SELECT COMMITTEE
INTO PUBLIC OBSTETRIC SERVICES

TRANSCRIPT OF EVIDENCE
TAKEN AT BUNBURY
MONDAY, 27 NOVEMBER 2006

SESSION TWO

Members

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

Hearing commenced at 1.00 pm

HOWE, DR KEITH
GP Obstetrician,
122 Spencer Street,
Bunbury, examined:

COMPARTI, DR MICHAEL
GP Obstetrician,
207 Spencer Street,
Bunbury, examined:

The CHAIRMAN: Welcome and thank you very much for coming to the committee. You will have signed a document entitled "Information for Witnesses". Have you read and understood that document?

The Witnesses: Yes.

The CHAIRMAN: These proceedings are being reported 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 document you refer to during the course of the hearing for the record. Please be aware of the microphone and try to talk into it for recording purposes. Ensure that you do not cover it with papers or make too much noise near it and, obviously, please try to speak in turn. 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 be taken in a closed session. If the committee grants your request, any public or 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 a 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?

Dr Howe: I do not think that either of us have anything prepared, but I guess one of our major concerns would be the work force issues with regard to general practice in general in Bunbury, and in particular GP obstetrics. We have an ageing general practice work force with many imminent retirements about to happen and there will be a significant difficulty in obtaining general practice obstetric services in the near future.

The CHAIRMAN: Can I just reiterate something? Are you representing yourselves as individuals or are you actually representing the Greater Bunbury Division of General Practice?

Dr Howe: Our original submissions were through the Division of General Practice. I think we could be considered to be representative of the division.

The CHAIRMAN: Did you want to make some comments?

Dr Comparti: I have been in the south west for over 20 years now. I came to general practice in the country because I wanted to help deliver babies as well as look after their families. I have enjoyed doing that and I want to keep doing it. I hope that there are not changes brought about that push me out of that before I am ready to retire, but I fear there will be.

The CHAIRMAN: What kind of changes are you fearful of?

Dr Comparti: That there will not be a place for general practitioner obstetrics. Some of the models that are proposed for changes seem not to have a place for us; and where I have always considered that general practitioner obstetrics are the ultimate in holistic care; that is, we know the

girls when they are teenagers right the way through to when they are pregnant and have their babies, and we know them afterwards. That seems to be to be a great model, but I do not know what is going to happen to it in the future. I have only 10 years left of my working life but I would like to keep delivering babies as long as I can, provided there is a system that allows me to do it.

The CHAIRMAN: Where are you getting the information from about the likely models that will be excluding you?

Dr Comparti: Suggestions for models, the discussion paper, which is the "Future Direction in Maternity Care: Health Policy and Clinical Reform" from the health department of Western Australia dated 6 October 2006.

The CHAIRMAN: Did you believe that there was documentation in there paper that referred to enhancing, supporting and expanding the role of GP obstetrics or the opposite?

Dr Comparti: I thought that the discussion paper, and I accept that it is just a discussion paper, and I accept that it is a very important issue to look at other models because there are not many of us left. It just seemed to miss out the step that there are still GP obstetricians who are out there willing to work, wanting to work and there just did not seem to be a suggestion of how we would fit into the new model. The concern to me is that it seems that midwife-led clinics and expertise will lift up a branch, and specialist obstetricians will come down a step, and then there is no role for the GP obstetrician, which is fine until those specialists retire, and then there is no-one. It seems to me that while there is still a group of us who like delivering babies - it is what we want to do, for me it is a passion - it would be a pity to marginalise us so that we are not there to encourage the next generation of doctors to at least consider it. Whether or not we can convince people to do it is another question, but if we are not there to sound positive about it, nobody will be.

The CHAIRMAN: Have you have any idea what percentage of deliveries are taking place in this local area or at Bunbury Regional Hospital say are GP-delivered?

Dr Comparti: I do not have statistics.

Dr Howe: No, I do not have a figure off the top of my head, but I would have put it at probably 60 per cent, at least, would be general practice people.

The CHAIRMAN: Can you just outline what the model is that operates at Bunbury hospital. Do you get paid fee for service; are you VMPs when you go there; or is there a rostered arrangement? Just give us a brief outline of how the model operates at Bunbury.

Dr Comparti: Essentially, for our patients, there is no difference whether they are private or public. We see them in our rooms; we look after their antenatal care; and when it comes to the delivery, that is where there is a difference. At the regional hospital the regional pays us a fee for service to be supervising that confinement; on the private side, we raise a fee, but the patients get the same care in our surgery.

The CHAIRMAN: Do you charge a booking fee of any sort for a public patient?

Dr Comparti: No, it is just a fee for visit for the antenatal care.

Hon LOUISE PRATT: Do you pick up new patients or is it largely your ordinary case load for patients that you have whom you see for their day-to-day health matters, or do you open yourself up to pick up new cases as someone is looking for someone to be their lead carer?

Dr Comparti: The majority are probably our practice, just simply because we have a large practice with lots of patients.

Hon LOUISE PRATT: So you refer within the practice -

Dr Comparti: Yes.

Hon LOUISE PRATT: Say, to the two of you who do -

Dr Howe: I am in a different practice, and there is only one other practitioner in my group who delivers. So we actually see a fair few patients from other sources, including one other general practice in town, the Aboriginal Medical Service and some out-of-town people. I see a significant number of patients coming up from Busselton, Harvey and Donnybrook.

[1.10 pm]

Dr Comparti: I do exactly the same - Harvey and Donnybrook. With places that no longer do obstetrics, we do a shared care; that is, the local GP asks me to look after their confinement and after the woman has delivered, I send her back to her GP in her own town.

The CHAIRMAN: Your submission indicates that the division does not have high expectations about inclusion in the health department's consultation process. Why do you think that is so?

Dr Comparti: There are a number of reasons. One reason is that we are fairly invisible to the health department because we are out there in private practise. We pay for all our own infrastructure and it does not cost it anything for us; therefore, we do not factor into its viewpoint. Another reason is that perhaps it can see the writing on the wall that there are fewer practitioners, let alone GP obstetricians.

Dr Howe: And probably past experience.

Dr Comparti: Yes, past experience. If you are not employed within the health department, with plenty of time to lobby, you are invisible.

The CHAIRMAN: Were you involved in the preparation, delivery of and feedback on the Cohen report, the Reid review or the "Clinical Services Consultation 2005" document? Did you have any involvement in any of those three processes?

Dr Howe: I did not as an individual. I was not administratively involved in the division at the time, so I do not know whether the division was involved.

Dr Comparti: Personally, no, and to my knowledge with the King Edward Memorial Hospital for Women inquiry - is that the Cohen inquiry?

The CHAIRMAN: No. The King Edward inquiry was the Douglas inquiry. The Cohen report came out after that, and it was a general discussion paper prepared by Harry Cohen to paint a picture of what the future of maternity services may look like.

Dr Comparti: I recall that. There was no consultation.

Dr Howe: Harry Cohen presented the finding of the Douglas report to us. It was really a medical education event rather than a formal process. Discussions took place at that time, but there was not a formal consultation process.

The CHAIRMAN: The committee has heard evidence from Dr Towler of the Department of Health that there is not a concordant voice among the health professions who provide maternity services. The committee was also told that the department would seek to recognise and address the needs of the different professionals so that future obstetric policy provides choice for consumers while ensuring clinical safety. With this in mind, what are the needs of GP obstetricians, particularly those in rural areas?

Dr Comparti: We talk about safety there. GPs need to be engaged in day-to-day obstetric care to build up their confidence and experience so that they are available for the emergencies. In obstetrics, even a low-risk maternity case can turn into a nasty emergency in minutes. In my 20-plus years' experience, it happens very often when it is not expected. If you are not doing normal obstetrics, looking after normal women, you cannot be anywhere near as good at dealing with the emergency. We need to encourage general practitioner obstetricians to remain engaged with low-risk obstetrics as well as medium-risk obstetrics, which is our forte.

The CHAIRMAN: When you say "remain engaged", do you mean be at the birthing and be a hands-on provider of that service or as a shared care arrangement? What do you mean by "remain engaged"?

Dr Comparti: To me, "remain engaged" means having a relationship with the woman throughout the pregnancy so that she knows me, I know her and there is a degree of trust that is implicit because we know each other. I feel that we should be at the birth. I do not physically do the delivery for most of the babies because I do not need the practice any more. The midwives are very good at that sort of thing. I need to be there in case there is a problem - that is my view - or very close. Being at home on call, to me, is not close enough for my women.

Dr Howe: I agree with that. I feel strongly that a doctor needs to be within very close range of a delivery. In Bunbury there are often no doctors with obstetric experience in the hospital unless the GP attends. All GPs actually physically attend all their deliveries, but the midwives very often do the uncomplicated deliveries - the hands-on delivery is done by the midwife - and the GP is there for every delivery.

The CHAIRMAN: Are the specialists rostered on call, but not necessarily in the hospital?

Dr Howe: That is correct.

The CHAIRMAN: Do the GP obstetricians have an on-call roster arrangement or is each GP on call for their patients?

Dr Comparti: Essentially. In recent times we have worked out a roster among ourselves for, for example, weekends or, informally, to cover when one GP obstetrician is away. Three of my colleagues in my practice share weekends. We hand over on a Friday night and take over again on Monday morning. That is a fairly recent innovation. Midweek we stay available to our women 24 hours a day.

Dr Howe: We have a slightly different arrangement where at any time if a patient presents at the hospital, her GP is called, but if the midwife cannot contact the GP - he may be on holidays or not available for any reason - there is a roster within our group and someone is on call and he must be available.

The CHAIRMAN: I refer to a couple of the models in Perth. Dr Simon Towler suggested to the committee that because of the work force constraints, there may have to be an acceptance that models will change. One of the proposed models is an arrangement for rostered doctors in the hospital. The attending GP would have to hand the patients to that rostered doctor. Other people have talked about continuity of care and issues around shared care arrangements. Do you have any comments about that potential model?

Dr Howe: One of the strengths of general practice obstetrics, as Michael said, is that you are the person with the overall knowledge of that patient - a relationship has developed with the patient during the pregnancy and perhaps having delivered the woman's other children - and there is a resistance to handing over the care of that patient to someone else. There is also a resistance to walking into a labour ward and seeing a patient that you have only just met for the first time when she is in late labour and is very hard to get to know. It is very intrusive on our lifestyle being available 24/7 to all our patients. A compromise has to be found and we have found that in our own way. It is very hard to build a model that will suit every situation.

Dr Comparti: Being practical, there have to be some changes for the future because there are not enough of us left. If we were to move to that sort of a model, I would prefer it if the person in the hospital were a person of my experience and background so that they know where I am coming from and they know about general practice. I have worked for years in obstetrics in the hospital system and know what it is like. If you are a junior doctor who just does obstetrics and has no idea of general practice, you quickly forget that there is a GP who knows that person really well, and when they go home, that GP will be looking after every problem. So, you need to hand over

appropriately. The model of having a hospital junior doctor only is not the best model for the overall care of the woman. If I was rostered on for a weekends to look after other doctors' patients, it is not ideal but at least I would know how to hand over to my colleagues and they would feel they could trust what I was saying because I knew what they need to know. Very quickly in the hospital system we find we have hospital-only doctors, and the GPs are forgotten very quickly. They do not realise there is anybody outside the hospital.

[1.20 pm]

The CHAIRMAN: What does the government need to do to support and encourage GP obstetrics in rural areas?

Dr Comparti: All the impossible things: it needs to encourage good midwives, provide the infrastructure and keep doing the fantastic job it is doing by supporting us with medical indemnity. It is doing a great job with that. It needs to make it a positive experience as far as possible for the younger doctors coming on. We try to talk them up.

Hon SALLY TALBOT: What is the process to become a GP obstetrician? We understand that there is an extensive period of training that may or may not be able to be undertaken locally.

Dr Comparti: It varies a lot in the model that we have undertaken. I will give you my experience. I did my six years university training, had three years in the public hospital system and then I went overseas for a year's obstetric training, and then came back to King Edward Memorial Hospital for Women and did a year as a registrar before I felt I was ready to come to the country. There are lots of different models. Keith can perhaps give you his model and then I will tell you what the current model is.

Dr Howe: Mine is similar: a primary degree, hospital training here and general hospital training, and a year in the United Kingdom. The diploma of the Royal College of Obstetricians and Gynaecology is the diploma that I hold. The equivalent in Australia is the Royal Australian and New Zealand College of Obstetricians and Gynaecology. I am not sure what is the current training model.

Dr Comparti: The current training model is more formalised than we undertook. We found our own jobs and did everything. The training program now is undergraduate, six years, plus a few years in a hospital and then you would seek specific training posts in Australia or possibly overseas where you would train in obstetrics and gynaecology. At the end, you would sit the diploma of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, which would be the prerequisite to your getting an accreditation to deliver babies in any hospital. Prior to the current arrangement, many of us had equivalent years of experience, so we retain our accreditation. New people seeking accreditation must have formal postgraduate training.

Hon SALLY TALBOT: Is it too hard for a GP to become a GP obstetrician?

Dr Comparti: Not if they want to, but it takes time.

Dr Howe: The vocational training for general practice, I do not know - the obstetric training would account for only some of that, would it not?

Dr Comparti: Yes.

Dr Howe: Part of the obstetric training would be credited to a person's vocational and general practice training, but it would add some time to the final attainment of full vocational training.

Dr Comparti: You have to shift to where the training jobs for obstetrics were. If you are married with a family, a person would need to move their family there. It takes an effort and then a person has to sit an examination, which is quite expensive.

Dr Howe: I am not sure whether that is the major barrier.

Hon SALLY TALBOT: That was to be my next question.

Dr Howe: Presumably any additional barrier is an additional barrier. My feeling from talking to younger graduates is that it is more, not a fear of litigation, but of things going wrong. They feel they will not get the confidence to handle it. Also, there are lifestyle issues; for example, how much time they will be required to be on call. It is those kind of issues. As Mike said, the cost of indemnity is no longer an issue for rural general practice because it has been managed very well.

The CHAIRMAN: Why is that fear you talk about more so now than 20 years ago, when probably there were more adverse outcomes? Why is that fear a bigger issue now?

Dr Howe: I think it is media influence. There is more publicity about high-profile cases. The kids growing up going through university are hearing a lot more of this stuff than we heard. I think we were more gung-ho!

Dr Comparti: We did a lot of training and got very confident at what we were doing. More importantly, in times gone past, there has been an acceptance that things go wrong when nobody is at fault. My biggest fear now is that my life could be ruined by an adverse outcome that had nothing to do with anything I did wrong or that I could have done better. That is far more frightening for me, because I do not fear that I will make a mistake. Hopefully, I am reasonably good at what I do. It is much more the fear of being ruined because of something I had no control over. The media -

Hon SALLY TALBOT: We were given some figures by the College of GPs, but I might confirm that, that suggest that the percentage of rural GPs doing obstetrics has dropped from 50 per cent to 25 per cent in eight years. That is a staggering reduction of supply.

Dr Comparti: I am impressed that it is only that small.

Hon SALLY TALBOT: Do you think the fear that you just described is the chief component in that?

Dr Howe. In that sense, yes the fear is a significant component.

Hon SALLY TALBOT: We have talked about the difficulty of training and lifestyle factors.

Dr Howe: The main drop in that element of the work force is due to either retirements, that you can nothing about, or people who are below retirement age but have chosen to give up obstetrics. For those people, it was probably lifestyle - the constantly being on call. That would be the biggest single factor. Do you agree, Mike?

Dr Comparti: I am not sure that it is single biggest, but it is a major factor. I am thinking of a couple of colleagues who have given up in recent times and it is earlier than they thought; they thought they would keep delivering babies until they were 65 or 70. It has got too much for them. Lifestyle is a big factor, but they read in the newspaper about colleagues who have been close to retirement age and their reputation has gone through something they had no control over. They thought they had done a fantastic job all their working life and will not risk something happening. The other thing that has dropped those numbers do not forget is that smaller towns cannot attract midwives and the hospitals have been not downgraded, which is an emotive term, but the range of services have been restricted. If you do not have enough good midwives and a willingness on the part of the health department to deliver women in that town, the doctors cannot keep going. In the town that I was in for 14 years, two of us were doing deliveries. When I left the other person could not attract someone else who did deliveries, and after a year he gave up because he could not do it himself and the numbers were dropping and there were not enough midwives. It is a vicious cycle. Most of those women now come to Bunbury to deliver.

Hon SALLY TALBOT: How many deliveries does a GP need to do over the course of 12 months to keep up his or her confidence?

Dr Comparti: It is pretty hard to say, but probably somewhere around 18 to 20. From my experience, that is a reasonable number.

Dr Howe: That is a minimum, I would think.

Hon SALLY TALBOT: That is a minimum of 18 to 20.

Dr Howe: Yes.

The CHAIRMAN: Is it possible for health services to address the needs of the various professions involved in the delivery of obstetric services and to provide greater choice in obstetric care? We have had a lot of information provided to us about all the different layers of - I will say conflict, but I do not really mean that because I sense there is a lot more collaboration than there has been in the past. It is between the specialist and GP obstetricians and midwives and medical practitioners and other things. Is it possible for us to get through all of that and find a collaborative model that offers greater choice in terms of models of care?

[1.30 pm]

Dr Comparti: Hopefully.

Dr Howe: I think so. You are right in identifying that there will always be conflict between groups. Essentially, locally there is a tremendous amount of consultation and collaboration. We are not fighting huge political battles in trying to do that. Although there are areas of disagreement and conflict, it is definitely possible to come up with a model that would suit everyone.

The CHAIRMAN: Would you describe this environment in Bunbury and perhaps the south west as very collaborative across the different providers involved?

Dr Comparti: What is your definition of "very"?

The CHAIRMAN: Perhaps you can give us an idea of some of the things that are still to be worked through.

Dr Comparti: There is a groundswell from midwives to set up standalone midwife-led clinics. It is a model that could work quite well providing other things are addressed; for example, if we are going to be involved, how will we feel safe that we will be at the delivery if something goes wrong? How will we get to know the women before they deliver? The last thing we want to be is an anonymous hospital doctor who does not know the woman and turns up with someone on the bed, and we go. That is not why we do general practice obstetrics. I could have been a hospital doctor if I wanted to do that. How do we address those issues, yet face the problem that as a traditional GP I fund a general practice, which is a multimillion dollar business that I have tied up in real estate, which is like a millstone around my neck, and I cannot leave my surgery and come into a clinic at the hospital? It costs me more to run my practice than I would ever be paid in a hospital. I cannot do it. Some recognition must be of that. If they want us to help at a clinic, they need to find a way to take the burden of our infrastructure costs off us. It often seems to be the case that the government thinks it will set up a new infrastructure and double it.

Hon SALLY TALBOT: Are you referring specifically to the family birth centre?

Dr Comparti: That is one of those sorts of things. I do not necessarily mean the birth centre itself. If you attend for the delivery, it can be in the middle of the night and that is not an issue. What I mean, for example, is an antenatal clinic set up, which is one of the models that will be put forward, where women will come to a central place for their antenatal care, but there needs to be medical input for some of those visits. Will those women come to my practice to see me and get to know me or do I need to work at that clinic? If I work at that clinic, how do I pay the mortgage on the building that I have just left?

Hon SALLY TALBOT: You are less concerned about the inpatient period of delivery and more concerned about the prenatal, antenatal care.

Dr Comparti: There is a case for me to be at the birth, because it is essential that a doctor is there. I also want to know the woman before I turn up at the birth. That works best for the woman

because there is no such thing as informed consent in the middle of a labour. They need to at least trust you a little bit and know where you are coming from and what sort of person you are when you discuss things. It is a dangerous situation walking into attend to a woman you have not met. It is not very pleasant.

Hon LOUISE PRATT: As a lead-on from that comment, we have heard evidence from midwives about how they work as lead carers in consultation with a woman's GP. You said that your GP is working as the lead carer in consultation with the midwives, who, I imagine, happen to be rostered on when you are at the hospital. What models of care could be structured to best suit the way you work, or for other women if they want other models? In an ideal world, how would you structure that?

Dr Comparti: That is why they are producing documents as big as the one I have in my hand. I do not have all the answers. I like the model I have got now, but obviously it will have to change. I hope somebody will take my point of view into account when they are making the new model.

Hon LOUISE PRATT: Are we making best use of specialist obstetricians with their availability and training etc that is required? Clearly, you hand over to a specialist if you deem that that is required, but, I suppose, via private practice, there are many women who start out with a specialist obstetrician, and it is hard for government to intervene in that relationship. How can that be examined by government?

Dr Howe: Historically in Bunbury that has changed slowly over the years. When he arrived, we had one obstetrician for the whole of the south west. Before he arrived, it was all general practice run. We got a specialist in about 1982, and he could not possibly cope with all obstetrics. He very wisely and strongly said he did not want to see normal obstetrics cases, and he wanted GPs to continue to do that, and that he would step in when required. It was a sensible use of his skills and time. Gradually we have more obstetricians. Slowly, some normal obstetrics has been filtering through to obstetricians. That is not a problem and we are not bitterly complaining about it, but it is not a particularly good use of obstetrician skills to be looking after normal obstetrics cases. That is the preference of some patients, and that is fine. In looking at models, the best use of obstetrician skills is not to be doing low-risk or normal obstetrics. In many cases, it is best to have them on call for midwife or GP-led deliveries to be called in if problems become evident.

Dr Comparti: I agree totally, but I would use slightly different words. I think specialists are a fantastic resource and they are fully utilised, but they should be for high-risk obstetrics. GP obstetricians' niche is medium-risk obstetrics, but to get the skills to look after medium-risk, you have to do some low-risk obstetrics. You cannot just do medium risk; otherwise, you do not build up enough numbers to keep up your skills.

Hon LOUISE PRATT: Using the same logic, midwives would do low risk.

Dr Comparti: I do not think that the skill sets that midwives and doctors have are the same. There is a group in the middle. Midwives have skills that we do not have and GP obstetricians have skills in medium-risk and emergency obstetrics that midwives cannot possibly have. They think differently and are trained differently.

The CHAIRMAN: Do GP obstetricians at Bunbury do Caesareans?

Dr Comparti: One does.

Dr Howe: It is mainly the area into which we fit - that is, forceps, vacuum deliveries and managing hypertension -

Dr Comparti: And mild diabetes and delay in labour.

Hon SALLY TALBOT: I was interested in the way that you both began your evidence to us. One of you was talking about supply problems. Dr Comparti talked about demand problems. It is one thing to take into account the needs and views of the stakeholders, but what about the views and

needs of the consumers? Do you have a sense that there is a demand problem when it comes to the provision of services by GP obstetricians? Are pregnant women looking for service other than the service that you give them?

[1.40 pm]

Dr Howe: There are always people looking for other choices - for example, homebirths and more midwife clinics. Some people want to go straight to an obstetrician. Consumer demand covers a wide range. I totally agree that a lot of this needs to be consumer driven, but you will find it difficult to get a consensus about consumers because women will want to have a wide range of options, and quite reasonably so. I think the vast majority of women have a general practitioner, and have a relationship with a GP. If their GP does obstetrics, they are generally very happy to continue that model. From a consumer's point of view, going to a GP for antenatal care is quite attractive because it is often convenient. They are not tied to particular dates and times. If the antenatal clinic is open on Wednesday afternoon, they can come in to see a GP at any time and it will just be slotted in as an antenatal visit. That is not always the case. They can often address other health issues at the same time. They can bring little Freddy in with his runny nose and sore ear during an antenatal visit. Those sorts of practical things are attractive. They also like the thought that their family GP has delivered their child and will continue to care for the child afterwards. That is an attractive option for a lot of women and families.

Dr Comparti: The group of women, which is still in the majority, that would identify a general practitioner as being their family doctor is very keen for us to be involved. In fact, they are surprised if we have to hand them on to somebody else if there is a complication. They expect that we will be there, we will look after their children and we will keep looking after them. There is a group of people - times have changed - who are looking for McDonald's. They want it now because it is convenient and they do not care who they see; they expect they are all the same. That is a group that I do not think identifies with any particular health practitioner.

Hon LOUISE PRATT: In the context of that, I wish to ask about your relationship with metropolitan GP obstetricians. There is a decline of use of GP obstetricians in the metropolitan area, and there are implications for the viability of GP obstetrics in rural areas. How does the cross-fertilisation of support within the Department of Health occur?

Dr Howe: We do not really have much of a relationship with city colleagues, apart from friendships we might have made years ago and occasionally meeting at educational events and things like that.

Hon LOUISE PRATT: Do you think that a failure to stem the decline of GP obstetrics in the metropolitan area may overrun into rural areas?

comp: Yes, I do. That was the point I was going to bring up, based on your question. The groups of women that I find interesting are the ones who come newly to the country from the city who just did not know that GPs looked after pregnant women. They just assumed they would go to an anonymous hospital such as King Edward Memorial Hospital or Osborne Park Hospital or whatever. That is a group that no longer knows that GPs do anything with babies.

The CHAIRMAN: I want to ask a question that is a little sensitive. What would it cost a woman to have her baby delivered by either of you over and above what she gets back from Medicare?

Dr Comparti: I will try to work that out. Probably about eight or nine antenatal visits. If they do not have a healthcare card or are not a pensioner, the gap would be $8 to $10 per visit. That would be the cost. Is that a reasonable ballpark figure?

The CHAIRMAN: Would it be $90?

Dr Comparti: Something like that - $90 or $100. On the public side, the government pays for the delivery.

Dr Howe: In the private sector, there could be out-of-pocket expenses, mainly from the anaesthetist, if they have an epidural or that sort of thing. There is often a gap on their private insurance, but not from us or the obstetrician.

The CHAIRMAN: How significant is the issue of resources in terms of obstetric practitioners and support services in the south west? Is there any area where it is particularly difficult to recruit those people? I am talking about people in the first instance but if there are other resource issues that you think are impacting on obstetric services, it would be useful to know about that, too.

Dr Comparti: The first thing is the closing of obstetric services in small hospitals. There are lots of reasons for that, but it impacts on those communities and it also impacts on us. That has a big effect. The next group is the shrinking number of GP obstetricians. My number of ladies is going up dramatically each year. I have not reached my ceiling yet but that will happen. The other thing in the delivery of obstetric services is anaesthetists.

Dr Howe: The resources of midwives are stretched too. Anaesthetic services for obstetrics is very problematic locally.

The CHAIRMAN: Do you have GP anaesthetists?

Dr Howe: We do but one of those is not practising at the regional hospital.

Dr Comparti: Two of them have stopped recently.

Dr Howe: Including Ivan?

Dr Comparti: No, but John Gliddon and Pete Bairstow have stopped.

Dr Howe: That leaves only one GP anaesthetist. The specialists are busy; they are often tied up in theatre. After hours they are often exhausted; they have been working in theatre all day and they have a fairly heavy emergency load. If you ring them at two o'clock in the morning for an obstetric epidural, which is, in a sense, elective - the patient is not going to die if they do not have it but it can make a huge difference to the obstetric management - they will often be very hard to get. You can often spend long periods on the phone trying to find somebody to do an epidural.

The CHAIRMAN: Do they have a roster? Are the anaesthetists rostered on call after hours or on weekends?

Dr Comparti: They are rostered on. The way the roster works is that there will be one anaesthetist on. That anaesthetist - because Bunbury drains everywhere - will be given anaesthetics almost non-stop from Saturday morning until Monday morning because they deal with all the obstetric cases, the orthopaedic cases and the surgical cases. There are not enough anaesthetists to have two rostered on. The emergencies get priority. As one of my anaesthetic colleagues said recently, he gets called at four o'clock in the morning to do an epidural. There is a woman who is not at risk of any danger until he puts a needle in her back when he is sleepy because he has been awake for the past 24 hours.

Dr Howe: When he is exhausted.

The CHAIRMAN: During normal hours on Monday to Friday, you obviously have anaesthetists in theatre constantly. Is it difficult to access them for what you need?

Dr Howe: Yes, it is often difficult. You can nearly always get one but it can often be quite difficult and not necessarily when you want him. There may be significant waiting time during which the woman is in pain.

Dr Comparti: I know there are some steps to try to address that, including having salaried anaesthetists employed by the hospital, which will go some direction, hopefully, if they get someone to apply for the job.

The CHAIRMAN: Has that been advertised?

Dr Comparti: I believe it will be. That is assuming there are spare anaesthetists out there who want to come to the country.

Hon LOUISE PRATT: Do you think work can be done with women to manage their expectations about whether they really need an epidural, in terms of lowering intervention rates overall?

comp: Of course. The most successful manoeuvre to reduce the need for intervention is calming, relaxing and knowing the person you are with. The biggest indicator of needing extra pain relief is having a stranger involved in your care, people whose shifts change over and things like that. Often we are the only constant person in that whole labour. The midwives spend more time with the patient, and that is absolutely essential, but then they change shifts and we are the only people who are constant.

The CHAIRMAN: I understand that the caesarean rate is about 31 per cent. Do you think that is high or do you think it is okay? Is it a convenience, when you have issues of not being able to find anaesthetists on weekends etc, or specialist obstetricians? Are caesareans done as a convenience in situations like this?

Dr Comparti: I do not believe so. The rate is too high and it will get much higher. People seem to be denying the fact that women are asking for them.

[1.50 pm]

Dr Howe: It is consumer driven to a significant extent. At least three patients have come to me early on in their antenatal care this year and said they want a caesar for their first baby. It is hard to argue against it. On scientific medical grounds there are arguments against it but they are not usually compelling. If that is what the patient really wants, it is very difficult to deny it. There is also the category of people who have had one previous caesar for a non-recurring condition; say, they had a breech in their first pregnancy and had a caesar because of that. The next time around they could have a vaginal birth if they wanted to. A lot of those women will choose to have a caesarean section which, again, from a medical point of view is hard to argue against but if the consumer wanted it, there is a significant chance of having a vaginal birth. I think those two factors have increased the rates a lot.

Hon ANTHONY FELS: Dramatically?

Dr Howe: I do not think there are many, if any, convenience-driven caesars, although to some extent we would probably have a lower threshold for doing caesars because it takes longer to organise. At King Edward you know that you can get somebody on a table in 15 or 20 minutes and you are prepared to wait a little longer. It can take well over an hour in the middle of the night to organise a caesar so you have to make that decision a little earlier.

Hon LOUISE PRATT: So it is very much a precautionary approach?

Dr Howe: Yes. If you have foetal distress that you might tolerate in a tertiary hospital and watch a bit longer, we would tend to have a lower threshold if we were going to caesarean section because of the risks of waiting longer. I do not think that is litigation driven; it is driven by being concerned about the baby.

Dr Comparti: I think the biggest increase is consumer driven. I get a bit upset when I read articles suggesting that it is not consumer driven because I sit there and talk to these women. I try to talk them through it. I do not try to talk them out of it but say, "Are you sure that is what you want? There is a good chance everything will be perfectly normal this time." It is increasing and it is their choice.

The CHAIRMAN: What is the basis of their choosing that?

Dr Comparti: Fears, convenience or timing on their part. They had a difficult labour the first time and they do not want to go through that, even though I can say that statistically they have a very good chance of having a totally normal birth this time. They might say, "Can you guarantee that,

doctor?" Of course I cannot guarantee it. I can say that statistically they have a very good chance. They say, "Oh, well, I don't think I want to put up with that." We have to respect their wishes. That is where we should be at.

Hon ANTHONY FELS: With the increase in concentration of births being done by specialists, particularly in the metropolitan area, is that creating a competition for GP obstetricians, for example, and GPs who used to do it in country areas? Is that making it more difficult for GP obstetricians to have room to practice?

Dr Comparti: I cannot answer that completely because I do not know city general practice. If I was thinking of leaving the country, that would be a factor that would stop me going back to the city if I could not deliver babies, but maybe that is just me. I do not know what happens in the city really.

Hon ANTHONY FELS: It is not as though you are just going on your ease of being able to practice in those areas. Is the issue of insurance and fault or no fault the biggest issue in wanting to continue in the profession? Would that be one of the biggest issues for newcomers wanting to go into the field?

Dr Comparti: I think not. I certainly tell all the young people I meet that that is an issue that is taken care of. The government has looked after us; it has subsidised it. The hospital system carries the indemnity insurance for us for our public patients.

Hon ANTHONY FELS: Aside from the cover being funded by the government, what about the peace of mind of having to come to the hearing and defend yourself?

Dr Comparti: The peace of mind comes from that fear of being blamed for something that you had no control over. You do your best, nobody could have done a better job, but you get blamed. I think all of us wear that. I imagine that weighs on some of the younger people.

Dr Howe: We constantly get told by our defence organisations that if we get sued, we should not take it personally, but we do, and it is a very traumatic event. We know we are being looked after financially but the fear of having to go through that traumatic process is still an issue.

Dr Comparti: It is much more important.

Dr Howe: It is a much more important issue now. I do not think the cost of insurance is an issue for rural doctors anymore. It may be for metropolitan doctors.

The CHAIRMAN: We have had quite a lot of representation from various groups about midwifery-led care. One of the comments that comes up frequently is that the midwives are able to recognise when things are not going according to plan and they will not leave it until it is too late; they would move these people into the next level of care, probably the hospital, and call the GP in in that circumstance. Are you comfortable under those circumstances to be the GP who is called in? Are you comfortable that the independent midwives are able to recognise that at an appropriate time?

Dr Comparti: The majority of well-trained midwives - you always have to say that because there are well-trained doctors and doctors who are not so well trained, so we are all the same - are capable of doing that. My fear would be to be called from home to an emergency, which is very different from King Edward where you just move someone next door and someone is there in two minutes. It is a very different situation. I would feel very uncomfortable being involved if I was not on the site for the birth when I can do something immediately. It would make me think about not being involved. I do not think I could carry that personal risk. If they are able to make those decisions, my involvement would need to be more close to hand.

Hon SALLY TALBOT: May I just clarify that. Are you saying that you would supervise a homebirth?

Dr Comparti: No, not a homebirth.

Hon SALLY TALBOT: That is what I am trying to clarify. What do you mean by being called in at home?

Dr Comparti: A birthing centre. A call from my home. For example, I will use the King Edward model. There is a birthing centre there. Now take King Edward away. There is the independent birthing centre and the midwife is doing a fantastic job. There is an unexpected complication and the midwife needs help. Will they call me at my home where I need to wake up, get up, get dressed, get in my car, drive for 10 minutes to get there and in the meantime someone has bled to death? I could not live with that. I would need to be on site for the birth, which is why I want to be there at the birth.

The CHAIRMAN: What if you were called by the independent midwife who was attending to that patient in her home and she recognised that the situation was such that the mother would have to be moved to the hospital? Would you be happy to meet her at the hospital?

Dr Comparti: I would need to have a little more knowledge of how that would work. Keith and I have different experiences.

Dr Howe: I have been involved in homebirths in the south west for a significant period. I make my involvement very clear - that I am there as a support person for advice antenatally and then I am prepared to meet them at the hospital for complications at any point that the midwife chooses to pull the pin. It is a model that I feel reasonably comfortable with. I do not feel entirely comfortable with it, but I do it to provide that choice that I know is there and which some women want. That can work okay but I am not entirely comfortable with it.

Dr Comparti: I do not get involved with homebirths because I feel it is outside my level of comfort. I would not go to the home because that is not my training. If I do not have my equipment and help around me, I cannot use my skills.

Dr Howe: I do not go to the home. I say I will meet the patient at the hospital because if I am needed, there is very little I can do at home; I need the resources of the hospital.

[2.00 pm]

The CHAIRMAN: We have heard a little about women going into a hospital setting and feeling disempowered with their choices and sense of ownership of how they want the birth to take place. This morning we heard about birth plans. If you were delivered a birth plan, would you see it as your absolute legal responsibility to follow the choice of the woman, unless you negotiated otherwise with her?

Dr Comparti: I think it is always about negotiation. We sit down and go through things and we discuss what I feel comfortable with and how she feels about that. That is what we do. That is how we practise. On the other hand, if we are given a birth plan and the baby is stressed and the birth plan indicates that we cannot help, that is a very uncomfortable situation. We need a chance to talk it over in advance. Of course we respect the woman's wishes, but does the woman know what can go wrong? That is why we need to talk it over in advance so that a birth plan is realistic.

Dr Howe: If the birth plan is negotiated and the doctor agrees to it, I do not know about a legal requirement, but the doctor has agreed to follow that birth plan and he or she would not do anything else. However, if there is something on the birth plan that the doctor cannot negotiate and does not agree with, the doctor has an ethical responsibility not to manage that patient. The doctor would say, "I can't live with that birth plan. You need to find another doctor", after obviously explaining why he could not live with it.

Dr Comparti: That has not happened to me in the past. We have always been able to talk things through.

Dr Howe: That is right. I have never refused a patient on that basis either. I can imagine that it might happen.

The CHAIRMAN: Thank you very much.

Hearing concluded at 2.01 pm