SELECT COMMITTEE
INTO PUBLIC OBSTETRIC SERVICES

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
ON MONDAY, 30 OCTOBER 2006

SESSION TWO

Members

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

Hearing commenced at 12.53 pm

MAGUIRE, DR PETER
Chairman, WA Facility,
Royal Australian College of General Practitioners, examined:

The CHAIRMAN: On behalf of the committee, I welcome you to the meeting. You will have signed a document entitled "Information for Witnesses". Have you read and understood that document?

Dr Maguire: Yes, I have.

The CHAIRMAN: These proceeding are being record 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 this hearing for the record. Please be aware of the microphones; try to talk into them and ensure that you do not cover them with papers. 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 that the 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 to the committee?

Dr Maguire: Briefly, I will tell you a little bit about my background. I currently work part time in general practice in Claremont and part time in medical education with WAGPET, which is the GP training provider in Western Australia. I have 25 years of experience in general practice. In the first nine years of general practice I practised GP obstetrics at Armadale-Kelmscott Memorial Hospital. I have some practical experience in this area. The thrust of the college's position in this area is that we believe that the community is best served with a team approach to maternity care. That team approach should involve the GP, the specialist and the midwife. In our view, the move towards centralising the facilities into four major centres does not advance that model of care. General practitioner obstetrics has been in decline for many years. Some people now think that it is in a precarious position. It needs all the support it can get to retain the role of family GPs in obstetrics in the metropolitan area and, to a lesser extent, in rural areas, where the number of GPs involved in obstetrics has diminished significantly over the past 15 to 20 years. With regard to the terms of reference, we are not aware of exactly how much consultation has taken place. We certainly do not feel that the role of the GP has been sufficiently taken into account. Our interpretation of what the community wants in terms of maternity services involves not only quality and safety, but also services that are within reasonable distance of people's homes for the sake of their families and the support services. The closure of the small facilities will work against what we see as the community preference.

The CHAIRMAN: I will go through some of the points you raised in your submission. You said that you do not believe that the community was appropriately consulted and that the community's views were inadequately incorporated. Why is that the case?

Dr Maguire: As I said, we are not really aware of the exact extent of the consultation that took place in the Cohen inquiry or in the other inquiries. I have seen the consumer input on the web site relating to this committee. It is true that it is difficult to know exactly what the community thinks

compared with advocacy or interest groups, which make their opinions known. I suppose I am not really aware of what consultation has taken place. Certainly, the views of the college were not particularly sought in terms of the importance of the role of the general practitioner.

The CHAIRMAN: You also refer to the fact that the changes have had the effect of de-skilling GP obstetricians and that they have led to the fragmentation of services. Can you outline the process that leads to that de-skilling in the context of GP obstetricians?

Dr Maguire: I am thinking how best to explain it. I will use Kalamunda District Community Hospital as an example because that is a service in which GPs are actively involved in maternity care and the delivering of babies in a local facility. If services are moved some distance away, the GPs have to decide whether it is feasible to work in the new area. Where they choose not to, those skills are not used, and over a period that doctor would not then feel competent or capable of resuming practice should the service reopen in that area. I do not have any data to support it, but, anecdotally, when GPs cease to practise obstetrics, they seldom restart. It is very difficult to get doctors to restart. The services depend on not only the doctors but also the midwives and the support of the facility for a variety of reasons. So, even if the doctor remains willing to practise but the facility becomes impossible to run for whatever reason, whether it be financial, staffing or whatever, skills will be lost over time.

The CHAIRMAN: Using that example you gave or any other examples, do you consider that, leading up to the official closure of the obstetric services at the hospital, any other part of the process of determining where services will or will not be delivered contributed to the de-skilling?

Dr Maguire: I think a lot of it is about supporting those GPs who are currently in obstetric practice to remain practising in that field. That requires a lot of different things to be in place, including roster and indemnity support. Some of those things have been done. They also require support from our specialist colleagues who work in that area. I do not think enough has been done across all those areas to keep the services viable to keep the GPs working in those areas. We have seen significant reductions in the number of practising GPs. I know Peel is rural, but I am aware of a number of GPs who have ceased practising obstetrics in the Peel region. Since I was in Armadale-Kelmscott, the number has drastically reduced for a variety of reasons. The skilling is part of it, but it is not the only factor. A lot of other things impact.

Hon SALLY TALBOT: Can you enumerate some of those?

Dr Maguire: Realistically, the big ones relate to lifestyle. The days of GPs being willing to remain on call seven days a week to practise obstetrics are probably gone forever. I cannot see us returning to the days of 20 to 25 years ago. Lifestyle is a big factor. Medical indemnity was a huge factor in precipitating a decline in GP obstetrics. That has been addressed to some extent. Even though young doctors now feel that the system is more affordable, they are still concerned with the risk of being sued. Doctors do not like being sued. GP obstetrics is a high-risk area compared to what GPs do in other fields, so indemnity risk is one. Remuneration is one, I guess. That has improved also since I was in practice. They are probably the main ones. Skilling is an issue. Being able to invest enough time in maintenance of skills to remain confident and competent is quite a tall ask. Again, the procedural training grants have helped that for rural practitioners. I do not think they are available for metropolitan practitioners.

Hon SALLY TALBOT: Can you tell us how the training process works for a new GP wanting to specialise in obstetrics and someone who has not practised for a while getting back into obstetrics?

Dr Maguire: The credentialling qualification to practise as a GP obstetric is the Diploma of the Royal Australian New Zealand College of Obstetricians Gynaecologists. It is a diploma qualification administered by the specialist college of obstetrics. It requires six months' additional training in an accredited maternity hospital, which, in WA, means King Edward Memorial Hospital, Joondalup Health Campus or Osborne Park Hospital at the moment, and an examination that is

administered by the college of obstetricians and gynaecologists. That gains the diploma that enables doctors to have maternity privileges in a public or private hospital in Australia. That is the initial training. There is a maintenance of quality assurance program requirement for reskilling every three years to retain that diploma. The number of GPs in training who undertake the diploma has plummeted in the past 20 years - even in the past 10 years. Going back a while when I went through my training, it was pretty much routine for a GP-in-training to take the diploma exam, and pretty much obligatory for a rural GP. Nowadays almost no metropolitan GPs-in-training take the diploma. A large proportion of rural trainees do not take the diploma. General practitioner obstetrics is not seen as a desirable career option at this stage. As I said earlier, it needs serious support to turn that around. GPs who have the diploma and want to return to GP obstetrics would need a period of fairly intensive re-skilling. If I wanted to go back, I would have to spend maybe a month or so at least in one of the major hospitals to re-skill to find out what has changed in the past 10 years.

Hon SALLY TALBOT: How many GP obstetricians are practising in Western Australia at the moment?

Dr Maguire: I do not know whether anyone has the exact number. The college of obstetricians and gynaecologists keeps the number of people who have a diploma, but that does not mean that they are practising. I still have an active diploma but I am not practising so I should not count in the numbers. I am not sure of the number practising to be exact. My guess is that the number is a hundred and something.

Hon SALLY TALBOT: Can you give us a rough split between metropolitan and country GP obstetricians practising?

Dr Maguire: They would be predominantly rural. It is hard to predict. I think there are probably only 20 or 30 in Perth. That is a guess.

Hon LOUISE PRATT: Is there an impact on rural areas because of the low number who practice in Perth? If there were a better exchange and a higher critical mass in the city, would that assist rural areas in maintaining a higher level of service, or are they not related?

Dr Maguire: We think they are related. It is perhaps not such a direct relationship, but if the overall number declines too much, I think it does impact on the potential rural services. Ideally, it is nice to have GPs who might work in Perth for some of their career and perhaps choose to move to the country later on. If they have not had obstetric training, they will not do that at that stage. It is hard to imagine 50-year-old GPs going right back to scratch, whereas someone like me, who did it, admittedly a long time ago, might think about retraining. I think there is a link between the demise of metropolitan general practice obstetrics and maintaining a good rural GP obstetrician work force.

Hon SALLY TALBOT: What are "maternity privileges"? We understand that varies quite extensively between hospitals?

Dr Maguire: I have not been directly involved in the receiving end of that for a while. In order to be able to work in a hospital and deliver babies in a maternity ward, almost every hospital will demand the doctor has a diploma in obstetrics in order to work unsupervised at least. Doctors who are assessed by the hospitals as having the requisite experience, or perhaps an overseas obstetric qualification or who have done the training but have not yet sat the examine, might be credentialled with supervision, for instance. Basically, the diploma qualification is the entry point to hospital work and to antenatal care, which is an important part of the whole debate. At this stage, any general practitioner who has a fellowship of the college of GPs or who has been recognised through the "grand-parenting" process can undertake antenatal care in the community. That capacity is under threat; that is not a given. We certainly think that standard general practitioner training is sufficient to enable a GP to undertake antenatal care.

The CHAIRMAN: Are you saying a GP without a diploma in obstetrics will not be able to do antenatal care?

Dr Maguire: That has been seriously proposed. That is not the case now.

The CHAIRMAN: Are those serious proposals from within your college?

Dr Maguire: Not from within our college, no.

The CHAIRMAN: Not from within your college, but from within the specialist obstetricians. It is a patch thing, is it?

Dr Maguire: There has recently been discussion from the Royal Australian and New Zealand College of Obstetrics and Gynaecologists and the midwives that general practitioners should be credentialled to do antenatal care specifically. In other words, they should have additional training and qualifications to undertake antenatal care. It might not be the full diploma; there might be another qualification. We do not believe that is necessary.

Hon SALLY TALBOT: My understanding is that at some hospitals, a GP obstetrician with a diploma would be able to do a caesarean section but not at other hospitals.

Dr Maguire: That is right, but it is a little complicated. I understand the credentialling committees will credential GPs with a diploma to do caesarean sections provided they show evidence that they have sufficient training and experience. There is an additional qualification, which is the Advanced Diploma of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, which requires 12 months' training rather than six.

Hon SALLY TALBOT: Is that an additional six months?

Dr Maguire: Yes, which will take the doctor to a high level of skill and competence sufficient to enable him to perform caesarean sections and to look after more complicated pregnancies. Many of the doctors in smaller, more remote towns in the north, such as Karratha or Broome, would either have that qualification or that level of accreditation with their local hospital.

The CHAIRMAN: One of the comments to arise in here is the issue about a common approach to the provision of GP obstetric services across area health services. It has come up also in other discussions about the confusion around the way obstetric services apply in different parts of the metropolitan area and in the country. Can you talk about the impact of not having a common approach to the provision of GP obstetric services across the metropolitan and country areas?

Dr Maguire: From our perspective, the merits of a common approach, I guess, that would at least recognise the importance of general practitioners mean that there would be no confusion in people's minds about the role. Doctors with various qualifications or skills could move between regions and understand that they could have the same level of recognition or credential and the same level of involvement in obstetric services. For argument's sake, if a doctor moved from somewhere like Rockingham, which has reasonably good general practitioner obstetric services and good support, to Ellenbrook or somewhere in the Swan Districts catchment that is not so supportive of GP obstetrics, his skills could not really be used. A different set of expectations would apply.

[1.15 pm]

From our point of view, if we had a good model of maternity care that effectively supported the involvement of all three sectors and gave due recognition to the specialists, midwives and the GPs, and if that model were universally applied to at least the metropolitan area - rural areas have different priorities - that would be a better system than one in which different things happen in different ways in different parts of Perth.

The CHAIRMAN: You also made the comment in your submission that the college understands that a further consultation process, in addition to the clinical services framework, will be undertaken and that you hope that you will be invited to participate in that. Has that started?

Dr Maguire: I am not aware of that. I do not know. I am not sure whether it was referring to this.

The CHAIRMAN: No, it certainly was not referring to this.

Dr Maguire: No, I am not aware of that having started.

Hon SALLY TALBOT: I follow up on my earlier question about the number of GP obstetricians. I can understand exactly what you are saying. How many births are led by GP obstetricians? That would be more quantifiable. That would be a better way of getting the information that I am looking for.

Dr Maguire: It is a better way of gauging their contribution to the system. I am sorry; I do not have those numbers.

Hon SALLY TALBOT: Can you take that question on notice and let us know?

Dr Maguire: Yes, I can. I do not know whether you have spoken to Dr Ann Karczub. A committee was formed last year basically with the aim of turning around the decline in GP obstetricians and finding out what we could all do to try to turn it around. One of the things that we decided at the end of that was that we needed some better data on what is happening out there, who is doing what and how many of those GPs are delivering babies.

Hon SALLY TALBOT: It will be interesting to see that data broken down by private and public deliveries. Obviously, some GP obstetricians would do the bulk of their births in the private sector, or at least a significant proportion of their total load.

Dr Maguire: I am not sure about that now. One of the difficulties with the indemnity issue is that it makes the GP who does a smaller number of deliveries less economically viable. Because public obstetrics is indemnified through the public system, I suspect that a lot of GPs may well deliver only through the public system, even in the metropolitan area, such as at Armadale-Kelmscott and Rockingham and the new facility at Kaleeya. I am not sure how many are involved in the private system, but my guess would be far fewer than used to be the case.

Hon SALLY TALBOT: If there is any data that you can give us, it would be very useful.

The CHAIRMAN: You have talked about the working party that should be convened. Is that the one that you have just referred to? A submission was made to Neale Fong. That working party has convened and reported.

Dr Maguire: Yes, that is right. One new group has been formed to try to get more GPs who do the diploma to go from that point to practising. The other significant fall-off spot is people who complete the diploma training but do not then move to practise obstetrics in their career. A significant number of GPs do the diploma in order to become better skilled in antenatal care and women's health in general but will never deliver babies for all the reasons that I mentioned before. The aim is to try to encourage more of those people to take the plunge by supporting them in the transition from the supported training environment to an independent practising environment.

The CHAIRMAN: You make reference to the goals for the WA maternity service, including two things that I would like you to make a brief additional comment on. The first is care closer to home and family. I would like to know what you mean by that and why that is important. The second is continuity of care. Can you expand on those two concepts, what they entail and why they are important?

Dr Maguire: Our colleagues who are still practising obstetrics are saying that they think their patients see closeness to their community as important. I think it is about the ability of a woman to be able to do it reasonably close to home. There are a few factors. One is the feeling that when she goes into labour, it will not be a huge distance, with the attendant anxiety about whether she will make it. There is that safety issue. More importantly, there is family support and the fact that if they have a partner and kids at home, they are within reasonable reach of the hospital, for visiting,

for child care and for the extended family. Although we are a mobile society, and people's extended families are all over the city, women still like to be looked after within their community and by people they know. The continuity aspect seems to be important. The good old days when a woman's baby would be delivered by the doctor whom she had known throughout the pregnancy, or a midwife whom she had known from antenatal classes or a previous delivery and who was a member of the community, are probably gone forever. However, there are still models of care that could include team care in facilities, so that when the woman eventually comes in for delivery, the people around her are familiar and are not total strangers. I think that is important.

The CHAIRMAN: You refer to the GP obstetrics collaborative care model under the objectives. Can you tell us what that model is?

Dr Maguire: We are talking about a team approach by a team of GPs who share rosters, so that it is a sustainable unit with good specialist backup and good midwifery services with an adequate number of well-trained midwives to assist in antenatal care and to look after women in labour and postnatally. Choice is another issue that we hear is important. In one of your previous submissions I read on the web site, the question that was asked was whether community opinion is a uniform thing, and it is not. I think there is a divergence of community opinion. Some women very much value a non-medical approach with minimal intervention and an as natural experience as possible, but with safety and quality. The prime concern of another group of women is safety and quality; they are much more comfortable with a more medical approach to delivery. The increasing rate of elective caesarean sections and other interventions is an example of that. Women value a choice within the parameters of safety. Thinking about rural areas, I worked in Beverley for a while last year, and women complained a lot, understandably, about having to travel very large distances to have their babies, with huge disruption to their families. Some of that is inevitable in Western Australia with our geography, but we should try to minimise that dislocation and provide choice.

Hon SALLY TALBOT: The committee wants to ask you about some measures that you referred to in your submission; that is, the moves that the New South Wales government has taken to encourage GPs to go back into obstetrics. Do you have any data on the effectiveness of that?

Dr Maguire: No, I am afraid I do not.

Hon SALLY TALBOT: Again, can you take that on notice?

Dr Maguire: Sure.

The CHAIRMAN: You talk about a program in New South Wales of six-months training, and with bonuses for GPs who undertake such a program.

Dr Maguire: I shall look at that.

The CHAIRMAN: Along the same line, there is also the fast-track upskilling of GPs with lapsed diplomas. Does that happen in WA?

Dr Maguire: Informally. There is no formal program to do that. If someone were practising or wished to practise in a town where maternity services were feasible and had a lapsed diploma, I am sure that WACRRM, as the rural work force agency, would, on an individual basis, support that doctor to reskill through one of the major centres in Perth, or even possibly in one of the major regional centres. It could be done.

Hon LOUISE PRATT: I want to clarify the nodes of care and the centralisation of where GP obstetricians can practise from and how that centralisation can be overcome. It has been put to us that 1 500 births per location is the minimum. Do you agree with that?

Dr Maguire: Certainly my GP obstetrician college would not agree that that is an absolute given. I cannot rattle off for you the evidence from research papers or the international evidence. However, my colleagues who have practised at smaller centres than that - that would disqualify most rural centres in Western Australia - would argue against that quite vigorously. My colleagues would

argue, with some justification, that part of the skill of GP obstetrics is to defeat the problems before they arise and transfer them to a tertiary centre such as King Edward. The anticipation of problems is part of the key to a safe service from a smaller location.

Hon LOUISE PRATT: If that is expected and possible in rural and regional areas, there is no reason that it should not be provided.

Dr Maguire: Yes, in terms of the four nodes. The difficulty for the GPs who do not happen to be close to any of the four is that obstetrics is not their full-time job; they have a practice to run and they have patients to see. Although it may be feasible to drop everything and go a short distance, it generally becomes impossible to drop everything and travel across Perth to deliver a baby and then travel back again. General practitioner obstetrics really is not compatible with travelling much of a distance from one's practice.

Hon LOUISE PRATT: What is good hospital management to facilitate access for GP obstetricians? What needs to be in place at a hospital for a good working relationship between midwives and specialists and for easy access to a suite at short notice? I gather that the level of access that a GP obstetrician may or may not have varies from hospital to hospital. What would you argue are the things that need to be bedded down to give a GP obstetrician confidence that he can access a hospital and provide a service to his patients at the hospital?

Dr Maguire: I think it is very much about that team approach, with each party both valuing and accepting the position of the other two, so that the GPs are made to feel welcome in the hospital and encouraged to take part in the obstetric unit, and they are treated well by management and by the midwives and specialists so that they actually feel well supported. Preferably that there is a critical mass of them so that there are reasonable cover arrangements and reasonable support, and good ancillary services from anaesthetists and paediatricians; that is probably a big issue. Also, good educational facilities for upskilling and maintenance of skills, and access to further training such as obstetrics courses. I think all of those things are important. The midwives also need to provide a good antenatal service for their patients. It is about a system, right from management through to the other health professionals involved, where everybody accepts and values the role of the GPs.

Hon LOUISE PRATT: So hospitals should not have the capacity that they seem to have currently to sideline GP obstetricians from accessing and being able to practise at the hospitals?

Dr Maguire: I would agree with that.

Hon ANTHONY FELS: I have one question in relation to the access of GP obstetricians to hospitals and tertiary hospitals. Is it your view that over time the health department will try to phase out their access and, given there seems to be a shortage of trained doctors going into the specialties as well, such as obstetrics, there will be a looming crisis at both ends? How do we avert that?

Dr Maguire: I certainly would not like to accuse the health department and all the tertiary hospitals of actively trying to elbow GPs out. I think it has been more neglect over the years that has allowed it to drift downwards the state it is in now in terms of GP access. I think there is a risk that if it falls below a certain level, the GPs will basically walk away from it because it is just not a system that is sufficiently friendly to their practices that they will take part. You are right about the workforce. We are facing significant problems here. The saving grace that everyone hopes for is that the number of medical students coming through will solve the problem down the track, but we are still some years away from seeing them in practice. In the interim, a lot of GP obstetricians are close to retirement, or at least retirement from obstetric practice, and similarly there are not a great number of specialists in training, as I understand it.

Restricting the services to major centres, as I discussed before, means that GPs who are not close to those services will probably cease practising obstetrics, so we will lose some potential GP obstetricians from the system by virtue of the fact that they are not within reach of the facilities any

more. I think we may well see a further fall-off in GP obstetrics over the next few years. Some of my colleagues say, "Forget it, it is dead; work out another model and move on." Maybe it is salvageable now, but if nothing else is done it will probably drift down and eventually there will be just one or two enthusiasts.

Hon LOUISE PRATT: Is it a risk for government to promote GP obstetrics as part of a realignment in maternity care if the growth in the number of GPs willing to engage in GP obstetrics is not forthcoming?

Dr Maguire: In other words, if you back the wrong horse?

Hon LOUISE PRATT: If the government starts to look at making a diversity of models of care available, it then has to see some kind of realignment, and the way it projects things it might not be possible. Would you agree that that is a potential risk?

Dr Maguire: It is by no means guaranteed that putting in the effort will actually deliver us more GP obstetricians. Maybe my colleagues are right; maybe it is a lost cause. Dismantling units that appear from our perspective to be running successfully, such as Woodside and Kalamunda, means it would be difficult to get them back. Having dismantled something, it is hard to build it up again. It is hard to get people back into a service they have left. I guess the bottom line is that there is a risk in trying to promote a regionalised service throughout Perth which incorporated general practitioner obstetrics, when the settings might not be in place to attract significant numbers, particularly significant numbers of young, newly qualified GPs. Having said that, we are trying, through the group that is now in the project run through WACRRM, to support GPs through the transition phase and into practice, both rurally and in the metropolitan area. We still have some reasonably well supported GP obstetric units through Armadale, Rockingham - that is about it.

The CHAIRMAN: What about Joondalup? What happens up there?

Dr Maguire: I think that is almost exclusively specialist run. It is not my part of town, so I am not sure. The training positions provide the doctors who do a lot of work at Joondalup.

Hon LOUISE PRATT: The reason for the diversity and whether it is or is not practised here is both the policy settings of the hospitals and the local dynamics in terms of whether there are GP obstetricians in the area willing to practice. Is one thing more than another influencing that?

Dr Maguire: It has probably just grown that way for historical reasons. Rockingham and Armadale-Kelmscott have always been strong GP obstetric hospitals. I do not think Joondalup was ever as strong, even from the start.

Hon LOUISE PRATT: So one of the problems of the current alignment of maternity services is that it is very piecemeal as to what is available and where. If the government was striving for a more universal model to say that once a hospital has reached a certain level - and I think this is in part where these four nodes come from - it should have all those kinds of care available. Is that an achievable objective considering some of those local forces?

Dr Maguire: I think I can see your point that there may be enough diversity in the ways the hospitals operate that maybe some of the others will not fit the model, and that is probably true.

The CHAIRMAN: If I recall rightly, it was the difficulty sometimes of getting specialists to locate in some areas which was the main driving force of keeping GP obstetrics going in most places, whereas in some of the so-called more liveable places, like Joondalup, GP obstetricians do not get a look in because the specialists are quite happy to locate there.

Dr Maguire: That has certainly been true with Armadale and Rockingham. They are growth areas in terms of population and young families, whereas Joondalup has had a much greater specialist concentration, for whatever reasons.

The CHAIRMAN: How would the college like to see future consultation by the department prior to the finalisation of this new maternity services plan that is about to hit the deck?

Dr Maguire: We would like to see the department listen to all the players, I guess, and that would include the local hospitals and the local medical and midwifery groups and, as far as can be done, the communities in those areas. I acknowledge that it is always a difficult process to really understand what is going to work in those communities. I think the local practitioners, the local hospitals and the local community groups would have a better idea than statewide bodies like the college, for instance. Our members know what happens in their parts of town. It is a question of listening to what the people at the grassroots are saying.

The CHAIRMAN: How should government go about consulting those people?

Dr Maguire: That is a hard one, isn't it?

Hon LOUISE PRATT: Workshops have been held on different issues, so there is no reason why they could not be held in this case.

Dr Maguire: I guess local workshops or local events. When people try to close something, generally people come out and advocate on the part of their facility. I hope there will be a higher level of interest in it than there was some years ago.

The CHAIRMAN: Do you have any final statements you would like to make?

Dr Maguire: No, I think that has covered it.

The CHAIRMAN: Thank you very much.

Hearing concluded at 1.40 pm
