

have recently completed a review of compliance with GDM testing in our area, knowing the true incidence of GDM, this has allowed us to revisit the accuracy of the data being recorded on the Midwives Data Collection Form.

In the city of Wollongong, NSW, with a population of around 280 000 and about 3000 births each year, all deliveries take place at two public hospitals (Wollongong and Shellharbour) and a private hospital (Illawarra Private Hospital). It is the policy of both the Obstetric Department and the Division of General Practice that all pregnant women should be tested for GDM in accord with the ADIPS guidelines.⁴

All women who delivered at the three hospitals over the 6-month period from January 2002 to June 2002 were identified from the Labour Ward records. A hospital-based delivery is used by 99.3% of women in the area.⁵ The results of testing for GDM were determined for all of these women.

There were 1655 deliveries at the three hospitals over the 6-month period. Seven women with known type 1 or type 2 diabetes were excluded, leaving 1648 women whose data could be examined. Women were considered to have been tested for GDM ($n = 1518$) if they had had either a glucose tolerance test ($n = 1502$) or a glucose challenge test ($n = 16$). There were 101 women diagnosed with GDM, giving an overall incidence rate of 6.6% (prenatal clinic, 7.1%; shared-care, 6.6%; private patients, 6.3%).

The most recent midwives data indicate an incidence of 5.7% at the public hospitals and 3.1% at the private hospital. It is thus apparent that the official statistics still underestimate the incidence of GDM. A similar degree of error may also be found for other entries, and hence data should be extrapolated with caution.

A redesign of the collection form may help remove some of the errors and omissions. For the question regarding GDM, we feel accuracy could be enhanced if there were separate "Yes" and "No" boxes, rather than a single check box. This might encourage further consideration of the problem. Accuracy could be further enhanced by allowing space for the glucose tolerance test results at 0 and 2 hours — these

would also be useful data in their own right.

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IN REPLY: Moses et al are correct in noting that gestational diabetes mellitus (GDM) is under-reported to the New South Wales Midwives Data Collection (MDC). The most recent validation study of the MDC was carried out in 1998. We reviewed a random sample of 1680 medical records from NSW public and private hospitals representing 1.9% of births reported in 1998. The sensitivity and specificity of reporting of GDM to the MDC were 86.7% and 99.6%, respectively.¹ In this sample, the incidence rate of GDM was 3.5% according to the MDC, and 4.0% according to the medical record review.

These population rates are lower than the rates reported by Moses et al among women attending hospitals in Wollongong. In addition to incomplete recording of diagnosed GDM on the MDC, the low rate of recording of GDM in medical records in our sample suggests that GDM was also under-ascertained at a population level. This is probably due to variations in the implementation of pregnancy screening for GDM between clinicians and across NSW hospitals.

In February 2003, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists endorsed the Australian Diabetes in Pregnancy Society GDM Management Guidelines.² The guidelines recommend universal screening for GDM, noting that selective screening may be appropriate because of limited resources or known low GDM incidence.

The suggestions for trying to improve reporting of GDM by redesigning the MDC form are welcome, and we will certainly consider them at the next review. We are also considering using the hospital Inpatient Statistics Collection (ISC), in which discharge diagnoses are classified according to the International Classification of Diseases, as an alternative source of information on maternal morbidity. We are currently reviewing a random sample of 500 medical records of mothers who gave birth in hospitals throughout NSW. The information obtained will be compared with matched ISC records provided to the NSW Department of Health to determine whether the ISC is a more reliable source of information on maternal morbidity than the MDC. In the longer term, I anticipate that the integration of the MDC with computerised medical records in hospitals will also contribute to improved reporting.

Under-reporting of maternal morbidity, including GDM, is an issue for all state and territory perinatal data collections in Australia. The information is used for planning and evaluation of healthcare services, so it is important that we get it right. I would like to thank Moses et al for raising this issue.

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Addressing the shortage of rural physicians in Victoria: maximising rural trainee recruitment

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TO THE EDITOR: Rural Australia has a substantial shortage of specialist physicians. In 1999, Victoria had 52 specialist physicians for 1.3 million people (a

physician to population ratio of 1:25 000).¹ The Australian Medical Workforce Advisory Committee recommendation is 1:10 000.² Although much has been written about the shortage of rural general practitioners, there is little about rural specialist physicians. However, evidence from Western Australia showed that advanced trainee physicians interested in rural practice were diverted to city-based practice during their training.³ Here, we outline a state-wide approach to encourage advanced trainee physicians to complete their training in rural Victoria.

The University of Melbourne Department of Rural Health in Shepparton provided support for rural Victorian physicians to develop a state-wide network, the Victorian Rural Physicians Network, under the Victorian State Committee of the Royal Australasian College of Physicians (RACP). A pilot survey in the 14 major rural Victorian centres demonstrated capacity for at least nine Advanced Physician Trainee positions across rural Victoria. The RACP accredited five positions initially, with others to be reviewed for accreditation if required. These positions were funded largely by the joint Federal-State Government Advanced Specialist Training Program in Rural Australia.

Four trainees completed 12 months of rural training in 1999–2000, and three are now working as rural physicians. These trainees were recruited through advertisements in the RACP newsletter and personal contacts. The trainees provided substantial benefits, both in service delivery, as their presence reduced the load on other doctors in the same hospital, and in medical education, as they provided more education and supervision for junior doctors and doctors from overseas. In 2001, a similar approach to recruitment identified eight potential applicants, but none came to interview.

In 2002, three new strategies were therefore introduced:

- Flexible, joint rural–metropolitan positions were created;
- A rural physicians' conference was organised;^{4,5} and
- A management consultant was employed to contact personally all 99 Victorian basic physician trainees expected to enter advanced training.

The response to the new approach is shown in the Box. A third of contactable trainees indicated an interest in rural practice at the end of their basic training. Ten applications were received for the rural training positions, and seven trainees were appointed (three with-

drawn). We believe that our new strategies have merit, and that the personal touch has created goodwill which may improve the response for 2004.

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The effect of female age on the likelihood of a live birth from one in-vitro fertilisation treatment

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TO THE EDITOR: Jansen's study¹ of the effect of maternal age on IVF outcome yields information that has not been available. However, the presentation of the data raises two questions.

Firstly, are the births reported all attributable to IVF intervention? A couple is considered infertile if they are unable to achieve conception after a year of unprotected intercourse, or the mother is unable to carry a pregnancy to a live birth.² In reports of infertility, there is a natural conception rate of about 25%–30% per annum,^{3–6} and Jansen's study, in effect, covers a 3-year period (or 4 years if you include the period for assessing the outcome of the pregnancies).

We need to know whether natural conception has contributed; whether the couples continued to have unprotected intercourse during the course of the study; and what means was used to identify a pregnancy as an IVF pregnancy (as distinct from a natural conception, if that distinction was made).

Jansen notes that there was a group of women who dropped out after treatments were initiated and before egg retrieval, and a further group for whom eggs could not be retrieved. It is unclear whether the former included those who had a natural conception. In terms of evaluating the success of IVF, more

