

**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, 15 October 2024 at 2pm**

**(Day 055)**

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

**Also present:**

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

1 THE COMMISSIONER: Yes, good afternoon.

2

3 MR MUSTON: The first witness this afternoon is Dr Tom  
4 Morrison. He is sitting there lonely at the panel table.

5

6 <THOMAS GALE MORRISON, affirmed: [2pm]

7

8 <EXAMINATION BY MR MUSTON:

9

10 MR MUSTON: Q. Dr Morrison, could you state your full  
11 name for the record, please?

12 A. Yes, my name's Thomas Gale Morrison.

13

14 Q. You are currently working as an unaccredited registrar  
15 in neurosurgery at St Vincent's Hospital?

16 A. Yes.

17

18 Q. That's a role that you have held since February 2023?

19 A. Yes, that's correct.

20

21 Q. I think next year, in 2025, you will be commencing the  
22 surgical education and training program in neurosurgery?

23 A. Yes.

24

25 Q. At St Vincent's?

26 A. At Liverpool, actually.

27

28 Q. At which hospital?

29 A. Liverpool.

30

31 Q. Prior to that, you've held roles at Royal Prince  
32 Alfred Hospital as an unaccredited registrar in  
33 neurosurgery?

34 A. Yes.

35

36 Q. I think from February 2020 to February 2023?

37 A. Yes, that's correct, three years.

38

39 Q. And before that you were a resident at RPA  
40 from February 2019 to February 2020?

41 A. Yes.

42

43 Q. And before that an intern at RPA?

44 A. That's correct.

45

46 Q. You are also the junior vice president of the  
47 Australian Salaried Medical Officers Federation?

1 A. Yes.  
2  
3 Q. Broadly known as ASMOF, and a member of the AMA  
4 council?  
5 A. Yes.  
6  
7 Q. And an executive member of the AMA Doctors-in-Training  
8 Committee since 2020?  
9 A. That's correct.  
10  
11 Q. You have prepared a statement to assist the Inquiry  
12 with its work?  
13 A. I have.  
14  
15 Q. That statement is dated 4 October 2024?  
16 A. Yes.  
17  
18 Q. Have you had a chance to read that statement before  
19 giving your evidence today?  
20 A. Yes, I have.  
21  
22 Q. That is to say, just before, as opposed to when you  
23 wrote it?  
24 A. I have, just before.  
25  
26 Q. Do you have a copy of it?  
27 A. Not in front of me, actually  
28  
29 Q. We can sort that out for you. Are you satisfied that  
30 the content of the statement is, to the best of your  
31 knowledge, true and correct?  
32 A. Yes, I am. Thank you very much.  
33  
34 MR MUSTON: That document is tendered as exhibit L20,  
35 Commissioner.  
36  
37 THE COMMISSIONER: Yes, thanks. I've found mine as well.  
38  
39 MR MUSTON: Q. Could I ask you to go to paragraph 10 of  
40 your statement, which is at the end of a passage where you  
41 tell us about what you perceive to be some of the benefits  
42 of rural placements during one's medical education?  
43 A. Yes.  
44  
45 Q. You tell us that you had a very positive experience of  
46 O&G in Griffith?  
47 A. Yes, I did.

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Q. You have told us in some little detail there but could you just explain what it was about that rural placement that you found to be a particularly positive experience?

A. I think the distinct difference between my rural placement in Griffith, which is a relatively small obstetrics department, and my other placement, which was in the Royal Hospital for Women, which is probably the largest obstetrics department in the state, was the amount of individual focus and experience that I had.

When I was in the Royal Hospital for Women I was one of I think four or five medical students. There was a large number of interns and residents, there were senior resident medical officers as well as registrars as well and also fellows, so when it came to a division of opportunities to learn, engage and perform procedures, there were just simply divided by virtue of a large number of people who were ahead of me, if you like, in the training food chain; whereas when I was in Griffith it was just myself and one other registrar, so I was able to get much more hands on, I felt like my individual learning needs and experiences were tailored.

I wasn't asked to leave or forgo learning opportunities because there was not enough space in the room or the patient or the woman had already seen X number of people already who were there to teach as opposed to deliver clinical care. So I felt overall I learnt a lot more, was a bigger part of the team and it was a much more enriching experience.

Q. You obviously have not chosen to pursue a career in that area of specialisation?

A. Yes.

Q. What is it which has kept you working in the metro, having had that good experience in a rural setting?

A. I suppose it was the duration of the experience, I was there for four weeks. I had an enjoyable four weeks but it was one of many rotations in medical school and after that I would have done - I believe that was at the beginning of year 6, I would have done another five or six placements in different fields back in Sydney. And I did actually think about doing obstetrics for a bit, but then I didn't get a term, an internship and then it becomes hard to get a term from then on and then you start pursuing other

1 things and, all of a sudden, unless you're really targeting  
2 a particular specialty, it can be quite hard to later go  
3 into it. So I suppose, you know, I became distracted and  
4 other opportunities availed themselves is the reason  
5 I didn't ultimately proceed to obstetrics.  
6

7 Q. Based on experience you have of your cohort of junior  
8 doctors, do you have a sense that those who have a longer  
9 stretch of rural experience as part of their training  
10 pathway are more likely to or, in your experience --

11 A. Yes.

12  
13 Q. -- do stick in rural areas?

14 A. That's certainly the sense I get. For example,  
15 I think I have put in my statement that of the two-thirds  
16 of people who do a rural placement in their final year at  
17 my medical school, I'd - sorry, of the people who did  
18 a rural placement in their final year, I would estimate  
19 two-thirds of them would stay to do a rural internship.  
20

21 Anecdotally there's very few people I know of, maybe  
22 like a handful, one or two as outliers, who would have done  
23 their final years of medical school placement in the city  
24 and then gone, "I'd like to go to a rural hospital  
25 preferentially". When it comes to an internship, it's just  
26 not an experience that I think people have.  
27

28 Q. In terms of the sort of things that might persuade  
29 people, junior doctors, to work in rural settings or to  
30 move away from metro settings where some of those social  
31 hooks might tend to draw them, do you have a view about  
32 what the system might be able to do to encourage people to  
33 move into different areas of the state to work?

34 A. I think you're right to say that people do get hooked  
35 in and, to a certain extent, that's what keeps people  
36 wanting to be in the same place. It doesn't just happen in  
37 terms of the city or not, it even happens in terms of the  
38 part of the city you are in.  
39

40 People who tend to do their internship at Liverpool or  
41 Westmead tend to gravitate towards registrar jobs in that  
42 part of town. People who do their internship in Newcastle  
43 tend to stay in Newcastle.  
44

45 I think part of the way that you can assist people  
46 with a bit of mobility is to, one, give them student  
47 experience in that more rural location, so no longer do

1 they have hooks, say, in Sydney and they're less willing to  
2 go.

3  
4 Another thing you can do is make it easy to transition  
5 between it. If I wanted to go rural now, it would honestly  
6 be quite difficult. I have no connections to any rural  
7 hospital from a personal perspective. I'd need to seek it  
8 out myself and apply in my own time, maybe travelling at  
9 significant expense, and there would be no guarantee I'd  
10 have a job and I'd apply for it, and then I'd also have to  
11 apply for all the others, and I would be fairly willing to  
12 say that a place I know, which I already have connections  
13 in, is going to give me a job preferentially and going to  
14 give me advanced notice of that prior to me getting a job  
15 in a rural location.

16  
17 Q. Can I just unpack that a little bit?

18 A. Yes.

19  
20 Q. We will come back to the process of applying that  
21 you've touched on and you've referred to in your statement,  
22 but what is it about the system that means if you happen to  
23 be in a metro area or in particular metro hospital, the  
24 ability for you to secure employment elsewhere is, at least  
25 in your view, compromised?

26 A. I think people preferentially try and stay at their  
27 hospital, regardless of where that hospital is, partially  
28 for the familiarity, they know the systems, they know the  
29 people; partially hospitals, to a certain extent, do try  
30 and recruit people who have already been there, especially  
31 in their junior years.

32  
33 If people are going to a different hospital, it's  
34 usually one that they have some kind of linkage too. For  
35 example, one of the consultants that I worked with at RPA  
36 also worked at St Vincent's so I informally inquired, "Do  
37 you think there is likely to be a job there?" "Yes, there  
38 is", and you fill in gaps, as such, that way as opposed to  
39 a more national or statewide recruiting process.

40  
41 It is easier to go somewhere that you know, that is  
42 familiar, and it's harder if the place is somewhat  
43 distanced, you don't have the connections, you don't have  
44 the social support, you don't really know what you're  
45 getting yourself into.

46  
47 Q. I gather from some of the answers you have just given,

1 in part there is the candidate feels, "The better the devil  
2 you know, I don't necessarily want to move to another  
3 hospital or to a local health district that I'm not  
4 familiar with if I can stay working where I am at the  
5 moment." But also in part, is it your sense that those  
6 same considerations inform who the hospitals choose to  
7 employ into junior medical positions?

8 A. I think for most jobs in the hospitals, while  
9 I haven't sat on the panel, I have a reasonably good sense  
10 that there's a preferred set of candidates before the job's  
11 advertised, and the most common circumstance is those  
12 candidates do go on to obtain those jobs, pending something  
13 extremely unforeseen happening in the process.

14  
15 Q. Do you get the sense that that, perhaps driven even by  
16 your own experience and the choices that you've made  
17 professionally - does that drive people, as junior doctors  
18 just embarking on their careers, into positions within the  
19 metro hospitals?

20 A. I think yes in an answer - but to unpack that a little  
21 bit further, the main reason I think people want to go to  
22 metropolitan inner city teaching hospitals for internship  
23 is because they're perceived to be the best for your  
24 career. They'll give you the best training, they'll give  
25 you the best experience, the best knowledge, the best  
26 ability to go and get that next job.

27  
28 So I think once that has occurred, then people - well,  
29 they're already in these big hospitals, because that's  
30 where the most majority of jobs are, but they desperately  
31 want to stay there and the cycle perpetuates itself.

32  
33 If you say - you know, the advice that you hear  
34 commonly given is someone wants to do something, say, like  
35 cardiothoracic surgery and, say, they're an international  
36 graduate, they're not guaranteed an inner city teaching  
37 hospital job, do one year at that hospital and then you can  
38 apply and come more centrally for your resident year. And  
39 anecdotally, resident jobs, it's quite easy to obtain and  
40 then move into one of the more junior level jobs at a large  
41 hospital and then people try their best to stay.

42  
43 Q. Whether the perception be right or wrong, is there any  
44 particular perception or view out there to the effect that  
45 training or starting your career in that big metro hospital  
46 is going to be better for you professionally in some way?

47 A. I think there is a perception there to a certain

1 extent and for certain specialties. For example, I would  
2 say RPA has a very good reputation for basic physicians  
3 training, so people want to try to get to RPA because they  
4 have a major exam and they know that it's associated with  
5 having a lot of support to get people through that exam.  
6 Then, once you've got through that exam, you can focus on  
7 other elements of your training.

8  
9 That reputation doesn't exist to the same extent for  
10 more rural hospitals. I think that's partially because  
11 there's more work and there's not as much staff so there's  
12 less of a focus or a perceived - perception that there will  
13 be less of a focus on the individual professional  
14 development.

15  
16 Q. You tell us in paragraph 11 of your statement that you  
17 believe there to be some scope within recruitment processes  
18 to better link rural work to positions offered in those  
19 perhaps more popular metropolitan positions. Could you  
20 unpack that a little bit and explain what you had in mind?

21 A. Well, I would start by saying that I think most  
22 people, especially if they're looking to get into a medical  
23 specialty, would be willing to work essentially anywhere,  
24 if they have the guarantee that they're going to go and  
25 progress in that specialty.

26  
27 I certainly, if I knew that I could have, you know,  
28 gotten on the training scheme a bit earlier than I have,  
29 that I'd have to do some rural time, I would have signed up  
30 in a heartbeat ages ago.

31  
32 The reason I make that point is I think if you were to  
33 offer rural training and have that training accredited and  
34 account for people progressing towards a career goal, I  
35 think people would jump on it very, very quickly, as  
36 opposed to doing unaccredited training or other jobs, even  
37 if they're in more desirable or prestigious locations.

38  
39 Q. So to the extent that it's within the power of the  
40 system, if we could use that broadly, as a combination of  
41 the colleges acting in consort, to locate training  
42 positions in rural areas - that is to say, accredited  
43 training positions in rural areas - it's your view that, at  
44 least in areas which might be seen as desirable from  
45 a training and career progression point of view - that is  
46 to say, areas of practice - you could draw people into the  
47 regions using that?



1 A. I think there would be very few junior medical  
2 officers wanting to become specialty registrars who would  
3 reject an accredited training position regardless of  
4 location. I think there would be unique family  
5 circumstances for some but I think the majority view is  
6 "I'll take that opportunity, yes, please."  
7

8 Q. You tell us in paragraph 12 that, at least as you  
9 understand the current arrangements, some of the programs  
10 involve relatively short stints in rural settings which -  
11 do we gather from that that you think a short visit like  
12 your four-week visit to a rural setting, as positive an  
13 experience as it was, is not really going to drive people  
14 into areas of need?

15 A. I think it enriches your training experience, but will  
16 it determine that that person's future career prospects?  
17 I don't think a short stint really will because I think you  
18 keep your home base in Sydney, for example. You don't stop  
19 paying rent, you go back every week end, you keep your  
20 social connections. Where if it's a longer placement where  
21 you're more ingrained in the community, you actually you  
22 have to - you know, "I'm now from Dubbo", for example, as  
23 opposed to, "I'm from Camperdown but I moved to Dubbo for  
24 two months". I think it changes your mindset and how you  
25 think with your future.  
26

27 Q. Just from the perspective of a junior doctor, do you  
28 have a view about the sort of time frame that we might be  
29 looking at in order to become someone who is from Dubbo as  
30 opposed to a --

31 A. I would be thinking 12 months, in that kind of sphere.  
32

33 Q. Do you think that there might be some scope, just  
34 coming back to the observation you make in paragraph 11,  
35 for a greater connectivity to be built or a greater sense  
36 of local connection to be built through an arrangement  
37 whereby someone spends part of their time in the metro and  
38 part in a rural setting, or do you think you really need to  
39 have that consolidated period of full-time practice in a  
40 rural setting, say your 12 months, in order to really start  
41 to build that proper connection?

42 A. It's a good question. I'm honestly not sure if you  
43 did, say, six months rural, six months city, six months  
44 rural, six months city, that would give you - that would  
45 have you feel more ingrained.  
46

47 I don't know about that. What I do know is that the

1 current situation, for example, four weeks of medical  
2 school, three months for a quarterly term rotation, is not  
3 enough to do that. For example, my housemates have both  
4 done rural placements, they both kept paying rent, they  
5 both came up every other weekend and they were getting  
6 through this period of rural placement and then they were  
7 going to come back home to Sydney. It was never considered  
8 that they may stay there. That didn't enter their mindset.  
9

10 Q. And not necessarily inviting you to express an opinion  
11 on what your housemates are or are not planning to do, but  
12 it's your view if, instead of that arrangement, someone, as  
13 part of their training, was required to spend, say,  
14 12 months in a location like Dubbo or Wagga or somewhere  
15 like that, that the chances of them becoming more closely  
16 connected with that community and potentially seeing  
17 a career path there would be enhanced?

18 A. I think that you become much more part of that  
19 hospital system. It'd be not a place you're passing  
20 through, it'd be a place that you are potentially settling  
21 down in or developing roots, developing connections. When  
22 it comes to apply for the job the next year, you already  
23 know the people there, "Maybe this is where I might go", as  
24 opposed to, "I'm not even thinking about it. I'm just  
25 temporary, visiting."  
26

27 Q. You tell us in paragraph 14 about the way in which the  
28 recruitment campaign for the junior medical officers works?

29 A. Yes.  
30

31 Q. You point to some opportunities for streamlining.  
32 Could I ask you to just tell us a little bit about your own  
33 experience in engaging with that process?

34 A. Yes, certainly. So you have a guaranteed job for your  
35 first two years as an intern and a resident, then you need  
36 to apply for apposition. Depending on what that position  
37 is, you may need to apply every year. For surgery, as  
38 I went into, that was my experience. I knew I wanted to do  
39 neurosurgery. I knew I had no guarantee of getting a job  
40 because it's relatively competitive, especially for people  
41 who've just finished residency. So I applied for every  
42 job, every neurosurgery job in New South Wales, of which  
43 there were, I think, 18 to 20 or so.  
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45 Q. When you describe them as neurosurgery jobs, was that  
46 a combination of accredited and unaccredited positions?

47 A. Only unaccredited jobs.

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Q. So they were one-year contracts?

A. Yes.

Q. To work as a registrar within a neurosurgery department, in a capacity that did not, other than building your experience, contribute to your training, in a way that was recognised?

A. That's correct. And I should add, those jobs also were not guaranteed. So I also applied for senior resident medical officer jobs in surgery and those jobs are also not guaranteed. So I also applied for senior resident medical officer jobs in general.

Q. How many --

A. About 30 applications.

Q. And in terms of the process, each was a separate application?

A. Each was an individual separate application.

Q. And was it something that you could just copy and paste and send the same words to each prospective or for each prospective job, or not that simple?

A. There was a deal of similarity and the questions were on the same vein but they were not the same. So for example, one might be, "Please describe your experiences of teamwork and how that is involved in patient care." And the other one might be, "Please describe your experience of teamwork and leadership." Just different enough that if you copied the same thing into everything and someone was looking at the questions, they would go, "This bloke is not quite answering the question. He has applied for 30 different jobs he doesn't want to come here."

So, of course, you're individually tinkering to show that you actually have read the question and that's quite time-consuming. I don't think the answers were substantially different, but they couldn't be copied and pasted.

Q. And you did this each year up until --

A. Yes.

Q. -- the most recent occasion when you did it, which secured your position as an accredited training position?

A. Yes, that's correct. So I have a little folder, if

1 you like, of all my previous applications and the questions  
2 do change very slightly each year, so I'd go and very  
3 slightly change the answers. So I became more efficient  
4 with the process but it would still take me many hours each  
5 year.

6  
7 Q. As a ballpark, the first time you did it, how many  
8 hours did it take?

9 A. I probably spent 30 hours on it, which sounds like  
10 a lot, but, you know, you've got no - I don't think I'm an  
11 outlier, to be honest. I think every - you are competing  
12 against lots of people, there's very little that  
13 differentiates you. You're not going to let something  
14 little go through, you're going to try and develop  
15 something that puts you through as a solid applicant. As  
16 I've grown on, I started to think that perhaps these things  
17 are not given the weight that you might expect they are  
18 when you're first applying to the process, and you think  
19 "Geez, that's a bit silly", in retrospect, but I don't  
20 think anyone is willing to take anyone's word for it and  
21 say, "No, no, just write something generic, you'll be  
22 right."

23  
24 THE COMMISSIONER: Q. Do you get asked about why you  
25 want to be a neurosurgeon?

26 A. No.

27  
28 Q. You don't?

29 A. No, I didn't get asked that.

30  
31 MR MUSTON: Q. You said a moment ago you're not an  
32 outlier. It's your sense, discussing this process with  
33 your peers, that they go through a similar process each  
34 year applying for a junior medical officer position?

35 A. Yes is the answer. Some are then are more  
36 streamlined. I know basic physician trainees, for example,  
37 they only have one interview, is my understanding. It's  
38 like there is a panel style process. Not quite the same  
39 for all specialties, though. I think especially when  
40 you're starting out, there is an extremely large amount of  
41 time that goes into applying for jobs. I have a friend,  
42 for example, wanting to do anaesthetics. I think he  
43 applied for something like 50 jobs or something very large  
44 like that, with no guarantee he's going to get any of them.

45  
46 Q. And the assumption that you make is that 30 different  
47 groups of people in 30 different facilities or units around

1 the state spend time reading your application, amongst, no  
2 doubt, many others?

3 A. Yes. I've talked to some of the people who go through  
4 and do this process and the feedback they say is a lot of  
5 these candidates are very hard to differentiate. They've  
6 all got statements that are very well written. They've all  
7 got CVs that look very similar. They don't know any of  
8 them and so it's down to finer points, this person  
9 published two papers, this person published one paper.  
10 Call up the referee and check, actually this person is not  
11 nearly as good as what might be said on the paper, but I've  
12 heard it takes a very substantial period of time to drill  
13 down the list of candidates to a pool you can potentially  
14 interview.

15  
16 Q. You indicate in your statement that, in part, it's  
17 your view that a lot of that time is wasted because there  
18 are jobs that you, and no doubt others, are applying for  
19 that you don't realistically think you are actually going  
20 to have to take; is that right?

21 A. Yes.

22  
23 Q. Could you just explain why that is?

24 A. So I think especially when you've been through the  
25 process a few times, you have a reasonable sense of perhaps  
26 your position in the pack. So to take last year, for  
27 example, I'd been a neurosurgery registrar for four years,  
28 I'd just missed out on selection for the training program.  
29 I was pretty confident that I was going to get an  
30 unaccredited job.

31  
32 Q. That is to say, at your hospital?

33 A. At my hospital, and I have good relationships with  
34 people there. While I was pretty confident, I had no  
35 certainty of that, nothing written down on paper, and if  
36 you only apply for one job and you don't get a job and all  
37 the jobs are gone, then potentially you are left without  
38 something to do for the next year and that is a big  
39 problem, financially, career progression-wise. So you go  
40 through and you put all your applications in, once again,  
41 because you need to cover your bases.

42  
43 Q. And you mentioned a moment ago the challenge in  
44 differentiating between candidates based on what they've  
45 written. I infer from the evidence you gave earlier that  
46 one thing that can and perhaps often is used to  
47 differentiate between candidates is the experience you've

1 had with that potentially small sample of them who happen  
2 to work in your hospital?

3 A. That's certainly the anecdotal appearance. People who  
4 have performed well on the job the year before are likely  
5 to be invited back.

6  
7 Q. And as a result of that, in your case, for example,  
8 you applied for 30 jobs, one of which you were fairly  
9 confident that you were going to get --

10 A. Mmm.

11  
12 Q. -- and 29 of which resulted in a range of no doubt  
13 very busy people - I say this entirely uncritically of you,  
14 it's the system - a range of very busy people across the  
15 state considering your application carefully and perhaps  
16 hoping that they might be able to secure you as an  
17 unaccredited registrar in their facility?

18 A. Yes, that's the case. And then I did get some offers  
19 for some of those jobs later on down the line but, some  
20 weeks, presumably when other candidates had taken other  
21 jobs and vacancies had been created and the list has been  
22 whittled down. By that time, almost everyone already has  
23 a job, there are very few candidates who no longer have  
24 one, so you say, "Thank you but no thank you."

25  
26 Q. Again, anecdotally, do you have a sense that the way  
27 that process rolls out is that positions in what might be  
28 perceived to be desirable locations like the metro  
29 hospitals get filled first, and then once you run out of  
30 candidates and there are more jobs than candidates, the  
31 ones that are left unfilled are those in what might be  
32 perceived to be less desirable rural and remote locations?

33 A. I think that that is the case. I wouldn't necessarily  
34 say it's only rural and remote locations that are less  
35 desirable. I think a big part of the desirability of a job  
36 is how supportive they're going to be for your training,  
37 whether or not that's accredited or unaccredited.

38  
39 For example, I know that there are some hospitals,  
40 even though they're not - you might not consider them to be  
41 in the nicest parts of Sydney, have the reputation for  
42 having the best training or the best support for getting  
43 people on to training programs or making good consultants  
44 and having the opportunity to get a consultant job at the  
45 other end. So those jobs can sometimes be highly  
46 desirable. On the other end, some hospitals in very nice  
47 locations in Sydney that you would perceive to be highly

1 desirable may not have the right culture or may have  
2 the reputation of not having good training and so people  
3 have prioritised them lower.  
4

5 Q. Again whether it be right or wrong, is it the case  
6 that amongst junior medical officers who are applying for  
7 positions and going through this annual cycle, there is  
8 a strong word-of-mouth sense of - well, there's lots of  
9 discussion about what's desirable and what's not desirable  
10 in terms of places to go?

11 A. Almost entirely word of mouth. This isn't written  
12 down anywhere. You can't really have a look at a job  
13 application as advertised by the hospital and say, "Oh,  
14 that one is going to be good". They all say that they're  
15 great and supportive, but there are reputations that are  
16 communicated amongst individuals.  
17

18 Q. Such that if I - and I'm not about to - were to ask  
19 you, "What's a desirable location and what's an undesirable  
20 location in a particular area", chances are the answer you  
21 would give me would be the same as another doctor of your  
22 experience --

23 A. Yes.  
24

25 Q. -- if they were sitting there in your position?

26 A. Yes, I think so  
27

28 Q. In terms of that process, there are a few ways that it  
29 might potentially be streamlined. The first is some form  
30 of centralisation such that, as a bare minimum, only one  
31 application had to be lodged for all of the jobs. Do you  
32 have a view about how that system, at least from the  
33 perspective of a junior doctor applying, might be better,  
34 more doctor-friendly?

35 A. I think that system exists to a certain extent for  
36 some specialties. Plastic surgery, I believe, for example,  
37 has one centralised interview and one centralised  
38 application process. I see no reason why it couldn't be  
39 done for the broad categories of jobs, senior resident  
40 medical officers, unaccredited cardiology trainees,  
41 unaccredited respiratory trainees, basic physician  
42 trainees, I think it would save a large amount of  
43 administrative time for both the candidates applying and  
44 also, at the other end, make it much easier to sift through  
45 the applications and determine which ones you would like.  
46

47 Q. So in your case, it may have resulted in three

1 applications, one for a surgical position, one for a senior  
2 resident medical officer position, and a third for the  
3 other position that I can't now recall but you told us a  
4 moment ago.

5 A. Yes, in my first year when I was applying for those  
6 30 jobs, had we had a centralised system, I would have  
7 applied for three broad categories; that's correct.

8

9 Q. So it's only once you get beyond those early years  
10 where you start to have to - you're starting to make these  
11 individual applications or --

12 A. No, no. If I were to detail the categories for you,  
13 for example, one might be a specialty specific training,  
14 neurosurgery position. One might be surgery in general,  
15 which is a slightly more junior position, and the other one  
16 might be a resident role. So I think regardless of your  
17 stage of training, everyone's going to be going for one of  
18 those broad sets of categories.

19

20 Q. Coming back to something you said a little bit  
21 earlier, if within that specialty category you applied  
22 centrally and perhaps were asked what your priorities were  
23 in terms of where you would like to go based on your  
24 personal circumstances and no doubt these unwritten  
25 reputational factors, if you were offered a training  
26 position in some location that was not metro Sydney but it  
27 was an accredited position, you presumably would, based on  
28 what you have told us, have gone?

29 A. Yes, I absolutely would have, and I'd go further to  
30 say I would imagine that you could count on your hand the  
31 number of people each year who would turn down an  
32 accredited training position in view of its location.

33

34 Q. That's because, from a career progression point of  
35 view, securing one of these accredited positions is  
36 something which is of such value that the geographic  
37 challenges that might be presented are --

38 A. Yes, very much so. It's so desirable and also once  
39 you have that, you have so much more certainty over your  
40 career. You don't have to apply for a job the next year.  
41 You've just got that ability to control some destiny over  
42 your life that you're just going to jump in it and take it,  
43 even if it means that you might have to move in order to  
44 have it.

45

46 Q. So part of the benefit of the training program is it's  
47 a career progression that you can - or career pathway that



1 is more secure for you from the point of view of it is  
2 a secure path toward a fellowship?

3 A. Mmm.

4

5 Q. And the second part of it is, if I've understood you  
6 correctly, you no longer having to apply each year for jobs  
7 because once on that career pathway, at least in your area  
8 of specialisation, you're employed for, what, a period of  
9 four years?

10 A. Five.

11

12 Q. Five years on the pathway, but that's --

13 A. Yes. I've experienced it myself this year. It's just  
14 a massive change in mindset from going, you know, "I don't  
15 know where I'm going next year,, I'm pretty sure I'm  
16 staying here but I've got no certainty of that", as, let's  
17 say, "I've got a contract, I'm going to Liverpool next  
18 year. I know where I'm going to be, I know at the end of  
19 next year, I'll have a job with that sense of certainty.  
20 I don't know where it is going to be but I have no doubt I  
21 will be given one." So it's a massive weight off your  
22 shoulders that junior doctors don't really have in an  
23 earlier stage.

24

25 Q. Can I ask you, you've told us a little bit in  
26 paragraphs 16 to 18 about the potential benefits, at least  
27 to the system, of unaccredited training roles?

28 A. Mmm.

29

30 Q. And as I understand what you tell us there, there are  
31 benefits to the system of unaccredited registrars being  
32 employed because there are aspects of the work that is  
33 required to be done in departments, in surgical  
34 departments, for example, which require a workforce --

35 A. Mmm.

36

37 Q. -- but there is insufficient procedures being done to  
38 enable that workforce, every member of that workforce to be  
39 accruing the training and experience they need as part of  
40 their training pathway.

41 A. Mmm.

42

43 Q. From the perspective, though, of a junior doctor, do  
44 you see any way in which that system might be reconfigured  
45 so as to increase the number of accredited positions and  
46 avoid the situation where you're having to go through this  
47 process annually?

1 A. I understand the tension there. I think the challenge  
2 is that for a lot of these specialties, neurosurgery,  
3 cardiology, respiratory medicine, we only need so many  
4 consultants at the other end. We don't necessarily need  
5 more neurosurgeons in Australia. We have a lot more people  
6 who want to go on and join these specialty workforces than  
7 we actually have a need for. We do, however, need people  
8 in the hospitals to do the grunt work, the background  
9 service work, the on-call work, seeing the consults.

10  
11 I don't have a good solution about how we could  
12 necessarily increase the number of accredited training  
13 positions and I believe the college of surgeons at least  
14 accredits every spot that they're able to in terms of  
15 volume. I do, however, think there is a problem for people  
16 who are in an unaccredited situation and have no guarantee  
17 or certainty for their future, because at the moment,  
18 there's really two ways out. One is that you get on to the  
19 training program and you finish, and that's fantastic, and  
20 the other one, that the majority in some cases end up going  
21 through, is that you leave, and all of your specialty  
22 knowledge, all of your experience, all of your skill that  
23 you've gotten up to that point essentially goes nowhere.  
24 Maybe you use a little bit of it in a different role but  
25 you're certainly not using it in the same capacity.

26  
27 Q. So when you say you leave, what is it that they leave  
28 to do? They cease to be an unaccredited registrar in  
29 surgery having tried but failed to get on to an accredited  
30 pathway?

31 A. Mmm.

32  
33 Q. They then pursue a different specialisation or what is  
34 it that they do?

35 A. Generally it's a different specialty. That might be  
36 radiology, a different kind of surgery, general practice.  
37 Some people leave entirely, might do something - have  
38 a career change, for example. I think it's wasteful of so  
39 many years' specialty training, because these people are  
40 probably very good doctors in the majority of cases, maybe  
41 just not quite competitive enough because there are so few  
42 spots available each year.

43  
44 The solution I propose to this problem is to formalise  
45 this unaccredited registrar role in a, say, career medical  
46 officer style position. So, for example, you're no longer  
47 every year applying to get on to the training program but

1 you've got a set number of hours, you've got a set contract  
2 for probably longer than a year, you've got some certainty  
3 about your career, and in a way, the pressure is off and  
4 you know what you're going to be doing and you're able to  
5 deliver your sub-specialty knowledge under the supervision  
6 of a consultant as opposed to being stuck in the  
7 unaccredited rat race trying each year and maybe not quite  
8 getting there and maybe you're never going to quite get  
9 there. I think that's the limbo that gets people really  
10 stuck.

11  
12 Q. You also tell us, toward the end of your statement,  
13 about some changing attitudes amongst the junior workforce,  
14 and that is to say changing approach to work and work/life  
15 balance, which we have been told has led to a significant  
16 excess of junior workforce into the locum market.

17 A. Mmm.

18  
19 Q. Do you see a way in which these years as an  
20 unaccredited trainee could potentially be adjusted or used  
21 to shift the balance in terms of that move into the locum  
22 market - that is to say, do you see value in there being  
23 a reward for loyal service to the system that doesn't  
24 involve you going locuming?

25 A. Look, I suppose I would say at the moment there isn't  
26 really a reward that I can identify for being loyal to the  
27 system. I'm going to apologise and say I don't have  
28 a great solution here but I can elucidate the problem  
29 a bit.

30  
31 For example, I had a conversation with someone only  
32 a few weeks ago who was saying, "You know, I've got my  
33 contract for next year, I think I'll just quit and locum  
34 the rest of the year." "Why would you do that?" "The pay  
35 is much better, I'm getting constantly called in. I'm  
36 overworked at the moment and I've got my ticket for next  
37 year. Why would I stay?"

38  
39 Obviously that's bad for the system, it's bad for  
40 fellow staff, that person is probably going to burn their  
41 bridges if they do do that at that hospital, but from their  
42 perspective, you know, the quote would be, "The system  
43 hasn't looked after me, why would I give back?"

44  
45 Q. Would it be right to assume that unless that person  
46 was hoping for an accredited position in the facility or  
47 facilitated through the facility that they were working in,

1 that that decision to cut their contract and come back next  
2 year after a period of locuming would have no adverse  
3 impact on their career progress?

4 A. I would go even further because the majority of these  
5 specialty positions are actually centrally allocated and so  
6 even if they do later get sent back to that facility, in a  
7 way, it doesn't matter. They've got their training spot,  
8 they get through that year, that hospital remembers them  
9 poorly because of what they did, that's going to be awkward  
10 for a week or two and then they're just going to get on  
11 with it. It's not going to have any long-term impact on  
12 them at all. There is really limited consequence aside  
13 from letting down your colleagues.

14  
15 Q. You said you didn't have a solution to that one, with  
16 apologies, but thinking about it, is there a way of  
17 building something into the way in which accredited  
18 training positions are offered that could be used to try  
19 and change that pattern of behaviour?

20 A. I can think of the carrot and the stick approach.  
21 Especially when you're starting out, desirable terms are  
22 things that people are after. Desirable terms might be  
23 things that advance people's individual career; less  
24 desirable terms might be things like nights or relief duty.  
25 I think if you have people on more than a year-long  
26 contract, they've got one term left and it's nights, the  
27 incentive to get up and go is pretty high; whereas if you  
28 are doing nights as your last term but you know you're  
29 going to have a great next few terms, people might be  
30 incentivised to stick through that.

31  
32 The other thing you could build in to application  
33 processes is for people who haven't completed their  
34 contract for a term of service, the year does not count in  
35 terms of their eligibility to apply, in terms of points  
36 they might get for career completion and things like that.

37  
38 Q. You mentioned points for career completion. Is there  
39 a points system that we need to understand?

40 A. Oh, look, there are many, unfortunately, for each  
41 individual specialty. Various points are given in terms of  
42 calculating the overall value of someone's CV. For  
43 example, you might get three points for a completed year up  
44 to a maximum of nine points, whereas, a way you could  
45 adjust - and I should mention, that overall ranking is then  
46 used to compare different candidates. If you were to say  
47 that, you know, your year is not credited towards your CV

1 application unless you complete your contract, that would  
2 majorly change behaviour, because I think there would be  
3 very few people who would be willing to quit right at the  
4 end knowing that they are not going to get the value for  
5 that year done.  
6

7 It's not universal, it doesn't apply to every  
8 specialty, it would need to be a tailored solution, but  
9 certainly if you told people that unless they do the time,  
10 the year is not going to count, that would change behaviour  
11 a lot more so than, "Oh, you really should stick it out.  
12 The hospital would appreciate it."  
13

14 Q. So the points system that we're talking about at the  
15 moment, at least in the context of your experience, is  
16 points which you accrue as part of your service which are  
17 effectively taken into account as part of an assessment of  
18 your application for entry into an accredited training  
19 scheme?

20 A. That's correct. And there's various different schemes  
21 for each of the different specialty colleges, but there's  
22 usually a combination of how long, if you've been in the  
23 job, have you done any particular research, have you gotten  
24 a higher degree, and it's combined to a total and that's  
25 used to differentiate people.  
26

27 Q. Accepting that it's probably a question better asked  
28 of the colleges who are joining us on Friday, but from the  
29 perspective of a junior medical officer, do you have a view  
30 about whether there is a good reason for having different  
31 systems for each of the different areas of specialisation  
32 in that respect?

33 A. I think the reason that there are different systems is  
34 that each individual specialty is setting their own entry  
35 requirements and they're not talking to the others when  
36 they go about doing it.  
37

38 Look, I am honestly not sure that the CV process  
39 appropriately differentiates people. I think to a certain  
40 extent your experience, how many years you've done  
41 something, tells you. I think if you have done a higher  
42 degree - I think almost everyone in surgery has done  
43 a Masters of Surgery at the University of Sydney, and  
44 really that just shows that you've got the ability to pay  
45 for that course and that you've ticked the box and you've  
46 done the online assessment. I think almost everyone has  
47 got some research. You get the same points, for the

1 majority of these, whether you do a very low quality case  
2 report or if you publish a groundbreaking study, so  
3 everyone goes and does some reasonably low quality research  
4 and ticks the box at the end of the case. Almost  
5 everyone's got the same CV score at the end. So I am not  
6 sure that it does a great job of differentiating candidates  
7 and ultimately selecting people who are going to be the  
8 best specialists at the end of the day.

9  
10 Q. Given everyone is, you tell us, largely able to tick  
11 all of these boxes, if going away and locuming resulted in  
12 a box not being ticked, that would potentially be  
13 a significant differentiating factor?

14 A. Very much so. I think if you failed to complete your  
15 contract and that prevented you from application or  
16 resulted in a points deduction, that would change behaviour  
17 drastically.

18  
19 Q. Your specialty training is being driven largely by the  
20 college of surgeons; is that right?

21 A. Yes, that's correct.

22  
23 Q. The process by which you sought and obtained entry  
24 into the accredited training program or pathway was  
25 something which was driven by the college of surgeons?

26 A. Yes.

27  
28 Q. From a junior doctor's perspective, do you see any  
29 benefit in a centralisation of that process whereby the  
30 training pathways, obviously conducted collaboratively  
31 between the college and the ministry, were run centrally  
32 through the ministry, from both a recruitment and a career  
33 pathway point of view?

34 A. I'm not necessarily sure that there would be an  
35 advantage to that being - that process being run centrally,  
36 and the reason being, I think to a certain extent the best  
37 people who are able to tell who should go on and join  
38 a profession are probably the members of that profession.  
39 So I imagine there is probably some benefit to allowing the  
40 individual colleges to set the standards or to set the  
41 assessment methods as to how they would apply. I'm not  
42 sure a centralised process would necessarily be  
43 advantageous there.

44  
45 Q. From the point of view of a junior doctor, it would  
46 probably make very little difference if you decided on  
47 a particular specialty that you were wanting to pursue, but

1 from the point of view of the system, do you see that  
2 there's not some potential for the system to distribute  
3 trainees, accepting that they may need to be chosen in  
4 collaboration with those experts who have the experience,  
5 in the way that best meets the needs of the system?

6 A. I can be more precise for you. I think the actual  
7 process for how they're selected is probably best left to  
8 the colleges. Where they go to fill workforce needs,  
9 absolutely I think there would be a value for collaboration  
10 with the Ministry of Health.

11  
12 I also - you know, back to my previous point, I think  
13 once people are in, they would be almost willing to go  
14 anywhere, especially with some knowledge or some certainty  
15 for the future. So I think there would be a great  
16 opportunity to collaborate there, to be honest.

17  
18 Q. And if the ministry, with probably a better sense of  
19 or better overall knowledge than any other organisation,  
20 including the colleges, as to precisely which procedures  
21 are being done where and in what volumes, had the capacity  
22 to utilise that information to increase the number of  
23 people who could be pushed through a training pathway, that  
24 would only be beneficial to junior doctors, in the sense  
25 that there were more training positions available?

26 A. Absolutely. I think if you told a junior doctor, "The  
27 ministry's found a way to increase the number of training  
28 positions", they'd say, "Oh my goodness. Thanks so much.  
29 Where do I sign?"

30  
31 Q. You tell us in paragraph 19 of your statement, or you  
32 make the observation, that the rates of pay and conditions  
33 for junior medical officers in New South Wales are at odds  
34 with those available in other jurisdictions --

35 A. Mmm.

36  
37 Q. -- that is to say, are in some respects less  
38 desirable.

39 A. Mmm.

40  
41 Q. Do you get the sense, based on your engagement with  
42 other junior medical officers, that that fact is actually  
43 driving people to work in other jurisdictions or is it just  
44 a source of irritation?

45 A. I think it depends on the mobility of the person who  
46 is applying. If you've got family and kids in school here,  
47 it's probably more of an irritation. If you're like me,

1 when I was first applying for a job, I applied all the way  
2 across the state. I stayed in New South Wales because the  
3 hospital I was currently at asked me to carry on, but  
4 I would certainly have had no great issues with going away,  
5 and I think the pay disparity has really only gotten  
6 greater as a result of the relative difference in wage  
7 increases here.

8  
9 I think it's certainly driving a lot of the behaviour  
10 of the more junior staff when they look to locum,  
11 especially. If you can quit your current job and get paid  
12 three times the amount and work in a similar location and  
13 then also can have a bit more control or flexibility in  
14 your hours, people make very good arguments about, "Why  
15 should I stay and continue to work for NSW Health?"  
16 There's not a lot of unique benefits that I'm able to tell  
17 as to why you should work in NSW Health. The benefits are  
18 because you are already here, it's where you grew up. It's  
19 not the organisation.

20  
21 THE COMMISSIONER: Q. Do I take from that answer,  
22 obviously the people that don't have the mobility you talk  
23 about might find it difficult to move, but in terms of  
24 people that do have that mobility, do I understand your  
25 answer to be it's more driving those junior doctors into  
26 becoming locums than moving to another state? Or is it  
27 both?

28 A. I think it's a bit of both. I think it's hard to  
29 justify continuing to work in a resident role towards the  
30 end of your contracted year. There's no real incentive to  
31 stay, it doesn't hamper your career progression if you  
32 leave, you can definitely get a much better rate if you go  
33 and locum, you can definitely get a much better rate if you  
34 go interstate. So if you don't have a good reason to stay,  
35 why would you? People vote with their feet.

36  
37 MR MUSTON: Q. But those who are seeking to pursue  
38 a position within an accredited training scheme somewhere -  
39 do you, again based on the observations that you've made of  
40 your own cohort, get the sense that there are people moving  
41 interstate --

42 A. Yes.

43  
44 Q. -- because of the pay difference?

45 A. I think in terms of the pay and condition difference,  
46 yes, certainly. I know of someone who moved to pursue  
47 specialty training, sorry, to apply for specialty training,



1 from New South Wales to Adelaide. There was no real reason  
2 to stay in New South Wales and the Adelaide department was  
3 perceived to be more supported and the Adelaide department  
4 pays you professional development leave, it's easier to  
5 access your study leave, you get a greater base rate. So  
6 it's a very easy and logical decision for them.

7  
8 Q. I that example, though, were they moving into an  
9 unaccredited position --

10 A. Yes.

11  
12 Q. -- or into an accredited --

13 A. From unaccredited position to unaccredited position.

14  
15 Q. And it was your perception, at least of that person,  
16 that the move was driven solely by what were perceived to  
17 be more desirable pay and conditions in the South  
18 Australian health system?

19 A. Not solely by that, but certainly it's a big factor  
20 when you think of a 30 per cent effective increase in your  
21 salary and also you are going to a supportive department  
22 who is going to progress your career.

23  
24 MR MUSTON: Commissioner, I've got no further questions of  
25 this witness on these topics, although he's sticking around  
26 to form part of the next panel, but I think we need to  
27 adjourn briefly --

28  
29 THE COMMISSIONER: Shall we take a short break?

30  
31 MR MUSTON: -- to enable that to occur. I think it is  
32 3 o'clock. So if we take nine minutes.

33  
34 THE COMMISSIONER: I will check with Mr Cheney. Do you  
35 have any questions for the witness?

36  
37 MR CHENEY: No, Commissioner.

38  
39 THE COMMISSIONER: All right. Thank you, Dr Morrison.  
40 You are excused for eight minutes. We will come back at  
41 3 o'clock.

42  
43 THE WITNESS: Thank you.

44  
45 **SHORT ADJOURNMENT**

46  
47 MR MUSTON: Dr Ingram, can you see and hear us, just

1 before we start?  
2  
3 DR INGRAM: Yes, I can, thank you.  
4  
5 MR MUSTON: Great. We'll start in just a minute.  
6  
7 THE COMMISSIONER: All right. I'm ready when you are.  
8  
9 MR MUSTON: Dr Morrison has been joined at the table by  
10 Mr Minns and online by Dr Ingram, both of whom should  
11 probably be sworn.  
12  
13 THE COMMISSIONER: Dr Ingram, can you hear me?  
14  
15 DR INGRAM: Yes, I can.  
16  
17 <MATTHEW JAMES INGRAM, affirmed: [3.00pm]  
18  
19 <PHILLIP GREGORY MINNS, sworn:  
20  
21 MR MUSTON: Could I start briefly with you, Dr Ingram.  
22 Could you state your full name for the record, please.  
23  
24 DR INGRAM: Matthew James Ingram.  
25  
26 MR MUSTON: You are a staff specialist in emergency  
27 medicine at Wyong Hospital?  
28  
29 DR INGRAM: That's correct.  
30  
31 MR MUSTON: That's a role you've held, I think, since  
32 2020?  
33  
34 DR INGRAM: That's correct.  
35  
36 MR MUSTON: And prior to that, you worked as a registrar  
37 and junior medical officer within the Central Coast Local  
38 Health District from, I think, 2013.  
39  
40 DR INGRAM: That's correct.  
41  
42 MR MUSTON: Amongst other things, you are an elected  
43 councillor for the Australian Salaried Medical Officers  
44 Federation --  
45  
46 DR INGRAM: Yes, that's right.  
47

1 MR MUSTON: -- otherwise known as ASMOF? You've prepared  
2 a statement to assist the Inquiry with its work dated  
3 27 September 2024.  
4  
5 DR INGRAM: That's right.  
6  
7 MR MUSTON: Do you have a copy of that handy?  
8  
9 DR INGRAM: I do.  
10  
11 MR MUSTON: Have you had an opportunity to read it prior  
12 to giving your evidence today?  
13  
14 DR INGRAM: Yes, I have.  
15  
16 MR MUSTON: And you're satisfied that its contents are, to  
17 the best of your knowledge, true and correct?  
18  
19 DR INGRAM: Yes, I am.  
20  
21 MR MUSTON: Thank you.  
22  
23 Mr Minns, for the record, could you state your full  
24 name again, please.  
25  
26 MR MINNS: Phillip Gregory Minns.  
27  
28 MR MUSTON: We know who you are, so I won't ask you those  
29 questions again, but you've prepared a further statement to  
30 assist the Inquiry with its work dated 8 October 2024.  
31  
32 MR MINNS: Yes.  
33  
34 MR MUSTON: Do you have a copy of that statement with you?  
35  
36 MR MINNS: I do.  
37  
38 MR MUSTON: You have had an opportunity to read it?  
39  
40 MR MINNS: I have.  
41  
42 MR MUSTON: And satisfied yourself that its contents are,  
43 to the best of your knowledge, true and correct?  
44  
45 MR MINNS: Yes.  
46  
47 MR MUSTON: I think that is tendered as exhibit L6 and

1 I should have said, Commissioner, Dr Ingram's statement is  
2 exhibit L14.

3  
4 THE COMMISSIONER: Thanks.

5  
6 MR MUSTON: Can I start with your statement, Mr Minns.  
7 Could I ask you to turn to the observations you've made at  
8 paragraph 6 and following about what you perceive to be  
9 a broad approach to the way in which decisions are made  
10 and, in particular, funding decisions are made, about  
11 public health in New South Wales, and perhaps if we could  
12 have those paragraphs of Mr Minns' statement brought up on  
13 the screen so Dr Ingram and Dr Morrison can see them as  
14 well. Paragraph 6 commences at the very foot of page 1 and  
15 then continues over to page 2.

16  
17 THE COMMISSIONER: Does 5 give context, a little bit?

18  
19 MR MUSTON: It does give some, I guess. To the extent  
20 necessary, operator, so that Dr Ingram and Dr Morrison can  
21 see 5, just scroll up. I think it is largely introductory.

22  
23 Could I ask you, Mr Minns, in relation to what you  
24 tell us in paragraph 6 about the general approach by  
25 treasury - that is to say, that the increased capital costs  
26 as a result of bringing new or upgraded facilities online  
27 are to be absorbed by existing operating budgets - the  
28 first question about that: I infer from what you tell us  
29 that when one builds a new facility or upgrades an existing  
30 facility, there are increased costs associated with  
31 operating that facility?

32  
33 MR MINNS: Yes. The chief financial officer can probably  
34 give you a more complete answer than I can, but if you look  
35 at some of the new builds that have come online since  
36 I have been in health, they are bigger facilities than what  
37 they replaced, and so simple things like the square metres  
38 that need to be cleaned in a new wing of a new developed  
39 hospital, it's larger than what it replaced.

40  
41 I think in your earlier remark in the question, the  
42 important phrase in here that I think needs to be stressed,  
43 and it is the fact, is that treasury is making an  
44 assumption that the growth allocation that's in our budget  
45 ought to be able to handle the impact of the new builds.  
46 That's why they have that as an opening position. But  
47 costs in newly built larger facilities - another cost can

1 be associated with single rooms which are built as  
2 a revenue strategy, but you will end up with more of those,  
3 typically, in a new build than what you had in what you  
4 replaced.

5  
6 MR MUSTON: I gather, though, based on what you - well,  
7 I infer from what you tell us in your statement that the  
8 growth, which is already built into the budget, is not, in  
9 fact, sufficient to actually meet the costs of the - the  
10 increased costs of running these new or upgraded  
11 facilities?

12  
13 MR MINNS: I think that would be our contention and the  
14 contention of the CFO when you've got several new builds  
15 that come on stream in a particular budget year.

16  
17 There is another point that I wanted to make, that  
18 I should have made first. Anyway. I think that's broadly  
19 true. There's --

20  
21 THE COMMISSIONER: It depends on how the growth  
22 assumption is set, doesn't it?

23  
24 MR MINNS: Pardon?

25  
26 THE COMMISSIONER: It depends on how the growth assumption  
27 is set - what are the assumptions.

28  
29 MR MINNS: Yes, and those are decisions that happen  
30 between treasury and health. The reason why I used the  
31 phrase there, and I did walk this through the finance team,  
32 "the general approach by NSW Treasury", is that I am aware  
33 in the seven or eight budgets that I've been a party to, at  
34 least understanding them, that sometimes that initial  
35 assumption has been adjusted because of what is occurring  
36 in a financial year that we're heading into, and that's my  
37 point that I forgot.

38  
39 It's not a perfect like-for-like arrangement. So  
40 I don't think I would be doing anyone a disservice by  
41 saying Tweed was a very large redevelopment and in terms of  
42 how the approach to new build funding, or, rather, growth  
43 funding, rolled out to northern New South Wales, I don't  
44 think it completely aligns with the sort of - sort of  
45 represents a reconciliation with the new build operating  
46 costs of the Tweed facility.

1 MR MUSTON: So is a consequence of that, in order to bring  
2 the delivery of services within a budget that has been  
3 allocated, you either need to - in circumstances of  
4 a rebuild like Tweed, you either need to find significant  
5 efficiencies - we might come back to that - or  
6 alternatively, contract services in other areas to meet the  
7 cost of the staffing/operating the new buildings?  
8

9 MR MINNS: It will likely be an allocation decision for  
10 the chief executive and their team, you know, how are we  
11 going to bring these facilities online but stay within our  
12 allocated budget, including the amount of growth that's  
13 there?  
14

15 MR MUSTON: Acknowledging that a more perfect  
16 understanding of or a more perfect answer to this question  
17 could probably be given by the chief executives of each  
18 local health district, is it your sense, viewing it  
19 centrally, that there are significant efficiencies still to  
20 be found within the system such that they're available to  
21 be found to meet this potential deficit or is the reality  
22 that efficiencies that exist within the system have largely  
23 been captured?  
24

25 MR MINNS: I think I would note that the CEs are going to  
26 be in a better position than me and so also the chief  
27 financial officer, but it is the case that, at this point  
28 in this financial year, several of our local health  
29 districts are over their budget, at year to date and  
30 forecast to the end of the year, and they are engaged in a  
31 range of strategies and initiatives to seek to address that  
32 budget issue. So they've got a plan to get back on budget.  
33 I wouldn't like to predict how many of them will achieve  
34 that, but it won't be a simple and easy task.  
35

36 THE COMMISSIONER: That means, do I take it, that it is  
37 not a simple or easy task, that there are not obvious  
38 inefficiencies to be found, first?  
39

40 MR MINNS: Look, it's a very big budget, Commissioner, and  
41 some of our districts are in excess of \$2 billion, so you  
42 have always got an opportunity to be adjusting services and  
43 points of expenditure in the system.  
44

45 THE COMMISSIONER: Adjusting services is different to  
46 finding efficiency, isn't it?  
47

1 MR MINNS: Well, it's the adjustment that might generate  
2 the opportunity to make a saving. Whether or not you can  
3 do that at scale and to the extent that is created by their  
4 budget context and sustain it in the face of any kind of  
5 commentary that occurs about the decisions you've made,  
6 that's where it becomes very much an art of what is  
7 possible and it's a challenging job for those chief execs.  
8

9 THE COMMISSIONER: I'm not expecting you to agree with  
10 this because I don't think it would be fair to put it to  
11 you, but it's also possible that - a possibility, I'm  
12 sorry, is that the amount that they were funded wasn't  
13 enough to begin with to deliver the services that ought to  
14 be delivered.  
15

16 MR MINNS: You will meet some people, Commissioner, who  
17 will say that.  
18

19 THE COMMISSIONER: I reckon I have already.  
20

21 MR MINNS: Quite possibly.  
22

23 MR MUSTON: The second challenge that you tell us, which  
24 is associated with these new builds and upgrades of  
25 hospitals, is a staffing challenge or a workforce  
26 challenge - that is, I infer from what you tell us, you  
27 build a new hospital, and I think we saw one in Bega that  
28 was a good example of it, a large and impressive new  
29 hospital, but insufficient staff in its early days to be  
30 able to actually operate it at its full capacity.  
31

32 MR MINNS: Bega is pre my time, but that's as it was  
33 reported to me.  
34

35 I think the other thing to note is that at times -  
36 when we do a new build, you know, the team that puts  
37 together the scope and design and the entire package of  
38 what's being proposed, they're building it for a 20- to  
39 30-year period. But often what happens - and this is what  
40 I'm partly referring to in these paragraphs - is that  
41 expectations, both within the community and sometimes  
42 within the clinical community - they sort of form the view  
43 that it is built, so now it must be completely used. So  
44 the idea that it's got two decades of capacity to absorb  
45 future activity growth kind of gets lost and there's a big  
46 push to open everything and have all facilities running,  
47 which you can sort of understand, but if you have tried to

1 do a build that is a bit future-proofed, with some scale  
2 still within it to expand to, it's not necessarily helpful  
3 if you have to start it all in the initial period, and  
4 I think that pressure is real and it can compound the  
5 workforce issues in some of these regional areas.  
6

7 Northern New South Wales, my understanding is that  
8 Tweed just recently has sort of got to a point where it has  
9 filled virtually all of its vacancies as a new build, but  
10 that took a very concerted recruitment effort, and given  
11 its location and the issues with the jurisdictional  
12 factors, that's pretty remarkable achievement.  
13

14 THE COMMISSIONER: Can I ask you - can I tell you, first  
15 of all, what I take from, say, paragraphs 7, 8 and 9 of  
16 your statement, and you tell me whether I'm  
17 misunderstanding you, but what I'm taking from paragraphs  
18 7, 8 and 9, at a very high level sense, is that - I don't  
19 think you're suggesting that it's inappropriate that there  
20 be new infrastructure, but that at least as important are  
21 the skills and the services for health in the future that  
22 will avoid as much as possible people having to go to  
23 either the shiny new facilities or the old decrepit  
24 facilities or facilities in between.  
25

26 MR MINNS: Yes, Commissioner.  
27

28 THE COMMISSIONER: That's the nub of the future health  
29 strategy, I think.  
30

31 MR MINNS: It is.  
32

33 THE COMMISSIONER: If I was going to give it one line,  
34 that's the nub of it. Is that a fair reading of --  
35

36 MR MINNS: It is a fair reading and I guess what I was  
37 trying to create across from 5 onwards was the sense in  
38 which it was very striking entering health from somewhere  
39 else in government that - just how compelling and appealing  
40 the idea of new facilities in as many parts of the state as  
41 possible had taken a hold of everyone's thinking.  
42

43 Now, of course we can't live in 50-year-old buildings  
44 forever, but it became - it was very much the go-to play  
45 and it's partly why I make reference to the context of  
46 defence, because I'm in part reminded on the workforce  
47 issues about the dilemmas that existed when I was in



1 defence, when the White Paper was being developed and there  
2 was the big push for submarines.

3  
4 I was a member of the defence committee, you know, it  
5 was the first time that the role of people had been  
6 elevated to that level, and I was trying to say in the  
7 early days of the planning piece, "You can't assume  
8 a submariner workforce. We have significant issues with  
9 our current fleet of six small submarines, we're going to  
10 have many more issues with a fleet of 12 that almost  
11 doubles the crew on each submarine." So you need to factor  
12 these issues in at commencement, at the start. I think  
13 I go on to say that I think health has a bit of a missing  
14 piece in that.

15  
16 MR MUSTON: I'll come back to the missing middle, just to  
17 explore that with you, but paragraph 9 in particular, is  
18 the essential point there, and again correct me if I've  
19 misunderstood it, a sustainable approach to the delivery of  
20 health care is to start by identifying the needs of the  
21 population and what it is as a public health system you're  
22 seeking to achieve referable to those needs - that's step  
23 one?

24  
25 MR MINNS: And, to that point, if I may, the  
26 Commissioner's point about where is the best balance  
27 between hospital based care and community based care and  
28 outreach based care.

29  
30 MR MUSTON: Which gets us to step two, which is how is the  
31 most - what is the optimum way of delivering on those needs  
32 or achieving those objectives in the sense that you've  
33 described? What are the right models of care or the  
34 optimal models of care? What are the best ways of  
35 delivering in terms of in hospital, out of hospital, what's  
36 primary care, what's acute care, et cetera?

37  
38 MR MINNS: And added to that, the point that Mr Griffiths  
39 made, I think yesterday at some point, that we need to  
40 start reflecting on the context you've described and then  
41 say, "How do we need to organise services and what kind of  
42 workforce mix do we need", rather than start with the very  
43 traditional view about the workforce that we will need and  
44 then go on to make planning decisions which kind of assume  
45 a workforce, which might not be present in all cases.

46  
47 MR MUSTON: Which is, whether it's a third step or whether

1 it's part of the same process, identifying exactly what we  
2 as a system need in order to deliver on those objectives,  
3 and that's going to be a function of people, so the  
4 workforce mix that you've just referred to, but also  
5 facilities, and so questions about whether or not there  
6 should be a larger hospital or there should be an upgraded  
7 hospital should be informed by a sense in which that is  
8 necessary to achieve an objective rather than the objective  
9 in and of itself.

10  
11 MR MINNS: Yes. I agree with that. And the last point  
12 being the making sure that the opportunities for treating  
13 the provision of the necessary services as a networked  
14 solution from all resources that we have available in  
15 NSW Health, rather than a singular location of a facility.  
16

17 MR MUSTON: That's where we come to the missing middle,  
18 I think, which you tell us a little bit about in paragraphs  
19 10 to 16, effectively. Perhaps instead of me telling you  
20 what I understand you to mean in those paragraphs, could  
21 you just talk us through the missing middle and the extent  
22 to which, as I understand it, it involves some balancing of  
23 a devolved system, which we've move to, and a centralised  
24 system, which we've moved away from, which captures the  
25 benefits that centralisation can bring without losing too  
26 many of the benefits of devolution?  
27

28 MR MINNS: Yes, so as it is explained to me, this used to  
29 be a very centralised planning process conducted in the  
30 ministry, and it's - I think there would pretty much be  
31 a consensus of people who were there at the time, and  
32 reflecting on it now, that it was too centralised, and it  
33 meant that the local community voice and the local clinical  
34 perspective didn't come through sufficiently, and so at the  
35 time of the Garling Inquiry, there was a fair bit of angst  
36 about what might be called the over centralise education of  
37 functions within the ministry.  
38

39 When the changes that occurred that created the local  
40 health districts unfolded, the system was in the last  
41 throes of a restructure to create the area health services  
42 under the last government that were meant to have three  
43 clusters that would support those area health services, and  
44 one of the things the clusters were meant to do was all of  
45 this kind of logistical planning within those three or four  
46 area health services that sat within their cluster.  
47

1 My understanding - and it might be wise to seek some  
2 evidence from people who were here at the time - but those  
3 clusters went as a decision of the new structure and all  
4 the capability in them went as well. It didn't go into the  
5 LHDs and it didn't go into the ministry. So people who  
6 might have been able to conduct this kind of work at  
7 a cluster level leave the building.

8  
9 That's as it has been explained to me, and it looks  
10 credible because we don't have this kind of capability in  
11 the centre and we don't have it in individual LHDs, and  
12 it's manifest in other areas as well. For example,  
13 strategic and operational workforce planning is pretty thin  
14 within our LHDs, because it was meant to be a function done  
15 by these cluster entities. So over time, we've kind of  
16 been rebuilding the capacity of the ministry to provide  
17 some support to each of the 16 LHDs and networks.

18  
19 I don't think anyone wants the recreation of the  
20 clusters. We just need to recognise that we've lost the  
21 capability and a function that has impacts and how would we  
22 put it back in, but doing it in the way you described, it's  
23 not about everything being driven from the ministry again.  
24 It can't be.

25  
26 MR MUSTON: There is a combination of things in play  
27 there. The first is the loss of a skill set from within  
28 the system, which I understand you to say is as a skill set  
29 being rebuilt in the middle so as to provide support in  
30 areas like workforce planning to the LHDs, but there's  
31 a second aspect of it, which is centrally there will be  
32 a corpus of information, which is system-wide information,  
33 which might be necessary for system-wide planning on issues  
34 like workforce, workforce distribution and the like, that  
35 is something that, even with the best skill set in the  
36 world, each of the LHDs, sitting in their isolated silos,  
37 would not be able to bring about effective system-wide  
38 change - would that be right - without the benefit of that  
39 central information?

40  
41 MR MINNS: What the central information gives is context  
42 to the right options that you might choose within your LHD  
43 context, and if it's absent, then the people in the LHD,  
44 both the executive team and the clinical community, really  
45 all they can focus on is the solution that appears to be  
46 best for them. So it's partly why sometimes we see LHDs  
47 almost competing with one another for the workforce to

1 provide a certain service that might be better shared or  
2 somehow networked between them. It's popped up around  
3 a focus on research in local health districts that, you  
4 know, each LHD feels the necessary, I guess, compulsion to  
5 make sure they have a strong research function within their  
6 own district and, indeed, their clinical community would  
7 expect that and demand it. But it's not necessarily  
8 helpful if you're doing that in competition with your  
9 neighbouring districts instead of in some kind of  
10 collaborative way that is referenced from a larger,  
11 overarching strategy. So I think that's the kind of key  
12 point that I'm trying to make across all of these  
13 paragraphs.

14  
15 MR MUSTON: So the conclusion that you reach is that there  
16 needs to be a local engagement which occurs in a coherent  
17 overarching context provided by system level design of  
18 network service delivery. What might that look like in a  
19 practical sense?

20  
21 MR MINNS: It means that we need to create inside the  
22 ministry - you know, we have a team that has been thinking  
23 about this work and working on it for, I think, the last  
24 six months. They probably need more resources to be able  
25 to ensure that, if they come up with a process to work with  
26 an LHD, that has forward capital funding to engage in the  
27 planning process. If they don't have enough resources to  
28 engage, then the assumption out there will be "The  
29 ministry's taken this over again."

30  
31 The process needs to be one that's very transparent  
32 and very clear so that the communities and, you know, both  
33 the non-LHD community, the actual community, understand  
34 that they are in a driving role around planning how to  
35 respond to their LHD's situation, its future needs and the  
36 capital that is available to it, but they are also doing it  
37 with a sort of statewide blueprint that adds value to the  
38 decisions they make and, most importantly, means that they  
39 don't duplicate anything that effectively is a poor use of  
40 limited capital resources.

41  
42 MR MUSTON: So bringing you back to something you touched  
43 on a bit earlier, that might mean, if the system were  
44 operating effectively, that ward within a new build  
45 hospital which is sitting unused is not seen by the  
46 community as a bad thing because it's understood that it's  
47 future-proofing the facility, whilst at the same time

1 ensuring a fair and equitable distribution of the resources  
2 available to the ministry across the system more widely to  
3 meet the existing needs of the wider population, as opposed  
4 to new hospital, closed ward, scandal.

5  
6 MR MINNS: If we could achieve that, that would be  
7 tremendous.

8  
9 MR MUSTON: Could I bring you, Dr Ingram, into this  
10 discussion briefly. From the perspective of someone  
11 working within a facility in an LHD within the Central  
12 Coast, do you have a view about the extent to which the  
13 balance between central control and central oversight by  
14 the ministry and decision-making at an LHD level is struck?  
15 Is it needing or could it benefit from some adjustment  
16 further towards the centre to where it currently sits, do  
17 you think?

18  
19 DR INGRAM: I think it's very, very challenging. No-one  
20 wants their porridge too hot or too cold and finding that  
21 balance is the challenge, but I think the devolution that  
22 I have seen in more recent years has been beneficial, you  
23 know, as Mr Minns said, the local clinician input and the  
24 local - the needs of the local community are best  
25 understood by the LHD and so I think that there has been  
26 significant value in that, appreciating that there is  
27 sometimes, as he has already described, some loss of value  
28 in other areas as well. So I think it is incredibly  
29 challenging. I don't necessarily have the answer, I'm  
30 sorry, other than to say that involving local communities  
31 and local clinicians is paramount.

32  
33 MR MUSTON: What about the proposition that the way in  
34 which that balance is currently struck leads inevitably to  
35 a level of competition between LHDs for resources and  
36 opportunities? Is that something which, as a matter of  
37 frank reality, you have seen or a sense that you have from  
38 an LHD perspective?

39  
40 DR INGRAM: I'm not particularly privy to the allocation  
41 of resources in the LHDs, so I couldn't necessarily speak  
42 to that, but in terms of my personal LHD's relationship  
43 with other LHDs is extremely strong. We're a busy regional  
44 LHD but we lack some of the tertiary services of our  
45 surrounding partners and so we have very strong clinical  
46 relationships with other LHDs to be able to refer people  
47 for sub-specialty services such as neurosurgery. So that's

1 not necessarily the clinical experience, but that doesn't  
2 really answer your question, I don't think.

3  
4 MR MUSTON: What about the distribution of workforce  
5 experience? You I think have told us about challenges, or  
6 your colleague Dr Spooner has told us about workforce  
7 challenges faced in the emergency departments in the  
8 Central Coast in terms of securing the necessary workforce.  
9 Do you see potential value in decisions around the  
10 distribution of the available workforce being made more  
11 centrally and perhaps with a better understanding of where  
12 the greatest needs exist?

13  
14 DR INGRAM: Yes, I echo Dr Morrison's comments earlier,  
15 that I think that there is an increased role for  
16 collaboration there and potential benefit for people,  
17 particularly in rural and regional areas, to start  
18 addressing the maldistribution of health care within  
19 New South Wales.

20  
21 MR MUSTON: Can I come to paragraph 18 of your statement,  
22 Mr Minns, and perhaps if we could get that up on screen.

23  
24 I might ask you first, Dr Morrison, because you're  
25 closest to the appropriate age bracket: is it your sense  
26 that there is a generational drift away from general  
27 practice?

28  
29 DR MORRISON: Definitely. It's borne out in the data but  
30 it's also borne out anecdotally.

31  
32 MR MUSTON: What are the drivers of that?

33  
34 DR MORRISON: I think the perceptions are: one, that  
35 remuneration is not as competitive and is continuing to be  
36 eroded as the Medicare rebates don't meet pace with  
37 inflation; two, I think there is a natural course of  
38 studies where people start at a medical school, they go to  
39 an inner city teaching hospital, because that's the one  
40 affiliated with the medical school, the people who practise  
41 there are not general practitioners. Your general practice  
42 involvement might only be a term or two - I did eight weeks  
43 out of my six years, for example - and everyone else,  
44 rightly or wrongly, says general practice is not as  
45 desirable or as prestigious as the other specialties and it  
46 is seen as a back-up for most. So I think that is the  
47 reason why only 12 per cent of people are indicating

1 general practice is their first preference when it used to  
2 be in the order of 50 per cent.

3  
4 MR MUSTON: When you say "everyone else", is that intended  
5 to be a reference to all of those people who provide  
6 guidance and mentorship to you in all but the six weeks or  
7 eight weeks' worth of your six years of study?

8  
9 DR MORRISON: You have so much exposure to people who are  
10 not general practitioners. Certainly you might meet -  
11 I met two general practitioners, for example, in the course  
12 who practise in general practice - that is, in the course  
13 of my six years of study. I would estimate I met maybe 50  
14 or 60, perhaps more, clinicians in other specialties. So  
15 I must admit I got very limited engagement, limited  
16 involvement in general practice.

17  
18 Then you go in the hospital system, there's no  
19 involvement in general practice, but I did get  
20 a neurosurgery term so I pursued down that track because  
21 they were people I knew. I started doing that work, that  
22 was work that I was interested in, and then life continues  
23 and, all of a sudden, I'm seven years through and I haven't  
24 done any general practice.

25  
26 MR MUSTON: From the point of view of the first of those  
27 issues or both, really, but the financial issues associated  
28 with perceptions around the adequacy of the Medicare  
29 rebate, do you think from the perspective of a young  
30 doctor, that a salary - the opportunity to work in a  
31 salaried position as a generalist within the public health  
32 system might make that course more desirable?

33  
34 DR MORRISON: I think you could certainly construct  
35 a position where people would see that that is attractive,  
36 especially if the conditions and remuneration were such  
37 that, all of a sudden, this becomes something that people  
38 would see themselves going into.

39  
40 I think there's certainly a perception, rightly or  
41 wrongly, but this is what's out there amongst medical  
42 graduates, that general practitioners get paid the least;  
43 you're a sole trader or your own practitioner, so you need  
44 to go and run your own business as well; and the degree of  
45 reward for the degree of effort required to get there just  
46 doesn't make it worthwhile.

1 MR MUSTON: It may be speculation on your part and mine,  
2 but do you think that were there salaried positions  
3 available in the public system for generalists to be  
4 delivering effectively general practice style care to  
5 communities where general practice was not otherwise  
6 available, the opportunity as part of your early career  
7 progression within the public system to rotate through  
8 a situation like that might enhance at least in the  
9 perception of the junior doctor, the desirability of that  
10 as a longer-term career path?

11  
12 DR MORRISON: I think it would certainly expose people to  
13 general practice, if you could do a general practice term,  
14 not as a medical student but as a registrar or as  
15 a resident, you're actually a "real doctor", when you did  
16 it, delivering actual clinical care. Whether or not it was  
17 ultimately attractive and generated people wanting to go  
18 into the industry, I think would depend on how the position  
19 was constructed and whether or not it did have the  
20 appropriate pay and conditions.

21  
22 I certainly know several colleagues who would be very  
23 attracted by the idea of knowing they have a set period of  
24 leave, knowing that they have set office hours, knowing  
25 that they have a set salary at the end of the day. So  
26 I certainly think the idea has merit. It would require  
27 a bit of work, of course.

28  
29 MR MUSTON: Dr Ingram, do you have anything you want to  
30 add on the drift away from general practice?

31  
32 DR INGRAM: Yes, I would say there are probably some  
33 linguistics here as well, you know, talking about  
34 generalists - general practitioners are certainly  
35 generalists with, in some regional and rural, a broad  
36 variety of medical conditions, and as an emergency  
37 physician, we probably see ourselves as one of the next  
38 best generalists. So there's a number of specialties that  
39 may be considered generalists that look after multiple  
40 organ systems and multiple different medical problems.

41  
42 In terms of the transition away from general practice,  
43 I think there is also a sort of societal expectation for  
44 many non-medical people to have their medical problems  
45 managed by a sub-specialist, so if you have a heart  
46 problem, many non-medical people might believe that that  
47 can be only be managed by a cardiologist and that a general



1 practitioner can't manage that. While that's true of some  
2 conditions it's certainly not true of all of them and there  
3 are many heart conditions extremely well managed by my GP  
4 colleagues. So I think there's some societal expectation  
5 driving some of this, and then reputation that comes with  
6 that, of defining yourself as a specialist or  
7 a sub-specialist outside of the generalists. However,  
8 obviously general practitioners are specialists in their  
9 own area as well.

10  
11 MR MUSTON: Dr Ingram, I might have to ask you to just  
12 speak a little bit more slowly. What you can't see,  
13 I suspect, on your computer is the two people sitting to my  
14 immediate right who are having to take down every word we  
15 each say, and I challenge them at times, but you are  
16 speaking pretty quickly.

17  
18 DR INGRAM: Apologies.

19  
20 MR MUSTON: In terms of that shift towards  
21 a sub-specialisation within medical disciplines which  
22 Mr Minns has also referred to, you see, in paragraph 18(c)  
23 of his statement there, to what extent is that, do you  
24 think, just a necessary consequence of the increased  
25 understanding that we have of medical matters, the  
26 increased complexity of medical issues which are driven by  
27 that increased understanding and also the public's  
28 expectation in terms of what is acceptable as an outcome?  
29 Is it inevitable --

30  
31 DR INGRAM: Yes, it's incredibly challenging --

32  
33 MR MUSTON: -- that there will be a drift towards  
34 sub-specialisation having regard to those factors, or any  
35 one of them?

36  
37 DR INGRAM: I think there is and I think we're already  
38 there. I think that that has already, at least in part,  
39 occurred, and I think - sorry, I've lost my train of  
40 thought there. I think that has already happened to  
41 a certain degree. It's very difficult to not offer  
42 a service when we know globally that the technology exists  
43 and that it's potentially or factually beneficial to  
44 patients - to then not offer that to all of our patients.  
45 I think it's very challenging to not have those specialties  
46 available to the patients.

47

1           But then equally, as a complete counterpoint to that,  
2 there's good data out there to show that primary prevention  
3 is far higher value health care than the tertiary services  
4 that we might be referring to. So a GP giving a vaccine to  
5 a baby at a young age and preventing them from getting  
6 a horrible communicable disease, a lifetime of illness and  
7 a lifetime of requiring high-level health care, is far  
8 higher value than a single procedure to a single patient.  
9 So I think there's a challenging balance in both aspects of  
10 that.

11  
12 MR MUSTON: Picking up on something you said earlier, in  
13 terms of the public's perception of cardiology, for  
14 example, whilst it may be the case that people with a heart  
15 condition of any sort think, "Well, I'm obviously going to  
16 get a better treatment from a cardiologist because they're  
17 an expert", do I take it from the answer you gave earlier  
18 that that might not be right; it might depend on what the  
19 condition is and the way in which it needs to be managed?  
20

21 DR INGRAM: Yes, I think that's very much situational,  
22 dependent on the condition and the clinicians, if you were  
23 drawing a direct comparison, but just to say that there's  
24 a wide scope of practice for general practitioners that  
25 doesn't always demand sub-specialty referral.  
26

27 MR MUSTON: And do you think that in some way, the  
28 public's expectation in terms of who will deliver care to  
29 them is a little bit out of kilter with that, where things  
30 naturally should fall within that spectrum?  
31

32 DR INGRAM: I think there's a general trend over time, the  
33 patients and their families and carers, to desire referral  
34 to sub-specialties at a higher frequency and want that  
35 "expert opinion", when they may actually already be getting  
36 an expert clinician's opinion on their care, so yes.  
37

38 MR MUSTON: I should probably ask you, Mr Minns, is that  
39 essentially what you were seeking to capture through your  
40 reference to the increased sub-specialisation in medical  
41 disciplines or was there more to it?  
42

43 MR MINNS: I think the one point I would add is that, you  
44 know, the rate of knowledge acquisition and the rate of  
45 technology deployment is, to Dr Ingram's comment, that the  
46 community expects to get the best possible service once we  
47 know it exists. Partly, I think I'm trying to address the

1 fact that - I'm not blaming the colleges for this. They  
2 find themselves in this context and they have to figure out  
3 how to approach the training of doctors in accredited  
4 training such that they get them to a point where they can  
5 deliver these new health outcomes, and so we're all kind of  
6 captives to what's going on with knowledge and technology  
7 in this regard.

8  
9 What I was really trying to convey is how do we  
10 somehow find a way to continue to value and bolster  
11 generalism in medical practice and that would require us  
12 doing some new thinking about some training and some new  
13 thinking about positions and some new thinking about  
14 remuneration.

15  
16 MR MUSTON: Dr Ingram or Dr Morrison, do you think there  
17 is scope to reverse the drift away from general practice  
18 with an adjustment in the settings within the public system  
19 somewhere and, if so, where?

20  
21 DR MORRISON: Would you like to go first?

22  
23 DR INGRAM: You go, Tom.

24  
25 DR MORRISON: I think there's definitely capacity to  
26 change the shifts and you would have to do it in a few  
27 ways. I think to break it down, I think you need to change  
28 the culture and perception of the universities so people  
29 understand this is a career with certain benefits and  
30 certain amounts of exposure, as opposed to, "This is a term  
31 that you might do for a short period of time before you go  
32 back to the hospital, where medicine is done the other  
33 95 per cent of the year."

34  
35 I think that the second component is it needs to be  
36 a more attractive career from a remuneration perspective.  
37 For example, if you go from being a registrar in a hospital  
38 to being a first-year general practice registrar, you take  
39 a substantial cut in your salary - not necessarily because  
40 the pay is different, but because you're no longer working  
41 after hours, you're no longer getting penalty shifts on  
42 weekends, you no longer have any on-call requirements, and  
43 it can be a cut in the order of \$20,000 or \$30,000, and  
44 especially in a state with a high cost of living, that is  
45 a factor. I think it becomes part of your considerations.

46  
47 If your choice is between going and doing general

1 practice or staying in the hospital system or more likely  
2 going into the private workforce, especially when you have  
3 a high degree of university debt associated with that  
4 decision, HECS inflation is now no longer capped, all of  
5 these things contribute to people being discouraged away  
6 from general practice.

7  
8 MR MUSTON: Did you have anything you wanted to add to  
9 that, Dr Ingram?

10  
11 DR INGRAM: No, I think that's extremely well said.  
12 I would just say that I think that the change that has been  
13 occurring to people entering general practice has occurred  
14 over a very long time and I think any reversal of that  
15 would also take an extremely long time and associated  
16 institutional change that's already being discussed here.

17  
18 I would add to that as an aside, I had a slightly  
19 different university experience to Tom, I did the first  
20 three years of my degree in Armidale, so a fairly  
21 rural/regional setting compared to Sydney, and so I was  
22 fortunate enough to have greater exposure to general  
23 physicians and general practitioners and fellows of the  
24 Australian College of Rural and Remote Medicine as well,  
25 and I suspect that, in part at least, that has - there's  
26 a general trend in rural and regional areas to pride  
27 yourself on being a generalist and pride yourself on being  
28 able to look after a broad variety of patients and the  
29 problems that they come to you with. So I think there is  
30 an interlinking between rural and remote health and the  
31 push that we're discussing here towards generalism, and  
32 I think that there's benefit to be had there in trying to  
33 access both of those.

34  
35 MR MUSTON: Can I come to the next point or point 18(b),  
36 the lack of appeal of non-metropolitan employment.  
37 I understand, Dr Morrison, from the evidence you have given  
38 that a large part of that is the fact that so much of your  
39 university and early doctor training happens in a  
40 metropolitan setting that the hooks of life get into you in  
41 a metro location.

42  
43 I might ask you, Mr Minns, what levers do you see the  
44 state government as having available to pull to try and  
45 loosen some of those hooks and move a workforce into the  
46 rural and regional settings?  
47

1 MR MINNS: I think one of the ones that's quite  
2 compelling, and its urgency, is related to accommodation.  
3 So we can do a certain amount within NSW Health and its  
4 capital budget and we have done that and we have had  
5 support from government to build more of those onsite  
6 accommodations or closer to site accommodations.  
7

8 The state government, through the Department of  
9 Regional New South Wales, has also focused heavily on the  
10 accommodation issue but also the attraction issue, the  
11 concierge issue, the whole range of deployable strategies  
12 that would be about getting any class of frontline public  
13 service person into regional and remote communities.  
14

15 So, you know, there are government programs and the  
16 investment has been there, and I'm sure the investment will  
17 continue.  
18

19 I guess I look at it from the perspective of someone  
20 who has been watching this kind of trend in regional  
21 communities for, you know, most of my adult life. I think  
22 we do what we do, we try, but there's a tide that we're  
23 fighting against, which is that there is a continual drift  
24 away from those communities and there is a different  
25 sentiment about vocations.  
26

27 I think one of the doctors talked about the idea of  
28 being a doctor as a vocation versus a job or form of  
29 employment in their statement. Certainly people who were  
30 GPs in rural settings, they were living out a vocation, and  
31 I just think there's a different set of expectations now  
32 about both a career and a life, and that is impacting on  
33 the sustainability of attracting people to regional  
34 employment.  
35

36 MR MUSTON: Is part of the challenge the fact that the  
37 public's understanding or expectation about what the public  
38 health system is and what it can offer in all locations has  
39 failed to keep up with that shift from vocation to job? Do  
40 you --  
41

42 MR MINNS: I just missed the middle phrase there.  
43

44 MR MUSTON: Is part of the challenge that the public's  
45 perception about what the public health system is and what  
46 it should be delivering to communities through local  
47 facilities and the like has failed to keep up with that

1 shift in workforce thinking around whether it is a vocation  
2 or a job?

3  
4 MR MINNS: Look, yes, I think it has failed to keep up.  
5 Doctor Lyons and I both spent a lot of time before the  
6 parliamentary inquiry into rural and regional health, and  
7 there were occasions where I walked away from regional  
8 briefings where it was pretty clear to me that the  
9 community would have preferred to have had a GP at their  
10 small facility who could possibly offer them urgent care  
11 but wouldn't do it as well as they could get 20 minutes or  
12 30 minutes down the road at a regional hospital, and that  
13 that might have longstanding implications across their  
14 life, but their preference was to have option 1, not option  
15 2. With that comes the expectation that, well, surely  
16 government can sort it and get a doctor there always.  
17 I think you've seen enough evidence that we can't. So in  
18 those circumstances, it's better to get the networked care,  
19 the virtual supported care, such that the person gets the  
20 best available medical solution, but they actually get it,  
21 even though they haven't got it in the way that they  
22 expected they always would.

23  
24 MR MUSTON: Can I pick up with you an issue that was  
25 raised in the evidence that Dr Morrison gave a little bit  
26 earlier around at least for that new, more recent cohort of  
27 doctors who might see an appointment as a job rather than  
28 a vocation, but a job in a metropolitan tertiary hospital  
29 might be seen for a range of reasons as significantly more  
30 desirable - do you see scope to, in a networked way, tie  
31 those positions more closely to some sort of professional  
32 obligation to deliver care out into areas where a permanent  
33 position might be seen as undesirable, in fact, so  
34 undesirable that the reality is we're never going to fill  
35 it?

36  
37 MR MINNS: I think there's always scope to investigate  
38 what options you have to influence the labour market and  
39 the choices that people make in it, but you do have to  
40 concede or recognise that you're in a national labour  
41 market. So if New South Wales acts in a way that is seen  
42 by young doctors or doctors in training as - well, they  
43 could see it as a punitive measure or at least as an  
44 undesirable measure if they lose some of their own choice  
45 and agency about where they go, and if New South Wales is  
46 operating that framework and we're the only jurisdiction  
47 that does, I'd have some potential concerns about what

1 choices do graduating students make? Do they decide that  
2 another state offers them some kind of more flexible  
3 arrangement where they're kind of controlling their  
4 choices? So if we acted alone, it could have unintended  
5 consequences.

6  
7 MR MUSTON: Could I ask you about that, Dr Morrison,  
8 because it's a little bit inconsistent, I think, with what  
9 I understood you to say, and obviously there's a balance  
10 that needs to be struck somewhere, but if an appointment  
11 to, say, an accredited training position and thereafter  
12 a staff specialist position at, say, Royal Prince Alfred  
13 Hospital or a hospital which was perceived to be desirable  
14 carried with it an expectation or a professional obligation  
15 to deliver networked care to rural and regional LHDs, would  
16 that, you think, be something that would, at least from  
17 your perspective and those that you know and speak to,  
18 drive junior doctors away from the New South Wales system?

19  
20 DR MORRISON: I think it depends a bit on what the  
21 ultimate reward is going to be for the completion of the  
22 service. I think if the outcome was that you could  
23 progress to an accredited training position, people  
24 actually would go to a far less desirable job. If it was  
25 more of a, "You have been allocated to this undesirable  
26 position as a condition of accepting an internship in  
27 New South Wales", I would agree that would be  
28 a disincentive to coming to work here.

29  
30 I certainly don't think it would be impossible to  
31 incentivise people to those rural locations, especially if  
32 that contributed to an ultimate accredited training  
33 position. I actually think that would be a big enough  
34 drawcard, I think we actually would have people coming to  
35 work in New South Wales and taking that up actually, as  
36 opposed to taking an unaccredited position in their home  
37 state. They're just that desirable.

38  
39 MR MUSTON: Would there potentially be some benefit, if  
40 that's right, throughout the four years or rolling series  
41 of four to five years' worth of accredited training  
42 positions, that might start to normalise a situation in  
43 which care was being delivered in a networked way, and part  
44 of a standard expectation of someone who secures  
45 a permanent staff specialist position in a New South Wales  
46 metropolitan hospital knows that they will, as part of  
47 their job, be delivering care in areas where it might not

1 be possible to have a permanent workforce delivering that  
2 care?

3  
4 DR MORRISON: If I could give you an example for me this  
5 year, when I was selected to the training program, I said  
6 yes before looking at my allocation. It wouldn't have  
7 mattered where it was. There was no way I was going to say  
8 no, so be that, you know - I actually found out the next  
9 day it was Liverpool. I didn't even see it on the  
10 contract. I would have been happy to go regardless of the  
11 situation.

12  
13 Is that the same as if I was applying for an  
14 internship and had the opportunity to apply for internship  
15 to other states? I am sure I would have looked at it much  
16 more carefully and weighed up my options.

17  
18 MR MUSTON: Do you want to add anything to that,  
19 Dr Ingram, as someone who might benefit from the  
20 availability of workforce that is not necessarily  
21 permanently available in your relatively metropolitan but  
22 regional LHD?

23  
24 DR INGRAM: Yes, I think Dr Morrison makes very good  
25 points, but he's also discussing a highly competitive  
26 specialty. In neurosurgery, there are not many training  
27 places, very, very high levels of requirements for entry,  
28 and so people who get to his point are extremely, extremely  
29 motivated to accept positions.

30  
31 He has rightly pointed to that if you were an intern  
32 or maybe a next level above, two years out from university,  
33 if you were described as a resident, you've get general  
34 registration, you could be a locum or an employed salaried  
35 doctor in any state in Australia with little to no barriers  
36 to moving between states.

37  
38 I think that New South Wales would potentially be  
39 a very unattractive state if you were going to be paid  
40 30 per cent less and then told that you're going to go to  
41 an area, a rural area, that you don't want to, because you  
42 are actually attracted to Sydney for its pros, then that's  
43 potentially - it presents a lot of workforce issues.

44  
45 So I think the devil is in the detail, and if  
46 something like this was to be carried out, then how is it  
47 done? What are the additional benefits that are offered to



1 compensate for being sent to an area that potentially you  
2 are not initially attracted to? Although I would very much  
3 defend the concept saying that these are very attractive  
4 areas for other reasons, including quality of training that  
5 they may offer and the other cultural aspects and the  
6 long-term lifestyle that might be offered.

7  
8 MR MINNS: If I could say that I concur with both doctors  
9 in their remarks. I would just add one point, and  
10 particularly the point about the relative competitiveness  
11 of places in accredited training is really, as Dr Ingram  
12 describes, a key issue.

13  
14 I think the other point I wanted to make has now gone.  
15 There you go.

16  
17 MR MUSTON: It is one of those afternoons, it is happening  
18 to us all.

19  
20 THE COMMISSIONER: It will come back.

21  
22 MR MINNS: I've spent a lot of time in industrial  
23 negotiations lately, Commissioner.

24  
25 THE COMMISSIONER: You are allowed to be drained. When it  
26 comes back to you, just chip in.

27  
28 MR MUSTON: I was going to move to a slightly different  
29 topic, but if it does come back to you, feel free to go  
30 back.

31  
32 THE COMMISSIONER: Otherwise, we'll just take your answer  
33 on notice and when you remember it in the shower tomorrow  
34 morning, you can send us an email.

35  
36 MR MUSTON: The other issue that you raise is pockets of  
37 the medical workforce, or medical workforce culture, which  
38 operate to frustrate consultation, dialogue and discourse  
39 about reform.

40  
41 If we could perhaps jump forward, operator, to  
42 paragraphs 28 and 29.

43  
44 I just wonder if you could expand on that a little  
45 bit. What is it that - what are these pockets and in what  
46 way are they frustrating consultation, dialogue and  
47 discourse around reform?

1  
2 MR MINNS: It's important that everything I say here  
3 reflects that idea that it's, you know, the literature  
4 would say, somewhere between 5 and 6 per cent. So it's  
5 not - by no means more than a minority.  
6

7 I think the two doctors on the panel might be able to,  
8 without dealing in individual cases, verify the fact that,  
9 on occasions, they have had to work with people who you  
10 might call unreasonable, and the unreasonableness can  
11 relate to how trainees are related to; it might relate to  
12 peer-to-peer issues; it might relate to interactions with  
13 nursing staff or allied health staff.  
14

15 You know, it's often characterised in the way that  
16 these particular individuals don't quite get the idea about  
17 an integrated team working collaboratively together to  
18 provide the best possible care for the patient, and when  
19 that kind of behaviour operates and exists, it is  
20 disruptive. You know, I've spent a fair quotient of time  
21 dealing with the consequences of these sorts of things  
22 because particularly if they don't get escalated and  
23 addressed, they tend to fester and over time things just  
24 worsen.  
25

26 They can end up as very intractable - very intractable  
27 local cultures that are disrupted and heading towards being  
28 broken, and it's really quite unfortunate when it occurs.  
29 The Inquiry has looked into issues where culture has been  
30 raised in accreditation matters. Often, that's what we're  
31 talking about. We're talking about a circumstance where  
32 there are members in that facility, that department that is  
33 the subject of the accreditation, who kind of fit this  
34 description of disruptive behaviour, and it's how you do  
35 something about it and the fact that sometimes we can't  
36 successfully do it that is what creates the problems for  
37 thinking about things differently, for models of care, for  
38 innovation, for whatever.  
39

40 MR MUSTON: At paragraph 35 you tell us about the  
41 Vanderbilt model. Could I just ask you to explain a little  
42 bit how that works - that is, perhaps by reference to the  
43 diagram there, which is, at least in my copy, a little bit  
44 small.  
45

46 MR MINNS: It is small in mine as well. I mean, I went to  
47 Vanderbilt precisely because I wanted to talk to people who

1 had introduced this, and Dr Gerry Hickson is one of the  
2 sort of architects of the framework from the very  
3 beginning. He explained the context via which he was asked  
4 by, I think, the president of the university to undertake  
5 the work that is done by the centre, the Center for Patient  
6 and Professional Advocacy.

7  
8 He said, in essence, they were being financially  
9 compelled to do something different because they were  
10 suffering the consequences of litigation from the behaviour  
11 of this cohort, this, you know, small cohort of doctors,  
12 because two things were happening: they were on the  
13 receiving end of legal actions by employees, and then they  
14 started to notice a correlation between this behaviour  
15 directed towards peers and suboptimal outcomes for patients  
16 and where those patients might go on to litigate.

17  
18 I think they'd had a particular case involving  
19 a person who might be - a practitioner who might be  
20 regarded as both a rainmaker and a brilliant clinician, but  
21 a very challenging individual, and it was when that person  
22 and their legal tail landed that the university said,  
23 "We've really got to do something about this."

24  
25 So the pyramid is part of the response but so also is  
26 a very structured program of patient feedback, of every  
27 clinician who works in Vanderbilt, and it's so hardwired  
28 into the system that, you know, most clinicians will get  
29 feedback every six months from at least 30 per cent of the  
30 patients that they've seen. So if you go to Vanderbilt  
31 medical centre, you are inculcated into this idea of, "You  
32 come here, you give us feedback", and then they give scores  
33 to clinicians and they say, "Well, yes, you're in a  
34 difficult challenging discipline and you see people from  
35 various socioeconomic groups, however, you're well out of  
36 market. The peer satisfaction of your national peer group  
37 is 4.1 and you're 2.6. So something needs to change."  
38 So the two teams work in concert.

39  
40 They've since gone on to introduce the same kind of  
41 scoring arrangement every six months from co-workers, and  
42 it was a big deal when nurses started offering feedback to  
43 doctors on their collegiality and other things.

44  
45 So the way that the pyramid works is that the first  
46 two levels are interventions that occur by people who are  
47 trained - and I think they call them, "messengers", you

1 know, it's an American institution. But level 1 is the cup  
2 of coffee conversation. It's meant to be a peer saying,  
3 "Something happened last week in theatre, something  
4 happened last night on the ward, I observed it", or  
5 "Colleagues observed it and told me. Are you okay? Is  
6 there anything that tipped you over the edge on this,  
7 because that's not how we behave in Vanderbilt". Indeed,  
8 they induct people that, you know, "You join us here, this  
9 happens."

10  
11 So people join, they experience that intervention. If  
12 it continues, they go to a second level, which is a more  
13 senior person, often not from their own department but  
14 a department from somewhere else, who sits them down, has  
15 a kind of wise conversation about the path that they might  
16 be on and the fact that it is not compatible to staying in  
17 Vanderbilt University hospital. Then after that they move  
18 to elevated interventions that involve managerial presence,  
19 and level 4 is the disciplinary and exit.

20  
21 Now, they would tell you that in their hospital  
22 system - and I think I have provided this to the CSO to  
23 offer to you. I asked for some further information  
24 a couple of weeks ago from Dr Hickson and he has just sent  
25 it through in the last few days. They believe that I think  
26 it's only 4 per cent, not 5 to 6, would enter their scheme,  
27 because of the overarching culture they have created over  
28 decades, and they think it's less than 1 per cent who end  
29 up at level 1 with a disciplinary action, which is very  
30 often termination.

31  
32 MR MUSTON: There are possibly two aspects there. The  
33 first is that respectful conversation, the "cup of coffee"  
34 conversation, in and of itself has a capacity not only to  
35 turn behaviour but also to maintain a particular level of  
36 relationship between the clinician and the hospital which  
37 is probably more conducive to them changing their behaviour  
38 than going immediately to a disciplinary response.

39  
40 MR MINNS: The fact that the first two levels are peer led  
41 and colleague led, I think it's where the strength is,  
42 because it's not a medical administrator having the  
43 conversation or it's not a non-medical HR person having the  
44 conversation; it's a fellow doctor saying, "What's going  
45 on?" They would also tell you that their system is so  
46 reliable, particularly when combined with the feedback from  
47 patients, that they will run overnight datasets for all of

1 the hospitals in the US system that have joined on to the  
2 scheme. So it doesn't just run in Vanderbilt anymore, it  
3 runs with about 50 or 100, I can't remember the number, of  
4 other health entities.

5  
6 They will run all these patient feedback scores and  
7 they will see that someone who has a record of 4+ from  
8 patients for five years suddenly has a day of less than 2  
9 scores, so they will immediately organise someone to be the  
10 messenger to go and have the check-in conversation to say,  
11 "What's happening?"

12  
13 Now, they contend that across the many thousands of  
14 doctors that this process is operating for, they have  
15 unearthed situations where people are at the beginning of  
16 serious illness that they have no awareness of that has  
17 produced a marked behaviour change, and they pick it up  
18 through this dataset. It really has shifted the culture in  
19 those organisations where it operates.

20  
21 MR MUSTON: So that's the relationship between sort of  
22 clinician and clinician but also executive or  
23 administration and clinician. Can I ask you about the  
24 medical staff councils and the extent to which they provide  
25 an avenue for communication between clinicians and  
26 administrators. Do you have a view about the extent to  
27 which the balance is - or where the balance should be  
28 struck there and what the purpose of medical staff councils  
29 should really be as a conduit for communication?

30  
31 MR MINNS: I do and it's a recently formed set of  
32 perspectives, because I've gone back and read the by-laws  
33 more closely than I think I ever have in seven years in  
34 preparation for today.

35  
36 I think what I've found curious was, compared to what  
37 is specified for clinical councils, what is said in the  
38 by-laws with respect to medical staff councils and medical  
39 staff executive councils, is pretty vague. I can't see  
40 anywhere a real description of their role. I think there's  
41 an unfortunate lack of detail about how a council should be  
42 structured, such that, really, you just have to have  
43 a chairperson of it and that's it, and I think we have  
44 seen - I have seen in seven years - instances where that's  
45 a little bit unfortunate. But there's precious little in  
46 the by-laws about what the medical staff council ought to  
47 be doing, whereas compared to a clinical council, it's

1 quite structured. It has, you know, (a) to (g) objectives  
2 that it has to follow; it's also got a reference to the  
3 fact that a clinical council performs its role in a  
4 context, and that context includes directions and policies  
5 of the government.  
6

7 So, you know, if you compare and contrast the guidance  
8 that's in the model by-laws between a clinical council  
9 versus a medical staff council, one is set up to succeed,  
10 because of the clarity about what it's for, how it's  
11 structured, the detail on its membership; and the other one  
12 is really just there as a bit of a vacuum to be filled and  
13 sometimes it's filled helpfully and well and sometimes it  
14 isn't.

15  
16 MR MUSTON: I note the time, Commissioner. Could we sit  
17 on for a while?

18  
19 THE COMMISSIONER: Of course we can.

20  
21 MR MUSTON: We will finish on this topic.  
22

23 Pausing there, can I ask you, Dr Ingram, do you have  
24 a view on that issue - that is to say, about whether the  
25 purpose of medical staff councils as disclosed in the model  
26 by-laws is ambiguous in a way which is perhaps less than  
27 ideal?  
28

29 DR INGRAM: The purpose of the medical staff councils is  
30 to provide advice to the board and the executive of the LHD  
31 or hospital within which they function. I haven't read our  
32 local by-laws perhaps as recently as Mr Minns, but I do  
33 think that there's probably a little bit more to them than  
34 has been presented. There's minimum numbers for quorum,  
35 there's minimum numbers of meeting, there's a reporting  
36 line, so it's not quite just having a chair. There's a bit  
37 more to it, and I would further defend them to say that  
38 keeping things broad as medical matters, as is described in  
39 the by-laws, allows them to function outside what might  
40 otherwise be overly defined.  
41

42 I agree that it may benefit from review and alteration  
43 along the line of the clinical council where there might be  
44 more examples or slightly more direction given, but I think  
45 keeping them broad as medical matters allows a level of  
46 reporting up to the highest level of the LHD, which I think  
47 is appropriate and relevant.

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MR MUSTON: What do you see as the function of the medical staff council in terms of the feedback it's providing and what matters it's reporting on? What is captured by that than concept of medical matters in your opinion?

DR INGRAM: It can be very broad, and some of the matters that have been brought to me as a previous chair were a huge variety. But the ones that are really a risk to the LHD and of concern to the executive and concern to the board are the ones that we spend most of our time working with addressing, attempting to aid investigation and facilitate conversations between the right people within the local health district. So it is quite broad, which is why I defend that concept of medical matters.

MR MUSTON: Mr Minns, what do you see as being the information which ideally should be being communicated from medical staff councils up through into the executive and the board?

MR MINNS: So I can't really answer the question without talking about the interplay between the two. I think that if you - I can't remember which section it is, and it follows, it's about 36 or something like that, and 37 is the functions of hospital clinical councils. You know, it is extensive, so it is very clear what should occur. I think that's very valuable for the way that these would operate.

I checked in to understand, you know, have we got an LHD clinical council, have we got hospital clinical councils attested as existing across the system? And we do to a very, very consistent level. There's, like, three aberrant situations which have all got an explanation and are being addressed.

To Dr Ingram's point, the way that I interpret 26 of the model by-laws --

MR MUSTON: Just pausing there, we can probably have them brought up, I think it is [SCI.0001.0002.0001]. Did you say 26 or 36?

MR MINNS: Twenty-six.

MR MUSTON: Which is on page?

1  
2 MR MINNS: Page 8 of mine.

3  
4 MR MUSTON: 0008.

5  
6 MR MINNS: As I review 26(a), to me, it's really only the  
7 medical staff executive council, or the staff council,  
8 where that's the only one that exists in the LHD, that is  
9 clearly defined as providing advice to the chief executive  
10 and the board.

11  
12 You will note from other parts of the by-laws and from  
13 the audit that I asked for, that many LHDs also involve the  
14 chairs of the staff councils below the executive council in  
15 some means or other on the board. I don't mean to say it  
16 is a bad thing. I mean, consultation is rarely if ever  
17 wasted in the health system, you know, so we need to have  
18 good relationships with clinicians, and senior clinicians  
19 are given a particular role and, I guess, a role they will  
20 probably say is deserved, but a privileged role in the way  
21 that they are provided for in these by-laws, because  
22 otherwise, the other clinical groups are in the clinical  
23 council construct.

24  
25 So having them work well and having them being an  
26 effective conduit between executive management and the  
27 chief executive officer and for their staff executive  
28 council to have that relationship with the board is, of  
29 course, a good thing.

30  
31 I just think we could give them more guidance on how  
32 to go about doing that, and I think that, you know, the key  
33 thing for me is number 37, for hospital clinical councils,  
34 says one of their functions, at (g) - 37(1)(g), is:

35  
36 *Effective management of the budgetary*  
37 *departments and units within the hospital,*  
38 *subject to conditions and directions under*  
39 *the law or government policy or established*  
40 *by the organisation.*

41  
42 Now, that, to me, is important context that says, you know,  
43 there are some limits on what can occur here in the  
44 dialogue between the executive of the hospital and the  
45 clinical council, you know? It takes place within  
46 a framework of governance. There's nothing like that with  
47 respect to either medical staff councils or medical



1 executive staff councils, and I think at times I have seen,  
2 across nearly several years, a staff council stray into  
3 areas that arguably are only peripheral to medical matters  
4 but have become the source of a great deal of conflict. So  
5 I just think that a little bit more structure and a bit  
6 more dialogue about how they operate - I don't think anyone  
7 would campaign strongly for their removal as an entity.  
8 I couldn't see a world in which our medical clinical  
9 community would accept that. But how can we give a bit  
10 more guidance to how they work and how they need to set up  
11 to work well in creating that bridge, both of advice and  
12 consultation and two-way feedback between executive  
13 management and medical clinicians?  
14

15 MR MUSTON: Dr Ingram, do you have a view about whether a  
16 little bit more guidance and perhaps a more structured  
17 two-way discussion between the executive and medical staff  
18 councils could be of utility?  
19

20 DR INGRAM: Yes, I think guidance and direction is  
21 potentially very beneficial, but not as far as limitation.  
22 I think you could always come up with some scenario where  
23 there's a medical matter that isn't easily covered by a set  
24 list for either the clinical council or the medical staff  
25 council, and that currently defaults to the medical staff  
26 council.  
27

28 I think losing that opportunity to escalate medical  
29 matters that are important to clinicians - and sometimes  
30 they may seem peripheral as medical matters but might be  
31 very important to the clinicians, and perhaps that's why  
32 they have created conflict. I'm obviously not aware of  
33 exactly what Mr Minns is referring to there, but you can  
34 easily imagine a scenario where a large group of clinicians  
35 think a topic is quite important and need it addressed at  
36 a chief executive or even board level, so I would suggest  
37 that limiting the scope of the medical staff council  
38 specifically is probably not helpful in that scenario, but  
39 yes, definitely guidance I think would be beneficial.  
40

41 MR MUSTON: Can I ask you about your own experience. In  
42 your local health district you tell us there are three  
43 medical staff councils at three different facilities within  
44 the Central Coast; is that correct?  
45

46 DR INGRAM: Yes. So there are technically at least four  
47 hospital facilities on the Central Coast, of which two are

1 the large regional hospitals. The large regional hospitals  
2 pair with one each of the smaller hospitals, and then  
3 there's a - so each have a medical staff council, and then  
4 there's a third medical staff council for the mental health  
5 team.

6  
7 MR MUSTON: At the moment, the chairs of the two medical  
8 staff councils in the larger paired hospitals are each  
9 invited attendees at board meetings?

10  
11 DR INGRAM: That's correct.

12  
13 MR MUSTON: Do you see that there's value in having the  
14 chair of the medical staff council invited as attendees at  
15 board meetings, as distinct from the chair of the executive  
16 medical staff council, which obviously would need to bring  
17 together the interests and concerns from a range of  
18 different facilities represented potentially by a range of  
19 different medical staff councils?

20  
21 DR INGRAM: That's slightly challenging for me to comment  
22 on. In my LHD, the chairs of both the medical staff  
23 councils attend the medical staff executive council and  
24 both attend the board. So I wouldn't be able to comment  
25 very much on other LHDs that I don't have experience in  
26 where they have a huge number of relatively small or  
27 peripheral hospitals. But I think there is great value on  
28 having the chairs of the medical staff councils at the  
29 board and that can be a two-way conduit as well.

30  
31 We've already spoken about raising issues with the  
32 board and the executive from the medical staff council, but  
33 it can also be helpful in trickling information down and  
34 answering these concerns and explaining information that  
35 was perhaps previously not understood to the medical staff.  
36 So I think it's extremely valuable.

37  
38 MR MUSTON: Mr Minns, do you have a view about the  
39 potential value in adopting a system like that which seems  
40 to be in play in Central Coast of the chairs of the medical  
41 staff councils being invited members, invited to attend  
42 board meetings, as opposed to the chair of the executive  
43 medical staff council, which I think under the by-laws is  
44 the more conventional arrangement?

45  
46 MR MINNS: I think that the attendance model at Central  
47 Coast is being achieved under the schedule to the Act about

1 attendance at board meetings - schedule 4A - that says:

2  
3 *The Board may invite any other person to*  
4 *attend any meeting of the Board, including*  
5 *both ordinary and special meetings.*  
6

7 So with my history in industrial matters, I would generally  
8 take the view that consultation that's occurring between,  
9 you know, entities with sometimes conflicting objectives,  
10 that occurs in a framework of broad goodwill about the need  
11 for the relationship to be sustained over time, then the  
12 more consultation the better.  
13

14 But if you enter a situation where the consultative  
15 environment is quite disruptive and, you know, there's not  
16 a lot of care for the maintenance of the strength of the  
17 relationship, which really everyone needs to be sustained,  
18 then you might go from having one dysfunctional environment  
19 to several.  
20

21 I guess my point is that this always comes back to  
22 context and it's partly why I say if we could have  
23 a universal approach about what good conduct is in the  
24 maintenance of robust relationships within the health  
25 system, perhaps generated by something like the  
26 accountability pyramid, I think it would aid us in our  
27 efforts, all of us.  
28

29 MR MUSTON: In terms of, for example, the situation we saw  
30 at Concord, the sense one gets is that the views being  
31 expressed by the medical staff at Concord - and  
32 experienced, at least as a felt experience by the medical  
33 staff at Concord - were quite different to the views and  
34 experience of those working at Royal Prince Alfred  
35 Hospital, such that having the chair of the Royal Prince  
36 Alfred Hospital medical staff council attending board  
37 meetings but not Concord would not necessarily give the  
38 board a sense of - a good ground sense of what was  
39 happening at Concord. Would you agree with that?  
40

41 MR MINNS: I certainly think the facts bear that out, but  
42 the person who would have been attending by invitation  
43 would have been the medical staff executive council for  
44 Sydney LHD, so presumably, they have a medical staff  
45 executive council and a staff council for Concord and  
46 a staff council for RPA.  
47

1 MR MUSTON: I think the attendee, though, as I understand  
2 the arrangements, would have been the chair of the  
3 executive medical staff council, not the entire executive.

4  
5 MR MINNS: Correct.

6  
7 MR MUSTON: And if the chair of the executive medical  
8 staff council happened to be the chair from RPA?

9  
10 MR MINNS: Then it kind of falls back to what are the  
11 mechanisms by which the medical staff executive council  
12 consults with its mini councils within the LHD. Again,  
13 there is no guidance about that. There is no sort of  
14 instruction as to how that role should be fulfilled.

15  
16 MR MUSTON: Acknowledging that that's right, a situation  
17 where the chair of each medical staff is invited, should  
18 they wish, to attend meetings of the board would provide  
19 a conduit whereby each of the facilities within an LHD with  
20 a medical staff council could share with the board issues  
21 and concerns to the extent they were felt to be board  
22 relevant issues and concerns.

23  
24 MR MINNS: It would create the opportunity. But I think,  
25 you know, in some instances that might mean that you're  
26 adding six or seven people to a board. We've actually been  
27 requested, as a result of a whole of government review of  
28 boards within the health portfolio, to trim our size of  
29 boards from - I think under the Act, we sort of generally  
30 assumed it was somewhere around about 12 or 13 members.  
31 We've been asked to work progressively to get -  
32 progressively with chairs to get down to eight or  
33 thereabouts.

34  
35 MR MUSTON: Why is that?

36  
37 MR MINNS: It's a direction of government about - so  
38 there's been a review of boards and committees across the  
39 entire government, coordinated by, I think, The Cabinet  
40 Office rather than the Premier's Department and health put  
41 forward the view that if, in consultation with the  
42 minister, we focused on improving the diversity of our  
43 board membership and reducing the size of our boards, would  
44 that satisfy government's intent in this matter, and  
45 I think they said yes. So I think it's probably part of  
46 the comprehensive expenditure review policies that  
47 government was keen to reduce the overall costs of boards

1 and committees statewide.

2

3 MR MUSTON: Is there a distinction, that being the case,  
4 between membership of the board on the one hand and an  
5 invited attendee on the other - that is to say, chairs of  
6 medical staff councils, whilst not formally a member of the  
7 board, are invited and welcome to attend to raise issues  
8 and provide that two-way conduit to the staff at individual  
9 facilities, without actually being paid-up members of the  
10 board?

11

12 MR MINNS: Look, I don't think the payment issue  
13 necessarily arises because, as employees, they can't  
14 receive further remuneration. I would make two points.  
15 I think probably what you're saying is right, and maybe its  
16 advantage is that the board would therefore convene  
17 a session in each of its meetings that was about feedback  
18 from medical staff council chairs, both the executive and  
19 the others, and that would be a two-way conversation,  
20 sharing of any information from the chief executive and the  
21 board and feedback from the medical staff chairs. But they  
22 might not have to stay for the entire board meeting, and  
23 that could be beneficial, I think.

24

25 The other point to remember is that what is in the  
26 by-laws says that the - I think it's the executive medical  
27 staff council gets to nominate, every three years, five  
28 nominees to the minister for appointment to health boards.  
29 Now, sometimes those appointments occur to another LHD's  
30 board, but they're also an opportunity to get medical  
31 clinicians onto the board as full board members.

32

33 I think if you take that into account, perhaps the  
34 model of saying that they are - you know, they attend board  
35 meetings for an exchange, a free, fair exchange of feedback  
36 and context, but they don't necessarily have to participate  
37 in the entire board meeting, maybe that's the path through.

38

39 MR MUSTON: And perhaps not every board meeting?

40

41 MR MINNS: Yes, depending on frequency. That will  
42 certainly be an impact for - and I think it's very  
43 important impact, too, because the by-laws create proxy  
44 arrangements. So if you've got six or seven staff council  
45 chairs coming along to a large LHD board meeting, but it's  
46 a different person each time because of the demands on  
47 a clinician's time, we're starting to get into a rotational

1 membership that I think is probably not going to be  
2 helpful. It can work for that feedback path but not for  
3 a full board participation.  
4

5 MR MUSTON: Dr Ingram, do you have anything you wish to  
6 add or contribute in relation to this issue of the value of  
7 potentially involving chairs of medical staff councils as  
8 invitees to board meetings but not necessarily requiring  
9 them to attend and participate in all aspects of the  
10 board's work?  
11

12 DR INGRAM: If you have a large number of medical staff  
13 councils and therefore chairs being invited to the board  
14 meetings, it's quite easy to envision a board meeting that  
15 is quite inefficient and difficult to manage and control.  
16 I'm sure we can all imagine that quite easily.  
17

18 I very much understand what Mr Minns is saying with  
19 not wanting to add however many additional medical staff  
20 members to the board meeting. However, I would say in my  
21 personal experience, I found there was great value in  
22 attending essentially all of the meetings and attending  
23 them for their duration. It gave me a lot of context to  
24 the priorities of the LHD and what's happening from  
25 a strategic priority that's often misunderstood by the  
26 senior medical staff, and I was obviously then able to pass  
27 that on to my colleagues and give a broader understanding  
28 of what's going on within the LHD and sort of allow that  
29 information to trickle down.  
30

31 It also allowed me to titrate the messages that I was  
32 bringing to the board and present them in a way that is  
33 relevant. So I think there is value, despite the sort of  
34 load, I guess, of attending as many of the meetings as  
35 possible for as long as possible.  
36

37 I personally found that very valuable, appreciating  
38 that my LHD's in the fairly privileged position of only  
39 having two MSC chairs on the board and not increasing the  
40 number too hugely. Overall, my feeling is that the  
41 presence of medical staff at higher level governance and  
42 board level - I think that medical staff are  
43 under-represented and I think that they have more to  
44 contribute generally and so I would like to see an increase  
45 in that sense, appreciating the difficulties of making it  
46 still an efficient governing body for the LHD.  
47

1 MR MUSTON: As a member of the junior medical workforce,  
2 do you have anything, Dr Morrison - I'll give you the  
3 opportunity - to add in relation to medical staff councils?  
4

5 DR MORRISON: I suppose junior medical staff officers  
6 aren't members of staff councils in a general sense. I'm  
7 sure we'd be willing to contribute as appropriate, but I'd  
8 probably leave the comments at that.  
9

10 MR MINNS: Just one final comment.

11  
12 MR MUSTON: Yes.  
13

14 MR MINNS: In a relationship sense, there is nothing that  
15 prevents the chief executive from forming an effective  
16 pattern and rhythm of consultation with staff council  
17 chairs, regardless of what ends up happening with the board  
18 construct. So I would think it would be beneficial if  
19 there were regular dialogue between district chief execs  
20 and their major medical staff councils, and it might become  
21 hard to decide who is not major and doesn't get to  
22 participate in that. So, you know, if it is not going to  
23 be through the board, then through an effective  
24 relationship that has got some regularity in its meetings  
25 with the chief executive, or if not the chief executive,  
26 the chief operating person, you know, the chief of  
27 operations.  
28

29 MR MUSTON: Presumably, to the extent that you have  
30 suggested a greater level of formality around precisely how  
31 the medical staff councils operate, it's your view that the  
32 by-laws should be adjusted in a way to better reflect  
33 whatever it is that both members of medical staff councils  
34 and LHDs, and the ministry, hope to achieve through that  
35 organisation?  
36

37 MR MINNS: I think if we worked on it and consulted with  
38 the relevant parties we could provide some useful guidance,  
39 and I think in part, that would set relationships up for  
40 more consistent success than we sometimes experience, but  
41 I also think doing something about, you know, respectful  
42 dialogue - disagreeing agreeably is an art form that would  
43 be very useful to have further expanded and integrated into  
44 the health system.  
45

46 MR MUSTON: I have no further questions for these  
47 witnesses, Commissioner.

1  
2 THE COMMISSIONER: Dr Morrison was talking about if  
3 a position in the bush was tied to an accredited position  
4 in a highly sought after specialty he would jump at  
5 the chance, but that it might be different for an  
6 internship, and Dr Ingram agreed with that and made the  
7 point that the idea of forcing people to go to particular  
8 locations, coupled with the relativities of rates of pay in  
9 New South Wales, would damage New South Wales'  
10 competitiveness at least for medical staff. That was at  
11 a point where you said you agreed with both of them, but  
12 then couldn't remember what the other point was that you  
13 wanted to make. Did that help, what I just said?

14  
15 MR MINNS: That wasn't the point.

16  
17 THE COMMISSIONER: Let's forget about it. I tried. It  
18 will come to you.

19  
20 Mr Cheney, do you have any questions?

21  
22 MR CHENEY: No.

23  
24 THE COMMISSIONER: To the three of you, thank you very  
25 much for your time. I think we are seeing two of you  
26 again. We appreciate it very much. Thank you, and you are  
27 excused today and we will adjourn until 12 o'clock  
28 tomorrow?

29  
30 MR MUSTON: Yes.

31  
32 THE COMMISSIONER: Thank you.

33  
34 <THE WITNESSES WITHDREW

35  
36 **AT 4.36PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED**  
37 **TO WEDNESDAY, 16 OCTOBER 2024 AT 12.00 NOON**  
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