

# TRANSCRIPT

## FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

### Inquiry into perinatal services

Melbourne — 4 September 2017

#### Members

Mr Paul Edbrooke — Chair

Ms Cindy McLeish — Deputy Chair

Ms Roma Britnell

Dr Rachel Carling-Jenkins

Ms Chris Couzens

Ms Maree Edwards

Mr Bernie Finn

#### Witness

Professor Michael Permezel, Immediate Past-President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

**The CHAIR** — I welcome to these public hearings Professor Michael Permezel — is that how I pronounce it?

**Prof. PERMEZEL** — Very well done, yes.

**The CHAIR** — Thank you — the immediate past-president from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists. Thank you for your attendance here today. All evidence at this hearing taken by the committee is protected by parliamentary privilege as provided by the Constitution Act 1975 and is subject to the provisions of the Parliamentary Committees Act 2003 and other relevant legislation. Any comments you make outside this hearing will not be afforded such privilege. It is also a contempt of Parliament to provide false evidence. These proceedings will be recorded, and you will be sent a copy of the transcript to proof. I now invite you to make a 10 to 15-minute presentation followed by some questions.

**Prof. PERMEZEL** — Thank you very much for having me along, and thank you for inviting the college to make a submission to this inquiry, which from our point of view is very welcome. Perinatal services are forever expanding. They are gaining amazing complexity with advances in technology, and it is just so important that everybody has an opportunity to engage in this expansion of technology and ensure that it is adequately funded. Presumably you have all had an opportunity to read the submission of the college.

**The CHAIR** — We sure have.

**Prof. PERMEZEL** — I thought that I would open by just highlighting a few of the key points. We open up with a desire for choice for all women in models of care, essentially advocating for a collaborative approach. There have often been some difficulties between craft groups in maternity care, but I am pleased to say that at the present time midwives and obstetricians, I believe, are working better together than they ever have.

About 18 months ago midwives and obstetricians gained consensus for our guidelines, so now we jointly agree on where the demarcation lies between midwifery and obstetric care. It took many, many years to get that consensus, but it is just incredibly good that we have done that. We engaged in their development. The national guidelines are currently under development for antenatal care, and we are engaging with the midwives in that forum. I just think we have come a long way, and I think when it comes to any further developments it is really important that that good relationship that currently exists between obstetricians and midwives continues.

One thing I think we need to be a little cautious about is dichotomising women during pregnancy into high and low risk. It is always tempting to say, 'We'll put the low-risk women over here for pregnancy and we'll give them a certain level of care, and those with complications sit over here and have obstetric care'. The problem with that is that inevitably a significant number of women, perhaps as high as 40 per cent, will develop needs to engage with obstetricians during pregnancy. It is so much better if the common models of care engage with both midwives and obstetricians throughout pregnancy.

The second issue I think is really important, particularly for our rural colleagues, is the situation with neonatal intensive care beds. On a day-to-day basis I work at one of the tertiary hospitals, but I have been very pleased to participate in the regional perinatal mortality meetings for the last couple of years. I get Shepparton, Wangaratta and Wodonga, but others have got Ballarat, Bendigo, Warrnambool and so forth. That has been going really well, but just the difficulties that they have in actually accessing the beds that they need in tertiary centres come about for two main reasons. One is the general lack of NICU beds and sometimes it is the lack of a maternity bed where the NICU bed is.

Obviously most often a mother is transferred before the birth of her child, so you need both the maternity bed and the neonatal intensive care bed at the same place. What can happen is that the poor rural specialist and the team of midwives, residents and registrars in the rural centre have difficulty engaging and finding an appropriate bed for their patient. It creates enormous stress in a rural centre if you feel you are sitting on a level of complexity that you do not have the resources to deal with should problems ensue.

It is our view that the health department has done really well managing up to a point with the NICU beds available, but we all think — and I think everybody who deals in this area — that the time has come for a significant expansion. You would be aware that the Western Hospital, Sunshine, is now birthing in excess of 5000 — getting on to 5500 — women. It is in an area of Melbourne that does not have any neonatal intensive care or high-level perinatal facilities. They do have an associate professor in maternal foetal medicine, which is

fantastic, and that is working well, but an additional neonatal intensive care unit in that area would be tremendous, not only for the women to the west of Melbourne but also for the areas that that serves, because clearly the Women's is located to well serve the north, Mercy is well located to serve the north-east and Monash the east, but the western side of Melbourne really needs a hub that it can refer to and relate to.

That is happening with the regional perinatal mortality meetings, which again I say have worked extremely well because the Women's is relating to Ballarat and Bendigo and we at Mercy are relating to the north-east — Wangaratta, Shepparton, Wodonga — and Monash are doing Gippsland very nicely, but Western, which has an extremely high-level obstetric staff but no neonatal intensive care unit, are relating very much to the west, so they are visiting hospitals to the west of Melbourne. I think it is just such an obvious thing for the next neonatal intensive care unit to progress reasonably soon into Western Health's hospital, Sunshine. That will help us as a college because of the training requirements. So for a trainee in obstetrics and gynaecology it is a six-year program, but much of it is in the more complex obstetrics, and in order to have the complex obstetrics patients to learn and train with you need to have a neonatal intensive care unit to support those patients, and Western is so obviously designed to be a hub for O&G training — again a neonatal intensive care unit in that area would be very helpful.

A related issue that I just want to mention that is needed is an inquiry into just the mechanisms of those transfers around the state. 'PIPER' is the current term for the group that organises it, so when I am in Wangaratta and they have a complex patient they ring PIPER to find out where the patient should go, where the bed is. PIPER then tries to ring around all the hospitals to find out the most appropriate place. There may be nowhere and the woman remains in Wangaratta maybe for days until something is sorted out. It has been running for quite a few years now under different names, but we feel that it is time we should look into how that is working and how it could work better. It is a fairly simple process. There is not currently a mechanism; there is a bit of frustration out there, partly the NICU, but it is not just the lack of NICU beds, and I think an inquiry into how PIPER is currently working and how it could function better would be very helpful.

Issue four — I only have six — is the genetic services. I opened up with the explosion in technology, and it is incredible. I began obstetrics in 1983, so that is quite a few years ago. Just the explosion in genetic information is truly amazing — and the availability. It is not just the knowledge; there is now testing that is very much available. The issue at the moment is equity of access, because the more accurate procedures, the less invasive procedures are now much more readily accessed in the private sector than in the public sector. I am talking particularly about non-invasive perinatal testing — that is, having a blood test instead of ultrasounds and potentially invasive amniocentesis to determine whether or not the foetus is affected with conditions like Down syndrome.

We have never had more chromosomal abnormalities than currently, because women are delaying child-bearing longer. Many of them are having babies at an older age, which means that these abnormalities are getting more and more common, and I think it is important that women from all backgrounds have access to these newer technologies. Clearly resources are not unlimited. I dare say again that some sort of inquiry into the optimal use of the resources available for genetics is needed so that particularly our maternal foetal medicine specialists, the college, the genetics people need to all get together and work out how best to use the resources that are available for antenatal diagnosis and genetics, but particularly centring around how within the public sector these can best be accessed by the people who most need them within the resources available.

That extends a bit to the country as well, because again regional centres mostly do not have a regular geneticist visit. They do not have a regular maternal foetal medicine subspecialist — maternal foetal medicine subspecialists of course being a group of obstetricians who specialise in highly complex pregnancies and particularly the diagnosis of foetal abnormalities. Rural centres have trouble accessing that, and there needs to be some sort of funding model. My own view is a hub-and-spoke model — that is, with the Women's providing those services to the north, Mercy to the north-east, Monash to Gippsland and Western ultimately to the west — and that the maternal foetal medicine genetic services are provided maybe through fortnightly visits to key centres but also telemedicine so that women in rural centres can access these really important services.

The second-last issue is the rural workforce. The college of O&G is predominantly a training organisation. Our primary role is to train the future obstetricians and gynaecologists. There are clearly enough obstetricians and gynaecologists in Australia and New Zealand — we are obviously a binational college — but the distribution is all wrong. We have got a number of measures in place to try and improve the rural distribution of the

workforce, particularly in obstetrics. I do not understand medicine and surgery. I have been in O&G for 35 years or whatever, but I can imagine in some of the more elective specialties it is okay to have to travel for some major surgery into Melbourne or Sydney, but clearly for obstetrics there is not the opportunity to travel. It is really important that measures are put in place to try and maintain an appropriate rural workforce.

Our college has a number of strategies; I will not bore you with them now. They start off before training, during training, after training, continuing to support the rural specialists that we think helps engage a rural workforce and maintain a rural workforce, but I think there are other measures that need to take place. I think it is partly through the universities. We know that research says the best predictor of future rural specialists in any discipline is coming from a rural background. A doctor that is raised in a rural centre is far more likely, all the research says, to become a future rural practitioner, a future rural specialist. Now the universities to their credit, and I understand it is on a voluntary basis, do try and maintain 25 per cent from a rural background, but it is clearly not enough. I and the college would like to see that proportion of doctors from a rural background be increased.

I heard you asking about Indigenous backgrounds as well. Equally we have other strategies to try and encourage an Indigenous workforce, which is key in training. We can have many strategies to improve Indigenous women's health, but one of the most important is getting Indigenous obstetricians and gynaecologists through our training program and having them engage with their community in an effective way. So I think there are strategies at the university, but also I think the other colleges can probably do more. I do not want to sit here and criticise other colleges, but having a rural obstetrician is not the answer — you need a rural anaesthetist, you need a rural paediatrician, you need rural midwives. I think that all of the colleges need to develop strategies to develop and then maintain a rural workforce.

The colleges are actually overseen by a body called the Australian Medical Council that provides standards against which the colleges are judged. At the moment there is not a clear standard that says, 'As a college' — a medical college, midwifery college, allied health, whatever — 'what are you doing in your training program to maximise an appropriate distribution of specialists to ensure that you are best serving the needs of your community?'. I think it is such an obvious standard for the Australian Medical Council. I do not understand the nursing council as well, but one would imagine that in midwifery allied health there could be similar standards put in place against which the training institutions will be judged to ensure that they are taking due care to make sure that the rural workforce is maintained.

Finally, just the obvious issue of access to family planning — you are going to hear from people much more expert in family planning than I, but perinatal services need family planning support. It is not just about termination; it is adequate provision of all family planning across the spectrum, and there are areas of Melbourne, for various reasons as cited in the report, where access to family planning is not as it might be compared to other areas. I think that really needs to be looked at from a government perspective to ensure that all women are provided appropriate access to the family planning that they want.

**The CHAIR** — Thanks, Professor. I will start off with the questions. In your submission you recommend the principle of informed choice for women, and that guides choices to maternity care. Just at the moment, to what extent does this happen in practice, particularly in our public hospitals?

**Prof. PERMEZEL** — Look, I think it is a whole lot better than it was. I think there was a history of decisions being made on behalf of women in the past, and the model of care and choices were assumed rather than genuinely made. We as a college are going to great lengths to provide better documentation for women so that they can be appropriately informed about the choices around childbirth, and there are so many choices, not just model of care but I mentioned genetics information, choices around antenatal diagnosis, place of birth, time of birth — there are many, many decisions that can be made. I think using technology — we have got an app now for the phone that can help women with access. We have not completed it yet. They cannot access too many things yet, but I think it is that sort of facility to help women gain as much information as possible and to make truly informed choices.

**Ms EDWARDS** — Thanks very much, Professor. It was very fascinating to hear your presentation, particularly because in our last inquiry, which was into autism services, we heard a lot about the shortage of specialists in rural and regional Victoria, particularly in relation to paediatrics and obstetrics. You have just reinforced, I think, what the committee already knows.

**Prof. PERMEZEL** — Well, obviously, from a binational college of Australia and New Zealand, Victoria is almost the luckiest. The situation in many other states is far worse.

**Ms EDWARDS** — Yes. I was thinking as you were talking about the college and the training that you do for your specialists — within that training is there any particular focus on women from CALD backgrounds in terms of cultural sensitivities and language? Is there some training involved to support women from different cultures?

**Prof. PERMEZEL** — Yes. Thank you for the question. Yes is the short answer. Our curriculum has very much evolved. If I go back to when I trained in 1983, it was very much, ‘How do you perform an instrumental birth?’, or whatever. Now the vast majority of the curriculum is in the non-technical aspects, and Indigenous women’s health — we have modules. The Maori women’s health area is extremely well-developed, as you would expect. Our Indigenous women’s health area — it is in the curriculum. We plan to develop specific online learning modules with the assistance of the Indigenous women’s health committee. We have an Indigenous women’s health committee chaired by our only Indigenous women’s health obstetrician. We have a single obstetrician in New South Wales from an Indigenous background, but we have five in training, so we are very hopeful that this area will expand.

Part of the curriculum is potentially examinable, but I think there is more that we can do in terms of developing educational resources. In many ways we are going to need to collaborate with other bodies to assist in the development of resources. As I said, Maori women’s health is extremely well-developed in this area and has a number of courses and online modules. There is less available in Aboriginal and Torres Strait Islander women’s health in Australia.

**Ms EDWARDS** — I just have a very quick question, which may or may not be quick, depending on your answer. In Bendigo we have both the Monash and the La Trobe schools of rural health, and that is about incentivising young professionals who are training to stay in our regions. You mentioned the incentives that your college has to retain people. You said that was too much detail to go into, but we actually are very interested in what those incentives are.

**Prof. PERMEZEL** — Good. Rural clinical schools play a role, but I do not think it is the absolutely most important role, especially as far as specialist training is concerned. I think as far as the college is concerned it is selecting the right people in the first place so that you start off with someone most likely, so that is rural background. So in our selection, which will come out in about three days time — we will find out which trainees we are getting and where they are going — we give large numbers of points. We give a huge number for those from an Indigenous background. I think they get 5 points — that does not mean anything in the context — but you get more for being from a rural background than you do for a PhD. So it is prioritised greatly by our selection process. That is getting them in to start with.

We have a compulsory rural rotation. Everybody must go to the country during the first four years of training. In truth I do not think the design of that is actually to increase rural specialisation, rather that everybody has an understanding of what it is like to be on the other end of the phone when they get the phone call from Bendigo. They have been there for six months during their training and they know what sort of resources are available and they have greater sympathy and understanding for the circumstances the rural specialist is in.

We have specific rural training programs during the first four years, where the trainee can spend three out of the four years. They still have to do one at a big tertiary hospital in the city, but they can spend all three out of the four years at a rural centre. There is not one in Victoria at the moment. They are currently in Orange, Bathurst, Mackay and Dubbo, but I was talking to the Wodonga and Wangaratta group only on Friday, which is when we had our meeting, and there is talk of them making an application to have a rural trainee. They need to do three years in, say, Wodonga and do one year in town.

**Ms EDWARDS** — Does that encourage them to stay there once they have completed training?

**Prof. PERMEZEL** — Yes, that is what I was coming to and that is where it gets complex. It is my view, because we are a six-year program, that if they did the first four years in a rural setting, then they feel as though they have got to come to the city. I think they tend to stay where they spend their last two years because their kids get to school and their partner — usually male, because between 80 and 85 per cent of our trainees are female — gains employment wherever they are doing those last couple of years. I think if they have been rural,

they then tend to go city for the last two years. My observation, and it is hard to collect data because the numbers are small, is that the rural specialists are largely those who spend their last two years in a rural centre. They did the first four years in the city and then they moved to the rural centre for the last two years. The kids are in the local school. The partner has a position or occupation within the rural centre and they stay on in that or in an adjacent rural centre.

We are working towards gaining those advanced training places, so that is where I would put the priority during training in rural centres. We are structuring our advanced training so it will be a lot easier to achieve the advanced training objectives in a rural centre. The breadth of training required is actually quite hard to get in a tertiary centre because there are too many others competing for the procedural training that the college needs. So I think there are clever strategies that will lead to more going to rural centres for their advanced training. Then beyond training there is, of course, support of rural specialists. Easy-to-access continuing professional development is, I think, very important as well as other resources being made available. The rural locum scheme you will all have heard about. It is really important for the rural specialist to be able to get that break, and the rural locum schemes are very important.

Underplayed is the importance of also having the anaesthetist, the paediatrician and the surgeon, because we can put everything we would like in place to get a rural obstetrician but unless the anaesthetist, the paediatrician, the surgeon and all the supports are around them, it is not going to last. So everybody needs to be doing similar stuff.

**Mr FINN** — Professor, I was fascinated — intrigued — to read your comments on congenital anomalies, as much for the name as anything else. As somebody who has been involved in supporting people with disabilities for a long time I am just not sure I am comfortable with the term ‘anomaly’ — but anyway. You mentioned your support and enthusiasm for amniocentesis. I am just wondering what happens if a child in utero is diagnosed with a disability via amniocentesis?

**Prof. PERMEZEL** — Firstly, with the name ‘anomaly’ it has been difficult reaching an appropriate term. Clearly many women, a majority in fact, want antenatal diagnosis. It is not necessarily for termination. I obviously work at a hospital where terminations do not take place, but it is still invaluable information for the woman and her partner to prepare for. It is incredibly useful for the paediatrician. If they know what to expect at the moment of birth, they can put the appropriate supports in, psychologically as well. I heard that great discussion on prenatal mental health. If the woman and her partner are prepared during pregnancy, they know what to expect so much better. Nevertheless, a significant number will elect to have a termination of pregnancy.

I am interested in the terminology. We have changed a lot of our college documentation. For instance we took out ‘risk’ because that was perceived as being not the right word to be using. When a woman may want to continue with a pregnancy, we have used ‘chance’ instead of ‘risk’. That has gone right through our college documentation. But it is difficult to get away from a word like ‘anomaly’ — maybe ‘variant’ or something like that. We are developing, so I absolutely take your point on board, but we are trying to avoid ‘abnormality’. I heard myself saying it a little while ago, but ‘anomaly’ is slightly less pejorative. We are trying to move our terminology so the whole community can relate to these things.

The key issue in genetics, though, is the availability of blood testing rather than amniocentesis. Of those women undertaking testing for Down syndrome, currently about 5 per cent will end up with an amniocentesis, 1 in 200 roughly of which will be expected to have a miscarriage. That can be avoided with a blood test, but that blood test costs \$450. If you are in the private sector, you avoid it. You do not avoid the miscarriage of a potentially healthy baby by paying that \$450. In the public sector you cannot avoid it because there is NIPT. The blood test is not available. They have to go through the amniocentesis and risk losing a healthy baby. In my 34 years I have seen one woman lose a healthy baby because she had an amniocentesis. That is just my anecdotal experience, but it probably fits with the 1 in 200 women who will potentially.

It is so tragic. These babies are all very much wanted. When the patient I was looking after lost her healthy baby it was tragic but all understood. Now if she knew that she had a funded blood test, she would have got the information without having had to have the amniocentesis. So it is a very difficult situation to be in. It is really cost; it is that lack of cost that is providing inferior care to huge numbers of pregnant women. That is why I think this inquiry into genetic services is needed — how best to use the available resources for all women, particularly in the public sector.

**Mr FINN** — If a child with a disability is fortunate enough to make it to birth, what is the level of care of a child born with a disability?

**Prof. PERMEZEL** — We as obstetricians clearly provide the support during pregnancy, and I mentioned before our subgroup of maternal fetal medicine subspecialists. Maybe 5 to 10 per cent of all obstetricians have trained specifically — an extra three years of specific training — in the management particularly of complex ultrasound, complex fetal abnormality and complex pregnancies. They have extremely good networks for supporting women during pregnancy and preparing them for the birth of the child with specific problems, perhaps future disability — so engaging with paediatricians — the same happens at the Royal Women's Hospital, the same happens at Monash Medical Centre, and hopefully in the future at Western Health.

There are multidisciplinary clinics where the paediatrician, the paediatric surgeon who is going to manage the abnormality, the obstetrician, sometimes the psychologist, sometimes perinatal mental health and the geneticist all engage together to try and give these women the maximum information and maximum support. From the time of birth we continue to engage during the early perinatal period, but it is essentially the paediatricians who then provide the support to the children beyond birth. With obstetric follow-up and so forth, it is nice to maintain that continuity, but inevitably the obstetrician loses continuity until the next pregnancy, when you find out how things are going.

**Mr FINN** — Anecdotally do you have any evidence which suggests that children born with disabilities do not get full care and support?

**Prof. PERMEZEL** — I had a little contact with a family. One of my close friends has two seriously disabled children. Clearly the supports could be a whole lot better, but I think the NDIS as planned is going a long way to making things better for those families. But I absolutely agree — again it is a bit like the genetics but a different subject — there are resources available. Let us make sure that what resources we have are used in absolutely the best possible way.

**Mr FINN** — So are you suggesting that perhaps to support a child with a disability is not using it in the best way?

**Prof. PERMEZEL** — No — that given the limited resources that are available they should be used in the most productive way. I am not familiar with the sector, but I have a colleague who very much is. The NDIS, as I understand it, is setting up structures that will make sure that those resources are put actually where they are needed — that is, perhaps to the patients rather than to an administrative structure.

**Mr FINN** — I have just one last question. I notice here in the summary of recommendations that under 1.d. i) you have recommended:

A hospital-based comprehensive family planning service must be established at Werribee hospital.

Now that of course is Werribee Mercy Hospital.

**Prof. PERMEZEL** — Yes.

**Mr FINN** — Have you run that past the management of the Werribee Mercy Hospital at all? I have a feeling they might not be all that keen on the idea.

**Prof. PERMEZEL** — It does not have to be within the Werribee Mercy Hospital. We have a geographic situation. I think it is one of the largest expanding areas of Melbourne. Certainly Werribee is exploding.

**Mr FINN** — I represent it; I know it well.

**Prof. PERMEZEL** — So between Geelong and Western it is the only hospital, and there is a need for family planning services which Werribee Mercy Hospital clearly cannot provide. So somebody else needs to do that. Some can be done in the community, but there are services that can only be provided in hospital. For instance, many women will elect to have a tubal ligation at the time of their second or third caesarean section. At the moment that cannot be done, as I understand it — I might be wrong — within Werribee Mercy Hospital. So I think there needs to be somebody to look at that particular problem. It is not just tubal ligation; there are many, many other issues around family planning that need hospital involvement. How is that going to be

managed for all those women who live between Geelong and Footscray? It just needs a government strategy. I am not telling the Mercy they have to do it, but I think there needs to be a government strategy as to how that issue is managed. Whether it be that Western or some other hospital takes on that responsibility that clearly Werribee Mercy cannot meet at Werribee, a strategy is needed.

**Dr CARLING-JENKINS** — Excellent questions, Mr Finn. Thank you very much, Professor, for making the time to come in and also making the time to write a submission. What I am hearing so far is that we have ad hoc screening, so some people can access a blood test and some cannot — or many cannot by the sounds of it. There is ad hoc resourcing happening in the sector as well, which was touched on with Mr Finn's questions around NICU deaths of children with disabilities, for example. I guess leading on from that, I feel there is ad hoc reporting as well within this sector, and I think that is something that you covered in regards to the regional perinatal morbidity and mortality project, which I found fascinating. What I really want to touch on is the reporting of data, particularly on deaths and reasons why deaths occur in that perinatal period in Victoria. Do you believe that the reporting is consistent across Victoria? What do you think really needs to be put in place in that area?

**Prof. PERMEZEL** — Can I just correct something with the first trimester diagnosis? 'Some can access, some can't' — all can access it; you just need \$450. If you go to a public clinic — or you go to your GP; it does not matter — you can still get the test, but it is going to cost you \$450.

**Dr CARLING-JENKINS** — For some that means it is not accessible.

**Prof. PERMEZEL** — Yes, that is right. It really is a lack of equity of access.

In terms of perinatal mortality reporting, I think these regional perinatal mortality meetings have been extremely good from the point of view of ensuring a thorough, quality project but also in terms of creating a vehicle for engagement between regional centres and the tertiary hospitals that are supporting them. I think that has worked really well. I think that within the city most of the level 2 hospitals are aligned with and supported by their tertiary counterparts. Obviously Monash has relationships with Dandenong, Mercy Heidelberg with Mercy Werribee, and so forth. I think the perinatal mortality side of things has improved a lot. As I said in the submission, the maternity services quality indicators for Victoria are extremely good. There is nothing that compares with that in any other state. To be able to look across — I think there are, I cannot remember — 11 or 12 maternity performance indicators at the moment, and to have those charted, openly accessible, and by hospital and comparisons with the private sector, it really is extremely good reporting data.

The deficit at the moment, as we say in our submission, is the congenital — I do not know what word to use now — 'anomalies' reporting or congenital 'variation' reporting, if you like. We need that reporting, because if for many reasons we want to know how we are doing in terms of this equity of access, part of that will come out of that reporting. But also you all know about the zika virus and potential microcephaly, and there may be other threats. There have been various issues where pockets of congenital abnormalities have arisen — in the extreme, thalidomide. Hopefully we will never see anything like that again. There needs to be some decent reporting of these important variations. They need to be picked up and collated so that, should anything new arise, we are on top of it quickly and it is not just through anecdotal accumulation of: 'I saw a few of these; maybe something is happening'.

**Dr CARLING-JENKINS** — So at the moment the main problem, you are saying, is we do not have a centralised dataset around, I just say, 'disability'?

**Prof. PERMEZEL** — There is not compulsory reporting, there is not mandatory reporting, of these important congenital variants that may lead to initiatives that we need to get on top of quickly.

**Dr CARLING-JENKINS** — Right. Thank you very much; I appreciate that.

**Ms COUZENS** — Thank you for your presentation. You have answered a lot of the questions that I had. I was interested to hear your comments around the loss of commonwealth funding for the national perinatal depression service. Do you have a position on that or how that will affect —

**Prof. PERMEZEL** — First of all, I really enjoyed hearing the last speaker. Yes. The answer: where the college sits at the moment is that, as we said with Indigenous women's health, cultural competencies that are



now a compulsory part of training, and where domestic violence is now a compulsory part of training, all this is becoming a compulsory component of college training. I think that that has become the essence of where the college can contribute into that area.

**Ms COUZENS** — Thank you.

**Prof. PERMEZEL** — Sorry, the other thing I wanted to say, though, of course is about the Medicare initiative. I personally chaired, not representing the college, the obstetrics clinical committee of the medical benefits schedule review, and we had excellent members of that particular committee that made the recommendation. It is a compulsory part of antenatal care now in order to attract that item number. I heard criticism of obstetricians, which is probably fair, criticism of midwives, and criticism of GPs that maybe they are not screening as they had. According to the Medicare benefits schedule, you have to screen, and not just during pregnancy, in order to get that item number. You have to screen postnatally as well in order to get that item number. I think that is not the answer, but it is a huge development. It is putting it out there in lights that this is really important.

I do think that the obstetricians of the future, the current, the contemporary obstetricians, are so much better at diagnosing all of these issues — prenatal mental health, domestic violence. All of these issues are much better handled by our contemporary obstetricians and gynaecologists compared to those of the past, but clearly more needs to be done, and particularly then the support so you pick it up — what is the next step in terms of management? There needs to be a whole infrastructure to support these problems once they are diagnosed.

**Ms COUZENS** — I have just got one more question. You mentioned earlier the one Aboriginal and Torres Strait Islander person that is now an obstetrician. Is that right — is it one?

**Prof. PERMEZEL** — Yes, there is just one, but we are not a lot different to the other colleges.

**Ms COUZENS** — And there are five —

**Prof. PERMEZEL** — Five in training.

**Ms COUZENS** — Is that in Victoria or is that across —

**Prof. PERMEZEL** — No. There is a lot of privacy and so forth. I believe there is one that is just graduating or has just graduated in Victoria, become a specialist, so that might be our second, but clearly there are privacy issues. The other thing that obviously happens when we have one Indigenous obstetrician — and I know it happens very much in other colleges as well; she is absolutely fantastic, but you can imagine the demands on her time, and she is a fully practising, clinically brilliant O&G — is that they have got all these demands, so we really need these others to come through. We have another one in Darwin who has been brilliant through her training — the previous chair of the Indigenous doctors association — so it is exciting, but we need more. In this current intake I do not believe there is an Indigenous trainee that we are just having for next year, so I think that is a really important point.

**Ms COUZENS** — So does the college offer incentives for Aboriginal and Torres Strait Islanders?

**Prof. PERMEZEL** — Yes. At the moment we have this massive number of points, so that if you apply, it is extremely likely you will at least get an interview. You get so many selection points for an Indigenous background that you are more than likely to get in, but not guaranteed. We have scholarships for Indigenous medical students to attend our annual scientific meeting, and we are developing different supports. I think one thing that is very much needed is support during training, particularly if they are from a remote location. They need different supports. All trainees need support — it is a big issue for the medical colleges how better to support the trainees during training — but Indigenous trainees need different supports, and those networks need to be established.

**Ms COUZENS** — So is there anything within the college structure where you can actually go out and seek potential Aboriginal and Torres Strait Islander people to be trained?

**Prof. PERMEZEL** — Yes. The issue really comes down to the universities providing that prevocational doctor from which we can then draw them into obstetrics and gynaecology. We believe we are quite a popular discipline. We have more than 200 applicants for 80 positions. We need Indigenous doctors sitting there who

have been graduated by the universities. If the universities do not get them into the universities, they are not there for us to take into our specialties. The same with the rural background — unless the universities are getting medical students from rural backgrounds, they are not there for us to recruit into our discipline and produce specialists that actually want to go and practise in a rural centre.

**Ms COUZENS** — Would you see that as a critical point in closing the gap in terms of all the perinatal —

**Prof. PERMEZEL** — From our point of view, I think Indigenous women's health is really special in that respect. But absolutely, having Indigenous specialists, Indigenous doctors — they do not have to be specialist obstetricians. As you know, there are two sorts of obstetricians — GP obstetricians and specialist obstetricians. Both are absolutely welcome and highly respected. But having Indigenous doctors managing Indigenous affairs, I think, is critical in closing the gap.

**Ms BRITNELL** — Thank you, Professor. Can I first of all congratulate you on your submission, and I agree — we have got some fantastic services. We are very, very lucky in this country to have the medical services that we do have in health services. I think that sometimes is not acknowledged as much as it should be. We are very lucky, but we can always continue to improve. The cycle of continuous improvement is very important. I have heard a lot today from you about how we can do better, particularly in encouraging people to get involved in the field that you are looking for. You have talked about not just needing obstetricians and gynaecologists but having paediatricians, surgeons and anaesthetists in the team, particularly the challenge in rural Victoria.

I share your frustration with trying to find beds. It is more of a nightmare than anything else, and in this day and age when we have technologies available to turn on light switches from workplaces before you get home, surely we can find a better way to coordinate knowledge around the state of where beds are available. But it continues to be a frustration. So my question to you is: how do we coordinate? You have had some suggestions in your thoughts today about making sure we do it better as a team, but where does government help and where does industry help, and how do we coordinate something to actually find those solutions rather than industry saying, 'We need that help', and each college having the same challenge? How do we actually bring that challenge together to find the solution and get government in or out where it needs to be?

**Prof. PERMEZEL** — That is a really good point. We recommend in here an inquiry into PIPER, which is essentially the movement of patients, particularly women with their baby, most commonly in utero, from rural centres to tertiary centres and back again. But also it is not just Warrnambool to Melbourne but also Portland to Warrnambool.

**Ms BRITNELL** — Correct.

**Prof. PERMEZEL** — My strong view is that hub and spoke is the way to do it — to develop strong relationships between clinicians in the tertiary centres to the larger regional centres, and then the regional centres developing relationships with their GPs and midwives in the outside areas. That is in terms of obstetric and maternity services. But the overall encompassing management of maternity services in rural Victoria — I think that is the PIPER review — and the PIPER review will need to involve the anaesthetists and it will need to involve the paediatricians.

Some of you may know about a recent look at a framework for maternity services by AHMAC. Are you familiar with that? Anyway, there was a look at maternity services nationally. A framework was set up, but it failed to involve paediatricians, GPs and anaesthetists. They are really key players in the delivery of maternity care. I think an initial inquiry into PIPER might point to some directions as to how we best manage these services, but I think it is specifically getting anaesthetists and paediatricians into the country. I think that the only organisation overseeing the colleges at the moment is the Australian Medical Council. They have 11 standards, and at the moment, as I understand it, there is not a standard that says, 'What are you doing to get more rural specialists in your discipline?'. There needs to be that standard, and government, through AHMAC, can put pressure on the Australian Medical Council to change their standards.

**Ms BRITNELL** — PIPER is an example of some of the frustrations that I am referring to, and you are saying that we need to have better services encouraging people out there. You think it should be the AMC, working with government perhaps, putting incentives in place to actually raise the KPIs that are needed to put in place to get quotas?

**Prof. PERMEZEL** — Yes. I think it is relatively easy. It is just a simple thing. I do not know why it has not happened. There are 11 standards. Examples of the standards are: that the college has appropriate governance measures in place and that its assessment methods are fair and appropriate — things like that. There needs to be a standard. The college is taking steps to ensure an appropriate distribution of the specialist workforce. Then they will put into place things like selecting the trainees who are more likely to practise rurally and putting measures in their training program that make it more likely that the specialists will practice rurally — all the things I have talked about. I am biased because I think we are doing a reasonable job. We can do better — everybody can do better — but I think that all colleges need to have measures in place that make it much more likely that their specialist workforce will improve in the rural centres.

**Ms BRITNELL** — Thank you. Can I conclude by saying I agree: we are doing a very good job in our state with our health care. Thank you.

**Prof. PERMEZEL** — Thank you very much.

**The CHAIR** — Thank you for your attendance here today, Professor, and thank you for your submission as well.

**Prof. PERMEZEL** — Good. Thank you very much.

**Witness withdrew.**