SELECT COMMITTEE
INTO PUBLIC OBSTETRIC SERVICES

TRANSCRIPT OF EVIDENCE
TAKEN AT BUNBURY
MONDAY, 27 NOVEMBER 2006

SESSION FOUR

Members

Hon Helen Morton (Chairman)
Hon Anthony Fels
Hon Louise Pratt
Hon Sally Talbot

Hearing commenced at 2.51 pm

MILES, MRS SYLVIA
Nurse Unit Manager/Site Manager, Collie Health Service,
PO Box 505,
Collie 6225, examined:

MARTINO, MS ANNE-MAREE
Acting District Manager, Blackwood District, Bridgetown District Hospital
PO Box 136,
Bridgetown 6255, examined:

The CHAIRMAN: On behalf of the committee, I welcome you to the meeting. To begin, please state your full name, contact address and the capacity in which you appear before the committee.

Mrs Miles: Sylvia Miles, nurse unit manager at Collie Health Service.

The CHAIRMAN: I will ask you to speak more loudly and, if possible, into the microphone. The reason being, we have the airconditioner on and Hansard is having difficulty hearing us.

Mrs Miles: I usually do not have a problem with my voice. I am obviously a bit nervous.

The CHAIRMAN: The airconditioning is quite loud too.

Mrs Miles: Sylvia Miles, nurse unit manager at Collie Health Service. My address is care of Collie Health Service, Deakin Street, Collie.

Ms Martino: I am Anne-Maree Martino, relieving district manager for the Blackwood area, which is responsible for three hospitals, two multi-purpose service sites, one of which is Bridgetown which performs obstetric services. The address is post office box 136, Bridgetown; or, Peninsula Road, Bridgetown.

The CHAIRMAN: You will have signed the document entitled "Information for Witnesses". Have you read and understood the document?

Mrs Miles: I have.

Ms Martino: Yes.

The CHAIRMAN: These proceedings are being recorded by Hansard. A transcript of your evidence will be provided to you. To assist the committee and Hansard please quote the full title of any documents you refer to during the course of this hearing for the record and please be aware of the microphone, as we mentioned, as speaking into them assists with the recording. It is not necessary for amplification. I remind you that your transcript will become a matter for the public record. If for some reason you wish to make a confidential statement during today's proceedings, you should request that the evidence is taken in closed session. If the committee grants your request, any public and media in attendance will be excluded from the hearing. Please note that until such time as the transcript of your public evidence is finalised, it should not be made public. I advise you that premature publication or disclosure of your evidence may constitute contempt of Parliament and may mean that the material published or disclosed is not subject to parliamentary privilege. Would you like to make an opening statement?

Mrs Miles: I will go first. As a midwife of 30 years, I have worked 24 years at Collie Health Service. Having been involved in midwifery for a very long time, I have been a little bit concerned

about choices for women in the rural sector. I have been very committed to midwifery care at Collie Health Service. There is a small group of midwives left at Collie; we have all been there over 20 years. We would really like to see some succession training for midwives so that we can start pulling back a bit. Also, the women of Collie would really like to birth at home, or should I say, at the hospital but in a home environment, with family and friends. All the evidence that has recently been shown through various countries supports the idea that women do far better in their own environment with support; obstetric outcomes are a lot lower and having the carer responsible for them gives them a sense of wellbeing. That is where I am at as a midwife. Hopefully, I am fighting to maintain rural services at Collie.

Ms Martino: I am also a midwife. We have a team of dedicated midwives at Bridgetown Hospital. We have three general practitioner obstetricians; two are able to do anaesthetics and so are able to perform epidurals etc. The population is over 4 000. We have about 60 to 70 births at present; they are low risk. The women are given care from antenatal onwards by the midwives and doctor. Not that it is a share-care model as such, but they visit us in the hospital and we form a rapport with them. Then, because we work closely with the visiting medical practitioners, that relationship continues. We see that we provide a positive and good outcome for the women in Bridgetown.

Mrs Miles: We did 103 deliveries last year. One of our senior GP obstetricians left, which left us with varying skills of obstetrics in our GPs. We have had to really look at how we are going to deliver obstetric and midwifery services in the future. The choices for women have been reduced by this senior GP leaving. We have been looking at an innovative way of maintaining a midwifery shared-care model in Collie. I have brought document for you to review. Hopefully, we can maintain our 100 births a year at Collie and give our women choices. Also, hopefully, we can recruit and retain midwives. Our midwives at Collie have a dual part to play due to the fact that we only have 100 deliveries. We have to be not only accident and emergency trained, but acute generalists as well. As the nurse unit manager, I have also been responsible for accident and emergency theatre, central sterile supply department, acute care and an aged care facility that has 28 beds. My passion has always been about maintaining midwifery services. We only have five midwives now and three casuals, who are very limited in what they can give us. The five remaining midwives - I am one of them - are really feeling the pinch of always being on call and being available. We would really like to have an innovative model of care where we can hopefully attract young midwives to take over from where we have been.

The CHAIRMAN: With the five midwives, how does that work out on a roster? Are there two on at any one time? How does that work out? There is just one on at any one time?

Mrs Miles: Yes. We do not meet our roster requirements. That is why we have an on-call as well. Not every day do we have a midwife but we have somebody who is on call, or I am in the hospital as the nurse unit manager.

The CHAIRMAN: Would you like to provide the briefest of overviews as to what is contained in your model?

Mrs Miles: Only very short. It is basically about sharing the antenatal care with the GPs in the GPs' rooms; having set clinic days, thereby giving the midwives more opportunity to be more at one with the women coming through, and also to reduce the load on the GPs; not only that, we feel that as midwives we will be able to do more about health and health promotion issues with the women antenatally. If women are seen by midwives antenatally we will have a continuity of care. We are very lucky at Collie; we have always been able to say that for any woman who comes into our hospital, the midwife on duty will stay with that woman. We have always been able to do that up until recently.
[3.00 pm]

The CHAIRMAN: What is the major obstacle that you foresee to implementing the model of the shared care arrangement in the GPs' rooms?

Mrs Miles: Finance.

The CHAIRMAN: Who pays for whom?

Mrs Miles: That is right. That is going to be the question.

The CHAIRMAN: Are the midwives not paid by the hospital?

Mrs Miles: Yes, we are.

The CHAIRMAN: So why can they not just walk down the road?

Mrs Miles: We can and we really want to.

The CHAIRMAN: So what is stopping that?

Mrs Miles: The model of care that I have proposed is that not all no-risk women need to see a GP at every antenatal visit. Therefore, that will be a reduction in GP finance and, as I put in my model of care, they need that finance to maintain their practice, so how do we get around if the midwife sees women antenatally and the GP does not? I have put some solutions in my model of care, some barriers and some challenges, but I feel deep down that the doctors realise that we work hand in hand and without each other we cannot go forward, so we have to look at a model of care that we can both sustain.

The CHAIRMAN: Have you been involved in any of the Department of Health's consultation processes to this point, and those that I give are the Cohen report, the Reid report or the clinical services consultation, and are you aware of the department's current consultation process?

Ms Martino: We certainly are aware of the consultation process and the feedback has been given by some of the midwives, and we certainly have been involved in and are aware of the Reid report.

The CHAIRMAN: Have you been involved in it? Have you been consulted about the Reid report, did you say?

Ms Martino: I have been part of it and been aware of it, etc.

Mrs Miles: I have been involved. This is my fourth obstetric report really - the Cohen report, the Hilda Turnbull report and the one previously. I have been around a long time, and I have also read the Reid report but I was not involved. I know about the clinical side and have made suggestions. I have also read the future obstetric statement.

The CHAIRMAN: Can you just give me an understanding of what you do. Do you do caesars at Collie?

Mrs Miles: Yes, we certainly do - epidurals, caesars, vacuums and forceps.

The CHAIRMAN: That is all done by GP obstetricians and GP anaesthetists?

Mrs Miles: We have a surgeon who can do caesars. Until December a senior GP did everything - epidurals and everything else. We have two anaesthetists who at the moment can put in epidurals.

The CHAIRMAN: Are they GP anaesthetists?

Mrs Miles: Yes, GP anaesthetists, but one is actually leaving to go to Fremantle in December, so that will leave us with one only GP to be able to put in epidurals. We have four GP obstetricians with varying levels of skill and two under supervision at the moment.

The CHAIRMAN: Would you just like to give an overview of your service?

Ms Martino: We have, as I said, three GP obstetricians, two of whom can do epidurals - actually one of those can and another one is a general anaesthetist who does epidurals for obstetrics. As I say, we provide low-risk care, which does not involve caesarean section. We do have a visiting gynaecologist, though, so on occasions when there is a planned caesarean that will be done. That is basically our service.

The CHAIRMAN: Can you just run through the centres that you manage again. Is it only Bridgetown that provides obstetrics? Do none of the others do obstetrics?

Ms Martino: No, but 35 kilometres away is the Manjimup hospital and that provides obstetric services as well.

The CHAIRMAN: That does as well, okay.

Ms Martino: That is low risk as well.

Hon SALLY TALBOT: Where do you send your high risk cases, to Bunbury?

Ms Martino: That is right.

Hon SALLY TALBOT: The same for Collie?

Mrs Miles: It depends. Some actually go to King Edward depending on what category they fall into in the high-risk area. The second category is a high risk that we would send to either Bunbury or King Edward. We have always done low to medium, and when our senior GP obstetrician was there, we often did high risk because of his skill level. He maintained his skills at a very high level for a GP obstetrician. At the moment we basically do low-risk women but they are not without their risk either.

Hon LOUISE PRATT: How do you manage risk for low-risk women when, for example, you do not have someone available to give a caesarean?

Ms Martino: How do we do that? It starts in the antenatal period, but obviously at times whilst a woman is in labour there will be foetal distress or something that we need to be aware of it, so our midwives are very astute and will certainly alert the GPs and work very collaboratively and have good relationships with them and also the specialists in Bunbury. We confer as early as possible and transfer out as expeditiously as possible.

Hon SALLY TALBOT: Do either of you do homebirths?

Ms Martino: No.

Mrs Miles: I used to.

Hon SALLY TALBOT: Can you have a homebirth in Collie?

Ms Martino: No.

Hon SALLY TALBOT: In Bridgetown?

Ms Martino: Not that I am aware of at the moment. In the past there have been private midwives and we have had clients, even up to three years ago, who would have had a homebirth but there were complications and so the client came into the hospital and delivered safely. Usually there was collaboration between the GPs in Bridgetown, and the homebirth midwife would consult with them. We encourage keeping the communication open in those situations with all of us, so we encourage the home midwives to work with us as well.

Hon LOUISE PRATT: Is that something you see as viable or is it something that you think is imposed on you?

Ms Martino: I certainly would not see it as imposed, but I think that working parties need to keep working together, as I know they are, for good outcomes for our communities and the mothers and allow them to have the choices within a safe environment.

The CHAIRMAN: Sylvia, has your model already been given some level of approval?

Mrs Miles: Yes.

The CHAIRMAN: Good. How far has it been approved?

Mrs Miles: It has reached south west.

The CHAIRMAN: What have they approved?

Mrs Miles: To collaborate with the GPs, which I have done, and they are actually reasonably keen to go ahead with this model of care.

The CHAIRMAN: Okay. We are not hearing a lot about it, are we?

Hon SALLY TALBOT: Do you have any opposition?

Mrs Miles: Not so far, no.

The CHAIRMAN: We have heard about the antenatal care level, what does the model entail after that?

Mrs Miles: My model entails that we have a core group of midwives who are taken out of acute care. They do not work on the acute care roster as they do now; they would just be purely midwives looking after women antenatally, interpartum - when they are in labour - and postpartum, and also in the home environment if they want early discharge and up to six weeks later for their check-up. They would carry on from there if necessary.

Hon LOUISE PRATT: Is that one-on-one or is that team?

Mrs Miles: You cannot maintain one-on-one. You probably could if we were younger, but all of us are over 50 years old now. We would like to do it, but I have made it that no midwife stays with a woman for more than 10 hours. If we all participate in antenatal care with the core group of midwives, the woman will have seen all of the midwives at one time during their antenatal care.

The CHAIRMAN: Is the only thing stopping it from going ahead a concern about a reduction in GP income on the basis that they would not be at all of the antenatal care?

Mrs Miles: No. I think we can get around that. I honestly believe that we have to provide a working model, a shared care model, for sustainability in rural practice. I also think it is necessary for recruitment of midwives so they can actually just be midwives, not acute care as well. I mean, I enjoy both and I am very good at both, but I think that to maintain midwifery services we need to go that way. There is also the fact that midwives have been out of antenatal care for quite a while. I have done the enhanced midwifery role because I have always been passionate about that. The other midwives at our hospital have not, so we have to look at a sort of self-directed learning package and we have to have very strict clinical guidelines, and all this has to be prepared before we can go ahead with this model. We have to look at a self-directed learning package, and we have to have very strict clinical guidelines. All this has to be prepared before we can go ahead with this model.
[3.10 pm]

Hon SALLY TALBOT: Is it a model that you think will fit other regional communities?

Mrs Miles: I am absolutely positive.

The CHAIRMAN: Ms Martino, would it fit your community?

Ms Martino: Yes, I believe it would.

Hon SALLY TALBOT: What about women who feel that the hospital environment is simply not suitable for them to give birth in? What do you envisage for them?

Mrs Miles: I feel all women should be given informed choices. Everything should be evidence based. If they wish to have a birth in their own home, if at all possible they should be allowed to do that.

Ms Martino: I feel that the women in our community are given choices and, because it is low risk - we aim to have low-risk deliveries - we are able to offer a choice for them with guidelines about what is safe. Those who come to us to seem to be able to decide on the care with the

understanding that if something goes wrong, these steps will need to be taken. That seems to be accepted.

The CHAIRMAN: What is the caesarean rate?

Mrs Miles: Well below the average standard.

The CHAIRMAN: Do you know what yours is?

Mrs Miles: Yes.

The CHAIRMAN: Is it around 17 per cent or something like that?

Mrs Miles: Yes. It is below the national standard.

The CHAIRMAN: About half the average?

Mrs Miles: I have it all in the report, yes.

Ms Martino: Ours would be low. I am sorry I do not know the exact statistics offhand, but I could find out. The midwives, certainly in Bridgetown, have good rapport with the women antenatally. We often look after them in labour. We have this relationship and because it is a small core of midwives, the relationship is strong. In that way, rurally, we differ from Bunbury because we are able to have that rapport and the number of deliveries is small. I do not see that as a disadvantage. In that particular low-risk set it is an advantage for the women. We do see them antenatally right through to postnatally. We encourage those who have attended antenatal classes to come back postnatally in a hospital group. The women find that they are happy with that.

Mrs Miles: There are plenty of models that are split when women are seen just by midwives or just by GPs, so you are doubling up. The model that will work for Collie is that women will be seen at all times either by a GP or a midwife, or both, depending on the circumstances, but at one place, with their own hand-held records, which means that they take on the onus for their own health and wellbeing and they have to make informed choices. I think, rurally, the reason that there has never been a big push for homebirths in Collie is that we provide a very homely atmosphere with reduced risk. They are having a baby in an area where, should anything go wrong, help is on hand. Our town is only about 20 kilometres from their homes. Most women prefer to deliver in the hospital. If they wish to have a homebirth, they can find independent midwives to do that. The majority of women enjoy the homely atmosphere of our birthing suite and that fact that we are a small rural hospital. We know a lot of the women in the community. I am delivering babies of women I delivered when I first went to Collie. You have that social network as well.

The CHAIRMAN: Do you know what percentage of women have babies in your catchment area? I could pick a couple of postcodes that relate to Collie. Of those who have babies, how many have them at Collie rather than go elsewhere?

Mrs Miles: Until December last year, 90 per cent of women in Collie had their babies in Collie.

The CHAIRMAN: Do you have any statistical information that could verify that? Can you get that type of information?

Mrs Miles: Yes, I can. I also have some for the past two years. There are women who have gone privately to St John of God since our senior GP obstetrician left. Up to date, we have only transferred, I think, four women from Collie to Bunbury Regional Hospital for regional care because they were at risk.

Hon SALLY TALBOT: Four in a year?

Mrs Miles: Four in the last -

Hon SALLY TALBOT: Since December?

Mrs Miles: Since January.

The CHAIRMAN: When you say 90 per cent, are you talking about not only the women who were intending to have babies at the hospital - four of them had to go somewhere else - but also all women who have had a baby, whether they have decided to stay with mum at Joondalup or anything like that?

Mrs Miles: I have some statistics. I think we had only five at St John of God. In 2005 King Edward Memorial Hospital had six; Bunbury Regional Hospital had 17; Collie District Hospital had 19; and, St John of God had four. I am probably correct in saying that 80 or 90 per cent of women stay in Collie, or did stay in Collie, to have their babies. Some women travelled from their homes in the north to Collie to be with their mothers and to have their babies.

The CHAIRMAN: Are you aware of tensions between the respective service providers in either of your locations - between the GPs and the midwives, or the midwives who want to work in hospitals and the midwives who want to work independently?

Ms Martino: Certainly not in Bridgetown; however, I am aware that there is potential disharmony in other areas. We are fortunate that at present we have very good partnerships with our medical team.

The CHAIRMAN: When you say other areas, are you referring to Manjimup?

Ms Martino: No. Generally you hear things. There is definitely no disharmony in our areas, which is very fortunate for our communities.

The CHAIRMAN: What is your catchment of the total number of deliveries?

Ms Martino: I would need to check those statistics properly, but I would say it was high and that those who are able to would stay in the area.

The CHAIRMAN: From my experience, they are very high.

Mrs Miles: I think we offer a fantastic obstetric and midwifery service with the degree of skill that we had until December. I think the statistics for this year might be a little bit different. The catchment would not be as high. Generally, we have had a very good relationship obstetrically and midwifery, and we have retained in our area. That does not mean to say that we do not disagree sometimes. That is healthy, I think, for professionals. We have varying of degrees of skills. As the GPs said, there are very good GPs and very good midwives. Some GPs have a sixth sense about obstetrics and some midwives have a sixth sense about midwifery. There are varying degrees without, but I can honestly say that we have delivered a very safe, quality service in the past.

Ms Martino: Part of that is because the women antenatally are very compliant in our areas, certainly in the Bridgetown area. We are going to capture mainly good outcomes for our hospital because of that. We do not get many unexpected women arriving at our doorstep who have not had antenatal care. For us, that is also an advantage.

Mrs Miles: My biggest concern is about the future.

The CHAIRMAN: What do you think is going to happen?

Mrs Miles: I hope and pray that we can actually have a shared-care model and that we can get younger women interested in being midwives, and that the populace has choice and availability.

The CHAIRMAN: What could happen to prevent that?

[3.20 pm]

Mrs Miles: I think not being able to recruit and retain midwives rurally and GP obstetricians. As I said, they go hand in hand; we cannot have one without the other. I think we must consider succession training right through the rural sector. I love living in the country. It is my choice to live in the country; I could have worked anywhere. However, maintaining a high standard of practice has been difficult at times. It has been difficult getting out to ensure that my skills are

maintained, mainly because nobody else can step into our roles while we go away to update our skills. For that reason we need to constantly keep our skills updated. The GPs also need to do it. We need young people coming in.

The CHAIRMAN: Sometimes that does not sound like it is too difficult. If you have to go to King Edward Memorial Hospital for Women for four weeks, surely someone from that hospital could come down to Collie for four weeks. What is the difficulty?

Mrs Miles: The difference is that rurally the midwives are also general clinical nurses. We maintain both roles every day in our work environment. King Edward midwives cannot maintain general acute skills. Midwives cover theatre, ANE, general ward, cardiac etc as well as midwifery skills. Midwives in the rural sector are extremely multiskilled.

The CHAIRMAN: With whom could you swap for four weeks?

Mrs Miles: It is very difficult. What we need to do is bring in a midwife. John was saying that it is really difficult because of the nature of being a rural midwife-cum-registered nurse; we have a dual role. My model is that we would have one role. That would mean that we would have to recruit to fill the acute sector.

Hon SALLY TALBOT: Would that make midwifery more attractive to young nurses?

Mrs Miles: Yes, especially with direct entry. The only course open for them would be to work in the metropolitan area in areas of midwifery. However, if we have these in the rural sector where we have this model of care, I feel it will be open to direct-entry midwives.

The CHAIRMAN: In the state's regional hospitals are midwives dedicated to a maternity area?

Mrs Miles: Yes.

Hon ANTHONY FELS: Is there a shortage of midwives at the moment?

Mrs Miles: Yes. It has taken us two months to get an agency midwife to cover me while I go on leave.

Hon ANTHONY FELS: Is that just in your area or is that across the state?

Mrs Miles: I think that applies across the state, but it is especially a problem in the rural sector.

The CHAIRMAN: I would be interested in having a decent read of your proposal.

Mrs Miles: It is not totally complete. I was given the time to do it; however, unfortunately I had to work clinically.

The CHAIRMAN: Thank you very much.

Hearing concluded at 3.25 pm