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SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Reference: Childbirth procedures

WEDNESDAY, 15 SEPTEMBER 1999

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SENATE
COMMUNITY AFFAIRS REFERENCES COMMITTEE

Wednesday, 15 September 1999

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

Substitute members: Senator Denman for Senator Evans

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 9.09 a.m.

KING, Associate Professor James Forrester, Chair, Queensland Council on Obstetric and Paediatric Morbidity and Mortality

CHAIR—I declare open the Community Affairs References Committee which is continuing its inquiry into childbirth procedures. I acknowledge that the hearing is taking place in the Mater Hospital in Brisbane and I place on record our appreciation of the assistance that we have been provided by the hospital. It makes a great difference for the committee having been able to look at the facilities that so many of you are going to talk about.

I welcome Professor James King to the hearing. The committee prefers all evidence to be given in public, but should you 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 which is No. 31. Do you wish to make any alterations to that, Professor King?

Prof. King—Only the misspelling of Mr Humphery's name for which I apologise.

CHAIR—That is a very pertinent correction. It is noted. We invite you now to make an opening statement and then field questions.

Prof. King—The Queensland Council on Obstetrics and Paediatric Morbidity and Mortality is a ministerial advisory council that conducts research into mortality and morbidity for mothers, infants and children in Queensland. As the chair of that council I was asked to make a submission to the inquiry. However, there was not sufficient time to receive written submissions from the other 11 members of the council and, for that reason, the submission that I made almost certainly has a fairly personal flavour to it. In a nutshell, I think it could be summarised as saying that the council would support recommendation 15 of the NHMRC document *Options for effective care in childbirth*. This is the section which calls for support for better evidence to assess the merits and shortcomings of options of care that are being provided in maternity care in Australia.

But what I would hope, Madam Chair, is that you would allow me to go into my background a little bit to give you an idea of where I might be coming from which might help with some other aspects of this submission.

CHAIR—Certainly.

Prof. King—I have been involved with childbirth for a very long time. I started my training as a medical student at the Royal Women's Hospital in Melbourne. It was such a terrible experience that the one thing I was certain about when I eventually graduated was that I would have nothing to do with childbirth. It was a very shocking experience for a young person.

CHAIR—Was that in the time of Professor Townsend?

Prof. King—It was.

CHAIR—But we do not attribute all your negative experiences to him?

Prof. King—That is correct. Anyway, I went into general practice and was associated with childbirth which made me realise how little I knew about it. I subsequently decided to train in obstetrics and gynaecology, which I did in England and Ireland. I practised in Ireland for several years and then I did further subspecialty training in Canada where I practised as an obstetrician largely. When I say ‘largely’, I mean that my main focus was obstetrics and maternal complications of pregnancy rather than gynaecology.

Then in 1984, in a sabbatical, I entered the world of inquiry in epidemiology and I spent some time in Oxford. I had always had a haunting suspicion that many of the interventions, tests and treatments that we applied in pregnancy and childbirth were unevaluated. I was raised in the paradigm of anatomy, physiology, biochemistry and pathology, not in the paradigm of probabilistic assessment and assessing risks and benefits, and so on. I subsequently did some postgraduate training in epidemiology and I now practice exclusively in the domain of perinatal research and epidemiology, though still with a major interest in childbirth and human reproduction in general.

The unit in which I work conducts the affairs of the state council but it also is involved in perinatal research activities—clinical research. Although the unit is actually based and partly funded by the Mater Hospital, I do not speak on behalf of the Mater Hospital nor am I involved in clinical service provision at the Mater Hospital.

I welcome the Senate inquiry into childbirth procedures because, being a keen observer of what has been happening with childbirth over the last 30 years, I know that practices can change without good evidence to support them. I suppose in a generation we have had a total revolution in the way in which childbirth provision is provided. In our grandmothers’ day—or certainly in mine—almost all births were at home, and now 99 per cent of births are in hospital in Australia. That in itself has been a massive change that has not been the subject necessarily of very satisfactory or systematic inquiry.

But within institutional childbirth itself, I have seen a change from operative intervention rates of two and three per cent up to 40 per cent. So there has been a massive change in childbirth procedures and the way in which they are delivered. As I refer to in my submission, the missing ingredient in many aspects of the childbirth discussion is good evidence. I am paraphrasing Sydney Sax when I say that childbirth is a contested terrain. There are many interested agencies in childbirth and those interests themselves vary. Just to name a few that I am sure you are well aware of: there are the territorial issues between general practitioners and obstetricians on the one hand and midwives on the other; there are the tensions between hospital and home, or hospital and community.

An area that I have been particularly interested in is the Australian mix of public and private in which the environments for childbirth care are quite different; the biology is the same. We see—and this, of course, has been referred to in the preamble to the inquiry—enormous variations in childbirth interventions from public and private hospitals without any systematic approach to whether those interventions are associated with more safety or more

satisfaction. There are all kinds of assumptions and presumptions about that, but precious little evidence.

Thank you for that opportunity, Senator. I conclude by saying that any intervention or change in practice, which is in itself a kind of intervention, that is recommended by this inquiry one would hope would carry with it an opportunity of adequate evaluation of that change.

CHAIR—Thank you, Professor King. When did the Obstetric and Paediatric Morbidity and Mortality Unit here get started?

Prof. King—It started as a proper entity in 1995. We have produced a triennial report, and we are just about to produce an annual report for the year of 1997. They are in the public domain.

CHAIR—Who was harder to persuade: the Minister for Health or the hospital?

Prof. King—It was actually one of those windows of opportunity—to use a phrase of jargon. The Minister for Health had a statutory obligation to have such a council, yet it had fallen into disarray related to—surprise, surprise!—restructuring. There were some funds to develop that council, and at the same time the hospital was interested in supporting perinatal research endeavours. So there was a partnership agreement between Queensland Health and the hospital to set up this agency.

CHAIR—How is the funding—is it fifty-fifty?

Prof. King—Approximately.

CHAIR—So that is fifty-fifty from the state government and the Mater Hospital?

Prof. King—Yes.

CHAIR—How long was that committee defunct in this state?

Prof. King—It was first established in 1987 but only operated in quite a superficial way until 1991 when—related to a change of government—it fell into a hole.

CHAIR—You are actually doing the research. Is there another unit that actually records the perinatal statistics in this state?

Prof. King—We are an interpretative service for routinely collected data and we also conduct confidential inquiries into individual cases in the circumstance of maternal mortality or into groups of outcomes as in the case of perinatal and paediatric. We review every death of every infant. There are about 550 perinatal deaths a year and there are usually eight or nine maternal deaths a year. We have a systematic confidential inquiry into each of those.

CHAIR—Do you have data about every hospital and every practitioner?

Prof. King—We do not.

CHAIR—Do you have data about every hospital?

Prof. King—We do not. We are provided by the routine agencies—

CHAIR—Excuse me, Professor King: could I just say that this has to be an audience that does not mind little noises. So anyone with a little noisemaker should feel untroubled or should make your own assessment at what level of little noisemaker you feel that you need to move back. But we would hate an inquiry into childbirth practices to make children feel unwelcome. I will leave it to good parental judgment about when you step to the back. I am sorry, Professor King, this means that you may have to speak over little squawks.

Prof. King—Your question is an important one. Do we like New South Wales report outcomes and childbirth procedures by hospital? The answer is no. There has not been a culture or a tradition of hospitals producing reports even in Queensland and there is virtually no data available on a routine basis from private hospitals. Public hospitals produce annual statistics but usually do not publish them. They contain a minimum data set of rates of caesarean section and operative deliveries as well as mortality but no morbidity outcomes.

CHAIR—If information came to your attention, and please tell me by what route, that a mother and baby had died in a private hospital at the occasion of childbirth, how would you know about it and what could you do then, particularly if this is a private hospital that is not publishing that data?

Prof. King—All maternal and perinatal deaths, regardless of whether they are at public or private hospitals, are routinely notified to the council. In the case of a maternal mortality at a private hospital, we would have the same approach to that because the council is authorised under the specific legislation to conduct such inquiries, and the information that is received by the council carries with it protection and immunity from subpoena.

CHAIR—By what process are you routinely advised?

Prof. King—That is a very interesting question, too. We are routinely advised by the government statistician's office—I am now speaking about maternal mortality—and the government statistician in turn is advised by the Australian Bureau of Statistics, which receives all mortality certificates, when a coder identifies that there is a term on the death certificate that triggers a pregnancy code. Then, the chain of events resulting in a notification for us happens.

CHAIR—How long is that process?

Prof. King—In the case of coronial inquiries it can be up to a couple of years. There is a case still sub judice from 1997 that we know about, but the coroner's inquest has not been held.

CHAIR—Routine notification carries with it, in my head, something a little shorter as to time lines than what you are saying. If somebody dies in Queensland and their general

practitioner has been looking after them for a while, and they fell off a ladder after a heart attack and it all seems quite comfortable—oh, no, that is accidental. Let us say somebody dies in bed from a heart attack; I presume the GP who knows this person signs the certificate and it goes to the Queensland births, deaths and marriages?

Prof. King—I am sorry; you are saying this is a woman who is pregnant?

CHAIR—No, this a man who fell off a ladder—no, he did not fall off a ladder, because that might be coronial. I am just trying to say that it seems to me there are two kinds of deaths reported. One is when somebody is comfortable to say, ‘There is nothing untoward here. It is an ordinary death certificate because this person was elderly, or I have been treating them for blood pressure.’ Then there are those that are not like that; they are to the coroner. But, are both of those different sorts of deaths reported to the Queensland births, deaths and marriages?

Prof. King—Yes.

CHAIR—Then that is reported to a statistician, who reports it to the ABS, which has a number that says it has got to do with maternal mortality and they contact you?

Prof. King—That is one mechanism.

CHAIR—Thanks, Dr King, perhaps you had better bring me up to speed on something else.

Prof. King—In the four-year period from 1994 to 1997, the council conducted a survey of all obstetricians in the state to try to find out about routine ascertainment. We knew that there were gaps in routine ascertainment, but we uncovered an extra one-third, 33 per cent, of maternal mortality cases. I am here to say that I suspect that that underascertainment is not confined to Queensland. That process has not been done in other states. It is being considered by the new Maternal Mortality Committee, but there is real concern about underascertainment of maternal mortality.

CHAIR—Can you tell us briefly why there is underascertainment of maternal mortality?

Prof. King—Some of the underascertainment relates to it never appearing on the death certificate.

CHAIR—What is never appearing?

Prof. King—The fact that the woman was recently pregnant.

CHAIR—Is that a requirement on your death certificates?

Prof. King—It is not. It is not a requirement on any death certificate in Australia, except in Tasmania. Come the republic, perhaps we will have uniform documentation of important life events like death, but we do not currently.

CHAIR—We were given information about this most interestingly yesterday. Senator Gibbs was asking a lot of questions about this information for New South Wales, raising the same concern: that a mother may die in association with pregnancy and childbirth but that it may not be recorded because there is no requirement to do so.

Prof. King—There are a few areas where this occurs. One is if a death occurs in early pregnancy related to, say, exsanguination from ectopic pregnancy. The woman may not die in the institution where the ectopic was diagnosed; she may be transferred. That is likely to result in underascertainment. If terminology that is used on the death certificate is obscure that can sometimes result in underascertainment. I am here to assure you that we are also having discussions with the government statistician's office and the mortality section of the ABS within the next few weeks to see if we can address these underascertainment issues.

CHAIR—I want to move away from that, if that is all right. There may be some questions we need to follow up in this area. I still find it quite bizarre that we do not have a national births, deaths and marriages register in this country. I am not sure that that is strictly to our terms of reference, although it has more than passing relevance to your unit. I want to turn now to some of your important points. On page 2 there are some figures stated that the caesarean section rate in South Africa for privately insured patients is 70 per cent. It also says:

A recent debate in the British Medical Journal (1999) indicated that a sizeable proportion of British obstetricians supported elective C/S at term for maternal request in the absence of any other indications.

Some things I have been learning on this inquiry take my breath away, and that certainly takes it away. There is a lot of evidence that the same is happening in this country. Could you discuss what you think is the conflict between best practice—that is, that maybe the medical profession or the midwives profession would draw up criteria that tell you what is best practice at the time of delivery—and a woman saying, 'No matter any of that, I want a caesarean section,' and the practitioner doing it? It seems to me to be a significant conflict of preferment.

Prof. King—Please get me back on the track if I diverge, but I think that the survey of London based female obstetricians and their partners has been overinterpreted. I would not like to think that London based female obstetricians would represent the general feelings of women in London or Britain, and the particular pressures on London based obstetricians to have their babies at a particular time might have been an unstated ingredient within this. But an important point stressed in this paper is that the main reason these obstetricians preferred to have an elective caesarean section at term was related to their concern about subsequent sexual function and, in particular, subsequent incontinence.

To return to your question of what is the evidence base to support that concern, that evidence base is quite flimsy. In the hierarchy of evidence, the evidence to support that childbirth itself is a high risk for sexual dysfunction or for urinary or bowel incontinence is gleaned in the least reliable way. There is no doubt that urogynaecologists and pelvic-floor surgeons see women who have had trauma from childbirth, but it is a mistake to extrapolate that to say—and I have heard this said in this very room—that childbirth is a high risk

process for women in the 1990s and that the vaginal bypass operation—the caesarean section—should be strongly recommended.

CHAIR—We should stop there because that is a really punchy line, Professor King. I think the term ‘vaginal bypass’ might have to enter the lexicon at this point. I know that I am rushing ahead and I appreciate that we do not have terribly much time—we started a bit late—but I do want to give my colleagues the opportunity to ask questions. I take it that what you are saying is your concern is that there is not a tough, rigorous examination of the evidence to suggest that, in large numbers of people, childbirth does lead to incontinence or sexual dysfunction?

Prof. King—Right. But I want to also stress that I think that is being taken up by obstetricians who find themselves, it seems, in a position where they are being criticised for performing more and more caesarean sections, the motives for which might be quite different: that here is an opportunity to quote a justification that would be very important to women, one that could justify increasing rates of caesarean section. My feeling is that the more subtle ingredients in the outcome, like a woman’s reaction to surgery and all that goes with the unnatural environment of a caesarean section, have been underconsidered. Over the years, I have developed a very powerful respect and regard for normal childbirth. I think that it is a casualty in these discussions.

CHAIR—Thank you, Professor King. We will not get into the philosophical of what is natural, but there has been a fair amount of evidence over time that vaginal childbirth works.

Senator GIBBS—Over many centuries, actually. I was quite interested in what you were saying about women being told that childbirth is a high risk to women in the 1990s. From evidence given to this inquiry, it seems to me that we have this culture of different ideas. When I was a young mother and ready to give birth, I was told that this is what a woman’s body is actually for and it is quite a normal thing and, of course, one did not have a caesarean unless there was a life threatening reason, unless it was really bad. How do you think this culture has evolved from this is the normal way of life and if things happen the doctors are always there to this is a high risk? What is wrong with us as Western women? Are we any different from other people in the world?

Prof. King—Well that is going to tap my resources beyond their limit, I would think. But I agree with you that in the societal change there has been a massive diversion from childbirth as being a natural life event to, within the nuclear family, childbirth being a huge hurdle that might have to be leapt, or at least a major challenge. Most women work, and scheduling a child within one’s employment responsibilities is sometimes awkward, and that can change the nature of the expectations. Most women have never seen a newborn baby by the time they have their own and there are a huge number of cultural changes in the last generation that have resulted in, I would say, women’s expectations of birth being different. The concept of painless childbirth is now often an expectation and there are varying appetites for outcomes, if I could use that expression.

I ran a workshop at the Royal Australian College of Obstetricians and Gynaecologists in Adelaide earlier this year, at which we had a hands-up of the obstetricians who would accede to a woman’s request for an elective caesarean section at term without any indications. The

majority of obstetricians—including, I would say, the vast majority of younger obstetricians—agreed. So there is a change in the point of view of the care receiver and there is also a change in the point of view of the care provider, but both of them might be misinformed in this.

Senator GIBBS—We have heard a lot about women demanding caesarean section. They are quite healthy women and there is nothing wrong with the child; they simply do not want to have the pain. Do you believe women should be actually given all of the details of a caesarean section, being told, ‘If you have this, you are going to be laid up and be in excruciating pain for probably six weeks and all sorts of things will happen’?

They could be told, ‘It is not going to affect your sexual life, just as a normal birth does not affect your sexual life.’ After all, how can it? If a vaginal birth actually affected your sexual life, I am sure none of us would be here because the world would stop. Do you believe that, if women were actually given all of the details and all of the information, they would still opt for the caesarean birth?

Prof. King—I am confident that there would be some. You say ‘giving all the information’, but all the information is not available. We cannot confidently say to an individual woman, ‘Large groups of women have taken the decision that you are embarking on. When compared to large groups of women who have taken an alternative option and planned for vaginal delivery’—say, this is in the instance of elective caesarean section—‘those women who have chosen the option of elective caesarean section have these outcomes compared to the others.’ That is the kind of information that I think women might be helped by to make the decision.

It seems to me we are getting hung up on elective caesarean section as a viable option to childbirth, when I would have thought the evidence should speak quite firmly already that women who choose to have an elective caesarean section without a medical indication should be advised that they are taking considerable risk, compared to the option of vaginal delivery. That includes balancing up sexual dysfunction and pelvic floor prolapse, which have been blown out of all proportion by the pelvic floor enthusiasts at the expense of the normalcy, the joy and the experience of normal childbirth. They, as I say, have been devalued in this.

Senator GIBBS—Obviously. Thank you for that. We have heard a lot about antenatal screening and ultrasound. Half of the entire health budget goes on ultrasound screening. The other half goes on all the other screenings and tests. This is an extraordinarily high percentage. A lot of obstetricians have said to us that GPs are actually ordering the screening and that, when some women go for their first visit to the obstetrician, they have already had two ultrasounds just because they want to see what the baby looks like.

We have heard that ultrasound is not necessary, it can be harmful and that too many ultrasounds are done. We have heard that at a certain time, yes, you must have the ultrasound but that people who are working with this equipment are not totally qualified—a lot of them buy this very expensive instrument and do it to just about everybody who walks in the door. What is your feeling on this? Is there a danger in ultrasound?

Prof. King—I do not think there are any biophysical risks. But ultrasound is an interesting example of fee-for-service remuneration gone mad. I chaired an NHMRC committee looking at services provided by midwives in Australia and we recommended against ultrasound being a test that could be ordered by midwives, except in exceptional circumstances, and I specifically refer to outback environments. We wanted to try to expand the role of the midwife but, at the same time, only into areas where there was evidence, and we have not got good evidence that routine ultrasound examination improves the outcome of pregnancy.

Indeed, in our mortality analyses, 20 per cent of perinatal deaths that are occurring right now in Queensland—and it is not too different in other parts of Australia—are related to lethal anomalies. Despite this epidemic of ultrasound examinations, which are supposed to give reassurance, at least one in five perinatal deaths are associated with lethal anomalies, many—if not most of which—are diagnosable by ultrasound.

Ultrasound is great fun. It is a terrific experience for a woman, particularly in her first pregnancy, and her partner to see the heart beating, but it is Hollywood stuff and it is tremendously costly. I have heard it said that all the medical costs for antenatal care are outweighed by the radiology costs for ultrasound.

Senator GIBBS—That is right.

CHAIR—We have been told that the cost of antenatal care, birth and postnatal care come to about \$45 million to \$50 million. The cost of ultrasound is about \$50 million to \$60 million. The cost of ultrasound is equal to the cost of all other costs associated with childbirth.

Senator GIBBS—That cost has to be excessive.

Prof. King—That is a massive misplacement of funds, isn't it?

Senator GIBBS—Absolutely.

Prof. King—If I could just make another point. I personally feel that fee-for-service remuneration is not a good model for practice of any description. I cannot see that that should not apply to midwives as well. I am a staunch supporter of expanding the role of the midwife as an accepted model of comprehensive primary care for child-bearing women.

But I would fear—and there is evidence to back this fear up, particularly from New Zealand—that, if this were given a fee-for-service remuneration—a Medicare thing—we would see the same kinds of problems with midwifery fee-for-service. It would not be exactly the same because midwives do not wield knives, but they will be just as open to commercial pressures for testing, laboratories, induction at the weekends and so on. I cannot see any reason why that would be a better model for midwifery than it is for current obstetrics, of which I have been a critic.

CHAIR—We are out of time—we started a bit late—so can I ask that our questions and answers be shorter.

Senator TCHEN—I am sorry for my late arrival. Can I ask one question about something which was covered in your submission. When you were referring to early discharge programs, you commented that the risk and benefits of many aspects of early discharge programs still required elucidation. Would you elucidate on that? Firstly, what do you consider to be early discharge in your practice?

Prof. King—I am referring to the massive recent change in arrangements for women in Australia whereby postnatal stays have been reduced from an average of four or five down to one or two. That has been driven by economic rationalism rather than by medical indications.

In general, I would think that women would be better out of hospital than within it, unless they had an illness or a disease, but I am not at all confident that the support that women need following childbirth has been translated from the hospital environment to the community environment. I know there are some examples of where that has been evaluated, but it has been a massive experiment without any controls.

Senator TCHEN—We have had quite a few people coming to us to give evidence and saying that there is a proposal that postnatal care should be extended and included as part of birth procedures. Actually perhaps it is the other way around—there is a concern that the birth event is regarded as a discreet event and that, after the child is born, that is it—it is out of the medical system, whereas the birth itself is regarded as a medical event. Apart from the merits of whether it should be regarded as a medical event, is it your view that we should extend the period of coverage as well?

Prof. King—Absolutely.

Senator TCHEN—What about the funding aspects? How do we fund the extended care? Can you give us some of your views on that?

Prof. King—One can only imagine that the shorter stays in hospital are related to cost savings. Where are those cost savings now being spent? Just to give a knee-jerk example: I would think if the funds that were being spent on unnecessary ultrasounds were used to support community midwifery that would be a very rational transfer of funding.

Senator TCHEN—Antenatal to postnatal?

Prof. King—Yes.

Senator GIBBS—I agree.

CHAIR—The trouble is of course that the funding for ultrasound is not readily available to you—it is locked up in the different rebatable system.

Prof. King—The Australian health care system is a myriad of intricacies which are designed to confound the most patient.

CHAIR—It is just as well that you did medical practice, but it is a terrible pity that you are not writing more. I think most of us are storing away some very good lines of yours, Professor King. We do appreciate a very dry sense of humour.

You say in an article in the *British Journal of Obstetrics and Gynaecology* April 1993:

Almost no private obstetric hospitals in Australia produce annual clinical reports and most mixed hospitals produce information in which public and private data are combined.

We saw yesterday a report from New South Wales that I think listed every hospital; that is, as much as we can tell from it. Have you seen this report?

Prof. King—Yes, I have.

CHAIR—Is this a change from when you wrote this?

Prof. King—Yes. New South Wales has been producing data by hospitals since 1996.

CHAIR—Does South Australia?

Prof. King—No.

CHAIR—So, not by hospital yet. This line is one of the things that we are dealing with: if we are looking at practice, the best that we can go on is Dr Lancaster's AIHW stuff that gives you the bald overall figures, but it is extremely difficult to then target that down to hospitals.

There have been some suggestions that it would be very good if there were a national register of all hospitals, public and private, that said what was the caesarean rate for public patients and what was the caesarean rate for private patients. This might be very useful information for people. We understand that there are all sorts of reasons as to why that information is not on the public record, including privacy and state laws. We are pursuing this for the absolute truth of the claim.

Prof. King—You would think that the onus should be on the institution to publish information rather than to withhold it.

Senator GIBBS—Of course.

CHAIR—That is a very interesting way to end the sentence, Professor King. I could have said 'on the government', but never mind. I thought you might have said that the onus is on the hospital to publish it, rather than the onus on the government to get it published. So I think that the notion of the onus being interestingly on them to withhold it is a curious comment indeed. I will just ask this last question. We have been told by Dr Mackay that in some places, like my own state of South Australia—and certainly in Tasmania in times past—that caesarean section rates—

Prof. King—Professor Correy.

CHAIR—I am sorry. I did not get that name right. Was it Professor Corrie?

Prof. King—Yes.

CHAIR—In times past or times present, it depends very much on the person in charge in an area. In a hospital a climate can be changed by a person who arrives in the hospital or has leadership in the hospital and says, ‘I am determined to see the caesarean section rate reduced. I want us to have meetings each week or each day on why we are doing the caesarean. You must come and justify it. We have got a climate that says every woman who comes in here is smilingly assisted to a vaginal birth, unless under particular circumstances. If anyone moves away from a normal vaginal birth, please come and tell the rest of us what were the circumstances that encouraged you to move away from it.’

Where you have had such a person, you can drive the caesarean section rate down. When such a person leaves the scene, the caesarean section rate has gone up. This seems to me shockingly away from best practice guidelines. I am just interested in your comment on whether we should be looking for the person or the process, or both?

Prof. King—I would have thought neither. What we are looking for is the evidence. Just to be brief, in 1968 in my training in Dublin I had to defend every caesarean section against a panel like this. ‘How come? Why didn’t you? Did you consider?’ and so on, because caesarean section was thought to be a massive invasion into the architecture of a mother. That has long gone by the board.

I would not like to see opinion leaders leading or dictating practice, either for or against caesarean section in our current climate, because choice is a very important ingredient in this mix. But what I would plead for is a continuing appraisal of the impact of what we do on the women in our care to see how we can measure those important aspects of safety and satisfaction. You cannot measure those by a survey on the day that the woman is going home. We do require longitudinal surveys of the reactions to childbirth in the populations that we are serving with the ingredients in the mix.

CHAIR—There is a longitudinal study on women’s health. It is very modest in terms of the amount of dollars associated with it, but would it be an interesting proposal that you would submit to them to include in their research portfolio?

Prof. King—Yes, I have sometimes thought of that and not for long enough. Lorraine Dennerstein is in charge of that.

CHAIR—I am not sure. All I know is that I had a hand in getting it started. So I would be very interested to see it progressing this way. Can I put to you a comment we have been putting to others. For some 2,000 years, women’s opinion has mattered for little, and it seems that suddenly they are able to ask for a caesarean section, and the mighty medical profession bows down and says, ‘Yes, of course.’ If, on the other hand, these women ask for no intervention, they are regarded as slightly odd. That is the kindest way I could put it. What is the difference of women’s power in these two situations?

Prof. King—And, of course, if you ask for an intervention and the person you ask it from is paid more to provide that intervention, it is not surprising that that intervention would be readily acceded to. If, on the other hand, the approach entails observation, patience, waiting, support and so on that does not carry with it a fee item, that would be necessarily less appealing to the person to whom the approach was made.

CHAIR—There is a lot of evidence that medical practice and health care are directed, not so much by best practice, but how the funding arrives.

Prof. King—Sure.

CHAIR—I take that point. I think your article makes that point very well. I think we could cheerfully spend a couple more hours taking evidence, discussing things and hearing your opinion. What you have essentially said to us is that there is a unit and you are doing some good stuff, but really you urge the committee to take account of the fact that a lot of what you do in obstetric practice, childbirth, antenatal care and postnatal care are large untested human experiments, which is what it was called yesterday.

Prof. King—Uncontrolled.

CHAIR—Large uncontrolled human experiments, which makes me think of Hitler. We have also had Paul Lancaster talking the same kind of language, that these are not rigorously tested, even with the different level of proof that epidemiology allows. We take the point that you are suggesting that it would be a good idea to have some evidence on which to make further decisions.

Prof. King—And that the outcomes of importance are not just medical, but that we seek the advice of those who are actually giving birth to draw up a list of important outcomes that we could assess in the analysis of the risks and benefits of the procedures.

CHAIR—If she says, ‘I want a caesarean section,’ to what extent can we say no?

Prof. King—I would think you could say no, but that is a plea for information. It would be foolish to just accede to that in a knee-jerk way. However, I believe there are some circumstances where, for whatever reason a woman might have such a strong conviction or such a phobia about natural labour and birth, that a caesarean section might well be a very preferable alternative for her. But that is very much the exception and this notion that women are all requesting elective caesarean section at term would require very careful analysis.

CHAIR—Thank you very much.

[10.04 a.m.]

BUCKLEY, Dr Sarah (Private capacity)

CHAIR—Welcome. Do you have anything to add to the capacity in which you are appearing?

Dr Buckley—I am appearing as a GP with training and experience in GP obstetrics—I did my training in New Zealand in 1985—as a breastfeeding mother who has experienced three homebirths in Australia; as a researcher and writer on pregnancy and birth issues; and as a community activist for improved birth services.

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 would give consideration to your request. The committee has before it your submission No. 110. Do you wish to make any alterations?

Dr Buckley—Yes, I have some additions to my evidence, some articles and some additional references that I omitted in my evidence.

CHAIR—Thank you. Would you like to make a brief opening statement and then we will have questions.

Dr Buckley—In my submission my intent is to look at the interventions in childbirth in the widest sense and ask what the possible adverse effects are, both immediate and long term, and looking at the evidence to support the effectiveness in terms of outcome. It is very heartening to see that the latter part has been well covered in the *Hansard* of the Melbourne hearing that I read, and from Dr King today.

I have also covered some areas that are currently on the scientific fringe, if you like, some of the evidence about what the possible long-term implications are of drugs used in labour. I touched in my submission also upon what is called behavioural teratology, which is a fairly new study of what happens at the brain level with insults from drugs and interventions used during birth. I am submitting another article along those lines.

With my extra submission is a background article on the hormonal physiology of labour. It is an article I wrote for *Australia's Parents*. It seems to me that one of the things that is happening in the childbirth area is that the hormonal physiology of natural birth is being interfered with on so many levels. This creates a lot of difficulty for women in giving birth. It also makes birth into an unpleasant experience. I am looking at the hormonal physiology of birth, for example, the major hormones of oxytocin and endorphin are both hormones of pleasure. In the birth process those hormones reach peak levels around the time the baby is born. You could say it is nature's reward system for birth. It is what makes us want to have more babies. In the use of drugs and the interventions those hormonal systems are interfered with to such an extent that it is difficult for women to have babies for a start, and when it happens it is not a good experience.

If I compare my experience of having my babies at home to what I observed of having a baby in hospital, I would say that perhaps some of the pressure on the caesarean section rate is because women do not want to go through the birth experience. It is not a good experience. I have heard Sheila Kitzinger talk about birth as rape. We are talking about a woman's most vulnerable sexual parts of her body being manipulated, being prodded and being poked in an environment that may not feel safe. Certainly I would not feel safe there having a baby in hospital.

In terms of the caesarean sections that we have been talking about, there is a lot of fear in our culture around giving birth, and I think that fear is justified. I think giving birth through standard birthing practices is not a good experience for the mother, the baby or long-term outcomes. Personally, I would feel fearful of having a baby in hospital, but I can discriminate my fear because I can say I am fearful of medicalised childbirth, but I am not fearful of birth.

I think generally that women in our culture are fearful of a whole package deal, and that is why they turn up asking for caesarean sections. In terms of what Dr King was talking about the long-term impact of vaginal birth, vaginal birth for me has increased my sexual capacities. I think that is the physiology of it and I think that is what it is intended to do. Do you want that in *Hansard*?

CHAIR—I think that is fantastic to have that on the public record for the rest of history to understand.

Dr Buckley—I will not tell you any more details.

CHAIR—We could now get into a wonderful digression about whether we are talking about sex, as in how to do it, or sex, as in how to enjoy doing it, but we will not be distracted.

Dr Buckley—I will say no more.

CHAIR—Before we ask questions, are there any more great lines like that that you would like to put to us?

Dr Buckley—Yes, I have another good line. This is from Germaine Greer's talk to the Home Birth Conference over the weekend about ultrasound. She said, 'We don't believe anything is real these days unless we see it on television.' In the ultrasound scan the baby is on the television.

CHAIR—Touche, to say nothing of East Timor. Have you finished your contribution?

Dr Buckley—In the additional evidence that I have got there, I have a paper from Karen Guilliland—and I do not know if you have this paper—which describes the process that New Zealand has gone through with the changes in the midwifery system and statistics.

CHAIR—That is very helpful. Thank you very much. We certainly know and have had a number of references to the significant changes there. The committee is trying to find out ways in which it could travel to New Zealand, Holland and the UK to check out the system.

Senator GIBBS—We are working on it really hard.

CHAIR—But we are not entitled, rest assured. But, I do think if it were possible and if we had the time, it could be a fantastic thing to go and look as well as to read about. Thank you very much for that.

Senator GIBBS—In your submission you talk about models of care. Can you elaborate on this? The models of care that we have actually seen in some hospitals are that there has been the birthing centre—not detached although there was one detached standing alone—in the hospital where the midwives are, and then they take you through the process. Is this sort of model of care that you are looking at?

Dr Buckley—I think the model of care that would be my personal preference would be the New Zealand model of care. I think there is a difficulty with birth centres in that they tend to be placed in hospitals and they have to follow hospital policy to some extent. I did some research for an article I wrote in 1996 in the *Age*, and one of the birth centres in Melbourne had a 60 per cent transfer rate for primiparous women. I think a birth centre model of care has some benefits to it.

The ideal model of care is continuity of care. That is one of the reasons why I chose homebirth, because I knew that I would have continuity of care from my midwife from the beginning of my pregnancy, right through to after my baby was born, and that is what I like about the New Zealand model of care. You can have your midwife or whether you go hospital, whether you have your baby at home. The midwife can be with you through the whole procedure, and the relationship that is built up is a really important part. It decreases interventions and builds up a relationship between a midwife and the woman.

Senator GIBBS—Where did you find your midwife? Is she independent?

Dr Buckley—Yes, an independent midwife. Yes, I was fortunate to have the same midwife with all three of my children.

Senator GIBBS—And where did you find the midwife?

Dr Buckley—At the birth of another friend.

Senator GIBBS—Really? So if I go to the Brisbane telephone book and look under midwives, can I find midwives there?

Dr Buckley—This was in Melbourne. No. You are right. The information is difficult to get. I have been involved in birth groups that have tried to get that information out, and one of them we got a 0055 number under homebirth listing. You might find that in the pregnancy services in the *Yellow Pages* some of the midwives are listed there. Really, because the independent midwives are generally working at home all over Australia, not

many independent midwives have hospital privileges. You need to go through the homebirth channels, but you need to know about that option as well, which is all in the private system. It is all paid for by the client.

Senator GIBBS—How many children do you have?

Dr Buckley—Three.

Senator GIBBS—Did you have any of your children here in Queensland?

Dr Buckley—No, not in Brisbane. I had them in Melbourne.

Senator GIBBS—Thank you. I notice here you say:

Personally I think that best practice would involve a voluntary restriction on the use of ultrasound.

We have heard a lot about the overuse of ultrasound and the enormous chunk of the health budget which goes on ultrasound. A lot of the professional people are actually saying, 'Yes, it is overused. It is misused.' Why voluntary? Why do you say voluntary?

Dr Buckley—I think I will retract that statement. Why did I say voluntary?

CHAIR—Voluntary by whom?

Dr Buckley—I also say later on in that sentence that that has been tried. There was a committee that was convened with the GPs, the obstetricians, the radiologists and the AMA as well, and they did not reach an agreement about any restrictions on ultrasounds.

Senator GIBBS—But, if we had a national code of best practice, how do you feel about the ultrasound then? How do you actually feel about the ultrasound? I take you are a medical doctor, as opposed to a career one.

Dr Buckley—Yes.

Senator GIBBS—As Dr Crowley would say, a real doctor.

CHAIR—I know. I say PhD is a real doctor. I have copped abuse all my life for being just a fake doctor.

Senator GIBBS—How do you feel about the ultrasound? Do you think it is overused?

Dr Buckley—With my submission there was an attachment of an article I wrote on ultrasound. Did you see that attachment?

Senator GIBBS—No, I did not.

Dr Buckley—There is an article I wrote for *Australia's Parents* which has statistics which I got from the Health Insurance Commission stating that the cost of ultrasound was

\$39 million for 1997-98. The cost of all other obstetric items, which I added up myself—Medicare items, not hospital care—was \$54 million.

Senator GIBBS—We have had that figure from somebody else. We also had a professor—I cannot remember her name—who she said that the cost of the ultrasound in one year was between \$50 million and \$60 million. That is an awful lot of money that could go somewhere else in the health system.

Dr Buckley—My problem is the use of routine ultrasound. Ultrasound is a good technology, it has its place. It has taken over a lot where X-ray would have been used in the past, but 99 per cent of women in one survey in Australia had an ultrasound. That is my problem. As Dr King said, there is no evidence that they improve outcomes for mothers or babies. In the article that is attached, I also said that there may be risks. There have been physical changes observed in tissues that have been exposed to diagnostic levels of ultrasound. Some studies have suggested, not conclusively, that there may be long-term impacts from ultrasounds.

Senator GIBBS—That is very interesting. There is another question I really want to ask you because I have an interest in this area. You talk about analgesic drugs, including epidurals, and you talk about nitrous oxide gas and then you make the statement:

A further worrying aspect of Nitrous oxide use is its possible link to the long-term risk of drug addiction. In a study using birth records in Stockholm, Jacobsen et al (1990) found that, controlling for other variables known to increase risk, children whose mothers had used nitrous oxide for more than one hour had an 20% increased risk of addiction compared to their unexposed siblings. The risk rose to 70% when use was for longer than 4 hours. The drugs of addiction in these cases were both amphetamines and opiates.

How reliable is that study?

Dr Buckley—It seems methodologically sound. He has compared probans, drug addicts with their siblings. He has controlled for a lot of variables, for example, by socioeconomic status. I think that that is one study that has shown that. It certainly needs to be investigated more. Physiologically, from other readings I have done, it seems quite plausible to me. He talks about an imprinting hypothesis, that what may be happening, in an ethnological sense—in the sense that ducks are imprinted when they are born with the first person they see—is that that is a time of vulnerability to the imprinting process, around the time of birth. So he talks about it in terms of that.

I have also read articles on animal experiments where barbiturates and valium have been given to pregnant mothers, rats, and where the offspring have had physiological abnormalities in hormonal systems based on those drugs that were given. It seems to me that that is another possible explanation for these findings. Nitrous oxide does actually have a dual pathway in the brain. I cannot remember the pathway receptors, but one of the pathways is opiates and the other pathway is another hormonal system that amphetamines are related to.

Senator GIBBS—In the 1960s when I gave birth this was quite common. You just hung onto that gas mask like you would not believe.

Dr Buckley—On that, I have also put figures in there. I think it is still around 70 per cent of women who still use gas, maybe for a short time.

Senator GIBBS—I tell you, it was wonderful, the old giggle gas. I just about killed a nun when she tried to take it away from me.

Dr Buckley—I guess the point I am trying to make is that there is a possible risk from all interventions.

Senator GIBBS—This is a very worrying thing to me. For those mothers who were given amphetamines, does this mean that they are responsible for the children—

Dr Buckley—The increased risk in that situation is not that great, it is not even doubling the risk, even at three hours, and that is a long time to use nitrous oxide gas.

Senator GIBBS—That is true.

Dr Buckley—The point of those figures is not to make people feel guilty, but rather to say that this is a possible implication of this model of care that we are using. There are other models of care where the rate of analgesic use is very low.

CHAIR—Do we need doctors to be cautious about the difference between correlation and cause?

Dr Buckley—That is true. In the paper, it is not stating a cause but I think it points to the need for further investigation in this area.

CHAIR—I think that is a reasonable point.

Senator TCHEN—Dr Buckley, in your submission you make some criticism of what appears to be the universal use of ultrasound in antenatal care. You say that:

There are many better and cost-effective uses for such a large budget, such as midwifery models of care and home births.

However, I notice in your submission you actually did not address one of the issues in our terms of reference, that is the postnatal care and early discharge programs. I suppose your experience of homebirths was the ultimate early discharge.

Dr Buckley—Yes.

Senator TCHEN—I asked Dr King earlier about looking at the childbirth procedure extending right across from antenatal to postnatal care. I wonder whether you would like to make some comment on that. Talking about midwifery models, as far as I understand, most midwifery models do not put any emphasis on the postnatal care aspects either. The main argument has been on the actual delivery.

Dr Buckley—The midwifery model of care that I use of homebirth does include postnatal visits. The New Zealand midwifery model of care does also include postnatal visits. I am not sure how long they go, but for me it was 10 days after the birth of my children. In New Zealand I am not sure—one to two weeks would be my guess. I think that is the ideal, to have that continuity after the birth as well as during pregnancy and labour.

Senator TCHEN—How important is it? That is the point I am driving at. In your paper you actually stop there too.

Dr Buckley—Yes, I did not have how important it is. I think it is very important in terms of establishing breastfeeding. I am a very strong advocate for breastfeeding. The problem that I see with some of the early discharge programs is that women are discharged before their breastfeeding is established. With the midwifery models of care that I have experienced, having the same carer advise me and not getting conflicting advice from different people, especially with my first baby, was very important. I think that the midwifery model of care that has continuity after the birth is a good model for establishing breastfeeding, and also for supporting their mother postnatally.

If you look at those figures that I gave from Dr Peter Lucas, who is my colleague in Melbourne, he said that the breastfeeding rate in those figures was 99 per cent at six weeks. He is a doctor but also works with midwives who provide that continuity at home.

Senator TCHEN—How did you fund it?

Dr Buckley—I paid for it personally out of my pocket. I think with my first baby I had private health insurance and there was a certain amount of money that was refunded by that particular health insurance company, but with the other two I did not and I paid for it myself.

Senator TCHEN—Can you give us some idea of the cost level, compared with antenatal?

Dr Buckley—Current costs are \$1,500 to \$2,000 for the whole package deal for a midwife—pregnancy, birth and postnatal care.

Senator TCHEN—What proportion of that would be in the postnatal care?

Dr Buckley—My midwife came to my home afterwards. I think it came to \$60 per visit postnatally. You could take it as a package deal that included those visits, but if you paid for them separately it was something like that. It is a very reasonable cost. I think the midwives are not actually remunerated fairly.

Senator TCHEN—So one ultrasound scanning can pay almost three visits.

Dr Buckley—Yes, that is a good comparison. I did not have ultrasound with any of my children.

CHAIR—I think there is a fair agreement that there is some ignorance and misinformation out there. Certainly there is a bit of fear and anxiety. What is your view of how we could best convey the information to imminent mums so that we could address that concern and fear?

Dr Buckley—I was very impressed with a publication from the UK called *Informed Choice* leaflets. Have you seen those?

CHAIR—I do not think we have. I noticed your reference to them.

Dr Buckley—They are excellent. They have done 10 so far. They are evidence based and they have one pamphlet for the professional and one pamphlet for the consumer on issues like epidural, ultrasound, breastfeeding, place of birth. Ten have been done so far and it is an ongoing process. It is really important to have that sort of information for women who want it. Women get their information from their carers as well, so it is a matter of informing the carer and having some way of ensuring that the carer is passing on information that is accurate. My observation is that that does not happen a lot of the time. The information that women are given from their carer, for example in relation to caesarean section, is not evidence based.

CHAIR—If a woman came to you and said, ‘I’m insisting on a caesarean section. I know what’s best for me. I’m going to have one,’ how would you tell the committee the best way to deal with that and/or do you think a woman should be allowed to have a caesarean section if she wants one?

Dr Buckley—First of all, as Dr King said, the woman needs the information that there are additional risks from that option. Personally if I was a GP and a woman came to me in that situation, I would be looking at why she is fearful of having a vaginal birth.

CHAIR—She might say, ‘I’m not afraid. I just want it done on Friday. I don’t want to waste time.’

Senator GIBBS—What Senator Crowley is saying is not ridiculous. When I was coming home from somewhere in our travels, my Comcar driver told me that he knew of two women who had had caesareans the day before, on 9/9/99, at guess what time? Nine o’clock. This is my favourite Comcar driver. We discuss everything under the sun. This is what women are actually doing. I have a friend who is a nurse in the Sunnybank Private Hospital, and she tells me—particularly Chinese women. It is all in the stars, it is all in the horoscope. They have it on a certain time on a certain day.

Dr Buckley—I guess to start your life as a parent with a caesarean section for purposes of control is not setting yourself up very well for parenting, which is an exercise where you do not have a lot of control necessarily over events.

CHAIR—A very useful addition to our deliberation, Senator Gibbs. I hope I meet your Comcar driver one of these days.

Dr Buckley—As I commented in my paper, I think it is ironic that the huge amount of resources from the establishment are put into that situation where a woman requests a caesarean, but if a woman requests a homebirth there are no resources available.

CHAIR—Can you give us any clue, Dr Buckley, about why the climate has changed. Twenty years ago, plus or minus a few, there was an extremely significant push across this country for a much more natural childbirth process. There was some very significant childbirth education happening across the country. Breastfeeding was back in favour. I am never quite sure why it comes and goes, but we now find ourselves arguing the value of breastfeeding in terms of immunisation and protection of children. It is quite surprising to me, but damage is done from somewhere, so we have to run a campaign about the normalness of birth, of vaginal deliveries and of breastfeeding.

Something has gone wrong since. We had the Leboyer method and other kinds of various fashionable bits and pieces, but essentially people were saying that women wanted to be more in charge of childbirth and they wanted to be assisted in that process by their doctors much more than midwives back then. Somehow all that has changed and the culture now is to say, ‘If you’ve got a problem, if you’ve got any trouble, whack it out with a caesar.’ I do not know that mothers around the world are leading this campaign, but they are certainly getting the message that it is all right to have a caesarean section. We had one person explain to us that they had a caesarean section to avoid pain. You would have to say, ‘What pain are you talking about? The post-operative care after an abdominal operation?’ So there is clearly something strange happening. Do you have any clue about where this new climate it is stemming from?

Dr Buckley—That is why I think we should call it ‘caesarean surgery’ rather than ‘caesarean section’, to emphasise that it is a surgical procedure. There have been such widespread social changes and I think these are reflected on birthing women. For example, we have increasingly a technological perspective in our culture as a whole and this is reflected in the birth process. In all aspects of our life, we think technology is good and more technology is better and we take this into the birth area where we think technology is good and most technology—caesarean section—must be better.

Also, I think we have lost a lot of faith in our bodies as women. Women have gone into traditionally masculine areas and in a philosophical sense we have left behind some of our faith in our bodies, faith in our own womanliness. Going into the hospitals, too, women do not see other women giving birth. The best preparation I had for having a baby was being with my friends giving birth. There is a lot of fear around that. We have lost the faith in our bodies to perform these natural processes.

There is a political agenda, too. The pendulum has swung the other way and I am optimistic about that. When I look across at my home country of New Zealand, I see the radical changes that have happened there which have benefited many women. That is possible, even in these difficult times that we have in Australia.

CHAIR—What would you recommend to the committee would be the one or two most important things that might help change that culture or swing the pendulum back? We can’t all go to New Zealand.

Dr Buckley—I think support for midwifery models of care, because that is the change they had in New Zealand and a lot of other changes followed. But it was the re-emergence of the status of the midwife as an independent person capable of managing a normal birth.

CHAIR—We know that in Australia if, as a woman—you may have heard this question which I put to Dr King—you asked for an elective caesarean section, you would get it because you are a powerful person and your opinion must be taken into account. If you ask for a midwife assisted birth, you are slightly nuts. Would you care to comment on the climate that is still very defensive about anything other than the medical model of childbirth in Australia? Midwives are still doing it very tough. Apart from private ones who are assisting with homebirths, a midwife is still a strange beast.

Dr Buckley—The situation I am in is certainly something I think a lot about. There is a lot of ignorance and that is one of the reasons I have done a lot of writing over the last two years.

CHAIR—Who do we have to educate?

Dr Buckley—I think women, and that is why I have written for *Australia's Parents* magazine, which is a national one that a lot of women buy. It is on lots of levels really—the women and the carers as well. We were talking about support for obstetricians, to defend their practice if they do not do a caesarean. The pressure on obstetricians to do caesareans is coming from the public as well. They are at risk of being sued if they do not do a caesarean at times. I worked with an obstetrician in New Zealand, completely in the public system, in 1985, and he said to me that he had never regretted doing a caesarean but he had sometimes regretted not doing one.

CHAIR—Thank you very much for coming and also for your very interesting submission and the information in there. I am terribly chuffed to discover that there are people who write that having a baby is like a mighty orgasm. That might be better put out there, and you would know this if you are awake at the time.

Senator GIBBS—It is absolutely wonderful. This is what we have to be teaching the young girls in school.

CHAIR—No, let us wait until they leave school.

Dr Buckley—That is one of the reasons why I had my babies at home. My daughters saw the birth of my third child and they know that on an instinctive level.

CHAIR—Some of the information in the extra submissions was also very helpful. Thank you very much.

JACOBS, Ms Jane Bronwyn, Nurse Researcher, Mater Misericordiae Mothers Hospital

OATS, Professor Jeremy J. Nicolle, Director of Obstetrics and Gynaecology and Clinical Professor, Obstetrics and Gynaecology, Mater Misericordiae Mothers Hospital

RAMSAY, Ms Kathleen Anne, Project Officer, Women's Health Strategic Plan, Mater Misericordiae Mothers Hospital

SKINNER, Mrs Jennifer May, Executive Director, Mater Misericordiae Mothers Hospital

TUDEHOPE, Associate Professor David Ian, Director of Neonatology and Associate Professor in Neonatal Paediatrics, Mater Misericordiae Mothers Hospital

CHAIR—Welcome. 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 may ask to do so and the committee will give consideration to your request. We have before us your submission, which is No. 78. Do you wish to make any alterations to that submission?

Mrs Skinner—We have two corrections to the submission. We have amended documents available for the panel if you would like them. The amendments are on page 13. We have now separated that table into two. We have separated the caesarean section rates from the intervention rates for induction and epidural, and that is just to clarify the data for you.

CHAIR—Last night I spent some time with this table and I have written at the side of it 'please explain', so thank you very much. But you might get the opportunity to explain it to me anyhow. And the second correction?

Mrs Skinner—It is on page 28 of the data, table No. 1.13. It refers to the number of women entering the early discharge program. We neglected to include the number of women who entered from the community midwifery program and that skewed the figures. The table now shows the community midwifery clients and it indicates that around 25 per cent of our client load remain in hospital for conventional care. They are the only two corrections.

CHAIR—Thank you very much. Would you like to make an opening statement—some or all of you?

Mrs Skinner—I will do that, thank you.

CHAIR—Thank you.

Mrs Skinner—Firstly, we would like to place on record the support of Mater Misericordiae Mothers Hospital for this inquiry into childbirth procedures in Australia. Secondly, your coming to Brisbane has provided an excellent opportunity for the key stakeholders to have input into the process, and we are most grateful for that.

In the development of our submission we drew on the resources of a range of experts from the Mater. What you see here this morning is the nominated team from this group, who are happy to address various aspects of the submission. It is certainly not our intent today to review the entire submission but we would like to highlight a number of issues that we believe are important.

We have addressed issues related to research in some detail in our report but, in summary, we believe that if we wish to focus on evidence based care and improved outcomes the research agenda needs to include emerging childbirth practices; evaluation of current models of care, and we believe that this should include recent developments in the role of the midwife, that is, the expanded role; the social dimensions of women's lives that affect their health during their childbirth years, and some examples of that are domestic violence and drug and alcohol dependence; and the impact of early discharge programs on the role of the general practitioner.

The further development of best practice guidelines and clinical indicators represents a mechanism for ensuring best quality outcomes for women and newborns. Obstetrics is a field that lends itself well to the development of national standards and practices that are evidence based. The joining together of the major women's services provided by the Womens Hospital Australia consortium provides an excellent mechanism for these national standards and practices to be developed.

We believe the partnership development between hospitals and general practitioners is of mutual benefit when you consider the small amount of time that women spend in the hospital setting during their reproductive lives. The hospital is responsible for an episode of care whilst the general practitioner has responsibility for the continuum of care through the various stages of life.

It is recognised that training and education of general practitioners is an essential and ongoing imperative if women and newborns are to receive high quality and cost-effective management. The Mater Mothers Hospital provides an upskilling program for our general practitioners in the fields of both obstetrics and newborn management. Our feedback from this group actually cements the view that education for general practitioners is both required and, indeed, requested by this group.

The issue of consumer expectations was highlighted in the 1996 NHMRC publication, *Options for effective care in childbirth* in 1996. We believe that consumer expectations can only be addressed by an authentic response to requests by women and their families for choice in reproductive health care. An innovative approach to developing models to meet the reproductive health care needs of women and their families must be adopted.

The appropriateness of current models of reproductive care requires ongoing evaluation to ensure they meet the changing needs of the local birthing population. There is no single approach or model that can accommodate all women, but there is the opportunity to respond at a local level through the provision of education and advice on the models of care available, and then inclusion of consumers in the development of the plan of care for their pregnancy.

Most frequently, the reproductive health care needs are best met by the provision of a range of choices and options for antenatal, intrapartum and postnatal care. This could include access to the range of options of care; provision of care that is culturally appropriate; accuracy in the identification of our indigenous clients to ensure appropriate care is provided; and recruitment and training of indigenous and non-English speaking health care professionals and visiting rights for accredited midwives.

The expansion of tele-health services to include tele-ultrasound will assist women who are geographically isolated to have access to expert medical assessment, while they are yet able to remain with their families during uncertain diagnostic situations. Specialised consultation via this medium cannot remain confined to major referral centres on the eastern seaboard, but needs to expand to remote and isolated communities to assist in offering a national standard of reproductive health care.

It is evident that current funding models do not recognise the needs of mothers and babies. This is particularly evident in neonatal services. As outlined in our report, the status of the neonate is determined by whether they are qualified or unqualified. Only qualified neonates qualify for funding under a casemix model or through private insurance. All neonates need to be admitted to hospital and funded according to treatment or the care provided, not on geographic location or where they are housed.

Alternative models of care traditionally have been funded as pilot projects for a set period of time. During this time evaluation and review are attended. At the completion of the pilot project the expectation has been that the program will be mainstreamed within the historical budget of the service. It is at this point that the alternative models are discontinued or substantially weakened.

For new or alternative models to be successful, new methods of funding must be determined and recognition must be given to the fact that when a hospital introduces a new model of care it adds to the options available to women. The current funding requirements require you to delete a model so that funding can be transferred from that service to the new model. This brings to a conclusion our overview of our report and the team is happy to answer any questions that you may have.

CHAIR—Thank you very much.

Senator GIBBS—It is quite a comprehensive report, thank you. Does Mater Mothers have the early discharge system?

Mrs Skinner—We do.

Senator GIBBS—How many days does a mother stay in hospital now?

Mrs Skinner—We have a length of stay of around 2.4 days. Mothers have the opportunity to go home from the delivery suite or within the first 24 or 48 hours. There is follow-up in the home for five visits post-discharge by qualified experienced midwives.

Senator GIBBS—So every mother who leaves here has a follow-up of five—

Mrs Skinner—Every mother who goes onto the early discharge program.

CHAIR—Do those five visits happen in 2½ days?

Mrs Skinner—No, in five days.

CHAIR—So it is one visit per day.

Mrs Skinner—It is one visit a day for five days.

Senator GIBBS—This is for breastfeeding or problems like that.

Mrs Skinner—Yes.

Senator GIBBS—If a particular first mother thinks she is fine and then she needs a revisit, say, maybe a week or two later because she might think things are going okay and then suddenly they are not—which can happen—what happens then?

Mrs Skinner—This is where the issue about the education for the general practitioners comes in. We link very closely with the general practitioners and they are involved in the management of the mother. The clients are referred to their general practitioner. If we are required to undertake an assessment from the baby's point of view, then they are often brought back to the neonatal nursery.

Senator GIBBS—Do we still have the six-weekly check-up after the birth?

Prof. Oats—The vast majority of those are done by the general practitioner, unless there are particular problems.

Senator GIBBS—You don't have to come back to the hospital now?

Prof. Oats—No. We would only see those who have complicated medical problems or particular problems with their labour and delivery.

Senator GIBBS—Good. Thank you.

Prof. Tudehope—From a neonatal perspective, we have the community midwife doing an examination of the neonate on day 4 or day 5. We still recommend that the neonate be seen by the general practitioner on day 7 to day 10 to establish a relationship with that family. Then he will see the neonate at six weeks of age and again at two months for immunisation. The difficulty is that we have wondered whether the six week could be rolled over into the two month for immunisations, but that would be a long consultation for a GP. That has been the difficulty and the sticking point. I do not personally think that it is necessary for GPs to see them all at six weeks and eight weeks if we could get around the time duration of the consultation. GPs are quite adamant that they cannot do everything that is necessary with just one short consultation with the neonate.

Senator GIBBS—Thank you for that. I take it that you have a team of midwives here and then they follow the women out and then come back. That is excellent. Would you regard GPs as being totally aware of what the options are for women when they become pregnant? When you go to your local GP and he says, ‘Yes, you are pregnant,’ are GPs totally au fait with the models of care that they can give to their patients?

Prof. Oats—We developed the models of care and the distribution of the information about that in conjunction with the southside divisions of general practice. They now have a web site. We share care with about 1,100 GPs in our area, and there is a web site that they can now access that in fact has details of all of this. We have been holding education programs every three months and that goes through the models of care. All our general practitioners who we share care with have been sent a large folder, because they initiate the care, and included in that is a brochure with details about the models of care available that they discuss with the woman so that when she comes to book into the hospital the potential models of care have already been discussed.

Senator GIBBS—When you say on the south side, does that extend to Ipswich?

Prof. Oats—It will to any general practitioner who shares care with us at the Mater.

Senator GIBBS—So if I go along to Dr Cruikshank and say, ‘I think I’m pregnant. Help,’ then he can say, ‘Here are your options’?

Prof. Oats—Yes.

CHAIR—You can test the system, Senator. Do you have a copy of those guidelines or advice that you provide to the doctors?

Prof. Oats—We can certainly provide that to you.

CHAIR—We can get the www address anyway.

Prof. Oats—Yes. But we will give you hard copy.

CHAIR—That would be great. Thank you.

Senator GIBBS—We have heard a lot of really disturbing evidence about the overuse of ultrasound screening. We have heard evidence which says that a lot of it is unnecessary. We do not make judgments on this committee; whatever is necessary has to be. But it seems to us that, if a lot of this is unnecessary, the huge amount of money that is actually going towards the screening could be better used in the hospital funding system elsewhere. What is your opinion on the ultrasound, bearing in mind that this has basically no reflection on the hospitals, or not much, but it is basically GPs and people outside who are not equipped and not properly trained who are just having a lovely time.

Prof. Oats—We have developed, in conjunction with the Royal Women’s Hospital, a shared care protocol. In that is detailed the advice about ultrasound, that ultrasound in early pregnancy is only indicated if there is, for instance, significant vaginal bleeding or abdominal

pain, so it is done on an indication. In that we state if a routine scan is done then it is best done at 18 to 20 weeks. That protocol has been distributed to all general practitioners. It has now been adopted by Queensland Health as the model for the whole of Queensland for the shared care program, so that now will be available throughout Queensland. It is a matter of education.

Senator GIBBS—So does that mean that Queensland Health has actually told doctors out there, ‘Don’t go doing three ultrasounds before the mother is 10 weeks pregnant’? Is this like a regulation that has been put on doctors and will they get into trouble?

Prof. Oats—It is not a regulation but it is education advice. I think it is fair to say that it is not just the general practitioner who is ordering it willy-nilly but there is a lot of pressure that can be put on the general practitioner to order the test because somebody wants to see and have it confirmed that there is a heartbeat. We certainly get that feedback. They have welcomed this protocol because they say, ‘Well, it says here it really is not indicated,’ and that will make it easier for them to order these tests responsibly.

Senator GIBBS—So this is pressure from the parents on the doc?

Prof. Oats—It could be pressure from a number of areas. It can be even down to as trivial as the person saying, ‘My husband was not able to come to that last scan. We would like another scan so he can come.’ That sort of request is surprisingly common.

Senator GIBBS—This is costing the taxpayer enormous amounts of money that could actually go to more beneficial things. Do you think that, unless it is necessary, maybe we should charge them?

Prof. Oats—That is certainly an option. I have said to people, ‘It is not indicated. If you want to go and pay for it, that is up to you.’ But that is not the system that has happened, of course.

Senator GIBBS—No, but it could be a thought.

Prof. Tudehope—There is just one complicating new development, and that is the nuchal fold thickness scan at 10 to 12 weeks to pick up Down syndrome and other anomalies. That is a changing practice somewhat.

Senator GIBBS—If the scan was for that, that would be totally legitimate. The doctor would say or whoever would say, ‘This is exactly what this is for.’ It is not exactly what we are talking about, just getting pretty pictures of the baby.

Prof. Tudehope—The 10- to 12-week scan is not a full anomaly scan and quite often, because it is done so early, other issues arise because it is being done for other purposes. But you cannot necessarily say that there are or are not anomalies on that 10- to 12-week scan.

Senator GIBBS—What are you saying? We should have it at 10 to 12 weeks or we should not have it at 10 to 12 weeks?

Prof. Tudehope—I think our society is basically judging that they do want to diagnose Down syndrome, a percentage of women anyway. We are not talking about women over 35; the majority of Down syndrome occurs in women under 35. The counselling is very complex, I must say, with nuchal fold thickness scanning, but a lot of women are opting for that scan to pick up the nuchal fold thickness and get into the Down syndrome diagnosis that way.

Senator GIBBS—Is that test totally accurate?

Prof. Oats—It is a screening test. What it does it brings a risk assessment. One of the major benefits that has already emerged from this screening program that is now at the Mater is that the number of amniocenteses, that is taking fluid from around the baby to do the diagnostic test, in women over 35 has actually fallen. So having a non-invasive ultrasound has had the benefit that it has reduced the number of amniocenteses done, because an amniocentesis itself carries a risk of miscarriage of about one per cent. So there is a major trade-off with that. The training for this, our nuchal translucency scan, is very meticulous. It is based on a program from Kings College Hospital in London and it takes a very detailed training to make for quality of control and factors in maternal age as well as the thickness of this.

Senator GIBBS—I have one more question, and that is about the elective caesarean sections. I notice here on page 13 we have got the public part of the hospital and the private part of the hospital, and elective caesarean section, 479 people, 42 per cent; private, 57 per cent. We have heard an awful lot about pregnant mothers who say, 'Look, I am just going to have the caesarean, I don't want any pain.' Does this happen in this hospital? Do women actually demand caesareans? We are hearing this a lot, that the doctors say, 'Well, they demand it. Their choice, their bodies, they can do with their bodies what they like.' Is this actually happening here in this hospital, being a Catholic hospital? I have had both my children here. I have got nothing against this hospital; I think it is wonderful. But what is the process at this hospital if women are actually demanding to have elective surgery?

Prof. Oats—Just in brief, because I did actually answer that on behalf of the WHO submission in Canberra, we do have a small number of women who are requesting elective caesarean section not for an obstetric indication. The usual process, if it comes early in pregnancy, is to discuss the issues and the options, the complications, the pros and cons for it, and then to review it later in pregnancy. I think I mentioned before that in my experience the majority by then have been through the childbirth education and often it is the fear about pain and those sorts of issues. So the numbers that are actually requesting it later in pregnancy are much lower, but in the end it has to be a partnership discussion and agreement.

Senator GIBBS—So after you have explained all the pros and cons and have not been able to talk her out of it and she says, 'No, this is what I want,' then you do not have much choice; that is it.

Prof. Oats—It becomes very difficult to deny that choice, yes.

CHAIR—Can I ask you to take me through this table. I have some trouble with the figures. It is a measure of my limitations, not the schedule. It shows 1997-98, public, private, total. We have elective caesarean sections which are 42 compared to 57, public to private. The caesarean section rate overall is 23 to 35, public to private. But in the last line, emergency section, it is completely reversed: 58 in the public to 43 in the private. Have I got that right?

Prof. Oats—Yes.

CHAIR—So emergency caesarean sections are done in a much higher percentage on public patients.

Prof. Oats—That is only percentage of total caesarean sections.

CHAIR—This is where I am a bit puzzled. What is the figure against which the 23 per cent is measured? In the first line, first column, under public, is 1,129 23 per cent of the total?

Prof. Oats—Twenty-three per cent of the total deliveries, yes.

CHAIR—Total deliveries of public deliveries?

Prof. Oats—Of public deliveries, yes.

CHAIR—So what is 650 58 per cent of?

Prof. Oats—That is 58 per cent of the total of that 1,129. So it is just showing the break-down, but in the public.

CHAIR—I see. So you have to add up sideways and up and down. Very exciting here. Take me through this slowly. Overall in the public sector there was a total of 1,129 caesarean sections, and 23 per cent of them is what? That is 23 per cent of all births?

Prof. Oats—All deliveries, yes.

CHAIR—But the next line is actually 42 per cent of 1,129.

Prof. Oats—That is correct.

CHAIR—Now, that is not funny. To switch the criteria on our little data just like that has had me freaking out here a little bit. Can I ask you to put a bold black line between line 1 and line 2? I know in some ways that is not a fair thing to conclude, but 42 per cent is actually 42 per cent of 1,000, whereas 23 per cent is 23 per cent of 4½ thousand. Thank you. You would allow that there is a possible confusion there?

Prof. Oats—Certainly.

CHAIR—I hereby record my confusion. I am helped by what you are telling me, but as I read these figures it would still suggest that emergency caesarean sections are done in much higher numbers on public patients than on private. That is actually true in absolute numbers.

Prof. Oats—Yes.

CHAIR—But in fact 650, which is 58 per cent of all the caesarean sections in the public, is not 58 per cent of all births, is it?

Prof. Oats—No.

CHAIR—That is why I think this table could do with a separation and a modification, or at least you could tell me that of all the public caesareans 42 per cent were elective and 58 per cent were emergency but that is a lower total of all caesarean sections than it is in the private. Is that right?

Prof. Oats—Yes.

CHAIR—That is why I think these figures are confusing, because they are not comparable percentages to the percentages that we have been dealing with from AIHW. I understand exactly what you are now making me understand from them. When I looked at this, I thought, ‘58 per cent emergency caesarean sections—what is the Mater up to?’ But now I see that it is up to comprehensive statistics. It is also very puzzling for us, and I am bold enough to say that if I am puzzled then perhaps other people are too. The first line is comparable to what we are seeing in other values, but the next line changes.

Prof. Tudehope—With respect, we have actually looked at the emergency caesarean section rate in public, 650 over 4,300 women who could have had an emergency caesarean. If you did that in the private sector, 393 over 2,000, in fact the emergency caesarean section rate of susceptible women would be marginally higher in the private sector than in the public sector.

CHAIR—That is right. That is why I think these figures do not tell us that kind of comparison. It is very useful to have this breakdown but it is a non sequitur comparison; I suppose that is the best way I can say it. What we understand is that the emergency caesarean section rate is much more comparable between public and private patients. It is the elective caesarean section rate that makes the major difference. Is that the story here too?

Prof. Oats—Yes.

CHAIR—That is one thing cleared up. Thank you very much. Senator Tchen, would you like to ask some questions?

Senator TCHEN—Could I say that, the shortcoming that Senator Crowley has identified notwithstanding, I congratulate the Mater Hospital for this comprehensive report and submission. It is most impressive. If it is an indication of the service you provide, and I am sure it is, I think the whole hospital service should be congratulated as well. This morning

when I came in I noticed the large number of volunteers walking around. In my experience, that is always a good indication of a well run community organisation. My congratulations to you.

Before I start, can I ask you, Mrs Skinner, if you are the chief executive of this hospital?

Mrs Skinner—The executive director.

Senator TCHEN—Is that the chief executive?

Mrs Skinner—No, we have a chief executive officer. We have six hospitals on the campus. Each of the hospitals has an executive director and we have a chief executive officer.

Senator TCHEN—You are the chief executive of the Mater.

Mrs Skinner—Yes, of the Mater.

Senator TCHEN—May I ask you your background?

Mrs Skinner—I have been working in management now for 15 years, but I came from a nursing background.

Senator TCHEN—I thought so, because to me it put to bed one of the arguments about who is in charge—nurses or doctors.

Mrs Skinner—Ours is definitely run by nurses. I need to clarify that.

Senator TCHEN—I should say whether a hospital is better run by nurses or doctors.

Mrs Skinner—At Mater Mothers we adopt very much a team approach, and I think that is evident today by the fact that we have very key people representing clinical services from the hospital here this morning.

Senator TCHEN—One of the things that particularly interests me is early discharge. It seems that you have a very good program running. There are a couple of points on which I would like clarification from you. You said the mothers can choose to participate in an early discharge program. What about those mothers who do not choose to participate in early release: what is the normal period of stay in hospital?

Mrs Skinner—Around four days for a normal delivery and around six for a caesarean section.

Senator TCHEN—Is that time determined by medical factors or practice or the financial factor?

Mrs Skinner—It is by clinical assessment.

Senator TCHEN—Thank you.

CHAIR—If I might intrude, Senator, you know that clinical assessment has changed fairly significantly over the last 50 years—has it not?—from two weeks, or possibly longer, to 10 days to seven days and now down to six days. I am just interested in this in terms of the savage objectivity of the medical profession.

Senator GIBBS—Only six days for a caesarean and four days for a normal delivery.

Mrs Skinner—Our caesarean sections that go on the early discharge program go home at between 48 and 72 hours; they can elect.

Senator GIBBS—Good Lord!

Mrs Skinner—And generally if they have good strong family support systems in place they do elect to do that.

Senator GIBBS—I cannot believe how tough women are.

Senator TCHEN—For the mothers who do not discharge normally, do you give the same postnatal support—the visits by the midwife?

Mrs Skinner—The early discharge nurses do not visit them at home.

Senator TCHEN—They do not visit them?

Mrs Skinner—No. But they are linked to the general practitioner. At the point of discharge for every client from our service, there is an automatic faxing of their discharge summary to the general practitioner so that he has an awareness that they have been discharged, an understanding of the care that was delivered in hospital and the ongoing management plan.

Senator TCHEN—I see. So the five visits by hospital based midwives are paid for by the hospital?

Mrs Skinner—Yes.

Senator TCHEN—I think I asked Dr King a question about this earlier, because we were talking about that as well and talking about how it is funded. Am I right to say that basically what the Mater has done is actually transfer the care to the GP and thereby transfer the cost back to the general medical practice?

Prof. Oats—Not exactly, I do not think, Senator.

Senator TCHEN—It seems a very smart way to do it!

Prof. Oats—Those that are in the traditional care or the hospital care are looked after within the hospital for that five to six days. What we have done is transfer the cost of that

into the cost of running the home care program. They remain patients of the hospital until they are discharged from the home care program. So, yes, there will be some increased load on the general practitioner but it is not really a major transfer from the hospital to the general practitioner.

Senator TCHEN—In your experience, are the five visits adequate, generally?

Mrs Skinner—On the majority of occasions, yes. But if there is a requirement for additional visits, then that occurs as well.

Senator TCHEN—So the costs are funded?

Mrs Skinner—It is a standard five but if there are more required then that does occur.

Senator TCHEN—Thank you.

Mrs Skinner—Could I just touch on the issue that Professor Oats raised. The early discharge program is actually an example of introducing a new model of care, where we have had to transfer dollars internally to fund that service. We have taken the dollars from the postnatal services and transferred them into the new cost centre. That is how we actually fund the service in the community.

Senator TCHEN—Can I ask you something on a different basis? In your discussion of your report recommendations, you mentioned your programs for indigenous mothers and also for mothers from non-English speaking backgrounds. Could you give us some background on what programs you have in place.

Ms Ramsay—I will place that request in context first. I have here a copy of the women's health strategic plan which was done after consultation with 139 women that use our hospital and also health professionals in the area. Out of that, eight key action areas evolved and one of those was access to services. This is the framework in which we address your question.

I will do non-English-speaking background women first. In terms of women who are of non-English-speaking background, we have really tried to tap into the recent refugee women who have come to Brisbane and also all newly arrived people. They have special needs, not the least of which is being able to communicate. One of the things we have done is set up an interpreter service at this hospital. The interpreter service job is also going to contain a health promotion component, so that worker will be able to run health promotion activities, such as what a normal pregnancy is like, as well as doing interpreting for health care requirements.

The populations that we are currently trying to access are the African women who have been relocated here from the Horn of Africa countries and states within Africa. They have been resettled here in South Brisbane in the Annerley- Yeronga-Fairfield area and they are housed here as well, so we are making great links with those. That is one group that we have a lot of work going with at the moment, in community midwifery and our antenatal clinic.

In terms of our indigenous women, we work very closely with the Aboriginal and Islander Community Health Centre, which is just in our backyard here at Woolloongabba. We work in consultation with them in looking after indigenous women. One of the projects that is about to start is the identification of indigenous people in this hospital. This is going to be a cross-campus initiative, but we are talking here about pregnant women. We want to actually find out, when people register, whether they are indigenous or not. Sometimes this question is asked very well; sometimes it is done quite poorly.

We hope to get a group of people across this complex together who will bring their expertise. We will have IT people, because we will need to change the way we record this, and we will have people who are in the first point of contact—that is, administration staff and nursing staff. We are going to be putting in a program where we can accurately identify whether these people are indigenous. That requires education and a whole approach which is quite discreet, which we will be starting soon. I hope I have answered your question. It was about non-English speaking background and indigenous—is that right?

Senator TCHEN—Yes, thank you.

CHAIR—Will you ask everybody what their racial background is?

Ms Ramsay—Yes, we will. We currently are making lots of assessment in addition to medical factors. We are asking women about social dimensions of their lives that affect their health. Domestic violence and illicit drug use are two. We also want to ask people about their Aboriginality. Sometimes it is not obvious, but we need to not just assume from their appearance that people are not from an indigenous background.

CHAIR—I must have been reared wrong, but I am very sensitive to labelling a group of people in any way. From what you are saying, I suspect you are very sensitive to it, too. But I would also like to know if you would be scoring people as non-Aboriginal. How are you going to deal with this? How are we going to make sure? Clearly, knowing that an X population of so many Aboriginal background people, from tribes far away or not so far away with family networks and all those other things, would be a very big help. On the other hand, you would not like to see that data abused to suggest, ‘X percentage of these people are more likely to—’ this, that and the other. I think there needs to be a delicacy with the data, and that means with the questions you ask in the first place. What provisions have you got to make this non-discriminatory?

Ms Ramsay—I talked earlier about the education program that is going to be in place that goes alongside this project. That education program will be making it very clear to people the importance of identifying indigenous people so that we can make our care more culturally appropriate. That is really what we are trying to do; it is certainly not to discriminate at all.

CHAIR—I appreciate that, but statistics can be discriminatory. ‘The percentage of drug use amongst young mothers is X times higher in population Y’ is one of those lines that certain unnamed media people would just love. It is the sort of thing that I think would be very contrary to the outcome you are aiming for.

Ms Jacobs—Another benefit of being able to more accurately identify our indigenous population is that we currently have an indigenous liaison officer. This gives us the cue to offer that as an alternative service to the clients we are servicing. There will be occasions where indigenous people who may not obviously be indigenous may choose not to identify as indigenous because they fear stigmatisation and discrimination. That is something that we anticipate will occur. But, in terms of being able to more effectively utilise our Aboriginal and Torres Strait Islander liaison service, I think this will be a more efficient way of using that particular resource and, as Kate has said, hook people into more culturally appropriate health care.

Senator TCHEN—This is probably a bit of a digression. Do you intend to screen all your patients this way?

Ms Ramsay—What we need to do is get an accurate idea of the number of people who present at this hospital group who are from an indigenous background.

Senator TCHEN—Yes, I understand that. Who is going to do all this?

Ms Ramsay—The answer to the question is yes, we are. The people who are our first point of contact now are our administration staff and, in some cases, nursing staff. That is why it is important that people have full access to the education program that goes with this project.

Senator TCHEN—You have got a major education program on your hands.

Ms Ramsay—Yes, we agree. That is why we have a reference group.

Senator TCHEN—Coming back to women from non-English-speaking backgrounds and also the indigenous population, in your experience in terms of the treatment they require and the outcome of their treatment, are there differences between women from this sort of background and the general public?

Ms Ramsay—Accurate interpreters are the main thing that this group of people need to be able to access the health care system as anybody can whose first language is English. That is the first thing that we have to ensure. After that, people may have all sorts of factors which influence their outcomes and they can then be determined.

Senator TCHEN—Have you had experience in that area yet—once you have got over the language hurdle?

Prof. Oats—Yes. The management of their expectations of labour can be very different from different ethnic groups. We are very reliant on information coming from those groups on how to sensitively manage that. Obviously, there are also some medical disorders which may be more prevalent from various ethnic groups. That may be part of screening—for example, for diabetes in an ethnic group known to be at high risk. There are other neonatal disorders which are of greater prevalence in some ethnic groups. Again, the knowledge of their ethnicity may well help to raise and heighten awareness so that people will look for those disorders.

Prof. Tudehope—An imbalance that bothers many of us enormously is hepatitis B vaccine. It is available for certain ethnic groups, but the majority of non-ethnic groups have to pay for hepatitis B vaccine in this society of ours. I think that is totally unjust and inappropriate and pro-discrimination. It causes a great deal of stress to the hepatitis B vaccine schedule that we have in this country at the moment.

Senator TCHEN—Do you come across any demand which is not based on clinical factors? For example, do you find that any one ethnic group makes more demands for a particular version of certain procedures than others?

Ms Ramsay—We have to be very sensitive to the different cultures that people come from and the different expectations that they have within those cultures for health care. Something that I have just thought about is the issue of female genital mutilation. Because we will have more people resettled here in the South Brisbane area that come from countries where that currently is a cultural practice, we are going to see more of them here in our hospital. We are linked in with the Family Planning Queensland project officer here, who has come to give us several in-services on how to look after women following female genital mutilation. So we already have some links in progress. Our antenatal clinic nurses and community midwives have been through a short training program about just exactly how it looks. That is one thing that will influence our care.

CHAIR—We have about 10 questions here.

Senator TCHEN—Yes, you go ahead.

CHAIR—Senator Gibbs, you go next.

Senator GIBBS—Can you inform me: what do you mean by ‘they come here after the mutilation’? Are we talking about a pregnant woman here or just somebody who has been mutilated?

Ms Ramsay—Female genital mutilation in some countries is practised when the girls are in early infancy or are young children. They come here already having had the procedure performed. We are finding that that is one of the cultural practices in some countries, but this project—the female genital mutilation project—is trying to dissuade people from hanging on to that cultural practice and to persuade them to place more emphasis on other things such as food, culture, dance and things like that in their culture.

Senator GIBBS—If you have a mother who comes here from one of these countries and this process has been done to her, does that affect the birth?

Ms Ramsay—Yes. I am probably not the best person to talk about that. I would like one of my colleagues to answer that.

Prof. Oats—It certainly can, Senator. It just depends on the degree of destruction—I guess one could call it—and how much distortion there is of normal anatomy. If it is extreme they may need a caesarean section. They may need a guided incision to release the

tissues. It just depends on the extent. There is an enormous range in how mutilation—using that word—is used.

Senator GIBBS—I do not know a great deal about this apart from that it is a process done in certain countries. Are we talking about a fair bit of destruction here?

Prof. Oats—It can be anything the equivalent of a so-called female circumcision, where there is a small incision made around the clitoris, to actual placing rock salt within the vagina to scar it, to removing the whole of the vulva and stitching across, often with thorns. There is a great variation in how is done.

Senator GIBBS—Oh, how can people do this? That is disgusting. That is barbaric.

CHAIR—Yes, Senator, I will talk to you about it off the record—mainly because, although it is extremely interesting and pertinent, we really do not have the time. There are I think four levels they talk about?

Prof. Oats—Yes.

CHAIR—Of general mutilation. This is not a fair question. I would love to put it out there, though. If a husband of such a wife demanded a caesarean section, would we have less trouble or more trouble? I am glad you smiled, Professor. This inquiry is fraught with those problems. We have troubles with caesarean sections; and less trouble, it seems, if women demand caesarean sections. But if any husband demanded a caesarean for his wife so as not to interfere with that, I think most of us would have major trouble in agreeing to that. But I would love to know what you would say.

Prof. Oats—I would certainly concur with you on that, Senator Crowley.

CHAIR—Has it ever happened? Has any husband of such a genitally mutilated wife demanded a caesarean?

Prof. Oats—We have actually had the reverse very recently where there was—in fact in the end the woman did deliver vaginally, but that was a potential issue, and it was in fact the uncle who refused to allow her to have a caesarean section.

CHAIR—I can see that life in a large hospital comes in many shades. I know that in Australia we are having some difficulty. The women's movement at any number of levels, including women in parliament, have been very concerned about this and the view to this point is that we would rather not legislate to ban this practice in Australia so much as educate for people who live in Australia to practice Australian practices. But I think we need to go through a period—that is the view at this time—and, as you say Ms Ramsay, educate and hopefully encourage people to know that the practice is not welcome in Australia.

Senator TCHEN—Why can we not ban it?

CHAIR—Well, we can.

Senator GIBBS—I would be for banning it too, Senator. I am with you on this.

A member of the audience interjecting—

CHAIR—We cannot have calls from the back, unfortunately, because they are not heard on the record. We note your comment and we will possibly get around to addressing that later. Can I just ask a couple of questions?

Point 3 of your recommendations is a very good submission. It has sort of written our final chapter for us, or at least made a bid to be included. Have you provided a copy of the report *1998 Women's Hospitals Australia: how to improve obstetric and midwifery care*—to the committee?

Mrs Skinner—No.

CHAIR—Would you be able to?

Prof. Oats—We can arrange for that to be sent to you.

CHAIR—It would be important that we have a look at it. I would be very interested to see what it does contain.

On dot point 11:

11. To support the care continuum, funding be allocated to provide education to General Practitioners in the management of the early post partum period and assessment and care of the newborn.

You have told me the 'why'. Funding from where?

Prof. Tudehope—On the 'why' bit, we have not said very much about the neonate, unfortunately. General practitioners were very ill-prepared for the transition of care of the neonate from hospital to the community. It happened in a very short transition period. Many of the cares of the neonate that we thought were hospital—the peak of jaundice, for instance, and excluding a whole lot of birth defects in the discharge examination—have now firmly fallen in the lap of the general practitioner.

General practitioners were in no way prepared for this. Our expectations of general practitioners is much higher than they were ready for. A lot of education has been going on. The more we educate, the more GPs require education. What we used to call a 'discharge exam of the neonate' excluded cataracts, clefts of the soft palate, cardiac lesions, coarctation, dislocated hips and Hirschsprung's disease. All of these things are now appearing in the community. It gives us considerable concern, partly from misdiagnoses and the perhaps later sequelae; also a little unease about perhaps medicolegal components of having misdiagnoses.

When we have babies discharged from the delivery suite, a number of these things are likely to be missed in the hospital and are clearly falling now in the lap of the general

practitioner. So he has to go back now and re-educate himself about the proper full physical exam, the management of jaundice and breastfeeding advocacy. All the preventative strategies that used to go on predominantly in the hospital are now firmly transferred to the community.

One of the fascinating things that we have done—thanks to the Medicare incentive grant—was to pioneer home phototherapy for jaundice. In that Medicare incentive program we had 32 babies. We had a number of safety mechanisms built into that survey. Now we have extended that into our community midwifery program. In the last 12 months, 66 babies have had their jaundice very satisfactorily managed with phototherapy in the community. There was only one readmission, and that actually was for postnatal depression, rather than jaundice. So that has been a very successful program of management of the peak of jaundice in the community.

CHAIR—How much of that care has been provided by midwives?

Prof. Tudehope—It has been provided predominantly by midwives in communication with a neonatal registrar or a neonatal consultant in the hospital. The midwife is essentially collecting the blood of the baby each day and having it analysed for the serum bilirubin. There is a number of protective issues in that program that we have to be very careful about which would come unstuck if a kernicterus occurred. So, there are a number of safety mechanisms that we built into the program.

CHAIR—What about research? If I asked you how many babes who have gone home after two days have actually been diagnosed in the next three days or in that next week with something that previously would have been diagnosed in hospital, could you answer that?

Prof. Tudehope—No. I can tell you anecdotes. One of the concerns that I have about the early discharge program is that we are aware anecdotally of many of the benefits but we really have not got properly evaluated outcomes in the way that I would like to see outcomes documented—for example, misdiagnoses and neonates, readmissions of neonates, any long-term deleterious effects of having missed the diagnosis. Obviously, we are interested in duration of breastfeeding and breastfeeding success. I do not really feel that we have got the sort of data that is necessary to evaluate our early discharge programs—certainly not to the extent that I would like to see it done.

CHAIR—When you are bidding for funding for your hospital, who do you address that to? Is it the federal government or the state government? This is a Senate committee; we are not going to be telling the state government anything.

Mrs Skinner—The federal government.

CHAIR—Would you also like it to fund the research?

Mrs Skinner—Yes.

CHAIR—Just in passing, Professor—this is not really a fair question—one of the comforts I have had in my life is the sense that mothers are extremely good at worrying at

the right time about their babes. If they turn up to hospital and say, 'I am worried,' would this be any comfort to you, or are you saying that in your experience that is not a sufficient picker upper of something that has gone wrong?

Prof. Tudehope—It is some small comfort. It is no use for dislocated hips. The mother will not sense that the baby has a dislocated hip until it starts to walk at around 12 months of age. We cannot afford to miss dislocated hips, so we do need to have skilled staff who can conduct an adequate hip examination.

CHAIR—Would you prefer to be able to say that for all of these early discharge people there should be a visit one week later back to the doctors in the hospital, to the midwives in the hospital or to the ward?

Prof. Tudehope—We have been tackling it another way. We have been training up our hospital mater community midwives, and they have been doing the discharge exam, including examination of the hips. I have a 12-month follow-up program this afternoon where I will be evaluating the skills of some midwives at hip examination, examination of the liver and spleen and eliciting red light reflex. So we are training nurses in these types of skills that had previously been very much medical skills.

CHAIR—What I think you are doing here is extremely interesting. If not now, at some other time, because I can see that this hospital has all the time in the world to write research papers—heavy irony again, Hansard—with best practice in general practice and with a closer relationship between hospital care and general practice care, there may be a need to look at this much more closely over an area wider than just early discharge and misdiagnoses with neonates. It certainly seems to me that lying in our general practice is massive research evidence that we have never ever documented.

I am interested in this because it seems to me that a lot of people practice their professional work up on their toes a bit if they are part of an ongoing research project—not that they are being measured so much as they feel as though their participation is a little more alive, as though someone is definitely noticing it and it is going to count. I know this to be the case in education. Under the previous government there was some research from university departments out in schools, and this was reported to have made a great difference in the way teaching was done. You seem to want to make a comment, Professor Oats. Would you care to at this point?

Prof. Oats—A lot of studies have showed that if you studied something your awareness is much higher. I think it is the Hawthorne effect. You will get a better outcome just because somebody is involved in the study.

There are two aspects of general practice. There are those in the divisions of general practice who are involved in ongoing education. I see the problem in the 24-hour clinics, where there is a continual turnover and the mother and the family are not seeing the same doctor. We are very conscious of these two standards of general practice, and that is an issue that I think does need to be addressed.

CHAIR—It does, and so does the issue of patient held records.

Prof. Oats—Yes.

CHAIR—Or the mother taking her mother and baby records. If she is one of those that floats to the 24-hour general practice, then maybe that would be of assistance. I can see a lot of research coming on in this area; it might be huge.

I want to ask you a couple of other questions that sort of follow on from that a bit. Whose responsibility is it to change the culture? I have the sense that there is a cultural change under way. Midwives do not receive the odium they once did, and they are emerging as much more part of a team in some parts of obstetric care. But it does not go far enough and certainly is not known about in the community. The headlines we are getting in the community are that, if a woman demands a caesarean section, she should get it; why should she have to have pain and suffering? I know that is not a fair analysis but, if you want to know the headline culture, that is what our committee has been picking up. That is the new fashion.

There is a huge amount of evidence to this committee that the world is changing. Midwives are doing much more of the care. Women are choosing to have continuity of care and/or carer. They like to come into the hospital to a birthing room, or to the labour ward if necessary. The practice in labour wards has changed dramatically, but none of that information seems to be getting out there. Whose responsibility is it to do that? Who contacts the media?

There are two things I want to know. Firstly, who is leading the change of culture of practice within this hospital for the community? Is it one person who comes in ready to rearrange everything and ‘My goodness, we are going to have midwives,’ is it midwives who finally fought to the front of the pack and are being heard or is it a collective change? Secondly, what responsibility does the hospital have to let the wider community know about the cultural change that is going on?

Ms Ramsay—I think I could talk to that. Firstly, we had Commonwealth incentive funding several years ago for a midwifery model of care in this hospital. When the incentive funding period ran out, we chose to continue that model of care here. That is now our community midwifery service. It underwent some changes, but it really is still very effective in the way it works.

CHAIR—How did you get the Commonwealth funding?

Ms Ramsay—It was incentive funding through the alternative birthing services project. The funding finished in 1996. An evaluation was done of that service, and we decided to retain that service here. That had to be done by internal cost shifting. There was no extra funding to allow that to go on, so we had to make some changes to the way midwifery services were conducted within this hospital. The number of women who were treated annually rose significantly after we adopted the model here, and we had to make several changes in order for that to happen. The key element is that it is midwifery care in consultation with medical officers, and our partnership is very much what we are emphasising here.

Just to build on that, we are going through a process of accreditation of visiting midwives, so women who choose to can have their own midwife—they do not want to have a homebirth; they want to have their own midwife—who can come and be accredited within this hospital, deliver the woman and then take the woman home. That process is under way. It has been lengthy but thorough. We still have not got to the end of it. My team members probably could build on what I have said.

Prof. Oats—The key is the team. Madam Chair, in answer to your question about getting the word out, again, it is very complex. We have tried to do it through general practice and the issues we talked about beforehand, but getting the awareness out that things really have changed is complex.

CHAIR—What you are saying to us is very worrying. It is quite worrying that people are saying to us, ‘It would be good if this thing happened,’ when that thing is actually happening and somehow that is not known. We are being told that women are anxious, ill-informed or whatever else, yet there are these good practices happening which are not yet known about by women in the community. I do think that is an important point. Certainly, you can have a Senate inquiry. We did not know we were going to be getting this kind of cutting edge information. I do not think people take too much notice of Senate committees.

Senator GIBBS—Except us.

CHAIR—The shame is that it might have a very good role in changing government funding allocations and so on. It would be a pity if it did not have an educative role. What you have been telling us today might also shift the way in which part of our report could be written. Certainly the report *A class act: inquiry into the status of teachers and development of the teaching profession* has been picked up by the practitioners and used by them in the community. This report, once it is written, will belong to you. I think, from what you are saying to us, that we should write it with a view to your best use of it, not just as your direct conduit to the money bags. We are a bit late, but I have been told that nobody worries about being a bit late here. This is an extraordinary climate, and we hope it is still true.

Senator GIBBS—Excuse me, Madam Chair! This happens to be the best state in Australia.

CHAIR—I am not arguing with it; I am just enjoying it. It is fantastic. Cream on our cakes—the whole lot. I think I can tick off on the indigenous service, because Senator Tchen has asked about that. How is a tele-ultrasound done?

Prof. Oats—It is done in real time. It is connected directly over a line and comes across as a data transfer. It comes up on a screen—for example, in our internal foetal unit.

CHAIR—So you are all arranged to be at a certain place at a screen at a certain time and up in Cairns the ultrasound set-up is all in place and you press the button and suddenly the pictures are being read here from the belly there?

Prof. Oats—Yes, as they do it.

CHAIR—It is fantastic—everyone could do it—but it would have to be enormously demanding of time. Who reads the ultrasound at this end?

Prof. Oats—It is done in consultation. It is done by our maternal foetal specialist, Prof. Chan, and Dr Cincotta. Those are the high risk ones where they need help with interpretation. It means that the woman usually does not have to come 2,000 kilometres down to Brisbane so the diagnosis can be made. Counselling can be given, and that often occupies a lot of the time. It can be done in conjunction with the caregivers in Cairns, so that people know exactly what the problem is, what advice has been given and what options there are, and can then plan the management. Some may be appropriately managed in Cairns; others may need to come down—if, for example, it is a bad cardiac problem—to be delivered in Brisbane so they have access to the paediatric cardiac surgeons.

CHAIR—One of the things I have been hearing from this hospital, from you and from other places is that the best obstetric health care is not just high-tech care. Can I be assured that the tele-ultrasound mothers are hooked up to not only high-tech care but also to comparable midwifery, antenatal care and so on? If they are not, does this make a difference?

Prof. Oats—Certainly; yes. Obviously, it is part of the drive to have good care and levels of care appropriate to the problems.

CHAIR—Do you have a sense that the care is as good all over Queensland as it is here?

Prof. Oats—If you are talking about the tertiary nature of it—the tertiary services available and tertiary units—I am not in a position to be able to speak about standards of care there.

Ms Ramsay—That approach is also multi-disciplinary, so we have a whole range of health care providers who can address the care of that woman and her family.

CHAIR—Just briefly, what is your responsibility for the provision of services in rural and remote areas?

Prof. Tudehope—Queensland Health has developed zonal networks, so the Mater is responsible for tertiary perinatal services in the southern zone—and, indeed, in northern New South Wales, although it is not Queensland's health concern—the Royal Women's is responsible for the central zone and Kirwan is responsible for the northern zone. The formalisation of zonal networks is a relatively new development, but we do believe we have an obligation for perinatal outreach education and, of course, for maintaining standards and providing tertiary services for those zonal networks.

CHAIR—Would it be a concern for you or for the Queensland government if you found that the outreach care that this hospital could offer to the southern zone was, for example, better than the care provided to people in other zones? What I am saying is: do you have a responsibility in your charter to work with the other hospitals in the other zones to try to get a comparable delivery of services across the state?

Mrs Skinner—Whether we have a responsibility in our charter or not, we have always believed that we have a moral obligation to ensure that mothers in Queensland can access good quality obstetric care. To actually be responsible for care throughout all of Queensland would be a very big task for Mater Mothers. We consider ourselves to be very good, but that is too big a task.

We believe we do have a very strong responsibility in the southern zone. We are moving towards setting up a network service with the other hospitals and working very closely with the senior leaders in those organisations—not so that we can tell them how to provide obstetric care, but for us to learn from them and for them to learn from us and for us to make sure that we have services that are networked very closely together so that at our end of the spectrum—where we provide for the high-risk, tertiary referral care—they can link into our service in a seamless way and also so that, once the neonate is through that critical stage, we can do a very seamless transfer back to their organisation.

CHAIR—It makes a bit of a challenge in terms of who defines best practice guidelines and who is responsible for implementing them. I do not want to get into that because we are way past time and I guess all of you have a million other things to be doing, to say nothing of the patient witnesses waiting behind. If there is more that we would like to talk to you about, we trust you would not mind if we contacted you. We just want dot points, we do not want a thesis; we do not want to put you to all that trouble. We have to finish. I want to thank you very much for your submission and for the points in it.

I am not sure that I know—and you might have told us this the other day, Professor; I will just refer to it—how long Women’s Hospitals Australia has been in existence. If you have sent us a page about its history, do not worry; otherwise take it on notice, if you could.

Prof. Oats—I believe it was in the submission from WHA.

CHAIR—I think it probably is; that is right. I just could not recall it. But you are part of that, aren’t you?

Prof. Oats—Yes.

Mrs Skinner—We have two more documents that we would like to table for the use of the committee. One is on the Women’s Health Strategic Plan and the other is on the educational programs that we provide.

CHAIR—Thank you very much for your submission, your presentation here and for your hospitality.

[12.03 p.m.]

GROSE, Ms Christine Elise, Vice-President, South Queensland Branch, Association for Improvement in the Maternity Services

RENKIN, Ms Catherine, Secretary, South Queensland Branch, Association for Improvement in the Maternity Services

TOCKER, Mrs Bronwyn Ruth, Treasurer, Australian Association for Improvement in the Maternity Services

WECKES, Ms Ulrike, Committee Member, South Queensland Branch, Association for Improvement in the Maternity Services

CHAIR—I welcome representatives from the Association for Improvement in the Maternity Services. The committee prefers that all evidence be given in public but, should you 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 would give consideration to your request. The committee has before it your submission, numbered 56. Are there any additions that you would like to make to that submission?

Mrs Tocker—I have some journals and membership forms.

CHAIR—Extra material—the committee thanks you for that. I ask you now to make a brief opening statement and then we will take questions.

Ms Grose—I thought I might give a little bit more detail than was provided in the submission about AIMS as to who we are and what we have done to date. AIMS began in 1960 in the UK. It has had a rather higher profile in the UK because we started in Australia in the early 1990s. During the Home Birth Australia Conference there was a call for an Australian AIMS to be formed and the South Queensland branch had its first meeting in 1994. In Australia, the national committee has moved from place to place. It began in Canberra, it went to Lismore and it is currently in Brisbane, which is why we are before you here in Brisbane.

Those in the UK have been involved over the last 40 years in quite a number of projects, including the development of guidelines for ethical research and maternity care. They have taken on board issues such as enforced caesareans and women prisoners giving birth in handcuffs—the whole gamut. Here in Australia, particularly in south Queensland which I have most familiarity with, our approach has always been fairly uncompromisingly consumerist. We see ourselves as advocates for consumers of maternity services and it is from that point of view that we look at maternity services and say, ‘What are they doing for women and their families?’ That forms the basis of the submission that we have put before you.

Much of our activities have revolved around community education about access and opportunities for birth care for women. As well as that, we have put a lot of energy into committee representation—trying to get the consumer viewpoint across to decision makers

and service providers. We have also attempted to bring change by visiting key decision makers such as health ministers, bureaucrats and service providers. With those representations our main focus has been an attempt to get informed choice as a basic tenet of how services are provided. We have provided a bit of detail of that in the submission. We do not feel that that informed choice is something that occurs on a regular basis or even very much at all.

We would like to see real choices involving the kind of supports that women really need, which you have discussed a little bit today, such as adequate postnatal care and continuity of care, which is quite a rarity. Although the term is not a rarity, the reality is. As well as that, we would like to see more formal acceptance of consumer participation in the way birth services are developed, implemented and evaluated. At the moment it is a very ad hoc process. I have lots more to say but I do not want to take up too much of the time.

CHAIR—If there are things that you really want to say and if they are not said in answer to questions, then you might just say, ‘Look, I have got three things more to say at the end,’ and we will hear them.

Ms Grose—Thank you.

CHAIR—Have you as a group been involved in any of the planning for continuity of care? The Mater had a group of witnesses, as you have just seen. Those witnesses certainly spoke the language of midwifery, of continuity of care, and of the medical, midwifery and consumer sides all contributing. The Mater witnesses may be the small percentage that is doing it well, and maybe you can comment on that for me.

As I listen to the language of what you are saying—‘we are a group on behalf of consumers’—it does not sound quite like the language of ‘we are here on behalf of the consumer voice in defining best practice’. You sound as though you are standing outside, looking at whether it is good enough, and then bringing complaint or change to bear. You do not sound like a player. Where are you?

Ms Grose—You have picked the language up very well. It is true that we do feel quite marginalised when it comes to how services are provided. It is still very much a case of things that are done to women and their families rather than a partnership. When you do hear discussions about partnership or a team, there generally is not an understanding that a consumer voice is included in that. If it is, we are talking about a rubber stamp.

CHAIR—We have had a very big challenge in our discussion so far, and I think some of you would have been here listening to it. Certainly the evidence has been—and from other places in earlier hearings—that, if women should ask for a caesarean section, specialists in particular are very inclined to give that caesarean section. But, if women should ask for homebirth, birthing centre or midwifery, there is nothing like the same encouragement in meeting that request. It seems you are a perfectly normal proper woman asking for a caesarean section; you are still a bit nuts—on the fringe—if you are asking for an alternative birth, a homebirth or a midwifery birth. Could you comment about this double perception of what women are up to in the community?

Ms Grose—Certainly. What you are saying is true although we would like to challenge the idea that there are lots of women asking for caesareans for no reason.

CHAIR—That is encouraging.

Ms Grose—Professor Oats mentioned that a very small number of women with no obstetric history might ask for a caesarean section. There is a current study undertaking here at the Mater, as I understand it, which is looking at this very question of why women ask for caesareans. What that study has shown so far is that 0.3 of women ask for a caesarean section if they have no current or past obstetric complications.

Of the women who have had a caesarean section before, a third of those say that they want a caesarean section again. Mind you two-thirds are not saying that. Two-thirds are willing to give it a go. But I guess what I am saying is: if women are saying that they want some sort of medical intervention or a caesarean section, often it has to do with the way they have been treated before. We have to look at that history.

CHAIR—It is also interesting though to note what has been picked up and is part of the myth or the emphasis in our media in the discussions about this. The emphasis is much more on shock, horror: a caesarean section for a woman when she asks; rather than on wonderful news: 90 per cent of women delivered vaginally.

Ms Grose—I also think it is passing the buck. It is saying it is women who are asking for this and it is not our responsibility.

CHAIR—Women have been asking for it for a long time, haven't they?

Ms Grose—I might pass you to Ulrike—if she does not mind—who can illustrate the example of her experience of asking for a particular form of care from her GP.

Ms Weckes—I was first pregnant 16 years ago and I had not long been in Australia. I come from Germany originally and from a place 30 kilometres from the Dutch border where one third of all women give birth at home and pregnancy and birth is not considered a medical condition. So, when I first consulted my GP and talked about my pregnancy I was dumbfounded about the hostility that I met when I said that I was going to have a homebirth. I subsequently gave birth to one baby in Alice Springs and one baby here in Brisbane. I found that there is generally if not hostility then certainly no encouragement for that option. I had to totally find my own way in finding a midwife who practised at home and also in financing that option.

CHAIR—Do you think that the climate is changing at all? Is there a shift in some sympathy if not for homebirths—which are still a concern for some in case something goes wrong, as is often the line, and I think one does need to be concerned—but for an alternative, such as your medical model in hospitals?

Ms Weckes—If I can briefly add one thing. When I first came to Brisbane and I was five-months pregnant two years ago, I had a choice of eight midwives practising at home. As

far as I am aware, there are two midwives left in the whole of Brisbane now. One of those midwives is located on the Gold Coast.

CHAIR—As in practising privately?

Ms Weckes—Yes.

Ms Grose—But I would like to say there is the one very exciting possibility that Kate Ramsay mentioned: they have been looking very seriously for a number of years at accepting visiting rights for midwives. That did happen before. I would like to say that my first child was born through that scheme with private obstetric backup which was withdrawn at the last minute. I was 39 weeks when it was withdrawn, but I was still able to have my child the way I wanted it. I think that would be a really exciting opportunity because it is through schemes like that that you get ripples.

That practice was becoming very popular and I think that, should it be offered again it will start to impact, not just on that particular service, but on the hospital service when you have people coming in from the outside who are operating a certain way, truly providing women-centred care and continuity of care. It may also change the attitude of people transferring from homebirths because, although there has been quite a change in the reception many women get when they transfer, you cannot be sure of that. It is still a bit of a mixed bag.

CHAIR—There is one question that particularly leaps out at me. The definition of best practice is something that has emerged in the course of this inquiry. It is a very big challenge—should it be in regard to obstetricians, midwives or women? I suspect that we would probably say it should be a bit of all although maybe there are some best practice guidelines that are specific to the professional body and their standards. But, when it comes down to childbirth, certainly the woman is an active player. To what extent does your group argue for definitions of best practice in terms of what a mother's role is at the time of birth, what the antenatal role is and what the postnatal care role is?

Ms Grose—You may have picked up from our submission a certain animosity towards the term. Generally, when we have heard 'best practice', it has come from an institutional setting, as in, 'We're going to hit you over the head with this because it's best practice. It's not what you want but too bad.' I guess that is part of our response. But we feel best practice also implies a single model of care. What we are on about is informed choice and a range of good care to allow an individual response for women. I think best practice is an excellent thing as a rule, and we really need to start looking at how we provide that and the impact that is having on the women and their families who are using the service. I feel that that is something that has often been left out. We are looking at mortality and morbidity and how it functions within the institutional environment, but we are not looking at what we are leaving in the community. That is certainly something I would like to see included in the best practice that incorporates what you are saying—everyone, all stakeholders, as players in that.

CHAIR—Do you actually talk to the media on behalf of a different perspective on what is best for women at the time of childbirth? Do you, for example, remind them that, in the

Netherlands, homebirths are at least one-third of the births, that midwives are the principal deliverers—I suppose the mothers are, but the midwives have a hand there—and that the caesarean section rate is extremely low whereas, in Australia, where we have much less midwife participation in childbirth, the caesarean rate is very high?

Ms Grose—Yes.

Ms Renkin—We try to comment and be proactive as we see things come up, but one of the limitations is that we are a group that have no funding. We have paid work commitments, family commitments and other social and community commitments, so it is very difficult for us to have a big impact.

Ms Grose—Or to have a coordinated response. It is a bit ad hoc, but we certainly see that as our major role, particularly with community education.

CHAIR—Can you or do you maintain a webpage?

Ms Grose—We do have some access. The HMA, whose witnesses are coming after us, have done a lot of work on the webpage. We have a little section on that webpage, but we do not actually have a webpage of our own that we update regularly. Fortunately, we have other very competent women in the community who are doing that for us.

Ms Renkin—You asked, ‘Do you see things as changing or as getting better in terms of not just homebirths but also hospital care?’ My understanding of the community midwifery program is that it started off with a big commitment to continuity of care and to midwifery managed care. The way the program has evolved, changed or been implemented has cut out a lot of the things that were offered originally, like initial visits to women in their homes. Postnatal care has sometimes been handed back to another team. While you might still have your five visits, it is a completely different team of people, having larger teams of midwives rather than two midwives assigned to one woman—for example, having six midwives who provide the antenatal and labour care. You might see a midwife only once before or not at all. They have had problems with staffing because of the pressure that the midwives are under. My experience of that program is that there has been a lot of change of staff. While the theory is excellent—and that is one of the reasons I chose that program—in practice there are a lot of hurdles in providing continuity of care.

Ms Grose—Cathy had her baby through that scheme. I was on the original reference group that was required as a condition of the funding when it was under the alternative birthing services. In my view, looking at even very recent changes this week that they are continuing to make to that program, they have kept the name, but I really do not think they have kept much else.

CHAIR—That is the alternative birthing service?

Ms Grose—This is the community midwifery scheme.

Senator GIBBS—Who runs this?

Ms Grose—It is run by the Mater.

Senator GIBBS—This is the program they have here?

Ms Grose—Yes.

Senator GIBBS—Is it constant? Is it all the time?

Ms Grose—Yes, it was a pilot scheme funded by the alternative birthing services program, and that provided case load management. In other words, you had two midwives. You would have one or the other look after you throughout your antenatal care. For early labour, they would come to your home and come to hospital with you. It was a domino scheme, in other words, just like the visiting midwives scheme would be, but it was publicly funded. Then they would visit you up to your six week visit.

Over time that changed. Now you virtually have an absorption into the mainstream hospital provision. Although on paper you might have different personnel working in the community midwifery scheme and the other hospital, the practices are very similar. You still have your antenatal visits limited in time, and you come and labour in hospital. It is very likely—considering the size of the teams and the way that they are making divisions among antenatal, labour and postnatal—that you will not see the same person twice throughout your pregnancy. That is not what the program was supposed to be about. I do not mean to say entirely that this happens with all women. I think that there are probably some cases where women might get a slightly better standard of care through the CMS than they would with the mainstream service, but I can say only that women who have reported to us have not noticed the difference.

Senator GIBBS—So you would not be getting the continuity of care? Wherever we have gone—and we have been to most states—women and midwives have been stressing that continuity of care is so important for the mental and physical wellbeing of the mother and the child. To have that person with you all the way through is so encouraging, particularly when you are giving birth. When they explained it to me privately earlier today, I understood it to be the same midwife visiting you who would then be with you during the birth. Is this not happening?

Ms Grose—I think that is the challenge. That is what they would like to have but, because of the size of the teams, the way they have shared care with GPs and the way postnatal care goes to the home team—in other words, a separate team of staff—that does not seem to be the reality. Because, as AIMS, we do not represent just those groups who have access to continuity of care models or so-named ones, I would like to talk a little bit about the pressures of labour wards in general in tertiary hospitals.

Because we are at the Mater, it is natural that they are on our minds and get more of a bagging. I do not think that is entirely fair but, if you look at the way that you as a woman in the public hospital get access to the labour ward, it is either that your baby is just about to come out or you ask for pain relief. That is not a good way to get into the labour ward to get a better ratio of care. In the labour ward, they aim to have two workers for three women. Including breaks, it means that it is quite possible that for much of the day—and that

depends on how busy they are, too; if more women come in, they have a problem—one midwife may be looking after three women for a considerable period of time. This is in the labour ward. Before you get into the labour ward, you are up in the antenatal wards and have a ratio of one midwife to six patients or one midwife to eight patients. They try to keep you up there as long as possible because, of course, it is a cost problem. I think we can accept that they have a lot of difficulties in trying to work out these cost difficulties.

Senator GIBBS—Why would you want the mother in the labour ward? Why would you want her in there for hours beforehand? If you are about to give birth, you do not want to just lie there on a table or on a bed; you want to walk around and have a cup of tea and move your body.

Ms Grose—If you have a look at the labour rooms, though, they are much roomier and more private than you would get on the antenatal wards. As well as that, the advantage for a woman is that, when you are in the labour ward, you have a better level of care giver. In other words, you have a care giver for more of your time. For many women left labouring alone for long lengths of time, this seems to impact quite negatively on their perception of the quality that they have received.

Senator GIBBS—I understand that. What I am saying is, if you are in the ward and you have your care giver there, that is fine, but what is the difference between being there with your support person and being in the antenatal ward? There might be two other women there, and you can be sympathetic towards each other, walk past them and do whatever. Do you know what I mean? You still have somebody with you. There is nothing more supportive than another woman who is just about to give birth like you are. This is sisterhood here.

Ms Grose—I think from the point of view of continuity of care, which is the big thing that is coming through, what women feel they get a lot of support from is not just having their partner or a support person—yes, that is very important—but as well as that, having someone who has seen other women birth on a number of occasions. That is a bit of a rarity in our culture. If you have a woman who stays with you the whole time who is saying, ‘You are doing great’, and you believe them because you know they have seen it before, that is really something. You do not get that in public hospitals. Most of the time you are with somebody who is just as scared as you are, until you finally go to the labour ward.

Senator GIBBS—Really. Times have changed.

Ms Grose—Am I being unfair?

CHAIR—Senator Gibbs, what you are actually saying is not all the changes are for the better and Hansard is happy to record that.

Ms Grose—Yes. What I would like to say is that it is the resource situation. When they are looking at setting up new programs they are taking money from other midwifery programs, and this is the problem. They are not taking money from ultrasounds or the obstetric budget which is where they should be doing it. If you have more continuity of care,

then you are reducing the need to have doctors seeing these patients, and that is where they should be looking at the budget implications.

Ms Renkin—You might note in our submission that we talked about the strong need we feel that any recommendations or conclusions that might come from this inquiry, there are ways of having them implemented. Our experience has been that it is very difficult for hospitals. You talked earlier about cultural change. We need mechanisms to ensure that those changes can happen. I see it as a cultural change, and to make those changes with resources appears to be very difficult. Even programs that are funded from outside, when it comes to the crunch it is very difficult to change the culture. I believe it is a cultural change for resources to go into things like postnatal care or midwifery, rather than obstetric care.

CHAIR—Point well made.

Senator TCHEN—You said your association was formed in the early 1990s and it has continued to grow. I assume that means you have found the market. There are people out there who share your views and are interested.

Ms Grose—Who are interested in what we are interested in.

Senator TCHEN—Yes. My wife and I have two children. The first one was born in 1975 and the second one in 1980. One of the things that a lot of people are talking about is homebirth. My wife's entire family—all her siblings—was born at home. I was the only one in my family born in the hospital. All the rest were born at home. So we are familiar with the concept. When we had our two children we basically went through this process here. Our experience was that we walked through all this without any difficulties. We had no problem with information, choice or support. Both births were natural and we had no problem with the postnatal support either, and I think our two children are normal. Although, if you ask my 24-year old daughter, 'Are you going to have any children?', her answer would be, 'Ha'. So what happened between 1975 and now, that you have all this difficulty?

Ms Grose—If you look at this panel here, three out of four of us had wonderful birth experiences, that is why I am here. I agree with you. I went through all of those but I felt afterwards that a lot of it was sheer luck. I just happened to be someone who came from a background who was willing to question and read. When I look at what is generally provided, it is not what I got and I just feel that that is terribly unfair. Yes, there has probably been a bit of a shift, because when you look at the financial implications there certainly is not the fat that might have existed in the seventies.

When it comes to consumer perception that is another aspect. We have higher standards and that is a reasonable request. From the point of view of accepting that birth is a very important life event in a family, I do not know if that has always been accepted when it comes to how service provision is organised. It is a medical event, rather than an important life event for the people involved. So I think that is part of it, too. There is a growing awareness. People are saying, 'Hey, my needs are not being met through this service.' What might have been acceptable 20 years ago is not going to be acceptable now.

Mrs Tocker—Perhaps I could speak now. I had my first child in 1981 and she will be 18 next month. For my first two children I had an obstetrician in a private hospital and then quite a few years later when I found myself pregnant with my third child, I was fortunate enough to be given the opportunity to have an independent midwife and the contrast in the two styles of care was absolutely amazing. For my first two children I was not as aware and I did not ask as many questions. However, when it came to my third child it was extremely important that I had a supportive care giver, which I found with an independent midwife. I was very lucky at the time that she had admitting rights to the Mater Hospital. She was the only person, the only care giver that I had. I had her during my pregnancy, during the birth and also postnatally. It was a one-on-one relationship. The saddest day for me was when my third child was six weeks of age when I had to say goodbye to my primary care giver.

One of the reasons why I have become involved in this sort of work was because of the relationship that I had with her. If more women had that opportunity, there would be fewer interventions and much more personal satisfaction; how you feel and how you relate to and bond with your children—that sort of thing. That is my personal experience that may answer some of your questions because my time frame is similar.

Senator TCHEN—So is it fair to say it is a case of, ‘Hey, things could be better,’ rather than a case of, ‘Hey, things are bad’?

Ms Grose—It depends on what day you ask us.

Ms Renkin—From my perspective I was shocked when I came to use childbirth services because I expected them to be a lot better. So from my perspective I would have to say things are bad. I had asked for a natural birth—I suppose I had come from that perspective—but in a hospital program. I was shocked at the number of interventions I was offered over and over again. I was very shaken by that. This goes back to the issue about women asking for caesareans and when they ask for other options that are not in line with current trends.

Maybe the answer to part of your question is that technology has increased and with the increase in technology there is an increase in use, or there is a perceived need that it is going to be better if there is an increased use, even if it is not evidence based in terms of better outcomes. That has been my experience. There has been a push. Rather than saying, ‘Have your baby’, there is a push now that you should have these interventions and that they are going to be of benefit to you, even if there is no evidence to indicate that.

CHAIR—What sorts of interventions were you offered, Ms Renkin?

Ms Renkin—Epidural, artificial rupture of the membranes, a number of pain relief things, gas, epidural, vacuum extraction and so on. Caesarean was mentioned at one stage as well during the birth.

Senator GIBBS—This is just while you are lying there just waiting?

Ms Renkin—I was not lying there.

Senator GIBBS—Or whatever you were doing.

Ms Renkin—Yes. It was a very long labour.

Senator GIBBS—How long? When people say hours, they seem to talk about 14 hours.

Ms Renkin—Forty hours.

Senator GIBBS—Forty hours? That is long, yes. I agree with that one.

Ms Renkin—But from my perspective, I had made the plan that if there was a medical emergency or distress for the baby or myself, I would be willing to have interventions, but it seemed to me that the interventions were offered before that point was reached, or I certainly was not informed. There was no indication there was anything wrong with the baby through all that time. It seemed to be the fact that these technologies are here and we can use them. I had syntocinon as well to speed the labour up. I know from other people who have spoken to me that that is routinely offered to women, very early in labour. That is the information that I have had from women.

CHAIR—We are getting close to the end of time. But one of the things that follows from your discussion, which is very interesting, is where do people get the information from? How can you be sure it is the best information? On the evidence to this committee, even with the best information, a lot of people are not going to take it in unless they are able to talk it through with somebody.

Ms Grose—Definitely.

CHAIR—Even if it tells you down the back that ‘ante partum’ means before birth and that a ‘primigravida’ means that you have dropped one. The language of the whole process is a bit mysterious. But even if you do understand the words, it is often, ‘How do I work my way through this? How do I really know?’ There is this whole sense that we now have to talk our way through it. In times past you got pregnant and some nine months later, more or less, for a large majority of people, you had a baby. Intervention was one of those things that helped women or babies who previously would have died to survive.

It seems that what has happened is that a lot of those interventions are now being provided routinely for anyone, not with the criteria of best practice. That seems to be the evidence that is coming before the committee. None of us would oppose a caesarean section for an obstructed labour. None of us would oppose a caesarean section for a major haemorrhage. We are talking about life threatening of mother or baby. We are enormously impressed that there are the high-tech facilities now for the saving of those lives, which is why Australia has, despite its high caesarean section rate, pretty low infant and maternal mortality.

One of the things that you are saying that I think is very interesting, and it answers Senator Tchen’s question, is that there is almost a fashion in childbirth. The trouble is that the fashion at the moment has moved away from the normal naturalness of it all. It seems to me that what people are reporting to us is that there is a fight going on to reclaim territory

that says that it is normal and natural to have a babe by the vaginal process. It is interesting for the committee to wonder why that has gone away. What has happened? What is the pressure and how do we get it back?

Ms Grose—That is right. I think also it is a framework. Cathy talked about the imperative that, if the machine is there or the doctors are there, they need to be used, and that is coming at a great cost.

CHAIR—The other question is about the pressure. You suggest that there might be some point in funding the childbirth process so that there was a financial incentive toward vaginal deliveries. We have been told that in America, the one factor that saw a great reduction in the caesarean section rate was when the financial payment for vaginal birth was more than for a caesarean section, and very suddenly the caesarean section rate fell dramatically.

Ms Grose—I think that is true. As Kes mentioned, medical insurance is having quite an impact on the way—at least in the private sector—the options are available to women. Because there is still an attitude by organisations such as the Medical Defence Union that doctors and midwives should not be working together. Doctors should not be providing backup for visiting midwives. This causes a problem, because it is difficult for midwives to get the required amount of insurance in order to have access to visiting rights in hospital. That is just one little example. But from a consumer perspective, we feel that medical insurance is important so that consumers do have some sort of protection if there is an adverse event.

CHAIR—On the other hand, if the midwives were salaried from the hospital and they were to work out in the community, then presumably there would be the protection that goes with the hospital. Not that I presume by this that we should put all the midwives on the hospital books and they can behave badly. It is not that implication at all.

Ms Grose—That is certainly one option. That is one model. It would be even better if you salaried the private doctors. You would save a bit of money there, too.

CHAIR—It is very interesting. I have just looked at the Queensland figures. These are figures for 1996. The average percentage of caesarean sections across all of Queensland is 20.6. That is just over one in five births which are by caesarean. But it is 16.2 for public patients and 29.4 for private patients. That is near enough to double.

Ms Grose—That is right and you will find it is even more obvious if you include the other operative birth rates. If you include forceps and ventouse, it is clearly double. If we had access to individual hospitals and practitioners that would be even better, because from a consumer prospective we could make choices. You hear rumours that certain private hospitals have c section rates of over 60 per cent but we have no way of proving that. We would love to know if that is the truth.

CHAIR—That is a terribly interesting point. We have heard evidence today that the private hospital data is not available and it is not available by hospital. Where the data may be available to the hospital, they are not publishing it in their annual reports. The data is provided to the Institute of Health and Welfare so that we can talk about the figures overall,

but we cannot do it on a hospital-by-hospital breakdown in Queensland. It will be very little comfort to Queenslanders to know that you now can in New South Wales. In the last few years they have introduced—and we saw yesterday in a 1998 publication—statistics of this sort from all public and private hospitals across the whole state. A lot of people have suggested that this might also be very helpful for parents if they could look and say that they can get a sense of what the climate in that hospital is like judging from those figures. We are past our time. Thank you very much indeed for your contribution this morning. Just quickly Senator Tchen.

Senator TCHEN—Did you know there is a lot of this information you can obtain if you go and ask? If you go to a private hospital and said, ‘Do you do a lot of c sections?’ they have to tell you. If they do not tell you, go somewhere else.

Ms Grose—That is correct. On an individual basis that woman could choose to go somewhere else, but from the point of view of us as a consumer group getting that information now, I can only say to date that we have not been successful.

Senator TCHEN—Yes, I know. But why can’t you tell your audience to go and ask? If you do not like it, then walk away.

Ms Grose—Yes, certainly.

CHAIR—Also, that are a lot of hospitals.

Ms Grose—Yes, and they all have the same policy.

CHAIR—You can ask, but also I think the evidence before the committee is that not everyone can be comforted that they are provided with the full story from each hospital. I suggest that we should qualify ‘go and ask’, because I do not think it is good news or the full answer in every case at the moment. If it were, why don’t they publish it, is the other big question. If they have no trouble in telling you when you come and ask, why they don’t they publish it? One last comment, Ms Grose.

Ms Grose—I would like to make one last comment. I just wanted to mention that there has been some recent Queensland research published this year by Deborah Creedy. She is based at Griffith University. It looked at some of the outcomes for women. It is just to address that earlier question of yours, Senator Tchen. She gave a random survey of women a diagnostic test. Five point six per cent of women met the diagnostic criteria for acute post-traumatic stress syndrome after their birth and 33 per cent—in other words, a third of them—reported stressful a birth event with at least three trauma symptoms, and I am talking psychological jargon here. So that was the incidence.

The cause was associated with the level of obstetric intervention and poor quality care. If you look at those figures—admittedly it is a recent study—5.6 per cent of women is awfully high, with 33 per cent of women with some symptoms. If we were providing adequate birthing services, I do not think you would see those kind of results.

Senator TCHEN—Yes, I know. But earlier when I raised this question, you could just tell people to ask. In this country the answer to first party questions has to be accurate. People are not obliged to answer third party questions and that is why you may not be able to get information from other people, but to get accurate information is a legal right and you should tell your members this. They have a right to ask questions.

Ms Grose—Informed choice is a legal right, too.

CHAIR—Thank you very much. While our next witnesses are coming, I would like to thank you all very much for attending. We do not usually have such a lively participation in our hearings, and this is fantastic. I want to officially thank the audience here today. It is not an audience; they are called the attending participants, the non-evidence givers. I want to acknowledge how nice it is to have a sense of people being interested in what we are talking about. They may not necessarily be supporting it all, but they are at least very interested.

[12.46 p.m.]

BEGOLO, Ms Marina Adriana, Media Development Officer, Home Midwifery Association (Queensland) Inc.

BOWMAN, Mrs Dierdre Michelle, Association Representative and Committee Member, Home Midwifery Association (Queensland) Inc.

CHAIR—Welcome. Do you wish to make any comments about the capacity in which you appear today?

Mrs Bowman—I am also a childbirth educator and the mother of three children. My first two children were born in a hospital setting by caesarean section, and my last child was born at home.

Ms Begolo—I am a mother of two. The first baby was born in hospital, eventually by emergency caesarean section, and the second baby was born at home.

CHAIR—You are a fine advertisement! The committee prefers all evidence to be given in public, but should you wish to give evidence, part of your evidence or answers to specific questions in camera, you can ask to do so and the committee will consider that request. We have your submission, which is numbered 94. Would you like to make any additions or changes to that submission?

Mrs Bowman—We do not wish to make any changes, but we would like to submit some extra research information

CHAIR—Thank you. I would ask you to make a brief opening statement, and then we will have questions from the senators.

Mrs Bowman—I am probably going to go over a fair bit of the information that has been covered today, but that is probably not a bad thing. It is the habit of the medical profession and others in this country to unjustly label homebirth as unsafe. We are told that, in choosing a homebirth, we as consumers are putting our babies at risk of disease, deformity and, worse, death. Having said that, these are statements that have been put to us by general practitioners as well as by obstetricians in hospitals. These statements are unsubstantiated as abundant research supports homebirth as a safe alternative. The right to choose homebirth in Australia and to be supported in that decision should be the right of all women. It is an issue of freedom of choice and, for women who choose this alternative, it provides a much greater chance than hospital birth to experience a spontaneous, normal birth. I would like to make further note here of some of the statistics that you quoted previously. You quoted some caesarean section statistics from 1986. I have some here from 1987-88.

CHAIR—Are you talking about 1987 or 1997?

Mrs Bowman—Did you say yours were from 1986?

CHAIR—Mine were from 1996.

Mrs Bowman—Sorry. Mine are from 1987-88. They actually have not changed very much in that time. However, I have included in those statistics the operative delivery rates, which includes forceps delivery and vacuum extraction. At that time, the statistics were 31 per cent of women, which implies that one in three women in Queensland could not give birth normally but had to have their babies cut out or pulled out of them.

Other interventions, like electronic foetal monitoring—which we have talked a lot about—and ultrasound, are used liberally and, as you know, cost the government a lot of money each year to provide. Yet they have never been proven to be totally safe or to have improved outcomes. Women choosing to birth at home are less likely to have interventions. Research on that now shows a dramatic decrease in the use of IVs, electronic foetal monitoring, episiotomy, analgesia and anaesthetic as well as low caesarean section, forceps and vacuum extraction rates. Research also demonstrates that the best caregivers to attend women in pregnancy and childbirth are midwives. In *A guide to effective care in pregnancy and childbirth*, the authors state:

It is inherently unwise and perhaps unsafe for women with normal pregnancies to be cared for by Obstetric Specialists even if the required personnel were available.

Further, they state:

Midwives and General Practitioners on the other hand are primarily orientated to the care of women with normal pregnancies.

Many women would choose to birth with an independent midwife in Queensland in a homebirth situation but are restricted in their choices by a medical system which refuses to support women's right to choose where and with whom they give birth and to supply us medical backup from a homebirth situation should that become necessary. Giving birth at home can cost in excess of \$2,000, and it is almost impossible to find private health cover that reimburses for home midwifery care.

Women are discriminated against further because they are also unable to get Medicare rebate for homebirth. The new Medicare rebate for complex births does nothing to help these women in their choices but rather encourages even more excessive and unnecessary intervention by medical specialists. Homebirth midwives provide continuity of care, which we have talked a lot about today. We feel the ongoing and continuous care fosters growth as individuals and helps women build confidence in their ability to give birth and to care for their own children. Midwifery models of care promote both healthy babies and satisfying experiences. They succeed on both accounts where obstetrics fails. We believe the role of an obstetrician is to manage disease and to restore health. The role of the midwife is to supervise normal healthy women and to prevent complications. Optimal care can only occur when primary and secondary caregivers recognise their complementary roles.

There is a marked disagreement between the professions of midwifery and obstetrics—as we have noticed—as to what constitutes effective care, from having a nice experience to shaving another fraction of a percentage off the peri-natal mortality rate. However, in deciding what is effective or appropriate care, we must make a distinction between efficacy and risk. Scientists can measure the chance a desired outcome will occur and the chance an undesired outcome will occur, but the person taking these chances—and, in this case, the

woman—is the only one who can legitimately decide whether one chance outweighs the other.

We believe that homebirth is safe and that it is the woman's right to choose with whom she gives birth. Women should have the right to decide for themselves. For the purpose of time, we have endeavoured to provide statistical facts and have avoided the use of anecdotal evidence because it is often disregarded in favour of scientific data and research. However, it is our opinion that, when you consider the unique and individual nature of each woman and the events surrounding the birth of her baby, individual stories are crucial in understanding the complexity of the birth process.

Ms Begolo—Absolutely.

Mrs Bowman—In making this statement, we are requesting that the Senate inquiry committee make time to hear individual perspectives of birth, which I notice you already have. But, in that information we gave you, we supply some information on personal stories that you could read.

Ms Begolo—I fought a losing battle until 1.30 a.m. this morning with my Apple Mac to print out the information that I got together. So I have jotted down some little notes on the bottom of this that I will have to reel out from my brain, basically.

CHAIR—Try them now and, if you would like to provide them to the committee when your Apple Mac behaves itself, feel very free. That is no inconvenience. We can happily receive that at some later date.

Ms Begolo—Thank you, that is a great opportunity. I have written here in consumer terms that we 'demand' admitting and visiting rights for midwives. I hope you understand I am talking as a consumer with my little placard here. We demand that Medicare provider numbers be provided for all midwives, especially for our homebirth midwives. We demand that the homebirth option be available to all Australian women within five years time. Every woman in Australia deserves to be able to choose this option if she feels it is the right option for her. We also demand that funding be directed as the consumer market dictates.

I am a non-economics person. It seems to me that, if there is this massive waiting list for the community midwifery service—there is not anymore; this is as it stood before—and for the birth centre, why isn't funding going to provide more places in those services? There is an abundance of space in the normal labour wards. To me it is very simple. However, any of the hospital administrators will insist that it is incredibly difficult and that there is just not the money for the services the women want. I cannot agree with that at all. If the women want the service, why can't the funding be put into that service? Anywhere else in Australia, we talk about economic reform, a level playing field, strong and healthy competition and no market domination, but I do not believe that is what is happening at the moment with the situation as it stands in maternity services.

In reference to something you were talking about before, it would be fantastic if every hospital had to display, as you walked in the door to the antenatal section, a large flashing neon board that showed the operative statistics so that women coming in would be able to

say, 'Yes, this hospital has a 50 per cent caesarean rate. Perhaps I'm going to trundle off down the road.' I have to correct something on the *Hansard* that AIMS mentioned before: I received the AIMS information to go on our Internet site only yesterday, and I have not yet had time to put it up, but that will be done probably within the next week or so. So AIMS will have a presence on the HMA web site, and I have also offered that opportunity to a group called Backup, which is a group set up specifically to provide backup to women who have had a caesarean and are seeking alternatives. There are a lot of women who are severely traumatised by the caesarean experience, who would do anything to escape that experience again and who are furious that the system is not going to support them. They have to form their own support groups within the community to find that support.

I want to touch on the fact that if you have continuity of care in pregnancy—which I had with my second pregnancy with a homebirth midwife—you develop a very intimate and trusting relationship with that person. That is not usual in a hospital environment but, in a homebirth environment, it can be. I would have to say that part of my success in achieving my vaginal birth—my completely natural, drug free, euphoric, fantastic, nine-hour birth—the second time was that I found a person who said, 'You're right: you can do this. There's no reason why you can't do this. Of course you're right, Marina, there's nothing wrong with you for demanding this. If you want it, you work for it, and I'll support you.' I got what I wanted, and a lot of other women do as well.

I want to draw your attention to Fiona Tito's book. I have handed up chapter 10—one chapter, because that was all I could afford to photocopy—which is about obstetric litigation. That is some extra information for you. I have noticed that if one homebirth practitioner is litigated against, the AMA, in particular, submits lots of press releases about that and it gets splashed all over the media headlines. However, nobody seems to pay obstetric litigation exactly the same attention. This gravely concerns me, and I have included that chapter from the book. But the entire book, entitled *Review of birthing services*, which is by Fiona Tito and was published in 1996, would be very good and relevant reading for this particular Senate inquiry.

Somebody talked before about women choosing high intervention births. I want to point again at the media images that we provide for our little girls, our daughters. As a consumer, I am not in the nitty-gritty of a system, and I plainly do not want to be. I would like to look at a more social context. Every time I turn on my TV, what do I see and what do I see my four-year-old daughter watching? I see birth education such as bottle-fed babies everywhere and not one naked breast in sight, as if to publicly breastfeed is the most dirty and despicable thing you can do. I do not agree with that. If it is possible, I would like this committee to consider the implications of that type of advertising and to see whether something could be done about that.

I also see on TV dramatic, painful births, with a completely helpless woman screaming her head off and requiring to be rescued by doctors in gowns with scalpels or by ambulances. It is all very frightening stuff and enough to make a young woman or teenager think, 'This is not something I want to do. No, thank you. Give me my elective caesarean.' I do know women in their twenties who have chosen elective caesarean because they were afraid of the pain, of losing control and of having vaginal exams by men they did not know. The typical American TV thing of a woman having a pleasant birth has her on her back in a

prone position with partner here and doctor there—usually both male—and with a green mask and a gown. She has drips coming out of her arm. She pants and then says, ‘Oh, thank you.’ It is ridiculous. There is absolutely no credit going to the powerful woman who gave birth to that baby—and who would have done so without anybody around anyway, as happens quite frequently.

CHAIR—Good question: who is doing the pushing?

Ms Begolo—Exactly. I want to touch briefly on the point of the community midwifery scheme from a consumer’s perspective, having listened to other consumers talk about that scheme. I heard the Mater saying, ‘The number of people accessing the scheme has increased, and that means the quality has gone down. Consumers think that scheme has really gone down the toilet.’ There was a very active consumer group that participated in the review of the scheme, and they were completely ignored and resigned in frustration en masse because the hospital said, once again, ‘We can’t do it your way. You don’t understand the financial aspect.’ It is about money. They could not take money away from obstetric, ultrasound and other unnecessary services to support a service that was very much in demand, was very popular and had a very active consumer group lobbying for it.

I want to raise a different point about responsibility and the law. We had an interesting discussion with Dr Dale Wainwright, the then chair of the Queensland branch of the AMA, earlier this year about homebirth and about AMA policy on homebirth. They still pretty well do not support homebirth, according to the document they released in 1991, whereas RACOG made a different homebirth policy last year that said that they supported women who chose the homebirth option where, basically, they could oversee the homebirth practice. Everybody that I know is saying, ‘As consumers, if we choose homebirth, we don’t want an obstetrician looking over our midwife’s shoulder, directing her and telling her what to do.’ This statement is lip-service and nothing more.

We raised that point with Dr Wainwright. What came out was very disturbing to me, and I am wondering whether you can give us some ideas of how to handle this. There are two different ways of understanding professional responsibility. According to Dr Wainwright, if a professional is taking on any sort of client—but, in this case, it would be a pregnant client—and this client has specific requests as to her care but that professional feels that the professional themselves would make different decisions about that care based on their knowledge, it is their legal duty—according to the law and according to their insurance—to force that client to be compliant with their wishes. To not do so puts them in grave risk of litigation.

This really concerns me. With homebirth, we understand the midwives are privately employed by the client. They are there to support the client and to do as they are told—I mean that in a respectful way; I do not mean it in a non-respectful way. Our understanding is homebirth midwives are employed directly by the client. They are going to support that client’s informed choices. That puts our homebirth midwives, of whom I am a supporter—I am not a midwife myself—in a very sticky situation, because that means that they can then be taken to court and litigated against for not forcing a client to change their mind. In fact, in Australia, this has already happened. There have been two cases recently where this happened.

This is of grave concern to us because our midwives are trying to provide the service that women themselves are shouting for. They are usually women that are very dedicated and devoted, and they put themselves at grave personal and professional risk in order to provide this service. Personally, as a consumer, I do not think that is fair. I think it is fair that consumers have the right to complain and that we demand a high quality of service, but I do not think that it is fair that the homebirth midwife trying to provide that service can be caught out by a point of law and that her service is dictated by insurance.

CHAIR—I want to interrupt there and ask questions. We have gone well past your time and, I suspect, past the feeding time of lots of people in the rows behind—though I notice many of little ones behind have no trouble with feeding; they are doing it at will. Can we go to questions now? If there is something else that you two very much want to put on the record, raise that with me at the end.

Ms Begolo—There is one burning point about funding that I would like to speak about at the end.

CHAIR—Okay. Let us take some questions and see if the funding issue comes up. If not, yes, by all means.

Senator GIBBS—I will not keep you very long because your presentation was absolutely excellent. Can I ask you two a really personal question? If you do not want to answer, just say no. As you have both been through a birth in the hospital system and then a homebirth—it is obvious that it has made a big impression on you and you feel a lot happier about the latter—how has it affected your children? Sorry, ‘affected’ is not the right thing to say. Have you noticed a difference in your children in any way? Are they happier or calmer?

Mrs Bowman—I would just love to answer that question.

Senator GIBBS—This might be totally out of line. If it is, just tell me to butt out.

Ms Begolo—No, it is certainly fine and I have no problem in answering this question. My first child was born in 1985. I was very uninformed at the time and chose a hospital birth. That birth was very long. I laboured for 68 hours before I consented to having a caesarean section. I ended up under general anaesthetic for that caesarean section and, mainly because I was not informed about what an epidural would feel like and about what sensations I would incur, I became very frightened and insisted they give me a general anaesthetic. When I woke out of that, I did not see my baby for eight hours after I had had her. Bonding was non-existent. For months I did not bond with my baby. Now, 14 years down the track, I am still trying to mop up the problems from that situation. I never bonded with that baby.

A lot of people would say, ‘Well, that was a caesarean section,’ or, ‘that was a hospital birth situation.’ But, nine years ago, I gave birth to a boy born by caesarean section also. The difference was that I had employed an independent practising midwife with the intention of giving birth at home. The labour was very long, again, and I was 41 hours at home before I chose to transfer to hospital. I might just say my midwife supported me in that decision

and was confident that I had gained enough knowledge and information to make responsible decisions about what was appropriate care for me.

I transferred to the hospital and was treated very badly. I was told that I could possibly murder my child in doing what I was doing. I was told that if I did not succumb to a caesarean section immediately, my baby was at risk of dying. I was a very informed person. I had a monitor hooked up to me and I knew that my baby was fine, but they kept coming at me. Eventually, that doctor went off duty for the night and another one came on who was much more pleasant and helpful and asked me what I would like to do. I eventually gave in to the caesarean section. But in doing that I maintained control of the situation. I requested that my husband be present with me to take my baby immediately it was born, that my midwife be allowed to be in the operating theatre with me, that if there were any procedures that needed to be done to my baby that my husband and midwife would go with that baby to the neonatal ward to be checked out and that it would never at any time be handed to the total care of the professionals in the hospital. To this day, I have a wonderful relationship with that child. It has nothing to do with the fact that I had a caesarean, but it has everything to do with the continuity of care I received in having an independent, practising midwife.

CHAIR—I am very aware of how late we are, and I just wonder if we can have our questions and answers shorter if possible. I do not want to interrupt.

Senator GIBBS—It is probably my fault because of the question.

CHAIR—If you take responsibility, Senator, we won't worry.

Mrs Bowman—I did not know how to shorten that.

Senator GIBBS—I was just so interested. Do you think the bonding problem with the first child was a two-way thing or basically only on your part?

Mrs Bowman—Do you mean that the baby was not receptive to me as well?

Senator GIBBS—Yes.

Mrs Bowman—Absolutely.

Senator GIBBS—These are things that I am thinking of.

Mrs Bowman—She was very dopey from the drugs that I had been given and quite unresponsive. I had much trouble breastfeeding and so, after 10 days of trying, I gave up.

Senator GIBBS—That is sad. Ms Begolo, you had a homebirth. didn't you?

Ms Begolo—Yes.

Senator GIBBS—And the first birth was at a hospital?

Ms Begolo—Yes.

Senator GIBBS—Does it make any difference with your children? Is one happier than the other?

Ms Begolo—We discussed this just the other day. I have actually felt that my eldest daughter has a tendency to want to be rescued, to be dependent and needy and to want people to do things for her whereas the younger one, who was a homebirth, has no problems making a decision and following it through right then and there, sometimes to my detriment. What really stood out for me about the two situations was my own reaction afterwards. The caesarean had been totally unexpected. I went in demanding natural birth and had people constantly saying, ‘Don’t you want pethidine. You’re a bit silly with this natural birth stuff, aren’t you,’ despite the fact that when I booked in they had said, ‘Oh, yes, we can support you with a natural birth. You don’t need to drive three hours for a homebirth midwife. We can give you what you want.’ Once I was in there in labour, that was a lie. They did not have the slightest clue how to support me in getting what I wanted. It was a cascade of intervention situation. I am sure you are both familiar with it by now. When I woke up afterwards, I grabbed my child. I loved her fiercely and I felt this very oppressive weight of guilt. I suffered from postnatal depression from three days after the baby’s birth and was medicated for that. I requested repeatedly to see a psychologist or a social worker, and I was repeatedly told that the nurses were busy and that they would get around to requesting a person to come and see me. That did not happen in the whole 11 days I spent in hospital.

Senator GIBBS—That is dreadful.

Ms Begolo—I carried a burden of guilt and I did not have anyone to talk to about it. It was my reaction to having to overprotect that child that affected our relationship more than the actual way she was born. With Theo, that was not an issue; it was not a problem. I did not have that oppressive weight of guilt. Since that time, I have been able to change some of my behaviour towards the younger child.

CHAIR—I hate to interrupt. These personal stories are very useful for us, but we are desperately behind time.

Senator TCHEN—I have discovered a few points which I would like you to clarify. They are out of your written submission. In the first sentence you say, Ms Bowman:

There are voices in Australia which unjustly and inaccurately label home birth as dangerous. (Refer attachment 1)

Which is attachment 1?

CHAIR—We do not have the attachment with us. It is at the committee secretariat. Do not try to look for it.

Senator TCHEN—I was under a misconception then that it was in fact the first article, which is in a different typeface? That is not the one?

CHAIR—Do you mean is the ‘Historical Perspectives Series’ attachment 1?

Senator TCHEN—Yes.

CHAIR—I don't think so. Is the archival documentation entitled 'Synopsis of the Official Medical Plan to Eliminate the Midwife 1910-1920' attachment 1?

Ms Begolo—Yes. The attachments refer to the attachments on the original submission.

Senator TCHEN—So historical perspectives is not the one?

CHAIR—It is the one and it is not the one, Senator. Ask the next question.

Senator TCHEN—The reason I ask that is because this one is 1910 to 1920. Those voices would be long dead. It says here:

There are voices . . . which unjustly and inaccurately label home birth as dangerous.

If it were 1910 or 1920, those voices would be long dead. They are not here.

Ms Begolo—The reference was given as an example of the types of attitudes that have been at work to wipe midwifery out of the business environment of maternity services. That statement was not a quote or anything.

Senator TCHEN—The second one is that you said:

This submission is based on the following undeniable facts:

1. Healthy women are physically able to gestate, birth and nurture their babies anywhere, anytime and alone if necessary.

Yesterday the committee heard evidence referring to a survey of about 158 home births. Twenty per cent of those required emergency transfer to hospitals. So how do you define 'healthy'? What do you mean by 'healthy'?

Ms Begolo—I have no idea of the research that you are referring to. I can only go on the Queensland research.

Senator TCHEN—I am not challenging you on that. I am just saying that that says 'healthy women' and I want to know how you define 'healthy'.

Mrs Bowman—I guess we are talking about women who do not have predisposed reasons for being in hospital.

CHAIR—For the clarification of us all, I am not absolutely sure—if I am wrong, Senator, please forgive me—but sometimes what causes a woman to be transferred urgently to hospital may be the discovery of twins or a bleed, neither of which makes her unhealthy. They just make her at risk. As I understand it, the statistics were trying to say that a percentage of people were transferred for particular reasons. I do not think it was trying to suggest that that was counter to most women.

Senator TCHEN—What I was concerned about is that this seemed to be a general statement which said ‘all women’. I know that is probably not what you meant, but your particular sentence can be read as, ‘All women should have home births.’

Mrs Bowman—That is certainly not what it is meant to say.

Senator TCHEN—That is right. That is fine, but that is how it reads at the moment.

Ms Begolo—That is not what we lobby for. We lobby for all women to have access to the choice and to the options.

Senator TCHEN—I understand that, but that is not how this sentence reads.

Ms Begolo—I apologise profusely.

Senator TCHEN—That is all right. I have another question which I have now lost track of. Maybe I will pick it up again. You go ahead.

CHAIR—The members of the committee would very much like the opportunity to go to New Zealand, Holland and England to have a look at their home birth practices. Of course, this is not allowed, and we do not have time for it, but it is fairly interesting. I would like to thank you for the bibliography with all these articles about home birthing, for instance, in the UK or in the Netherlands, where this is not still regarded as a battle to convince people. It is very helpful and assists the committee a whole lot to have such articles as the *British Medical Journal* editorial, 1996. It is not exactly a raving leftie feminist rag, is it? It says ‘Home birth, Safe in selected women, and with adequate infrastructure and support’. That is one of the things that I think is the thrust of what you were saying.

Home births do certainly get a very bad press. One thing goes wrong for home births and the ceiling falls in. What concern does your organisation have to ensure that, if women make this choice, they are provided with optimal likelihood of a good outcome? You talk about transition to hospital if something should go wrong. I would also like to ask Ms Begolo if she can have another run at that sentence in the conversation about legal liability. It says that the midwife is employed by the woman to do what the woman says. Sometimes the midwife is properly going to have to say, ‘This must not proceed here. You are now at risk.’ The mother could certainly say, ‘I’m staying,’ but that would put the midwife in an invidious position. I wondered whether we are not talking about a much more equal relationship between a midwife who has expertise and a mother who has a baby coming.

Mrs Bowman—As to the first part of your statement about what our responsibility is to inform women—

CHAIR—Not so much a responsibility. I beg your pardon—I must have said that wrong. What do you see as the best way to advertise home births and, at the same time, take account of the fact that sometimes people will have to go on to hospital?

Mrs Bowman—Firstly, I need to say that it is not our position as an association to dictate to women what their rights are. What we do is provide a support and referral system

whereby women can come, seek information, talk to midwives and mothers concerning birth and its outcomes and seek out an independent practising midwife of their choosing. In doing that, we encourage women to ask lots of questions. We encourage them to talk to midwives about their transfer rates and their statistics, to ask for a visible form of data that supplies those statistics to them and to inquire about the types of care that they are prepared to give and the types of care they are not. Again, it becomes the woman's responsibility. We cannot dictate to her what she should choose.

CHAIR—Ms Begolo, did you want to add some words about that relationship between the midwife and the mother?

Ms Begolo—Yes. It is a really different relationship from the one you would have with a person who you see in a hospital once a month for 10 minutes until the baby is born. It is a much more respectful relationship. You come to a point where the two in this relationship become friends. That is what has happened to me, and that has happened to most people I speak to. You are respected as an autonomous individual with reasonable boundaries and the midwife is the same—an autonomous individual. You choose to relate to each other truthfully about all the possibilities, outcomes and information about that person's health care. Also, home birth midwives tend to point the mother off in the direction of finding her own information and finding out what she needs rather than trying to provide her with everything. It is just not possible to tell somebody everything about their particular body and their health. How would I rephrase that? Midwives are—

CHAIR—I think you have done extremely well, Ms Begolo. I understand what you are saying. You were making that point vis-a-vis where the legal liability lies. You were not saying that the midwife will do whatever the woman says. As I understood it, you were saying that, legally, the midwife is effectively answering to the woman who has hired her, employed her or contracted with her for the purpose of this delivery, and that is different from how the two of them are going to get on from day to day.

Mrs Bowman—Even in this inquiry, we hear a lot about informed choice, informed decision, best practices and evidence based practice. As I see it, it is part of the job of this association of independent midwives to supply unbiased information to women on all the procedures and types of care, all likelihoods of problems that could go wrong and the for and against of those issues. Then it is the woman's responsibility to make that choice. However, where the legality comes in—and this is something we have been debating ourselves at the Home Birth Conference just recently—there may come a point where the midwife has to say, 'I'm sorry, I don't feel comfortable with where you are at. If you choose to go ahead, I cannot choose to support you.' But that needs to be a decision that is made independently.

CHAIR—We have to finish. I want to thank you very much for coming.

Ms Begolo—Senator, I have to clarify that point because that is not quite what we discussed at the conference.

CHAIR—Can I ask you to take that on notice and write to us? It is an important point in the detail, but I have to finish. We are now way over time. I am sorry. If you could drop that on a line to us, that would be really useful.

Ms Begolo—Did you want the same with the funding? There is something very quick that I could say on that issue.

CHAIR—In 30 seconds—and I am watching.

Ms Begolo—Okay. If there were another way of making funding available to home birth or alternative birth programs, perhaps that way could be for independent midwifery group practices, independent practices or home birth associations like our own to get a per pregnancy payment of X dollars which we would then administer as a body. We hire the midwives. We dole the money out. We pay for the insurance. We take some responsibility. In effect, we would be paid for X number of births per year by being given this amount of money to do it with.

CHAIR—That was 20 seconds—excellently done. It is extremely interesting to the committee. We are becoming more and more aware that there are pockets of information where people may know a lot. There are very uneven childbirth or antenatal educational services around Australia. That was huge 20 years ago, but it seems to have gone into the doldrums. In some places it is emerging very strongly. In other places it is not out there.

The one thing that is interesting is how consistently up the noses of people the homebirthing organisations are. It may be that you are just regarded as the worst example of that whole range of people who want to do something else besides the standard delivery. There is a recognised flag out there called 'homebirthing'. A lot of people are not going to choose it, but you have not been deleted from the landscape of childbirth and public information, and for that we do thank you. The committee stands adjourned for lunch.

Proceedings suspended from 1.26 p.m. to 2.11 p.m.

FAHY, Dr Kathleen Margaret, Associate Professor and Master of Midwifery Course Coordinator, University of Southern Queensland

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

Dr Fahy—I am also an active member of the Australian College of Midwives. They will be making a separate presentation.

CHAIR—We have your submission, which is No. 15. Is there anything you would like to change or add to that?

Dr Fahy—I am checking that we are looking at the same one because I originally sent in a submission fairly early, under my own authorship, and then Karen Lane read it and had some things to add, so we sent in a new one.

CHAIR—Excellent. I invite you to make a brief opening statement. I warn my colleagues: we are going to have to be fierce in terms of time. We are very behind. I apologise to you for that.

Dr Fahy—I expect that what I will say will be different from some of the things that you have heard. I have looked in *Hansard* at some of the things that were said in Canberra for instance. Some of the things that I am going to say are quite different. I would like to situate what I am going to say by talking about the experience by which I came to hold the views that I now hold.

CHAIR—Can you do that, Dr Fahy, and can you also tell us, perhaps at a later stage, which particular points you disagree with?

Dr Fahy—There were things about caesarean sections and intervention rates, that kind of thing, which I think will come up naturally. If they do not, I will be happy to address them.

CHAIR—Thank you.

Dr Fahy—Five years ago I shared the conventional belief that medicine has made childbirth safe and that hospital birth with direct medical support is the safest way by far to give birth to a baby. My understanding has undergone a radical revision which initially was difficult for me to believe and emotionally difficult for me to deal with.

My education around the safety of birth began because I completed a PhD in sociology while practising as a community midwife at the Young Women's Place in Toowoomba, studying teenage transition to motherhood. During that time, everything I had been taught about birth, obstetrics and midwifery was challenged and had to be re-conceptualised, reconsidered and evidence had to be found. Of particular significance to my increasing consciousness around the factors that make childbirth safe was reading Marjorie Tew's book *Safer Childbirth*—and I have referred to that a lot in the submission.

In addition, and very persuasively for me, the House of Commons select committee report, also called the Winterton report, accepted Tew's basic arguments and epidemiological evidence and drew the following conclusion:

The policy of encouraging all women to give birth in hospital cannot be justified on the grounds of safety.

Another factor that was very influential in causing me to probe further and to look deeper was the media outcry around the Maggie Lecky-Thompson case in Sydney and the way in which the Bastian study—do you know to what I refer when I refer to the Bastian study?

CHAIR—Please help us.

Dr Fahy—You probably remember from the media report that the Bastian, Lancaster and Keirse study was presented at the time as evidence that homebirth was very unsafe, that babies were dying in homebirth and mothers lives were being put at risk. The Medical Association of Australia made a big public comment about it. There was a lot of muddying of the waters around the whole issue. I had to get an expert in research to look at it because I could not understand that homebirth was unsafe. It did not seem to read that way to me, but then I am not a statistical expert. Maybe I made a mistake. The expert confirmed for me that the evidence in that article showed that homebirth for low risk women, which is 90 per cent of the population, is safe. What that study showed and all that that study showed, even if we accept the methodological basis, was that for women who had high risk pregnancies, that is, twins or premature births, it may be less safe than hospital birth, but for low risk women, homebirth was safe in Australia. To their credit, Bastian, Lancaster and Keirse have since agreed to that and written it in the *British Medical Journal* 1999. I have got the reference for that if you want it.

CHAIR—We would appreciate that.

Dr Fahy—That is in the submission, I think you will find. At the time that article was published, I had been collecting data on the safety of out of hospital births, particularly data around birth centre births and homebirths in other countries, but my efforts intensified. So when the Senate inquiry came, I was still in the process of collecting data—I have brought some along with me today. I am not ready to write a full academic article on the safety of birth, but that is my intention. This submission represents a first draft towards a midwifery critique of the evidence around the safety of out of hospital birth, which includes birth centre birth and homebirth.

Essentially, in this submission I am providing evidence that there is no scientific support for the medical control of birth for low risk women who constitute 90 per cent of Australian women. I am giving evidence to support the claim that medical involvement in low risk birth worsens rather than improves health outcomes for mothers. For babies it may be about the same or worse and there is no improvement in peri-natal mortalities. I want to present evidence that women and their families do not have available to them adequate information in relation to the choices of safe practice. Neither do they have adequate choices in birth, as we have known for a long time. It does not seem to matter how many times we say it; it makes no difference in real practice.

Finally, their support for the recommendation that midwifery models of care, as defined in my paper—there are a lot of misnomers about what a midwifery model of care is—are best clinical practice. It is the safest. It is the most satisfactory and by far the cheapest way to provide birthing services for well women in Australia. In my capacity as the coordinator of a master of midwifery course, I have been challenged to develop that course as an evidence based course. I and my colleagues are constantly reading the evidence for the practices that we are recommending for students in the course. Only about 20 per cent of practices have any evidence. That is because the medical control of childbirth happened without any evidence and still does not have it.

Where the evidence does exist, often the obstetric protocols which control midwifery practice, and therefore what happens to child bearing women, are counter to the evidence that is available in terms of research evidence. I have been involved in a partnership arrangement to deliver the midwifery course that we delivery. The students are employed at Cairns Base Hospital and next year at Toowoomba Base Hospital and a couple of rural hospitals, including Thursday Island hospital. The issue of indigenous birthing has been really important to me at different points over the last five years. I was a member of a regional health authority when Queensland Health, with federal government prompting, decided that they were going to make birthing on the homelands happen in Queensland. That was nine years ago.

There have been loads of money spent and numerous committees and all kinds of wise medical people have decided that it is not safe. I am here to say that for indigenous women it is four times less safe to have your baby now, and that is with as much medical control as we can possibly place on indigenous women. They are taken from their communities. They are forced to live in hostels away from their families. They are hospitalised and medicalised and treated, and still we are not making it. We cannot improve it by increasing medical control. That is not the way. It is a primary health care issue. It needs an indigenous-friendly approach. Birthing on the homelands is something that I think we really have to take a handle on and really do something about. That is enough for now.

CHAIR—Thank you, Doctor.

Senator GIBBS—I am very interested in your opinion that for indigenous women to give birth in hospitals is four times less safe.

Dr Fahy—Can I rephrase that? That is not exactly the meaning that I meant.

Senator GIBBS—What did you mean?

Dr Fahy—I am saying the peri-natal mortality rates for indigenous women are about 3.6 compared with white Australian women, and as part of that they have their babies in hospital. I am not saying if they did not have their babies in hospital that it would be the same or less than white women. We just do not know. But I do not believe it could be any worse.

CHAIR—Can I be clear about those figures. Some of the latest evidence we have would say 1.5 to two times more likely to have peri-natal mortality than—

Dr Fahy—I am not going to challenge that figure because I have not looked recently. But when I looked—and it was not that long ago—

CHAIR—Did you say peri-natal mortality?

Dr Fahy—Yes. Peri-natal mortality was three to four times higher than for the white population.

CHAIR—Our figures are 1.5 to two, as the latest quote. About two times is the figure that it has come down to. More recently we were told three times, then in the evidence in this inquiry, 1.5 to two times more likely.

Dr Fahy—Which state are we talking about? Are they Australian figures? I looked at the Australian figures from the Australian Bureau of Statistics in about April or May this year.

CHAIR—What we will do is see if we can find a note here. But it is interesting to have your figures and appreciate where you are coming from is access to a lot of data, and the committee is assisted by that.

Dr Fahy—I am only going on my recall of it, but I feel fairly confident of what I read in the Australian Bureau of Statistics figures.

CHAIR—I think you may indeed be recalling accurately. I would not criticise your recall. Sorry, Senator Gibbs, I interrupted you.

Senator GIBBS—We have heard a lot about the problems with indigenous women in all of the states where they have to travel long distances and stay in motels. What has actually come out of this is that for the women to give birth in their communities or closer to home, because of the culture it would be beneficial to train midwives.

Dr Fahy—Indigenous midwives.

Senator GIBBS—Of course. Proper training, proper handling, proper care. How do you feel about this and how do you think we can implement this?

Dr Fahy—I think we could implement it next week. I really do. And if I was going to implement it I would implement it at Yarrabah, 20 minutes outside Cairns; half an hour by road and 20 minutes by helicopter. It could happen tomorrow. There are indigenous health workers there who are very well educated in antenatal care and have excellent relationships with child-bearing women. The white midwives, as I understand it, take a secondary role to that and provide back-up and support. There is absolutely no safety reason why, for the well woman whose baby is not premature, she cannot birth her baby there in that hospital. But there are lots of political reasons which I will not discuss here.

Senator GIBBS—You can tell me privately afterwards.

CHAIR—I must say that if you judge that those reasons are able to be on the public record, I think it would help the committee to hear them.

Dr Fahy—I wish I could. You see, they are hearsay. I know people at Yarrabah. I know people who have worked there. I know people who are currently working there, people who have had senior positions there—

CHAIR—You judge they cannot be put on the record.

Dr Fahy—And they tell me things that are hearsay.

Senator GIBBS—Maybe I should take a visit up there and talk to them myself. You might be pleased to know that in other states they are actually taking the models from North Queensland and trying to implement them, or are in the process of implementing them.

Dr Fahy—What, bringing women into major capital cities, away from their families?

Senator GIBBS—No, the other way around. They are actually looking at the model of indigenous women looking after their own on the—

Dr Fahy—But that has to include birthing.

Senator GIBBS—Of course it does. What we have heard in other areas in other states, particularly in South Australia, is that, as far as midwifery goes, they are going to introduce a four-year direct entry university course—

Dr Fahy—I absolutely support it.

Senator GIBBS—Do you think this will raise the status of midwives?

Dr Fahy—Absolutely.

Senator GIBBS—I will rephrase that. Not raise the status but, in terms of as how obstetricians regard and treat midwives, that if they have this university course they might be looked at as more of a professional and an equal than they are now. We have been hearing so much of this culture and this professional animosity by obstetricians towards midwives, that they do not regard them as they should.

Dr Fahy—You ask a lot of things in one go, in a sense. I would answer this way. I do not think it would matter what qualification was the qualification for midwifery. I do not think it would matter whether it was a diploma, bachelor's degree, masters or PhD. If midwives being able to practise midwifery depends upon the support and encouragement of the obstetricians, we are pushing uphill. We really are. I think we have to accept that the kinds of things I am suggesting, that is, that 90 per cent of Australian women could be cared for under a midwifery model of care at a cost that that would cost without a hospital stay for most of those women—you come in, birth your baby and go home—would totally undercut obstetrics. There would be so little left. And there are so many trained obstetricians and obstetricians in training. The whole system is designed to support the training of obstetricians and the obstetricians will be in charge. If only 10 or 15 per cent of women—or let us blow it out and say 20 per cent of women—actually need medical intervention, then

the kinds of things I am suggesting are quite radical, and I do not expect them ever to be supported by obstetricians.

Senator GIBBS—But if we adopted this model where we have the low risk women who come into the hospital, give birth with their midwife and go home, isn't this going to have a significant impact on the health budget?

Dr Fahy—A fantastic impact.

Senator GIBBS—I need this to get this on the record. That money that we save out of the health budget could go to other areas of dire health need, because we always need more money for the health budget.

Dr Fahy—Exactly. Like sick people actually being able to get into hospital and actually being able to stay there and well people staying out, like pregnant women. As I understand it, the number one reason for admission to Australian hospitals is pregnancy, and that is not an illness. It is not a disease. It does not require medical intervention unless there is some illness or disease that happens as part or intercurrent to that. If pregnancy was not a reason for admission to hospital, I cannot imagine how many billions of dollars that would save, but absolutely billions.

Senator GIBBS—It is the highest intake to hospital beds in one particular year. I will not keep you long on this, but can I just get back to Yarrabah and the indigenous women up there. Are you telling me that there are actually trained Murrie midwives who practise?

Dr Fahy—No, there are Murrie health workers, and I have heard from midwives who work alongside them that they are excellent. That is all hearsay, but I do not have any reason to doubt it. They can have a woman in strong labour not wanting to go and she will be pushed into an ambulance and made to go to Cairns and have the baby on the way or just as soon as she arrives there. It is crazy stuff.

Senator GIBBS—We can actually implement this next week if we want to?

Dr Fahy—I think we absolutely could.

Senator GIBBS—It is very interesting.

Senator TCHEN—Your submission is in line with a lot of evidence we have received already. Can I ask you something that came up to us in evidence yesterday? It was suggested that there may be some tensions perhaps between what was described as academic midwives and practising midwives in the way they see the current system and how far changes have to be made to it. The academic midwife analogy is to the retired academic doctors, who tend to be very critical of some of the medical practices which they are no longer involved with. The academic midwives tend to be perhaps more critical than they need to be to the extent that the relationship may be, in describing the term, called horizontal violence. Have you heard that, and can you comment on that?

Dr Fahy—Yes, I would like to comment on that. I think there is a real potential for people who do not practise to live in ivory towers and to cast stones. I think there is a real potential and I am not saying that does not happen, but it is not true in my case. I very recently practised in a community health centre as a midwife. If you want to know what real practice is, then working with disadvantaged single teenage mothers who have been thrown out of their homes and have sexual abuse in their backgrounds and going with them when they go to the hospital, and being part of their experiences, is a very real practice of midwifery. In addition, I have practised part-time at the local base hospital. So I am very well aware of the experiences that midwives have to work under.

I would like to tell two stories that will exemplify practice now. One concerns an indigenous young woman who gave birth at a major base hospital. She had hypertensive disease in pregnancy. She was 17 years old. She had never been outside her community. English was her second language. She was brought down with a support person to this particular hospital and she was admitted to try and stabilise her hypertensive disease of pregnancy. Her support person was not present and there is a whole lot of cultural evidence about how unwelcome support people feel in white Australian hospitals. When she laboured, she was left alone. Here she was, in a totally alien environment, lying on a bed experiencing labour that was induced by oxytocin, crying and frightened.

The midwives could not stay with her, not because they did not want to but because they were given too much work to do because things are seen to be more important than staying with somebody when they are labouring. The midwives were each given two or three other labouring women to care for, and it should be one on one care. You know how much we spend on ultrasound, which has no evidence base for improving outcomes. It is billions. But we cannot have a midwife stay with a woman in labour. We are really a sick society in relation to childbirth.

This young woman lost it, and why wouldn't she, crying and writhing, and the answer to that was, 'I'll get her a epidural.' That is what happened. She had the epidural and then she had the caesarean. You would love to think that that is a really way-out example, but it is not, it is a common every day example. The midwives cry because of it and they burn out for it. They get out of midwifery. Some of them harden up and most of them find ways of coping, but it is really common and it is really horrible. I have forgotten what the other story is. That is good enough.

Senator TCHEN—You said you have four main topics and you provide evidence in various parts. On your second point, you said you have provided evidence to support the claim that medical involvement in low risk births worsens rather than improves health outcomes. Again, that is similar evidence to what has come before us already, so I do not want to particularly argue about that. But I have noticed that the evidence you have quoted here, although it was published in 1990, it was actually 1958 and 1970 data out of England. Surely obstetrical practice in Australia today can be expected to be quite different from England in 1958 or 1970. Do you have other information that can throw some light on this?

Dr Fahy—I think there is other information. I might just need to find it in here.

Senator TCHEN—You do not have to do it straight away.

Dr Fahy—The reason that Tew’s work is included is that that was census data. Every single birth that occurred at that time was recorded and the analysis was done. That was only ever done twice, and it was done by the obstetricians and gynaecologists. They were absolutely convinced that they would show how much safer childbirth was.

Senator TCHEN—And they have never done it again. I can understand that.

Dr Fahy—They stopped doing it, and they never will. Just as when we now say that home birth is safer than hospital birth for low risk women, there is plenty of evidence but there is no randomised controlled trial that is going to show that. You are never going to get it because ethically you cannot do it, but there is no evidence on the other side. I see it a bit like how maybe judges and juries have to weigh the evidence. The evidence on the safety of out of hospital birth is quite large and expanding. The Cochrane Library is seen as the place where they can evaluate research evidence. It is interesting that the Cochrane Library has not put out a position on this because they say that the evidence is not of the kind that they like, which is the randomised control kind. But the author, Olsen, who is the only author who is included in the Cochrane Library in relation to home birth, has done a meta-analysis of home birth. He argues quite convincingly. He was certainly persuasive in my understanding that the evidence from around the world is that home birth—and particularly birth centre birth—is much safer than standard hospital birth. Have I answered the question?

Senator TCHEN—Actually mine was not a question; I was hopeful you might have more current data that you could present.

Dr Fahy—About that epidemiological data.

CHAIR—The data is actually terribly interesting. If you have a look at it, to my mind what it shows is that the peri-natal mortality in England fell dramatically between 1958 and 1970. There was an extremely interesting drop in figures, almost shockingly dropped. If you look at this graph from north to south, it is really interesting that in every category there was a very significant reduction in peri-natal mortality. Then if you look horizontally, it is an extremely powerful set of data. In both of those categories, despite the significant drop, the peri-natal mortality was much worse in an obstetric unit than anywhere else.

Dr Fahy—Absolutely. The figures have been around for a long time, as you say, but they are still absolutely persuasive.

Senator TCHEN—It persuades me that there is something wrong in England.

Dr Fahy—Does it?

Senator TCHEN—But it does not persuade me that in fact in Australia we have the same thing still apply.

Dr Fahy—I think the argument absolutely applies. I do think it is really important, when we think about generalising data, because we can get this cultural cringe in Australia that says—and this is often what happens: ‘If the research supports the argument that we should

have more obstetric control, then we will take that on board. But if it doesn't, then we will say it wasn't done in Australia.'

CHAIR—Can you tell me in this data what a GPU is?

Dr Fahy—It is a general practitioner unit. It is a rural hospital. This is one of the huge sadnesses for me. Rural hospitals are being closed down all around Australia on the basis of absolutely nothing. The rhetoric has been—I used to believe it, so I cannot be too critical—that it was not safe for women to birth in rural hospitals. In fact, it is a lot safer. Those figures would be available; Queensland health figures would be available. Somebody has to do the work that Marjorie Tew did. Marjorie Tew was an epidemiologist. She was teaching in a department of obstetrics. She was teaching medical students epidemiology. She came across these figures and thought she would use those as the basis for teaching students, and all this unexpected stuff came up. That is the basis for her book and her subsequent book. She not only wrote that book but she has continued to read the international literature on the safety of out of hospital birth and continues to add that to her book. Maybe it is her 1995 book, if you want more up-to-date figures, but I agree with you when you say we will never get another census. That just will not happen.

Senator TCHEN—I am not looking another census if you say it has not been done, but there must be more up to date information that would be helpful to us.

Dr Fahy—I have got some of it. If we are talking about the safety of out of hospital births, yes, I have got some of that.

Senator TCHEN—You do not have to look for it now. I am sure you can make additional submissions.

Dr Fahy—Yes.

Senator TCHEN—I do not think you will get any argument from me about the closure of country hospitals either.

Dr Fahy—It is really sad and it is still happening.

CHAIR—There is one other very good criterion—it is called dollars. We might have to come back to that.

Dr Fahy—Yes, I have got suggestions for that.

CHAIR—Excellent, Dr Fahy. Can you tell me about how you get to be a midwife in Queensland? I understand that one group of midwives is what used to be called double certificated nurses, and I am not sure these days whether you are an enrolled nurse—an EN?

Dr Fahy—Yes, EN, and an AIN for an assistant in nursing.

CHAIR—Thank you very much. That allows you to become double certificated?

Dr Fahy—Oh, no.

CHAIR—Oh, no? Oh, no what?

Dr Fahy—An AIN is an untrained person or she may have done a small amount—

CHAIR—What does it stand for?

Dr Fahy—Assistant in nursing. Most AINs are—

CHAIR—So an EN is the one who goes through university?

Dr Fahy—No. An enrolled nurse now, I think, does a TAFE course, but up until fairly recently it has been hospital based training. It is a one-year course.

CHAIR—Who is the nurse who can go on to do a second certificate?

Dr Fahy—The registered nurse, and they have bachelor degrees all around Australia now. Bachelor degree nursing has radically changed the way we think about everything, and I think we as academics, we as nurses and we as midwives are still coming to terms with that. One of the outcomes has been that, in Queensland and all across Australia now, to be a midwife you first of all have to be a registered nurse. So, if you want to be a midwife, you have to be a nurse even though you do not want to be. Then you generally have to have a year's clinical experience and then you have to do a graduate diploma or a masters degree in midwifery in order to be a beginning practitioner in midwifery.

It has now become so clear to us in midwifery that this is excluding and slowing down the training of people who want to be midwives. If we can have a direct entry bachelor of midwifery then people who want to be midwives can train in three years. It also gives us the opportunity. We have got some lay-midwives across Australia, and I am sure there is a huge variation in their competence and skill, but some of them are fantastic and could, through a process of accreditation of prior learning, be given advanced standing and progress through this course into—I hate to say 'obstetric nursing', but I was really trained as an obstetric nurse. I have had to learn midwifery, to the extent that I have, the very hardest way, because it wasn't possible. But I think the homebirth midwives actually have knowledge and skills that we need in midwifery more generally.

CHAIR—Can you please comment on whether we need to have some kind of registration of midwives that would include direct entry? They would be double certificated or whatever you were telling us is the program. It may even include people who have learned midwifery through some other program or opportunities and who may have skills, but who—I think for the comfort of themselves and the community—need to come under some kind of registration process.

Dr Fahy—This might seem strange for an academic to say because I am generally very supportive of higher education, but I have certainly met independent midwives who are lay-midwives, who are extremely well educated, and who apparently—I have not seen their practice directly—are very skilled, very experienced, and they should be able to be

registered, in my view. I would be interested in how the Australian College of Midwives Inc. would answer that, but in my view absolutely.

Senator TCHEN—These are lay-midwives?

Dr Fahy—Lay-midwives. They should be able to be registered in terms of competencies. We have a set of competencies for it.

CHAIR—A lay-midwife is actually a person who has done no formal training?

Dr Fahy—No formal training—a traditional midwife. They have done apprenticeship training—often very extensive.

CHAIR—Where do you do traditional training in midwifery?

Dr Fahy—The Home Midwifery Association were presenting before me. I believe they have a home program, an apprenticeship program, that goes over a number of years and has competency criteria. I have not looked at it deeply but I have seen it. What I saw of it looked impressive. Elizabeth Davies, who is a world renowned midwife, a traditional midwife, and who has written major texts in midwifery that are used by hospital based midwifery courses, has got a PhD in holistic health. She is a very impressive person. She is registered in the United States. She was never a nurse and she has never done a bachelor of midwifery. I think it is something that is possible and should be done.

CHAIR—‘That is possible and should done’ refers to registration?

Dr Fahy—Midwives who meet the competency standards of the Australian College of Midwives, through whatever means, should be able to register as midwives.

CHAIR—There is an agreement about what those criteria might be?

Dr Fahy—I think there is nationally. The Australian College of Midwives standards, I believe, are the standards by which midwives now register, but they always do a formal course of training first.

Senator GIBBS—Weren’t they always nurses, RNs, who took on midwifery after—

Dr Fahy—Yes.

Senator GIBBS—It has always been like that in Queensland.

Dr Fahy—That is the thing. Let us just talk about that for a minute. When I trained in 1971, there was a clear career pathway for being a nurse. You were a registered nurse, you worked for a couple of years or you went straight into midwifery and you became a midwife. Most people never practised in midwifery. We might have been—I think we were—a very cheap labour force. You got a certificate at the end for your year of service.

It is not like that now. Education is a very expensive commodity. Students are paying for it themselves. The health departments around Australia are saying that they do not have enough midwives. Mind you, that is a lot about the way in which we organise maternity services, and we could do much better with many less midwives than we currently have. The notion that we will continue to get midwives via bachelor degree, graduate diploma, masters degree is ludicrous. We need to have people who only train as midwives, train for three years and then practise as midwives, not get a certificate and then never practise—it is ridiculous.

CHAIR—I wanted to turn to your interesting stuff about the adequacy of information provided to expectant mothers and their families in relation to the choices for safe practice available to them, which starts on page 14. It is somewhat depressing. Essentially, what you are saying is that you—was it you?

Dr Fahy—This particular part is Karen's writing.

CHAIR—She contacted a number of hospitals around Australia and got no information of any importance.

Dr Fahy—She did. That is right.

CHAIR—And I am not sure where the Diamond Valley Mercy Hospital is. Are you able to tell us that that is Victoria?

Dr Fahy—Yes.

CHAIR—Alexandra District Hospital?

Dr Fahy—I understand it is Victoria because Karen did this and she is a Victorian.

CHAIR—They are all Victoria.

A member of the audience replying -

Ms Cornfoot—They are all in Melbourne, or most of them are.

CHAIR—Yarrawonga is not quite, is it?

Ms Cornfoot—Most of them are.

CHAIR—Mitcham?

Ms Cornfoot—Northern suburbs.

CHAIR—Northern District Hospital?

Ms Cornfoot—Melbourne.

CHAIR—Alexandra?

Ms Cornfoot—Country Victoria.

CHAIR—It is not quite urban.

Senator TCHEN—Chairman, I think these are all Victorian hospitals.

CHAIR—Masada? I have never heard of it.

Senator TCHEN—That is metropolitan.

CHAIR—Benalla and Corangamite I gather would be in Benalla and Corangamite. Is Lilydale metropolitan yet?

Ms Cornfoot—Pretty close.

CHAIR—It says that the Mercy, Bendigo, Bairnsdale, Rosebud and Wimmera hospitals health care units did provide some statistical information. The Monash birth centre rang to say they were being compiled and sent on shortly. The Royal Women's Hospital and other metropolitan hospitals did not reply. Was this to written information?

Dr Fahy—I cannot be certain whether she contacted them by telephone or mail, but I would say by mail. But it is certainly true for my home town. You cannot get information about intervention rates. You cannot know formally, for instance, the huge variation between individual obstetricians in a particular town. We have one obstetrician who tells us that his women elect caesareans and has a very high caesarean rate.

CHAIR—Does he explain to you why he does it when women ask?

Dr Fahy—He has told me it is a vaginal bypass, that women's vaginas need to be protected in his view.

CHAIR—Is he there on behalf of the mother or the vagina, or both?

Dr Fahy—Or the partner?

CHAIR—It is a very interesting thing. I would love to know how to talk to that doctor. We have had evidence given to us that there is a difference of between something like three per cent through to 60 per cent caesarean section rate, depending on which practitioner you are talking about. We cannot associate that to any particular practitioner, but my recollection is that might have been data given to us in a submission from the Australian Institute of Health and Welfare. The point you are making is very powerful. I said earlier that we saw yesterday the 1998 book and data from New South Wales which lists every hospital, public and private. That was introduced in 1996, was it? It was very recently. Your submission says:

The Mitcham Private Hospital replied ‘with regard to the information you sought about our Maternity Care I wish to advise that some of the information is commercially sensitive and as such is not available and that we encourage our clients to visit the hospital to discuss any particular details’.

Dr Fahy—Yes. That would say something about power and knowledge.

CHAIR—In the light of Senator Tchen’s questions to an earlier witness, if you ask you are bound to have some reply, but it may not be the sweep of information from that hospital. I am not wanting to talk for Senator Tchen, but I am very interested that this hospital said, ‘Well, if you come along, we will have a chat to you about it, but we cannot provide the statistical data in the broad.’

Dr Fahy—Of course they can, but they do not.

CHAIR—Do you know whether your colleague has looked at the annual reports of any of these hospitals and found the answers?

Dr Fahy—I can ask her to send you that information.

CHAIR—That will be good. We understand that some private hospitals publish the data and if you wanted to look at their annual report you would find the statistical data for the hospital without ascribing it to any particular practitioner. But other hospitals will say that it is commercially sensitive and will not put that information out, so they do not even publish it in their own hospital report.

Dr Fahy—On the earlier point about caesarean section and the high rate of it, one woman that I recently interviewed for the course that I am teaching had asked for an induction of labour in her first pregnancy not knowing what it meant. The doctor acceded to her wishes when he would have known that at 38 weeks the chances of induction were not very great. At the end of the day, he said, ‘You can either stay like this and keep going all night or you can ask me for a caesarean and I will do it.’ He did the caesarean.

I was interviewing her about halfway through her second pregnancy. She had said to the doctor that she wanted to have a normal birth this time. He said, ‘Well you have about a 50 per cent chance of that being so.’ When she told me this, I said, no, and I found the evidence that, even if you include women who have had infections in their wound site, the incident of the scare rupturing is 0.05 per cent. I showed it to her and said, ‘Go back and talk to him.’ She came back and said she had talked to him and he said, ‘It is entirely up to you whether or not you want to have the baby vaginally. It does lead to incontinence in later life’—this is very controversial—‘but that is your choice. A lot of women say that it interferes with sexual pleasure.’ That is not true. ‘Your husband might find that sex is not as pleasurable afterwards.’

Guess what she chose to do? She chose to have a caesarean. That was the only information she was given. What she was not given was all the side effects of the caesarean section, including an increased peri-natal mortality rate, which is so paradoxical. I believe when doctors suggest a caesarean that they think it actually saves babies’ lives, but the evidence shows that there is a greater peri-natal mortality rate associated with caesarean

section. Of course, the morbidity for the mother can be in terms of hospital acquired infection, shock, haemorrhage and long-term consequences. One of the women I spoke to has had to have a bowel resection and a colostomy because of a complication from a caesarean section. Another one I know had to have her kidney removed because the urethra was tied accidentally instead of the blood vessel. It is not without its complications.

CHAIR—This is true, but they are also fairly remote. There is no doubt that, according to the data, there is a four times risk factor associated with caesarean section. I do not want to argue about that, but I think we can all get an example which is really the worse example. We can then in some people's minds seem to be overstating the case or skewing the debate. A doctor might say that you will have less satisfactory sex and incontinence in old age and that should be refuted. You do not need to go to other statistics to make the case that yes, that might happen, but so can this. It actually seems to me that it would be very important to have some reliable data on how many women who shove babies into the world through the vagina finish up perfectly happy with subsequent sex and never incontinent.

Dr Fahy—Often better after the birth of the first child.

CHAIR—The incontinence or the sex?

Dr Fahy—The sex.

CHAIR—We have read a wonderful paper from Dr Buckley who tells us that the best thing for sex is to have a baby.

Dr Fahy—Yes.

CHAIR—No, she did not. But she did suggest exactly as you have said. We have to finish up, but please say what you were going to say.

Dr Fahy—I was just about to say that, when challenging what a particular obstetrician says to a particular woman in the privacy of his own office, actually hearing that is quite unusual, that is, having somebody actually tell you the detail. It is like trying to put out bushfires all over the place. The antenatal information that women are given is so poor, because midwives are controlled by the organisations for which they work, when they try to give information to women they are often severely criticised. I am sure some burn out because of it.

Very recently somebody gave information to women about the side effects of epidural blocks, that it significantly increases their chance of the baby experiencing neonatal distress. Forceps births go up, caesareans go up by a third and she was absolutely prevented from saying that any more in her classes. She was stopped from doing it. So midwives who know the truth, or have the potential to know the truth, and to share that with women can be prevented from speaking because they are controlled by the organisations in which they work.

CHAIR—I thank you for that. I have to say that one of the things that is emerging as very important is the availability of data, really tough, good and up-to-date information.

Dr Fahy—We have got it.

CHAIR—But also somebody to take you through that information.

Dr Fahy—That is right.

CHAIR—It is one thing to read it, but then it is often important for people to have the opportunity to talk it through. I have not heard until now that anybody is being stopped from giving evidence or research. If that is the case, are you prepared to name the institution?

Dr Fahy—Not here. Yes, I am.

CHAIR—If you would like to drop us a line, we can actually treat that information confidentially.

Dr Fahy—I will have to check with the person. The person who told me was the childbirth educator herself.

CHAIR—We do not need necessarily know it. If you want to provide it to us, we would be able to deal with that in a matter of confidentiality. So far that is the first time we have heard of anybody being told absolutely that they cannot say this analysis of data, they must say that. At least I think it is. I do not remember reading that or hearing it before. I find that a bit concerning, particularly as it runs counter to the evidence we are getting of the importance of antenatal care and childbirth education, and a recognition and resurgence in that area, but also a recognition that there is a long way to go.

Dr Fahy, I am actually desperately trying to redeem myself from letting it all get out of control this morning. We have run a little bit later. I want to thank you very much for your contribution. If there is anything further you really must tell us, we would be pleased to receive it.

Dr Fahy—Thank you.

[3.00 p.m.]

DUNNE, Ms Carmel Lynne, Vice-President, Australian College of Midwives (Inc), Queensland Branch

SCHNEIDER, Mrs Patricia Ann, President, Australian College of Midwives (Inc), Queensland Branch

CHAIR—I welcome representatives from the Australian College of Midwives, Queensland branch. The committee prefers all evidence to be given in public, but should you 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 that request. We have before us your submission which we have numbered 73. Are there any alterations you would like to make that?

Mrs Schneider—I have a couple of additions that I would like to put before the inquiry if I may.

CHAIR—Thank you for that. If I can now invite you to make a brief opening statement. We will have someone collect the additions in a minute, and then ask questions.

Mrs Schneider—I thought I would open by introducing and telling you a little bit about the Australian College of Midwives, Queensland branch. The Australian College of Midwives is the professional organisation for midwives throughout the nation, and specifically in Queensland. The college in Queensland is a branch of the national organisation, and it is through the national organisation that Queensland midwives are affiliated with the International Confederation of Midwives, also known as ICM.

The college is pleased to have had the opportunity to submit to and appear before the Senate inquiry into childbirth procedures. With reference to the written submission—and this does need to be taken in the context of the written submission—and on behalf of the members of the college in Queensland, I would offer the following summary.

Firstly, midwives offer comprehensive care to child-bearing families throughout the child-bearing and child-rearing year. Secondly, midwifery led care is acknowledged in the literature as providing for excellent clinical outcomes, particularly in terms of both safety and cost effectiveness. Thirdly, a midwifery model of care is woman centred; is characterised by reduced or non-existent technological intervention in pregnancy and childbirth; is underpinned by a philosophy of partnership with women; and works in collaboration with medical care models.

At present, midwifery led care is available to a minority of women in Queensland. The college supports the extension of midwifery services to provide this option for all women in the interest of choice and equity. This is particularly applicable to those women who choose the services of a midwife in private practice and give birth either in a public or private hospital or at home.

Reduced length of stay following birth in hospital is desirable in terms of the promotion of birth and new parenting as normal life experiences. There are issues in relation to community midwifery support for mothers and newborns in their own homes, which need to be addressed if length of stay is to be reduced and continue without compromising the health and wellbeing of new families, particularly in relation to breast feeding. Breast feeding is an essential ingredient for the long-term health of the human race. Midwifery care contributes extensively to the successful establishment of lactation and the continuation of breast feeding to ensure optimal health outcomes for women and their children.

Although the College of Midwives has developed competency standards, these focus specifically on beginning level practitioners. Therefore, the college supports the development of best practice standards and/or a code of practice for midwives for advanced practitioners working across the spectrum of practising environments, including at home. Access to information concerning child-bearing options for women and their families is restricted by a number of factors, including the limited availability of alternative care choice models.

The financial support extended to child-bearing women from Medicare and from the private health insurance is at present inequitable. This situation is highlighted by the recent introduction of the Medicare rebate for complex births, which is applaudable from the perspective of those women who genuinely need medical intervention, but discriminatory for those women who choose the services of a midwife in private practice and cannot receive a rebateable fee for that service.

The position of midwives within maternity services is inequitable, particularly in terms of autonomy and clinical privileges. This situation could be rectified with the granting of visiting rights for midwives to both public and private hospitals and the extension of hospital based midwifery services to provide midwifery care for those women who choose to birth at home.

Throughout history the midwife and the childbearing woman have worked together. This ancient couple has been the architect of human survival for centuries with the relationship being fractured comparatively recently through the medicalisation of childbirth. The last decade has witnessed the revitalisation of the midwife-woman relationship in recognition of quality of care, safety and satisfaction for all partners in the childbearing experience. The college is therefore committed to midwifery as the care option for all women, and we would like to thank the committee for providing us with the opportunity to summarise our position in relation to the terms of reference of the inquiry. Thank you.

CHAIR—Thank you very much. Senator Gibbs?

Senator GIBBS—Mrs Schneider how many midwives are practising privately in Queensland?

Mrs Schneider—Very few. The number of midwives practising privately in Queensland is at the moment probably less than 10, if you are looking at midwives who are endorsed by the Queensland Nursing Council to practice midwifery. There are a number of midwives who are not endorsed to practice midwifery, and I am referring to traditional midwives there.

Senator GIBBS—How many traditional midwives would we have?

Mrs Schneider—I would have no idea.

Senator GIBBS—But they practice privately?

Mrs Schneider—They can, yes—they do.

Senator GIBBS—I notice that in (e) you talk about ‘given the demand for midwifery care’, and then, in point 3, you say:

Midwives in private practice be afforded admitting rights and/or clinical privileges in Queensland public hospitals.

How much opposition is there to this, and how would you go about it? Is this something that the state government accredits and how does this happen—or is it hospital by hospital?

Mrs Schneider—It is probably both. There are two endorsed midwives who have recently been granted admitting rights in a public hospital in Queensland. They are the first. There are a number of other midwives throughout the state who have explored the possibility with their local public hospital and have been refused. I feel that because this has happened at one public hospital it will extend and other hospitals will serve to open their doors to midwives in private practice. That is in the public system. When you look at the private system the situation is vastly different in that at the moment if a woman chooses to go to a private hospital to have her baby she has to be under the care of a private obstetrician. She cannot be under the care of midwife in private practice, even if she chooses to pay for that herself.

Senator GIBBS—What about the obstetrician and the midwife?

Mrs Schneider—That does not happen. The obstetrician does not have a share-care arrangement with a midwife in the private sector.

Senator GIBBS—Shouldn’t that be the woman’s choice? She is actually employing these people.

Mrs Schneider—It should be, but it is not.

Senator GIBBS—Thank you. How do you feel about a tertiary course—three or four years?

Mrs Schneider—Direct entry midwifery?

Senator GIBBS—Yes.

Mrs Schneider—I was actually going to offer you a copy of a discussion paper that has been produced by my colleagues in Victoria—perhaps you have it—called ‘Reforming Midwifery’. It is about the introduction of bachelor of midwifery; in other words, direct entry programs in Victoria. Do you have that document?

Senator GIBBS—I do not think we do.

Mrs Schneider—I can arrange for you to have one.

Senator GIBBS—That would be very good. Thank you very much.

Mrs Schneider—If you tell me where to send it, I will send it to you. It is copyright so I cannot copy it, but I can certainly arrange for you to have a copy sent.

CHAIR—Lovely.

Mrs Schneider—Certainly I support it, and the college supports it in principle as well. Our position statement is reflective of that.

Senator GIBBS—Do you think this would overcome the problems of accreditation in hospitals?

Mrs Schneider—No. I think it would serve to deepen, strengthen and reinforce the position of midwives within the health service. But I think the issue of visiting rights and clinical privileges is steeped in history. It is incredibly political. It is largely about money and it does mean that even direct entry midwives—midwives who have undergone a process that does not involve education as a nurse first—would still have difficulty unless the health service and the government were receptive to the application from midwives for clinical privileges or admitting rights.

Senator GIBBS—Thank you. I notice in your submission you are talking about midwives in private practice being given Medicare provider numbers. We have heard this quite a lot. The argument has been that, if there were a Medicare rebate, women would have a wider choice and more women would be able to afford to have their own midwife. As it stands at the moment, unless you have got the money and can afford it—which not everybody has—basically only an elite group of women can afford their own midwife. When we started out we were hearing a lot about this and it sounded terrific. But a couple of witnesses have said that, if we give the midwife a provider number and there is a rebate, this could lead to intervention rates such as the obstetricians are doing now—that maybe it would lead to wrong practices on their part because of fee for service. The argument was that, because the doctor has a fee for service and he or she is more inclined to say, ‘Okay. Let’s do that’—and that the midwife would do the same. Tell me what you think about that.

Mrs Schneider—Perhaps five years ago I would have pushed very strongly for a Medicare provider number for every midwife who chose to work in private practice. In principle, the college believes that midwifery care should definitely be funded. But we would not wish to see midwives subjected to the same scrutiny, threat of overservicing and control of their practice as general practitioners have been subject to. If you place such limits as short/long consultations onto midwifery care, you immediately restrict control and perhaps even destroy the relationship between midwife and woman. It is very much a double-edged sword. It is not as simple as saying, ‘Let’s rebate midwifery care under Medicare’.

If we could develop a system whereby midwifery care was funded—and if you like I can suggest to you a model that would sort that through—still allowing for the uniqueness of midwifery care and preserving this ancient couple relationship that I have referred to, you would have, in a sense, the best of both worlds, or the best of several worlds. You would have women who were not discriminated against because they had chosen a midwife as their lead professional for their pregnancy and birthing care. You would have a midwife who was not disadvantaged because he or she chose to work in private practice and you would have a family who were getting both safety and satisfaction from a service that was meeting their needs and was not organisationally governed but family focused.

Senator GIBBS—Thank you for that. If you would like to pop your model along to us, maybe when you send us that little booklet as well, that would be greatly appreciated

Mrs Schneider—Not a problem. Certainly.

Senator GIBBS—That would be great. Thank you very much.

Senator TCHEN—Mrs Schneider, in your written submission, you suggest that the midwifery models of care are cost-effective when compared with the more traditional models. You also said that it is a strange irony that women would choose that low cost approach that is actually ignored. I suggest it is probably not irony but rather ignorance on the part of the decision maker, because I think cost-effectiveness would be a very powerful argument. Can you expand a little bit on the basis on which it is more cost effective? I know you quoted a study here.

Mrs Schneider—Can I ask you what page you are referring to, please?

Senator TCHEN—The first page, the third paragraph from the bottom.

Mrs Schneider—Basically it is very simple: midwives do not earn as much as obstetricians.

Senator TCHEN—Yes, that is my instinctive conclusion, too. But I was wondering whether you had actually have more data costing it out?

Mrs Schneider—Even if the birth is uncomplicated, a doctor will earn far more and charge more than a midwife for the same care, particularly if you look at, for example, a midwife who is employed by a hospital. A woman who goes to a birth centre to have her baby will not cost the hospital as much as a woman who births in the labour ward, simply because the number of caregivers and the amount of intervention provided are very different.

Senator TCHEN—Yes, I gather that. Perhaps I should suggest to you that—

Mrs Schneider—If you are looking for data, I would need to send that to you.

Senator TCHEN—Yes, you may like to actually cost out your model against a standard hospital model and perhaps send us the information as well. That could be very helpful.

CHAIR—Senator Tchen, could I also interpolate there that we appreciate getting any comparison of like with like. When it comes to health dollar, it is extremely difficult. I note that you have quoted McDonald and Morero there and we will have a look at that paper. If you could provide anything further to the question Senator Tchen has asked, that will be extremely helpful. But I also appreciate that trying to work out what it costs in terms of labour costs and staffing costs, et cetera, is a difficult equation. If you can, we would welcome what you can offer us.

Mrs Schneider—I would expect that my colleagues who are following me may be able to provide an update on that in relation to money.

Senator TCHEN—That would be very helpful. Coming back to your college: does your college have the registration function?

Mrs Schneider—No. Can I explain to you how midwives are regulated in this state?

Senator TCHEN—Yes.

Mrs Schneider—Midwives are registered nurses, registered by the Queensland Nursing Council, who are statutorily obligated to maintain a register of persons who are nurses and endorsed to practice midwifery. The College of Midwives has an accrediting function, in that midwives can apply to the college to be accredited. That is a quality assurance mechanism, particularly for midwives in private practice but it is extended to midwives who are hospital practitioners as well.

Senator TCHEN—What advantage does the accreditation confer?

Mrs Schneider—It is a quality improvement process for customers—for women. If the college has accredited a midwife, then the customer who comes along to choose a midwife in private practice would see the accreditation certification at the midwife's home or wherever. Incidentally, it is also something that is being asked for when midwives apply for visiting rights to hospitals.

Senator TCHEN—If a registered nurse has midwifery qualifications, would they still need college accreditation?

Mrs Schneider—No, they do not need college accreditation.

Senator TCHEN—I see, it is automatic. So it is dual track?

Mrs Schneider—Yes. Accreditation is entirely voluntary. You do not have to be an accredited midwife in order to practice.

Senator TCHEN—I see. In that case, I will go one step further. It was suggested that the college should consider accrediting traditionally trained midwives. Is the college looking at that? Is there a pro and con to that?

Mrs Schneider—There are definitely pros and cons. The college is obviously made up of midwives who have different views, as with any organisation, and there are tolerance levels and there are intolerance levels. I am sure you appreciate that. At this moment in time, those people who are members of the college and therefore have voting rights are registered, endorsed midwives. Therefore, that excludes traditional or lay midwives. However, we do have midwives who are lay midwives or traditional midwives as associate members.

Senator TCHEN—One of the suggestions from one of the witnesses this morning was that there is a special relationship between the midwife and the woman—to the extent that she was arguing that, in terms of the advice the midwife gave and the supervision she gave, she should not be legally liable for her advice. The argument was that there is a different relationship than between a doctor and a patient, because it is more of a friend type of relationship. Does the college share that view? You also suggest that there is a special relationship between the midwife and the woman.

Mrs Schneider—I would be surprised at that view. I did not hear that submission and I have not read it. Certainly the relationship is special, unique and different but it does not absolve the midwife from his or her professional and therefore legal accountability in relation to duty of care.

However, if the midwife is operational, working within a midwifery model of care as I have indicated in my opening statement, that is based on partnership and the midwife and the woman work together throughout the pregnancy—in fact, usually before the pregnancy starts. We advocate pre-conceptual care. That relationship is built very solidly, certainly before the woman comes to labour and birth. Therefore decisions that are needing to be made in relation to safety will be made in partnership between the woman and the midwife. Does that answer your question?

Senator TCHEN—It clarifies it a bit. I have another question. It has been suggested to us quite often there exists conflict of views between what were described to us as ‘academic midwives’ and practising midwives—that probably means midwives who practice in hospital, because there are so few independent midwives—to the extent that there is some conflict described to us as ‘horizontal violence’. Can you throw some light on that, to indicate whether you support that view?

Mrs Schneider—I am disappointed that that has been drawn to your attention. The college takes the view that a midwife is a midwife. At the end of the day, a midwife is a person who is as defined in the international definition. Some of us choose to work in academia; some of us choose to work in clinical practice; some of us choose to work in research; and some of us choose, like those of us that sit before you, to work in all three. That does not mean that there is competition or violence between those areas of midwifery practice. At the end of the day, midwives work as a team towards the common good. I do not believe that it is midwifery that has a problem with horizontal violence. I believe it is the oppressed group behaviour that is a demonstration of what is happening to midwives within the health service sector. It is that position of midwives within the health service sector that breeds the horizontal violence that you are alluding to.

Senator TCHEN—Thank you.

CHAIR—I am not here to fight with the witnesses, Mrs Schneider. But I would love to suggest I know lots of guys who get involved in so-called horizontal violence from a position of great strength.

Mrs Schneider—Is that right?

CHAIR—Let me introduce you to hospitals and the groves of academe before we even get into politics. I do not dispute what you say. I would be reserved about whether or not it is because midwives are in an oppressed state. I think there is a lot of evidence that very unoppressed people brawl. There seems to be a limited amount of revenue so academics point out that they are more needy than practitioners and practitioners have more need than researchers. I think it is a bit of a disappointment. I must say I was pretty shocked to read this kind of expression as a description of difference of opinion between one part of midwifery and another. It is really par for the course all over the world and I would not like it to be ascribed to midwifery in a special kind of way.

Mrs Schneider—Can I just make a comment about that? I think it is really difficult to judge the position of midwifery, now that it has transferred to an academic educational perspective, in terms of other academic disciplines. Midwifery is relatively new to academia. It is such a clinically focused discipline that those of us who work in academia have to maintain clinical credibility in order to be able to teach. There is no discrepancy. There is no blurring of lines here. In academia, if we do not work then our students do not see us as credible and because they are our customers we have to be credible clinically. And I guess that helps.

CHAIR—I do not dispute what you are saying at all, but I know there is evidence from here to there that people in different areas of life fight under this new heading of ‘horizontal violence’. I must say I had never understood those words to mean what they are now being taken to mean—but then I have a strange mind.

Under the third of your terms of reference, your submission says:

In Britain there is a mandate governing practice which requires postnatal women to be provided with follow-up care for 10 days and up to 28 days post partum if necessary.

How long has that mandated practice been in existence?

Mrs Schneider—May I confer? This is my early discharge specialist. You will have to look it up in the reference which is Schmied and Everitt 1996. It is in the reference list.

CHAIR—I am really very interested that it is actually mandated. We will therefore go to the article and see.

Can you tell me about a seeming contradiction in the area of early discharge? On the one hand, we are being told that early discharge is essentially being driven by cost constraints, and that it is perhaps putting the babes at risk because maybe some neonatal difficulties may not show up until day four or five or even a bit later and it is perhaps putting mums at risk

because they might be more at risk of postnatal depression or the breast feeding has not been established.

On the other hand, we have a number of people who are encouraging homebirth or birthing centres, where mothers may indeed get up and walk around straight away. At home, at least, they do not go home—they are there. But others are going home within 12 hours sometimes. Now there seems to me to be a big contradiction here. Can you discuss this contradiction?

Mrs Schneider—I think initially the term ‘early discharge’ was appropriate. I do not think it is appropriate any longer in that, if you say ‘early discharge’, what do you mean by early? I would prefer to refer to it as ‘reduced length of stay’. And as we know, reduced length of stay is getting more and more reduced. Women who come into hospital and go straight home from labour ward are now starting to become the norm. We will see caesarean sections going home within 24 to 48 hours very soon.

Much of that has to do with funding. But it is also an issue that gels well with the notion of normalcy—the notion of this being a normal life event. There is nothing wrong with reduced length of stay, provided the conditions are right at home, provided the community services by midwives—not nurses—are available for women and their newborn in the community, provided the mother has easy, ready available access to the place of birth, either the birth centre at the hospital or the midwife who has attended her at home. So if she is in trouble in the middle of the night less than 24 hours after her birth—if she is bleeding or her baby will not settle or she has got a problem—she does not have to go and sit in a casualty department for 12 hours because she is triaged at level 3. She goes straight to the maternity unit and is seen by a midwife or can talk to a midwife on the phone. Those services are not in place and that is why reduced length of stay is sometimes hazardous.

CHAIR—For those who might read this report in the future, I should ask for an explanation of triage at level 3.

Mrs Schneider—I am talking about emergency departments.

CHAIR—Triage is that process that—

Mrs Schneider—It is that process in an emergency department where clients are assessed and then allocated a level of urgency to be seen by a medical officer.

CHAIR—As demonstrated by M*A*S*H?

Mrs Schneider—Good idea, yes.

CHAIR—I just think we need a sort of lay term for understanding.

Mrs Schneider—Certainly. I apologise for not defining that.

CHAIR—Not at all. Level 3 would mean you can sit and wait for a bit?

Mrs Schneider—There are several triage scales but level 3 is perhaps down the track of being urgently needed.

CHAIR—And so this could be a very big turn-off to somebody who worries and thinks, ‘I’ve got to go to hospital and sit around for all that time’?

Mrs Schneider—Exactly—particularly when statistically most of the problems that happen in the early postnatal period happen at night.

CHAIR—Why can’t a nurse be a midwife? If a nurse is a midwife, is it all right for her to do postnatal care?

Mrs Schneider—If a nurse is a midwife, absolutely, provided that person is a midwife first—figuratively, not literally—provided that person is focussing on midwifery care and not operational under a nursing model of care which is illness rather than wellness focused.

CHAIR—Postnatal care provided by midwives: how are you finding that tick-tacking with the GPs, seeing we have already heard that early discharge means that there has been an involvement of the share-care GPs in the early home going and those docs have been participating in an educational program to assist them in the new management that they are now taking on?

Mrs Schneider—I think in certain areas it works extremely well. As I said in my opening statement, midwifery models of care do not work in isolation; they work in collaboration with medical models of care. I think the key is the relationship building, particularly between the woman, the general practitioner and the midwife. Many women will choose to go back to their family practitioner for their antenatal care right up until the birth, go to a midwife for the birth and then go home, be cared for by a midwife in the early part of the puerperium—because it is quite intense and general practitioners do not have time for home visiting, et cetera—and then go back to their GP six weeks after the birth. That is fairly common, and there is no problem with that where that works well.

CHAIR—Mrs Schneider, we are very tight for time. Thank you both very much for your contribution. Thank you also for the offer of the extra information.

Mrs Schneider—I have some things I can leave with you.

CHAIR—If there is anything further to provide, please feel free to do so. Thank you very much for your contribution today.

[3.33 p.m.]

YOUNGMAN, Dr John Glover, General Manager, Health Services, Queensland Health

CHAIR—Welcome. The committee prefers all evidence to be given 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 that request. We have your submission, which has been numbered No. 166. Are there any additions or alterations you would like to make to that?

Dr Youngman—I have got a number of documents which I would like to submit to the committee: a formal presentation, which I will summarise in an opening statement; an evidence based synthesis of Queensland Health documents which we use as far as our policy is concerned; and a document relating to indigenous health, looking at maternal health services in Aboriginal communities.

CHAIR—Thank you very much. Would you like to make your opening statement?

Dr Youngman—Thank you for the opportunity to do this presentation. Basically, as indicated, we do have a document which is an evidence based approach to addressing how policy in Queensland Health is addressed from the point of view of mothers and babies, and that is with you. With respect to what I will say today, I want to concentrate on best practice guidelines, hospital data and interventions, outcomes for mothers and babies from non-English speaking backgrounds and litigation and midwifery work force issues, because I think these are some of the key areas that the inquiry is looking at gaining information about.

Most of the information that I will provide is based on the Queensland Perinatal Data Collection which was set up in 1986. There is a legislative requirement that data for every child born in the state be provided to the Collection to be managed by Queensland Health. So it is a reasonably good source of documentation which we keep very accurately over time. It was commenced in 1986. What I am presenting today will basically come out of 1997, which is the last complete year of the information.

Queensland Health is the major provider of maternity services in Queensland. In 1997, 72.6 per cent of those giving birth used public facilities of which 9.1 per cent were privately accommodated. Since 1994 there has been a steady increase from 62.4 to 66 per cent in the number and proportion of mothers using public accommodation. In 1997 the Perinatal Data Collection recorded 47,278 deliveries, resulting in 48,038 births. We allocate approximately \$80 million per year for this particular program.

With respect to policy and planning, Queensland Health has no corporate reproductive health policy. However, we are developing strategic directions for maternity care through the Women's Health Outcomes Plan which is presently in a state of development. It is basically being developed on the evidence that I have already indicated in the document. We have a consultation process in place. We have an Obstetric and Gynaecology Services Advisory Panel, which is a multidisciplinary group of obstetricians, midwives and other service providers and policy analysts which guides our policy direction. The panel may be interested

to know that the two issues most commonly raised in the workshops we have held as far as our policy derivation is concerned relate to early discharge and the need for more community based and outreach services. I think you have heard a lot about that material already today.

With respect to indigenous mothers and babies, indigenous health is a significant issue and concern for Queensland Health. While obstetric outcomes are generally good, there are still some areas of concern—notably the unacceptable disparity between outcomes for indigenous mothers and babies and others. The proportion of Aboriginal mothers fell slightly, to four per cent of those giving birth in 1997. The rate for Torres Strait Islanders remained constant at 1.2 per cent of all mothers.

Indigenous mothers were more likely than other mothers to give birth to pre-term and low birth weight babies. Twelve per cent of indigenous mothers compared to 7.8 per cent of all other mothers had pre-term births and 12 per cent of indigenous mothers compared to 6.6 per cent of all other mothers had babies who weighed less than 2,500 grams. The perinatal death rate was 24.2 per 1,000 babies born to indigenous mothers which is more than double that for babies of non-indigenous mothers for whom the rate was 10.8 per 1,000.

CHAIR—Dr Youngman, what were those figures for perinatal mortality?

Dr Youngman—The perinatal death rate was 24.2 per 1,000 for babies born to indigenous mothers and 10.8 for non-indigenous mothers.

CHAIR—This is 1997.

Dr Youngman—Yes. It has changed but I do not have credible figures; I am quoting anecdotal figures from Cairns.

CHAIR—For the better?

Dr Youngman—Yes.

CHAIR—Thank you.

Dr Youngman—There has been a significant number of initiatives which have been pursued which I will briefly talk to. The reasons for this are complex and relate to wider environmental and cultural issues, as well as to clinical factors including poor general nutritional status, substance abuse, diabetes, high parity and low rates of antenatal care. Seven and a half per cent of indigenous mothers had less than two antenatal visits compared to 1.5 per cent of other mothers. No antenatal care was recorded for 2.5 per cent of indigenous mothers compared to 0.3 per cent for non-indigenous mothers.

I would like to recognise that in 1991 a group of indigenous mothers, led by Roberta Felton of Mornington Island, developed the concept of a Birthing on Homelands Project. This has progressed slowly, with Queensland Health emphasising that the primary responsibility is to ensure the safety of mothers and babies. In 1997 the project led to a clinical needs assessment of services for the five communities designated in the original proposal. It is a document that I have tabled which basically goes through those five

communities, which are in North Queensland, addressing the various issues that are associated with indigenous obstetric care. I think the report can be pursued further.

CHAIR—Is the department likely to proceed with birthing in the homelands?

Dr Youngman—We are supportive of the concept. The issue of quality pervades the agenda. One of our major challenges in proceeding with this is the work force. We do need trained staff in the homelands. We have extreme difficulty in recruiting both trained midwives and medical practitioners who are competent in obstetric services to provide backup to these communities. It must be appreciated that some of these communities are an hour or two by plane from the nearest medical facility. By road it is an impossibility to see a transfer of—

CHAIR—Would the department give any thought to testing it in one that is not so far away, 20 minutes west of Cairns?

Dr Youngman—We have got a plan to do this but it is going through various stages. The first stage has been putting midwives into these communities.

Senator GIBBS—Would this be Murrie midwives, Aboriginal midwives?

Dr Youngman—If they are available and can be recruited, yes. The difficulty is being able to recruit and retain these individuals in those communities. It is training up Aboriginal health workers as well to be supportive of these women.

CHAIR—Dr Youngman, I am sorry, I stopped you before you had quite finished your contribution.

Dr Youngman—With respect to birthing centres, with the support of the Commonwealth through funding arrangements together with state based funding, there have been birth centres established in a number of cities throughout the state—Mackay, Bundaberg and Brisbane. The centre in Mackay still continues and is funded on an ongoing basis by the district. The centre in Bundaberg has ceased its operation but the Royal Women's Hospital is continuing to function as a birthing centre. I think it is reasonable to point out that Queensland Health has been undergoing a major redevelopment program within our hospitals in this state to the extent of \$2.5 billion being spent over a decade.

CHAIR—Starting when?

Dr Youngman—It started three years ago. I am raising this because I think that many of our facilities had what I would call the sterile birthing environments of days gone by. What I am witnessing in the new facilities is a far different sort of environment to accommodate the needs of mothers, their children and their families.

CHAIR—I think you will find it most interesting, Dr Youngman, to read what people in Queensland have said to our committee today. Their evidence will be a considerable help to the department. There have been some very good submissions from across the board—from

the Mater, from women's groups, from midwives, et cetera. I suspect you will find it very interesting.

Dr Youngman—With respect to women who have had experience of domestic violence, another initiative which is apparently unique to Queensland at this stage relates to domestic violence in pregnancy. Research at the Royal Women's Hospital in Brisbane—and it may be related to in the next presentation—and elsewhere indicates that obstetric outcomes for women who have experienced violence are likely to be poor. The prevalence of domestic violence in pregnancy is estimated at between eight per cent and 30 per cent. Violence in pregnancy is associated with pre-term birth, low birth weight and higher incidence of spontaneous and induced abortion, stillbirth and risk factors including higher rates of substance misuse, antidepressant drugs, asthma and epilepsy.

CHAIR—What is a spontaneous and induced abortion? Does that actually mean miscarriage?

Dr Youngman—Yes.

CHAIR—I thought it meant that, Doctor. It might be useful to add that word.

Dr Youngman—In 1998-99, Queensland allocated \$1.05 million over four years to combat the health impact of violence against women. A major component of the strategy is the establishment of routine universal screening for domestic violence in antenatal clinics.

With respect to caesarean sections, since 1987 the caesarean section rate for all births in Queensland has risen from 18.7 per cent to 22.5 per cent. In 1997, 18.5 per cent of babies born to public patients in Queensland were delivered by caesarean section compared with 29 per cent of babies born to private patients in public facilities and 31.1 per cent of babies born in private facilities. These figures do not distinguish between elective and emergency caesarean sections. Addressing the public sector figures for primiparous mothers aged 20 to 34 with singleton delivery at term, the highest rate, 18.5 per cent, was for Aboriginal mothers compared to 17.1 per cent for non-indigenous mothers.

Senator GIBBS—How much is it for caesareans for Aboriginal mothers?

CHAIR—Just start again from that bit 'in public hospitals, women aged between 20 and 34'.

Dr Youngman—Considering the public sector figures for primiparous mothers aged 20 to 34 with singleton delivery at term, the highest rate, 18.5 per cent, was for Aboriginal mothers compared to 17.1 per cent for non-indigenous mothers.

CHAIR—And they were?

Dr Youngman—They are basically—

CHAIR—Single babies, but there was some word you used for the mothers.

Dr Youngman—Primiparous.

CHAIR—Primips. I did not get the first bit.

Dr Youngman—However, the rate for older mothers, aged 34 or over, was 31.7 per cent. In general maternal populations, the reasons for caesarean section included 'repeat electives' for 26.5 per cent, failure to progress, breech presentations and foetal distress. It is difficult to estimate the proportion of elective caesarean section for first births from the available data. I am skipping through this as a summary.

CHAIR—Maybe we should stop you there because I know you have to go around 4 o'clock.

Dr Youngman—Could I just address the midwifery work force?

CHAIR—Just take one minute to put on the record—take your time—what you want to now and what you think you can give to us later, Doctor.

Dr Youngman—We have a number of concerns, probably, in summary.

CHAIR—We have the copy of your submission and we can read through that. Find the bits that you particularly want to put on the record now.

Dr Youngman—The work force is a significant issue for us in Queensland, particularly in rural and remote Queensland. This does not just relate to midwives; it relates to medical practitioners as well. We have difficulty obviously in recruiting and retaining young doctors who have got the appropriate skills and we have similar difficulties in retaining midwives and recruiting them to rural and remote Queensland. It is not such an issue in the major centres, but the predictions are that it will become an issue.

In rural and remote Queensland we provide a flying obstetrician service which is based in Roma, which services most of western Queensland. He in turn goes up to Mount Isa and his plane is used by the obstetrician in Mount Isa to provide specialist services to the remote communities at Mornington Island and Doomadgee. We also have an obstetrician in Cairns who provides, with a team, outreach services from Cairns to the indigenous communities in the Cape.

I think one has got to reflect on what has happened over the last 10 years. There has been a significant shift from a model which I think has been well typified to you to one whereby there is a significant freeing up of the sort of services that are being provided. Shared care with general practitioners now is in excess of 90 per cent in many of our facilities. That does not mean to say it is in all facilities, but I think there has been a significant shift in thinking about the different models.

There is a midwifery model which is being developed in Cairns which has now been in place for around 12 months. I think it is a model which should be considered by a number of other services as an opportunity to provide a more appropriate service where the need is appropriate.

I would sum up by saying that I do believe that our staff are intent on providing the best quality service to the consumer of their services. It should not be ignored that there has been significant progress in addressing the needs of consumers. There is still a long way to go. I recognise that we need to be pursuing these agendas with both the consumers of care and the various providers of care.

CHAIR—Thank you very much, Doctor. I understand that 4 o'clock is your deadline.

Dr Youngman—Yes.

CHAIR—We will try and meet that. The Queensland health department spends \$80 million per annum effectively on maternal care?

Dr Youngman—That is as a program. It is always very difficult in program budgeting to come down to exact figures, but that is a reasonable figure.

CHAIR—What has happened to the alternative birthing program in Queensland? Are there any alternative birthing programs still running under the old Commonwealth title?

Dr Youngman—In Mackay.

CHAIR—What is in Mackay under alternative birthing?

Dr Youngman—They still have maintained the service that they originally set up as a self-contained entity within the Mackay Hospital.

CHAIR—Within a private hospital?

Dr Youngman—No, in a public hospital.

CHAIR—Can they do that without talking to you?

Dr Youngman—They have talked to us. They can do it without talking to us. It comes back to the sustainability of the service with funding, et cetera. The alternative birthing services—I hate the word 'alternative'; it seems to be normal birthing—were basically set up with the support of both the Commonwealth and state moneys. They were more expensive than the traditional ways of delivering services and the data from both Mackay and Bundaberg would indicate that. Because of the need of the community and the support of both community and staff, the Mackay saw the opportunity to continue that program.

CHAIR—Can you provide us with some data about the Mackay Centre and also the funding of it. On all the evidence we have, paying a midwife or nurse is considerably cheaper than paying a doctor. We are told, almost counterintuitively, that alternative birthing services are more expensive. Can you help us with that contradiction?

Dr Youngman—Some of the issues come back to the awards that these people are employed upon. If a midwife is going to follow through with the same client/consumer, then you get the scenario where from the point of view of their award payments it becomes very

expensive. Unless you have an opportunity to look at how they are actually being paid that is probably the major issue with regard to cost.

CHAIR—The salaries of the midwives.

Dr Youngman—If they are going to be on call 24 hours a day seven days a week to look after the woman who they are managing. We have various views being put forward about the ongoing care by one midwife with a relationship with one consumer.

CHAIR—I have never known a health department or a state department of any sort that could not counter the claims for salary expenditure, whether it is by doctors or whoever. Can you take that on notice. If you could provide us with some data that would be extremely useful. Could you also tell us how many people are involved—are we paying for midwives on this alternative birthing service plus one secretary and two cars.

Dr Youngman—Yes.

CHAIR—Are we paying people for 24-hour care or are they doing eight-hour shifts and rostered?

Dr Youngman—This came back to the philosophy at each centre. There was a variation between the centres. In some centres there was the view that we needed to have this ongoing relationship right throughout the confinement and that was one of the issues. Whether that is right or wrong when there is that philosophy in that unit, it is very hard to oppose it.

CHAIR—Why? You have fought all sorts of famous people, Dr Youngman. Why was it hard to oppose this lot? In your day, I bet you have arm wrestled with the best of them.

Dr Youngman—Yes, I have. The bottom line is that, if people are committed to a particular process in the best interests of their consumer, then it is very hard to negate that when you are looking at an alternative system of birthing.

CHAIR—If you could provide us with anything about that it would be very useful. I still find it very counterintuitive that paying nurses is more expensive than paying doctors, particularly when you take the infrastructure costs that really need to be put in there when you are doing a like with like comparison.

On alternative birthing, can you provide us with any information you have got still under the old Commonwealth funding, continuation of initial programs that the state has now picked up on, programs that the state will not continue to fund and have lapsed. Also, under alternative birthing, that funding is still coming from the Commonwealth but I believe it is now rolled into one program called broadbanding. Is that right?

Dr Youngman—Yes.

CHAIR—Is it called broadbanding?

Dr Youngman—Broadbanding is a concept whereby special directed funds are actually rolled into the big bucket.

CHAIR—And did you get a 10 per cent cut?

Dr Youngman—I cannot quote a figure.

CHAIR—The federal department said that instead of getting a three per cent efficiency dividend the broadbanding was going to give everyone a 10 per cent dividend. But I wondered if you could still tell us if there is money allocated under that broadbanding in Queensland coming from the Commonwealth designated—in your mind; after all, you are punching it out—as alternative birthing funding. Can you do that for us?

Dr Youngman—Yes.

CHAIR—That would be very useful. Is early discharge something that the department would encourage in terms of reduction of costs in our big hospitals?

Dr Youngman—It is encouraged, yes.

CHAIR—For cost saving?

Dr Youngman—There are a combination of factors, and cost saving would be one of them. Most services these days have been benchmarked with respect to performance. I recognise, as I mentioned before, the issues that have been raised of making sure that there are educational processes in place for the women who are going through these programs; in other words, right throughout their pregnancy. The major issue that has been raised, which I have heard before here today, is the lactation issue. Many women do not establish good lactation until several days post-discharge and the whole issue of support and education is a very key ingredient. Queensland probably has some problems that may be unique insofar as many families have moved here from the south and do not have a lot of family support in our growth areas and that, in fact, compounds the issue.

I think there are a lot of discussions going on at the moment with respect to how we can reinforce support within the community. Again, in a number of our facilities, it is the ongoing support provided by the facility back into the community. We still have some doctrines where the community people see themselves as being independent of the hospital, but they are the sorts of historical agendas which have got to be broken down.

CHAIR—Are you concerned about the rate of caesarean section?

Dr Youngman—We are concerned about any inappropriate intervention in any patient, and caesarean section is one of those that we are constantly reviewing on the basis of the evidence that is provided. The Perinatal Data Collection has given us a significant amount of information over the last 15 years.

CHAIR—You are twice as likely to have a caesarean section if you are privately insured. Is this a matter of concern to the department?

Dr Youngman—The department has got a responsibility for private as well as public; yes, it is. We refer a number of these issues to our expert panels to give advice. There is a perinatal committee which addresses many of these issues. The difficulty is as to what we have got control over. Obviously in the public sector we have got much more control from the point of view of clinical practice and the ability to question than we have in the private sector.

CHAIR—I am very interested in that. Do you think it would be useful for Queensland to introduce what is now available in New South Wales, and that is a book each year published, which lists every hospital—public and private—and the statistics about numbers of births, morbidity, mortality and intervention rates?

Dr Youngman—As long as the information is very much clear as to what it is saying. Statistics can be used inappropriately and I think that—

CHAIR—The numbers of caesarean sections?

Dr Youngman—as long as the information is clearly explained, I do not believe there is any opposition to the release of information.

CHAIR—We have been told that there are many places in Queensland, many private hospitals, that do not publish that information nor provide it.

Dr Youngman—From my understanding, it is a legislative requirement for all confinements to be reported through to the perinatal database.

CHAIR—That is right, and they are. The aggregate data is available to you and to all of us through the AIHW, the Australian Institute of Health and Welfare. But we cannot then say that these caesarean sections were done in that hospital in Queensland, or these from that. We can say that these caesareans were done in Queensland and we have got a breakdown on public and private, but we cannot then subset it. I must say that I find it extremely problematic that we can have our public hospitals putting out such data—being required to and properly trying to provide that data—and our private hospitals up the road, refusing to provide the same comparable data. Could you provide something to the committee about that and also provide us with whether the department might be thinking to go the way of New South Wales and publish the data by hospital for every hospital in Queensland.

Dr Youngman—Yes, I can take it on notice.

CHAIR—That would be really interesting. This is a shocking question, Dr Youngman, are you in favour of midwives?

Dr Youngman—We could not do without them.

Senator GIBBS—In other states we have heard about the state governments implementing direct entry courses into university for midwifery. Could this be implemented in Queensland and would you be in favour?

Dr Youngman—In Queensland, as you probably realise, nursing has only recently entered into the university environment. We are probably the last cab off the rank from that perspective. I think many of the postgraduate areas are only just starting to receive attention, mainly because of the deficiencies in the work force that we are perceiving in areas like mental health, midwifery, et cetera. We have just had a ministerial group looking at the recruitment and retention of nurses within the state. That group has only just put their report to the minister and it is addressing a number of these issues. I really do not want to pre-empt anything in that report in this forum. Certainly, those sorts of issues are being addressed in that report and are obviously of concern to the department because of our future work force strategies.

Senator GIBBS—Is the minister looking at an educational course for midwives; if not, could somebody bring it to her attention?

Dr Youngman—It is the educational courses in most of what we would call the postgraduate areas requiring specialist qualifications in nursing, such as midwifery, operating theatres, intensive, critical care, et cetera.

Senator GIBBS—What about Murrie midwives, midwives in the Aboriginal communities? Everywhere we have been, we have heard—and I know this myself because I have a lot to do with Murrie people—that there is this cultural thing: they have to leave their home, they have to travel, they have to come to the city, they have to live in a motel, it is hard for them to give birth, they are isolated—all these sorts of things? Why can't we have trained midwives who are actually out there in the communities working with the health people, but their own people doing this?

Dr Youngman—I think that this is a complex issue that we certainly are spending a lot of time on at all levels of the work force within the indigenous communities, from the Aboriginal health workers through to registered nurses, midwives, et cetera. Unless we get indigenous individuals into the educational sector, it is very hard to get them trained to go back to their communities. We are working through a number of programs, addressing the children at school, trying to make sure that they are informed so that they can see the opportunities. There have been various remote programs which have been going on to try and look at how we can train the Murrie individuals to be midwives, or train nurses in the first instance. But it is not an easy issue to address, and we are having difficulty even to be able to recruit and retain any nurses to go to some of these communities, given some of the issues.

Senator GIBBS—I am talking about midwives; I am not talking about nurses.

Dr Youngman—Midwives are nurses.

CHAIR—Not entirely, Dr Youngman.

Dr Youngman—Yes, but they are nurses basically, aren't they, first and foremost.

CHAIR—No.

Senator GIBBS—No.

CHAIR—There are midwives who are nurses, who become effectively the old double certificate—they have done midwifery after their basic nursing course—but we have also learnt that there are a number of other ways in which people become midwives.

Senator GIBBS—Traditional midwives.

CHAIR—There are traditional midwives and then there are people who are midwives through a different pathway.

Senator GIBBS—Absolutely.

Dr Youngman—I would need to learn some of those issues.

CHAIR—Thank you very much. I appreciated that, Doctor.

Senator GIBBS—We had a witness earlier and I said to her that what was mentioned in other states was that we need midwives out there with the women in the communities so that they do not have to be torn away from their own people. I asked, ‘How soon could we implement this?’ and she said, ‘Next week.’ What do you say to that?

Dr Youngman—There are some midwives in some of these communities. We have provided funding to employ them. It is the first stage of the Birthing on Homelands Program. There are midwives in some of these communities.

Senator GIBBS—But which communities? How widespread is this? How much money are we spending?

CHAIR—Are you prepared to ask Dr Youngman to take this on notice?

Senator GIBBS—If he would.

Dr Youngman—We are starting off as pilot programs with five communities. There are a lot of issues to do with indigenous women and birthing. I can recollect that, in one community that I visited, there was the intent to have women birthing in that community, but the majority of women who were presenting were so at risk—because of nutrition, alcohol, drugs and other areas—that it was seen to be inappropriate by the midwife that they should have their birth in that community. I think it is a complex issue. I am happy to take it on notice.

Senator GIBBS—I understand that, and I appreciate that. To my way of thinking, if they had their own people as midwives—your sisters there—they can teach them antenatal, they can teach them to eat the right way, they can tell them not to smoke, they can tell them not to drink alcohol—all of the things that a midwife does. If they had their own people as midwives they would be far more comfortable and would probably listen to them more—particularly if you got to the older women, the elders. Could you take all that on notice.

Dr Youngman—This does not just apply to the obstetrics side; it applies to many other aspects of the Aboriginal health and their issues and how to address them.

Senator GIBBS—I appreciate that.

CHAIR—You have got to go, Doctor, and we are going to try and help you do that. You have got a page of questions here. I wondered if we could provide these questions to you at some stage in the very near future for your dot points. We do not really want a thesis back and we will need to go through the information you have provided, which might answer some of them. If you could provide that further information about midwives for Senator Gibbs that would be really great. I wondered if I could give you one last question on notice, unless you had the chance to give us an answer in 13 seconds.

We have had a big push for early discharge and the need to put with that good postnatal care. It is one thing to discharge people early but, given the points that you raised, for example, the establishment of breastfeeding et cetera, postnatal care is very useful.

Postnatal care by midwives is going to be funded out of the hospital budget. If you can send them out there to their GP of course you have just stopped their hospital expenditure, the state expenditure, and put it on the Commonwealth purse. That is not optimal care. Could you take on notice whether, if postnatal care is going to be done by midwives outreaching from the joint midwife program in the hospital, say this hospital, that is going to have to come out of the hospital budget. It is a big chunk. Would the department give consideration to increased funding through the state budget for that kind of program, or would you say to the hospital, 'Tough, you'll have to cut your costs somewhere else.' That is an important question. The strange way funding happens for health care—

Dr Youngman—We do not fund hospitals, we fund districts, which includes both the community component and the hospital component and any other component of service within the district. The decision as to how services are delivered tends to come back to the districts. You will see that we have 38 districts in Queensland. There is a variation in the way those services are delivered because of the emphasis on the various leadership in some of the districts and the various views by the providers. One of the things I find quite interesting as you travel around the state is that you do not have a consistency of opinion as to how services should be delivered, be it in this service or any other service. There is not one easy answer. What they do in Cairns is different from what they do in Bundaberg and what they do in Longreach.

CHAIR—Can I ask you, on notice, if you can provide us with any information about the funding. I do not want the whole Queensland breakdown; I think it would be unfair to ask you that. In particular, can you deal with the question of postnatal care: if postnatal care is going to be an extension out of the hospital into the community and the current district funding does not accommodate that—whether it is through district or hospitals, it is out of the state budget; sending people out to the GPs is out of the Commonwealth budget. So to increase postnatal outreach is going to possibly be an increased outlay for all sorts of good benefits down the line. What do people do? Do they lobby you?

Dr Youngman—We would still be seeing the general practitioners as being party to the process.

CHAIR—Yes, they are, but some people also want the midwife.

Dr Youngman—I do not have any hesitation in agreeing with you.

CHAIR—If there is something you could provide us with on that, that would be great. Dr Youngman, that is actually eight minutes late. We are doing our best and thank you very much for coming along. We will let you go and we promise you the page of questions is not horrible.

Dr Youngman—I don't mind.

[4.17 p.m.]

CAVE, Dr Donald George, Director, Maternity Services, Royal Women's Hospital Health Service District

DAVIES, Ms Corelle, Project Officer, Maternity Services, Royal Women's Hospital Health Service District

CHAIR—I welcome the representatives of the Royal Women's Hospital Health Service District, Brisbane. The committee prefers all evidence to be given 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 that request. We have before us your submission which is No. 16. Are there any additions you would like to make to that?

Dr Cave—No, Senator.

CHAIR—We invite you to make an opening statement and then the senators will ask you questions.

Dr Cave—On behalf of the Royal Women's Hospital, I would like to thank you for the opportunity to submit to the inquiry and to be here today and to congratulate the Senate on initiating what we believe is an important inquiry.

The way in which we deliver maternity services, its systems and practice arrangements has been reviewed by most of the states over the last 10 years. An example of that is the New South Wales health department's Shearman report in 1989, the Victorian Health Department report in 1990, the Western Australian report in 1990 and the National Health and Medical Research Council report *Guide to effective care in pregnancy and childbirth* in 1996. We have done our own Royal Women's Hospital birth centre review in 1998 and then the Royal Women's Hospital Maternity Services review in 1998-99.

CHAIR—Dr Cave, have we got copies of those or would you be able to provide them?

Dr Cave—We would certainly be able to provide them. We are happy to do so.

CHAIR—That would be wonderful. Thank you.

Dr Cave—The rate of change in health care provision—

CHAIR—Sorry, Dr Cave—not the whole list.

Dr Cave—No, I am sure you have got the rest of the list.

CHAIR—Just the ones for the Royal Women's Hospital.

Dr Cave—I am happy to do that. The rate of change in health care provision in general as well as maternity services is currently driven by technological advances in maternity care;

secondly, increased level of information and participation available to consumers; and, thirdly, health care providers and funders developing innovative and cost-effective ways of providing care.

The Royal Women's Hospital is currently undertaking a monumental restructure of the way in which we provide maternity services. The impetus for this has been not only the evidence outlined in the various reviews undertaken in Australia over the last 10 years but also our own local review which further validated all the other review findings. Central to our new model is 'client and family centred care'. Clients will be cared for by multidisciplinary teams and will be given a range of care choices with wellness and participation in decision making being the core values. The NHMRC report has been adopted as the blueprint for the provision of maternity services at the Royal Women's Hospital.

The Royal Women's Hospital provides care for low risk women in a midwifery managed birth centre established over four years ago. Birth centre type care is increasingly popular for women and their families wishing to experience a low intervention rate. The centre has recently expanded from two to three rooms in order to respond to the demand for placements. Whilst this has increased the places available, it still does not satisfy all of the requests, as 20 per cent of our clients would like to be managed in this way and we cannot manage 20 per cent at this stage. However, we have increased it by 50 per cent of what we were doing previously in the last eight or 12 months. This unmet demand, as well as our maternity services review, clearly indicates to us that more women would like to be cared for in this way. Therefore, the birth centre philosophy underpinning this type of care is central to our new services model for all women.

The Royal Women's is strongly represented on the obstetric and gynaecological advisory panel which is an important initiative of Queensland Health, with multidisciplinary representation advising the Department of Health on matters pertaining to women's health issues, including birthing services. Issues presented and discussed by this panel provide the future direction for service development in women's health issues.

The issue of caesarean section rates at the Royal Women's Hospital is being closely monitored in terms of clinical decision making and outcomes. We believe this monitoring leads to improved communication and development of management plans in keeping with our 'women and family centred' model of care. The aim of our care teams is to develop appropriate management plans for clients—both low and high risk—to ensure that medical intervention is appropriate and timely with collaboration between all members of the multidisciplinary team and the client. This is consistent with the philosophical aim of the NHMRC recommendations. Our service aim is to provide equity of access and appropriate management for all women accessing our services.

The Royal Women's Hospital recognises the need for culturally appropriate care and carers and through our team structure will aim to provide this care as best we can, but we acknowledge that, in the current multicultural environment, access to all culturally appropriate services may not be attainable. However, our service aims to be culturally sensitive and non-judgmental, encouraging women and their families to actively participate in decisions about the birth process according to their own beliefs and culture.

Solutions to the issues raised in maternity care provision are not simple. This is evidenced by the plethora of reviews over the last 10 years, basically recommending the same things and yet how much has changed? However, it should be noted that not only do we have the interests of professional groups and financial constraints influencing the direction of health service provision but also society as a whole. The perception that childbirth and technology go hand in hand cannot be denied. Childbirth to some has evolved to incorporate, firstly, hospitalisation for varying lengths of time—and that is known as the illness model; secondly, pain relief and drug use; thirdly, technology, such as monitoring, evasive or non-evasive; fourthly, separation from family as few hospitals provide facilities for partners or support people to stay for any time outside the actual birth; and, fifthly, conditions such as incontinence being ostensibly related to normal birth processes. This may induce women to pursue alternative birthing practices—such as caesarean section—in order to reduce the risk of these complications.

CHAIR—Dr Cave, just for the record, you did say ‘ostensibly associated with vaginal birth’?

Dr Cave—Yes.

CHAIR—I think that word does need to be clearly conveyed to some of the listeners in this room. Thank you.

Dr Cave—With perceptions such as these it is not just the professional and financial issues that require attention and review but a long term commitment by care providers to changing public perception in this area if we are to be successful with implementing any change. The role of acute care facilities in the provision of maternity services is evolving as is the need to examine alternative community care arrangements for maternity clients and the forging of new multidisciplinary practices by health care facilities and workers. The Royal Women’s Hospital has a creditable history in the area of adapting to change and aims to continue improving maternity service provision by ongoing review and evaluation of the effectiveness of the services provided.

In conclusion, it cannot be overemphasised that remaining focused on the needs of child-bearing women and their families is the one critical issue which must be realised by any organisation providing maternity services if the services are to be relevant and responsive to our customers or consumers. Thank you.

CHAIR—Thank you very much. May I just ask—although we on this side of the table have agreed that Senator Tchen gets first call, and he has been very agreeable; I am just giving you a minute’s notice Senator Tchen—the caesarean section rate on the last page of your data says 28 per cent in 1997-98 and 26 per cent in 1998-99. Is that an amalgam of your public and private caesarean rate?

Dr Cave—Yes.

CHAIR—Can you give us the breakdown in public and private?

Dr Cave—The public caesarean section rate at the moment is around 21 per cent and the private caesarean section rate at the moment is around 34 per cent.

CHAIR—I guess that is sometimes by the same doctors.

Dr Cave—Yes. For the most part that is true.

CHAIR—It is a curious discrepancy.

Dr Cave—It is interesting. I have been involved in providing maternity services for a long time and a few years ago was ‘in charge of’ a public maternity service which is a different one from where I am now. We made some attempt to change the public caesarean section rate and were able to from about 21 per cent to about 11 per cent. The private caesarean section rate in that organisation also changed without my having any involvement in the care of private clients.

CHAIR—Did it follow yours down?

Dr Cave—Yes. Not as far, however.

CHAIR—Please elaborate, Dr Cave. What enabled you to reduce the caesarean section rate in the public sector from 21 per cent to 11 per cent?

Dr Cave—I think there were lots of factors. One of the factors was a lot of navel gazing.

CHAIR—That is a dreadful expression.

Dr Cave—And it is not easy to do—

CHAIR—Not for the pregnant belly! Sorry, Dr Cave. We have had a lot of bad puns today but we are very pleased to finish on that one.

Dr Cave—That was a critical examination of each caesarean section that we did.

CHAIR—Was this a one-person initiative or was it agreed by the nursing and medical staff? Was it one person who said, ‘We’re going to do something about this’?

Dr Cave—I guess it was one person who said, ‘We are going to do something about this’, at least to start with.

CHAIR—Was it you?

Dr Cave—Yes, it was to start with.

CHAIR—We would like to know this on the record. We have had evidence, Dr Cave, that in some places like in the Queen Elizabeth, one person there managed to significantly drop the caesarean section rate.

Senator GIBBS—Dr Pridmore.

CHAIR—We have had the history of Tasmania with Dr Mackay, we were told also Dr Correy. So whichever one it is, that person in association with all the providers of obstetric care in Tasmania significantly lowered the caesarean section rate and the minute he left the scene, it went through the roof again.

Dr Cave—Well that is true. That is interesting because in the place where this happened, the caesarean section rate has increased again. I am not sure what it is right now, but I know two years after I left it was back up to about 16 per cent, I think. The important thing though is that we do not do that and compromise something else like outcomes—

CHAIR—Presumably you did not.

Dr Cave—Well we did not. At least we did not for what we measured and we measured the outcomes for the babies and we attempted to measure the outcomes for the mothers in terms of satisfaction. So the outcomes for the baby were measured by admissions to special care nursery and Apgar scores.

CHAIR—I would like to spend some time on this but we know we have got limited time so we might come back to it. I should call Senator Tchen.

Senator TCHEN—Thank you Madam Chair. Can I just say that, Dr Cave, you have certainly proved that Bryce Courtenay is right.

Dr Cave—Bryce Courtenay said lots of things.

Senator TCHEN—Well the *Power of One*. Dr Cave in your submission, under reference (a), you suggested that further research is needed into systems of antenatal screenings to establish a clear basis for practice. Actually I am a bit worried about this further research business, but can I firstly make one comment and then ask a couple of questions.

My comment is: can I suggest to you that the provision of antenatal education is not an intervention? And it should probably be provided as a matter of course or improved or developed rather than being regarded as intervention?

Dr Cave—Yes.

Senator TCHEN—My question is, firstly: can you suggest some particular areas where you think further research to establish the basis of practice is particularly relevant or has higher priority? You suggest a number of areas here. And the second thing that I would like you to perhaps comment on is, if cost savings can result from a better practice base, can the savings be transferred to other areas—under the management system?

Dr Cave—Yes. I think that I can give a couple of examples of the evidence—or research for want of a better term—for instance, gaining relevant evidence about the value of particular interventions antenatally, for example ultrasound scanning. Now ultrasound scanning is an incredibly costly investigation—and I cannot remember the latest figures—but

a few years ago I was looking at the cost to the Australian community of providing routine 18 week scans and it was enormous. And I do not know that there was any really proven benefit in doing that. There might have been a few marginal gains. I think that we could look at that quite critically and see what the evidence is, if it in actual fact enhances the outcome for mothers and babies. That is one area.

Another area would be, for example, glucose intolerance in pregnancy or abnormal glucose handling or gestational diabetes. Does making the diagnosis make any difference to the outcome? So I think there are at least those couple of big areas which are important to look at. Is it important to screen women for anaemia four times during their pregnancy? It is time honoured but does it really make any difference to the outcome? I think there are lots of areas that we need to look at really critically in terms of the investigations that we do and see if it really makes any difference to the outcome.

Senator TCHEN—What about the benefits of it? If you can sort of control that top cover expenditure, how can you utilise the benefit?

Dr Cave—We have just undertaken a review of our maternity services and we have involved a lot of people in the community, including our consumers, other health care providers and so on. None of what they are asking us to do is rocket science. They have not asked us for anything impossible; what they have asked us for is family focused, women focused, consumer focused provision of services. Generally, they are not really costly so my view would be that if we diverted some of the resources that we pour into high technology type areas into some of these other areas, we could deal with issues like the length of stay that you were talking about earlier on, and things like that. I think it is time we took the responsible approach and started to deal with some of those things.

Senator TCHEN—But can you manage it, though, because one of the things in a bureaucratic environment is that this lot of money from here is to be spent here and that is to be spent there.

Dr Cave—Well, it is not easy, I have to say. But, having said that, we are given a budget and it is possible—within some constraints obviously—to sort of shift it around a bit.

Senator TCHEN—As long as it is possible and can be done.

CHAIR—You almost need the skills of a reverend mother, don't you?

Senator TCHEN—Can I ask you something else. In your experience are many GPs aware of the antenatal options available to pregnant women?

Dr Cave—No, my experience is that they are not as aware as they might be. I mean, I have a real concern at the moment that we have fewer and fewer general practitioners wanting to be involved in the provision of maternity services and I think that that and the involvement of midwives in the provision of maternity services would almost certainly be a more cost-effective alternative than providing high-tech services with questionable benefits in terms of the outcomes.

Senator TCHEN—That may require the hospital to take a more proactive role in educating the GPs as well.

Dr Cave—Yes, absolutely, and we have recognised that in our recent maternity services review.

Senator TCHEN—Finally, can I ask you, you mentioned about an early discharge program under your care model but you actually have not specified what your program is.

Dr Cave—No. I have been at the Royal Women's Hospital for just over 12 months and the maternity services review was begun in October of last year. So, we are in the process of implementing most of the recommendations that have been made, having gleaned that information from our consumers et cetera. Some of those details need to be ironed out. I have to say that there is a long way to go. We have been a very traditional provider of birthing services for a long time—very traditional. It has taken some effort to move us this far forward.

Senator TCHEN—In that case, very quickly, can you tell us what you intend to do with the women under your early discharge program? Basically, after you have sent them home, what do you do?

Dr Cave—We have an extended midwifery service at the Royal Women's Hospital, similar to the domiciliary midwifery service that I was involved in when I worked at the Queen Victoria Hospital in Adelaide and also at Toowoomba when I was there. It is a midwifery based service where the women are visited in their homes following discharge but, unfortunately, it does not extend as far as I would like it to. But that is negotiable.

CHAIR—Is that time or geography, Doctor?

Dr Cave—Sorry, Senator?

CHAIR—It does not extend as far as you would like it—is that time or geography?

Dr Cave—Certainly time. Geography we do not do too badly, but, again, not as well as we could.

Senator TCHEN—At the Mater, their program is five visits over five days. How does the Royal Women's compare?

Dr Cave—That is not dissimilar.

Senator TCHEN—Thank you, Madam Chair. I think I am way out—

CHAIR—No, Senator, you have been—

Senator GIBBS—Very good actually. Can I just ask one quick question before Senator Crowley starts because I know what she is like.

CHAIR—Certainly. I call Senator Gibbs.

Senator GIBBS—I am very interested in this Royal Women's Hospital Health Service District, Brisbane. You are the women's hospital but you are called the district. Is that right?

Dr Cave—Yes. But it is part of the Royal Brisbane Hospital Health Service District as well.

Senator GIBBS—Yes, and these are the districts that the health department has spread out all over the place. When you have these innovative ideas of actually reducing the caesarean sections in your hospital, do you actually report to somebody within the health department, that is, a director general—or the minister even? Are your recommendations actually taken on board or are you just left out there to organise your own little district and if you look absolutely fantastic and the others do not that does not really matter? How does this work state wide?

Dr Cave—Senator Gibbs—

CHAIR—To put this again, Doctor, did you tell them this in the interview before you started or was it observed as you retreated?

Dr Cave—When it happened there was interest from the health department in that it could be achieved.

Senator GIBBS—And did they go out and tell other hospitals, 'This is terrific. This is the practice. I want you to do this in this hospital because we want to see the caesareans down and we want to actually have this best practice throughout the whole state'? Or is that too Stalinist?

Dr Cave—No, I do not think that happened. But I think we need to be careful about necessarily believing that a low caesarean section rate by itself is the ultimate aim.

Senator GIBBS—I realise that.

Dr Cave—There was not, to answer your question seriously, a state-wide campaign then to promulgate the information. But then, in fairness, it was reported in a national journal, not necessarily back through the channels of the health department.

Senator GIBBS—This is the problem. We have come across individuals in certain hospitals believing in this sort of culture, putting it into place and everything is working great. But then, of course, as you say, when you go somebody else comes in and stuffs the whole damn thing up again, basically, don't they? This is very concerning.

Dr Cave—It is very frustrating, too, I have to tell you.

Senator GIBBS—It is to us, too.

Dr Cave—I personally believe—and I know that it is not a belief that is shared by all of my colleagues by a long chalk—that the caesarean section rate is too high. That is just a belief that I have.

Senator GIBBS—So do I.

Dr Cave—As I said, I am prepared to admit that there are different points of view. However, I wanted to know whether we could do it and demonstrate that the outcomes we measured were, at least, no worse. We looked at the previous year before I got there retrospectively and then we did the prospective. Some people would question the validity of some of our methodology but I happen to think that it was okay.

CHAIR—Reasonably random?

Dr Cave—It was.

CHAIR—All the disasters did not happen the year before you got there.

Dr Cave—That is right. I do feel passionate about the caesar rate, and I think there are ways to deal with it, without being too interventionist.

Senator GIBBS—Thank you very much. I know Senator Crowley is dying to ask you questions.

CHAIR—Yes, I am. This is just far too interesting. The whole day has been far too interesting. Unfortunately, we have had to give as many witnesses as possible as much time as possible. We have had to try to make it a bit short. I wanted to just read you some evidence from the Association for Improvement in the Maternity Services. On page 2 of their submission they say:

For example the Birth Centre at the Royal Women's Hospital where exclusion of women outside a small geographical area and a ballot system are used to cope with demand which far outnumbers the small number of births which can be accommodated in this program. The Community Midwifery Scheme based at the Mater Mothers Hospital also excludes women according to their home address.

I put that in for equity, fairness and balance.

Dr Cave—Sure.

CHAIR—The interesting thing is that that line about the Royal Women's Hospital completely confirms your saying that about 20 per cent of women would like that option. You can say we have increased our capacity by 50 per cent, which is called two becomes three—

Dr Cave—That is exactly right. That is exactly what happened.

CHAIR—It is hopelessly insufficient. It is interesting because we have gone through the inquiry to this point and the sense we are getting is that all the women in Australia—or every third one—are marching in and demanding a caesarean section and that moving

towards technology is the way to go. Here is the Royal Women's Hospital where a huge number of women are saying, 'No, we actually want the birthing centre option', which seems to be wonderfully counter to the major message—that I think is not accurate, but is the sort of sexy one, the headline one.

Dr Cave—That is right. We did about just over 200 birth centre births in the last year that we looked at. We have increased that to a little over 300. But you are absolutely right, the demand is far greater than that. What we are hoping to do with our new model of care is to promote the birth centre philosophy into our new model of care so that many more women who come into the Royal Women's Hospital wanting that sort of care will be able to have that sort of care, or at least more like that sort of care than they can now. So, for example if midwives want a case load, then we are hoping to be able to give them the option to do that.

CHAIR—These are salaried midwives on the books at the Royal Women's Hospital?

Dr Cave—Yes.

CHAIR—Okay. Do you actually allow private midwives to have visiting rights?

Dr Cave—We are in the process of negotiating.

CHAIR—That is very encouraging. Is any of the midwives able to accompany a woman into the labour ward but not necessarily to do anything more than be there with them?

Dr Cave—Do you mean from the birth centre?

CHAIR—No, from a homebirth, an external provider.

Dr Cave—Yes, they are able to accompany women into the labour ward. At this stage they are not able to do anything more with them.

CHAIR—Their role then becomes that of a support person but not midwife, effectively.

Dr Cave—That is right.

CHAIR—If they are assisting in a birthing centre and they cross the corridor to the labour delivery for whatever reason, is the midwife allowed to accompany, but again, no longer is supervising?

Dr Cave—No, she accompanies and continues the care.

CHAIR—Into the labour ward.

Dr Cave—Yes.

CHAIR—There are different practices in every birthing centre.

Dr Cave—That is right. We are actually hoping to make that a wider focus than we have now. Also, we are hoping that if we can negotiate satisfactorily some of the stormy seas, we might be able to do similar sorts of things with the midwives from outside the organisation.

CHAIR—All these reviews and no action.

I keep saying Senator Gibbs asks these extremely brave questions. ‘If you lower the caesarean section rate,’ says Senator Gibbs, ‘whom did you tell?’ I totally love that question. If you decided to implement all the recommendations of the NHMRC in your hospital, firstly, can you; and secondly, whom would you tell?

Dr Cave—We would like to implement all of the recommendations of the NHMRC because it is our belief that that was a very well balanced, sensibly constituted body with a lot of people whose opinions we respect. I think it is a very good document. Can we implement them all? I think so. Whom will we tell? The world.

CHAIR—Do you have to tell the health department, and will you have to ask them for any dollars?

Dr Cave—I think we will have to tell them, but we will not have to ask for any dollars.

CHAIR—So if you do not ask for dollars, it does not really stop you. You can pretty much, not quite do what you like, it has to be within reasonable standards of care, but there is quite a large opportunity for you to rearrange how that funding is allocated?

Dr Cave—Yes.

CHAIR—One of the things that interests me a whole lot is where midwives are in this whole process. Do you think if we implemented all the best recommendations from our report when it is written, from NHMRC and everybody else, we would have the balance right between delivery in a hospital—and the old medical model labels that go with that—versus the midwife, less intervention, and even homebirthing? Would you see any place for homebirths in Australia?

Dr Cave—My answer would be that I think that if we could make the environment appealing and perfectly safe, then I would like to say that fewer women would want to opt for homebirth, but I have no evidence to say that. But, I understand why many women opt for homebirth.

CHAIR—Why? What is your understanding of why they do?

Dr Cave—I think they are concerned about the fact that the model has been a very medical model for so long. If one is taken into a hospital, there is a notion that one is sick, which is not true. If one is taken into a hospital which has got high-tech machinery all over the place then, sure as God made little apples, someone is going to want to use it. It sort of increases the intervention rate simply because it is there. It does not change the peri-natal outcome one jot. A good example of that is cardiotocography. It has not made one jot of difference to the peri-natal outcomes. It has cut down the number of neonatal seizures in the

first few days of life, but the long-term outcome has not been shown to have changed at all. Maybe we have not measured it for long enough.

CHAIR—You are making a very good case for homebirths, Doctor. Why aren't you going to support it?

Dr Cave—Because, I think that the safety net of having ready access to caesarean sections, surgical skill, blood, whatever, is more compelling for me than that which is available. I just think it is a bit too high risk, but that is my personal view.

CHAIR—Can I ask, are you saying that if women choose homebirth, that you would be in support of their choice and your hospital would provide the necessary backup, admission without question, organise the homebirth—but we know we will have to go to the Royal Women's if something goes wrong, no questions asked, not triage level 3 through casualty but directly into labour et cetera.

Dr Cave—In fact, that is exactly what we have said. We have made statements that if people make their choices, then we have to support the choices in a non-judgmental way and provide backup if they have problems.

CHAIR—I must say there is a real sense in which, if you look at the childbirth perinatal statistics and maternal mortality from 50 years ago, there has been a significant reduction in the last 50 years, and some of that is clearly down to blood transfusion, caesarean section, the capacity to save a woman labouring until she is exhausted to death and her baby has gone too. So we know that there is sometimes a benefit from that high-tech.

What is the concern of this committee is whether it needs to be as high as the data shows, and you have already said, and many others say, 'No, no, our figures are far too high and they can be reduced with no change in outcome.' I guess the point I am really making is that there is a concern though that if all those things have helped in the last 50 years to reduce infant mortality and even maternal mortality, what women are saying is that we have now gone far too far—and I do not think it is only women. You are saying it yourself and that your hospital is saying, 'Whoops, hold about, we are not taking everybody in through a medical technology chute; we are still just dropping babies as we have for centuries: how can we best help women do that?'

But those of us who have been around hospitals for a long while are concerned that if something changes and the mother and baby are at risk, then how far away and under what conditions do you have to be to make sure that that person can get to where that risk can be dealt with—by caesar or blood transfusion?

Dr Cave—That is right.

CHAIR—That is a concern but what we are doing is an exercise in overkill in the other direction, is it not?

Dr Cave—I think so.

CHAIR—High-tech. So everyone goes through the hospital in case something goes wrong and anyone who asks to be out there is regarded as potty, whereas really what we should be saying is that everybody is out there and one per cent—or whatever the small percentage is, one in five, I suppose it is now—come in. We have got it around the wrong way, do you think?

Dr Cave—I think so. But I have been at this game for a long time and I suppose I went through the era of wanting to get involved in the high-tech. It could be said that I was certainly more interventionist than I am now and I have probably come to that opinion because I do not know that I changed the outcome in terms of benefits for anyone and, in some cases, I think I made it more uncomfortable for the women.

CHAIR—One of the things that seems important to us is the consideration of continuity of care—any number of witnesses have put that to us—and also continuity of carer; that women might cope with two or three but they are not terribly good at six or seven; and even if they had met two or three on their way through antenatal stage, to find a complete stranger in the labour ward is a real shock. There is not even a pretence of continuity. What we need to be looking at is the staffing arrangements that might deliver continuity of care of a different sort. Certainly some of the things we have heard today suggest that there are good prospects and possibilities. However, a number of the witnesses have been a bit scathing about what hospitals call ‘a move in the right direction’. How do you talk with those people and how can they talk with you, or are you constantly talking?

Dr Cave—With the consumers?

CHAIR—No. With the midwives organisations, in particular, and with consumer groups.

Dr Cave—As I said, we started this process in October of last year so we have had a reasonable amount of dialogue in the last almost 12 months.

CHAIR—If some of the witnesses, who I might say are sitting behind you now and are indicating that it might be fun to have the opportunity to talk with you—fun perhaps is not what they are indicating. How can they? How could a group of midwives, for example, or a group of mothers get to talk to somebody in the Women’s Hospital and who would that person be? How would they make that contact? This is not just something that we should be organising here but presumably from time to time people will want to contact the Women’s.

One of the things we have found is that a lot of women feel like they just beat at the door, they do not know which door to beat at to be let in, and then when they beat they are not heard.

Dr Cave—That is right. At the Women’s we have established this review and it is in the process at the moment of being implemented. We have an implementation team to which Corelle Davies, my colleague, is central and she really has been heavily involved in this project and process. We would be delighted to hear from whomever wants to talk to us.

CHAIR—That is a statement on the Hansard record and so the witnesses who have come today and read *Hansard*—because they will all be provided with a copy—can know that. Is it you they should contact, Ms Davies?

Ms Davies—A lot of the groups that have presented here today have actually been part of our consultative groups—ACMI and the improvement of midwifery services. I think 60 other community groups did participate in our review.

CHAIR—Indeed, what you are saying is that some of the changes are actually as a result of those discussions.

Ms Davies—Absolutely. And the plan is to feed back to them no later than November as to what has resulted from their contributions—

Dr Cave—So far.

Ms Davies—with a view to that being an ongoing process.

CHAIR—Do you think there is any substance to the *cri de coeur* that you cannot get a good homebirth in a hospital, if you will allow what I am saying—I think you understand?

Dr Cave—I would hope that that is not true. I am still idealistic enough even at these advanced years to hope that we could actually make it much more pleasant than it has been. I see what has happened in the birth centre at the Royal Women's Hospital and the satisfaction of most of the clients is so overwhelmingly positive and obvious that if we can actually translate a lot of that philosophy in to our general care then I think that we can go a long way towards satisfying many of the needs. And, as I said earlier on, women are not asking us for rocket science, they are just asking us for a bit of kindness, consistency of information, continuity of care—nothing too difficult for us to provide you would hope. The challenge will be to see if we can do it.

CHAIR—Well that is a very interesting point to more or less to conclude on. I just wanted to say that—and it is interesting, I have asked this question of others—women, it is reported, if they ask for a caesarean section are provided with one. Now I do think that this is an overstatement but there is a sense in which women, whom I like to sometimes say have been powerless for 2,000 years, can now suddenly ask for a caesarean section and it is likely they would get it. If, on the other hand, they should ask for no intervention and a homebirth or a birth centre birth they are regarded as distinctly odd—dotty might be a better word—and, just to paraphrase what you are saying, women are not asking for much. They are asking to be left to let nature take its course in a supportive, informed environment.

Dr Cave—That is right.

CHAIR—And that is what you are saying. You are very understanding and sympathetic to that. Has this also been your philosophy over a long time or has the recent inquiry assisted?

Dr Cave—I think certainly the recent inquiry—well I suppose it has been my philosophy for some time that we have not really been terribly sensitive to people's needs and, as I said, I have come to that over the last few years. But I guess, having read some of the documents which I mentioned earlier on, we have got plenty of evidence that this is what women have been asking for for 10 years now at least, and no one has ever done anything much about it.

CHAIR—A hundred and fifty.

Dr Cave—Well sure, but I mean 10 years of my reading.

CHAIR—Well we can give you some good references. I am not sure—were you at a comma or a full stop there?

Dr Cave—A full stop will do.

CHAIR—Senator Gibbs was saying before something really interesting about the assistance of midwives in Aboriginal communities; that maybe, if there were Aboriginal midwives in the community known to the women, maybe working with the elders in the community—the women elders—you would have better understanding of antenatal care and nutrition, better capacity to reduce smoking or other negative practices, that indeed the whole process of moving toward a midwife in the local community could have kind of incremental benefits as the reasons for intervention might be reduced precisely because the midwife was in the community and there all through the pregnancy.

Dr Cave—Yes.

CHAIR—Does the Royal Women's have a capacity to support midwives, Aboriginal midwives, in Aboriginal communities, a la, I suppose, the Royal North Shore Hospital which is working with Aboriginal communities in western New South Wales?

Dr Cave—I have to say at this stage of our evolution the short answer is no—not because it is not on the agenda but because I think we have got a lot of other things to put right yet. However, I am not saying that because I think it is not so important. As far as the Royal Women's Hospital is concerned, the number of indigenous women accessing our services is much lower than the number of indigenous women accessing the services of this hospital for example, or Cairns Base Hospital or Mount Isa.

Having said that, I do not think that is a reason why we should not address the issue. We certainly have an Aboriginal liaison officer on staff to assist in some of these areas, and I think we obviously need to go further. The issue of outcomes for Aboriginal health is absolutely appalling, and birthing is no different. We heard earlier on that the peri-natal mortality rate for Aboriginal and Torres Strait Islander women is two to three times higher than it is in the general population. That is dreadful.

CHAIR—It is no comfort, really, to know that in the early 1980s a study of Aboriginal women's health put the peri-natal mortality figures at times five. I think it has been overlooked that there has been a considerable improvement. It is now times 2½ to three. That is still dreadful and far too high, but it is a very big improvement on times five.

Dr Cave—Yes.

CHAIR—One of the things I would love to know is what has caused that improvement. I do not believe there is any good documentation on what has caused that improvement. We have had a cry with almost every question we have asked that we need the research to back that up.

On that note and it being after 5 o'clock, I think we should call it a day. If it is not perfect it is at least a warm and smiling end to the day. Thank you both very much for your contribution. Thank you to those people who have stayed all day to listen, to the Hansard staff and to the Mater.

Committee adjourned at 5.06 p.m.

