

TRANSCRIPT

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Warrnambool — 11 October 2017

Members

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Dr Liz Uren, obstetrics and gynaecology, South West Healthcare.

The CHAIR — Welcome, everybody, to this public hearing of the Family and Community Development Committee's inquiry into perinatal services in Victoria. The committee is delighted to be here in lovely Warrnambool for this, the first of the regional public hearings for this inquiry. Under the terms of reference for this inquiry the committee will examine the quality and safety of health services delivered to women and their babies during the perinatal period, the provision of an appropriately qualified workforce and perinatal mental health services for women. A major issue for this inquiry is the disparity in outcomes between regional and metropolitan locations, and we look forward to hearing today from local health professionals and the community here in Warrnambool about these issues.

Later in the hearing we will be opening up proceedings to members of the public to have their say in a community forum, and I encourage anyone who wishes to speak to the committee about their experiences to take this opportunity, and if you are in the gallery today and you are keen to make a submission, please let us know prior to lunchtime. Our committee staff, Greg and Rachel, are here to help.

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. Note that the broadcasting or recording of this hearing by anyone other than accredited media is not permitted, and today we also have Parliament's broadcast team here, who are filming the hearing. All mobile phones should now be turned to silent. That being said, thank you for welcoming us to Warrnambool today, and we hope that we will get lots and lots of information that will inform the recommendations of this very important inquiry.

I welcome you to these hearings, Liz Uren, specialist in obstetrics and gynaecology from South West Healthcare. Thank you for attending 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 the hearing will not be afforded such privilege. It is a contempt of Parliament to provide false evidence. These proceedings will be recorded, and you will be sent a proof copy of the transcript.

Now that that is out of the way, you have got some of the friendliest people in Parliament, so do not be nervous. Perhaps you would like to begin by making a 10-minute statement, and then we might ask some questions if that is okay with you.

Dr UREN — Thanks for the opportunity to address the committee. I set mine out as per the terms of reference and missed a couple of them out which were not particularly relevant to me.

Regarding the quality and safety issues, our greatest barrier to receiving or providing information about our referrals to the city units is really the lack of universal records, results and all that sort of thing. So we have a lot of trouble still with even receiving letters back from the units in town; probably Australia Post has something to do with it. I think there is some sort of hole in Geelong where stuff sits for several weeks. I am not quite sure, but it can be quite a long time before we get some letters back. That just makes it quite dangerous if we have got people who have got decisions made in town and we have not got the answers to what we are supposed to do with them, particularly in pregnancy because it is a time-limited part of someone's management.

There is no uniformity amongst any of the hospitals with respect to their IT set-up or their records provision, and even within our hospital we have five different systems within the maternity services. So there is a paper-based hospital record, there is a paper-based patient-carried record, there is an antenatal computer-based record and then there are two other IT systems on the ward. One is for monitoring fetal heart rate and the obs in labour, and one is postnatal on the ward. So that is five for each person. You can get access to most of them most of the time, but it is fraught with danger really in terms of people missing out on information.

I think it is an ongoing problem for all the hospitals. I think that there needs to be some sort of statewide clever IT solution that needs a big logistics company with high-level expertise. I just do not think each hospital is very good at designing their own systems or buying them. There are products on the market, but they all look very good when you bring the people round and they show you the gizmos. I think it needs to be something that is addressed throughout the state.

The other thing that I find personally a waste of time and energy is this lack of universal protocols for obstetric care. There was an attempt about 10 years ago now with the 3centres protocol between Monash, Royal Women's and the Mercy, and they really did not quite get to consensus at the time. This was for how you

manage a pregnancy kind of stuff. That has slipped even further back at this stage, and all the hospitals are basically making their own protocols up all of the time, basically using the ones from other hospitals and then putting their own stamp on it for the purposes of accreditation. I just find that such a silly thing, that then you might have staff rotating through the different hospitals and their protocols are all different for stuff that should essentially be sorted out beforehand. That is something that I do not think could be that difficult. I think Queensland and Western Australia are a little bit more on track with a universal protocol system, so I think we should be looking at that.

As to the emotional health program, obviously the PEHP program, we are all a bit worried that that was filling a lot of the gaps that we have with psychiatric and drug and alcohol services. We would certainly like to see that continue, but the funding I understand is not necessarily guaranteed. We have very difficult problems with inpatient liaison psychiatry being very unavailable most of the time unless we scream and shout quite a lot. The outpatient care is probably even scarcer to acquire, and there is very little continuity of practitioners for psychiatry that we have here.

I think the other thing we need to understand is in the last 10 years the treatment for bipolar and psychosis disorders has actually left a lot of women's fertility intact, whereas it did not used to before, so we have got a lot more women in the system now who have potential for severe exacerbations of their psychiatric disorders by being pregnant, and they do very well most of the time until a crisis occurs, and then the crisis management is left wanting. So we do have that problem.

We also have trouble having an appropriate for-pregnancy drug and alcohol service in Warrnambool. That is just fairly difficult. There is one drug and alcohol physician in the hospital, and his expertise with pregnancy is limited. We had a woman recently who we were hoping to transfer up to the Royal Women's drug and alcohol unit because she was on a large dose of morphine. We were just not managing her as well as we should have been, and we really were refused access to that bed because presumably they did not have one. She ended up in Melbourne eventually because she had to be delivered at 26 weeks gestation, but it was really not an appropriate thing to happen here.

Number three is the availability of services to deal with very high risk births. For complicated pregnancies I think a few of the other hospitals have recommended in their submissions that telemedicine could be used more for some of the foetal medicine unit reviews. Whether or not they can have all those reviews out of Melbourne really is to do with the ultrasound departments that they have to attend to have the formal scans done, but some of the reviews did not necessarily need to be done in Melbourne.

The only thing with that would be when you have a telemedicine consult you really do need a little bit more time with the patient to actually set it all up at the time. So that would have to be counted into the scheduling, I suppose. Some of the patients that refuse to travel are actually the ones that really need to be seen by the high-risk unit, so I think telemedicine would be the backstop there for some of those people.

The other thing I think is that there may need to be more accommodation options for women who are required to wait for delivery in Melbourne or the bigger centres. We have got a problem there where we will not deliver women with a BMI over 50. We have had a couple of occasions where women have been sent down and they were supposed to stay in Melbourne or wherever to deliver their baby and they have just said, 'No, I can't do it. I can't afford it. I'm just going to go home'. So we end up with them anyway, and it sort of defeats the purpose of referring them.

Access to appropriate workforce: Warrnambool has got a permanent state of stable workforce crisis in that we have to still use locums for weekends — every one in four — at the moment for obstetric specialists. Our main source of good recruitment over the years has actually been using senior registrars. Everyone is focused very much on putting rural students through medical school, but the other part of that is that when you do specialist training, you end up in Melbourne for a lot of the time doing a lot of your training. The bit that we want to get them at is the last leg — the last couple of years of their training — because that is when you can influence their plans for work and where they settle and all that sort of thing.

So we would really like to promote that the O and G college have a commitment to training generalists, which means obstetrics and gynaecology in the same specialty. There has been a bit of a push these days to split it into two sections. It works better in Melbourne, but it does not work at all here; we need to be both. We feel that you

would have to have double the number of specialists here if we had split obstetrics and gynaecology. I think we need to just make sure there is a commitment to training generalists within our college.

There also needs to be funding of senior registrar positions in places like Warrnambool. At the moment there is a job here that is funded federally by the ESTP funding model, which is the federal money, through St John's hospital, and the St John's hospital is wavering a bit in its happiness to keep going with that, so we would really need to be funding that position through the Warrnambool Base Hospital if we were going to continue with it.

There is also a push at the moment to have a rotating senior registrar position that Ballarat and Albury-Wodonga are happy to have on rotation with us, but we would also have to fund the hospital position here. There has been a bit of a general push for hospitals to cut registrar budgets, so we are a bit anxious that we would get the senior registrar position funded at some point, because it is really the home stretch for recruitment for us. Whether the psychiatrists could use senior registrars — maybe they would recruit people more too — I do not know. I do not get to see them very often, so I do not know whether there is a way they could do that.

I think the medical staff are the people who do recruit their newer colleagues. We support each other. The ads in the paper generally get short duration results; they tend to get people in for a little while who do not particularly want to be there and tend to live as quickly as they start.

The other thing I would like to say personally is that good secondary schools are key in the case of keeping specialists in the country, and GPs as well. I think that is something that people do not recognise. It is much more key than any other reason. It is certainly not the weather in Warrnambool that keeps us here. The main reason I have stayed here for the last 15 years has been the outstanding high schools. This is much more important than people realise. I think I should do a study and publish it or something.

The other thing is that exit interviews are important. I do not think that happens. I think the CEOs of the hospitals should have exit interviews with any specialist that leaves. They really need to know what the problems have been. Sometimes it is just the secondary schools that they are not happy with or whatever. As far as lactation practitioners go, I have a personal beef with this. I think there should be more practitioners involved with lactation, including GPs, obstetricians and more midwives. The current acceptance of the American lactation qualification, I do not know where that came from. That it is the only qualification is, I think, the problem, and it is a bit onerous for people, particularly in rural places, to get that qualification. You need 1000 hours before you can even sit the exam.

So I think we need an Australian-based grad. dip. course. But I am not going to start it. I do not know anyone who wants to. But I think it is ridiculous that we have to rely on an American exam for people to become lactation practitioners. It is actually a bit of an anti-doctor course. I have actually been through this process with one of my practice midwives, and some of the questions are quite non-collaborative, you would say, with the medical workforce, and I do not think that is a good thing to promote, because it requires all members to be on team for those problems.

Regarding number 6, disparity in rural outcomes, I think our issue at the moment with emergency cases in Warrnambool is theatre availability. I know we are supposed to be getting new theatres, but it is also the after-hours staffing. We have got much more growth of subspecialties, and we have had a few cases where we have had ectopics and placental abruptions that were taking way too long to get to theatre. That is because the theatres were occupied and we do not have second teams necessarily on call at the moment.

There is also just a lack of staffing in theatre after hours, including orderlies and technicians, and that is a bit of an occupational health risk for us as far as lifting patients on and off beds. There is an increased complexity of cases. There is obviously an obesity problem with pregnant women. All that sort of stuff makes life a bit more difficult after hours particularly.

The other issue for us as obstetricians here is that we are also sub-managing Portland, Camperdown, Terang and Hamilton. They are our feed-in hospitals around the place. The transfer times can be a bit dicey. We had a lady who took 7 hours to transfer in with a fourth-degree tear — that is a vaginal tear into the rectum — and that was a very long time to get her here. It did not improve her surgical outcome.

We are also expected to keep an eye on those hospitals as far as whether their risk assessments are appropriate and whether we should be seeing more of those or they should be going to Melbourne or anywhere like that.

Often I think we feel that there is a perception that we are trying to poach their patients or their numbers, because to them numbers are important as far as their services go. I think it would be better if there was an external formula that everyone had to follow for booking in visits. That is again another protocol thing that is not uniform. Whether there is a way where that is what happens without us telling them what we think they should do, it is more a 'everybody should do it' thing. I think patients need to understand what the availability of staffing is at the small units, and I do not think that always happens.

I suppose the only other two little things are that we are using Medicare to fund our clinics here at the moment. The cost of providing outpatient staffing is obviously outstripping the Medicare rebates, so it is becoming expensive for us to run the clinics and probably costing the hospital money. The other thing is that I do worry slightly sometimes about our hospital postnatal care. Sometimes the safety of home visits for the midwives is not ensured. The idea that everyone should be able to be cared for after their delivery — after a day or two in the hospital and then at home — does not fit for every single person. I think it would be inappropriate for some people to be going to houses, especially on their own. I do not think midwives visiting houses on their own is always a good idea. That is my list — my wish list.

The CHAIR — Thank you. We have been taking copious amounts of notes.

Dr UREN — Thank you.

The CHAIR — Do you mind taking some questions?

Dr UREN — No, that is fine.

The CHAIR — I might start. Just going back to the example of the fourth-degree tear and the 7-hour transfer, as a bunch of laypeople — except for Roma, here — would you be able to explain to us how that happens?

Dr UREN — I think the problem with these delayed transfers is that usually the ambulance has already left with somebody else. So I think it is an in-and-out issue. I do not understand the ambulance services completely, but I gather there is a limited number of cars, so either they leave from here to go there to pick someone up and bring them back, or there is a car that lives there that brings patients here and then has to go back again and go back again. I think it was something to do with that. Obviously the fourth-degree tear was not an emergency as far as a death-type outcome, which is good, but it just seemed a very long time for that person. And equally, it could have been something more urgent or pressing.

The CHAIR — So it is not mismanagement at all; it is just resourcing at this stage?

Dr UREN — No, I think it is just an ambulance resource thing actually.

The CHAIR — Just because I am not from this beautiful area, how far do women travel to access the health care services in Warrnambool?

Dr UREN — From other places to here?

The CHAIR — Yes.

Dr UREN — The outstations would be more like about 2½ hours. You get some coming in from, say, Casterton and places like that — Princetown. Apollo Bay tends to go further the other way. We get some Colac people. If Geelong gets very full with things, particularly over Christmas, we seem to get a bit of a Colac flush, so that is another couple of hours down the road.

The CHAIR — A final question from me: just in regard to services that South West Healthcare provide for Aboriginal and Torres Strait Islander people, can you give us a couple of examples of where that works or where it does not work?

Dr UREN — I suppose with antenatal care, personally I think it is working reasonably well. The Gunditjmara co-op have a medical service that also has a midwife attached to that, and the midwives from there — there are various ones at different times; Kaye is, I think, about to retire — come with the patient to our

antenatal clinic. They might provide some of the midwife visits there, and then they might bring those women in for their visits. It is all very collegial and fine. I think it is well run, actually.

Dr CARLING-JENKINS — Thank you very much for coming, Dr Uren. We really appreciate your time.

Dr UREN — That is okay.

Dr CARLING-JENKINS — I was quite disturbed with some of your description around the continuity-of-care issues, particularly when it seems like it could be solved quite easily through communication — what you were describing as uniformity just basically in IT. That was quite staggering. It was very well articulated, so I thank you for that. Just to confirm what you were saying, you are looking for a statewide IT system, so there is no snail mail going on, it is real-time reporting.

Dr UREN — It seems crazy that we are still doing it.

Dr CARLING-JENKINS — It does.

Dr UREN — I do not know whether everyone is too scared of the cloud idea. I know I am, but I have heard that we are not supposed to be.

Dr CARLING-JENKINS — We can all work our way through that.

Dr UREN — Yes. I presume it is to do with concerns about privacy and stuff, but the system at the moment is so ridiculous that it could not be any worse, I imagine.

Dr CARLING-JENKINS — It sounds like it.

Dr UREN — I do not know whether patients could have their passwords into their own records, and then they sit in front of you and enter their password. Look, I am not an IT person. I have sons that are, but I do not know how it works.

Dr CARLING-JENKINS — We are in the same boat there: I am sure my son could design something. But just so long as someone tells me how to use it, I am fine.

Dr UREN — I am happy, yes.

Dr CARLING-JENKINS — I just find it staggering. We have got a piece of legislation in front of us at the moment around real-time monitoring of prescriptions, so those systems are possible.

Dr UREN — I know the oncologists — because my husband does use some more centralised thing — I think they are talking about getting a web-based chemotherapy system as well. But there should be —

Dr CARLING-JENKINS — But in this area, it is just —

Dr UREN — Yes. People do not necessarily all stay in the same place. Pregnant women move a lot.

Dr CARLING-JENKINS — It is just very ad hoc. That must be extremely difficult.

Dr UREN — It is very frustrating. I think it is also costly. I think people often get blood tests repeated that should never have been repeated. That is just silly that people are having the same blood tests because someone cannot find the result from that one, and then they do not always have them on them. I personally try and make the patient take copies of their stuff with them all the time, but not everyone will do that. That is double entering, though; you are also writing and typing on the computer.

Dr CARLING-JENKINS — But you know then the file is going with them, and I guess with the high-risk cases, where women are being transferred to Melbourne, that making sure the files —

Dr UREN — If they are actually going to Melbourne to stay — into a hospital — everything goes with them. It is more this business where we have got some patients with a complicated pregnancy — say, there is something wrong with the baby or whatever and they have to go to Melbourne for several visits. It is often the slowness of those letters and the correspondence coming back. I mean, I can send them off with their

paper-based thing and say, 'Can you just get the pen of the person in front of you when you're there, get them to write it down?', because at least we will get that back.

Dr CARLING-JENKINS — So you are not waiting two weeks for a letter from the specialist, which is a lot of time in a nine-month time frame.

Dr UREN — Yes.

Dr CARLING-JENKINS — Fair enough — staggering. Thank you. A great recommendation for us, though. I also note the frustration around retention of staff that you spoke about, and that must be frustrating not just for the hospital management but for students, for women — locums seeing differing people. So it is again a lack of continuity, is it not?

Dr UREN — We have a meeting at lunchtime every Wednesday where we talk about the high-risk cases and things like that. Obviously the locums do not come to those. They turn up on a weekend and they will not know any of the patients really, and they will not have been involved in their antenatal care. So it is a continuity thing that is a problem.

Dr CARLING-JENKINS — Yes. Right through the system.

Dr UREN — So wherever you are using locums, it is usually a less optimal arrangement.

Dr CARLING-JENKINS — Sure; I understand. You also mentioned the issues around psychiatry. I think this is all the same thing, is it not? It is all around continuity of care and perhaps the training that is needed in other specialities. What other specialities would you identify as needing to have more of an upskill in the way different specialities deal with particularly complex pregnancies or women who are pregnant in distress?

Dr UREN — The physician staff in Warrnambool are generally good because they actually see us a lot, so we have got a lot of interaction. We learn off each other and things like that. It is not too bad here. I think we are lucky in a way that our gang are pretty good at learning stuff about obstetrics. I think general practice has become a bit of an area where there is a very small group who have done any obstetric training and the rest have not done any at all. So there is a very limited number of GPs who have actually done any formalised training in obstetrics during their junior medical years, other than as a medical student. I think it would be nice if more of the GPs did a bit more training, because sometimes we do get things that are left too late or things that have gone past their time issue.

Dr CARLING-JENKINS — So more professional development available that is easily accessible?

Dr UREN — Yes. I think the trouble is they are either doing a whole six-month diploma — there are some shorter jobs available that some of them are doing, but they tend to be more service jobs. They end up doing all the discharge summaries, all those sorts of boring jobs, rather than being involved in antenatal care particularly. I think general practice has been left behind the system somehow, other than the people who are formally doing diplomas of obstetrics, but that is only a small number that do it.

Dr CARLING-JENKINS — Interesting. Okay. Thank you very much.

The CHAIR — Before I ask Roma if she would like to ask any questions, I just want to clarify that as far as record-keeping systems go, there is obviously a deficiency there. Is there one model that any healthcare provider in the state, that you are aware of, is using that actually works that could be rolled out statewide.

Dr UREN — No idea.

The CHAIR — Thanks for being honest.

Dr UREN — There probably is, but I do not know it.

Ms BRITNELL — Thank you, Dr Uren, for coming today; we really appreciate your time. You have done a fantastic job of presenting very succinctly the challenges that we do face here in the regions and particularly here in this part of the world. Can I just ask you to elaborate on a few things. Over your period of time here have you noticed that there has been an increase in the high-risk cases that you have had to refer to Melbourne?

Dr UREN — I probably do not have any statistics in my head for it, but it feels that there is. I suppose obesity is one of those things that creates high-risk obstetrics for us, and it just makes generally looking after the pregnancy more difficult, even just being able to visualise the foetus with abnormalities, growth issues or anything like that. It just makes life more difficult — monitoring them in labour and that sort of thing. I suppose the other thing is there are more women who are older having babies, so they are generally high-risk pregnancies, and again, women on other medications. A lot of the medications for medical conditions and psychiatric conditions have improved, and so people are more well. Even things like inflammatory bowel disease, people are not as sick as they used to be 15 years ago, and so they are having more successful pregnancies. So we are seeing people who have other medical conditions in pregnancy carrying through with successful pregnancies, but all of that requires a lot more work; that is the thing — more looking after and being careful.

Ms BRITNELL — You talked earlier about the lack of continuity in IT, and we have heard previously about the challenges of finding neonatal beds and the time-consuming element of it as well. Is that a challenge we face here when you have —

Dr UREN — Transfers and things like that? Yes. The system a different acronym every couple of years anyway. It is still a lot better than when I was a registrar and we used to have to ring four different hospitals to see if we could get a bed. It is still a more centralised system than we used to have. It is time consuming. The time-consuming bit when you have got an acute problem that is obvious is not that bad. Usually if you can say, ‘This person is very sick, they have got terrible pre-eclampsia and they are only 26 weeks’, no-one will turn you away. It is pretty good. It is more when you have got people who have got a subacute problem that is not quite terrible yet, and they will say, ‘Look, can you keep them there for the moment?’. Then we will say, ‘So then we will just send them when they are really, really bad?’. That is where it becomes tricky, because we really would like them to be seen there now, but obviously the workforce constraints from the referral centres are very high too.

Ms BRITNELL — Do you find yourself thinking around the anomalies with IT — you talked about double bloods being done and different pathologies being used, I imagine, and the privacy or even the other issues around having different labs. Do you often find yourself thinking that there is such wastage and that you could improve things if we had more money for other things in the health budget?

Dr UREN — Yes. I think everything you waste in one spot has to be taking it out of another spot. I think that is the problem. So if people were not spending as much time entering things twice or checking things — the midwives in our service have to spend so much time in the antenatal clinic just ringing and chasing blood tests. That time is another time you could be using for looking after people in a different way.

I just think there is a lot of clunkiness in the system at the moment, and it is only because IT has turned up and no-one has been quite ready for how to establish it in hospitals. We are not qualified. In hospitals we are not IT professionals. I do not know whether the IT guys know what we need either. This is the other problem, I think. It is always difficult to say what we actually need to them.

Ms BRITNELL — So the analysis is lacking?

Dr UREN — Yes.

Ms BRITNELL — With the psychiatric challenge you talked about having more successful pregnancy outcomes with people who are being treated for bipolar that used to be compromised as a result — their fertility. What do you see as ways to improve that so we can address the possible crisis — avoiding crisis?

Dr UREN — I suppose it is really that they have actually got plugged into a psychiatrist that they can see, that is their own person that they can see regularly, and not just a different one each time and that they are not expensive. I think the patients here are probably paying too much for psychiatric care; I do not know. There is private psychiatry, but I do not think there is an easily accessible, publicly funded psychiatry unit, and often those patients do not have any money anyway. So there is probably a non-attendance issue with some of them. And then the crisis thing is where we need to be able to get hold of a psychiatrist now and they need to go see them. We can all recognise when the wheels have fallen off, and it is really just a matter of getting someone there immediately.

Ms BRITNELL — Is that a new problem in this region, or has that been happening for quite some time?

Dr UREN — I think it is a long time thing.

Ms BRITNELL — The lack of special —

Dr UREN — Lack of psychiatric care, yes.

Ms BRITNELL — You talked about the GPs. So 20 years ago GPs used to be more encouraged to be involved in obstetrics and gynaecology —

Dr UREN — I think so.

Ms BRITNELL — and then we went down the specialist line. You are seeing that as having consequences now, where there has not been the encouragement of GPs to be —

Dr UREN — I think the way it has been taught has been that you are either completely into doing lots of deliveries and caesars and forceps deliveries and stuff like that or out of it altogether. There is a certificate for GPs that they can do, which is like a three-month placement, but I do not know if that is even the model. There needs to be a bit more women's health taught within general practice, because there are a lot of people that really just think, 'That's women's health. It's too hard. I haven't done a lot of it. Go and see the one chick in this whole practice that does obstetrics and she can deal with all of those problems'. I think it needs to be shared out a bit more amongst GPs. You cannot make people do things, though.

Ms BRITNELL — Was there an issue some years ago with insurance costs, and that is what deterred GPs? Was that one of the — —

Dr UREN — I think it was more for when they are actually doing deliveries. It is not so much them doing deliveries that is the problem. It is more being able to even care for women well who are pregnant or planning pregnancy, particularly things like medications that they are taking and stuff like that. I think a lot of them are getting strange advice and not feeling familiar — or postnatal care. We certainly do not have time to see all the patients postnatally, so the GPs are doing that. But some of them are more or less qualified or happy managing the problems that occur. Again that is where it runs into this lactation stuff. A lot of them are underskilled for that sort of thing.

Ms BRITNELL — Can you elaborate a little bit more on the challenge we have being three hours from city support and then having to manage Portland and Hamilton particularly with their outlying areas of Casterton, Nelson and whatever? Portland had no obstetrics for a number of years and they have just reintroduced it in the last few years. That is my memory of it.

Dr UREN — They have had it ticking along. They had a person there and then another one and then another one — a moving feast of different people. I suppose the problem for them is that it is a distance issue on the other side of Portland, really, because there is a big gap between there and the border and then there is Mount Gambier on the other side. Mount Gambier does drain a little bit of that work as well, which is good for us — that they manage to —

Ms BRITNELL — Can you help the committee understand the numbers issue, from retaining and maintaining staff and skills to hospital funding to actually —

Dr UREN — The problem is that if, say, I went to a job in Portland, you might have to be on call all of the time. Unless you have got two obstetricians, you cannot have a roster, more than being on call all of the time or them getting in locums all the time. What they have done there is that they will ring us and say, 'We're offline now. You guys have to manage the ones that are coming in'. That is what currently happens if their doctor has time off. I think they are trying to recruit a second person there. They also do not have any registrars. It is not quite as easy or as rewarding for them if they cannot do the more high risk pregnancies and they do not have any training. Training registrars is a good thing for us to do. We like doing it. So for them not to have that sort of thing reduces the richness of their practice. It is not a great job for people to go to because it is going to be hard work at night and under-recognised, probably.

Ms BRITNELL — Hard work because it is not able to be supported?

Dr UREN — They could be on call all of the time.

Ms BRITNELL — And without support?

Dr UREN — Yes.

Ms BRITNELL — From a hospital's perspective, if you have got less births, you have got less productivity to justify the cost of two.

Dr UREN — Exactly.

Ms BRITNELL — Is that how it works?

Dr UREN — Yes, so it is a bit of a spiral. I do not promise to have any solution for that, actually, at the moment. It is more I suppose that they would have support from here that was consistent and available as far as getting patients to here if they needed to. It is a problem for the fact that they have got a smaller population and they are at a bigger distance.

Ms BRITNELL — So when they say, 'We're offline', is that a coordinated approach, or is that just that you get notice and you have to pick up the slack?

Dr UREN — Yes. It is on a Friday usually, and they will say, 'The guys are —

Ms BRITNELL — So your locum actually is the one who has got the double burden of not knowing his caseload?

Dr UREN — It could be. The locum is not every weekend, but whoever is on on the weekend might get that call.

Mr FINN — Thank you, Doctor, for your contribution to this inquiry. This is coming from an old Colac boy.

Dr UREN — I can tell.

Mr FINN — I am told that. You can take the boy out of the country but you cannot take the country out of the boy, so they say. Are mothers and babies at greater risk in the country, here in the south-west, than they would be if they were in Melbourne, and if so, how great is that risk, and how can we balance that?

Dr UREN — A greater risk. It is hard to put any sort of number on that sort of thing because there are obviously risks. We have a different population of people too, I think. We do not have, say, perhaps as many immigrant women that they have in Melbourne with the language problem. We have some, but it is not anywhere near as many, from my experience working in Melbourne for years and years as a registrar.

There are some things that are easier here for us to manage, but I suppose it falls a lot upon the patient to get themselves to things that we need them to go to. If they need to travel to a unit where they need a more intensive intervention, they have to get in their car and they have to drive there. They can fill out forms and get some petrol money back and things like that, but there is a lot of upheaval for the patients, I think.

There are certain services that are really just a little bit more difficult for them to access. Particularly the drug and alcohol stuff we are finding is a new problem in a way. It is not a new problem, but it is becoming a bit more difficult to manage at times. There are certain drugs that are more difficult, and there is a bit more alcohol being used. I think everyone has got the same problem everywhere, but we do not have the backup services. That is the reason why it is a bit more difficult here.

Mr FINN — I was surprised to hear you refer to the issue of safety of midwives on home visits. What are the issues there? What are the problems that the midwives face? I personally would have thought, if a midwife is coming to help a mother and a new baby, that was a great thing.

Dr UREN — It is a good thing most of the time, and I do not think it is generally a problem, but there would be some houses where it would be a little more concerning to be visiting.

Mr FINN — What are some of the issues that midwives have faced?

Dr UREN — Aggressive partners.

Mr FINN — Really?

Dr UREN — Yes, and dogs and things like that.

Interjection from gallery.

Dr UREN — And snakes, yes. These guys here behind me all could talk to that much better than I could.

Mr FINN — We are members of Parliament; we know about snakes.

Ms BRITNELL — I am learning.

Dr UREN — I do not have to do it, so it is really the midwives here. That concerns me sometimes. I really do think that they are putting themselves at risk occasionally when they are visiting houses.

Mr FINN — Is that a big issue?

Dr UREN — You might have to ask the team behind me.

Mr FINN — I will ask that in a moment. You referred earlier to the universal protocol system. How important is that, do you think?

Dr UREN — I think it is very important. It should be Australia-wide. It could be worldwide, but we would never agree with the Americans on most things. There are good studies that have been done. There are people who can analyse the studies and then say, 'This is what we should do'. Like I said, a couple of years ago there was the 3centres consensus towards midwifery care, and that has sort of fallen by the wayside a bit, I think. If all the hospitals in Victoria at least could agree to follow one set of guidelines for, say, care of group B strep or ruptured membranes or using magnesium sulphate, we should not have to rewrite these things because basically people are cutting and pasting anyway, and there is a risk when you cut and paste something that you might not do it correctly. We do not think that happens too much, but it really is silly that we are actually spending time and energy on writing protocols that should just be statewide, because if people move, they should be able to get the same care. It should be about everyone getting the same care.

Mr FINN — I would have thought that most hospitals, if not all hospitals, would be aiming to provide best medical practice available. Is that not happening now?

Dr UREN — I think it is by people working very hard at it, but they should not have to work so hard at having the same good protocol.

Mr FINN — On the issue of perinatal anxiety and depression among women, and even now men we are discovering, how prominent is that in the south-west and how do you cope with that?

Dr UREN — I would say it is increasingly prominent. We find a lot of women now are on antidepressants at the beginning of their pregnancy that we never used to see previously. Look, that is okay, but obviously there is some gap in either them being recognised with more depression or they have got more depression because their lives are more difficult or they have got more depression intrinsically. There are a lot of programs to try and help combat that. There is a good system whereby the GPs have psychologists in their rooms now that they can refer to, which is a good system. I think that probably it would be good if there was more of that available. I think there is a limit in number of the visits that they can have; I think it is something like six visits for a year or something like that. I think anything like that that can help support women is good. We do not have that capacity in antenatal clinic to provide that there, as in unless there was a psychologist who was attached to our antenatal clinic.

One thing that we have managed to have introduced in the last couple of years is we have got the diabetes educator and the dietician to actually come to our Wednesday antenatal clinic, and they see all the women at the same time that they are seeing us for their visits, so that has been a good thing. Similarly maybe there would be a psychologist person that could come and help. I do not know that would work within an antenatal clinic

because those appointments would obviously take a lot of time. I think it is just a time and energy thing with the antenatal depression. It is hard work looking after them afterwards as well, and then there is a continuity problem. They have had antenatal care with us, and they would then go back to their GP. That is where we need the GPs involved as well.

Mr FINN — Thank you.

Dr UREN — No problem.

The CHAIR — Thanks so much, Dr Uren. We really appreciate your time today.

Dr UREN — No trouble.

The CHAIR — You have given us a lot of food for thought. Thank you so much.

Dr UREN — And there is more coming. Thank you.

Witness withdrew.