Workforce trends in specialist and GP obstetric practice in Victoria

Cameron S Loy, R Bruce Warton and James A Dunbar

ABSTRACT

Objective: To provide a contemporary picture of the general practitioner and specialist obstetric workforce in Victoria.


Main outcome measures: Sex, age and geographical distributions and patterns of retirement from and recruitment to the GP and specialist obstetric workforce in Victoria.

Results: 244 Fellows (77.0%) and 652 Diplomates (67.8%) participated. The average age of Diplomates was 42 years; only 20% were involved in procedural obstetrics. Of GPs practising procedural obstetrics, 56% intended to cease within 7 years. Two-thirds of specialist obstetricians continued to practise obstetrics. Among those ceasing obstetrics, almost half had done so since 2000. Among Fellows ceasing obstetric practice, there is a peak in the 50–60-year age group, but cessation of obstetric practice occurred across all age groups.

Conclusion: The proportion of GPs involved in procedural obstetrics has fallen markedly over the past decade, with half of those ceasing practice in the 40–50-year age group. New GPs entering the workforce with the Diploma and overseas doctors are unlikely to meet the procedural workforce shortfall. Attracting the large cohort of doctors aged 40–50 years back to obstetric practice must be a priority. Given the patterns of retirements from obstetrics, there will be insufficient numbers of specialists to maintain current levels of service. The reasons include non-participation in obstetrics by new graduates and international medical graduates, the inadequate number of new graduates, and the predominance of women among specialists aged under 40 years, whose work output tends to be affected by family commitments.

METHODS

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) stores a database of doctors who hold the Diploma of the College (DRANZCOG) and those who hold a Fellowship (FRANZCOG). Most procedural GP obstetricians will hold the Diploma, and those who have a Fellowship are considered specialists. This study is a census of doctors on the College's database.

Postal surveys were sent to all 961 Diplomates and 317 Fellows listed on the Victorian database in September 2003. A modified Dillman protocol was implemented. We determined locality information for the towns in which respondents worked using an Internet-based community information...
RESEARCH

1 Age and sex distribution of 646 Diplomates of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists in Victoria, September 2003

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Women (n = 336)</th>
<th>Men (n = 310)</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td>40</td>
<td>35</td>
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<tr>
<td>30</td>
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<td>65</td>
<td>0</td>
<td>0</td>
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<tr>
<td>70</td>
<td>0</td>
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No. of Diplomates

2 General practitioner obstetricians, Diplomates and full-time-equivalent GPs by Rural, Remote and Metropolitan Area classification in Victoria, September 2003

<table>
<thead>
<tr>
<th>Rural, Remote and Metropolitan Area classification</th>
<th>All</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP obstetricians</td>
<td>128</td>
<td>28</td>
<td>26</td>
<td>38</td>
<td>58</td>
<td>116</td>
<td>3</td>
</tr>
<tr>
<td>Diplomates</td>
<td>635</td>
<td>394</td>
<td>26</td>
<td>38</td>
<td>58</td>
<td>116</td>
<td>3</td>
</tr>
<tr>
<td>Full-time-equivalent (FTE) GPs</td>
<td>6411</td>
<td>4759</td>
<td>240</td>
<td>326</td>
<td>356</td>
<td>712</td>
<td>18</td>
</tr>
<tr>
<td>% of Diplomates who were GP obstetricians</td>
<td>20.2%</td>
<td>7.1%</td>
<td>10.5%</td>
<td>43.1%</td>
<td>58.6%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>% of FTE GPs who were GP obstetricians</td>
<td>2.0%</td>
<td>0.6%</td>
<td>1.2%</td>
<td>7.0%</td>
<td>9.6%</td>
<td>16.7%</td>
<td></td>
</tr>
</tbody>
</table>

Intention to practise procedural obstetrics: Of the doctors who had undertaken Diploma training, 67.5% (428) did intend to practise procedural obstetrics; 14.3% subsequently decided during training not to practise, and a further 56.5% stopped procedural practice after training. Overall, 71% of GPs who completed the Diploma intended to practise procedural obstetrics, but 0.2% remained in procedural practice.

Sustainability of GP obstetric workforce: Diplomates retired from practice with increasing frequency over the 1990s. During the years 1996 to 1998, the number retiring from obstetric practice exceeded the number of new Diplomates. The number retiring yearly fell from the year 2000 (Box 3). Doctors of all age groups retired from practice. Women doctors who completed the Diploma tended to retire from procedural practice earlier than men; 58% retired in less than 2 years, and 90% in less than 7 years.

The geographical distribution of Diplomates who had retired from procedural practice showed the greatest loss in urban areas (RRMA 1–3), with less loss in rural areas (RRMA 4–7). Numerically, the largest loss of GP obstetricians occurred in Melbourne; of the total 310 Diplomates who retired, 206 were from Melbourne (Box 4). Of the GPs practising procedural obstetrics, 56% intended to cease within 7 years. This loss of workforce is likely to occur in all geographical areas except in RRMA 7, "other remote areas" (Box 5).

Ethical approval was obtained from Flinders University Social and Behavioural Research Ethics Committee.
4 Involvement of general practitioner Diplomates in obstetric practice by Rural, Remote and Metropolitan Area classification in Victoria, September 2003

<table>
<thead>
<tr>
<th></th>
<th>Rural, Remote and Metropolitan Area classification</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>All</td>
</tr>
<tr>
<td>All</td>
<td>635 (100%)</td>
</tr>
<tr>
<td>Currently involved</td>
<td>128 (20.2%)</td>
</tr>
<tr>
<td>Involved in the past</td>
<td>310 (48.8%)</td>
</tr>
<tr>
<td>Never involved</td>
<td>197 (31.0%)</td>
</tr>
</tbody>
</table>

Specialists (Fellows)
Sixty-nine per cent of Victorian Fellows (168) were male. Box 6 shows the distribution of Victorian specialists by age and sex. The proportion of the female workforce decreased with increasing age. Among Fellows aged under 40 years, the workforce was predominantly female in each age cohort.

Of the 244 respondents, 15.6% (38) were identified as having obtained their primary medical qualifications outside Australia. Only six of these doctors were practising outside the Melbourne metropolitan area.

Responses from Fellows showed that 66.7% (162) were currently practising obstetrics, 24.7% (60) had ceased practising obstetrics, and 8.6% (21) had never practiced obstetrics. Of the 162 who were currently practising obstetrics, 23.5% (38) were in private practice, 28.4% (46) worked in public obstetrics, and 48.1% (78) worked in both private and public obstetrics. There were 38 specialists (32 men and six women) practising outside the Melbourne metropolitan area; this represented less than 16% of the overall specialist obstetric workforce in Victoria. Of the 60 specialists who had ceased to practise obstetrics, 46.7% (28) did so after 2000 (Box 7A). The age of specialists leaving obstetrics is shown in Box 7B.

Qualitative data
Respondents were asked four questions:

- Please describe what you enjoy about managing women in labour and attracts you to this type of work;
- Please describe the barriers and problems (both clinical and non-clinical) that make managing women in labour difficult;
- What steps could be taken to help you resume or commence managing women in labour?; and
- What steps could be taken to recruit doctors to manage women in labour (both new graduates and existing doctors)?

Three main themes emerged strongly from the data. GPs and specialists were concerned about indemnity costs (33% and 27% of respondents, respectively) and fear of litigation (23% and 39%). Both groups were concerned about obstetric working hours (39% and 47%), with 12.5% of specialists expressing an opinion about the strain because of obstetric practice. Clinical issues were prominent. GPs were concerned about maintaining their skills and competence (28%). Specialists identified supply of anaesthetic services, interactions between midwives and obstetricians, and the training and referral patterns of local GPs as barriers.

In response to the question asking what would help them start or resume obstetric practice, 47% of GPs and 49% of specialists strongly expressed the view that nothing would tempt them back into obstetric practice.

The question about strategies for encouraging others into obstetrics uncovered a wide range of options within the three main themes of indemnity, lifestyle and clinical issues.

DISCUSSION
While we acknowledge that a study restricted to Victoria may provide only an indication of the national situation, it does represent a census that covers a quarter of the Australian obstetric workforce, and our findings are consistent with the trends shown in other national studies.

The proportion of GPs involved in intra-partum care in Victoria has fallen markedly, and most of this decline occurred in the late 1990s. Although the retirement of GPs from obstetric practice closely matched the emergence of new Diplomates, most new Diplomates were unlikely to engage in obstetric practice. A high proportion of doctors entering Diploma training reported an intention to practise procedural obstetrics. Of those who changed their minds, most did so after they had started practice, not during their training. A stated intention not to practise procedural obstetrics before training was highly predictive of not practising procedural obstetrics. Over half of the currently active GP obstetricians intended to cease practice within 7 years.

Our findings support the prediction that there will "soon be a shortage of experienced practicing obstetricians in Australia." Retiring specialists are mainly in older age.

5 Intentions of general practitioner obstetricians about ceasing procedural obstetrics by Rural, Remote and Metropolitan Area classification in Victoria, September 2003

<table>
<thead>
<tr>
<th></th>
<th>Rural, Remote and Metropolitan Area classification</th>
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<tbody>
<tr>
<td></td>
<td>All</td>
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<tr>
<td>Total practising GP obstetricians</td>
<td>128</td>
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<tr>
<td>Those intending to cease:</td>
<td></td>
</tr>
<tr>
<td>Within 2 years</td>
<td>23 (18.0%)</td>
</tr>
<tr>
<td>Within 7 years</td>
<td>71 (55.5%)</td>
</tr>
</tbody>
</table>
Sex of specialist obstetrician/gynaecologists in Victoria by age, September 2003

Percentage

Age (years)

20-24 25-29 30-34 35-39 40-44 45-49 50-54 55-59 60-64 65-69 70+

Women

Men

to 38 in 2003. The 2000 RANZCOG/National Association of Specialist Obstetricians and Gynaecologists workforce study reported its findings on 226 provincial specialists in Australia and New Zealand. It determined that 32% of specialists had left provincial practice after 5 years or less, and 40% of specialists still in provincial practice saw 5 years as the maximum they were prepared to work outside a major city.

Current policy considers that the emerging workforce will be adequate to provide obstetric services. We believe this policy needs to be revised urgently. There can be no doubt that the substantial reduction in the number of Australian medical graduates since the early 1990s has had a profound impact on the medical workforce of today. While the numbers of Australian graduates are now being increased, it will take at least another decade for the impact to be felt. Factors such as the larger proportion of women in medical schools (who may interrupt their careers to care for family), the move to part-time work by both men and women in medical practice, and the loss of doctors aged under 40 years in rural areas and from the medical workforce overall, have a net result of reducing the number of full-time-equivalent doctors.

The recruitment of overseas-trained specialists has not had a significant impact on rural practice. Indeed, our data suggest that most overseas-trained doctors practise in Melbourne. Staff specialist positions protect those doctors from the requirement to work in an “Area of Need”. Overseas-trained doctors are subject to Medicare provider number restrictions under sections 19AA and 19AB of the Health Insurance Act 1973 (Cwlth). To deliver a service that receives a Medicare rebate, doctors can apply for an exemption to work in an Area of Need, often in a rural location. Hospital appointments lie outside these legislative restrictions. Overseas-trained doctors also represent a small percentage of the overall Diplomat workforce and are unlikely to make a significant contribution to the workforce shortage in obstetrics.

The age profile of specialist obstetrician/gynaecologists in Victoria does not, in itself, show any particular cause for concern. The number of Fellows graduating in Victoria each year is relatively constant and, from that point of view, the number of specialists being added to the Victorian workforce (excluding overseas-trained doctors) is predictable. However, the assumption that one new Fellow is equivalent to one retiring Fellow is flawed, because those entering the workforce do not represent sufficient full-time equivalents to maintain current service levels.

The important factors are the significant rate of retirement from obstetric practice over the past decade across all ages, an increasing intention to not practise obstetrics, a fragile rural and regional specialist workforce, and a rapidly changing sex distribution. Workforce policy focused exclusively on new Fellows and trainees is unlikely to be enough. Attempts to increase raw numbers by recruiting from overseas do not seem to be making a large impact. Solutions need to take a wider view, based on what the workforce is reporting as barriers to practice.

The 2002 prediction in this journal of an unsustainable specialist obstetric workforce is upon us. Meanwhile, some improvements to conditions of service may help, including
assured locums, more cooperative working practices to enable acceptable rosters, changes in the pattern of work to accommodate practitioners with children, and improving the quality of rural placements for medical students and trainees. Recent federal government initiatives to increase the number of medical graduates, such as bonded scholars and bonded students, may provide more new doctors entering the workforce and, in proportion, more GPs, and more GPs involved in obstetric services. These initiatives will not be realised for many years.

Our findings for Victorian GP obstetricians suggest that significant increases in the workforce will not occur through vocational training alone. Our finding that the GP obstetric workforce will reduce further within 7 years adds to concerns about the future sustainability of obstetric services, especially in rural Victoria. The large group of doctors, mostly in their 40s, who have ceased procedural obstetric practice, offers a potential workforce solution. This group is much larger than the doctors remaining in procedural practice or those entering vocational training.

If a satisfactory rural workforce is to be maintained, it will require action from both government and practitioners. Government needs to support the required training positions. It should also consider loading financial incentives for intrapartum obstetric services, especially in rural areas. Substantial financial incentives are probably the only means of inducing the 40-50-years age group of GPs back into active obstetric practice. Lifestyle issues, such as balancing on-call duty with family commitments, would be best managed by a combination of enhanced income and the willingness to cooperatively share the care of patients.

Providing obstetric services across rural and regional Victoria requires a workforce of both specialists who staff RRMA 3 towns and GP obstetricians who staff RRMA 4 and 5 towns. Our findings point towards an urgent need to rebuild that workforce by developing policies based on the evidence in this and other studies.

ACKNOWLEDGEMENTS

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COMPETING INTERESTS

None identified.

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REFERENCES


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