

GP obstetrics: Windows of opportunity

In the current obstetric practice environment, you might be forgiven for thinking that general practitioners' interest in obstetrics is waning. However, the College's current data, as outlined in the sidebar suggests quite the opposite.

The story out on the hustings, both in metropolitan areas and in rural and remote regions around Australia, also supports the College's data. GP proceduralists are still very enthusiastic about practising obstetrics, office gynaecology and shared care and it seems some patients still have a high preference for obstetric care by general practitioners. If there are fears about the future, the concerns of GPs seem to be less about litigation, medical indemnity premiums or lifestyle, but more about opportunities to practise and maintain their procedural skills. The general practitioners and the Diploma Trainee who were interviewed for this fea-

ture not only enjoy (or until recently enjoyed) thriving practices, but want to expand their interests in co-operation with specialists and midwives. Unfortunately, for some, both practical and administrative factors have to date worked against their aspirations.

For Steve Lapin, a Diplomate from the East Bentleigh Medical Group in Melbourne, the closure of the Monash Medical Centre's Moorabbin GP obstetrics unit in January 2004 means the group practice's delivery numbers and income will decrease significantly.

For Murray Barrell, the restructuring of the Southern Area Health Service's facilities in Bateman's Bay in New South Wales persuaded him to look to Ingham in Queensland's far north to expand his practice. Despite being a favourite of patients in Bateman's Bay for seven years, he spread his wings to Queensland to avoid losing his

skills in obstetrics.

For Tim Kelly, a Diplomate in Crystal Brook, South Australia, the closure of GP obstetric services in outlying towns promises to draw more patients to Crystal Brook's group practice. However, there is still a question about whether the patient influx will be enough to sustain the presence of three GPs with obstetric interests in the practice.

For Deena Case, a Diploma Trainee who expects to complete her training in April 2004, the opportunity to gain as much obstetric experience as she could persuaded her to spend 12 months training at Cairns Base Hospital. She does not believe that she would have had the same exposure to procedural obstetrics in her native Sydney as she has subsequently had in Cairns.

Only Kim Thu Le, a general practitioner

Enthusiasm for the Diploma of Obstetrics - The statistics

- In 2004, the RANZCOG has 2688 Diplomates in its membership.
 - Of this total, 717 Diplomates (or 27 per cent) are still financial members in 2004, but are not practising obstetrics.
 - Approximately 1971 (or 73 per cent) of the total number of currently enrolled Diplomates are engaged in continuing professional development in obstetrics.
 - Eight hundred and ten Diplomates participated in CPD in the 1999-2001 triennium. The number of Diplomates now engaged in CPD is 1971 - more than twice the number of 1999-2001.
 - Between 2000 and 2003, 398 Diplomates ceased obstetrics and withdrew their financial membership of the College.
 - The number of Diplomates from year to year who have not renewed with the College has steadily fallen since 2000. In 2003, 75 Diplomates did not renew their memberships with the College (compared to 155 in 2000).
 - Six hundred and sixty-five GPs have participated in the Diploma or the Advanced Diploma training programs since January 2000.
 - There are 276 Diploma Trainees currently involved in the six month Diploma or 12 month Advanced Diploma training programs.
- All statistics have been collected from the RANZCOG's CPD program and STARS database.**

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working in Springvale, Victoria, has indicated that she would like to scale down her practice, largely because it is so busy. A holder of the College's former Certificate of Satisfactory Completion of Training (CSCT) in women's reproductive health, Dr Le fulfils a crucial role for women of non-English speaking backgrounds. Her Vietnamese background means that she is the first port of call for women and their families, principally of Vietnamese, Cambodian, Chinese, Indian and Pakistani descent. She plays a significant part in referrals to gynaecologists at Monash Medical Centre, explaining to the patients in their native language the importance of treatments and how they will proceed. She also participates in shared care arrangements with the medical centre. Dr Le is hopeful that she will be able to recruit a female practitioner who can alleviate some of her workload in the near future.

For these four general practitioners and Diploma Trainee, obstetrics is a special interest from which they derive enormous personal enjoyment and satisfaction and which they hope to enlarge and consolidate in their daily practice. Whether they are able to expand their interests is in part determined by the environments in which they live and work.

All of these GPs chose obstetrics as a special interest largely to complement their general practice skills. Steve Lapin describes obstetrics as 'a way of having a hands on clinical practice and growing my general practice'. Murray Barrell is a self-professed 'obstetric junkie' who so enjoyed working in the labour ward at Canberra Hospital as a registrar that he used to volunteer for night shifts. He initially trained to become an O and G specialist before he decided that he would much rather prefer to do a mixture of obstetrics, gynaecology, surgery, emergency medicine and anaesthesia in a rural general



Members of East Bentleigh Medical Group. From left: Steve Lapin, Andrew Batty and Richard Christiansen.

practice setting. It allowed him more variety and continuity of care.

Tim Kelly originally treated obstetrics as being 'part and parcel of providing a comprehensive service' as a GP. 'I guess I actually went into obstetrics thinking that I was almost obligated to do it,' he explains, 'but I actually ended up continuing to do it because I really enjoyed it.' Kim Le similarly states that she undertook her CSCT training because of the needs of her patients, 'but grew to love and enjoy my role'.

Deena Case turned to obstetrics because she was interested in remote general practice. 'I felt that not having any obstetric training was going to be a disadvantage.' Before entering the DRANZCOG Advanced training program, Deena Case had also worked for three months as a gynaecology resident at Cairns Base Hospital and as a medical student had worked an elective term in obstetrics in Vietnam.

GP OBSTETRICS IN AN URBAN SETTING

Steve Lapin is one of eight doctors in the East Bentleigh Medical Group in Melbourne. Four of those doctors practise either obstetrics or shared care, including Andrew Batty, who was head of the Monash Medical Centre's GP obstetric unit at Moorabbin Hospital, Richard Christiansen, Rebecca Fradkin and Dr Lapin. The clinic used to manage a combination of private and public deliveries through its rooms, as well as caring for patients who were admitted through the outpatients at Moorabbin Hospital and Monash Medical Centre in Clayton. Steve Lapin states that five years ago, the clinic would have supervised up to 200 private and public deliveries per year. This figure has dropped to 120 per year after the clinic stopped practising private obstetrics (due to rising indemnity premiums). The clinic now only treats public obstetric patients.

'The procedures that we do now are nor-

mal deliveries, ventouse and low forceps deliveries and we assist at caesarean sections', explains Dr Lapin. 'Until very recently, we were inserting Implanon, but because of indemnity requirements, the clinic no longer inserts Implanon or IUDs. We now limit ourselves to performing general gynaecological assessments, such as hormone replacement therapy and Pap smear tests.'

For the most part, the bulk of the clinic's obstetric patients are cared for antenatally without intervention from a specialist or a hospital. However, the clinic is involved in shared care arrangements for some patients. 'The patients may visit a specialist either privately or in a hospital setting two or three times in the antenatal period and then we supervise the rest of the antenatal visits', Dr Lapin explains. 'It depends on the patient. A lot of our patients prefer to see us because they've known us all their medical lives or because we are easier to talk to or we may be easier to get in to and see. However, we do get requests from patients to be referred to specialists and that's fine too. We enjoy a good relationship with the specialists at Monash and we help them with the overload and they in turn help us with difficult problems.'

Dr Lapin describes the East Bentleigh clinic as 'a very good model to have because it provides doctors and patients with the best of both worlds. It enables us to look after patients who do not have private health insurance in a comfortable general practice setting. This means they can still see the doctor of their choice, particularly the doctor they've chosen as their GP. It's very easy for them to come in and see us. If they're feeling unwell, they can book an appointment the same day. The other alternative for public patients is to either visit a public outpatients at a hospital or a birth centre. The problem with outpatients



Steve Lapin: 'You gain the most enjoyment out of practising obstetrics if you are in a stable environment ...'

is there is often a long wait, the patient sees a different doctor each visit and the clinics have set days. The other option is a birth centre which caters for women who prefer midwife care.'

While the clinic will continue to admit obstetric patients to Monash Medical Centre, the options of where women can have their deliveries has now diminished with the closure in January of the Moorabbin GP obstetrics unit. The unit was run very successfully over 20 years, but was closed down by Monash Medical Centre as part of a rationalisation of its services. Now, the East Bentleigh Medical Group's obstetric patients will be required to give birth at Monash's Clayton Campus or Sandringham Hospital.

Dr Lapin explains that the eight doctors who were on the roster at Moorabbin Hospital are now continuing to practise

obstetrics at either Monash Medical Centre's Clayton site or Sandringham Hospital. He says that he expects some of his patients will miss the smaller, more personable 'general practice feel' of the old Moorabbin obstetric unit. The environment at the Clayton site will not 'be quite the same for the patients'.

Dr Lapin predicts that there will be a decrease in the practice's delivery numbers. 'I will be continuing obstetrics on a smaller scale. The only patients I'll be seeing will be those who will be coming through my clinic and who I'll be delivering at Clayton. That's going to halve my numbers straight away, in terms of obstetric experience in the labour ward because I won't be called for the outpatient public patients as we did at Moorabbin. The plus of that is I won't be on a roster and I'll only be on call for my own patients, but the minus is that I'll become de-skilled because I'll be doing less deliveries.'

It is the importance of having sustainable GP obstetric services which has motivated Dr Lapin to continue practising obstetrics. 'I think you gain the most enjoyment out of practising obstetrics if you are in a stable environment where as a GP obstetrician you are respected and your clinical decisions are respected.'

'I've also enjoyed being involved with the workings of the hospital and being able to work in a close-knit work environment with the midwives. We've all known each other for a long time and that made life easier when it came to decisions about the urgency of calls. The doctors knew each other very well and we also knew the midwives very well, so it was a very good team. Working with a very good team which has been together for a very long time motivated us all to continue in obstetrics.'

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OFFICE GYNAECOLOGY IN SPRINGVALE

Dr Kim Thu Le emigrated to Australia from Vietnam when she was 24. She left Vietnam when she was in her final year of medical school but restudied medicine at the University of Melbourne. Once she started general practice, she began to treat Vietnamese and other non-English speaking patients for a variety of obstetric and gynaecological complaints which persuaded her to undertake the College's former CSCT qualification and to primarily practise office gynaecology and to a lesser extent, antenatal and shared care. She estimates that up to 60 per cent of visits are for gynaecological or obstetric matters.

Dr Le refers her obstetric patients to Monash Medical Centre in Clayton for preliminary antenatal tests in the first ten weeks. She will then supervise the patient's antenatal care monthly until term, referring the patient to the specialist for consultation at 28 and 36 weeks. She manages her gynaecology treatment in her rooms. 'I usually initiate treatment for minor infections or will conduct Pap smear tests. If I do have to refer patients to a consultant, I will test them first and then explain to them in detail what needs to be done before I refer them to a specialist or hospital. I tend to write very detailed reports to the consultant, so that the specialist is clear in their understanding of the patient's condition and can decide what to do straight away; it would only confuse the patients if they were sent back to me for further tests. Some of my patients do not speak a word of English and it's hard for them when they're required to take a certain course of action without fully understanding what they have to do.'

Many of Dr Le's patients are not just local to Springvale. She has patients visit her from

neighbouring suburbs like Box Hill and Nunawading and from country regions as far away as Sale and Phillip Island. As Springvale is a popular shopping and restaurant haven for many Australians with Asian backgrounds, it also means that they are more likely to seek medical treatment in Springvale rather than in their own localities. Often many patients visit her because of the reputation she has earned by word of mouth. Although she speaks fluent Vietnamese, Dr Le has also hired multi-lingual practice staff who are conversant in Chinese and Cambodian. She will also rely on family members of patients who are fluent in English to explain procedures to her patients.

In many ways, Dr Le's role is as much social worker as it is general practitioner. This can be personally draining and she has been told that she works too hard. 'Some people say I am too kind, that I am too involved with my patients. My patients comment that I am a very thorough doctor, compared to other doctors they see. I am very thorough with my examinations and I allow the patients the time to talk to me about their problems in depth. I don't see more patients than the other doctors in the area but I do spend time with my patients and they are very appreciative.

'I don't mind the hard work. Sometimes I inquire after my patients' social welfare or I organise meetings between them and social workers to discuss problems or arrange appointments for them to discuss financial assistance. It's a lot of extra work to have to do, but if I refuse to listen to their other needs, there really isn't anywhere else that they will feel confident to go. Because many of them are not skilled in English, they are less inclined to visit English-speaking doctors.'

Dr Le is considering expanding her prac-

tice into a woman's health clinic over time, although she concedes that it may be difficult to recruit another partner. Alternatively, she is hopeful that she can recruit a male practitioner who could handle the general practice side of her clinic and enable her to focus more on obstetrics and gynaecology. However, despite the demands on her, she has no intention of giving up either general practice or office gynaecology for the foreseeable future. 'As long as I continue to have the support of my colleagues at Monash and I can maintain a high standard of health for my female patients, I am happy to continue.'

GP OBSTETRICS IN BATEMAN'S BAY

Murray Barrell echoes Steve Lapin's concerns when he discusses the impact that rationalisation of hospital facilities has had on his practice. He has just relocated his practice to northern Queensland from the holiday town of Bateman's Bay in southern New South Wales after the local Southern Area Health Service (SAHS) began to rationalise its facilities and its workforce in 2003. The SAHS administers two hospitals 35km apart in the Eurobodalla region: Bateman's Bay Hospital and Moruya Hospital. Both hospitals oversee between 150 and 180 deliveries per year, with other presentations being transferred to Canberra Hospital or to Sydney. Until December 2003, Dr Barrell was the director of the Bateman's Bay Hospital emergency department.

Although Bateman's Bay, which is located 380km south of Sydney and 190km east of Canberra, has a population of 18,000, the population can swell up to 100,000 in the summer months. This is due to a drainage of patients from outlying areas and an influx of holiday revellers. Dr Barrell estimates that one-third of his confinements were women he had not treated antenatally. Nevertheless, he relished the opportunity to

treat women without a prior history 'there and then on the spot'.

'That, to me, is the joy of doing obstetrics', Murray Barrell says, 'because you get to triage all your patients at first base, so to speak. As a GP, you often receive patients after the initial complaints have been handled by someone else. As a result of seeing patients first, I get the simple cases as well as the patients with complex problems. That, for me, is one of the strengths of being a rural GP with a special interest in obstetrics and gynaecology.'

Aside from being the visiting medical officer to Bateman's Bay Hospital, Murray Barrell also ran consulting rooms that provided antenatal and postnatal care, ultrasound and office gynaecology. He estimates that half of the visits to his rooms were antenatal or obstetric-related issues, 40 per cent of consultations were paediatric (for children under five years of age) and the other ten per cent were general medical issues. He supervised between 80 and 110 deliveries per year over a six year period; about 15 per cent of these were performed by caesarean sec-

tion.

The area of obstetrics that most fascinates Dr Barrell is fetal medicine, which meant he was in regular contact with maternal-fetal medicine subspecialist David Ellwood in Canberra. In 2003, he visited Canberra Hospital once a week every week for six months to hone his high risk obstetrics and ultrasonography skills. He is also an instructor in the Advanced Life Support in Obstetrics (ALSO) program and also has dedicated his time to clinical lecturing in rural obstetrics for the Australian National University's and the University of Sydney's medical schools.

'I offer every patient I see an informed medical opinion', explains Dr Barrell. 'I have always tried to offer women a local solution because I'm aware that for some women, it's a huge issue to have to travel 200km to Canberra or 400km to Sydney. However, if I don't know the answer, I will be honest with the patient and ask her if she would like a second opinion. If a treatment is not working as well as it should be or the patient believes the treatment isn't working, then I

will offer her an opinion and provide a range of options, for example, whether she would like to see Dr Holland locally or visit a specialist in Sydney or Canberra.'

SAHS policy is to employ overseas-based career medical officers (CMOs) to supplement the local medical workforce at Bateman's Bay and Moruya Hospitals on weekends. Although it is still questionable whether the SAHS favours the introduction of CMOs as a long-term measure, Dr Barrell decided to seek other opportunities away from Bateman's Bay. He feared that his role in the emergency medicine department would be gradually reduced and that in turn reduced hospital skills would impact on his obstetric practice. 'It would be very embarrassing for me in 12 months' time to be a clinical lecturer in rural obstetrics for the University of Sydney and yet not be involved in high risk obstetrics at a hospital level, merely in my rooms. I decided to go to Ingham to maintain skills, develop new skills and utilise the skills that I could not do at Bateman's Bay.'

Dr Barrell is looking forward to new challenges in Ingham. He will be Director of Clinical Services at Ingham Hospital, but will also continue to run his own practice, enabling him to see 'category four or five triage patients' in his rooms, at little expense to the hospital. He is also planning to manage an antenatal clinic in his new rooms as well which will enable him to train midwives from within the hospital. One of his other briefs is to set up Ingham Hospital as a teaching hospital for Trainees of the Australian College of Rural and Remote Medicine and co-ordinate rotations with Townsville Hospital for interns, where 'they will have more autonomy and can decide about their career path, whether they want to be a specialist or a qualified GP or a rural and remote GP'.



Murray Barrell at the entrance to Ingham Hospital, where he is the new director of clinical services.

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Tim Kelly states that the key to maintaining the viability of Crystal Brook's obstetric services is to attract more patients from outlying areas.

Murray Barrell's departure from Bateman's Bay has led to a rationalisation of the services in the Eurobodalla area. Obstetric services at Bateman's Bay and Moruya hospitals are expected to merge and to be run solely from Bateman's Bay Hospital. This will combine the number of annual deliveries at the one site to 350, thereby enabling Bateman's Bay Hospital to apply for recognition as a teaching hospital. Dr Barrell anticipates that this will make the vacancy at Bateman's Bay Hospital more attractive for either another Diplomat who is keen to practise obstetrics or a senior registrar currently training in obstetrics. Once appointed, Dr Barrell's replacement will work with Dr Michael Holland, the region's sole O and G specialist.

GP OBSTETRICS IN CRYSTAL BROOK

Crystal Brook, 200km north of Adelaide and 30km from Port Pirie, might not seem like the home of a bustling obstetric practice. Yet despite its relatively small population of 1200, it features a three-doctor practice which offers obstetrics and office

gynaecology. It comprises three Diplomates: Tim Kelly, Richard Mackinnon and Donna Taylor, the latter a recent addition to what was historically a two-doctor, all male practice. The practice oversees 60 deliveries per year and runs antenatal and intrapartum care in conjunction with midwives at the local hospital. It has a theatre for minor

gynaecological procedures such as curettes and an ultrasound machine. The practice is also working with Repromed in Adelaide to establish IVF scans for women in the mid-north of the State.

Although Crystal Brook is small, the practice caters for women within a 40km radius. Indeed, with the closure of other nearby GP obstetric services in recent years, the Crystal Brook practice has catered for women living up to 100km away.

Tim Kelly concedes that to have three GPs practising obstetrics in such a small town is 'top heavy. We certainly do more deliveries than you'd normally expect in such a small town. Normally a town this size would have one chief obstetrician and manage 20 deliveries a year. However, because it's been a special interest of Richard Mackinnon's for a long time, we've managed to expand and do more. We did over 100 deliveries at one stage.

'The key for us to maintain the viability of our service is to "drain" more women from areas where GPs have given up obstetrics.



Despite its population of 1200, Crystal Brook is home to a bustling obstetric practice.

It's actually a good time for us to be in obstetrics, but how long we can be viable depends on our patient numbers. We're interested to see what the inclusion of a female obstetrician will do for our numbers. That may determine whether it's sustainable to have three doctors practising obstetrics or whether one of us will set that aside for the time being.'

Another factor in the success of the service lies with the difficulty of retaining and recruiting multi-skilled midwives in the country. 'The biggest problem for us in maintaining an obstetric service is keeping midwives', Tim Kelly explains. 'There's been a trend towards subspecialisation in nursing in recent years and unfortunately small rural hospitals cannot provide the numbers to justify that level of subspecialisation. We don't have enough obstetrics here to employ a nurse purely as a midwife, she has to be



Tim Kelly says that in rural areas there is a need for multi-skilled nurses and midwives.

working in other areas like theatre and general and aged care.

'Unfortunately, the average age of multi-

skilled nurses is increasing and younger people aren't taking on broader nursing roles. Also, people can now train in midwifery without training in broader nursing, so there

Reinvigorating obstetrics in the community: The DRANZCOG Advanced program and Cairns Base Hospital

Cairns Base Hospital's Department of Obstetrics and Gynaecology has a long tradition of focusing its obstetric teaching and training on rural GP Trainees. In the past, the hospital had only one specialist Trainee and at times none, so employing non-specialist registrars was vital for the existence of its service. Now there are two specialist registrars, but their responsibilities are mainly gynaecological. The service has evolved to place its primary emphasis on good obstetric training and experience for rural GP Trainees. The Department aims to provide them with the skills necessary to practise independent operative obstetrics, in a rural setting or otherwise.

Five GP Trainees are employed at any one time for 12 month

terms. Four commence at three monthly staggered intervals, and one functions as relief for the O and G specialist and paediatric registrars, spending about eight months doing obstetrics and gynaecology and the remainder in paediatrics. They are all eligible for RANZCOG's Advanced Diploma qualification. The Trainees are responsible for the care of the maternity patients, and function as true obstetric registrars. They liaise with the consultant who has no other commitments when on call and is directly available to them. The roster rotates weekly between daytime duties on labour ward, postnatal care, evenings and night duty. The Trainees are exposed to high risk obstetrics, emergency cases, routine pregnancy care and also attend gynaecology clinics. This is a very responsible job as they are the first point of call for all emergencies and referrals. Often it is the first time these young doctors have shouldered this level of responsibility. After a year at Cairns, a Trainee will have performed typically between 50 and 60 caesarean sections, between ten and 20 assisted

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will potentially be fewer multi-skilled midwives coming through in the future. That is definitely going to have an impact in rural areas down the line because we won't be able to recruit those midwives if they do not have the additional nursing skills.'

Tim Kelly has worked in several rural hospitals in South Australia and Queensland. He originally completed the six month Diploma course in Adelaide in 1995, but decided to undertake the 12 month Diploma Advanced course in 2000 to improve his skills in operative obstetrics. Keen to gain as much clinical exposure as he could to cement his knowledge and skills, Dr Kelly decided to train at Cairns Base Hospital.

'One of the concerns that GPs have about obstetric training in a tertiary hospital is having enough exposure', he comments. 'I knew Cairns Base Hospital was well set up to train rural GPs. There were two O and G special-



Deena Case has enjoyed the 'opportunity to do a lot more hands on stuff' at Cairns Base Hospital.

ist registrars there, but they were mainly responsible for the gynaecology, and there were four principal GP registrars doing the obstetric work. The four of us covered the

labour ward and this gave me the exposure I wanted. I was able to perform a lot of procedural work and manage complications in pregnancy.

vaginal births and a number of manual removals, suction curettages and other minor surgeries. They also manage to attend an appropriate number of normal births despite this busy workload! It is expected that a year at Cairns provides sound training on which to base their future obstetric practice wherever they choose to work.

Previous Trainees have spread themselves far and wide since completing their training. Most of them go on to practise 'hands on' obstetrics. Most of the smaller regional centres in far north Queensland would not be able to provide maternity services without these people. This includes places as far apart as Innisfail, Atherton, Mareeba and Thursday Island. It is invaluable to have all of these surrounding smaller hospitals staffed with former Diploma Trainees, as it opens up clear pathways for obtaining advice and arranging transfers of high-risk women if required. Other past Trainees have entered rural practice in South Australia and Western Australia. Some currently work with the Royal Flying Doctor Service, and some

have chosen to pursue obstetrics as a specialist career.

It has been very rewarding for Cairns Base Hospital's Department of Obstetrics and Gynaecology to contribute to the continued viability of obstetrics performed by rural general practitioners. Its Trainees, past and present, are enthusiastic and diligent doctors who want to make a difference to country life. Much is said about obstetric practice vanishing from rural and regional areas of Australia and it seems that in many places this is sadly true. However, interest in obtaining good obstetric experience is alive and well in far northern Queensland. It is hoped that the Department's approach can serve as a model for other hospitals wishing to re-invigorate obstetrics in their own communities.

Paul Howat FRANZCOG
Director of Women's Health
Cairns Base Hospital
Cairns Queensland

'I'm not sure many other hospitals would expose you to such a high number of deliveries. At Cairns, 2000 deliveries were essentially shared between the four GP registrars. Any other hospital that has that many deliveries is usually a tertiary level hospital where there are a lot of training specialist registrar jobs. When I did the initial Diploma, we had 550 deliveries shared between four registrars and four residents, so in Cairns, I clinically got eight times the exposure.'

For the purposes of his own practice, Tim Kelly considered the Advanced Diploma of Obstetrics beneficial, but believes it is up to each GP if he or she wishes to become more skilled in operative obstetrics. 'At the moment, it's probably more important that you can say that you've done 100 caesarean sections rather than to say you have an Advanced Diploma of Obstetrics, but I can foresee a time when having the Advanced Diploma will be a prerequisite for doing complicated GP obstetrics. Undertaking the Advanced Diploma also gave me a focus. I was thinking about the implications of it on my rural practice, for example, "How would I manage this?" or "Would I send this out?" or "Would I be able to manage this?" I was asking myself the type of questions that were relevant to rural practice.

'It really suited me to update my obstetric skills. Certainly, at this stage I feel as if I've had enough exposure to feel comfortable for a long time to come even if I am only doing 30 deliveries a year.'

TRAINING IN CAIRNS

Like Dr Kelly before her, Deena Case is currently enrolled in the College's Advanced Diploma training program at Cairns Base Hospital and is one of four GP obstetric registrars covering deliveries. 'We have four PHOs doing their Diploma and there are two



Deena Case, attending to a newborn's crib: 'You walk away feeling very satisfied when there is a good outcome for a mother and her baby.'

Membership Trainees, and there is a gynaecology resident who assists them', she explains. 'It is quite clearly demarcated that the four Diploma Trainees exclusively do obstetrics; the Membership Trainees almost exclusively do gynaecology. We cover the birth suite three out of every four weeks as well as the antenatal and postnatal women and we really only do gynaecology out of hours and on weekends. We have three full-time consultants and two locums. The consultants are available for backup and advice. They are very supportive and not intrusive, so we often make the first decisions on our own and seek their input if we need it. From that point of view, it's an excellent learning environment.'

Dr Case initially joined Cairns Base Hospital as a gynaecology resident in 1999, relieving doctors in local hospitals in Cooktown and Gordonvale. She then completed 18 months as an unaccredited registrar in general medicine and paediatrics. She was always impressed by the calibre of Diploma training within the Department of Obstetrics

and Gynaecology. 'I had thought I would like to do the training at some time and it just happened that a training position became available. I'm actually doing my GP training in reverse. I decided to do the Advanced Diploma of Obstetrics as a means of joining the GP training program and I will start my GP training after I complete the Advanced Diploma in April this year.

'I undertook the Advanced Diploma because as registrars, we are encouraged to stay for 12 months. I don't think the Advanced Diploma requires any more work than the six month Diploma, but I think it will give me more options to practise at the end.'

An aspect of high risk obstetrics which most interested Deena Case was the management of labour. 'I've been very keen to learn how to manage deliveries safely on my own and particularly to identify when it is safe to continue managing the patient in an isolated area', she says. 'As a resident in Cooktown, I had an experience of having to treat a lady who was 29 weeks pregnant in threatened labour. I had not really done much

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obstetrics at all up to that point and I felt so helpless because I didn't know what to do. That made me realise how much I needed to learn about managing an early labour and how to be confident about what to do in an isolated place.'

As a result of this experience, Deena Case has grown to enjoy operative obstetrics. 'We manage a lot of caesarean sections and instrumental deliveries with consultant supervision. I now really enjoy that, particularly when you get a good outcome for the mother and the baby. You walk away feeling very satisfied.'

Deena Case originally completed her internship at St Vincent's Hospital in Sydney before she moved to Cairns. She agrees with Tim Kelly's comments that the GP obstetric registrars at Cairns do have more exposure to obstetrics than might ordinarily be the case in a city-based hospital. 'We have a huge patient turnover and you get to see a wide range of obstetrics. We also get to see a lot of high risk obstetrics in patients from the



Deena has enjoyed the 'opportunity to do a lot more hands on stuff' at Cairns Base Hospital.

Tablelands and the Cape, which is more than what you would probably see in a random sample in a city hospital.

'It's very different working in Cairns. I enjoyed working in a massive teaching hospi-

tal in Sydney because I was exposed to a wide range of pathology and I learned from some excellent professionals. It gave me a very good grounding to work in Cairns, but I also think that you get to see a wider range of pathology and assume far more responsibility for the standard that you are at in a smaller hospital. I've really enjoyed the opportunity to do a lot more hands on stuff and the standard of teaching here is excellent. I certainly don't regret my first two years in Sydney, but from a work point of view I far prefer working in Cairns now at this level.'

Deena Case is planning to spend a year from January 2005 practising rural general practice on Thursday Island with her partner Michael Stuckey, another Advanced Diploma candidate. She views it as an opportunity to 'see what it will be like to live, as well as practise rural obstetrics and remote medicine in an isolated place'.

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Deena enjoys dealing with a 'wider range of pathology' and being able to assume 'more responsibility in a smaller hospital'.