SELECT COMMITTEE
INTO PUBLIC OBSTETRIC SERVICES

SESSION TWO

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
ON MONDAY, 30 APRIL 2007

Members

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

Hearing commenced at 2.19 pm

FENWICK, DR JENNIFER
Associate Professor of Midwifery,
Curtin University of Technology and King Edward Memorial Hospital for Women, examined:

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

Dr Fenwick: Yes.

The CHAIRMAN: These proceedings are being recorded by Hansard. A transcript of your evidence will be provided to you. To assist the committee and Hansard, please quote the full title of any document you refer to during the course of this hearing for the record and please be aware of the microphone and try to talk into it. Ensure that you do not cover it or make noises around it. 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.

I understand that you have said you do not want to make an opening statement to the committee. We might launch into asking you some questions. I think you have been reading the transcript or you understand the terms of reference and the interest that we have in seeing some modifications to the way maternity services are being provided in WA. What legislative changes do you think might be necessary for us to move down a track that would see more community midwifery-led services operating both at a state and federal level?

Dr Fenwick: One of the things that has happened is that we now have the Nurses and Midwives Act and midwifery is a recognised profession. One of the issues for the college, especially federally, is to look at midwives having provider numbers to provide care as primary lead care professionals, in consultation with bigger teams. We have obviously been pushing that for 15 years. That would make a huge difference in being able to provide midwifery-led services and women could get rebated for that. That is one of the biggest legislative changes. There are still some legislative changes that need to be made around the Poisons Act in terms of carrying drugs. Obviously, you do not need a lot but you need some specific ones. We can do that now through other people. That is certainly something that would be helpful in terms of referral to ultrasound and those kinds of things that women need. We have seen a change in the midwifery legislation of the definition of a midwife. Curtin is going ahead with the direct entry program. Hopefully, that will kick off next year, 2008. That is just the start of looking at what we need to do.

Hon SALLY TALBOT: I wish to ask you some questions about workforce issues. Concern has been expressed from various quarters, including midwives themselves, about the ageing of the workforce. This problem is obviously not confined to midwives. I am particularly interested in the possibility of introducing direct entry courses in Western Australia. Are there any direct entry midwife tertiary courses operating at the moment?

Dr Fenwick: No.

Hon SALLY TALBOT: Firstly, do you have a view about whether it would be appropriate? Secondly, would it solve some of the workforce issues? Thirdly, if that is not the way forward, what is the way forward if we move to some increase in midwives as lead carers?

Dr Fenwick: Yes, I do think it is appropriate. As I said, Curtin is commencing a direct entry program in 2008. Obviously, that will be quite small in the initial period while we see how it works. The other states have had some issues. We are certainly looking at how they have done things so we can make sure that we do not make the same mistakes and we can build on their work. That starts next year. It will not replace the postgraduate course of study because we will still draw on lots of nurses who want to be nurses and midwives. Lots of people want to do that. There are also lots of people who just want to be midwives. There will always be a place for both and it would be silly to say one will take over from the other. They are both there and they will both provide us with the midwives of the future.

We do have some workforce issues. At one stage we were a little better off than the rest of the country. We have gone down a little bit there. We certainly have problems keeping midwives. We are educating a good amount for this state at the moment but there are issues of keeping them in a profession where more and more they feel like they cannot practise their full skills. Having said that, there are some issues with us not upskilling. In some senses, a number of my colleagues are being de-skilled as well. Fragmented tertiary care de-skills the midwife in terms of only doing this or only doing that. If we look to a more social model of maternity care, which is what I believe we should be moving to - therefore, we need more midwives - we will need to put some resources into making sure that we can provide the numbers and get their confidence and their assessment skills back, which are there but people are not practising across the whole realm of pregnancy, birth and early parenting.

Hon SALLY TALBOT: Has any research been done into enticing midwives who are no longer working as midwives back into the profession?

Dr Fenwick: Yes, but I could not quote it.

Hon SALLY TALBOT: Could you take that question on notice if you think there is some research that might be of value to us?

Dr Fenwick: The Australian maternity mapping project that was done by Professor Barclay and colleagues in New South Wales has certainly looked at this. I know why they are leaving but I am not sure about the issue of midwives who have left and are coming back. I can tell you from some of the work we have done that there are issues around fear of litigation in Western Australia. As a result of the Douglas inquiry, to some extent it has had a ripple effect. Yes, it is contextualised to Western Australia; however, that issue is worldwide. While our obstetric colleagues also worry about that, the research says that midwives are very concerned and actually overreact to some extent. That is certainly an issue that we need to address. Again, there are issues about them leaving. Often they are working in one area. If midwives are working in a labour ward or a birth suite, they often reframe what birth is to some extent and end up leaving because they get burnt out. Whereas if you work across the continuum, there is always a chance of an adverse outcome. There are no guarantees for women and their families in terms of birth, just like lots of other things.

[2.30 pm]

If it is worked across the continuum, one is more likely to keep a level balance on what is normal and what is not, and to integrate that normally through practice and maintain those skills. There is certainly enough around. There is lots of nursing research; I certainly think midwifery stuff is around autonomy and responsibility, being well supported, and just not being able to practice in some of the models in which they would like to practice. However, that is not everyone; there are those who feel fearful and will stay in a model that they feel is more protective - a medical model, of course. They feel protected in that.

Hon SALLY TALBOT: Can a midwife who is not also a registered nurse work in Western Australia?

Dr Fenwick: Absolutely. We have the largest number of direct entry midwives in Western Australia - about 55, I think, mostly from the UK.

Hon LOUISE PRATT: How many direct entry places are there coming into your 2008 course?

Dr Fenwick: There will be only about 20, and yet the demand is much more than that. I think while we kick off we are trying to be reasonable in making sure we do it correctly and look at clinical places. One of the biggest issues is giving those students an opportunity to work in continuity of care models. That is one of the issues we face - everyone has faced it - in providing the follow-through so that students are getting that follow-through experience and they are not just learning how to work in this area and that area and then they find they really like doing something so they stay there. We have to make sure we address that. So initially there will be 20 until we figure out how things are going. Of course, the university has its agenda as well.

Hon SALLY TALBOT: Are the problems you have referred to in other states that have introduced direct entry education of midwives to do with the practical components of the course?

Dr Fenwick: Yes, just places.

Hon SALLY TALBOT: You said that we were learning from mistakes.

Dr Fenwick: Yes, in terms of how to do things, and that is some curriculum stuff and what that looks like, and where to place students and how to place them, how much, how many follow-throughs - we call it "follow-throughs", where they follow a woman through - and how many hours are appropriate. We are learning from the other states and we believe we have a program that is looking really good, certainly modelled on the UTS model, which is working very well.

Hon SALLY TALBOT: Are the 50 direct entry midwives working in WA in the tertiary hospitals?

Dr Fenwick: I know about King Edward because I am there, and there are a fair few there, but I could not tell you where they are. I know we have quite a few of them but I am sure they are scattered around.

Hon SALLY TALBOT: And they are mainly from the UK?

Dr Fenwick: That is my understanding, but that is just from my listening to what we have been talking about.

Hon LOUISE PRATT: You have mentioned before that one of the pieces of legislation that we would need to change relates to the provider number under Medicare. If that did not happen, and similarly if we did not make any changes to the way that midwives are insured - at the moment I understand community midwives are all insured under RiskCover and are therefore employed by the government - would that limit things or would we be able to grow midwifery-led maternity services with those two things as they are?

Dr Fenwick: Yes, I think so. Those things would give us even more scope, but I still think there is scope to change. People have to want to change and be prepared to say yes, we are going to move to a model whereby we really encourage most women to be seen by a midwife who works in collaboration with a team and there is a seamless transfer service. I think we can do it. I think it restricts models in the country, perhaps. However, and I am not sure I know the exact figures, if we are prepared to pay so many thousands of dollars for an anaesthetist to be in hospital overnight on call, my argument would be that we do not always need epidurals. What is appropriate? What are the appropriate services that we need? Sometimes we do not need all those services. We need to be able to give women those services if they need them but we need to look at what is appropriate in terms of a normal healthy birth. If we offered midwives the right kind of remuneration such as we offer other people, we might be able to get more people to go to the country and work in a team.

We can do ultrasounds via the Internet now. I know it is still difficult. There is communication by email. We should be able to do some of that stuff. Yes, there are some issues around the numbers but if we said we were really going to provide midwives with what they need and build a team so that they could look after women in their own communities, I think we could do it. Certainly it has been done in different places around the world.

The CHAIRMAN: Can I ask what you think needs to be done? We have a new directions document that is being worked on by government. What kinds of things need to be put in place in the Department of Health and hospital management to manage into the future this very siloed scope of practice that midwives have so that we can gradually build the capacity and over time transform it into the kind of vision that is being outlined in the future directions?

Dr Fenwick: I guess it is a real commitment at all levels for this to happen. That is from our perspective as a college as well. We also have to get to our midwives and say that this is really important and really good. There needs to be a real commitment from the Health Department. It is going to move in that direction and that is the way it sees itself going forward. There needs to be some directives so hospitals have the capacity and the people to move things forward. In the UK, for instance, with clinical consultant positions around normal birth and midwifery, those people are clinical people who have expertise in normal birth and push models and can set them up. It is like any leadership issue: there has to be a commitment at all levels for us to be able to do this. I guess that is probably what we are struggling with a little bit at the moment - this commitment from different people at different levels. There has to be a real push from everybody to show that this is the way forward.

Hon LOUISE PRATT: Our terms of reference relate quite specifically to consultation. Would you like to express a view about how you see the consultative process leading up to the recent changes and the introduction of the future directions for maternity services process?

Dr Fenwick: It is hard to comment in one way because I have sat on so many different groups and it has all got a bit confusing as to what we were doing with whom. I was new to Western Australia in 2001. I know the Cohen report came out in 2002 but I am not aware of some of the build-up to that, so I am a little hazy on that background. When I read the terms of reference, I had to think. I know the ACMI through Graham Broadley was invited to participate in some workshops and I have certainly been to different clinical workshops, but there has not been a lot of feedback. We go and then we do not hear anything, and we go again. It gets a bit mixed up for me because at the same time King Edward also had a whole lot of meetings around models arising from the fact that we might be moving. I am trying to explain that in my mind there is some confusion about those meetings at King Edward but they seemed to develop into something more. Does that make sense? We were meeting sometimes at King Edward and it was a bit confusing as to whether we were meeting to discuss moving to a new hospital and what that might look like and then all of a sudden the clinical network framework happened. It is not clear in my mind how some of that developed and how the decision was made around the four hospitals, although I know it reflects the Cohen report. There were not a lot of consumers in some of those meetings and the ACMI did not receive any feedback in terms of the president going along and representing the college. We have written numerous documents and been participants in different ways over the last year and a half.

Hon LOUISE PRATT: Is there anything else you would like to tell us in particular?

Dr Fenwick: No, not unless you want to ask me about caesarean sections specifically. We might not go there!

Hon LOUISE PRATT: No, please tell us. Give us a one minute overview!

The CHAIRMAN: How do we bring down the escalating rate of caesarean sections in this state? Clearly, changes in these kinds of models would help, we would hope. I do not know whether the

university has done any research on how we marry models of care and, from a public health point of view, women's expectations about what kind of model of care they are accessing.

Dr Fenwick: We have done quite a bit of research on expectations as well. I think we face an issue with the media; it is a hot debate and one that people can set up as either right or wrong. We have a really big issue with caesarean sections and I am concerned for the future about what this means for women and their families and birth because I think we have lost, or are losing, the significance of birth. Sometimes it is easy to say it is women's fault; they are choosing it. I do not believe that is true. It is much more complicated than that. Lots of women are consenting when they are given only half the story. There is no doubt we need to provide women with, and look at rebuilding, our cultural knowledge around birth. Certainly I believe that if we moved the slant to a social model of health and provided women with midwifery-led care or a chance to regain that knowledge. Everyone is a little fearful about birth, and that is a good thing. There is no doubt that some women are so fearful that they will actively choose that option.

The CHAIRMAN: I was looking at *New Idea* the other day and Princess Mary's second child and how incredibly anxious and upset and stressed she was about the impending birth, and how it was promoted. It turned out that it was a completely normal and straightforward birth, but that is what is being pushed out in the media and that is what is in our popular culture.

Dr Fenwick: If you picked up *New Idea* and *Woman's Day* about a week and a half ago, when I flew to Sydney, I was appalled at what was splashed across it, saying that caesarean sections were safer and that they save a woman's pelvic floor. That is not true. Categorically the research shows that and yet those messages are continuing, and that is where they are being sold.

The CHAIRMAN: We have had obstetricians tell us that.

Dr Fenwick: It is the message that is being sold to women and it is really concerning because it has implications. We know perhaps the emotional wellbeing of women who have caesarean sections is not as healthy as we would like it to be. I think we really need to do something about redressing the balance.

Hon LOUISE PRATT: If there was one area that you could significantly influence to bring about that redress, what would it be?

Dr Fenwick: Move to a social model like that or –

Hon LOUISE PRATT: What would you do to move to a social model? If you could make only one thing happen to move to a social model in maternity services, what would you do?

Dr Fenwick: Gosh, I do not know if there is one thing; it takes a lot. I do not think there is one thing. If you asked me that question in terms of bringing down the section rate, I could give you one thing: we need to encourage more vaginal childbirths after caesarean sections, and look at how we do that. I cannot give you one thing, because had there been one way to do it we would already have done it.

Hon LOUISE PRATT: Can you tell us what you mean by a social model? What is the difference between what we are doing now -

[2.44 pm]

Dr Fenwick: I guess we are based very much on a medical model and we see that issue of swinging the philosophy around birth back to it being a normal, healthy, significant life event that is part of a family, and demedicalising to some extent. I know that is difficult and I am not sure that we have all the answers. However, it is a matter of promoting small units that do not offer every technology under the sun, because as soon as more and more women are put in one area, more and more intervention occurs and more and more money is spent. As much as accountants might like to think that if everyone is put together we save, I think experience around the world shows that it just escalates the amount of intervention. I guess then the question is, keeping birth community with

normal, healthy women in their communities if they can. They should be birthing close to home but with really good collaborative care where good transfer is available if needed.

The CHAIRMAN: Do you think that maternity services would be better placed under family and children's services rather than under health department services?

Dr Fenwick: They have suggested that in Queensland, I think; namely, that maternity care move out of health and under family. Have they?

The CHAIRMAN: I do not know.

Dr Fenwick: I think they have; I think the Hirst report suggested that they look at putting maternity services in under another department and building hubs, to try to look at this issue. I do not know. I do not think I am cluey enough to be able to really answer that.

Hearing concluded at 2.46 pm