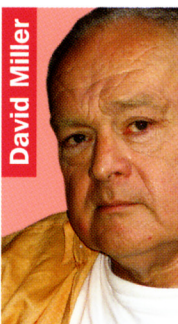


The Doctor is

David Miller



David Miller looks at the possibility of the GP becoming a thing of the past

I RECENTLY RECEIVED a call from my 30-year-old daughter to tell me about her job redundancy.

Even though she saw it coming, it was a challenge to her because her sense of self-worth went straight down the drain. "I wish I hadn't bothered to get up this morning," she said over the phone, "going to all that trouble to get dressed and then just being sent home."

As doctors we identify strongly with our jobs which give status, money and a sense of belonging in the community. Remember graduation when we donned our virtual mantle and cape, giving a sense of identity and a worthy place in the world? So what happens to doctors who can't work anymore for whatever reasons?

The wise ones just retire gradually but some get caught out unexpectedly through illness, or just not being able to cope with the complexities of being a modern doctor, or worst of all, a lawsuit.

Others are cast out like the 'butcher of Bega' or 'Dr 'Death' Patel' because they lost their way in fields of madness. Cases like this do not help doctors, at a deep political level. Those left in the medical workforce just keep doctoring on, thinking our jobs are recession proof, but there are job threats in some areas.

In Mullumbimby, for example, at the low-risk birth centre,

with the 'caseloading' model being adopted, there is a shift towards midwifery and away from GP obstetrics care.

Mind you, none of the four obstetrician/GPs feel aggrieved, really more supportive, in the knowledge that our species shares a fate with the thylacine, such is the scarcity of young GP obstetricians in the wings, along with natural attrition amongst 'Dad's Army'.

Succession planning has been sub-optimal and the lights have been going out for a few years now. Only ACCRM and the RDAA have been very vocal about this issue but without anyone taking any notice. It's all in the too-hard-basket. Look

In Mullumbimby, at the low-risk birthing centre, there is a shift towards midwifery and away from GP obstetrics care

at Pambula, forcibly closed and several GPs no longer involved in childbirth.

So, here is the new spare tyre which looks like this. Called 'caseloading,' each expectant woman is assigned one particular midwife of 'a share pair'.

In this model, when labour starts, the hospital birth centre is opened for the occasion and the assigned midwife comes in for however long it takes. After the birth the lights are turned off and the midwife goes home. Here is the rub. The rostered

VMO is not called in unless some unexpected problem arises, say for stitching, or transfer out in a serious situation.

One of these doctors commented, "we are effectively being put out of a job, because to stay accredited, a certain number of births are required each triennium."

One other problem with this arrangement is the increasing average age of midwives. Young women seem reluctant to take on country hospital obstetrics because they have to also do general ward duty if labour is not on.

Caseloading regulations must include insurance for midwives in order to legally attend birth, the same as for the doctors covered under the TME.

From a safety point of view, the difference between Mullumbimby Hospital and a well-organised homebirth is little. Homebirth crisis goes directly by ambulance to the obstetrician and never via the birth centre because there's not much extra on offer.

Strange as it may seem, many of the young midwives I speak to would gladly attend homebirths, but there is no insurance available for home birth midwives apparently due to numbers, too small for actuarial underwriting.

However, it means that homebirths will be further marginalised, not stopped. It also means that practitioners will be working illegally, even if fully qualified, due to lack of insurance. Some women choose to birth without professional help. Being totally private, it's also expensive.