeing lesser acuity patients in a different
29 environment to lessen the load to patients appearing at the
30 emergency department. So there are many ways of the LHD
31 dealing with workforce challenges in the emergency
32 department, and I used the example of the Wyong nurse
33 practitioners also, earlier. There are now two full-time
34 nurse practitioners appointed at Wyong as well as several
35 transitional NPs --
36

37 Q. On the way?

38 A. -- providing seven days a week coverage.
39

40 Q. You've spoken in paragraph 32 about incentives and
41 programs to attract workforce to rural, remote and regional
42 locations, and you've proffered the opinion that, in your
43 view, they're reasonable.

44 A. (Witness nods).
45

46 Q. What are you actually referring to in that sentence?

47 A. I'm referring to the historic government enhancements

1 and incentives that have been around over time to attract
2 people to rural and regional Australia, and my view is
3 those incentives, over time, provided by government were
4 reasonable. The market keeps evolving and the expectations
5 of the employees keep evolving, and that's the element that
6 we have lesser ability to control.

7
8 Q. You go on in the last sentence of paragraph 32 to say
9 that or suggest that a more centralised management of locum
10 rates or a cap could be a useful tool. What do you mean by
11 that? Do you mean by the ministry or --

12 A. By the ministry may be one example. So at the moment,
13 locum agencies can command high rates, especially during
14 high-demand periods, such as Christmas and new year and
15 school holidays. And maybe not the case at Central Coast,
16 but I've heard situations at other LHDs in remote New South
17 Wales who have to pay very high hourly rates to attract
18 locums to work there to ensure an acute medical service is
19 covered. If there's some way of controlling the rates,
20 there may be a better outcome for all involved.

21
22 Q. What about centralised retaining and distribution of
23 locums?

24 A. That helps too, yes.

25
26 Q. That might be something that would assist?

27 A. Yes.

28
29 Q. Just lastly on workforce, paragraphs 37 and 38, you
30 touched on VMOs, or visiting medical officers, within your
31 district. Just two issues arising, you've said that at
32 Gosford - and you only have the two major hospitals --

33 A. Yes.

34
35 Q. -- Gosford and Wyong; correct?

36 A. Yes.

37
38 Q. You have said at Gosford, VMOs are engaged on
39 sessional contracts, whereas at Wyong they're engaged on
40 fee for service contracts?

41 A. (Witness nods).

42
43 Q. Is that across specialties?

44 A. Yes.

45
46 Q. Why is that? Is that a historical --

47 A. It's a historical arrangement. Generally for

1 procedural specialties like surgery, fee for service is
2 a more attractive arrangement, and for medical specialties,
3 the sessional arrangements are acceptable.
4

5 Q. Is that an indicator of the different services that
6 are provided at those different hospitals?

7 A. (Witness nods).
8

9 Q. Is Wyong more surgical than Gosford; is that why?

10 A. It also reflects the relative ability to attract
11 specialist surgeons to particular areas.
12

13 Q. The other matter I wanted to raise with you is: you
14 proffered the opinion that the VMO determinations, the two
15 relating to sessional contracts and that relating to fee
16 for service contracts - paragraph 38, you've offered the
17 view that those determinations enable New South Wales to
18 recruit and retain a sustainable workforce. What is it
19 about the determinations, in your view, that enable --

20 A. I guess my primary context there is in reference to
21 Central Coast right now. We are at the moment going
22 through our quinquennial reappointment process, and we are
23 about to conclude the previous five-year contracts and
24 moving on to the new five-year contracts, come 1 October
25 2024.
26

27 In the rounds of discussions we've had, the VMOs seem
28 to be very content with their respective arrangements at
29 both Gosford and Wyong hospitals and that's the context of
30 my statement there, that I see no particular concern from
31 a Central Coast perspective regarding the determination.
32

33 Q. In other words, the practitioners themselves aren't
34 raising concerns about the terms of those contracts?

35 A. Correct.
36

37 Q. Just lastly, in section G of your statement, over
38 a number of pages, you outline a history of the process by
39 which accreditation was reviewed and then eventually
40 withdrawn by the Royal Australian and New Zealand College
41 of Radiologists at the Central Coast, withdrew
42 accreditation for training in radiation oncology at the
43 Central Coast Cancer Centre at Gosford, and you annex
44 a significant number of items of correspondence. I won't
45 be taking you through that, they speak for themselves.
46 I just want to ask you two things --
47

1 THE COMMISSIONER: Sorry, just on that, I know we only got
2 this statement yesterday. Are those documents in the
3 tender bundle, because I couldn't find them?
4

5 MR FRASER: They should be - I was told they were not yet
6 in but that they were going in.
7

8 THE COMMISSIONER: It's not helpful to me to be given
9 a statement where - this isn't a criticism of you. If
10 there's a statement where there's a whole lot of documents,
11 I need to be given the documents as well as the statement,
12 if they're not in the tender bundle.
13

14 MR FRASER: I thought you had been, Commissioner.
15

16 THE COMMISSIONER: The other thing, presumably the
17 professor and those assisting him feel this is important,
18 otherwise it wouldn't be in the statement. There is
19 a reason they want me to know about this. Have you had
20 time to read all this correspondence and absorb it for the
21 purposes of asking --
22

23 MR FRASER: Only at a superficial level, Commissioner. I
24 think the question -
25

26 THE COMMISSIONER: I think what we will do - it may well
27 be - well, I think what we'll do, you finish your
28 questions, but I think you need some time to read this
29 correspondence and I do, and then we'll have to decide
30 whether, regrettably, we ask the professor to come back -
31 not tomorrow, but at another time convenient to him,
32 because I'm going to make the assumption I'm being told
33 this because it's relevant, because it wouldn't be there
34 unless - if it was of no assistance to this Inquiry or to
35 me, I'm sure the professor and those assisting him wouldn't
36 put it in there. So there must be a reason why it is
37 important, which means, I think, we all need the chance to
38 look at the correspondence.
39

40 MR FRASER: The context, as I understand it, is that it is
41 one of the case studies that was raised by the college,
42 although in its statement, it --
43

44 THE COMMISSIONER: It might be even more important, then,
45 that we both have a chance to look at the correspondence.
46

47 MR FRASER: Perhaps I can just ask a question.

1
2 THE COMMISSIONER: You go ahead.

3
4 MR FRASER: It doesn't relate to the correspondence.

5
6 THE COMMISSIONER: You go ahead and finish.

7
8 MR FRASER: Q. Professor, just putting aside the rights
9 and wrongs of your views on that process and whether
10 a decision was right or not, from the district's
11 perspective, what's the effect of a withdrawal of
12 accreditation, other than the obvious, that accredited
13 training can no longer take place at that site?

14 A. Can I start by saying that the LHD has accepted the
15 decision of the college. We are actually working towards
16 improving the culture of the department and fulfilling the
17 suggestions from the college in relation to training and
18 supervision, and it is our desire to seek reaccreditation
19 some time in the beginning of next year. So we are working
20 with the college to try and meet our standards for the
21 trainees.

22
23 In terms of your question relating to the trainees, as
24 a result of the withdrawal of the accreditation, the
25 trainees that we have now are no longer accredited for the
26 training, so the time they work in Central Coast radiation
27 oncology department will not be counted for their specialty
28 training. Despite that, we were able to recruit to fill
29 the positions, so three unaccredited trainees commenced in
30 the beginning of the year, so there was no service
31 interruption.

32
33 Indeed, during the time last year when the service was
34 withdrawn from accreditation, we were able to fill the
35 positions with locums, so that the service will continue.

36
37 Q. And what happened to your trainees who were on the
38 program?

39 A. Yes, the trainees that were there last year all
40 received new positions in various other training centres in
41 New South Wales.

42
43 Q. And in terms of the fact that you were able to fill
44 those positions, either previously with locums and now with
45 unaccredited trainees, does that mean effectively that you
46 were able to avoid any negative impact on the provision of
47 clinical services --

1 A. Correct.

2

3 Q. -- that may rely on the assistance of those trainee
4 staff?

5 A. Correct. Correct. And the department continues to
6 have four staff specialists and four VMOs and nurses and
7 radiographers.

8

9 MR FRASER: Indeed. Commissioner, we might attend to the
10 folder of material.

11

12 THE COMMISSIONER: Yes.

13

14 MR FRASER: Other than that, I don't have any further
15 questions.

16

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

18

19 MR CHENEY: No, Commissioner.

20

21 THE COMMISSIONER: Thank you very much for your time,
22 Professor. We are a very grateful. Just because your
23 statement came yesterday, and Mr Fraser hasn't read through
24 all of that correspondence - it may well be that we don't
25 need you to come back. If we do, though, we will work out
26 a convenient time and we might even be able to do it by
27 Teams to avoid you having to come to Sydney, if that's more
28 convenient. So I won't fully excuse you now. We'll let
29 you know in due course, but thank you for today.

30

31 THE WITNESS: Okay, thank you.

32

33 <THE WITNESS WITHDREW

34

35 MR MUSTON: The next witness, Commissioner, is Dr Lloyd
36 Ridley. I note the time. It may be convenient for us to
37 sit on for a while, if it is convenient to you, say for
38 half an hour, to get some of his evidence down, given he's
39 been waiting here this afternoon.

40

41 THE COMMISSIONER: Yes.

42

43 MR MUSTON: Unfortunately, things took a little bit longer
44 than expected with the last few witnesses. Dr Ridley is
45 not available to continue tomorrow. That's the only issue.
46 He is available on Thursday morning.

47

1 THE COMMISSIONER: I see. All right.
2
3 MR MUSTON: If we start with him today, he will have to go
4 over until Thursday.
5
6 THE COMMISSIONER: All right.
7
8 <LLOYD JOHN RIDLEY, affirmed: [3.50pm]
9
10 <EXAMINATION BY MR MUSTON:
11
12 MR MUSTON: Q. Dr Ridley, could you state your full name
13 for the record, please?
14 A. Lloyd John Ridley.
15
16 Q. You are a staff specialist radiologist in the
17 department of radiology at Concord Repatriation General
18 Hospital?
19 A. Correct. Yep.
20
21 Q. Broadly referred to within the system as "Concord"?
22 A. Yes.
23
24 Q. You've held that role since 1998?
25 A. Correct, yes.
26
27 Q. Between 2000 and 2010 you were head of the department
28 of radiology?
29 A. Yes.
30
31 Q. But you no longer hold that position?
32 A. Yes, not since then.
33
34 Q. You're also a clinical associate professor with the
35 University of Sydney?
36 A. Correct.
37
38 Q. And you've prepared a statement to assist the Inquiry
39 with its work dated 14 July 2024?
40 A. I did.
41
42 Q. There's a number of attachments to that statement.
43 A. Yes.
44
45 Q. Do you have a copy of your statement with you?
46 A. I have a copy of the statement, thank you.
47

1 Q. Have you had an opportunity to read it before coming
2 to give your evidence today?

3 A. Yes, thank you.
4

5 Q. You're satisfied that the contents of it are, to the
6 best of your knowledge, true and correct?

7 A. Yes.
8

9 MR MUSTON: In due course, that will be tendered.
10

11 Mr Cheney for NSW Health might have some questions for
12 you, Dr Ridley.
13

14 MR CHENEY: No, I don't.
15

16 MR MUSTON: That makes it very quick. I had perhaps
17 anticipated that that might have been communicated a bit
18 earlier.
19

20 THE COMMISSIONER: Can I ask you, then - I'm sorry, can
21 I just ask, does that mean that you are accepting what's in
22 the statement?
23

24 MR CHENEY: No, Commissioner. There is some push-back
25 about what's in the statement to be advanced in statements
26 yet to be served, and I'm in that usual predicament of not
27 having those statements. I think one of them is - my
28 learned friend told me that he has received just recently
29 one of those statements, this afternoon, and there is
30 a second one to follow.
31

32 THE COMMISSIONER: Do you need those for the purposes of
33 asking any questions of Dr Ridley or are they not necessary
34 for that?
35

36 MR CHENEY: Having seen the draft of one of them, it may
37 be that there are some propositions I need to put to
38 Dr Ridley but I'm not sure whether they have found their
39 way into the settled - I suspect I won't. On the usual
40 analysis of whether fairness dictates that I put it to
41 Dr Ridley, I don't think I will need to.
42

43 THE COMMISSIONER: So when you say you don't have any
44 questions, is that, "I don't have any questions now but I'd
45 like to reserve might right to ask the doctor a question
46 later on", or, "I just don't have any questions"?
47

1 MR CHENEY: The former, Commissioner. I should have made
2 it clear, that if upon service of this material, there's
3 anything that I need to take up with Dr Ridley - I suspect
4 it won't arise but I might --

5
6 THE COMMISSIONER: Q. Can I just ask you a couple of
7 questions, then, Dr Ridley?

8 A. Sure.

9
10 Q. Have you got your statement in front of you?

11 A. I do.

12
13 Q. Could you just go to paragraph 6, and just so
14 I understand what you mean by "obsolete", is equipment like
15 the mammography equipment you're referring to obsolete
16 before its end of life?

17 A. The meaning of that statement was that Medicare has
18 a rule about capital sensitivity, which I'm not sure if
19 you're familiar with. Capital sensitivity is the tool that
20 Medicare uses and it's in some of my statements, but
21 basically, it means the Medicare won't pay for services
22 done on old equipment, they say they want to ensure that
23 the Australian population gets access to high-quality
24 equipment. So after a period of time, they pay nothing in
25 terms of Medicare rebate.

26
27 Q. And whatever that time period is that Medicare sets,
28 it may be before the actual end of life of the equipment
29 itself?

30 A. That's correct. It's about quality of the equipment.

31
32 Q. In paragraph 13, where you talk about your
33 understanding concerning the second MRI, were you told, or
34 do you know, why the purchase order was cancelled?

35 A. We - the head of department was asked at very short
36 notice to sign a purchase agreement, an S1. When the rest
37 of the department found out that the purchase had happened
38 with no procurement process at all that we were aware of -
39 so normally our staff would be involved in making
40 recommendations about what the requirements were for the
41 machine and normally we'd also be involved in evaluating,
42 for example, the image quality - so none of that had
43 happened, the process went from being discussed as
44 a proposition to being - so there was not even a business
45 case - to being a signed procurement document in a 24-hour
46 period with no process.

1 The staff in the department were unhappy because of
2 that. There was a petition going round. At the time,
3 John McDonald from ProActive was in communication with me,
4 so I contacted him and pointed out to him that there were
5 problems. I presume you are familiar with ProActive and
6 their involvement.

7
8 Q. Mmm-hmm.

9 A. So John McDonald subsequently contacted the chief
10 executive --

11
12 Q. Well, what I know is the documents attached to these
13 witness statements, so that's the extent of my knowledge.
14 I have to say that.

15 A. Sure. So that was part of a review that happened into
16 radiology. He was conducting a culture review, so was
17 talking to a lot of staff in the hospital about what had
18 gone wrong over time and was trying to improve the dialogue
19 between the executive and the staff. So through him I was
20 able to communicate to the chief executive and I pointed
21 out to him and he subsequently pointed out to the chief
22 executive that - well, I don't know what he said, but
23 I said that the procurement process had not been done
24 properly and the machine that was being selected was not
25 one that was felt by our staff to be suitable.

26
27 Q. Can I ask you about paragraph 17 of your statement,
28 where you talk about the difficulty of attracting staff in
29 interventional radiology. Why is there a difficulty in
30 relation to that discipline?

31 A. It has, over the years, been a relatively unattractive
32 part of radiology.

33
34 Q. Because?

35 A. Because you're up in the middle of the night doing
36 procedures. I've done that myself. You turn up at
37 3 o'clock in the morning, you finish a case at 6 o'clock in
38 the morning and then you turn around and start work.

39
40 Q. There's a lifestyle issue with that discipline, is
41 there?

42 A. So there are challenges. That has changed over the
43 last few years. The issue at Concord was more about that
44 the working conditions, and particularly the pay at
45 Concord, were less than in other locations and so people
46 had decided to leave. The most senior interventional
47 radiologist had, shall we say, been pushed out of the

1 department by - so you're aware from my statement that
2 there were a number of code of conduct issues.

3
4 Q. Yes.

5 A. There was the PID that happened to a number of us. He
6 underwent an even more severe review for a minor
7 complication that was threatening his registration and he
8 chose to resign.

9
10 Q. In paragraph 18, where you talk about staff shortages,
11 you say, "have put patients at risk", I assume, first of
12 all, that's your opinion as a clinician?

13 A. That's correct, yes.

14
15 Q. And can you just give me some idea about - some more
16 specifics about the risks that you're talking about?

17 A. Examples would be that I remember a child who
18 presented to the emergency department, the x-ray was not
19 reported. When a radiologist finally got to report it
20 several - like, I think it was six or eight weeks later, it
21 was discovered that a fairly severe fracture had been
22 missed. So then you have a young child who has a
23 potentially lifelong injury because they haven't been
24 properly cared for initially, they have to have
25 a re-operation, delayed operation.

26
27 My main concern is that there are cancers that would
28 have been missed on x-rays. So if you pick the cancer when
29 the x-ray is done, you can deal with it. If you let it
30 grow for one or two years, it becomes much harder to treat.

31
32 Q. Perhaps related to that, the backlog of scans that you
33 mention in paragraph 20 of your statement, the 50,000
34 scans, how do - tell me, I assume that's not 50,000
35 patients or is it?

36 A. It's not 50,000 patients. It's 50,000 - it's mostly
37 x-rays. So some patients will have --

38
39 Q. Multiple?

40 A. Multiple x-rays, yes.

41
42 THE COMMISSIONER: That's all I will ask you about for
43 now. You heard what Mr Cheney, senior counsel for
44 NSW Health, has said. I'm only going to ask you to come
45 back if I think it's necessary. So someone will have to
46 convince me that it's necessary. But if they do, I will
47 ask you to come back, but we will make arrangements that

1 it's, again, at a time that's most convenient to you.

2

3 THE WITNESS: Sure.

4

5 THE COMMISSIONER: For the time being, though, thank you
6 very much for your statement. We're very grateful, and
7 thank you for your time today. I won't finally excuse you,
8 and as I'm talking, Mr Muston sounds like he wants to say
9 something.

10

11 MR MUSTON: I only had one question arising out of
12 a question you asked to clarify our understanding of it.

13

14 THE COMMISSIONER: Yes.

15

16 <EXAMINATION BY MR MUSTON:

17

18 MR MUSTON: Q. You were asked some questions about
19 paragraph 6 and the obsolescence of machinery from
20 Medicare's perspective?

21 A. Yes, correct.

22

23 Q. Just from the point of view of the impact that that
24 has on the department and those practising within the
25 department, to the extent that Medicare refuses to pay
26 in respect of imaging done on a particular piece of, at
27 least from the Medicare perspective, obsolete equipment,
28 that has an impact on private billings --

29 A. Patient care - oh, patient billings, yes.

30

31 Q. -- to the extent that a private patient - that
32 a patient has identified as being a private patient?

33 A. I should perhaps know the details, certainly
34 outpatients that are done under Medicare billing. I'm not
35 quite sure about the arrangement with the inpatients who
36 are billed under private arrangements like private health
37 insurance.

38

39 Q. I suppose what I'm trying to understand is, to the
40 extent that a patient presents as a purely public patient
41 and is imaged using this piece of equipment, the imaging is
42 reported upon, does the absence of Medicare rebate have any
43 impact on practitioners within the department?

44 A. The rebate will feed in to the rights of private
45 practice, which is part of the staff specialist award.

46

47 Q. But that is in respect of patients who are identified

1 as a private patient rather than a public patient?

2 A. That's correct, and in that setting, a Medicare
3 payment is a private patient. So it does - if Medicare
4 doesn't pay because the equipment is done and out of date
5 equipment, that affects the right to private practice
6 revenue and it also affects the ability to purchase
7 equipment because that money is obviously used for
8 equipment.

9
10 Q. So putting to one side the issue of whether the
11 equipment is so out of date that it presents a risk to the
12 patients, from a financial perspective, those who are
13 working within the radiology department, who are reporting
14 on the images, are suffering a financial disadvantage by
15 reason of the equipment being, at least from Medicare's
16 perspective, out of date?

17 A. In fairness to the ministry, perhaps I should say that
18 we have been put under - there have been a number of months
19 where we have not been paid the full amount that we were
20 entitled to, but at the end of the financial year, an
21 effort was made to make up the shortfall. So there have
22 been some short-term, but over the long term, not so much
23 at this stage.

24
25 Q. When you say the full amount that you were entitled
26 to, is that a reference to the full amount that you would
27 have been entitled to from Medicare had the equipment not
28 been out of date?

29 A. What I'm saying is that the staff specialist award has
30 a right to private practice arrangement and that there is
31 a ceiling about how much we can be paid, and there is an
32 expectation in radiology that we meet that ceiling. So if
33 we don't have enough patients who we can bill to reach the
34 revenue to reach that ceiling, then we have a shortfall.

35
36 Q. So to the extent you reach that ceiling and then there
37 is the additional portion of that Medicare billings which
38 go into the number 2 trust --

39 A. Our number 2 trust is also quite healthy. We have
40 been understaffed for a long period of time and been
41 working very hard for a long period of time. So there is
42 a fairly substantial amount in that account for the number
43 2 activities.

44
45 Q. But is there any supplementation of moneys going into
46 that number 2 account to, as it were, make up for the fact
47 that equipment that is being used within the department is,

1 from Medicare's perspective, out of date?

2 A. I did put it to the chief executive seven, eight years
3 ago, in a meeting, that that should happen as an incentive
4 for the organisation to replace the equipment on time, but
5 needless to say, she didn't like that option.

6

7 Q. Do we take it from that answer that it didn't happen?

8 A. It did not happen, no.

9

10 MR MUSTON: Thank you. No further questions from me
11 today.

12

13 THE COMMISSIONER: It's not Mr Muston's fault but
14 I actually have another question now. It's unrelated.

15

16 Q. Can you go to paragraph 33 of your statement, please,
17 where you tell me that you went to this meeting on
18 21 February 2023 and there were representatives from
19 radiology, nursing, emergency, et cetera, to make
20 a presentation to the chief executive and to - how do
21 I pronounce that doctor's name?

22 A. John Sammut. So he's the representative of the Sydney
23 local hospital board.

24

25 Q. All right. You gave a presentation, you tell me, in
26 relation to workload, staffing and equipment procurement,
27 and if I was to summarise the big issues that are of
28 concern to you, it's those three issues?

29

A. Yes.

30

31 Q. You then tell me in paragraph 34 that you attended
32 a meeting with the chief executive on 11 April 2023, and
33 your recollection is you were told staff were leaving
34 because of the "poor culture of the department". Have you
35 put that in quotation marks because that's the best memory
36 you have of what was actually said to you?

37

A. Well, that was the words that were used.

38

39 Q. Was any detail given about what the poor culture was?

40

A. It was discussed that the executive were working very
41 hard and that they were under-appreciated and that we
42 needed to be more grateful for what they were doing.

43

That's not the word that was used, but it was that sense
44 that they were doing a very good job. The staff of the --

45

46 Q. More grateful about what they were doing, what was it
47 they were doing you should have been grateful for? Were

1 you told?

2 A. No. No. They had been working very hard, for
3 example, COVID, was one of the things that was talked
4 about. COVID actually reduced our workload so it made our
5 life easier. But they have talked about that they have
6 a number of other things that they're dealing with.

7

8 Q. Was there anything more specific, though, in relation
9 to the allegation of poor culture, that you recall? Was
10 there a specific example, "This happened", or, "This was
11 said and that's poor culture"?

12 A. No, not specific. Not specific. It was about being
13 negative. If we say something that was negative, that was
14 what was meant by poor culture.

15

16 Q. Then you say:

17

18 *... I was left with a strong impression*
19 *that I was perceived to be responsible for*
20 *this by raising issues.*

21

22 Just first step, the issues you're referring to are the
23 issues of workload, staffing and procurement that you
24 previously have mentioned?

25 A. That's correct, yes. In broader terms, that's the key
26 ones, but I have over the time talked about more than just
27 those issues.

28

29 Q. The strong impression, what gave you the strong
30 impression that you were referring to?

31 A. Well, when I was asked to try and clarify what I could
32 recall, I was struggling a little bit. It's one of those
33 ones where I guess, in the legal fraternity, you're
34 familiar with when you interview a witness, you know which
35 way you want them to go so you give them the message
36 without actually ever telling them what you want. So it's
37 a very political approach to something --

38

39 Q. I think we should just stick with what gave you the
40 impression --

41 A. My expertise --

42

43 Q. -- rather than going to the legal profession. Don't
44 feel as though there's any problem with this. Often we are
45 just left with an impression and can't recall what
46 particularly has caused that. Is that where you are or was
47 there something specific said in relation to you and what

1 you're raising as an issue?
2 A. Yes, it was never quite said that it was me, but on
3 the other hand, it was pretty much a monologue that was
4 telling me that the administration were doing a great job,
5 the department was not performing well, people were
6 complaining, that was a bad thing. They had a go around
7 the room to - there were three people there, all given the
8 opportunity to talk about the things that I had done that
9 were not helpful, in terms of raising issues. So it was
10 that sort of - they were telling me their disapproval.

11
12 Q. Perhaps if I can help you this way: you say that the
13 discussion - sorry, that during the meeting on several
14 occasions the discussion turned to the need for you, as
15 a senior radiologist, "to speak primarily of the positive
16 aspects of the department". Was any detail given about
17 that? What should I take that to mean?

18 A. That they recognised that I had played a leadership -
19 well, the way I saw it was that I had played a leadership
20 role by being the spokesperson for the department and I see
21 myself very much as the spokesperson for the department
22 because I have previously been a head of department, the
23 head of department had been having difficulty in his
24 communication with the executive and I was trying to
25 provide some assistance in terms of raising issues, so it
26 was --

27
28 Q. Were you told you shouldn't be raising issues about
29 workload or staffing or procurement?

30 A. I don't recall that I was particularly, no.

31
32 Q. Or that you should do it privately or --

33 A. I don't recall that I was particularly. I saw it
34 basically as being a dressing down for having spoken up at
35 the clinical quality council.

36
37 THE COMMISSIONER: Did anything arise out of that?

38
39 MR MUSTON: No.

40
41 THE COMMISSIONER: You want to reserve your position,
42 Mr Cheney?

43
44 MR CHENEY: If I may, Commissioner. I should emphasise,
45 I doubt that I will have to trouble --

46
47 THE COMMISSIONER: Yes, you may.

1
2 All right. Thank you very much for your time.
3 I won't finally excuse you.
4

5 THE WITNESS: Sure.
6

7 THE COMMISSIONER: As I said before, if I'm convinced
8 there is a need for you to come back, we will to have ask
9 you to come back at a convenient time, but we will just see
10 what happens there and we will let you know. If we are
11 told by Mr Cheney that you are not needed, we will also let
12 you know that.
13

14 THE WITNESS: Good. Thank you for your time.
15

16 THE COMMISSIONER: Thank you.
17

18 <THE WITNESS WITHDREW
19

20 THE COMMISSIONER: All right. So adjourn until
21 10 tomorrow?
22

23 MR MUSTON: Yes.
24

25 THE COMMISSIONER: We will adjourn until 10 o'clock
26 tomorrow.
27

28 **AT 4.11PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED**
29 **TO WEDNESDAY, 31 JULY 2024 AT 10AM**
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47

- 4235:46, 4236:6,
4236:12, 4236:22,
4236:28, 4236:33
abilities [3] - 4272:7,
4272:12, 4273:26
ability [9] - 4233:12,
4247:28, 4251:15,
4256:34, 4270:29,
4291:16, 4292:6,
4293:10, 4303:6
able [24] - 4189:12,
4203:6, 4213:3,
4216:39, 4228:14,
4229:28, 4239:34,
4248:34, 4249:11,
4250:42, 4251:2,
4253:19, 4270:29,
4270:44, 4273:19,
4278:46, 4279:15,
4279:30, 4295:28,
4295:34, 4295:43,
4295:46, 4296:26,
4300:20
Aboriginal [1] -
4228:9
absence [1] - 4302:42
absolutely [31] -
4184:3, 4186:42,
4191:33, 4192:33,
4199:3, 4199:41,
4200:28, 4200:33,
4201:29, 4209:31,
4214:24, 4217:26,
4218:6, 4220:38,
4221:39, 4222:41,
4223:1, 4224:8,
4229:26, 4238:34,
4240:44, 4274:5,
4274:29, 4275:10,
4275:16, 4279:1,
4280:34
absorb [1] - 4294:20
ACCC [7] - 4206:9,
4206:10, 4206:21,
4206:45, 4206:47,
4207:7, 4207:13
accept [2] - 4214:20,
4256:39
acceptable [1] -
4293:3
accepted [3] -
4236:25, 4262:25,
4295:14
accepting [3] -
4248:45, 4262:11,
4298:21
accepts [1] - 4267:8
access [9] - 4222:27,
4228:29, 4230:36,
4232:27, 4273:25,
4277:19, 4277:20,
4279:29, 4299:23
accessing [3] -
4223:14, 4228:24,
4281:28
accommodation [2] -
4203:31, 4230:32
accordance [1] -
4212:39
according [4] -
4290:13, 4290:24,
4291:9, 4291:12
account [3] - 4247:22,
4303:42, 4303:46
accountability [1] -
4191:4
accredit [5] - 4202:27,
4202:30, 4227:19,
4261:4, 4261:14
accreditation [82] -
4188:43, 4189:34,
4190:5, 4193:1,
4194:9, 4194:11,
4194:12, 4194:19,
4194:21, 4194:47,
4195:3, 4195:4,
4198:16, 4198:17,
4198:35, 4198:40,
4198:46, 4199:8,
4199:37, 4199:44,
4200:44, 4201:12,
4201:13, 4201:14,
4201:15, 4201:30,
4201:39, 4201:46,
4202:6, 4202:7,
4202:23, 4202:34,
4203:38, 4203:44,
4204:36, 4210:6,
4212:11, 4214:4,
4214:9, 4214:12,
4214:21, 4214:44,
4215:39, 4217:24,
4217:27, 4217:30,
4218:15, 4218:22,
4236:41, 4248:40,
4258:24, 4258:31,
4258:33, 4258:45,
4261:20, 4261:24,
4263:17, 4263:21,
4266:1, 4272:4,
4272:6, 4272:14,
4272:16, 4273:18,
4275:27, 4275:29,
4275:39, 4276:37,
4276:42, 4276:45,
4277:3, 4277:27,
4277:30, 4277:35,
4277:40, 4278:1,
4278:25, 4293:39,
4293:42, 4295:12,
4295:24, 4295:34
accredited [29] -
4186:10, 4188:36,
4191:5, 4202:3,
4202:34, 4209:28,
4209:35, 4210:19,
4214:11, 4236:36,
4237:31, 4237:37,
4238:20, 4238:31,
4238:34, 4239:36,
4239:47, 4245:26,
4247:36, 4252:26,
4252:30, 4253:45,
4254:6, 4265:7,
4272:28, 4289:34,
4295:12, 4295:25
accrediteds [1] -
4238:2
accrediting [5] -
4201:31, 4260:45,
4261:5, 4261:8,
4261:20
ACCRM [1] - 4227:23
accurate [2] -
4257:32, 4265:22
achieve [7] - 4199:9,
4200:14, 4248:11,
4248:13, 4248:22,
4254:27, 4256:27
achieved [3] -
4193:17, 4198:36,
4265:25
achieving [2] -
4200:14, 4251:21
ACI [2] - 4225:25,
4231:27
acknowledge [1] -
4266:9
acknowledging [1] -
4191:8
acronym [1] - 4206:30
acted [1] - 4212:38
acting [1] - 4268:18
action [3] - 4217:23,
4217:39, 4235:10
actions [5] - 4236:2,
4236:9, 4236:12,
4236:25
active [1] - 4275:20
activities [2] -
4194:32, 4303:43
activity [6] - 4285:32,
4285:34, 4285:43,
4285:47, 4287:7
actual [3] - 4191:1,
4255:28, 4299:28
acuity [1] - 4291:28
acute [2] - 4260:3,
4292:18
ad [3] - 4230:30,
4233:23, 4233:30
add [8] - 4185:21,
4189:37, 4193:38,
4199:43, 4213:26,
4218:13, 4218:42,
4229:36
addition [6] - 4189:42,
4190:15, 4246:6,
4249:21, 4258:34,
4265:34
additional [7] -
4184:20, 4243:42,
4246:9, 4246:20,
4289:22, 4289:25,
4303:37
address [2] - 4218:9,
4258:17
addressing [2] -
4267:21, 4277:29
adequacy [2] - 4219:9,
4288:21
adequate [3] - 4269:9,
4277:25, 4283:30
adjourn [4] - 4252:1,
4252:10, 4307:20,
4307:25
adjust [1] - 4247:21
adjusting [1] -
4248:23
adjustments [3] -
4183:44, 4206:12,
4264:42
admin [4] - 4196:19,
4201:17, 4202:19,
4210:12
administer [1] -
4205:25
administered [4] -
4187:44, 4187:45,
4188:1, 4245:22
administering [4] -
4187:4, 4187:28,
4187:37, 4218:21
administration [4] -
4186:39, 4216:20,
4285:21, 4306:4
administrative [8] -
4190:2, 4190:7,
4190:29, 4190:31,
4194:26, 4201:38,
4201:42, 4202:17
administrator [2] -
4210:13, 4228:43
Administrators [1] -
4282:20
administrators [1] -
4216:35
admission [2] -
4223:31, 4223:32
admissions [1] -
4223:31
admit [1] - 4228:39
admitted [2] -
4223:19, 4223:40
adopted [1] - 4236:25
advance [3] - 4258:31,
4276:37, 4283:29
advanced [2] -
4232:26, 4298:25
advantage [1] -
4248:42
advantages [1] -
4256:41
adverse [1] - 4217:23
advert [1] - 4276:30
advertised [2] -
4290:21, 4290:29
advice [2] - 4218:23,
4253:20
adviser [3] - 4215:20,
4215:22, 4242:17
advocacy [2] - 4185:2,
4185:19
advocate [2] - 4185:9,
4185:16
advocating [2] -
4231:31, 4233:25
affects [2] - 4303:5,
4303:6
affirmed [2] - 4268:10,
4297:8
afford [1] - 4222:23
afternoon [2] -
4296:39, 4298:29
age [2] - 4247:13,
4286:46
Ageing [1] - 4210:44
ageing [1] - 4222:13
agencies [3] - 4280:7,
4283:31, 4292:13
agenda [2] - 4190:22,
4241:4
ago [11] - 4194:39,
4205:20, 4216:13,
4216:14, 4223:43,
4244:15, 4262:38,
4273:43, 4279:38,
4286:37, 4304:3
agree [21] - 4186:28,
4186:35, 4186:44,
4186:46, 4198:17,
4198:34, 4198:46,
4199:37, 4199:46,
4200:22, 4200:25,
4200:31, 4201:1,
4208:39, 4216:2,
4217:19, 4218:1,
4284:24, 4284:36,
4286:22, 4286:27
agreed [5] - 4236:1,

4236:9, 4236:10,
4236:12, 4236:25
agreeing [1] - 4239:31
agreement [10] -
4189:45, 4190:33,
4227:29, 4271:17,
4271:21, 4271:24,
4271:31, 4275:43,
4291:7, 4299:36
agrees [1] - 4235:43
ahead [9] - 4191:30,
4191:44, 4219:32,
4271:12, 4271:38,
4275:26, 4279:18,
4295:2, 4295:6
Ahpra [2] - 4206:36,
4235:29
ailment [1] - 4280:39
aim [2] - 4198:40,
4291:27
aimed [1] - 4198:47
akin [1] - 4261:26
Alfred [1] - 4234:7
algorithm [3] -
4261:42, 4261:47
aligned [1] - 4272:16
allegation [1] - 4305:9
allied [3] - 4224:5,
4274:31, 4279:45
allocate [3] - 4251:20,
4276:7, 4288:34
allocated [2] -
4257:10, 4288:37
allocation [5] -
4260:17, 4260:19,
4276:10, 4286:35,
4289:12
allow [3] - 4208:12,
4256:41, 4280:41
allows [2] - 4248:26,
4280:24
almost [3] - 4224:13,
4242:22, 4276:10
alone [1] - 4287:13
alternative [3] -
4203:22, 4273:3,
4287:25
amazing [2] - 4191:44,
4225:25
AMC [10] - 4191:6,
4193:1, 4201:26,
4202:23, 4204:11,
4204:16, 4206:36,
4218:14, 4235:29,
4239:36
amount [8] - 4201:46,
4202:4, 4213:32,
4290:19, 4303:19,
4303:25, 4303:26,
4303:42
anaesthetic [1] -
4256:27
anaesthetics [3] -
4224:40, 4256:13,
4256:16
anaesthetised [1] -
4256:24
anaesthetist [1] -
4257:29
Anaesthetists [1] -
4273:45
anaesthetists [4] -
4227:33, 4255:44,
4257:1, 4276:14
analysis [3] - 4220:24,
4269:33, 4298:40
ankle [1] - 4203:4
annex [1] - 4293:43
annexed [3] -
4284:19, 4284:21,
4288:8
annual [3] - 4262:3,
4286:22, 4289:8
answer [14] - 4206:46,
4210:22, 4226:17,
4237:22, 4244:15,
4251:7, 4253:23,
4260:26, 4267:41,
4276:35, 4277:38,
4284:6, 4287:14,
4304:7
answered [1] -
4192:18
answering [1] -
4240:41
answers [4] - 4224:14,
4231:34, 4240:16,
4274:44
anti [1] - 4233:35
anti-rural [1] - 4233:35
anticipated [1] -
4298:17
anyway [2] - 4212:4,
4235:7
AOA [1] - 4191:2
Aotearoa [1] - 4185:3
apologise [1] -
4184:41
appearing [1] -
4291:29
appendix [1] -
4234:20
applicant [3] -
4261:36, 4262:7,
4262:23
applicants [7] -
4243:38, 4259:26,
4259:28, 4259:30,
4260:13, 4261:34,
4262:7
application [5] -
4205:4, 4209:20,
4209:25, 4214:4,
4289:30
applications [5] -
4190:4, 4204:44,
4204:47, 4205:3,
4210:6
applied [1] - 4244:23
applies [1] - 4186:36
apply [10] - 4186:15,
4186:36, 4193:3,
4209:7, 4233:3,
4245:43, 4245:46,
4270:39, 4281:19,
4288:27
applying [3] -
4207:33, 4246:1,
4246:21
appoint [2] - 4244:23,
4290:41
appointed [2] -
4290:38, 4291:34
appointment [3] -
4233:24, 4233:42,
4245:20
appointments [5] -
4233:5, 4233:41,
4234:8, 4234:10,
4234:11
appreciated [1] -
4304:41
apprenticeship [1] -
4207:31
approach [13] -
4203:22, 4209:8,
4247:14, 4256:12,
4272:28, 4272:29,
4272:32, 4276:19,
4279:20, 4279:25,
4279:35, 4280:30,
4305:37
approaching [2] -
4209:27, 4247:19
appropriate [10] -
4194:24, 4213:30,
4219:18, 4258:19,
4258:31, 4266:14,
4266:18, 4267:38,
4272:1, 4272:23
appropriately [4] -
4212:29, 4217:16,
4220:23, 4266:41
approval [2] -
4206:13, 4209:23
approved [2] -
4184:46, 4278:18
April [4] - 4240:32,
4241:9, 4282:25,
4304:32
area [19] - 4203:19,
4229:41, 4230:34,
4247:30, 4249:4,
4252:44, 4255:26,
4259:45, 4260:1,
4270:15, 4273:8,
4274:10, 4274:11,
4274:12, 4274:22,
4276:8, 4280:25,
4280:26, 4285:25
areas [31] - 4191:33,
4191:35, 4206:15,
4206:23, 4206:25,
4206:27, 4208:40,
4212:11, 4230:6,
4248:33, 4253:43,
4255:16, 4259:34,
4262:45, 4264:6,
4270:47, 4273:12,
4273:20, 4273:26,
4274:4, 4274:7,
4274:15, 4274:27,
4274:28, 4274:30,
4274:35, 4274:39,
4274:41, 4279:40,
4289:39, 4293:11
arise [4] - 4189:35,
4278:23, 4299:4,
4306:37
arising [5] - 4283:10,
4285:26, 4288:20,
4292:31, 4302:11
arm [1] - 4221:33
arms [3] - 4235:31,
4280:20
arrangement [8] -
4190:43, 4191:13,
4197:4, 4230:30,
4292:47, 4293:2,
4302:35, 4303:30
arrangements [9] -
4198:10, 4230:31,
4233:30, 4256:37,
4284:3, 4293:3,
4293:28, 4301:47,
4302:36
array [1] - 4262:45
arrival [1] - 4193:42
arrive [3] - 4285:27,
4285:30, 4285:40
arrived [1] - 4286:27
articulated [1] -
4184:19
aside [6] - 4186:20,
4188:6, 4193:18,
4208:21, 4224:13,
4295:8
aspects [3] - 4191:26,
4277:16, 4306:16
assault [1] - 4290:27
assembled [1] -
4240:37
assess [2] - 4238:6,
4285:33
assessing [3] -
4214:34, 4214:43,
4285:35
assessment [7] -
4207:1, 4247:2,
4256:20, 4272:6,
4272:11, 4273:17,
4289:31
assist [11] - 4183:23,
4205:10, 4234:39,
4242:31, 4256:13,
4268:29, 4284:4,
4289:41, 4291:28,
4292:26, 4297:38
assistance [6] -
4205:35, 4215:21,
4215:42, 4294:34,
4296:3, 4306:25
assistant [1] - 4239:12
assisted [1] - 4287:28
Assisting [5] -
4182:26, 4182:27,
4182:28, 4182:29,
4182:30
assisting [3] -
4183:18, 4294:17,
4294:35
Associate [24] -
4183:6, 4183:22,
4183:34, 4184:23,
4185:24, 4185:39,
4187:3, 4191:17,
4194:8, 4195:33,
4196:47, 4200:30,
4200:41, 4204:46,
4211:10, 4214:14,
4218:18, 4218:44,
4225:47, 4226:43,
4234:47, 4237:17,
4241:25, 4251:35
associate [1] -
4297:34
Association [2] -
4190:45, 4254:37
association [3] -
4184:38, 4191:24,
4228:40
assume [5] - 4220:35,
4229:23, 4248:12,
4301:11, 4301:34
assumed [1] - 4256:19
assuming [1] -
4275:39
assumption [1] -
4294:32
assumptions [1] -

4247:31	4239:37, 4249:23,	4251:18, 4253:31,	4219:26	4230:47, 4231:10,
assured [2] - 4206:20,	4270:24, 4283:42,	4256:19, 4257:27,	benchmarking [1] -	4232:3, 4238:25,
4206:27	4287:25, 4289:19,	4257:41, 4261:8,	4269:20	4274:16, 4304:27
asthma [1] - 4223:15	4290:45, 4296:45,	4261:34, 4261:36,	benchmarks [1] -	bigger [1] - 4276:7
AT [2] - 4307:28,	4296:46	4262:7, 4269:9,	4221:42	biggest [2] - 4271:5,
4307:29	AVL [1] - 4183:6	4269:11, 4269:44,	beneficial [1] -	4289:39
attached [2] - 4232:6,	avoid [2] - 4295:46,	4285:33, 4286:34,	4231:37	bill [1] - 4303:33
4300:12	4296:27	4291:4	benefit [8] - 4185:17,	billed [1] - 4302:36
attachments [1] -	award [5] - 4257:19,	basic [6] - 4254:38,	4212:4, 4243:20,	billing [1] - 4302:34
4297:42	4257:36, 4257:37,	4254:39, 4256:47,	4255:12, 4262:27,	billings [3] - 4302:28,
attempt [2] - 4270:4,	4302:45, 4303:29	4262:5, 4262:15,	4274:3, 4274:6,	4302:29, 4303:37
4272:40	awards [1] - 4228:33	4281:7	4279:28	binational [1] -
attend [1] - 4296:9	aware [20] - 4191:14,	basis [11] - 4197:1,	benefits [2] - 4257:9,	4222:45
attendance [1] -	4192:2, 4196:31,	4197:4, 4197:12,	4274:26	births [2] - 4276:26,
4268:4	4211:46, 4217:33,	4248:19, 4270:8,	best [22] - 4183:41,	4285:30
attended [1] - 4304:31	4227:15, 4231:25,	4276:44, 4283:46,	4184:16, 4191:39,	bit [16] - 4189:12,
attract [4] - 4291:41,	4244:6, 4252:41,	4286:22, 4289:8	4205:22, 4205:24,	4191:31, 4195:26,
4292:1, 4292:17,	4256:44, 4257:12,	Bathurst [1] - 4232:2	4231:16, 4242:43,	4230:40, 4232:20,
4293:10	4257:40, 4258:2,	battling [1] - 4231:12	4243:13, 4251:20,	4235:24, 4239:32,
attracting [3] -	4263:39, 4263:42,	bear [2] - 4240:28	4255:39, 4261:29,	4243:25, 4244:38,
4283:27, 4283:28,	4273:1, 4275:20,	bearing [1] - 4196:24	4261:30, 4261:43,	4246:32, 4248:6,
4300:28	4279:7, 4299:38,	Beasley [1] - 4182:14	4262:31, 4268:43,	4252:4, 4265:46,
attractive [2] -	4301:1	become [1] -	4269:20, 4282:47,	4296:43, 4298:17,
4192:15, 4293:2		4195:19, 4208:32,	4285:44, 4298:6,	4305:32
audit [2] - 4233:13,	<hr/> B <hr/>	4217:20, 4222:9,	4304:35	block [1] - 4239:32
4233:44	back-up [1] - 4196:19	4245:27, 4247:34,	better [15] - 4198:7,	blocked [1] - 4197:5
August [1] - 4268:26	background [1] -	4248:1, 4274:21,	4199:25, 4216:25,	board [15] - 4184:32,
Australasian [1] -	4232:21	4277:5, 4277:39,	4219:17, 4224:32,	4184:36, 4184:37,
4254:33	backgrounds [1] -	4278:7	4225:23, 4225:31,	4189:29, 4190:10,
Australia [15] -	4232:25	becomes [2] -	4225:34, 4230:4,	4190:32, 4190:47,
4185:3, 4186:11,	backlog [1] - 4301:32	4271:31, 4301:30	4233:37, 4265:24,	4192:22, 4192:28,
4186:14, 4186:21,	bad [5] - 4193:26,	becoming [5] -	4265:26, 4277:34,	4192:38, 4201:29,
4186:30, 4192:5,	4194:43, 4223:15,	4209:2, 4238:31,	4287:12, 4292:20	4201:30, 4205:24,
4194:38, 4207:28,	4266:24, 4306:6	4239:5, 4264:12,	between [28] - 4187:5,	4231:17, 4304:23
4208:6, 4243:37,	balance [4] - 4200:8,	4288:5	4188:13, 4188:18,	Board [2] - 4244:35,
4244:35, 4244:45,	4213:18, 4246:33,	bed [4] - 4197:5,	4189:13, 4189:46,	4244:45
4254:35, 4275:5,	4259:44	4223:18, 4229:44,	4190:9, 4190:33,	boards [10] - 4188:17,
4292:2	balanced [1] -	4230:40	4193:44, 4203:38,	4189:43, 4190:11,
Australia's [1] -	4237:38	bed-blocked [1] -	4207:33, 4230:5,	4190:46, 4192:39,
4220:4	Ballarat [2] - 4234:7,	4197:5	4231:33, 4232:13,	4194:13, 4201:12,
Australian [15] -	4234:11	beds [2] - 4221:44,	4237:36, 4244:7,	4236:3, 4236:9,
4183:4, 4188:36,	bandaid [1] - 4222:32	4231:27	4253:12, 4253:29,	4236:15
4190:44, 4200:43,	banking [1] - 4219:38	began [1] - 4210:22	4253:34, 4254:9,	bodies [1] - 4206:37
4220:23, 4254:36,	barrier [2] - 4271:25,	beginning [3] -	4257:20, 4259:30,	body [3] - 4187:14,
4258:8, 4258:35,	4271:28	4203:11, 4295:19,	4259:44, 4275:33,	4192:32, 4218:23
4258:43, 4267:12,	barriers [5] - 4235:19,	4295:30	4280:1, 4281:11,	bonded [4] - 4248:7,
4269:22, 4282:19,	4236:40, 4279:33,	behave [1] - 4217:16	4290:37, 4297:27,	4248:10, 4248:18,
4286:11, 4293:40,	4280:27	behaviour [7] -	4300:19	4248:47
4299:23	based [36] - 4191:29,	4194:43, 4217:9,	beyond [2] - 4196:25,	bono [4] - 4194:27,
authorisation [3] -	4192:12, 4198:18,	4217:10, 4217:13,	4198:2	4194:28, 4195:11,
4207:7, 4207:13,	4198:25, 4198:26,	4266:33, 4266:34,	bi [3] - 4233:5, 4234:8,	4195:24
4207:18	4198:41, 4199:7,	4267:27	4234:11	borne [1] - 4254:8
authority [2] -	4199:8, 4199:27,	behavioural [1] -	bi-directional [3] -	bottleneck [1] -
4263:43, 4267:3	4199:36, 4199:38,	4266:5	4233:5, 4234:8,	4256:18
autonomy [1] - 4247:8	4199:47, 4200:6,	behaviours [1] -	4234:11	bottlenecks [3] -
availability [3] -	4200:31, 4204:43,	4266:10	big [15] - 4194:39,	4255:42, 4255:43,
4221:44, 4223:22,	4211:3, 4219:40,	belief [4] - 4183:41,	4201:34, 4216:15,	4255:47
4280:26	4221:47, 4228:24,	4184:16, 4243:14,	4216:29, 4216:38,	bottom [3] - 4198:11,
available [11] -	4231:45, 4250:11,	4268:44	4229:14, 4230:2,	4233:38, 4288:31
4186:10, 4232:30,		benchmark [1] -	4230:17, 4230:23,	box [1] - 4202:11

branch [2] - 4242:10, 4242:20
breach [1] - 4206:21
break [4] - 4224:11, 4226:1, 4255:27, 4279:33
breaking [1] - 4222:37
breath [1] - 4223:16
Brendan [2] - 4235:4, 4235:7
briefly [1] - 4248:4
bring [6] - 4191:46, 4205:8, 4205:24, 4215:11, 4266:36, 4275:13
broad [8] - 4202:45, 4222:45, 4235:35, 4256:24, 4266:8, 4267:24, 4267:26, 4276:8
broader [5] - 4203:44, 4255:17, 4266:25, 4267:34, 4305:25
broadly [5] - 4187:27, 4222:43, 4267:11, 4267:25, 4297:21
broken [3] - 4221:33, 4222:15, 4222:18
brought [4] - 4189:31, 4192:9, 4268:33, 4286:13
brunt [1] - 4197:24
budgets [3] - 4254:44, 4264:39, 4264:43
building [2] - 4249:43, 4250:18
bulk [1] - 4283:4
bullying [10] - 4194:40, 4215:47, 4216:13, 4216:42, 4217:20, 4218:3, 4218:10, 4266:34, 4267:3, 4267:30
bundle [2] - 4294:3, 4294:12
burden [3] - 4201:38, 4201:43, 4202:17
Bureau [1] - 4220:25
bureaucratic [3] - 4202:4, 4210:9, 4236:42
business [3] - 4184:38, 4216:28, 4299:44
buy [1] - 4225:8
buy-in [1] - 4225:8
BY [7] - 4183:15, 4237:15, 4242:3, 4268:12, 4282:6, 4297:10, 4302:16

C

caesarean [2] - 4276:25, 4276:27
campaigns [1] - 4290:42
cancelled [2] - 4197:21, 4299:34
Cancer [2] - 4265:47, 4293:43
cancer [3] - 4227:31, 4230:37, 4301:28
cancers [1] - 4301:27
candidate [1] - 4261:40
candidates [3] - 4246:20, 4246:22, 4260:4
cannot [4] - 4217:15, 4269:43, 4269:46, 4271:15
canvass [1] - 4237:18
cap [2] - 4209:16, 4292:10
capability [3] - 4245:17, 4249:40, 4284:18
capable [4] - 4202:46, 4203:6, 4209:2, 4209:22
capacity [14] - 4194:25, 4194:26, 4196:25, 4197:29, 4197:38, 4198:4, 4198:8, 4224:18, 4224:19, 4264:44, 4272:1, 4272:8, 4272:12, 4284:18
capital [2] - 4299:18, 4299:19
caps [1] - 4209:19
cardiologists [5] - 4265:14, 4265:17, 4278:30, 4278:33, 4279:6
cardiology [5] - 4265:8, 4278:19, 4278:25, 4278:28, 4279:38
care [48] - 4198:6, 4214:26, 4222:13, 4222:14, 4222:15, 4222:17, 4222:31, 4222:32, 4222:38, 4223:8, 4223:22, 4223:43, 4224:3, 4224:4, 4225:23, 4227:36, 4228:18, 4228:24, 4228:26, 4228:30, 4229:13,

4231:4, 4263:32, 4269:18, 4269:26, 4269:39, 4270:31, 4274:10, 4274:14, 4279:30, 4280:25, 4280:31, 4280:34, 4281:20, 4281:24, 4285:37, 4287:10, 4287:11, 4287:12, 4287:14, 4287:23, 4287:25, 4287:36, 4291:25, 4291:26, 4302:29
Care [1] - 4228:9
cared [1] - 4301:24
career [17] - 4193:15, 4195:42, 4203:20, 4233:8, 4233:46, 4238:38, 4238:42, 4239:5, 4239:6, 4239:10, 4245:28, 4245:44, 4246:26, 4246:37, 4246:39, 4274:39
careers [4] - 4185:31, 4203:10, 4228:44, 4246:15
carried [3] - 4195:26, 4271:29, 4278:26
case [37] - 4196:11, 4202:39, 4202:45, 4203:29, 4203:34, 4203:39, 4204:10, 4209:21, 4215:15, 4219:23, 4219:24, 4228:3, 4228:8, 4228:15, 4228:36, 4229:22, 4229:37, 4230:47, 4236:24, 4238:20, 4251:17, 4252:8, 4254:43, 4256:20, 4256:29, 4264:41, 4266:41, 4270:10, 4271:20, 4276:46, 4289:11, 4289:14, 4289:16, 4292:15, 4294:41, 4299:45, 4300:37
caseload [7] - 4198:11, 4202:39, 4203:29, 4203:33, 4203:40, 4209:21, 4238:20
caseloads [1] - 4238:47
cases [9] - 4197:15, 4198:12, 4219:30, 4231:2, 4231:13, 4236:3, 4247:41, 4259:41, 4275:45

catch [1] - 4204:26
category [2] - 4239:38, 4254:2
caused [1] - 4305:46
causing [1] - 4222:5
CCLHD [1] - 4288:35
ceiling [4] - 4303:31, 4303:32, 4303:34, 4303:36
censor [1] - 4189:22
cent [7] - 4192:5, 4192:7, 4195:28, 4216:30, 4224:44, 4248:9, 4287:18
central [7] - 4194:11, 4215:41, 4218:23, 4249:45, 4250:20, 4251:18, 4285:21
Central [11] - 4265:47, 4282:15, 4282:23, 4283:26, 4288:28, 4292:15, 4293:21, 4293:31, 4293:41, 4293:43, 4295:26
centralised [3] - 4288:23, 4292:9, 4292:22
centrally [3] - 4251:10, 4264:45, 4265:25
Centre [2] - 4265:47, 4293:43
centre [5] - 4231:3, 4271:5, 4274:17, 4281:27, 4291:26
centres [1] - 4295:40
centric [5] - 4224:30, 4224:31, 4248:41, 4273:12, 4273:20
CEO [2] - 4184:39, 4215:27
certain [6] - 4208:35, 4246:6, 4253:43, 4262:22, 4278:28, 4284:1
certainly [24] - 4191:3, 4206:16, 4208:30, 4208:40, 4212:30, 4218:32, 4228:27, 4247:26, 4249:24, 4254:8, 4255:36, 4256:2, 4256:12, 4256:40, 4260:7, 4262:9, 4263:35, 4264:10, 4264:22, 4264:43, 4267:12, 4273:34, 4279:42, 4302:33
cetera [1] - 4185:34, 4191:46, 4194:26,

4201:17, 4202:16, 4206:16, 4253:15, 4267:3, 4269:12, 4278:23, 4304:19
chair [8] - 4184:36, 4189:22, 4190:47, 4192:21, 4192:27, 4192:33, 4205:34, 4235:9
chairs [6] - 4188:16, 4189:19, 4189:21, 4189:28, 4189:31, 4192:34
chairwoman [1] - 4240:32
challenge [4] - 4264:9, 4264:22, 4265:21, 4289:39
challenges [9] - 4248:31, 4264:4, 4264:27, 4274:1, 4274:13, 4279:39, 4280:33, 4291:31, 4300:42
challenging [2] - 4274:11, 4281:13
champions [1] - 4229:41
CHAN [1] - 4282:4
Chan [4] - 4251:35, 4282:1, 4282:9
chance [3] - 4268:39, 4294:37, 4294:45
change [10] - 4193:9, 4203:16, 4204:30, 4211:2, 4230:2, 4233:40, 4277:47, 4285:37, 4287:11
changed [4] - 4237:43, 4248:29, 4258:3, 4300:42
changes [3] - 4192:12, 4258:32, 4291:23
changing [2] - 4213:19, 4239:16
character [1] - 4266:34
charge [1] - 4188:23
check [2] - 4203:33
checks [1] - 4205:7
CHENEY [12] - 4237:13, 4237:15, 4237:17, 4241:18, 4268:1, 4281:38, 4296:19, 4298:14, 4298:24, 4298:36, 4299:1, 4306:44
Cheney [10] - 4182:35, 4226:28, 4237:10,

4267:46, 4281:36,
4296:17, 4298:11,
4301:43, 4306:42,
4307:11
chief [10] - 4184:43,
4184:45, 4189:22,
4265:1, 4300:9,
4300:20, 4300:21,
4304:2, 4304:20,
4304:32
child [2] - 4301:17,
4301:22
children [2] - 4256:23,
4256:28
children's [2] -
4256:8, 4256:28
Children's [1] -
4256:19
Chiu [1] - 4182:35
choice [3] - 4247:36,
4247:37, 4270:1
choose [7] - 4245:43,
4245:46, 4249:1,
4249:5, 4249:7,
4270:19, 4280:46
chose [2] - 4270:23,
4301:8
Christmas [1] -
4292:14
churn [2] - 4262:10,
4262:24
circumstance [1] -
4214:40
circumstances [2] -
4200:18, 4259:27
city [11] - 4199:14,
4224:32, 4224:37,
4233:2, 4233:3,
4233:36, 4233:42,
4233:45, 4238:25,
4274:17, 4281:27
clarify [8] - 4190:28,
4250:2, 4255:17,
4261:32, 4275:28,
4287:44, 4302:12,
4305:31
classifications [1] -
4257:19
clear [7] - 4206:45,
4218:2, 4233:46,
4258:14, 4267:13,
4287:46, 4299:2
clinic [3] - 4197:40,
4202:15, 4222:27
clinical [22] - 4196:1,
4225:33, 4231:44,
4231:46, 4232:13,
4233:12, 4233:44,
4268:19, 4270:28,
4274:30, 4274:31,
4276:38, 4280:2,
4280:17, 4280:18,
4284:19, 4285:13,
4288:8, 4295:47,
4297:34, 4306:35
clinically [4] -
4220:28, 4220:42,
4220:44, 4224:20
clinician [4] - 4219:24,
4221:29, 4280:38,
4301:12
clinicians [6] -
4219:31, 4225:30,
4270:46, 4272:20,
4277:7, 4280:14
clinics [3] - 4198:3,
4222:31, 4225:21
close [5] - 4188:17,
4188:22, 4229:30,
4230:36, 4250:43
closely [3] - 4229:42,
4280:17, 4280:18
closer [2] - 4237:36,
4263:3
Clota [20] - 4183:7,
4184:5, 4184:38,
4184:41, 4185:14,
4186:44, 4189:37,
4192:24, 4193:29,
4193:38, 4193:47,
4198:22, 4199:43,
4201:1, 4204:20,
4213:25, 4218:8,
4218:35, 4225:39,
4241:31
CLOTA [29] - 4183:13,
4184:8, 4184:13,
4184:18, 4184:45,
4185:16, 4186:46,
4189:40, 4190:26,
4190:36, 4190:42,
4191:13, 4192:47,
4193:41, 4194:4,
4199:46, 4200:20,
4200:27, 4201:3,
4204:23, 4204:35,
4212:1, 4213:28,
4213:40, 4214:1,
4217:44, 4218:13,
4218:41, 4226:22
cluster [1] - 4215:13
coaching [1] -
4232:43
coast [1] - 4263:3
Coast [11] - 4265:47,
4282:15, 4282:23,
4283:26, 4288:28,
4292:15, 4293:21,
4293:31, 4293:41,
4293:43, 4295:26
code [1] - 4301:2
coding [3] - 4257:30,
4265:31, 4265:32
coffee [1] - 4215:23
cohort [2] - 4246:36,
4246:45
collaborate [1] -
4228:47
collaborating [4] -
4189:8, 4212:37,
4255:46, 4267:15
collaboration [11] -
4205:23, 4217:14,
4230:5, 4251:26,
4253:11, 4255:7,
4255:23, 4260:40,
4262:29, 4266:27,
4279:37
collaborations [1] -
4229:30
colleague [1] -
4226:12
colleagues [2] -
4196:40, 4222:1
collect [1] - 4266:22
collection [1] -
4265:24
collective [5] - 4192:1,
4192:9, 4193:16,
4193:22, 4205:20
college [125] -
4183:22, 4184:35,
4184:38, 4184:43,
4185:8, 4185:17,
4185:22, 4185:28,
4185:38, 4186:10,
4186:16, 4186:24,
4186:36, 4187:5,
4187:9, 4187:46,
4188:42, 4189:1,
4189:7, 4189:22,
4189:29, 4189:30,
4189:46, 4190:9,
4190:33, 4190:40,
4191:14, 4191:23,
4192:40, 4193:42,
4193:44, 4194:11,
4194:38, 4200:35,
4200:41, 4201:10,
4201:41, 4202:29,
4203:23, 4204:10,
4205:30, 4206:47,
4207:6, 4207:25,
4208:4, 4208:19,
4208:22, 4209:16,
4209:27, 4209:33,
4209:34, 4212:4,
4213:29, 4214:34,
4214:41, 4214:43,
4215:15, 4216:2,
4216:7, 4216:14,
4216:41, 4217:19,
4217:23, 4217:37,
4218:9, 4218:19,
4218:31, 4227:41,
4229:12, 4231:31,
4235:34, 4235:43,
4236:2, 4236:9,
4236:25, 4237:1,
4237:2, 4237:31,
4238:11, 4239:31,
4239:34, 4241:11,
4245:31, 4245:33,
4247:27, 4247:29,
4247:36, 4247:42,
4247:47, 4248:1,
4248:40, 4252:26,
4252:31, 4254:46,
4255:28, 4255:46,
4256:36, 4256:37,
4256:39, 4259:11,
4259:31, 4263:26,
4264:19, 4264:20,
4266:15, 4266:33,
4272:8, 4272:19,
4272:28, 4272:29,
4272:41, 4273:37,
4273:43, 4275:42,
4276:14, 4276:24,
4278:40, 4278:41,
4279:28, 4294:41,
4295:15, 4295:17,
4295:20
College [7] - 4183:4,
4187:27, 4254:33,
4273:45, 4282:19,
4286:11, 4293:40
college's [11] -
4185:9, 4186:12,
4187:5, 4188:35,
4192:32, 4194:9,
4207:23, 4218:17,
4234:21, 4236:20,
4239:43
colleges [63] -
4186:37, 4186:38,
4200:43, 4201:25,
4204:5, 4206:35,
4208:12, 4208:18,
4215:40, 4218:2,
4222:47, 4224:30,
4235:17, 4235:21,
4246:5, 4246:9,
4247:27, 4248:32,
4253:12, 4254:29,
4255:23, 4258:4,
4258:14, 4258:22,
4258:44, 4258:46,
4259:6, 4260:18,
4260:44, 4261:1,
4261:8, 4261:13,
4262:17, 4262:29,
4263:12, 4263:23,
4263:24, 4263:25,
4266:4, 4266:22,
4266:28, 4266:36,
4267:10, 4267:11,
4267:13, 4267:25,
4271:41, 4271:45,
4272:22, 4273:2,
4273:12, 4273:24,
4273:28, 4273:35,
4275:12, 4275:22,
4275:33, 4276:7,
4276:12, 4276:21,
4276:29, 4277:4,
4278:3
colonoscopy [1] -
4227:26
combination [3] -
4258:38, 4285:38,
4285:40
comfortable [3] -
4238:30, 4242:42,
4280:47
coming [15] - 4194:8,
4198:16, 4201:28,
4202:37, 4214:8,
4223:34, 4233:45,
4249:15, 4251:3,
4251:17, 4254:43,
4255:41, 4282:36,
4287:17, 4298:1
command [1] -
4292:13
commence [3] -
4236:34, 4237:4,
4286:4
commenced [3] -
4248:21, 4286:38,
4295:29
commencement [1] -
4277:38
commencing [3] -
4248:9, 4257:16,
4269:1
commensurate [1] -
4222:25
comment [3] -
4185:25, 4204:21,
4286:40
comments [1] -
4218:8
Commission [6] -
4182:7, 4183:18,
4183:23, 4184:28,
4242:32, 4268:29
COMMISSION [1] -
4307:28
Commissioner [27] -
4182:13, 4183:3,

4221:40, 4226:41, 4231:34, 4235:13, 4237:7, 4237:13, 4240:9, 4241:18, 4241:23, 4241:43, 4242:47, 4251:31, 4266:45, 4268:1, 4281:34, 4281:47, 4283:5, 4294:14, 4294:23, 4296:9, 4296:19, 4296:35, 4298:24, 4299:1, 4306:44

COMMISSIONER ^[111]
- 4183:1, 4183:9, 4196:30, 4196:39, 4196:45, 4198:24, 4198:31, 4198:39, 4198:46, 4199:7, 4199:17, 4199:21, 4199:31, 4207:43, 4210:21, 4210:27, 4210:32, 4210:36, 4211:10, 4211:16, 4211:20, 4211:25, 4211:31, 4211:39, 4212:3, 4212:15, 4212:22, 4212:27, 4212:46, 4213:23, 4219:17, 4219:43, 4220:3, 4220:9, 4220:15, 4220:20, 4220:33, 4220:41, 4221:6, 4221:13, 4221:21, 4221:28, 4221:37, 4221:46, 4222:5, 4222:17, 4222:30, 4222:37, 4222:43, 4223:5, 4223:46, 4224:10, 4225:1, 4225:12, 4225:38, 4225:43, 4225:47, 4226:5, 4226:11, 4226:19, 4226:27, 4226:35, 4226:39, 4234:35, 4234:41, 4234:45, 4237:10, 4241:20, 4241:25, 4241:31, 4241:36, 4243:2, 4251:33, 4251:40, 4251:47, 4252:8, 4252:16, 4266:47, 4267:44, 4268:3, 4281:36, 4281:40, 4283:7, 4294:1, 4294:8, 4294:16, 4294:26, 4294:44, 4295:2, 4295:6, 4296:12, 4296:17, 4296:21, 4296:41,

4297:1, 4297:6, 4298:20, 4298:32, 4298:43, 4299:6, 4301:42, 4302:5, 4302:14, 4304:13, 4306:37, 4306:41, 4306:47, 4307:7, 4307:16, 4307:20, 4307:25

Commissioner's ^[1] - 4240:42

commitment ^[2] - 4233:26, 4233:27

Committee ^[1] - 4189:18

committee ^[22] - 4188:16, 4188:22, 4189:14, 4189:24, 4189:28, 4189:31, 4190:16, 4190:24, 4190:32, 4190:39, 4191:1, 4191:2, 4192:22, 4192:35, 4192:38, 4205:34, 4205:35, 4214:17, 4215:16, 4215:19, 4235:13

committee's ^[1] - 4204:47

committees ^[35] - 4187:12, 4187:13, 4187:14, 4187:18, 4187:45, 4187:46, 4188:2, 4188:6, 4188:8, 4188:11, 4188:14, 4188:18, 4188:26, 4188:30, 4189:1, 4189:4, 4189:6, 4189:14, 4189:17, 4189:20, 4189:25, 4189:33, 4189:44, 4190:1, 4190:11, 4190:46, 4192:39, 4192:44, 4194:13, 4202:30, 4204:44, 4205:21, 4229:2, 4236:4

Commonwealth ^[12] - 4229:18, 4231:39, 4243:28, 4243:40, 4243:42, 4243:46, 4244:7, 4244:13, 4248:14, 4248:29, 4251:16, 4254:5

Commonwealth-supported ^[1] - 4243:42

communicate ^[1] - 4300:20

communicated ^[1] - 4298:17, 4298:32, 4298:43, 4299:6, 4301:42, 4302:5, 4302:14, 4304:13, 4306:37, 4306:41, 4306:47, 4307:7, 4307:16, 4307:20, 4307:25

communicating ^[1] - 4251:1

communication ^[8] - 4215:39, 4216:23, 4258:7, 4258:9, 4258:21, 4280:23, 4300:3, 4306:24

communications ^[1] - 4217:36

communities ^[4] - 4185:33, 4194:33, 4274:29, 4274:32

community ^[14] - 4185:18, 4191:40, 4199:13, 4199:27, 4200:28, 4212:5, 4223:39, 4223:41, 4228:25, 4230:37, 4274:37, 4280:38, 4281:3

community-led ^[1] - 4230:37

comorbidities ^[2] - 4219:35, 4223:35

comparators ^[2] - 4269:19, 4269:27

compared ^[1] - 4192:38

compel ^[1] - 4270:10

competency ^[4] - 4191:29, 4192:12, 4202:14, 4211:3

competency-based ^[3] - 4191:29, 4192:12, 4211:3

competent ^[4] - 4200:15, 4200:24, 4200:27, 4202:46

competing ^[2] - 4249:38, 4259:25

competition ^[3] - 4186:29, 4186:35, 4249:30

competitive ^[2] - 4208:34, 4209:1

complain ^[1] - 4216:22

complained ^[1] - 4210:47

complaining ^[1] - 4306:6

complaint ^[9] - 4214:38, 4215:1, 4215:12, 4215:17, 4215:26, 4215:28, 4215:32, 4266:10, 4267:3

complaints ^[12] - 4185:34, 4194:43,

4214:27, 4215:5, 4215:10, 4215:38, 4215:41, 4215:47, 4217:20, 4218:10, 4259:1, 4267:29

complement ^[1] - 4289:19

complete ^[3] - 4186:23, 4188:37, 4244:43

completed ^[1] - 4236:39

completely ^[3] - 4188:3, 4199:46, 4219:24

completion ^[2] - 4186:9, 4244:36

complex ^[2] - 4238:47, 4287:1

complexities ^[1] - 4280:23

complexity ^[1] - 4286:45

complication ^[1] - 4301:7

complications ^[2] - 4219:34, 4230:24

composition ^[1] - 4207:26

compounding ^[1] - 4231:2

compromised ^[1] - 4214:14

computers ^[1] - 4277:20

concept ^[1] - 4263:22

conceptual ^[1] - 4263:28

concern ^[7] - 4214:41, 4214:42, 4263:14, 4266:7, 4293:30, 4301:27, 4304:28

concerned ^[1] - 4248:33

concerning ^[1] - 4299:33

concerns ^[7] - 4214:13, 4218:3, 4218:9, 4258:23, 4259:2, 4267:36, 4293:34

concise ^[1] - 4224:2

conclude ^[1] - 4293:23

Concord ^[4] - 4297:17, 4297:21, 4300:43, 4300:45

concurrently ^[1] - 4183:5

condition ^[2] - 4281:8,

4286:2

conditions ^[2] - 4207:14, 4300:44

conduct ^[2] - 4265:17, 4301:2

conducted ^[1] - 4284:38

conducting ^[1] - 4300:16

confident ^[1] - 4243:13

confirmed ^[1] - 4206:22

conflict ^[1] - 4229:2

conjunction ^[1] - 4273:22

connected ^[3] - 4224:28, 4231:46, 4232:4

connecting ^[1] - 4231:43

connection ^[4] - 4188:22, 4207:33, 4218:42, 4232:13

consequence ^[1] - 4207:6

consider ^[4] - 4200:16, 4253:31, 4269:45, 4272:27

consideration ^[5] - 4249:46, 4250:20, 4250:26, 4250:36, 4277:22

considerations ^[4] - 4235:38, 4247:22, 4250:12, 4261:15

considered ^[4] - 4244:32, 4253:1, 4254:25, 4263:39

considering ^[1] - 4217:20

considers ^[1] - 4270:5

consistent ^[2] - 4193:2, 4284:10

consolidated ^[1] - 4260:12

constant ^[1] - 4270:8

constituent ^[1] - 4229:6

constitute ^[1] - 4254:22

constructing ^[1] - 4286:12

consultant ^[1] - 4271:1

consultants ^[1] - 4274:18

consultation ^[4] - 4197:20, 4227:22, 4284:43, 4284:46

consultations [1] - 4296:36, 4296:37, 4197:19, 4302:1, 4307:9
consulted [1] - 4285:9
contact [6] - 4210:44, 4258:11, 4258:17, 4277:45, 4278:10
contacted [2] - 4300:4, 4300:9
contacting [1] - 4258:22
contains [2] - 4284:22, 4286:19
contemplates [1] - 4248:18
contemplating [1] - 4238:42
contemporary [1] - 4193:45
content [1] - 4293:28
contents [2] - 4242:42, 4298:5
context [10] - 4220:22, 4263:15, 4263:30, 4267:29, 4269:5, 4290:36, 4290:43, 4293:20, 4293:29, 4294:40
continue [6] - 4199:14, 4231:10, 4245:27, 4280:27, 4295:35, 4296:45
continues [2] - 4252:46, 4296:5
continuing [2] - 4239:35, 4247:33
continuous [2] - 4288:10, 4288:11
continuum [1] - 4232:10
contract [8] - 4193:23, 4196:11, 4196:13, 4196:16, 4196:23, 4196:30, 4196:33, 4283:32
contracts [7] - 4292:39, 4292:40, 4293:15, 4293:16, 4293:23, 4293:24, 4293:34
contrast [1] - 4208:12
contribution [1] - 4213:45
control [3] - 4252:36, 4289:4, 4292:6
controlling [1] - 4292:19
controls [1] - 4200:8
convenient [8] - 4268:36, 4294:31, 4296:26, 4296:28, 4296:36, 4296:37, 4302:1, 4307:9
conversation [4] - 4208:41, 4214:1, 4273:42, 4277:27
conversations [3] - 4215:24, 4277:10, 4277:13
conversion [2] - 4238:12, 4238:35
convert [1] - 4238:19
convey [2] - 4240:16, 4253:40
convince [1] - 4301:46
convinced [1] - 4307:7
coordinated [5] - 4205:34, 4209:8, 4245:23, 4256:12, 4256:41
coordinates [1] - 4261:33
coordinating [1] - 4225:34
coordination [3] - 4225:36, 4235:20, 4260:11
copy [10] - 4183:23, 4183:29, 4184:5, 4234:38, 4242:35, 4243:19, 4268:35, 4282:29, 4297:45, 4297:46
core [2] - 4185:1, 4185:17
correct [105] - 4183:32, 4183:40, 4184:15, 4184:18, 4184:24, 4184:26, 4185:40, 4185:42, 4185:45, 4185:47, 4186:26, 4186:32, 4186:33, 4188:3, 4188:40, 4188:43, 4188:45, 4190:36, 4190:42, 4194:4, 4194:14, 4194:16, 4199:19, 4200:20, 4200:27, 4203:42, 4207:21, 4213:40, 4217:44, 4224:8, 4242:43, 4243:14, 4245:9, 4245:14, 4245:17, 4247:38, 4248:2, 4250:25, 4251:11, 4251:23, 4252:6, 4252:23, 4252:27, 4252:32, 4252:37, 4255:2, 4255:10, 4256:26, 4257:22, 4259:32, 4259:43, 4260:42, 4261:11, 4262:3, 4262:47, 4263:30, 4264:1, 4264:35, 4265:19, 4268:30, 4268:43, 4269:6, 4270:7, 4271:9, 4271:10, 4272:41, 4272:42, 4275:2, 4275:30, 4275:31, 4276:2, 4276:20, 4277:40, 4277:41, 4280:4, 4281:9, 4282:11, 4282:12, 4282:20, 4282:26, 4282:47, 4283:17, 4283:18, 4283:22, 4287:20, 4287:22, 4288:2, 4289:9, 4292:35, 4293:35, 4296:1, 4296:5, 4297:19, 4297:25, 4297:36, 4298:6, 4299:30, 4301:13, 4302:21, 4303:2, 4305:25
correction [1] - 4220:35
correctly [1] - 4190:30
correspondence [9] - 4211:26, 4212:23, 4293:44, 4294:20, 4294:29, 4294:38, 4294:45, 4295:4, 4296:24
corridors [1] - 4231:33
cost [5] - 4194:29, 4222:25, 4230:31, 4232:29, 4270:32
Council [5] - 4188:37, 4200:43, 4258:8, 4258:35, 4258:43
council [14] - 4184:35, 4184:36, 4184:47, 4189:23, 4190:17, 4190:23, 4201:23, 4206:33, 4206:34, 4236:14, 4306:35
Council's [1] - 4267:12
council's [1] - 4189:24
councillor [2] - 4184:31, 4189:23
Counsel [5] - 4182:26, 4182:27, 4182:28, 4182:29, 4182:30
counsel [3] - 4183:17, 4226:28, 4301:43
counselling [2] - 4236:43, 4236:44
count [1] - 4283:13
counted [1] - 4295:27
country [17] - 4187:15, 4194:29, 4195:15, 4195:24, 4195:31, 4210:43, 4216:16, 4224:33, 4224:38, 4224:42, 4231:40, 4232:36, 4237:44, 4244:18, 4269:18, 4269:27, 4270:7
couple [8] - 4197:39, 4214:33, 4217:29, 4224:41, 4230:32, 4237:13, 4275:28, 4299:6
course [6] - 4242:46, 4251:33, 4260:44, 4286:44, 4296:29, 4298:9
courses [3] - 4194:42, 4232:27, 4232:29
cover [4] - 4183:28, 4203:5, 4256:21, 4256:22
coverage [1] - 4291:38
covered [4] - 4194:1, 4242:28, 4268:26, 4292:19
COVID [8] - 4196:28, 4197:23, 4217:4, 4223:16, 4231:8, 4231:11, 4305:3, 4305:4
CPD [2] - 4239:35, 4239:37
CPM [1] - 4206:40
CPMC [4] - 4201:23, 4206:23, 4206:30, 4222:47
create [3] - 4214:5, 4255:14, 4262:44
created [2] - 4253:41, 4253:42
creates [1] - 4233:34
creation [2] - 4231:32, 4231:36
criteria [4] - 4199:38, 4246:5, 4246:10, 4261:10
criticism [1] - 4294:9
cross [3] - 4188:21, 4189:33, 4227:32
cross-fertilisation [1] - 4188:21
cross-fertilise [1] - 4189:33
crucial [1] - 4216:34
CSET [14] - 4189:18, 4189:20, 4189:22, 4189:29, 4189:30, 4190:15, 4190:47, 4191:38, 4192:28, 4192:34, 4192:35, 4205:16, 4236:18
CSPs [1] - 4248:9
CT [2] - 4201:16, 4202:16
cultural [9] - 4195:4, 4195:6, 4202:14, 4215:13, 4217:1, 4218:3, 4218:11, 4267:21
culture [27] - 4194:37, 4214:25, 4214:28, 4214:33, 4214:35, 4214:41, 4214:44, 4215:7, 4215:34, 4217:12, 4233:35, 4233:40, 4266:3, 4266:8, 4266:14, 4267:6, 4267:22, 4267:26, 4267:27, 4267:31, 4295:16, 4300:16, 4304:34, 4304:39, 4305:9, 4305:11, 4305:14
cup [1] - 4215:24
current [6] - 4203:38, 4204:35, 4243:35, 4256:37, 4283:11, 4284:19
curriculum [1] - 4218:20
custom [1] - 4279:32
cut [3] - 4213:7, 4213:9, 4267:40
cut-off [2] - 4213:7, 4213:9
CV [1] - 4205:8
cycle [4] - 4250:7, 4250:37, 4288:10, 4289:11
cycles [2] - 4251:3, 4251:17

D

daily [1] - 4283:45
Dame [2] - 4228:46, 4232:17
Dan [1] - 4183:17
Daniel [1] - 4182:30
data [29] - 4209:42, 4210:37, 4210:45, 4211:32, 4212:5,

4213:44, 4214:1,
4221:14, 4221:18,
4239:44, 4240:10,
4240:24, 4240:33,
4240:37, 4241:11,
4241:16, 4251:19,
4257:27, 4257:41,
4260:12, 4261:2,
4261:14, 4262:28,
4265:22, 4265:24,
4269:12, 4281:8,
4284:47
date [12] - 4191:13,
4193:42, 4210:4,
4242:17, 4243:9,
4290:15, 4290:17,
4303:4, 4303:11,
4303:16, 4303:28,
4304:1
dated [7] - 4183:29,
4241:9, 4242:32,
4243:4, 4268:30,
4282:32, 4297:39
dates [2] - 4191:22,
4191:28
day-to-day [2] -
4184:37, 4216:28
days [11] - 4197:20,
4219:22, 4221:33,
4221:34, 4223:24,
4230:32, 4232:18,
4258:26, 4258:34,
4290:44, 4291:38
deal [5] - 4243:22,
4264:9, 4266:39,
4269:2, 4301:29
dealing [9] - 4216:27,
4218:2, 4238:47,
4258:3, 4261:39,
4266:5, 4269:4,
4291:31, 4305:6
dealings [1] - 4258:4
deals [1] - 4253:18
dealt [3] - 4252:31,
4253:23, 4266:11
Deborah [1] - 4215:38
December [1] -
4220:33
decide [3] - 4237:47,
4269:38, 4294:29
decided [2] - 4235:27,
4300:46
decision [12] -
4190:10, 4190:38,
4205:20, 4214:45,
4245:26, 4245:38,
4247:5, 4252:42,
4255:5, 4295:10,
4295:15
decision-making [3] -
4190:10, 4190:38,
4252:42
decisions [7] -
4249:20, 4252:34,
4261:3, 4261:13,
4263:39, 4264:38,
4264:44
declining [1] -
4262:12
defer [1] - 4265:1
define [3] - 4270:25,
4271:46, 4271:47
defined [1] - 4269:22
definitely [1] -
4208:47
definition [1] -
4269:20
delay [1] - 4222:6
delayed [1] - 4301:25
delegated [1] -
4264:36
delighted [1] -
4249:32
deliver [8] - 4184:47,
4185:1, 4190:2,
4191:5, 4197:28,
4197:29, 4203:34,
4263:32
delivered [7] - 4190:8,
4194:23, 4195:11,
4198:37, 4200:17,
4245:13, 4287:15
delivering [2] -
4279:40, 4287:12
delivers [1] - 4276:41
delivery [9] - 4188:7,
4188:19, 4188:23,
4219:14, 4231:11,
4237:41, 4238:22,
4238:26, 4280:30
demand [4] - 4224:20,
4224:23, 4287:28,
4292:14
demographics [4] -
4269:34, 4269:35,
4274:13, 4284:30
depart [1] - 4193:8
department [56] -
4202:10, 4202:36,
4203:30, 4203:33,
4209:12, 4212:10,
4213:20, 4214:25,
4214:28, 4215:2,
4215:4, 4215:12,
4216:22, 4219:13,
4219:25, 4221:18,
4221:21, 4225:7,
4225:8, 4225:35,
4227:15, 4229:46,
4230:5, 4239:26,
4253:18, 4265:47,
4267:31, 4279:11,
4286:7, 4286:12,
4286:37, 4287:2,
4290:35, 4291:30,
4291:32, 4295:16,
4295:27, 4296:5,
4297:17, 4297:27,
4299:35, 4299:37,
4300:1, 4301:1,
4301:18, 4302:24,
4302:25, 4302:43,
4303:13, 4303:47,
4306:5, 4306:20,
4306:21, 4306:22,
4306:23
Department [2] -
4206:13, 4210:44
department" [2] -
4304:34, 4306:16
department's [1] -
4286:35
departments [12] -
4201:39, 4215:43,
4216:26, 4216:37,
4222:33, 4223:7,
4239:19, 4258:22,
4263:40, 4266:32,
4279:14, 4286:20
dependency [1] -
4222:12
dependent [3] -
4222:10, 4271:40,
4289:14
deploy [2] - 4270:3,
4272:40
deployment [1] -
4264:4
depth [1] - 4280:44
deputy [1] - 4205:46
dermatologist [1] -
4257:43
dermatologists [1] -
4227:32
describe [12] -
4184:28, 4184:42,
4185:20, 4189:12,
4201:41, 4204:46,
4243:27, 4269:15,
4273:7, 4275:13,
4279:24, 4280:10
described [11] -
4185:7, 4192:24,
4207:8, 4231:21,
4236:8, 4240:4,
4269:42, 4275:8,
4276:18, 4279:38,
4280:30
describing [2] -
4228:15, 4274:43
description [2] -
4275:29, 4275:34
desirable [2] -
4208:22, 4208:26
desire [1] - 4295:18
desires [1] - 4247:11
despite [2] - 4282:40,
4295:28
detail [6] - 4189:12,
4224:1, 4243:31,
4247:30, 4304:39,
4306:16
detailed [1] - 4234:29
details [1] - 4302:33
determinants [2] -
4269:37, 4269:45
determination [1] -
4293:31
determinations [3] -
4293:14, 4293:17,
4293:19
determine [7] -
4244:29, 4254:23,
4254:35, 4254:37,
4262:34, 4263:8,
4271:29
determined [4] -
4254:46, 4265:13,
4269:19, 4269:27
determining [5] -
4208:5, 4249:19,
4264:29, 4269:8,
4287:6
devalues [1] - 4233:31
develop [9] - 4200:43,
4201:12, 4227:24,
4248:26, 4258:10,
4258:44, 4259:1,
4273:3, 4275:22
developed [8] -
4194:11, 4200:23,
4201:21, 4201:32,
4222:26, 4230:27,
4258:7, 4273:10
developing [4] -
4200:44, 4203:23,
4218:20, 4238:7
development [7] -
4185:31, 4185:35,
4239:36, 4242:10,
4242:19, 4273:46,
4279:34
dialogue [1] - 4300:18
dictate [1] - 4276:15
dictates [1] - 4298:40
difference [5] -
4192:37, 4192:45,
4193:4, 4216:38,
4275:10
differences [1] -
4262:6
different [42] -
4189:35, 4190:12,
4190:43, 4191:10,
4191:18, 4201:18,
4207:46, 4213:15,
4215:2, 4216:15,
4218:28, 4227:31,
4231:1, 4231:5,
4231:15, 4245:32,
4247:15, 4255:4,
4255:33, 4256:30,
4257:20, 4263:26,
4263:31, 4263:40,
4263:41, 4264:13,
4264:16, 4279:43,
4280:20, 4284:8,
4284:29, 4284:30,
4285:35, 4285:38,
4286:45, 4291:28,
4293:5, 4293:6
differentiate [1] -
4257:20
differentiation [1] -
4259:30
difficult [15] - 4191:21,
4193:12, 4208:27,
4208:34, 4209:42,
4210:14, 4210:37,
4211:31, 4213:21,
4215:33, 4216:19,
4216:21, 4232:26,
4259:28, 4264:28
difficulty [8] -
4266:19, 4283:27,
4283:28, 4283:31,
4283:41, 4300:28,
4300:29, 4306:23
direct [5] - 4185:39,
4207:44, 4214:28,
4276:15, 4288:35
directed [2] - 4185:12,
4185:14
direction [5] -
4204:27, 4258:1,
4258:2, 4258:5,
4258:6
directional [3] -
4233:5, 4234:8,
4234:11
directions [1] - 4285:1
directly [7] - 4189:24,
4258:15, 4268:47,
4275:44, 4277:9
director [6] - 4202:1,
4242:9, 4254:40,
4268:18, 4282:14,
4283:36
directors [7] -

- 4190:18, 4258:16,
4277:7, 4277:9,
4277:15, 4277:24,
4278:10
dis [1] - 4195:3
dis-accreditation [1] -
4195:3
disadvantage [1] -
4303:14
disadvantaged [2] -
4232:20, 4232:24
disagree [3] - 4224:2,
4283:43, 4284:14
disapproval [1] -
4306:10
disaster [1] - 4193:15
discipline [3] -
4247:37, 4300:30,
4300:40
disciplines [1] -
4280:2
discovered [1] -
4301:21
discrete [1] - 4274:12
discretely [1] -
4264:30
discrimination [3] -
4216:1, 4216:43,
4218:10
discuss [2] - 4239:9,
4277:45
discussed [6] -
4205:16, 4265:23,
4267:22, 4279:26,
4299:43, 4304:40
discussing [3] -
4213:44, 4241:15,
4267:1
discussion [11] -
4197:33, 4215:36,
4224:15, 4225:18,
4244:7, 4244:11,
4259:19, 4271:29,
4291:3, 4306:13,
4306:14
discussions [4] -
4222:1, 4227:41,
4267:9, 4293:27
disease [2] - 4223:27,
4223:35
display [1] - 4284:47
disposal [1] - 4251:20
distinct [1] - 4220:16
distribute [2] - 4251:9,
4251:20
distributed [4] -
4250:7, 4250:21,
4250:38, 4262:30
distributing [1] -
4261:28
distribution [20] -
4213:33, 4213:46,
4248:11, 4248:12,
4248:15, 4248:23,
4249:47, 4250:26,
4250:28, 4253:9,
4255:35, 4260:3,
4261:27, 4261:47,
4264:29, 4264:42,
4264:45, 4269:2,
4288:22, 4292:22
District [4] - 4268:20,
4282:16, 4282:24,
4283:26
district [55] - 4205:39,
4209:26, 4228:45,
4264:39, 4265:2,
4265:6, 4269:43,
4269:45, 4269:46,
4269:47, 4270:3,
4270:11, 4270:12,
4270:22, 4270:43,
4271:1, 4271:4,
4271:15, 4271:17,
4271:20, 4271:24,
4271:26, 4271:32,
4271:34, 4272:25,
4272:27, 4272:32,
4272:39, 4272:44,
4273:36, 4273:39,
4274:45, 4274:46,
4275:1, 4276:8,
4276:32, 4277:2,
4278:20, 4278:26,
4278:37, 4278:38,
4279:3, 4282:14,
4283:12, 4283:40,
4284:23, 4284:24,
4285:22, 4289:4,
4289:23, 4289:24,
4290:26, 4292:31
district's [2] -
4288:19, 4295:10
districts [10] -
4244:29, 4250:32,
4253:3, 4258:15,
4264:32, 4264:37,
4272:2, 4272:8,
4272:13, 4276:9
ditch [1] - 4217:27
diverse [1] - 4192:16
diversity [4] -
4191:40, 4191:45,
4192:14, 4193:17
divide [1] - 4203:37
divided [2] - 4187:5,
4201:13
dividing [1] - 4230:46
DMS [2] - 4202:19,
4215:27
DMSs [3] - 4205:46,
4210:11
Doctor [3] - 4266:47,
4281:31, 4281:40
doctor [8] - 4186:11,
4186:21, 4223:16,
4223:23, 4232:28,
4233:37, 4270:11,
4298:45
doctor's [1] - 4304:21
doctors [18] -
4188:37, 4198:42,
4199:1, 4199:10,
4231:22, 4233:3,
4239:14, 4239:37,
4245:26, 4245:43,
4246:13, 4246:40,
4270:1, 4277:14,
4277:18, 4278:27,
4279:44, 4288:22
document [10] -
4220:46, 4234:21,
4234:23, 4234:30,
4237:23, 4286:10,
4286:12, 4286:15,
4286:33, 4299:45
documented [1] -
4196:18
documents [5] -
4269:23, 4294:2,
4294:10, 4294:11,
4300:12
DOHA [2] - 4206:23,
4206:36
dominated [1] -
4192:3
done [50] - 4190:10,
4198:12, 4201:28,
4202:5, 4204:4,
4205:29, 4208:13,
4214:5, 4219:30,
4219:32, 4219:33,
4219:39, 4220:24,
4221:35, 4224:26,
4225:25, 4227:34,
4229:9, 4230:2,
4230:42, 4231:13,
4235:32, 4239:2,
4243:45, 4247:20,
4248:46, 4252:46,
4256:8, 4262:9,
4264:8, 4273:15,
4273:16, 4273:17,
4273:22, 4275:12,
4276:27, 4279:45,
4284:42, 4284:46,
4285:2, 4290:23,
4299:22, 4300:23,
4300:36, 4301:29,
4302:26, 4302:34,
4303:4, 4306:8
door [5] - 4230:27,
4278:31, 4278:32,
4278:34, 4278:42
dot [3] - 4187:30,
4187:39, 4187:43
doubt [5] - 4255:7,
4256:19, 4262:28,
4284:41, 4306:45
down [20] - 4185:45,
4186:3, 4187:24,
4202:22, 4203:19,
4204:45, 4216:26,
4216:37, 4220:34,
4222:15, 4222:18,
4222:37, 4246:30,
4249:4, 4255:27,
4260:37, 4279:33,
4296:38, 4306:34
Dr [21] - 4182:28,
4228:40, 4241:42,
4242:5, 4251:35,
4268:8, 4268:14,
4283:35, 4286:8,
4286:26, 4290:32,
4290:43, 4296:35,
4296:44, 4297:12,
4298:12, 4298:33,
4298:38, 4298:41,
4299:3, 4299:7
draft [4] - 4236:15,
4236:17, 4284:45,
4298:36
drawn [1] - 4278:8
draws [1] - 4285:4
dress [1] - 4306:34
drive [1] - 4230:22
driving [3] - 4247:4,
4250:8
Dubbo [2] - 4232:2,
4261:19
due [6] - 4211:2,
4229:29, 4242:46,
4257:19, 4296:29,
4298:9
during [9] - 4214:12,
4231:8, 4231:11,
4256:20, 4273:32,
4274:45, 4292:13,
4295:33, 4306:13
dynamic [2] - 4279:2,
4285:40
-
- E**
-
- early** [3] - 4225:18,
4258:26, 4258:34
easier [1] - 4305:5
easily [2] - 4209:13,
4224:16
eastern [1] - 4199:34
easy [4] - 4257:19,
4262:44, 4263:2,
4263:33
ED [14] - 4222:22,
4222:25, 4222:27,
4223:9, 4223:14,
4223:24, 4223:27,
4286:41, 4286:47,
4287:1, 4287:27,
4287:29, 4287:33
Ed [1] - 4182:26
EDs [1] - 4286:45
education [17] -
4185:1, 4189:21,
4190:16, 4191:5,
4192:23, 4195:20,
4197:45, 4198:1,
4200:9, 4227:35,
4228:45, 4232:26,
4266:26, 4277:7,
4277:10, 4278:11
Education [3] -
4189:19, 4206:3,
4239:27
educational [2] -
4189:7, 4214:13
effect [4] - 4214:28,
4240:37, 4280:29,
4295:11
effective [4] - 4186:38,
4265:38, 4270:31,
4270:32
effectively [5] -
4190:32, 4245:39,
4249:2, 4287:6,
4295:45
effects [1] - 4215:35
efficiencies [1] -
4239:18
efficiency [1] -
4255:25
efficient [1] - 4239:13
efficiently [1] -
4255:47
effort [3] - 4194:39,
4216:15, 4303:21
eight [7] - 4184:32,
4191:23, 4205:18,
4239:16, 4290:38,
4301:20, 4304:2
either [3] - 4224:3,
4255:13, 4295:44
elaborate [3] -
4191:35, 4227:11,
4228:14
elective [17] -
4197:21, 4198:12,
4219:5, 4219:6,
4219:7, 4219:14,

4219:25, 4219:27,
 4219:32, 4219:40,
 4220:4, 4220:10,
 4220:28, 4220:42,
 4221:35, 4225:22
electives [1] - 4231:12
electronic [2] -
 4281:22, 4281:23
element [1] - 4292:5
eligible [2] - 4243:38,
 4244:44
elsewhere [1] -
 4267:10
email [1] - 4258:17
emerge [1] - 4241:20
emerged [1] - 4267:9
emergency [31] -
 4219:23, 4219:34,
 4219:38, 4221:18,
 4221:21, 4221:28,
 4222:6, 4222:32,
 4223:6, 4223:11,
 4228:43, 4254:4,
 4254:7, 4254:9,
 4279:10, 4279:14,
 4283:36, 4286:7,
 4286:9, 4286:12,
 4286:20, 4286:37,
 4287:2, 4290:34,
 4290:39, 4290:40,
 4291:9, 4291:30,
 4291:31, 4301:18,
 4304:19
Emergency [1] -
 4286:11
emerging [1] -
 4287:10
emphasise [1] -
 4306:44
employ [2] - 4263:40,
 4270:47
employed [5] -
 4247:21, 4264:35,
 4264:36, 4266:6,
 4278:19
employees [1] -
 4292:5
employer [2] -
 4266:11, 4266:38
employers [4] -
 4266:2, 4266:16,
 4267:6, 4267:14
employing [1] -
 4205:39
empt [1] - 4276:45
enable [3] - 4261:2,
 4293:17, 4293:19
encourage [1] -
 4279:45
end [16] - 4184:1,
 4198:12, 4223:24,
 4235:6, 4244:24,
 4245:25, 4245:37,
 4247:45, 4248:21,
 4259:19, 4271:4,
 4273:36, 4273:47,
 4299:16, 4299:28,
 4303:20
endocrinologist [2] -
 4257:43, 4261:18
endorsed [2] -
 4287:45, 4287:46
endorsement [1] -
 4287:47
ends [3] - 4225:19,
 4271:3, 4273:39
enforced [1] - 4196:32
engage [3] - 4207:7,
 4266:33, 4277:13
engaged [6] -
 4196:13, 4196:47,
 4197:11, 4273:35,
 4292:38, 4292:39
engagement [1] -
 4244:12
engaging [1] -
 4273:33
enhance [3] -
 4272:29, 4273:25,
 4277:47
enhancements [1] -
 4291:47
enhancing [2] -
 4272:30, 4276:38
enormous [2] -
 4194:30, 4202:4
ensure [6] - 4217:21,
 4251:1, 4256:3,
 4258:10, 4292:18,
 4299:22
ensures [1] - 4217:37
ensuring [3] -
 4256:14, 4280:33,
 4291:21
ENT [1] - 4202:3
enter [1] - 4246:31
entering [3] - 4245:1,
 4246:15, 4246:17
entitled [5] - 4188:38,
 4234:24, 4303:20,
 4303:25, 4303:27
environment [4] -
 4219:37, 4266:27,
 4267:16, 4291:29
equal [1] - 4193:31
equally [1] - 4193:3
equipment [19] -
 4270:23, 4299:14,
 4299:15, 4299:22,
 4299:24, 4299:28,
 4299:30, 4302:27,
 4302:41, 4303:4,
 4303:5, 4303:7,
 4303:8, 4303:11,
 4303:15, 4303:27,
 4303:47, 4304:4,
 4304:26
equity [3] - 4201:34,
 4227:47, 4235:10
equivalent [1] -
 4283:17
especially [1] -
 4292:13
essentially [3] -
 4252:19, 4254:45,
 4254:46
establish [2] -
 4248:28, 4289:25
established [3] -
 4255:18, 4261:23,
 4291:2
establishing [2] -
 4244:32, 4289:29
establishment [1] -
 4291:26
et [11] - 4185:34,
 4191:46, 4194:26,
 4201:17, 4202:16,
 4206:16, 4253:15,
 4267:3, 4269:12,
 4278:23, 4304:19
evaluating [3] -
 4214:35, 4214:43,
 4299:41
event [5] - 4217:27,
 4240:46, 4288:32,
 4289:43, 4291:2
eventually [1] -
 4293:39
eventuate [1] - 4289:2
everyday [1] - 4217:15
evidence [33] -
 4183:5, 4198:18,
 4198:25, 4199:7,
 4199:25, 4199:26,
 4199:36, 4199:47,
 4204:43, 4214:31,
 4219:8, 4242:39,
 4243:9, 4243:10,
 4248:25, 4248:31,
 4255:43, 4261:46,
 4263:11, 4268:40,
 4282:37, 4283:35,
 4283:40, 4284:8,
 4286:8, 4286:26,
 4286:31, 4290:32,
 4290:33, 4291:1,
 4291:12, 4296:38,
 4298:2
evidence-informed
 [1] - 4199:47
evolve [1] - 4287:11
evolving [5] - 4287:9,
 4287:37, 4287:38,
 4292:4, 4292:5
exactly [3] - 4204:1,
 4265:11, 4267:19
examination [1] -
 4284:22
examinations [1] -
 4218:21
example [56] -
 4190:22, 4192:6,
 4197:39, 4202:2,
 4202:36, 4203:3,
 4204:3, 4205:28,
 4206:2, 4206:15,
 4219:20, 4225:26,
 4229:13, 4229:45,
 4230:35, 4232:1,
 4232:2, 4237:35,
 4238:23, 4238:26,
 4249:6, 4249:7,
 4254:32, 4255:37,
 4255:42, 4256:16,
 4256:23, 4256:32,
 4261:16, 4262:5,
 4264:21, 4270:16,
 4270:20, 4270:47,
 4276:14, 4276:23,
 4277:1, 4277:2,
 4277:19, 4278:15,
 4279:1, 4279:6,
 4279:11, 4281:7,
 4281:15, 4283:46,
 4287:1, 4287:27,
 4288:32, 4289:28,
 4289:35, 4291:32,
 4292:12, 4299:42,
 4305:3, 4305:10
examples [6] -
 4270:34, 4279:7,
 4279:26, 4289:15,
 4290:20, 4301:17
exams [1] - 4247:47
excellence [2] -
 4230:6, 4266:26
excellent [7] -
 4192:12, 4192:13,
 4194:22, 4199:24,
 4228:23, 4228:33,
 4231:11
except [1] - 4251:11
excess [1] - 4220:44
exchanged [1] -
 4211:27
excuse [3] - 4296:28,
 4302:7, 4307:3
excused [4] - 4226:20,
 4241:36, 4268:4,
 4281:41
executive [14] -
 4184:37, 4184:43,
 4184:45, 4268:18,
 4284:44, 4300:10,
 4300:19, 4300:20,
 4300:22, 4304:2,
 4304:20, 4304:32,
 4304:40, 4306:24
executives [1] -
 4277:16
exercise [2] - 4207:25,
 4225:28
exercised [1] -
 4190:24
exhausted [1] -
 4244:22
exhibit [1] - 4234:23
exist [2] - 4187:10,
 4254:13
existence [1] -
 4261:23
existing [2] - 4285:32,
 4285:43
exists [2] - 4191:15,
 4191:18
expand [4] - 4256:11,
 4256:45, 4272:29,
 4287:41
expanded [2] -
 4255:13, 4291:25
expanding [2] -
 4257:5, 4262:15
expansion [2] -
 4231:32, 4231:35
expect [2] - 4285:29,
 4288:13
expectation [1] -
 4303:32
expectations [2] -
 4247:16, 4292:4
expected [7] -
 4192:42, 4241:11,
 4269:18, 4269:26,
 4270:6, 4285:45,
 4296:44
expedite [2] - 4212:9,
 4212:10
expensive [1] -
 4230:26
experience [15] -
 4222:38, 4229:24,
 4246:20, 4246:24,
 4254:8, 4256:22,
 4256:40, 4273:40,
 4274:35, 4277:11,
 4277:17, 4278:34,
 4279:3, 4279:10,
 4284:11
experienced [1] -

4274:32				
experiences [7] -				
4231:23, 4246:1,				
4246:6, 4246:13,				
4254:27, 4274:5,				
4279:44				
experiencing [1] -				
4284:5				
experiential [2] -				
4246:10, 4277:17				
expert [1] - 4218:23				
expertise [4] -				
4187:11, 4188:20,				
4247:30, 4305:41				
experts [1] - 4206:1				
expiry [1] - 4288:14				
explain [9] - 4195:11,				
4223:5, 4229:28,				
4229:30, 4231:35,				
4234:30, 4253:24,				
4254:18, 4276:4				
explained [1] -				
4202:35				
explore [2] - 4238:38,				
4266:3				
explored [2] -				
4239:22, 4257:9				
exposed [5] -				
4256:35, 4256:36,				
4274:37, 4276:22,				
4276:23				
exposing [1] -				
4279:29				
exposure [8] - 4272:7,				
4272:12, 4274:16,				
4274:19, 4278:21,				
4278:28, 4278:45,				
4279:15				
expressed [1] -				
4263:15				
extend [2] - 4227:27,				
4257:35				
extended [1] -				
4232:42				
extending [1] -				
4223:10				
extensive [1] - 4285:2				
extent [9] - 4205:38,				
4236:24, 4244:27,				
4266:31, 4300:13,				
4302:25, 4302:31,				
4302:40, 4303:36				
extra [2] - 4202:38,				
4230:20				
extremely [6] -				
4191:42, 4192:8,				
4194:44, 4195:7,				
4228:22, 4230:26				
eye [1] - 4200:24				
	F			
	faced [1] - 4248:31	4234:6, 4236:36,	4185:12, 4185:27,	4222:9, 4222:20,
	facilities [11] -	4252:40	4185:42, 4185:47,	4222:35, 4222:41,
	4250:14, 4252:22,	FATES [2] - 4235:18,	4186:7, 4186:14,	4222:45, 4223:13,
	4260:22, 4261:24,	4236:38	4186:26, 4186:32,	4224:8, 4224:23,
	4263:41, 4264:47,	fault [1] - 4304:13	4186:42, 4187:9,	4225:4, 4225:15,
	4272:20, 4274:34,	feasible [1] - 4262:2	4187:22, 4187:32,	4225:41, 4226:3,
	4277:19, 4278:47,	February [3] -	4187:41, 4188:1,	4226:9, 4226:15,
	4279:43	4234:25, 4235:34,	4188:10, 4188:16,	4226:24, 4226:32,
	facility [17] - 4228:26,	4304:18	4188:28, 4188:33,	4226:46, 4227:9,
	4252:25, 4252:29,	federal [3] - 4210:3,	4188:40, 4188:45,	4227:14, 4227:44,
	4257:42, 4270:23,	4235:18, 4269:29	4189:4, 4189:17,	4228:6, 4228:12,
	4275:40, 4276:42,	fee [6] - 4197:1,	4191:21, 4191:37,	4228:17, 4228:39,
	4277:2, 4277:33,	4197:4, 4197:11,	4192:27, 4192:32,	4229:9, 4229:20,
	4279:27, 4280:15,	4292:40, 4293:1,	4192:42, 4193:12,	4229:26, 4229:33,
	4280:45, 4280:46,	4293:15	4193:36, 4194:16,	4229:39, 4230:14,
	4281:12, 4286:22	feed [1] - 4302:44	4194:21, 4195:14,	4231:25, 4231:39,
	fact [14] - 4187:45,	feedback [7] -	4195:37, 4196:4,	4234:18, 4234:27,
	4192:40, 4197:34,	4194:44, 4263:35,	4196:8, 4196:16,	4234:33, 4235:3,
	4227:15, 4231:10,	4266:14, 4266:18,	4196:37, 4196:42,	4235:41, 4235:46,
	4242:31, 4244:15,	4266:22, 4266:24	4197:3, 4197:15,	4236:6, 4236:12,
	4252:46, 4253:8,	feedbacks [1] -	4197:32, 4198:20,	4236:22, 4236:28,
	4263:34, 4264:34,	4258:13	4198:28, 4199:3,	4236:33
	4269:1, 4295:43,	fellow [1] - 4282:19	4199:12, 4199:19,	fielding [1] - 4184:19
	4303:46	fellows [8] - 4185:10,	4199:23, 4199:33,	figure [1] - 4220:43
	factor [6] - 4244:32,	4185:20, 4205:10,	4199:41, 4200:33,	figures [1] - 4290:17
	4247:9, 4249:24,	4233:20, 4248:1,	4200:39, 4200:46,	fill [12] - 4212:34,
	4263:38, 4287:6,	4264:20, 4266:6,	4201:5, 4201:10,	4212:35, 4213:3,
	4287:9	4266:33	4201:45, 4202:33,	4259:26, 4259:28,
	factors [10] - 4222:7,	fellowship [1] -	4203:28, 4203:42,	4263:2, 4264:6,
	4244:33, 4247:3,	4195:19	4204:1, 4204:13,	4284:5, 4290:44,
	4247:7, 4249:21,	felt [1] - 4300:25	4205:3, 4205:33,	4295:28, 4295:34,
	4250:11, 4254:25,	female [3] - 4192:4,	4205:42, 4206:33,	4295:43
	4263:4, 4263:7,	4192:7, 4193:14	4206:43, 4207:4,	filled [13] - 4212:31,
	4285:40	fertilisation [1] -	4207:11, 4207:16,	4212:38, 4213:10,
	failed [3] - 4224:3,	4188:21	4207:21, 4207:30,	4259:45, 4259:46,
	4290:20, 4290:21	fertilise [1] - 4189:33	4208:1, 4208:9,	4262:41, 4283:45,
	failing [1] - 4224:3	few [16] - 4183:43,	4208:17, 4208:26,	4283:47, 4284:1,
	fair [8] - 4186:38,	4194:39, 4195:37,	4209:19, 4209:31,	4284:2, 4284:10,
	4193:34, 4205:31,	4210:1, 4217:28,	4209:38, 4210:25,	4291:19, 4291:20
	4207:24, 4217:22,	4218:45, 4225:43,	4210:30, 4210:34,	filling [3] - 4223:36,
	4217:38, 4249:37,	4226:11, 4237:46,	4210:40, 4211:14,	4261:28, 4283:41
	4259:5	4268:27, 4273:43,	4211:18, 4211:22,	final [1] - 4257:3
	fairly [3] - 4249:3,	4274:44, 4283:9,	4211:29, 4211:37,	finally [6] - 4234:20,
	4301:21, 4303:42	4290:24, 4296:44,	4211:42, 4212:7,	4265:45, 4279:18,
	fairness [2] - 4298:40,	4300:43	4212:20, 4212:25,	4301:19, 4302:7,
	4303:17	field [1] - 4193:31	4212:29, 4213:2,	4307:3
	faith [1] - 4212:39	Fielding [16] - 4183:6,	4214:17, 4214:24,	financial [6] - 4185:4,
	fall [1] - 4254:2	4183:22, 4184:23,	4214:37, 4214:47,	4195:17, 4265:1,
	familiar [7] - 4200:36,	4185:24, 4185:40,	4215:19, 4216:5,	4303:12, 4303:14,
	4264:12, 4284:21,	4187:3, 4191:17,	4216:12, 4216:46,	4303:20
	4286:10, 4299:19,	4194:8, 4195:33,	4217:26, 4217:41,	financially [1] -
	4300:5, 4305:34	4200:30, 4200:42,	4217:46, 4218:6,	4232:24
	families [3] - 4263:7,	4204:46, 4214:15,	4218:26, 4218:38,	fine [2] - 4251:40,
	4280:43, 4281:1	4218:18, 4218:44,	4219:1, 4219:11,	4281:2
	family [2] - 4213:16,	4237:17	4219:20, 4220:1,	finish [4] - 4251:41,
	4223:41	FIELDING [173] -	4220:7, 4220:13,	4294:27, 4295:6,
	fantastic [1] - 4274:41	4183:11, 4183:26,	4220:18, 4220:31,	4300:37
	far [4] - 4231:27,	4183:32, 4183:38,	4220:38, 4221:4,	finished [3] - 4226:30,
		4183:43, 4184:3,	4221:11, 4221:16,	4236:38, 4237:3
		4184:26, 4184:31,	4221:26, 4221:32,	finite [1] - 4256:9
			4221:39, 4222:3,	

first [28] - 4183:3, 4192:4, 4193:19, 4206:10, 4216:17, 4216:46, 4228:9, 4240:22, 4240:26, 4242:32, 4243:21, 4243:22, 4244:43, 4244:46, 4248:8, 4252:20, 4255:28, 4256:2, 4260:4, 4260:13, 4261:40, 4262:34, 4271:39, 4277:1, 4278:23, 4301:11, 4305:22
firstly [6] - 4183:21, 4200:35, 4202:26, 4259:29, 4280:31, 4288:22
five [15] - 4216:13, 4221:34, 4231:41, 4244:8, 4247:42, 4247:45, 4276:8, 4281:3, 4288:9, 4288:11, 4290:33, 4291:1, 4293:23, 4293:24
five-year [4] - 4247:45, 4288:9, 4293:23, 4293:24
fix [1] - 4199:15
fixed [2] - 4221:34, 4272:33
flexibility [3] - 4247:8, 4275:13, 4275:24
flexible [5] - 4246:47, 4247:14, 4272:34, 4273:9, 4273:13
flow [1] - 4223:10
flow-on [1] - 4223:10
fly [5] - 4202:19, 4232:44, 4233:23, 4233:36, 4273:17
fly-in/fly-out [5] - 4202:19, 4232:44, 4233:23, 4233:36, 4273:17
flying [2] - 4233:42, 4233:43
focus [4] - 4238:12, 4250:31, 4250:33, 4250:43
focused [1] - 4198:35
folder [1] - 4296:10
follow [2] - 4200:44, 4298:30
following [3] - 4220:35, 4265:15, 4271:8
foot [1] - 4203:3
force [10] - 4209:39, 4210:23, 4210:38, 4210:41, 4240:13, 4240:25, 4240:32, 4240:47, 4250:8, 4260:9
forced [1] - 4249:2
forever [2] - 4197:47, 4287:23
form [4] - 4199:8, 4236:17, 4263:46, 4283:4
formal [1] - 4256:13
formally [2] - 4240:22, 4268:25
former [1] - 4299:1
forming [1] - 4239:9
formulation [1] - 4285:9
forward [7] - 4191:25, 4257:14, 4259:18, 4264:26, 4269:36, 4273:44, 4277:28
forward-thinking [1] - 4191:25
four [13] - 4202:39, 4221:33, 4230:22, 4270:27, 4270:30, 4274:18, 4276:8, 4288:30, 4290:25, 4290:33, 4291:1, 4296:6
fourth [1] - 4238:10
FRACS [2] - 4227:5, 4227:44
fracture [3] - 4223:39, 4227:30, 4301:21
frame [2] - 4204:33, 4258:19
framework [3] - 4218:2, 4245:17, 4259:1
frankly [1] - 4219:11
FRASER [14] - 4281:47, 4282:6, 4282:8, 4283:4, 4283:9, 4294:5, 4294:14, 4294:23, 4294:40, 4294:47, 4295:4, 4295:8, 4296:9, 4296:14
Fraser [2] - 4182:29, 4296:23
fraternity [1] - 4305:33
free [1] - 4268:36
Frew [1] - 4215:38
friend [1] - 4298:28
friend's [1] - 4252:4
front [3] - 4226:6, 4258:42, 4299:10
frustrating [1] - 4219:37
FTE [4] - 4263:40, 4286:35, 4290:34, 4291:1
fulfil [2] - 4276:15, 4276:26
fulfilling [1] - 4295:16
full [18] - 4221:43, 4230:19, 4239:40, 4242:5, 4247:28, 4247:42, 4248:34, 4249:11, 4268:14, 4282:8, 4283:17, 4289:12, 4289:19, 4291:33, 4297:12, 4303:19, 4303:25, 4303:26
full-time [3] - 4247:28, 4283:17, 4291:33
Fuller [2] - 4182:30, 4183:17
fuller [5] - 4219:45, 4224:15, 4226:11, 4226:27, 4226:39
FULLER [151] - 4183:3, 4183:15, 4183:17, 4183:28, 4183:34, 4183:40, 4183:46, 4184:5, 4184:10, 4184:15, 4184:23, 4184:28, 4184:41, 4185:7, 4185:14, 4185:24, 4185:38, 4185:44, 4186:2, 4186:9, 4186:20, 4186:28, 4186:35, 4186:44, 4187:1, 4187:17, 4187:24, 4187:34, 4187:43, 4188:5, 4188:13, 4188:25, 4188:30, 4188:35, 4188:42, 4188:47, 4189:12, 4189:37, 4190:22, 4190:28, 4190:38, 4191:10, 4191:17, 4191:35, 4192:21, 4192:30, 4192:37, 4193:8, 4193:33, 4193:38, 4193:47, 4194:6, 4194:18, 4195:9, 4195:33, 4195:47, 4196:6, 4196:11, 4196:47, 4197:11, 4197:27, 4198:16, 4198:22, 4198:34, 4198:44, 4199:36, 4199:43, 4200:14, 4200:22, 4200:30, 4200:35, 4200:41, 4201:1, 4201:8, 4201:41, 4202:26, 4203:22, 4203:37, 4203:44, 4204:10, 4204:20, 4204:32, 4204:41, 4205:28, 4205:38, 4206:30, 4206:40, 4206:45, 4207:6, 4207:13, 4207:18, 4207:23, 4207:41, 4207:46, 4208:3, 4208:11, 4208:21, 4209:16, 4209:25, 4209:33, 4213:25, 4213:37, 4213:43, 4214:8, 4214:20, 4214:33, 4214:40, 4215:15, 4215:47, 4216:7, 4216:41, 4217:19, 4217:36, 4218:1, 4218:8, 4218:17, 4218:35, 4218:44, 4219:3, 4225:45, 4226:41, 4227:1, 4227:11, 4227:38, 4228:2, 4228:8, 4228:14, 4228:36, 4229:5, 4229:17, 4229:22, 4229:28, 4229:35, 4230:9, 4231:20, 4231:30, 4234:14, 4234:20, 4234:29, 4234:38, 4234:43, 4234:47, 4235:37, 4235:43, 4236:1, 4236:8, 4236:20, 4236:24, 4236:30, 4237:7, 4241:23
fully [2] - 4248:42, 4296:28
function [8] - 4189:13, 4190:7, 4190:38, 4194:18, 4199:44, 4217:17, 4218:22, 4276:37
functioning [1] - 4201:17
functions [9] - 4189:2, 4189:10, 4190:3, 4190:20, 4190:24, 4190:29, 4190:31, 4204:41, 4205:11
funded [9] - 4231:40, 4243:28, 4244:40, 4249:18, 4260:21, 4264:31, 4265:3, 4265:5
funding [31] - 4210:2, 4210:3, 4213:38, 4219:40, 4222:24, 4225:12, 4225:13, 4225:15, 4225:30, 4228:19, 4229:11, 4229:17, 4235:18, 4236:38, 4243:46, 4249:22, 4249:24, 4249:25, 4249:29, 4249:32, 4250:12, 4251:11, 4252:20, 4257:5, 4257:10, 4257:12, 4264:38, 4264:42, 4265:6, 4265:7, 4265:16
Funding [1] - 4182:9
future [27] - 4202:28, 4206:28, 4213:15, 4213:31, 4214:3, 4243:35, 4244:1, 4252:39, 4253:35, 4253:43, 4253:45, 4262:31, 4265:14, 4284:28, 4285:29, 4285:33, 4285:34, 4285:36, 4285:41, 4285:44, 4286:2, 4286:3, 4286:5, 4287:6, 4287:13, 4287:14, 4287:41

G

gain [4] - 4195:17, 4278:34, 4279:16, 4280:39
gained [1] - 4256:22
gaps [1] - 4283:29
gastroenterologist [1] - 4274:21
gastroenterology [2] - 4274:18, 4289:29
gastroscopy [1] - 4227:26
gather [2] - 4249:28, 4266:35
gathered [1] - 4285:5
general [41] - 4192:6, 4192:7, 4200:22, 4201:36, 4202:2, 4203:35, 4211:1, 4211:27, 4212:16, 4212:30, 4213:4, 4218:1, 4222:22, 4222:23, 4222:24, 4223:8, 4224:4, 4224:14, 4224:40, 4227:16, 4237:5, 4237:45, 4238:27,

- 4244:36, 4244:44,
4245:4, 4245:8,
4249:8, 4254:35,
4273:34, 4274:9,
4275:29, 4275:34,
4279:13, 4281:19,
4281:21, 4285:32,
4285:34, 4290:7,
4291:27
General [2] - 4254:34,
4297:17
generalist [1] -
4203:18
generally [10] -
4195:4, 4223:30,
4245:26, 4248:37,
4265:27, 4280:11,
4286:34, 4289:18,
4290:18, 4292:47
generic [7] - 4201:15,
4201:30, 4202:7,
4202:35, 4204:4,
4258:10, 4258:17
geographical [1] -
4233:35
given [23] - 4211:35,
4211:45, 4219:6,
4220:10, 4243:9,
4249:46, 4250:6,
4250:20, 4250:36,
4250:37, 4255:43,
4260:27, 4262:44,
4263:31, 4275:39,
4280:40, 4287:32,
4294:8, 4294:11,
4296:38, 4304:39,
4306:7, 4306:16
Glover [1] - 4182:27
GLOVER [4] - 4268:8,
4268:12, 4268:14,
4281:31
goal [1] - 4287:41
goodwill [1] - 4196:27
Gosford [9] - 4289:27,
4290:37, 4291:19,
4292:32, 4292:35,
4292:38, 4293:9,
4293:29, 4293:43
governance [15] -
4186:39, 4189:5,
4189:43, 4190:13,
4190:19, 4190:39,
4190:44, 4190:45,
4192:37, 4193:5,
4233:12, 4233:44,
4268:19, 4270:26,
4270:29
governed [1] - 4190:8
governing [2] -
4187:14, 4192:32
Government [2] -
4231:39, 4234:16
government [11] -
4210:4, 4215:38,
4231:14, 4232:39,
4232:47, 4234:5,
4234:15, 4235:18,
4269:29, 4291:47,
4292:3
governments [1] -
4232:47
GP [4] - 4223:3,
4249:9, 4279:9
GPs [10] - 4222:21,
4222:47, 4227:23,
4227:25, 4227:33,
4227:35, 4227:45
graduate [7] -
4186:15, 4243:26,
4243:34, 4243:47,
4244:41, 4247:34,
4249:15
graduated [1] - 4263:6
graduates [9] -
4186:20, 4244:17,
4244:39, 4245:25,
4248:10, 4263:5,
4263:46, 4264:5,
4264:22
graduation [1] -
4248:19
Grafton [3] - 4228:9,
4228:18, 4229:10
granted [2] - 4185:28,
4207:13
grappling [1] -
4247:18
grassroots [1] -
4216:37
grateful [8] - 4241:27,
4268:4, 4281:41,
4296:22, 4302:6,
4304:42, 4304:46,
4304:47
great [4] - 4216:47,
4219:20, 4233:20,
4306:4
greater [5] - 4247:8,
4255:14, 4260:17,
4260:28
Griffith [2] - 4232:4
Griffiths [1] - 4253:19
grounding [1] -
4203:18
group [23] - 4189:7,
4189:18, 4191:43,
4191:46, 4192:16,
4192:18, 4192:35,
4205:9, 4212:37,
4215:10, 4231:28,
4235:35, 4236:13,
4239:25, 4246:25,
4246:34, 4246:36,
4246:47, 4247:2,
4253:18, 4254:21,
4257:15, 4287:26
groups [4] - 4191:30,
4191:43, 4279:8,
4286:46
grow [1] - 4301:30
growing [2] - 4219:4,
4220:4
growth [5] - 4243:39,
4285:44, 4285:45,
4287:7, 4287:18
guarantee [4] -
4250:42, 4250:44,
4251:15, 4289:1
guess [6] - 4189:40,
4199:1, 4204:23,
4220:42, 4293:20,
4305:33
guide [1] - 4285:32
guidelines [5] -
4194:41, 4205:15,
4206:8, 4206:21,
4206:45
gynaecologists [1] -
4276:24
gynaecology [2] -
4279:12, 4290:26
4215:11, 4240:25,
4269:21, 4283:13,
4297:27, 4299:35,
4306:22, 4306:23
heading [1] - 4228:3
health [86] - 4191:41,
4191:45, 4195:34,
4195:38, 4201:34,
4205:38, 4206:38,
4208:14, 4209:11,
4209:26, 4217:2,
4219:13, 4219:25,
4222:12, 4223:23,
4224:5, 4224:31,
4225:8, 4225:35,
4227:15, 4227:46,
4228:19, 4228:45,
4229:2, 4230:5,
4230:11, 4230:34,
4231:23, 4235:9,
4239:26, 4240:5,
4244:1, 4244:29,
4245:13, 4246:38,
4249:44, 4250:19,
4258:15, 4258:22,
4259:25, 4261:29,
4264:16, 4264:37,
4264:38, 4269:18,
4269:26, 4269:37,
4269:39, 4271:32,
4272:2, 4274:10,
4274:14, 4274:31,
4275:2, 4278:26,
4278:41, 4279:20,
4279:25, 4279:45,
4280:11, 4280:12,
4280:22, 4280:23,
4280:25, 4280:26,
4280:31, 4280:34,
4280:41, 4280:43,
4280:46, 4281:11,
4283:12, 4283:40,
4284:23, 4284:24,
4285:6, 4285:26,
4285:27, 4287:11,
4287:12, 4287:14,
4288:18, 4289:4,
4289:23, 4302:36
Health [50] - 4182:35,
4198:13, 4200:36,
4205:39, 4205:42,
4205:47, 4206:2,
4206:13, 4206:36,
4208:42, 4208:45,
4209:40, 4210:15,
4210:28, 4210:38,
4210:40, 4210:41,
4210:44, 4211:3,
4211:32, 4212:10,
4212:17, 4212:35,
4212:39, 4220:23,
4220:25, 4225:25,
4226:28, 4234:16,
4235:12, 4239:23,
4239:27, 4239:28,
4240:10, 4240:18,
4240:23, 4242:11,
4242:18, 4243:44,
4244:10, 4258:36,
4268:20, 4269:22,
4280:6, 4280:20,
4282:15, 4282:24,
4283:26, 4298:11,
4301:44
Healthcare [1] -
4182:9
healthy [1] - 4303:39
hear [2] - 4195:3,
4243:33
heard [14] - 4196:42,
4196:43, 4231:28,
4248:31, 4263:11,
4263:15, 4263:17,
4263:35, 4271:45,
4273:28, 4283:35,
4286:8, 4292:16,
4301:43
held [4] - 4242:14,
4242:22, 4282:24,
4297:24
HELEN [1] - 4268:10
Helen [1] - 4268:16
help [27] - 4206:2,
4209:12, 4210:16,
4210:17, 4212:41,
4216:24, 4216:37,
4219:39, 4220:46,
4224:17, 4227:18,
4227:34, 4232:19,
4232:34, 4233:5,
4233:41, 4233:47,
4234:1, 4238:16,
4240:19, 4240:20,
4266:25, 4275:23,
4276:44, 4279:34,
4281:5, 4306:12
helped [1] - 4206:18
helpful [2] - 4294:8,
4306:9
helpfully [1] - 4288:17
helps [3] - 4239:12,
4292:24
heterogeneous [3] -
4246:25, 4246:34,
4246:36
HETI [29] - 4206:2,
4239:27, 4239:33,
4245:22, 4245:23,
4254:30, 4255:6,
4255:13, 4255:21,
4261:26, 4261:32,

H

- H6** [1] - 4234:41
H6.2.2 [1] - 4234:23
half [1] - 4296:38
halfway [4] - 4185:45,
4186:3, 4187:24,
4204:45
hand [3] - 4203:14,
4227:30, 4306:3
handed [1] - 4243:19
hands [2] - 4252:4,
4265:39
happily [1] - 4260:5
happy [8] - 4183:44,
4198:2, 4210:17,
4212:10, 4226:17,
4227:19, 4231:14,
4238:17
harassment [6] -
4194:40, 4216:1,
4216:43, 4217:21,
4218:3, 4218:10
hard [5] - 4234:38,
4268:35, 4303:41,
4304:41, 4305:2
harder [1] - 4301:30
head [9] - 4211:39,

- 4261:39, 4275:20,
4276:35, 4276:36,
4276:41, 4277:4,
4277:9, 4277:13,
4277:22, 4277:39,
4277:45, 4278:3,
4278:7, 4278:18,
4278:41, 4279:27,
4289:31
high ^[11] - 4190:19,
4200:9, 4215:42,
4279:19, 4283:20,
4284:22, 4284:33,
4292:13, 4292:14,
4292:17, 4299:23
high-demand ^[1] -
4292:14
high-level ^[2] -
4190:19, 4215:42
high-quality ^[1] -
4299:23
higher ^[3] - 4189:6,
4189:14, 4230:24
higher-level ^[1] -
4189:6
highest ^[1] - 4262:1
highlight ^[1] - 4204:23
highly ^[2] - 4208:29,
4271:40
Hilbert ^[1] - 4182:35
Hillston ^[1] - 4230:35
hip ^[1] - 4203:4
historic ^[2] - 4286:34,
4291:47
historical ^[5] -
4191:27, 4193:9,
4292:46, 4292:47
historically ^[1] -
4209:5
history ^[1] - 4293:38
hmm ^[2] - 4220:31,
4300:8
hoc ^[3] - 4230:30,
4233:23, 4233:30
hold ^[2] - 4220:21,
4297:31
holds ^[2] - 4188:42,
4213:44
holidays ^[1] - 4292:15
Home ^[2] - 4239:35,
4239:37
home ^[1] - 4239:36
hone ^[1] - 4203:18
hope ^[1] - 4204:13
hopefully ^[7] -
4202:23, 4204:16,
4216:25, 4226:12,
4226:29, 4262:31,
4282:2
hoping ^[1] - 4265:18
- horizon** ^[1] - 4265:15
Hospital ^[6] - 4256:19,
4278:29, 4281:29,
4283:37, 4289:30,
4297:18
hospital ^[45] - 4196:1,
4197:5, 4201:16,
4202:7, 4202:13,
4202:15, 4203:31,
4209:26, 4216:17,
4219:23, 4219:39,
4221:9, 4221:37,
4223:19, 4223:34,
4223:36, 4223:42,
4228:24, 4228:28,
4228:45, 4229:15,
4229:46, 4230:19,
4230:26, 4230:34,
4231:9, 4232:5,
4233:4, 4238:28,
4238:29, 4245:16,
4271:5, 4274:17,
4278:21, 4278:31,
4278:34, 4280:41,
4280:45, 4281:27,
4291:4, 4300:17,
4304:23
hospital's ^[3] -
4204:6, 4222:26,
4230:19
hospital-based ^[1] -
4228:24
hospitalist ^[2] -
4239:6, 4245:28
hospitals ^[26] -
4197:38, 4205:47,
4216:15, 4216:27,
4216:30, 4221:43,
4222:10, 4224:6,
4230:46, 4231:43,
4232:3, 4238:18,
4238:22, 4238:25,
4238:45, 4239:4,
4250:14, 4254:21,
4256:8, 4256:29,
4262:46, 4290:37,
4291:19, 4292:32,
4293:6, 4293:29
hospitals" ^[1] - 4220:5
hospitals' ^[1] -
4261:24
hotel ^[3] - 4230:18,
4230:27, 4230:37
hour ^[1] - 4296:38
hourly ^[1] - 4292:17
hours ^[1] - 4200:3
hours' ^[1] - 4230:22
house ^[1] - 4279:14
hub ^[2] - 4232:6,
4232:12
- hubs** ^[4] - 4224:42,
4231:40, 4231:42,
4232:8
huge ^[3] - 4228:28,
4238:1, 4275:10
hugely ^[1] - 4196:26
hurrying ^[1] - 4251:34
husband ^[1] - 4228:42
hypothetical ^[1] -
4277:2
-
- I**
-
- lan** ^[1] - 4182:29
idea ^[6] - 4202:6,
4203:24, 4203:37,
4226:25, 4230:45,
4301:15
ideal ^[3] - 4193:28,
4220:43, 4264:8
ideally ^[1] - 4285:46
ideas ^[1] - 4189:9
identical ^[1] - 4286:47
identified ^[9] -
4209:47, 4210:5,
4235:44, 4249:22,
4250:4, 4250:11,
4257:4, 4302:32,
4302:47
identifier ^[1] - 4281:25
identifies ^[2] -
4255:35, 4272:39
identify ^[5] - 4212:42,
4227:18, 4246:29,
4252:47, 4257:31
identifying ^[2] -
4255:22, 4260:28
Illawarra ^[2] -
4268:19, 4271:30
image ^[1] - 4299:42
imaged ^[1] - 4302:41
images ^[1] - 4303:14
imagine ^[2] - 4199:1,
4269:30
imaging ^[2] - 4302:26,
4302:41
IMG ^[1] - 4264:11
immediately ^[3] -
4212:35, 4245:46,
4246:31
impact ^[8] - 4214:22,
4246:11, 4271:16,
4291:15, 4295:46,
4302:23, 4302:28,
4302:43
impacting ^[1] -
4197:29
impacts ^[1] - 4217:10
impart ^[1] - 4197:40
implement ^[3] -
4184:46, 4236:10,
4259:10
implementation ^[3] -
4204:25, 4204:29,
4258:41
implemented ^[5] -
4217:41, 4245:18,
4258:8, 4259:9,
4259:15
implementing ^[2] -
4258:36, 4259:7
importance ^[1] -
4215:34
important ^[18] -
4186:37, 4191:42,
4192:1, 4192:8,
4192:17, 4202:17,
4202:42, 4217:8,
4217:21, 4229:39,
4249:3, 4263:22,
4263:46, 4267:19,
4287:10, 4294:17,
4294:37, 4294:44
imposing ^[1] -
4272:19
impression ^[5] -
4305:18, 4305:29,
4305:30, 4305:40,
4305:45
improve ^[7] - 4201:35,
4258:37, 4260:11,
4266:2, 4267:6,
4277:47, 4300:18
improvements ^[1] -
4258:39
improving ^[2] -
4267:22, 4295:16
in-house ^[1] - 4279:14
in/fly ^[5] - 4202:19,
4232:44, 4233:23,
4233:36, 4273:17
inadequacy ^[1] -
4219:9
inadequate ^[4] -
4219:6, 4219:25,
4220:10, 4224:4
incentive ^[3] -
4265:31, 4265:38,
4304:3
incentives ^[4] -
4271:6, 4291:40,
4292:1, 4292:3
incentivised ^[2] -
4265:24, 4265:34
include ^[1] - 4234:15
includes ^[4] - 4232:2,
4284:28, 4290:1,
4290:4
including ^[4] - 4275:5,
4284:44, 4291:22
- income** ^[2] - 4197:22,
4197:25
incorrect ^[1] - 4282:41
increase ^[9] - 4206:14,
4209:34, 4211:6,
4212:42, 4219:34,
4227:24, 4227:35,
4250:31, 4285:47
increased ^[2] -
4198:4, 4285:46
increasing ^[5] -
4197:36, 4212:8,
4222:12, 4238:12,
4273:20
incredibly ^[2] -
4219:15, 4274:29
indeed ^[5] - 4240:22,
4285:36, 4288:7,
4295:33, 4296:9
independent ^[2] -
4228:41, 4234:2
indicate ^[1] - 4252:3
indicated ^[9] - 4254:4,
4254:5, 4260:26,
4264:10, 4265:30,
4277:38, 4287:40,
4288:30, 4289:38
indicator ^[1] - 4293:5
Indigenous ^[3] -
4191:45, 4228:19,
4274:12
individual ^[9] -
4185:20, 4194:14,
4194:23, 4201:38,
4202:47, 4203:39,
4210:14, 4213:29,
4247:27
individually ^[1] -
4289:34
individuals ^[1] -
4283:16
individuals' ^[1] -
4247:11
infancy ^[1] - 4279:31
infer ^[1] - 4249:37
inferred ^[1] - 4249:31
inferring ^[1] - 4253:39
influence ^[2] -
4207:26, 4207:43,
4213:29, 4213:32,
4213:37, 4269:43,
4269:46, 4270:12,
4270:23, 4270:43,
4271:15, 4271:25,
4271:34, 4272:19,
4272:22, 4272:25,
4272:36, 4288:36,
4288:39, 4288:40,
4289:1
inform ^[1] - 4252:41

- Information** [1] - 4220:26
- information** [22] - 4184:20, 4189:9, 4189:34, 4189:40, 4193:2, 4214:2, 4215:21, 4219:8, 4221:22, 4229:5, 4229:12, 4253:2, 4253:8, 4257:17, 4258:14, 4258:18, 4277:20, 4281:8, 4281:22, 4281:28, 4284:47, 4285:5
- informed** [4] - 4198:18, 4198:25, 4199:47, 4261:14
- infrastructure** [4] - 4194:25, 4195:5, 4225:16, 4233:20
- initial** [3] - 4205:4, 4214:3, 4214:18
- initiative** [3] - 4228:18, 4249:44, 4250:19
- initiatives** [1] - 4209:33
- injury** [1] - 4301:23
- innovative** [2] - 4264:15, 4264:23
- inpatients** [1] - 4302:35
- input** [4] - 4218:30, 4271:20, 4271:34, 4272:36
- inputs** [4] - 4200:1, 4200:5, 4200:7, 4200:16
- INQUIRY** [1] - 4307:28
- Inquiry** [6] - 4182:7, 4273:32, 4282:28, 4283:35, 4294:34, 4297:38
- insignificantly** [1] - 4285:5
- insofar** [6] - 4248:32, 4256:44, 4257:40, 4258:2, 4263:39, 4266:5
- instance** [2] - 4285:30, 4285:31
- instances** [2] - 4276:9, 4280:8
- instead** [1] - 4218:22
- Institute** [4] - 4206:3, 4220:23, 4239:28, 4269:22
- instrument** [3] - 4189:45, 4190:9, 4193:29
- insurance** [2] - 4222:11, 4302:37
- integral** [1] - 4217:17
- intend** [1] - 4252:5
- intended** [1] - 4248:13
- intent** [1] - 4255:37
- interact** [1] - 4216:7
- interaction** [2] - 4212:22, 4275:23
- interested** [2] - 4239:15, 4243:32
- interesting** [1] - 4274:36
- interestingly** [1] - 4273:42
- interests** [2] - 4185:9, 4185:16
- interim** [1] - 4226:12
- intern** [25] - 4243:38, 4244:16, 4244:24, 4244:27, 4244:29, 4244:30, 4244:32, 4244:42, 4245:3, 4245:20, 4246:7, 4249:16, 4249:18, 4249:19, 4249:29, 4249:38, 4250:5, 4250:26, 4250:41, 4250:43, 4251:9, 4251:16, 4261:27, 4261:39, 4265:12
- international** [5] - 4186:15, 4186:20, 4263:45, 4264:5, 4264:21
- internationally** [3] - 4205:22, 4214:31, 4224:26
- interns** [11] - 4239:14, 4244:35, 4249:33, 4249:47, 4250:13, 4250:29, 4250:37, 4251:3, 4251:20, 4261:47, 4290:2
- internship** [5] - 4232:10, 4232:28, 4244:36, 4244:43, 4244:44
- internships** [1] - 4265:5
- interoperative** [2] - 4270:16, 4270:18
- interrupt** [1] - 4234:35
- interrupted** [1] - 4246:19
- interruption** [1] - 4295:31
- interventional** [2] - 4300:29, 4300:46
- interview** [7] - 4205:17, 4205:43, 4205:44, 4206:4, 4215:5, 4262:7, 4305:34
- interviews** [8] - 4205:7, 4205:13, 4205:17, 4205:19, 4205:25, 4206:7, 4212:33, 4215:1
- invented** [1] - 4286:35
- investigate** [4] - 4215:16, 4216:44, 4266:38, 4267:3
- investigated** [1] - 4206:47
- investigating** [1] - 4216:42
- involve** [2] - 4275:14, 4277:13
- involved** [34] - 4189:24, 4192:8, 4192:43, 4195:29, 4196:17, 4196:28, 4199:4, 4205:40, 4205:42, 4206:3, 4206:4, 4206:37, 4207:34, 4208:3, 4208:14, 4208:23, 4208:33, 4214:18, 4217:20, 4217:28, 4218:26, 4231:26, 4256:33, 4256:46, 4275:18, 4277:5, 4277:39, 4278:7, 4284:37, 4284:43, 4292:20, 4299:39, 4299:41
- involvement** [4] - 4204:47, 4207:24, 4255:14, 4300:6
- involves** [3] - 4184:29, 4185:33, 4251:1
- involving** [1] - 4231:36
- isolated** [1] - 4236:45
- isolation** [1] - 4263:13
- issue** [20] - 4193:31, 4195:9, 4197:27, 4204:21, 4214:8, 4218:45, 4225:12, 4225:15, 4253:6, 4260:3, 4267:21, 4267:22, 4275:27, 4280:21, 4296:45, 4300:40, 4300:43, 4303:10, 4306:1
- issued** [2] - 4258:5, 4258:7
- issues** [42] - 4189:35, 4191:41, 4194:37, 4195:5, 4195:6, 4206:18, 4213:46, 4216:21, 4216:29, 4216:34, 4216:43, 4216:44, 4222:14, 4227:4, 4227:11, 4228:28, 4229:1, 4234:25, 4242:27, 4253:13, 4256:7, 4258:23, 4263:12, 4266:5, 4277:28, 4277:40, 4277:44, 4277:46, 4283:21, 4292:31, 4301:2, 4304:27, 4304:28, 4305:20, 4305:22, 4305:23, 4305:27, 4306:9, 4306:25, 4306:28
- italics** [1] - 4228:10
- item** [5] - 4187:24, 4214:10, 4219:3, 4227:1, 4231:30
- items** [2] - 4190:23, 4293:44
- iterations** [1] - 4284:45
- itself** [7] - 4191:1, 4192:11, 4215:15, 4215:19, 4280:20, 4283:44, 4299:29
-
- J**
-
- January** [1] - 4194:2
- Jetty** [1] - 4291:26
- JMO** [4] - 4252:21, 4252:35, 4252:43, 4253:41
- JMOs** [4] - 4254:44, 4257:25, 4264:34, 4289:44
- job** [3] - 4233:9, 4304:44, 4306:4
- jobs** [1] - 4214:3
- Joe** [1] - 4228:40
- JOHN** [1] - 4297:8
- John** [4] - 4297:14, 4300:3, 4300:9, 4304:22
- joint** [3] - 4229:44, 4230:16, 4230:38
- joints** [1] - 4203:15
- journey** [3] - 4248:5, 4280:34, 4281:5
- journeys** [1] - 4276:45
- judge** [1] - 4208:27
- July** [8] - 4182:22, 4183:29, 4241:12, 4242:32, 4243:5, 4268:30, 4282:32, 4297:39
- JULY** [1] - 4307:29
- jumping** [1] - 4226:15
- junior** [4] - 4232:28, 4253:32, 4262:3, 4291:8
- juniors** [1] - 4277:8
- jurisdiction** [9] - 4213:32, 4213:37, 4213:44, 4214:5, 4215:31, 4217:38, 4218:32, 4223:1, 4223:38
- jurisdictional** [3] - 4205:45, 4208:13, 4235:28
- jurisdictions** [12] - 4206:37, 4208:42, 4216:8, 4216:16, 4217:32, 4232:47, 4235:26, 4244:11, 4259:6, 4273:3, 4275:2, 4275:9
-
- K**
-
- KAREN** [1] - 4268:10
- Karen** [1] - 4268:16
- keen** [3] - 4227:34, 4232:37, 4239:34
- keep** [9] - 4224:27, 4224:38, 4230:25, 4230:36, 4230:40, 4263:34, 4289:43, 4292:5
- keeps** [1] - 4292:4
- Kerin** [1] - 4183:6
- KERIN** [1] - 4183:11
- key** [4] - 4185:18, 4258:9, 4287:9, 4305:25
- kick** [1] - 4204:15
- kind** [20] - 4193:22, 4193:29, 4197:20, 4201:15, 4205:33, 4207:32, 4212:36, 4213:7, 4215:41, 4217:12, 4222:27, 4227:30, 4230:28, 4233:22, 4233:23, 4235:27, 4236:43, 4238:33, 4278:45, 4279:37
- knee** [3] - 4203:4, 4221:35, 4225:27
- knocked** [1] - 4206:26
- knowing** [1] - 4281:4
- knowledge** [13] - 4183:41, 4184:16,

4197:41, 4221:47, 4222:38, 4228:36, 4242:43, 4267:7, 4268:43, 4283:1, 4283:25, 4298:6, 4300:13	leadership [3] - 4217:29, 4306:18, 4306:19	4269:26, 4269:39, 4270:6, 4270:15, 4270:30, 4270:42, 4271:31, 4273:19, 4275:23, 4279:19, 4281:7, 4283:20, 4284:22, 4284:33, 4291:8, 4294:23	4233:14, 4233:24, 4281:23	look [53] - 4191:22, 4191:39, 4191:40, 4191:41, 4197:32, 4202:9, 4202:36, 4202:37, 4203:29, 4203:30, 4203:33, 4204:8, 4207:37, 4209:20, 4211:5, 4212:7, 4212:40, 4213:4, 4214:9, 4215:3, 4218:33, 4223:13, 4225:21, 4229:10, 4230:40, 4232:17, 4234:45, 4238:17, 4239:39, 4244:47, 4245:31, 4255:38, 4256:2, 4256:4, 4256:27, 4264:13, 4264:14, 4264:23, 4269:34, 4269:36, 4271:2, 4272:30, 4273:44, 4276:21, 4276:22, 4276:26, 4277:16, 4280:37, 4294:38, 4294:45
known [3] - 4219:6, 4220:10, 4223:33	leading [1] - 4258:43	levels [7] - 4190:20, 4285:28, 4286:20, 4286:27, 4286:31, 4286:34, 4287:6	linked [1] - 4199:27	live [3] - 4210:10, 4263:3, 4263:8
knows [1] - 4257:25	learn [2] - 4238:5, 4239:16	LHD [19] - 4196:33, 4222:39, 4252:21, 4252:36, 4265:16, 4269:5, 4269:33, 4273:23, 4273:33, 4275:42, 4275:43, 4278:8, 4278:46, 4278:47, 4284:19, 4284:42, 4288:35, 4291:30, 4295:14	links [2] - 4233:4, 4280:24	live-in [1] - 4210:10
KPI [1] - 4265:35	learned [1] - 4298:28	LHDs [23] - 4249:18, 4249:23, 4249:30, 4249:32, 4249:38, 4250:8, 4250:11, 4251:1, 4251:27, 4252:41, 4254:44, 4255:7, 4258:4, 4260:21, 4260:41, 4262:29, 4264:43, 4264:47, 4265:25, 4265:39, 4278:12, 4292:16	list [3] - 4197:42, 4225:22, 4244:23	lives [1] - 4249:3
KPIs [1] - 4265:38	learning [1] - 4185:31	LHDs' [1] - 4246:12	listed [3] - 4185:44, 4187:7, 4190:3	Lloyd [2] - 4296:35, 4297:14
Kruk [1] - 4264:14	learnings [1] - 4235:38	liaise [1] - 4278:3	listen [1] - 4214:47	LLOYD [1] - 4297:8
	least [16] - 4200:17, 4221:8, 4243:44, 4244:17, 4246:37, 4246:43, 4249:37, 4257:7, 4257:41, 4263:22, 4263:39, 4270:4, 4284:23, 4286:32, 4302:27, 4303:15	library [2] - 4201:16, 4203:31	listening [1] - 4222:47	load [2] - 4225:32, 4291:29
L	leave [6] - 4213:16, 4246:37, 4252:10, 4271:14, 4300:46	life [3] - 4299:16, 4299:28, 4305:5	lists [2] - 4225:17, 4231:3	local [2] - 4225:32, 4291:29
laboriously [1] - 4286:19	leaving [5] - 4186:20, 4188:6, 4208:21, 4216:44, 4304:33	lifelong [2] - 4185:31, 4301:23	live [3] - 4210:10, 4263:3, 4263:8	Local [4] - 4268:19, 4282:15, 4282:24, 4283:26
lack [7] - 4186:35, 4215:33, 4215:44, 4223:21, 4223:22, 4229:13, 4265:22	led [4] - 4209:39, 4210:27, 4229:45, 4230:37	lifestyle [1] - 4300:40	live-in [1] - 4210:10	local [23] - 4205:38, 4209:26, 4215:45, 4228:45, 4229:40, 4230:33, 4230:34, 4244:29, 4258:15, 4264:36, 4264:38, 4269:10, 4278:26, 4283:12, 4283:40, 4284:3, 4284:23, 4284:24, 4288:18, 4289:4, 4289:23, 4304:23
lady [1] - 4260:36	left [3] - 4244:23, 4305:18, 4305:45	limb [1] - 4203:4	lives [1] - 4249:3	locally [1] - 4279:12
language [1] - 4186:23	legal [2] - 4305:33, 4305:43	limit [1] - 4248:41	Lloyd [2] - 4296:35, 4297:14	location [7] - 4231:1, 4248:26, 4248:28, 4249:12, 4249:13, 4260:5, 4265:17
large [6] - 4205:9, 4233:18, 4233:19, 4238:46, 4246:44	less [11] - 4233:11, 4233:12, 4246:17, 4247:28, 4256:36, 4260:3, 4273:19, 4274:22, 4300:45	limited [5] - 4259:25, 4259:37, 4260:2, 4263:32, 4264:7	load [2] - 4225:32, 4291:29	local [23] - 4205:38, 4209:26, 4215:45, 4228:45, 4229:40, 4230:33, 4230:34, 4244:29, 4258:15, 4264:36, 4264:38, 4269:10, 4278:26, 4283:12, 4283:40, 4284:3, 4284:23, 4284:24, 4288:18, 4289:4, 4289:23, 4304:23
larger [1] - 4275:45	less-populated [1] - 4274:22	Linda [2] - 4241:42, 4242:7	load [2] - 4225:32, 4291:29	local [23] - 4205:38, 4209:26, 4215:45, 4228:45, 4229:40, 4230:33, 4230:34, 4244:29, 4258:15, 4264:36, 4264:38, 4269:10, 4278:26, 4283:12, 4283:40, 4284:3, 4284:23, 4284:24, 4288:18, 4289:4, 4289:23, 4304:23
last [33] - 4184:33, 4201:34, 4210:47, 4211:2, 4212:16, 4213:3, 4213:13, 4217:27, 4217:28, 4217:42, 4220:25, 4220:27, 4223:24, 4227:2, 4235:10, 4243:37, 4244:20, 4250:40, 4253:23, 4255:43, 4275:38, 4278:16, 4281:2, 4283:35, 4287:18, 4287:38, 4289:16, 4290:41, 4292:8, 4295:33, 4295:39, 4296:44, 4300:43	lessen [1] - 4291:29	line [6] - 4198:11, 4216:23, 4216:36, 4235:25, 4266:37, 4271:39	load [2] - 4225:32, 4291:29	local [23] - 4205:38, 4209:26, 4215:45, 4228:45, 4229:40, 4230:33, 4230:34, 4244:29, 4258:15, 4264:36, 4264:38, 4269:10, 4278:26, 4283:12, 4283:40, 4284:3, 4284:23, 4284:24, 4288:18, 4289:4, 4289:23, 4304:23
last-ditch [1] - 4217:27	lesser [2] - 4291:28, 4292:6	lines [1] - 4288:30	load [2] - 4225:32, 4291:29	local [23] - 4205:38, 4209:26, 4215:45, 4228:45, 4229:40, 4230:33, 4230:34, 4244:29, 4258:15, 4264:36, 4264:38, 4269:10, 4278:26, 4283:12, 4283:40, 4284:3, 4284:23, 4284:24, 4288:18, 4289:4, 4289:23, 4304:23
lastly [3] - 4288:7, 4292:29, 4293:37	lesson [1] - 4230:11	link [4] - 4188:18,	load [2] - 4225:32, 4291:29	local [23] - 4205:38, 4209:26, 4215:45, 4228:45, 4229:40, 4230:33, 4230:34, 4244:29, 4258:15, 4264:36, 4264:38, 4269:10, 4278:26, 4283:12, 4283:40, 4284:3, 4284:23, 4284:24, 4288:18, 4289:4, 4289:23, 4304:23
late [2] - 4223:17, 4241:12	letter [7] - 4183:28, 4240:24, 4240:31, 4240:32, 4241:8, 4241:9		load [2] - 4225:32, 4291:29	local [23] - 4205:38, 4209:26, 4215:45, 4228:45, 4229:40, 4230:33, 4230:34, 4244:29, 4258:15, 4264:36, 4264:38, 4269:10, 4278:26, 4283:12, 4283:40, 4284:3, 4284:23, 4284:24, 4288:18, 4289:4, 4289:23, 4304:23
latter [2] - 4288:42, 4288:44	Level [1] - 4182:18		load [2] - 4225:32, 4291:29	local [23] - 4205:38, 4209:26, 4215:45, 4228:45, 4229:40, 4230:33, 4230:34, 4244:29, 4258:15, 4264:36, 4264:38, 4269:10, 4278:26, 4283:12, 4283:40, 4284:3, 4284:23, 4284:24, 4288:18, 4289:4, 4289:23, 4304:23
laying [1] - 4249:4	level [38] - 4189:6, 4189:14, 4190:19, 4190:23, 4190:24, 4202:31, 4206:4, 4209:34, 4213:29, 4215:31, 4215:42, 4216:10, 4216:37, 4217:22, 4217:33, 4250:36, 4251:2, 4252:40, 4263:32, 4269:11, 4269:18,		load [2] - 4225:32, 4291:29	local [23] - 4205:38, 4209:26, 4215:45, 4228:45, 4229:40, 4230:33, 4230:34, 4244:29, 4258:15, 4264:36, 4264:38, 4269:10, 4278:26, 4283:12, 4283:40, 4284:3, 4284:23, 4284:24, 4288:18, 4289:4, 4289:23, 4304:23
lead [2] - 4228:27, 4258:23			load [2] - 4225:32, 4291:29	local [23] - 4205:38, 4209:26, 4215:45, 4228:45, 4229:40, 4230:33, 4230:34, 4244:29, 4258:15, 4264:36, 4264:38, 4269:10, 4278:26, 4283:12, 4283:40, 4284:3, 4284:23, 4284:24, 4288:18, 4289:4, 4289:23, 4304:23
leader [3] - 4184:34, 4191:26, 4235:11			load [2] - 4225:32, 4291:29	local [23] - 4205:38, 4209:26, 4215:45, 4228:45, 4229:40, 4230:33, 4230:34, 4244:29, 4258:15, 4264:36, 4264:38, 4269:10, 4278:26, 4283:12, 4283:40, 4284:3, 4284:23, 4284:24, 4288:18, 4289:4, 4289:23, 4304:23
leaders [3] - 4189:21, 4206:36, 4235:17			load [2] - 4225:32, 4291:29	local [23] - 4205:38, 4209:26, 4215:45, 4228:45, 4229:40, 4230:33, 4230:34, 4244:29, 4258:15, 4264:36, 4264:38, 4269:10, 4278:26, 4283:12, 4283:40, 4284:3, 4284:23, 4284:24, 4288:18, 4289:4, 4289:23, 4304:23

lucky [1] - 4231:26
lucrative [1] - 4246:39

M

M&M [2] - 4233:13,
 4233:44

machine [2] -
 4299:41, 4300:24

machinery [1] -
 4302:19

MacPherson [4] -
 4241:43, 4242:1,
 4242:5, 4242:7

Macquarie [1] -
 4182:18

macro [1] - 4270:42

main [2] - 4256:7,
 4301:27

maintain [5] -
 4185:29, 4251:2,
 4251:15, 4265:32,
 4270:30

major [6] - 4206:37,
 4215:13, 4231:3,
 4232:5, 4281:2,
 4292:32

majority [3] - 4195:30,
 4237:42, 4246:24

maldistribution [4] -
 4197:35, 4199:17,
 4206:18, 4254:9

male [1] - 4192:3

male-dominated [1] -
 4192:3

mammography [1] -
 4299:15

manage [3] - 4251:8,
 4259:1, 4266:19

managed [8] -
 4223:39, 4230:39,
 4245:22, 4247:46,
 4254:29, 4254:30,
 4254:40, 4269:11

management [7] -
 4185:4, 4216:3,
 4217:22, 4253:33,
 4255:29, 4258:16,
 4292:9

managerial [2] -
 4232:12, 4232:33

managers [1] -
 4189:32

manages [2] -
 4254:35, 4261:33

managing [3] -
 4216:9, 4255:39,
 4256:42

mandated [1] -
 4194:45

map [1] - 4244:39

March [1] - 4220:34

market [2] - 4208:34,
 4292:4

marking [3] - 4205:8,
 4205:14, 4205:26

marks [1] - 4304:35

massive [1] - 4194:27

masters [1] - 4232:22

match [7] - 4237:45,
 4261:33, 4261:43,
 4262:9, 4262:33,
 4262:35, 4285:46

matches [2] - 4261:43,
 4262:5

matching [3] -
 4261:36, 4262:10,
 4262:18

material [3] - 4258:32,
 4296:10, 4299:2

matter [1] - 4293:13

matters [9] - 4216:1,
 4216:3, 4216:9,
 4216:42, 4218:4,
 4218:11, 4235:44,
 4259:8, 4274:43

maturity [1] - 4191:31

maximises [1] -

4255:25

McDonald [2] -

4300:3, 4300:9

McGirr [1] - 4228:41

mean [43] - 4185:27,

4187:19, 4192:2,

4192:28, 4195:12,

4196:12, 4198:5,

4198:26, 4198:28,

4198:39, 4205:33,

4207:30, 4207:31,

4210:42, 4211:37,

4211:42, 4213:13,

4214:37, 4215:32,

4216:27, 4220:35,

4222:18, 4222:25,

4223:1, 4223:7,

4224:4, 4224:17,

4227:38, 4229:31,

4240:16, 4246:14,

4248:46, 4250:2,

4255:17, 4260:19,

4261:35, 4279:24,

4292:10, 4292:11,

4295:45, 4298:21,

4299:14, 4306:17

meaning [1] - 4299:17

means [5] - 4186:28,

4260:6, 4264:6,

4294:37, 4299:21

meant [3] - 4231:9,

4265:4, 4305:14

measure [3] -

4219:12, 4219:13,
 4219:17

measures [2] -

4219:18, 4219:21

mechanism [4] -

4194:43, 4244:12,

4248:24, 4264:31

Medical [9] - 4188:36,

4200:43, 4244:35,

4244:45, 4258:8,

4258:35, 4258:43,

4267:12, 4282:20

medical [63] -

4186:15, 4186:20,

4186:37, 4187:11,

4188:20, 4195:44,

4196:6, 4201:23,

4202:1, 4206:33,

4206:34, 4206:40,

4210:11, 4210:12,

4213:19, 4216:34,

4217:12, 4224:38,

4224:43, 4228:42,

4228:46, 4232:8,

4232:9, 4235:8,

4235:21, 4238:38,

4238:42, 4239:6,

4239:10, 4242:17,

4243:26, 4243:34,

4243:47, 4244:9,

4244:40, 4246:26,

4247:34, 4248:7,

4257:18, 4262:3,

4263:5, 4263:45,

4263:46, 4264:5,

4264:21, 4264:32,

4268:18, 4269:3,

4271:41, 4274:31,

4277:15, 4277:20,

4281:22, 4282:15,

4283:13, 4285:45,

4286:13, 4289:15,

4291:18, 4292:18,

4292:30, 4293:2

medically [1] -

4283:47

Medicare [13] -

4299:17, 4299:20,

4299:21, 4299:25,

4299:27, 4302:25,

4302:27, 4302:34,

4302:42, 4303:2,

4303:3, 4303:27,

4303:37

Medicare's [3] -

4302:20, 4303:15,

4304:1

medicine [14] -

4194:38, 4223:44,

4224:40, 4248:9,

4254:4, 4254:7,

4254:9, 4274:36,

4283:36, 4286:9,

4287:11, 4288:34,

4290:39, 4291:9

Medicine [1] - 4286:11

meet [16] - 4200:27,

4206:35, 4240:1,

4243:35, 4243:47,

4244:35, 4250:42,

4253:34, 4253:36,

4253:42, 4253:45,

4272:40, 4286:3,

4295:20, 4303:32

meeting [10] -

4205:17, 4241:4,

4267:20, 4267:23,

4267:29, 4287:28,

4304:3, 4304:17,

4304:32, 4306:13

meetings [6] -

4196:20, 4211:23,

4211:25, 4241:2,

4277:10, 4278:12

meets [6] - 4240:47,

4261:6, 4261:9,

4261:29, 4262:31

Melbourne [2] -

4226:16, 4226:19

member [3] - 4192:22,

4228:40, 4228:41

members [11] -

4185:30, 4188:26,

4188:30, 4189:32,

4190:17, 4205:10,

4205:47, 4215:2,

4217:8, 4239:19,

4284:43

membership [3] -

4185:27, 4239:23,

4239:38

memory [1] - 4304:35

mention [2] - 4201:5,

4301:33

mentioned [13] -

4189:15, 4190:29,

4193:41, 4196:31,

4204:41, 4214:33,

4214:40, 4217:37,

4222:38, 4235:6,

4239:25, 4276:35,

4305:24

mentoring [2] -

4264:7, 4266:15

merely [1] - 4255:8

merit [2] - 4261:5,

4261:8

message [2] - 4252:9,

4305:35

met [1] - 4250:45

method [1] - 4279:39

methods [1] - 4284:9

metro [11] - 4224:30,

4224:31, 4231:33,

4248:41, 4249:4,

4254:10, 4259:45,

4259:46, 4273:12,

4273:20, 4274:7

metro-centric [5] -

4224:30, 4224:31,

4248:41, 4273:12,

4273:20

metropolitan [7] -

4199:26, 4233:14,

4233:17, 4259:43,

4262:38, 4262:41,

4262:46

micro [1] - 4270:42

mid [1] - 4206:1

mid-tier [1] - 4206:1

middle [3] - 4201:33,

4257:16, 4300:35

might [56] - 4196:20,

4197:17, 4197:19,

4202:1, 4205:18,

4214:41, 4224:11,

4226:29, 4234:22,

4239:11, 4243:41,

4244:38, 4245:46,

4245:47,

- Ministry** ^[1] - 4242:11
ministry ^[39] -
 4246:43, 4246:44,
 4247:3, 4247:20,
 4249:29, 4249:46,
 4250:36, 4251:8,
 4251:18, 4251:28,
 4252:40, 4252:44,
 4253:12, 4255:7,
 4255:13, 4255:21,
 4255:45, 4256:32,
 4256:33, 4256:44,
 4257:11, 4257:20,
 4257:24, 4260:16,
 4260:28, 4261:26,
 4262:28, 4264:11,
 4264:28, 4264:31,
 4264:43, 4265:13,
 4273:2, 4275:15,
 4275:18, 4275:21,
 4292:11, 4292:12,
 4303:17
ministry's ^[4] -
 4246:12, 4258:3,
 4258:4, 4259:13
minor ^[2] - 4183:43,
 4301:6
minuted ^[2] - 4211:22,
 4211:23
minutes ^[4] - 4211:26,
 4225:45, 4226:27,
 4226:29
mismatch ^[3] -
 4253:29, 4253:34,
 4253:39
mismatched ^[1] -
 4198:14
mispronouncing ^[1] -
 4184:42
miss ^[1] - 4184:1
missed ^[2] - 4301:22,
 4301:28
mitigate ^[1] - 4277:46
mix ^[10] - 4202:39,
 4202:45, 4203:29,
 4203:34, 4203:39,
 4209:21, 4238:20,
 4256:20, 4256:29
mmm-hmm ^[2] -
 4220:31, 4300:8
modalities ^[1] -
 4273:18
modality ^[1] - 4278:35
model ^[19] - 4201:24,
 4201:25, 4204:11,
 4204:25, 4217:9,
 4218:19, 4218:24,
 4228:22, 4228:30,
 4230:10, 4230:27,
 4258:45, 4262:16,
 4285:37, 4286:19,
 4286:41, 4286:47,
 4287:22, 4287:36
modelling ^[9] -
 4217:14, 4247:29,
 4252:45, 4252:46,
 4253:8, 4254:4,
 4254:5, 4284:28,
 4285:14
models ^[13] - 4207:32,
 4225:30, 4230:1,
 4230:3, 4230:7,
 4231:4, 4231:15,
 4231:20, 4264:15,
 4264:23, 4285:26,
 4286:9, 4287:10
modes ^[1] - 4273:16
modules ^[3] -
 4227:24, 4227:27,
 4227:30
MOH.0011.0019.0001
^[1] - 4268:34
MOH.0011.0020.0001
^[1] - 4243:23
MOH.0011.0032.0001
^[1] - 4243:21
moment ^[27] - 4186:5,
 4195:9, 4197:38,
 4198:10, 4198:17,
 4201:45, 4202:27,
 4202:28, 4204:32,
 4213:44, 4224:29,
 4224:40, 4225:7,
 4233:30, 4235:6,
 4236:30, 4237:1,
 4243:33, 4244:15,
 4255:33, 4257:8,
 4262:37, 4279:38,
 4290:24, 4290:37,
 4292:12, 4293:21
money ^[4] - 4197:6,
 4204:14, 4232:29,
 4303:7
moneys ^[1] - 4303:45
monitoring ^[4] -
 4250:41, 4250:44,
 4251:1, 4251:14
monologue ^[1] -
 4306:3
months ^[4] - 4198:13,
 4281:2, 4284:38,
 4303:18
morning ^[9] - 4183:1,
 4183:3, 4183:4,
 4183:19, 4226:1,
 4271:45, 4296:46,
 4300:37, 4300:38
most ^[9] - 4195:25,
 4216:34, 4229:39,
 4233:30, 4245:11,
 4247:40, 4288:28,
 4300:46, 4302:1
mostly ^[1] - 4301:36
mountain ^[1] -
 4219:38
MOUs ^[1] - 4216:15
move ^[6] - 4193:25,
 4200:7, 4264:26,
 4273:44, 4274:30,
 4278:33
moved ^[1] - 4193:18
movement ^[2] -
 4255:5, 4255:15
moving ^[4] - 4191:28,
 4255:24, 4256:33,
 4293:24
MRI ^[3] - 4270:16,
 4270:18, 4299:33
multi ^[2] - 4205:17,
 4237:2
multi-college ^[1] -
 4237:2
multi-interviews ^[1] -
 4205:17
multifactorial ^[1] -
 4222:14
multiple ^[12] - 4203:1,
 4203:5, 4203:25,
 4204:5, 4205:18,
 4223:34, 4235:20,
 4262:11, 4262:24,
 4279:43, 4301:39,
 4301:40
MURPHY ^[1] - 4268:10
Murphy ^[7] - 4235:4,
 4235:7, 4251:35,
 4251:44, 4268:8,
 4268:14, 4268:16
must ^[1] - 4294:36
Muston ^[5] - 4182:26,
 4252:16, 4267:1,
 4267:5, 4302:8
MUSTON ^[26] -
 4241:42, 4242:3,
 4242:5, 4242:46,
 4243:4, 4243:17,
 4251:31, 4251:38,
 4251:44, 4252:3,
 4252:12, 4252:18,
 4266:44, 4296:35,
 4296:43, 4297:3,
 4297:10, 4297:12,
 4298:9, 4298:16,
 4302:11, 4302:16,
 4302:18, 4304:10,
 4306:39, 4307:23
Muston's ^[1] -
 4304:13

N

name ^[8] - 4183:17,
 4184:42, 4224:40,
 4242:6, 4268:15,
 4282:8, 4297:12,
 4304:21
narcissism ^[1] -
 4233:35
narrow ^[2] - 4203:10,
 4256:18
nation ^[1] - 4286:42
National ^[3] - 4200:36,
 4235:12, 4258:36
national ^[18] - 4206:6,
 4206:8, 4206:16,
 4206:24, 4206:37,
 4209:39, 4210:23,
 4220:16, 4221:41,
 4222:46, 4232:46,
 4234:24, 4235:4,
 4235:8, 4244:10,
 4260:9, 4269:11,
 4276:10
national-wide ^[1] -
 4220:16
nationally ^[5] -
 4210:45, 4215:37,
 4216:24, 4235:7,
 4264:1
nature ^[5] - 4189:41,
 4215:25, 4215:28,
 4280:45, 4288:21
nearby ^[1] - 4230:25
necessarily ^[5] -
 4270:25, 4273:14,
 4280:16, 4281:28,
 4286:41
necessary ^[4] -
 4200:16, 4298:33,
 4301:45, 4301:46
need ^[95] - 4186:23,
 4188:21, 4188:36,
 4192:14, 4193:8,
 4193:24, 4194:30,
 4194:42, 4196:20,
 4199:28, 4199:46,
 4200:1, 4202:10,
 4202:13, 4202:36,
 4202:45, 4203:12,
 4203:17, 4204:7,
 4206:15, 4206:24,
 4206:25, 4206:28,
 4208:32, 4211:7,
 4211:8, 4212:11,
 4212:12, 4213:45,
 4218:29, 4222:15,
 4223:6, 4223:18,
 4223:31, 4224:24,
 4224:25, 4224:37,
 4225:8, 4225:12,
 4225:22, 4225:27,
 4225:28, 4225:34,
 4227:15, 4228:29,
 4228:32, 4232:22,
 4232:27, 4232:29,
 4232:43, 4233:21,
 4233:40, 4235:27,
 4235:32, 4236:35,
 4238:4, 4238:34,
 4239:43, 4240:24,
 4243:31, 4243:41,
 4244:30, 4253:1,
 4253:32, 4254:26,
 4255:38, 4261:16,
 4261:17, 4263:37,
 4264:12, 4264:14,
 4264:23, 4265:13,
 4272:39, 4273:11,
 4273:40, 4274:20,
 4276:15, 4279:3,
 4285:31, 4285:38,
 4294:11, 4294:28,
 4294:37, 4296:25,
 4298:32, 4298:37,
 4298:41, 4299:3,
 4306:14, 4307:8
needed ^[8] - 4201:37,
 4202:8, 4208:44,
 4209:36, 4239:47,
 4286:5, 4304:42,
 4307:11
needing ^[2] - 4208:40,
 4255:44
needless ^[1] - 4304:5
needs ^[34] - 4199:13,
 4199:27, 4200:28,
 4202:5, 4208:41,
 4209:11, 4219:33,
 4223:31, 4223:32,
 4223:47, 4231:16,
 4240:1, 4243:36,
 4244:1, 4244:8,
 4244:28, 4248:16,
 4250:33, 4252:21,
 4252:26, 4253:35,
 4253:43, 4261:29,
 4262:32, 4269:10,
 4270:5, 4270:46,
 4284:2, 4284:23,
 4284:28, 4285:26,
 4285:27, 4285:33,
 4291:4
negative ^[3] - 4295:46,
 4305:13
negotiate ^[1] -
 4243:45
network ^[16] -
 4250:14, 4254:18,
 4254:20, 4254:22,

- 4254:23, 4254:24,
4254:40, 4254:41,
4256:41, 4261:29,
4262:8, 4262:17,
4262:30, 4263:41,
4276:18, 4285:6
- networking** [2] -
4254:13, 4255:14
- networks** [16] -
4231:32, 4231:36,
4254:39, 4255:6,
4255:15, 4255:18,
4255:24, 4256:13,
4256:34, 4256:45,
4257:5, 4257:8,
4262:6, 4288:24,
4288:34
- neurology** [2] -
4289:15, 4289:16
- neurosurgery** [1] -
4249:6
- never** [3] - 4196:42,
4196:43, 4306:2
- new** [10] - 4201:12,
4202:23, 4203:22,
4217:34, 4217:46,
4239:13, 4257:5,
4292:14, 4293:24,
4295:40
- New** [35] - 4182:19,
4185:3, 4192:4,
4195:34, 4195:38,
4195:45, 4197:3,
4197:30, 4205:28,
4210:46, 4220:21,
4220:26, 4229:18,
4231:41, 4232:16,
4232:37, 4234:15,
4237:35, 4237:44,
4242:11, 4244:17,
4244:20, 4250:6,
4259:7, 4263:47,
4279:20, 4279:25,
4279:31, 4280:12,
4280:31, 4292:16,
4293:17, 4293:40,
4295:41
- news** [1] - 4240:46
- next** [17] - 4229:22,
4230:18, 4230:27,
4237:3, 4241:42,
4244:8, 4249:15,
4251:7, 4260:36,
4268:8, 4278:31,
4278:32, 4278:34,
4278:42, 4281:47,
4295:19, 4296:35
- NHPO** [7] - 4201:21,
4201:28, 4202:21,
4203:23, 4204:26,
4204:27, 4215:37
- night** [2] - 4238:29,
4300:35
- nine** [2] - 4185:40,
4189:20
- nods** [10] - 4259:35,
4260:31, 4271:18,
4283:23, 4284:15,
4284:34, 4288:25,
4291:44, 4292:41,
4293:7
- nomenclature** [1] -
4189:44
- nominal** [1] - 4239:39
- nominate** [1] -
4188:25
- non** [7] - 4221:29,
4227:44, 4245:28,
4274:7, 4274:31,
4280:2, 4280:18
- non-clinical** [3] -
4274:31, 4280:2,
4280:18
- non-clinician** [1] -
4221:29
- non-metro** [1] -
4274:7
- non-specialist** [1] -
4245:28
- none** [1] - 4299:42
- noon** [2] - 4226:6,
4226:35
- norm** [1] - 4280:13
- normal** [1] - 4194:32
- normally** [5] - 4213:7,
4213:9, 4214:38,
4299:39, 4299:41
- Northern** [1] - 4206:15
- note** [3] - 4243:37,
4251:31, 4296:36
- nothing** [9] - 4197:6,
4204:23, 4210:19,
4218:13, 4218:42,
4223:41, 4241:18,
4281:2, 4299:24
- nothing's** [1] -
4212:44
- notice** [9] - 4221:16,
4244:3, 4246:46,
4253:16, 4257:38,
4257:44, 4283:29,
4283:30, 4299:36
- Notre** [2] - 4228:46,
4232:16
- November** [2] -
4217:42, 4217:44
- NPs** [1] - 4291:35
- NSW** [33] - 4182:35,
4198:13, 4205:39,
4205:42, 4205:47,
4206:36, 4208:42,
4208:45, 4209:40,
4210:15, 4210:28,
4210:38, 4210:40,
4210:41, 4211:3,
4211:32, 4212:10,
4212:17, 4212:35,
4212:39, 4225:25,
4226:28, 4228:9,
4234:16, 4239:28,
4240:10, 4240:18,
4242:18, 4243:44,
4280:6, 4280:20,
4298:11, 4301:44
- nuance** [3] - 4185:20,
4191:2, 4193:5
- nuanced** [1] - 4200:11
- nuances** [1] - 4202:47
- number** [86] -
4197:18, 4207:14,
4208:35, 4209:16,
4209:28, 4209:34,
4211:6, 4212:8,
4212:42, 4219:5,
4219:9, 4220:1,
4220:9, 4222:10,
4233:18, 4233:19,
4235:37, 4235:39,
4236:1, 4237:24,
4238:1, 4238:2,
4238:46, 4243:26,
4244:22, 4244:27,
4244:29, 4248:10,
4248:32, 4249:19,
4249:46, 4250:41,
4251:16, 4253:5,
4253:31, 4253:34,
4253:35, 4256:9,
4256:23, 4256:45,
4259:30, 4259:37,
4260:2, 4263:11,
4263:40, 4267:38,
4269:2, 4269:9,
4269:43, 4269:46,
4270:4, 4270:12,
4270:39, 4270:44,
4271:5, 4271:16,
4271:26, 4271:39,
4271:46, 4272:25,
4273:9, 4273:28,
4276:25, 4283:16,
4285:41, 4285:46,
4286:21, 4287:13,
4288:17, 4288:22,
4288:45, 4289:2,
4289:39, 4293:38,
4293:44, 4297:42,
4301:2, 4301:5,
4303:18, 4303:38,
4303:39, 4303:42,
4303:46, 4305:6
- numbers** [13] -
4202:46, 4206:14,
4207:37, 4209:3,
4209:8, 4211:5,
4212:47, 4237:36,
4237:37, 4269:17,
4269:25, 4285:46,
4288:40
- nurse** [9] - 4287:27,
4287:32, 4287:45,
4287:46, 4288:1,
4288:4, 4291:32,
4291:34
- nurses** [3] - 4217:2,
4279:44, 4296:6
- nursing** [2] - 4274:31,
4304:19
-
- O**
-
- o'clock** [5] - 4226:33,
4252:1, 4300:37,
4307:25
- oath** [1] - 4195:18
- obesity** [1] - 4223:35
- objective** [1] - 4199:38
- obligations** [1] -
4191:4
- observation** [5] -
4259:24, 4265:42,
4275:19, 4277:43,
4285:4
- observations** [2] -
4273:7, 4275:8
- observed** [1] -
4274:45
- obsolescence** [1] -
4302:19
- obsolete** [3] -
4299:14, 4299:15,
4302:27
- obstetricians** [2] -
4276:24, 4285:31
- obstetrics** [4] -
4237:1, 4279:11,
4279:14, 4290:26
- obtain** [1] - 4186:21
- obtained** [2] -
4287:47, 4290:17
- obtaining** [2] -
4237:30, 4240:10
- obvious** [1] - 4295:12
- obviously** [17] -
4185:33, 4203:9,
4207:31, 4208:3,
4215:47, 4224:33,
4228:28, 4232:37,
4232:41, 4236:35,
4255:28, 4256:29,
4260:40, 4265:30,
4266:8, 4285:34,
4303:7
- occasions** [2] -
4214:34, 4306:14
- occupancy** [1] -
4216:30
- occupation** [1] -
4230:40
- occupies** [1] -
4254:45
- occur** [2] - 4191:6,
4260:40
- occurred** [1] - 4215:10
- occurs** [1] - 4190:33
- October** [6] - 4204:37,
4236:18, 4236:31,
4236:33, 4242:14,
4293:24
- OF** [1] - 4307:28
- offender** [1] - 4215:4
- offer** [5] - 4203:7,
4251:17, 4262:9,
4262:25, 4279:43
- offered** [4] - 4186:30,
4204:2, 4209:12,
4293:16
- offering** [4] - 4271:2,
4273:44, 4289:13,
4289:22
- offers** [4] - 4185:38,
4262:11, 4262:24,
4289:5
- office** [2] - 4195:43,
4223:2
- officer** [9] - 4184:43,
4184:45, 4196:6,
4238:38, 4238:43,
4239:7, 4239:10,
4262:3, 4265:1
- officers** [2] - 4291:18,
4292:30
- often** [29] - 4199:25,
4200:2, 4200:5,
4202:18, 4206:26,
4207:38, 4215:22,
4223:18, 4230:19,
4232:20, 4232:24,
4232:30, 4237:40,
4238:25, 4238:32,
4239:2, 4258:13,
4263:6, 4263:31,
4264:5, 4270:1,
4274:11, 4274:15,
4274:34, 4274:37,
4274:40, 4284:9,
4289:11, 4305:44
- old** [3] - 4225:20,
4282:40, 4299:22
- older** [1] - 4263:6
- Ombudsman** [3] -

- 4200:37, 4258:37, 4259:14
- ombudsman** [2] - 4204:24, 4204:27
- ombudsman's** [1] - 4258:41
- once** [3] - 4203:45, 4210:2, 4245:37
- oncology** [4] - 4265:47, 4289:15, 4293:42, 4295:27
- one** [86] - 4183:17, 4186:22, 4190:42, 4191:43, 4201:13, 4201:47, 4202:1, 4202:6, 4204:41, 4205:44, 4209:7, 4215:9, 4215:12, 4216:17, 4221:41, 4224:10, 4224:13, 4228:9, 4229:43, 4230:14, 4230:39, 4232:1, 4233:14, 4239:3, 4239:7, 4243:22, 4244:31, 4244:39, 4244:40, 4245:37, 4247:9, 4249:23, 4252:22, 4253:6, 4255:1, 4255:42, 4256:7, 4257:3, 4258:9, 4258:13, 4258:30, 4260:7, 4260:9, 4262:6, 4262:9, 4262:11, 4262:25, 4263:4, 4263:28, 4264:4, 4264:23, 4264:33, 4265:18, 4267:26, 4270:10, 4277:4, 4278:27, 4279:6, 4279:39, 4280:25, 4282:40, 4285:27, 4285:30, 4286:41, 4287:9, 4287:13, 4287:19, 4287:27, 4287:47, 4288:5, 4288:13, 4289:35, 4290:26, 4290:27, 4292:12, 4294:41, 4298:27, 4298:29, 4298:30, 4298:36, 4300:25, 4301:30, 4302:11, 4303:10, 4305:3, 4305:32
- one-off** [1] - 4215:9
- onerous** [5] - 4196:26, 4201:31, 4210:15, 4234:1
- ones** [6] - 4208:5, 4225:20, 4230:14, 4305:26, 4305:33
- ongoing** [3] - 4185:30, 4207:18, 4235:23
- onus** [1] - 4233:17
- onwards** [1] - 4283:11
- open** [1] - 4227:41
- opened** [1] - 4239:35
- operate** [3] - 4197:16, 4197:17, 4254:18
- operating** [6] - 4198:5, 4198:6, 4209:10, 4225:32, 4258:33, 4285:47
- operation** [2] - 4301:25
- operations** [4] - 4184:47, 4252:39, 4270:28, 4270:31
- operator** [1] - 4271:13
- operators** [1] - 4243:20
- opinion** [6] - 4220:16, 4220:21, 4221:47, 4291:42, 4293:14, 4301:12
- opportunities** [23] - 4235:38, 4248:35, 4248:42, 4248:43, 4249:7, 4249:9, 4256:5, 4256:10, 4256:11, 4260:7, 4260:10, 4261:31, 4271:2, 4272:31, 4273:4, 4273:9, 4273:45, 4274:16, 4277:47, 4278:44, 4289:22, 4289:23, 4289:25
- opportunity** [12] - 4183:35, 4184:11, 4217:22, 4217:38, 4238:37, 4239:21, 4242:38, 4243:8, 4246:28, 4260:16, 4298:1, 4306:8
- opposed** [5] - 4185:19, 4247:5, 4257:28, 4261:30, 4283:16
- optimum** [1] - 4280:34
- option** [2] - 4264:24, 4304:5
- options** [1] - 4247:26
- Orange** [1] - 4232:1
- order** [7] - 4188:37, 4200:14, 4214:5, 4214:44, 4245:7, 4284:4, 4299:34
- organically** [1] - 4233:46
- organisation** [10] - 4184:47, 4185:5, 4185:28, 4190:18, 4191:5, 4191:32, 4273:35, 4277:16, 4277:25, 4304:4
- organisations** [4] - 4208:14, 4254:34, 4269:30, 4280:16
- organise** [5] - 4205:6, 4205:7, 4205:8, 4205:9, 4205:13
- organised** [1] - 4255:46
- Orthopaedic** [2] - 4190:45, 4254:36
- orthopaedic** [17] - 4191:22, 4191:24, 4192:2, 4192:13, 4192:23, 4192:27, 4192:38, 4193:10, 4193:14, 4193:25, 4197:41, 4202:10, 4202:40, 4224:18, 4224:19, 4225:1, 4254:37
- orthopaedics** [12] - 4191:19, 4192:15, 4192:33, 4197:24, 4201:37, 4202:2, 4202:9, 4202:38, 4203:3, 4227:17, 4237:5, 4239:15
- orthopaed** [3] - 4192:4, 4209:13, 4224:16
- orthopods** [1] - 4225:7
- osteoarthritis** [1] - 4225:26
- osteoporosis** [1] - 4223:38
- otherwise** [2] - 4278:1, 4294:18
- ought** [1] - 4259:14
- outcome** [5] - 4198:41, 4200:24, 4204:36, 4248:11, 4292:20
- outcomes** [18] - 4198:18, 4198:25, 4198:26, 4198:35, 4199:47, 4200:6, 4204:28, 4214:26, 4214:29, 4214:30, 4215:34, 4217:10, 4234:25, 4235:30, 4248:12, 4248:23, 4251:22
- outcomes-based** [2] - 4199:47, 4200:6
- outer** [1] - 4259:46
- outlier** [1] - 4191:7
- outline** [1] - 4293:38
- outlined** [5] - 4189:42, 4190:13, 4204:26, 4204:39, 4213:41
- outpatients** [2] - 4202:15, 4302:34
- outside** [5] - 4256:28, 4273:11, 4274:46, 4275:1, 4282:2
- overall** [6] - 4187:9, 4201:14, 4248:10, 4250:32, 4250:44, 4253:44
- overarching** [3] - 4184:34, 4185:18, 4216:35
- overcome** [1] - 4279:39
- overflow** [3] - 4230:20, 4230:28, 4230:39
- overload** [1] - 4236:42
- overnight** [3] - 4217:31, 4238:23, 4238:26
- overrun** [1] - 4229:15
- oversaw** [1] - 4278:18
- overseeing** [1] - 4217:28
- overseen** [2] - 4189:29, 4194:13
- oversight** [8] - 4185:4, 4185:34, 4185:36, 4189:23, 4190:19, 4191:33, 4205:30, 4276:36
- oversubscribed** [1] - 4259:42
- oversupply** [1] - 4233:2
- overtime** [1] - 4284:4
- overview** [2] - 4283:11, 4287:32
- Owen** [1] - 4183:29
- own** [9] - 4193:13, 4193:19, 4200:44, 4204:8, 4206:7, 4234:3, 4238:29, 4279:14, 4290:45
- paediatrics** [3] - 4256:6, 4256:18
- page** [18] - 4185:44, 4187:7, 4187:19, 4187:25, 4204:45, 4214:10, 4219:3, 4219:45, 4226:43, 4228:2, 4231:30, 4237:22, 4238:10, 4245:36, 4286:18, 4289:37
- pages** [1] - 4293:38
- paid** [7] - 4196:12, 4197:12, 4197:15, 4197:16, 4197:28, 4303:19, 4303:31
- pandemic** [1] - 4220:35
- paper** [7] - 4235:4, 4235:31, 4235:33, 4235:37, 4235:44, 4236:1, 4236:14
- paper** [1] - 4234:25
- papers** [1] - 4197:34
- paperwork** [4] - 4191:42, 4196:20, 4202:5, 4210:13
- parachuting** [1] - 4255:8
- paragraph** [63] - 4227:1, 4231:31, 4238:11, 4249:17, 4249:22, 4249:39, 4250:18, 4251:6, 4251:8, 4253:22, 4254:12, 4255:41, 4257:14, 4257:18, 4257:46, 4259:19, 4259:24, 4264:3, 4264:26, 4265:45, 4266:1, 4266:35, 4267:1, 4267:2, 4268:47, 4269:1, 4269:8, 4269:41, 4271:8, 4271:12, 4271:14, 4271:38, 4271:39, 4272:18, 4273:1, 4275:26, 4275:28, 4276:34, 4276:35, 4277:6, 4278:16, 4279:18, 4280:1, 4283:11, 4284:17, 4287:40, 4288:20, 4288:23, 4289:37, 4289:41, 4289:42, 4291:40, 4292:8, 4293:16, 4299:13, 4299:32, 4300:27, 4301:10, 4301:33, 4302:19,

P

- pack** [1] - 4191:44
- package** [1] - 4195:40
- paediatric** [4] - 4203:14, 4255:45, 4256:8, 4256:11

4304:16, 4304:31
paragraphs [10] -
4245:35, 4248:6,
4249:28, 4249:45,
4257:4, 4257:15,
4283:21, 4287:31,
4287:44, 4292:29
parameters [1] -
4271:21
parental [1] - 4246:33
parking [1] - 4203:32
parliament [1] -
4228:40
part [56] - 4185:8,
4190:18, 4190:47,
4192:17, 4192:18,
4195:17, 4195:20,
4195:21, 4196:11,
4196:13, 4196:16,
4201:31, 4213:17,
4215:35, 4217:6,
4217:7, 4217:8,
4217:13, 4217:14,
4217:15, 4217:17,
4217:37, 4218:14,
4223:21, 4225:4,
4227:38, 4229:14,
4231:12, 4238:38,
4239:11, 4244:30,
4246:43, 4247:26,
4247:28, 4249:12,
4256:32, 4257:15,
4261:17, 4262:27,
4263:46, 4265:14,
4265:15, 4267:4,
4267:40, 4271:31,
4274:37, 4275:20,
4276:18, 4278:3,
4283:4, 4284:46,
4285:9, 4300:15,
4300:32, 4302:45
part-time [2] -
4247:26, 4247:28
participate [1] -
4269:31
particular [38] -
4188:20, 4189:43,
4193:5, 4193:10,
4203:35, 4209:17,
4209:29, 4218:29,
4228:31, 4230:9,
4230:10, 4244:6,
4251:2, 4252:30,
4252:35, 4253:5,
4254:1, 4257:25,
4257:42, 4264:46,
4264:47, 4266:32,
4270:34, 4273:32,
4275:40, 4276:42,
4278:35, 4280:39,
4285:28, 4286:1,
4287:26, 4289:26,
4291:8, 4293:11,
4293:30, 4302:26
particularly [22] -
4197:24, 4197:32,
4202:17, 4212:11,
4214:13, 4218:27,
4227:16, 4230:32,
4233:10, 4238:28,
4238:46, 4253:36,
4259:43, 4267:19,
4273:36, 4273:47,
4274:11, 4288:20,
4300:44, 4305:46,
4306:30, 4306:33
partnering [1] -
4189:45
partners [2] - 4263:7,
4278:32
partnership [2] -
4213:34, 4228:44
parts [2] - 4247:25,
4255:27
pass [5] - 4195:19,
4215:21, 4241:31,
4247:46, 4277:34
passage [1] - 4271:14
past [5] - 4192:16,
4215:5, 4215:21,
4239:32, 4254:4
pathway [7] - 4186:10,
4232:34, 4237:33,
4237:41, 4238:4,
4249:5, 4256:14
pathways [5] -
4186:16, 4255:20,
4257:21, 4274:40,
4277:9
patient [25] - 4200:11,
4214:26, 4214:29,
4214:30, 4215:34,
4217:10, 4219:35,
4260:36, 4270:32,
4280:25, 4280:42,
4281:5, 4281:26,
4281:29, 4302:29,
4302:31, 4302:32,
4302:40, 4303:1,
4303:3
patient's [2] -
4280:33, 4281:8
patients [24] -
4197:18, 4220:27,
4223:1, 4223:36,
4230:20, 4230:21,
4233:34, 4239:1,
4274:14, 4279:28,
4280:37, 4280:43,
4281:1, 4281:25,
4286:46, 4291:28,
4291:29, 4301:11,
4301:35, 4301:36,
4301:37, 4302:47,
4303:12, 4303:33
pause [3] - 4204:24,
4204:28, 4219:43
pausing [3] - 4221:46,
4225:39, 4276:12
pay [12] - 4194:29,
4197:7, 4211:43,
4211:44, 4231:14,
4233:34, 4292:17,
4299:21, 4299:24,
4300:44, 4302:25,
4303:4
paying [2] - 4211:44,
4232:25
payment [1] - 4303:3
payroll [2] - 4257:27,
4257:41
Pearce [4] - 4240:25,
4240:31, 4240:36,
4241:10
people [91] - 4192:16,
4193:23, 4195:3,
4205:44, 4206:2,
4206:25, 4206:26,
4207:33, 4207:34,
4207:38, 4208:31,
4209:2, 4213:15,
4213:16, 4213:17,
4215:24, 4215:45,
4216:29, 4220:41,
4221:13, 4222:11,
4222:21, 4223:6,
4223:7, 4223:14,
4223:23, 4223:27,
4223:34, 4224:25,
4224:27, 4224:28,
4224:38, 4224:45,
4225:26, 4228:24,
4228:29, 4228:31,
4229:41, 4230:17,
4230:23, 4230:31,
4230:37, 4231:22,
4232:20, 4232:33,
4233:32, 4233:41,
4235:27, 4237:41,
4239:4, 4239:19,
4239:38, 4244:22,
4244:23, 4245:11,
4245:20, 4245:31,
4246:25, 4246:30,
4247:4, 4247:13,
4247:16, 4247:21,
4247:23, 4247:24,
4248:25, 4248:27,
4255:15, 4255:35,
4255:36, 4255:47,
4256:3, 4256:14,
4256:17, 4258:19,
4258:30, 4261:36,
4261:43, 4262:11,
4263:2, 4263:8,
4264:11, 4290:4,
4290:41, 4292:2,
4300:45, 4306:5,
4306:7
per [12] - 4191:6,
4192:5, 4192:7,
4195:28, 4216:30,
4224:44, 4248:9,
4269:21, 4283:47,
4285:30, 4286:20,
4287:18
perceived [3] -
4244:1, 4279:33,
4305:19
perfectly [2] -
4198:24, 4209:2
perform [2] - 4191:4,
4194:32
performance [2] -
4266:23, 4266:25
performed [7] -
4190:30, 4190:38,
4204:42, 4204:44,
4214:15, 4218:22,
4220:45
performing [2] -
4190:31, 4306:5
perhaps [40] -
4185:21, 4198:40,
4200:11, 4212:5,
4229:35, 4233:10,
4246:5, 4246:16,
4246:25, 4246:27,
4246:31, 4246:33,
4247:15, 4247:18,
4247:21, 4248:39,
4248:41, 4250:40,
4254:4, 4254:17,
4255:21, 4259:37,
4259:43, 4259:45,
4259:46, 4260:12,
4261:26, 4262:15,
4262:41, 4267:37,
4272:32, 4278:46,
4279:39, 4291:3,
4294:47, 4298:16,
4301:32, 4302:33,
4303:17, 4306:12
period [14] - 4214:12,
4215:11, 4220:45,
4245:12, 4246:37,
4247:45, 4284:38,
4285:2, 4288:9,
4299:24, 4299:27,
4299:46, 4303:40,
4303:41
periods [3] - 4232:42,
4284:29, 4292:14
perioperative [2] -
4198:6, 4225:23
permanent [1] -
4239:19
permit [1] - 4278:33
permitted [1] - 4255:1
person [2] - 4225:22,
4254:45
personal [3] -
4229:23, 4246:32,
4270:1
perspective [21] -
4218:17, 4243:44,
4246:12, 4247:19,
4250:1, 4250:30,
4250:39, 4254:17,
4259:13, 4260:30,
4261:9, 4262:23,
4264:19, 4293:31,
4295:11, 4302:20,
4302:27, 4303:12,
4303:16, 4304:1
PET [1] - 4233:21
petition [1] - 4300:2
PGY1 [6] - 4245:3,
4245:7, 4265:6,
4290:7, 4290:8,
4290:10
PGY2 [4] - 4245:12,
4245:25, 4245:37,
4290:11
PGY3-plus [1] -
4239:37
PGY4 [2] - 4257:26,
4257:28
PGY5 [1] - 4257:26
pharmacist [2] -
4280:39, 4281:3
pharmacy [1] -
4280:40
phase [1] - 4205:5
phases [1] - 4201:13
PhDs [1] - 4232:21
philosophy [1] -
4200:23
physical [1] - 4273:14
physician [8] -
4228:43, 4254:38,
4254:39, 4257:28,
4262:5, 4262:15,
4271:1, 4278:11
physicians [6] -
4237:2, 4255:4,
4255:8, 4256:47,
4273:38
pick [3] - 4195:10,
4219:44, 4301:28

- PID** [1] - 4301:5
- piece** [2] - 4302:26, 4302:41
- pipeline** [3] - 4213:6, 4213:14, 4227:4
- place** [11] - 4189:46, 4191:11, 4200:9, 4214:6, 4215:1, 4216:9, 4221:6, 4233:10, 4237:31, 4295:13
- placed** [1] - 4261:25
- placements** [2] - 4244:16, 4252:43
- places** [6] - 4213:40, 4230:23, 4243:26, 4243:40, 4243:42, 4243:47
- plan** [17] - 4202:28, 4225:9, 4235:8, 4235:10, 4236:17, 4236:20, 4236:33, 4237:4, 4284:19, 4284:21, 4284:37, 4284:38, 4284:45, 4285:1, 4285:13, 4285:36, 4288:8
- plane** [1] - 4226:15
- planned** [1] - 4204:18
- planning** [25] - 4199:5, 4214:2, 4242:10, 4242:19, 4247:22, 4250:1, 4250:28, 4250:39, 4251:18, 4251:22, 4252:39, 4253:13, 4260:29, 4261:3, 4261:15, 4261:17, 4265:14, 4265:16, 4269:36, 4284:18, 4284:42, 4285:15, 4285:39, 4288:8, 4288:21
- plans** [1] - 4256:45
- play** [8] - 4216:42, 4238:43, 4266:2, 4267:5, 4267:8, 4275:35, 4278:24, 4285:40
- played** [3] - 4261:26, 4306:18, 4306:19
- playing** [1] - 4193:31
- pleasure** [1] - 4281:43
- pneumonias** [1] - 4223:33
- pockets** [1] - 4231:18
- point** [9] - 4192:45, 4200:14, 4213:28, 4225:5, 4245:11, 4252:9, 4258:11, 4263:21, 4302:23
- pointed** [3] - 4300:4, 4300:20, 4300:21
- points** [3] - 4187:30, 4187:39, 4187:43
- policy** [6] - 4218:14, 4258:1, 4258:5, 4258:6
- political** [2] - 4193:34, 4305:37
- pool** [1] - 4259:25
- poor** [8] - 4214:25, 4214:26, 4267:31, 4304:34, 4304:39, 4305:9, 4305:11, 4305:14
- popular** [3] - 4259:34, 4260:1, 4261:31
- populated** [1] - 4274:22
- population** [17] - 4222:13, 4228:31, 4248:15, 4262:44, 4263:33, 4269:10, 4269:12, 4269:21, 4269:34, 4269:35, 4269:37, 4269:44, 4274:1, 4274:12, 4284:24, 4299:23
- portal** [1] - 4204:3
- portion** [1] - 4303:37
- portions** [1] - 4250:22
- position** [37] - 4197:27, 4200:12, 4203:35, 4225:6, 4233:4, 4237:38, 4238:28, 4244:20, 4246:41, 4247:35, 4247:36, 4247:46, 4252:21, 4252:25, 4252:29, 4252:35, 4254:19, 4254:45, 4260:23, 4261:5, 4261:8, 4261:14, 4261:39, 4264:46, 4265:6, 4265:8, 4265:22, 4272:28, 4272:30, 4277:4, 4277:33, 4282:23, 4282:25, 4289:26, 4289:30, 4297:31, 4306:41
- positions** [123] - 4208:5, 4208:36, 4209:4, 4209:9, 4210:18, 4212:32, 4212:38, 4212:43, 4213:11, 4213:38, 4215:9, 4225:9, 4232:40, 4236:45, 4238:18, 4238:20, 4238:31, 4243:35, 4243:38, 4243:39, 4244:24, 4244:28, 4244:30, 4244:33, 4244:41, 4245:21, 4246:14, 4246:29, 4248:7, 4248:11, 4249:18, 4249:20, 4249:25, 4249:26, 4249:29, 4249:31, 4249:38, 4250:6, 4250:17, 4250:21, 4250:27, 4250:33, 4250:35, 4250:42, 4250:43, 4250:44, 4251:9, 4251:16, 4253:14, 4253:25, 4253:26, 4253:30, 4253:32, 4253:34, 4253:35, 4253:41, 4253:42, 4253:45, 4254:6, 4254:13, 4254:18, 4254:44, 4255:24, 4255:36, 4255:38, 4257:31, 4259:26, 4259:27, 4259:29, 4259:31, 4259:38, 4259:41, 4259:44, 4260:3, 4260:18, 4260:22, 4260:29, 4260:45, 4261:4, 4261:5, 4261:23, 4261:25, 4261:28, 4261:36, 4262:10, 4262:30, 4262:34, 4262:39, 4263:10, 4264:6, 4264:30, 4264:32, 4264:45, 4265:4, 4265:12, 4265:26, 4265:27, 4265:30, 4269:9, 4271:40, 4272:26, 4272:33, 4273:46, 4278:26, 4283:17, 4288:45, 4289:5, 4289:12, 4289:33, 4289:38, 4290:19, 4290:25, 4290:29, 4290:34, 4291:2, 4295:29, 4295:35, 4295:40, 4295:44
- positive** [3] - 4273:37, 4276:36, 4306:15
- possibility** [1] - 4253:29
- possible** [5] - 4199:39, 4210:5, 4256:1, 4256:4, 4265:12
- possibly** [2] - 4265:36, 4265:43
- post** [11] - 4190:4, 4202:33, 4203:1, 4209:7, 4214:4, 4214:11, 4214:14, 4214:18, 4214:21, 4239:39, 4248:19
- postgraduate** [2] - 4244:46, 4245:30
- posts** [10] - 4202:30, 4209:28, 4209:35, 4211:6, 4212:8, 4212:34, 4212:42, 4213:2, 4236:35, 4239:47
- potential** [3] - 4210:1, 4255:12, 4257:8
- potentially** [4] - 4253:41, 4258:24, 4279:42, 4301:23
- practical** [8] - 4207:26, 4207:43, 4208:31, 4263:29, 4263:37, 4269:15, 4274:19, 4280:36
- practically** [1] - 4193:4
- practice** [21] - 4191:39, 4203:10, 4203:12, 4205:22, 4205:24, 4219:27, 4222:23, 4222:24, 4227:42, 4231:17, 4233:43, 4249:8, 4269:20, 4270:27, 4273:34, 4279:32, 4281:19, 4302:45, 4303:5, 4303:30
- practising** [1] - 4302:24
- practitioner** [6] - 4223:8, 4228:42, 4279:13, 4287:47, 4288:1, 4288:4
- Practitioner** [2] - 4200:36, 4258:37
- practitioners** [11] - 4224:5, 4281:21, 4287:27, 4287:33, 4287:45, 4287:46, 4291:27, 4291:33, 4291:34, 4293:33, 4302:43
- practitioners"** [1] - 4227:45
- pre** [6] - 4191:13, 4191:22, 4193:42, 4232:27, 4276:45, 4277:27
- pre-accreditation** [1] - 4277:27
- pre-date** [2] - 4191:13, 4193:42
- pre-dates** [1] - 4191:22
- pre-empt** [1] - 4276:45
- pre-vocational** [1] - 4232:27
- predicament** [1] - 4298:26
- predict** [1] - 4285:36
- predicted** [1] - 4269:35
- preference** [9] - 4260:5, 4260:13, 4260:14, 4261:41, 4262:1, 4262:4, 4262:10, 4262:18, 4263:2
- preferences** [5] - 4247:13, 4254:27, 4261:34, 4261:37, 4262:8
- preparation** [2] - 4277:32, 4284:37
- preparative** [1] - 4277:27
- prepared** [4] - 4242:31, 4243:4, 4268:30, 4297:38
- preparing** [1] - 4230:15
- present** [5] - 4182:33, 4223:17, 4248:45, 4280:33
- presentation** [2] - 4304:20, 4304:25
- presentations** [3] - 4284:46, 4286:21, 4287:28
- presented** [7] - 4201:22, 4236:14, 4236:15, 4264:4, 4281:3, 4281:29, 4301:18
- presenting** [1] - 4286:46
- presents** [2] - 4302:40, 4303:11
- president** [11] - 4184:19, 4184:24, 4184:33, 4184:34, 4185:21, 4189:42, 4190:13, 4204:25, 4213:40, 4273:43
- presidential** [1] - 4212:36
- presidents** [3] - 4201:23, 4206:34

pressure [1] - 4193:22
presumably [7] - 4250:20, 4250:25, 4282:36, 4284:21, 4287:7, 4290:28, 4294:16
presume [1] - 4300:5
presumes [1] - 4287:22
pretty [5] - 4195:45, 4205:46, 4208:29, 4221:32, 4306:3
preventative [2] - 4223:22, 4223:44
preventing [3] - 4223:26, 4225:1, 4225:2
prevention [1] - 4224:5
previous [3] - 4239:33, 4251:4, 4293:23
previously [5] - 4274:5, 4287:26, 4295:44, 4305:24, 4306:22
prevocational [1] - 4244:47
primarily [2] - 4190:1, 4306:15
primary [21] - 4222:14, 4222:15, 4222:17, 4222:32, 4222:37, 4223:8, 4223:22, 4223:43, 4224:3, 4224:4, 4228:18, 4228:26, 4228:30, 4229:13, 4281:20, 4281:23, 4285:6, 4287:5, 4291:25, 4293:20
principle [1] - 4200:22
private [26] - 4195:27, 4195:28, 4222:11, 4231:9, 4231:14, 4233:31, 4233:33, 4233:37, 4278:20, 4278:30, 4278:34, 4278:41, 4278:47, 4279:27, 4280:14, 4302:28, 4302:31, 4302:32, 4302:36, 4302:44, 4303:1, 4303:3, 4303:5, 4303:30
privately [1] - 4306:32
pro [5] - 4194:27, 4195:11, 4195:24, 4274:40
ProActive [2] - 4300:3, 4300:5
problem [25] - 4195:6, 4197:45, 4199:15, 4199:17, 4210:11, 4213:6, 4213:13, 4213:14, 4215:13, 4216:33, 4217:1, 4221:41, 4221:42, 4222:46, 4223:21, 4225:16, 4229:15, 4248:46, 4257:34, 4264:9, 4264:33, 4305:44
problems [2] - 4235:38, 4300:5
procedural [4] - 4227:25, 4227:44, 4274:20, 4293:1
procedure [1] - 4200:43
procedures [6] - 4200:16, 4270:35, 4270:40, 4278:28, 4286:1, 4300:36
proceed [2] - 4204:29, 4226:39
process [75] - 4184:21, 4186:17, 4193:1, 4198:37, 4200:2, 4201:12, 4204:27, 4204:28, 4204:38, 4205:18, 4205:40, 4205:43, 4206:4, 4207:34, 4208:33, 4210:9, 4210:16, 4212:33, 4215:39, 4216:7, 4216:20, 4216:25, 4216:36, 4217:30, 4223:5, 4231:22, 4243:32, 4244:6, 4245:21, 4248:38, 4249:16, 4250:4, 4251:27, 4252:20, 4253:25, 4255:34, 4257:31, 4259:20, 4261:33, 4262:27, 4269:16, 4269:28, 4269:42, 4270:27, 4271:35, 4272:4, 4272:6, 4272:14, 4272:16, 4273:33, 4275:35, 4275:46, 4276:4, 4276:41, 4276:43, 4277:3, 4277:5, 4277:33, 4277:35, 4277:36, 4278:8, 4278:9, 4278:18, 4278:23, 4280:22, 4284:46, 4286:4, 4288:10, 4293:22, 4293:38, 4295:9, 4299:38, 4299:43, 4299:46, 4300:23
processes [13] - 4186:18, 4186:39, 4200:1, 4207:1, 4207:8, 4216:8, 4255:39, 4258:38, 4259:11, 4260:11, 4275:29, 4276:37, 4278:1
procurement [6] - 4299:38, 4299:45, 4300:23, 4304:26, 4305:23, 4306:29
produce [1] - 4235:30
produced [1] - 4235:33
produces [1] - 4202:24
producing [4] - 4192:13, 4198:41, 4198:47, 4222:20
profession [5] - 4185:19, 4185:30, 4217:6, 4217:7, 4305:43
professional [6] - 4185:30, 4185:35, 4195:21, 4239:36, 4239:40, 4274:20
professionalism [2] - 4185:29, 4195:20
professionals [2] - 4264:17, 4279:29
Professor [35] - 4183:6, 4183:22, 4183:29, 4183:34, 4184:19, 4184:23, 4185:24, 4185:39, 4187:3, 4191:17, 4194:8, 4195:33, 4196:47, 4200:30, 4200:42, 4204:46, 4211:11, 4214:15, 4218:18, 4218:44, 4226:1, 4226:43, 4234:47, 4237:17, 4241:25, 4251:35, 4251:36, 4251:44, 4252:4, 4282:1, 4282:8, 4282:28, 4295:8, 4296:22
professor [4] - 4294:17, 4294:30, 4294:35, 4297:34
proffered [2] - 4291:42, 4293:14
program [30] - 4186:9, 4186:23, 4187:15, 4189:5, 4191:25, 4191:29, 4192:11, 4192:12, 4202:23, 4204:16, 4206:6, 4206:17, 4207:37, 4210:3, 4211:2, 4216:13, 4224:30, 4232:18, 4232:19, 4237:43, 4238:6, 4248:13, 4248:14, 4248:29, 4255:29, 4260:6, 4264:11, 4272:21, 4276:32, 4295:38
programs [18] - 4185:39, 4186:29, 4186:40, 4187:5, 4188:7, 4188:36, 4188:37, 4194:10, 4224:39, 4225:29, 4245:31, 4245:33, 4248:7, 4248:32, 4255:1, 4259:21, 4290:4, 4291:41
progress [2] - 4236:26, 4258:42
progressing [4] - 4258:46, 4259:3, 4259:5, 4259:10
project [4] - 4204:36, 4231:26, 4285:44
projected [4] - 4244:8, 4285:27, 4285:34, 4287:7
projection [1] - 4287:1
projects [6] - 4235:19, 4236:38, 4236:40, 4236:47, 4237:3, 4260:9
promote [2] - 4209:34, 4275:23
pronounce [1] - 4304:21
proof [1] - 4199:9
proper [1] - 4233:13
properly [3] - 4199:29, 4300:24, 4301:24
proportion [1] - 4195:27
propose [1] - 4284:20
proposed [1] - 4201:42
proposition [2] - 4218:1, 4299:44
propositions [1] - 4298:37
protect [2] - 4263:34, 4263:38
protected [4] - 4200:2, 4200:3, 4263:18, 4263:22
protection [3] - 4195:2, 4263:28, 4263:29
protocol [6] - 4215:39, 4216:24, 4217:36, 4258:7, 4258:9, 4258:21
provide [39] - 4184:20, 4189:40, 4189:47, 4193:24, 4196:14, 4210:43, 4227:36, 4230:11, 4244:33, 4247:30, 4248:34, 4251:7, 4253:8, 4253:19, 4265:3, 4265:16, 4266:18, 4269:17, 4269:26, 4269:38, 4270:5, 4270:15, 4270:31, 4271:25, 4272:8, 4272:13, 4272:31, 4273:19, 4275:42, 4276:21, 4277:8, 4277:19, 4278:45, 4279:15, 4279:30, 4280:15, 4287:25, 4291:23, 4306:25
provided [21] - 4183:22, 4185:33, 4210:3, 4229:17, 4241:26, 4252:21, 4253:3, 4256:28, 4264:16, 4269:23, 4269:44, 4272:2, 4278:29, 4278:30, 4282:28, 4283:10, 4287:26, 4291:21, 4292:3, 4293:6
provider [2] - 4275:45, 4278:42
providers [1] - 4281:11
provides [3] - 4244:31, 4276:36, 4286:40
providing [11] - 4195:31, 4204:6, 4228:26, 4266:14, 4266:16, 4266:28, 4267:37, 4271:2, 4273:25, 4277:25, 4291:38
provision [6] - 4196:30, 4214:22, 4238:33, 4271:30, 4273:13, 4295:46
provisional [1] -

4245:5
psychiatry [2] -
 4224:41, 4290:27
public [18] - 4195:26,
 4219:7, 4220:5,
 4220:11, 4221:14,
 4222:10, 4222:12,
 4224:6, 4233:28,
 4233:32, 4233:38,
 4245:13, 4246:38,
 4279:27, 4280:15,
 4280:31, 4302:40,
 4303:1
publicly [1] - 4269:39
published [4] -
 4221:18, 4252:47,
 4253:2
pull [1] - 4247:3
pulled [1] - 4228:20
pulling [2] - 4217:27,
 4229:10
purchase [4] -
 4299:34, 4299:36,
 4299:37, 4303:6
purely [2] - 4199:24,
 4302:40
purpose [5] - 4185:1,
 4185:17, 4185:18,
 4185:21, 4185:28
purposes [3] -
 4248:45, 4294:21,
 4298:32
pursuant [1] - 4190:33
pursue [4] - 4246:27,
 4246:38, 4247:5,
 4249:1
push [3] - 4247:3,
 4255:47, 4298:24
push-back [1] -
 4298:24
pushed [2] - 4256:17,
 4300:47
put [12] - 4197:47,
 4201:38, 4229:35,
 4230:31, 4270:6,
 4294:36, 4298:37,
 4298:40, 4301:11,
 4303:18, 4304:2,
 4304:35
puts [1] - 4224:6
putting [3] - 4233:17,
 4295:8, 4303:10

Q

qualifying [1] - 4227:5
quality [7] - 4185:32,
 4195:1, 4200:9,
 4299:23, 4299:30,
 4299:42, 4306:35

quantum [1] - 4213:33
quarantined [1] -
 4263:34
quarantining [1] -
 4263:13
quarter [2] - 4220:27,
 4220:34
quarterly [2] -
 4220:25, 4221:1
quaternary [3] -
 4281:20, 4281:24,
 4287:2
Queensland [2] -
 4237:35, 4275:5
questions [31] -
 4183:19, 4205:13,
 4218:45, 4225:43,
 4226:11, 4226:17,
 4234:29, 4237:8,
 4237:11, 4240:17,
 4240:42, 4252:18,
 4266:44, 4267:46,
 4274:44, 4281:33,
 4281:36, 4281:38,
 4283:9, 4288:20,
 4294:28, 4296:15,
 4296:17, 4298:11,
 4298:33, 4298:44,
 4298:46, 4299:7,
 4302:18, 4304:10
quick [1] - 4298:16
quickly [6] - 4212:30,
 4256:3, 4259:18,
 4263:10, 4263:45,
 4274:38
quid [1] - 4274:40
quinquennial [1] -
 4293:22
quite [28] - 4191:26,
 4193:28, 4194:39,
 4196:28, 4197:18,
 4202:42, 4205:42,
 4207:38, 4208:45,
 4209:47, 4213:21,
 4215:44, 4216:19,
 4216:21, 4217:11,
 4217:31, 4220:22,
 4232:3, 4235:5,
 4239:9, 4261:35,
 4265:38, 4266:8,
 4270:39, 4279:19,
 4302:35, 4303:39,
 4306:2
quo [1] - 4274:40
quota [1] - 4213:8
quotation [1] -
 4304:35

R

RACGP [1] - 4227:23
RACMA [1] - 4237:1
RACS [20] - 4184:24,
 4184:32, 4187:14,
 4187:18, 4189:5,
 4189:10, 4191:1,
 4191:4, 4193:18,
 4201:35, 4205:4,
 4205:5, 4205:10,
 4205:15, 4227:4,
 4235:10, 4235:14,
 4235:20, 4239:38
radiation [3] -
 4265:47, 4293:42,
 4295:26
radiographers [1] -
 4296:7
radiologist [4] -
 4297:16, 4300:47,
 4301:19, 4306:15
Radiologists [1] -
 4293:41
radiology [8] -
 4297:17, 4297:28,
 4300:16, 4300:29,
 4300:32, 4303:13,
 4303:32, 4304:19
raise [5] - 4183:47,
 4240:31, 4265:21,
 4293:13
raised [10] - 4206:46,
 4216:1, 4239:22,
 4240:22, 4240:24,
 4240:26, 4263:12,
 4264:14, 4277:29,
 4294:41
raising [6] - 4293:34,
 4305:20, 4306:1,
 4306:9, 4306:25,
 4306:28
ran [1] - 4235:34
range [1] - 4203:7
ranking [1] - 4206:8
rankings [1] - 4262:8
RANZCR [4] - 4266:2,
 4267:2, 4267:5,
 4267:7
rapid [2] - 4222:27,
 4222:30
rare [1] - 4195:40
rate [1] - 4230:40
rates [4] - 4292:10,
 4292:13, 4292:17,
 4292:19
rather [15] - 4188:2,
 4191:21, 4198:36,
 4199:33, 4199:38,
 4200:24, 4202:30,

4203:45, 4208:14,
 4215:43, 4216:43,
 4231:17, 4262:42,
 4303:1, 4305:43
ray [2] - 4301:18,
 4301:29
rays [3] - 4301:28,
 4301:37, 4301:40
re [2] - 4281:29,
 4301:25
re-operation [1] -
 4301:25
re-presented [1] -
 4281:29
reaccreditation [1] -
 4295:18
reach [7] - 4210:47,
 4251:35, 4251:40,
 4271:3, 4303:33,
 4303:34, 4303:36
reached [3] - 4209:45,
 4211:3, 4264:46
read [9] - 4229:33,
 4242:38, 4243:8,
 4268:39, 4282:36,
 4294:20, 4294:28,
 4296:23, 4298:1
readily [1] - 4274:39
reading [1] - 4219:45
ready [2] - 4202:21,
 4257:40
real [2] - 4197:45,
 4210:11
realise [1] - 4209:6
reality [2] - 4247:19,
 4247:23
really [54] - 4185:29,
 4185:35, 4188:23,
 4191:31, 4191:44,
 4192:17, 4192:42,
 4192:44, 4194:39,
 4199:4, 4199:28,
 4202:20, 4204:15,
 4207:37, 4208:4,
 4208:31, 4209:5,
 4216:29, 4216:38,
 4217:8, 4218:29,
 4222:22, 4225:22,
 4225:26, 4225:29,
 4227:34, 4228:25,
 4228:32, 4229:2,
 4229:43, 4230:2,
 4230:19, 4231:3,
 4231:9, 4233:7,
 4233:8, 4233:18,
 4233:24, 4233:40,
 4235:31, 4243:31,
 4246:34, 4265:11,
 4273:20, 4273:35,
 4273:37, 4274:15,

4274:23, 4274:38,
 4276:6, 4277:32,
 4279:1, 4285:39
reappointment [1] -
 4293:22
reason [18] - 4191:10,
 4191:14, 4191:37,
 4193:8, 4193:33,
 4193:34, 4201:32,
 4211:34, 4211:46,
 4215:36, 4217:32,
 4229:14, 4257:7,
 4259:13, 4262:14,
 4294:19, 4294:36,
 4303:15
reasonable [3] -
 4237:45, 4291:43,
 4292:4
reasons [1] - 4246:32
rebate [3] - 4299:25,
 4302:42, 4302:44
receive [1] - 4289:12
received [6] - 4240:17,
 4240:36, 4258:13,
 4258:18, 4295:40,
 4298:28
receives [1] - 4208:5
receiving [1] -
 4289:19
recent [1] - 4215:36
recently [5] - 4183:36,
 4184:11, 4206:22,
 4289:28, 4298:28
recognise [2] -
 4263:4, 4280:42
recognised [1] -
 4306:18
recognising [1] -
 4251:26
recognition [2] -
 4186:16, 4186:17
recollection [2] -
 4267:24, 4304:33
recommendation [3] -
 4200:42, 4258:42,
 4258:47
recommendations [9]
 - 4200:37, 4201:22,
 4258:37, 4258:46,
 4259:8, 4259:9,
 4259:14, 4278:27,
 4299:40
recommended [5] -
 4220:28, 4220:42,
 4220:45, 4232:46,
 4286:32
recommending [1] -
 4238:11
reconvene [2] -
 4226:32, 4226:33

record [3] - 4198:32, 4242:6, 4297:13
recorded [1] - 4280:41
records [1] - 4277:21
recruit [10] - 4206:27, 4208:18, 4270:4, 4275:43, 4275:44, 4276:31, 4290:20, 4290:21, 4293:18, 4295:28
recruited [2] - 4254:19, 4254:20
recruiting [3] - 4274:26, 4289:39, 4290:30
recruitment [13] - 4205:29, 4207:24, 4208:3, 4208:13, 4208:23, 4213:26, 4244:24, 4260:11, 4261:33, 4262:4, 4286:4, 4290:40, 4290:42
recruits [1] - 4291:4
redeployment [1] - 4284:3
redistribute [1] - 4264:31
reduce [7] - 4201:30, 4201:37, 4202:6, 4202:16, 4212:31, 4225:32, 4262:24
reduced [3] - 4222:10, 4228:20, 4305:4
reduces [1] - 4262:10
reducing [3] - 4201:42, 4228:23, 4228:26
reduction [4] - 4211:1, 4211:5, 4212:16, 4212:47
refer [9] - 4210:37, 4238:11, 4238:37, 4253:29, 4257:3, 4266:1, 4272:11, 4280:1, 4281:15
referable [1] - 4262:17
referee [1] - 4205:7
reference [8] - 4186:3, 4195:10, 4197:12, 4254:47, 4263:18, 4271:16, 4293:20, 4303:26
referenced [1] - 4286:11
referred [11] - 4201:25, 4219:4, 4244:15, 4245:39, 4249:39, 4249:44, 4250:17, 4285:18, 4289:40, 4289:44, 4297:21
referring [11] - 4272:5, 4272:18, 4276:5, 4277:6, 4280:6, 4290:43, 4291:46, 4291:47, 4299:15, 4305:22, 4305:30
reflect [1] - 4248:15
reflective [3] - 4244:28, 4247:11, 4280:22
reflects [2] - 4248:37, 4293:10
reform [1] - 4242:9
refuses [1] - 4302:25
regard [1] - 4250:27
regarding [4] - 4196:31, 4214:27, 4288:21, 4293:31
regards [4] - 4189:41, 4190:3, 4190:44, 4210:12
region [3] - 4228:23, 4232:14, 4270:13
regional [15] - 4201:36, 4224:41, 4231:40, 4231:42, 4232:6, 4232:8, 4232:36, 4236:34, 4250:29, 4250:31, 4259:46, 4260:5, 4279:40, 4291:41, 4292:2
regions [1] - 4259:44
register [1] - 4281:27
registered [2] - 4186:11, 4276:31
registrar [5] - 4209:6, 4238:21, 4238:27, 4238:34, 4239:3
registrars [12] - 4195:16, 4195:42, 4208:46, 4215:6, 4233:19, 4238:13, 4238:46, 4278:33, 4288:35, 4289:47, 4290:1
registration [9] - 4186:22, 4188:38, 4244:36, 4244:44, 4245:4, 4245:5, 4245:8, 4301:7
regrettably [1] - 4294:30
regular [6] - 4189:30, 4202:19, 4270:8, 4276:44, 4277:10, 4278:12
regularly [4] - 4206:35, 4233:27, 4234:6, 4290:40
regulations [2] - 4193:3, 4217:34
reiterated [1] - 4229:11
relate [4] - 4190:23, 4203:45, 4220:15, 4295:4
related [6] - 4195:4, 4199:13, 4224:10, 4224:12, 4267:34, 4301:32
relates [3] - 4206:8, 4228:9, 4288:21
relating [4] - 4288:18, 4293:15, 4295:23
relation [31] - 4189:47, 4190:28, 4207:1, 4217:24, 4220:21, 4228:15, 4229:23, 4248:7, 4249:43, 4250:17, 4254:14, 4257:17, 4257:34, 4258:1, 4258:41, 4260:1, 4261:27, 4263:10, 4263:12, 4267:8, 4267:21, 4279:38, 4282:23, 4284:28, 4286:8, 4288:7, 4295:17, 4300:30, 4304:26, 4305:8, 4305:47
relationship [6] - 4188:13, 4189:41, 4193:44, 4237:36, 4272:34
relationships [3] - 4207:36, 4275:22, 4279:4
relative [1] - 4293:10
relatively [3] - 4229:29, 4251:44, 4300:31
relay [2] - 4258:14, 4258:15
relevant [10] - 4190:32, 4236:10, 4240:41, 4252:26, 4258:18, 4261:10, 4261:14, 4272:21, 4278:8, 4294:33
rely [1] - 4296:3
remains [1] - 4190:46
remember [1] - 4301:17
remit [3] - 4195:18, 4217:6, 4217:7
remote [8] - 4202:44, 4230:23, 4236:40, 4236:45, 4274:4, 4274:27, 4291:41, 4292:16
remotely [2] - 4264:16, 4273:16
remove [1] - 4200:7
removing [1] - 4217:30
remunerated [1] - 4197:46
remuneration [4] - 4195:24, 4195:31, 4195:43, 4197:9
Repatriation [1] - 4297:17
repeat [1] - 4215:4
repeated [1] - 4201:47
repeatedly [1] - 4290:29
replace [1] - 4304:4
replacement [3] - 4225:27, 4229:44, 4230:16
replacements [2] - 4221:35, 4230:39
report [11] - 4189:5, 4189:6, 4189:18, 4200:37, 4203:23, 4216:22, 4216:36, 4220:25, 4236:26, 4280:24, 4301:19
reported [6] - 4194:40, 4220:47, 4241:10, 4277:44, 4301:19, 4302:42
reporting [4] - 4189:13, 4190:19, 4216:25, 4303:13
reports [3] - 4190:15, 4195:16, 4221:1
repository [1] - 4215:41
representation [3] - 4192:7, 4235:29
representative [3] - 4205:45, 4290:18, 4304:22
representatives [5] - 4206:23, 4277:14, 4278:12, 4278:13, 4304:18
represents [1] - 4290:19
reputation [1] - 4228:33
request [2] - 4272:28, 4288:45
requesting [1] - 4240:33
requests [3] - 4193:1, 4211:11, 4211:12
require [4] - 4205:43, 4246:6, 4249:20, 4254:3
required [20] - 4187:11, 4191:33, 4213:35, 4238:7, 4244:34, 4253:34, 4253:36, 4253:42, 4253:45, 4254:6, 4254:22, 4256:21, 4256:35, 4263:32, 4269:17, 4269:25, 4270:26, 4277:26, 4278:28, 4285:28
requirement [7] - 4192:34, 4196:34, 4200:4, 4228:24, 4264:19, 4269:21, 4286:3
requirements [20] - 4201:18, 4218:27, 4244:35, 4246:10, 4247:47, 4248:40, 4249:35, 4253:30, 4253:36, 4253:46, 4258:9, 4261:6, 4263:25, 4269:36, 4271:30, 4275:14, 4276:16, 4276:23, 4299:40
requires [3] - 4232:39, 4239:17
research [3] - 4185:2, 4213:16, 4224:35
reserve [2] - 4298:45, 4306:41
residency [1] - 4232:11
residents [1] - 4290:1
resign [1] - 4301:8
resolve [1] - 4267:19
resort [1] - 4223:24
resources [3] - 4263:32, 4270:3, 4272:40
respect [3] - 4216:13, 4302:26, 4302:47
respective [1] - 4293:28
respiratory [1] - 4223:35
respond [3] - 4212:29, 4217:23, 4217:38
responded [1] - 4212:35
responding [1] - 4267:20
response [5] - 4240:17, 4240:36,

- 4240:42, 4240:43,
4241:8
responses [1] -
4277:18
responsibility [4] -
4187:4, 4187:10,
4191:3, 4246:33
responsible [7] -
4185:3, 4187:27,
4187:36, 4189:1,
4218:20, 4249:19,
4305:19
rest [2] - 4191:46,
4299:36
result [4] - 4253:33,
4269:42, 4290:42,
4295:24
resulted [1] - 4258:32
results [1] - 4277:20
resume [1] - 4226:7
retain [3] - 4270:4,
4270:44, 4293:18
retained [2] - 4269:47,
4271:27
retaining [2] -
4274:26, 4292:22
retention [1] - 4234:24
retirement [1] - 4198:3
revenue [2] - 4303:6,
4303:34
review [15] - 4183:35,
4184:11, 4204:29,
4204:38, 4205:7,
4206:10, 4212:32,
4214:15, 4214:18,
4215:37, 4264:14,
4288:10, 4300:15,
4300:16, 4301:6
reviewed [3] -
4214:12, 4231:16,
4293:39
reviewing [1] - 4239:1
revised [1] - 4204:25
revisit [1] - 4204:10
rheumatologist [1] -
4257:43
Richard [3] - 4182:14,
4182:35, 4253:19
RIDLEY [1] - 4297:8
Ridley [12] - 4251:36,
4252:4, 4296:36,
4296:44, 4297:12,
4297:14, 4298:12,
4298:33, 4298:38,
4298:41, 4299:3,
4299:7
rights [2] - 4295:8,
4302:44
ringing [1] - 4223:2
risk [5] - 4185:4,
4213:14, 4230:24,
4301:11, 4303:11
risks [1] - 4301:16
role [55] - 4184:29,
4184:43, 4184:46,
4185:8, 4185:9,
4188:6, 4189:38,
4194:1, 4196:1,
4212:36, 4216:41,
4217:9, 4217:14,
4217:29, 4237:18,
4238:21, 4238:33,
4238:43, 4239:10,
4239:27, 4239:33,
4242:14, 4242:22,
4242:26, 4255:13,
4255:22, 4255:45,
4256:4, 4260:17,
4260:28, 4261:25,
4261:26, 4264:29,
4266:1, 4266:4,
4266:16, 4266:20,
4266:28, 4266:36,
4266:38, 4267:5,
4267:7, 4267:8,
4267:14, 4267:21,
4267:24, 4267:25,
4268:23, 4268:25,
4268:26, 4276:35,
4284:36, 4297:24,
4306:20
roles [1] - 4225:33
room [1] - 4306:7
roots [2] - 4248:26,
4249:4
Ross [1] - 4182:27
roster [4] - 4253:33,
4253:36, 4253:37,
4283:42
rosters [2] - 4254:3,
4283:30
rotate [2] - 4254:23,
4256:38
rotation [1] - 4256:26
rotations [3] -
4254:13, 4254:24,
4255:30
rough [1] - 4244:39
round [1] - 4300:2
rounds [5] - 4197:8,
4197:17, 4239:1,
4290:39, 4293:27
Royal [8] - 4183:4,
4254:33, 4273:37,
4273:43, 4273:45,
4276:24, 4282:19,
4293:40
RPA [1] - 4287:2
rule [1] - 4299:18
run [9] - 4197:40,
4198:3, 4202:10,
4206:24, 4218:29,
4227:32, 4233:13,
4262:34, 4264:11
running [8] - 4184:37,
4197:38, 4224:39,
4225:7, 4225:29,
4228:45, 4235:20,
4236:47
runs [2] - 4206:7,
4219:25
Rural [1] - 4235:12
rural [98] - 4191:41,
4191:45, 4193:14,
4197:3, 4197:33,
4199:25, 4201:34,
4201:35, 4202:18,
4202:44, 4204:15,
4206:16, 4206:26,
4206:28, 4208:41,
4210:9, 4219:21,
4224:23, 4224:25,
4224:27, 4224:28,
4224:29, 4224:36,
4224:43, 4224:44,
4227:23, 4227:25,
4227:35, 4227:45,
4227:46, 4228:44,
4229:1, 4229:41,
4230:32, 4231:32,
4231:33, 4231:36,
4231:43, 4231:44,
4231:45, 4231:46,
4232:12, 4232:20,
4233:1, 4233:4,
4233:5, 4233:7,
4233:8, 4233:9,
4233:13, 4233:22,
4233:35, 4233:37,
4234:2, 4234:24,
4235:9, 4235:11,
4235:13, 4235:19,
4235:25, 4236:40,
4236:41, 4236:42,
4237:4, 4248:25,
4248:28, 4248:33,
4248:36, 4248:42,
4248:47, 4249:7,
4249:8, 4249:11,
4249:12, 4249:30,
4249:31, 4249:37,
4249:44, 4250:19,
4250:22, 4250:29,
4250:31, 4254:10,
4255:37, 4259:46,
4260:5, 4273:26,
4274:4, 4274:27,
4274:35, 4279:40,
4291:41, 4292:2
rural/regional [1] -
4212:12
rurality [1] - 4279:46
Ruth [1] - 4235:12
-
- S**
-
- S1** [1] - 4299:36
sadly [1] - 4196:28
safe [2] - 4200:3,
4270:31
safety [2] - 4195:1,
4200:10
Sammut [1] - 4304:22
satisfied [2] -
4249:40, 4298:5
satisfy [1] - 4247:47
saw [2] - 4306:19,
4306:33
SC [3] - 4182:14,
4182:26, 4182:35
scanner [2] - 4201:16,
4202:16
scanning [1] -
4220:46
scans [3] - 4233:21,
4301:32, 4301:34
scenarios [1] - 4278:7
scheme [1] - 4237:31
scholarships [1] -
4232:30
school [5] - 4195:44,
4224:38, 4224:43,
4246:26, 4292:15
schools [4] - 4231:44,
4231:46, 4232:14,
4276:38
SCI.0011.0178.0001
[1] - 4234:23
SCI.0011.0242.0001
[1] - 4286:14
scope [4] - 4203:10,
4227:42, 4260:27,
4278:44
scoping [1] - 4227:26
scoring [1] - 4213:8
scratch [1] - 4286:36
screen [10] - 4226:6,
4234:22, 4234:36,
4234:43, 4268:33,
4268:34, 4286:14,
4288:31, 4289:42
script [1] - 4223:2
second [15] - 4184:33,
4192:4, 4193:21,
4205:5, 4227:1,
4227:38, 4231:31,
4243:4, 4244:46,
4252:25, 4260:14,
4265:21, 4265:46,
4298:30, 4299:33
secondary [2] -
4281:20, 4281:24
secretary [4] -
4264:35, 4264:36,
4271:17, 4271:25
section [3] - 4269:3,
4276:27, 4293:37
sections [1] - 4276:25
sector [15] - 4195:26,
4195:27, 4195:29,
4219:7, 4220:11,
4222:12, 4222:21,
4230:43, 4233:28,
4233:31, 4233:32,
4233:33, 4244:2,
4244:9, 4246:38
secure [4] - 4247:35,
4247:46, 4249:30,
4257:9
secures [1] - 4261:30
see [52] - 4185:8,
4185:44, 4186:3,
4187:6, 4187:17,
4187:24, 4193:8,
4197:18, 4197:27,
4209:21, 4215:3,
4227:2, 4227:7,
4228:3, 4228:4,
4228:10, 4231:35,
4237:23, 4238:6,
4238:19, 4238:39,
4250:42, 4250:44,
4253:24, 4255:12,
4257:16, 4259:13,
4260:16, 4261:25,
4265:23, 4266:4,
4267:13, 4267:40,
4268:35, 4269:12,
4271:41, 4273:4,
4274:3, 4276:1,
4276:38, 4278:44,
4279:21, 4279:37,
4280:3, 4280:21,
4281:26, 4283:29,
4288:31, 4293:30,
4297:1, 4306:20,
4307:9
seeing [4] - 4197:19,
4238:37, 4281:4,
4291:28
seek [2] - 4280:37,
4295:18
seeking [5] - 4245:47,
4246:13, 4246:20,
4246:22, 4253:40
seeks [1] - 4256:45
seem [3] - 4265:38,
4285:4, 4293:27
select [2] - 4206:21,
4206:27

selected [3] - 4246:7, 4255:37, 4300:24
selecting [3] - 4213:30, 4245:31, 4255:33
selection [25] - 4189:34, 4190:4, 4204:45, 4204:47, 4205:19, 4205:29, 4206:6, 4206:16, 4206:24, 4207:8, 4207:24, 4207:35, 4208:4, 4208:13, 4208:24, 4212:32, 4213:7, 4213:10, 4213:26, 4246:5, 4246:10, 4255:28, 4255:34, 4259:20
self [1] - 4244:40
self-funded [1] - 4244:40
Senior [1] - 4182:26
senior [11] - 4189:21, 4203:9, 4205:47, 4206:35, 4226:28, 4235:11, 4235:16, 4239:27, 4300:46, 4301:43, 4306:15
seniority [1] - 4216:26
sense [16] - 4191:7, 4198:41, 4204:32, 4211:42, 4211:45, 4219:31, 4233:3, 4236:30, 4246:44, 4257:27, 4257:35, 4258:29, 4263:37, 4263:38, 4280:36, 4304:43
sensitivity [2] - 4299:18, 4299:19
sent [3] - 4233:32, 4240:32, 4241:8
sentence [6] - 4227:7, 4227:39, 4275:38, 4278:16, 4291:46, 4292:8
separate [4] - 4218:22, 4231:1, 4272:14, 4285:25
separating [1] - 4231:5
September [1] - 4268:23
seriously [3] - 4194:44, 4195:7, 4214:29
serve [1] - 4191:40
served [1] - 4298:26
service [46] - 4197:1, 4197:4, 4197:12, 4200:10, 4203:7, 4219:14, 4228:23, 4228:27, 4228:32, 4229:10, 4230:3, 4230:33, 4230:34, 4233:23, 4237:40, 4238:22, 4238:26, 4238:32, 4240:1, 4244:31, 4248:18, 4248:47, 4261:30, 4265:3, 4270:15, 4271:17, 4271:21, 4271:24, 4271:30, 4271:31, 4271:47, 4280:15, 4280:41, 4285:28, 4285:37, 4288:7, 4290:27, 4291:25, 4292:18, 4292:40, 4293:1, 4293:16, 4295:30, 4295:33, 4295:35, 4299:2
services [31] - 4189:47, 4197:13, 4202:1, 4202:20, 4214:22, 4218:29, 4228:25, 4230:11, 4256:28, 4259:25, 4268:18, 4269:44, 4270:6, 4270:26, 4270:45, 4271:3, 4272:1, 4277:15, 4279:20, 4279:25, 4280:44, 4282:15, 4284:19, 4284:29, 4285:13, 4288:8, 4291:21, 4291:23, 4293:5, 4295:47, 4299:21
sessional [4] - 4197:1, 4292:39, 4293:3, 4293:15
sessions [2] - 4197:39, 4286:1
set [16] - 4194:22, 4215:40, 4216:15, 4216:24, 4228:18, 4232:35, 4233:45, 4235:37, 4244:38, 4257:17, 4257:30, 4258:21, 4275:34, 4288:17, 4288:41, 4289:40
sets [2] - 4236:1, 4299:27
setter [1] - 4217:11
setting [5] - 4185:2, 4245:16, 4248:36, 4249:1, 4303:2
settings [1] - 4250:29
settled [2] - 4224:42, 4298:39
seven [2] - 4291:38, 4304:2
several [16] - 4201:11, 4205:20, 4209:45, 4216:13, 4219:22, 4227:27, 4227:29, 4235:17, 4235:19, 4236:47, 4241:1, 4247:40, 4286:37, 4291:34, 4301:20, 4306:13
severe [2] - 4301:6, 4301:21
sexual [1] - 4290:27
shaking [1] - 4211:39
shall [1] - 4300:47
share [3] - 4189:9, 4204:2, 4231:22
shared [2] - 4204:5, 4230:4
sharing [3] - 4214:1, 4230:6, 4281:7
sheets [2] - 4252:47, 4253:8
shift [4] - 4247:12, 4284:2, 4284:6, 4286:21
shifts [9] - 4238:23, 4238:26, 4283:45, 4283:47, 4284:1, 4284:9, 4290:44, 4291:18, 4291:20
Shoalhaven [4] - 4268:19, 4270:17, 4270:19, 4270:28
short [7] - 4223:15, 4224:1, 4230:16, 4251:45, 4290:14, 4299:35, 4303:22
short-term [1] - 4303:22
shortage [2] - 4222:21, 4264:6
shortages [3] - 4202:18, 4218:46, 4301:10
shortfall [4] - 4290:18, 4291:9, 4303:21, 4303:34
shortly [1] - 4243:10
sic [1] - 4185:32
sicker [2] - 4223:18, 4223:25
side [2] - 4248:5, 4303:10
sides [1] - 4272:36
sign [3] - 4236:16, 4236:18, 4299:36
sign-off [1] - 4236:18
signatory [2] - 4183:34, 4184:10
signed [1] - 4299:45
significant [14] - 4192:45, 4207:26, 4207:43, 4213:32, 4214:21, 4214:27, 4239:18, 4243:39, 4264:29, 4274:1, 4274:6, 4274:15, 4291:8, 4293:44
significantly [4] - 4202:16, 4272:22, 4273:20, 4281:5
silo [1] - 4281:15
siloed [4] - 4279:20, 4279:24, 4279:35, 4280:29
silos [4] - 4209:10, 4280:1, 4280:6, 4280:13
SIMG [1] - 4186:17
similar [8] - 4202:24, 4204:17, 4216:1, 4216:43, 4218:3, 4238:33, 4279:7, 4280:21
simply [2] - 4221:7, 4270:10
single [2] - 4281:25, 4284:2
sit [7] - 4188:16, 4189:20, 4189:29, 4192:35, 4192:40, 4281:23, 4296:37
site [37] - 4194:23, 4194:24, 4195:1, 4195:5, 4201:32, 4202:30, 4202:33, 4203:45, 4206:22, 4209:6, 4209:21, 4209:29, 4210:13, 4214:22, 4214:35, 4214:42, 4214:44, 4214:45, 4215:22, 4215:23, 4215:27, 4217:22, 4224:45, 4231:6, 4232:3, 4233:11, 4233:14, 4233:15, 4258:23, 4259:2, 4262:23, 4262:41, 4275:45, 4279:11, 4279:12, 4286:22, 4295:13
site's [1] - 4209:22
sites [14] - 4194:34, 4201:14, 4202:34, 4209:35, 4210:1, 4210:4, 4210:5, 4210:10, 4216:16, 4227:18, 4231:45, 4231:46, 4232:36, 4233:18
sits [5] - 4190:39, 4192:23, 4192:28, 4192:33, 4252:36
situation [4] - 4191:18, 4209:26, 4255:5, 4261:40
situations [3] - 4290:21, 4291:20, 4292:16
SIU [1] - 4282:4
Siu [1] - 4282:9
six [4] - 4187:30, 4216:13, 4268:26, 4301:20
size [1] - 4229:30
skills [13] - 4185:36, 4208:28, 4208:31, 4208:47, 4238:5, 4238:7, 4270:30, 4272:7, 4272:11, 4273:25, 4274:20, 4279:16
skin [1] - 4227:31
slice [1] - 4248:9
slight [6] - 4191:2, 4193:31, 4211:1, 4211:5, 4212:16, 4212:46
slightly [4] - 4207:44, 4255:4, 4255:46, 4263:26
slots [1] - 4283:42
slowed [1] - 4202:22
small [4] - 4207:36, 4229:29, 4230:41, 4238:2
smaller [4] - 4233:10, 4233:11, 4274:15, 4274:21
SO [1] - 4214:37
social [1] - 4193:23
societies [36] - 4186:4, 4187:6, 4187:10, 4187:36, 4187:44, 4188:2, 4188:5, 4188:14, 4188:17, 4188:18, 4188:25, 4188:43, 4189:38, 4189:47, 4190:31, 4190:43, 4193:2, 4193:3, 4193:30, 4193:45, 4204:43, 4205:6, 4205:23, 4205:30, 4205:36, 4207:25, 4208:4, 4208:23,

4218:31, 4227:29,
4235:16, 4235:25,
4235:26, 4235:30,
4236:13
societies' [1] -
4207:23
society [12] - 4190:8,
4190:9, 4190:12,
4190:34, 4191:11,
4191:19, 4192:23,
4193:6, 4193:10,
4193:24, 4212:31,
4212:37
solely [1] - 4287:18
someone [9] -
4196:32, 4219:23,
4225:6, 4232:44,
4233:25, 4239:11,
4243:19, 4248:21,
4301:45
sometimes [11] -
4200:6, 4215:5,
4215:33, 4215:43,
4225:27, 4253:33,
4259:44, 4263:33,
4274:33, 4283:41,
4284:2
somewhere [2] -
4202:44, 4203:7
sorry [19] - 4185:14,
4186:2, 4192:19,
4193:47, 4215:37,
4218:41, 4226:16,
4227:33, 4234:31,
4234:35, 4234:45,
4234:47, 4240:29,
4260:19, 4271:13,
4294:1, 4298:20,
4306:13
sort [10] - 4207:7,
4208:29, 4213:13,
4227:32, 4230:30,
4235:24, 4236:41,
4253:11, 4261:35,
4306:10
sorting [1] - 4223:25
sorts [4] - 4198:4,
4200:4, 4216:9,
4231:20
sought [2] - 4207:6,
4280:42
sound [1] - 4221:29
sounds [4] - 4204:43,
4221:23, 4224:2,
4302:8
source [2] - 4214:42,
4221:14
South [33] - 4182:19,
4192:4, 4195:34,
4195:38, 4195:45,
4197:3, 4197:30,
4205:28, 4210:46,
4220:21, 4220:26,
4229:18, 4231:41,
4232:16, 4232:37,
4234:15, 4237:35,
4237:44, 4242:11,
4244:17, 4244:20,
4250:6, 4259:7,
4263:47, 4279:20,
4279:25, 4279:31,
4280:12, 4280:31,
4292:16, 4293:17,
4295:41
southern [2] -
4273:36, 4273:47
space [1] - 4227:34
speaking [1] -
4258:30
SPECIAL [1] - 4307:28
special [3] - 4197:4,
4239:10, 4251:11
Special [1] - 4182:7
specialisation [4] -
4253:43, 4255:16,
4259:34, 4260:2
specialised [2] -
4203:19, 4208:29
specialist [37] -
4186:17, 4186:37,
4188:38, 4195:34,
4195:39, 4199:10,
4210:2, 4233:36,
4245:27, 4245:28,
4245:44, 4245:47,
4246:1, 4246:16,
4246:21, 4246:23,
4252:19, 4253:5,
4253:30, 4253:35,
4253:46, 4264:21,
4264:30, 4264:34,
4265:22, 4265:27,
4269:9, 4271:40,
4272:20, 4272:26,
4279:9, 4290:25,
4290:34, 4293:11,
4297:16, 4302:45,
4303:29
specialists [40] -
4187:6, 4195:38,
4195:41, 4196:9,
4219:6, 4219:9,
4220:10, 4233:2,
4233:18, 4247:35,
4248:1, 4253:6,
4253:9, 4254:7,
4254:9, 4257:35,
4257:36, 4257:37,
4257:42, 4262:45,
4265:29, 4266:6,
4266:32, 4269:3,
4269:17, 4269:21,
4269:25, 4269:43,
4269:46, 4270:5,
4270:12, 4270:44,
4271:16, 4271:26,
4274:3, 4274:27,
4290:38, 4290:40,
4290:44, 4296:6
specialties [32] -
4185:40, 4185:44,
4186:12, 4186:22,
4186:30, 4188:20,
4189:20, 4191:39,
4203:5, 4203:25,
4204:2, 4208:6,
4209:17, 4213:19,
4218:28, 4224:39,
4253:1, 4253:37,
4253:44, 4254:3,
4254:38, 4262:19,
4262:40, 4279:41,
4285:35, 4285:36,
4288:27, 4288:28,
4289:18, 4292:43,
4293:1, 4293:2
specialty [49] -
4187:6, 4187:12,
4187:13, 4187:36,
4187:44, 4188:13,
4188:25, 4188:43,
4189:38, 4189:46,
4190:9, 4190:31,
4190:34, 4190:43,
4191:30, 4192:3,
4201:11, 4201:18,
4201:19, 4201:45,
4201:47, 4202:8,
4203:12, 4203:28,
4203:39, 4203:46,
4204:8, 4218:27,
4227:32, 4235:30,
4236:3, 4245:1,
4245:32, 4246:27,
4246:31, 4249:5,
4249:10, 4254:30,
4254:32, 4254:34,
4255:20, 4257:18,
4259:45, 4265:31,
4265:32, 4289:14,
4289:26, 4290:4,
4295:27
specific [11] -
4203:39, 4270:17,
4270:46, 4270:47,
4273:11, 4280:13,
4305:8, 4305:10,
4305:12, 4305:47
specifically [7] -
4196:18, 4197:28,
4198:39, 4210:40,
4210:46, 4221:23,
4267:34
specifics [1] - 4301:16
spectrum [2] -
4195:44, 4281:11
spend [2] - 4197:20,
4249:2
spent [2] - 4201:11,
4204:14
spine [3] - 4203:4,
4203:15, 4223:40
spoken [3] - 4288:23,
4291:40, 4306:34
spokesperson [2] -
4306:20, 4306:21
Spooner [2] -
4283:35, 4286:8
Spooner's [3] -
4286:26, 4290:32,
4290:43
spots [1] - 4289:19
spread [1] - 4250:13
St [2] - 4233:25,
4287:3
staff [50] - 4190:8,
4190:30, 4195:34,
4195:37, 4195:39,
4195:41, 4196:9,
4257:35, 4257:37,
4257:42, 4262:44,
4265:27, 4265:29,
4266:5, 4266:31,
4274:32, 4274:33,
4274:34, 4277:13,
4279:45, 4280:2,
4280:18, 4284:3,
4284:4, 4284:43,
4285:38, 4285:39,
4286:3, 4287:18,
4290:25, 4290:34,
4290:38, 4290:44,
4290:45, 4291:22,
4296:4, 4296:6,
4297:16, 4299:39,
4300:1, 4300:17,
4300:19, 4300:25,
4300:28, 4301:10,
4302:45, 4303:29,
4304:33, 4304:44
staffing [11] - 4283:13,
4285:28, 4285:45,
4286:20, 4286:27,
4286:31, 4286:34,
4287:6, 4304:26,
4305:23, 4306:29
stage [1] - 4303:23
stakeholders [2] -
4235:35, 4258:10
stamped [1] - 4243:19
stand [7] - 4206:31,
4252:21, 4252:34,
4252:42, 4254:44,
4259:8, 4277:3
standard [9] - 4185:2,
4191:6, 4195:45,
4204:7, 4214:14,
4217:11, 4256:36,
4258:45, 4278:9
standardised [1] -
4286:41
standards [30] -
4185:32, 4194:9,
4194:11, 4194:12,
4194:19, 4194:21,
4198:16, 4198:17,
4198:35, 4198:40,
4198:47, 4199:8,
4199:37, 4199:44,
4199:47, 4200:6,
4200:23, 4200:44,
4203:38, 4203:44,
4217:8, 4218:21,
4261:21, 4263:17,
4263:25, 4267:13,
4272:19, 4272:41,
4295:20
standing [1] - 4190:22
standstill [1] -
4235:24
start [12] - 4201:36,
4212:8, 4215:20,
4218:17, 4236:31,
4248:4, 4248:16,
4285:43, 4289:31,
4295:14, 4297:3,
4300:38
started [8] - 4194:1,
4216:12, 4216:38,
4224:41, 4234:9,
4268:25, 4287:38,
4291:17
starting [5] - 4183:21,
4200:41, 4202:22,
4227:23, 4234:12
state [21] - 4196:24,
4197:46, 4206:7,
4209:9, 4210:18,
4217:33, 4229:44,
4230:1, 4230:4,
4230:7, 4230:12,
4232:47, 4242:5,
4244:7, 4250:8,
4250:21, 4250:22,
4273:47, 4276:9,
4280:16, 4297:12
state's [1] - 4251:15
statement [75] -
4183:23, 4183:35,
4184:6, 4185:45,
4187:7, 4187:20,

4187:25, 4204:42,
4214:10, 4219:3,
4220:15, 4226:44,
4228:3, 4230:15,
4234:21, 4237:18,
4241:26, 4242:28,
4242:35, 4243:4,
4243:13, 4243:21,
4243:25, 4245:36,
4249:17, 4251:6,
4252:5, 4253:22,
4254:12, 4257:3,
4257:15, 4257:30,
4257:47, 4259:20,
4263:5, 4264:3,
4264:10, 4264:27,
4265:31, 4265:46,
4267:4, 4268:30,
4269:4, 4271:9,
4271:12, 4282:28,
4282:32, 4283:10,
4283:44, 4284:17,
4287:32, 4288:17,
4289:41, 4293:30,
4293:37, 4294:2,
4294:9, 4294:10,
4294:11, 4294:18,
4294:42, 4296:23,
4297:38, 4297:42,
4297:45, 4297:46,
4298:22, 4298:25,
4299:10, 4299:17,
4300:27, 4301:1,
4301:33, 4302:6,
4304:16

statements [6] -
4242:31, 4298:25,
4298:27, 4298:29,
4299:20, 4300:13

states [3] - 4230:17,
4237:33, 4237:44

statewide [2] -
4211:44, 4221:41

stations [1] - 4205:18

status [1] - 4214:11

stay [9] - 4192:18,
4198:2, 4224:29,
4224:45, 4226:5,
4230:16, 4230:20,
4237:47, 4274:41

stays [1] - 4229:44

Steevie [3] - 4282:1,
4282:9, 4282:11

STEEVIE [2] - 4282:4,
4282:11

step [8] - 4196:12,
4247:33, 4249:15,
4252:20, 4252:25,
4260:21, 4305:22

step-wise [1] -
4260:21

STEPHANIE [1] -
4183:13

Stephanie [5] -
4183:7, 4192:44,
4208:18, 4211:46,
4217:42

Stewart [1] - 4235:12

stick [2] - 4265:18,
4305:39

still [19] - 4191:32,
4192:5, 4192:23,
4197:7, 4197:8,
4209:47, 4210:5,
4218:36, 4220:20,
4220:27, 4236:20,
4246:28, 4251:34,
4279:30, 4280:11,
4280:13, 4284:9,
4287:38

stood [2] - 4253:25,
4264:47

stop [2] - 4222:17

stopping [1] - 4222:30

STP [1] - 4210:2

strain [3] - 4217:4,
4224:6, 4263:31

strategic [2] - 4235:8,
4235:10

strategy [4] - 4184:46,
4201:35, 4227:47,
4235:14

streamlined [1] -
4260:10

Street [1] - 4182:18

stressed [1] - 4280:45

stretched [4] -
4196:26, 4196:28,
4216:28, 4223:9

strict [1] - 4194:41

strive [1] - 4199:37

strong [4] - 4214:31,
4305:18, 4305:29

structure [4] -
4191:11, 4191:18,
4193:9, 4193:10

struggle [1] - 4274:33

struggling [1] -
4305:32

student [3] - 4232:9,
4232:18, 4243:26

students [5] -
4228:46, 4232:9,
4232:17, 4248:46,
4249:1

studies [3] - 4228:4,
4228:8, 4294:41

study [4] - 4228:15,
4228:36, 4229:22,
4229:37

stuff [7] - 4204:4,
4221:43, 4223:25,
4223:30, 4223:31,
4223:32, 4223:42

stumbling [1] -
4239:32

sub [1] - 4254:34

sub-specialty [1] -
4254:34

subcommittee [2] -
4190:16, 4192:24

subjective [1] -
4199:38

submission [2] -
4190:3, 4219:46

subsequently [2] -
4300:9, 4300:21

subsidiaries [1] -
4194:14

substance [1] -
4186:28

substantial [1] -
4303:42

substitution [3] -
4222:31, 4287:24,
4291:22

suburbs [1] - 4199:34

succeeds [1] -
4229:29

success [1] - 4240:10

successful [1] -
4290:30

succession [2] -
4225:9, 4261:17

suffering [1] - 4303:14

sufficient [4] - 4191:3,
4243:34, 4243:46,
4248:10

suggest [2] - 4241:9,
4292:9

suggested [3] -
4234:5, 4234:14,
4286:19

suggesting [1] -
4262:33

suggestions [3] -
4239:3, 4285:1,
4295:17

suitable [4] - 4255:38,
4256:40, 4269:38,
4300:25

suite [1] - 4248:35

sum [2] - 4223:47,
4224:1

summarise [3] -
4277:32, 4287:36,
4304:27

summarising [1] -
4284:33

summary [1] -
4205:31

super [1] - 4233:36

superficial [1] -
4294:23

supervise [1] -
4195:16

supervision [13] -
4236:40, 4238:30,
4244:34, 4249:34,
4264:7, 4264:13,
4264:15, 4264:23,
4266:13, 4273:18,
4275:14, 4295:18

supervisor [3] -
4266:23, 4273:14

supervisors [12] -
4194:31, 4194:42,
4195:14, 4263:19,
4264:20, 4266:3,
4266:17, 4266:20,
4266:29, 4266:31,
4267:7, 4267:37

supervisory [1] -
4194:25

supplementation [1] -
4303:45

support [44] -
4185:30, 4189:47,
4190:2, 4190:4,
4190:32, 4194:26,
4194:31, 4196:19,
4200:35, 4200:42,
4202:38, 4202:40,
4222:24, 4223:41,
4224:35, 4229:13,
4232:33, 4232:39,
4232:40, 4232:43,
4233:1, 4233:12,
4236:43, 4248:14,
4249:25, 4249:34,
4253:32, 4256:5,
4264:11, 4266:20,
4266:26, 4266:28,
4267:15, 4271:46,
4273:11, 4273:25,
4273:37, 4273:38,
4274:14, 4276:21,
4277:8, 4277:24,
4280:37

supported [5] -
4225:29, 4225:31,
4233:27, 4243:40,
4243:42

supporting [3] -
4260:8, 4273:46,
4279:2

supportive [4] -
4266:27, 4267:15,
4274:29, 4277:36

supports [5] -
4233:43, 4245:18,
4255:35, 4255:36

suppose [2] -
4229:39, 4302:39

supposed [1] -
4196:17

surgeon [32] -
4191:22, 4193:14,
4195:18, 4195:19,
4195:21, 4197:42,
4202:40, 4202:43,
4203:14, 4208:28,
4208:32, 4210:14,
4213:31, 4219:22,
4224:18, 4224:20,
4224:21, 4225:2,
4233:9, 4233:45,
4234:2, 4238:8,
4239:11, 4254:36,
4257:29, 4261:18,
4270:17, 4270:19,
4270:29, 4270:47

surgeons [34] -
4192:13, 4193:25,
4194:32, 4195:25,
4195:27, 4195:30,
4196:24, 4196:27,
4197:23, 4198:1,
4199:14, 4208:22,
4208:33, 4208:41,
4209:3, 4209:43,
4213:4, 4217:2,
4225:19, 4225:21,
4225:33, 4227:5,
4227:16, 4233:33,
4233:47, 4234:10,
4234:24, 4236:42,
4236:44, 4240:5,
4254:43, 4254:47,
4273:43, 4293:11

Surgeons [3] -
4183:5, 4254:33,
4254:34

surgeries [1] -
4220:45

surgery [55] - 4185:2,
4185:32, 4192:2,
4192:6, 4192:7,
4195:38, 4195:40,
4196:9, 4197:36,
4198:5, 4201:36,
4202:3, 4202:42,
4202:47, 4209:1,
4217:12, 4219:5,
4219:27, 4219:32,
4219:34, 4219:38,
4219:40, 4220:4,
4220:29, 4220:42,
4221:1, 4221:7,
4221:23, 4221:28,

- 4222:6, 4223:11, 4225:18, 4227:16, 4229:45, 4230:24, 4230:25, 4230:47, 4231:1, 4231:8, 4231:10, 4231:11, 4232:35, 4235:11, 4237:5, 4238:1, 4238:27, 4239:14, 4239:40, 4274:36, 4288:34, 4293:1
- Surgical** [1] - 4189:18
- surgical** [31] - 4185:40, 4186:4, 4186:22, 4186:30, 4191:5, 4194:22, 4197:12, 4197:29, 4200:15, 4204:42, 4205:29, 4205:30, 4207:27, 4208:6, 4208:23, 4209:17, 4211:1, 4212:16, 4212:31, 4213:31, 4214:22, 4215:20, 4215:22, 4219:26, 4238:38, 4238:43, 4239:10, 4239:12, 4278:11, 4293:9
- suspect** [2] - 4298:39, 4299:3
- sustain** [1] - 4276:30
- sustainable** [2] - 4286:12, 4293:18
- sustaining** [2] - 4249:43, 4250:18
- sworn** [4] - 4183:11, 4183:13, 4242:1, 4282:4
- Sydney** [6] - 4182:19, 4234:1, 4281:26, 4296:27, 4297:35, 4304:22
- system** [28] - 4195:35, 4195:39, 4196:26, 4198:14, 4199:28, 4200:10, 4211:44, 4222:9, 4224:31, 4228:28, 4231:16, 4231:23, 4237:19, 4239:18, 4245:13, 4249:47, 4250:38, 4251:21, 4257:26, 4258:33, 4263:30, 4264:12, 4265:12, 4265:27, 4280:24, 4280:26, 4280:32, 4297:21
- system's** [1] - 4217:3
- systematic** [1] - 4231:21
- systems** [7] - 4229:15, 4275:2, 4280:12, 4281:21, 4281:22, 4281:23, 4281:25
-
- T**
-
- table** [8] - 4257:16, 4286:36, 4286:40, 4289:40, 4289:43, 4290:13, 4290:24, 4291:9
- talent** [2] - 4242:10, 4242:19
- Tamsin** [1] - 4182:28
- task** [9] - 4209:39, 4210:23, 4210:38, 4210:41, 4240:13, 4240:25, 4240:32, 4240:47, 4260:9
- Taskforce** [3] - 4239:24, 4240:23, 4244:10
- tea** [1] - 4226:1
- teach** [2] - 4197:40, 4198:3
- teaching** [9] - 4195:17, 4195:25, 4196:34, 4197:7, 4200:3, 4200:9, 4225:34, 4238:25, 4238:45
- team** [10] - 4217:13, 4229:12, 4232:11, 4232:12, 4238:39, 4238:43, 4239:11, 4239:13, 4239:17, 4275:21
- Teams** [1] - 4296:27
- technical** [3] - 4187:11, 4188:19, 4208:27
- telehealth** [1] - 4271:3
- tend** [1] - 4203:10
- tendency** [1] - 4280:11
- tender** [4] - 4252:6, 4283:4, 4294:3, 4294:12
- tendered** [3] - 4242:46, 4243:17, 4298:9
- tends** [2] - 4195:6, 4262:38
- tenure** [1] - 4191:13
- term** [21] - 4201:34, 4239:14, 4240:4, 4250:1, 4250:27, 4250:30, 4250:39, 4251:21, 4256:18, 4256:20, 4256:26, 4256:37, 4260:29, 4261:3, 4261:15, 4266:8, 4267:26, 4277:34, 4303:22
- terms** [41] - 4189:42, 4193:4, 4193:5, 4193:43, 4193:45, 4199:7, 4199:36, 4200:2, 4200:12, 4204:29, 4204:38, 4207:23, 4213:30, 4213:33, 4245:20, 4245:43, 4246:9, 4247:18, 4248:23, 4249:3, 4250:47, 4252:3, 4252:34, 4252:41, 4255:22, 4256:22, 4258:3, 4259:6, 4269:15, 4274:9, 4275:12, 4285:13, 4285:39, 4289:22, 4293:34, 4295:23, 4295:43, 4299:25, 4305:25, 4306:9, 4306:25
- terrible** [2] - 4221:32, 4222:26
- Territory** [1] - 4206:15
- tertiary** [4] - 4279:11, 4279:12, 4281:20, 4281:24
- theatre** [6] - 4221:44, 4225:17, 4231:27, 4270:16, 4270:18, 4285:47
- theatres** [1] - 4225:32
- theme** [1] - 4236:2
- themes** [1] - 4235:39
- themselves** [7] - 4188:5, 4208:15, 4248:28, 4249:40, 4261:1, 4293:33, 4293:45
- theoretical** [1] - 4263:38
- there'll** [1] - 4205:14
- thereabouts** [1] - 4226:30
- therefore** [10] - 4243:41, 4244:24, 4244:31, 4246:16, 4246:28, 4248:26, 4263:7, 4265:3, 4270:18, 4286:4
- they have** [13] - 4191:25, 4201:16, 4211:44, 4244:43, 4254:47, 4258:22, 4264:7, 4277:10, 4278:11, 4298:38, 4301:24, 4305:5
- they've** [9] - 4223:16, 4223:39, 4233:20, 4234:8, 4234:9, 4234:10, 4240:19
- thinking** [1] - 4191:25
- thinks** [1] - 4224:31
- third** [1] - 4186:2
- threatening** [1] - 4301:7
- three** [22] - 4187:39, 4187:43, 4190:2, 4205:44, 4230:22, 4232:2, 4234:10, 4235:10, 4235:14, 4235:23, 4247:42, 4247:45, 4248:18, 4248:22, 4248:27, 4248:47, 4276:30, 4276:31, 4281:2, 4295:29, 4304:28, 4306:7
- throughout** [7] - 4185:31, 4187:15, 4208:6, 4232:27, 4232:36, 4233:46, 4290:40
- Thursday** [2] - 4296:46, 4297:4
- tick** [1] - 4202:11
- tier** [1] - 4206:1
- timeline** [2] - 4236:34, 4248:19
- timelines** [1] - 4236:38
- tiny** [2] - 4231:2, 4231:17
- title** [1] - 4235:5
- TO** [1] - 4307:29
- today** [9] - 4204:43, 4242:39, 4268:40, 4282:37, 4296:29, 4297:3, 4298:2, 4302:7, 4304:11
- together** [21] - 4189:8, 4189:32, 4191:43, 4203:26, 4205:21, 4205:23, 4209:11, 4213:20, 4228:44, 4228:47, 4229:1, 4229:2, 4231:44, 4232:17, 4266:2, 4266:16, 4267:6, 4267:14, 4279:28, 4280:17, 4280:18
- tomorrow** [9] - 4212:8, 4240:47, 4241:1, 4241:2, 4241:15, 4294:31, 4296:45, 4307:21, 4307:26
- took** [2] - 4197:24, 4296:43
- tool** [2] - 4292:10, 4299:19
- top** [1] - 4271:4
- topic** [6] - 4189:38, 4193:45, 4211:27, 4241:4, 4269:2, 4269:4
- topics** [2] - 4193:39, 4213:26
- total** [1] - 4283:16
- touched** [3] - 4275:27, 4283:20, 4292:30
- touches** [1] - 4231:34
- towards** [5] - 4201:34, 4204:38, 4247:13, 4262:38, 4295:15
- track** [1] - 4246:30
- train** [18] - 4197:40, 4198:3, 4199:14, 4208:30, 4208:39, 4208:40, 4208:44, 4209:6, 4209:13, 4209:43, 4213:41, 4224:16, 4224:18, 4224:19, 4224:25, 4224:28, 4248:25, 4253:1
- trained** [8] - 4198:41, 4198:47, 4203:14, 4224:37, 4225:2, 4239:19, 4253:7, 4274:27
- trainee** [17] - 4200:10, 4202:38, 4203:6, 4207:27, 4209:22, 4214:30, 4215:1, 4215:35, 4224:42, 4254:18, 4254:26, 4254:27, 4266:19, 4274:14, 4279:7, 4296:3
- trainee's** [1] - 4203:35
- trainees** [88] - 4194:28, 4194:36, 4195:2, 4197:8, 4197:41, 4198:36, 4200:15, 4200:24, 4200:27, 4203:17, 4205:29, 4205:39, 4206:14, 4208:35, 4209:9, 4209:16, 4211:2, 4212:16, 4215:3, 4215:35, 4224:15, 4224:42, 4224:43, 4232:26, 4232:42, 4237:19,

4237:29, 4237:32, 4237:34, 4237:40, 4238:13, 4248:35, 4254:36, 4254:37, 4254:40, 4255:24, 4256:33, 4256:34, 4257:18, 4263:14, 4263:19, 4264:34, 4266:15, 4266:23, 4271:46, 4272:9, 4272:31, 4272:40, 4273:10, 4273:25, 4273:39, 4274:6, 4274:17, 4274:19, 4274:22, 4274:24, 4274:30, 4274:38, 4275:43, 4275:44, 4276:7, 4276:15, 4276:22, 4276:25, 4276:30, 4276:31, 4276:38, 4277:11, 4277:26, 4277:29, 4278:13, 4278:19, 4278:45, 4279:2, 4279:9, 4279:13, 4279:15, 4295:21, 4295:23, 4295:25, 4295:29, 4295:37, 4295:39, 4295:45

trainers [6] - 4194:31, 4194:42, 4194:45, 4195:15, 4232:41, 4263:14

Training [3] - 4189:19, 4206:3, 4239:28

training [316] - 4185:1, 4185:34, 4185:38, 4186:9, 4186:23, 4186:29, 4186:40, 4187:5, 4187:10, 4187:12, 4187:13, 4187:15, 4187:17, 4187:45, 4188:2, 4188:6, 4188:7, 4188:8, 4188:10, 4188:14, 4188:16, 4188:18, 4188:22, 4188:23, 4188:26, 4188:30, 4188:35, 4189:2, 4189:4, 4189:6, 4189:13, 4189:17, 4189:19, 4189:25, 4189:28, 4189:31, 4189:43, 4189:44, 4190:1, 4190:4, 4190:10, 4190:11, 4190:23, 4190:46, 4190:47, 4191:1, 4191:6, 4191:25, 4191:27, 4191:29, 4191:45,

4192:22, 4192:28, 4192:34, 4192:35, 4192:38, 4192:39, 4194:9, 4194:13, 4194:22, 4194:26, 4194:27, 4194:33, 4194:45, 4195:1, 4195:11, 4195:15, 4195:20, 4195:25, 4195:29, 4195:31, 4195:40, 4195:41, 4196:14, 4196:17, 4196:31, 4197:28, 4197:29, 4197:46, 4198:1, 4198:5, 4198:37, 4199:9, 4199:25, 4199:26, 4200:15, 4200:17, 4201:12, 4201:35, 4201:36, 4202:14, 4202:29, 4202:30, 4202:40, 4203:5, 4203:18, 4203:35, 4204:15, 4204:44, 4205:34, 4205:35, 4207:1, 4207:8, 4207:35, 4208:5, 4209:20, 4209:28, 4209:35, 4210:3, 4210:43, 4211:3, 4212:8, 4213:31, 4213:40, 4214:5, 4214:11, 4214:17, 4214:21, 4217:9, 4217:12, 4217:15, 4218:20, 4224:21, 4224:24, 4224:30, 4224:36, 4224:44, 4225:5, 4227:24, 4227:33, 4227:35, 4228:46, 4231:32, 4231:33, 4231:36, 4231:40, 4231:42, 4231:44, 4232:6, 4232:8, 4232:10, 4232:11, 4232:12, 4232:18, 4232:19, 4232:22, 4232:34, 4232:36, 4232:40, 4234:24, 4235:19, 4235:25, 4236:3, 4236:15, 4236:34, 4236:44, 4237:4, 4237:30, 4237:31, 4237:33, 4237:41, 4238:4, 4238:5, 4238:28, 4239:41, 4240:6, 4243:34, 4244:34, 4245:1, 4245:12, 4245:32, 4245:44, 4245:47,

4246:1, 4246:7, 4246:11, 4246:15, 4246:21, 4246:23, 4246:32, 4247:6, 4247:26, 4247:29, 4247:36, 4247:40, 4247:46, 4248:21, 4248:32, 4248:33, 4248:35, 4248:38, 4248:40, 4248:42, 4249:2, 4249:8, 4249:9, 4249:11, 4249:12, 4249:34, 4252:19, 4252:43, 4253:14, 4253:26, 4253:30, 4253:41, 4253:45, 4254:14, 4254:19, 4254:20, 4254:26, 4254:38, 4254:39, 4254:41, 4255:1, 4255:18, 4255:20, 4255:25, 4255:29, 4255:42, 4255:44, 4255:45, 4256:3, 4256:5, 4256:8, 4256:11, 4256:42, 4256:47, 4257:8, 4257:20, 4257:28, 4257:29, 4258:16, 4259:2, 4259:20, 4259:37, 4259:41, 4260:2, 4260:17, 4260:22, 4261:9, 4261:30, 4262:6, 4262:16, 4262:29, 4262:39, 4263:10, 4263:13, 4263:16, 4264:30, 4264:32, 4264:45, 4264:46, 4265:17, 4265:22, 4265:26, 4265:30, 4266:13, 4266:17, 4266:26, 4267:16, 4267:27, 4267:37, 4269:9, 4271:40, 4272:1, 4272:7, 4272:12, 4272:20, 4272:26, 4272:30, 4272:33, 4273:3, 4273:19, 4273:34, 4273:46, 4274:3, 4274:16, 4275:46, 4276:32, 4277:4, 4277:8, 4277:14, 4277:17, 4277:18, 4277:24, 4278:25, 4278:27, 4278:33, 4279:29, 4279:38, 4279:40, 4279:44, 4279:45, 4288:18, 4288:23,

4289:5, 4289:12, 4289:23, 4289:26, 4289:29, 4289:33, 4289:38, 4290:4, 4293:42, 4295:13, 4295:17, 4295:26, 4295:28, 4295:40

trajectory [3] - 4244:39, 4245:44, 4247:33

transitional [3] - 4287:45, 4288:4, 4291:35

transparent [1] - 4186:38

trauma [11] - 4203:15, 4219:21, 4219:24, 4219:31, 4221:1, 4221:7, 4222:6, 4223:10, 4227:30, 4231:10

traversed [1] - 4242:26

travesty [2] - 4228:27, 4228:34

treat [1] - 4301:30

treatment [4] - 4230:38, 4280:39, 4280:40, 4280:42

tried [2] - 4208:30, 4215:30

tries [1] - 4205:23

trouble [1] - 4306:45

true [10] - 4183:40, 4184:15, 4184:18, 4242:42, 4243:14, 4252:5, 4268:43, 4282:47, 4283:44, 4298:6

truly [1] - 4291:5

trust [2] - 4303:38, 4303:39

try [14] - 4201:35, 4202:2, 4206:21, 4209:34, 4209:40, 4215:40, 4243:45, 4247:20, 4249:30, 4252:42, 4255:13, 4257:31, 4295:20, 4305:31

trying [12] - 4189:8, 4191:38, 4206:14, 4215:16, 4227:46, 4235:24, 4247:35, 4274:19, 4291:27, 4300:18, 4302:39, 4306:24

Tuesday [1] - 4182:22

turn [3] - 4187:19, 4300:36, 4300:38

turned [1] - 4306:14

tutorials [1] - 4267:38

two [24] - 4183:4, 4186:18, 4197:22, 4201:13, 4228:8, 4230:21, 4230:22, 4242:31, 4244:41, 4244:46, 4245:17, 4247:25, 4252:20, 4255:27, 4257:15, 4276:6, 4290:26, 4290:41, 4291:33, 4292:31, 4292:32, 4293:14, 4293:46, 4301:30

two-step [1] - 4252:20

two-year [1] - 4245:17

type [7] - 4247:22, 4251:27, 4253:5, 4253:13, 4261:3, 4262:16, 4266:35

types [4] - 4264:13, 4284:29, 4285:38, 4286:46

typical [2] - 4221:37, 4221:40

typically [1] - 4239:22

U

ultimately [1] - 4224:6

unable [2] - 4284:9, 4290:44

unacceptable [3] - 4266:9, 4266:34, 4267:26

unaccredited [15] - 4208:46, 4210:18, 4237:19, 4237:29, 4237:32, 4237:34, 4237:37, 4237:40, 4238:12, 4238:21, 4239:3, 4246:14, 4246:29, 4295:29, 4295:45

unaccrediteds [4] - 4237:42, 4237:46, 4238:2, 4238:19

unattractive [1] - 4300:31

under [20] - 4183:28, 4187:24, 4190:39, 4192:40, 4196:14, 4205:30, 4206:9, 4217:4, 4218:31, 4219:3, 4227:1, 4231:30, 4256:23, 4256:37, 4258:47, 4263:31, 4302:34, 4302:36, 4303:18,

4304:41
under-appreciated [1] - 4304:41
undergo [1] - 4277:3
undergraduate [3] - 4243:26, 4243:34, 4243:46
underprivileged [1] - 4228:31
understaffed [1] - 4303:40
understandably [1] - 4280:44
understood [1] - 4199:31
undertake [3] - 4246:22, 4247:28, 4262:18
undertaken [6] - 4246:6, 4251:18, 4251:27, 4262:4, 4262:5, 4285:14
undertaking [3] - 4258:36, 4260:10, 4269:28
underwent [1] - 4301:6
undesirable [1] - 4222:5
unfortunately [6] - 4197:5, 4202:22, 4207:35, 4219:12, 4237:43, 4296:43
Ung [1] - 4183:29
unhappy [1] - 4300:1
uni [1] - 4232:16
unit [3] - 4238:46, 4284:42, 4285:15
units [1] - 4279:15
universities [3] - 4243:27, 4243:35, 4243:47
University [2] - 4228:46, 4297:35
university [3] - 4231:43, 4244:40, 4248:5
unless [4] - 4183:46, 4231:25, 4280:47, 4294:34
unlike [1] - 4265:4
unrelated [1] - 4304:14
unstable [1] - 4218:41
unsuccessful [1] - 4237:30
unusual [1] - 4215:11
up [47] - 4191:41, 4194:22, 4195:10, 4196:19, 4202:22,

4203:25, 4204:11, 4204:17, 4204:26, 4215:40, 4216:15, 4216:23, 4216:24, 4216:36, 4219:38, 4219:44, 4220:33, 4223:24, 4223:36, 4223:47, 4224:1, 4228:18, 4230:46, 4232:35, 4233:46, 4239:35, 4247:27, 4252:21, 4252:34, 4252:42, 4253:25, 4254:26, 4254:44, 4264:47, 4268:33, 4268:34, 4277:3, 4286:13, 4289:41, 4289:42, 4290:13, 4299:3, 4300:35, 4300:36, 4303:21, 4303:46, 4306:34
update [1] - 4282:44
uphold [2] - 4185:29, 4217:7
upper [1] - 4203:4
upset [2] - 4211:4, 4212:17
urgent [4] - 4219:28, 4219:32, 4222:31, 4291:26
urology [1] - 4202:3
useful [2] - 4250:30, 4292:10
uses [2] - 4219:13, 4299:20
usual [2] - 4298:26, 4298:39
utilisation [1] - 4231:27
utility [4] - 4251:25, 4255:21, 4262:14, 4262:22

V

vacancies [3] - 4244:25, 4284:6, 4291:2
vacancy [1] - 4284:5
vacant [4] - 4289:38, 4290:19, 4290:25, 4290:34
value [2] - 4193:22, 4197:47
valued [1] - 4197:47
Vanderbilt [1] - 4215:23
variances [1] - 4275:33
variation [1] - 4191:15

variety [1] - 4273:15
various [5] - 4260:22, 4283:31, 4284:29, 4284:44, 4295:40
vary [5] - 4245:32, 4249:9, 4249:10, 4252:30, 4259:31
vascular [1] - 4202:3
versus [1] - 4253:35
via [1] - 4240:31
Victoria [2] - 4234:7, 4275:6
video [5] - 4218:35, 4236:42, 4236:43, 4236:44
view [20] - 4185:7, 4192:45, 4194:18, 4201:42, 4222:31, 4248:39, 4249:21, 4251:21, 4263:21, 4263:31, 4264:8, 4264:45, 4265:18, 4272:26, 4280:29, 4291:43, 4292:2, 4293:17, 4293:19, 4302:23
views [1] - 4295:9
vignettes [2] - 4230:41, 4231:20
Vincent's [2] - 4233:25, 4287:3
vintage [3] - 4247:24, 4257:25
visit [2] - 4215:23, 4229:9
visiting [2] - 4196:6, 4292:30
VMO [7] - 4196:6, 4196:8, 4196:11, 4196:13, 4196:23, 4293:14
VMOs [6] - 4262:45, 4290:39, 4292:30, 4292:38, 4293:27, 4296:6
vocational [16] - 4232:11, 4232:27, 4246:21, 4246:23, 4247:5, 4247:40, 4248:21, 4248:33, 4248:35, 4248:37, 4249:2, 4252:19, 4252:43, 4254:14, 4262:16, 4263:15
volume [2] - 4234:36, 4234:38
voted [1] - 4184:32

W

Wagga [29] - 4196:1, 4196:9, 4202:1, 4202:4, 4202:37, 4202:44, 4204:4, 4209:13, 4216:17, 4221:40, 4224:16, 4225:2, 4228:41, 4229:23, 4229:29, 4229:36, 4230:12, 4230:18, 4230:22, 4232:6, 4232:16, 4232:38, 4233:11, 4233:26, 4233:27, 4233:47, 4261:18
Wagga's [1] - 4232:3
wait [19] - 4204:26, 4204:28, 4219:7, 4219:14, 4219:21, 4219:22, 4219:26, 4219:34, 4219:41, 4220:4, 4220:11, 4221:2, 4221:8, 4221:21, 4221:33, 4223:10, 4223:30, 4225:28
waiting [13] - 4197:36, 4209:47, 4219:4, 4219:30, 4220:28, 4220:41, 4221:17, 4221:23, 4221:30, 4222:25, 4223:28, 4225:22, 4296:39
Wales [33] - 4182:19, 4192:4, 4195:34, 4195:38, 4195:45, 4197:3, 4197:30, 4205:28, 4210:46, 4220:21, 4220:26, 4229:18, 4231:41, 4232:16, 4232:37, 4234:15, 4237:35, 4237:45, 4242:11, 4244:17, 4244:20, 4250:6, 4259:7, 4263:47, 4279:21, 4279:25, 4279:31, 4280:12, 4280:31, 4292:17, 4293:17, 4295:41
walked [1] - 4248:20
wants [2] - 4240:5, 4302:8
ward [5] - 4197:8, 4197:17, 4239:1, 4239:12
warning [1] - 4258:31
Waterhouse [1] - 4182:28

ways [7] - 4207:25, 4255:33, 4276:6, 4285:35, 4287:12, 4291:21, 4291:30
wealth [1] - 4261:1
website [1] - 4253:2
WEDNESDAY [1] - 4307:29
week [4] - 4197:22, 4255:43, 4283:35, 4291:38
weeks [6] - 4197:6, 4239:16, 4268:26, 4268:27, 4273:43, 4301:20
WEI [1] - 4282:4
Wei [1] - 4282:9
weighting [1] - 4262:38
welcome [1] - 4217:33
Welfare [2] - 4220:24, 4269:23
well-trained [2] - 4198:41, 4198:47
Western [1] - 4275:5
whereas [3] - 4192:5, 4255:4, 4292:39
whereby [3] - 4244:6, 4253:25, 4278:18
whichever [1] - 4268:36
whilst [6] - 4190:45, 4213:28, 4257:24, 4260:4, 4267:18, 4280:13
whole [7] - 4193:15, 4195:42, 4203:7, 4203:30, 4228:44, 4232:10, 4294:10
wholly [2] - 4248:36, 4252:36
wide [2] - 4220:16, 4262:45
wider [4] - 4250:28, 4255:22, 4256:5, 4262:17
willing [2] - 4229:42, 4239:9
wise [1] - 4260:21
wish [2] - 4247:34, 4282:44
withdrawal [5] - 4214:8, 4258:24, 4258:31, 4295:11, 4295:24
withdrawing [1] - 4214:20
withdrawn [2] - 4293:40, 4295:34
WITHDREW [6] -

4226:22, 4241:40, 4268:6, 4281:45, 4296:33, 4307:18	4248:24, 4249:44, 4250:1, 4250:19, 4250:28, 4250:39, 4251:19, 4251:22, 4252:39, 4252:45, 4253:13, 4253:30, 4253:43, 4253:46, 4260:29, 4261:2, 4261:3, 4261:15, 4261:27, 4262:28, 4262:31, 4263:47, 4264:6, 4265:14, 4275:21, 4283:12, 4284:18, 4285:26, 4285:39, 4286:9, 4286:13, 4286:20, 4287:24, 4287:25, 4288:19, 4291:22, 4291:31, 4291:41, 4292:29, 4293:18	4287:29, 4287:33, 4287:37, 4289:26, 4289:30, 4290:37, 4291:19, 4291:32, 4291:34, 4292:35, 4292:39, 4293:9, 4293:29	4248:47, 4261:16 yesterday [3] - 4232:38, 4294:2, 4296:23 young [2] - 4225:19, 4301:22 younger [2] - 4247:13, 4247:16
withdrew [1] - 4293:41			
withhold [1] - 4185:32			
WITNESS [13] - 4241:29, 4241:34, 4241:38, 4241:40, 4268:6, 4281:43, 4281:45, 4296:31, 4296:33, 4302:3, 4307:5, 4307:14, 4307:18			
witness [19] - 4237:8, 4241:42, 4259:35, 4260:31, 4266:44, 4268:8, 4271:18, 4281:33, 4281:47, 4283:23, 4284:15, 4284:34, 4288:25, 4291:44, 4292:41, 4293:7, 4296:35, 4300:13, 4305:34			
witnesses [2] - 4183:4, 4296:44			
Wollongong [2] - 4278:29, 4281:29			
won [1] - 4228:33			
word [1] - 4304:43			
wording [1] - 4220:3			
words [4] - 4196:32, 4212:18, 4293:33, 4304:37			
work's [1] - 4235:23			
work/life [3] - 4213:17, 4246:33, 4247:16			
workforce [85] - 4194:28, 4195:23, 4195:30, 4197:34, 4199:5, 4202:18, 4207:27, 4208:39, 4209:9, 4209:39, 4209:41, 4210:11, 4210:23, 4213:15, 4213:19, 4213:46, 4214:2, 4216:29, 4218:46, 4222:13, 4224:15, 4225:9, 4233:1, 4233:7, 4235:4, 4235:8, 4235:9, 4239:3, 4242:9, 4242:10, 4242:19, 4243:36, 4244:1, 4244:8, 4244:12, 4244:28, 4244:31, 4246:11, 4247:19, 4247:22, 4247:29, 4248:12,	Workforce [3] - 4239:23, 4240:23, 4244:10 workload [4] - 4304:26, 4305:4, 4305:23, 4306:29 workplace [5] - 4216:3, 4216:10, 4216:44, 4216:46, 4266:34 works [9] - 4184:37, 4189:13, 4231:3, 4256:25, 4261:47, 4270:17, 4271:32, 4277:9 workshop [5] - 4234:25, 4234:31, 4235:1, 4235:28, 4235:34 workshops [2] - 4189:30, 4284:45 world [4] - 4193:28, 4220:43, 4224:27, 4269:19 worry [1] - 4251:47 worse [1] - 4217:4 worsening [1] - 4223:26 worth [4] - 4191:8, 4235:18, 4248:18, 4248:47 wrap [1] - 4203:24 writing [1] - 4211:11 wrongs [1] - 4295:9 wrote [2] - 4234:27, 4243:10 Wyong [20] - 4283:37, 4283:46, 4286:32, 4286:37, 4286:46, 4287:1, 4287:27,	x-ray [2] - 4301:18, 4301:29 x-rays [3] - 4301:28, 4301:37, 4301:40	
	X		
			Z
			Zealand [2] - 4185:3, 4293:40 zero [1] - 4220:43
	Y		
		year [44] - 4184:33, 4194:2, 4197:25, 4204:37, 4209:40, 4210:47, 4211:2, 4212:17, 4213:3, 4213:13, 4217:42, 4236:31, 4237:3, 4240:33, 4243:37, 4244:21, 4244:41, 4244:43, 4244:46, 4245:3, 4245:17, 4245:25, 4245:30, 4245:38, 4247:45, 4270:28, 4270:31, 4271:29, 4282:33, 4287:18, 4287:38, 4288:9, 4289:14, 4289:16, 4290:41, 4292:14, 4293:23, 4293:24, 4295:19, 4295:30, 4295:33, 4295:39, 4303:20 year" [1] - 4210:32 yearly [1] - 4288:9 years [38] - 4184:32, 4191:23, 4191:24, 4194:39, 4195:42, 4197:41, 4201:11, 4205:20, 4216:13, 4216:14, 4217:29, 4223:43, 4224:36, 4232:28, 4235:5, 4235:11, 4235:14, 4235:23, 4239:28, 4242:23, 4244:9, 4244:46, 4244:47, 4247:40, 4247:42, 4248:22, 4248:27, 4249:3, 4250:41, 4251:4, 4284:20, 4286:37, 4288:11, 4300:31, 4300:43, 4301:30, 4304:2 years' [3] - 4248:18,	