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)

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

Also present:

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

THE COMMISSIONER: Yes, good afternoon.

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

<THOMAS GALE MORRISON, affirmed: [2pm]

<EXAMINATION BY MR MUSTON:

MR MUSTON: Q. Dr Morrison, could you state your full name for the record, please?
A. Yes, my name's Thomas Gale Morrison.

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

Q. That's a role that you have held since February 2023?
A. Yes, that's correct.

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

Q. At St Vincent's?
A. At Liverpool, actually.

Q. At which hospital?
A. Liverpool.

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

Q. I think from February 2020 to February 2023?
A. Yes, that's correct, three years.

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

Q. And before that an intern at RPA?
A. That's correct.

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

A. Yes.

Q. Broadly known as ASMOF, and a member of the AMA council?
A. Yes.

Q. And an executive member of the AMA Doctors-in-Training Committee since 2020?
A. That's correct.

Q. You have prepared a statement to assist the Inquiry with its work?
A. I have.

Q. That statement is dated 4 October 2024?
A. Yes.

Q. Have you had a chance to read that statement before giving your evidence today?
A. Yes, I have.

Q. That is to say, just before, as opposed to when you wrote it?
A. I have, just before.

Q. Do you have a copy of it?
A. Not in front of me, actually

Q. We can sort that out for you. Are you satisfied that the content of the statement is, to the best of your knowledge, true and correct?
A. Yes, I am. Thank you very much.

MR MUSTON: That document is tendered as exhibit L20, Commissioner.

THE COMMISSIONER: Yes, thanks. I've found mine as well.

MR MUSTON: Q. Could I ask you to go to paragraph 10 of your statement, which is at the end of a passage where you tell us about what you perceive to be some of the benefits of rural placements during one's medical education?
A. Yes.

Q. You tell us that you had a very positive experience of O&G in Griffith?
A. Yes, I did.

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

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

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

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

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

Q. In terms of the sort of things that might persuade people, junior doctors, to work in rural settings or to move away from metro settings where some of those social hooks might tend to draw them, do you have a view about what the system might be able to do to encourage people to move into different areas of the state to work?
A. I think you're right to say that people do get hooked in and, to a certain extent, that's what keeps people wanting to be in the same place. It doesn't just happen in terms of the city or not, it even happens in terms of the part of the city you are in.

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

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

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

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

Q. Can I just unpack that a little bit?
A. Yes.

Q. We will come back to the process of applying that you've touched on and you've referred to in your statement, but what is it about the system that means if you happen to be in a metro area or in particular metro hospital, the ability for you to secure employment elsewhere is, at least in your view, compromised?
A. I think people preferentially try and stay at their hospital, regardless of where that hospital is, partially for the familiarity, they know the systems, they know the people; partially hospitals, to a certain extent, do try and recruit people who have already been there, especially in their junior years.

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

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

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

in part there is the candidate feels, "The better the devil you know, I don't necessarily want to move to another hospital or to a local health district that I'm not familiar with if I can stay working where I am at the moment." But also in part, is it your sense that those same considerations inform who the hospitals choose to employ into junior medical positions?
A. I think for most jobs in the hospitals, while I haven't sat on the panel, I have a reasonably good sense that there's a preferred set of candidates before the job's advertised, and the most common circumstance is those candidates do go on to obtain those jobs, pending something extremely unforeseen happening in the process.

Q. Do you get the sense that that, perhaps driven even by your own experience and the choices that you've made professionally - does that drive people, as junior doctors just embarking on their careers, into positions within the metro hospitals?
A. I think yes in an answer - but to unpack that a little bit further, the main reason I think people want to go to metropolitan inner city teaching hospitals for internship is because they're perceived to be the best for your career. They'll give you the best training, they'll give you the best experience, the best knowledge, the best ability to go and get that next job.

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

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

Q. Whether the perception be right or wrong, is there any particular perception or view out there to the effect that training or starting your career in that big metro hospital is going to be better for you professionally in some way?
A. I think there is a perception there to a certain

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

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

Q. You tell us in paragraph 11 of your statement that you believe there to be some scope within recruitment processes to better link rural work to positions offered in those perhaps more popular metropolitan positions. Could you unpack that a little bit and explain what you had in mind?
A. Well, I would start by saying that I think most people, especially if they're looking to get into a medical specialty, would be willing to work essentially anywhere, if they have the guarantee that they're going to go and progress in that specialty.

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

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

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

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

Q. You tell us in paragraph 12 that, at least as you understand the current arrangements, some of the programs involve relatively short stints in rural settings which - do we gather from that that you think a short visit like your four-week visit to a rural setting, as positive an experience as it was, is not really going to drive people into areas of need?
A. I think it enriches your training experience, but will it determine that that person's future career prospects? I don't think a short stint really will because I think you keep your home base in Sydney, for example. You don't stop paying rent, you go back every week end, you keep your social connections. Where if it's a longer placement where you're more ingrained in the community, you actually you have to - you know, "I'm now from Dubbo", for example, as opposed to, "I'm from Camperdown but I moved to Dubbo for two months". I think it changes your mindset and how you think with your future.

Q. Just from the perspective of a junior doctor, do you have a view about the sort of time frame that we might be looking at in order to become someone who is from Dubbo as opposed to a --
A. I would be thinking 12 months, in that kind of sphere.

Q. Do you think that there might be some scope, just coming back to the observation you make in paragraph 11, for a greater connectivity to be built or a greater sense of local connection to be built through an arrangement whereby someone spends part of their time in the metro and part in a rural setting, or do you think you really need to have that consolidated period of full-time practice in a rural setting, say your 12 months, in order to really start to build that proper connection?
A. It's a good question. I'm honestly not sure if you did, say, six months rural, six months city, six months rural, six months city, that would give you - that would have you feel more ingrained.

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

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

Q. And not necessarily inviting you to express an opinion on what your housemates are or are not planning to do, but it's your view if, instead of that arrangement, someone, as part of their training, was required to spend, say, 12 months in a location like Dubbo or Wagga or somewhere like that, that the chances of them becoming more closely connected with that community and potentially seeing a career path there would be enhanced?
A. I think that you become much more part of that hospital system. It'd be not a place you're passing through, it'd be a place that you are potentially settling down in or developing roots, developing connections. When it comes to apply for the job the next year, you already know the people there, "Maybe this is where I might go", as opposed to, "I'm not even thinking about it. I'm just temporary, visiting."

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

Q. You point to some opportunities for streamlining. Could I ask you to just tell us a little bit about your own experience in engaging with that process?
A. Yes, certainly. So you have a guaranteed job for your first two years as an intern and a resident, then you need to apply for apposition. Depending on what that position is, you may need to apply every year. For surgery, as I went into, that was my experience. I knew I wanted to do neurosurgery. I knew I had no guarantee of getting a job because it's relatively competitive, especially for people who've just finished residency. So I applied for every job, every neurosurgery job in New South Wales, of which there were, I think, 18 to 20 or so.

Q. When you describe them as neurosurgery jobs, was that a combination of accredited and unaccredited positions?
A. Only unaccredited jobs.

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

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

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

THE COMMISSIONER: Q. Do you get asked about why you want to be a neurosurgeon?
A. No.

Q. You don't?
A. No, I didn't get asked that.

MR MUSTON: Q. You said a moment ago you're not an outlier. It's your sense, discussing this process with your peers, that they go through a similar process each year applying for a junior medical officer position?
A. Yes is the answer. Some are them are more streamlined. I know basic physician trainees, for example, they only have one interview, is my understanding. It's like there is a panel style process. Not quite the same for all specialties, though. I think especially when you're starting out, there is an extremely large amount of time that goes into applying for jobs. I have a friend, for example, wanting to do anaesthetics. I think he applied for something like 50 jobs or something very large like that, with no guarantee he's going to get any of them.

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

the state spend time reading your application, amongst, no doubt, many others?
A. Yes. I've talked to some of the people who go through and do this process and the feedback they say is a lot of these candidates are very hard to differentiate. They've all got statements that are very well written. They've all got CVs that look very similar. They don't know any of them and so it's down to finer points, this person published two papers, this person published one paper. Call up the referee and check, actually this person is not nearly as good as what might be said on the paper, but I've heard it takes a very substantial period of time to drill down the list of candidates to a pool you can potentially interview.

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

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

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

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

had with that potentially small sample of them who happen to work in your hospital?
A. That's certainly the anecdotal appearance. People who have performed well on the job the year before are likely to be invited back.

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

Q. -- and 29 of which resulted in a range of no doubt very busy people - I say this entirely uncritically of you, it's the system - a range of very busy people across the state considering your application carefully and perhaps hoping that they might be able to secure you as an unaccredited registrar in their facility?
A. Yes, that's the case. And then I did get some offers for some of those jobs later on down the line but, some weeks, presumably when other candidates had taken other jobs and vacancies had been created and the list has been whittled down. By that time, almost everyone already has a job, there are very few candidates who no longer have one, so you say, "Thank you but no thank you."

Q. Again, anecdotally, do you have a sense that the way that process rolls out is that positions in what might be perceived to be desirable locations like the metro hospitals get filled first, and then once you run out of candidates and there are more jobs than candidates, the ones that are left unfilled are those in what might be perceived to be less desirable rural and remote locations?
A. I think that that is the case. I wouldn't necessarily say it's only rural and remote locations that are less desirable. I think a big part of the desirability of a job is how supportive they're going to be for your training, whether or not that's accredited or unaccredited.

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

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

Q. Again whether it be right or wrong, is it the case that amongst junior medical officers who are applying for positions and going through this annual cycle, there is a strong word-of-mouth sense of - well, there's lots of discussion about what's desirable and what's not desirable in terms of places to go?
A. Almost entirely word of mouth. This isn't written down anywhere. You can't really have a look at a job application as advertised by the hospital and say, "Oh, that one is going to be good". They all say that they're great and supportive, but there are reputations that are communicated amongst individuals.

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

Q. -- if they were sitting there in your position?
A. Yes, I think so

Q. In terms of that process, there are a few ways that it might potentially be streamlined. The first is some form of centralisation such that, as a bare minimum, only one application had to be lodged for all of the jobs. Do you have a view about how that system, at least from the perspective of a junior doctor applying, might be better, more doctor-friendly?
A. I think that system exists to a certain extent for some specialties. Plastic surgery, I believe, for example, has one centralised interview and one centralised application process. I see no reason why it couldn't be done for the broad categories of jobs, senior resident medical officers, unaccredited cardiology trainees, unaccredited respiratory trainees, basic physician trainees, I think it would save a large amount of administrative time for both the candidates applying and also, at the other end, make it much easier to sift through the applications and determine which ones you would like.

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

applications, one for a surgical position, one for a senior resident medical officer position, and a third for the other position that I can't now recall but you told us a moment ago.
A. Yes, in my first year when I was applying for those 30 jobs, had we had a centralised system, I would have applied for three broad categories; that's correct.

Q. So it's only once you get beyond those early years where you start to have to - you're starting to make these individual applications or --
A. No, no. If I were to detail the categories for you, for example, one might be a specialty specific training, neurosurgery position. One might be surgery in general, which is a slightly more junior position, and the other one might be a resident role. So I think regardless of your stage of training, everyone's going to be going for one of those broad sets of categories.

Q. Coming back to something you said a little bit earlier, if within that specialty category you applied centrally and perhaps were asked what your priorities were in terms of where you would like to go based on your personal circumstances and no doubt these unwritten reputational factors, if you were offered a training position in some location that was not metro Sydney but it was an accredited position, you presumably would, based on what you have told us, have gone?
A. Yes, I absolutely would have, and I'd go further to say I would imagine that you could count on your hand the number of people each year who would turn down an accredited training position in view of its location.

Q. That's because, from a career progression point of view, securing one of these accredited positions is something which is of such value that the geographic challenges that might be presented are --
A. Yes, very much so. It's so desirable and also once you have that, you have so much more certainty over your career. You don't have to apply for a job the next year. You've just got that ability to control some destiny over your life that you're just going to jump in it and take it, even if it means that you might have to move in order to have it.

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

is more secure for you from the point of view of it is a secure path toward a fellowship?
A. Mmm.

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

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

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

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

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

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

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

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

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

Q. They then pursue a different specialisation or what is it that they do?
A. Generally it's a different specialty. That might be radiology, a different kind of surgery, general practice. Some people leave entirely, might do something - have a career change, for example. I think it's wasteful of so many years' specialty training, because these people are probably very good doctors in the majority of cases, maybe just not quite competitive enough because there are so few spots available each year.

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

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

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

Q. Do you see a way in which these years as an unaccredited trainee could potentially be adjusted or used to shift the balance in terms of that move into the locum market - that is to say, do you see value in there being a reward for loyal service to the system that doesn't involve you going locuming?
A. Look, I suppose I would say at the moment there isn't really a reward that I can identify for being loyal to the system. I'm going to apologise and say I don't have a great solution here but I can elucidate the problem a bit.

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

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

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

that that decision to cut their contract and come back next year after a period of locuming would have no adverse impact on their career progress?
A. I would go even further because the majority of these specialty positions are actually centrally allocated and so even if they do later get sent back to that facility, in a way, it doesn't matter. They've got their training spot, they get through that year, that hospital remembers them poorly because of what they did, that's going to be awkward for a week or two and then they're just going to get on with it. It's not going to have any long-term impact on them at all. There is really limited consequence aside from letting down your colleagues.

Q. You said you didn't have a solution to that one, with apologies, but thinking about it, is there a way of building something into the way in which accredited training positions are offered that could be used to try and change that pattern of behaviour?
A. I can think of the carrot and the stick approach. Especially when you're starting out, desirable terms are things that people are after. Desirable terms might be things that advance people's individual career; less desirable terms might be things like nights or relief duty. I think if you have people on more than a year-long contract, they've got one term left and it's nights, the incentive to get up and go is pretty high; whereas if you are doing nights as your last term but you know you're going to have a great next few terms, people might be incentivised to stick through that.

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

Q. You mentioned points for career completion. Is there a points system that we need to understand?
A. Oh, look, there are many, unfortunately, for each individual specialty. Various points are given in terms of calculating the overall value of someone's CV. For example, you might get three points for a completed year up to a maximum of nine points, whereas, a way you could adjust - and I should mention, that overall ranking is then used to compare different candidates. If you were to say that, you know, your year is not credited towards your CV

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

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

Q. So the points system that we're talking about at the moment, at least in the context of your experience, is points which you accrue as part of your service which are effectively taken into account as part of an assessment of your application for entry into an accredited training scheme?
A. That's correct. And there's various different schemes for each of the different specialty colleges, but there's usually a combination of how long, if you've been in the job, have you done any particular research, have you gotten a higher degree, and it's combined to a total and that's used to differentiate people.

Q. Accepting that it's probably a question better asked of the colleges who are joining us on Friday, but from the perspective of a junior medical officer, do you have a view about whether there is a good reason for having different systems for each of the different areas of specialisation in that respect?
A. I think the reason that there are different systems is that each individual specialty is setting their own entry requirements and they're not talking to the others when they go about doing it.

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

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

Q. Given everyone is, you tell us, largely able to tick all of these boxes, if going away and locuming resulted in a box not being ticked, that would potentially be a significant differentiating factor?
A. Very much so. I think if you failed to complete your contract and that prevented you from application or resulted in a points deduction, that would change behaviour drastically.

Q. Your specialty training is being driven largely by the college of surgeons; is that right?
A. Yes, that's correct.

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

Q. From a junior doctor's perspective, do you see any benefit in a centralisation of that process whereby the training pathways, obviously conducted collaboratively between the college and the ministry, were run centrally through the ministry, from both a recruitment and a career pathway point of view?
A. I'm not necessarily sure that there would be an advantage to that being - that process being run centrally, and the reason being, I think to a certain extent the best people who are able to tell who should go on and join a profession are probably the members of that profession. So I imagine there is probably some benefit to allowing the individual colleges to set the standards or to set the assessment methods as to how they would apply. I'm not sure a centralised process would necessarily be advantageous there.

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

from the point of view of the system, do you see that there's not some potential for the system to distribute trainees, accepting that they may need to be chosen in collaboration with those experts who have the experience, in the way that best meets the needs of the system?
A. I can be more precise for you. I think the actual process for how they're selected is probably best left to the colleges. Where they go to fill workforce needs, absolutely I think there would be a value for collaboration with the Ministry of Health.

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

Q. And if the ministry, with probably a better sense of or better overall knowledge than any other organisation, including the colleges, as to precisely which procedures are being done where and in what volumes, had the capacity to utilise that information to increase the number of people who could be pushed through a training pathway, that would only be beneficial to junior doctors, in the sense that there were more training positions available?
A. Absolutely. I think if you told a junior doctor, "The ministry's found a way to increase the number of training positions", they'd say, "Oh my goodness. Thanks so much. Where do I sign?"

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

Q. -- that is to say, are in some respects less desirable.
A. Mmm.

Q. Do you get the sense, based on your engagement with other junior medical officers, that that fact is actually driving people to work in other jurisdictions or is it just a source of irritation?
A. I think it depends on the mobility of the person who is applying. If you've got family and kids in school here, it's probably more of an irritation. If you're like me,

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

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

THE COMMISSIONER: Q. Do I take from that answer, obviously the people that don't have the mobility you talk about might find it difficult to move, but in terms of people that do have that mobility, do I understand your answer to be it's more driving those junior doctors into becoming locums than moving to another state? Or is it both?
A. I think it's a bit of both. I think it's hard to justify continuing to work in a resident role towards the end of your contracted year. There's no real incentive to stay, it doesn't hamper your career progression if you leave, you can definitely get a much better rate if you go and locum, you can definitely get a much better rate if you go interstate. So if you don't have a good reason to stay, why would you? People vote with their feet.

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

Q. -- because of the pay difference?
A. I think in terms of the pay and condition difference, yes, certainly. I know of someone who moved to pursue specialty training, sorry, to apply for specialty training,

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

Q. I that example, though, were they moving into an unaccredited position --
A. Yes.

Q. -- or into an accredited --
A. From unaccredited position to unaccredited position.

Q. And it was your perception, at least of that person, that the move was driven solely by what were perceived to be more desirable pay and conditions in the South Australian health system?
A. Not solely by that, but certainly it's a big factor when you think of a 30 per cent effective increase in your salary and also you are going to a supportive department who is going to progress your career.

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

THE COMMISSIONER: Shall we take a short break?

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

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

MR CHENEY: No, Commissioner.

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

THE WITNESS: Thank you.

SHORT ADJOURNMENT

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

before we start?

DR INGRAM: Yes, I can, thank you.

MR MUSTON: Great. We'll start in just a minute.

THE COMMISSIONER: All right. I'm ready when you are.

MR MUSTON: Dr Morrison has been joined at the table by Mr Minns and online by Dr Ingram, both of whom should probably be sworn.

THE COMMISSIONER: Dr Ingram, can you hear me?

DR INGRAM: Yes, I can.

<MATTHEW JAMES INGRAM, affirmed: [3.00pm]

<PHILLIP GREGORY MINNS, sworn:

MR MUSTON: Could I start briefly with you, Dr Ingram. Could you state your full name for the record, please.

DR INGRAM: Matthew James Ingram.

MR MUSTON: You are a staff specialist in emergency medicine at Wyong Hospital?

DR INGRAM: That's correct.

MR MUSTON: That's a role you've held, I think, since 2020?

DR INGRAM: That's correct.

MR MUSTON: And prior to that, you worked as a registrar and junior medical officer within the Central Coast Local Health District from, I think, 2013.

DR INGRAM: That's correct.

MR MUSTON: Amongst other things, you are an elected councillor for the Australian Salaried Medical Officers Federation --

DR INGRAM: Yes, that's right.

MR MUSTON: -- otherwise known as ASMOF? You've prepared a statement to assist the Inquiry with its work dated 27 September 2024.

DR INGRAM: That's right.

MR MUSTON: Do you have a copy of that handy?

DR INGRAM: I do.

MR MUSTON: Have you had an opportunity to read it prior to giving your evidence today?

DR INGRAM: Yes, I have.

MR MUSTON: And you're satisfied that its contents are, to the best of your knowledge, true and correct?

DR INGRAM: Yes, I am.

MR MUSTON: Thank you.

Mr Minns, for the record, could you state your full name again, please.

MR MINNS: Phillip Gregory Minns.

MR MUSTON: We know who you are, so I won't ask you those questions again, but you've prepared a further statement to assist the Inquiry with its work dated 8 October 2024.

MR MINNS: Yes.

MR MUSTON: Do you have a copy of that statement with you?

MR MINNS: I do.

MR MUSTON: You have had an opportunity to read it?

MR MINNS: I have.

MR MUSTON: And satisfied yourself that its contents are, to the best of your knowledge, true and correct?

MR MINNS: Yes.

MR MUSTON: I think that is tendered as exhibit L6 and

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

THE COMMISSIONER: Thanks.

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

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

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

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

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

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

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

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

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

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

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

MR MINNS: Pardon?

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

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

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

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

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

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

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

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

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

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

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

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

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

THE COMMISSIONER: I reckon I have already.

MR MINNS: Quite possibly.

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

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

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

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

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

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

MR MINNS: Yes, Commissioner.

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

MR MINNS: It is.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR MUSTON: What are the drivers of that?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR INGRAM: Apologies.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR MORRISON: Would you like to go first?

DR INGRAM: You go, Tom.

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

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

If your choice is between going and doing general

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

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

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

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

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

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

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

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

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

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

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

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

MR MINNS: I just missed the middle phrase there.

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

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

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

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

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

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

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

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

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

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

be possible to have a permanent workforce delivering that care?

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

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

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

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

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

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

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

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

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

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

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

THE COMMISSIONER: It will come back.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

THE COMMISSIONER: Of course we can.

MR MUSTON: We will finish on this topic.

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

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

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

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?

MR MINNS: Page 8 of mine.

MR MUSTON: 0008.

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

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

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

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

> *Effective management of the budgetary departments and units within the hospital, subject to conditions and directions under the law or government policy or established by the organisation.*

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

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

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

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

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

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

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

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

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

DR INGRAM: That's correct.

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

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

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

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

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

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

> *The Board may invite any other person to attend any meeting of the Board, including both ordinary and special meetings.*

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

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

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

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

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

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

MR MINNS: Correct.

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

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

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

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

MR MUSTON: Why is that?

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

and committees statewide.

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

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

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

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

MR MUSTON: And perhaps not every board meeting?

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

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

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

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

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

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

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

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

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

MR MINNS: Just one final comment.

MR MUSTON: Yes.

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

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

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

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

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

MR MINNS: That wasn't the point.

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

Mr Cheney, do you have any questions?

MR CHENEY: No.

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

MR MUSTON: Yes.

THE COMMISSIONER: Thank you.

<THE WITNESSES WITHDREW

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

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