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Official Committee Hansard

SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Reference: Childbirth Procedures

MONDAY, 6 SEPTEMBER 1999

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SENATE
COMMUNITY AFFAIRS REFERENCES COMMITTEE
Monday, 6 September 1999

Members: Senator Crowley (*Chair*), Senator Knowles (*Deputy Chair*), Senators Bartlett, Evans, Gibbs and Tchen

Participating members: Senators Abetz, Brown, Brownhill, Calvert, Chapman, Coonan, Crane, Denman, Eggleston, Faulkner, Ferguson, Ferris, Forshaw, Gibson, Harradine, Lightfoot, Mackay, Mason, McGauran, O'Brien, Parer, Payne, Quirke, Tierney, Watson and West

Senators in attendance: Senators Crowley, Gibbs and Tchen

Terms of reference for the inquiry:

To inquire into and report by 30 December 1999 on childbirth procedures, with particular reference to:

- (a) the range and provision of antenatal care services to ascertain whether interventions can be minimised through the development of best practice in antenatal screening standards;
- (b) the variation in childbirth practices between different hospitals and different States, particularly with respect to the level of interventions such as caesarean birth, episiotomy and epidural anaesthetics;
- (c) the variation in such procedures between public and private patients;
- (d) any variations in clinical outcomes associated with the variation in intervention rates, including perinatal and maternal mortality and morbidity indicators;
- (e) the best practices for safe and effective births being demonstrated in particular locations and models of care and the desirability of more general application;
- (f) early discharge programs, to ensure their appropriateness;
- (g) the adequacy of access, choice, models of care and clinical outcomes for rural and remote Australians, for Aboriginal and Torres Strait Islander women and for women of non-English speaking backgrounds;

- (h) whether best practice guidelines are desirable, and, if so, how they should be developed and implemented;
- (i) the adequacy of information provided to expectant mothers and their families in relation to the choices for safe practice available to them; and
- (j) the impact of the new Medicare rebate provided for complex births, including the use of the term ‘qualified and unqualified neonates’ for funding purposes, and the impact that this has had on improved patient care and reduction of average gap payments.

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Committee met at 10.12 a.m.

FISHER, Dr Jane Rosamond Woodward, Lecturer, Key Centre for Women's Health in Society, University of Melbourne

CHAIR—I declare open this session of the Senate Community Affairs Reference Committee inquiry into childbirth procedures. I welcome Dr Jane Fisher who is a lecturer at the Key Centre for Women's Health in Society at the University of Melbourne.

The committee prefers all evidence to be heard in public, but should you at any time wish to give your evidence, part of your evidence or answers to specific questions in camera, you may ask to do so and the committee will give consideration to your request. We have before us your submission No. 26. Do you wish to make any alterations to the submission?

Dr Fisher—No, I do not.

CHAIR—Would you now like to make an opening statement and at the end of that we will ask questions.

Dr Fisher—Certainly. Thank you very much for the opportunity to come and speak to you. I have three matters of concern that arise both out of my own research and my knowledge of the theoretical literature in this field. These are matters that have tended to be given less attention than other matters in reviews of the use of procedures of this kind.

The first is that, as summarised in my report, there is an enormous tension between whether pregnancy and childbirth should be regarded as normal events for which women require supportive well-informed care, or whether they are more rightly regarded as matters which are inherently dangerous in which women should be subject to medical scrutiny and an enormous amount of technical intervention and examination. I think this tension continues and has been reviewed by a number of authors in different ways.

The matters that I am particularly concerned about are the enormous variations in the use of highly intrusive operative obstetric procedures, in particular, caesarean surgery. As I know you are aware, there is a very wide range of use of this procedure in this country and in other countries, in particular countries which have two-tier health systems, that is, private and public health systems. The difference is much more marked in those countries than in a country like Britain which has mostly a nationalised health care system and the variation in use is much less observable there.

In Australia it is absolutely clear that the rates of use of caesarean surgery are almost twice as high among women who are privately insured than among those who receive their care through state provided public services. Private insurance is a very good marker of high socioeconomic status, and we know that high socioeconomic status also linked with good health and in general with lower obstetric risk. The fact that the rates of use are so high among women who are privately insured is a matter of very serious concern.

The usual rationale provided by the clinicians who provide this care is that women are demanding these procedures. To my knowledge, there is very little evidence to support this

assertion, although I do concede that there has not been a great deal of research. I am aware of a number of prospective studies—one of them being my own—which have asked women in pregnancy about their expectations of their experiences in childbirth. Women are undoubtedly realistic; they accept that this is not a completely predictable event. However, they mostly enter pregnancy with high hopes and with the expectation that they will have a normal vaginal delivery. I have to say that I have some difficulty in accepting the assertion that women enter pregnancy demanding an elective caesarean delivery. I think, in fact, this is a very infrequent event.

I have a general concern about the impact of a range of non-clinical factors on obstetric decision making and these are matters that have been quite difficult to define. The one that has been most readily defined is the fear of malpractice litigation. Work has certainly been done in Canberra by both Fiona Tito in her report, and Linda Hancock, on the impact of medicine. It seems to me there are a number of other non-clinical factors which I think we have had more difficulty defining. One, of course, is convenience. Private practice unavoidably means that people have great demands placed on them as individuals possibly to supervise deliveries in a number of different centres and, of course, to try to attend to office practices as well. Unavoidably this must enter consideration.

We have evidence from a number of sources now that the length of labour in privately insured women is shorter than those who are in the public system, because interventions are used to bring labour to a premature halt more commonly. The best work of this kind is by Dr Andrew Cary in Brisbane who did a very systematic review of a large number of cases. It certainly is supported by my own much smaller study of this kind.

However, I think there are other non-clinical factors that have proved much more difficult to investigate. It is to do with the nature of the relationship that develops between an obstetrician in private sole practice and a patient in his care. And it is mostly 'his care', although not exclusively, because largely male obstetricians provide this care. It does seem that this becomes a relationship where a woman becomes extremely dependent upon her care provider, who may in turn develop very strong feelings which I do not think are ones that are readily described or discussed, but which may in turn alter clinical objectivity when the time comes to give birth.

In psychiatry these feelings are best termed transference and counter transference. They are the feelings that develop between clinicians and patients in their care. In obstetrics these feelings are essentially denied, and a notion is promoted that clinicians can remain entirely objective and dispassionate in their decision making, which to my mind is a very doubtful assertion. I do not believe any of us can remain entirely objective in these circumstances.

Where there are team or shared care models of care provided to pregnant women, there is much less chance that these feelings develop. There is a much greater chance in shared care that people are cared for by a group of people and there is not the obligation on a single individual to provide all the reassurance, information and scrutiny for a pregnant woman.

I would like to recommend strongly that somehow we are helped to understand these complexities of the obstetrician-patient relationship better. My doctoral dissertation—which was completed six years ago, but I have no reason to believe the findings would have

changed—was a prospective study in which women were interviewed and assessed late in pregnancy before they gave birth to their first baby. Later on, after they had given birth, I was able to look at the data collected before they had given birth to see if any of it was associated with mode of delivery. If birth is a biological process, no psychological factors should in any way be different—psychological factors should not be good predictors of mode of delivery. However, what I found was that women who were privately insured, confident, independent in their functioning, had high self-esteem and were mature women were significantly more likely to have caesarean deliveries than women who were passive, compliant, of low self-esteem and low socioeconomic status. To me, while this is not direct, it is suggestive that something about caring for women of this kind interferes with objectivity. It may well be that, for obstetricians caring for women who are of a similar socioeconomic status to their own, it is more difficult to maintain objectivity in that relationship. I think the whole area of non-clinical determinants of obstetric decision making is one which requires much more scrutiny.

My other concern though relates to the notion of informed consent. This ethic assumes that the two contributors to making this decision are in positions of equal power so that the person making the decision is equally able to say no or to say yes and not to have adverse consequences from saying no. A lot has been asserted that people make an informed choice in labour to have these procedures. In my opinion, I cannot imagine people being in more different positions of power than a woman who is naked, in labour, prone on a hospital bed and someone who is a clinical care provider who is in a position of responsibility. I find it very hard to accept that you can give fully informed consent in such circumstances, which is not to say that we should not try to give it. I do not think we should pretend, though, that such a thing is possible.

I believe that it is in fact very difficult for women to give informed refusal in such circumstances, because they are very fearful that care will be withdrawn if they refuse recommendations that their baby's life is in danger or their own life is in danger and that these procedures are necessary. So my other concern is that we need to look very carefully at the ethics of decision making in these fairly extreme circumstances.

The final matter that I would like to bring to your attention concerns the psychological impact of these procedures. We now have quite a number of studies which have used a range of methodological approaches—some stronger than others—which very consistently are showing that caesarean surgery and, to a lesser extent, operative intervention vaginal delivery contribute to at least short-term adverse psychological sequelae, which are probably best understood as being features of post-traumatic distress. What happens in post-traumatic distress is that anybody who experiences it has a psychological numbing and, in order to cope with traumatic events, other psychological reactions are shut down for a time. It does appear that this exerts quite an adverse impact on their early relationship with their baby. While this is not a lasting effect, to me, it is a matter that needs to be taken seriously.

We now have evidence from a number of international studies of adverse psychological sequelae measurable in caesarean delivered women up to a year after giving birth. Research that I have completed recently, which is not yet published and which was funded by the National Health and Medical Research Council, shows that this is re-aroused in a subsequent pregnancy and remains evident up to eight months after they give birth to their next baby.

So these are not modest psychological sequelae. I think they do warrant serious consideration. Of course our primary concern has to be with physical health, but I believe that these other sequelae warrant serious attention as well.

Senator GIBBS—Your submission was excellent. I have all sorts of questions. You talked about the caesarean section and said that you do not believe that a lot of women are demanding a caesarean.

Dr Fisher—No.

Senator GIBBS—We have been told—

Dr Fisher—I am sure you have!

Senator GIBBS—that women are demanding caesareans. In fact, at another hospital this morning we spoke to an obstetrician who talked about the deskilling of obstetricians. He said that he has been doing breech births for years. He said that if he says to one of his patients the day before, ‘You can have a natural birth’ and she says, ‘I want a caesarean’, he will give it to her. How do we counteract this?

Dr Fisher—It is a very difficult matter. I think we need some historical understanding of how women have been viewed generally in a lot of research, particularly in obstetric research. A lot of the early research that looked at the psychological aspects of childbirth was methodologically very poor, but its main inquiry was to indicate that somehow neurotic women were more likely to have obstetric difficulties. There was substantial research endeavour to say that anxious, neurotic women who were insufficiently feminine who, God forbid, wore trousers to antenatal appointments, were more likely to have obstetric difficulties. I think we have now disproved this fairly effectively.

CHAIR—This connection between trousers and neuroticism seems to be very interesting.

Dr Fisher—It is fascinating. It was published, admittedly, three or four decades ago, but it remained very influential. Somehow pregnancy anxiety, particularly anxiety about femininity, contributed to ‘poor obstetric performance’. That is how it was termed. I think that better scientific scrutiny has disproved this notion pretty effectively. But we are now seeing a new wave of ‘mother blaming’ or ‘women blaming’. It is now their fault in another way—that they are too jolly assertive by demanding premium babies and perfect delivery experiences. Of course, there is always anecdotal evidence to support this. Any clinician will provide anecdotal evidence. I have a strong concern that anecdotal evidence is no substitute for proper scientific scrutiny of large representative samples of women who are asked, in objective ways, about these matters.

There have been a few fairly modestly scaled studies which have asked women in pregnancy what their expectations are about childbirth. Almost invariably their expectation is that they will have a vaginal delivery. There is some evidence that I have not yet seen in print but which I heard about at a conference last year of a thing called tokophobia, which is a newly defined phobia which I had not heard about. A psychologist working in Britain—I was very impressed: it was a very large study—had found that about five per 1,000 women

in her study had a clearly defined phobia about giving birth vaginally and that this had all the hallmarks of a clear phobic avoidance of vaginal delivery. Some of them had never made it to a term pregnancy: they had had serial abortions. But these were women who were about to give birth and were truly demanding a caesarean. She found a very high incidence of a history of sexual abuse in these women. This was completely unascertained by their obstetric care providers. However, it is a rare event. It is one which we need to investigate. I would very much like to investigate this properly. I would accept that, for that small group of women who have perhaps had sexual trauma, the notion of giving birth vaginally might be extremely frightening and it may be an unascertained factor. In general, though, I am much less persuaded that there is this large body of assertive women demanding caesarean deliveries. I note, looking at the college's submission to you, that it makes this assertion, but it is not supported by a reference to the literature. That, to me, really is of concern. Anecdotal evidence is no substitute for a proper survey of a large sample of women asking them about this.

Senator GIBBS—Reports we have received say that the doctors are frightened of litigation and that women can actually sue. A few days before this inquiry, previous witnesses stated that the high rates of caesarean in this country are due to women giving birth at a later age. We have had other reports which say that women who give birth at a later age in life would prefer a vaginal birth. How do you feel about that? Do you think that it is because of the older age of women giving birth?

Dr Fisher—There is no doubt that the average age of first birth in particular has increased. It has increased quite markedly in Australia. There has been some very clever scientific scrutiny of this in the United States—in particular one study where they took 3,000 obstetric records and removed any sociodemographic information from them. They asked clinicians to respond to the question, 'Given this obstetric history, what would you recommend?' It was found from that that maternal age alone was being used as an indicator for caesarean delivery, completely apart from any clinical indicators. It may be that maternal age is exerting some impact, but in my study—this prospective study I talked about before—maternal age was only one of 17 factors. The other factors were stronger contributors. It contributes a bit, but it does not explain it all.

Senator GIBBS—It was interesting this morning when this obstetrician at the Mercy Hospital talked of the deskilling of obstetricians. He said that, of 25 obstetricians, only five would be comfortable delivering a breech birth. That is a very small number. He said that what normally happens with the younger doctors coming through is that when it is a breech birth the women will say, 'I would rather have a caesarean', and he will say, 'Okay.' This seems to be a problem. It seems to be a quick fix solution. Are you finding that it is a case of, 'Let's do the caesar and that'll be it'?

Dr Fisher—I am sure that happens.

Senator GIBBS—A lot of women—and I have known a couple—opt for a caesarean because it is the easy way out: they can just go in and have their baby between certain hours and they think it is not going to radically change their body.

Dr Fisher—I have two responses to that. Firstly, there probably are anecdotal reports of women saying, ‘It will be convenient to have it next Thursday, thank you very much.’ The evidence that we have suggests that clinicians overestimate how much women actually mind—what day of the week or whether the curtains are pink or blue—and that what they really mind about is autonomy, choice, a sense of self-control and having support people available to them. They do not really mind whether the paint is peeling or the bed looks like a double bed nearly as much as the care providers assume that they will mind.

There is no doubt that there is a great climate of fear that they will be sued. It is my understanding that the actual rate of suing is nothing like the feared rate of suing. There are very highly publicised cases, but they are really very infrequent. Suing is also very much influenced by the difficulties women have in getting an explanation when things go wrong. When something goes wrong, they need an opportunity to go over it and say, ‘Why did this happen? I now have to live with something that is unanticipated.’ They frequently meet a very defensive response without being given a well elaborated explanation. It is that which leads to this cycle of anger and frustration that can ultimately lead to litigation. But litigation is a most regrettable outcome, I believe. I do not think it serves women well and I do not think it serves clinicians well. There would be much better mechanisms in place to deal with this.

Senator GIBBS—I have come across women who have said, ‘Why are you doing this inquiry? After all, if I want a caesarean, that is my choice and my right. It is between me and my doctor and it is nobody else’s business.’ There seems to be a perception that if I am pregnant and I want to have a caesarean, I am entitled to because it is my right. Natural childbirth is so much better. Do you think we need better education programs?

Dr Fisher—You are raising a very important point. Almost invariably when a caesarean is discussed the benefits of the procedure are promoted. To my knowledge, almost never are the risks mentioned to women. There are very serious risks. The maternal mortality rate from the procedure alone is two to four times higher than with vaginal delivery. Maternal mortality is very rare, and it is very rare in Australia.

Nevertheless, the round of maternal mortality statistics published in 1993 shows that caesarean surgery was a significant contributor to maternal mortality in Australia. Apart from the mortality rate, all kinds of post childbirth morbidity are higher following caesarean delivery, including bleeding, wound infection and later uterine infection. There can be surgical damage to other intra-abdominal structures, such as the bladder, fallopian tubes and uterus. They are not risk free or benign procedures, but that is how I think they are discussed in the community. They are discussed as somehow very benign procedures.

Another thing that women are completely shocked by after having a caesarean is the pain. Somehow it is promoted as a pain free, straightforward procedure. Post delivery, they are quite disabled with pain and they require narcotic pain relief. They are filled with catheters, drips and tubes. They are unable to get out of bed for several days. In my opinion, when a caesarean is being discussed, these matters need to be talked about just as much as any theoretical benefit to a mother and an infant. I want it made clear that I am not opposed to caesarean surgery. I accept that it is a procedure with great clinical benefits in clearly

defined circumstances. However, there is a very widespread view that it is used to great excess in Australia.

CHAIR—Thank you for that. I would like your comment on a quote. I think you have probably mentioned just about all the points, but I would like to run through some of them. In a study by Lomas and Enkin in 1989, the authors comment that in a current private practice climate a woman wanting a caesarean section is much more likely to have her request met than a woman who is wanting a non-interventionist approach. If I understand that, there still seems to be a climate that says that if women are saying, ‘Let me have a natural birth quietly and with minimum intervention’, they are far less likely to get it. However, if they say, ‘I demand a caesarean section’, the doctors roll over.

Dr Fisher—Absolutely. They say that you can have one tomorrow, if you like.

CHAIR—Does this amaze you?

Dr Fisher—It disturbs me. I think it is why increasingly the people who are opposed to these interventions are being perceived as more and more strident because you have to say these things more and more strongly. In my study of 272 women, only nine women had no intervention of any kind. Some were modest. They were on a drip or given an anaesthetic or something like that. But only nine women had just given birth with supportive care.

This evidence has been supported by a doctoral candidate working under my supervision who has just surveyed 200 women. There are very similar findings. To really have a supported delivery in a safe place such as a hospital setting without any intervention or amniotomy, electronic monitoring, pethidine or anything else is quite an exceptional experience. It is perhaps less so in the dedicated birth centre beds, but they are still the minority. About six per cent of deliveries in Victoria are now in those dedicated birth centres, but it is far from the majority.

CHAIR—What do you put that down to? You said before that you thought it would be very interesting to ask women about their request or non-request for a caesarean section or any intervention. What about research to ask the doctor?

Dr Fisher—This is what I would really like to do. I have put up two research proposals to do this. One is by anonymous survey, where they will not have to be identified, and one is where I would go and ask them in a non-identifying way about the difficulties they face. One proposal went to the National Health and Medical Research Council and one went to the Victorian health department. They were both rejected with what I would regard as strong and highly defensive reviewers comments that these are not matters that anyone outside the profession has any right to have an opinion on. Certainly they are matters that not only people within the profession are equipped to discuss or talk about. Clearly, it would require a great deal of skill and care to do it properly. I think it is an essential area of inquiry and endeavour.

CHAIR—This goes back to what you were talking about earlier regarding informed consent and/or the ethics of decision making. If women ask to have no intervention, they are not likely to be taken too seriously. However, if they ask for a caesarean, they are. It

astounds me. It is as though for some reason or other many doctors are prepared to abdicate their professional competence.

Dr Fisher—There is this great tension that the profession is highly trained surgically. It is suggested that they get more gratification from action than expectancy. People have described it in pretty gross terms. They say they are pretty sick of standing at the foot of a bed watching a woman grunting. That is what observant, expectant care regards as being supportive, present and observing. But it has been said that the profession is highly trained surgically and, therefore, they have a strong urge to act. Their perception of danger is probably heightened. Their perception of risk is probably heightened. Their sense of achievement professionally comes from acting and intervening in this circumstance.

CHAIR—Years ago when I was a student there was a slogan that said that patience is the watchword of the obstetrician. Are you suggesting that this old slogan has changed?

Dr Fisher—Yes, I am. I think we have some evidence for that. In settings where midwifery care is the primary model of approach, rates of intervention are much lower. Midwifery care undoubtedly and primarily involves this expectant, supportive, careful observation of a woman. It does not involve active intervention. Probably the best evidence we have in Australia is the randomised control trial at John Hunter Hospital in Newcastle that was published a few years ago. Women were randomly assigned to routine care in the antenatal clinics and to a midwifery team care approach. The rates of intervention were lower in the midwifery team care approach but all maternal and infant health outcomes were better in the midwifery lot. They had no higher rates of predicted adverse outcomes. They had better rates. The midwives were the primary care providers.

In Holland, where most births are managed at home and there is a strong emphasis on midwifery care, similarly, their maternal and peri-natal mortality and morbidity rates are among the most outstanding in the world. They have very low intervention rates.

CHAIR—What is Holland's caesarean section rate?

Dr Fisher—It is my understanding that it is six per cent. The most recent international summary published is the article I have cited that was published by Stephenson and many other authors in *Paediatric and Perinatal Epidemiology* in 1993. There may well be an update on it, but it is my understanding that in the Netherlands the caesarean section rate is six per cent.

CHAIR—Do you know the figures for the UK and New Zealand?

Dr Fisher—The UK, it is my understanding, is about 12 per cent. New Zealand's is not very much lower than ours, although it is lower than ours. The difference in New Zealand is that midwives can operate as private practitioners in New Zealand. I am not yet aware whether studies have been published comparing the rates of use of procedures among the different models of care in New Zealand.

It is of concern in Australia that in some states our data is not disaggregated by health insurance status. Victoria has only just changed this. But it has meant that, until now, in

Victoria we have not known the difference in rates between the two public and private groups. We have had to generalise from the other states, which do disaggregate their data. Clearly, we have to make people continue to tell us the difference between the public and the private rates.

CHAIR—The analysis of national patterns of usage of these technologies is hampered by the fact that perinatal and hospital usage statistics are collected by individual states in different ways. Medicare claims are payable but not for others, particularly services provided by the public hospitals. I do not know what page this is because they are not numbered. It is about the second or third page. On the other hand, we were told by Paul Lancaster from the Australian Institute of Health and Welfare that they get perinatal statistics based on hospitals.

Dr Fisher—Yes, they do. The perinatal data is the best we have. It is recorded by a midwife after every hospital delivery. The Medicare claims really apply more to antenatal scrutiny. If a hospital provides antenatal care, it is provided as part of the package of services. We do not have rates of antenatal screening procedures as completely. But we have very good data on the perinatal data collected at birth. Each state collects their own perinatal data. It is then put together by Paul Lancaster and his group. Most states collect data identifying the health insurance status of the mother. Victoria, until recently, has not done that. There has been a lack. Nevertheless, Paul Lancaster still publishes an average national rate. He does not publish an average national private rate and an average national public rate, which would be very different.

CHAIR—He does give you those figures, though?

Dr Fisher—He does give you the figures. You can get it, yes.

CHAIR—It is one of the reasons why we are having this inquiry, because the data shows very conclusively that if you are privately insured, you are much more likely to have a caesarean section than if you are not.

Dr Fisher—Absolutely. His data is the best we have. It is really very good. Individual hospitals that provide both private and public care within their individual setting often do not publish different rates. They say, ‘The caesarean rate at our hospital was’, whatever it was.

CHAIR—Even when they are providing data to the perinatal sector?

Dr Fisher—No, not that, I do not think, but if they are publishing their annual report.

CHAIR—We need to chase this down, because we are told that every hospital puts its data out in its annual report. We are not sure and, if what you are saying is the case for many hospitals, then it is confusing. People cannot know which hospital has a lower rate.

Dr Fisher—No, because it really obscures this variation. Now that Frances Perry is in fact a separate hospital here, this hospital may publish their data separately. But when Frances Perry House, which is the private section of this hospital, was run as part of the

hospital it was my understanding that they just published an average rate for the whole hospital. It was not disaggregated by the health insurance status of the mother.

CHAIR—Somewhere or other it is disaggregated so that Paul Lancaster can make a fairly good—

Dr Fisher—That is on this perinatal report. I think even Paul Lancaster would agree that in Victoria we do not have it.

CHAIR—He agrees that it is not perfect.

Dr Fisher—Yes, and he writes that in Victoria and in the Northern Territory we do not have, until now, data disaggregated by the health insurance status of the mother. We have no reason really to believe that it is very different from the other states where they do disaggregate it.

CHAIR—One of the things that interests me in particular as a South Australian senator is that, disaggregated or not, the claim is that my state has the highest number of caesarean sections in Australia. I cannot imagine what is happening to the women in South Australia.

Dr Fisher—Exactly.

CHAIR—And I do think it is worth trying to find out.

Dr Fisher—Absolutely.

CHAIR—We need consistent, reliable disaggregated data and we need to have it across all categories.

Dr Fisher—Absolutely. Yes, even within the public, I think it would be very good if we could know what the midwife care and the shared care with a GP is. Obviously, there is an effect of referral on, and you would have to accept that people who are identified in pregnancy as high risk are going to be referred out of the midwifery models of care. But, nevertheless, I think it would be very helpful to have the data broken down in those ways.

CHAIR—One of the other points that you make is that there is a difference in the rate of use between centres, even those serving women of similar levels of obstetric risk. You state:

... (for example, from 0% to 29% in Victorian hospitals in 1987 with 10% of hospitals having a rate above 22%. . .

How do you say to us that these are centres serving women of similar levels of obstetric risk?

Dr Fisher—That citation is from the review of birthing services and it is evidence collected by them. There is no doubt that the tertiary hospitals have a higher proportion of women at higher risk. That figure really refers to the fact that, even among general hospitals

servicing women who broadly should not be epidemiologically very different, some hospitals appear to have a much higher rate of intervention than others.

CHAIR—We had evidence from Francis Sullivan representing Catholic Health Australia last Friday and he said that, if there were some clearly established clinical best practice criteria, doctors and midwives could defend their practice against those criteria, and therefore reduce the litigation. Do you have a view about that?

Dr Fisher—I do. I think that is a very helpful recommendation. The whole area of foetal distress is one that has been described in the literature as an area of grey. It is, as I understand it, currently the most common indicator for the use of caesarean section, that the baby is getting distressed. But it is my understanding that the interpretation of these records is open sometimes to a range of opinions. I think it is also of concern that often babies who are delivered because of supposed foetal distress are in fact delivered with very high Apgar scores. I think this notion of how we ascertain foetal risk is a complex one and it would be very helpful to have much more definitive guidelines about that as an indicator for caesarean surgery.

CHAIR—If that is the case, foetal distress does not seem to be covered by the first attendance at antenatal; once a woman discovers she is pregnant and she says, ‘I’m having this baby by caesar,’ there does not seem to be an indication of foetal distress?

Dr Fisher—Precisely not.

CHAIR—If doctors say yes, she having demanded it—for example, in anticipation of a breech birth—this again would not be evidence of foetal distress?

Dr Fisher—I do not believe so; no.

CHAIR—What I really need to know is the percentage of caesarean deliveries that are put down to foetal distress. Do we have any figures that give a breakdown?

Dr Fisher—It is my understanding that there is a range and that probably between 40 and 60 per cent are put down for foetal distress. Multiple birth and breech delivery are others and maternal illness—pre-eclampsia—is obviously a clear indication. I think there are some that are very clear indicators and that probably serious maternal illness is one. But it does not explain by any means this; it certainly does not explain variations in rates of use.

CHAIR—Can you tell us of any evidence that says the fear of being sued is higher than the actual number of cases of litigation? There is a mention here of Hancock in 1993. If doctors fear that they are going to be sued and if that is actually affecting their practice—and I am presuming that is doctors more than midwives, although you can comment on them too—is that another area that you would say needs further research?

Dr Fisher—It would be my opinion that it really requires further research. I think that both Fiona Tito’s and Linda Hancock’s work found that every doctor has a very heightened fear of being sued but it was their conclusion that, in fact, the actual likelihood of being sued is far lower than the feared likelihood of being sued.

CHAIR—At this stage the last question I would like to ask you—of about 2,000 that I am waiting to ask—is this: a lot of the childbirth education material seems to be produced by other than obstetricians or midwives, although—from what I understand—midwives tend to have more of an ongoing say about what is happening, so are therefore practitioners of childbirth education to some extent. Can you comment about that? Do you know whether the obstetricians, apart from doing childbirth education—which I understand they rarely do—contribute to or have any say in what goes into childbirth education material or is that left to the sisters?

Dr Fisher—I am not an expert. It is my understanding that childbirth education can now, in fact, be a tertiary qualification. I think the course in this state is run by Deakin University; you can get a certificate in childbirth education. So people from a range of health disciplines qualify themselves as childbirth educators, although it has in the past been a thing that well informed volunteers have done.

Of the settings with which I am familiar, obstetricians often speak at a single class. But it is not an area in which they have very much input at all. They do provide information to individual women in their care, although there is certainly evidence that they tend to be somewhat paternalistic and underestimate how much women want to know about potential adverse outcomes. This was described in this Brisbane paper as *Don't worry your pretty head about that*, but the paper really showed that women had wanted much more information from their obstetricians about possible adverse outcomes. I would suggest that too is an area of very fruitful further inquiry, whether obstetrician input to antenatal education and preparation could be useful.

CHAIR—It sounds a little bit as though—and I will probably be slugged from far off for saying this—the obstetricians might do well to know what it is about.

Dr Fisher—And might attend it themselves or something.

CHAIR—That is right. Earlier on you were saying that often what women want is a comprehensive, calm, reasonable explanation about where things have gone wrong or as to what is happening during the process. Then, if they feel satisfied with the information—rather than being met by, ‘Don't worry your pretty little head about that,’—they are much more likely to cope in a constructive kind of way.

Dr Fisher—Absolutely.

Senator TCHEN—I have three very short questions, Dr Fisher. You mentioned that in New Zealand midwives operate as private practitioners. Given what we heard earlier in evidence talking about other models, can you tell me if the maternal mortality rate in New Zealand is higher than—or different from—Australia's average?

Dr Fisher—I cannot say that I know the answer to that. It would be information that could be obtained. The change in New Zealand models of care is a relatively recent one so it might, in fact, be too soon to be able to know from epidemiological evidence whether there is any difference in that.

I do know that midwives in New Zealand who are in private practice say that obstetricians bring a great many formal complaints against them about their practice. Clearly, there is substantial tension between the two professions. Ideally of course you would have all these professional groups collaborating highly with each other.

Senator TCHEN—When you referred to your research, you mentioned that you found that more confident, highly educated, articulate women are more likely to have caesarean interventions. Did you delve into the possible causes of that?

Dr Fisher—All the women in my study were approaching childbirth expectantly. They were a very small group who knew in late pregnancy, when I interviewed them, that they had some indicator of risk—but they were a very small group. Others were all approaching it saying, ‘This is an important event for which I am as well prepared as I can be.’ But none of them were saying at all, ‘I am expecting a caesarean delivery.’ Yet over 20 per cent of the privately insured women have it.

I think it is to do with the relationship that develops between an obstetrician and a patient in his care in late pregnancy. I am not saying these are malicious motives but I think the whole issue of maintaining objectivity is more difficult when you have actually developed a very close relationship with someone in your care. It is difficult to subject it to scrutiny but I believe we have an obligation to do so.

Senator TCHEN—Do you think there is a possibility of a desire to control the situation?

Dr Fisher—You could certainly postulate that.

Senator TCHEN—My third question actually has nothing to do with the inquiry; it is just out of curiosity. With the research that you are proposing—the survey of practitioners—is it possible for you to get a partner who is actually a professional?

Dr Fisher—As a collaborator in research?

Senator TCHEN—Yes.

Dr Fisher—I think that would be essential. I do not think you could get a project of this under way effectively unless the Royal Australian College of Obstetricians was prepared to collaborate with it.

Senator TCHEN—No, I do not mean that. Obviously you are not getting that collaboration; I am saying that you get one other researcher who is actually a practitioner and he or she will put that proposal.

Dr Fisher—That might well be a good way to proceed.

Senator TCHEN—Thank you.

CHAIR—Pardon me, Doctor, but one would have a nice little fight about whose intellectual property that research was.

Dr Fisher—All that sort of stuff is familiar in universities.

CHAIR—If there were some best practice clinical guidelines established for deliveries, what mechanism do you see that we would need to get those into our hospitals and birthing centres? It is one thing that we might just describe them and it is also clear, even from reading the submissions, that practice is different from one hospital to another—ergo, I presume, the first-level differences in rates. Would we need the obstetric police?

Dr Fisher—We would have to have some form of scrutiny. I do not think it would be a thing that people would do voluntarily. I do not know whether that means you scrutinise individual practitioners—which they do in some hospitals in America where everyone's statistics are put up each month and they have to be able to speak to them, to defend them—or whether there was more a hospital form of scrutiny. I think there would have to be a mechanism for doing that.

CHAIR—Do you know of anything that is in place already that might do this? We were told, for example, about peer review or assessment in Tasmania some while ago. One senior obstetrician in Tasmania used to collect the data from different hospitals and then there would be a time when that senior obstetrician would meet with all the other obstetricians—I am not sure about midwives; I suspect they were not included at that time—and there was a lot of encouragement for non-intervention. So practitioners felt supported by their colleagues in a whole climate of non-intervention. It is interesting that when that senior obstetrician ceased practice—retired—and was replaced by a different person with a different attitude caesarean section rates rose dramatically in Tasmania.

Dr Fisher—I think that is a very good illustration of what this man, Jonathon Lomas, writes about—that if you have a key opinion leader who is highly regarded by contemporaries that person can be the key to altering rates of intervention but that peer convention is a much stronger determinant of practice than anything you learnt in your training or in any upgrading of your training you have had since or anything published in the literature. If your contemporaries are doing things one way, that is the way you are more likely to practise. I would suggest that obstetric practice in Australia is conventionally highly interventionist.

CHAIR—It is interesting, because I suppose a lot of mothers in Australia might say that having that kind of person in the system is a bit risky—and what happens when they are not there? We are also told that in America the most important factor for changing intervention practices was when it became financially more advantageous to not intervene. I note that you make some comment here about the fact that, if there were a financial reward for allowing labour to proceed without intervention as apart from increased assistance for caesarean section, this might make a difference.

Dr Fisher—That is certainly my view. I think it is a considerable concern that the financial incentive that used to exist for intervention that was removed has now been replaced and that there will be a further incentive—if any further incentive is needed.

The other thing that has been suggested is that one of the financial incentives is the physician convenience—that you can do five deliveries in a day fairly readily if they are all

lined up to go into the theatre. But if you are actually hanging around in five labour wards for five long labours that is much more difficult to do. So part of the financial incentive comes in time management of a busy practice. Incidentally, the obstetrician who published this view has been really vilified for having had the courage to state it—it was James King from the Mater Hospital in Brisbane who had the courage to write about this. He has been subjected to very cruel treatment by his colleagues.

CHAIR—That is probably not a good note to finish on, but I think the committee is very much assisted by your paper, your research and the questions you pose. Thank you very much. If there is anything further, would you mind if we raised further questions with you?

Dr Fisher—Not at all. I would be delighted if you did that.

Proceedings suspended from 11.09 a.m. to 11.21 a.m.

COLLETTE, Mrs Julienne Eve, Honorary President, Victorian Branch, Australian College of Midwives Inc.

JOHNSTON, Ms Joyce Isabella, Professional Officer, Victorian Branch, Australian College of Midwives Inc.

CHAIR—I welcome representatives of the Victorian branch of the Australian College of Midwives. The committee prefers all evidence to be heard in public but, should you at any time wish to give your evidence, part of your evidence or answers to specific questions in camera, you may ask to do so and the committee will give consideration to your request. The committee has before it your submission, which we have numbered 14. Do you wish to make any alterations or additions to that submission?

Mrs Collette—No.

CHAIR—Would you like to make an opening statement and at the conclusion of it we will have some questions.

Mrs Collette—I wish to speak in support of our submission. We are from the Australian College of Midwives. We believe that pregnancy—and birth—is not an illness; that is certainly so from the World Health Organisation recommendations of 1985. We also believe that midwives should be considered the primary carers. They are able to work without supervision but in collaboration with their medical colleagues as necessary.

There is certainly evidence to support that midwifery is a cost-effective option of care and that it is very safe. We want you to recognise that 60 per cent of all pregnancies do result in no complications at all and that the current system is very high cost for something that is a normal process of life. We want you to recognise there is restricted access to information for health professionals and also consumers in relation to birth outcomes. There are certainly variations in childbirth practices between both public and private areas. There seems to be a lack of informed choice for women, and it is a very costly with some of those adverse outcomes.

We believe the current system is anticompetitive towards midwives and also towards women. There are restrictions on midwives to practise. There are very few hospitals in Victoria for which midwives actually have visiting rights to practise. Casemix funding allows for a medical component but not for a midwifery component. We know that the midwifery model of care is both safe and appropriate. Our recommendations out of all of this are that we believe there should be a major reform of maternity funding. All births should be allocated a midwifery component and we would also like to see statistical information available on childbirth practices.

CHAIR—Ms Johnston, do you wish to say something in opening comments?

Ms Johnston—Yes, I would like to add to the comments that Julie has just made. A question was asked previously about the New Zealand experience, whether there was a

difference in maternal morbidity or mortality. We do not really have access to the figures. Maternal death is so small; it is a tiny number.

But we do have access to recent data from New Zealand on neonatal outcomes, the baby outcomes, and you can find them on page 7 of our submission. These were published by the New Zealand College of Midwives in 1998 from a survey of a large number of women. They all had the choice of a midwife as the primary carer, a GP and midwife shared or an obstetrician and a midwife shared. In New Zealand they say every woman needs a midwife. The woman has the right to choose a midwife as her carer, whether her case is totally uncomplicated or there is a need for collaboration with other professionals.

Quite astonishing figures have come up in this review. The women who chose a midwife as their lead carer had a figure of 88 per cent vaginal birth and 3.6 out of 1,000 were perinatal mortality, so those are dead babies at the end of the business. The difference with GP-midwife shared care was 82 per cent vaginal birth and 11.5 per 1,000 deaths. The obstetrician and midwife was 50.4 per cent vaginal birth and 14.9 per 1,000. In this study these were all well women so you cannot argue that the women who chose the obstetrician were at a greater risk of needing obstetric care. These figures have just been published. I would like to draw your attention to them.

CHAIR—Just before we get into the formal questions, can you tease out this information for us? You say they were all well women. Do we know at what stage in pregnancy the women made this choice?

Ms Johnston—As I read the figures, the women chose their carer and then it was if indication came that they needed to move from one model to another. ‘Other models’—their last figure of 16 per cent—were the women who moved out of their first model of care, which would have either been midwife or GP-midwife, into an obstetric care model because of need.

CHAIR—So the 14.9 perinatal mortality actually includes the last two figures?

Ms Johnston—No.

CHAIR—Only the 6.1?

Ms Johnston—That is right.

CHAIR—If I were to be a bit of a devil’s advocate here, I would say we do not really know what the cause was—if there was any cause—for a caesarean section and whether the cause for the caesarean might have contributed to the infant mortality.

Ms Johnston—I would like to postulate that the lines of communication are very clear where you have a known midwife being the primary carer. We believe, as a college of midwives, that it is the true role of a midwife to go through simply being with the woman, not pushing her into doing this or doing that, believing that giving birth is her body’s right and that, as we are with her through this, we provide that level of safety. Some of those

midwife births would have been at home but most would have been in hospital. The homebirth rate in New Zealand is about 10 per cent, whereas here it is 0.1 per cent.

CHAIR—Do you know where the Maori mothers were in this survey?

Ms Johnston—I did not see any indication of them, but the New Zealand college does keep very careful note of Maori women. Maori women have been particularly choosing Maori midwives to be their primary carers.

CHAIR—On the face of it, these are very powerful figures.

Ms Johnston—They are astonishing.

Mrs Collette—They certainly do need more investigation as to why there is that 14.9.

CHAIR—For example, there are conditions like placenta praevia and things of that sort that you cannot anticipate when you start pregnancy but, sure as hell, you are not going to argue about it when things literally come unstuck at the end and if you should start putting your blood pressure through the roof with pre-eclampsia. There are conditions like that; the whole pregnancy may be smooth and fantastic and there are acute conditions of that sort.

These figures are certainly worth our looking at to see what we can find further and also to make any breakdown. As far as you can tell us, Ms Johnston, what you are saying is that well women in the early stages of their pregnancy made a choice about midwife, midwife plus GP or midwife plus specialist. As a result of the women's original choices, this is the outcome. It is very recent data.

Ms Johnston—Yes.

CHAIR—Do you know how many people there were?

Ms Johnston—I did see the figure and from memory it was over 2,000.

CHAIR—Anyhow, do not worry; I am sorry, Ms Johnston. We will follow that up.

Ms Johnston—The issue was that there was no cost incentive whichever they chose. The ones who went to obstetricians probably paid a bit more. It cost the woman nothing for either a midwife or a midwife and GP.

Mrs Collette—The payment to the midwife and the GP is the same in New Zealand.

CHAIR—Sorry, the payment to the—

Mrs Collette—The payment to the midwife or the GP from the government is exactly the same in New Zealand.

Ms Johnston—So the payment is linked to the birth, to the woman, not to who provides the care.

CHAIR—Have you finished your opening statement?

Mrs Collette—Yes.

Senator GIBBS—I will just follow on from that point. This payment is obviously in the public hospitals?

Ms Johnston—Public care, whether it is hospital or home.

Senator GIBBS—That is very interesting. I am interested in these birth centres. It has been quite a while since I had children. We did not have birth centres. When did they start? When was it the norm? Hopefully, it will become the norm for women to have the care of a midwife. When did you actually start this process?

Mrs Collette—Birth centres really started in the late 1980s. Probably most of the major hospitals in Victoria have a birth centre. We do recognise that there are problems with birth centres. Because it is low risk criteria, should anything happen throughout the pregnancy or labour and the woman becomes high risk she is actually transferred out of the birthing centre and goes into the traditional labour ward. From a woman's point of view, what happens is that the midwife does not usually follow her through. So where the woman has built up a great rapport with the midwife or the team of midwives who are caring for her, she goes into the other model of care and does not have that midwife when she has had her all the way through.

There are different midwifery models that provide total continuity of care. An example is a caseload model. The midwives actually take a caseload of about four women throughout their pregnancies and provide the antenatal, intrapartum and postnatal care. Should the woman be high risk at any stage the midwife is there throughout that whole process.

Senator GIBBS—It is a very important process. Was it difficult to actually start these programs?

Mrs Collette—There was a consumer demand. That is really what helped, but, yes, it was very difficult.

Senator GIBBS—If I found myself pregnant—I would have to be a lot younger, of course—how would I know about you? If I go to the local public hospital or if I go to my local doctor, discover I am pregnant and decide I need care, am I actually told that I can have a midwife to look after me or am I told I can go to a birth centre as opposed to going to see an obstetrician or going to a public hospital and seeing the obstetricians there? Am I going to be told of these services?

Mrs Collette—That is probably the most difficult part of the whole process. If you are not informed, what do you do when you are pregnant? There is no centralised place where you can go and find out what your choices are. Every hospital will talk about different choices that they have available at their organisation. Some have midwifery models of care and some do not. If women want a home birth, for instance, usually word of mouth is how they find out about that. When women come along to an organisation they are given

information regarding the different models of care. What should happen from there is that the woman should be able to choose her model of care, but sometimes that is a medical decision depending on which organisation you go to.

Senator GIBBS—There must be a lot of women out there who are ready to become mothers who do not know about your services?

Mrs Collette—That is certainly right. There are a lot of women out there who do not know about this.

Ms Johnston—Women who say they want to have a midwife as their primary carer and be outside the hospital system—whether it is for a birth in a hospital or a birth at home—are often told that this is a very dangerous thing to do. Midwives are actively discriminated against in hospitals. We do not have visiting access. We do not have the ability to walk into a hospital with our own client and continue on as the midwife, whereas if we were employed by an agency we could do that and we could work with a stranger. A woman does not have a right in Victoria to bring her own midwife to most hospitals.

CHAIR—I thought you were extremely moderate in your description of difficulty to get midwives mentioned at all. I thought war zone might have been a more appropriate description.

Ms Johnston—We really need the doctors for the complicated births. I have quoted Murray Enkin, who has now passed away, but was the head of the huge volume on effective care in child birth and pregnancy. He said to get proper obstetric care you need primary and secondary carers working together properly. We see ourselves as primary carers. We see ourselves working with the woman, but those who need medical attention need the best and right away. It is not something we should be fighting over. We really have to maintain good relationships with our obstetric colleagues, but we see it is a very unwise and unsafe—Enkin says this too—for the obstetrician to be involved on that primary care level. Jane Fisher mentioned that the doctor may lose objectivity. We midwives are able to continue on with that one-to-one care throughout because we rely on that woman to let us know if there is a complication and then, by our definition, by our code, we must call in obstetric care if there is a need for that.

Senator GIBBS—Really the ideal of the whole birthing process would be to actually work together. I do not want to be sexist, but, let's face it, if you are lying there in extreme pain having a baby and you have other women around you who are knowledgeable and know what they are doing that is more comforting than having a man there, even though technically he is probably very highly trained. Giving birth is a very emotional thing for women. All those hormones are running rampant. To have other women there who have been through the process and know exactly how you are feeling is extremely comforting for your whole psychological well being. It does not matter how old you are, if anything happens you always want mum, don't you.

Mrs Collette—The key point is about knowing somebody. If a midwife meets up with a woman in the early stages of pregnancy and works in partnership throughout the whole pregnancy, there is a good working relationship. There is certainly evidence to say that for

women in this circumstance there is less pain relief in labour, the episiotomy rate is better, they spend shorter time in the labour ward, in the birthing suite, and they spend most of their early labouring time at the home. That is because of the good relationship they have with the woman.

Senator GIBBS—Are midwives trained nurses?

Mrs Collette—At the moment they are. They go through a three-year nursing degree and then it is 12 months on top of that to do midwifery. A bachelor of midwifery is being proposed by quite a few states of Australia at the moment. A discussion paper has just been put out by the Australian College of Midwives Victorian Branch discussing a bachelor of midwifery, which would be a three year course.

Senator GIBBS—Years ago was it not the normal thing for nursing staff—I am going back to the 1960s—to do their training and if they worked in maternity hospitals they would do their midwifery training? Was that the norm or am I wrong?

Mrs Collette—It was probably the norm that most people went through a three- or four-year nursing training and then went off and did their obstetrics.

CHAIR—Double certificated nurses, as we used to call them.

Senator GIBBS—Have we moved away from that process over the years?

Mrs Collette—No, the process is still the same, although I do not think as many people are becoming double certificated like they used to in the past. I do not have the numbers. Do you have them?

Ms Johnston—No. There has been a projected shortage of midwives, particularly in rural areas, by the work force planning unit of human services. But I would like to say that this is the issue that Senator Crowley raised a little earlier. Midwifery has become almost lost, and midwives are now asserting ourselves because the evidence is showing that women do not need to be treated like sick people being looked after by nurses who jab them with narcotics to get them out of their pain. They need to be empowered to use their bodies to the best of that body's ability in giving birth. Birth is not an illness and we should not be treating it like an illness.

Over quite a few generations the role of the midwife has become more and more that of a nurse. Now we as a college—and this has been a position statement from the National Australian College of Midwives for the past 15 years—asserts that the role of the midwife is not that of nursing; it is a separate identity. It is quite definable as a distinct profession.

Senator GIBBS—How do we change this culture? How do we change the culture where the doctor or the obstetrician has become the primary carer? Obviously, people do think that if they have a child at home, that is a dangerous thing and they need that doctor just in case anything happens. How do we change this? How do we get doctors and midwives to work together as a whole and have a holistic approach?

Mrs Collette—I think it needs to be changed at all levels, right from a policy level, and whether we do look at the Medicare side of it, funding issues, plus down at the local level. Certainly from a local point of view what is happening is that a lot more midwives are asserting themselves. More midwifery models of care are actually starting to develop throughout the whole of Victoria, particularly in the metropolitan area. In the country areas the midwives and the women are very disadvantaged, because the midwives actually have to work as nurses and midwives. Sometimes their commitment is really given to the nursing side rather than the midwifery side.

We are lucky here in Victoria at the moment because the government has actually put out a Maternity Services Enhancement Strategy. They have given out \$60 million over a four-year period. Certainly that money has been allocated by separations to each individual hospital and homebirth does not come into it because there is no public money for homebirths. What is happening with a lot of the money is that strategies have been worked out with midwives and doctors at the local organisations to work together and develop models of care that are more suitable for women.

CHAIR—One way you do it is to have a Senate inquiry. It has been a very interesting battle. I know in South Australia there were a series of public meetings. This was as much as anything about homebirthing apart from just midwifery. You were also drawing a distinction between homebirthing and midwifery where sometimes the baby may be delivered in hospital.

There were a very interesting series of meetings in the South Australia, one of which caused considerable upset because the mothers and the midwives in the end worked out that you would be better off with an ambulance. The ambulance drivers were prepared to be very helpful and assisting. They said, 'We would have humidicribs and whatever else you needed. We would race you to the public hospitals or wherever', whereas the obstetricians were still being obstructionist. I think in the end people realised that some kind of detente had to be worked out, but for some time it was quite bloody minded. I guess you would have to say, all courage to those extraordinary women who have been battling for 20, 30 or 50 years to try to change this culture. There is still a long way to go.

I wanted to ask you a couple of things that are contradictory. This comes from Dr Fisher's work and it refers to the inverse care law, where the lower the social status, the higher the medical risk and the lower the intervention rate. This is really quite interesting. The higher the social status, the less likely you are to be at risk because of better nutrition and other things, and the higher the likelihood of intervention. Can you talk about that? Can you tell us about your figures? Because we are being told that the people who seek out midwives tend to be more middle-class or not from a lower socioeconomic status. That is why I would be interested to know about Maori people in New Zealand, for example, who may be in general more represented among the lower socioeconomic groups than the higher ones. I do not say that for all Maori people at all.

Ms Johnston—I would like to comment on that. To have a midwife provide care, whether it is for birth at home or in hospital, the woman has to come up with between \$1,500 and \$2,000, whether it is a public hospital or not. If she is going to a private hospital, there will be more money for that hospitalisation. So, it is a broad generalisation that middle-

class, more wealthy people would choose the midwife. The woman who birthed at home this morning with me was not wealthy. Her husband is a student. She was booked into a public hospital and she chose to change because she said, 'I am going along the each month. I am seeing different people and I feel as though I have no control over what is being done. I just see them very briefly.'

The model of care that I offer is an hour consultation prenatally regularly so that we are getting to know each other and we are working together. Then when she is in labour, I come to the home and ask, 'Are you happy to stay at home?' She said, 'Yes, I'm right', and within an hour she had had her baby this morning, just to facilitate my coming here. They are not all well women either, in that structured sense. Some have been rejected from birth centres because of a previous caesarean or something like this. But the only criteria I must stay by is that at the time there are no complications. Women who are 42 years old and having a baby, and this sort of thing, are often choosing to have their own midwife because they are very aware of their need for personal care. This is a very intimate time and they are not wanting to be treated like another person on a production line.

I am very aware of Jane Fisher's work and it was very definite. These women are often saying, 'I want the best. I am having a baby. I am not having many children. I want the very best care.' What is the best care? You go to the top and the top of the tree in this case seems to be the obstetrician. We as midwives would say that they should only go to the doctor if they are sick.

CHAIR—I thought you are going to say that they wanted the very best, and so they get midwives.

Senator GIBBS—That is what I thought she was going to say.

Ms Johnston—Some do, but it is a tiny minority.

CHAIR—Some of these things are almost counter-intuitive, so the lower the socioeconomic status, the more risk; or, if not counter-intuitive, at least contradictory to what you would expect. The other matter I find interesting that we have not talked about much is the early discharge from hospital. On the one hand we are being told that this is all because wicked governments are trying to save money. That is probably true, isn't it? Whatever the facts are, wicked governments exist to save money. There is said to be a cost push to get people out of hospital quickly. For example, some people are claiming that breastfeeding is not necessarily established so that might be a setback. There are a number of things that are better if a mother stays in hospital for a few days and get those things established. On other hand, with homebirths the mother is up and about in no time at all. I bet she does not stay in bed for three or four days at home.

Ms Johnston—She rests, and she has someone else to do the jobs, so she is certainly not cooking meals. She looks after the feeding.

CHAIR—In some cases, that is right.

Ms Johnston—It is one of the things we inform them of, definitely.

CHAIR—Lots of people go home from hospital two, three or five days later. It is all significantly different from the time when our grandmothers had babies and they were in bed for two weeks.

Ms Johnston—Yes, two weeks.

CHAIR—Then it went down to ten days and there was a sucking in of breath and shock horror. Then it went down to a week, and then there were people up and walking around within a few hours of having a baby.

The interesting stuff in your submission is that the breastfeeding rate at six months is highest in the group of women in this study who were discharged in the first two days. It is another little piece of contradictory evidence. Could you comment on that study and give us a clue as to why that might be the case?

Mrs Collette—At the time when milk is coming in there are usually lots of midwives around in hospital, and there is lots of conflicting advice. If the woman is at home, she works one-to-one with a midwife. You get more quality time at home than you do in hospital. On the second day, you are probably allocated something like four hours of a midwife's time if you are in the hospital environment, but that time is full of interruptions. We practise in a terrible way in the hospital environment. So if the women are at home and there is just one person giving that advice, they do so much better than when they are in hospital.

CHAIR—So you are saying that this outcome is because once they leave hospital they are then in the care of one person and the advice is consistent and continuous?

Mrs Collette—Definitely.

CHAIR—That is very interesting.

Ms Johnston—There is also the issue of empowerment—it is a bit of a buzz word, but the woman expects to have it. In the model where they stayed in hospital longer, the midwives were really good at getting babies on the breast, whereas now there is much more talk about hands off. The mother is the one who has to learn to breastfeed, and the baby has to learn too, so we should give her the information and the skills and help her to work out what she has to do rather than our being the experts and doing it for her. That is what has to be done, so that when a midwife says to a woman, 'Are you okay? I'm leaving you now,' she says, 'Yes, I know what to do.'

CHAIR—What do you do if she says, 'Help'?

Mrs Collette—We are there to support and help all the way through.

CHAIR—Do you replace or do you support the Nursing Mothers Association?

Mrs Collette—We support.

Ms Johnston—We work together.

CHAIR—They have built a remarkable reputation over the years, haven't they?

Mrs Collette—Yes. They have a hotline available 24 hours a day to give phone support to women.

Ms Johnston—When a woman is under case-load care—so she knows her midwife well—or under a private independent practitioner, she knows the phone number where she can get onto that midwife, and so she can work through. There are some breastfeeding problems that really do need specialist help. It is the same with anything else: if those problems occur, then you work through a system but you do not let the baby starve in the meantime. There are other methods to help the baby to get the milk—through a teaspoon or a cup or something like that—and the mother learns those skills.

CHAIR—The most creative method I ever heard was to dunk a new face washer in milk, and a little baby—less than a week old—was getting its milk out of the face washer.

Ms Johnston—You wonder what else it got, don't you!

CHAIR—The mother assured me that it was a clean face washer. In fact, the baby thrived beautifully, so I am all for creative alternative practice. One of the things that used to concern me was that almost all mothers who have a baby are visited by a 'mothers and babies' nurse. What are they called now?

Mrs Collette—Maternal and child health nurse.

Ms Johnston—It will be different in each state, so do not try to learn this one.

CHAIR—Don't I know! Maternal and child health nurses are different from midwives?

Ms Johnston—Yes.

CHAIR—Midwives can do maternal and child health work?

Mrs Collette—No. The midwife has the knowledge to deal with babies up to six weeks of age. How many years do maternal and child health nurses go to?

Ms Johnston—A couple of years, but the maternal and child health nurse has usually done midwifery before she went into that specialty.

CHAIR—One of the things that I have been constantly told is that a lot of people will have that first visit in hospital but will not have any follow-up visits from the maternal and child health nurse because those nurses are seen as, 'They're from welfare and they have come to take my baby away.' Do you know whether any of that myth is still being practised?

Mrs Collette—Of the organisations I have been involved with, no, not at all.

CHAIR—It is interesting because nothing like 100 per cent of mothers go on seeing the maternal and child health sister, and quite often the people who do not continue to have the contact are often the people who might do well for having it.

Ms Johnston—There is definitely that fear amongst some people. I see quite a few people who home school, and they will bring this type of issue to me: is someone going to be checking on whether I am an appropriate parent? The maternal child health nurses here tend to visit the mother within the first week or so but, after she has gone home from hospital, they do a home visit and then they introduce themselves and welcome the mother to come to the centre at the given time.

CHAIR—Do you do much with women who at risk, for example women who are doing drugs? Do midwives get involved with the street-kid mums?

Mrs Collette—Certainly not from a college point of view, but they do in the workplace. The Royal Women's hospital has a chemical dependency unit, and since 1997 they have had to decentralise and get people to care for women who have any sort of substance abuse in their own communities, so there are organisations throughout the metropolitan area who are now starting to care appropriately for women. Because they are marginalised groups, they are usually cared for under a midwifery model of care, with input as well from the doctors. Those are the models of care that are being developed around the metropolitan area at the moment. Women will see the midwife for eight visits and then see the obstetricians or their medical colleagues for around four or six visits, although I think that is a little different at the Royal Women's Hospital at the moment.

CHAIR—Is there anything happening in this state that will bring cases against the mother for putting the foetus at risk by doing drugs, alcohol or smoking during pregnancy?

Ms Johnston—We have not heard any publicity on that. One recent statistic I heard was from the Angliss Hospital, which is a public hospital on the outskirts of Melbourne, towards the east. They set up a young mothers' clinic, particularly for women up to about 20 or 21. They found that the rate of carrying the baby to term so that the baby could stay with the mother increased greatly, so the rate of babies needing to be admitted to special care nursery at birth decreased. This was focused, one-to-one, care for those young mothers who had been identified as a risk group. Many of them would have been alcohol users and probably soft drug users.

CHAIR—It certainly is the case in the States. I do not know whether you have looked at any of their work, but mothers were arrested on the birth of a child because they did drugs or smoked during pregnancy. There is a bit of conflict about whether that is a good way to go.

Ms Johnston—There has been a recent arrest in France of a woman who had her baby at home. She was told that that was putting the baby at great risk, and the baby was taken from her.

CHAIR—Has she got it back?

Ms Johnston—The last I heard—it was on the email chat line—was that it was continuing. The mother was allowed to stay with the baby but the baby was in custody.

Mrs Collette—With a lot of the women who have a chemical dependency, there are child protection issues, so it is not uncommon that child protection workers are involved throughout the pregnancy. We seem to be faced more and more with foster care issues and all sorts of things within those first couple of days post birth.

CHAIR—I have one last question: I am interested in the evidence you have given us on page 9 about midwives who have written to say:

We . . . are at a loss to know how to get the doctors to stop inducing the women.

On Friday's induction day we also had evidence—more of the anecdotal sort—that no doctor wants to be called in over the weekend. We do not know how accurate it is, but we do know it is certainly the case that lots of inductions happen on Fridays. I am very interested in the quote:

We . . . are at a loss to know how to get the doctors to stop inducing
the women.

It is a bit of a concern that the midwife is put at risk. Could you comment on best practice? In what ways do you see that best practice can be introduced into hospitals? If we got to a stage where a whole set of criteria of best practice were agreed to, how do you see that it should be implemented? I asked before whether we need obstetric police, and I presume that people understand the heavy irony in that, but in what way are we going to see best practice introduced, particular if somebody who is making a comment about an alternative way of doing things, like reducing induction rates, is then put at personal risk?

Mrs Collette—There is a project going on at the moment that is being funded by the department here, involving the three key centres—Mercy, Monash and the Royal Women's Hospital. They are all working together to develop antenatal guidelines. The guidelines currently being used in Victoria are probably from the Victorian times. There has not been much change over many years. So I think that, by going through this process, there will be ownership by those three large organisations to work with best practice for antenatal care. I think when we develop those guidelines, which is going to happen over a period of 15 months, they will be implemented into the organisation and, perhaps, we will wait to see how that works, and then the next stage could be to look at the intrapartum period. I think that may be one way it could be very effective.

Senator TCHEN—Mrs Collette, you mentioned earlier that 60 per cent of births have no complications. Is that a confirmed statistic?

Mrs Collette—Yes, it is. That is printed in the perinatal data, and that is for all of Victoria.

Senator TCHEN—Only 60 per cent?

Mrs Collette—Yes.

Senator TCHEN—I think we might be in trouble if it is only 60 per cent.

Mrs Collette—But some of the complications are very mild. That statistic is for births with absolutely no complications at all.

Senator TCHEN—I do not think this question has been asked before but if we are looking at developing different models, particularly introducing midwives as primary carers as a principal model, we probably need to look at other things as well. My understanding is that women from different cultural backgrounds quite often behave differently during birth and also in the pattern of prenatal and postnatal behaviours. Have you had any experience of that, and should that affect midwifery practice?

Mrs Collette—Yes, I have certainly had experience. Where I was working previously, over 22 per cent of our population were from non-English speaking backgrounds. We were also very fortunate that some of the midwives were also from different cultural backgrounds and, where possible, we would try to get them to work with the women. But that, of course, does not happen all the time. I think that here at the Royal Women's Hospital 40 per cent of women come from different cultural backgrounds. Certainly there is a lot of research done by the centre for women's and children's health in relation to the different needs of women from different cultural backgrounds. Interpreter services are available and well utilised. Many of the publications are also in different languages and also assist women. Where possible, we try to meet their needs. Mind you, you cannot always have the birth exactly the same as it would have been in their home country, and a lot of the time women do not really want that either. They would prefer to start to assimilate into their Australian environment.

Ms Johnston—Senator Tchen, I would say that this issue of one-to-one care is very important in recognising and acknowledging every woman's need to be treated as an individual during the birthing process. Our code of practice here in Victoria, which is quite a well-recognised document, says that we provide woman-centred care and that the midwife works in partnership with the woman. This is a concept that does not occur in any medical literature. The medical literature teaches about things to combat illness whereas we are working in a partnership centred on the woman.

Senator TCHEN—What happens if a woman comes to birth and demands or requires treatment that is outside the normal procedure—for example, treatment which is predicated by her cultural background or her community expectation but which is outside of standard procedure?

Mrs Collette—I suppose it depends on what is. Provided it caused no harm, I think we would go along with it. If she walked in and said that she wanted a caesar on the spot, then and there, straightaway—

Senator TCHEN—No, not a caesar.

Mrs Collette—From a midwifery point of view, I think there is certainly flexibility. That is about working in a partnership and trying to meet women's needs as much as possible.

Ms Johnston—Issues of female genital mutilation are often involved in this sort of thing, where the cultural demands of a certain group of people have interfered with the woman's normal genital tract. We now have direction from the World Health Organisation that as professionals we are not going to support that. For instance, we are not going to, say, stitch-up again after a woman has had a baby. But these things need very specially trained people who understand the implications. Just on a simple level, a woman from a different culture may prefer different food. We encourage her to think through what she is going to need—bring her own food or organise for her family to support her in the way they would if she were at home. Once women realise that is easy, the midwives definitely work very happily with all that.

CHAIR—Unfortunately, we have gone past time so the thousands of questions we are sitting on will have to wait. If as a committee there is anything further that we need to ask of you we will get in touch with you. Thank you very much indeed for coming before the committee today.

Ms Johnston—I do have a confidential letter. Would it be appropriate to hand it over now?

CHAIR—Yes, it would, thank you very much.

[12.07 p.m.]

BROOKS, Mrs Rosemary, Field Staff, Domiciliary Infant Care, Royal District Nursing Service

McPHERSON, Miss Patricia Dawn, Policy Officer, Royal District Nursing Service

CHAIR—Welcome. The committee prefers all evidence to be given in public, but should you at any stage wish to give your evidence, part of your evidence or answers to specific questions in camera you may ask to do so, and the committee will give consideration to your request. The committee has before it your submission, which is numbered 111. Is there anything you would like to add to or change in that submission?

Miss McPherson—No.

CHAIR—Once you have made a brief opening statement I am going to have to condense our time because we have run a little late, and then we will have some questions.

Miss McPherson—As you will have seen from our submission, we concentrated only on early discharge. The Royal District Nursing Service has been the major if not the only provider of domiciliary postnatal care in this city until about the mid-1990s, when the context in which we work changed. That changed with the early discharge programs, the introduction of casemix funding in Victoria and contestability. RDNS supports choice. It supports a woman's right to choose early discharge, to choose to have follow-up postnatal care in the community or not to have follow-up postnatal care. Likewise, we support their right to choose not to be discharged early if they believe their needs could not be met satisfactorily at home. It is our experience—and it is concentrated in one particular region in Melbourne at present—that the early discharge programs do not necessarily offer women this choice.

The other point that we want to make—as you will see from our submission—is that, whether women are discharged early on an early discharge program appropriately or inappropriately, the fees do not meet the need, and early discharge programs are largely being subsidised through our service with HACC money—Home and Community Care—money.

CHAIR—Is there anything at this stage? Mrs Brooks?

Mrs Brooks—We are referred patients and sometimes we get patients who are not referred. Because they go home so early there does not seem to be any criteria for who gets referred and who does not. Some of them do not even know about us and are not given a contact number so that they can get some help for themselves. You have to be fairly English-speaking and fairly brave to ring an organisation that you have never had any contact with and ask for help, so we find a lot of them just slip through.

CHAIR—You have raised some very important points. 'Fairly English-speaking and fairly brave'—I like it, Mrs Brooks; that is very good. Can I just start with a clarification on Home and Community Care funding. I am now a bit confused as to who does what to

whom. If I should have a midwife look after me through hospital, can I have the midwife see me afterwards or could I be referred to you or would I be forced to have you?

Miss McPherson—You can be referred to us. We have always had a comprehensive service at RDNS. But with the introduction of the HACC funding act in 1985, our act—the Home Nursing Subsidy Act—was one of the four major acts subsumed under that act. As you know, the HACC act covers the elderly, the frail elderly, the disabled and their carers. But people like us, who offered a comprehensive service, were allowed to continue these extraneous services like post-acute and postnatal at 1985 levels. They were called no-growth services and they could not be expanded. We could not go after growth money for those services.

When that happened it was always the understanding of politicians, I suppose, or government that funding for post-acute, postnatal, palliative care and the whole range of services that we provided would be picked up elsewhere. Eventually that has happened. The Commonwealth now funds palliative care, and post-acute money from Medicare goes to the hospitals to buy services. With case mix funding in Victoria, in 1994 or 1995 a cost weight was added to the obstetric DRG and an average of \$75 was added for the postnatal visits. So that was the basis of the underpinning of the early discharge programs in Victoria.

CHAIR—What is RDNS doing in there when we have midwives and maternal health nurses?

Miss McPherson—As I said, we were always there. Our work is being gradually disseminated to the new players as they come into the system.

CHAIR—It seems it is a funding nightmare that drives your life.

Miss McPherson—We made a philosophical decision that we would provide a postnatal service. That is being eroded with contestability. Our service in the western region has been tendered out to another health care network. We work within the early discharge fee-for-service programs.

CHAIR—Who won the contract in the western metropolitan region?

Miss McPherson—The Mothers and Babies Health Care Network, which was based in the Royal Women's and Royal Children's hospitals.

CHAIR—So we have two public sector nursing organisations tendering?

Miss McPherson—You have health care networks. There have been changes within the Southern Health Care Network through the Maternity Services Enhancement Strategy. The previous speakers talked about that. That was a Victorian funded strategy. The Victorian government funded this in the last budget.

CHAIR—Would life be easier for you if you gave away all of this and just devoted yourself to other than post-maternity care?

Miss McPherson—We are in transition. The west has gone—we have lost the west. As I said, we support choice. We can see that the needs of the women are moving towards continuity and demedicalisation—all of that—and we support that. We are not fighting for territory, but in the northern and eastern regions where we still offer a service, the early discharge ones are fee for service. A very small amount of work is coming to us there. We are still mainly servicing the southern DHS region, but that is under negotiation at present because the Southern Health Care Network is going to offer continuity of care under the auspices of the Maternity Services Enhancement Strategy. So we are probably phasing out. But, having said that, a lot of our money and HACC money is supporting the service of the early discharge program, so that is something that has to be kept in mind.

CHAIR—HACC money—Commonwealth or state?

Miss McPherson—That is a mixture: two-thirds Commonwealth; one-third state.

CHAIR—My brain is beginning to burst.

Miss McPherson—It is a shared care program. The interesting thing is that the Commonwealth and the state have just renegotiated the 1988 HACC funding agreement. I got a copy of it about a month ago. Whilst there is still some provision for a little bit of palliative care and post-acute care, there is no reference there at all to postnatal care. So I think the expectation of the Commonwealth and the state is that HACC funding is not to be used in that way. But we work on a global budget, so we choose to put some of our money into that service; but for how long I do not know.

CHAIR—I am now going to be a devil's advocate and ask a bloody-minded question. If having a baby is such a normal, healthy process, why do you need nurses to look after people after they have dropped the kid?

Mrs Brooks—Although there is the expectation that it will be a normal, healthy process, there is always the odd complication or problem that can be unforeseen. It is a very emotional time and it is a time of huge change for a family. When RDNS receives a postnatal client, we take a medical history and a social history and we physically do checks to make sure everything is going normally, so that early intervention can happen if it is necessary. I suppose you could think upon us as insurance. We are very supportive in an overall way. If the lady does not speak English, we know that we will need more community support for her. If she has been in this area for only two months and does not know a soul, we can alert people to that.

Not everything we do is lifesaving, but occasionally we are there just at the right moment. It is more a holistic approach. The women have more confidence if the nurse is coming—if somebody who is not emotionally involved actually say, 'Yes, your baby has gained 50 grams' or 'This is a little problem, but we can help you fix it.' It is very hard to measure in concrete terms, but it is of value to the society. We probably keep women out of hospitals for various things and we probably help with their mental health, because it is a stressful time as well as an enjoyable time. We can see things more clearly than someone in the family. They may have their mother to help them, but her ideas may be from a

generation ago and they may need some support to put their own ideas further. There is a myriad of things we do.

Senator GIBBS—I take it you would work basically with first-time mothers.

Mrs Brooks—We do get referred more first-time mums than second-time mums, but there are reasons why we get second, third and fourth. Not everyone succeeds with breastfeeding on their first attempt, and it is fairly overwhelming. So the second time at least they have been a mum, and they know how to change a nappy and they know that there are times when the baby will not settle, so then we can concentrate on the breastfeeding, which is one of the major parts of our job.

Senator GIBBS—I was interested in this early discharge. In here you say:

. . . the programs are predicated on the geographical location vis-a-vis hospital boundaries and the amount of dollars the hospital is prepared to pay irrespective of need.

Can you elaborate on that and explain to me what you mean?

Miss McPherson—Yes. When I did the research to write this submission, it rang so many bells in my mind that I went back and did some more work. We talked about one region where we are largely involved with the early discharge programs. One of the hospitals there gives us \$75 per episode of care. Another one gives us \$60 per episode of care and the other one gives us \$40 per visit.

Senator GIBBS—What do you mean by ‘per episode of care’? How long does that take?

Miss McPherson—The first one was up to four visits—up to the fourth day. If we go more than that, we have the luxury of being able to continue to do that, because we have some HACC funding. We found out that whilst the hospital pays us \$75 for that episode, it costs us \$153, so we subsidise each episode by \$78—and that is a very conservative estimate.

Mrs Brooks—These extra visits are on a needs basis. We always have a reason why we are going back. Maybe the milk did not come in until day 5. Maybe the mother had terrible blood pressure and we sent her to the doctor and she has just started a new medication, so we need to get in and check that that is working. Nobody gets visits unless they are needed, and it is up to us to assess. Usually the reasons are that the baby is still losing weight or there are breastfeeding problems. So we assess them. Say they go home on day 2 and we have visited them. It is after day 5 or whatever by the time they are up to these visits, but they have still got nursing needs. They have still got a baby that is 200 or 300 grams under birthweight and the breastfeeding is not going right.

CHAIR—I just wanted to ask if you could make your answers shorter. This is not fair, because there is lots to say, but if you could, we can get more questions in.

Senator GIBBS—Is this early discharge program a policy of the hospital? I notice you have said:

Dandenong Hospital discharges about 60% of women onto the Early Discharge Program usually on day 3.

I take it that not every woman is discharged early. How do they work out who is going to be discharged early, who is not going to be discharged early, and what is the normal length of stay in hospital these days after one has a baby?

Mrs Brooks—There is no ‘normal’. There is no written criteria that I know of; it is up to the ward staff at the hospital in the postnatal ward to assess. From their hierarchy, they are told roughly how many patients they can refer, and they have to pick the ones they think need the most care, and they do that. We find we do miss referrals and occasionally a mother will refer herself—or maternal and child health will—but there is no set standard.

Senator GIBBS—So some women can leave on day 3 if everything is going fine?

Mrs Brooks—Yes.

Senator GIBBS—But for others, obviously, there are cracked nipples and all those other sorts of things that happen.

Mrs Brooks—Yes. But even those women discharged on day 3, where everything was fine, can get into trouble after their discharge.

Senator GIBBS—Of course they can.

Mrs Brooks—But if there is something obvious, like bleeding nipples, they will be referred and given priority. But the fact is that not every woman is offered postnatal care, even if they go home early.

Senator GIBBS—What are the criteria for being offered such care?

Miss McPherson—There are no written criteria in the programs that we are involved in.

Mrs Brooks—It is up to the nurse in charge of them in the postnatal ward to assess their needs, with budgetary impositions obviously being applied. If there were no budgetary impositions, I think the nurses would like to refer everyone.

Senator GIBBS—Of course they would. That is very disturbing, isn’t it?

Mrs Brooks—Yes.

Senator GIBBS—Thank you. I know everyone else wants to ask questions.

CHAIR—We are running a little behind and I would like to finish with one last question. Do you have any idea what the Maternity Services Enhancement Strategy is going to mean for you?

Miss McPherson—Going back to the southern region where we are involved, we have been informed by the Southern Health Care Network that they are now going to provide this

service in that area, except for three postcode areas which are on the outer limits of their catchment area—out in the scrub—and they are negotiating with us to what extent we can cover that area. So that is what is happening.

CHAIR—So RDNS is being confined to the boondocks?

Miss McPherson—That happens in some of these early discharge programs. Often agencies want us to provide a service beyond the 25-kilometre limit.

CHAIR—I notice you referred to that about Angliss Hospital, too.

Miss McPherson—Yes.

CHAIR—This is a very interesting small part of our inquiry and it certainly indicates that there are some useful questions we have to ask in this area. Thank you very much for your submission. If anything further strikes us, may we contact you for further information?

Miss McPherson—Yes, you may.

CHAIR—Thank you very much.

Miss McPherson—I would like to table these handouts about our organisation.

CHAIR—Thank you.

[12.28 p.m.]

GRIFFIN, Ms Lynn, Investigator, Health Services Commissioner

WILSON, Ms Bethia Alice, Commissioner, Health Services Commissioner

CHAIR—We are sorry to have kept people a little late. I welcome the Victorian Health Services Commissioner and an investigator with the commissioner. The committee prefers all evidence to be heard in public but, should you wish to give answers to specific questions or part of your evidence in camera, you can ask to do so and the committee will give consideration to your request. We have before us your submission No. 168. Are there any alterations or additions that you would like to make to that?

Ms Wilson—There was one addition. In our recommendations, we thought that more information on education should be supplied to women who use the services that are relevant this inquiry. On reflection, we think much more effort needs to go into the service providers, in educating them to better communicate information to women.

CHAIR—A pungent addition. Thank you.

Ms Wilson—An important one.

CHAIR—Would you like to make an opening statement and then field questions.

Ms Wilson—I thought we might proceed by me very briefly explaining to the inquiry the role of my office and the work that we do and then I will hand over to Lynn, who did most of the work in preparing this submission. The Health Services Commissioner is really a health ombudsman. We exist to receive and resolve complaints about health service providers from users of health services. While most of our work is complaints handling, we also have a very important policy role in that the legislation that establishes my office also gives me a duty to try to improve the overall quality of health services within Victoria. Mediation and conciliation play a large role in our office—in other words, we are there to help people to resolve the complaints themselves.

Strict confidentiality applies. In any of the details that we have given to you about complaints, the complaints have therefore been altered so that no-one can be identified. We acknowledge at the outset that, while our office is impartial, our sample is a biased one. By that I mean that we see only the complaints. People rarely come to us to say that things went very well. Occasionally they do, but mostly we see the cases that have gone wrong. As I say, we are an independent, impartial statutory authority but we bring you a biased sample. For us, the major issues arising from the complaints are poor communication, a lack of choice and the failure of some professionals to give sufficient information to women at a time when they can deal with it. Many women still consider that they are treated in a patronising manner and as though they are sick. I might hand over to Lynn there.

Ms Griffin—When we looked back over the complaints that we had received, we saw complaints about receiving interventions in childbirth and also about not receiving them or about delays in interventions. This was a ratio of about 60 per cent complaining about an

intervention of some kind and 40 per cent complaining that intervention did not occur or was late occurring. Women felt that they were not adequately advised of their choices about the risks and benefits of interventions and not sufficiently involved in the choice of whether or not these should take place. Mostly, when people complain to us, it is because some adverse outcome has occurred. We saw a similar ratio between public and private hospitals, with 60 per cent saying, 'Something happened that I think should not have happened' and 40 per cent saying, 'It did not happen and it should have.' So there was not any difference in whether it was a public or private hospital.

We have very few complaints about early discharge, except where it relates to some subsequent complication. If a woman goes home and haemorrhages or develops postnatal depression—or there is some other complication like that—and they believe that they were discharged too early, then we might get the complaint. But, generally, we tend to find that complaints simply about early discharge are handled within the hospitals themselves. We noticed that women complained about less access and choice in rural areas. We do not get a lot of complaints from the Koori community, but I understand that this is an issue for them as well. We looked at some research that indicated that this is indeed the case.

Generally, I think that the standard of information given in antenatal care seems to be pretty good, but the complaints that we receive suggest that it could be better. I think it would be of benefit to ask: if best practice guidelines could be developed for antenatal education, what should they include? Consumer groups, such as the Health Issues Centre and PANDA, would probably have some good input into developing best practice guidelines for antenatal education. That is a summary of what we found.

CHAIR—When did you get established?

Ms Wilson—In 1987.

CHAIR—Why?

Ms Wilson—I think the reason was that, before the Health Services Commissioner existed, a multiplicity of agencies dealt with complaints and it was a very confusing maze for people to find their way through. There still are organisations other than ours—for example, the Medical Practitioners Board—but the legislation anticipates that we will consult very closely with registration boards. We do that and it works very well. Also, we are an alternative to litigation. This can be very important for women who have had difficulties with childbirth because going to court is risky, it is expensive; it is a very uncertain business. But people who have had bad outcomes can come to us, it does not cost them anything, and we can get a good outcome which often includes compensation.

CHAIR—How do people find out about you?

Ms Wilson—Not as well as we would like them to. I think that one of the reasons for the low number of complaints is that people do not know about us. Although I vigorously promote my office, people still say that they have never heard of us. One thing that we have done is recommend to our government that the name be changed from Health Services

Commissioner to health services ombudsman, because people seem to understand that role better.

CHAIR—Absolutely. In fact, I have spent some time trying to find out what a health services commissioner does. I am pleased to discover that you are an ombudsperson.

Ms Wilson—It is a Scandinavian word, so we do not have to worry about the ‘man’, I am told: it is gender neutral.

CHAIR—Ah, Scandinavian men are gender neutral!

Ms Wilson—Possibly; I do not know. I am no expert on that.

CHAIR—I am fascinated by the language. One thing you say in your submission is that:

If all women are receiving the same levels of information and choice about interventions then it would be reasonably expected that there would be no variation between hospitals’ intervention rates other than in those hospitals accepting referrals of the most “at risk” women.

Your evidence suggests that there is a considerable difference?

Ms Griffin—No, not from our evidence. As you can see, we only get a very small number of complaints. We do not have data to compare them. I do not know whether the data are available but they would be very interesting.

CHAIR—How do you work with the medical defence people, or whatever their name is? We are told that there is a very big concern among obstetricians that, if they do not do some intervention or provide what women ask for/demand—for example, women say, ‘I insist on having a caesar’ and obstetricians say they must do this—they will face litigation. One of the pressures is fear of litigation. How does your commission cut across that?

Ms Wilson—We have developed some very good links with the medical insurers—the medical indemnity funds—which has assisted us because they then cooperate in conciliation and we can get good outcomes for women. Fear of litigation is certainly a driving force in this area. Whether that fear is perceived or real is, however, contentious. I notice that the medical defence funds themselves are increasingly telling specialists and doctors that they can say they are sorry, that they can acknowledge someone’s pain or grief, without admitting legal liability. I do wonder whether we give our medical colleagues enough advice and information about the law. There is a lot of misleading information out there.

CHAIR—You can say ‘sorry’ without admitting liability. Is this a generic line that we could use in other areas?

Ms Wilson—We have had a nurse come to us who had a specialist sit beside the bed of a patient and say, ‘I am so sorry. I really stuffed up in your case.’ Within 10 minutes she was patting the specialist on the back, saying, ‘There, there, dear; it’s all right. We all make mistakes.’ Whether she should have reacted in that way or not is another matter, but an apology and good information is very powerful both before and after the fact.

CHAIR—Against this, we are advised that the cost of medical indemnity for an obstetrician has risen from \$2,000 to \$45,000 and that it is very likely to go to \$90,000 in the very near future. If the medical indemnity people are suggesting that if they say ‘sorry’, apologise or provide more information this might reduce litigation, why should the cost per obstetrician in particular be going through the roof?

Ms Wilson—You would need to ask the medical funds about the way they arrive at their fees. All I can tell you is that our experience is that, where proper explanations are provided, people are unlikely to go to law. We see that over and over again. That is what the insurers are telling their members.

CHAIR—Is that information being provided to the parents, the mothers, or to the doctors and midwives—or to both?

Ms Wilson—Mainly, I would say, to professionals—not to the other groups. I go out and tell people that they can come to us, rather than going to law, because I think they will get a better outcome. Also, some of the complaints that come to us would never be suitable for litigation in any event, but they are very important to the person concerned. They can range from things like an unfortunate case we had where a lady’s baby died—it was stillborn—and the account was sent to ‘the foetus Smith’, which was very hurtful to her. Those are not things that go to the High Court, but they matter to the individual concerned. If we can get a sincere apology, and an assurance that it will not happen again, that is a better way to go, I would say.

CHAIR—That is a very interesting illustration. If people complain to you, can you advise them? Or is it not appropriate for you to say, ‘This would be better settled by going through the courts’?

Ms Wilson—No, we advise people all the time.

Ms Griffin—There is a long process of helping people to resolve their complaints. We would only suggest that they try getting legal advice, if that is what they seem bent on doing. Generally, we can resolve complaints through our office—whatever it is that people are looking for.

CHAIR—Did you say earlier that sometimes you can even get compensation payouts?

Ms Wilson—Yes, and that is by agreement. It is not because my commission has the power to make a determination that a person will pay up. It is because the parties get to sit down at the table together to talk through their differences and, with the support of the medical indemnity funds, compensation may be paid. It is flexible. It could be a wheelchair, it could be a washing machine, it could be money.

CHAIR—Do you have more payouts for the 60 per cent who say that something went wrong or the 40 per cent who say that something should have happened?

Ms Griffin—I could only guess, but I would say they are pretty similar, because both events can have an adverse outcome. With us, it is pretty much the same as the courts,

where what you need is to have some evidence that maybe negligence occurred causing the adverse outcome. Withholding or delaying a caesarean is just as likely to produce an adverse outcome as having the caesarean.

CHAIR—I might ask other experts about that. The jury might be out on that claim too.

Ms Griffin—From our experience, people report adverse outcomes in both circumstances.

CHAIR—If you had evidence of negligence—and I presume sometimes you might, or at least a case where it looks as though there had been negligence—do you still try to assist people to settle there rather than go through the courts?

Ms Wilson—Yes, they are told of their options. Conciliation is not only confidential, it is also privileged. So when a stage is reached in negotiations where an offer is on the table, the conciliators will adjourn the meeting so the parties can go away and think about it. I do not allow lawyers to be present at those meetings, except in special circumstances, but the parties can then go away and consult their legal advisers about whether they should accept the payment or not.

CHAIR—If they do, does that preclude them going to court?

Ms Wilson—Yes.

CHAIR—So if they settle for \$10,000 that means no claiming through the courts.

Ms Wilson—That is right. A release form is signed.

CHAIR—Can you tell us whether the claims are more against individuals or institutions?

Ms Griffin—It is pretty much evenly divided. They are against individuals, of course, if you go to a private hospital with a private doctor; and they are against the institution if you are a public patient. As far as how they are represented in the community is concerned, I would say they are fairly evenly divided.

CHAIR—How much work are you doing with the professions, particularly the obstetricians? And can you tell me whether they are beginning to see a reduction in the complaints, or are they happy to go your way? It seems to me that what you are saying should be a great comfort to the professionals and that it should be reducing the fear of litigation and it should be therefore reducing the pressure for intervention—but that is not quite the story we are hearing. Are you too new?

Ms Wilson—When we first started there was a lot of suspicion about the role of an external watchdog—the medical profession did not like it. Our experience today is that they are very cooperative for the most part, with a few individuals aside. We have a very good record with obstetricians giving us expert opinions. They would prefer to do that in conciliation than for litigation purposes, because they see that as being in the interests of

their own profession—hopefully in the interests of the women involved as well. Does that answer the question?

CHAIR—I am just interested in whether you have any evidence that you are beginning to assist the profession to feel less pressure for intervention.

Ms Wilson—I do not think I have any evidence for that. I would hope so.

Ms Griffin—I think it is probably too early to actually see a trend. Again, too few of the people who are dissatisfied actually complain to us, so all we know is what happens in response to our complaints. We are talking about 100 women over five years, which is a very small percentage.

CHAIR—It is, isn't it?

Ms Wilson—But most people never complain. In Victoria there are 22½ million unreferral visits to doctors a year and 900,000 separations from hospital. We have 7,000 inquiries a year with a caseload of about 2½ thousand, which either means that Victorians are very happy with the health services or they have never heard of us or it is just jolly difficult to complain. We try to be accessible but it is a process that is emotional and involves you in a lot of time. I do not know if you have ever tried to complain to a bank, for example; you practically have to take annual leave to do it.

CHAIR—It is probably all of that, and we do not know which proportion is which. But it is certainly true that infant mortality and maternal mortality are dramatically down in this country and have been dramatically down—with tiny hiccups—over many years, and we are now dealing with the difficulties of that low percentage of at risk people. So it is a change. If my colleagues do not, I might just ask you to make a few comments about Koori population.

Senator GIBBS—There are five million questions I would like to ask. I would like to talk about the Koori women. I notice here the findings of a childbirth report. We are talking about how isolation contributes to difficulties. I am from Queensland, so I do not understand the situation here in Victoria, but in Queensland we have communities and I understand that. When we are talking about isolation here, do you have Aboriginal communities here?

Ms Wilson—Yes, we do. They are certainly not as extensive as in Queensland. We also have community controlled health organisations here. The government has put money into VACCHO, the Victorian Aboriginal Community Controlled Health Organisation, so it is Kooris delivering services to Kooris because they will not come and get services otherwise. That is why I asked the Minister for Health in Victoria for funding for a full-time Aboriginal liaison officer, who has now been with us for just over six months. So we are in the process of going out and visiting those communities and visiting the health service providers. We are in the early stages of a quite dramatic and very interesting learning process.

Senator GIBBS—So are the services provided to the women medical? Is there a doctor there? Is there a midwife or are there nurses?

Ms Griffin—They vary from service to service depending on how well resourced they are and where they are, but they also play an important role in linking Aboriginal women into mainstream services, and there is an emphasis on that in the funding policies at the moment. At most of the hospitals now there is an Aboriginal liaison officer to help with that kind of process. Just as Aboriginal women will not come to us if there is no Aboriginal person there to identify with, similarly they will not seek services, unless they really need to, unless there is someone they can feel comfortable with.

Senator GIBBS—Thank you. I was extremely interested because in here we have got that Aboriginal women accounted for 30 per cent of all maternal deaths between 1988 and 1990, which is fairly high. It says that it seems much more likely that lack of intervention rather than intervention is a contributing factor in these cases. All the witnesses we have had so far have said that we seem to have an extraordinary amount of intervention during the birth process whether the woman wants it or not. I find it interesting that lack of intervention is mentioned. Can you explain this?

Ms Griffin—As you see, that particular quote about the percentage is footnoted, so it is someone else's research, not ours.

Senator GIBBS—I see. Right.

Ms Griffin—But somebody pointed out to me subsequently that that is a very small whole number.

Senator GIBBS—Is it?

Ms Griffin—Yes. It is a very small number.

Senator GIBBS—That is a seven?

Ms Griffin—I was told that it is something like a total—someone else may be able to correct me—of five to seven maternal deaths in childbirth a year in total, which means 30 per cent is not a large number here.

Senator GIBBS—Okay.

Ms Griffin—Our Aboriginal liaison officer said to me that she suspected that if in fact Koori women were dying in childbirth it would be more likely because they were not accessing the services than because they were.

Senator GIBBS—I see. Do the women have English as their first language, or is there a language barrier?

Ms Wilson—Usually English—well, always in Victoria.

Ms Griffin—I think the barriers are cultural rather than language.

Senator GIBBS—That is basically all I wanted to ask on that. I will quickly ask about one of your complaints here, complaint No. 2, and the woman was complaining that she did not have a caesarean birth and that was her right. We are hearing this a lot, where women actually think that it is their right to go to the doctor and say, ‘Look, just get the kid out. Let’s have it by caesarean on Friday afternoon,’ and all that sort of thing, and that that is her right to do that. Are you finding that this is happening a lot? Do you get a lot of complaints?

Ms Griffin—Not a lot, but it does seem to be a common theme that runs through, that in some cases women have a right to procedures and interventions, which is why we believe that if women were fully informed about not only the benefits of various technologies and interventions but not only the risks that they would not make those requests so freely. If a woman was aware of the risks of a caesarean section as well as the potential benefits, perhaps she would not think of it as a right.

Senator GIBBS—So are you finding that women are not told of the risks?

Ms Griffin—Yes.

Senator GIBBS—A lot of women and a lot of people out there in non-medical land think that to have a caesarean they slice you down the middle, pull out the baby and just stitch you back up again. It is all very nice and painless and you do not have to go through that painful process. So this is the case, they are simply not being told.

Ms Griffin—Not only with caesarean sections, it is the same with inductions, with epidurals—with any kind of procedure which they think is to benefit themselves and their baby. The ones who complain to us—as I say, it is a small number—have not been told, ‘But there are some other potential complications that can occur, they are these, do you want to weigh it up and consider what your plan is.’ People just think that all these things are benefits and that they have a right to them.

Senator GIBBS—No, absolutely. That brings me to my last quick question. Because of that, how can a code of best practice actually be established? I think one of the other witnesses was saying, ‘Who is the obstetricians’ watchdog?’ How can you actually have a code where all of these things are law, where you must tell women before they go into the labour, ‘This could happen and this could happen.’ At the last minute when they are thinking, ‘Get this thing out of me’ and they are saying, ‘We might need to do this and we might need to do that,’ obviously you are going to say, ‘Sure.’ If we need to do this and inform them of everything, how do we actually establish that Australia wide?

Ms Wilson—First of all, I agree it is a national process. I do think there is a real need for national leadership in this area. The way that you do it is the way that you are working. We have to listen to the people who are undergoing childbirth. All too often, professionals get together and draw up codes that they think are very relevant but they are not consumer focused. So it requires consultation—and representative consultation—of the people who know what it is all about, which is why I have brought Lynn today, because I have not had any children and she has.

CHAIR—Are there any particular groups of people who do the complaining? Middle class? Wealthy?

Ms Griffin—We do not actually ask those questions but I would say non-English speaking background women, women from other cultures are underrepresented. They are more likely to be Western women.

Ms Wilson—One requirement of our legislation is that the complaint be in writing, and that is a significant barrier to many people. We do what we can to help people but it is a barrier.

CHAIR—How many people who complain to you go on to take legal action, do you know?

Ms Wilson—Very few. Conciliation would be about two per cent.

CHAIR—Of your complaints, are most in relation to specialists, GPs or midwives?

Ms Griffin—As far as childbirth goes, they seem to be either against a public hospital or against their obstetrician-gynaecologist—so in about an equal ratio probably.

CHAIR—We have had complaints about midwives.

Ms Wilson—We have had complaints from midwives about not being able to get access to some hospital services, those in private practice. That is just part of my policy role rather than complaints role.

Ms Griffin—We do get complaints about midwives as well, about the actual management of labour once they are in hospital. Yes, we do.

CHAIR—Would you go and see a hospital and suggest that maybe midwives should have more access? Would you have an advocate's role on behalf of midwives or the complainant?

Ms Wilson—We have to be impartial. We are not an advocacy service. We are bound by the rules of natural justice so we have to give everyone a fair go. But I do an enormous amount of work with quality committees and talking to relevant groups. So yes, I certainly push that forward. If that is what women want—and the indication is that they do—we will support them in that in a policy arena rather than in the resolution of individual complaints.

CHAIR—You also mentioned that you do not have information about intervention rates. First, would you like it? And, second, have you sought it?

Ms Griffin—I suppose we would like it from the point of view that it is interesting. But I am not quite sure what we would do with it. We would not be able to advise women, for example, in terms of 'Go to this hospital. It suits your philosophy more.' We do not actually point them towards particular service providers.

Ms Wilson—We cannot do that.

Ms Griffin—From the point of view of the commissioner's general interest in improving service, it would be good information for that purpose.

CHAIR—It is not particularly pertinent to your contribution, but I am finding it very interesting that, for example, we cannot easily say, 'Hospital X has a very low caesarean rate; if you are not interested in caesareans you might like to start there.'

Ms Wilson—The Victorian government has just released a very interesting discussion paper about hospital services in which the consultants recommend amongst other things that we should have report cards on doctors and report cards on various hospitals because, they say, there is a significant information asymmetry between the consumers and the providers of services which is, in itself, a significant barrier to competition. These are all part of competition reviews, remember. So a consumer cannot choose the best service if they have no information about them. So we are tentatively supporting those recommendations. I think women should be given that information.

Senator GIBBS—I think you are absolutely right, because we went to the Mercy Hospital this morning and had a look at the birth centre there. It was very interesting. We spoke to an obstetrician, man, an older doctor, who told us that, of the 25 doctors or obstetricians at that hospital, only five would be comfortable delivering a breach birth naturally—vaginally. If the woman wanted a breach or said, 'Let us just do the caesarean,' they would say, 'Okay' and they would do it. He said that when he and the other doctor—who obviously were the two senior doctors—retired there would be virtually no obstetricians here who would be comfortable with a natural breach birth. That is frightening, is it not? Very frightening.

Ms Wilson—Yes, disturbing.

CHAIR—Do you have the name of this report?

Ms Wilson—*Health Services Act policy review discussion paper*. It is worth looking at.

CHAIR—With respect to the notion of competition policy in this area, I do not know what competition policy means. ut I am not at all sure that it means that Mrs Jones can wake up in the morning and say, 'I think this doctor swings the knife very readily. This one does not. I will choose whatever.' I am not at all sure that is how people choose their obstetricians, but maybe what you are suggesting is that the practitioners—presumably the specialists themselves—and the college of obstetricians and gynaecologists have come out saying that every doctor's performance should be—

Ms Wilson—No, what I said was that it is proposed in the discussion paper that there should be report cards. What they are saying is that you cannot have genuine competition if one of the important parties, the consumer, does not have any information. You will know about the deaths at Bristol: if the parents of those children who died had known about the rate of adverse events they would not have taken their kids there; they would have gone somewhere else.

CHAIR—Bristol?

Ms Wilson—That is where a very disproportionate number of young children died while being operated on for cardiac conditions.

CHAIR—I guess that is the hospital rather than practitioners but it is very interesting indeed.

Ms Wilson—It was the practitioners in that case.

CHAIR—So this recommends that there should be report cards on individual practitioners?

Ms Wilson—And on hospitals, so that people can find out about waiting lists things like waiting lists or anything else that is pertinent to their making a choice. I have had a lot of doubts about competition policy in the area of health, because it is not like buying a can of sardines, but the more I have thought about it, the more I think competition actually has the potential to be beneficial to consumers, providing that we can do something about the information asymmetry and there is genuine choice.

CHAIR—It may also be that what we are talking about here is what in the past might have been called good practice and is not necessarily defined under competition policy.

Ms Wilson—I agree with that. It is just that the competition policy reviews have given us an opportunity to look at things like access to information, including legislation for access to medical records, which we also support.

CHAIR—On that particularly interesting note, thank you very much for your contribution.

Sitting suspended from 1.03 p.m. to 1.38 p.m.

[13.38 p.m.]

DELANEY, Ms Laura, Editor, *Birth Matters*, Maternity Coalition

DEMPSEY, Ms Rhea, Executive Committee, Maternity Coalition

REIGER, Dr Kerreen, Committee Member, Maternity Coalition

SPRAGUE, Ms Anne, Midwife Member, Maternity Coalition

CHAIR—Do you have any comments to make on the capacity in which you appear?

Ms Delaney—I am here today as the epitome of the consumer of the mainstream maternity services and also as the editor of *Birth Matters*, which is the journal of the Maternity Coalition.

CHAIR—The committee prefers all evidence to be heard in public, but should you wish to give your evidence, part of your evidence or answers to specific questions in camera, you can ask to do so and the committee will give consideration to your request. We have before us your submission, which is No. 92. Are there any alterations or additions you want to make to that submission?

Ms Dempsey—No.

CHAIR—I now invite one or both of you to make an opening statement and then field questions.

Ms Dempsey—I would first like to draw your attention to who the Maternity Coalition is, because I think it is relevant to the breadth of the information we might be able to give you. The organisation has been going for 10 years and was formed by a number of groups which have been working for a long time around birthing issues, combining at the time of the Victorian ministerial review into birthing services. We have always included mothers as well as midwives in the Maternity Coalition, so we have that breadth.

We have, as part of our executive and membership, academics who work in the areas of sociology, medical anthropology and psychology. We also have childbirth educators and lactation consultants, as well as many mothers, so there is a broad range of expertise and experience in our organisation. Many of them are women who have been part of the birthing movement through the 1970s, 1980s and 1990s and are continuing with great passion. We are thankful for the opportunity that the Senate committee gives to look at the issues behind childbirth and to make a change.

I want to address the question that you asked the midwives at the end of their presentation. You said that it appeared that the midwives were suggesting quite a cultural change in what they were bringing forward, and you asked a question about how this change in consciousness or awareness could be made. This is one of the main aims of Maternity Coalition. We are trying to look at making this cultural change around birth.

There are one or two points that we in Maternity Coalition feel would be useful to help make this change. Information about intervention levels and what happens in births needs to be made available to mothers and consumers for two reasons: firstly, so that they can make clear choices about what they are wanting in their birth. Many women have a feel of what they want but they need to match that with what is possible in terms of the places and the caregivers they are choosing. A number of the speakers have been making the point that women need to have this access to information.

Secondly, they need access to that information because, as it stands at the moment, many women coming through the system who require intervention in their birth feel like failures because they feel that it is because of them and their bodies letting them down. Whereas in fact, those of us who are on the outside of these systems see that it is much more about the system failing the mother rather than the mother and her body not working properly. If women continue to feel that it is their bodies that are letting them down, this fuels the culture of fear about childbirth being incredibly painful or incredibly dangerous, which leads them of course to keep seeking that medical attention, because they view birth as being very dangerous. If they can see the relevance of what the system is doing, they can reflect more on how the system is failing them rather than their bodies failing. Those are important issues.

We also need to have the different models of care being possible and being equally funded so that—in the jargon and political terms which are used quite a lot—it is an equal playing field, and women can make choices from a set of equally funded and equally accessible models so that the possibility is there in their awareness.

That brings into question the issue of funding for maternity services, and we, as with the midwives, agree that funding should be based with the mother and then used for her to choose the services that she wishes to have, which would allow midwifery to become more of a possibility.

The other point I wanted to make is that many women in childbirth have never had the experience of having somebody with them—somebody who is knowledgeable and who knows them—through the whole of this process. That relates to the issue of the continuity of care. Many women do not have a feeling of what that could mean for them in birth. During their pregnancy many women may make an emotional attachment to the obstetrician without understanding that, in the moments of labour, that particular emotional attachment has no bearing on what is happening in the labour. It is the midwives who are going to be with them. If they had known the midwives throughout the pregnancy and then at the birth had had that emotional continuity, that would make a huge difference—as the studies across the world show—in terms of outcomes of birth. So we would agree with you that a change in the culture would be highly desirable and that these are some of the points that might help that to happen. Thank you.

CHAIR—Thank you. Did you wish to speak now, Ms Delaney?

Ms Delaney—Yes. I would just like to elaborate on my introduction where I said that four years ago I felt that I was the epitome of a mainstream consumer of maternity services. I accessed information that was readily available to me, and that was all mainstream

information about birthing. I believed that I could give birth naturally. I felt that the mainstream system paid lip-service to that—that I could give birth without all the necessary drugs and intervention. But in reality, it was not like that at all. My experience of it was absolutely horrendous.

As a result of that experience, I sought out the organisation The Maternity Coalition. I really could not believe that an experience that is supposed to be potentially joyous and wondrous and empowering for a woman could be so filled with horror and disempowering for me as I started my role as a new mother. Somebody asked me recently how I found The Maternity Coalition, and I said that I would have climbed Mount Everest to find women who felt the same way that I felt about that whole experience.

CHAIR—That is what drove you, but do answer the question: how did you find them?

Ms Delaney—I actually wrote a letter of complaint to Beth Wilson, the commissioner who was here previously. I was one of the very few who actually got it together to complain. She sent me back information—I think it was about The Maternity Coalition. My GP, who fortunately is married to an independent midwife, referred me to go and see Rhea.

CHAIR—Are you prepared to briefly tell us on the record what your nightmare was?

Ms Delaney—Yes. Choosing the mainstream system, ideally I wanted to give birth in a birth centre because it looks nice. I think a lot of women choose a birth centre because they feel like it is a home away from home. And they promise a continuity of carer. There was a team of midwives made up of four or five, so I was introduced to those five during my pregnancy. Then when I actually went into labour, I had never before met the midwife who spent the night with me while I was in labour. I had briefly met her in the corridor, but I actually had not spent any time with her before. So that was quite disconcerting. Some comments during my labour from that midwife impacted on me psychologically quite significantly.

CHAIR—What were those comments?

Ms Delaney—That I had chosen a very busy night to have my baby. She also told me the gender of my child, which she incidentally got wrong. She was not aware that I had significant issues around the gender of my child because of family history. I knew that I was going to have a girl and my husband was the same, and we were told when I was in labour that I was having a boy. So that had a huge impact on me. Rhea has pointed out to me about the cervix being the gateway. I did not want to give birth to this boy. I knew that I was going to have a girl, so it impacted on me, and my cervix refused to dilate. Then it was a roller-coaster into Monash hospital, where was transferred. I was strapped up to a monitor; I had all the drugs in the world. I call it the birth with the lot. I had an epidural, high rotation forceps, and five male doctors assisted the birth of my child. So it was a nightmare, considering the expectations that I had and believed that I could give birth naturally.

CHAIR—Before you were moved to Monash, where were you?

Ms Delaney—Moorabbin birth centre.

CHAIR—So an unsympathetic midwife was really the start, do you say?

Ms Delaney—I blame the system, actually. Even though they are offering you a team of midwives, in reality it really means discontinuity of carer. This girl, this midwife, was on my team but because of the way my antenatal appointments were organised, when it came time for me being in labour she was the one who was there and I had never met her before. She had no idea who I was. I do not really believe that she actually read my file, because she would have seen that I had quite a few genetic tests during the pregnancy and they are related to gender of child and all of that. So I blame the system. I do not blame her or that team of midwives.

CHAIR—Is that the little one over there?

Ms Delaney—Yes.

CHAIR—You have proof of something marvellous, which she is. It is probably the resilience of women. Thank you for that. Is there anything further you would like to add at this time? You were saying that, in general, you found The Maternity Coalition and that it has been like a strength for you?

Ms Delaney—Without a doubt. The more I spoke to women, the more disillusioned I got that women were not prepared to open up and be honest about the experience. I feel that they have been brainwashed almost to believe that it does not matter how the baby is born; as long as you have this baby in your arms and it is a healthy baby and you are alive, it does not really matter. Whereas in fact it mattered to me greatly. I was diagnosed with postnatal depression. It was an absolutely horrendous time. So I needed to seek out people who were prepared to say ‘Yes, it was horrendous.’ I became proactive as a result of that. But I do believe that the mainstream literature just reinforces that for women: it does not matter how your baby is born, as long as the baby is alive, the mother is alive, that is fine.

CHAIR—I guess, in the end, if you had to put up the two highest criteria, they are the priority ones, aren’t they? You do want a live, well baby and a live, well mother.

Ms Delaney—Absolutely. We all do.

CHAIR—But you are saying that, as that is the expectation in most cases, the process of getting there can make this outcome fantastic or it can make it so negative that it almost cancels the good result.

Ms Delaney—Absolutely it does, most definitely. I got to the point where I was suicidal very soon after the birth of my child. I was a happy, emotionally strong, physically strong woman before I gave birth. Then it just all fell apart. So there was obviously something wrong—terribly wrong—within the system.

CHAIR—That actually confirms some of the things Ms Dempsey was saying; that is, one of the things that can happen through a less than optimal birth is that the mother finishes up with a strong sense of her own inadequacy, which is not a good way to start rearing a little one.

Ms Dempsey—I just want to make another point. Laura's situation will be individual but not uncommon in that there are many women who go into their birth experiences with fears and particular personal issues that are going to have an impact in the birth. The models of care that provide a continuity of carer—particularly of midwife who is going to be with the woman during the labour, who gets to know the woman and knows what these issues might be and who finds the sensitivity to work with giving the mother support in the way that is appropriate for her—would mean that in Laura's case, some of the issues that came forward for her would never have been issues.

Senator GIBBS—With that continuity of care, if the midwife is there during the pregnancy, then any questions that you have can be answered.

Ms Dempsey—Yes.

Senator GIBBS—I am sure a lot of women even today have a lot of questions that are never answered. They are given wrong information. I know when I was first pregnant I asked my mother and she just said, 'You'll find out.' I thought, 'Gee, thanks, Mum', and I did.

CHAIR—Can I cut across that for a moment? That is a very important question. One of the things that has been drawn to my attention is that, because the size of the family is so much smaller now, there are fewer mothers who have experience of being around babies. In some ways that actually adds to it. It is not only likely to be like it was 25 years ago, but, indeed, possibly worse in terms of information because there are fewer people with babies.

Ms Dempsey—Yes.

CHAIR—Lots of mothers have never held a baby until they hold their own.

Ms Dempsey—Yes.

CHAIR—It is a very changed world.

Senator GIBBS—I noticed that most of the theme of your submission is that you have really strong support in the midwife system for continuity of care. It is very important. You were saying that models of care should be equally funded. I guess that is what this inquiry and us as senators have to get across to governments. If we start with the federal government, we must get across that it is extremely important that there is equality of funding and accessibility. I have not had a chance to ask the previous witnesses this question, but when we are talking about independent midwives, there is absolutely no Medicare rebate at all?

Ms Dempsey—No Medicare, no.

Senator GIBBS—Not at all?

Ms Dempsey—No.

Senator GIBBS—What about private health insurance?

Ms Dempsey—I believe there is one private health insurer who will rebate a proportion.

Ms Sprague—Regarding health insurance, at the moment it depends very much upon the consumer actually showing the health fund that they have a justifiable cause. Australian Unity will reimburse the client 75 per cent of a midwife's fee for antenatal, attending the birth and postnatal care, but that is only if the client births at home. If she needs to be transferred to hospital, because the health fund will have to pay for the hospital bed as well, she will not get all of that back. But we are talking about a fund that is costing women in excess of \$60 a week to pay for that.

Unfortunately, because there is no financial reimbursement for women, we are catering predominantly to a white Anglo-Saxon, well-educated population who say, 'We spend \$2,000 on a car. Why not spend \$2,000 on continuity of care and continuity of carer?' So women from non-English speaking backgrounds, women who have specific cultural or religious beliefs are being denied access to services that really should be funded. Women who choose to birth outside a hospital are actually costing me, the taxpayer, less money. I spent a number of years working with the Vietnamese community, and a lot of those women were often classified as a BBA, a born before arrival in hospital. That was purely because they were so fearful of attending because they could not guarantee that somebody would be sensitive to their religious and cultural beliefs.

Senator GIBBS—Because there is no rebate, this is actually disadvantaging a lot of women in society. There must be a lot of people who have come to this country from other regions who culturally believe that giving birth and having a midwife there is a natural process.

Ms Sprague—And a family event that is taking place. People are born and die at home in their family. They are not attended by strangers in other places. If we look at the Tito report, a number of people who are admitted to hospital end up being sicker purely because of being in hospital than if they remained at home. We have some very nasty bugs in hospitals that are transmitted to women.

Senator GIBBS—Absolutely. Of course, we are a multicultural society and a lot of people come from countries where it is pretty dangerous to go into hospital because the hygiene is not the best.

Ms Sprague—Yes. Also it is traditional for them to be cared for by the women in their family, and by midwives historically. We are the second oldest profession in the world.

Senator GIBBS—Yes.

CHAIR—And the first one is what led to the babies.

Ms Sprague—Yes.

Senator GIBBS—So, they complement each other, really, don't they?

Ms Sprague—We do. But really there should be some kind of financial equality for women who choose to birth outside, because they do save the taxpayer money. Coming back to the private health claim, women have been able to demonstrate that the \$3,000, for example, that they might spend for all of their antenatal care, the birth plan meeting, attending the birth, a week's postnatal care in their own home, somebody being on call for them 24 hours a day, seven days a week and two midwives, is pretty cheap. For someone who goes into the Freemason's hospital and ends up with a caesarean section and stays for a week in hospital it costs \$5,000, \$7 000 or \$10,000. Those women have been able to say to their health fund, 'Listen, I am saving you money. You should reimburse me.' Some funds, such as HBA, make rules and regulations that you can only provide postnatal care if the woman is in her own home. Who are they to dictate where the care should take place? They are paying money.

I think we need to change the focus, too. As professionals if women were not having babies, we would not have an income, yet women feel that they have to be 'good girls'. The focus should be that the carers are the ones who are able to practice their job and earn an income because of the women. The women are doing us a favour; not the other way around, and that is often what it is seen as. They are very compliant. Emotional blackmail comes into this so much because of that thing about wanting a nice, live, healthy baby like Laura said. No woman at the time when she is most vulnerable is able to say, 'No, piss off, and leave me alone.' That is emotional blackmail. If someone says, 'Oh, your baby might be at risk', of course she is going to defer to a professional.

Senator GIBBS—Yes, thank you. This is very interesting. Really, the private midwife is actually catering to a very small group of advantaged women.

Ms Sprague—Yes, and women who have been given that knowledge. I have to back up what Laura was saying. I often find that women come to me in their second pregnancy because they believed that the system was going to support them in their first pregnancy, and they feel incredibly let down by it. It comes back to them then feeling that there is something wrong with them, that their body did not do it.

Ms Dempsey—Part of my work in birth is as a childbirth educator, a birth attendant and trained counsellor. A lot of the work I do with women who come for counselling after births is precisely the scenario that Annie and Laura are talking about. Women who have had certain expectations of their first birth had that demoralising experience through the first birth. Then when they are pregnant with the second baby they are full of fear, and wishing and hoping for something different. Firstly, they want information about making wiser choices about how to work the system to their own ends in the second birth. Also, with the residue of psychological and emotional damage to be worked through, they want to be in a place where they could give birth to a baby in a joyous situation. That is exactly what has been said.

Ms Sprague—Giving birth is a bit like making love. You don't do it in the middle of Myers with strangers around. If we put ourselves back to being purely animals, we have a fight and flight hormone. In nature, when wild animals are in the midst of giving birth, if they are disturbed they will do one of two things: they will either shut down completely and run away; or they will birth very quickly and leave their new to suffer the consequences.

Think of the number of stories that you hear of women going to hospital and, as soon as they walk through the door, everything stops. We cannot switch those things off. Women need to feel completely safe. They need to be able to get within themselves and know that some stranger is not going to walk through the door or make inappropriate comments. They need to be able to trust so much the people around them, as well as be supported to trust themselves. And that does not happen.

CHAIR—What you are saying is extremely interesting and very helpful for our inquiry, but we are now cutting into time for our next witnesses. Can I ask you to keep your answers short?

Dr Reiger—My interests are in research into the childbirth field. I have only one comment because people have been adding so much from our experience of working with birthing women. The one comment I make—and it comes partly from research into historical changes in the organisation of birth, because I have just completed a book about the changes in maternity care since the 1960s—is that we have seen enormous change and, therefore, many people think that everything is okay now. The problems are now quite different and complex. On the one hand we have quite humane care in birth centres and in home birth, and certainly some attitudes have changed, and on the other hand we have the escalating technology. I think that government, at the state and federal levels, has an important role to play in being able to generate cultural change. Funding mechanisms and so on are absolutely critical as part of that process.

CHAIR—Are you a medical doctor or a real doctor?

Dr Reiger—A real one?

CHAIR—I have copped that abuse all my life! Does that mean you are a PhD?

Dr Reiger—Yes.

CHAIR—In what field?

Dr Reiger—In changes in family, including the hospitalisation of childbirth.

CHAIR—Are you a sociologist?

Dr Reiger—I am a historian and sociologist.

CHAIR—In your submission you give a line that I totally love, but I would just like to check it. You state:

The World Health Organisation observes that the concept of ‘normality’ is not standardised . . .

Those of us who have a wild mind think the idea of a non-standardised normality is a bit exciting.

Dr Reiger—I have just come back from the Australian College of Midwives conference in Hobart, as of yesterday. One of the most interesting comments was by an American midwife who said that the notion of normality in birth is a crazy one because the norm is variety: the norm is variation. Every single birth is different. Although normality is, in one sense, a range, it is a range of incredible complex variation. Therefore, in that sense, it cannot be standardised.

Ms Dempsey—It gets confusing because we often talk about ‘normal’ physiological childbirth. We might talk about what is normal in terms of sociological or cultural birth or practices or the individual woman’s expression in the birth process. This is where we have this non-standardised ‘normal’. But when we talk about the ‘normal’ physiological process, we talk about the hormones working, the body opening up and the internal workings of the mother. There is a normal process that we would hope to facilitate, which is, I guess, mostly what we are talking about and what we would hope these changes would bring—that more women are able, through their individuality and non-standardised ‘normal’ cultural and social expectations, to have a birth that fits them—meanwhile facilitating the normal physiological process, as opposed to the high intervention rates which lead to not normal physiological birth. In the language we use the word ‘normal’ in a number of different areas without understanding clearly what we are differentiating.

CHAIR—It is loosely used. That is of help to us. Can you tell me whether antenatal classes in Victoria are still subsidised, are free, or are no longer free and everyone has to pay?

Ms Dempsey—Mostly, people have to pay. They are subsidised in some of the hospitals, particularly for cultural groups, but mostly women have to pay. I am an independent childbirth educator. There are very few of us now practising. I have been doing this for 20 years so I have seen the shift from childbirth education, starting in the 1950s and 1960s but particularly in the 1970s, as being seen as a radical activity happening outside of the systems to inform women in the ways that we are talking about now about the choices and practices that happen within particular hospitals and with particular doctors. I remember that we used to have consumer files on doctors in hospitals that women would come in off the street and check. All of these things were happening through the 1970s because childbirth education was an independent activity with the childbirth education groups—consumer groups—providing it.

In the 10 or 15 years since then, childbirth education pretty well exclusively happens within the hospitals where the care is provided. Childbirth education then becomes the dissemination of information about what happens in that particular hospital, what the routines are and what women can expect in that situation, rather than a broad range. I would also say, anecdotally, as I am a member of the National Association of Childbirth Educators, that, from discussions with other childbirth educators who work within hospitals, they cannot give the sort of information that they feel many women would require because of the expectations of the birth that they might like to have, because they run the risk of being hauled over the coals by their superiors or obstetricians who say, ‘What are you telling my women?’ when women go and question care that is being offered or suggested to them because of what is being said in the classes. I think that childbirth education in general is in a very sorry state because it is exclusively happening within the hospitals and fairly well under the control of the dominant medical system about what is being disseminated.

CHAIR—What costs are people paying for it? Do you have any idea of the price range?

Ms Sprague—It would be \$160 to \$200 or \$300, depending on how long—

CHAIR—For a month?

Ms Sprague—It could be six or eight weeks of classes.

CHAIR—Does that mean that lots of people would miss out because they could not afford it?

Ms Sprague—If it is a choice between buying food for your family that week and going to antenatal classes that will tell you, ‘You will do this, this and this’, people are voting with their feet and are not attending in the same numbers that they were.

CHAIR—Let us leave out that last bit and say that maybe people are making a choice between food and classes and we will determine whether or not the classes tell them, ‘You will do this, this and this.’ That might be a bit heroic, do you think?

Ms Sprague—I am hearing back from women attending certain hospitals that this is the hospital routine and that is what they are teaching them in the classes.

CHAIR—What distribution does the publication *Birth matters* have?

Ms Delaney—I think there are about 200 on our subscription list and it is growing. In the last two years it has been steadily increasing.

CHAIR—Who is it targeted to?

Ms Delaney—Members of the Maternity Coalition. As we described at the beginning, academics, mothers, midwives—quite a broad range of readers.

CHAIR—Unfortunately, we have run out of time. Unless someone wants to say something in one minute?

Dr Reiger—I will say one thing because it comes back to the ‘normalcy’ of birth. One of the most useful comments I heard the other day about ‘normalcy’ and ‘variation’ was that we should start thinking and talking about a healthy birth as against a ‘normal’ birth.

Senator TCHEN—Ms Delaney, you described to us the experience of the birth of your daughter. Was it a difficult birth? Were you admitted to Monash hospital as an emergency case?

Ms Delaney—I was admitted to Monash because the labour was failing to progress.

Senator TCHEN—It was an emergency case then?

Ms Delaney—I do not know whether it constitutes being an emergency case. I had laboured all night. I was told that I was going to give birth to my baby within an hour. Then a midwife came in and did an internal examination and told me that my cervix had not dilated at all. So failing to progress warranted being transferred to the hospital.

Senator TCHEN—Did you have an obstetrician?

Ms Delaney—No, I did not.

Senator TCHEN—You only had a midwife?

Ms Delaney—Yes.

Senator TCHEN—Was that at a birth centre?

Ms Delaney—Yes.

Senator TCHEN—You say you blame the system not the midwife, but at least four years ago the birth centre would have been experimental, it was not part of the main system.

Ms Delaney—The birth centre in Moorabbin had been around for a number of years.

Dr Reiger—Twenty years.

Senator TCHEN—We have been told in other evidence that birth centres are a good idea and are better than hospitals.

Ms Delaney—I personally believe that I should not have left my home; I should have given birth at the home. When it is your first child you want to do the right thing and, being in the main stream, the right thing you are told is to go into the hospital system. You are given this option of a nice birth centre with midwives. It is appealing, but, in retrospect, I feel I should not have left my home. That is when I say the system failed.

Senator TCHEN—Ms Dempsey, you said earlier that The Maternity Coalition comprises practitioners, doctors, midwives academics and also mothers. How do you find your mothers?

Ms Dempsey—Women come to want to work around birth issues either from having a fantastic birth experience and wanting to share that empowerment and that feeling that everything is possible which comes for a woman when she gives birth and they want to share that with other women or they come for a radicalisation about child birth and want to do something with it out of very distressing experiences and wanting to make change. We have women from both areas.

Senator TCHEN—Earlier Ms Wilson told us that her sample was skewed. I wondered whether your sample would be skewed? We would need to take that into account, if that is the case.

Ms Dempsey—It would be a skewed sample certainly from the point of view of women who have access from different cultures.

CHAIR—If there are any further questions or we need to follow things up we might contact one or some of you to get some dot point answers. Thank you very much for appearing before the committee.

Ms Dempsey—Thank you for the opportunity.

[2.18 p.m.]

BAYLY, Dr Christine Margaret, Divisional Director, Community Health Services, Royal Women's Hospital

DUNLOP, Ms Lisa, Unit Manager, Department of Perinatal Medicine, Royal Women's Hospital

HOGAN, Ms Rosemary, Divisional Director, Maternity Services, Women's and Children's Health Care Network, Royal Women's Hospital

JOSS, Ms Janet Bridget, Manager, Well Women's Services, Women's and Children's Health Care Network, Royal Women's Hospital

MATTHEWS, Dr Leonard Hillel, Consultant Obstetrician, Royal Women's Hospital

ROY, Dr Robert Neil Davie, Divisional Director (Medical), Network Neonatal Services, Women's and Children's Health Care Network, Royal Women's Hospital

CHAIR—I welcome the representatives from the Royal Women's Hospital. Thank you very much for your hospitality today, for the opportunity to have a hearing here and, in a short while, to have a look over the hospital. Very often inquiries are held in Commonwealth offices and you never get to see the real world at all. We are very appreciative of your assistance and cooperation for our hearing today.

The committee prefers all evidence to be heard in public, but should you wish to give your evidence, part of your evidence or answers to specific questions in camera you can ask to do so and the committee will give consideration to your request. We have before us your submission No. 46. Do you wish to make any alterations or additions to that submission?

Ms Hogan—No.

CHAIR—I am not quite sure how you are planning to do this. We will be interested to find out. Could you speak briefly to your submission and then we will have questions.

Ms Hogan—We will perhaps be unique in that we have not practised all this. We are certainly happy to speak to our submission. I think it is fair to say that the submission is a distillation of the views that we have canvassed across the organisation. It does not reflect any one perspective but rather the perspective of the clinicians working within a tertiary centre.

That having been said, in addressing the first point, which is the range and provision of antenatal care services to ascertain whether interventions can be minimised through the development of best practice in antenatal screening standards, I think it is fair to say, as you have probably received information already, that antenatal screening is somewhat problematic. There is a range of recommendations and guidelines available on antenatal care but certainly our experience has been putting those recommendations and viewpoints in the

context of the client patient group that you serve has not always been done terribly successfully. In fact, we are working on a project with a number of other tertiary centres to try to address that and to actually pick up whether we can do an evidence based practice on that particular issue.

Certainly there is a lot of tradition and training associated with antenatal care as opposed to perhaps empirical good evidence. Some of the evidence we do have is that women actually like to see a health care practitioner during their antenatal period. It is a very special period in most women's lives. Whilst there is probably good evidence around to say that we could do with fewer visits, in actual fact that is not always associated with a high level of client satisfaction. That is not a point that we made in this submission but I think it is fair comment.

The next point is the variation in child birth practices between different hospitals in different states. I do not think we can comment other than recording what we have found from our own data. That is the intervention is possibly greater than many level 2 or level 1 hospitals by the nature of the services that we provide and the availability of facilities, such as the largest neonatal intensive care unit in Victoria, and it perhaps drives some of those intervention rates that women come here because they are actually able to have intervention that results in the birth of a child that might not otherwise occur in a level 2 or level 1 hospital.

The other issues that we make a comment about is the shortage of anaesthetists. There are certainly hospitals in Victoria at which you wait at least 20 minutes or longer to access an anaesthetic service. Some women will preferentially seek out care in this organisation because we are able to provide a 24-hour service and generally at considerably less than 20 minutes waiting time. Whether that influences the data that you see for the state of Victoria about intervention rates I am not sure. It is possibly a factor.

Certainly, the data from the Royal Women's Hospital has demonstrated a rising caesarean section rate. We have seen in our data the fact that early intervention delivery by caesarean section for those neonates at less than 33 weeks gestation—Neil might like to comment—was not a feature of a few years ago.

Dr Roy—I think that is one of the points about the place of this hospital in the system—because we attract the very high risk population we are going to have a very high intervention rate. One of the tensions in a hospital like this is between the provision of the very highest quality of interventionist medical model for those women who really do have big problems with their pregnancies versus trying to provide the best humanitarian type of delivery for normal deliveries. That is where this institution has made great progress in being able to see the difference between the need for medical intervention and at the same time going back to dealing with normal deliveries in a significantly more humanitarian way than we did, say, two decades ago. We heard what you were just talking about with the coalition about the provision of things like a birth centre practice. The birth centre has been a feature of this institution for probably 20 years now too.

CHAIR—For those of us who think 20 years ago means you are back in the 1950s it is a shock to remind us that it is the 1980s.

Senator GIBBS—Don't remind everybody of our age.

CHAIR—I'm not; I'm only reminding people of mine—and also that history changes very quickly. It seemed a long time anticipating 20 years but when you look back—I suppose one of the things I find quite interesting is whether, if you have had a birthing centre for 20 years, the number of people using it has increased and, if not, why not.

Dr Roy—I think the number is in fact relatively static, but one of the things that has happened is that the birth centre culture has filtered out through the rest of the practice of midwifery. I say this as an outside observer in a way as the baby advocate. I see the sorts of philosophies that the birth centre brought in going through what one used to call labour wards—we call them delivery suites these days. That would be an outsider's comment, as it were. I will leave it to my midwifery and obstetric colleagues for their own comments.

CHAIR—Do other people wish to make comments at this opening stage?

Dr Matthews—I would like to just talk to that. I think the multicultural society which we have may well increase our numbers in the family birth centre. I think it is just the beginning of perhaps a much larger input into and interest in the family birth centre type of situation when the multicultural and perhaps less educated or informed people are becoming more and more informed of that option.

CHAIR—What makes you say that, Doctor? That is an interesting comment.

Dr Matthews—I think that up to now the birth centre philosophy and birth centre facility have not been exploited as much as they should have been with some of the ethnic groups which we now have. There is a lot of potential for that to become a very much more used option.

CHAIR—Where do you see that lack of use happening? Is it because the doctors were not telling the patients from non-English speaking background? Was it the midwives? Was it the hospital? How come the information was not actually getting through?

Dr Matthews—I think it is probably as a result of the backgrounds that they have come from. I do not think that, in the societies that they have come from, people are used to that sort of model of care. I think it is a learning experience for them, and it is being promoted more and more so at the moment.

CHAIR—Some evidence given to us already suggests that people from non-English speaking backgrounds would be much more familiar with a midwife-type arrangement and a home birth than a hospital one. That is kind of counter to what you have said. Can you comment on that?

Dr Matthews—The sort of birthing centre in the precinct of a tertiary hospital is what I am specifically implying rather than midwifery care or a home based type delivery.

CHAIR—So you anticipate that there could be an increase. Dr Bayly, did you want to add something, or was it Ms Joss?

Ms Joss—I think we are coming to recognise that we have not promoted options of care broadly enough and in ways that are accessible to women, especially women of non-English speaking background but also women who are illiterate—who make up a surprising number of women in our culture—and we need to be able to promote this in a range of modalities that is more in tune with the year 2000 than with the 1950s. More resources need to go into producing information to women in a range of modalities that are accessible to them, and accessible to them at a local level rather than just at a tertiary level.

We have recently been working with a group of women from the Horn of Africa. In consulting with them, we have found that the family birth centre style of having their babies is something that they feel more comfortable with and more closely aligns the model that they would have back in their own country. But I do not think we should generalise about women from non-English speaking backgrounds—they are a very diverse group. Vietnamese women, for instance, would normally go to hospital to have their baby in Vietnam. I think that we have to treat every woman as an individual, whether she is from a non-English speaking background or not.

CHAIR—Did you say that the Vietnamese women would go to hospital in Vietnam?

Ms Joss—Yes, they would. We have to have adequate resources to be able to treat women as individuals. That is a constant challenge for us here at a large tertiary institution where 41 per cent of our women are from non-English speaking backgrounds. Just to give you an idea of the complexity that we are actually dealing with here, in any one week we could provide interpreters for 56 different language groups.

A lot more effort needs to be put into informing women. I do not think it needs to be just the responsibility of the hospital that is providing the care; I would like to see a much more generic effort put in at a state wide or, indeed, a national level to inform women about the range of choices that are available for birthing and where they might access those choices rather than one hospital just talking about what particular choices they can offer women.

Of course, a lot of women come here because we have a very large language services department, and that is another issue. Many women from non-English speaking backgrounds actually choose this hospital because they know they will be supported with interpreters. Another critical area in providing individualised care for women is the availability of interpreters and support people for those women.

CHAIR—Did you want to add anything, Dr Bayly?

Dr Bayly—Yes, I would like to talk a little bit about the history of the huge expansion of numbers of models of care that we can offer. Twenty years ago hospital based care was standard hospital antenatal care and delivery suites, and then came the birth centres. Now there is a whole range of models of care—midwife care, shared care, satellite clinics and so on. Echoing to some extent what Janet has said, our capacity to describe and effectively communicate those different choices to the diverse range of people we may need to see has perhaps lagged behind the availability of the models, and the availability of the models has not always matched the choices that people might like to make.

In respect of those born elsewhere, not far short of half the women who have babies here were born themselves outside this country—not all from non-English speaking backgrounds, but it is a very high proportion of women we see. I think there are some major communication issues and community education issues. Certainly part of it is our need to communicate with those women about the sorts of choices they can make in an immediate sense. But there are issues in terms of the sorts of demands that we need people to make of us. They need to communicate to us what their needs and choices are, and an empowerment approach in community education will make that easier. The easiest thing for us as a service has been the default model of care, if you like, and it is more difficult where there is some kind of communication barrier to make some of those other choices.

That just characterises some of the difficulties there. Hopefully, you will find that our submission alerts you to some of the challenges that we are facing in the ways in which we are trying to meet some of those challenges more effectively in terms of better meeting the needs and wishes of the women who seek to use our services.

CHAIR—You have heard a little of the evidence of the group who were here before you. They certainly seemed to suggest that they were not getting a very sympathetic hearing in some of the institutional areas. It is interesting to know how much their challenge is with institutions as it is with practitioners. You shocked me a little. You actually admit that things could be better, and I would like to congratulate you on this approach. I mean that terribly seriously, because one of the things that has happened for a lot of people is that they butt against a brick wall: ‘This is the way we do it here; if you come in, too bad.’ You suggest that you are at least listening and also that you are in the process of appreciating the need to change. Is that in response to what women ask?

Dr Bayly—Yes, I think that is a major driver. We conducted a major community consultation two years, which we are continuing to feed into our processes. We have established a community advisory committee to build ongoing community consultation and influence into our development of services.

CHAIR—I have just a couple of quick questions. How many caesarean sections are done in this hospital because women demand it?

Ms Hogan—It would almost be impossible to count, because invariably it is never coded as that being a sole indication.

CHAIR—Good; now that we know it is not counted, tell us how many you feel it is?

Ms Dunlop—I think that it is fair to say that, whatever the numbers, they are increasing. A number of women—for a variety of reasons—are choosing the elective caesarean section.

CHAIR—What do you say about professional practice or standards of professional practice that can be blown out the window by a woman demanding to have a certain procedure? I think this is yours, Dr Matthews, isn’t it?

Dr Matthews—As Rose pointed out, there is an increasing demand for, for example, elective caesarean section, driven by certain things. I think it basically boils down to the fact

that women have a right to express that opinion. It has to be weighed up against the advantages and disadvantages of any procedural type intervention. One has to weigh all those factors up. As long as there is informed communication as to all these advantages and disadvantages, a decision will be made between the patient and her medical provider. Whether this is best practice type medicine or not is disputed.

CHAIR—One of our witnesses today said that if women ask to have no intervention they are very much less likely to have that request seriously regarded than if they ask to have a caesarean or intervention. Would you care to comment?

Dr Matthews—I think that is reasonably true. I think it also depends to a large extent on the medical provider. Everyone is an individual and we all have our standards and our preferences, but I think that certain practitioners will be sought out, particularly in the private sector, for those qualities.

CHAIR—The qualities of go and see Dr X because he is pretty likely to do a caesar with not too much questioning.

Dr Matthews—And the other way as well: go and see Dr Y; he may be non-interventional. But, of course, in a setting such as this there are certain protocols and standards that must be set. As long as best practice is pursued, that is the way it should be.

CHAIR—I understand that the World Health Organisation says that ‘normal’ is not standardised. My philosophy contacts will be enormously edified by this claim. But, even though the norm is not standardised, what possible justification is there for any professional in this field to say to a woman, ‘Yes, your claimed right to demand a caesar outweighs the delivery of a baby per vagina’? What possible professional standard or criteria would justify a woman having a caesar for no other reason than that she says, ‘I want it’?

Dr Bayly—I think it comes down to expectations. Personally, I do not believe I know the answer to this question, but there are reasons that a woman will seek a caesarean section in that context, and they are because of what she may see as the disadvantages, the potential consequences, of a vaginal delivery. Some of those may be short-term things to do with speed of delivery, avoidance of pain and those sorts of things, but some of them may be to do with what she perceives as harm or damage to her in the longer term in relation to damage to the genital tract, scarring, vaginal prolapse and those kinds of issues. They are the arguments that people will use, so it is not something that stands alone as a request. I do not believe we have really good evidence to provide an evidence based answer as to whether that is ever justified or not. I think they are difficult arguments to counter.

CHAIR—There is a fair amount of evidence, isn’t there, that if most babies are shoved into the world they are not followed immediately by prolapses, falling bladders or failure to enjoy sex.

Dr Roy—I am neither going to support nor deny the practice but merely observe: I am not a direct reader of much obstetric literature, but I am well informed that in a recent survey of female obstetricians in the UK, who must be among the best-informed people in

this matter, it was found that 80 per cent elect to have caesarean sections. That is not saying whether it is right or wrong, but that information is from a well-informed clientele.

CHAIR—Tell us your response, Dr Roy.

Dr Roy—My response to the figure being as high as 80 per cent was for the jaw to drop somewhat.

CHAIR—Yes. It is extraordinary.

Dr Roy—I know I am going to get myself into hot water if I give my male version of what womanhood is about, but I think there would be plenty of other people who have submitted to the committee who would suggest that a normal vaginal birth, if all is well, is one of the ultimate satisfactions of womanhood. But, you see, that is a terrible male perspective on things.

CHAIR—No, I do not think so. There are quite a few people who would say that.

Dr Roy—That is what I hear people say. Read Sheila Kitzinger—she would suggest that.

Dr Bayly—I will give the other end of that spectrum. We have encountered women who have refused to have a caesarean section when that is the only thing that will save their baby's life, and the baby has died as a result of that refusal to have a caesarean section. That is really just to clarify for you the differences in expectations. At the one end, caesarean section is totally unacceptable; at the other end, some prospect of future—20 or 30 years later—vaginal prolapse is an unacceptable outcome or expectation for the woman who insists, if you like, on a caesarean section.

Dr Roy—I am very grateful to Dr Bayly for raising that because the same thought crossed my mind about two minutes ago, and as an advocate for the foetus and the baby, obviously I am appalled that that happens. I am aware that it does happen, and my understanding of the legal situation is that the foetus has no legal right in that situation and that the woman has every right to refuse a caesarean section and to let her foetus die.

CHAIR—In the past she has also had the right to object to a termination and allow herself to die so that the child might live. We are in complex country, aren't we.

Dr Roy—Yes.

Senator GIBBS—First of all, I must thank you for being so open and willing to answer our questions so honestly. I cannot come to grips with the fact that women seem to think they have a right to say, 'Okay, I want to have a caesarean section; let's do it,' because it is a convenience. You go to your doctor and say that and he says, 'Yes, sure, let's do it.' This happens. Don't you say, 'You are a healthy woman. The pregnancy is fine and there is no need for this; vaginal childbirth is a normal thing'? After all, if God wanted us to have caesareans, all women would have been born with an in-built zip, wouldn't we? Don't you explain to women that this is the normal process? Sure, you are going to have pain—we all

have pain. But nature makes you forget these things afterwards. Why are we allowing healthy women to have caesarean sections?

Ms Joss—I do not think that these things happen in a cultural vacuum, either. We are living in a technological age.

Senator GIBBS—That is the problem, isn't it.

Ms Joss—We are living in a technological age. We are living in the age of perfection, and we are living in the age where we believe that our technology can solve problems for our lives and, indeed, that is a safe way to go. It is about women trusting their bodies to do the job it was meant to do and be supported in that. I feel there has been a shift since the 1970s. I was around in the 1970s, too, when there was a shift by women to claim their bodies back, if you like, and to take control over the birth process. I do feel that, again, there is a bit of a shift away when you have these younger women who are in their 20s and early 30s and who are of a very different generation. Besides all the other arguments, I think education is a big one. Women need education about the dangers of a major procedure like a caesarean section and that, because it is a caesarean, it does not guarantee a perfect outcome either and that there are complications from that. Often that is the assumption: that is the safe or the easy way to go. So we cannot discuss it in a vacuum of it just being around the consultant and the woman.

Senator GIBBS—Maybe we should educate women to the fact that their bodies are far more perfect machines than what technology is and that they should actually have some more faith in themselves. To me a caesarean is performed when things go wrong and it is a necessity; it is not an advisable thing.

Ms Hogan—Having sat in and witnessed some of the discussions that occur around this particular issue, it does not happen in a vacuum. I think the vast majority of clinicians and health care providers, when they are tackled with this particular question by a woman, do try to argue the case for proceeding with a vaginal delivery.

But what they or I might regard as being a reasonable occurrence during childbirth, such as unexpected and unknown pain levels, the issues around recovery and some of those sorts of things, the prospect of possibly a forceps delivery for a small percentage of women in fact may be considered by some women as a huge disincentive to even contemplate trying for a vaginal delivery and opting for a caesarean section. It is fair to say that in Australia having an epidural anaesthetic with an anaesthetist on hand is an extremely safe procedure. We simply do not get the mortality issues associated with them perhaps like we did 40 or 50 years ago as perhaps associated with the general anaesthetic and the increased mortality-morbidity issues for women and their babies.

CHAIR—That is true, Ms Hogan, but it is also pretty painful post-operatively after a caesar, isn't it?

Ms Hogan—Absolutely.

CHAIR—Because you have had a major abdominal opening. Your peritoneum has been given a breath of fresh air, which is not good for the peritoneum.

Ms Hogan—I think that one of the challenges that there have been for anaesthetists—one that they have actually risen to—is in improving post-operative pain relief. They have been very successful in improving that; 48 hours now with the post-anaesthetic epidural. I do not think it is particularly desirable or good. I think that you sure cannot beat having a baby vaginally. As Senator Gibbs pointed out, it is a terrific thing.

Senator GIBBS—That is true.

Ms Hogan—But we really struggle, I think, as clinicians and others to argue particularly successfully when you trot out some of the stats.

CHAIR—We are pressed for time. We are happy to take a little out of our walk around the hospital and perhaps you witnesses could stay for a bit longer. But I am wondering if we committee members could actually discipline ourselves to ask shorter questions and if you could shorten your answers.

Senator GIBBS—I will tell you the problem I have with this. This morning we went over to the Mercy Hospital and had a look at their facilities. The obstetrician we spoke to was an older doctor. He told us that, of the 25 obstetricians who were working in that hospital, two were basically experts in vaginal breech delivery and five would be comfortable with it. He called it ‘deskilling’ of obstetricians.

He said—and he was quite comfortable with this; he has practised for years—that when he and the other older obstetrician eventually retire that will leave three because of this. A younger obstetrician says, ‘It is a breech birth and I can do this.’ But then if the mother says, ‘No, let’s just do the caesarean,’ he will say, ‘Okay,’ because it is the easier way out.

This is quite disturbing. We have technology supposedly enhancing our lives but there is the opposite side of it, too, where natural practices are going. Are you finding this happening in your hospital?

Ms Hogan—It is a universal experience across Australia, I would suggest.

Senator GIBBS—It is disturbing, isn’t it?

Dr Roy—I am an older paediatrician. I have worked with many of the older obstetricians who are extremely skilful at manipulative obstetrics and are managing to get excellent results from difficult deliveries. I do not have the statistics at my fingertips but, for instance, the incidence of severe complications of damaged babies as a result of the very best standard of vaginal breech delivery was very much higher in the days of manipulative obstetrics. That is no disrespect to those obstetricians.

As Ms Joss has pointed out, we live in an age of perfection—and probably rightly so—so you can reduce the incidence of severe complications down to as close to zero as possible by

saying, 'You're a primigravida woman and you have a breech. Your outcome is demonstrably better if you have a caesarean section.'

Even though the likelihood of having a normal baby after vaginal delivery is still excellent, nevertheless that small percentage of complications drops down by having a caesarean section. It is a self-fulfilling cycle then. As people do that more often, they have less opportunity to become skilled at a breech delivery, so if they get caught with a breech delivery then they do not have the experience that the older obstetricians have.

Dr Bayly—It is important to make the distinction between a pregnancy where there is some additional factor such as breech and there is a completely normal pregnancy. In the times when there were much higher rates of manipulative deliveries, caesarean section and anaesthesia were also much less safe. I think that has to be considered in the equation. That is an important difference between those uncomplicated pregnancies.

Senator GIBBS—I wish to digress. I notice that you have a chemical dependency unit here. One of my main interests in life is drugs, illicit drug users and the help that we can give them. How many women would actually use this unit?

Ms Hogan—About 150 women go to the unit and give birth at the Royal Women's Hospital and there are other women that use the unit on a more ad hoc basis and might deliver elsewhere. We certainly provide the antenatal and intrapartum care for about 150 women on average.

Senator GIBBS—Is this a free service?

Ms Hogan—Yes.

Senator GIBBS—What are your success rates with the children afterwards? Obviously, a lot of the babies would be drug dependent when they are born.

Ms Hogan—A significant number are. The paediatricians assist in withdrawal and there is a range of modalities as far as that is concerned.

Dr Roy—About one in six of them have to come to our nursery to detoxify. We have about 25 here.

Senator GIBBS—Do all the babies live? Do you have deaths there at all?

Dr Roy—There are other issues other than the drug dependency. There are nutritional and social issues which do make the perinatal mortality rate higher.

Senator GIBBS—So it is higher?

Dr Roy—Yes.

Senator GIBBS—What would be the mortality rate?

Ms Hogan—I am sorry that I do not have that statistic with me at this moment but I could certainly furnish it to you. It is somewhat higher than the average mortality-morbidity rates for the rest of the population coming here. Again, we are dealing with small numbers.

Senator GIBBS—Obviously you are.

CHAIR—What about the evidence we are hearing that early discharge may indeed disguise the fact that a baby is drug dependent?

Ms Hogan—The chemical dependency unit only picks up those women that elect to go to the service and the potential for a woman to be chemically dependent.

CHAIR—Do you have any evidence or data on how many people come back with drug dependent babies who go off the boil a few days after leaving hospital?

Ms Hogan—No, but I am not aware of any babies. We do collect data on our readmissions and I am not aware of that as being a readmission diagnosis, but it is possible that they would attend some other facility or service.

Senator TCHEN—This is a rather confusing time for me because we have had many obviously well meaning people coming to say to us, ‘Midwives are not getting access to hospital,’ and then we get people like you coming—as the Chair observed—to say, ‘We are very sympathetic.’

One of the problems that we have heard is that midwives are being denied access to labour wards. I do not have much experience with midwives except that both my sisters-in-law are double-certificate nurses. They both have the mannerisms of upholstered T-34 tanks which we associate with double or more certificate nurses.

CHAIR—It must be a marvellous Christmas get-together.

Senator TCHEN—They tell me that nurses actually run hospitals; doctors think they run hospitals but nurses run hospitals. So when did this culture start that midwives are denied access to maternity wards?

Ms Dunlop—I think what they are referring to is midwives in private practice. In the delivery suites within the hospital and in fact in all the maternity wards they are all midwives. What they are referring to is midwives in private practice who would like access to bring their patients or their clients into the hospital setting.

Senator TCHEN—With them as the primary carer?

Ms Dunlop—Yes, that is correct.

CHAIR—Do you allow GPs to follow their patients into the hospital?

Ms Hogan—If they choose to, yes, but very few do. The vast majority of associations that general practitioners have with the Royal Women’s Hospital are as share care providers.

The vast majority of GPs in Victoria—or certainly in the metropolitan area—do not do deliveries now. They primarily do antenatal share care and some postpartem care.

CHAIR—Why do not you let the midwives follow their clients into hospital? Is this a hospital policy?

Ms Hogan—It is not a hospital policy. It is something that has been brought to our attention. I think it has been very challenging for us, within the framework that we have operated in both in terms of the funding models and our own systems and processes, that we have not addressed that in a way that has been more successful. We certainly do provide share care with the Aboriginal health centre. It is going to be one of our challenges to tackle the funding models and the constraints that we operate under at present and our political realities.

CHAIR—So should we tell any midwives who are listening not to lose heart—that they should keep on coming to your door and that collectively you might tackle the state government for different funding?

Ms Hogan—I am sure that, from the perspective of the midwives who run their own private businesses, they are probably experiencing a high degree of frustration with organisations such as the Women's, and I can understand that. I guess we have some issues about getting our own house in order for us to deal with that successfully.

Senator GIBBS—What about private patients? Do you have private patients here?

Ms Hogan—Yes, we do.

Senator GIBBS—Even the private patient cannot be accompanied by her own midwife?

Ms Hogan—No, any patient is entitled to bring a support person in. It is in terms of the role that they fill once they are in here. So if Senator Gibbs wanted to have another child here, there is no reason why she could not bring in a midwife with her to be involved with her care. It is just the relationship and what they would be legally able to do within the organisation—

CHAIR—They would not be allowed to be a midwife once they got in the door to the hospital. They could hold your hand, talk to you, comfort you but not midwife you?

Ms Hogan—Yes.

Senator GIBBS—But if I brought my own doctor in here, he could practise?

Ms Hogan—No, he would have to have admitting rights here. All health care providers from a variety of settings have to have admitting rights and be recognised by the organisation.

CHAIR—Can I just ask you about care maps and how you say they have not really worked? In three seconds.

Ms Hogan—That was antenatal care maps?

CHAIR—Yes.

Ms Hogan—Bad project.

CHAIR—Why?

Ms Hogan—Not enough resources thrown at it to get it right in the first place.

CHAIR—What was wrong with it?

Ms Hogan—Lack of understanding from the clinicians that were actually using it and in terms of providing education. The evaluation from the women, though, is that they like it. So now we just have to fix up the other bit.

CHAIR—The patients like it but the doctors do not?

Ms Hogan—Yes.

CHAIR—Now there is a novel approach.

Ms Hogan—But that is okay.

CHAIR—That history might describe things that are about 100 years old. Is this true?

Ms Hogan—Quite possibly.

CHAIR—Can I just ask very quickly: have things changed in the Women's Hospital in the last 20 years?

Ms Hogan—I do not know. I was not here 20 years ago. But I think so.

Dr Roy—Dramatically.

CHAIR—Since you have a community health centre, a women's health centre in the grounds of this hospital or in the front door, that certainly seemed to me to indicate an extremely significant change, so that women who came in here could actually come in as something more than a lump of meat to have things done to them. They are now expecting to have a view, to have an opinion, to get information and to be resourced and assisted. Am I wrong about that?

Ms Hogan—No.

CHAIR—There has been a very significant change. I came to the opening of that women's health centre on your ground floor, and it certainly seemed to me that the winds of change were blowing like a gale through this place.

Ms Hogan—A fairly stiff breeze.

CHAIR—Certainly it seems to me that people behind you are indicating that there is a change still to come. But you have already said that yourself. So are you going to continue with the care maps, or is that one gone and we will look at different ways in which we can involve the doctors contributing in the future?

Ms Hogan—No, when we get the final report, we will sit down and review it. I think a patient held record which involves a multidisciplinary approach and puts the woman at the centre of it is absolutely the right way to go. We just need to clean up our act in terms of the way it is formatted, in the way that we educate people to use it—those sorts of things. There is really some right down to the basic typesetting sort of stuff that we need to fix up.

CHAIR—I wanted to ask you particularly about the DRGs. You do suggest that it is not a satisfactory tool. Are you suggesting that you have not got enough money? What is the problem with DRGs—that they are not satisfactory or that you do not have enough money?

Ms Hogan—They do not recognise a lot of the work that we do. They certainly do not pick up psychosocial issues particularly well and the input of social workers—that sort of multi-disciplinary team—and they certainly do not deal always terribly successfully with the complexity. In some ways, it is the way they are administered. When you assign a particular DRG and then go through all the rigmarole of the coding process and all the rest of it you can get women with quite complex social as well as medical as well as obstetrical needs that actually fall into a lowish DRG just because of the actual diagnoses that they might present with. It is not always satisfactory.

CHAIR—So the hospital is out of pocket sometimes with those people?

Ms Hogan—Yes.

CHAIR—Do you have another source of funding to cover the social dimension, if you like, as apart from the medical diagnosis?

Ms Hogan—There are some specified grants and there are some specified grants dealing with complexity. Our top 10 DRGs actually deal with 80 per cent of our population so, when you have only a restricted number of admission diagnoses, there are not a lot of swings and roundabouts to balance out your gains and losses and I think that is a problem for us.

CHAIR—Is DRGs a fight with the state government or the Commonwealth government?

Ms Hogan—I think it is perhaps more a state issue but I can see that, with the move towards all states embracing DRGs as a methodology of funding, it will become a Commonwealth issue in the longer term.

Ms Dunlop—It is a particular problem with antenatal admissions that women admitted with an antenatal problem may need to be in for several weeks. If she happens to deliver during that admission, we are funded purely on the delivery component and so the previous

two weeks, six weeks, 12 weeks that she has perhaps spent in hospital are not included. It is just purely that short postnatal stay.

CHAIR—Who got that wrong? Antenatal admissions during pregnancy have been happening over quite some time. Why is there no DRG to cover it?

Ms Hogan—I think it is the way it is administered and interpreted.

CHAIR—Is it because the bean counters got it wrong?

Ms Dunlop—The DRG is implemented on your discharge diagnosis, not your admission diagnosis. That is where pregnancy is different from any other major illness—your admission diagnosis might be, for example, for something like placenta praevia where you have a low lying placenta but your discharge diagnosis is that you have had a baby, you have had a delivery.

CHAIR—When I wrote the discharge diagnoses you actually had to say placenta praevia, too. So what are you doing wrong?

Ms Dunlop—The discharge diagnosis is what type of delivery you had—not whether it was a complicated or uncomplicated, normal delivery, caesarean, et cetera.

CHAIR—Is this something you have raised with the DRG people?

Ms Hogan—Yes, and we do get a specified grant to help address some of those anomalies, but I think specified grants always follow a year or two after the problem becomes apparent.

CHAIR—Very quickly, what does the women's hospital mean by 'antenatal screening'?

Ms Hogan—Predominantly ultrasound, but it can also refer to quadruple screening.

CHAIR—So it is foetal screening rather than maternal screening?

Ms Hogan—Maternal screening is included. We certainly do significant psychosocial screening for women.

CHAIR—Psychosocial, yes—but the old basic screening of what is her blood pressure, what is her pulse rate, what is her haemoglobin, what is her blood sugar, and what is her weight—simple old-fashioned things like that: are they still part of screening?

Ms Hogan—Yes.

CHAIR—And as well as that, we now add the super high-technology foetal screening as well.

Ms Hogan—Yes, we do.

CHAIR—Do you have enough funding to cover all of those things, or do you have governments screaming at the cost of ultrasound?

Ms Hogan—Ultrasound is like a vast, bottomless pit.

CHAIR—Would your hospital have a view yet as to whether a screening at 18 weeks and no further screenings unless particular criteria are met is a good thing?

Ms Hogan—Our hospital would be happier to sit with an 18-week screen—there is debate around the evidence and the value of that. It is the clinician who is doing the 18-week ultrasound who has the skills to detect the foetal anomalies, because that is essentially what it is about. And we certainly get a lot of women coming back in for repeat ultrasounds, which would be quite unnecessary had they had their ultrasound in the first place in the hands of somebody who was skilled and able to detect what that ultrasound was for in the first place. There are a lot of ultrasounds done in the broader community in which you see a report saying, ‘Come back in a week’s time because we are not too sure.’ If they had been in the hands of the right clinician at the time, they would have perhaps had a much better chance of getting—

CHAIR—Or, if you were really cynical: if they were in the hands of the right people who actually know that there is a considerable profit in doing them regularly.

Ms Hogan—Yes, I guess that is possible.

CHAIR—Yes, highly probable, given the experience in the past on high technology, et cetera. I am just aware that cuts in that area have been flagged, and I guess it is one area where there will be a requirement for best practice criteria. Do you believe it is possible to establish best practice criteria for the birthing process, against which most mothers being delivered can be assessed?

Ms Hogan—Who is defining the ‘best practice’?

CHAIR—That is for you to do.

Ms Hogan—If you take it from the perspective of the woman and what she regards as being best practice—or the clinician or the morbidity or mortality outcome—and the evidence for that, it becomes quite challenging to reconcile with those groups the distillation of what is actually best practice. I think best practice guidelines are helpful for all clinicians.

Ms Dunlop—I think it is important, though, with best practice guidelines, that they do not become just minimum standards and that is all the woman is entitled to. I think there also has to be some mechanism built in that women require a variety of services and some women will need more than what is designated as best practice, and there needs to be some flexibility.

CHAIR—Presumably they will need more than best practice because of certain criteria. Best practice criteria are not usually minimum standards, are they?

Ms Dunlop—No, but sometimes they can be used from funding perspectives as minimum standards.

CHAIR—Ah, the dollar question.

Dr Bayly—There needs to be, perhaps, some best practice information that would include some basis on which people could choose to accept or refuse some of the things that might be regarded technically, if you like, as best practice.

CHAIR—Our first terms of reference really ask us to have a look at why there is such a difference in caesarean section rates across the country—why my state of South Australia, for example, is higher than anywhere else. I cannot believe the women in South Australia are all that different from women in the rest of the country. It is also interesting why they are much higher for private patients than for public patients. I am just interested in whether best practice criteria might help us reduce that difference, and whether we might look at some kind of more comparable care across the women of Australia at the time of being delivered of baby.

You must have a vast range of examples of childbirth coming through your hospital, from the heroically normal—non-standardised—to the rare and way-out. In this women's hospital, do you reckon you could write some best practice guidelines, in particular the ones that would mean you could defend yourself against litigation? We were told last Friday that maybe if there were some good best practice guidelines, these could be used in any court case and a doctor or a midwife practitioner could say, 'These are the best practice guidelines and this is how I conform to them, so don't sue'?

Dr Bayly—They would be a help, but they would not totally resolve that problem.

CHAIR—Does that mean you would say you do not have them at the moment?

Dr Bayly—I think it is possible to find experts who would argue about a number of issues where you would seek to provide a guideline. I think there is no an ultimate answer in a lot of situations like some of the ones we have been talking about.

CHAIR—It is not a fair question, but I am interested to ask you: if you finished up in a court of law—you as a panel—and the patient was suing because 'I demanded a caesarean section; it is my right and they would not give me one', how would you judge?

Ms Dunlop—I think you would have to ask us for a set of personal opinions on that one.

CHAIR—Would I? Who is prepared to give me a personal opinion on that one? Do I detect from you a lack of comfort about women demanding their right to have a caesarean section? Or is there a sense that maybe women do have a right to demand a caesarean section?

Ms Dunlop—I think it is a very difficult question. This is me personally, but you have women demanding to have their varicose veins done, or some other surgical procedure, and I feel uncomfortable saying to somebody, 'You cannot have any particular mode of care'. I

think we have an obligation to give them the facts, but I think ultimately we have to educate the women if we are wanting to say, 'You cannot have a caesarean section' or 'You cannot have this model of care'. I think you can give them the information but ultimately it is their decision, and they will go somewhere else.

CHAIR—Is there anywhere else in medical care—nursing care, hospital practice—where the patient has really got the right to ask for what most of you are trying not to say is not best practice?

Dr Roy—Lots of plastic surgery—unnecessary plastic surgery.

CHAIR—Do you mean breast implants, penile implants?

Dr Roy—Yes.

CHAIR—These are actually, by and large, paid for by the patient. They are not considered within the range of normal good practice.

Senator GIBBS—They are paid for by the patient, totally.

CHAIR—So there is a difference? I am afraid we have got to finish and go look at this hospital with you, but this is a crunch question and you, more than anybody else, should be able to provide this committee with some kind of serious deliberation about this. One of the reasons, we are told, that there is a very high rate of caesarean section among privately insured patients is that, amongst other things, women are demanding, as a right, to have caesarean sections. I do not know, and maybe you can tell me, what percentage of caesarean sections—in your private sector, let alone your public sector—is being done on demand from the women, or whether there is an extremely small number of caesarean sections but they are being used to cover a range of other reasons for increased caesarean section numbers.

Dr Matthews—Perhaps I should talk from a private point of view. I would think there are very few requests for caesarean sections to be done on the grounds where there are no medical indications. In my practice, I would find very few. If you go into the background of a patient, you may find some factors which contribute to such a request—for example, previous sexual child abuse where the patient may not feel comfortable with a vaginal delivery. The patient may not voluntarily give that information, but you can sometimes understand why, under those circumstances, she would request an elective caesarean section where there may not be grounds for it on a medical basis. Under those circumstances, the patient has a right. It is her body, her baby and her child. I think she has the right to at least feel that she is justified in asking for it. The important point here is that of informed consent. When she knows the risks involved in caesarean section as opposed to vaginal delivery and still opts for a caesarean section, and if the medical provider is happy to be part of that, I think that is reasonable.

CHAIR—Do you agree with evidence given to us earlier that the negatives of caesarean sections are not promoted nearly as much as the benefits, in terms of giving information to mothers?

Dr Matthews—I would say so, particularly in the private sectors.

CHAIR—Do you agree that it is more likely to be: ‘That’s all right. This’ll be okay. It’s a very safe operation now,’ et cetera, and not, ‘You’ll be in pain for three days, and you won’t be able to sit the baby on your belly for a couple of weeks’? The negatives are not told, but the good news is, so women cannot be giving informed consent, because they are not getting all the information.

Dr Matthews—Yes.

CHAIR—So you agree with what I am proposing?

Dr Matthews—I return to the point that the majority of the best informed population is still electing to have caesarean sections.

CHAIR—You are actually saying that you reckon very few mothers in the private arena demand caesarean sections for no other reason. It may be that women are saying, ‘Look, I’ve had a caesar once before. I’m having a second baby. Out of the trial of labour and going straight to a caesar, let’s do the caesar.’ Is that what you as saying is more likely to be the case?

Dr Matthews—Certainly.

CHAIR—Or the breech birth: ‘Why wait?’

Dr Matthews—Certainly. But there are those whose friends have had difficult forceps deliveries. There are the complications of vaginal delivery—the recuperation time and the pain and suffering which takes place with a difficult vaginal delivery. They are aware of those, and they are informed of those too. That may also be a factor which is driving it.

Dr Bayly—Again, it is necessary to think of this in the bigger picture of expectations and levels of risk. It is helpful to consider a broader picture. If there is a fifty-fifty risk of harm to the baby, it is easy to decide to do a caesarean section. What if it is 10 per cent? What if it is five per cent? What if it is one per cent? What if it is one in 1,000—and we are talking here about a situation where it is near enough to zero chance of harm by the caesarean, but the risks are different risks perceived by the woman. Where do you draw those lines? I think that makes it little easier to think about, although perhaps not to resolve.

CHAIR—We thank you for putting our question back to us. We will now read our *Hansard* and come back to you, Dr Bayly, for an answer to that question. One of the things that are interesting to us is that people have asked, ‘What are you doing? You have no right to be setting best practice standards.’ We say, ‘Absolutely. We’re not doing that; that’s not our job.’ We are interested in trying to find out why there are such differences between one state and the next, between one hospital and the next and between private and public patients. That seems to me to be a very worthwhile question to ask on the data that is available. Why are there considerable differences?

I am very interested that, on the evidence given to us last Friday, the best thing to reduce the caesarean rate in America was when the financial benefits of having a natural childbirth outweighed the benefits of having a caesar. Down went the caesarean rate. I am sure doctors in Australia are not persuaded by dollars like that—of course not. I am glad you are saying no, Dr Roy; I note your insistence on that. But it means there are a number of factors here. We have to have a look. Anyhow, the Senate has charged us to have a look. I think it is fair for us to ask, ‘Who better to help us than the Women’s Hospital, with a huge history and also a very large knowledge?’ You claim in your submission that you do more than anybody else in Victoria. I have no reason to dispute it, and I think we would be helped by it. As we now go off and have a look at the hospital, is it acceptable for us to contact you again if we see some questions that we might want to come back to you about?

Ms Hogan—Yes.

CHAIR—That would be fantastic. I have to put on the record again our appreciation for letting us have your facilities and for your openness in answer to questions. What you tell me is that you acknowledge there is a climate of change happening. It is important that we get as much information to assist us with whatever we conclude on either best practice guidelines or changes in terms of midwifery, et cetera. Are we agreed?

Ms Hogan—Yes. The last few years have seen some research into what goes into the decision making processes of caesarean sections. In lots of ways, none of us understands that terribly well. We see on the surface some indications for caesarean sections, and we make some assumptions and some judgments about whether they are a factor that drives us on to the decision for a caesarean section. But I suspect that we do not understand at a deeper level the factors that contribute towards the decision to go ahead with a caesarean section or otherwise. There is some very interesting work being done in your home state in which we have participated in and which is looking at what clinicians will advise people to do and what they will choose to do themselves and then tying that in with data and with some other research. When that is eventually published, which is a year or two away, it will be very illuminating because we have just started to scratch the surface of this particular issue. We struggle to come to grips with the variation in practice as well and with how to tackle that successfully.

Dr Roy—If I may make a point on the matter of best practice standards of practice, obstetrics has led the field in looking for best practice. Obstetrics was the first group of professionals who contributed to the Cochrane Collaboration for evidence based medicine. Obstetrics was first, and neonates was second. There may now be 100 meta-analyses of randomised controlled files of obstetric practice, but that is still scratching the surface of what is best practice in all the myriad different situations that one comes across within the normal to the abnormal in obstetric care. Best practice is something with which the obstetric profession and the midwifery profession have been struggling longer than almost any other branch in medicine.

CHAIR—That is a very helpful comment. Maybe what we have to define is the directions for the struggle for the next little while. Dr Paul Lancaster from the Institute of Health and Welfare, giving evidence last Friday, pointed out that most things in obstetric care were really ‘large uncontrolled experiments’ and, on the time of leaving hospital or the

time of having indications or whatever, that there are lots of areas that say, 'We've always done it like that,' or, 'Let's try this,' and that they are not properly researched. In the one minute remaining before we have to get up and go, would you like more money for research? What a silly question. I thought I would let you finish on a positive note.

Ms Hogan—Would you like the long answer or the long answer?

CHAIR—In other words, research is happening in the hospital, and there is a willingness to do more, but the funding of it is a challenge. We have to suspend proceedings now while we tour the hospital in 30 minutes flat so as to be back to listen to the obstetricians and gynaecologists at 4 o'clock. Thank you very much. We will be in touch if we think of good questions for you.

Proceedings suspended from 3.30 p.m. to 4.05 p.m.

[16.05 p.m.]

CAMPBELL, Dr Samuel Norbert, Vice-President, National Association of Specialist Obstetricians and Gynaecologists

DUKE, Dr Janet Elizabeth, Honorary Secretary, Royal Australian and New Zealand College of Obstetricians and Gynaecologists

WOINARSKI, Dr Jillian Elizabeth, Treasurer, National Association of Specialist Obstetricians and Gynaecologists

CHAIR—I welcome representatives from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and the National Association of Specialist Obstetricians and Gynaecologists. The committee prefers all evidence to be given in public, but should you wish to give part of your evidence or answers to specific questions in camera you may ask to do so and the committee will give consideration to your request. We have before us your submissions No. 17 and No. 100. Do you wish to make any alterations or additions to the submissions?

Dr Duke—I do not.

CHAIR—Would you like to make a brief opening statement and then answer questions?

Dr Duke—Yes, I would be delighted to. I would first like to acknowledge that this submission was written by Dr John Campbell, who is overseas, and that I was on a small committee that helped create the submission. Basically, the college submission is talking about the standards of care because, as a royal college, that is what we are set up to do. We are responsible for the training of future obstetricians and gynaecologists in our community and the continuing medical education of those people who have been certified before as specialists. We are also very actively involved in working with midwives and with GPs through a variety of systems that have been set up over the years.

The college not only has a particular interest in the care of women within the city but also freely acknowledges that 35 per cent of all births in Australia occur outside capital cities. We have a particular interest in the obstetric care of women within rural, provincial and island areas of Australia. That becomes quite relevant when one looks at where it is appropriate for women to deliver, particularly if they are in outback Queensland, Western Australia or the Northern Territory. We have a committee which is involved very much with indigenous women's health, and we have a very good working relationship with various parts of the Aboriginal and Torres Strait Islander community. In fact, one of the last honorary fellowships that we gave was to an Aboriginal midwife who has been very involved in skills transfer. We are very aware of the need for Aboriginal women to give birth in their homelands, if that is at all possible, and that is an area in which we are increasingly being involved.

As we have written in our submission, there is a lot of variation in childbirth practices around Australia. This occurs for a variety of reasons. The first reason that we would like to emphasise is the fact that, nowadays, women have choice in the type of care that they wish

to have. That may be from women who wish to go to a birthing centre in a very isolated area of Australia, as some of our Aboriginal women do, down to women who are saying at their first antenatal visit or even before their first visit that they wish to be delivered by an elective caesarean section.

One of the consequences of giving patients the right to have a say about their medical treatment is that they have a right to say something about the mode of delivery. It can sometimes be very difficult persuading a woman who comes in who is determined that she is going to have one mode of delivery that that is not what is appropriate for her. That is an area that is taking increasing time for most obstetricians practising in Australia. We have more primigravida women delivering. The women of Australia are being divided into two groups. There is the group of patients who basically seek public care and are relatively young at the time that they have their first baby, and then there is the subgroup of professional and businesswoman who elect to have their children much later in their lives, often when they have careers that are very established, and they have great demands in terms of the type of care that they wish to have. Antenatal screening is now freely available within our community. That then means that we try to identify potential problems during a pregnancy.

There is an increasing push by the women of our community to have a perfect baby. We know that that is not possible, but there is an increasing desire that they will have all the tests that they possibly can have antenatally to check the health of their baby and their own health. One of the consequences of doing increasing tests is that you will find increasing problems, which will then lead to increasing intervention. Sometimes it is difficult to work through with women exactly what the consequences are of those tests. We need to also understand that perinatal mortality in Australia is now at an all-time low of 7.1 per thousand births. The perinatal mortality figures in our states are all the deaths that occur after 20 weeks of gestation. If you look at WHO data, most of it is from 24 weeks of gestation onwards. As you will have just seen from coming to a tertiary referral hospital like the Royal Women's, we now have a reasonable survival rate for babies who are born at 23 weeks gestation, providing those babies are born in good condition.

CHAIR—Just a second. What is perinatal mortality?

Dr Duke—Perinatal mortality is a combination of the stillbirth rate and the neonatal death rate. The neonatal death rate is the deaths that occur, varying from state to state, within 60 to 90 days after a baby is born. That means that many of these babies are not even actually due at the time that they get over that death rate.

CHAIR—Say that again.

Dr Duke—If you deliver a baby at 23 weeks of gestation, that means that the baby is 17 weeks early. Ninety days is in fact three months, and that is what was traditionally used. Twenty-eight weeks used to be the cut-off point before which it was deemed that babies would not be viable. That is no longer true.

CHAIR—Keep going, please.

Dr Duke—This very low perinatal mortality rate explains why you will see variations in intervention rates between what we would regard as a tertiary or—some people would say—a fourth generation hospital, such as the Women’s here, and a small independent birthing centre in the suburbs of Melbourne, such as the Hawthorn Birth Centre, which is a totally freestanding facility that has no access to caesarean section facilities and anaesthetics and no backup other than the very expert care that is provided there by a couple of midwives and one obstetrician. You would expect to see differences in intervention rates between those different models of care. We know that if babies are inborn at tertiary referral hospitals, if they are less than 34 weeks gestation—normal pregnancies are 40 weeks, so these are babies who are greater than six weeks early—those babies do much better. This hospital has not lost a baby over 25 weeks gestation who was born without a congenital abnormality this year. We are looking at very high good outcomes.

We also know that it is extremely important that if you are going to deliver babies early you give those babies to the paediatricians in the best possible condition. That is normally with the very little babies by delivering them by caesarean section. Many of the babies who need to be born very early are also being born because, if their mothers are not delivered rapidly, we are looking at a very high potential death rate for women. In Australia, the death rate for women is profoundly low. Unfortunately, we are working with some fairly old triannual figures because of the problems that there were with the funding of the NHMRC several years ago. In the last triannual figures that have been looked at, there were 82 deaths in Australia over a three-year period. Of those deaths, fewer than a third were direct deaths as a consequence of that woman being pregnant. The rest of the deaths then get divided into indirect deaths and deaths that are related to incidental things such as car accidents, fires at home and suicide, which is now a varying area as to those women who die. We now recognise there is a problem of antenatal depression and that, if that is adequately treated, you can in fact prevent some of those suicide deaths.

Australia has leading outcomes, both for the women and for the children who are born. It is important that we have a variety of places where women can deliver and a variety of intervention rates that are correct for that particular woman and that we acknowledge that couples now have a right to have a say in how they are cared for, both in pregnancy and delivery.

CHAIR—That should give us about three hours worth of questions, Dr Duke. Thank you. Who from the national centre is going to speak?

Dr Campbell—I think the submission by NASOG was basically related to item (j) on the terms of reference, but by way of introduction perhaps a few general remarks might be appropriate to some of the other items as listed. In terms of intervention rates, it is fair to say that if nature is left to herself, she is an indifferent obstetrician, so that some intervention is required in maternity services. What represents too much intervention and what represents not enough intervention? I do not think the answer to that is quite clear at this stage.

There is increasing concern about the burgeoning caesarean section rates in the western world and there are very good articles to suggest that that is perhaps not doctor driven or health care worker driven but that the patients themselves, as Janet has referred to, have been looking at the options and taking advantage, if you like, in their eyes, of the advances in

modern technology with reference to the mode for delivery. On point (a), the range and provision of antenatal care services, we would have hoped that, in another place at another time, the review of obstetric and gynaecology ultrasound provision might be handed on to the clinical specialty group of obstetrics and gynaecology. We believe firmly that there will be efficiency gains to be had there and better utilisation of the Medicare expenditure, if you like, towards the patient outcomes—better than what is happening at the moment.

Point (b) refers to the variation in childbirth practices between different hospitals and different states. I was looking at some combined details on the active management of labour out of the *British Journal of Obstetrics and Gynaecology* in 1996. There were two controlled trials compared to judge the operative delivery rates where there has been active management of labour by early rupture of membranes and use of syntocinon and drips. In these two famous studies, the caesarean section rates varied enormously. In one study it was 19.5 per cent and in the other study it was 2.6 per cent, and much the same in the study group as in the control group in both studies. The author made the point that the two very different operative delivery rates in these studies emphasise the pitfalls of comparing operative delivery rates in different populations. The very low caesarean section rate was in a Dublin population.

CHAIR—And the high one?

Dr Campbell—That was an US study. So coming on to point (c), variations between the public and private patients, as Janet has referred to, patients with the means to have private care—either by health insurance or by paying their own way—perhaps have more ability to discuss equally with their doctor issues of informed consent, and this may have something to do with the apparent increased intervention rates in private patients. A lot has been said about the fear of litigation. I think the AMA submission that you might have seen at this inquiry referred to that, that the fear of litigation might lead to more intervention. We as private obstetricians definitely see someone from the public sector who might have had an adverse outcome in the first pregnancy or a preceding pregnancy who then makes sure that they will have private health insurance for their second and subsequent deliveries. So, in the current drift from private to public care, there is a definite reversal from public to private care in patients that quite often need intervention.

As for early discharge programs, there is not a lot of time length study done yet as to their appropriateness. The worry, of course, is postnatal depression and, from the baby's point of view, neonatal jaundice. With reference to best practice guidelines, these are in the phase of being established and it is difficult to comment upon their result and effect.

CHAIR—Who is establishing them, Doctor?

Dr Campbell—I think that some of these best practice guidelines are being looked at with clinical pathways within individual hospitals in the states and critical pathway analysis, and also I think that the Royal College is making some contribution in that way. Certainly the Royal College is associated with an incident monitoring program, which is perhaps the other side of the story, but it starts to lead into the same overall general quality assurance assessment.

As to the adequacy of information provided to expectant mothers and their families in relation to the choices for safe practices available to them, we have a feeling that those things should be advertised—whatever the models of care in a particular setting are—with full information as to who is actually providing the model of care, whether it is a doctor service or whether it is a midwife or maternity nurse service. The patient should be clear in her own mind and be given full information as to what the potential advantages and possible disadvantages of each of those systems are and, if possible, with any statistical evidence of outcome and results, particularly with reference to intervention.

Point (j) refers to the impact of the new Medicare rebate provided for complex births. The President of NASOG, Dr David Molloy, has done a second survey on fees and gaps by the obstetricians of Australia. He found there had been a reduction, as I think the department did, in the gaps charged to patients who use the complex item. I think the reduction figure was something like \$100, and those figures came from the department. The gap reduced from \$310 to \$218. Dr Molloy would wish the proposal to be put to the inquiry that this has happened over a two-year period from 1997 to 1999 during the time that the complex item was introduced, and during that time practice costs have risen enormously. There has been an increase in medical indemnity premiums from 20 to 30 per cent between, in some states, \$5,000 and, in other states, \$15,000 a year. The practice costs for other areas have gone up by four and five per cent. Yet the Medicare benefits schedule, apart from the complex item, has increased by three-quarters to perhaps 1¼ per cent over this time. So the point to make is that those increasing practice costs have all been borne by the doctor without any change in the gaps to the patient with the introduction of the complex item. So the complex item and its ability to enhance the amount of Medicare rebates available to obstetrics cannot be taken in isolation. It must be looked at in terms of what else is happening during that time frame that it was introduced.

CHAIR—Can I ask you to remind me of the figures for medical insurance premiums?

Dr Campbell—Yes. From 1997 to 1999, the medical indemnity premiums across the states has gone up from 20 to 30 per cent by a figure of \$5,000 to \$15,000 a year, varying between the states.

CHAIR—\$5,000 has gone up to 15,000?

Dr Campbell—Sorry, no. In one state it might be \$5,000 and in another state it might be \$15,000 over the two-year period.

CHAIR—From what to what?

Dr Campbell—Let's give a maximum amount. In New South Wales it is \$40,000. If we put that into perspective, the average private practice for an obstetrician in Australia is 100 to 120 confinements a year and the schedule fee for the so-called uncomplicated confinement is less than \$500. So in fact it is a loss situation in the obstetrics sector.

Dr Molloy would wish to say that if you look at those same doctors who charge the gaps for their obstetrics services, those doctors on average charge 2.2 times the Medicare benefit schedule fee for obstetrics. When it comes to gynaecology surgery, those same doctors

charge 1.1 times the Medicare benefit schedule for gynaecology surgery. In other words, it cannot all be put at the doctor's feet, as it were, about the level of gaps in obstetrics.

CHAIR—You have nothing to say at this time, Dr Woinarski?

Dr Woinarski—I think Sam has covered our submission well. The CEO of UMP, which is the major medical indemnity insurer in New South Wales, does talk about figures of medical indemnity insurance up to \$96,000 if cross-subsidisation between the specialties and GPs to the obstetricians does not occur. That would be \$900 per delivery at a rate of maybe 100 to 120 deliveries a year. That definitely would be a loss situation for obstetricians. The problem is that if this situation continues the gaps will simply have to increase or else the number of obstetricians will decrease within Australia, therefore giving patients less of a choice, and there will be a greater burden on the public hospitals.

CHAIR—What is the difference between the Royal Australian College of O and G specialists and the national association?

Dr Duke—The Royal Australian and New Zealand College was set up in 1979. It was an offshoot of the British college. The decision was made that we should have a college of our own here in Australia. We have joined with the New Zealanders in the last 12 months. It was recognised that the royal colleges are basically set up as standards of care organisations and for training and that there was a necessity for there to be a political arm and an arm that dealt with government about the matter of fees. It has traditionally not been that the royal colleges have talked about money with government in terms of individual remuneration for their fellowship.

CHAIR—That is what the national association does.

Dr Duke—Yes.

Dr Campbell—NASOC was set up in 1988. But there is a little bit of discrepancy among the royal colleges. It was thought by the RANZCOG that it would interfere with their royal charter for tax deductible gifts and contributions if they were involved in medico-political activities, but that is no longer seen to be true. Having said that, the Royal Australian College of Radiologists certainly does get involved in medico-political matters as well as academic matters. So there does not seem to be a standard definition; it is all pragmatic.

CHAIR—You sound somewhat sad.

Dr Campbell—Well, I have been around and seen it all happen, and everybody just does what they can.

CHAIR—Senator Gibbs will open the batting.

Senator GIBBS—Dr Campbell, you were talking before about fear of litigation, and you were saying that fear of litigation meant there would be more interventions. What is your reasoning for that? We have heard from quite a few witnesses that women actually demand

to have a caesarean section whether they need it or not. Is this in connection with caesareans?

Dr Campbell—I think there are two aspects of that. There is the patient demand. Recently in Adelaide there was an annual scientific meeting of the college and the question was posed to the 300 obstetricians in attendance that if a patient demanded a caesarean section would you do it. The 300 obstetricians all said yes. Not one said no, because of the fear of litigation. If something went wrong with the outcome for the baby and the mother had requested a caesarean section, there might be a legal discussion to follow.

The other aspect is that in the major court cases on obstetrics and litigation nobody has been sued for doing a caesarean section. Many people have been sued for failing—in the eyes of the plaintiff and her defence—to do a caesarean section.

Senator GIBBS—Is that when something has gone wrong with the child?

Dr Campbell—Yes. The question is: why wasn't a caesarean section done? In other words, with the eyes of retrospectivity, regardless of the management mode, the outcome has been used to suggest that perhaps things should have been handled differently.

Senator GIBBS—But if, as far as the doctor knows, at the time of the birth there is nothing wrong with the child and the woman is quite healthy, wouldn't it be a bit bizarre to wield the knife?

Dr Campbell—That is the climate of medical indemnity that we are in at the moment. That raises the issue of what can happen when the labour goes on for several hours. The definition of normal labour is 'labour that takes less than 24 hours'. So if you get past 24 hours and there is slow progress but everything seems to be all right, how long do you wait? It is known that the foetal death rate in labour is one in 3,000 in Western countries. In fact, if you wait for the spontaneous onset of labour after 38 weeks and up to 41 weeks, the foetal loss rate is one in 700. These are the things that can happen, but it all becomes very different if there is an adverse outcome and there is a legal case. The impact—and this is in the AMA's submission—that has on a doctor, his professional life and his practice is enormous.

CHAIR—We were told earlier that if women asked to have a caesarean section—and I am very fascinated about this—in South Australia, 300 specialists said, 'Yep, we would do it,' whereas if women asked for no intervention, 300 specialists would not say yes.

Dr Campbell—They would point out that it was likely that intervention would be necessary. There was a previous hearing in the Western Australian upper house, and I read the full volume of the details in the transcript. I think that in Western Australia 49 per cent of mothers deliver their babies without any intervention at all. The other 51 per cent need some sort of intervention from an episiotomy. So, based on that one in two outcome, the obstetrician would find it difficult to inform the mother that she could certainly have the baby without any intervention—he would need to give her full information of the likelihood of intervention—but he could certainly strive to help her to achieve that aim.

This brings us back to another point: in the Medicare confinement fee there is absolutely no reward for the effort involved in managing a difficult confinement through to a normal vaginal delivery and for using one's clinical skills. In the same way, there is no reward for effort for delivering a baby as a breech. In our day, training at this very hospital in the early sixties, we certainly saw breech deliveries, and they were healthy babies. There is a bit of controlled study result data that suggests that breech babies may be better off being born by caesarean, but this fluctuates from time to time.

CHAIR—Dr Duke, do you want to comment on these questions?

Dr Duke—Yes. In view of the intervention discussion that you have with women, we know from the birth centre data that over 50 per cent of women who are having their first baby who have been deemed to be low risk at the beginning of their pregnancy will need to be transferred out of a birth centre for some form of intervention—antenatally or in the early stages of labour. There are some women for whom it is totally appropriate to have no intervention, but other women need intervention. It is sometimes very simple intervention, such as an amniotomy or a rupture of their membranes, because that is all they need in order to coordinate their labour so that their labour will progress more quickly, so that they have enough energy to push their baby out in such a way that they will end up with absolutely no intervention such as an episiotomy.

As has been pointed out in our submission, the days of obstetricians routinely cutting episiotomies have virtually gone. They are what caused women much anguish. Obstetricians need to sew them up. They need to be looked at every day. They are more likely to have problems with healing. The days when episiotomies were routinely cut have definitely gone.

We now deal with some of the consequences of not cutting an episiotomy. Recently I was on duty here as the public obstetrician for the weekend. I spent 2½ hours in theatre, and a woman had 20 units of blood. If she had had an episiotomy cut more appropriately, perhaps we would not have dealt with the vaginal tear that she suffered. So there are consequences of not cutting episiotomies—just as there are consequences of not performing caesarean sections—and when they happen, they happen very quickly and they are often very costly to the woman. The woman I spoke of had been successfully run as a trial of scar until she got to full dilatation and then got into problems.

Senator GIBBS—We were talking earlier about a code of best practice. Obviously, you support a best practice code. Would it have to be Australia-wide?

Dr Duke—No.

Senator GIBBS—Could it be state by state?

Dr Duke—No, I think it should be hospital by hospital, and that was a point that Dr Campbell made. There is so much variation. What is right in a small peripheral hospital would not be right in a tertiary referral hospital.

Senator GIBBS—Could you elaborate on that?

Dr Duke—The more multinational the group of women that you look after, the more likely it is that you will need to see intervention. There is very good data now that first generation migrants in a multi-racial community need more intervention in childbirth if they are going to have as good an outcome as the women who belong to that community.

The Dublin study that Dr Campbell talked about was a homogenous study. The women who were pregnant and giving birth were Irish, and they were being looked after by Irish midwives. If you come to a hospital in any capital city—here or the Royal Prince Alfred Hospital in Sydney or the Sir Charles Gairdner Hospital in Perth—you will find that at least 47 per cent, and in some hospitals up to 60 per cent, of the women are first generation migrants. Particularly if they marry outside their racial group, they grow babies with body habitus which is different to that of babies born in Vietnam, Somalia or Ethiopia.

Also, in many of those countries if a baby is not well in labour a decision is made to let that baby die. That is not acceptable in our community. We cannot go to the Consultative Council on Obstetric and Paediatric Mortality and Morbidity and say that the baby was sick and a decision was made to let the baby die. Those days are no longer available to us.

CHAIR—Why? If that lady had demanded a caesarean section, according to the obstetricians in South Australia, that would have been done. But if that lady demanded that no intervention happens, would it not be done?

Dr Duke—I know of at least five coroner's cases that are going on in Victoria at the moment where babies have died. The difficulty in getting informed consent at 3 o'clock in the morning from a woman who does not speak English, when you are dependent upon a husband interpreting, is that they can say that they want absolutely no intervention and then, if the baby does die, there are major problems. As I said, I know of five coroner's cases that are around at the moment where they did not have intervention and the baby has died. Those women and their families are then very angry and very litigious.

CHAIR—Has any doctor been taken to court because they did intervene?

Dr Duke—There have certainly been cases where we have got permission from the Supreme Court to intervene. These cases have mainly involved women who have been mentally retarded or women who have been psychotic or who have had major psychiatric illness.

CHAIR—What about a standard comparable group—perfectly ordinary, not psychotic? I think the ones you were talking about are special exceptional cases.

Dr Duke—I do not know of anybody who you would regard as being of sound mind being taken to court in this country. There have certainly been court cases overseas where the court has in fact directed the obstetrician to perform a caesarean section.

Senator GIBBS—I might be a bit slow, but I still do not quite understand why you have to have hospital by hospital. I can understand that there could be a difficulty with non-English speaking migrants, but surely there could be a basic code of practice. We are talking here about the skills of the doctor or whatever you do—I am not a medical type person—but

there is a certain code of conduct and a certain code that you must adhere to, just as we do as politicians. Why can it not be national? Why can it not be a standard thing throughout all of Australia rather than hospital by hospital?

Dr Duke—It depends upon what you mean by a code of conduct. All of us belong to an organisation which has ethical standards. If you mean that sort of code of conduct, we already have that.

Senator GIBBS—No, I mean best practice.

Dr Duke—If you mean a code of conduct of best practice then the best practice will vary. You may be at a hospital that has no after hours facilities whatsoever. A piece of paper that came across my table recently was about a woman who was diagnosed of a breech in a peripheral hospital in Western Australia. She was transferred immediately to the tertiary hospital. She arrived there at quarter to one and the body of the baby was delivered at five past one. Unfortunately, the baby suffered a fractured cervical spine and is now a quadriplegic. The question that is being asked is: why did she not have a caesarean section? The answer is quite simple: she had elected to be delivered in a hospital without caesarean section facilities after hours, so she needed to be transferred to a tertiary hospital and there was not time, when she arrived at that tertiary hospital, to have the caesarean section.

So you cannot have a code of practice that says a hospital like this should be able to get women to theatre within 20 or 30 minutes and then have another hospital which, in fact, may be 20 or 30 miles from a tertiary hospital and where there is no after hours facilities. That is why I think there needs to be variations in your code of practice depending upon where you practice.

Dr Campbell—I think one can amplify that a bit to say, for instance: the availability of an anaesthetist and a paediatrician. It could be as simple as that. We may be in a country centre where the anaesthetist is a general practitioner who will give a general anaesthetic for the caesarean section but he has not been trained and is not skilled in giving the safer epidural type anaesthetic. People have to do what they can to the best of their ability with the available equipment and personnel. That is why I think that, by definition, best practice means for that location and for that particular person at that particular time. I think that is what best practice means, and it does vary.

CHAIR—Do you think that any best practice criteria will say, 'If she demands it, we'll give it to her'?

Dr Campbell—That seems to be coming into the international literature. Perhaps I should leave you this article written by Nicholas Fisk from Queen Charlotte's Hospital as to the reasons why women demand a caesarean section. In some areas of Brazil, the caesarean section rate is about 65 per cent. That is what is happening.

CHAIR—And in some sections of Brazil the babies die.

Dr Campbell—Absolutely.

CHAIR—I am not at all sure the standards from Brazil should be standards for anyone, should they?

Dr Campbell—But it is a note that it happens in some parts of the world among educated people. The reasons given are the maternal and foetal problems with vaginal delivery. Obviously, the maternal ones are related to prolapse, bowel and bladder problems.

CHAIR—Doctor, did you ever think that you would attend a conference of 300 obstetricians who would say one criteria for doing a caesarean section is because women ask for it?

Dr Campbell—No, I did not. This very article says:

In 1987, a BMJ editorial pontificated that a woman's request for a caesarean section in an uncomplicated pregnancy should be refused, and the same journal in 1997 said that

the conventional anxiety about rising caesarean section rates was recently questioned and it has been pointed out that the uptake of caesarean sections in informed women is more appropriate than any target to reduce the caesarean rate.

That is how attitudes have changed among patients and their health care providers.

Dr Woinarski—I would just like to stress that women do not just march into a doctor's surgery and say, 'I want a caesarean section,' without having thought about it in great detail. For a start, these women may have had complications with a previous delivery and even non-obstetrical complications like severe stress incontinence and bladder problems after having a normal, totally uncomplicated vaginal delivery. That is certainly a well-recognised complication of even an easy delivery, but certainly more so with a complicated delivery.

But there is a group of women who have not had children who are just petrified of the thought of going through a vaginal delivery. It might be a matter that we consider fairly minor, such as she is going to lose her dignity. She might be terrified of the thought of a baby coming through the vagina. I know it sounds strange to us, but we cannot absolutely guarantee this woman that everything is going to be normal. I can remember one patient who was petrified of a forceps delivery. 25 per cent of women having their first babies will have a forceps delivery. I could not guarantee this woman that she was not going to have a forceps delivery. If I had done a forceps delivery and the baby had ended up with neonatal problems there would have been major problems. But it was her anxiety that was the major problem there.

The majority of women come in saying, 'I want a natural birth without any intervention if possible.' The group wanting caesarean sections is very small, but they are women who have thought about what they want. They have thought about their choices, and this is what they want.

CHAIR—You say that it is a very small percentage. What are the other more significant contributions to the increased caesarean rate? What you said might be helpful to us, because the headlines are 'Women demand . . .,' and it seems to me that this is something of a distraction from the main game, which is that all sorts of other reasons are increasing caesarean sections rather than mother demand.

Could you explain to us, if you can, why there is such a disparity between one state and another? I might accept the difference from one hospital to another if it is rural and remote compared to a large urban centre—or something of that sort—but I find it difficult to understand why the caesarean rate in South Australia is so much higher than the rest of Australia. What is it about the women in my state? I think there is probably no difference from the women, on average, in other states. I am also interested that, within my own state, for example, I have been advised that one hospital has a caesarean rate that is less than half of the average rate. These are major concerns to this committee. Can you give us some clue as to why there is such a difference?

Dr Campbell—I can give a very brief assessment. The main increase—and it has been going on since the mid-1970s—has been the so-called failure to progress in labour situations with the first baby. The cervix does not reach full dilatation within a certain time and the patients and the doctors are concerned about the foetal wellbeing. We are now aware that the methods for monitoring the foetal condition in labour are not foolproof. So a decision is made to interrupt the labour and deliver safely by caesarean section. If that has happened in the first labour, the mother then comes back for her subsequent children and then probably—having had one trial of labour—either she or her doctor will elect for a repeat caesarean section. So in families of two, three or four children, there is a build-up of the caesarean sections that are being performed.

The other two main groups are foetal distress in its own right, and I have said that the methods for assessing that vary. Some hospitals have what is called a CTG or electronic foetal monitoring. Other hospitals have, in addition to that, foetal scalp pH analysis. But it is generally only the tertiary referral hospitals that run the foetal scalp pH analysis. The college has stated that, if you do not have that, you have to act on the CTG, do the safe thing and deliver the baby by caesarean.

The third thing that has come into the rising caesarean section rate is what we mentioned before: breech presentations. That has brought about a big increase. It is fair to say now that, with a touch of experience, you can identify some of those ladies who go a week overdue who, quite clearly, have unfavourable signs for vaginal delivery. And you can talk to them about whether they want to have a labour and probably end up with a caesarean section or whether they would prefer an elective caesarean section. Now, occasionally that would obviously be wrong because you cannot pick every circumstance, but you can certainly get some idea with many patients.

CHAIR—What is your understanding of the increased caesarean rate after induced labour?

Dr Duke—I have brought these figures, which I will leave with you, which set out the caesarean sections in Victoria for this period of time. Failed induction is a very minor contribution to caesarean section. In this period of time, it was only three per cent of all the caesars that were performed—not three per cent of all the births but three per cent of all the caesars.

I think the other difference that has occurred in the time that I have been a practising obstetrician is that we now totally differently manage women who have complications of

pre-eclampsia and hypertension in pregnancy with much better outcomes for the mother. It is now very rare to have a mother who will either have a stroke as a consequence of her pre-eclampsia or will have an eclamptic fit. So less than 0.1 per cent of all the women who deliver in Australia will now suffer from eclampsia.

If you look at the figures of the 1920s, one in 100 women delivering in this hospital died whilst in labour. Of those women who did not die, at least 10 per cent of the women had fits. That led to long-term neurological consequences and also long-term psychiatric consequences in many cases. So we now very differently manage women who have very significant pre-eclampsia or hypertension, particularly at earlier stages. As I mentioned earlier, to give the paediatrician the baby in good condition, you have not got 24 or 36 hours to try to deliver a 28-week baby vaginally.

We also manage very differently antepartum haemorrhages. Some very good studies were done in the eighties that showed that, if a woman had a significant antepartum haemorrhage—that is, she had a very significant bleed before she came into labour—and the baby was delivered by caesarean section, there was a much better outcome for the baby.

We also have a very different attitude towards infertility. The consequences of infertility treatment is that, if women go over 38 weeks gestation and they have conceived either as a result of a Clomiphene induced pregnancy, which is a tablet induced pregnancy, or IVF, they are much more likely to have unexplained stillbirths, no matter what the mode of monitoring of those women. That is a group of women who may well have taken five, six or seven years to get pregnant, and there is a major push from those women. They have already had a lot of intervention to even get pregnant. They have often needed screening in their pregnancy because of their advanced maternal age to look for Down syndrome. They know with this pregnancy that they have not got an abnormal karotype and that they are at risk of placental insufficiency. So they are another group that push caesarean section.

It is the same, finally, for multiple pregnancy. There are fewer and fewer twins delivered vaginally, and certainly fewer triplets or quadruplets. In fact, in today's legal situation, you could not justify delivering a set of viable triplets vaginally.

CHAIR—Why?

Dr Duke—Because you cannot monitor them. It is very difficult. When you have three babies on board, you can put a scalp clip on the first triplet, but, unless you are going to do constant real-time ultrasound, which would mean that you would have to have a person there with two ultrasound machines to monitor the other two babies' heart beats, you will miss one of the triplets if it gets into trouble. The other issue with triplets is that it is profoundly rare for triplets to be equally grown. In most cases of triplets there is at least one who is compromised before the onset of labour. You may have one triplet that is 1.5 kilos and another triplet, the littlest triplet, that is only 700 grams. So one of these babies is already very severely compromised.

Dr Campbell—Senator Crowley, could I offer one other factor that is important in this equation about rising caesarean section rates?

CHAIR—Yes.

Dr Campbell—What has happened is that there has been an enormous advance in the safety of caesarean section—an enormous advance. With the advent of spinal and epidural techniques for the anaesthetic, there is minimal blood loss, and much less blood transfusion than we remember. There is much less respiratory depression for the neonate and resuscitation required. The mother previously, when she had a general anaesthetic and relaxants, was in danger of inhaling her own gastric content and getting Mendelson's syndrome and becoming very ill.

The maternal mortality rate of caesarean section is very low; 7.8 per 100,000 is the figure. It is four times that of a normal vaginal delivery. Both are very, very low. But, in days gone by, when families were much larger, a caesarean section scar to a mother who might be expected to have six, seven or eight children posed the risk of subsequent uterine rupture. They were in the days before Pincus and Rock released the pill. And we saw those in this hospital; the mothers, the multiparas, the grand multiparas. We do not often see that now. So the decision for caesarean section takes in a different modern clinical context, because the mothers probably, maybe, are having three children at the most.

Senator GIBBS—In your opinion, when these women decide, after all of this thought, that they are going to have a caesarean, are they told by their physician of all the dangers? For example, 'This can happen; that can happen. Yes, you can have this perfect babe, but then you're going to be in pain afterwards because this is a major operation. It is not like we just cut the belly, pop it out and sew you back up. There are a lot of other things involved in this.' Are they told the full facts?

Dr Campbell—I think they are in my experience. There are two studies. There was one quoted in the *Medical Journal of Australia* from Adelaide which said that only about 70 per cent felt that they participated in the decision making process. Interestingly, a study out of London said the same thing; that 70 per cent felt like that. Other studies of mothers' recollections about tests they have had and procedures that they have had performed show that there is a little bit of discrepancy between what actually happened at times and what the mothers' memory is because it is such a vulnerable time.

Senator GIBBS—I am not talking about a woman lying there in absolute pain and the doctor saying, 'Look, I think we have to do a caesarean. What do you think?' I am not talking about that, where she thinks, 'Hell, just get the thing out of me. I can't stand this any longer.' I am not talking about that. I am talking about women who make an educated decision before all of this starts, 'Okay, I'm going to have a caesarean.' If a woman who, for whatever reason—perhaps she has to go back to work in a week—says, 'I want a caesarean,' is she told all of the facts? Would you say, 'These are the things that are actually going to happen to you,' or 'No, we've got a week to go. You are healthy. There is nothing wrong with the baby. If you go in there, sure you will have a bit of pain; it is not going to be that nice, but you are going to pop it out and everything will go back to normal'?

Dr Campbell—I think most doctors would tell the patient the true options and talk them through the complications as they foresee it down to the last bit. Now, the same sorts of things can happen with elective cosmetic surgery, and yet the complications are there. If we

are talking about venus thrombosis, pulmonary embolism, collapse, anaesthetic accidents and those sorts of things, and yet patients still go for their cosmetic surgery, non-essential services—

Senator GIBBS—Because all they have to think about is themselves. Whereas, if you are having a baby, you think of yourself and the child that you are carrying, which is a very important thing to a mother. You probably think more of the child than you do of yourself. But, if I want to go and have a nose job, I am inflicting pain on myself because I want that nose job. I am not damaging a child that I might be carrying because of it all.

Dr Campbell—I think most mothers would believe that caesarean section is a better way of being born for the baby in that sort of situation.

Senator GIBBS—Why?

Dr Campbell—I will offer this document to you to read. This will explain the reasons. Perhaps we could table that document.

Senator GIBBS—I cannot come to grips with this. I am not here to judge; we are just inquiring. There was a time in the world where caesarean was not the norm, like it seems to be today. The world did survive. We are here.

Dr Duke—Can I say several things. When Dr Campbell talks about it being the way that women think is the right way to deliver their babies, he is talking about this profoundly small subgroup of women. I want to make that quite clear. He is not saying that all women in our community believe that.

The second thing is that yes you do go into far more detail about the complications of a totally elective caesarean section with someone for whom you do not think there is a medical ground for doing that caesarean section. You go into minute details. Whereas if you have someone who has foetal distress in the labour ward and you know that you need to deliver that baby, you talk with the couple about their sick baby, you do not talk to them, apart from briefly about infection and bleeding, about the very rare complications of caesarean sections.

Senator GIBBS—That is understandable.

Dr Duke—My feeling would be very strongly that any woman who comes in and says this is how she wishes to deliver, and who is very narrow in her thoughts will get much more discussion than a woman who comes in and says, 'Let's wait and see what happens. I will have the pain relief I need in labour, if I need intervention then we will discuss it when I need it.' The more narrow a woman is, whether she wants a totally normal child birth or she is at the other extreme that she wants an elective caesarean section, the more they probably get told about the complications of whichever group they wish to be in than the women in the middle who are willing to go with the flow.

CHAIR—I understand you people have gone to considerable trouble to meet our time schedule because you were not available earlier in the day. I am not at all sure whether that means at 5 o'clock you have to go—I suspect it does. Anyhow, very soon we are going to

have to go because there is a plane waiting. Can I give you some questions that you can take on notice. I do not want to give you the challenge of a PhD just some dot points. You might even answer some of these on the quick flick through. United Medical Protection is the monopoly provider. Are all doctors members of this fund or do they have some other options?

Dr Duke—There are a number of medical defence unions around Australia.

Dr Campbell—They are retracting to two or three. Most obstetricians belong to one of two or three major MDUs.

CHAIR—What does it mean ‘it is a monopoly provider’?

Dr Duke—That is not a correct statement. I think that people have options. The difficulty in some states is that they are coming down to only one provider. We are very lucky in Victoria, we have two medical defence organisations which have local offices to which we can belong.

Dr Campbell—It could be a monopoly provider in New South Wales.

Dr Duke—I think there is a little bit of competition. It is becoming increasingly so in New South Wales.

CHAIR—If there is something further you can tell us about that that would be helpful. Also if you could elaborate on the statement that the UMP failed to pass on savings made when the NSW government agreed to fund public sector indemnity in 1999.

Dr Campbell—I can give you a quick answer to that. The western metropolitan O and G specialists in Sydney found that they had very little private practice and they were paying private indemnity cover mainly to deliver or be responsible for the public hospital patients. So they negotiated with the New South Wales Department of Health who agreed to reimburse them a certain amount in lieu of their medical indemnity premium. When they took that to the MDU, the authorities of the MDU said, ‘In that case, we have subsidised your premiums by a long way, because the outgoings from obstetrics are higher than the premiums you pay, we will now add on that amount to your premium. We will not keep you at the same premium.’

CHAIR—We might have to ring them. Do you think the Commonwealth has any role in supporting or promoting the development of best practice guidelines?

Dr Duke—Yes, I do think they have a role. The NHMRC has already developed good guidelines for things such as the use of anti-D in pregnancy. Anti-D is a drug that is used to stop women from becoming Rhesus immunised. We recently had a major kaffuffle because there was not enough of it and we had to relook at the guidelines. It is very expensive to create good practice guidelines. The college has looked at it at length. There are some guidelines which have come out of Edinburgh called the sign guidelines. You might be interested in looking at those. They have a very good web site and I can easily get you the web site address.

These guidelines looked at various aspects of best practice. We have best practice in terms of the timing of amniocentesis in pregnancy and who is appropriate to do chorionic villus sampling, which is another test that is used for prenatal diagnosis. The difficulty with creating all of these guidelines is the cost of them and certainly the Commonwealth government in its quality assurance programs, like the running of the ultrasound funding changes that we hope will come through, has a major role in providing quality assurance money.

CHAIR—One of the issues I would love addressed, you might answer this now or take it on notice, is the improvement in infant mortality figures—that is, fewer babes dying and fewer mothers dying. Do you put this down to caesarean section or not?

Dr Campbell—It is a combination of modern obstetric care that talks about antibiotics, blood transfusion, intravenous therapy, all sorts of interventions. There was a study done in New York that showed that clearly if you took one component out of that whole care offering you might adversely affect the results. It was very difficult to pinpoint the contribution of each separate component part of the obstetric care.

CHAIR—How much do you think general public health, living standards and better nutrition has contributed?

Dr Duke—That has contributed a lot, but it has also created some of our problems, particularly with first generation migrants. If you are in fact a woman who works as a farmer in Vietnam you can anticipate that your baby will weight between 2.2 and 2.4 kilograms. That is a much easier baby to deliver than a baby that is born as a consequence of McDonald's fast food and good Australian nutrition and your baby is over three kilograms. Having said that, in the major centres in Vietnam their caesarean section rate is somewhere between 20 and 30 per cent.

Dr Campbell—If the Commonwealth government could have a public health edict that all women would be advised to attend their doctor by 10 weeks of pregnancy, that would be an enormous help in terms of cost savings, accuracy of diagnosis and planning management in pregnancy.

CHAIR—What would you say to the midwives who might say, 'Why should they go and see a doctor, why can they not come and see us at 10 weeks?'

Dr Campbell—I would say that the midwife is trained in nursing care; she is not trained in diagnosis. If we look at the Western Australian upper house study we find for various faculties of midwifery around Australia that the curriculum is quite variable. There is not a lot of input from medical personnel these days. That was one of the points I had thought about earlier. We have been out of the midwifery classroom now for more than a decade, certainly in our state, and yet we are meant to be part of a team when it comes to management of maternity services. There is no interaction at all in our state.

Dr Duke—The college's attitude is that it is important that women attend for care early in the first trimester. There is no debate that if you can accurately date a pregnancy and the earlier in a pregnancy that an ultrasound is done, the more accurate that ultrasound is, the

less intervention you will then have. We have a technique in Victoria called quadruple screening which is a blood test that is done at 16 weeks gestation to look for Down's Syndrome, neural tube defects and another rare abnormality called trisomy 18.

We have a huge consequence of the fact that women are told that they have an abnormal result because their dates are not correct. The women who have their labours induced unnecessarily in late pregnancy because they are supposedly 10 days over are in fact only just reaching term. Accurate dating of early pregnancy is very important. I do not mind who the women see providing that person has the skills. It is only very recently that we have sufficient midwives who can in fact do that first visit. I believe at this point in time it should still be run by doctors. Having made that first visit, having got your diagnosis about the number of weeks pregnant you are, if you then wish to go to a midwifery model of care then I have no difficulty and the college has no difficulty with that whatsoever.

CHAIR—Does the college work closely with midwives?

Dr Duke—It is like lots of political situations: there is a joint consultative committee and we intermittently work very closely with midwives. It depends a bit on who are the powerbrokers in both of the groups. We have been asking, as a college, for the last 12 months that that committee meet but, for a variety of reasons which are not the midwives' fault at the moment but rest in the general practitioners' area because they are so divided, it has yet to meet. We tried very hard. Interestingly, you did not have an obstetrician on the committee that presented the data today.

CHAIR—From the Women's Hospital?

Dr Duke—Yes.

CHAIR—You mean to say they are obstetricians but are not practising as such?

Dr Duke—They are not practising as such, yes. They are people who were trained as obstetricians but are not practising as such. So there are a number of models of communal care, and that is very important for them.

Dr Campbell—In the current context, I think the doctor has to make the initial risk assessment of the pregnancy before it has moved across to whatever model of care is available in the local institution. I think that is fairly important. The diagnostic skills of the doctor, his training, is not there in the midwifery training program at this stage.

Dr Duke—But that may change.

CHAIR—That is certainly a question that we will put to the midwives—to either those whom we have spoken to today or those whom we are going to speak to. I think it is a very interesting point and maybe what we need to do is get the best intermingling of both expertise groups. But a lot of people have said to us that, once the doctors get hold of patients, they are into hospitals, they are seen as sick, there is intervention and so on. In hospital, you are far more likely to get an agreement to do a caesarean than to do nothing. This inquiry is certainly challenging a lot of things at the back of my brain.

Dr Duke—As a practising obstetrician at this hospital, I would challenge that very strongly. I work in a clinic on a Tuesday morning and I would send most of the women whom I see in that clinic to shared care. The women have already elected, before they come to see me, that they do not want to go to the birth centre. I do not believe that we are pushing people into a doctor-centred model. The women who go private are electing to do that. If you look at Judith Lumley's data—which was published from her very large review of birthing services here in Victoria—at the time that study was published, the women who had the highest satisfaction rates with the model of care they had chosen were in fact those who had elected to go to private obstetricians. Part of that is because they are in a financial situation where they can make that decision—I freely admit that.

CHAIR—That is right. If you pay a lot for it, then you are going to find satisfaction quite often—so one would have to put that kind of qualifier on it.

Dr Duke—I do not think that that is necessarily true. There are a large number of things we do in our life that we pay a lot for that we are not necessarily happy with.

CHAIR—Yes, that is true, but there is also the counter-impression. We were told by witnesses earlier that the most effective thing lowering the caesarean rate in America was when the remuneration for a normal or vaginal delivery was higher than for a caesarean section. Do you think such an approach would have an effect in Australia?

Dr Campbell—I mentioned earlier that there was no reward for the original clinical skills that an obstetrician was trained in 30 years ago—vaginal breech delivery and trial of scar, if you like, after a previous caesarean section.

Dr Duke—That is not true.

Dr Campbell—In the schedule as it exists.

Dr Duke—We are in fact rewarded for a trial of scar or breech delivery.

Dr Campbell—Now we are with the new item number. Sorry.

Dr Duke—I agreed with what Dr Campbell said earlier. At the moment, you are not rewarded for having the higher item number until the woman's partographic evidence shows that she has a labour that has gone over 12 hours. But you are also not rewarded for buying out, one hour into her labour, to do a caesar. You do not get paid more money under the item numbers at the moment for doing a caesarean section, except for caesarean sections that are performed for documented foetal distress.

Dr Woinarski—This can be looked at through the item numbers. I cannot remember the exact years but it used to be that doctors were paid more for performing caesarean sections, so a global fee was brought in with the idea of paying the same amount for every delivery. There was not a reduction in caesarean sections. The global fee has now been disbanded and there has not been dramatic increase in the number of caesarean sections. I think that tends to state the case.

CHAIR—I think it is complex. The more we ask, the less easy it is getting but, I think you would have to say, the more interesting. Is that right, Senator Gibbs?

Senator GIBBS—Absolutely.

Dr Campbell—Could I offer one final point.

CHAIR—Yes, please.

Dr Campbell—It is a worry to obstetricians if there is a model of care that will not offer a woman an episiotomy. We see this quite regularly now where there is a model of care that it is mainly midwifery controlled during the pregnancy and labour process and there is a laceration—as Janet alluded to earlier—or what is known as a third-degree tear of the perineal muscles. It is fair enough that those complications can happen to anybody, but if the mother—without being fully informed—does not understand that she has no hope of getting an episiotomy for her delivery, I do not think that is quite right. She should have the availability of the episiotomy if it is required.

Dr Woinarski—May I make one statement as well. I think one of the problems with the caesarean section rate, as we have been discussing it today, is that no-one really knows what the optimum caesarean section rate is. Is a 25 per cent caesarean section rate too high if we are going to have a significantly low maternal and peri-natal mortality rate?

CHAIR—The figures in Holland would suggest yes.

Dr Duke—As was explained earlier, Holland is a very homogenous population. It is like the Dublin population. If you deal with a homogeneous population with very little migration, you can have much lower caesarean section rates. One of the difficulties we have is that Australia is now a multicultural society and we have a lot of intermarriage between our communal groups. The reality is that, if you are a little Filipino woman who is five-foot nothing and you start off your pregnancy at 42 kilos and have an Australian male husband who has a head circumference such that he takes extra large hats, your chance of being able to deliver that baby vaginally is virtually non-existent without significant trauma to yourself.

CHAIR—I think that is very interesting information. Indeed, the whole day has been very interesting and I thank you very much. I just wondered, as a last question to ask you: do you think that the fear of litigation is shaping the way specialist practice happens? Is it the fear of litigation that makes 300 obstetricians say that, if a woman asks for a caesarean section, she will get it?

Dr Campbell—To some extent, yes, but it is not the only factor. I think economic viability is shaping obstetric practice, by obstetricians walking away from the practice of obstetrics. I think that is to the disadvantage of the community.

CHAIR—I think those answers are very important and useful. We are now clear about the further questions that we have to ask, but the information that you have provided is also very helpful. Thank you very much for the trouble that you taken to come as witnesses,

especially as I understand that you had to rearrange your day or find some time for us late in the afternoon.

Committee adjourned at 5.20 p.m.