Submission

Response to Questions on Notice and Supplementary Questions from the NSW Legislative Assembly Select Committee on Remote, Rural, and Regional Health

Thank you again for inviting the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG, the College) to attend the public hearing of the Select Committee held on 3 June 2024 where RANZCOG was represented by Dr Lilach Leibenson. Dr Leibenson has prepared a response to both the questions received on notice at the hearing and supplementary questions received after the hearing, with support from RANZCOG staff.

Questions-on-Notice

1. *"Dr Leibenson, I am interested—the college of obstetricians and gynaecologists trains specialist obstetricians in New South Wales and Australia. Is there a training program designed to graduate practitioners for rural practice within the college? How many practitioners from that program in the last decade, say, have taken up rural specialist practice?"*

The Fellowship of RANZCOG (FRANZCOG) training program takes place over two phases: four years (184 weeks) of Basic Training and two years (92 weeks) of Advanced Training. The College accredits all training sites offering FRANZCOG throughout Australia and New Zealand. During the Basic Training portion, trainees are placed in an Integrated Training Program (ITP) which is made up of a combination of different physical sites in a consortium arrangement. Trainees receive a significant proportion of their experience at a single base site and rotate to other sites within the ITP. All RANZCOG trainees must undertake rural rotation. Additional points are given to training program candidates for rurality during trainee selection process. The College has *Rural* ITPs (RITPs) in Dubbo and Orange.

It is anticipated that RITP trainees will commence practice as specialist obstetricians and gynaecologists in rural centres. Trainees undertaking a RITP will typically spend:

- Year 1, Year 2 and Year 4 in rural sites, preferably within a single rural centre or cluster;
- Year 3 in a major tertiary metropolitan teaching hospital (in the case of Dubbo and Orange, at Westmead Hospital); and
- Advanced Training in a combination of rural and/or metropolitan sites depending on the trainee's specific learning needs and areas of expertise they wish to further develop.

Since its inception in 2016, 10 trainees commenced FRANZCOG training on the RITP pathway: six of the trainees at Dubbo Base Hospital, and four of the trainees at Orange Base Hospital.

Of the 10 trainees, three have received Fellowship. These three Fellows are not currently based in rural specialist practice. While RITPs are promising in terms of creating attachment of prospective Fellows to the rural areas in which they train, and to the prospect of career-long rural practice generally, trainees are not obligated to practice rurally at the conclusion of RITP experience. Career pathways are often influenced by the availability of choices that are subject to system conditions that the Committee has heard about (CPD/upskilling and life-long career development, remuneration/contracts, support/system resources, etc.)

2. *"My question is for both Dr Leibenson and ASMOF in relation to the obstetrics and gynaecology map. I wanted to know if you could pinpoint which areas of New South Wales are facing the most critical shortages of obstetrics at the moment."*

Dr Leibenson reached out to senior doctors and/or Maternity Unit Managers (MUMs) in five inland units across rural NSW (noting that the situation is better in towns along the coast) and asked for information in relation to staffing and other acute shortages. It seems that the situation is dire. The scenarios provided are taken from commentary by people associated with each hospital and reflect first person views of the facts on the ground, not aggregated data.

Dubbo Hospital

There are extreme shortages of staff for a hospital carrying out **1400 deliveries per year**. Only two consultants have been regularly working at Dubbo since 2018 (except for a short time with three consultants). Dubbo was staffed for four consultants many years ago (and a need for more consultants was identified), but we have not been able to recruit to this level for several years. Dubbo is approved for six FTE Registrars, but only four positions are filled. Consequently, Dubbo relies heavily on locums, at both consultant and registrar levels, which yields major issues in coverage, access and continuity of care.

Outreach services to Burke and Walgett could not be supplied for years owing to the above shortages. Hence, diagnosis and treatment of patients with cancer from those areas is being unduly delayed. Competent and experienced consultants who were considering joining the team changed their mind and took positions in Queensland and elsewhere, due to the remuneration gap with substantively lower fees in NSW and lack of transparency of the administration in relation to the contractual agreements.

Midwifery is also regularly short of workers, with approximately 10 FTEs (20% of midwifery staff level) not filled on a permanent basis. Fly-in-fly-out arrangements are possible.

Orange Hospital

Orange Hospital also suffers extreme staffing shortages despite seeing about **1200-1300 deliveries per year**. Consequently, smaller units in the surrounding towns have closed or are doing much less. Acuity and complexity of the patients are very high in this hospital catchment.

Five out of seven required consultant positions are filled. A consultant who was willing to join as a Staff Specialist, was denied a rest day after weekend on-call (noting that on-call ratio is 1:6 in Orange, compared with 1:30 in metropolitan areas), and accepted a position in the city instead. Three of six Registrar positions are filled. As in other units, junior doctors do not wish to train and work in GP Obstetrics, and those training positions are repeatedly not filled (like Tamworth Hospital).

Theatres were built about 10 years ago. Five functioning theatres that are available are not enough to meet the demand. Caesarean sections from smaller towns are now done in Orange. Obstetrics and gynaecology theatre time is allocated almost exclusively to obstetrics due to the demand for Caesareans.

Staffing issues in Orange lead to major issues with cancer patients. There is no tertiary hospital willing to take patients for gynaecology oncology services (used to be referred to Westmead, but the gynaecology oncology unit there is now short of staff as well). Doctors need to call and beg for acceptance of gynaecological cancer patients to tertiary referral centres.

Smaller towns which refer to Orange Hospital:

Bathurst Hospital - used to have 650 deliveries per year, now 400-500 (the complex cases transferred to Orange). Two part time staff specialists are leaving/retiring. Relying mostly on locums.

Parkes - stopped obstetric services.

Cowra - doing much less, and much less acuity.

Forbes – facing major recent issues with obstetric services.

Wagga Wagga Hospital

A new hospital has been opened. Number of deliveries in Wagga has gone from about **750-800 in 2015, to 1400+ in 2024.** Wagga Hospital has four consultants, though again, more are needed. Ideally the target number would be seven if compared to hospitals with a similar number of deliveries. Wagga has also only four of the recommended six Registrar positions filled. The same sub-regional trend of smaller units closed or significantly reduced activity is reported (Cootamundra, Temora and Tumut all closed). Griffith hospital provides obstetric services, but limited acuity and case selection.

Inverell Hospital

Inverell is possibly the busiest Level 3 rural unit in NSW at currently about **200 deliveries** per year. Prior to Covid-19, Inverell had about 240 deliveries per year on average. Anaesthetic services by regular locum anaesthetists (2) were withdrawn by Government/HNEAHS. Inverell is now relying on ad hoc GP Anaesthetist locums, which has created gaps in services. There is insufficient cover by theatre nursing staff (not enough nurses to fill in on-call roster) which further aggravates gaps in theatre coverage. This forces obstetric transfers to higher level facilities, e.g. ARRH (Armidale) and TRRH (Tamworth) units. This, in turn, increases unnecessary patient load on these facilities, as well as patient anxiety and apprehension of potential transfer. In addition, these shortages cascade into huge stresses on midwifery and medical staff in having to organise such transfers in a timely and safe manner – which is not always possible.

Midwifery services are well covered, including an on-call midwife. GP Obstetricians (of which there are only two; both very experienced, but not early in their careers) provide coverage almost 100% of the time, but gaps occur when both of them are away for holidays or professional development. Pathology services are well covered in Inverell hospital, with on-call services available.

Gunnedah Hospital

Gunnedah recently provided about **200 deliveries** per year. Subsequently, due to the absence of sufficient after-hours theatre cover and pathology services the number was reduced to merely **25-35** elective Caesarean Sections per year. Effectively, maternity services at Gunnedah are so in name only.

[redacted]

Clinicians are requested to cover all the available shifts citing contractual agreements and are expected to always make themselves available for phone consults even when on personal or sick leave. Clinicians have to hold fundraisers for basic clinical equipment.

The health care providers who shared the information above, have all been dedicated to Rural NSW Health for a long time. They are all happy to answer any further questions that might rise.

Supplementary Questions

1. *Dr Leibenson advised that Pathology services were being removed within the next fortnight – and that other basic services required by doctors to do their jobs are being removed. Could you please expand on this?*

In relation to this question, the premise is not quite correct. The scenario of pathology services being removed in the coming fortnight (from the hearing date of 3 June) was introduced by another member of the hearing panel, not Dr Leibenson.

Nevertheless, the availability of pathology services is a pressing concern. Dr Leibenson provides two local examples:

At **Gunnedah Hospital**, on-site pathology testing services were fully terminated two years ago. Currently there is only the option for collection on-site for four hours per day, from 8:00am to noon. The tests are then forwarded to Tamworth pathology services. This practice has a significant impact on the safe provision of Obstetric services, as well as other services (such as the Troponin test used in care for patients with acute myocardial infarct, and others).

At **Narrabri Hospital** current discussions are taking place with plans to limit pathology services in a similar fashion to Gunnedah in the foreseeable future.

2. *What work is being done by RANZCOG to address the shortage of specialist obstetricians in RRR NSW?*

The College has a RANZCOG Australian Rural, Regional and Remote Women's Health Strategy (Strategy). A key aim of the Strategy is to help address the need for workforce retention, succession planning and continuity of service provision for Specialists Obstetricians and Gynaecologists and other College Members across rural, regional and remote Australia.

A key priority area of the Strategy is developing the FRANZCOG Rural O&G Advanced Specialist pathway to Fellowship that will foster specialist practice in MM3+. The 2025 program will place trainees in rural practice and encourage them to return to rural, regional and remote communities when they complete their FRANZCOG training.

The College recommended a significant and nationally coordinated investment to boost the health workforce in MM2 to MM7 in a June 2023 report to the Commonwealth Government [redacted] The Mapping Project mapped the distribution of services, workforce and levels of service across rural, regional and remote Australia (including NSW), and found that:

- very few health services in small rural towns (MM5) offer any gynaecological services;
- women living in MM2 to MM5 areas have limited access to abortion services after 12 weeks compared to other gynaecological procedures; and
- the treatment for high grade endometriosis was mostly only accessible in areas of greater population density.

2.a. How many college graduates in the past decade have commenced practice in remote, rural and regional NSW in NSW Health facilities and what are the locations?

To help respond to this question, we have drawn from the most recent RANZCOG Activities Report, which is available here: Activities Report 2022 (ranzcog.edu.au)

Drawing on data available from page 34 to 37 of that report shows pertinent practice trends over time and by rurality. Table 32 on page 34 shows the number of active Fellows by location starting in 2018. Total Fellowship in NSW as a whole grew 6 per cent during this period.

Table 35 on page 36 shows the regional breakdown of Australian Fellows by Region and Remoteness Area using the Modified Monash Model. 88 per cent of Fellows in 2022 were practicing in MM1, with the remaining 12 per cent practicing in MM2-MM5, with none in MM6 or MM7 in NSW. Additionally, Table 36 on page 37 shows equivalent date for specialist international medical graduate Fellows. Of this cohort, 67 of 93 Fellows (72 per cent) were practicing in MM1, with an additional two in MM2 and 24 in MM3. Five Fellows did not report their practice location.

Please refer to the Activities Report provided in the linked file to view relevant data sets.

Summary

RANZCOG acknowledges with thanks, the contribution of Dr Lilach Leibenson for her participation in the hearing of 3 June and for the responses provided in this reply to the questions on notice and supplementary questions.

Yours sincerely,

[redacted]

Dr Gillian Gibson
President