FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Bairnsdale — 7 December 2017

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Witness
Dr Antoinette Mowbray, and
Dr Elizabeth Boyd.
The CHAIR — Welcome, Antoinette.

Dr MOWBRAY — Thank you.

The CHAIR — Take it away. Probably give us about 8 to 10 minutes of what you think is going on here, and we might not ask questions or we might. We just want to hear your thoughts and your experiences on what is happening around in this area and how we could improve.

Dr MOWBRAY — I would have to agree with everything that Liz has said so far. It saves me repeating a lot of that, and adding some things of my own. I guess I might preface it by saying that as someone who grew up on the other side of Cann River, I am quite passionate about rural medicine.

Ms McLEISH — You know remote and rural!

Dr MOWBRAY — So let us say 12 ks of dirt before you get to my parents’ place, and they still live there. My teenage dream was to go back to Orbost, but reflecting on the sort of things that stop people going back, once I did my advanced obstetrics diploma in Warragul — I was one of David Simon’s protégés, I guess — going back to Orbost would mean not being able to do anything but the bare minimum, normal stuff and not being able to do things very often. So I guess for me Bairnsdale was a better place to start, and since then the obstetrics service has closed in Orbost. But still, thinking about going there and taking up that place, for me, even though it is closer to my home base, would mean not being able to do anywhere near as much obstetrics. I guess it is a multifactorial thing.

Just an overall thing, I have some notes I wrote down before. As we have said, we have seven GP obstetricians here. One of those is planning to retire next year, so we will have six after that. I think I found it a really good experience moving here. It was still a big learning curve coming from Warragul to here. I was thinking about one of the first caesars I was doing by myself in the middle of the night with another experienced GP obstetrician. You think the nearest specialist obstetrician is 40 minutes down the road and cannot come and help you if you need it. I had great mentorship by both Liz and her husband, and I think that helped a lot in seating me into thinking that I felt comfortable within my role here. I think I would reinforce —

The CHAIR — Is that just luck, Antoinette, having that support?

Dr MOWBRAY — Not necessarily. Probably partly, but I think in both of the main clinics here there has been senior support for many years. The GP obstetricians here have been here for 30 years, and what they have not seen is not worth talking about.

Ms BRITNELL — But is it a formalised mentor program or is it a —

Dr MOWBRAY — It is not a formalised mentor program here, other than looking for people as far as succession planning and then having a two or three-year crossover. I guess that was planned.

Dr BOYD — We have the bridging posts.

Dr MOWBRAY — Yes, so bridging posts was something that I did after my year of advanced diploma training in Warragul. They have something where you do half-time obstetrics, half-time general practice, where you are still doing semi-supervised obstetrics for a year prior to then moving out somewhere where you are a little less supported. I think that is critical. My level of confidence —

Ms McLEISH — Is that new?

Dr MOWBRAY — No, but I think that is something that is specific to Gippsland. I do not think they do it in Queensland. It is something that David Simon has done.

Ms McLEISH — So it has been going for five years; is that right?

Dr MOWBRAY — Yes, I would say so.

Dr BOYD — It is about five years and we have had three people.
Dr MOWBRAY — Yes. So, as Liz said, we have got three or four of the ones who are here who have benefited from that, and I think it is really critical. As I said, my level of confidence at the beginning of that bridging-post year compared to the end — I would tell David about everything I was doing, then towards the end I would only tell him about the ones I thought I needed to. Even now, we sometimes ring up and just go, ‘I’m doing this; do you think that’s reasonable?’ and go, ‘Yes’ or ‘No’, and provide advice. I think it is really important having that regional network of people. As we often say, it is always better having two heads. Often the decision you are making is the right one, but never being arrogant enough to think that you never need to ask for advice.

Given that David is moving away, there are another couple of obstetricians that I will talk to sometimes. I will reiterate that sometimes it is difficult with the obstetricians who are not familiar with what we have here. We have some — perhaps one — who came and tried to meet us and said, ‘Do you do caesars here?’; and we said, ‘Yes’. ‘What sort of support do you have?’ The answer was, ‘That’s not good enough’, and, ‘Do you do instrumental deliveries?’. To ask someone that in a small regional hospital where if you were not confident doing instrumental deliveries and were not confident doing caesars, then you should not be working here, to say, ‘Do you do it?’ — if we ring for advice, the support we get is ‘You can’t do anything’, and that —

Ms McLEISH — If you ring who, the obstetricians?

Dr MOWBRAY — Some people for advice, yes. If we ring for advice, unfortunately unless it is the one person who is very supportive and understands what our skills are, who now only works one day a week, we then ring someone at Traralgon or Warragul who understands where we are at.

Ms BRITNELL — Is that because they have got to be risk-averse with the advice otherwise that puts them in a predicament themselves?

Dr MOWBRAY — It is possible, but you could say that they are at more risk by asking us to do something that is less safe than managing a patient well here. It is possible. I think that if they honestly do not understand what our training has been and what we are honestly capable of and not capable of, it makes it very hard for them to provide good advice. But sometimes I think if you come from a certain area where GP obstetrics has never been a feature, you would find it really hard to get.

Ms BRITNELL — Can I seek clarification? Are you saying these are specialists who do not understand, who just look down on GP obstetricians because they think they do not know what they are doing? Is that what you are saying?

Dr MOWBRAY — I think that is probably what it is, yes.

Ms BRITNELL — The hierarchy of the medical world. Okay, I get it.

Dr MOWBRAY — Yes. There is possibly an element of, ‘We don’t think you should be doing it’. There may be some cultural elements to it as well. I do not know what to say other than that. It does make it difficult, though. If you ring up for some advice and you get told something which you know from your own training is unsafe, it makes it difficult. So sometimes we then ring somebody we know we can trust.

Ms McLEISH — Is that formalised, so this week you would go to this person, next week you would go to somebody else?

Dr MOWBRAY — You ring who is on call for that particular hospital. I know that the one in Sale who I am comfortable speaking to only works on a certain day of the week, so if it is that day I ring them. But, yes, it is awkward. I guess I am being a bit frank.

Ms McLEISH — It is good.

Dr MOWBRAY — I think part of the crucial part of maintaining a GP obstetric workforce here is the good training that we were given in that Gippsland hub, and I think it is really crucial that that continue. Also, the opportunity for maintenance of skills, conferences and opportunities for upskilling, the government grants that are given, the $2000 a day procedural grant, which helps to make up for the loss of income from leaving the clinic where you were, as well as pay for conference costs as well as go to a hospital and spend a day with a consultant to make sure you are not learning any bad new tricks, I think is really crucial. I benefited from the
HECS reimbursement scheme as well, and the RAMUS, and I think all of those things are critical for maintaining a rural workforce.

Again, the good collaboration with midwives and the staffing challenges are something I would go on with. The perinatal emotional wellbeing resource is critical and it is always overstretched. I know there is limited funding for that. As far as just feeding that back, some women who are acutely emotionally depressed postpartum and antenatally have to still wait four weeks to see the perinatal emotional wellbeing counsellor because she is so stretched. She is excellent and she is a fantastic resource, but it is something we could use more.

Ms McLEISH — Where is she?

Dr MOWBRAY — She is based in Traralgon, but she comes up here one or two days a week.

Dr BOYD — She is based here, but she has responsibility for east of Traralgon.

Dr MOWBRAY — Oh, based here, but you have to refer through Traralgon, so I thought that she was based there.

The CHAIR — Fair enough, too.

Dr MOWBRAY — She is responsible for everywhere east of Traralgon.

Ms McLEISH — Can you just clarify that for the record? She is based in?

Dr MOWBRAY — She is based in Traralgon, by the sounds of it. No, she is based in Bairnsdale, sorry.

Ms McLEISH — But you have to call through Traralgon —

Dr MOWBRAY — You have to call through the mental health triage at Traralgon to refer. I do have her email address and we correspond about specific patients sometimes. That helps bridge the gap, but the waiting list is often four weeks to see somebody. Again, PIPER: very helpful most of the time, especially for advice on occasions where we have had conflicting advice from other consultants, where we have had challenges, they have been helpful. But sometimes it has been a case of, ‘Okay, we have organised a bed here; now you can organise an ambulance’, and that is sometimes where the delay is because the ambulance feels that perhaps a 27-weeker with ruptured membranes can wait till midnight when it is 3.00 o’clock in the afternoon.

Ms BRITNELL — So PIPER organise the bed but you have to organise the ambulance. Is that what you said?

Dr MOWBRAY — Often, yes.

The CHAIR — I thought it was all the same program.

Dr MOWBRAY — Not always.

The CHAIR — Is that just in the regions?

Dr MOWBRAY — It depends. If it is lights and sirens really urgent and they actually need to send a team up to retrieve someone, like a sick baby, then that is often the case, but I transferred a 27-weeker with ruptured membranes last Tuesday, and we organised an ambulance and the ambulance said, ‘Can it wait till midnight because we’re transferring someone else out?’; and I said, ‘Probably not for someone who has had two babies before, unless you want a 27-weeker to deal with’. We have had 30-weekers born here before, and they will usually come for those. Sometimes they just happen too fast and you have just got to deal with it here.

Ms McLEISH — A 30-weeker, would you take that to Sale, or is there not the right capability at Sale?

Dr MOWBRAY — If the mother is pushing, then it is too late.

Ms McLEISH — Yes, but I mean once the baby is born.
Dr MOWBRAY — No, Sale will keep over 34 weeks, Traralgon will keep over 32 and beyond that goes to Melbourne.

Ms McLEISH — So Sale, Traralgon then Melbourne?

Dr MOWBRAY — Yes. So a 30-weeker would go straight to Melbourne. I think the biggest thing I wanted to raise was the issue with support from some places because, as Liz said, part of our strength relies on the support we can get, because you do have to deal with some high-risk patients here. We have got a few cases of twins, which I classify as high-risk, but some of them have financial issues. They do not or they will not travel further on. I remember having one young mum with twins who had not seen anyone for 10 weeks who rocked up one day and I went, ‘Hang on a minute. You need a few things done and you need to actually see somebody other than us’. And sometimes those things just happen and you just have to deal with it the best you can. We are trained as part of our upskilling days to make sure that we have regular training in managing breech deliveries and managing twins if we have to. Obviously we do not go looking for it, but if we need to, then we need to be prepared for that.

Ms McLEISH — Can I just ask a question about the support and ringing the person on call? Is that a statewide system? For other areas, at smaller hospitals like this, with GP obstetricians, would that same service be available in each of the regions, do you know?

Dr MOWBRAY — I would think so. I cannot really comment on the other regions. I worked in Tamworth before and usually if they needed something, the next biggest hospital was Newcastle and you would ring whoever was on call there.

Ms McLEISH — Is this a department of health region? When you talk about region —

Ms BRITNELL — I do not think it is formalised. I think it is just how it has evolved.

Dr MOWBRAY — No. It is just that Sale is our next hospital, and if it is appropriate for them we ring them first. So if we have someone who is under 37 weeks who has ruptured their membranes and needs to go somewhere, we know that that fits Sale’s criteria, so we ring them and say, ‘Can you take them?’ If it is for —

Dr McLEISH — What about for advice?

Dr MOWBRAY — For advice? That tends to be who you know, relationship-based.

Ms McLEISH — Okay. That is just who you know. There is nothing formalised?

Dr MOWBRAY — No.

The CHAIR — Antoinette, just from a layperson’s perspective, is that because something is not as straightforward as you think it could be, and you would ring someone off your own bat for advice just to support your opinion and know you are doing the right thing? There are no forms or anything like that?

Dr MOWBRAY — No forms.

The CHAIR — No forms that they fill out or anything? It is just you ring them and get some —

Dr MOWBRAY — And then I document what they have told me, yes. Normally the process would be we would ring the next hospital. It is due in part to the difficulties with some of the support we have had and some of the advice that we have been given at times that sometimes we have then rung the next person we felt comfortable with, and they have thankfully been very supportive in that regard. They are aware of the issues. We have tried to escalate the issues in the past. We are trying to work on them, but it is a slow process.

The CHAIR — So you are ringing someone for advice, they are putting you impossible positions, and you seek other advice, essentially?

Dr MOWBRAY — Yes.

Ms BRITNELL — And document it.
Dr MOWBRAY — Yes, pretty much.

The CHAIR — Very good — cover yourself.

Dr MOWBRAY — But the other support we have had from other people who understand the situation has been invaluable, and they do it gratis, which I think is a credit to them.

The CHAIR — Anything else that you want to pass on to us today?

Ms BRITNELL — When you have finished, many people go to a big centre, and obviously part of your training is within — I do not know where you did a lot of your placements and training?

Dr MOWBRAY — For obstetrics or for general practice or both?

Ms BRITNELL — The whole lot, what you did.

Dr MOWBRAY — I went to Newcastle for my undergraduate. I spent the last two years in a rural clinical school in Tamworth. I then stayed on for my intern and resident year there. Then I got onto the GP training program in eastern Victoria because I wanted to come back and I knew that they had some good procedural skills, plus someone had talked me into doing obstetrics and in the process I fell in love with it.

Ms McLEISH — Lucky!

Dr MOWBRAY — My 12 months DRANZCOG advanced was based at Warragul. They made us do three months in Dandenong for some tertiary experience. David Simon said, ‘To get yourself enough experience, I want you to get 100 caesars in that year’, to which I initially went, ‘That’s a lot’, but I managed to achieve it, plus a few. Part of that involved going to Sunshine Hospital for caesar lists and Casey Hospital, as well as Dandenong. Interestingly, I got way more experience at Warragul and the other places than I did at Dandenong because there is much less competition for training. At Warragul I was there as one of two GP registrars, both doing obstetrics with the consultants. We got really good guidance, whereas going to Dandenong you are competing with other people who take priority because they are further up the training line-up. So in the three months in Dandenong I did one vacuum, one forceps. In Warragul, I did 70 vacuums in the other nine months.

The CHAIR — Is vacuum ‘ventouse’?

Dr MOWBRAY — Yes.

Ms BRITNELL — You have answered my question.

The CHAIR — Or ‘cone head’, as I think one obstetrician put it.

Dr MOWBRAY — Something like that. It helps to avoid a caesar occasionally.

The CHAIR — Can I just say thank you for coming in today, because it is the first time we have actually heard from — I do not know whether to call you a junior practitioner or someone that is new to it —

Dr MOWBRAY — That is fine. I fellowed two years ago.

A MEMBER — You look so young.

Dr MOWBRAY — Let us say I finished high school 14 years ago.

The CHAIR — We are not judgey here. Your frankness is certainly appreciated because that is very useful to us. We have had people trying to paint certain pictures about funding and whatnot, and often we have to dig. We did not have to dig too far today. Thank you so much for coming in.

Dr MOWBRAY — No worries. Thank you so much for coming to ask us. I think having the opportunity to say something is really heartwarming.

Committee adjourned.