Ms Theanne Walters, I can see in the corner there, the deputy CEO of the Australian Medical Council, and she has prepared a statement for you, Commissioners. You will find that in Tender Bundle A behind Tab 61, so it's Volume 2 of Tender Bundle A.

Then I can see Professor Richard Murray --- if I can ask you to signal to let the Commissioners know - who is appearing for Medical Deans of Australia and New Zealand, and a copy of the Medical Deans statement you will find behind Tab 53 of the Tender Bundle Part A in volume 1, it's the final document in that folder.

And Professor Inam Haq, who I can see in the corner, who is the Associate Dean (Education) at the Faculty of Medicine and Health at the University of Sydney, and a copy of his statement is at Tabs 14 and 15 of Tender Bundle A in Volume 1.

This panel is going to focus on three of the propositions, Propositions 1, 6 and 8, and I ask that those proposition also come up onto the screen.

Proposition 1, Commissioners, you have heard some discussion on during the course of the evidence today. Proposition 1 is under the heading "Competency Framework". You will see that as Counsel Assisting, we have advanced four parts to that proposition. First, a competency framework for health professionals should be developed promptly including for medical practitioners, nurses, dentists, clinical pharmacists, psychologists and relevant allied health professionals.

So that is the competency framework.

Then, secondly, to develop a competency framework, there should be consultation with people with disability and a range of stakeholders. So that is the consultation aspect.

Thirdly, that the competency framework should specify core knowledge, skills and attributes required by health professionals to equip them to provide quality healthcare to people with cognitive disability.

Then the fourth part is a suggestion that the competency framework contain guidance on four particular areas which you will see set out on the screen there. That is: fundamentals within all training and education, education at different levels, education that is tiered to specificity and complexity and where to find teaching resources.

Now, relevant to Proposition 1, the two other propositions that we want to focus on with the panel this afternoon are Propositions 6 and 8. So can I just ask that those Propositions come up. If we look at Proposition 6 first. The focus is on university and vocational education, and this is curricula review and reform.

You will see that what we have proposed is that the curriculum developers should review and revise curricula for primary medical programs, and that should enhance

or incorporate content concerning the healthcare of people with cognitive disability. And we have made some suggestions if a competency framework is developed.

Then Proposition 8 comes to the accreditation standards, and our proposition is that
5 accreditation authorities should review and revise the standards to ensure minimum competency in providing health care with people with cognitive disability to ensure that they are adequately addressed.

So those are the propositions I want to explore with our witnesses this afternoon.

10

CHAIR: Before you do that, could I please thank those who have come along this afternoon, Ms Walters, Professor Murray, Professor Haq and Dr Palipana. I think we should congratulate Dr Palipana, who has been named, as I understand it, Queenslander of the Year.

15

MS EASTMAN: You've stolen my thunder, I was saving that up in my introduction.

CHAIR: Yes, I'm accustomed to doing that and we will continue to do as long as the Commission lasts.

20

Congratulations, Doctor Palipana, and thank you also for the help you have been giving this Royal Commission, which we greatly appreciate.

DR PALIPANA: Thank you so much.

25

MS EASTMAN: I want to start by providing a short overview and summary of the evidence that has been provided by the witnesses participating in the panel this afternoon. I may not do justice in the summary to the very extensive and detailed statements that have been provided, but let me start with the Australian Medical
30 Council. It is the accreditation authority for medical education and training. It sets accreditation standards for medical degrees and assesses medical schools and degrees against those standards. The AMC has accreditation standards for both university level education and for specialist programs of the college also. We will explore tomorrow the colleges; our focus at the present time is on the university.

35

Now, the standards are then approved by the Medical Board of Australia. Looking at the accreditation standards, other than a reference to medical students with disability, there is no reference to people with cognitive disability in the accreditation standards. As we saw on the previous panel, nursing has its own accreditation standards, and
40 each profession expresses its accreditation standards differently.

The Department of Developmental Disability Neuropsychiatry at the University of NSW has recommended minimum capacities in intellectual disability knowledge and skills should be included in any future revisions of accreditation standards for
45 medical practitioners. And you will find a copy of that article in Tender Bundle B behind Tab 26.

If this recommendation was accepted, it would have the effect of mandating curriculum changes by education providers. This morning you heard from Dr Jane Tracy. She gave evidence, but in addition to her oral evidence she has also provided to the Royal Commission an article in which she argues that accreditation and regulatory organisations should mandate universal medical education in the area of cognitive disability. A copy of that you will find in Tender Bundle B behind Tab 41, and the specific recommendation is made at page 28.

Dr Tracy considers that without these bodies being onboard, the system will remain where it is, and that is that cognitive disability content is either not included or it can be easily dropped out of curriculum, depending on other priorities.

We have this afternoon the opportunity to hear from Medical Deans Australia and New Zealand. It comprises all of the 22 universities in Australia and New Zealand who have an accredited medical program for professional entry-level medical education training and research.

As I read their statement, this peak body does not support taking a mandatory approach to defining curriculum in this area. But we do know that Medical Deans and their members play a key role in facilitating collaboration across medical schools and other stakeholders in medical education and training.

You have a copy of the Medical Deans statement that's Tab 53 in Tender Bundle A Part 1. The Medical Deans state that accreditation standards and its own strategic plan are focused on high-level, and not on particular patient populations or groups, and therefore do not specifically refer to the teaching of healthcare for people with cognitive disability.

There is one exception in terms of identifying a particular population, and that is in the area of Indigenous health. And it is interesting to note that it was the Medical Deans who led the development of the first curriculum Indigenous framework back in 2004. Medical Deans, as I understand it, will tell you that medical graduates are still in an early stage of their careers and the focus should be on teaching the core elements of patient-centred care and socially accountable practice, and the Medical Deans refer to the pressures on medical school curricula to constantly increase the time and focus on specific topics, and I want to explore that issue this afternoon.

So the question for this panel is, if there is to be a change in the curricula of medical schools across Australia, how can this be done? What can be done? And if there is not to be a change, what are the alternative ways to enhance education content and increase consistency in teaching the across Australia to better support health outcomes for people with cognitive disability?

We know some universities recognise the need for a greater and deeper focus on vulnerable patient groups, and I'm going to ask Professor Haq in due course about his statement which identifies the approaches taken at the University of Sydney, and as I understand it, an acknowledgement that more could be done to enhance content in

relation to people with cognitive disability. But before I start, I want to take you back to some evidence that you heard at the hearing in Homebush in February, and you may remember the evidence of Tara Elliffe, and I will replay some of her evidence now.

[VIDEO RECORDING PLAYED]

MS ELLIFFE: One day in 2018 I was feeling unwell and had a pain in my stomach. I went to the GP with my father; but it wasn't my usual GP. This doctor asked me how my pain was, and I was feeling gentle. The doctor told me to go to the hospital. I went to the hospital with my dad. When I got to the hospital, I was in a lot of pain. I was --- I had to sit outside for about ten minutes before I went into see the doctor who I was --- who saw me. I had blood tests, X-ray and scans. I saw a lot of different doctors. I felt like a yo-yo going for the test.

MS EASTMAN: Okay. So you want --- do you want to keep reading? If you want to change your mind, just let me know.

MS ELLIFFE: I keep reading. Thank you.

MS EASTMAN: Keep reading? Okay.

MS ELLIFFE: My head was exploding from all the noise and different people. It was building and crushing down on me. My stomach was in so much pain. It was like a jackhammer was in my stomach. The big doctor came in to tell me that I was ready to go home. This didn't look at me at all. He just looked at my dad and said, "What's her problem?" Mum asked me to point on her back where the pain was. I pointed to her shoulder. Then the doctor ordered another ultrasound. The lady who did my ultrasound was good. She explained what she was going to do and said: Sorry if it hurts." I had an operation the next day.

After the operation, I was in hospital for what I felt like ages. It took a bloody long time to get home.
Every morning in the hospital I would wake up at about 4 o'clock am in the morning because I was in pain. I would call out to Mum, "I need painkillers now." I was hurting again. I had to press the button to call the nurse, but she would not give me medication. I needed my mum and my dad to be there to help to get the painkillers and feel safe. I was in pain, just wanted to go home. I don't ever want to go back to a hospital again.

I have a lot of things that I think doctors and hospitals can do better. Listen carefully to people with a disabilities; ask simple questions; use pictures to help people understand; answering people's questions; talk to me and not my parents; have documents in Easy Read. Also, think doctors and nurses should have disability training. Any disability training would be good, and to have 30 people with a

disability doing same of the training. Mum has worked in hospital, so I have been to hospital before. But some people have never been to a hospital. It would be good if people with disability could have a tour in the hospital when they are well.

5 MS EASTMAN: All right. And then over the page, one more bit to read.

MS ELLIFFE: Thank you. If people with a disability can have a tour of a hospital, they would know
what to expect if they had to go to the hospital in emergency one day.

10 MS EASTMAN: Can I check, is there anything --

[VIDEO RECORDING ENDED]

15

MS EASTMAN: Thank you again to Tara Elliffe for sharing her account and replaying that.

20

EXAMINATION-IN-CHIEF BY MS EASTMAN

MS EASTMAN: All right, Dr Palipana, can I start with you. You are now a senior
25 resident working in a busy Emergency Department in a hospital in Queensland?

DR PALIPANA: Yes, Senior Counsel.

MS EASTMAN: And you can bring a unique perspective on the training and
30 education of medical practitioners and health professions as a person with lived experience with disability?

DR PALIPANA: Yes, and I must apologise for my background and environment, it is a bit noisy, the timing.

35

CHAIR: Some of it is actually quite entertaining.

DR PALIPANA: Thank you.

40 MS EASTMAN: You are currently a senior house doctor working in emergency at the Gold Coast Hospital?

DR PALIPANA: I am.

45 MS EASTMAN: You have worked in this service since you started your career as a medical practitioner since about January 2017?

DR PALIPANA: Yes, that's correct, Senior Counsel.

MS EASTMAN: You are also a lecturer and a researcher at the Griffith Institute and Menzies Health Institute of Queensland respectively?

5

DR PALIPANA: Yes.

MS EASTMAN: You hold a Doctor of Medicine from Griffith University?

10 DR PALIPANA: I do.

MS EASTMAN: For reasons --- I won't ask you to explain but you also hold a Bachelor of Laws from Queensland University of Technology, and a couple of months ago you were admitted as a legal practitioner in the Supreme Court of
15 Queensland?

DR PALIPANA: I was, Senior Counsel.

MS EASTMAN: You are also an ambassador for Physical Disability Australia?

20

DR PALIPANA: That's correct.

MS EASTMAN: You are a Member of the Inclusive Workplace Committee for Commonwealth Treasury?

25

DR PALIPANA: Correct.

MS EASTMAN: You are a member of the Scientific Advisory Committee of the Perry Cross Spinal Research Foundation?

30

DR PALIPANA: Yes.

MS EASTMAN: And you are the doctor for the Gold Coast Titans Physical Disability Team?

35

DR PALIPANA: That is correct.

MS EASTMAN: And you were nominated for and awarded Queenslander of the Year this year?

40

DR PALIPANA: I was very humbled to have been, yes.

MS EASTMAN: You have also done some work with Medical Deans Australia, and as I understand it, you have been part of a working group to develop a consultation
45 paper on Inclusive Medical Education, Guidance on Medical Program Applicants and Students With Disability, and the consultation paper was published in November this year?

DR PALIPANA: That is correct.

MS EASTMAN: You wanted to make it clear that any views that you discuss in this course of your evidence today don't represent any of the organisations to which I have referred, but they are based on your personal views and experience. Is that right?

DR PALIPANA: They are, Senior Counsel.

MS EASTMAN: Okay. So let me start. How much of your training --- sorry, your education as an undergraduate involved learning about people with cognitive disability?

DR PALIPANA: It was minimal, Senior Counsel. We learned about the medical aspects of some of the conditions such as Down syndrome, but due to the depth and breadth of medical curriculum, specific training around caring for patients with disabilities was minimal.

MS EASTMAN: Have you had any training on the job over the past few years that you have worked in the Emergency Department?

DR PALIPANA: I have not.

MS EASTMAN: Have you had occasion to treat any patients coming into emergency who has presented with an intellectual disability or cognitive disability?

DR PALIPANA: I have, Senior Counsel. We frequently treat patients with cognitive disability and intellectual disabilities in our Department, and over my time I have had the privilege of treating many patients with such disabilities.

MS EASTMAN: So, have you had the adapt the way in which you communicate with those patients or explain concepts that allow the patients to give consent to particular medical procedures, and if so, what have you had to do?

DR PALIPANA: Yes. I think it is a very tricky situation because when you normally treat a patient, gaining the history is one of the most important parts, and taking a comprehensive and detailed history about their presenting issue helps guide the remaining treatment and investigations that you will carry out. So in the event that a person is unable to clearly explain what kind of pain they are having or what kind of symptoms they have been having, it makes the rest of the consultation complex, and there are some critical questions that you sometimes need to ask that might really change the course of management. So I think one of the most complicated parts of it has been to make sure that we are getting the right history and a detailed history that points towards a problem --- or at least allows us to exclude any life-threatening issues that might be occurring.

MS EASTMAN: Many witnesses have told us at previous hearings that in an Emergency Department the doctors might not speak to them but speak to their parents or their carers, and has that been your experience in being able to take a history?

5

DR PALIPANA: I suppose my approach has been coloured by my own experiences as a patient, but I often will talk to the patient first, and then with their permission and if they are happy I will talk to their caregiver or the parent as well to gain additional information about what brings them there.

10

But, even me as a previously medical student and as a medical graduate, I have instances where I have had difficulty navigating the medical system myself, but I have had the privilege of being health literate so I have been able to get about things the right way. But certainly there are instances where you can be treated a little bit

15 differently by virtue of having a physical or cognitive disability.

MS EASTMAN: Thank you for that perspective. I will come back to you in a motion.

20 Commissioners, I omitted to say that before coming into the hearing room that all of our witnesses have given their oaths or affirmations. I want to introduce and come to the other members of the panel.

Professor Murray, can I start with you. You are Richard Murray?

25

PROF MURRAY: Yes, that is correct.

MS EASTMAN: You are the acting Deputy Vice-Chancellor in the Division of Tropical Health and Medicine at James Cook University Townsville.

30

PROFESSOR MURRAY: That's correct.

MS EASTMAN: You are the President of Medical Deans Australia and New Zealand?

35

PROFESSOR MURRAY: That is correct.

MS EASTMAN: So you are speaking on behalf of the Medical Deans of the 22 universities that conduct undergraduate or immediate graduate medical programs in

40 Australia and New Zealand?

PROFESSOR MURRAY: Yes, that is the case.

MS EASTMAN: Can you tell us a little about what Medical Deans is and what it

45 does and what are the objectives of the deans having this organisation?

PROFESSOR MURRAY: I guess they are a community of practice among health

professional entry-level programs is common, and certainly Medical Deans, previously first established as the committee of - our Council of Deans of Medical Schools, it is a common arrangement and I guess the value in that comes from being able to connect a community of practice across various things, not least of which is the continuously evolving art and science of health professional education.

I suppose that there is development that is to do --- or standards, if you like, of medical education that is about meeting a minimum standard, for instance, that which you would expect coming out of an accreditation system, assuring a minimum standard. I guess in relation to medical education and training, creating a connection amongst medical programs so that there can be a continuous learning exchange and development of the art and sciences per se of producing entry-level doctors is really what that component is about.

There are other point of interest too, including around how we might advance (audio distorted) the conduct amongst medical schools, the development of a cadre of web force for instance, clinical academics to be staffed in clinical education, but certainly central to it all, I think, is the collaboration around the practice of medical education, curriculum, assessment, particular population groups, whatever it might be.

MS EASTMAN: The Medical Deans have, as you have said in the statement, nine specific objectives. One of these objectives is to provide leadership in medical education, research excellence and advocacy. Is that advocacy, advocacy around better outcomes of medical education? What does that entail?

PROFESSOR MURRAY: Yes, that is right, I suppose, speaking for and on behalf of the collective of medical schools across Australia and New Zealand in advancing, as I say, the practice of medical education and strengthening of that. I think by way of example, for instance, over the period of my association, a very strong movement has been around greater awareness of the special responsibility of medical schools as the monopoly providers, really, of medical education and the next generation of doctors, to have an accountability to society, so-called social accountability, and how we might better reflect that mandate to align teaching service and research to the priority needs of communities and in partnership with communities.

So those notions, for instance, have been an area of development and advocacy for Medical Deans.

MS EASTMAN: I have just mentioned a little earlier the recent consultation paper published by Medical Deans on inclusive medical education. Now, while that does not focus on patients and the care of people with cognitive disability, this is quite a significant step, isn't it, for the medical deans to really say, "We need to have a cohort of medical practitioners who may also be people with lived experience of disability, but if we are going to do that, we need to find ways of ensuring that medical practitioners with disability can practice safely, but at the same time a recognition that medical schools have to make adjustments to enable doctors with disability to be part of the future workforce".

So Dr Palipana, i think, has been part of that consultative group, and he brings that perspective of a young doctor with lived experience of disability.
What was it that really triggered the Medical Deans to look at the cohort of doctors and say, "We need to find a way of creating more inclusive programs to have doctors with disability", and then I will come to the other issues around accreditation and patients with cognitive disability, but can I just start with that? I would be interested in your perspective, and then Professor Haq, I might ask you whether from the University of Sydney you have a perspective on this proposal.

PROFESSOR MURRAY: Thank you very much for the question.

I think it comes from a broadly held view amongst the leaders of medical schools to see a greater, I guess, broadening of participation in --- from a wider cross-section of society in the opportunity to become medical practitioners. In Australia and New Zealand, as in most of the world, those who manage to get into generally a highly-contested process to enter medical school tend to be predominantly from metropolitan locations, for instance, predominantly from affluent and professional background, predominantly exceptionally high-achieving in their prior education, often historically in secondary school. And that such, whilst they are all terribly admirable people, as such often are not really a mirror on society. So the whole question of being able to have a breadth of participation as part of a social obligation, really, for medical schools is really the driver. That is one.

The other is, I guess, individual medical schools dealing with, through their admissions processes, requests for consideration or exceptions around various sorts of disability. And the need, the recognition of the need, really, for providing some sort of guidance advice or a framework to maximise participation. Clearly, that cannot be open-ended, but to try to frame that in a way that - if you like maximising the opportunity to enable participation by people who may be living with various sorts of disability was the intention, and so it is a resource really for the community of practice developed within the community of practice and in partnership with various individuals and agencies, so it is some sort of a guidance to good practice, I suppose, in enabling and broadening participation.

But as I say, it is part of a broader piece which is about maximising opportunities for broad participation in - from across various strata in society in the opportunity to become the doctors of the future.

CHAIR: Isn't that something that the University of Newcastle did many years ago? That is, to say broaden their admissions policy along the lines you have just referred to?

PROFESSOR MURRAY: Indeed. My colleagues at Newcastle when I think established in the late 1970s --- 1978, I think --- were very keen for instance on admission through interview as well as scholastic criteria as well as undertaking work to demonstrate that that was not a problem in relation to subsequent academic

achievement. And indeed, if you look around, James Cook University perhaps is another example where there is a particular emphasis on enabling participation for those who have had a rural or remote background and often educational disadvantage as a result, and also special admission arrangements for Aboriginal and Torres Strait Islander students. So there is again a quite diverse practice around the country that is perhaps a bit of a theme, but a learning community of practice, I would say, in relation to broadening participation.

MS EASTMAN: Professor Haq, can I bring you in at this point. The Commissioners have a copy of your detailed CV, but for those following this particular Public Hearing, you are the Associate Dean (Education) in the Faculty of Medicine and Health at the University of Sydney?

PROFESSOR HAQ: Correct.

MS EASTMAN: It is a role you have held since August 2018?

PROFESSOR HAQ: Correct.

MS EASTMAN: Before that, you had worked as a co-director of the Sydney medical program, and you are yourself a medical practitioner?

PROFESSOR HAQ: That's right, a rheumatologist.

MS EASTMAN: It is the day of the rheumatologist, I think, today, we've had the highest number of medical practitioners today. We will see how we go tomorrow.

Let me come back to Sydney University. Its admission policy has changed over time, has it not, from an undergraduate course into a graduate course?

PROFESSOR HAQ: Yes.

MS EASTMAN: To what extent has there been consideration of applicants to join that program as people with disability? Has that been at the forefront of what Sydney University has done?

PROFESSOR HAQ: I think particularly with regards to medicine, if I'm right and that is what you are asking, I think absolutely agree with Professor Murray that we want to broaden the diversity of our intake so that they - it reflects the community that our graduates will go and serve in the future, either whichever part of this country or indeed abroad, as we have students coming internationally as well. We have participated in university-wide broadening access schemes for school entries, certain entry students from economically disadvantaged areas, and also with access schemes for those of Aboriginal and Torres Strait Islander origin.

We do receive applications from students with different types of disabilities, absolutely, and we will look at those on an individual basis, in discussion with them,

looking at the requirements of the degree and their particular circumstances, and make decisions accordingly. So I think absolutely we would welcome applications from anyone, absolutely. And we would look at each individual distinctly based on those circumstances.

MS EASTMAN: Professor Murray, I want to ask you about a part of your statement, this is page 6 where you say there are currently no specific requirements regarding cognitive disability health content for medical school curricula. And you say on page 7 that.

> *We question whether a mandatory approach to defining curriculum elements is most effective.*

Am I right in understanding your statement that the Medical Deans would not be supportive of mandatory curriculum contents that covered the healthcare for people with cognitive disability being included in the curriculum?

PROFESSOR MURRAY: That is correct, but it needs a little nuancing, I think.

What I would say is that medical curricula are inevitably and particularly with the trends, the shortening of medical courses from the traditional six-year models to a more common four-year model. The problems of crowded curricula, and in particular the need to avoid a sort of highly atomised prescriptive content, so that there is a mandatory accreditation requirement or other, that essentially sets out medical education, topic by topic, in --- and how that all relates in great detail is in our view to be avoided.

It is not regarded as best practice in terms of medical curricula around the world, which is not to say that there should not be a considerable volume of material and readily available learning resources, of one might even call a syllabus or common models that are shared, but mandating them in a standard curriculum in detail in a single topic area means that potentially, thousands of similar topic areas must similarly be mandated, there is no point at which you would stop with that approach, and by and large that --- (overspeaking) ---

MS EASTMAN: Can I put this to you - we know from the data that people with intellectual disability are more likely to die 20 years before their peers without intellectual disability, and we know that the mortality rate for people with intellectual disability is even, and significantly lower than that for Aboriginal and Torres Strait Islander people. We know the stats indicate that the prognosis for a person with intellectual disability who is diagnosed with cancer is that they are 8 times more likely to die. Can I ask at what point does the (audio distorted) curriculum have to give way to addressing statistics like that?

PROFESSOR MURRAY: I would certainly agree with the objective, which is to make comprehensive learning of --- appropriate to the level of an entry-level practitioner in being a part of the healthcare of people with providing healthcare for

people with intellectual and cognitive disability, I agree. It is more about a means to an end, so I agree with that as an end. How we get there is perhaps what I will focus on.

5 There is a lot of very good practice in modern medical education around the country, in my own medical school and indeed in many others, around the specific instruction and supervised experience for students in being able to provide appropriate care to the people with and caring for people with intellectual and cognitive disabilities. So I think firstly there is good practice that can be shared.

10

I think there are also good models by which such practice can be disseminated. For instance, having standard and available high-quality learning resources that are updated and are readily accessed by educators, for instance the National Prescribing Service in Australia has a set of standards and modules that are commonly accessed
15 by medical schools and others for standardising and supporting quality learning and teaching around medication use.

So I think that is an example of a means to an end. I think the other ---

20 CHAIR: Would you mind if I approach this from a slightly different angle. Would you agree that if it is a core competency or capability, depending on which expression you want to use, for a medical graduate who intends to practise medicine, to have an understanding of how to communicate with people with intellectual disability or cognitive disability, to understand the dangers of diagnostic
25 overshadowing and to understand all the other nuances we have heard about in the Royal Commission and I'm sure you are familiar with, concerning the way in which the person with intellectual disability themselves or their families are dealt with in the system? Is that not part of the core competency or capability of every medical practitioner in 2020, and if it is, then all we need to talk about are the means and ends
30 by which those core capabilities or competencies can be achieved within the medical degree.

PROFESSOR MURRAY: Look, if I might respond then, I strongly agree with that view, and I think we heard earlier on the testimony from Tara in relation to what it
35 was that she expected, and actually the things that she I think very nicely explained were really about the ability to communicate in a way that is appropriate and tailored to the individual with appropriate use of, for instance, plain language, diagrams, picture, take turning the trouble to speak to the person themselves, not only their career or support person, and having the practised and deliberate skills to be able to
40 do so.

So that is an absolutely core underpinning skill, and I would say it is also shared in common with numbers of other vulnerable patient groups who similarly benefit from that approach to a style of communication with a medical practitioner. So I think it is
45 not unique, it is just a particular example of the absolute importance of treating each person as an individual with dignity and being able to explain and illicit information in a way that is responsive to that person's needs.

I agree also that that must take account of the specific example of the people with a cognitive or intellectual disability.

MS EASTMAN: Would you accept this proposition - if you say as a starting point that everybody should expect that their doctor treats them with dignity and respect, and if you accept as a starting point that that is the minimum expectation of a medical practitioner, if that same standard is applied to everyone but the person with cognitive disability does not have that same capacity to engage in that communication with the doctor, then treating everybody the same like that just continues and indeed entrenches and a perpetuates that inequality, doesn't it?

PROFESSOR MURRAY: It does. Sorry, Senior Counsel, to interrupt, and that is why I would strongly disagree with any notion that communication should be standard. The whole point is of person-centred care, and the great emphasis in certainly all of our teaching and supervision and assessment of person-centred care is that it must be specific to the context of the individual, to reflect their values, their understanding, their context, and tailored to that. That is a set of skills that needs to be practised, learnt and practised. It is not automatic.

MS EASTMAN: Dr Haq, do you agree with that?

PROFESSOR HAQ: I absolutely agree that our students and health students, particularly at University of Sydney, have a lens of patient/client-focussed care, and the principles behind that, starting from a junior student to a senior and graduating student, they understand the principles of what that means, and then they apply it in practice in either simulated or real environments under supervision with the absolute requirement that it is bespoke to that person's situation. That there is not a one level, absolutely.

MS EASTMAN: So how do the medical students learn that if most of the clinical situations they find themselves in are not for that 1.8 per cent of the population of Australians with intellectual disability, but what might be described as more mainstream population? How do you teach students to know when and how to adapt communication?

PROFESSOR HAQ: I think that comes from academic best practice. I think that is where Professor Murray's concept of the community of practice is really important. I think we must engage the community as partners in co-creation of whatever we decide to come up with, whether it is modules or shared resources. I think the lived experience is incredibly powerful. I know our students find that the most powerful learning tool, I could talk about X or Y, but actually hearing from the person about their lived experience of something is - it stays with the student. I think Tara's testimony ---

MS EASTMAN: Let me put this to you. Tara did not have time, when she got to that Emergency Department with a very significant problem, to share her lived

experience with the emergency doctor before she wanted treatment. She wanted that to be done when she got there.

PROFESSOR HAQ: Yes.

MS EASTMAN: So, sometimes there is not time to wait, is there, to learn the right communication technique?

PROFESSOR HAQ: But I think that is where - so, coming from a - my job is around training people to graduate to become those entry-level practitioners. We need to give them the tools, (a), to recognise that a person, an individual requires a different level of need or communication and recognise that quickly. To be able to advocate, I think, very, very importantly, if they see that not happening. And I think to use the principle and to work quickly in a situation which is often not - it can't be sort of planned for - to get those skills that become automatic. That is what we do. So we try to get the skills and understand the reason for the skills, we then can test them in a simulation environment, a safe environment, which can include patients and clients from the community to come and help them, and we can debrief and say what went well, what didn't go well, and in supervised practice they can actually apply those skills absolutely. At the time they can use the skills they have learnt at the time without having to have had half an hour to think about what to do, and in many cases you can not do that.

In Tara's situation we would hope that our graduates would say "I can now see that Tara has specific needs, I can move to a quiet room, or I can help communicate. I can talk through what the tests are going to be. If Tara needs blood, I will explain how that may work", and obviously get her consent, and informed consent to make that happen. So we want to give student those skills so that when they enter to the workforce they are ready the use them in the real world.

MS EASTMAN: Dr Palipana, without telling tales on any of your colleagues, but no doubt on the shopfront floor in a busy Emergency Department at the Gold Coast, do you see your colleagues being able to apply these techniques that Professor Murray and Professor Haq have spoken about?

DR PALIPANA: The emergency environment is a highly dynamic and chaotic environment sometimes, and we have a wide range of medical practitioners that practise, and it can be certainly challenging for a lot of people that come through. I think the outcomes --- in all honesty, it is variable. I do like to add, though, that training entry level and junior practitioner with the appropriate skills is important because they end up being the workforce that manages and faces the patients the most. So sometimes a junior doctor, even in their first or second year, will see a patient, and then they will report back to their senior who may not see the patient sometimes. So having that junior entry level doctor well equipped to elicit the right information and manage it is really important.

Some of the junior doctors also end up in rural areas where they may be the only

person around at night. So really having them equipped to face those situations is important, but from my experience, the outcomes are variable.

MS EASTMAN: Ms Walters, I will bring you in here. The Medical Deans say in their statement that they acknowledge that the AMC standards are a significant lever. They not only bring an approach to about - to bringing about change and improvements, but that medical schools and would-be medical practitioners have to be able to meet the AMC standards. Do you agree that the AMC Accreditation Standards are a significant lever in terms of the development of or changes in curriculum? And if you want to explain a little bit about how the Accreditation Standards work, I will certainly invite you to do that.

MS WALTERS: Thank you. So the standards can be a lever, but I think most importantly standards are an enabler, and by that I mean the AMC's approach has been to set standards that provide the threshold requirements, but without such detail that then they are inflexible for medical schools that want to pursue excellence in an area or have a particular focus on an area. But also so the standards, medical schools can adapt and change without us constantly changing the standards to keep up with the medical schools. So I think in relation to - so this is why the standards don't specify core curricula or the content of the medical programs, because knowledge changes all the time and it would be impossible for us to have standards that kept up with that.

MS EASTMAN: So where does one strike a balance between standards at a general level that gives a university flexibility in following a particular system of values or social objectives, but also ensuring that we are producing a generation of medical practitioners who can respond to the community's needs, including this part of our community whose life expectancy and health outcomes are so disproportionately poor compared to the rest of the community. Surely that has to be a factor in terms of identifying accreditation standards if you are looking at the purpose of developing a medical workforce that can address these dire health needs?

MS WALTERS: Yes. So I think - so I agree, but I think one of the things to think about is how the standards work with other elements of the system. So the accreditation standards is one part of the AMC's tools, if you like. We link - we accredit medical programs on behalf of the Medical Board of Australia. The Medical Board is responsible for the Code of Conduct, for doctors, so that Code sets out expectations and requirements of all medical practitioners. So we work together in those two areas, so this might be than a area, for example, where the Medical Board's Code could also be augmented.

The Standards, in the past the AMC has issued explanatory notes with its Standards. The current version of the Medical School Standards don't have that, the Specialist Standards do, and that has been where we have said, "What is an area of particular importance or particular focus in this reading of the Standards?" So again that is a possibility in terms of the AMC's tools. So it may be the Standards, it may be the notes, it may be working with the Medical Board, or it may be the overarching

statements, the graduate outcome statements.

MS EASTMAN: In terms of the AMC, can I just go back and look behind what the AMC actually is, and it is a body established under the *Health Practitioner Regulation National Law*, and it has particular functions in relation to accreditation, not just of universities but also the specialist colleges.

And the Accreditation Standards cover a range much issues, not just curriculum but also assessment and other particular outcomes that are sought. Is that right?

MS WALTERS: That is right.

MS EASTMAN: That is a quick paraphrase of the Australian law. But there are members of the Australian Medical Council, and those members are decided by the AMC Constitution, and you have set that out at page 3 in your statement in terms of membership.

It appears that the members of the Council are intended to cover all relevant people who are involved in the practice of medicine but also the delivery of medical training and education, but also some of the representative bodies like the Australian Medical Association. Is that right?

MS WALTERS: That is right.

MS EASTMAN: Now, the Constitution provides that one person who is an Aboriginal and Torres Strait Islander has to be a member of the Committee; is that right?

MS WALTERS: Yes. We have - pardon me. So we have one person who is an Aboriginal or a Torres Strait Islander, and who is also a registered medical practitioner. Then we also have a person who is an Aboriginal or Torres Strait Islander who does not need to be a medical practitioner, and a Maori person who does not need to be a medical practitioner.

MS EASTMAN: And there is no reference to - in the list of members, to a member as a person with lived experience of disability, including intellectual disability. Do you agree with that?

MS WALTERS: I do. There are two people with background and knowledge of health consumer issues, so those are people appointed by an expression of interest from the wider community. It would be the broader category.

MS EASTMAN: Have the directors of the AMC ever appointed a person with lived experience of intellectual disability to be a member of the Council?

MS WALTERS: No, not a person with lived experience of intellectual disability.

MS EASTMAN: Do you know if there has been any consideration of whether a person with lived experience of intellectual disability or an advocate from one of the advocacy groups such as Inclusion Australia or the Council of Intellectual Disability to be considered for membership of the Council?

MS WALTERS: I do not think it has been discussed in those terms, but certainly the call for expression of interest is a wide one, and applications from such people would be welcome.

MS EASTMAN: The process of developing the Accreditation Standards is a process that takes a period of time, it requires applications and submissions to be made, and then very carefully assessed. Is that right?

MS WALTERS: Yes.

MS EASTMAN: And the objective is to create a set of accreditation standards that will last for a period of time, indeed, up to 10 years, so that universities and the specialist colleges - I will not forget them - have some certainty about what is expected in the delivery of the education and training and meeting all of the other standards. That is right?

MS WALTERS: Yes, the usual period for review of accreditation standards would be five years. We are at, I think, seven years with the review of the Medical School Accreditation Standards which we have started a review of now, simply because of the developments in the National Registration and Accreditation Scheme, so we paused our most recent review.

MS EASTMAN: In that five-year period there has been a lot of changes, you would agree, in relation to the delivery of disability services within Australia? We now have the NDIS that has rolled out. And even though not all people with disability participate in the NDIS, that has raised a significant change in terms of standards that we expect of delivery of services, and also the role of a Quality and Safeguards Commission in ensuring that delivery of services meet particular standards.

To what extent would any review of the accreditation standards take into account those broader changes in the delivery of services to people with disability in the community?

MS WALTERS: At the moment, the AMC is going through its initial, I suppose, scoping work on the review of the Standards which is precisely looking at these issues, what has changed in health services and requirements since the last review, and what should be reflected in the revised Standards.

MS EASTMAN: Can I pause on the Standards and come back to Professor Murray and Professor Haq.

In terms of the flexibility you have in curriculum development at the university level,

what has changed, if anything, to respond to the changes brought about by the NDIS and the delivery of disability services in Australia? Has there been any specific changes to the way in which you have developed the curricula?

5 MS WALTERS: So the Accreditation Standards have not changed in that period, but what I have observed --- in preparation for this hearing, I have looked at the accreditation submissions made by medical schools, and not systematically but by looking at, say, four to five submissions to the AMC. What I can observe is a focus in medical schools, particularly in the last 18 months, where they are talking about
10 the sorts of changes that the University of Sydney is making, and talking about changes in expectations about longitudinal placements for students, a broadening, if you like, of clinical placements and experience.

So even though it is not in the Standards, what we see is medical schools are making
15 their own changes which fit within the standards.

MS EASTMAN: Professor Murray, Professor Haq, do you want to comment on those issues at all?

20 Professor Murray first?

PROFESSOR MURRAY: Thank you very much. I absolutely agree, and it has been a long push, really, for moving the context of learning, and in particular the phase of medical education that is spent under supervision in a real-world environment
25 dealing with individuals, families. From the big teaching hospital it was the tradition, I suppose, where I mostly trained, although we did have --- 35-odd years ago we did have community experience, but there is a lot more of that now, so that has been a very deliberate move.

30 I think, as well, in the - so in some ways it has paralleled the developments of NDIS, a greater emphasis upon medicine in the community as opposed to in the hospital. A greater emphasis upon function, dignity and family rather than sickness and treatment in the hospital. So those have been all very deliberate and sort of long-running trends in medical education.
35
I think I will come back to the question of placement, if I might, because I think it is a really fundamental opportunity perhaps that the Royal Commission may consider.

I might just go back to the AMC process. I think some of the value of the AMC is
40 not whether or not a checklist on whether one is deemed to have met the minimum standards of accreditation as set out. I think in some ways that is the least valuable aspect of their education process, but I have been around the world advocating for these things, is that the culture is very much about continuous enhancement or continuous improvement, so those of us who participate either as the one being
45 accredited or on the accreditation panels that would include community people, are very active in sharing and disseminating ideas in a community practice, and I think that has been a very valuable aspect of the work of the AMC. It is in fact not a

checklist auditor but a facilitator of best work practice, which I think is a great strength.

MS EASTMAN: Professor Haq? I think the word of COVID-19: you are on mute.

PROFESSOR HAQ: Yes, I know, terrible.

I concur with Professor Murray, certainly in the medical program, with our revised program that I was involved in developing, have become more focused on community placement activity, precisely for the reasons that Professor Murray said, and most people do not spend their lives in hospital. They spent their lives out of hospital in their actual daily lives, how do our students access those placements opportunities and lived experience opportunities, with a range of healthcare providers, that is what we are engaging in Year Two. Particularly one of the strengths in Sydney that my role is, is interprofessional education. Patients with intellectual or cognitive disabilities are not just looked after by a doctor or nurse, but it's multi-disciplinary teams, and something we are really looking forward to developing is actually getting our students together in any particular different context, but this would be another excellent on how to best care for a patient and their family care or support workers with an intellectual or cognitive disability, so I think that is where we are moving, and NDS fits in to that sort of broad area too.

MS EASTMAN: The Royal Commission has heard a lot about the importance of multi-disciplinary teams, particularly in the Royal Commission - and the Commissioners have not produced a report yet, but they have heard evidence in relation to the prescribing of psychotropic drugs that challenging behaviours on behaviours of concern, sometimes it is the doctor, and usually a GP or a paediatrician, who will be that first port of call as to whether the prescription is going down a behaviour management pass, or a health path. And the importance of a multi-disciplinary approach has been raised there, how do you meet the Accreditation Standards in bringing in that multi-disciplinary approach, and do the Accreditation Standards need to be more open to incorporating multi-disciplinary approaches, particularly for people with cognitive disability?

PROFESSOR HAQ: I think I probably concur, there is going to be work in the revised AMC standards on interprofessional and multi-disciplinary learning, I think that is going to be really important, it is really important now, even more so for our health professionals of the future. We at Sydney have developed a framework from entry to exit for interprofessional capabilities, is what we've called them, working with other students and learning from them in classroom environments, simulated environments, and then the real clinical environments under supervision. That covers a variety of contexts, multi-disciplinary team meetings, managing conflict and so on and so forth. But I could see a vulnerable population would also fit into an area where we could teach and learn in a multi-disciplinary context, yes.

MS EASTMAN: Ms Walters, I see you have just disappeared off the screen. I hope you have not left us?

Apologies. I thought normally it is hard for a witness to escape but maybe on the Zoom it is a bit easier. Can I ask you this - there is absolutely nothing in either the national law or the policies for developing accreditation standards that would prevent there being a specific accreditation standard directed to the care and treatment of people with cognitive disability? There is nothing preventing that going into the Standard, is there?

MS WALTERS: No, there is nothing.

MS EASTMAN: And the reservation as to including a specific standard concerning people with cognitive disability is really here a floodgates, that if we have cognitive disability in, then we will have to have all of these other vulnerable characteristics added as well, am I reading the evidence correctly, that that seems to be a concern about being overly prescriptive in it guying a particular population?

MS WALTERS: Yes, that is certainly the expressed concern. I think it is fair to say that in the current review of the accreditation standards, the structure of the standards is one of the issues that we will be looking at, because clearly, the way the Standards are structured now probably make the curriculum and the content of the curriculum, I suppose, a smallish part of the eight standards even though it is an incredibly important part.

One of the things we are looking at is how might we structure the standards, so themes and issues that arise, curriculum themes, issues about including particular sections of the community or particular patient groups within curriculum design, if you like, or in teaching, is one of the topics that we are currently discussing.

So it is possible to change it.

MS EASTMAN: And you have gone down this path in the past in relation to specific identification of Aboriginal and Torres Strait Islander and Maori population, and picking up the New Zealand concept of cultural competency, or --- and I think New Zealand has recently revised this to describe it as cultural safety. That is a model which we have heard does put pressure on a crowded curriculum, but as I understand the evidence given to the Royal Commission this morning, even though that has created challenges for universities, it has been possible to incorporate within the curriculum.

Should it be a question about how much more space there is in a curriculum, or should it really be about curriculum design to incorporate some of these particular areas such as First Nations people or, may I add, people with cognitive disability? Can that be done?

MS WALTERS: It - certainly the accreditation standards can certainly be structured in a different way that would give focus and attention to other curriculum topics and other populations. I guess it is the issue of whether there is agreement that that

should be the way it's done. But the issue about curriculum overcrowding, I think, would best be answered by Dr Haq or Professor Murray.

MS EASTMAN: Commissioners, in the time that is available, I want to ask the members of the panel whether they have read the proposition document we circulated earlier, and I can ask you Professor Murray, can I start with you - do the Medical Deans have any violent objections to any of the propositions that we have circulated?

CHAIR: Is that different from an objection?

MS EASTMAN: I qualify it by "violent" objection.

CHAIR: You can ignore the word "violent".

PROFESSOR MURRAY: I quite like "violent agreement". I am in violent agreement as to the objective that we produce medical graduates who are able to understand in a very authentic way the lived experience and perspective of individuals and families living with intellectual disabilities. So I'm completely on board with that - violent agreement there.

So where we differ is the means to the end. I absolutely get that the general public and many would say, well just put it in the curriculum. And that can join a very long list I can tell you, because we get letters every other week, "We need more of this in the curriculum".

From all sorts of patient groups, we get gender issues, be it particular age or ethnic group, refugees, particular disease groups, whatever it might be, there is a multitude of completely legitimate interests in particularity.

What is underpinning all or many of those, however, are more fundamental things about the skills and attitudes of medical practitioners when it comes to the ability of some of the fundamentals, such as accurate, empathetic, person-centred communication, being an example we touched on earlier, and I think we would try to put a much greater emphasis on that. I think there is room for developing some higher-quality learning resources that are updated and readily accessed.

So for instance, in our own curriculum, again we have a six-year curriculum so we have a bit more headroom and it is a bit unusual, but we have a entire week on disability, including individual patients, of individual people attending with particular sorts of lived experience, and indeed a video exercise analysing and reflecting upon the experience of a mother and daughter with an intellectual disability so there is quite a lot of good practices (audio distorted) I think they provide a high quality learning resource in the style of NDIS that are readily accessed by very receptive community access, which would appreciate the availability of such things to use and/or adapt. I think that would be an impactful thing to do.

But the other thing I must say, if we are coming to time, one of the biggest reforms I would really invite the Commission to consider, and that is not a feature of the circumstance at the moment, is the question of supervised quality placements. It is a fact of history that the way in which medical schools and clinical placements are funded, is that most of those resources are tied up in public hospitals --- that is the way in which the funding system works, there is a requirement that public hospitals under the national reform agreements and their predecessors provide clinical teaching and supervision opportunities for medical students, but that then limits it to the hospital setting.

We have, in more recent times, had the opportunity for there to be payments to general practitioners to have medical students placed in community general practice, and so have a formal paid teaching role for students in community general practice. But as far as other agencies, and particularly community agencies and those managing and supporting people and families living with intellectual or cognitive disability, there is no mechanism for remuneration or support for that environment, and indeed with the development of NDIS, the whole question of there being a sort of parallel investment in the health profession, medical and other health professional placement in the community support services around NDIS, it simply does not exist. It has not yet been developed yet.

I believe that is a major gap. I think Proposition 7, if I recall, goes to that, and I would really like to underscore that. I think that is a very important opportunity for the Commission to contemplate.

But beyond that, as far as means and ends, I agree with the end. As a specific means, detailed, highly atomised prescriptive curriculum and standards in a very literal sense --- I'm not talking syllabus but curriculum --- I think would not be a sensible way to achieve the end. But I'm completely on board with the end.

CHAIR: Wouldn't that be a false dichotomy? There are various ways in which you can achieve the end. The starting point has to be, I would have thought, whether there is something particularly significant about the position of people with cognitive disability and the way in which the medical profession interacts with those people. If there is, then it may be entirely a matter for medical schools and for judgement as to how the necessary skills, empathy, understanding, and so on, skills are communicated. Not necessarily by a prescriptive separate subject, or anything like that.

I expect the description may be in the discussion which has occurred. And I may be misunderstanding it, but for you, Professor Murray and for you Professor Haq, you seem to think a pedagogical approach that leaves the students having more sympathy, capacity to communicate is transferrable among different vulnerable populations, and I wonder about that.

I wonder if there are not things specific to particular populations. From what we have

heard in this Royal Commission, and in a number of hearings, the issues that arise for people with cognitive disability do not seem to have ready counterparts in other vulnerable populations. They may have other issues, and there may be some overlay, but I just wonder whether your approach may not be a little too generic, if I may put it that way.

PROFESSOR HAQ: I think that is probably starting from where I was coming from. I think that under an umbrella of vulnerable populations, of which there are many with many different needs, I think we need to teach our students in nuanced ways what the needs of particular groups are that are completely different, I agree. But again these are students who are going to graduate. This is part of the learning continuum. They do not learn everything at point of graduation. There is another 20 to 30 years for them to keep on learning.

Our job is to give them a platform and a foundation for where they are going to go in the future. So there are general capabilities, absolutely right. But there are also specific capabilities for disabilities of different kinds and other vulnerable types of groups that we should be ensuring our students have the capacity to recognise. I think that is really, really important. And then work out which bits of those skills armoury, they need for which particular time for whichever group of patients or community they are dealing with, and also how to work effectively in a team for the benefit of that patient. I think also really important is to recognise poor practice they may well see in a health environment all over the country, and how then to call that out. That is the really important. I think our students really want to be able to do that, but do not feel empowered to. And that is something we really need to work on.

So absolutely, Senior Counsel. I think it is not about saying generic capabilities will solve everything, but giving a foundation and applying that foundation in specific circumstances, and seeing what nuances are needed.

MS EASTMAN: Ms Walters, any view about the propositions or any, as I said, violent disagreement with those propositions?

MS WALTERS: I wanted to tease out the competency framework, if I could. I think we see lots of documents written as competency frameworks, which I think variously are taken up by medical schools, and in different ways. But I think there is actually value in the development of the competency framework. Because it is the thing about, the discussion about what are key skills and core competencies, and the engagement with the stakeholders to develop the document and to think about what does this mean. I think there is real learning in that. If I think, for example, the Indigenous health competency framework, I think there was as much value in the actual development of the document, and then the development of the resources that are available for medical schools to apply to their course. I think that is a really valuable exercise. I think there is material already available in Australia that could form the basis of that. The work done by New South Wales Health in the development of its mental health capabilities for people with intellectual disability is a great start as a competency framework.

In relation to the accreditation standards, I suppose it is how the standards are changed that is the important issue. I guess we, in terms of the AMC's thinking about this, we are at very early stages in thinking about the scope of change to the standards, but it is certainly an issue that we will pick up in this review and will consult on widely early in 2021.

MS EASTMAN: Dr Haq, did you want to add something?

PROFESSOR HAQ: Again, working together as a team rather than each university or jurisdiction working independently, if we could agree some capabilities. For me that is a great word. What do we want our students to be able to do on graduation in a group, in the vulnerable patient group as a whole but within specific areas in intellectual disability and cognitive disability. I think that would help. It would prevent each university having to do their own thing and create their own, and allow us as a community of practice to develop resources, or use existing resources, that we could then map onto that.

MS EASTMAN: Professor Murray, that proposal that Professor Haq has just described seems to be perfectly placed in the work of the Medical Deans. Would you agree?

PROFESSOR MURRAY: Yes, I do. Having a competency framework, and set of commonly share learning resources around that, and being able to put that through. For instance, our Medical Education Collaboration Committee, which is a specific committee of practice of which Professor Haq is an active participant, is precisely the right way to have this. Because every curriculum, sequencing, structure --- the way in which particular case examples, for instance, in a problem-based curriculum will vary. But being able to draw upon a common resource set and a set of understanding of what good practice looks like I think helps to facilitate (inaudible).

MS EASTMAN: Dr Palipana, can I give you the final say as a recent medical graduate, what are your views on the propositions, and any final perspectives as a person with lived experience of disability, but also serving on the front line, so to speak?

DR PALIPANA: I have no violent objections to the proposition. But I think medical education is a complex continuum with a lot of stakeholders. So the medical schools graduate doctors, and then subsequently the specialist training colleges that will have them on. I think each speciality has its own subtleties of how to deal with people with disabilities. For example, how does an anaesthesiologist best deal with a patient with a cognitive disability? How does a psychiatrist, how does a surgeon? But in between graduating medical school and undertaking a training program there is a large cohort of doctors that do a lot of front-facing work, in the emergency departments, clinics, in and around hospitals. And there are thousands of them across Australia. And they will be there from the graduating year to five, six, seven, eight years sometimes before they start speciality training.

So I think it is really important that that big group of doctors are best equipped to care for people with disabilities, because they may sometimes be the only doctor that a person with a disability sees, and they may not have any other senior input in
5 extreme circumstances.

So I do think it is important that we prepare people to best care for people with cognitive impairments. I do agree there is a huge gap and risk with people with cognitive disabilities and other disabilities that we need to do better as a profession to
10 care for.

MS EASTMAN: Can I thank you all. You have put an enormous amount of time and care into the preparation of the material for this hearing of the Royal Commission. We are indebted to all of you. Commissioners, that concludes the
15 questions I wish to ask the panel members.

CHAIR: Thank you, Ms Eastman. I will ask my colleagues if they have any questions? Commissioner Atkinson?

20 COMMISSIONER ATKINSON: I do have a lot, but I think the time has come to finish with a word. Thank you.

CHAIR: Commissioner Bennett?

25 COMMISSIONER BENNETT: No, thank you.

CHAIR: May I endorse the comments of Ms Eastman. We are very grateful for each of you for the evidence you have given and for the considerable thought and effort that has gone into the preparation of the documentary material that you have
30 provided. It has, again, been an extremely interesting, informative and suggestive discussion, and we have I think some very valuable ideas to go on with. So thank you very much for your contributions.

PROFESSOR HAQ: Thank you.

35

DR PALIPANA: Thank you.

PROFESSOR MURRAY: Thank you.

40

THE WITNESSES WITHDREW

MS EASTMAN: Commissioners, that concludes the proceedings for today. I would
45 ask you to adjourn, and resume tomorrow at 10.00am.

CHAIR: We will do that. We will resume at 10.00am tomorrow Sydney time.

Thank you.

ADJOURNED AT 4.14 PM (ADST) UNTIL WEDNESDAY, 16 DECEMBER
5 **2020 AT 10.00 AM (ADST)**

Index of Witness Events

OPENING STATEMENT BY CHAIR P-2
OPENING STATEMENT BY MS EASTMAN P-3

DR JANE TRACY P-9
PROFESSOR GARY VELAN P-9
PROFESSOR ROSALIND BULL P-9
PROFESSOR MICHELLE LEECH P-9
EXAMINATION-IN-CHIEF BY MS WRIGHT P-13
THE WITNESSES WITHDREW P-34

ASSOCIATE PROFESSOR NATHAN JOHN WILSON P-35
PROFESSOR CHRIS BREBNER P-35
MS LIZA EDWARDS P-35
DR MARGARET GATLING P-35
EXAMINATION-IN-CHIEF BY MS WRIGHT P-40
THE WITNESSES WITHDREW P-62

DR DINESH PALIPANA P-62
MS THEANNE WALTERS P-62
PROFESSOR RICHARD MURRAY P-62
PROFESSOR INAM HAQ P-62
EXAMINATION-IN-CHIEF BY MS EASTMAN P-67
THE WITNESSES WITHDREW P-88

Index of Exhibits and MFIs

5

EXHIBITS #10.1 TO #10.40 - EXHIBITS IN TENDER BUNDLE A P-8

EXHIBITS #10.41 TO #10.87 - EXHIBITS IN TENDER BUNDLE B P-8

[VIDEO RECORDING PLAYED] P-11

[VIDEO RECORDING PLAYED] P-66