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

THE COMMISSIONER: Good morning.

MR FULLER: Good morning, Commissioner. First this morning are two witnesses from the Royal Australian College of Surgeons who will be giving their evidence concurrently by AVL. I call Associate Professor Kerin Fielding and Ms Stephanie Clota.

THE COMMISSIONER: Thank you.

<KERIN FIELDING, sworn: [10.06am]

<STEPHANIE CLOTA, sworn: [10.06am]

<EXAMINATION BY MR FULLER:

MR FULLER: My name is Dan Fuller, I'm one of the counsel assisting the Commission, and I'm going to be asking you some questions this morning.

Firstly, can I ask each of you, starting with you, Associate Professor Fielding, the college has provided a statement to assist the Commission. Do you have a copy of that with you?

A/PROFESSOR FIELDING: Yes, I do.

MR FULLER: It's under the cover of a letter from Professor Owen Ung dated 12 July 2024; is that the copy you have?

A/PROFESSOR FIELDING: That's correct.

MR FULLER: Associate Professor, you are not a signatory to the statement but have you had the opportunity to review it recently?

A/PROFESSOR FIELDING: Yes, I have.

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

A/PROFESSOR FIELDING: Yes, it is, with a few minor adjustments which I'm happy to tell you as we go.

MR FULLER: All right. Unless there is anything you want to raise now you can raise those as we go through and if

I miss anything please tell me at the end.

A/PROFESSOR FIELDING: Absolutely.

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

MS CLOTA: Yes, I do.

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

MS CLOTA: Yes, I have.

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

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

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

A/PROFESSOR FIELDING: That's correct.

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

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

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

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

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

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

A/PROFESSOR FIELDING: Is that directed to me?

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

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

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

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

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

A/PROFESSOR FIELDING: That's correct.

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

A/PROFESSOR FIELDING: That's correct.

MR FULLER: I should say, sorry, about a third of the way down, and then we see about halfway down a reference to "surgical societies", which I will come back to in a moment; that's right?

A/PROFESSOR FIELDING: Yes, yes.

MR FULLER: The completion of a training program accredited by your college is the only pathway available in Australia for a doctor to be registered in any of your college's specialties; is that right?

A/PROFESSOR FIELDING: No. You can come to Australia as an international medical graduate and apply through the college for recognition and there are pathways for specialist recognition through the SIMG process, so they're the two processes.

MR FULLER: Leaving aside international medical graduates, if I'm a doctor in Australia and I want to obtain registration in one of the surgical specialties, to use that language, I need to complete a training program through your college; is that right?

A/PROFESSOR FIELDING: Correct. That's correct.

MR FULLER: You would agree that means, in substance, there is no competition for the training programs that are offered in surgical specialties in Australia?

A/PROFESSOR FIELDING: No, that's correct. That's correct.

MR FULLER: Do you agree that the lack of competition - which doesn't just apply to your college but also applies to other specialist medical colleges - makes it important for colleges to have fair, effective and transparent processes for the governance and administration of their training programs?

A/PROFESSOR FIELDING: Absolutely. Absolutely.

MR FULLER: Ms Clota, do you agree with that?

MS CLOTA: Agree, yes.

MR FULLER: Thank you.

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

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

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

A/PROFESSOR FIELDING: Yes.

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

Broadly, the College is responsible for administering ...

and then there are six dot points.

A/PROFESSOR FIELDING: Yes.

MR FULLER: Then:

With specialty societies responsible for administering --

and three dot points.

A/PROFESSOR FIELDING: Yes.

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

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

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

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

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

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

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

A/PROFESSOR FIELDING: They do, yes.

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

A/PROFESSOR FIELDING: Yes, yes.

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

A/PROFESSOR FIELDING: Correct.

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

A/PROFESSOR FIELDING: That's correct.

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

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

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

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

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

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

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

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

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

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

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

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

MS CLOTA: Yes.

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

MS CLOTA: That is correct.

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

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

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

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

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

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

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

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

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

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

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

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

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

MR FULLER: Yes.

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

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

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

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

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

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

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

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

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

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

A/PROFESSOR FIELDING: Yes, probably.

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

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

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

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

MS CLOTA: Correct.

MR FULLER: Thank you.

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

A/PROFESSOR FIELDING: That's correct.

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

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

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

So the accreditation is all about looking at the

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

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

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

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

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

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

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

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

A/PROFESSOR FIELDING: Yes, yes.

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

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

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

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

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

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

A/PROFESSOR FIELDING: No.

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

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

THE COMMISSIONER: Thank you.

MR FULLER: Are you, Associate Professor, engaged on

a sessional basis or a fee for service basis?

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

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

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

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

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

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

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

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

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

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

A/PROFESSOR FIELDING: Yes. Yes.

MR FULLER: Ms Clota?

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

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

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

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

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

MR FULLER: Yes. Thank you.

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

doctors, I imagine, as a guess?

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

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

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

THE COMMISSIONER: The maldistribution problem?

A/PROFESSOR FIELDING: Correct, correct.

THE COMMISSIONER: Sure.

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

THE COMMISSIONER: Yes, understood.

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

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

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

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

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

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

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

MS CLOTA: That's correct.

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

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

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

A/PROFESSOR FIELDING: Absolutely, yes.

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

A/PROFESSOR FIELDING: Yes, yes.

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

A/PROFESSOR FIELDING: Yes, we do.

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

MS CLOTA: Yes, we do.

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

MR FULLER: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A/PROFESSOR FIELDING: Yes, correct.

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

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

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

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

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

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

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

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

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

is?

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

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

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

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

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

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

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

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

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

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

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

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

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

A/PROFESSOR FIELDING: Yes, yes

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

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

A/PROFESSOR FIELDING: Yes, yes.

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

A/PROFESSOR FIELDING: Yes.

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

A/PROFESSOR FIELDING: Yes.

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

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

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

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

MR FULLER: Can I ask it --

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

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

A/PROFESSOR FIELDING: Yes.

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

A/PROFESSOR FIELDING: Yes, yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A/PROFESSOR FIELDING: Yes.

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

A/PROFESSOR FIELDING: Yes.

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

A/PROFESSOR FIELDING: Yes.

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

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

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

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

A/PROFESSOR FIELDING: Yes.

THE COMMISSIONER: They are?

A/PROFESSOR FIELDING: Yes.

THE COMMISSIONER: All right. And have you --

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

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

A/PROFESSOR FIELDING: Yes.

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

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

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

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

MS CLOTA: No.

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

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

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

A/PROFESSOR FIELDING: Yes.

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

A/PROFESSOR FIELDING: Yes.

THE COMMISSIONER: Okay.

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

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

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

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

THE COMMISSIONER: Thank you.

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

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

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

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

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

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

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

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

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

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

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

A/PROFESSOR FIELDING: SO do you mean when there's a complaint or normally?

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

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

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

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

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

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

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

MR FULLER: Obviously if complaints of bullying,

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

A/PROFESSOR FIELDING: Yes, yes.

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

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

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

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

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

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

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

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

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

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

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

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

MS CLOTA: Correct, November 2023, yes.

A/PROFESSOR FIELDING: It is very new.

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

A/PROFESSOR FIELDING: Absolutely. Yes, absolutely.

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

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

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

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

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

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

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

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

A/PROFESSOR FIELDING: Sure.

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

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

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

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

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

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

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

A/PROFESSOR FIELDING: Number 3, yes.

THE COMMISSIONER: -- the wording used is "long and growing wait times for elective surgery in Australia's public hospitals".

A/PROFESSOR FIELDING: Yes.

THE COMMISSIONER: Then you say that the number of specialists appears inadequate given the known elective wait times in the public sector.

A/PROFESSOR FIELDING: Yes.

THE COMMISSIONER: Does that statement also relate to - is that a national-wide opinion, as distinct --

A/PROFESSOR FIELDING: Yes, it is. Yes, it is.

THE COMMISSIONER: And can I ask you, though, do you still hold the same opinion in relation to New South Wales? Let me give you some context for that, though. You've, quite appropriately, used the Australian Institute of Health and Welfare. I haven't gone back and done a long analysis, but the last quarterly report from the Bureau of Health Information in New South Wales tells me - tells everyone - that in the last quarter, we still had 3,419 patients waiting longer than clinically recommended for elective surgery --

A/PROFESSOR FIELDING: Mmm-hmm.

THE COMMISSIONER: -- which is up from the December quarter but it's about 10,000 down from March 2023, which I assume would mean some correction following the pandemic. Would that be how you would understand it?

A/PROFESSOR FIELDING: Yes, absolutely. Yes, that's what happened, yes.

THE COMMISSIONER: Now, 3,419 people waiting longer than is clinically recommended for elective surgery, I guess in an ideal world that figure would be zero, and it doesn't tell me, I don't think, how in excess of the clinically recommended period those surgeries are being performed. Just help me, I'm actually scanning this document as we speak. I don't think there is anything reported in these

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

A/PROFESSOR FIELDING: No.

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

A/PROFESSOR FIELDING: Yes.

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

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

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

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

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

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

THE COMMISSIONER: Is that typical for your hospital?

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

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

discussions with your colleagues --

A/PROFESSOR FIELDING: Yes.

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

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

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

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

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

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

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

A/PROFESSOR FIELDING: Absolutely, absolutely.

THE COMMISSIONER: -- more broadly?

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

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

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

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

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

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

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

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

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

A/PROFESSOR FIELDING: Absolutely correct.

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

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

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

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

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

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

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

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

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

A/PROFESSOR FIELDING: I think we have.

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

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

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

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

A/PROFESSOR FIELDING: Sure.

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

A/PROFESSOR FIELDING: Okay.

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

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

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

<MS CLOTA WITHDREW

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

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

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

THE COMMISSIONER: 12 noon. Thank you very much.

SHORT ADJOURNMENT

THE COMMISSIONER: Yes, please proceed, Mr Fuller.

MR FULLER: Thank you, Commissioner.

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

A/PROFESSOR FIELDING: Yes.

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

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

Do you see that sentence?

A/PROFESSOR FIELDING: Yes.

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

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

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

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

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

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

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

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

A/PROFESSOR FIELDING: Yes.

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

A/PROFESSOR FIELDING: Yes.

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

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

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

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

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

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

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

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

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

A/PROFESSOR FIELDING: I don't know.

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

A/PROFESSOR FIELDING: Yes, absolutely.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A/PROFESSOR FIELDING: All of them, yes.

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

A/PROFESSOR FIELDING: Yes, which I wrote.

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

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

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

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

THE COMMISSIONER: H6?

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

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

MR FULLER: Sorry, Associate Professor, how did the

workshop come about?

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

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

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

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

A/PROFESSOR FIELDING: Yes.

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

A/PROFESSOR FIELDING: Yes, we do.

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

A/PROFESSOR FIELDING: Yes.

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

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

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

A/PROFESSOR FIELDING: Yes.

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

A/PROFESSOR FIELDING: Yes.

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

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

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

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

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

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

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

<EXAMINATION BY MR CHENEY:

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

Q. If you go to your answer to question 13 on page 13 of the document, do you see there --
A. Number 13?

Q. Yes.
A. Yes.

Q. Are we right to think of unaccredited trainees as those who have been unsuccessful in obtaining a training place in an accredited college training scheme?
A. Not usually. Unaccredited trainees are usually on a pathway to training. So in some states there are a lot more unaccredited trainees than we believe there should be - for example, in Queensland. New South Wales has a much closer relationship between the numbers of unaccredited and the numbers of accredited, which is, I think, a much more balanced position.

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

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

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

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

Q. Can you help with us that?
A. So we have said that we are very happy to look at a lot of those positions, where hospitals have a lot of unaccrediteds, to see if we can convert some of them to accredited positions, if there's enough caseload, case mix. It depends on the role of the unaccredited registrar. In a lot of hospitals they will be used for service delivery, for example, for shifts overnight.

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

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

Q. Are you contemplating that such a career medical officer would play a surgical role in the surgical team, or are you --
A. Yes. So in a lot of the teaching hospitals, there's a large number of registrars in a unit, particularly if you are dealing with a lot of complex caseloads, there's a lot

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

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

Q. You speak about that as an opportunity that should be explored. Is that something that would be typically raised by you through your membership of the Health Workforce Taskforce?
A. Yes, we have mentioned it with that group and also directly to the health department and I, prior to this role, had a senior role in HETI, the Health Education and Training Institute for NSW Health, for many years and it's something we've been talking for a long time.

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

Q. You spoke earlier about the college's need for some data on --
A. Yes.

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

to meet service needs?
A. Yes.

Q. I think, to use your term, you described it as wanting to know where health wants more surgeons and where we could be training them?
A. Yes.

Q. The Commissioner, I think, asked you about whether you had had any success in obtaining that data from NSW Health?
A. Yes.

Q. Or from the task force; is that right?
A. Yes, yes.

Q. Did you mean to convey by your answers to those questions that you had not received any response from NSW Health about --
A. Oh, they said they would help us. They've said they would help us.

Q. Indeed, you raised it formally I think for the first time, did you not, with the Health Workforce Taskforce - that is, raised this need for data - by a letter to the task force head, Ms Pearce --
A. So it was first raised --

Q. Just bear with me. Could you just bear with me?
A. Sorry, sorry.

Q. Did you raise it via a letter to Ms Pearce, who is the chairwoman of the task force, a letter you sent on 4 April this year requesting that data?
A. Yes.

Q. And you received a response from Ms Pearce, did you not, to the effect that the data was being assembled for you?
A. Yes.

Q. Did you not think that would be relevant to answering the Commissioner's questions about what the response --
A. No, it should have been in the response, you are absolutely right.

Q. In any event, the good news is, I think, is it, that the task force meets again tomorrow, does it not?

A. Tomorrow, yes, it does. Yes. I've got several meetings tomorrow. Yes, it does.

Q. The topic is on the agenda for that meeting, as you understand it?
A. Yes.

Q. And the letter that was sent to you in response to your 4 April letter, a letter that I suggest was dated 15 May from Ms Pearce, reported, among other things, that the data was expected to be to you, to the college, by late July? Do you recall that?
A. Yes, that's right.

Q. And it's likely you'll be discussing that tomorrow?
A. Yes, we haven't had any data.

MR CHENEY: Nothing further, Commissioner.

THE COMMISSIONER: Thank you. Did anything emerge from that?

MR FULLER: No, thank you, Commissioner.

THE COMMISSIONER: Associate Professor, thank you very much for your time and for the statement you have provided. We are very grateful.

THE WITNESS: Thank you.

THE COMMISSIONER: Please pass on our thanks to Ms Clota as well.

THE WITNESS: I will, thank you very much.

THE COMMISSIONER: You're excused, thank you.

THE WITNESS: Thank you.

<THE WITNESS WITHDREW

MR MUSTON: I think the next witness is Dr Linda MacPherson, Commissioner.

<LINDA MacPHERSON, sworn: [12.36pm]

<EXAMINATION BY MR MUSTON:

MR MUSTON: Q. Dr MacPherson could you state your full name for the record, please?
A. Linda MacPherson.

Q. You are the director workforce reform, within the workforce planning and talent development branch of the New South Wales Ministry of Health?
A. Yes.

Q. You have held that role I think since October 2023.
A. Yes.

Q. Prior to that date, you were a medical adviser to NSW Health?
A. Yes, and the workforce planning and talent development branch.

Q. That's a role that you held for almost or around 20 years, I think?
A. Yes.

Q. And in that role, you traversed many of the same issues, as we understand it, to those which you have covered in your statement?
A. Yes.

Q. You have prepared two statements, in fact, to assist the Commission with its work, the first dated 12 July 2024?
A. Yes.

Q. Do you have a copy of that statement with you?
A. Yes, I do.

Q. Have you had an opportunity to read that before giving your evidence today?
A. Yes.

Q. Are you comfortable that the contents of it are true and correct to the best of your knowledge?
A. Yes.

MR MUSTON: That will be tendered in due course, Commissioner.

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

perceived to be future workforce needs within the health sector?
A. I would have to take that on notice.

Q. So it's not to say that it doesn't happen, but you're not aware of any particular process whereby there's discussion between the state and the Commonwealth about projected workforce needs over the next, say, five to 10 years, probably 10 to 20 years, within the medical sector?
A. Through the national Health Workforce Taskforce, there's a discussion by all jurisdictions about what workforce, so through that mechanism there is engagement with the Commonwealth.

Q. A moment ago in your answer you referred to the fact that there were more intern placements than there were graduates, at least within New South Wales?
A. No, across the country.

Q. So within New South Wales, what's the position - last year?
A. Again, we exhausted the number of people who had applied. There were no people left on the list to appoint to positions, therefore, at the end of intern recruitment there were vacancies.

Q. To what extent, if at all, is the number of intern positions reflective of, say, the needs of the workforce?
A. Local health districts determine the number of intern positions they need. They - intern positions are part of the workforce that provides service, therefore, that is one factor that will be considered when establishing intern positions. The other factors are whether they can provide the supervision and the training that is required for interns to meet the Medical Board of Australia requirements for general registration at the completion of internship.

Q. I might come back to that. Just to set a bit of a map, the rough trajectory of one of the graduates from one of these funded or self-funded medical university positions is they graduate, they then do a year or two as an intern?
A. The first year is internship. They have to complete internship to be eligible for general registration with the Medical Board of Australia. And then they will usually do another second postgraduate year, and those two first years are called prevocational years, and then they will look at

entering specialty training.

Q. So PGY1 is the intern year where you don't yet have registration, your general registration?
A. You have provisional registration.

Q. You've got get through your PGY1 in order to get your general registration?
A. Correct.

Q. At which point most people, but not all, will go on and do their PGY2 which is a further period of training delivered by the public health system --
A. Correct.

Q. -- within the hospital setting?
A. Correct, and the two-year capability framework that has been implemented supports that.

Q. In terms of the appointment of people to intern positions, that's a process which is, as we understand it, managed by HETI or administered by HETI?
A. It's coordinated by HETI, yes.

Q. At the end of the PGY2 year, these graduates, now generally accredited doctors, have a decision to make about whether or not they want to become a specialist or continue to work as a non-specialist, or a career hospitalist; is that right?
A. Yes. It's usually from the postgraduate 3 year that a lot of college programs will look at selecting people into specialty training. It does vary across the different college programs.

Q. Could I ask you to go to paragraphs 36 and 37 of your statement on page 8, just to make sure we're talking about the same thing. Once one gets to the end of their PGY2 year, the decision that they're making is this decision that effectively you've referred to in 36 and 37; is that right?
A. Yes.

Q. In terms of 37, the doctors who choose not to apply for specialist training, what is the career trajectory for them?
A. They might not choose immediately to apply for specialist training because they might be seeking further

experiences before applying for specialist training later on.

Q. Why might they do that?
A. Some colleges, as selection criteria, perhaps will require certain experiences in addition to those undertaken as an intern to be selected into training.

Q. In terms of the colleges that have those additional experiential requirements as selection criteria for training, what impact does that have on workforce from the ministry's perspective or from the LHDs' perspective?
A. Those doctors will then be seeking those experiences through unaccredited positions. It does mean that they will be entering training later in their careers and therefore how long they perhaps work as a specialist might be less than somebody entering earlier.

Q. So I think I interrupted you. There are the candidates who are seeking that additional experience before applying for vocational training as a specialist. Are there candidates who are not seeking to undertake vocational training as a specialist at all?
A. My experience is that probably the majority - it's a heterogeneous group. There are some people perhaps who know right from medical school what career they want, what specialty they want to pursue; there are others who perhaps are still not sure and therefore will take the opportunity to work in unaccredited positions to identify where they want to go down the track; and there are some people who perhaps immediately might not want to enter specialty training for personal reasons, you know, looking for a bit of work/life balance or perhaps parental responsibility. So it's a really heterogeneous group.

Q. Is there a cohort amongst that heterogeneous group who, at least for a period of their career, leave the public health sector to pursue what might be seen as more lucrative career in locuming?
A. I understand there would be some doctors in that position, yes.

Q. Does the ministry, or at least the part of the ministry that you work in, have any sense of how large that cohort is?
A. I would have to take that question on notice. It's a flexible group.

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,

become fellows of the college and are specialists?
A. Correct.

Q. Can I then just take us back very briefly to the start of that journey, to the university side of it. In paragraphs 46 and 47 you tell us a little bit about the bonded positions within medical programs. In relation to that, the first question is: do you think the 28.5 per cent of all commencing CSPs in medicine as a slice of the overall graduates is a sufficient number of bonded positions to achieve the outcome, the distribution outcomes, workforce distribution outcomes, that I assume that program is intended to achieve?
A. To support - it's a Commonwealth program and it's looking to reflect what the population and distribution needs are. So I think it is a good start, yes.

Q. It contemplates three years' worth of bonded service post graduation. On the basis that, on the little timeline that we've just walked through, that probably comes to an end before someone has commenced their vocational training, do you think three years is long enough to actually achieve outcomes in terms of adjusting the distribution of the workforce through this mechanism?
A. There is evidence that having people train in a rural location allows them to develop those roots, therefore, I think three years gives those people time to work and establish themselves in a rural location. It is a Commonwealth program and it has changed over time.

Q. We've heard some evidence about challenges faced by a number of colleges, programs, insofar as training, vocational training within rural areas is concerned, in that they are not, they feel, able to provide the full suite of training opportunities to vocational trainees within a wholly rural setting. Is that something which generally reflects your understanding of that vocational training process?
A. Yes. There also has been a view that perhaps some college training requirements or accreditation requirements are metro-centric so that they perhaps limit the opportunities to fully take advantage of rural training opportunities, yes.

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

setting, if they are students who choose to pursue vocational training, are then effectively forced to spend some fairly important years of their lives, in terms of laying down roots, in a metro area?
A. It depends on which specialty pathway they choose. For example, something like neurosurgery, you will not have many rural opportunities, but if you, for example, choose to do general practice training, there are a lot of rural GP training opportunities. So it does vary on the specialty, and it also will vary on if you can't do - you might not be able to do the full training in a rural location, but you can do part of your training in a rural location.

Q. So coming to the next step for the graduate, which is this intern process that you've told us about, could I take you to paragraph 62 of your statement. You tell us that intern positions are funded by the LHDs, and it's the LHDs that are responsible for determining the number of intern positions they require. In making those decisions, do you have a view about whether, in addition to the factors that you've identified there in paragraph 62, the funding available to LHDs is another one?
A. Certainly funding will be another factor - how many positions they can support and the funding for those positions.

Q. I gather from what you tell us in paragraphs 63 and 64 about the ministry funding of the 45 intern positions and the competition amongst rural LHDs to try and secure some of those positions, that it might be inferred if the rural LHDs had more funding they would be delighted to take more interns?
A. If they can support the supervision and training requirements.

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

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

term workforce planning perspective?
A. How - can you please clarify? How do you mean?

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

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

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

Q. And presumably, but correct me if I'm wrong, that consideration about the distribution of the intern positions has some regard to things like longer term workforce planning and where a wider distribution of interns within rural and regional settings might, from a longer-term perspective, be useful?
A. The focus has been to increase rural and regional overall and to ask the districts where - you know, where their focus is and the needs of the positions, yes.

Q. My question is: other than those 45 positions, is there any consideration being given at ministry level about how many interns there should be in any given cycle and the way that they should be distributed across the system from a longer term workforce planning perspective?
A. If I can go back, over the last perhaps more than 10 years, we have been monitoring the number of intern positions to see that we are able to meet our guarantee for the intern positions, so that has been close focus on monitoring of positions overall to see that that guarantee has been met.

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

monitoring involves communicating with the LHDs to ensure that each of them is able to maintain a particular level of interns in coming cycles?
A. It has over the previous years, yes.

Q. I might take you to paragraph 135 of your statement, which might provide an answer to my next question, but in paragraph 135 you tell us the ministry does not manage or distribute, amongst other things, intern positions centrally.
A. Correct, except for when there are special funding, such as those 45, yes.

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

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

MR MUSTON: I note the time, Commissioner.

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

MR MUSTON: We may.

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

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

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

adjourn until 2 o'clock.

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

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

MR MUSTON: Thank you.

LUNCHEON ADJOURNMENT

THE COMMISSIONER: Yes, Mr Muston.

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

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

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

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

Q. Are there any future workforce planning operations happening at a ministry level there, so far as you are aware, to inform what the LHDs are doing in terms of decision-making around where and when to try and stand up JMO placements for vocational training?
A. The ministry - as I say, it's not my area that I work in, but I understand workforce modelling - workforce modelling has been done and continues to be done. Fact sheets are published, have been published, that identify

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

Q. So the number of a particular type of specialist is one issue. Another issue is where those specialists are being trained; is that right?
A. Yes, the modelling fact sheets do provide information on the distribution of specialists, yes.

Q. Do you know what sort of collaboration, if any, is happening between ministry and colleges about those workforce planning type issues - that is to say, where training positions should be, how many training positions there should be, et cetera?
A. I would have to take that on notice.

Q. Who within your group or department deals with that?
A. I think Mr Richard Griffiths would be able to provide advice on that.

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

Q. And you refer to the possibility of a mismatch between specialist training positions and workforce requirements?
A. Based on, yes, that they will consider also the number of positions that they need junior positions to support management of the roster, and that can sometimes result in a mismatch between the number of positions required to meet future specialist needs versus the number of positions required to meet roster requirements, particularly in specialties where there is a 24/7 roster.

Q. So when you say the "mismatch", are you inferring or seeking to convey there that it may well be that there are more JMO positions being created and potentially training positions being created than are required to meet the future workforce needs in certain areas of specialisation?
A. In some specialties there may be overall more accredited training positions than required to meet future requirements for specialist workforce.

Q. Are there any in particular that you have in mind that would fall into that category?
A. So the specialties that require 24/7 rosters, emergency medicine in past modelling has indicated perhaps that there might be - the Commonwealth modelling indicated that we might have more accredited positions than required, of the emergency medicine specialists. However, I think that is not borne out by experience. There is certainly a maldistribution of emergency medicine specialists between metro and rural.

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

Q. Could you just perhaps, from the perspective of a trainee, explain how those network positions operate?
A. So when they are recruited to a training position, they will be recruited to a training network, and so they will know which are the group of hospitals that the - that constitute their network and where they may be required to rotate to. It is then within the network will determine the rotations across the network, and I understand that that would - the factors that would be considered are where the trainee is up to in their training, what they need to achieve, the experiences and trainee preferences.

Q. And is that something which is managed by the colleges or managed by HETI or does it depend on which specialty we're talking about?
A. It depends on which specialty. So, for example, the Royal Australasian College of Surgeons and the sub-specialty organisations such as General Surgeons Australia manages general - determine where the general surgeon trainees go and the Australian Orthopaedic Association determine where the orthopaedic trainees go. For other specialties such as the basic physician training, that we have 11 basic physician training networks, where the trainees go will be managed by the network director of training for that network.

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

permitted into one of their training programs?
A. Correct.

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

Q. Do you see there to be potential benefit in an expanded role of either HETI or the ministry to try and create or take a greater involvement in that networking and the movement of people through those networks than - across all areas of specialisation than it currently has?
A. Can you clarify, you mean in broader than just the training networks that we have established now?

Q. Yes. So for all specialty training pathways, do you think there would be utility in the ministry, perhaps HETI, having a wider role in terms of identifying, in collaboration with the colleges, who should go into those positions and moving trainees through the networks and through their training in a way that maximises efficiency within that area?
A. And if I can break it down into two parts - there's, first of all, obviously the actual selection into a college training program, and then the management of those rotations.

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

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

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

Q. Just looking at that anaesthetics example, as we understand it, the way in which people are pushed through that narrow bottleneck of paediatrics is they do a term at the Children's Hospital and it's assumed, no doubt based on some assessment of the case mix, that during that term they will cover off all of the things that they are required to cover off in terms of the gained experience through that, for example, the number of children under 2 that are anaesthetised. Is that your broad understanding of the way that works?
A. Correct. My understanding is, yes, the term rotation to look at what they can achieve, but there are anaesthetic services provided for children outside of the children's hospitals as well, but obviously the case mix may be different.

Q. If, for example, the ministry or some part of the ministry was involved in moving trainees through these networks, there might be an ability to have trainees exposed to each of the things that they're required by the college to be exposed to, in less time than the standard term that the college, under current arrangements, might rotate them through?
A. I can't speak to what the college would accept as, you know, suitable time experience, but certainly the advantages of a network, it does allow a more coordinated way of managing training.

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

I know there are others, but anaesthetists are not. Is there some --
A. As I refer to in my statement, one of the final paragraphs, there is, my understanding, no identified funding for new networks or expanding the networks we have.

Q. So do I take from that that the reason, at least at the moment, that more networks and the potential training benefits that they might secure has not been explored is because there is no funding allocated to that by the ministry?
A. I'm not aware of funding for them.

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

Q. So do we take it from that that whilst the ministry knows how many JMOs of a particular vintage - that is, to say PGY4, PGY5, might be out there in the system, you don't, based on that payroll data, have any sense of whether that PGY4 is training to be a physician as opposed to training to be a surgeon or an anaesthetist?
A. As I set out in my statement there, that the coding of positions has been a process to try to identify that, but it is not as accurate as it could be.

Q. Can I ask you, in relation to that problem, does that extend also to staff specialists, in the sense that staff specialists are all on the same award?
A. Staff specialists are all on the same award? I'd have to take that on notice, yes.

Q. But insofar as you are aware, there is no ready way, based on at least the payroll data, to work out whether staff specialists in a particular facility are an endocrinologist or a dermatologist or a rheumatologist?
A. I'd have to take it on notice.

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

policy direction. In relation to the ministerial policy direction, what has, insofar as you're aware, actually happened or changed in terms of the ministry's dealing at the LHDs and the ministry's dealings with the colleges since that policy direction was issued?
A. Since the ministerial policy direction has been issued, the communication protocol has been developed by the Australian Medical Council and it has been implemented. One of the key requirements of the communication protocol has been to ensure that all stakeholders develop a generic contact point to contact each other.

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

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

Q. So it's early days --
A. Yes.

Q. -- but do you have any sense of making sure whether the right people are speaking to one another and appropriate advance warning of withdrawal of accreditation has actually resulted in any material changes in the way that the accreditation system is operating?
A. As you say, it is early days. In addition to that, there is the work that the Australian Medical Council is also undertaking on implementing the National Health Practitioner Ombudsman recommendations to improve processes, so I think a combination of things there is looking to make improvements, yes.

Q. In relation to the implementation of the ombudsman's recommendation, what progress has been made on that front?
A. As I say, the Australian Medical Council is leading the work and they are working with colleges to develop a model accreditation standard that would be used by all colleges. So work is progressing on the recommendations. Work will be under way, too, around recommendation 13 to

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

Q. So would it be fair to say work is progressing in terms of the way in which colleges and jurisdictions such as New South Wales might go about implementing those recommendations, but as matters currently stand, the recommendations have not been implemented?
A. They are being - work is progressing to implement them, and they will be around college processes, yes.

Q. From the ministry's perspective, do you see any reason why the recommendations made by the Ombudsman ought not be implemented?
A. No.

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

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

Q. So some areas of specialisation are very popular?
A. (Witness nods).

Q. And perhaps have a limited number of training positions?
A. Yes.

Q. And in those cases, those training positions are likely to be oversubscribed?
A. Correct. Particularly perhaps in metropolitan regions, so there's sometimes a balance between positions filled perhaps in the metro area and for the same specialty perhaps not filled in an outer metro or rural and regional.

Q. But in relation to a very popular area of specialisation with a very limited number of training positions, the distribution issue is less acute - that is to say, some candidates, whilst it might not be their first preference, will happily go to a regional or rural location if it means getting on to the program?
A. They certainly have those opportunities. One thing that, through the work that I'm doing supporting the national task force and one of the projects that we are undertaking of looking at streamlined or opportunities to improve recruitment processes and coordination is that we perhaps do not have good consolidated data as to, you know, applicants if they don't get into their first preference, do they take their second preference or not.

Q. Do you see an opportunity for the ministry to have a greater role in the allocation of those training positions across all of the colleges?
A. Sorry, how do you mean, "allocation"?

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

Q. I think you've indicated in an answer that you've already given that there might be some scope for the ministry to have a greater role in identifying where those positions should be from a longer term workforce planning perspective?
A. (Witness nods).

Q. You've got to say it out loud --
A. Yes, yes.

Q. -- so the very patient lady next to us can take it down.
A. Yes.

Q. Obviously that would have to occur in collaboration with the LHDs?
A. Correct, yes.

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

Q. The colleges themselves don't have a wealth, we're told, of workforce data which would enable them to make decisions of a longer term workforce planning type?
A. Although when they accredit positions, they should be accrediting the positions on the merit of the position, of whether it meets the requirements or not.

Q. Colleges are accrediting a position based on the merit of whether, from a training perspective, it meets the relevant criteria?
A. Correct.

Q. Colleges are not making decisions about whether to accredit position informed by data that is relevant to longer term workforce planning considerations? For example, do we need another - in 10 years' time are we going to need, as part of our succession planning, another surgeon in Wagga Wagga, or another endocrinologist in Dubbo?
A. They're accrediting against the accreditation standards, yes.

Q. Having established the existence of positions and the accreditation of the hospitals' facilities in which those positions are to be placed, do you see any role for the ministry, perhaps akin to the role played by HETI in relation to the distribution of the intern workforce, in filling those positions and distributing them across the network in a way which best meets the needs of the health service as opposed to best secures the training opportunities in the locations which are popular?
A. Just to clarify, my understanding is that HETI coordinates the recruitment process and manages the match of applicants based on their preferences. But I'm not quite sure the way you mean - they're not sort of - they're matching people to the positions based on applicant preferences.

Q. But every position - just dealing with the HETI intern situation, every candidate is not getting their first preference?
A. The algorithm, my understanding of the algorithm is that it matches people to their best - to their best match, yes.

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

which gives as many of them their highest preference as is feasible?
A. Correct. And in the annual junior medical officer recruitment, that is undertaken, there are preference matches also undertaken, for example, for basic physician training. But one of the differences is that the networks interview the applicants and then, based on applicant preferences and the rankings by the network, again, there is a match done and one offer is made, and certainly preference matching reduces the churn of positions, of people getting multiple offers and then accepting one and declining.

Q. And for that reason, would there be utility, do you think, in expanding, perhaps even the basic physician training type model, out to the vocational training referable to other colleges within the wider network?
A. To undertake preference matching for other specialties?

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

Q. As part of that process, with the benefit of the workforce data that the ministry has, no doubt in collaboration with the LHDs and the colleges, training positions could be distributed across the network in a way which best meets or hopefully best meets future workforce needs?
A. So as well as just doing the match, you're suggesting first of all determine where the positions are and then run the match?

Q. Yes. Because as I think you have told us a moment ago, there tends to be a weighting towards metropolitan training positions?
A. That is my - in some specialties, yes, there would be more likely to perhaps have a metropolitan site filled rather than the --

Q. Easy to create, given the population of staff specialists and VMOs in a wide array of areas in metropolitan hospitals?
A. Correct, yes.

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?

A. Correct. And nationally.

Q. You've told us at paragraph 159 of your statement that one of the challenges presented by the deployment of international medical graduates is they're often used to fill positions in areas of workforce shortage, which means they have more limited mentoring and supervision than might be ideal. Do you have a view about what could be done to deal with that problem, that challenge?
A. So certainly, as I indicated in my statement, the ministry has run the IMG program there to support people becoming familiar with the system. I think we also do need to look at different types of supervision, and it has been raised by the Kruk review as well, that we need to look at innovative models of supervision, whether supervision can be provided remotely or can be provided by different health professionals.

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

Q. Could you move forward to paragraph 166 of your statement where you tell us about some challenges. You tell us that it's difficult for the ministry to have a significant role in determining the distribution of specialist training positions as they are not discretely funded by the ministry, so no mechanism to redistribute medical training positions across the districts. That's problem one. Can I ask you about that? All of the specialist trainees - that is, the JMOs - are, in fact, employed by the secretary; that's correct, isn't it?
A. They are employed by the secretary, delegated to local health districts. So my understanding is that the decisions, as I said, and the funding, is from local health district budgets.

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

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

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

Q. As to the second challenge that you raise there, being a lack of accurate specialist training position data, that we've already discussed, is there a way you can see that collection of that data could be better incentivised through the LHDs or achieved centrally - that is to say a better understanding of how training positions and staff specialist positions across the system more generally are --
A. As I say, I can't speak to the staff specialists, but the training positions, obviously, as I've indicated in my statement with the specialty coding, there is no incentive to maintain the specialty coding.

Q. It could be incentivised, say, through the addition of a KPI?
A. Possibly, yes.

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

Q. Is that your observation?
A. Possibly, yes.

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

accreditation. In paragraph 19 you refer to a role that RANZCR has to play, together with employers, to improve the culture of supervisors. I am just wanting to explore with you, what do you see the role of the colleges as being insofar as dealing with, say, behavioural issues by staff specialists employed who happen also to be their fellows, of concern?
A. Obviously the term "culture" is quite broad and I think we acknowledge that there are unacceptable behaviours where there is a complaint made that has to be dealt with with the employer.

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

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

Q. To the extent, though, that supervisors or staff specialists within particular departments who may happen to be fellows of a college engage in behaviour which is of a bullying character or unacceptable workplace behaviour of any type, I gather you're not telling us in paragraph 19 that you think it's the colleges who have a role to bring them into line but --
A. No, that's the role for the employer to investigate and deal with that.

Q. Appropriately as the case may be?
A. Yes.

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

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

in that paragraph that Mr Muston was just discussing, where you've already said at paragraph 18 RANZCR doesn't have the authority to investigate a bullying complaint, et cetera, and then in 19, just on that part of the statement where Mr Muston was asking you that RANZCR has a role to play, together with employers, to improve the culture of their supervisors, to your knowledge, is that a role that RANZCR accepts, that it does have a role to play in relation to that? Has that emerged out of your discussions with the colleges or elsewhere?
A. I'd say more broadly. I speak to a lot of colleges, as I say, and certainly the Australian Medical Council's standards, too make it clear that they see that colleges and employers have a role in working together in collaborating to support - to have that supportive environment for training.

Q. And whilst I don't know that it's going to be particularly important for me to exactly resolve what was said at the meeting that you're responding to, was that issue of having a role in relation to addressing a cultural issue or improving culture, was that discussed at that meeting?
A. My recollection is that the broad role that - as I said, broadly, that colleges have a role. When we - culture is a very broad term. One is the unacceptable behaviour, but more that the culture of that training --

Q. This meeting was in the context of some complaints about bullying, wasn't it?
A. It was about a poor culture in the department, I understand.

Q. Specifically related to that or was it broader than that?
A. I understand there was also, as well, concerns about training - perhaps supervisors not providing, you know, appropriate number of tutorials or things like that, yes.

Q. I see. All right. Okay. Did I cut you off, part of your answer?
A. No.

THE COMMISSIONER: All right. Thank you.

Yes, Mr Cheney, do you have any questions?

MR CHENEY: No, Commissioner.

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

<THE WITNESS WITHDREW

MR GLOVER: The next witness is Dr Murphy.

<KAREN HELEN MURPHY, affirmed: [2.42pm]

<EXAMINATION BY MR GLOVER:

MR GLOVER: Q. Dr Murphy, could you tell us your full name, please?
A. It is Karen Helen Murphy.

Q. You are the acting executive director medical services and clinical governance, for the Illawarra Shoalhaven Local Health District?
A. I am.

Q. You have been in that role since about September '22; is that right?
A. No. I started in the role 'December 23 formally, and I covered the role for around six weeks August '23 and a few weeks before that as well.

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

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

Q. Have you had a chance to read it again before giving your evidence today?
A. I have.

Q. Is it true and correct to the best of your knowledge and belief?
A. It is.

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

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

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

Q. Would you just describe in practical terms what that process is, as you understand it?
A. Yes. The numbers of specialists required to provide the level of health care that's expected in this country is determined through comparators around the world but also best practice and benchmarking, and then the definition of requirement of those specialists per population head is what is defined in the Australian Institute of Health and Welfare and in some of the other documents provided.

Q. So when you say "the numbers of specialists required to provide the level of health care that's expected in this country is determined through comparators", who is undertaking that process?
A. It would be through the federal government, I would imagine, and then other organisations. That's not something that I participate in.

Q. So how is that analysis or work used by your LHD?
A. So we look at our population demographics. We look at the predicted population demographics, because we're always forward planning, and then we look at the requirements of our population, the health determinants of the population and then decide what would be suitable to provide the health care at that level publicly.

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

A. Because it's a personal choice of the doctors, often.

Q. Right, but the district can deploy its resources to at least attempt to recruit and retain the number of specialists that it considers that it needs to provide the level of services, as you put it, that's expected in the country; correct?
A. Which we do, on a regular basis and a constant basis.

Q. So is it simply the case that because one can't compel a doctor to come and work in the district, that you say the district can't influence the number of specialists in its region, or is there something more to it than that?
A. No, it's mainly that. At times it's also about the level of service that we can provide in the area. So, for example, we may not have an interoperative MRI theatre in Shoalhaven and a specific surgeon only works using an interoperative MRI when you're in theatre, therefore, that surgeon wouldn't choose to come and work in Shoalhaven. That would be an example.

Q. But that is something that the district could, if it chose to, influence by making that equipment, facility, what have you, available, could it not?
A. Not necessarily, because the way that you would define how services are required is also around the governance practice and process. So if you were only doing four of those operations a year in Shoalhaven, the clinical governance - so the ability of the surgeon to be able to maintain their skills level by only doing four of those operations a year - would not provide safe effective care for that patient nor would it be cost effective.

Q. These are particular examples of particular procedures, though --
A. They are.

Q. -- are they not?
A. They are. But that would apply to quite a number of procedures.

Q. But taking it out of the micro level into the macro, there are things that the district can do to influence the number of specialists that it might be able to retain for its services, are there not?
A. There are very specific needs for clinicians in specific areas. So we can, for example, employ a surgeon

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

Q. You tell us some of them in paragraph 25 and following of your statement; correct?
A. Correct.

Q. Can I take you ahead to paragraph 9 of your statement, please. Just before I do, I'm sorry, operator, before I leave paragraph 7, in that passage that I was just taking you to where you say that the district cannot influence the number of specialists, you reference the impact of the district service agreement with the secretary?
A. (Witness nods).

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

Q. So in what way does the district service agreement with the secretary provide a barrier to the influence that the district can have on the number of specialists that are retained by it?
A. I don't believe there's a barrier, there's a discussion that is carried out every year to determine the requirements of the service provision in the Illawarra, and that then becomes part of the service level agreement that the health district works with.

Q. But the district can have influence and input into that process?
A. Yes, it can.

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

Q. In what way?
A. The colleges, as you have heard this morning, can define the number of trainees that they can support going through their service; they will also define the

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

Q. Is this the accreditation process that you're referring to?
A. It's the accreditation process and also the assessment of what the skills and abilities and exposure to training capacity that the districts can provide to college trainees.

Q. When you refer to the "assessment of what the skills and abilities and exposure of the training capacity that the districts can provide", is that something that is separate to the accreditation process, to your understanding?
A. No, it's aligned with the accreditation process.

Q. So do we understand in paragraph 9 you to be referring to the influence the college has in imposing standards on facilities for the training of specialist clinicians within the relevant program?
A. The colleges do influence that significantly, but in the appropriate way.

Q. Does the district have any influence over the number of specialist training positions, in your view?
A. Yes. The district can also consider whether they want to approach a college to request an accredited position. They can approach a college to expand and enhance that training position. We can also look at enhancing the opportunities that we can provide to trainees, so looking at perhaps more of a district approach in some of those training positions. So, yes, there's a - it's not a fixed relationship; it's a very flexible relationship.

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

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

Q. And your district does that from time to time, does it not?
A. It does.

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

Q. Can you just describe some of your observations in that area, please?
A. Yes. There's a number of more flexible opportunities that are being developed now, understanding that trainees may need specific support if they're working outside of the metro-centric areas. The colleges are being a lot more flexible and understanding that the provision of a supervisor may not necessarily be a physical supervisor that's there all the time; it may be done through a variety of modes, so it could be done remotely at times, it could be done through a fly-in/fly-out assessment and accreditation of supervision. So the modalities of being able to provide that level of training in the less metro-centric areas are really increasing significantly.

Q. And is some of that work being done in conjunction with your LHD?
A. It is. We are looking at the colleges that would enhance and support us providing trainees access to skills and abilities in some of our more rural areas.

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

Q. -- during this Inquiry. Are there any in particular that are engaging with your LHD in this process?
A. Certainly both of the general practice training colleges are really engaged with our organisation, particularly at the southern end of our district. We've got some really positive support from the Royal college of physicians as well, again, looking at how we can support trainees across both ends of our district and make sure that they get the experience they need.

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

where our population has significant challenges.

Q. I take it that you see benefit in specialists training in more rural and remote areas, do you?
A. Absolutely, and previously in other experiences, there is a significant benefit to trainees in working in the non-metro areas, for sure.

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

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

Q. The matters that you have been describing in your answers to these few questions, are they things that you have observed during your time within the district?
A. Within the district and outside of the district.

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

Q. Including Queensland and Western Australia?
A. And Victoria.

Q. And the observations that you've just described are things you have seen in those jurisdictions as well?
A. Absolutely. It makes a huge difference.

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

Q. In what way is the ministry involved in that work, to your observation?
A. I'm aware that HETI has taken a very active part in that, as well as the workforce team at the ministry as well, to develop those relationships with the colleges and help promote that level of interaction and then flexibility.

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

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

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

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

Do you see that?
A. That's correct.

Q. Can you just explain what the process that you're referring to there is, please?
A. I can. There are really two ways of doing that. Some of the bigger colleges will allocate trainees across a broad district area, so it may be across four or five districts, it may be across the state, in some instances it's almost a national allocation.

Q. Just pausing there, which colleges do you have in mind?
A. The college of anaesthetists, for example, they will direct and dictate where the trainees need to go to fulfil their requirements.

Q. As part of what has been described to us as a "network approach"?
A. Correct. That's correct. And then some other colleges will look at the support that you can provide to trainees, look at the things that they can be exposed to, so those are requirements to be exposed, for example, with the Royal college of obstetricians and gynaecologists, a number of caesarean sections that trainees have to fulfil. So you would look at how many births, how many are done by caesarean section.

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

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

Q. Is this a process that HETI delivers prior to a particular facility going through an accreditation process?
A. It can - it does on a regular basis and will help pre-empt some of those accreditation journeys. Not in every case.

Q. Well, let's take that example first. So let's just take a hypothetical example in your district. A facility is about to undergo an accreditation process to stand up a training position for one of the colleges, how would HETI become involved and what would the process be that you're referring to in paragraph 17?
A. So we have directors of education who are clinicians who provide the support to our juniors in their training pathways. HETI works directly with those directors of education and they have regular meetings, conversations about trainees and the experience of the trainees.

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

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

Q. So to summarise that, it's really a preparation process to get the facility into a position where it is likely to pass, for want of a better term, the accreditation process?
A. It is a supportive process, yes.

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

Q. In what other way, to your observation?
A. So if there were reported issues, we would be in - HETI would be in contact with us to discuss what those issues were, what we can do to mitigate those issues and what the opportunities are to change, improve, enhance or

otherwise the accreditation processes.

Q. As part of this, does HETI liaise with the colleges as well?
A. They do.

Q. And in both scenarios, how does HETI become involved? Are they drawn into that process by the relevant LHD?
A. They can be. They also have a standard process where they will always be in contact with the directors of physician education and surgical education. They have regular meetings with the representatives of the LHDs and the representatives of the trainees.

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

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

et cetera. First of all, how did that process arise and then play out?
A. The accreditation for the cardiology training positions was carried out in the local health district and one of the recommendations was that the training doctors required further exposure to certain cardiology procedures that were not provided in the Wollongong Hospital, but that were provided by the same cardiologists in the private hospital next door. So we looked at the - how we could actually work with our partners next door, and also the cardiologists, to permit the training registrars to move into the private hospital next door to gain that experience in that particular modality.

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

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

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

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

Q. And you've used the cardiologists as one example. Are you aware of other similar examples for other trainee groups?
A. Yes, specialist GP trainees. So there are GP trainees who may also want to get experience working in an emergency department in a tertiary site, for example, or obstetrics and gynaecology in a tertiary site, and so we work locally with the general practitioner trainees and then we can work with our own in-house emergency departments and obstetrics units to be able to provide exposure to those trainees to gain skills.

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

Q. Can you just describe what you mean by "siloed approach across health services in New South Wales"?
A. I think that the examples that we've just discussed, where a private facility and a public facility and HETI and a college work together for the benefit of the patients to have access to exposing the training professionals to be able to provide that care is still in its - probably in its infancy in New South Wales, and I think that that's more about the custom and practice and I think the more we can break down those barriers or perceived barriers about doing that, I think that will help us with that development of a not so siloed approach.

Q. Do you also see the collaboration of the kind that you described a moment ago in relation to cardiology training as being one method to perhaps overcome the challenges in delivering training in rural and regional areas to be specialties?
A. Potentially. It could be. And certainly where there are multiple facilities that can offer different experiences to training doctors and training nurses and training allied health staff, it could be done to encourage that rurality.

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

Q. Are you there referring to silos within NSW Health agencies?
A. In some instances, yes.

Q. Can you just describe what they are?
A. There is still a tendency in health generally, not just in New South Wales, that health systems work in specific silos. So it's still not the norm that whilst you would have clinicians who may work across a private facility, a public facility and provide a service in another state, those organisations don't necessarily work closely together and that can be through the clinical or non-clinical staff not working closely together.

Q. What about different arms within NSW Health itself? Do you see a similar issue there?
A. It is reflective of the process that is health and the complexities of health, and it can be around communication links. So there may be a system that allows us to report patient care in one health area that doesn't talk to the system availability in another health area. So those are some of the barriers that we continue to work on.

Q. And what effect, in your view, does the siloed approach that you've just described have on delivery of health care, firstly, within the New South Wales public system?
A. It can present challenges to ensuring that a patient's journey through health care is absolutely optimum

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

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

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

Q. -- between health providers across the spectrum of the facility?
A. It's very challenging that way.

Q. It's an example of the silo that you refer to?
A. That's right.

Q. Are there any others?
A. The same could apply for general practice into - from primary care into secondary, tertiary and quaternary care. The systems that the general practitioners use, the electronic systems for their medical information, don't link in to the electronic systems that sit with primary and - with secondary and tertiary and quaternary care systems. Patients - there's no single identifier of a patient, so a patient can go to see somebody in a Sydney city centre hospital and register there, but there wouldn't necessarily be a way of accessing that information if that patient re-presented at Wollongong Hospital.

MR GLOVER: Thank you, Doctor.

I have no further questions for this witness, Commissioner.

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

MR CHENEY: No questions.

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

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

<THE WITNESS WITHDREW

MR FRASER: Commissioner, the next witness is

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

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

<EXAMINATION BY MR FRASER:

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

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

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

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

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

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

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

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

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

Q. -- that you wish to update?
A. No.

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

knowledge; is that right?
A. Yes.

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

THE COMMISSIONER: Yes.

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

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

Q. Thank you. Just at a high level, you've touched on, at paragraphs 8 and 9, issues to do with locums; is that correct?
A. (Witness nods).

Q. Can I ask, is there any - to your knowledge, do you have, at the Central Coast Local Health District, difficulty in attracting locums?
A. There's no difficulty attracting locums. We usually have advance notice when we see that there are gaps in the rosters, and with adequate notice there's usually no difficulty in finding locums through the various agencies that we have a contract with.

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

Q. -- in your local health district. His evidence was that there is sometimes difficulty in filling all the available slots on the roster, even with locums. Do you disagree with that?
A. That statement in itself is true as well, because there are actually many shifts to be filled on a daily basis. At Wyong, for example, there are more than 40 shifts medically per day to be filled. So there are

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

Q. His evidence was that, using all the different methods, often there were still shifts that were unable to be filled each day. Is that consistent with your experience?
A. I would not say each day, no.

Q. You disagree with that?
A. (Witness nods). Not every day.

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

Q. And it includes modelling in relation to future needs over various periods of different types of services and the different demographics?
A. Yes.

Q. And I am summarising this in a very high level --
A. (Witness nods).

Q. -- would you agree with that? Are you, in your role, involved in that preparation of the plan?
A. So the plan was conducted over a many months period of time.

Q. No doubt?
A. It was done by the planning unit of the LHD and it involved consultation of more than 100 members of staff, including the executive and including myself in various workshops and iterations of the draft plan. There were presentations done as part of the consultation process to display the information, the data, and some of the

directions and suggestions of the plan. So yes, it was done over an extensive period of time.

Q. And as an observation, it would seem that it draws upon, not insignificantly, some information gathered by the primary health network; is that right?
A. Yes.

Q. Are they consulted as well as part of the formulation of the --
A. Yes.

Q. -- clinical services plan? Thank you. And in terms of the modelling that is undertaken, is that within the planning unit --
A. Yes.

Q. -- that you've just referred to --
A. Yes.

Q. -- which is within the central administration of the district; is that right?
A. Yes.

Q. Thank you. Just as a separate area, I want to ask you about workforce models arising out of what the health needs or projected health needs are. How does one arrive at what the required staffing levels for a particular service in the future will be, ie, you might know or expect there to be 45 births per day, for instance. How does one arrive at how many obstetricians you need, for instance?
A. In general you use the existing activity as a guide for the future, so you would assess your needs based on projected activity for the future, in general. Obviously different specialties have different ways of assessing the future. Some specialties might indeed predict or plan for a change in model of care or change in service. They may need different types of staff in different combination of staff. So in terms of workforce planning there's really a combination of dynamic factors at play to arrive at a future number.

But to use existing activity as a start would be probably the best way, and if we project future growth, then we'll have an expected growth in the medical staffing numbers, ideally, to match the number of increased activity. So if we were to increase operating theatre

sessions for particular procedures or a particular condition in the future, we would want to make sure that there's enough staff in the future to meet that requirement and therefore commence any recruitment process for the future if needed.

Q. I'll just come back to the emergency department. We heard some evidence from Dr Spooner in relation to workforce models in emergency medicine. I'll just take you to a document and ask if you're familiar with it. He referenced the Australian College of Emergency Medicine document, "Constructing a sustainable emergency department medical workforce", I'll just have that brought up on the screen. It's [SCI.0011.0242.0001]. I will just ask, is that a document you have seen before?
A. Yes, I have.

Q. I'll just take you to page 7. Without going through it laboriously, it contains a model with suggested workforce staffing levels for emergency departments per shift, depending on the number of presentations on an annual basis at the facility or at the site. You'd agree with that?
A. Yes.

Q. And Dr Spooner's evidence is that this is not how their staffing levels have been arrived at. Do you agree with that?
A. Yes.

Q. And his evidence was that the staffing levels, at least at Wyong, were lower than recommended in this document. Is that something --
A. Staffing levels generally are based on historic allocation of the department's FTE. It wasn't invented from scratch. So this table would not have been around several years ago when Wyong emergency department commenced.

On this table, I do want to comment that it provides one model of an ED which is not necessarily standardised across all the nation.

Q. Of course.
A. Different EDs have different complexity, different types of patients presenting, age groups. So Wyong may or may not be identical to the model ED that is used in this

projection. Wyong ED would not be as complex, for example, as a quaternary emergency department like RPA or St Vincent's.

Q. I'll just ask you this question, though: the primary factor in determining future staffing levels is effectively activity or projected activity growth, presumably; is that right?
A. That's one key factor, but I would also say evolving and emerging models of care would also be important, because medicine and health care do evolve and change and there are better ways of delivering health care in the future that we may not know yet, and one number alone may not be the answer to the way future health care is delivered.

Q. And that was what I was coming to. So it's not solely, you had 10 staff last year and a 10 per cent growth so we give you one more - that's right, isn't it?
A. That's correct.

Q. Because that presumes that that is the correct model of care and forever more?
A. And there's also workforce substitution, an alternative workforce available to provide care that previously was not provided by that particular group. So nurse practitioners in Wyong ED is one example of how that has assisted in meeting the demand of presentations to Wyong ED.

Q. Thank you. In paragraphs 10 through to 16 of your statement you've given an overview of the use of nurse practitioners in the Wyong ED?
A. Yes.

Q. Which I think, to summarise, is a model of care that is evolving at Wyong; is that right?
A. It started last year so it's still evolving.

Q. And I think you have indicated at paragraph 16, the goal is to further expand it in the future?
A. Yes.

Q. And just to clarify, in those paragraphs you talk about endorsed nurse practitioners and transitional nurse practitioners. Just to be clear, an endorsed nurse practitioner is one who has obtained the endorsement as

a nurse practitioner?
A. Correct.

Q. And a transitional nurse practitioner?
A. On the way to becoming one.

Q. Indeed, thank you. Lastly in relation to service planning, the clinical services plan that you have annexed, which is for a five-year period, is that a five yearly cycle of review or is it a continuous process?
A. It is continuous every five years.

Q. So we should expect another one some time before the expiry of 2028; is that right?
A. Yes.

Q. In your statement you've helpfully set out a number of things relating to the training of the local health district's workforce. I'd just like to ask you some questions, particularly arising from paragraph 26, which relates to the nature and adequacy of planning regarding the number and distribution of doctors. Firstly, you've spoken in that paragraph about the centralised training networks?
A. (Witness nods).

Q. Do they apply for all specialties?
A. Most specialties at Central Coast, yes.

Q. And you've indicated that, just looking four lines from the bottom - I see we don't have it on the screen, but in any event - for example:

> *When medicine and surgery networks allocate registrars to CCLHD, the LHD has no direct influence over who and how many will be allocated.*

Just on that, is what you are saying no influence at all or no influence on whether you get the numbers that you have set --
A. It's the latter.

Q. It's the latter?
A. So we make a request of number of positions.

Q. Yes.

A. But there's no guarantee and no influence that I can make that that number will actually eventuate.

Q. Because the local health district has control over how many training positions it offers?
A. Yes.

Q. On an annual basis --
A. Correct.

Q. -- on each cycle? Is it the case that often you don't receive the full allocation of training positions that you're offering?
A. It's specialty dependent. In the case of this year, the examples I used were neurology and medical oncology, and that has been the case for neurology last year as well.

Q. And generally in other specialties, you have been receiving your full complement of available spots?
A. Usually. Usually.

Q. In terms of opportunities for offering additional training opportunities, in your local health district, is that something that is looked at across the district, whether there are opportunities to establish an additional training position, say, at Wyong in a particular specialty or at Gosford?
A. Yes. The example I can use is recently we were looking at establishing a gastroenterology training position at Wyong Hospital and we made an application to HETI for that to start the assessment.

Q. What about training positions that have to be accredited individually by --
A. So that would be one. That's the example, yes.

Q. In paragraph 27, just over the page, you have indicated that currently, for vacant training positions, the biggest challenge is recruiting to a number of areas, and you referred to the table that you set out at paragraph 30. It would assist if we had the statement up on the screen. Can we get paragraph 30 up on the screen? In any event, we will keep going. In that table you've referred to JMOs.
A. Yes.

Q. Does that take in registrars as well?

A. So that includes registrars and residents, but not interns.

Q. So it includes people on specialty training programs?
A. Yes.

Q. As well as the general PGY1?
A. Not PGY1.

Q. Not PGY1?
A. PGY2 or above.

Q. Thank you. And all up, according to that table, you're short 66?
A. As of that date.

Q. As of the date that you obtained the figures. Is that representative of the shortfall that you generally have?
A. So that represents the amount of vacant positions we have that we failed to recruit. So these are examples of situations where we have advertised and failed to recruit.

Q. We'll come to some of what can be done about that in a moment. According to your table, there are only a few, only four staff specialist positions currently vacant across the district, two in obstetrics and gynaecology, one in psychiatry, and one in the sexual assault service, presumably?
A. So these are positions where we advertised repeatedly over time and have not been successful in recruiting.

Q. Again, I'll just ask you about Dr Spooner's evidence. His evidence was that there were, I think, four or five staff specialist positions FTE vacant in the emergency department.
A. Yes, I'm not sure I understand his context. So at the moment, between Gosford and Wyong hospitals, there are more than 65 staff specialists appointed, as well as about eight VMOs in emergency medicine. We've had rounds of recruitment for emergency specialists regularly throughout the last year or two and we usually appoint people as a result of the recruitment campaigns. So I'm not sure I understand Dr Spooner's context. Maybe he's referring to days where he's unable to fill shifts of staff specialists where his own staff are not available to work. I'm not sure.

Q. His evidence was that there were four or five FTE vacancies within his established positions. In any event, that's perhaps a or discussion that --
A. The hospital recruits based on their needs and, yes, I'm not truly understanding what he was saying there, yes.

Q. Where there seems to be some agreement is, at that junior level, that there's a significant particular shortfall in emergency medicine according to your table --
A. Yes.

Q. -- and also according to his evidence?
A. Yes.

Q. How does that impact, on your understanding, on the ability to --
A. I think I started talking about that earlier. So there are more than 40 shifts of medical officers being filled across both Gosford and Wyong hospitals every day, and in situations where shifts can't be filled, there are other ways of ensuring that services can be provided, including the use of other staff, workforce substitution, changes in the way you provide services.

We have expanded our primary care service through the establishment of the urgent care centre at Long Jetty, also with the aim of trying to use general practitioners to assist with seeing lesser acuity patients in a different environment to lessen the load to patients appearing at the emergency department. So there are many ways of the LHD dealing with workforce challenges in the emergency department, and I used the example of the Wyong nurse practitioners also, earlier. There are now two full-time nurse practitioners appointed at Wyong as well as several transitional NPs --

Q. On the way?
A. -- providing seven days a week coverage.

Q. You've spoken in paragraph 32 about incentives and programs to attract workforce to rural, remote and regional locations, and you've proffered the opinion that, in your view, they're reasonable.
A. (Witness nods).

Q. What are you actually referring to in that sentence?
A. I'm referring to the historic government enhancements

and incentives that have been around over time to attract people to rural and regional Australia, and my view is those incentives, over time, provided by government were reasonable. The market keeps evolving and the expectations of the employees keep evolving, and that's the element that we have lesser ability to control.

Q. You go on in the last sentence of paragraph 32 to say that or suggest that a more centralised management of locum rates or a cap could be a useful tool. What do you mean by that? Do you mean by the ministry or --
A. By the ministry may be one example. So at the moment, locum agencies can command high rates, especially during high-demand periods, such as Christmas and new year and school holidays. And maybe not the case at Central Coast, but I've heard situations at other LHDs in remote New South Wales who have to pay very high hourly rates to attract locums to work there to ensure an acute medical service is covered. If there's some way of controlling the rates, there may be a better outcome for all involved.

Q. What about centralised retaining and distribution of locums?
A. That helps too, yes.

Q. That might be something that would assist?
A. Yes.

Q. Just lastly on workforce, paragraphs 37 and 38, you touched on VMOs, or visiting medical officers, within your district. Just two issues arising, you've said that at Gosford - and you only have the two major hospitals --
A. Yes.

Q. -- Gosford and Wyong; correct?
A. Yes.

Q. You have said at Gosford, VMOs are engaged on sessional contracts, whereas at Wyong they're engaged on fee for service contracts?
A. (Witness nods).

Q. Is that across specialties?
A. Yes.

Q. Why is that? Is that a historical --
A. It's a historical arrangement. Generally for

procedural specialties like surgery, fee for service is a more attractive arrangement, and for medical specialties, the sessional arrangements are acceptable.

Q. Is that an indicator of the different services that are provided at those different hospitals?
A. (Witness nods).

Q. Is Wyong more surgical than Gosford; is that why?
A. It also reflects the relative ability to attract specialist surgeons to particular areas.

Q. The other matter I wanted to raise with you is: you proffered the opinion that the VMO determinations, the two relating to sessional contracts and that relating to fee for service contracts - paragraph 38, you've offered the view that those determinations enable New South Wales to recruit and retain a sustainable workforce. What is it about the determinations, in your view, that enable --
A. I guess my primary context there is in reference to Central Coast right now. We are at the moment going through our quinquennial reappointment process, and we are about to conclude the previous five-year contracts and moving on to the new five-year contracts, come 1 October 2024.

In the rounds of discussions we've had, the VMOs seem to be very content with their respective arrangements at both Gosford and Wyong hospitals and that's the context of my statement there, that I see no particular concern from a Central Coast perspective regarding the determination.

Q. In other words, the practitioners themselves aren't raising concerns about the terms of those contracts?
A. Correct.

Q. Just lastly, in section G of your statement, over a number of pages, you outline a history of the process by which accreditation was reviewed and then eventually withdrawn by the Royal Australian and New Zealand College of Radiologists at the Central Coast, withdrew accreditation for training in radiation oncology at the Central Coast Cancer Centre at Gosford, and you annex a significant number of items of correspondence. I won't be taking you through that, they speak for themselves. I just want to ask you two things --

THE COMMISSIONER: Sorry, just on that, I know we only got this statement yesterday. Are those documents in the tender bundle, because I couldn't find them?

MR FRASER: They should be - I was told they were not yet in but that they were going in.

THE COMMISSIONER: It's not helpful to me to be given a statement where - this isn't a criticism of you. If there's a statement where there's a whole lot of documents, I need to be given the documents as well as the statement, if they're not in the tender bundle.

MR FRASER: I thought you had been, Commissioner.

THE COMMISSIONER: The other thing, presumably the professor and those assisting him feel this is important, otherwise it wouldn't be in the statement. There is a reason they want me to know about this. Have you had time to read all this correspondence and absorb it for the purposes of asking --

MR FRASER: Only at a superficial level, Commissioner. I think the question -

THE COMMISSIONER: I think what we will do - it may well be - well, I think what we'll do, you finish your questions, but I think you need some time to read this correspondence and I do, and then we'll have to decide whether, regrettably, we ask the professor to come back - not tomorrow, but at another time convenient to him, because I'm going to make the assumption I'm being told this because it's relevant, because it wouldn't be there unless - if it was of no assistance to this Inquiry or to me, I'm sure the professor and those assisting him wouldn't put it in there. So there must be a reason why it is important, which means, I think, we all need the chance to look at the correspondence.

MR FRASER: The context, as I understand it, is that it is one of the case studies that was raised by the college, although in its statement, it --

THE COMMISSIONER: It might be even more important, then, that we both have a chance to look at the correspondence.

MR FRASER: Perhaps I can just ask a question.

THE COMMISSIONER: You go ahead.

MR FRASER: It doesn't relate to the correspondence.

THE COMMISSIONER: You go ahead and finish.

MR FRASER: Q. Professor, just putting aside the rights and wrongs of your views on that process and whether a decision was right or not, from the district's perspective, what's the effect of a withdrawal of accreditation, other than the obvious, that accredited training can no longer take place at that site?
A. Can I start by saying that the LHD has accepted the decision of the college. We are actually working towards improving the culture of the department and fulfilling the suggestions from the college in relation to training and supervision, and it is our desire to seek reaccreditation some time in the beginning of next year. So we are working with the college to try and meet our standards for the trainees.

In terms of your question relating to the trainees, as a result of the withdrawal of the accreditation, the trainees that we have now are no longer accredited for the training, so the time they work in Central Coast radiation oncology department will not be counted for their specialty training. Despite that, we were able to recruit to fill the positions, so three unaccredited trainees commenced in the beginning of the year, so there was no service interruption.

Indeed, during the time last year when the service was withdrawn from accreditation, we were able to fill the positions with locums, so that the service will continue.

Q. And what happened to your trainees who were on the program?
A. Yes, the trainees that were there last year all received new positions in various other training centres in New South Wales.

Q. And in terms of the fact that you were able to fill those positions, either previously with locums and now with unaccredited trainees, does that mean effectively that you were able to avoid any negative impact on the provision of clinical services --

A. Correct.

Q. -- that may rely on the assistance of those trainee staff?
A. Correct. Correct. And the department continues to have four staff specialists and four VMOs and nurses and radiographers.

MR FRASER: Indeed. Commissioner, we might attend to the folder of material.

THE COMMISSIONER: Yes.

MR FRASER: Other than that, I don't have any further questions.

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

MR CHENEY: No, Commissioner.

THE COMMISSIONER: Thank you very much for your time, Professor. We are a very grateful. Just because your statement came yesterday, and Mr Fraser hasn't read through all of that correspondence - it may well be that we don't need you to come back. If we do, though, we will work out a convenient time and we might even be able to do it by Teams to avoid you having to come to Sydney, if that's more convenient. So I won't fully excuse you now. We'll let you know in due course, but thank you for today.

THE WITNESS: Okay, thank you.

<THE WITNESS WITHDREW

MR MUSTON: The next witness, Commissioner, is Dr Lloyd Ridley. I note the time. It may be convenient for us to sit on for a while, if it is convenient to you, say for half an hour, to get some of his evidence down, given he's been waiting here this afternoon.

THE COMMISSIONER: Yes.

MR MUSTON: Unfortunately, things took a little bit longer than expected with the last few witnesses. Dr Ridley is not available to continue tomorrow. That's the only issue. He is available on Thursday morning.

THE COMMISSIONER: I see. All right.

MR MUSTON: If we start with him today, he will have to go over until Thursday.

THE COMMISSIONER: All right.

<LLOYD JOHN RIDLEY, affirmed: [3.50pm]

<EXAMINATION BY MR MUSTON:

MR MUSTON: Q. Dr Ridley, could you state your full name for the record, please?
A. Lloyd John Ridley.

Q. You are a staff specialist radiologist in the department of radiology at Concord Repatriation General Hospital?
A. Correct. Yep.

Q. Broadly referred to within the system as "Concord"?
A. Yes.

Q. You've held that role since 1998?
A. Correct, yes.

Q. Between 2000 and 2010 you were head of the department of radiology?
A. Yes.

Q. But you no longer hold that position?
A. Yes, not since then.

Q. You're also a clinical associate professor with the University of Sydney?
A. Correct.

Q. And you've prepared a statement to assist the Inquiry with its work dated 14 July 2024?
A. I did.

Q. There's a number of attachments to that statement.
A. Yes.

Q. Do you have a copy of your statement with you?
A. I have a copy of the statement, thank you.

Q. Have you had an opportunity to read it before coming to give your evidence today?
A. Yes, thank you.

Q. You're satisfied that the contents of it are, to the best of your knowledge, true and correct?
A. Yes.

MR MUSTON: In due course, that will be tendered.

Mr Cheney for NSW Health might have some questions for you, Dr Ridley.

MR CHENEY: No, I don't.

MR MUSTON: That makes it very quick. I had perhaps anticipated that that might have been communicated a bit earlier.

THE COMMISSIONER: Can I ask you, then - I'm sorry, can I just ask, does that mean that you are accepting what's in the statement?

MR CHENEY: No, Commissioner. There is some push-back about what's in the statement to be advanced in statements yet to be served, and I'm in that usual predicament of not having those statements. I think one of them is - my learned friend told me that he has received just recently one of those statements, this afternoon, and there is a second one to follow.

THE COMMISSIONER: Do you need those for the purposes of asking any questions of Dr Ridley or are they not necessary for that?

MR CHENEY: Having seen the draft of one of them, it may be that there are some propositions I need to put to Dr Ridley but I'm not sure whether they have found their way into the settled - I suspect I won't. On the usual analysis of whether fairness dictates that I put it to Dr Ridley, I don't think I will need to.

THE COMMISSIONER: So when you say you don't have any questions, is that, "I don't have any questions now but I'd like to reserve might right to ask the doctor a question later on", or, "I just don't have any questions"?

MR CHENEY: The former, Commissioner. I should have made it clear, that if upon service of this material, there's anything that I need to take up with Dr Ridley - I suspect it won't arise but I might --

THE COMMISSIONER: Q. Can I just ask you a couple of questions, then, Dr Ridley?
A. Sure.

Q. Have you got your statement in front of you?
A. I do.

Q. Could you just go to paragraph 6, and just so I understand what you mean by "obsolete", is equipment like the mammography equipment you're referring to obsolete before its end of life?
A. The meaning of that statement was that Medicare has a rule about capital sensitivity, which I'm not sure if you're familiar with. Capital sensitivity is the tool that Medicare uses and it's in some of my statements, but basically, it means the Medicare won't pay for services done on old equipment, they say they want to ensure that the Australian population gets access to high-quality equipment. So after a period of time, they pay nothing in terms of Medicare rebate.

Q. And whatever that time period is that Medicare sets, it may be before the actual end of life of the equipment itself?
A. That's correct. It's about quality of the equipment.

Q. In paragraph 13, where you talk about your understanding concerning the second MRI, were you told, or do you know, why the purchase order was cancelled?
A. We - the head of department was asked at very short notice to sign a purchase agreement, an S1. When the rest of the department found out that the purchase had happened with no procurement process at all that we were aware of - so normally our staff would be involved in making recommendations about what the requirements were for the machine and normally we'd also be involved in evaluating, for example, the image quality - so none of that had happened, the process went from being discussed as a proposition to being - so there was not even a business case - to being a signed procurement document in a 24-hour period with no process.

The staff in the department were unhappy because of that. There was a petition going round. At the time, John McDonald from ProActive was in communication with me, so I contacted him and pointed out to him that there were problems. I presume you are familiar with ProActive and their involvement.

Q. Mmm-hmm.
A. So John McDonald subsequently contacted the chief executive --

Q. Well, what I know is the documents attached to these witness statements, so that's the extent of my knowledge. I have to say that.
A. Sure. So that was part of a review that happened into radiology. He was conducting a culture review, so was talking to a lot of staff in the hospital about what had gone wrong over time and was trying to improve the dialogue between the executive and the staff. So through him I was able to communicate to the chief executive and I pointed out to him and he subsequently pointed out to the chief executive that - well, I don't know what he said, but I said that the procurement process had not been done properly and the machine that was being selected was not one that was felt by our staff to be suitable.

Q. Can I ask you about paragraph 17 of your statement, where you talk about the difficulty of attracting staff in interventional radiology. Why is there a difficulty in relation to that discipline?
A. It has, over the years, been a relatively unattractive part of radiology.

Q. Because?
A. Because you're up in the middle of the night doing procedures. I've done that myself. You turn up at 3 o'clock in the morning, you finish a case at 6 o'clock in the morning and then you turn around and start work.

Q. There's a lifestyle issue with that discipline, is there?
A. So there are challenges. That has changed over the last few years. The issue at Concord was more about that the working conditions, and particularly the pay at Concord, were less than in other locations and so people had decided to leave. The most senior interventional radiologist had, shall we say, been pushed out of the

department by - so you're aware from my statement that there were a number of code of conduct issues.

Q. Yes.
A. There was the PID that happened to a number of us. He underwent an even more severe review for a minor complication that was threatening his registration and he chose to resign.

Q. In paragraph 18, where you talk about staff shortages, you say, "have put patients at risk", I assume, first of all, that's your opinion as a clinician?
A. That's correct, yes.

Q. And can you just give me some idea about - some more specifics about the risks that you're talking about?
A. Examples would be that I remember a child who presented to the emergency department, the x-ray was not reported. When a radiologist finally got to report it several - like, I think it was six or eight weeks later, it was discovered that a fairly severe fracture had been missed. So then you have a young child who has a potentially lifelong injury because they haven't been properly cared for initially, they have to have a re-operation, delayed operation.

My main concern is that there are cancers that would have been missed on x-rays. So if you pick the cancer when the x-ray is done, you can deal with it. If you let it grow for one or two years, it becomes much harder to treat.

Q. Perhaps related to that, the backlog of scans that you mention in paragraph 20 of your statement, the 50,000 scans, how do - tell me, I assume that's not 50,000 patients or is it?
A. It's not 50,000 patients. It's 50,000 - it's mostly x-rays. So some patients will have --

Q. Multiple?
A. Multiple x-rays, yes.

THE COMMISSIONER: That's all I will ask you about for now. You heard what Mr Cheney, senior counsel for NSW Health, has said. I'm only going to ask you to come back if I think it's necessary. So someone will have to convince me that it's necessary. But if they do, I will ask you to come back, but we will make arrangements that

it's, again, at a time that's most convenient to you.

THE WITNESS: Sure.

THE COMMISSIONER: For the time being, though, thank you very much for your statement. We're very grateful, and thank you for your time today. I won't finally excuse you, and as I'm talking, Mr Muston sounds like he wants to say something.

MR MUSTON: I only had one question arising out of a question you asked to clarify our understanding of it.

THE COMMISSIONER: Yes.

<EXAMINATION BY MR MUSTON:

MR MUSTON: Q. You were asked some questions about paragraph 6 and the obsolescence of machinery from Medicare's perspective?
A. Yes, correct.

Q. Just from the point of view of the impact that that has on the department and those practising within the department, to the extent that Medicare refuses to pay in respect of imaging done on a particular piece of, at least from the Medicare perspective, obsolete equipment, that has an impact on private billings --
A. Patient care - oh, patient billings, yes.

Q. -- to the extent that a private patient - that a patient has identified as being a private patient?
A. I should perhaps know the details, certainly outpatients that are done under Medicare billing. I'm not quite sure about the arrangement with the inpatients who are billed under private arrangements like private health insurance.

Q. I suppose what I'm trying to understand is, to the extent that a patient presents as a purely public patient and is imaged using this piece of equipment, the imaging is reported upon, does the absence of Medicare rebate have any impact on practitioners within the department?
A. The rebate will feed in to the rights of private practice, which is part of the staff specialist award.

Q. But that is in respect of patients who are identified

as a private patient rather than a public patient?
A. That's correct, and in that setting, a Medicare payment is a private patient. So it does - if Medicare doesn't pay because the equipment is done and out of date equipment, that affects the right to private practice revenue and it also affects the ability to purchase equipment because that money is obviously used for equipment.

Q. So putting to one side the issue of whether the equipment is so out of date that it presents a risk to the patients, from a financial perspective, those who are working within the radiology department, who are reporting on the images, are suffering a financial disadvantage by reason of the equipment being, at least from Medicare's perspective, out of date?
A. In fairness to the ministry, perhaps I should say that we have been put under - there have been a number of months where we have not been paid the full amount that we were entitled to, but at the end of the financial year, an effort was made to make up the shortfall. So there have been some short-term, but over the long term, not so much at this stage.

Q. When you say the full amount that you were entitled to, is that a reference to the full amount that you would have been entitled to from Medicare had the equipment not been out of date?
A. What I'm saying is that the staff specialist award has a right to private practice arrangement and that there is a ceiling about how much we can be paid, and there is an expectation in radiology that we meet that ceiling. So if we don't have enough patients who we can bill to reach the revenue to reach that ceiling, then we have a shortfall.

Q. So to the extent you reach that ceiling and then there is the additional portion of that Medicare billings which go into the number 2 trust --
A. Our number 2 trust is also quite healthy. We have been understaffed for a long period of time and been working very hard for a long period of time. So there is a fairly substantial amount in that account for the number 2 activities.

Q. But is there any supplementation of moneys going into that number 2 account to, as it were, make up for the fact that equipment that is being used within the department is,

from Medicare's perspective, out of date?
A. I did put it to the chief executive seven, eight years ago, in a meeting, that that should happen as an incentive for the organisation to replace the equipment on time, but needless to say, she didn't like that option.

Q. Do we take it from that answer that it didn't happen?
A. It did not happen, no.

MR MUSTON: Thank you. No further questions from me today.

THE COMMISSIONER: It's not Mr Muston's fault but I actually have another question now. It's unrelated.

Q. Can you go to paragraph 33 of your statement, please, where you tell me that you went to this meeting on 21 February 2023 and there were representatives from radiology, nursing, emergency, et cetera, to make a presentation to the chief executive and to - how do I pronounce that doctor's name?
A. John Sammut. So he's the representative of the Sydney local hospital board.

Q. All right. You gave a presentation, you tell me, in relation to workload, staffing and equipment procurement, and if I was to summarise the big issues that are of concern to you, it's those three issues?
A. Yes.

Q. You then tell me in paragraph 34 that you attended a meeting with the chief executive on 11 April 2023, and your recollection is you were told staff were leaving because of the "poor culture of the department". Have you put that in quotation marks because that's the best memory you have of what was actually said to you?
A. Well, that was the words that were used.

Q. Was any detail given about what the poor culture was?
A. It was discussed that the executive were working very hard and that they were under-appreciated and that we needed to be more grateful for what they were doing. That's not the word that was used, but it was that sense that they were doing a very good job. The staff of the --

Q. More grateful about what they were doing, what was it they were doing you should have been grateful for? Were

you told?
A. No. No. They had been working very hard, for example, COVID, was one of the things that was talked about. COVID actually reduced our workload so it made our life easier. But they have talked about that they have a number of other things that they're dealing with.

Q. Was there anything more specific, though, in relation to the allegation of poor culture, that you recall? Was there a specific example, "This happened", or, "This was said and that's poor culture"?
A. No, not specific. Not specific. It was about being negative. If we say something that was negative, that was what was meant by poor culture.

Q. Then you say:

... I was left with a strong impression that I was perceived to be responsible for this by raising issues.

Just first step, the issues you're referring to are the issues of workload, staffing and procurement that you previously have mentioned?
A. That's correct, yes. In broader terms, that's the key ones, but I have over the time talked about more than just those issues.

Q. The strong impression, what gave you the strong impression that you were referring to?
A. Well, when I was asked to try and clarify what I could recall, I was struggling a little bit. It's one of those ones where I guess, in the legal fraternity, you're familiar with when you interview a witness, you know which way you want them to go so you give them the message without actually ever telling them what you want. So it's a very political approach to something --

Q. I think we should just stick with what gave you the impression --
A. My expertise --

Q. -- rather than going to the legal profession. Don't feel as though there's any problem with this. Often we are just left with an impression and can't recall what particularly has caused that. Is that where you are or was there something specific said in relation to you and what

you're raising as an issue?
A. Yes, it was never quite said that it was me, but on the other hand, it was pretty much a monologue that was telling me that the administration were doing a great job, the department was not performing well, people were complaining, that was a bad thing. They had a go around the room to - there were three people there, all given the opportunity to talk about the things that I had done that were not helpful, in terms of raising issues. So it was that sort of - they were telling me their disapproval.

Q. Perhaps if I can help you this way: you say that the discussion - sorry, that during the meeting on several occasions the discussion turned to the need for you, as a senior radiologist, "to speak primarily of the positive aspects of the department". Was any detail given about that? What should I take that to mean?
A. That they recognised that I had played a leadership - well, the way I saw it was that I had played a leadership role by being the spokesperson for the department and I see myself very much as the spokesperson for the department because I have previously been a head of department, the head of department had been having difficulty in his communication with the executive and I was trying to provide some assistance in terms of raising issues, so it was --

Q. Were you told you shouldn't be raising issues about workload or staffing or procurement?
A. I don't recall that I was particularly, no.

Q. Or that you should do it privately or --
A. I don't recall that I was particularly. I saw it basically as being a dressing down for having spoken up at the clinical quality council.

THE COMMISSIONER: Did anything arise out of that?

MR MUSTON: No.

THE COMMISSIONER: You want to reserve your position, Mr Cheney?

MR CHENEY: If I may, Commissioner. I should emphasise, I doubt that I will have to trouble --

THE COMMISSIONER: Yes, you may.

All right. Thank you very much for your time. I won't finally excuse you.

THE WITNESS: Sure.

THE COMMISSIONER: As I said before, if I'm convinced there is a need for you to come back, we will to have ask you to come back at a convenient time, but we will just see what happens there and we will let you know. If we are told by Mr Cheney that you are not needed, we will also let you know that.

THE WITNESS: Good. Thank you for your time.

THE COMMISSIONER: Thank you.

<THE WITNESS WITHDREW

THE COMMISSIONER: All right. So adjourn until 10 tomorrow?

MR MUSTON: Yes.

THE COMMISSIONER: We will adjourn until 10 o'clock tomorrow.

AT 4.11PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED TO WEDNESDAY, 31 JULY 2024 AT 10AM

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