

TRANSCRIPT

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Wangaratta — 25 October 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

Witnesses

Ms Libby Fifis, director of clinical services, nursing and midwifery,

Dr Leo Fogarty, director of obstetrics, and

Dr John Elcock, director of medical services, Northeast Health Wangaratta.

The DEPUTY CHAIR — Welcome, everyone, to this public hearing of the Family and Community Development Committee’s inquiry into perinatal services in Victoria. This is the sixth hearing to be held by the committee for this inquiry in a series of hearings that will be conducted in Melbourne and regional Victoria over the next few months. The committee is delighted to be in Wangaratta today, particularly in this building, and looks forward to hearing from the local community. Please see our website for details of upcoming hearings.

These proceedings today are covered by parliamentary privilege and as such nothing that is said here today can be the subject of any action by any court. Please note that the broadcasting or recording of this hearing by anyone other than accredited media is not permitted. All mobile phones should now be turned to silent.

Our first witnesses are Dr John Elcock, Ms Libby Fifis and Dr Leo Fogarty. If you would like to begin by making a 15 to 20-minute statement, that will be followed by some questions from Roma and me.

Dr FOGARTY — I will start off. I am Leo Fogarty. I am a specialist obstetrician. I have been in Wangaratta for 32 years. I am currently the subregional director of clinical governance in obstetrics for the Central Hume area and have been since that position was instituted about five years ago. As a result of that I have a pretty close association and cooperation with the smaller regional hospitals, which have GP and midwife-based obstetrics — midwifery — happening. The Wangaratta hospital currently has about 1680 births per annum, and the number is rising. All of these births are public. There is no private obstetrics in Wangaratta.

We are a level 4 maternity hospital and level 3 for neonatal. As I alluded to, we have a regional role. We are the referral hospital for two level 3 and one level 2 and also two level 1 regional hospitals — smaller hospitals — which means that adds up to approximately an additional 250 births in the region. These regional hospitals are constantly struggling with 24-hour cover with GP obstetricians, GP anaesthetists and midwives, and as a result we are not infrequently also covering their bypass at Wangaratta hospital. The Wangaratta hospital, as I mentioned, is entirely public in its births, and we run a very busy antenatal clinic on Tuesday, which goes all day Tuesday, and a second high-risk clinic on Friday mornings. We are dealing with normal as well as complex and medically high-risk pregnancies, the main exclusion being that theoretically we should not be birthing anyone less than 34 weeks gestation.

We manage all this with six post and antenatal beds — six in total — four delivery rooms and six neonatal beds. We have no assessment room, so that pregnant women who come in off the street or are referred to us with problems during pregnancy need to be seen in one of the delivery rooms, which puts quite a bit of pressure on us geographically or with rooms. I should point out that the consultant obstetricians and paediatricians — the specialists — are contractors; we are not employees of the hospital. We are not quite fee for service but effectively fee for service, and we have limited junior medical staff. That is just a bit of background.

Some issues that we struggle with — you have heard all of these before in other submissions, I am sure — include that our medical workforce is a bit of an issue. As I said, we have currently only four specialist obstetricians, five paediatricians and eight anaesthetists. In terms of junior medical staff we have two obstetric and gynaecological registrars. One is in the third of six years core obstetrics and gynae training, and the second registrar is doing a one-year advanced diploma of obstetrics. This second job is funded largely by the Murray to the Mountains intern resident officer scheme, which you may have heard of.

As a result of having only two registrars, we have a lack of registrar cover out of hours and on weekends. We have only registrar cover on three nights out of seven and none at all from Friday evening to Monday morning. Even to cover the nights we do cover, our registrars are working extended hours. The result of this is that the specialist consultants are very hands-on compared to, say, a tertiary hospital. We also have to work pretty long on-call sessions as a specialist, so we may work three to five 24-hour days in succession on call.

In terms of midwifery workforce, Libby will cover most of this shortly, I think. Some issues we have are direct entry midwives, which Libby will talk about, and, as I mentioned also, midwives struggling with assessing people when we do not have an assessment room.

Just a couple of other issues that I would like to run through, if that is okay, in no particular order. Continuing education and CPD is something that we all welcome and we realise it is necessary, but in our particular situation where we are non-salaried specialists, it is very expensive for us to do CPD. It is rarely funded by anyone. We have to pay for it ourselves. We usually have to leave town, and when you have to leave town you still have to keep your medical practice running and be paying employees et cetera.

In particular I do not think we should have to pay for CPD, such as the annual foetal surveillance that we do, which is basically foetal monitoring revision each year, and neonatal resuscitation. We are all very happy to do it, but it is sort of a little bit galling to have to pay for it when you are actually taking time out from your own practice to do it.

PIPER has been covered, I think, in other submissions, including by Professor Permezel. I would, firstly, have to say that having PIPER organising transfers for us is a vast improvement on the previous situation we had of having to ring around three different tertiary hospitals, which is something I remember from 10 or 15 years ago. Most of the problems we have with PIPER and with transfers are, I am sure, due to the unavailability of sufficient neonatal intensive care beds in Melbourne. But we also do have some PIPER clinicians on the other end of the phone in Melbourne who do seem to have very little understanding of our situation and our staffing and our capabilities. As a result of difficulties with transferring patients, we are now fairly regularly left to deal with situations which are outside our capability framework, such as holding on to very premature babies because there is nowhere for them to go in Melbourne.

The other issue I would say about interhospital transfers is that locally here — and I am sure it happens in the rest of the state — if, for instance, someone needs to be transferred urgently in labour from Yarrowonga to, say, Wangaratta, or any of our other smaller regional hospitals, we usually bypass PIPER and organise that ourselves and organise that through Rural Ambulance Victoria, which works very well, except that none of that is getting recorded or audited. In terms of what is happening in hospital transfers, I am not sure it is all getting recorded.

Antenatal care — as I said, we run an antenatal clinic. We run a shared care model with GPs and midwives. We also in this hospital have a midwife care model for low-risk patients, if I am allowed to use that term. I think this midwife care model was the first in rural Victoria, and it has been going since about 1992 or 1993. One of the difficulties we have with antenatal care is that some of the GPs we are sharing antenatal care with have not had sufficient training in antenatal care, and we really cannot control that. We cannot control what is happening in GP practices around the region. As a result of some GPs having insufficient training we are getting issues such as late referrals for high-risk pregnancies, failure to order appropriate routine tests and failure to offer things like Down syndrome screening in some cases. As I said, we cannot say which GPs can and cannot do antenatal care, but perhaps the health department could somehow or other just say to all hospitals, ‘You can’t accept patients from GPs who are not qualified to do antenatal care’. In that way if we all had the same rules, those GPs would have to have someone else in their practice doing the antenatal care.

Perinatal mental health was mentioned in the terms of reference, and I would just like to say on that that we do have an excellent local early motherhood program. It really is an incredibly useful program, but it was previously threatened by a withdrawal of federal government funding. I think currently the state government has stepped into the breach and continued the funding. But I just would like to make the point that it is an essential and highly valued service which needs to continue to be funded. I think they are presenting to you later in the day. Also if we have a pregnant or recently pregnant mum who needs admission for mental health reasons, it is very, very difficult to organise that in this region. I think perhaps we do need at least a small regional perinatal health inpatient unit.

Postnatal home-based care is vitally important, especially now that we have such a short length of stay in hospitals. It can sometimes become quite disjointed, largely because there are multiple providers and no single point of contact. We sometimes have difficulty accessing it, especially if we have weekend discharges or interstate people who are going interstate, because we do have some of our mums who come from southern New South Wales. The other postnatal service we have is a lactation clinic, which is also an excellent asset to our service, and I think Cate will be presenting something on that later.

Three or four years ago — as a result of Djerriwarrh, I think — statewide regional perinatal mortality and morbidity committee meetings were set up for the regions. We have a meeting with the three smaller regional hospitals at Albury, Wodonga and Wangaratta, which happens every three months. We all think this is an excellent initiative. It has given us great opportunities for learning in all directions, up and down, from Professor Permezel, who is our peer support person, down to us and back in the other direction. I think some of the messages get back to Melbourne that we have been struggling to get back to Melbourne for a long time. It is a fantastic learning opportunity. Our only concern with it is that it is administered centrally from Melbourne — and administered very well centrally from Melbourne — by Bree Bulle, but the funding for the central

Melbourne administration has been under threat, we gather. I think it would be very important to not only keep these meetings going but also to keep the central administration going.

Just a couple of other issues. We are trying to get our pregnant women to have influenza and pertussis vaccine. We encourage them all in our clinic to get this done. But because the hospital is not specifically funded to give these vaccines in an outpatient setting, we have to get them to go and see their GPs. That is a little bit of a weakness because while that usually does happen, sometimes they miss out. We have recently had a severely ill patient, a pregnant woman with influenza, who had not had an influenza vaccine when she presented to us at 35 weeks gestation.

Another issue is family planning and termination of pregnancy services. There is no local or regional specifically state-funded service. We are currently entering a partnership with Gateway Health, and we will be able to provide a limited service.

Clinical indicator reporting — we just have some issues with some of the clinical indicators that are reported. As regional people we would like to have a bit more input into the clinical indicators. For instance, with something as basic as perinatal mortality, our perinatal mortality in Wangaratta from time to time can look higher than it should be in the reports. This is because we are inheriting — for instance, if someone has an unfortunate fetal death in-utero in one of our smaller regional hospitals, they are sent to us. We have nothing to do with the antenatal care, but we deliver the mum in Wangaratta hospital and they then get counted in our figures. I have over the years sent various letters and in more recent years emails to people about this but had very little response.

One of my hobbyhorses is ultrasound. One of the big challenges in obstetrics is trying to reduce the incidence of stillbirth at full-term, or near full-term. Fifty per cent of these stillbirths occur in women who have growth-restricted babies. To pick up the growth-restricted babies you need very good quality ultrasound. We are finding at present that some of the ultrasound reporting is not of high quality. I think the sonographers who are doing the scans are doing a great job. We are getting ultrasound reports from multiple different places apart from our own hospital, and frequently the reporting leaves a bit to be desired. If we are having those problems, I am sure other people in the state are having the same problems.

The other thing I would like to mention is telehealth. I was very interested recently to hear that one of our ex-registrars, who is now working as a consultant in Darwin, does telehealth with the maternal fetal medicine unit in the Mercy Hospital in Heidelberg from Darwin. I am sure there is a place for regional hospitals to be doing the same with some specialist units in Melbourne, but it is going to need funding at both ends, I presume.

Just the last thing, while on the subject of mentioning a recent registrar, I think in Professor Permezel's presentation on behalf of the college he mentioned that the college is trying to do something to increase the number of rural obstetricians. They hope to do that by increasing the number of trainees who have come from rural areas. Currently out of the four obstetricians in Wangaratta, two came through here as registrars rotating from the city. Both of them are originally from rural areas. We have got another one of our ex-registrars who has come through here coming to be a specialist next year as well. So I think there does seem to be some evidence that rural doctors who were brought up in rural areas finish up as doctors in rural areas if you give them the opportunity. I think Libby wanted to mention something about midwifery.

Ms FIFIS — Thanks for the opportunity to speak today. I am Libby Fifis, director of clinical services, nursing and midwifery at Northeast Health Wangaratta. I have been here a little under two years in this role. I would just like to address dot point 4 of the terms of reference about access and provision of an appropriately qualified workforce, particularly midwifery staff. So recruitment of midwives continues to be testing across the state, and I have noted the various submissions highlighting this challenge with the committee. Having very rarely had the need to use agency midwives in the past at Northeast Health Wangaratta, in the last three months the use of agency midwives to meet ratios has cost our organisation in excess of \$60 000. I would also like to take this opportunity to highlight the impact that the safe patient care act has had on our maternity service, noting that Northeast Health Wangaratta is a level 2 health service in accordance with the act.

Within the act, section 27 states that infants in a special care nursery may only be cared for by a nurse. The definition of a nurse in the act precludes the ability of bachelor of midwifery qualified midwives — or direct-entry midwives, as they are called — to care for infants in the nursery. The definition of a midwife in the act also precludes registered nurses undertaking postgraduate midwifery training to work as part of the ratios.

So previous to when the act came into play last year we were able to ensure that our postgraduate students, when it was safe to do so, were able to work as part of the ratios. We cannot do that at this point in time. Furthermore, due to broader health service bed pressures, it is not unusual for our obstetric ward to accommodate surgical gynaecological patients. The act again requires that a nurse cares for these patients. Again that means a midwife qualified as such through a bachelor of midwifery qualification is not allowed to care for the post-op gynaecology patient. These examples demonstrate how challenging, frustrating and confusing it has become to our staff to staff our particular unit in accordance with the act. While some of the above obstacles can be overcome via a formal agreement with the union, they present an unnecessary barrier to optimising an existing workforce for the provision of safe and effective midwifery and patient care.

As previously mentioned by Dr Fogarty, antenatal assessments generally occur in the birth suite when not undertaken in our formal antenatal clinic on Tuesday and Friday. Until recently assessments were carried out by the available midwifery staff on the floor. Our organisation has recently approved an above ratio shift, Monday to Friday, to be available for women requiring assessments and not compromising the existing ratios. However, I would like to point out that the lack of ratio guidance provided in the act to cater for women requiring emergency antenatal assessment is less than ideal for patient care. That is all I had to say.

Dr ELCOCK — I might make a couple of comments, if I may. I am John Elcock. I am the director of medical services at Northeast Health Wangaratta, a position that I have held for over 14 years. If I could just note one key issue, which is the importance of subregional and regional health services in their role in supporting small rural health services in obstetric service delivery. We are all well aware of the tyranny of distance and the risk that that basically brings to women and to their babies. In the country you could be faced with a choice of either spending a significant number of weeks within cooee of a big hospital or living in your community with the intention of birthing safely in that community or nearby.

The ability of the small rural health services to support safe obstetric delivery is really dependent on them having the right workforce and the right structure process and the right clinical governance to support that. Regional and subregional health services like NHW have a significant role to play in terms of supporting both of those issues: firstly, in terms of workforce by doing what NHW does in terms of providing training positions for GP obstetricians and GP anaesthetists and opportunities for them to continue to refresh their skills and by providing links at the midwifery level and opportunities for midwives to again upskill and refresh skills; and secondly, by providing the process around clinical governance, such as Leo's role as a subregional director for clinical governance in obstetrics, so that we can support the small rural health services to have the right processes, the right policies and the right set-up to provide safe care delivery. This includes things like shared protocols for treatment, agreed transfer criteria et cetera. It also provides for continuing professional development and education. It provides for audit and review of cases.

I guess that feeds into the reinforcement of Leo's point about the value of the regional morbidity and mortality committees that were set up by the Department of Health and Human Services. My understanding is they are currently on time-limited funding, which will run out at the end of this year. These committees have been incredibly effective in terms of sharing learning and understanding across health services and also providing a vehicle for central capture of key issues. Having the central leadership of those committees we think is a key issue in terms of ensuring that they continue to function, and function well, and provide a vehicle for key issues to be raised through bodies such as Safer Care Victoria.

The DEPUTY CHAIR — Thank you. We will spend the next little while just having some questions from Roma and me. I just want to start first of all by asking about the first hospitals that feed into Wangaratta. You said there are number of level 1 and level 3 hospitals, I think. Which hospitals are they?

Dr FOGARTY — Benalla and Mansfield are level 3. Yarrawonga is a level 2 hospital. Myrtleford and Bright have recently stopped doing any births, but they are level 1 in that they need to be prepared to have someone birth there if they arrive.

The DEPUTY CHAIR — We heard yesterday in Bendigo about the risk that they have been dealing with at the hospitals in terms of birthing. The higher risk pregnancies were really on the rise, probably because of a couple of factors including the smaller hospitals referring. Do you know what higher levels of high risk you have here, percentage-wise?

Dr FOGARTY — I could not give it a percentage, but certainly for the number of births we do it is a lower percentage of low-risk and higher percentage of high-risk births — than you would expect because the other smaller regional hospitals are hanging onto the low-risk births and sending us all their diabetics, twins, obese women — you name it — previous severe, pre-eclampsia. All of those higher-risk women from the region come to our hospital, and they look after the low-risk ones.

The DEPUTY CHAIR — Within that high-risk category, are there particular trends where you are noticing or more of something and less of something else?

Dr FOGARTY — More obesity and more gestational diabetes are the main trends.

The DEPUTY CHAIR — Do you know why there is an increase in gestational diabetes?

Dr FOGARTY — Two reasons — well, probably three reasons. One is obesity, and then the fact that mothers are having babies later in life. The average age of having babies has increased. The third is that we have altered the definition of gestational diabetes to bring in a larger number of women, which was based on research — it was not just done on a whim.

The DEPUTY CHAIR — Is that national or international?

Dr FOGARTY — International. International and national. I think something like 12 per cent of our pregnant women are diagnosed with gestational diabetes.

The DEPUTY CHAIR — Earlier I think Dr Fogarty it was you who mentioned that the physicians in Melbourne do not understand what happens in country health practices and hospitals. Do you want to elaborate a little bit more about what you think it is that they do not understand?

Dr FOGARTY — This is the PIPER obstetricians the other end of the phone when we are trying to transfer. Most of them have never worked in a rural area. Most of them are working in tertiary level hospitals. They have large numbers of registrars, senior registrars, laid on, and I do not think they quite understand that we are trying to get by with much more limited resources than they are. I do not think they understand, for instance, that if they leave us with someone at, say, 29 weeks who is threatening to go into labour and they say they cannot take them, that for us to suddenly have a 29-weeker in our hospital we are really struggling. We can deal with them, but we really struggle with resources in that we do not have a whole layer of registrars and trained staff to deal with those sorts of things.

Ms BRITNELL — I just want to seek clarification first of all on what you were saying around the ultrasound equipment. Is it that the quality of the equipment is on the improve so you can get better images now but that in a private situation it is up to the practice to upgrade, so some are and some are not?

Dr FOGARTY — Certainly the quality of the equipment has improved dramatically over the last 10 years, and we can get much more useful information from pregnancy ultrasound now than we could. The quality of the actual scanners who are doing the ultrasound scans is usually good, but I think the people who have been left behind a bit in some places are the radiologists. You have one person who actually does the ultrasound scan — this is in X-ray departments in, you know, private places in faraway towns. We get ultrasound reports from probably seven or eight different places, most of them privately run. The main issue is not so much the quality of the equipment or the quality of the ultrasound technique, but it is the quality of the reporting. It needs to be standardised to a greater extent.

Ms BRITNELL — I am trying to understand what that would look like. So you are saying there needs to be improved regulation around how the standards continue to be set. Is that what you are saying?

Dr FOGARTY — Yes. We are mainly interested in late pregnancy ultrasounds in fetal growth, which depends upon certain measurements being done accurately and then being reported in a particular way, and we are just not getting the information we need in the reports. We can usually chase that up and get it improved on, but what concerns us is what is getting missed out in the general practices as well because of the poor quality, in some cases, of reporting.

Dr ELCOCK — If I may comment on that. Some years ago now the college of pathologists basically brought in a standardised format for reporting histopathology — that is what tissue looks like under the

microscope. That standardised format greatly improved the quality of information in the reports and the clinical information then that the referring specialists and GPs could get out of the reports. Ideally what we would like to see is a similar standardised reporting format applied to obstetric ultrasound. My understanding is that correspondence has occurred between the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and the radiologists college, but we are not seeing any outcome from that in terms of an agreed reporting format.

Ms BRITNELL — Which leads me to a question that I was going to leave till a bit later. I note you are involved in the clinical governance, and you have mentioned a few things where there are challenges in standardisation. Do you feel — and I would like each one of you to answer this question — that the Department of Health and Human Services, DHHS, should or could play a more active role throughout Victoria in setting protocols and assisting hospitals? You guys are probably the same size as Warrnambool, and it seems like each hospital is doing their own policy and procedure manual, the private practices and public system are sort of finding their own way and doing a very good job. I think we have got a terrific health system, but you can see that there are anomalies that, with the department overarching, should easily be more standardised. Could they play a greater role in assisting, not overarching directing but working with the hospitals?

Dr ELCOCK — If I might start with that one? I think the short answer is yes, I think there is scope for that. Conscious of the fact that we are spruiking something we started here with the subregional director of clinical governance roles, I think there is scope throughout the rest of rural Victoria for similar arrangements to be set up, and I know of at least one other centre that is actually looking at that. The advantage of that is that it provides a local but not a microscopic solution, so it actually helps to provide commonality and agreed standards and processes between hospitals that mirror patient flow. So patients moving from hospital A to hospital B know that the treatment they start in hospital A, if they get transferred, is going to be continued in hospital B. It is not all going to be changed around, for example. I think there is the potential within Victoria for the subregional directors of clinical governance model to be replicated. I think that can then be assisted at a central level in order to reduce the duplication of effort that you are referring to there. And somewhere in that there is a balance of the reduction of duplication of effort but nevertheless something that recognises local issues such as travel times, distance and the local resources available, both human and material.

Dr FOGARTY — Can I just add to that? In terms of clinical protocols, strangely enough, when we are looking for a new protocol the first place we go to is the King Edward Memorial Hospital in Perth, because they have produced this fantastic set of guidelines which are all publicly available. Efforts in the past to produce clinical guidelines, such as the three centres some years ago, which was Monash, the women's and the Mercy, I think sort of foundered on differences between the three hospitals. Currently we have just produced something called the eHealth handbook — I think it is called — which is giving us some clinical protocols which are meant to be for advice or for statewide use, but I think there are only five protocols out so far, and they are incredibly complicated for the same reasons, because there is a bit of disagreement in Melbourne about different people doing different things in different ways. So we tend to put our own protocols together, and we tend to use sources like King Edward Memorial Hospital and do a bit of copying and pasting, I must confess.

Ms BRITNELL — Libby, did you want to add to that?

Ms FIFIS — I guess I would just add that in the post-Duckett environment certainly with the formation of Safer Care Victoria and the review of all the clinical networks I think we are starting to move into that space. It has certainly been a long time coming, and I guess it is just part of our devolved governance environment in which we work.

The DEPUTY CHAIR — I just wanted to pick up on the safe care act, Libby, that you mentioned before about nurses with the bachelor of midwifery being excluded. Was that an oversight, or was that considered that they would be?

Ms FIFIS — I was not privy to the development of the act. It has certainly been recognised post-implementation and, as I said, there are ways around it. We are currently working with the ANMF — and I think Julie will probably speak a bit to that — to try and get some kind of agreement whereby our current bachelor of midwifery midwives can work in the special care unit. But it would be nice to have that removed from the act, or some more appropriate wording put in place so that organisations did not have to jump through that hurdle.

The DEPUTY CHAIR — And with regard to the reliance I guess you have had on casual midwives in the last three months —

Ms FIFIS — Agency midwives.

The DEPUTY CHAIR — Agency midwives — sorry. Can you talk a little bit about the recruiting of midwives in the area? Are they difficult to come by? Are there not enough trained?

Ms FIFIS — Yes. We have been trying to recruit midwives probably from late last year. I think we had recognised, when we were working towards the implementation of the act, that we needed to increase our EFT in maternity services and in doing so created some greater vacancies in our service. From that time we have been really trying very actively to recruit midwives, and they are just not responding to our advertisements. It is not through lack of trying. We have had continuing ads running. Having spoken to the chief nurse only last week, it is an issue clearly across the state. It is not just something in this region, and I guess we have talked with our partner hospitals about opportunities of sharing staff, that type of thing. But we are just really in a position now where just to be able to safely care for women in accordance with the ratios we have had to engage some agency staff. We are hoping that will be a sort of short-to-medium plan for us. It is certainly not a long-term plan, but it is a place we have had to go to to safely staff the ward.

The DEPUTY CHAIR — And do you share the belief that if you could have homegrown country midwives who may train elsewhere and come back, that would be a —

Ms FIFIS — Yes, absolutely. I guess one of the other points I would make is the cost of postgraduate training for midwifery — and not just midwifery, all specialties. Whilst there are some scholarships available to staff from the department of health, most of the people that we are trying to encourage to take on the postgraduate training are usually young families trying to buy a house — all the rest of it — and finding it very difficult to afford to take on the costs of postgraduate training.

The DEPUTY CHAIR — Are there any private midwives operating in the area?

Ms FIFIS — Not to my knowledge.

Dr FOGARTY — Not currently. We have had in the past but not currently.

The DEPUTY CHAIR — Can you comment on homebirthing? Is that on the rise, on the decline or stable in the area?

Dr FOGARTY — I think there is someone doing some homebirths in the area but not as many as maybe 10 years ago.

Ms BRITNELL — You were talking about education and the challenge you have finding the cost benefit for you to leave your practice and the knowledge — I think you were saying — you were gaining. When you then talked about going to the morbidity meeting — I cannot remember the name of the committee — every three months, you talked about the learnings and the value. Is it the actual value you were receiving for the return on investment of the time and money from the CPD versus what you are getting from the coordination meetings that were actually there? I seem to see some sort of difference in your tone there.

Dr FOGARTY — No. There is great value from those meetings. I spend quite a bit of time preparing for those meetings. I think I was trying to make the point that if you are a private practitioner running a private practice, employing staff, paying rent and all those sorts of things and you then have to — say to do an ultrasound course, for instance — leave town and go to Melbourne or somewhere else, then you leave your practice for a week, but you still have to be running the practice and paying wages and that sort of thing in addition to having to pay out of your own pocket for the course that you are doing. I think the general practitioners have quite a bit of federal support for continuing education, but specialists have virtually none. I would not say absolutely none, but virtually none. We all acknowledge that we have to do CPD and that it is good for us, and we are all interested in doing CPD, but it is just very extensive.

Ms BRITNELL — In view of the fact that country specialists and doctors have to go away to training, because it is often in Melbourne I imagine, I wonder can you see an opportunity in the system that you and specialists operate in — rather than me, because I do not know your system — but you talked about people in

the city, like PIPER, having no understanding of the country; you sort of have to go to Melbourne to actually keep up. Could that be reciprocated — that the city, which needs to be working with the country to run a service such as PIPER, and there will be other services, needs to spend time in the country? Would that be a workable possibility?

Dr FOGARTY — NETS, neonatal emergency transport service, do bring education to the country, which is great, and they probably — by doing that — do get some idea of the problem. They then become more familiar with our particular local issues, so that works quite well, and I am sure there is a place for more of that to be happening.

Ms BRITNELL — So would it be beneficial, as part of the training for medicos, that they actually spend time in the country, seeing as it is a state system that they are working in? Is that something that could be put through their training, or would that be too difficult, do you think?

Dr FOGARTY — It could be done in earlier stages of their training. Our college — the college of obstetricians and gynaecologists — insist that every trainee spend at least six months, usually in the third year of their training, in a rural post. I am not sure which other colleges do that, but it would be a useful thing for other colleges, such as the paediatricians for instance, to institute.

Ms BRITNELL — So some colleges do as far as you are aware. Just one last question: the federal government announced the rural health commissioner late last week. I just wondered, given the challenges that you are talking about today, some of those would be quite relevant for rural — would your organisation take advantage of using that connection to improve the system, do you think, as well?

Dr ELCOCK — Yes. We will take advantage of any connection into central mechanisms to represent what we see as the issues here, because we do not believe we are unique, and the issues that we see here will be seen at other rural centres as well.

The DEPUTY CHAIR — Thank you so much. Our time has elapsed quite quickly. Roma and I always have lots of questions, but we greatly appreciate your spending the time here with us this morning and the level of expertise that you have brought to our inquiry.

Dr ELCOCK — Thank you. We appreciate the opportunity.

Witnesses withdrew.