SELECT COMMITTEE
INTO PUBLIC OBSTETRIC SERVICES

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
MONDAY, 3 JULY 2006

Members

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

Hearing commenced at 11.03 am

COHEN, DR HARRY
Consultant Gynaecologist, King Edward Memorial Hospital for Women, examined:

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

Dr Cohen: My name is Harry Cohen. My work contact address is King Edward Memorial Hospital in Subiaco. I presume I have been asked to appear on the basis that I chaired the group that did the statewide obstetrics services review and subsequently wrote the report. I am currently working at King Edward as a consultant gynaecologist. I have retired from obstetric practice, but I work in a building with a lot of obstetricians and bureaucrats, and I know what is happening on the obstetrics scene and I am kept well informed. One of the recommendations I made was to set up the statewide obstetrics support group. The people who are involved in that group are in the same building as I am, and we often have discussions about what is happening in that direction.

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

Dr Cohen: 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 that you refer to during the course of the hearing for the record, and please be aware of the microphones and try to talk into them. Ensure that you do not cover them with papers or make noises near them. 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 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 public 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 Cohen: I have been in the practice of both private and public obstetrics and gynaecology for more than 40 years. More recently, in the years before I retired from obstetrics, I was a full-time employee of King Edward Memorial Hospital. In the latter years, I have been working in gynaecology only. I believe that my long experience in the specialty has served me well in terms of understanding the problems of maternity care in both the city and country areas of this state. I suspect that is why I was asked by the Health Reform Committee of the Department of Health to chair the group almost six years ago.

The CHAIRMAN: First, can you provide the committee with some background to the statewide obstetrics services review and, in particular, the reason for the review, its aim and what it was intended to be used for at the time that you were asked to chair that group and write the report?

Dr Cohen: As I understand it, the Health Reform Committee was looking at reform in the health sector following the preliminary report of a number of senior people. Fiona Stanley was one member of the group that wrote recommendations to the state government. After it was elected at the last election, the state government had a review of health services. The Health Reform

Committee was the overarching body that met and looked at the review of health services right across the spectrum, including emergency services, cancer services and so on. I was asked by Dr Bill Beresford, who was part of the Health Reform Committee, to chair the group looking at obstetric services. That is how the group was set up. We had a group of some 15-odd people. I think it is in the report of the project working group. A number of people from all the clinical services in both the city and country areas were on that committee. There were two consumers, one from the city and one from the country, on the committee. We met frequently and discussed and debated the issues. Robyn Collins, who is the director of midwifery at King Edward Memorial Hospital, and I travelled quite a bit up and down the state and talked to both medical and midwifery staff and, when possible, consumers in the various country towns that we visited. Most but not all of the obstetric units were visited. We also spoke with various metropolitan obstetric units - in fact, I think we spoke with all of them - in which all public patients were delivered. That formed the basis of the report that I wrote.

The CHAIRMAN: What was the intended use of the report? What was meant to happen with it at the time that it was written?

Dr Cohen: The intended outcome was for improved obstetric maternity services. The intention of the report was to make recommendations that would improve the service to the public. We felt at the time, and certainly still do, that the obstetric maternity service was in a state of crisis for a number of reasons that have been outlined in the report, such as manpower and womanpower shortages, people dropping out of midwifery, changing demands and expectations of patients and the community, changing practice, and litigation looming very large as a factor that was making it difficult to recruit both obstetricians and midwives into the speciality. All these factors were impinging on the sort of service that was being provided. It was felt that a review would look at all those factors and come up with recommendations that would improve the service. This was something that had not been done. There was a perception by the obstetric and midwifery communities that the Department of Health was not listening to their concerns and they were grateful that people like Robyn and I were taking the trouble to go and talk to them. We let them know before we came that we would be coming, what information we wanted and what we would talk about so that there was some feedback at each of the sessions we had. The general feeling was that there was a need for this, that they were not being supported by the various branches of the health department that looked after their area and, that, for the first time, somebody specifically was seeking them out to talk about it and was seeking their views and opinions about the various issues that were confronting them on a day-to-day basis.

The CHAIRMAN: You have commented in that paper a few times about its being a review from a clinicians' perspective. I understand that. I think there is also reference in the report to its being a discussion paper that would lead to further work being done. Can you comment on, first, whether it was meant to be a discussion paper or something else and, secondly, whether you perceive it very much as a paper from a clinicians' perspective?

Dr Cohen: I think it was more than a discussion paper. Certainly it was a basis for change, and I did say in the report that it was not the be-all and end-all. The recommendations, if followed through, would deal with the range of issues that were raised. There were 16 or 17 recommendations, and each of those required a substantial amount of work to deal with the issues that were raised. In a sense it was a discussion paper, but many of the things in there required teasing out, elaborating and additional work. For instance, we felt that the recommendation for the statewide obstetrics support unit was one of the most important recommendations, and that the unit would require funding and would have a huge amount of work to do to follow through on many of the work force issues and those sorts of matters that we were made aware of when we talked to clinicians and midwives. In a sense it was a discussion paper and a start, but we hoped that the recommendations that we made in the report would be carried through in time. We realised, of

course, that it would take time, but I am pleased to say that some of them are in the process of being carried through right now.

[11.15 am]

The CHAIRMAN: You also mentioned the need for an audit and review of models to determine their strengths, weaknesses and suitability. Has that been done?

Dr Cohen: Not to my knowledge. I take it you are referring to the metropolitan model and the country model of obstetric practice. I believe the country model will be a function of the statewide obstetric service. When the metropolitan model is finally implemented, a range of issues will come out of it which will need to be looked at to see whether it works or whether the recommendations that were made about the various units that constituted that metropolitan model have been implemented and how they are working. That is an ongoing process. Likewise with the country model. I am not aware that any particular audit has been done because the recommendations made about the country model have not come into force.

One of the issues about country hospitals was whether they were going to close or whether we were going to recommend that they close because of the small number of deliveries they do. We said we were not going to close any country hospital. The obstetric units in country hospitals are closing themselves. There has been a considerable amount of centralisation of obstetric services right across the country areas, particularly in the wheatbelt. It was not really necessary for us to say that X or Y should close because of the very small number of deliveries they carry out. Country districts are unique and we did not feel that the model that we proposed for the metropolitan area would any way suit or be appropriate for country hospitals and country people.

The CHAIRMAN: You state in the report that you were asked to service the review from the clinicians' perspective. Why was that approach adopted as opposed to a more general review that would have involved a substantial involvement of consumers?

Dr Cohen: It was a question of time and money. It was felt that once the Department of Health was given this document, which would be a framework for where we should go, it would then carry out the necessary community consultation. It was the department's remit to follow that through. We were constrained by limited time and money to provide a report from the perspective of clinicians and midwives.

The CHAIRMAN: Do you believe that the health department has followed through on that?

Dr Cohen: I am not sure that it has. I am not aware of a great deal of community consultation. I know there has been some. There has been some reaction to the closure of the obstetrics units at Kalamunda District Community Hospital and Woodside Maternity Hospital.

The CHAIRMAN: The report indicates that the working party undertook extensive consultation with the obstetric practitioners and other groups with clinical involvement. What was the benefit of this approach and what information did it reveal?

Dr Cohen: As one would anticipate, it revealed that everybody wanted to protect their patch, which is something I mentioned in the report. We knew that that would be the case. If they were involved in a practice such as Kalamunda or Woodside, they liked what they were doing there. They did not like the concept of the plan where the basic requirements of the metropolitan hospital were a backup service, anaesthetist, pathology services, availability of blood and so on. These were essential for any metropolitan hospital delivering over 1 000 or 1 500 babies. Obviously these two hospitals did not fit that plan. Clinicians were concerned about it. Indirectly I was recommending their closure, which I was not actually, but that was a decision that had to be made by the health department. There were concerns by clinicians. I felt that those clinicians who were practising obstetrics in those areas should and would be able to take their general practice obstetric practices to other units in the metropolitan area. That was part of the recommendation I made. It may not have been made in writing. In my reporting to the health department - I am on the public record as

saying this - I said that no hospital unit should close until the recommendations were in place, until the necessary infrastructure was there. That included the facility for the general practitioner or obstetrician to continuing to practise obstetrics until they were in place.

The CHAIRMAN: You commented - I cannot remember exactly how you said it - about the necessity to have anaesthetic services and consultant obstetrician services available to a service. Does that also include the mother being able to move from one hospital to another to access that service within, I think, a 30-minute time frame, or is it only that the consultant and the anaesthetist have to be able to come to the mother in the hospital, or is it interchangeable?

Dr Cohen: I do not think it is interchangeable. Clinicians need to be within half an hour of a hospital to deal with an emergency. That is a fairly standard time. Obviously clients, pregnant women, need to be as close to an obstetric unit as is possible, but there are constraints about the need to have those specialist services available at those units. The ideal situation is for women to be able to have their baby as close to home as possible. We have to bear in mind that we are living in changing times, and what is considered by many pregnant women as the ideal is not always achievable in this day and age, from the point of view of cost, staffing availability and essential services. Those things are not necessarily available any more. The expectations of patients has changed so much that they require all those additional services which we believe we can provide in the larger unit but cannot provide in smaller ones.

The CHAIRMAN: I understand some of the cost issues associated with services at Bentley, Osborne Park and Kalamunda, for example - I am more familiar with the ones at Kalamunda. The cost differences between the service that was operating at Kalamunda versus the amount that will be saved by that service closing and moving to Swan District is quite minimal. Are there other cost issues that you are referring to other than the pure cost of providing this service?

Dr Cohen: We are talking about the cost of laboratory services, the cost of providing a blood facility on site. I do not think there was a facility on site at Kalamunda; correct me if I am wrong. If somebody had a haemorrhage at Kalamunda, blood had to be got from Bentley or somewhere else. Quite often there was a delay. That was pointed out to me by certainly the midwives at Kalamunda hospital. The cost of providing a more complete service, including laboratory technicians at close call, would be an additional cost. There are costs which are perhaps not all that obvious from the point of view of simply staffing it with midwives. That would need to be included, but that is not the major factor. There are costs in keeping small country units going. As I said, the country is different. Country people need that whereas metropolitan women, much as they might like to have their baby in a lovely little hospital looking down the Bickley Valley or wherever, we have to remember that they are in hospital for only two or three days and they only have an average of two babies in a lifetime.

Down the road from me is a home called Tresillian. It is in the same street as me. Many years ago, Tresillian was a small hospital. I believe that many people about my vintage were actually delivered at Tresillian. Perth had a number of very small hospitals dotted around its periphery, some of which I used to visit to deliver babies, such as Devonleigh Maternity Hospital in Cottesloe, the South Perth Community Hospital. I used to run all over the city. It was nice to be able to deliver babies in those little hospitals. I can see why women liked them; they were family sized and friendly. However, times have changed, not just in Perth, but in all western areas. We have a crisis in staffing and we have increasing medical costs, which need to be considered. We simply cannot spend more and more on our health services. We have to eventually ration that. AS I said, client expectations have changed. Women want to have their babies safely. The ideal is in a larger unit that provides them with the range of services they would get at a birth unit at King Edward, for instance, in a labour ward in a hospital which does not look too much like a labour ward or the units at Osborne Park Hospital, which look much friendlier. We need to provide friendly services and a whole range of services but in perhaps lightly larger hospitals.

The CHAIRMAN: You mentioned Osborne Park, which is one of the hospitals that has been earmarked for closure of obstetric services. It has over 1 000 births a year and has all those services on site that you are referring to. It would appear to me to be a hospital that should continue to provide obstetric services.

Dr Cohen: Osborne Park fits quite nicely into my plan as a secondary unit in the metropolitan area. You are quite right: it delivers an appropriate number of babies. It has all the services there. I think you would have to ask the health department why it feels a need to close that. Perhaps it has earmarked Osborne Park for other services that it wants to expand, like rehabilitative services, caring for the aged and so on. I guess a certain amount of rationalisation will have to take place in relation to those expanded services that are needed.

The CHAIRMAN: The literature looked at indicators and guidelines established overseas in relation to issues such as the minimum birth numbers that you referred to, practitioner availability and equipment needs. The UK report of the Royal College of Obstetricians and Gynaecologists on safer childbirth seems to have been relied upon most strongly by the working party. Why was this report considered particularly relevant?

Dr Cohen: I do not think it was relied on all that much by the working party. We looked at reports from a whole range of countries, including Germany, the US, Canada and the UK. I guess we have a strong bond with the UK as that is where many of us are trained. I do not know that we placed undue emphasis on the UK report. Our college does have a strong link with the English college. We had to come up with a number. It was 1 500. I do not think that we should get too tied up with numbers.

[11.30 am]

As the committee will see from those figures, the number of deliveries in the metropolitan and country areas has been remarkably stable over the past 10 years. We still deliver between 25 000 and 26 000 babies per year. I doubt whether the Treasurer's exhortation to have an additional one in the country will make any difference to the birth rate. The numbers will stay around that number. The number is not critical. What is important is the services, and they will have to be rationed, if that is the right word, and they could quite nicely be incorporated into those units which the government has in mind - Rockingham, Swan District, Joondalup, Fiona Stanley hospital and Armadale.

The CHAIRMAN: I certainly understood the report to suggest, and I have heard others make this comment, that critical mass equals quality and improvement in safety of services. Is that the connection that you are making between the numbers and outcomes?

Dr Cohen: I know you do not like the term "critical mass". I read the comments in *Hansard* in that regard; therefore, I have tried to avoid that term. We do not need a critical mass to be able to provide an excellent service. However, we need that to, in a sense, be able to provide all the other backup services and make sure that they are provided and are used economically. Again, we are looking at a critical shortage of staff, particularly midwives, whose average age is, I am led to believe, now in the 50s. They are most important. In spite of the importation of midwives and doctors from overseas, we have a major problem, particularly in country areas. In effect, we are already seeing a rationalisation and rationing of people working in that area and we have to take that into account when we are developing those other units. We will find that 1 500, or thereabouts, will be the number that they will deliver. It may be 1 500 upwards to 2 000.

The CHAIRMAN: Does that equate to a minimum number for safety?

Dr Cohen: There is no question that we can safely deliver in small units. There is no argument about that so long as the patients are carefully selected. We, as trained obstetricians, always believe that nothing is safe about childbirth until it is all over. I guess what I am saying is that we need to provide the backup services in the event that some intervention or additional service is required.

One in 10 patients will require some sort of assistance at delivery. It may be not as straightforward as we would like.

The CHAIRMAN: Do you have a guideline that says that those backup services to which you are referring have to be available within a certain amount of time? I think it is half-an-hour.

Dr Cohen: That is right.

The CHAIRMAN: Does that mean that the backup service can be available elsewhere and the woman who is experiencing difficulty in labour can get to that service by ambulance or does the backup service have to be available at the place where she is delivering?

Dr Cohen: If we restrict obstetric practice to those four or five units, then all those services must be provided at each of those units. In other words, each unit must have the ability to carry out interventions, have blood cross-matched on site, and carry out a Caesarean section as an emergency, which means that paediatricians, anaesthetists and other staff must not be further than half-an-hour away from the hospital.

The CHAIRMAN: Is that an ideal model for the metropolitan area?

Dr Cohen: It is.

The CHAIRMAN: However, it cannot apply in the country.

Dr Cohen: In the country other factors need to be looked at, including the number of deliveries and the availability of larger units close to smaller country hospitals. For example, I will refer to a small town like Mt Barker. I am not sure of the number of deliveries at that hospital, but it is quite small. Mt Barker is only half-an-hour from Albany. Mt Barker has some very enthusiastic doctors who want to practise obstetrics and it has midwives, and no way in the world should the Mt Barker hospital be closed, because it is only half-an-hour from Albany. However, if we look at a similar situation such as in Wagin, which is a small wheatbelt country town that is sandwiched between two larger towns - Katanning and Narrogin - in my opinion there is no way in the world that the obstetric unit at the Wagin District Hospital can continue, because Wagin is a small, one-doctor town and does not have any of the facilities that are available at the Narrogin and Katanning hospitals. As much as the women in Wagin would love to have their babies in Wagin, for the two or three days they will be in hospital it would be safer for them to go to one of these bigger towns. A range of issues like these must be taken into account.

The CHAIRMAN: I know that the report does not canvass the views of what should happen in private hospitals, but if there is a guideline for obstetricians around safety, numbers etc, should that same guideline be applicable to country and private hospitals?

Dr Cohen: Absolutely. If we are providing the best possible service for public patients, then private patients, who pay a heck of a lot more, should get no less than the appropriate service.

The CHAIRMAN: Is it your view that some small private hospitals are delivering fewer than the number you referred to?

Dr Cohen: I am not aware of where most of the private patients now deliver in Perth. I suspect most of them deliver in the larger private units - St John at Murdoch and Subiaco.

The CHAIRMAN: I would say that that is where most are delivered. However, I assume that places like Attadale Hospital, Glengarry Hospital and Mercy Hospital are smaller private hospitals.

Dr Cohen: They are smaller and the clinicians who use those hospitals to deliver their patients certainly would be within half an hour of that hospital. I suspect that those hospitals would have easier access to the facilities, such as anaesthetists, paediatricians, blood and so on.

The CHAIRMAN: In looking at the evidence and documents from different countries to assist with the model that you have come up, were there comparable reports from Australia or overseas

that had developed similar benchmarks and guidelines? I am particularly interested in the use of Australian literature you might have had in coming up with the guidelines and model?

Dr Cohen I have now retired from obstetrics practice. It was five years ago that we started meeting and the report was written four years ago. I think our report was the first of its kind of statewide review. In fact we had people who came over from the east to talk to us about it because they felt that what we were saying and the guidelines we were laying down were something they might take on board. I do not know how far that went. We certainly had a lot of interest from people in the eastern states and they may still be interested. We did not have much to go on. We certainly talked to people from around Australia in e-mails and discussions.

This state is unique insofar as there are so few deliveries in such a huge area. We have nothing to go on that is similar. It is very special where we have women who deliver in the Kimberley. In places like Kununurra, Wyndham and so on there must be general practitioner obstetricians who are sufficiently skilled in obstetrics to be able to carry out a Caesarean section if it is required as an emergency. There are, and they often come to King Edward for a refresher and to brush up on their work. We realise that the general practitioners in the remote area of Western Australia need special skills that metropolitan general practitioners do not require. Places like Kununurra, Wyndham, Carnarvon, which is a fair way from Geraldton, and Esperance require special services and well-trained general practitioners. These towns are miles from anywhere. The Royal Flying Doctor Service cannot provide the sorts of cover for these places that is needed when something is needed in a hurry. The situation in this state is unique and the remarkable thing is that the results are as good as they are. They are excellent, considering the remoteness and distance and the potential problems that can arise. It says a lot for the care that is given to remote area people and the recognition by local practitioners that there may be a particular problem with a patient. They will arrange for the transfer of a patient, say, to a regional larger centre, before her baby is due on the basis that she may have a problem at delivery and, therefore, should be moved out. All these things have shown us, and we have stated this on more than one occasion, that the service that is provided is remarkable considering the problems that we have to deal with.

The CHAIRMAN: Are you aware of more recent research that has been done in Australia since your paper was written relating to the safety of birthing in small units?

Dr Cohen: I am not specifically aware. I know that small units can be safe; there is no question about that. They need the backup services and very careful selection. Women who have particular problems should not be delivered in small units. I am certainly not opposed to women having their babies in small units, or at home, if necessary, or in the spectrum of where they want to have their babies.

The CHAIRMAN: It comes down to the backup?

Dr Cohen: It is the need to understand that problems can happen and can happen quickly; therefore, there needs to be careful selection, standards set and guidelines laid down outlining who should be delivered at small units or at home. That is important. As I said, the backup services must be in place.

The CHAIRMAN: I have to ask this question: is that not possible to have been provided at Kalamunda hospital?

Dr Cohen: I am sure it was possible to provide it there, but it was a question of having to rationalise our services. We need to rationalise our services. It would have been possible to provide a good backup service at Kalamunda, but I am aware that Kalamunda had problems. As far as I am aware, it certainly did not lose babies or mothers, but there were a number of near misses. Certainly that formed part of the discussions we had with some of the midwives when we visited the Kalamunda unit. We do not always read about the near misses. We all have near misses, but when they occur an hour away from available blood, or an anaesthetist is not available that

particular night because they are too tired or one cannot be dragged out of bed, these issues become very important.

The CHAIRMAN: Did you follow up and look into the evidence of those comments to ascertain whether the near misses actually occurred? I have looked at the Apgar scores and I wonder whether you followed up on the comments that were made?

Dr Cohen: No, but the comments were made by more than one person. They were certainly issues. They are not peculiar to Kalamunda hospital. However, with the small number of deliveries and the services not being available at Kalamunda, but being available just the road, it was inevitable that the obstetric unit at Kalamunda would close.

[11.45 am]

The CHAIRMAN: I am also interested in your comments about care selection, but I might leave that for the time being. The report notes that the literature review revealed little in the way of research that was of direct relevance to the unique Western Australian situation, but I think you have already talked about that. Were any other significant gaps in data and research indicated in the literature review? I realise it was five years ago.

Dr Cohen: I could not put my finger on any gaps in the literature. I do not think that I could truthfully answer that question.

The CHAIRMAN: Did the working group receive submissions in response to the discussion paper?

Dr Cohen: Yes, we did. I had a file of submissions that I meant to bring in. We received a whole lot of submissions from groups all over the state.

The CHAIRMAN: After the discussion paper was put out?

Dr Cohen: Yes, after it was made public.

The CHAIRMAN: How were they dealt with?

Dr Cohen: I responded to them. I wrote to virtually all the people who wrote to me. Some of them had concerns, as we knew there would be. I tried to answer them in as truthful and open a manner as possible. I kept a very large file of responses from various groups around the state.

The CHAIRMAN: Are those responses public?

Dr Cohen: I do not see why not.

The CHAIRMAN: Are the submissions that you received from people public?

Dr Cohen: They are not really public; I think they were written to me in my capacity as chairman of the working group. Many of them were happy with the report. Some were concerned about what it might mean - whether I might recommend that their hospital be closed. I have not made any closure recommendations in the report, but that was what was read into it. We received a lot of information.

The CHAIRMAN: Other than written submissions, were there any responses in person, or meetings held with people following the discussion paper?

Dr Cohen: No, we did not hold meetings with people who responded subsequent to the report coming out. The meetings were all held before that.

The CHAIRMAN: The need for the teaching of obstetricians, midwives and general practitioner obstetricians has frequently emerged in discussions. I know that we do not like to use the term "critical mass", but we talk about the need for a critical mass of people in order to effect an appropriate teaching situation. Why is it that the critical mass has to be in one location? Why can the teachers and trainees not go to a variety of places to achieve critical mass?

Dr Cohen: It certainly does not have to be in one place. Indeed, with the anticipated increase in the number of medical students going through the University of Western Australia, there will need to be additional hospitals used for teaching purposes in both the metropolitan area and in country areas. They already are. We have the Rural Clinical School, in which medical students are allocated to various sites in the country. That system is working out extremely well. When I was in Port Hedland, I came across a medical student who had been seconded there for a while. She was part of the Rural Clinical School and was doing a video link-up with her chief medical officer and someone in Perth. She told me what a great system it was. I also met medical students in Kalgoorlie, where the head of the Rural Clinical School was based. It is important to use outlying facilities, where it is possible to be arranged. Obviously, the university has to do that in such as way as to be able to organise it adequately. However, I believe it is important for students to have a balanced view of childbirth. It is as important for them to be able to see normal deliveries at the birth unit, where women might have a baby and be home within 24 hours, as it is for them to see the whole spectrum of obstetric practice. It certainly should not be, and is not, limited to the tertiary unit.

The CHAIRMAN: What role does concern about potential litigation play in the models?

Dr Cohen: Unfortunately, litigation breathes down everybody's neck, both doctors and nurses, and it certainly influences medical and midwifery practice; there is no question about that. Practitioners are forever looking over their shoulder. There are more complaints than there used to be. The fact that we have in our hospital a customer service department with a staff of about four or five people, and a full-time nurse lawyer, is indicative of the changing nature of the way we practice and of patients' perception that if something goes wrong, somebody is to blame. It has a considerable bearing, and I have no doubt that it is one of the factors - although not the only one - contributing to the very high Caesarean section rate in the western world, including Perth. I think that is unfortunate. Litigation is certainly an influence, as is the changing expectations of patients. That is one of the factors contributing to the shortage of nurses going into midwifery, and possibly the shortage of doctors, although there does not appear to be a shortage of people wanting to enter the obstetrics training program. It always amazes me that people still want to do that, in spite of what they read and some of the patients they meet in their day-to-day activities.

The CHAIRMAN: Did the review commence after the findings of the Douglas inquiry were reported?

Dr Cohen: We started after the Douglas inquiry was completed, but the implementation process was still continuing. The implementation of its 200-odd recommendations was an ongoing process. It was towards the end of the inquiry and the beginning of the implementation process, as far as I can recall.

The CHAIRMAN: Given that the inquiry was quite damning of practices at King Edward, of the role of consultant obstetricians and the culture that had emerged at the hospital, what influence did that have on the report and review?

Dr Cohen: I am not sure that it had any specific influence on the report. However, it may have been one of the factors that accelerated the need for a review of services and doing something about them. The problems we had at KEMH were not unique to that hospital. Many groups working in other hospitals would make the comment, "There but for the grace of God go I." In many ways we welcomed the report. We knew there were problems and that they had to be dealt with. The Douglas report was a catalyst in improving things. We think we have done that. One of the biggest factors - which we have repeatedly maintained - was the lack of full-time staff at the hospital and hence the lack of 24-hour supervision etc. One of the major outcomes of that review was the increase in the number of full-time consultant staff and junior staff in the hospital. That has resulted in a great improvement in the ability to improve governance, and an improvement in a range of areas.

The CHAIRMAN: Are you talking specifically about King Edward?

Dr Cohen: Yes.

The CHAIRMAN: You have mentioned in your report and also today your support for general practitioner obstetricians having ongoing involvement in the metropolitan area. How do you see that specifically? Do you see them coming into hospitals on a fee-for-service basis? How do you envisage GP obstetricians maintaining their role under the new model?

Dr Cohen: That is a very important issue. One of the recommendations I have made is for statewide obstetrics services to look at that specific situation as a first priority. GP obstetrics need to frame the way in which they can be incorporated into hospitals, and there is a need to train GPs who want to work in country and remote areas. It is very important, and that is a subject for ongoing discussions. I understand that Dr Ann Karczub, Head of Obstetrics at King Edward Memorial Hospital, has chaired or is chairing a group of doctors and others, looking on that very issue. She has written quite a comprehensive report on it. I believe she has presented it to the health department, or to Dr Fong; I am not absolutely sure where the report is going, but she has made a number of observations and good recommendations. I think it is very important. I would certainly envisage general practitioners continuing to deliver babies. It has been mooted and perhaps should be reconsidered. Until 25 or 30 years ago, general practitioners delivered babies at King Edward Memorial Hospital. They still attend antenatal clinics. They are still associated with the hospital. They attend the birth centre; I do not think they deliver babies, but they attend the centre. Perhaps there will be a need to expand that so that we have a general practitioner unit at KEMH in which general practitioners actually come and deliver babies. They used to deliver babies at Woodside Maternity Hospital; I understand that general practitioners are able to deliver patients at Kaleeya Hospital. They continue to at Rockingham-Kwinana District Hospital; they do not at Swan District Hospital, because of the particular set up there, which was negotiated between the consultants and the health department, to the exclusion of general practitioners. That, I think, was unfortunate in some ways. That is something that the health department will, in its own time, have to deal with. It may well be that general practitioners should be invited back to deliver patients at Swan District Hospital. I am not sure about the set up at Joondalup. However, I think it is important to re-involve general practitioners, because they need to be involved in practising the learning of obstetrics in the metropolitan area, so that they can go out into the country and practice obstetrics and look after patients in country areas. They are the backbone of obstetrics practice in country areas.

Hon LOUISE PRATT: You have had some feedback, post-reporting, over a number of years. You mentioned that you had a large file of responses. With the benefit of hindsight, would you revisit any of your recommendations, considering the way in which things have evolved since then?

[Noon]

Dr Cohen: I will have a look at the recommendations again and go through them. With regard to the endorsement of the services models, I still believe that those models form a basis and are appropriate, so I do not shy away from that recommendation. The chief medical officer is the person who determines who can and who cannot act; I think that is appropriate. I think we are all keen on the importance of clinical governance, and that should be part of every unit's practice. The statewide obstetric service is basically up and running, albeit in an attenuated form, but I think that is important and it is a development.

I think consumer education is very important, so that consumers know what choices they have and what risks there are. That is very important. There are consumer linkage, information and the work force issue working group, which is very important because work force issues loomed large in the discussions that we had as we toured the country.

The enhancement of the midwife is very important. The midwifery training and ways and means of attracting and retaining midwives are important. Recommendation 10 is about obstetricians; there is no argument there, and likewise with recommendation 11. With regard to recommendation 12, the mother and baby unit is currently being built at King Edward, so that is one of the recommendations that is coming to fruition. We have just discussed recommendation 14 about general practitioner obstetricians. Recommendation 15 is for practitioner education and training. The others relate to the academic situation. I do not really feel that I need revisit those.

Hon LOUISE PRATT: It is a very good record.

Dr Cohen: I am probably biased, of course.

Hon LOUISE PRATT: We have had some discussion about issues of critical mass. There has clearly been some community and work force reaction to the size of units, as that is translated into real decisions on the ground. Do you have any further comment to make?

Dr Cohen: Only that I do not think we should be hung up on the critical mass or the size. As the numbers of births have been static and are predicted, according to the ABS and various other bodies, not to biase substantially in the near future, we will get similar numbers of deliveries. If you work all that out, those that are going to occur in the metropolitan area - the number of 1 500 or whatever - fit quite nicely into the number of public deliveries that are going to occur outside King Edward and the Fiona Stanley hospital when it is built. I do not feel we should get too hung up about numbers or, in fact, critical mass.

The CHAIRMAN: Would it be a problem, from your point of view, if Osborne Park, Bentley and Kaleeya Hospitals continued to provide obstetric services in the new model?

Dr Cohen: No, it would certainly not be a problem from the obstetric point of view. I suspect there will be other issues, as I said before, which will supersede that. I suspect that the Cohen report may well be used as a lever to bring about other changes in other hospitals. I would not like to feel that I am recommending the closures of Osborne Park, Kaleeya or Bentley Hospitals, although I think that Bentley is a very old unit. I am not sure of the number; I think it is 700 or something at Bentley.

The CHAIRMAN: It has gone down.

Dr Cohen: It could well be incorporated into the new Fiona Stanley and Armadale units. The Bentley unit is certainly very old and below standard. I am quite sure that obstetric care and midwifery care is great, as it is in all units. Everybody does their best. It is a small unit. There is something about a small unit that means in some ways it is preferable to going into a large unit. I think what we have to do with the large units is to make them in some ways like the small units, but provide all the additional services to fulfil the need.

Hon LOUISE PRATT: I wanted to go through with you the question of additional services. You have considerably enhanced my understanding of the notion of services coming in versus them being provided on site as one of the reasons that they needed to be rationalised in the way that they have been and how that has informed current decision making. Can you give me a reasonably comprehensive list of what those kinds of things are?

Dr Cohen: All units will have what we call level 2 nursing, with which we can look after babies that are born, say, after 36 weeks' gestation, when they have minor breathing difficulties, or other babies with minor problems who would need a paediatric service. Neonatal paediatricians will not necessarily staff the post, because they will not necessarily have to be there on site, but they will certainly need to be attached to those units. With anything more complex than that, those babies are transferred to the intensive care units as King Edward and PMH. There are paediatrics, blood and anaesthesia, which is certainly required on the basis that the anaesthetists are available or on roster and can be got within half an hour. There are other services. I have mentioned pathology services and the availability of blood. There are more specialised services, which obviously cannot be

provided at all of the units. Genetics services are one of them, for instance. It is highly complex. Although the basic testing can be done in the ultrasound departments of these hospitals, and they will certainly have ultrasound departments, as they currently have X-ray departments, more complex testing requiring antenatal testing of certain varieties will probably still have to be done at the more specialised units.

Hon LOUISE PRATT: You are clearly talking about some prenatal and postnatal issues. What is the importance, in the management and service sense, of having those prenatal and postnatal services attached to where someone gives birth?

Dr Cohen: It is not critically important. For instance, in smaller country hospitals, there is no reason that antenatal care cannot be carried out by a general practitioner. For instance, there is no reason that patients at Wagin could not be looked after for most of their antenatal care by a good, keen general practitioner or midwife, or both, and then when it came to having their babies, they could go Narrogin or down to Wiluna, so it is not critically important that they have all their care on site. Indeed, we have such a thing that we call shared care. We have that at King Edward. That has been promoted and is successful. One of the things that makes that a lot easier and makes it flow more smoothly is that the patient carries her own notes now. It is called "empower". The system is variable in the country, but we are doing it here. Patients carry their own antenatal records. They may go to a particular doctor, carer or midwife antenatally, and they can travel around the state, in theory, with their antenatal notes. If they come to Perth and suddenly and unexpectedly go into labour, they have their notes with them wherever they are going to have the baby. In a sense, it is not critically important to have the carer there, but obviously patients would like to know and develop a relationship with their carer and would probably prefer to have the same person looking after them before, during and after the delivery.

Hon LOUISE PRATT: In looking at the structure of care, I note that you support, and I do, too, community midwives being able to conduct births in the community. What is the difference between that and a unit like Kalamunda continuing? Is the assumption that the patient will travel to the hospital where the blood and anaesthesia services are? Is that the logic behind that?

Dr Cohen: In a sense, yes. Community midwives are called out and deliver the patient in her home. Hopefully, if the patients have been carefully selected, as they should be, there should be no demand on those additional services, hospitals or additional clinical staff of any sort. They are just a backup service if they are required. It is a transfer to a hospital that already knows about it and has that woman's details in case that transfer is required. There should be no draw on other services apart from that one midwife who will deliver the baby at home.

Hon LOUISE PRATT: I want to follow up on the difference between somewhere like Kalamunda and Mt Barker. Are some of those issues to do with catchment? There are issues relating to the Kimberly and whole of the state. How we judge, when a pregnant woman is in the community, whatever stage of her pregnancy, is a matter of making the best available decision on how far she needs to be from the nearest facility. Places like Mt Barker can still be strategically important from that point of view.

Dr Cohen: Country people are different and the country is different. As I said before, I think we should be leaning over backwards to see that country services are enhanced in whatever way we can and not closed down because the numbers are low or whatever. We need to take into account everything; the keenness or otherwise of the practitioners who are there who want to practise obstetrics, whether there are sufficient midwives, how far away they are and how long it takes for an ambulance trip from A to B. Denmark is similar to Mt Barker and is about an hour or three-quarters of an hour from Albany. Again, it has a very small personalised unit, with the numbers that go there, but again it has very keen midwives and practitioners. Albany hospital has the careful selection of patients and a supportive and helpful staff, including the GPs there who will become involved and who will act as a backup service, sometimes reluctantly, but who, on the whole, will

act in helping that service; whereas, in the metropolitan area, several sizable units are able to provide the facilities that we require and that we consider to be core. I guess that is why the Department of Health reasoned that Kalamunda hospital could go and that those patients who usually went there could be as well looked after in units not all that far away.

Hon LOUISE PRATT: Do you have any opinions on the strengths and weaknesses the reform process as it currently stands?

Dr Cohen: Not really, except that I think the reform process will take an awfully long while to be implemented. Various groups are working very hard on this. I can speak only from the point of view of my own report, and there are some things that are happening there. It is slow. As I have said, it is five years since we started working on it. It requires time and money. One would hope that ultimately the reforms will be carried out, but it is certainly a slow process, as it always has been in the health arena. Health takes up a huge amount of the budget. It is understandable why they would move slowly.

[12.15 pm]

Hon LOUISE PRATT: In relation to consumer input and involvement in planning, you said that because of the time frame and the resources that were available to you, you were not able to engage in a wide range of community consultation.

Dr Cohen: I believe it was the role of the health department to follow that through.

Hon LOUISE PRATT: You have also indicated that clearly this will have a long time frame. It does not appear that you have closed off any area that required community input in that regard, other than the fact that the size of units and how close they are to a facility have implications for the community. Those decisions were made based on clinical and planning issues as opposed to community input in the current hierarchy. Is there still adequate room for community consultation on models of care and the wide range of areas that are still open to reform?

Dr Cohen: I believe there should be ongoing consultation with the community. Yes, I believe there is still room for that. There should be ongoing consultation because this reform process is ongoing and slow. The community certainly needs to be kept informed by one means or another, through either the health consumers association or other bodies. However, I think there absolutely needs to be ongoing dialogue with consumers.

Hon ANTHONY FELS: Will the concentration of resources at some tertiary hospitals, like at block K at King Edward, lead to more and better training of experienced staff or increased resources overall? You have said that there is no shortage of GPs wanting to train. Why is that any better than doing it through other hospitals around town?

Dr Cohen: One of the advantages of a critical mass is a certain collegiate support for each other, and this is particularly so with midwives. If there is a major problem or a bad outcome of whatever sort, support, somebody or a group to discuss it with or an educational meeting or a debriefing on it are very important when looking at outcomes. If there is a larger unit, there are more people who can be talked to about it and more educational activity can occur. Naturally, that is just the way it goes with bigger institutions; there are more opportunities. That is not to say that small hospitals cannot have their own regular meetings, analyses and post-mortems - if that is the right word - about events that have occurred. They do have them and they are certainly invited to partake in, for instance, the activities that are generated at King Edward Memorial Hospital. One of the things about our hospital is the publication of protocols and guidelines for almost every complication that can occur, and for incidents that are not necessarily always a complication. Our hospital organises and sends out a huge amount of published material either in hard copy or via the web to all the midwives and public obstetric institutions throughout the state. We provide a huge amount of information and material, and we encourage interchange and discussion. We have video link-ups

and so on with these institutions. I am not sure whether that answers your question in a roundabout way.

Hon ANTHONY FELS: It contributes to it. How did the existing resources and staff in the system gain their experience in the past, and what is the difference between the way in which that was done, say, 20 or 30 years ago and how it is done now?

Dr Cohen: We cannot practise on our patients anymore, which is what we used to do. The old adage was see one, assist with one and then do one. Those days are gone.

Hon ANTHONY FELS: When did that stop?

Dr Cohen: I should think that stopped about 10 or 15 years ago. Gradually, there has been a process so that education is different. People learn with models, groups and video linkage. We do not teach young doctors on our patients anymore. However, they must be involved and they have to assist. There is a process now called credentialling, which is very important. That is one of the things that came out of the Douglas inquiry, although we were credentialling our doctors and midwives before the inquiry. We need to credential people so that they are appropriately trained in whatever procedure they want to do; for instance, sewing up a tear after delivery. It sounds easy and simple, but it can be complex and difficult. The young trainee must be credentialled and have done a certain number of these under supervision or with the assistance of someone more senior before he or she can be permitted to do the procedure on his or her own. Credentialling has changed the nature of the way we teach and sign people off as being suitable and safe for carrying out certain procedures.

Hon LOUISE PRATT: I have been told that because of the limited number of births in Western Australia - it is similar in other parts of Australia - opportunities to witness or carry out procedures are limited for people seeking accreditation. Is that part of the reason behind consolidating some of the areas -

Dr Cohen: That may be factor. This is one of the reasons that we send our resident staff, our training staff, to the peripheral hospitals. I am not sure whether they go to Armadale; Armadale has resident staff, as does Osborne Park. Our registrars and residents will go to Osborne Park, which has a sizeable number of deliveries but fewer staff competing for the deliveries or to do interventions, to assist or whatever. By moving them out into the outer metropolitan hospitals, they are getting sufficient training. However, in some institutions that can be difficult. At King Edward, for instance, resident and registrar staff are competing with midwives who have to do X number of deliveries to become certified finally or before they can sit their examinations and so on. It can be a problem, particularly because the number of deliveries is not going up; it is reasonably static. We have to look for additional sources, and that may mean moving them outwards or even into the country.

The CHAIRMAN: Has the number of trainees gone up?

Dr Cohen: Not really, and only as is required by the safe-hours practices. Yes, I suspect that they have gone up. Young doctors are not working the number of hours that we used to. They have to be off at a certain time, which means that more junior staff are doing the work that we used to do. It has been a slow process, but it is definitely true.

Hon ANTHONY FELS: What is the proportion of problem births now compared with 20 or 30 years ago? Is there a worsening trend, or is it just a change in expectations and does it have a lot to do with litigation and the expectations of the service provided?

Dr Cohen: I would not call it a worsening trend, but there is a trend towards more complications in childbirth. Two factors certainly contribute to that. One factor is that women are having their babies later in life; they are leaving it until their 30s and late 30s. We know from the evidence that the later they leave it, the greater the risk they have of certain complications. Secondly, more and more women are having their babies by assisted reproductive techniques such as IVF. We know

that these women and babies are more at risk in certain areas. That is another factor. A third factor that would complicate things is obesity. We are seeing an increasing number of women who are morbidly obese, and that produces tremendous potential problems in childbirth, such as increased risk of diabetes, big babies, obstructed labour, haemorrhage and so on. A few months ago the newspapers vilified the Armadale hospital because it would not deliver a certain large lady and it said that she had to come to King Edward Memorial Hospital. That was interpreted by the girl and the media as being discriminatory. In actual fact, what Armadale was doing was absolutely right; it was referring that child - that is all she was - to King Edward because we are more used to delivering the babies of large ladies. We even have beds that will cope with women who are more than 200 kilograms, for instance. That complicates things and produces a huge amount of work for the staff. A number of factors are making obstetrics more complicated. In addition to that is the factor that we mentioned earlier about antenatal testing. This has complicated it as well. We are now able to test the developing foetus for a range of possible diseases and this complicates the early antenatal care.

Hon ANTHONY FELS: What would be the problem with having low-risk births - that is, excluding women on IVF programs, those in the 30 to 40-year age group, obese women and those sorts of situations that would cause women to be at high risk - in the outer metropolitan and regional hospitals, where they would be only 30 minutes from a better equipped and better staff-resourced hospital?

Dr Cohen: There need not necessarily be any problem. The unfortunate thing about obstetrics is that something can happen suddenly and unexpectedly; it cannot always be predicted. One in 10 deliveries will be complicated in some way. Nothing is more hair raising than having a normal delivery followed by a massive post-partum haemorrhage, for instance. It can certainly be a difficult situation if a woman is miles from nowhere and is on her own with a midwife. That does not happen very often, but it happens enough to scare the living daylights out of us. In spite of the fact that we can try to select out complicated patients or select patients who are uncomplicated in every way and say, yes, they are okay to deliver in a small unit, there will always be a concern that something may go wrong. I do not think that should necessarily dictate the way we select altogether, but it is something that we need to bear in mind. That is why if women are to have a safe and uncomplicated delivery in one of these units, they have to be within a certain distance or certain time from all those other supports that we have said we require.

Hon ANTHONY FELS: Does the rough indication of one in 10 problem births apply to the overall number of births, or are you taking out the potential problems?

Dr Cohen: No, that is overall. Some of those complications are minor; they are not all major complications.

Hon ANTHONY FELS: Once the ones that are high risk are excluded -

Dr Cohen: It is still one in 10.

Hon ANTHONY FELS: However, of the births that would be considered low risk before labour, what would be the proportion of births that become high risk or complicated?

Dr Cohen: It could be a little less, but I would say that it is higher than one in 10 if a lot of complicated patients such as older women and obese women are dealt with. It is more likely to be one in 10 in a low-risk population.

[12.30 pm]

We see that, for instance, in women who are booked to have their babies at the birth centre at King Edward. These women are carefully selected so they have no potential complicating problems, but when a significant number of them go into labour, something develops and they have to be transferred to the labour ward at King Edward. It is a very significant number; it is quite high. It may be that the patient wants an epidural anaesthetic and cannot have it in the birth centre. That is

not really a complication in the true sense of the word, and that may be one of the factors which necessitates her being transferred out of the birth centre. There are other factors which also necessitate transfer.

Hon ANTHONY FELS: Is that an issue in these smaller hospitals; for example, of women wanting an epidural when there is no anaesthetist available?

Dr Cohen: Yes, that would certainly be an issue in some of the smaller hospitals such as Mt Barker where many of the general practitioner obstetricians are very good general practitioner anaesthetists but there is a need for more than one doctor.

Hon ANTHONY FELS: What about the metropolitan ones?

Dr Cohen: They would not have a problem if they are staffed by an anaesthetist on call. The smaller ones would have to call in an anaesthetist. They would have access to them, but sometimes they would have difficulty getting them if they are not rostered on call.

Hon ANTHONY FELS: What consideration has been given to trying to get more experienced staff developed in those smaller hospitals, especially for low-risk births? You might have general nurses who are not qualified midwives but can certainly assist by being around at the time. They might take an interest and go on to further training in that area in one of the bigger hospitals.

Dr Cohen: We would then be moving into the whole area of demarcation disputes between midwives and nurses, and that is a different ball game. The whole issue about the training of midwives and whether they will continue to be trained in the way they are or have direct entry into midwifery schools is a very complicated area. That is one of the problems in country hospitals. Midwives are expected to do general nursing where they know nothing about some of the general nursing histories because they are not trained to do that sort of thing or their training has lapsed in that area. We do have problems of that nature in country hospitals which lead to demarcation disputes.

Hon ANTHONY FELS: What about having another tertiary hospital aside from King Edward? Instead of having all the concentration at one hospital, could it be split with another hospital located in the metropolitan area while still maintaining the small hospitals for the low-risk patients?

Dr Cohen: I understand that the Fiona Stanley hospital will be a large public general hospital associated with Murdoch. That will have a public obstetric unit and it will be a tertiary referral unit in much the same way as King Edward. I believe we need one south of the river. If there is a large unit there, the two peripheral units would use the Fiona Stanley hospital as their transfer point, and they would be Armadale and Rockingham hospitals.

Hon ANTHONY FELS: You were talking about Wagin District Hospital and Narrogin and Katanning being 30 minutes away or close by. If low risk births continued to be done in Wagin because the families wanted to have them there, what complications could there be that would see the need for the mothers to be transferred to Narrogin or Katanning versus being put in an ambulance, if the condition was serious enough, and sent straight to Armadale or somewhere in Perth, which is probably two hours from Wagin?

Dr Cohen: Wagin is a one-doctor town. I do not think babies should continue to be delivered in one-doctor towns. It is too strenuous and most doctors will not want to do it and will not do it. To put a woman in that potentially dangerous situation where she has to be transferred to Narrogin - it would take hours for the Royal Flying Doctor Service to get there and hours to get back - is a scenario which I think would be very, very unsafe.

Hon ANTHONY FELS: What if they were at Narrogin hospital, which has more than one doctor, or Katanning, but they are still only reasonably small towns?

Dr Cohen: They do have facilities there. They have operating theatres, availability of blood and more than one doctor, so one can anaesthetise if necessary. As a last resort, they can transfer the

patient by RFDS. Quite often the problem can be dealt with by telephone discussion or, if it is a pre-term baby and looks like it is going to be delivered, the neonatal transport unit can be flown down from Perth to the hospital to deal with it or to look after that little baby and bring it back to the nursery at King Edward if necessary. That is a different scenario.

Hon LOUISE PRATT: Surely in that sense there is an inevitable need to have services located in those areas, even if they are logistically difficult, because if there are pregnant women nearby you cannot necessarily predict that they will be in a place where they can give birth close to those facilities. You cannot predict an emergency situation in a normal birth.

Dr Cohen: That is why it is important that they be close by or in a town where those facilities are present and where there is more than one doctor.

Hon LOUISE PRATT: Those facilities should not be withdrawn unnecessarily, because pregnant women will be living in those areas and cannot relocate themselves weeks before a birth.

Dr Cohen: I would not withdraw the services from Narrogin or Katanning but I would certainly withdraw the obstetric service from Wagin for those reasons. As I said earlier, they are withdrawing themselves. For instance, there are no towns in the northern wheatbelt that deliver babies, including Mullewa, Perenjori and Northampton. That whole area drains into Geraldton, which provides all the services that I have suggested are needed, including a consultant obstetrician gynaecologist. Geraldton has the required facilities.

Hon LOUISE PRATT: Is that viable from a risk point of view in terms of women being able to get to Geraldton quickly enough if they give birth unexpectedly?

Dr Cohen: I suspect a lot of them would move down to Geraldton beforehand and stay there for a while. One of the recommendations that I made somewhere in my report was that these regionalised services, in addition to providing the basic things that I have suggested, should also provide residential accommodation for pregnant women and their families who may have to travel so far that they would prefer to stay there for a week or whatever. There is a new hospital at Geraldton. I asked the hospital whether it was providing this accommodation, which I felt was important. I do not know whether it is but it should. We provide some accommodation at King Edward at Agnes Walsh House. All of these regional units should do that, because we are a huge state and we should do our best to make it easier for our country clients.

Hon ANTHONY FELS: I refer to the move to concentrate the resources at tertiary hospitals and close down some of the smaller hospitals for services. How much consideration was given to increasing the funding to the smaller hospitals to provide and train additional staff and how much extra would that cost versus concentrating obstetric services in fewer hospitals?

Dr Cohen: I cannot answer the second part of the question. As far as building up the services in the smaller service hospitals is concerned, our resources are not limitless. We are constrained by rising costs. That is a factor which cannot be ignored and has to be taken into account. If a small hospital is delivering 400 babies a year and one just down the road is delivering more than 1 000 babies a year and 11 or 12 people are being used at the small hospital at Kalamunda, a health bureaucrat would put two and two together and say that one is not viable, particularly if we want to provide all the services which I believe we should provide. If they are not available at Kalamunda, we then have to increase the number of staff in a whole range of areas. We are battling a shortage of midwives. We will not be able to increase the supply. Most of those who come through go overseas, go elsewhere, go into general training or say they want that additional certificate because they think it will come in handy. We need to look at other issues, like how we retain midwives, whether training is appropriate and how we keep them. I do not think we are in a position to be able to dissipate them into smaller units than we already do. I do not think that is feasible.

Hon ANTHONY FELS: How many of the problems that you experience in obstetrics relate to the mother's potential problems and how many relate to the baby's problems? Also, what is the relative indication of problems that occur antenatally and postnatally?

Dr Cohen: I do not know that I can answer that. Most of the problems occur antenatally. Toxaemia of pregnancy, which is a common complication in pregnancy, occurs in about seven per cent of all women. Seven per cent of women will develop this condition, which is associated with high blood pressure, swelling and kidney problems and may be associated with difficulties and problems with the foetus, the baby, which may require urgent treatment or urgent delivery. That may occur very suddenly without much warning. With careful selection, we ought to be able to predict the problems that occur with babies. If we feel the baby is going to have a low Apgar score - in other words, it will arrive into the world under par - we will transfer the parents out, but we cannot always predict that. There could be a haemorrhage during labour or a cord problem or something of that nature. They are some of the unpredictables that make obstetrics the kind of specialty that it is. Some of them are predictable but some of them are not. With careful selection, we ought to be able to keep the numbers of unexpected problems with the babies down to the absolute minimum as long as we think the baby is of a reasonable size, we are monitoring the progress of the baby during labour, we hear its heartbeat and we know it is okay. Our methods of determining foetal wellbeing are pretty crude and they do not always tell the whole story.

Hon ANTHONY FELS: Finally, I want to get your views on whether there is an alternative way to improve things in this area. With the potential incidence of litigation affecting workers in this industry and the cost of professional indemnity insurance, do you have any views on how this can be better addressed to make it easier for specialists to operate, for midwives to work in the field and for patients and consumers of obstetric services to be comfortable that they are getting a quality service and will be looked after if problems arise?

Dr Cohen: That is an area that has taxed better brains than mine. One of the systems that has been looked at is the New Zealand system, which puts a cap on the amount of money that is paid out, say, in cerebral palsy cases. The government believes that the parents of all handicapped children, whatever the cause, need to be supported financially to enable them to look after their child to the best of their ability. That is something that we need to look at. We should not be looking to the law courts and clever lawyers to determine how many millions a particular patient gets. If we take on board the work of Fiona Stanley, who showed that in the majority of cases cerebral palsy is not associated with birth trauma but with some antecedent problem that occurred during pregnancy, we will realise that the payment of large sums of money by medical defence unions to parents of babies who have this condition is probably not right, not correct, and not the way we should be dealing with this situation. We need to look at systems that are in place in other countries. The system in New Zealand is certainly one that appears to be working very well, with far less cost to the community than is ours. Those costs, of course, now amount to about $100 000 per annum for obstetricians. They are passed on to the consumer and she and her husband are paying an awful lot more for obstetric services than they used to pay me when I first went into practice, when it was 25 guineas per delivery from A to Z. Times have changed

The CHAIRMAN: Thank you very much. I am very conscious that you have been here for well over an hour and a half.

Dr Cohen: Have I? I enjoyed it.

The CHAIRMAN: We have not even talked about things like the remote and Aboriginal issue.

Dr Cohen: It is a very important issue.

The CHAIRMAN: I know it is a very important issue. The committee will go into regional Western Australian to understand more about that and we may want to talk to you after we have been there, if that is possible.

Dr Cohen: I will make a final comment, and I used to say this to all my patients when they were talking about the way they wanted to have their baby and where they wanted to have it: you can have your baby any way you would like, I do not mind and I am very flexible. It is important for women to have a good birth experience in the place they want to have their baby, but what is more important is the nurturing of the child when it arrives and giving it the sorts of things that babies and kids need. The birth experience can be good, but there is no doubt that it can be traumatic and can influence people. For example, depression may be one of the outcomes of a bad birth experience. What is more important is the way in which that child is looked after when it arrives.

The CHAIRMAN: Thank you.

Hearing concluded at 12.47 pm