Submission

to

Productivity Commission
Health Workforce Study

from

The Royal Australian and New Zealand
College of Obstetricians and Gynaecologists

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CONTENTS

EXECUTIVE SUMMARY

The Royal Australian and New Zealand College of Obstetricians and Gynecologists (RANZCOG) has serious concerns about the long-term future of obstetrics particularly in the rural sector. The specialty of obstetrics and gynecology is unusual in that Fellows can practice in obstetrics or gynaecology, or both, In addition maternity services may be provided by a range of health professionals: specialists, general practitioners and midwives. In ideal circumstances, these three groups of health professionals provide complementary services. Unfortunately, maternity services have often been a focus for professional rivalries.

In 2002, RANZCOG re-established the Joint Maternity Services Committee, representing RANZCOG, Royal Australian College of General Practitioners (RACGP), Australian College of Rural and Remote Medicine (ACRRM) and the Australian College of Midwives Incorporated (ACMI) to address the controversial issues in obstetrics. RANZCOG has recently collaborated with the Rural Doctors Association of Australia (RDAA) and NSW Rural Doctors Network in a successful funding submission to the Commonwealth to conduct a scoping study to establish a Specialist Obstetric Locum Service, if the recommendations from the submission are successful this will lead to the establishment of a funded specialist obstetric locum service which is primarily focused on supporting the rural obstetricians. In the last month the collaboration was invited to prepare a further funding submission to the Commonwealth to develop a national consensus on rural maternity services. This last submission was prepared in conjunction with other key stakeholders – ACMI ACRRM.

Recent workforce surveys have indicated that increasingly Fellows are ceasing to practice obstetrics in the private sector and to a lesser extent in the public system. At the same time an increasing number of trainees are choosing not to practice obstetrics at all. In 2001, a survey of 5th and 6th year trainees found that 26% did not intend to practice obstetrics.

The College has found that AMWAC have had a very limited role in assisting and advising in workforce planning. Workforce information has been fragmented rather than acknowledging the interdependence of the various specialties and health workforce; AMWAC needs to be able to take a broader view of the health workforce so that a comprehensive view of the workforce required to provide maternity services can be appreciated and appropriate action taken.

The College and AMWAC agree that there is limited data on the practice profile of the fellowship. RANZCOG will conduct a further workforce survey and trainee survey in February 2006.

The College supports national perinatal data collection data collection of obstetric data in a comprehensive and timely manner.

The gynaecology workforce appears to be well served in rural and urban areas. However, with the ageing of the workforce, the difficulties of recruiting specialists to rural areas, gynaecology services may also be under significant pressure in the future.

The College supports a consistent approach, Australia wide to the assessment of overseas trained specialists (OTS) and area of need practitioners.

This RANZCOG submission is complemented by a submission from the Chair RANZCOG Provincial Fellows, Dr D Mohen, focusing on rural obstetric services.

OVERVIEW

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) is dedicated to maintaining the highest possible standards in obstetrics and gynaecology in Australia and New Zealand. The primary role of the RANZCOG is to train and accredit doctors in obstetrics and gynaecology. All practising obstetricians and gynaecologists in Australia and New Zealand participate in the RANZCOG's continuing professional development (CPD) program, incorporating the practice review and clinical risk management (PR&CRM) program. The College trains general practitioners in two recertifiable qualifications; the 6 months Diploma of obstetrics (DRANZCOG) and the 12 month Advanced Diploma (DRANZCOG Advanced) The College also supports research into women's health and acts as an advocate for women's health care by forging productive relationships with individuals, the community and professional organisations, both locally and internationally.

The speciality of obstetrics and gynaecology encompasses women's health with particular emphasis on the diagnosis and management of women's reproductive health and disease. Traditionally obstetricians and gynaecologists practised both obstetrics and gynaecology, but increasingly Fellows are choosing to focus on gynaecology and cease practising obstetrics or to subspecialise. This trend was demonstrated in the 2003 RANZCOG workforce survey (RANZCOG Workforce Survey 2003).

The O&G workforce is ageing; there is a feminisation of the workforce, a reluctance of younger fellows to take on the excessive workloads of their predecessors and a misdistribution of the obstetric workforce. Financial incentives exist for obstetricians working in areas with high rates of private insurance such as the larger capital cities. Rural obstetrics is in crisis whilst the larger capital cities appear to be well served by obstetricians. At the same time gynaecology services have generally been maintained, however with the ageing specialist workforce pressure on rural gynaecology services is likely in the future. Community expectations and the medico-legal environment have affected the profession, as will the Australian Safety and Quality Council initiative of safer working hours, which is supported by RANZCOG.

The provision of maternity services is not the sole province of specialist obstetricians and gynecologists. Obstetric care is provided by a range of health professionals in a number of settings; specialists, general practitioners and midwives in both public and private hospital settings, birthing units and less frequently by midwives in the woman's home. The three professions have complementary roles to play in the provision of maternity; obstetricians play an essential role in managing life threatening obstetric emergencies when there are complications of pregnancy or labour and depend increasingly on midwives and general practitioners to support them in providing antenatal care. However, some view the obstetrician involvement in normal childbirth, and the use of medical interventions as intrusive. The increased obstetric intervention rate has coincided with increased medicolegal pressures such as increased rate of litigation and the consequent increase in medical indemnity fees. A team approaches that values the contribution of all health professionals is supported by the College. The RANZCOG in collaboration ACMI published a statement in the Medical Journal of Australia 'Obstetricians and midwives modus vivendi for current times - Obstetric services need to be women-centred and based on mutual respect and collaboration', this is a milestone in developing cooperative relationships between key maternity service providers.

WORKFORCE

Over recent years, the RANZCOG Council has focused on workforce issues, namely the recruitment, training and retention of specialist obstetricians and gynaecologists. The College recognises that these same workforce issues face both general practitioners and midwives and must be considered in the context of maternity services workforce planning.

Workforce tensions

The College is concerned about the often strained relationships with other maternity service providers, particularly the midwives. To facilitate discussion between maternity care providers, the RANZCOG re-established the Joint Committee for Maternity Services in 2002. This has representatives from the RANZCOG, the Australian College of Midwives, the Royal Australian College of General Practitioners, and the Australian College of Remote and Rural Medicine, as well as consumer representation. The committee has made some progress in reviewing international clinical guidelines for possible use in Australia, but has been hampered by lack of funding, obstetricians suspicious of change, and midwives frustrated by lack of change. Difficulties have arisen in reconciling differences between obstetricians, general practitioners and midwives in how to provide safe evidence-based care that will not diminish current levels of safety.

Recently , the Commonwealth Department of Health and Ageing (DoHA)agreed to fund a scoping study to establish a National Rural Specialist Obstetric Locum Service. This submission was devleoped collaboratively by the Rural Doctor's Association of Australia (RDAA), RANZCOG and the NSW Rural Doctor's Network DoHA has since invited the collaboration to prepare a funding submission to develop a National Consensus Framework on Rural Maternity Services. In developing the submission RDAA, RANZCOG and NSW Rural Doctors Netwrok invited ACMI to join the collaboration. These two projects if successful have the potential to dramatically impact on the provision of rural maternity services – the locum service by providing much needed support to rural 0bstetricians and the National consensus framework by creating a shared understanding of maternity services.

Workforce numbers

Fifty years ago the majority of new RANZCOG Fellows were male and intended to practice both obstetrics and gynaecology, at least initially, with some Fellows developing a special interest in a specific area of the specialty - subspecialty. Over time, it has evolved that some new Fellows choose not to practice obstetrics at all. This means that the main workforce challenge faced by the College is that of sustaining obstetrics, increasing numbers of existing Fellows are ceasing obstetrics for medico-legal and lifestyle reasons. As obstetricians, when faced with indemnity issues and antisocial hours they have the choice of opting out of one area of practice and only practicing gynecology. A parallel can also be drawn with general practitioners who can cease doing obstetrics but continue with general practice and with many midwives who can opt out of midwifery if they so with to pursue a career in nursing only.

According to the AMWAC report, April 2004 gynaecology services appear to be well provided for across Australia (AMWAC report 2004 p66). The areas of concern relate to the provision of obstetric services particularly in rural and remote areas. Refer to separate submission from, Dr Diane Mohen, Chair RANZCOG Provincial Fellows.

The 2003 RANZCOG workforce survey sought to gain an insight into the future practice intention of the fellowship. In summary,

- 25% of Fellows are aged 60 and over, an increase from the year 2000,
- 75% of Fellows in their 60's still practice (median= 44 hours weekly) as do 40% of those in their 70's,
- 16% of Fellows are aged 30-39, a decrease from the year 2000,

- There is an increasing proportion of female Fellows. Amongst the youngest Fellows (those aged in their 30's) more than 50% of Fellows are female. The proportion of female Fellows who remain in the workforce is similar to that of male Fellows, although overall female, Fellows work about 10% fewer hours per week than male Fellows. A greater proportion of female Fellows than male Fellows are in a sub-specialty training programme.
- Median number of hours worked is 51, with the longest hours worked by Fellows in their 50's
- Based on Fellows' intentions, the proportion of Fellows practising obstetrics will decline, as will the proportion practising obstetrics in the private sector. 55 Fellows intend to cease private obstetrics in 2003 and a total of 150 say that they will stop in the next 5 years. The typical Fellow to stop private obstetrics is a male practitioner aged 50-59. The median number of babies delivered in 2002 by such a practitioner was 120, but 10% of such practitioners delivered more than 300 babies. These projections should be considered along with the practice intentions of current trainees. In 2001, 26% of senior trainees reported that they did not intend to practise obstetrics
- Fellows stopping private obstetrics are stopping for lifestyle/indemnification/medico-legal reasons
- Fellows stopping public obstetrics are most likely to be aged in their 60's and are stopping for lifestyle/age/medico-legal reasons

The RANZCOG survey results support the contention by the Productivity Commission in the Issues paper that;

> The efficacy of policy settings affecting cost and availability of professional indemnity insurance is also relevant in this context. A common contention is that the rapid increase in the cost of such insurance in recent years has been a trigger for some highly skilled professionals to cease providing particular services – especially in the area of obstetrics – or even exit the sector p44 PC

The RANZCOG Council conducted a Forum to consider and debate the issues raised in the survey with particular emphasis on models of practice. The traditional model of solo private practice no doubt contributes to professional isolation and burnout amongst the fellowship. It is interesting to note that almost 20% of trainees favored establishing group practices rather than the traditional solo practice compared to 6% of Fellows who had established group practices. This choice is being influenced by lifestyle reasons.

Workforce planning

Peaks and toughs in the supply of medical graduates have created a 'feast or famine' pattern in the supply of medical graduates so that in some years, there are too many doctors and in others, a lack of available graduates to fill training posts. College surveys indicate that a significant percentage of trainees in both Australia and New Zealand are not considering obstetric practice. In recent years College data shows that recruitment to the specialty failed to meet the Australian Medical Workforce Advisory Committee (AMWAC) recommended target of 55 commencing trainees in 2001, 2002 and 2003. It is pleasing to note that in 2005 the number of applicants in the majority of jurisdictions has increased and that RANZCOG would be able to increase the number of trainees above the AMWAC limit.

Historically health care was based on silos with little or no consideration of the patient, this view changed over twenty years ago with the acknowledgement that patient centered care provided better coordination and health outcomes, Unfortunately AMWACs role has not kept pace with the health industry. AMWAC's terms of reference focus on the medical workforce, but as already stated the obstetric workforce includes midwives. Fellows, general practitioners and midwives also require the services of other medical specialists, namely anesthetists and paediatricians to enable them to manage life threatening obstetric emergencies. A number of rural maternity services have

closed not because of a lack of a specialist obstetrician or general practitioner but because of no anaesthetic service. The College has found that AMWAC have had a very limited role in assisting and advising in workforce planning. Workforce has been segmented rather than acknowledging the interdependence of the various specialties, AMWAC needs to be able to take a broader view of what teams are needed to sustain maternity services.

Outcome data for maternity services

In December 2004 the Australian Institute of Health and Welfare (AIHW) published a Report on the evaluation of the Perinatal National Minimum Data Set. The aim of the evaluation was to assess the quality and utility of the Perinatal NMDS to determine whether the data collection suits current requirements and to make recommendations to improve data quality and consistency. The methodology included: a review of compliance, a review of utility, based on consultations with data providers and users; and formulation of a number of recommendations. The College supports this initiative to obtain consistent and complete data on perinatal outcomes and would welcome timely report of this data in the future.

EDUCATION AND TRAINING

The College is aiming to be self sufficient in the education and training of specialist obstetricians and gynaecologists, rather than rely on a pool of overseas trained specialists to maintain the workforce.
Attracting and retaining doctors in the discipline is a key issue. The College is of the view that bonded scholarships for rural positions could be introduced to complement the current College program.

In 2003 the Australian Medical Council accredited the RANZCOG training and CPD programs. January 2004 marked the introduction of the new RANZCOG Curriculum, a first in medical education in Australia. The curriculum presents a framework of characteristics and competencies, designed to guide and support the training of specialist obstetricians and gynaecologists. These characteristics are described as;

- clinical expertise combining medical expertise and effective communication;
- academic abilities comprising self-learning and research abilities and the capacity to teach; and
- professional qualities encapsulating management responsibilities, practice review and development, teamwork, ethical attitudes and conduct, a commitment to what is best for the patient, and health advocacy.

The RANZCOG curriculum is more than a syllabus listing medical topics. It encompasses an educational plan designed to bring about change. Furthermore, it is acknowledged that the professional nature of women's healthcare is undergoing change — through advances in technology, an increased emphasis on medical management rather than surgical options, and the demand for healthcare that involves an informed partnership between specialist and patient.

Co-ordination of education and training

The College strongly supports the principle of effective, meaningful and regular consultation with health jurisdictions, government bodies, medical organisations and hospitals. For example, RANZCOG has worked closely with the AMC to obtain accreditation as a medical college and to implement recommendations arising from that accreditation process. The College also liaises closely with the AMC in the assessment of Overseas Trained Specialists and Area of Need practitioners, and follows their assessment guidelines in these areas.

The RANZCOG recognises that it must work closely with government to achieve and maintain a highly trained, competent and committed specialist workforce and see both AHWOC and AMWAC

as being close allies in meeting this objective. Although the College is concerned AMWAC does not always consider all issues that influence workforce- the need for a team of health professionals to support obstetric services, namely anaesthetist, paediatricians, general practitioners and midwives along with the infrastructure and resources to maintain the service.

An example of the consultative process in action has been the planning for the re-accreditation of all RANZCOG accredited hospitals, which will commence in July 2006. The College is currently working to strengthen the guidelines so that the expectations of training units are clear, particularly in relation to such issues as core O&G clinical experiences for trainees, their supervision, and their access to structured on-site educational programs. The RANZCOG will be submitting the draft criteria to a range of bodies for their comment before this key document is finalised by late 2005. These bodies include the ACCC, AHWOC and health jurisdictions in each state. This will ensure that the re-accreditation process will be based on valid criteria, consistently applied across all states and training sites.

Recruitment

Undergraduate medical education no longer requires all medical students to attend a delivery. This lack of exposure of medical students to obstetrics in medical schools has removed a powerful motivator in encouraging medical student to consider a career in obstetrics. This lack of exposure to obstetrics along with the adverse publicity that accompanies the reporting of legal action associated with adverse obstetric outcomes (e.g. cerebral palsy cases) and the crisis in medical indemnity in 2001 on wards have acted as negative influence on the recruitment and retention of specialist in the field of obstetrics.

Training program

Peaks and toughs in the supply of medical graduates have created a 'feast or famine' pattern in the supply of medical graduates so that in some years, there are too many doctors and in others, a lack of available graduates to fill training posts. In recent years College data shows that recruitment to the specialty failed to meet the Australian Medical Workforce Advisory Committee (AMWAC) recommended target of 55 commencing trainees in 2001, 2002 and 2003. It is pleasing to note that in 2005 the number of applicants in the majority of jurisdictions has increased and that if funding were available, RANZCOG would be able to increase the number of trainees above the AMWAC limit.

The content of the curriculum and length of the training program were considered during the development and consultation phase of the curriculum development. The RANZCOG considered a range of alternatives including separate streams for obstetrics and gynaecology and reduced training time but opted for a training program designed to give practical application to all aspects of the educational framework. The structure of the training program comprises two main parts:

1. the Integrated Training Program (ITP) covering core learning and experiences in Years 1 to 4; and
2. the Elective Program enabling prospectively-approved selected learning and experiences in Years 5 and 6.

The ITP is designed to give trainees a foundation for growth plus certainty and security of experiences in the first four years. In accrediting a training site the College must be satisfied that there is:

- a commitment to quality of patient care and to education at the institution;
- an adequate number of patients available for teaching purposes;
- a suitable training supervisor and an organised program of clinical and other educational experiences designed to meet the educational objectives of the ITP;
- there are sufficient resources available at the hospital to provide all trainees with the opportunity of receiving comprehensive training in the core areas of the specialty;

- the academic aspects of the program are consistent with the concept of post-graduate education; and
- a satisfactory system for the on-going assessment of trainees.

The elective program enables further skilling and knowledge in needed or interest areas, or the opportunity for overseas experience. These requirements are detailed in the Training Program Handbook. The ITP culminates in Membership of the RANZCOG and the elective program culminates in Fellowship of the RANZCOG.

Selection process

It is noted that the College is not the legal employer of trainees and does not have the sole authority to appoint. However, the College, through its regional T&A committees and the selection panels which function under their auspices, does recommend to hospitals which trainees should be appointed.

The College does not have a quota system; indeed, in some years there may be unfilled training positions in some States because of the lack of sufficient applicants who have the qualifications and ability to train as specialists in obstetrics and gynaecology. A number of factors has contributed to the decline in applications for obstetrics and gynaecology, particularly the feminisation of the workforce; changed expectations of working hours; and the high cost of indemnity.

The College recognises that it is not training enough obstetricians, but at the same time it must be concerned with training standards and not just increasing trainee numbers. Owing to a lack of government funding of training facilities training opportunities for obtaining operative and consulting skills are limited at all levels in obstetrics and gynaecology; to increase our annual intake beyond the current limit would seriously impact on the quality of training and supervision.

To help counteract this repeated trainee shortfall the College has standardised the timing of the annual selection process in each State as much as practicable. This enables States to share information about candidates, eg an applicant who is not successful in one State may be recommended to another. Unfilled posts are also widely advertised through the College's monthly e-mail bulletin and through close liaison between the Training Services Department at College House and the chairs of each regional T&A committee. In some States it is also possible to accommodate additional Year 1 trainees in the system as PhDs return for further training later each year (mid-year intake). These are, of course, short-term solutions to on-going problems. Prospective trainees are advised at the time they apply of the number of training positions available each year in each Australian State and in New Zealand, and applicants are asked to indicate their preferred ITP or hospital in the relevant region.

Recruitment and retention in rural areas

As outlined in the paper from the RANZCOG Provincial Fellows by Dr D Mohen on rural workforce issues; attracting new specialists, general practitioners and midwives to rural areas is critical for the maintenance rural maternity services. This provides the context and experience that often encourages trainees to consider these positions, although remuneration compared to city colleagues and lifestyle issues are key in the decision making process.

One way of achieving this is through rural training posts. The challenges of maintaining rural training posts include adequate funding by state governments and appropriate supervision and coordination from tertiary centres who organise these rotations.

Since the inception of the Integrated Training Programs (ITP), six-month rural rotations are a fundamental part of the training program The feedback from trainees and supervisors interviewed as part of all formal ITP reviews conducted in each state and in New Zealand confirms the importance and effectiveness of rural rotations. It is often only at these sites that trainees gain extensive gynaecological surgical experience, which is more difficult to obtain at the home or base hospital because of the numbers of trainees and the often limited surgical lists. As indicated in a number of the above reports, many ITP Program Co-ordinators frankly acknowledge that without the rural rotations their trainees would not get the balanced range of core O&G experience stipulated by the College. Feedback received from trainees via the Six-monthly Trainee Feedback Questionnaire, which trainees are asked to complete at the end of each six-month rotation, confirm this – trainees consistently cite their rural experience as the most effective and rewarding of their rotations. Their logbooks also indicate a substantial range of gynaecological surgical and obstetric procedures at their rural rotation.

The rural rotations whilst providing valuable clinical experience frequently impose significant lifestyle difficulties for the trainees – this is particularly so with the increasing feminisation of the workforce with female trainees separated from school age children during their rural rotation.

Assessment of Overseas Trained Specialists (OTS)

The current reliance on overseas-trained specialists is an unsustainable model for solving workforce problems. The College is concerned that recruitment of doctors from developing countries is depriving their home nation of much needed skills. Attracting such doctors raises moral and ethical questions that could be resolved with better workforce planning, training and retention policies with our own population.

As a short term solution RANZCOG developed a process to assess OTS and Area of need doctors. This scheme relies on the contribution and time of RANZCOG Fellows in assessing potential doctors on a pro bono basis.

The criterion for assessment of overseas trained specialists (OTS) is based on the criteria for FRANZCOG. The procedures RANZCOG uses to assess OTSs are laid out in the Training Program Handbook under regulation 18. Copies of the regulations are provided to applicants at their request. The College's procedures are demonstrably fair and meet the requirements of equity and natural justice. However, the difficulty of the task of assessing OTSs is well recognised by the College, and it has made strenuous efforts in the past few years to improve its assessment process. Not withstanding these efforts, there are still difficulties in the process. To highlight these difficulties it is useful to compare OTS assessment with the assessment of College-trained specialists. For trainees of the College assessment data is collected over time, giving confidence that estimations of competence are acceptably reliable and valid. The summary of this process yields an acceptable assessment of competence because it combines a sample of high reliability assessments (for example, knowledge-rich performance as measured in written and oral examinations) and high validity assessments (for example, direct observation of actual clinical performance). In addition, these performances are judged over a period of time, in a variety of contexts and by a number of assessors. In addition, trainees are progressing through a course where the educational objectives, content and training activities are known to the assessors.

On the other hand, assessing the competence of an overseas-trained specialist is a much more complex task. In such assessments of competence, the emphasis must be on the candidate’s ability to move directly into professional activity within an Australian setting. Traditional assessments are often ill-suited to this task. For example, examinations enable assessment of knowledge of candidates who have recently completed a program of intense study, but are a poor tool for measuring the intuition and insights that characterise the judgment and decision-making abilities of a competent experienced specialist. The College approach is to conduct interviews and

oral responses to several case scenarios. These provide useful strands of information, but are necessarily limited to the topics covered. Whilst the College continues to grapple with such questions, it has made considerable progress with the processes it follows.

In the past two years, the OTS Committee has recommended to the RANZCOG Council that a number of applicants be granted RANZCOG Fellowship;

2004 -13 out of 42 assessed as equivalent granted Fellowship
2005 -Jan - June 10 out of 39 equivalent and granted Fellowship

During 2004, 15 of 18 applicants were assessed as suitable for area of need positions.

The College recognises the high quality of care provided by many OTSs, jurisdictions bypassing the AMC system undermine the integrity of the profession and potentially compromises the quality and safety of care, especially for rural women who are the main recipients of OTS care. The College supports a consistent approach Australia wide to the assessment of OTS.

The RANZCOG is currently developing a paper on assessment options for the Commonwealth Department of Health and Ageing and is developing an enhanced process for the assessment of overseas trained specialists and doctors being considered for area of need positions.

RANZCOG STRATEGIES

The College has undertaken a number strategies in response to workforce issues, these include:

- addressing indemnity issues. The College has worked with the DHA to address the medical indemnity issues;
- alerting governments to the shortage. The College regularly conducts workforce surveys; the next survey is planned for February 2006;
- promoting alternative models of healthcare. The College has encouraged the fellowship to consider varying models of care that provide lifestyle-friendly options of obstetric care;
- 'Talking up' obstetrics. A Council Forum was held to address this matter. Despite this, 'talking down' obstetrics still occurs in some cases;
- in collaboration with RDAA, funding has been secured from DoHA to conduct a feasibility study to establish a National Rural Obstetric Specialist Locum Service;
- the Commonwealth DoHA has invited RANZCOG and RDAA to prepare a submission to develop a National Consensus Framework on Rural Maternity Services. This submission has been developed in collaboration with the NSW Rural Doctors Network and ACMI;
- the College is a leader in continuing professional development and encourages multidisciplinary professional development.
  This has been achieved by;
  - multidisciplinary activities developed under the Commonwealth Support Scheme for Rural Specialists involving obstetricians, anesthetists, pediatricians, GPs and midwives,
  - the development of a CPD framework for medical specialists,
  - testing of the CPD framework in the Learning Education and Professionalism LEAP project,
  - the RANZCOG Fetal Surveillance Education program is conducted for the maternity services team in an organisation. The project provides education, encourages multidisciplinary quality review of fetal surveillance and in the future will include credentialing.

ON-GOING ISSUES

Of concern to all medical colleges is the constant tension that exits between the need for protected training time for trainees and the public hospital and community demand for service delivery. The ever-increasing demand on the public health sector for more services and reduced waiting times

mean that it is unlikely that this conflict will be solved in the short term. Currently, training positions are not available in the private sector where there is an untapped pool of clinical material.

The question has been asked – 'should obstetricians do normal deliveries? A team, consisting of obstetrician, general practitioner and midwife working cooperatively has the opportunity to utilise the workforce in the most efficient manner with midwives and/or general practitioners providing antenatal care and performing normal deliveries with a robust triage system that ensures that at-risk women are referred in a timely manner to the specialist obstetrician. Substitution of health professionals has been suggested as a way in which some workforce shortages may be addressed but the College is of the view that this may only postpone the problem. In New Zealand anecdotal reports indicate that the greater involvement of midwives as lead maternity carers is resulting in a number of midwives reducing or ceasing obstetric practice due to the unpalatable busy obstetric lifestyle. The results of the New Zealand experience need to be carefully evaluated to ensure that an increased workload is not shifted to other maternity service providers already experiencing workforce shortages. Careful consideration should be given to the resources required to support obstetric services, particularly in rural areas rather than move the problem as a 'quick fix'.

Professor Stephen Duckett, in a recent article has challenged the existing models of medical education and the roles of health professionals in the workforce. Substitution between health professionals with an emphasis on interprofessional work and common foundation learning are emerging issues for the College to grapple with.

RECOMMENDATIONS

1. That strategies to support the recruitment and retention of all facets of the obstetric workforce be considered a high priority.

2. That the Commonwealth funds the establishment of a Specialist Obstetric Locum Service to support the rural obstetric workforce.

3. That national registration of doctors be introduced as a priority to facilitate more flexible movement of the medical workforce across state boundaries

4. That AMWAC's terms of reference be expanded to consider service areas rather than the medical work force in isolation.

5. That comprehensive national perinatal data collection data is undertaken in a timely manner to support workforce planning.

6. The College supports a consistent approach, Australia wide to the assessment of overseas trained specialists (OTS) and area of need practitioners.

This RANZCOG submission is complemented by a submission from the Chair RANZCOG Provincial Fellows, Dr D Mohen, focusing on rural obstetric services.

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