

## Submission to the Maternity Services Review Rural Doctors' Association of Victoria



### Main Points.

29.10.08

1. Rural Maternity Units continue to close down throughout Australia. Without affirmative intervention, rural mothers will have very little 'choice' at all. This is not confined to Victoria. Travelling distances of 100-200 Km are commonplace and numerous en-route deliveries have been occurring. Our Victorian projections (maps attached) for 2010-15 show few remaining centres.
2. Obstetrics is not an inherently safe activity. There are reasons why Mortality rates have progressively decreased. Great caution has to be exercised in the provision of services.
3. Rural Obstetrics has been no less safe than Metropolitan. There are reasons for this.
4. Lack of rural maternity services poses a significant threat to health.
5. Collaborative models of midwifery are highly desirable in rural locations.
6. Provision of support, especially intra-partum back-up, to independent community midwifery is beyond the capacity of rural units without compromise of obstetric safety and other health processes. The occasional presence of independent midwives has been a major source of anxiety to rural obstetricians.
7. Childbirth as rural community focus, activity and identity is becoming a thing of the past.
8. In the event of serious economic depression, transport-dependent rural obstetrics could be expected to experience substantial break-down. Allowing units to close is very poor risk management.
9. **Steps need to be taken urgently to obtain State agreement to halt closures and if necessary reopen Maternity Units in agreed key rural locations. Decisions need to be made at the highest political level,**
10. All due measures need to be taken to ensure adequate obstetricians, midwives and anaesthetists to maintain safe rosters.
11. The Queensland Rural Generalist model of medical training and remuneration is strongly recommended as a mode of attracting doctors into Maternity-unit locations, providing that a proper Generalist skill-set is utilised in the training pathway.
12. Urgent measures are required to restore supply of rural midwives.
13. **From the rural perspective it is vital that this review is used to address the genuine almost catastrophic reduction in maternity services that continues to occur in rural Australia. Three more services will have been lost by the end of 2008 in Victoria.**

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## Attachments

1. [Victorian Poverty](#)
2. [RDAV Procedural GP Age Profiles](#)
3. [2008 Rural Obstetric locations survey, Maps, Projections '83, '97, '08, '10-15](#)
4. [Victorian Rural Collaborative Maternity Care. The Kilmore Model](#)
5. [2007 RDAV Submission to the Ministerial Review of Victorian Public Health Medical Staff: Supplementary paper: Victorian Rural Obstetrics.](#)
6. [2002 RDAV Position Statement on Small Unit Rural Obstetrics](#)
7. [References for Position Paper](#)

### 1. **Preamble**

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The Association has already contributed to the development of the National Consensus framework through the RDAV. The new review is welcomed because it appears to the RDAV that there is currently no move to limit continued drastic Australia-wide reduction of available rural maternity services, in particular by Bureaucracy-driven closure, nor to redress inherent deficiencies in delivery of maternity care. The loss of services in Victoria since 1983 has been monitored by RDAV and its progenitors, and closing locations contacted at the time of closure.

The National Consensus framework contains a set of self-evident statements completely necessary for safe rural obstetrics. However it has been left to rural doctors to establish and maintain viable generalist obstetrician rosters. Hospitals and services have not shown capacity to do this. A host of not altogether un-remediable factors have diminished viability of rural practice and supply of obstetricians. There has been similar lack of attention paid to the Midwife workforce. In rural 2008 the question is no longer a matter of choice of services but the presence of **any** service.

The current crisis in Pambula illustrates the complete lack of understanding of rural exigencies that exists. Due to temporary shortage of midwives, Hamilton Hospital Victoria currently has midwives rostered on call for deliveries rather than in situ on roster. The requirement to have a midwife on the ward at all times could easily be made a question of hospital judgement. Nursing sisters can be up-skilled within hospitals for post-partum care just as they are currently being up-skilled within hospitals to full midwife capacity.

Temporary shortages of midwives or obstetricians should never be used as an excuse for permanent closure. Once cast aside, a team of GP obstetricians containing decades of corporate ability and experience can rarely be reassembled.

Locally married midwives also are often reluctant to resume practice because of education requirements. It has to be emphasised that there is nothing to indicate that, on present trends in Victoria, rural midwifery will not shrink to a few regional centres (Maps) where it will be necessary to obtain obstetricians from overseas at major expense who will not have gynaecological skills appropriate to the Australian setting.

The text of this submission is brief and contains mostly observations and generalisations. More specific information and references is contained in the attachments: open and closed Victorian locations since 1983; the Kilmore (collaborative) model; 2007 submission to the 2007 Victorian Ministerial medical workforce inquiry and the 2002 RDAV Position Statement. It has been prepared at short notice and is not therefore cross-referenced.

## 2. Safety in rural Obstetrics

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1. Safety in obstetrics these days is often taken for granted, without thought given to the agonising that has occurred for the last 100-200 years, the monthly meetings, the constant analysis of outcomes with fine tuning of processes, the significant part that safety processes played in obstetric education.
2. There seems to be a divide between those who believe that safety has been obtained by a highly interventional approach and those that feel that a low key intervention-reserved approach, the successor of 'relaxed childbirth', that maximises maternal control and 'empowerment', produces just as good if not better outcomes.
3. It has often been assumed that in rural, without tertiary back up, good standards and outcomes in obstetrics are impossible to achieve. Multiple NSW closures in the early 1980s were based on this assumption. The converse is the case. The 1983 Victorian Health Commission survey of small hospitals found paradoxically that the smaller the hospital the better the outcomes, and multiple studies have since confirmed the safety of rural obstetrics.
4. The Victorian Bush Nursing Association annual obstetric returns were professionally reviewed annually for several decades into the 1990s, with emphasis awarded to their "unparalleled" safety, with very few intra-partum transfers. This reflected good case selection, the availability of a GP obstetrician at every delivery (doctors did not go on holiday if a confinement was due), capacity to perform Caesarean section, and above all maternal satisfaction with services.
5. Maternal comfort of choice, trust in providers, and consequent relaxation in labour is a potent promoter of good outcomes. There is no doubt that support amongst a community of women of child bearing proclivity will lead on to successful maternity unit activity. By the 1980s there was a network of 130 maternity centres in rural Victoria delivering excellent outcomes enjoying huge support from their communities. Most of these have now closed. Consumer sentiment has not waned towards local services and the 1995 establishment of a collaborative model of obstetrics at Kilmore, utilising available midwives and a mixture of GPs and part-time specialists, tripled total use of the centre in the space of a few years (attachment).

6. Conversely, travelling in Labour poses a significant threat to maternal and perinatal infant health. Whilst studies are lacking it is inevitable that lack of available immediate intervention at this critically dangerous period will incur actuarial risk. The greater the population, the greater the distance, the greater the compounded morbidity and mortality. Bureaucracies intent on rationalising and centralising maternity care consistently avoid confronting this issue. It appears that without direct political intervention there is an inexorable tendency for the process to continue independently of all other public sentiment and informed medical opinion.
7. The limitations of retrieval services must be emphasised. Prevention of air transport through inclement weather is not uncommon in Victoria. A neonate with bilateral pneumothorax was managed for 3 days in Swan Hill for this reason. Retrieval to Melbourne takes 4-6 hours on average.
8. Appropriate referral of high risk cases might appear to have a major bearing on safety but has not been fully studied and the 1970s Cohuna retrospective study, where no mothers at all were referred antenatally or intrapartum, with very low Caesar rates, showed similar outcomes to the best tertiary hospitals. Antenatal referral can be very difficult to organise from a distance, especially now that premature labour is so common. Any travel in labour above 30 mins occasions quite serious risk to mother and baby.
9. Rural risk has to be managed differently from Metropolitan. Hospitals tend to be reluctant to accept risk but the actuarial facts should be considered in relation to the staff situation of the hospital. If rosters can be provided of suitably trained staff then direction from elsewhere should ordain that obstetrics remains open. Victorian hospitals are independent entities, which poses problems for centralised direction but gives them protection from cannibalisation by larger hospitals, (a risk of the 'hub and spoke' model).
10. Victorian rural indemnity is provided by the State financed Victorian Managed Insurance Agency at low cost to doctors, and we are informed that rural GP obstetricians have low rates of malpractice suites.
11. Tragically, a single obstetric accident can blight the life of a GP obstetrician or anaesthetist, and result in cessation of practice. Analysis of events usually shows that management was reasonable and the accident unavoidable or the result of a combination of circumstances which overtook human capacity. However, temptation to demean the rural proceduralist is sometimes too great for press and public. Affirmative support for rural obstetrics is required which recognises the overall balance of risk. Raising the status of GP obstetricians as 'Rural Generalists' is discussed below.

### 3. Obstetric Zones

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1. **Metropolitan Obstetric units** have been rationalised to a few units, with closure of fringe units, (and resultant deficit in capacity due to the rise in birth rate), but access is enjoyed for the most part within 30 minutes travelling time. Obstetric intervention can be organised within a significantly safe time, which presumably gives opportunity for domiciliary midwifery, providing stringent guidelines are observed to preserve safety. There has been tension between midwives wishing to practice midwife obstetrics and physicians inclined to a more interventional approach. Caesar rates have progressively risen.

2. **Fringe Metropolitan Obstetrics.** Units have progressively closed despite the fact that driving time through the metropolitan penumbra can be extended over one hour. The reasons have been as complex as rural and partly due to lack of GP obstetricians, as in Rosebud. The bureaucracy has not always been helpful. GP Obstetricians in Warburton have been refused State-subsidised indemnity, because their RRMA 5 hospital is a 'spoke' of a metropolitan hospital. The success of the Kilmore model suggests that the problem has not been one of consumer sentiment but of inappropriate midwifery models.
3. **Regional obstetric units** have been struggling to attract obstetricians, Large numbers of GP obstetricians were excluded from service in the 1990s and are no longer available. Opposition of Specialists to GP Obstetricians has been part of the problem in some locations, especially to GPs performing Caesars. This has caused a necessity of hospitals to scabble continually for locums and to run rosters short. The 2007 Victorian State Ministerial Medical Workforce Inquiry report recommended combining GPs and Specialists together to implement rosters.
4. Smaller rural units have been closing at a rate of 3-4 a year since the mid 80s (attachment). 3 more will have closed by the end of 2008. Factors have been retirement of doctors, administrative manoeuvre, and lack of midwives. A number have continued with very small numbers. The situation of all units is uniformly tenuous, and only a minority have guaranteed viability for more than 5 years on present staffing patterns.

#### 4. **Operation of rural units.**

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1. Rural units operate best on the assumption that there is no such thing as an entirely safe delivery. This means being able to conduct Caesarean section if progress is unsatisfactory whether by natural or interventional means, or to transfer if indicated (always risky) all in consultation with NETS.
2. There has to be close understanding and cooperation with the Hospital administration to facilitate flexible local protocols, immediacy of communication, and understanding of exigencies of medical roster and theatre availability. When this fails the unit closes. Seymour has thankfully reopened following a change in administration.
3. Administrations trend to have a blind spot for the exigencies of rosters. We are coming out of an era when rural generalists were, despite their merits, expected to be available 24/7. To achieve safe working hours the UK now debars doctors from medical indemnity cover if they work over 50 hours in a given week. This would of course destroy rural medical work in Australia but we do have to go a great deal further in the matter.
4. Hospitals should not claim to have 'a maternity service' as they have done, with one obstetrician working 3/7 and alternative week-ends. If you offer obstetrics it should be 24/7 or not at all and the doctors and midwives have to be found to do it. Mothers have to plan ahead for their delivery. It is not at all satisfactory to ambulance them out if the hospital happens to be closed to maternity that day.

5. Maternal choice of midwife, whether nurse or doctor is not always possible where staff have limited capabilities. Where the number of deliveries is very small, selected persons should conduct all deliveries for safety reasons, and it is generally well accepted when it the doctor elects to do this. In larger units nurse midwives are increasingly performing deliveries without the doctor being called in. There is a slight degree of risk but providing neonatal resuscitation skills are good, and the doctor is available within 5-10 minutes it works well and minimises sleep deprivation.
6. The Kilmore model (attachment) proves that communities even close to the city want local care, and want both midwives and doctors collaboratively involved in their care. Once the hospital was fully and visibly committed, and a satisfactory model was put in operation, with a critically important combined antenatal clinic, numbers of deliveries tripled and have remained at that level for a decade. Our Association is taking every opportunity to promote this model and is currently helping negotiate it in Colac.
7. Rural Units make use of whatever manpower resources are available. Midwives often travel to fill shifts. However GP proceduralists have multiple responsibilities within the town and cannot afford days off unless there is an arranged locum. They are unable to take a day off if they are up all night. It is rare that they cover another town
8. Formerly clusters of small towns operated with GPs travelling across to assist with complicated deliveries and Caesarean section. These cluster are progressively disappearing but some persist and new clusters are appearing with even larger towns sharing on call not just for obstetrics but for all on call. The Alpine towns of Mt Beauty, Myrtleford and Bright now assist each other. The Corangemite cluster of Timboon, Terang and Camperdown collapsed this year with significant implication for Camperdown. Stawell and Ararat are alternating obstetric on call at 45 minutes driving apart. The spectre of Portland obstetric collapse is significant for Hamilton. Wonthaggi, Foster and Leongatha have increasing association. Kilmore assists Seymour, and absorbed its massive overflow without proper recompense when it closed for several years.
9. Given the tenuous situation of rural maternity services, and only one or two centres have not had problems with supply of obstetricians and tight or unsafe rosters over the last 5 years, it is absolutely vital that the management of services is understanding and sensible. The attempted introduction of a midwife-led model in Portland led initially to threatened withdrawal of services and in the long run to resignation of the entire VMO complement. In Seymour, deprivation of GP Anaesthetists of the surgical lists necessary for maintenance of skills, led before long to prolonged major loss of acute services and several years' closure of obstetrics. These are only salient examples.
10. Visiting GP procedural services on which hospitals depend, are based in community medical practices. GPs are required to provide the infrastructure. Group practices require solid longstay groups of GPs. These practices are integral to the workings of community health and in Victoria, and many of them are equivalent to the supercentres desired by the present Labour administration. This system produces the best outcomes for the community because it provides community based skills in health promotion and intervention. It also provides high output medicine and continuity of care through Medicare funding. The Queensland model of Hospital based doctors with rights of community practice requires a hospital based clinic model, with salaried staff, which invariably has much lower throughput than fee-for-service.

11. Reintroduction or setting up new Obstetric services is made very complex by the need for balance in community General Practice. Once a service is shut down it can be very difficult to reopen. It will be interesting to see whether Beau Desert, 60 Km from the Gold Coast, formerly with 200 deliveries a year, currently the subject of a campaign, will be reopened.

## 5. Comments on obstetric staff

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1. **Specialist obstetricians.** Some surprisingly small Victorian towns had specialists until recently and GPs working together in obstetrics working with GPs. This has now passed and the supply of rural SOs is now very tenuous. Every location is in trouble and administrators are looking overseas and scrabbling for locums. The SOLS locum scheme has been a useful and timely innovation. There is much to suggest that many FRANZCOGs are having second thoughts about the sleep deprivation associated with hands on obstetrics and are inclined to practice only Gynaecology. In particular specialist obstetricians with large midwifery workload are becoming less common in regional towns, which may have a favourable effect on Caesar rates.
2. **GP Obstetricians.** There are still about 150 in rural Victoria. Age cohorts in the appendix show that they are moving into their 50s and towards retirement. Many of these trained in the UK. There was never any systematic training of Australian graduates, and the build up of the workforce, as for GP anaesthetists, was adventitious and the result of a fashion for rural generalism such as is now occurring in Queensland combined with the common pursuit of travel to the UK to travel and acquire skills. Whilst there are still a few GPOs who seek to personally deliver as many babies as possible, it is increasingly common for GPOs to work collaboratively with midwives, deliver only more complex cases and where neonatal resuscitation skills are good, not necessarily attend the delivery (See appendix: Kilmore model). Not a sufficient number of GPOs have Caesar skills, and this needs to be remedied in training programs. Extension of the SOLS locum scheme will only be a bandaid for shortages.
3. **GP Anaesthetists.** Isolated maternity units should be able to conduct Caesarean section and this requires a roster of GP Anaesthetists. It is therefore best to conduct rural midwifery in hospitals that have a flow of routine and emergency surgery sufficient to sustain a roster of at least 3 anaesthetists. Like GPOs, GPAs rely upon 2/3 of their income or so from community rural generalist practice.
4. **Midwives.** The Inquiry will presumably receive submissions. They are also in short supply both in metropolitan and rural areas. The Women's hospital is said to be 20 EFT short. Hamilton Base hospital is unable to fill its roster and is reliant on a system of call-in for a delivery. History does not relate if they are able to provide 24/24 midwives until discharge, which has been a major headache for rural hospitals. Single certificate midwives are not able to assist with other aspects of nursing when there are no midwifery cases in, so are not a favourite of smaller rural hospitals. The new system of up-skilling Div 1 general nurses is experimental and presumably they will need a year or two more assistance after graduation to get up to speed.

- a. Major financial stimulus is needed to boost the sector such as removal of hex fees. There should be at least one school of rural nursing and midwifery in each State to train double certificate nurses. Further relevant comment is to be found under models.
  - b. Rural Midwives have the same age distribution as rural GPs, are retiring at the same rate, and are due to have the same shortages.
  - c. The original failure of Australia to develop midwifery on the UK model was always a surprise to incoming UK doctors. In the UK midwives deliver babies and medics assist with complications. This model is not suitable for smaller bush locations where care must be collaborative.
5. **Independent Midwives.** Not many Independent midwives are known to be practicing in rural areas but there have been a number of anecdotes received from doctors with experience in Victoria, Tasmania and Queensland. There are some commonalities. Doctors have been concerned about possible adverse outcomes resulting from complications in labour, and the impact it might have on their own indemnity. They have offered protocols for transfer of care in labour. These protocols have been ignored. Deliveries have occurred at great distance (100Km+) from hospitals, not always with the midwife present. Risky deliveries have been undertaken, such as twins, even twins with a previous caesarean. What is the status of independent midwife indemnity? What is taught about avoidance of risk? This category is not without merit but a great deal of thought is required as to where and how the skill is practiced. It is not fair for a busy rural GP with multiple hospital responsibilities to have additional responsibilities for being available for the much more difficult management of complications arising from home births.

## 6. Antenatal and postnatal care

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1. In line with rural obstetric risk management it is essential that obstetricians be involved in antenatal care. Mothers should also have a choice in whether they select a single doctor to case-manage their confinement.
2. However it is important that accepted protocols for antenatal care are observed and information collated at each successive visit, properly acted upon, and summated at confinement.
3. The Kilmore model (attachment) has demonstrated that a combined collaborative antenatal clinic can be cardinal in success of maternity units.
4. This is easier than it seems, partly because of the mobility of rural populations and their tendency to pop up in different locations for antenatal visits, particularly in the case. Often they do not arrive with the somewhat cumbersome records in which doctors object to replicating notes. Standard practice has become to print out one's record from Medical Director and place it in the folder if available.
5. Koori patients in particular often travel a long way in the third trimester to the preferred confinement destination, and arrive late, unbooked, sometimes in labour, sometimes without notes.
6. We are a long way off direct IT communication for records and it is difficult to export information out of medical director. Perhaps it should be a requirement for medical software.
7. Referral of high risk cases is all very well, but often antenatal care becomes fragmented and...what if they go into labour early? If you are 2 hours away from the nearest tertiary centre you have to be prepared to deal with all categories of risk. You would like your Caesar rates to be lower but you err on the side of caution.

8. Perinatal and Neonatal retrieval services are very well conducted in Victoria. We are not in receipt of complaints, and are in liaison with the management. GPs do however have to be prepared for sometimes prolonged delays in call-out.
9. Post natal services tend to be pretty deficient in rural. This is a vulnerable period when mothers can be alone. There also needs to be flow through of care in needy cases into the infant and toddler stages. NSW Greater Southern Health have had a very good model for this, with antenatal risk assessment, which is hopefully still going.

## 7. Where there is no service:

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1. Rural mothers with the maternity unit 50-100+ Km or so away face quite a difficult task in deciding what to do. They tend to select a location with family support, which may be far further than the nearest service location. This increases birth en-route substantially.
2. The Local GP may have postgraduate obstetric experience or not. Many mothers assume the latter and repeatedly travel the whole distance many times to obtain antenatal care, not only for consultation but for investigations if these have not been co-arranged. The cost, at 70 cents/Km is quite substantial. Many end up with gaps in care. Some present very late in pregnancy.
3. Greater poverty rates are associated with fewer facilities (attachment). The overall poverty rates in 2005 for rural Victoria were 11.1% but we believe them to rise to 25% in some parts. Robinvale is an example, with a huge multinational population, about 100 births a year, and 90 Km from Mildura.
4. If the GP is interested in shared care they will often be required to undergo further training before consideration and to enter into agreements, whether or not they have postgraduate experience and irrespective of the undergraduate training they have all had, with requirements to attend regular updates. It is simply not worth their while. Rural GPs have a vast area of practice to cover and confine their practice to the most basic effective algorithms feasible.
5. Many obstetricians insist that a 6 month internship with a Diploma in Obstetrics is the minimum necessary for GPs to conduct antenatal care. This combined with awkwardness in setting up shared care arrangements sometimes creates an impression that the wellbeing of mother and child is not a main driver in care provision.
6. Admittedly there is a huge range of options and managements with potential to improve pregnancy outcomes, many not yet in standard use. The Victorian [Three Centres Consensus Guidelines](#) however provide a relatively simple algorithm which could easily be incorporated into a working arrangement without elaborate training and requirement. Mothers would at least have tests done at the appropriate time. Review of risk factors, adverse features, and obstetrician palpation can be structured into a few strategic visits.
7. It really needs an absolutely routine arrangement in every region, with somewhat less voluntary and personality-driven arrangements than at present, with systematic and sympathetic approaches being made to outlying rural practitioners.
8. Casting the net wider, there is some merit in a national over a State approach because of cross border travel.
9. Do you wait to go into labour before travelling? Early travel might be dictated by previous early labour and complications. One has the impression that premature labour is on the increase. Unfortunately rural mothers often have other children and significant involvement in the family business especially at time of harvest delaying departure until the last moment.

10. The further dwelling is from intended place of confinement, the greater the risk of delivery en route. Birchip has been particularly unfortunate in this respect, whether the intended location was Horsham, Bendigo or Ballarat.
11. In the past the idea of hostels, or subsidised motel accommodation. The State subsidy is designed to discourage rather than encourage travel to medical care. Accommodation rebate and kilometrage rates are appallingly low. Whilst this discourages demands for referral that have an underlying social agenda, it is not fun for families having babies.

## **8. Training of rural GP obstetricians**

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1. Traditionally a lot of Australian graduates went to the UK in the 1970s, less in the 1980s, and only a few in the 1990s. This is reflected in the age cohorts of Victorian GPOs and GPAs, few of whom are aged under 45.
2. Another category which made up the workforce was UK derived with experience in Commonwealth countries, mostly now retired.
3. Recently a number of proceduralists of all nationalities have transited mainly from or through South Africa where they have obtained substantial experience. In Victoria the locations of Swan Hill, Horsham, Stawell, Maryborough, Hamilton, Portland and Orbost at the very least have only been able to continue obstetrics because of such graduates. These IMGs need a high degree of support to commence and continue practice for the first 1-2 years.
4. Most regrettably the requirement for IMGs to acquire the FRACGP has resulted in a large number of them relinquishing their procedural capabilities and leaving rural zones for fringe metro, often interstate, once they are free to do so.
5. The need for advanced rural training led to the creation of the Australian College of Rural and Remote Medicine in 1997. There has been quite extraordinary reserve about this concept and the ACRRM battled for many years to get acceptance. The deadlock was resolved by COAG recognition of Rural Medicine in 2006.
6. Fellowship recognition commenced in 2007 and 30 Fellows have graduated. The ACRRM has 1800 grandfathered fellows and an additional 600 members.
7. The FACRRM pathway aims to graduate rural generalists with advanced management skills and a specific subspecialist area including obstetrics and anaesthetics. The core curriculum contains obstetrics and women's health, focussing on necessary skills. An advanced curriculum is in development. The JCC Obstetrics curriculum set is probably some years old now. Some attention could probably be paid to collaborative models in both curricula, though there might still be some professional opposition to this.
8. The Queensland Government has established a rural generalist pathway using the FACRRM which guarantees SMO rates of pay in Queensland Hospitals. There are 54 in training, 30 entrants accepted for 2009 with growth to 40 and then 55 annually by 2011. Their education is paid for by the State. There will be an equal sized parallel stream of FACRRM-based emergency management generalist (GEMs) to staff Emergency Departments throughout Queensland.
9. Other States are looking with interest at the model.
10. There are criteria RDAV has developed for the training of rural proceduralists. For example, Centres must be fully committed to the process and distinguish it from specialist training. ARSP Curriculum must be adhered to. Mentoring by a practising rural proceduralist must occur. Core skills, including Caesarean section for generalist obstetricians, must be included.

11. Of great importance is the need for IMG entrants to rural to enter FACRRM training immediately. Dependence on IMGs is currently up to 60% in many areas, 30-40% overall, and is going to remain at 30% in Queensland, despite the generalist pathway, because of further attrition from the workforce of older doctors.
12. With respect to CPD for GP Obstetricians and Anaesthetists, availability of good education continues to increase, partly fuelled by the procedural training subsidy negotiated by ACRRM and RDAA. Some of these courses are stunningly good, particularly the RWH Maternity Emergency Program. The ALSO course has numbers of rural GPs involves (as have all the main emergency courses). Divisions regularly construct obstetric days and NETS travels out to conduct emergency courses.

## 9. Comments and observations.

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1. The loss of rural obstetrics was quite unthinkable a few years ago and could be greeted with astonishment by a medical profession that has taken public concern with obstetric safety for granted, and endured the penalties of failure to provide anything but fully standard care. It is simply and starkly unsafe for large populations of women to have to travel to deliver their babies, but this is what is happening.
2. Greatly increased availability of personal transport has decreased the significance of rurality and altered the demography of rural areas. It has also produced a laissez-faire attitude to health planning, allowing consumer sentiment to determine pattern of service. Much health care has become personal-transport dependent, increasing throughput in specialised units but incurring unspecified cost to the community, addition to importation, and pollution of the environment.
3. The decrease in rurality has encouraged the tendency of bureaucrats to centralise services. Large numbers of hospitals and services have been lost. Hospitals within 20 km, then 30 km, recently 40 Km and now 50 Km from large hospitals have suffered from cutback and closure. Our lists in the attachments show the story in Victoria. Sadly it is the most impoverished towns (Jesuit study quintiles) that lose services first (attachment), with populations that can least afford to travel. Midwifery, theatre, XRay are removed, and finally the town is reduced to aged care and a visiting doctor clinic. Other States are the same but Tasmania has been particularly hard hit.
4. To date the process has been regarded by administrations as inevitable, with no line drawn in the sand, no systematic workforce analysis with institution of countermeasures. Only Queensland, reacting to Bundaberg is as yet attempting systematic measures.
5. There appears to be no attempt to quantitate need on the basis of population size and time to travel (distance and average road speed) and then to seek solutions to rural problems. DHSV disclaimed in one meeting with RDAV legal responsibility for systematic provision of rural services. It is not inconceivable that technically this is legally correct. Perhaps constitutionally there is neither State nor Federal obligation. The plight of Cobar in NSW, with a population of 5-6,000, a young mining population, 159 Km from Bourke, but with no obstetrics is a good example. There is no evidence that, except in Queensland as a result of Bundaberg, States are seriously deliberating how to solve this problem. WA has a planning process, but judging by a recent presentation they are not seriously looking at this issue. Victoria is showing no signs, despite our best efforts, of taking the issue seriously, continuing to concentrate instead on standards and processes in surviving units that make little reference to workforce availability or a safety net of services.

6. On the contrary, reforms are introduced which have a predictably negative effect on rural services, with no thought given to the consequences. Every such reform should have 'rural impact' statement built in. This was the thinking behind the RDAA recommendation for a 'rural obligation'. It would be our greatest wish that the Maternity Services review have a rural section containing a recommended 'Template' for preservation and restitution of rural maternity services.
7. Currently a Maternity and Newborn Clinical Network has been created in Victoria which appears to have a positive attitude towards generalist obstetricians, and a more definite commitment towards preservation of services than there has been.. Regrettably we have been unable to find doctors with time available to attend the week-day meetings, but are maintaining informal liaison. There had been a period when a State-directed fixation with increasing the balance of midwife input had led to quite serious problems in some locations.
8. The view that the State cannot interfere because of the technical independence of Victorian hospitals does not seem to prevent a high degree of direction going out from the DHSV which affects every aspect of rural hospital function. Were the State to adopt a more proactive approach to the provision of rural obstetric services, it is highly unlikely that anyone would object. There are also ways and means of providing inducement.
9. Given the generational change towards less working hours and better quality of life, the Generalist/Midwife collaborative model of Obstetrics is likely to find a natural place in rural units. At the present, with older and newer style obstetricians and midwives mixed in most locations, it takes time and tact to negotiate a satisfactory formula.
10. The RDAV has offered its services to locations in difficulty and showing interest in the Kilmore model. Currently Colac is being assisted, but no traction has so far been obtained in Sale, both locations urgently needing revision of model used. The attached paper makes it clear that certain rules have to be observed for the model to work. The model has been communicated to the Maternity and Newborn Clinical Network.
11. We know that travelling time in excess of 30 minutes is highly likely to increase maternal and perinatal mortality. (A UK study demonstrated that every extra 10 Km of distance in general ambulance transfers has a discernible effect on mortality.) We have been forced to propose a maximum time limit of 60 minutes travel in labour. Remember that this is time from home to hospital which can be more than the distance between towns because of population that live the wrong side of town.
12. What the population/travel quotient might be is difficult to say but in general you would be pretty uncomfortable about a closely spaced population of 5,000 living more than one hour from the nearest maternity service with 60-70 or so births a year. We have not performed population studies in Victoria but we might well be close to such levels in some areas. The Maps (attachment) show how sparse the network is becoming.
13. The Review paper laudably comments on the importance of obstetrics in community life. In rural towns Births have been structurally integral to the operation of community. This alas is being totally lost.
14. Young mothers are a vulnerable population with little political say. Although obstetric mishaps get good press coverage, in rural this is rarely translated into action when it has resulted from a lack of local service legitimately required.

15. The provision of services needs to be divorced from politics and hence needs to be Federally determined.
  - a. Proper demographic survey of needs is required
  - b. Very long term plans (10 years) are then needed to repair defects and preserve services
  - c. Only affirmative processes will provide a recruitment gradient into rural.
  - d. The popularity of the Queensland rural Generalist pathway (presented 2008 ACRRM/RDAA conference) offers hope that Doctors are still interested in a rural career provided requisite training and remuneration are provided. This model could be encouraged through the Health Ministers Conference. It still requires political overview to ensure the FACRRM gains AMC approval and is expanded further to its full potential to absorb uncommitted doctors with good relevant experience, and that rural generalists are recognised in the National Registration process.
  - e. The rural Midwife workforce requires the same kind of attention. It is suggested there be an immediate moratorium on all midwife training fees and that work begin to providing State rural midwife salary scale.
16. The previous federal administration introduced some measures to improve rural GP retention.
  - a. Interestingly the rural retention payment has been greatly valued by rural doctors as 'recognition' indicating or confirming that they have felt undervalued.
  - b. Recognition has been identified as a high priority by the Queensland administration, which is intent on gaining recognition by the Queensland Medical Board for Fellowships accepted for the Rural Generalist pathway.
  - c. The debate with Tony Abbott over the Obstetric retention payment was not resolved by the time of the election. RDAA held out for a substantial payment for anyone significantly involved in an obstetric roster but the Department wanted higher volume doctors to be paid more
  - d. This ignored the fact that some doctors are able to attract more clients , that midwives conduct a significant part of the work, and the purpose of grants should be primarily to attract sufficient doctors to fill rosters.
17. It is an unfortunate fact that despite many federal financial measures, Australian doctors have not been attracted into the rural sector. The innovations in Queensland are therefore of great interest. We feel that these innovations are sufficiently advanced to merit COAG and/or Health Ministers conference consideration. What is needed most of all is changes in attitude, in doctors towards rural, in administrations towards doctors, and in the public towards administrations and doctors. The credibility of rural doctors probably does need some restoration but this will first need measures to restore the Australian trained workforce. Restoring the rural medical workforce might well be a major underpin to regaining nursing confidence in rural midwifery.
18. The simple crude measure of tripling medical school output will be of no help without workforce reform. Very few Australian graduates have found their way into rural – less than 4%. Worryingly, remaining Australian graduate rural doctors are carrying a disproportionate load of medical education which they will no doubt be asked to increase. The huge increase in graduates will result in vast numbers of specialists, stepping up craft competition with the rural sector as it did in the 1980s. All this will interfere with ability to provide obstetrics.
19. It is therefore imperative that a robust rural workforce be progressively developed Australia-wide to deal ably with all its duties and expectations and able to stand up to traditional competition and manoeuvring by the specialist sector. It is the rural public who deserve and desperately need adequate medical services. The rural agricultural and mining economy require good local medical services to operate effectively.

20. It is a challenging thought that we might be going backwards in rural Australia but unless actions are genuinely strategic rather than political, this process will continue without any doubt. Effective rural affirmative policies need to be bipartisan.

### Attachments

1. Victorian Poverty
2. RDAV Procedural GP Age Profiles
3. 2008 Rural Obstetric locations survey, Maps, Projections '83, '97, '08, '10-15
4. Victorian Rural Collaborative Maternity Care. The Kilmore Model
5. 2007 RDAV Submission to the Ministerial Review of Victorian Public Health Medical Staff: Supplementary paper: Victorian Rural Obstetrics.
6. 2002 RDAV Position Statement on Small Unit Rural Obstetrics
7. References for Position Paper

### 1. Victorian Poverty and Medical Closure

### Attachments

#### % Victorians living in poverty by electorate. Age Newspaper 24.5.05

- **11.1% or more:** All rural Victoria and Gellibrand except below
- **9.6 - 11%:** Calwell, Lalor, Gorton, Maribynong, Melbourne, Wills, Batman, Scullin
- **7.6 - 9.5%:** McEwan\*, Corangemite\*, Hotham, Bruce, Issacs, Dunkley (\*Rural)
- **5.1 – 7.5%:** Casey, LaTrobe, Jagajaga, Menzies, Deakin, Chisolm, Aston, Holt, Ports.
- **5% or less:** Kooyong, Higgins, Goldstein

NB. Henderson half average poverty line = ½ average equivalent disposable household income for a standard household.



#### **First (worst) quintiles of Victorian poverty by postcode. Jesuit studies 2003**

3242 Birregurra\*\*; 3322 Cressey; 3324 Lismore\*\*; 3333 Meredith; 3360 Linton; 3370 Clunes\*\*; 3371 Talbot (Clunes hospital); 3412 Goroke; 3424 Jeparit\*; 3475 Bealiba; 3448 Elphinstone; 3462 Newstead; 3467 Avoca\*\*; 3472 Bet Bet; 3518 Wedderburn\*\*; 3523 Heathcote\*; 3563 Lockington; 3580 Koondrook (Barham hospital\*); 3594 Nyah (Nyah West Hospital); 3595 Nyah West\*\*; 3612 Rushworth; 3821 Neerim\*; 3833 Noojee; 3887 Nowa Nowa; 3889 Cape Conran. \*\*Hospital closed; \*Loss of Hospital Services.

#### **Locations (25) with full acute bed closure since 1990:**

Kooweerup, Rutherglen, Chiltern, Rutherglen, Eildon, Tongala, Rushworth, Maldon, Dunolly, Clunes, Trentham, Lismore, Mortlake, Cobden, Birregurra, Beeac, Koroit, Avoca, Lake Bolac, Beulah, Natimuk, Pyramid Hill, Wedderburn, Redcliffes, Murrayville.

**Towns classed in 2000 as providing after-hours care but currently having-non resident doctors: (9)** Murtoa\*, Willaura\*, Skipton, Rainbow\*, Chiltern, Lismore, Mortlake, Birregurra, Beeac, (Boort recently reinstated) \*still have beds.

## 2. RDAV Procedural GP Age Profiles

[Attachments](#)

**GP proceduralists in Rural Victoria 2006** (Obstetrics, Anaesthesia or dual) by age and sex.

Age	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	Total
M/F	0/2	5/4	11/3	29/5	40/8	44/4	24/1	11/0	163/27

**GP Obstetricians in Rural Victoria 2006** by Age and Sex

Age	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	Total	Grand Total
M/F	0/2	3/3	7/3	20/3	36/6	37/3	17/1	11/0	131/21	152

**GP Obstetricians in Rural Victoria 2004 and 2006** Compared to show attrition

Age	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	Total
04/06	2/2	8/6	15/10	39/27	42/42	35/40	17/17	9/11	167/155

**GP Anaesthetists in Rural Victoria 2006** by Age and Sex

Age	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	Total	Grand Total
M/F	0/0	2/0	8/1	16/1	22/4	30/1	12/1	8/0	98/8	106

**GP Anaesthetists in Rural Victoria 2004 and 2006** Compared to show attrition

Age	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	Total
04/06	0/0	4/2	19/9	22/17	25/26	25/31	17/13	6/8	118/106

**Specialist Obstetricians in Rural Victoria 2004 and 2006** Compared to show attrition

Age	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	Total
04/06		1/1	3/1	5/6	2/3	12/7	3/8	6/7	32/32

[Attachments](#)

## 3. 2008 Rural Obstetric locations survey, Maps, Projections '83, '97, '08, 2010-15

**Obstetric Units closed since 1983: (88):**

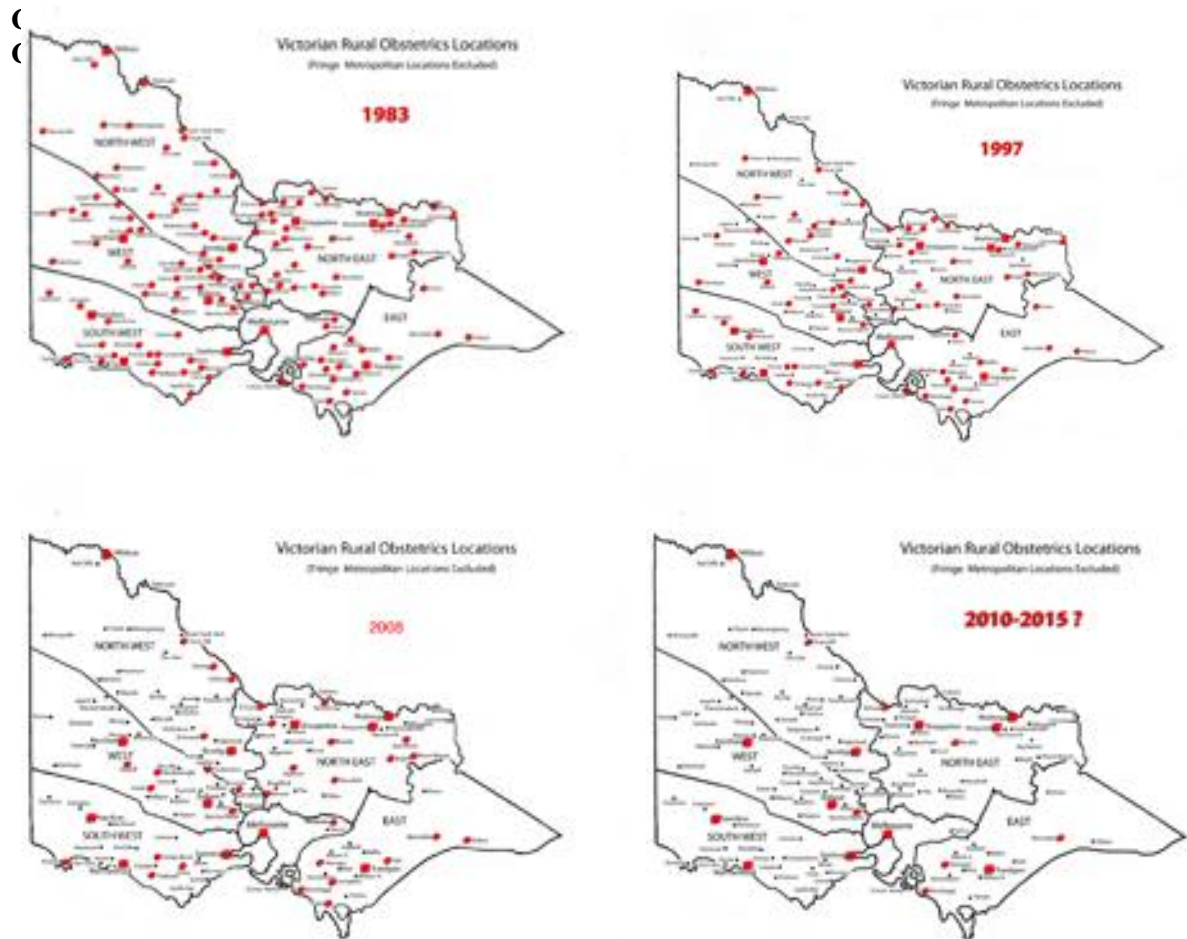
Alexander, Apollo Bay, Avoca, Ballan, Beechworth, Beulah, Beeac, Birchip, Birregurra, Boort, Casterton, Charlton, Clunes, Cobram, Coleraine, Corryong, Cowes, Creswick, Dimboola, Donald, Dunolly, Eildon, Edenhope, Elmore, Euroa, Gisborne Heyfield, Heywood, Hopetoun, Inglewood, Jeparit, Kaniva, Kooweerup, Koroit, Korrumburra, Lancefield, Lismore, Lorne, MacCarthur, Maffra, Maldon, Manangatang, Minyip, Mirboo Nth, Moe, Mortlake, Murchison, Murrayville, Murtoa, Nagambie, Nathalia, Natimuk, Neerim South, Nhill, Numurkah, Nyah West, Omeo, Orbost, Ouyen, Penshurst, Port Fairy, Pyramid Hill, Rainbow, Redcliffes, Robinvale, Rochester, Rupanyip, Sea Lake, Seymour, Skipton, Sunbury, Talangatta, Tatura, Terang, Timboon, Tongala, Trentham, Walwa, Warley, Warracknabeal, Wycheproof, Wedderburn, Willaura, Yackandanda, Yarra junction, Yarram, Yea.

**Obstetric Units closed since 1997: (37):**

Alexander, Beechworth, Birchip, Boort, Casterton, Charlton, Cobram, Coleraine, Corryong, Cowes, Creswick, Dimboola, Donald, Edenhope, Hopetoun, Korrumburra, Lorne, Maffra, Maldon, Nathalia, Nhill, Numurka, Omeo, Ouyen, Penshurst, Port Fairy, Rosebud, Rupanyip, Seymour, Talangatta, Tatura, Terang, Timboon, Warracknabeal, Wycheproof, Yarram, Yea.

**Obstetric locations still open (42):**

- **Small 5:** Bright, Castlemaine, Daylesford, Healesville, Mt Beauty, St Arnaud
- **Medium:** 22: Ararat, Benalla, Camperdown, Castlemaine, Cohuna, Colac, Foster, Kerang, Kilmore, Kyabram, Kyneton, Leongatha, Mansfield, Seymour (just reopened), Maryborough, Myrtleford, Orbost (intermittently operational), Portland, Stawell, Wonthaggi, Yarrawonga.
- **Larger Centre:** 9: Bacchus Marsh, Bairnsdale, Echuca, Hamilton, Horsham, Kilmore, Sale, Swan Hill, Warragul.
- **Regional/Subregional:** 8: Ballarat, Bendigo, Mildura, Shepparton, Traralgon, Wangaratta, Warrnambool, Wodonga.



**Note:**

The 2010 predictions are based on centre by centre networked information based on age and individuals, combined with current workforce supply status. Apologies for blurring of detail. Good images available on request.

4. **Victorian Rural Collaborative Maternity Care. The Kilmore Model. Feb 2008**

[Attachments](#)

**John Griffiths. GP Obstetrician Kilmore**  
**Mike Moynihan. GP Obstetrician Swan Hill**

1. **Preamble**
2. **The Kilmore Model**
3. **The Results of the Kilmore Model to date**

**1. Preamble:**

For a variety of reasons approximately 90 obstetric units have closed in rural Victoria since 1983. Shortage of GP obstetricians and midwives has been only one factor. Often locally resident GPs have been available and remain in the locale to continue their community practice and have been lost to the obstetric pool.

Because of a general State and National lack of commitment to rural medicine, which is possibly, but slowly, being addressed, very few rural obstetricians have been trained in the last 20 years. As a result the Victorian pool of GP Obstetricians, as in other States, is ageing and depleted.

At the same time, there has been no replenishment of the pool of rural midwives because of expense of training, and the single certificate approach. Additionally, newly trained midwives, who are trained to deliver babies rather than only assist the doctor to do so, often find rural practice dissatisfying.

In Kilmore, these factors, combined with a lack of GPs available to do obstetrics, combined with availability of some specialists willing to offer occasional on-call, led to the development of a collaborative model which all have found satisfying, has been safe in terms of outcomes, and has proved extraordinarily successful in reversing consumer drift to Melbourne

This model has much to suggest and commend itself to other locations in rural Victoria, as a vehicle for the survival of rural obstetrics which currently faces extinction in the next 5-10 years.

In rural, stand-alone midwifery and home birthing pose substantial risk. The turn-around in Kilmore suggests that a large cohort of mothers find collaborative care as attractive as specialist care, and that this model could well bolster the numbers of mothers delivering in local units which currently are experiencing consumer drift from GP-midwifery.

This collaborative model overcomes traditional differences between midwives and obstetricians. It fosters qualities and intellectual attributes imbedded in GPs and midwives by virtue of their training in other disciplines and areas of expertise and gives the unit great depth to draw upon. In essence it closely resembles the traditional UK model.

It may will not initially suit Obstetricians who wish to continue a model of GP-midwife care and personally deliver all the mothers, but as most are ageing they could at this stage review their practice and evaluate the model's potential for the future survival of obstetrics in their community. The model has been found to be fully satisfying to participating mothers, and delivers to obstetricians and midwives fulfilment in their practice, safe working hours, adequate remuneration and much better sleep.

## 2. The Kilmore Model

[Attachments](#)

**Mission statement of the Kilmore birthing unit.** “The responsibility for birth is a shared one. It includes the individual woman, her family, caregivers and the service providers”

### **Establishment of the unit**

- The Unit is established according to clearly defined guidelines. It is envisaged that similar units will develop their own modified protocols. Documents, protocols and procedures are therefore created for the particular needs of the unit
- Very small units will not be able to fully carry out the recommendations of this document but can evolve
- The unit and its workings are endorsed by the hospital’s committee of management. A budget with due process is allocated. There is a report in the annual yearly report of the hospital. Proper support is required for the working of the unit by the administration of the hospital. An audit process is established. The unit participates in the quality improvement process of the hospital.
- The aims of the unit are provision of safe and effective, family focussed maternity care, utilising the full potential of midwives and obstetricians, whether specialist or GP, ensuring safe working hours and providing proper recompense. The orientation of each group is recognised and channelled to further the aims of the unit by working as a team.

### **Management of the whole pregnancy and aftermath**

- Responsibility for the process through to the end of the puerperium is shared by the team rather than attachment to particular doctors. GP recompense is based on involvement rather than attendance. This allows efficient use of GP obstetrician manpower and enables non-obstetric GPs to refer their own patients without fear of transfer of allegiance.
- Women may choose midwife or doctor delivery but not which doctor or midwife.
- Antenatal care is in a stand-alone clinic attended by the duty GP obstetrician working collaboratively with midwives. Especially where there is more than one practice in town, this is best located in the hospital for ease of functioning and to emphasise its status as a referral-from-GP unit. Adherence is kept to standard ordering of tests and monitoring protocols. The clinic has a defined childbirth education role. This unit can be attended by doctors participating in shared antenatal care; it is increasingly the practice for shared-care doctors to be accredited.
- To optimise outcomes, induction of labour is strictly on clinical grounds. The doctor on call is responsible for the child birth. Attendance at the delivery is on a basis of clinical need. Midwives are trained in neonatal-resuscitation pending arrival of the GP in cases of compromise. Where Specialists are involved it is also on an as-needed basis.
- Protocols are evidence-based
- Protocols for the management of higher risk pregnancies will reflect the capabilities and degree of isolation of the unit
- It is recognised that there is no fully satisfactory answer to the problems of isolation and transport

## [Attachments](#)

### **Payment of workers**

- The payment of obstetricians evolves as the unit is developed and adjusted as the unit evolves. A starting point can be for aggregate fees for intrapartum care among the participants are divided according to the number of days on call per month. The next section details current arrangements at Kilmore. A doctor who makes him/herself available, consults and takes responsibility, but has few or no deliveries, is still fairly remunerated.
- The unit has to evolve disincentives for Obstetricians to induce labour for rostering convenience, and incentives for the hospital to call Obstetricians if there is any uncertainty
- Payment of PIP incentives to GP obstetrician participants continues directly from the Commonwealth on certification from the unit
- Proper payment must be made to GPs and midwives attending the antenatal unit. It is essential that the attendance of the GPO in smaller clinics is financially worthwhile.
- However use of Medicare rebates in the antenatal clinic has not so far been established. In busier units the GP doesn't want or need to see every mother. Smaller units may need every mother to be bulk-billed to create financial viability for the attending GP.
- The clinic needs to be able to operate on the same level as Community GP and nurse midwives allowed to perform antenatal services unsupervised. This needs to be investigated and negotiated by RDAA

### **Building and maintaining Unit capability**

Unit capability has to be assessed taking into account the pre-existing skills of midwife and GP participants.

- It can be seen that where midwives are not taking full responsibility for normal births they will need up-skilling. Midwives in general will need systematic improvement of neonatal resuscitation skills.
- It has to be recognised that GPs rely on hands-on involvement to maintain their own skills and 'sense' of the direction of a particular labour. This particularly applies to younger GPs who also require opportunities to conduct normal deliveries.
- GP Obstetricians or local surgeons with Caesarean capability and GP anaesthetists with epidural capability should be on hand at all times.

## [Attachments](#)

### **Operation of the Unit**

- Operation of the unit is overseen by a standing committee. This must be in place from the outset but has a flexible structure as the unit evolves
- The Unit director is desirably a community G.P clinician with ability to facilitate balance between midwives and obstetricians. This person is the lynchpin of the unit and acts as a mediator and lighthouse, and must have genuine authority. This requirement is the most reliable means of assuring participation and cooperation of available obstetricians and should only be bypassed if no candidate is available. In particular he has to be able to sell adjustments to the financial structure.

- This paper makes the point that rural GP proceduralists are trained to and operate at a level comparable with specialists over a wide range of the medical spectrum. To be retained in the rural sector for activities such as obstetrics they have to be accorded a commensurate degree of respect and involvement. Otherwise they have an increasing variety of other opportunities open to them.
- In the absence or unavailability of a lead GP Obstetrician, the lead midwife, presumably the hospital maternity unit manager, manages the committee
- It is observed that day to day management of the maternity unit is a separate though closely related issue
- Regular meetings of the committee are held bimonthly
- Additional representation on the committee is consumer (especially important in the early stages for community networking) and ancillary medical, including social worker and dietician/diabetic educator .
- Role of senior hospital administration
- The formation and administration of the roster is overseen by the lead obstetrician and lead midwife together
- Obstetrician in Kilmore have participated according to predilection. A senior may go 2<sup>nd</sup> on call for a junior, and this is a good way to keep seniors involved. Adjustments to the financial structure are made.
- All workers participating in the unit have their credentials checked and are given clinical privileges to work on the unit. Director and lead midwife are on the selection panel for staff and clinicians along with Director of Nursing and Director of Medical Services.
- Midwives on the unit have a defined scope of practice.
- New members of the team, including obstetricians and trainees, are given orientation. Mechanisms are established to ensure that doctors and midwives are given or obtain necessary initial and ongoing education
- Reliable means of communication are established including weekly and other bulletins. If possible all members of the unit have daily accessed emails

#### **Promotion of the unit**

- The unit is able to advertise, which is not the case with individual doctors.
- For medicolegal reasons, transparency is essential in regard to what services are available, when not available and what the limitations of the unit might be.

#### **Medical Indemnity**

- Midwives are indemnified by the Hospital through the Victorian Managed Insurance agency, which is the State insurer. Most rural GPs are also separately insured with VMIA as well as enjoying public hospital cover though some make their own additional arrangements with other insurers. The VMIA enjoys regular liaison and advice from the RDAV
- The VMIA does not at this time have concerns about the safety and risk of rural obstetrics, and State and National consensus has been growing since 1983 with regards the proven safety of rural obstetrics
- Midwives on the unit have a defined scope of practice. This is not necessarily restrictive but because the doctor is taking nominal responsibility, the doctor and by implication, the doctor's Medical Defence Organisation, must have the reassurance that there is a midwife scope of practice appropriate to the individual midwife's level of expertise and accreditation.

- Active risk management. What may be best practice in a larger centre or teaching hospital where most nurses and doctors receive their basic training may not be appropriate in a rural setting.

#### **Future wish-list**

- Software for unit auditing
- Dedicated funding for flexible rural midwife training
- Increased ARSP training for rural GP aspirants, which requires culture change in some teaching hospitals
- Improved affirmative input from rural Directors of Medical Services
- Improved rural obstetric outcomes data collection
- Medical postgraduate year 1 and 2 rural maternity attachments
- Data collection about the activities of procedural GPs and recommendations to DHS particularly

#### Attachments

### **3. The Results of the Kilmore Model to date**

The unit serves a population of about 10,000, 60 Km from the centre of Melbourne. In 1996 there had been considerable consumer drift to Melbourne Hospitals, only 1/5 of mothers delivering locally, and this was considered to be not in their best interests.

An antenatal clinic and collaborative obstetric care model were set up in November 1997 currently with midwives, and 2 each GP obstetricians, specialist obstetricians, and shared care GPs. There was substantial response within weeks and the unit has thrived ever since. The clinic also hosts midwife and medical students.

The clinic is open 5/14 and sees up to 100 mothers during this period. A booking in clinic (45 – 60 minute bookings) is held on Tuesdays, antenatal care on Wednesdays, and first time obstetrician visits alternate Thursdays. On other days antenatal care is available at the hospital maternity unit. Interval review and follow of results is by midwives in consultation with duty GP obstetricians.

Necessary up-skilling has occurred. The confidence of the nursing staff has grown so that they will conduct normal deliveries in the absence of the doctor but be ready to call for help usually in a timely manner when progression to delivery is not smooth. GP up-skilling to perform Caesarean section has occurred.

Maternal satisfaction surveys have been very encouraging. The staff of the unit have also been positive about their experience. Relevant aspects have been felt to be good communication, risk management, regular meetings with case audit, multidisciplinary team effort with GP leadership, supportive culture, joint educational activities, evidence based practice and comprehensive, accessible records.

Deliveries at Kilmore rose from 85 in 1995 to 165 in 1997 and, despite attempted capping of bookings in 2003, to 235 in 2004, with further absorption of the overflow in 2005 onwards from the closure at Seymour. Intrapartum transfers have been substantially reduced. No incidents have been reported back to the unit from LAOS (Limited adverse occurrence screening).

Difficulties for Kilmore have been theatre availability often only 5/7, staff shortages, and necessity for the 2<sup>nd</sup> back-up midwife to be employed in other skill areas.

The financial model for paying doctors has been subject to changes and is expected to be further experimented with. Previously the total fees for births occurring were totalled and divided between participating doctors according to the time spent on call. Currently a satisfactory 24 hour stipend is provided for being on call, and a delivery fee is paid if the doctor attends the confinement. A 50% addition is made to the fee for instrumental delivery, Caesarean section, retained placenta, 3<sup>rd</sup> degree tear repair and so on. Aims are to maintain incentive for the hospital to call the doctor in, and disincentives for doctors to induce labour to fit in with their own period of on-call

Involvement of the Community, the Hospital Board of Management, with support from local politicians were all felt to be useful in the inception of the project. A public launch generates necessary interest. It is felt that seeding money would have been useful, that the Regional Health office should have been brought onside at the beginning, and that better recognition of the lead GP and midwife should have been implemented. Funding of the antenatal clinic, a fundamental lead-in to success of the process, remains a problem and may require negotiation with HIC. The Division of General Practice was not involved but this could have been a consideration.

### References

**Salkeld, Jennifer.** Collaborative Care Model for Midwifery, Kilmore and District Hospital. Outback.doc. Vol 2 Iss 2 April-June 2005

**Griffiths, John.** Collaborative Care in Birthing, Kilmore model. Developing and implementing a model of collaborative care in rural birthing. Presentation to Australian College of Midwives' conference 20.11.06

### [Attachments](#)

#### 5. **2007 Submission to the Ministerial Review of Victorian Public Health Medical Staff: Victorian Rural Obstetrics.**

(2007 Rural doctors' Association of Victoria (RDV: www.rdv.com.au)  
Submission to the Ministerial Review of Victorian Public Health Medical Staff:  
The Victorian Rural Hospital Sector. Discussion paper No 11.)

There is steady attrition of Obstetric units since 1983. 88 have closed, 35 since 1997 (Table below). We expect that without significant measures the number of units to drop to 20 or less by 2015. The situation now requires mothers to travel up to and in excess of one hour in labour. There are many in-transit, roadside, and small (non-obstetric) deliveries occurring. This may decrease as mothers become more savvy, but short of taking up residence in the target town from 34 weeks, there will still be a significant number, with ongoing risk for premature labour and other mishap. Maps for 1983, 1997 and a projection to 2010-15 are attached

The closure of units has been due to retirement of GPs and midwives, loss of administrative will, and decreased Board determination. Small unit size however small has been found to have no impact on outcomes. Bereft of expert advice in the absence of GP VMO members, rural Hospital Boards have made some extraordinary decisions, for example to provide part time stand alone obstetric services, or to exclude VMOs from obstetrics 'except in emergencies'. Such decisions have led to closure when the hospital has lost the confidence of the VMOs.

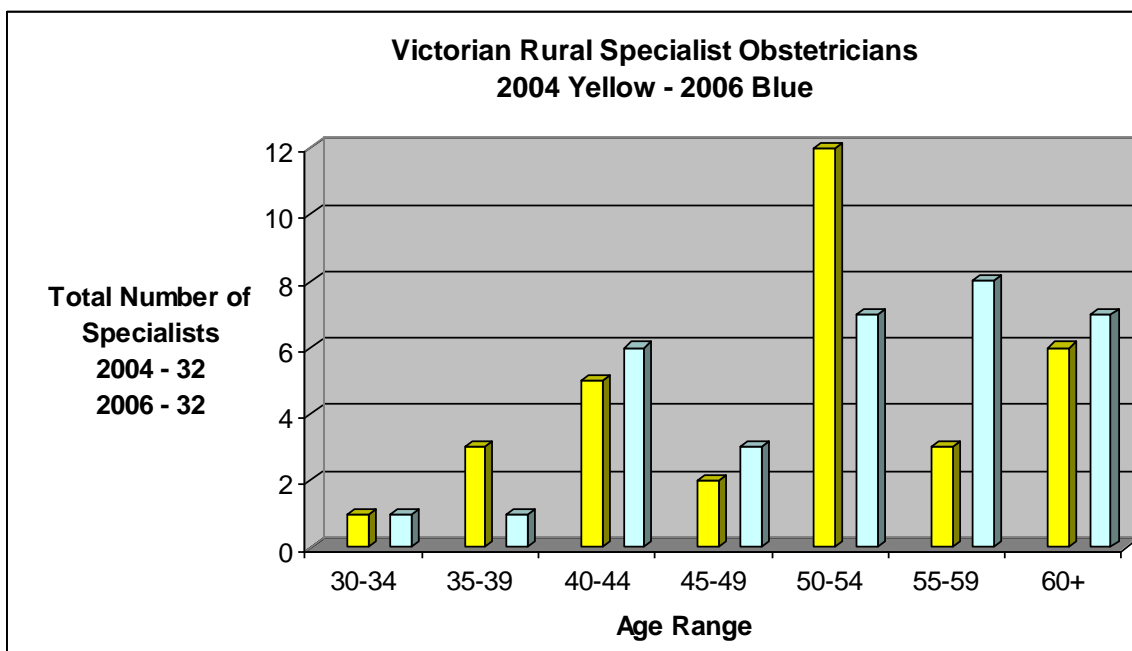
Whilst a semblance of a network has been preserved, the closure of larger units is now threatened, with Portland, Stawell, Kilmore and the Corangemite managed network (Camperdown, Timboon and Terang), currently threatened. Horsham, Hamilton, Portland and Swan Hill, otherwise precarious, have been lucky to find GP obstetricians native to or transiting through South Africa. In the next 5 years, Colac, Benalla and Kyabram are expected to feel pressure.

Cooperative arrangements for obstetrics are in operation in the Corangemite managed network (Camperdown, Timboon and Terang), between Stawell and Ararat, and between Foster and Wonthaggi. Unless Stawell recruits 2 obstetricians this year, services will cease, putting pressure on Ararat.

Pressure on doctors is eased by gaining acceptance for midwife obstetrics for normal deliveries, reserving medical input from for intervention or for patient choice. Collaborative models between midwives and doctors are essential but tensions and disagreements are actually rare.. An effective roster requires 3-4 Obstetricians and Anaesthetists. When some of these are dual qualified (these will start to phase out) or married, rostering can be tricky but not insuperable, requiring locums on occasion.

### Rural Victorian Specialist Obstetricians

Indications are that Specialist Obstetricians for all but very large rural hospitals will only be found overseas. Surveys of new graduates demonstrate a reluctance overall towards Obstetric rather than Gynaecological practice. The appendix gives details of ageing and supply, indicating quite rapid attrition. Obstetricians have to maintain themselves through Gynaecological practice and depend on referrals from GPs. GPs will not refer locally unless competence is perceived from outcomes and patient satisfaction. Good service can be obtained from fully Australian trained visiting specialists



## **Rural Locations with specialist Obstetricians 2006 (Mourik)**

### **GPO = GP Obstetrician**

Ballarat	4, (66,55,52,40) one near retirement 'just managing';	1 GPO
Bendigo	4 (62,60,53,43) (one public only) 'concerned' 62, 60, 53, 42;	1 GPO
Hamilton	1 (56) 'not likely to attract replacement'	2 GPO
Horsham	1 (?age) having second thoughts, doing locums elsewhere.	2 GPO
Kyneton	1 (67)	2 GPO
Mildura	3 (58,55,51,45)	0 GPO
Sale	3 (54,52,45)	3 GPO
Shepparton	3 (62,44,40) 'problems anticipated';	0 GPO
Traralgon	2 (65,58) + locum cover 'serious situation'	5 GPO
Wangaratta	2 (55,55) both 'burnt out', 1 OTD 'staff obstetrician', rely on locums	0 GPO
Warragul	2 (50,46) 'problems before long'	3 GPO
Warrnambool	3 but 2 female part time (55,53,41)	3 GPO
Wodonga	4 (55,53,41,?) FT, + 1 Part time, (Mansfield, Portland Nil – recently retired)	12 GPO

All units outside of the main Base Hospitals of Geelong, Ballarat, Bendigo, Shepparton and Albury-Wodonga are expected to remain under increasing pressure. In the worst scenario only these major units would be able to sustain obstetrics.

### [Attachments](#)

### **GP Training**

At present 5 advanced one year GP obstetric training positions (ARSP) are operant through the Regional registrar training programs based in Bendigo, North East, Morwell and Warrnambool. Current posts are Wodonga (funded from NSW), Shepparton, Bendigo, Ballarat, Warrnambool, Warragul and Sale. They are State funded and will be increased from 5 to 8 in 2008. It is not enough merely to train. An expectation of a fair deal has to be created during the student and registrar years, and the experience once in practice has to match up to this. More could be made available by utilizing HO posts currently filled with GPs intending only to practice antenatal care, for whom a 3 month training experience would be more appropriate.

It must be stressed that for retention of rural obstetricians, a rural dimension is desirable through student, registrar and ARSP training. A dedicated training pathway such as the FACRRM is preferable, and the Gippsland model of interspersing procedural training through the 4 registrar years offers great promise.

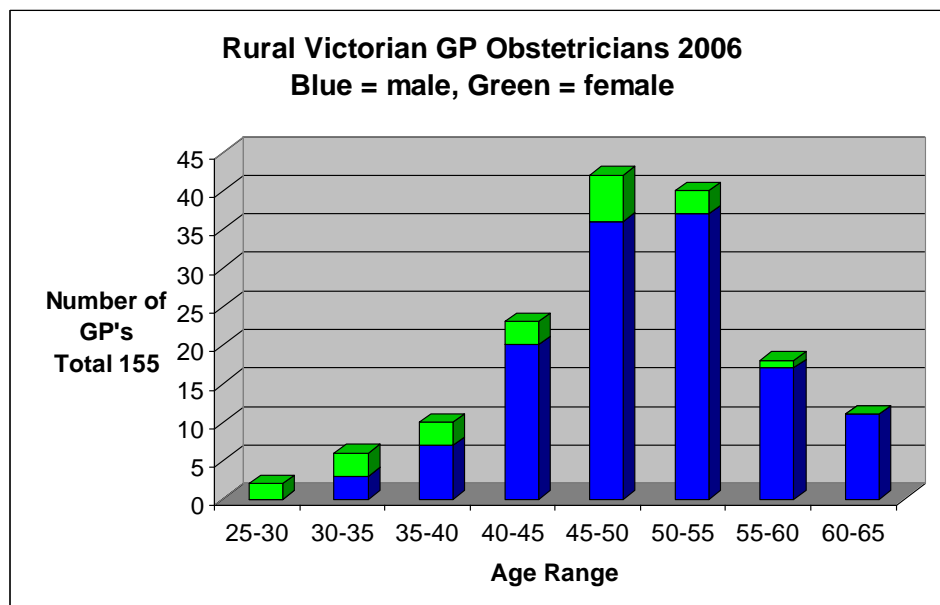
### **GP Obstetrician Workforce**

The appendix suggests that a significant part of the current workforce will be phasing out in 5-10 years, and that there has been very little input for the last 15. Attrition has been ameliorated through recruitment of IMGs. This source has considerably diminished the last few years and only a proportion continue in procedural practice. Attrition will continue at best at 5 per year and at worst 10. It will be essential for all graduates of the program to work in Victoria, and can be a tricky business to accomplish. We would prefer the number to be 10-12.

The Wodonga experience (currently 12 GPOs) shows that with proper encouragement it can be easy to recruit GPs to obstetric practice. It has been a location specific problem when GPs have in the larger towns gone out of practice in large numbers over the last 10 years. GPs are quite capable of working at registrar level in Obstetrics (as currently in a number of Group B hospitals) on a part time basis, implementing intervention up to and including Caesarean section. Regrettably Wodonga seems to be determined to move away from this model. GP Obstetricians in Warrnambool have also been given 3 months notice we understand.

A review of the Obstetric workforce State-wide would be indicated to establish where the obstetricians are going to come from in the future, and what if any the potential role for GP obstetricians is in all areas. The requirements for GPs to have the Diploma in Obstetric simply to practice community antenatal care is excessive, and means that funded potential positions for training for GP intra-partum care are being blocked.

IMGs have been required to sit the FRACGP, a community based degree, to gain permanent Australian residence and Vocational recognition. Apart from distracting from CPD for maintenance and development of procedural skills, this has resulted in a considerable number of IMGs with obstetric skills on-locating to community practice in fringe metropolitan areas in mainly Sydney, Perth and Melbourne once it is achieved.



**GP Obstetricians:**

155 including 62 who are also GP anaesthetists.

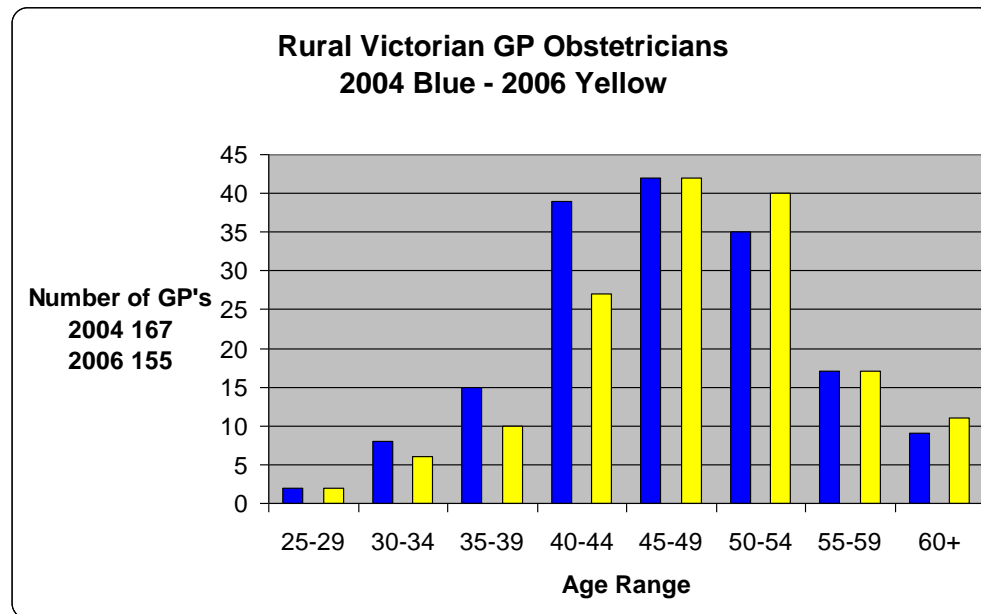
5-10 retiring per annum

Current Shortfall approx 50

Currently in training in State 4, females showing encouraging participation

South Africa derived IMGs very significant in some locations especially Hamilton, Horsham, Ararat, Maryborough, and Swan Hill.

**The age break-up between 2004 and 2006 showed some worrying deterioration**



**Victorian remaining Rural Obstetric Locations (in Bold, with GPO and SO numbers, and 2005 deliveries in brackets)**

Alexandra DH (15)	Heywood RH	Sea Lake DandH
Apollo Bay	Inglewood DandHS	Seymour DMH (183)
<b>Ararat (3) (102)</b>	Jeparit	Skipton
<b>Bacchus Marsh (4)(418)</b>	Kaniva	<b>Stawell RH (4) (82)</b>
<b>Bairnsdale (8) (294)</b>	<b>Kerang DH (3) (81)</b>	<b>St Arnaud (1) (5)</b>
Birchip	<b>Kilmore and DH (1) (2 Vis SO) (153)</b>	<b>Swan Hill (7) (250)</b>
Ballan DHC	KooweerupRHS	Tallangatta HS
Beaufort	Korumburra,	Tatura
Beechworth HS	<b>Kyabram and DHS (4) (176)</b>	<b>Terang (3) (39)</b>
<b>Benalla Dand MH (8) (132)</b>	<b>Kyneton DHS (3) (133)</b>	<b>Timboon and DHS (2) (67)</b>
Boort DH	<b>Leongatha MH (3)(213)</b>	<b>Traralgon (4) (1 SO) (1352)</b>
<b>Bright (2) (20)</b>	Lorne CH	Walwa BNH
<b>Camperdown (4) (52)</b>	Maffra	Wangaratta (EM shift only) (513)
Casterton MH	Maldon H	Warley H
<b>Castlemaine (5) (66)</b>	Manangatang and DH	Warracknabeal
Charlton	<b>Mansfield DH (4) (58)</b>	<b>Warragul (3) (2 SO) (442)</b>
Cobden DHS	<b>Maryborough (3)(106)</b>	<b>Warrnambool (5) (3 SO)(513)</b>
Cobram DH	<b>Mt Beauty (4) (6)</b>	Winchelsea
<b>Cohuna DH (1) (56)</b>	<b>Myrtleford (3) (53)</b>	Willaura
<b>Colac Area H (1) (173)</b>	Nagambie H	<b>Wodonga (12) (4 SO) (674)</b>
Coleraine	Nathalia DH	<b>Wonthaggi (5) (137)</b>
Corryong	Neerim D Soldiers Memorial H	Wycheproof
Creswick DH	Nhill	Yackandanda BNH
<b>Daylesford DH (3) (34)</b>	Numurka DandHS (63)	Yarram and DHS
Dimboola DH	Omeo DH	<b>Yarrawonga DHS (4) (82)</b>
Donald	<b>Orbost RH (1) (45)</b>	Yea and DM
Dunolly	Ouyen	
<b>Echuca (7) (334)</b>	Penshurst DandMH	
Edenhope and DH (8)	Port Fairy	
Euroa H	<b>Portland DH (2) (180)</b>	
<b>Foster (4) (75)</b>	Rainbow	
<b>Hamilton (2) (1 SO) (195)</b>	Robinvale DHS	
<b>Healesville (2) (30)</b>	Rochester and Elmore DHS	
Hopetoun	Rupanyip	
<b>Horsham (3) (1 SO) (363)</b>	Rushworth	
Heathcote	<b>Sale (3) (2 SO) (432)</b>	
Heyfield H		

6. Position Statement On Small Unit Rural Obstetrics 2002

February 2002

1. **MAIN STATEMENT** (The material is fully referenced in the second section.)

**The persistent tendency for smaller rural obstetric units to close in Victoria is a significant component of rural rundown.** There were over 40 of 123 unit closures in the years 1983 to 1997<sup>(1)</sup>. Safe confinement facilities close to home are an essential component of viable Australian rural community and economy. Rural viability requires minimum disruption to family life and rural industry. The prime objective of a healthy mother and baby must be met by the safest possible obstetric system. Repeated studies have shown small rural units, however small to have **substantially better outcomes** and are cheaper per confinement than metropolitan or provincial units. The corollary is that closure leads to increasing morbidity and mortality. *There is not and never has been any valid argument for closure of small rural obstetric units on grounds of **safety or smallness**.* The wishes of mothers must be respected and facilities provided.

**There will be a supply of GP obstetricians.** It is the avowed intention of The Australian College of Rural and Remote Medicine (ACRRM) and hence of Regional Rural GP Training programs established under General Practice Education and Training Ltd (GPETL) to train GPs with obstetric capabilities for the bush. In addition to the substantial core of remaining GP obstetricians, there continues to be a substantial supply of obstetrically experienced procedural GPs from overseas, GP Obstetricians however continue to haemorrhage<sup>(2)</sup> from the workforce and in general do not resume obstetric practice, so that every effort has to be made in improving workforce retention. Examination for and maintenance of accreditation in Standards for GP Obstetrics are the responsibility of the Joint Consultative Committee for Obstetrics (RACOG, ACRRM and RACGP).

**Recommendations of the RDAV** – Safety in rural Obstetrics requires the following:

**Recommendation 1. Good access.**

Closer is better, but in excess of one hour is generally accepted as posing unacceptable risk. Where this is the case, the provision of accommodation at the referral centre is desirable as recommended in NSW<sup>(3)</sup>. Travel in labour is highly undesirable especially in multiparous mothers who should desirably spend the two weeks previous to the estimated date of delivery at the intended location of birth. The catastrophic decline in numbers of rural obstetric units has occurred because of planning through politics. There remains a strong case for reappraisal and the establishment of policy to provide units in selected locations, re-establishing where indicated.

**Recommendation 2. Good capability.**

- a. With continuing entry of GPs with a variety of backgrounds into the workforce, **credentialing** of GPs is a matter of judgement. This assessment is best conducted by peers, by the kind of GP that has contributed to the excellent record of rural obstetrics. On no account should it be given to specialists with lack of rural knowledge and/or potential personal or craft conflict of interest.

- b. **Advanced training** in obstetrics and anaesthesia is available during rural GP training to Australian graduates and will accelerate from 2002 on. Refresher courses and attachments are available, but the State Government needs to provide a level of support for ongoing continuing medical education and skills maintenance, to often isolated practitioners, that is at a level that will encourage continuation of this vital service. This level of support is far from adequate in current CME arrangements. The advanced emergency obstetric course ALSO may be available soon.
- c. There is no evidence to support a move away from the **team model of rural obstetrics**. The GP and the midwife share responsibility for the conduct of labour, with the GP taking ultimate responsibility for decisions. To increase flexibility and optimise human resources the midwife could however move to being on call as opposed to being on duty when there are expectant mothers. Importantly, there is potentially an observational and care role for non-midwife nursing staff once mother and child are stable, when the midwife can be on call, as has been recommended for review<sup>(4)</sup>.
- d. Provision of capability for **Caesarean section** is a location by location matter. Provision implies a functional operating theatre in use for elective surgery and stabilisation of emergency cases prior to transportation. The needs of the community are paramount. This area has been addressed by another RDAV policy statement<sup>(5)</sup>. Rural GP skills require a critical mass of inter-related ongoing experience for maintenance. No caesarean capability does not necessarily preclude obstetrics, depending on the location, and this requires review and study. The Monash School of Rural Health could be funded to conduct this. There are locations in Victoria such as Mt Beauty providing safe obstetrics that have never pretended to aspire to Caesarean Section. The presence of a network of hospitals can be a factor in organisation and provision of effective obstetrics. Such key services require more scientific and less political input in determining location than at present. The rationalisation that is occurring in rural care must not allow the enhancement of one community at the expense of another.

**Recommendation 3. Good equipment.**

Up to date anaesthetic and obstetric equipment including tochography, infant resuscitation units and humidicribs are required. Properly negotiated these will usually be funded by the community. Standardisation facilitates the process of on site maintenance.

**Recommendation 4. Good support.**

The State Government has been hugely and justifiably supportive in meeting the cost of indemnity. The public purse needs further protection by according rural obstetrics the profile and respect it deserves by its achievements. To preserve the confidence of the public the Government needs to have better advice on the conduct of malpractice suits. These should be contested where possible and the evidence and situation thoroughly examined. Rural Obstetrics remains a vital necessity and needs to be fully defended. An affirmative Departmental philosophy could be extended to regional and local management to prevent the placing of constraints upon medical and obstetric practice.

## Recommendation 5. Data.

In no State of Australia is it possible to establish patterns of obstetric outcomes based on place of residence. Revision of data collection and computerised databases would make this a relatively easy task. The RDAV is in no doubt as to the validity of previous studies. However there is a need to monitor the effect of widespread closure on mortality patterns at least. For this some retrospective study to about 1985 would be desirable and again School of Rural Health could be funded.

## [Attachments](#)

### 2. SUPPORTING OBSERVATIONS AND DOCUMENTATION

The figures from rural units completely confirm that effective transfer of high risk cases by antenatal screening combined with effective safe obstetric practice has reduced rural perinatal mortality to a minimum. Whereas sophisticated interventions in unexpected and unforeseeable emergencies may save some mortality and morbidity, the overall figure will be offset for rural women in larger units by troubled labour, caused by maternal anxiety, in unknown and distant institutions, with resultant instrumentation and operation, and by mishaps resultant from lengthy transportation during labour. Unassisted and hence much safer labour and childbirth are up to 50% more common in rural units, where the primary attending GP obstetrician is of much greater experience than junior staff in metropolitan and provincial units.

**The 1983 Victorian State Inquiry**<sup>(6)</sup> found a direct ratio of safety to smallness. Units under 50 deliveries a year of any size, even if they deliver less than 25, were found to be extremely safe. *Perinatal mortality was found to double (5.5 to 10.5) in units over 50 and tripled (15.0) in tertiary units.* Bush Nursing Hospital standards were consistently described as “extraordinarily high” in annual reports by Professor Roger Pepperell<sup>(7)</sup>. Judith Lumley studied small unit safety<sup>(8)</sup>, and later chaired the **1990 Ministerial Review of Birthing Services in Victoria**<sup>(4)</sup>. Many rural submissions were received. The report notes (p49): “unlike other places, Victoria has no established policy of closing small units in rural areas” and “the closure of such units is not warranted on safety grounds.” In 1983 Prof. Pepperell (Quoted 6 p6) speculated that it would be difficult to envisage a further reduction (in the perinatal mortality of 5.5 at bush nursing hospitals) “even had the babies been delivered in teaching hospitals”. To gainsay this and emphasise small unit safety the VBNA figure in 1988-9 had fallen to 1.8 while the State rate was still 10.4<sup>(10)</sup>. In 1991 Professor Quinn wrote<sup>(7)</sup> that the VBNA figures were “*unparalleled (ie in the world) and should be noted by Government*”.

Since then Victorian Health Authorities have allowed most of these units to close. The 1998 State perinatal mortality published 2000 was 7.3, achieved at the cost of assisted labour in nearly 50% of women and a caesarean section rate of 21.0%, still four times that of the VBNA in 1988. The figures for larger GP run units are similarly impressive, and equal to those of the best units<sup>(3 and 9)</sup>.

The **NSW 1989 Shearman report**<sup>(11)</sup> likewise found safe maternity care and effective transfer of high risk cases in NSW, significantly noting the much higher rate of completely spontaneous deliveries (75% Vs 54%), which we argue substantially reflects decreased maternal anxiety. The 1993 **Tito Review of Professional Indemnity**<sup>(12)</sup> likewise found a high standard of care in 5950 NSW rural GP confinements, indicating that the community needs to be more aware that rural GPs are providing the “same quality of care as the specialists”.

Young<sup>(13)</sup> studied an isolated unit in Penrith, UK and found that “the low mortality, the low level of intervention and the preference of women all support the retention of isolated units”. Even where there were no referrals, and all 730 mothers *without exception* were delivered locally (Cohuna 1970-80), the perinatal mortality rate was significantly lower than State or National figures, *with a caesarean rate of 2.3%* <sup>(14)</sup>. Comparison studies between outcomes for rural women delivering in their home and at distant hospitals are definitely called for.

In 1983 NSW classified units under 80 deliveries per annum as “**unviable**” and closed 35. The seemingly unremitting bureaucratic hostility to small units at local, regional and State level is hard to fathom. The pleas of communities and the wishes of Mums-to-be are ignored and the matter is left to the next State election. No ongoing appraisal which takes into account past findings seems to exist. There is no interstate or national departmental collaboration. **The view that closure will lead to increased maternal and baby mortality rates** has much to support it <sup>(15)</sup>. A retrospective and continued State database to study this matter should be a priority. *Finance is not an issue*. Shearman<sup>(11)</sup> and others<sup>(13,16, 4p22)</sup> have noted the low cost of small units.

Ultralow perinatal mortality rates in Victoria were achieved by GPs and midwives making decisions unsupervised, taking advice when they saw fit. Any professional guidelines and recommendations therefore should remain just that, and flexibility of local practice must be respected <sup>(15)</sup>. Any bureaucratic interference in local practice is likely to worsen outcomes. The actual need for Caesarian section facilities needs further study <sup>(15)</sup>. To date, reviews e.g. Woollard<sup>(17)</sup> have not suggested a change in figures when Caesarians are not performed. Units such as Mt Beauty have practiced safely for years without the availability of onsite caesarian section by judicious application of clinical principles.

Whereas the supply of GP proceduralists appears to be turning round there seem to be currently lower numbers of qualified midwives in rural areas. (Though units are closing even where there are sufficient of both.) There is widespread sentiment that in small units the 24-hour ward presence of a rostered midwife per se, is not necessary after the process of delivery is completed. On call is sufficient. Certainly this is not obligatory in home births. The legislation does not require it. However the Nursing Council of Victoria, and subsequently the Nursing Board, has insisted that no non-midwife attend in any way a mother lying in <sup>(18)</sup>. *A review of this requirement has been recommended by the Department* <sup>(4, p4)</sup>.

**Rural Obstetric practice, like all rural medicine needs adequate defence.** The wise decision of the State to meet obstetric indemnity costs averted a major crisis in 1996, when rural GPs threatened to withdraw their services. Malpractice suits will however occur from time to time and attract a high profile because of biased perceptions towards rural practice. Such cases need adroit handling to maintain public confidence. This unfortunately did not occur in one case in 2000 when the Victorian State solicitors appear from the information to hand to have failed in their duty to the rural hospital and GP concerned <sup>(18)</sup>. No evidence was presented to the settlement hearing even though the defendants had denied liability, and there was no request for the usual agreed confidentiality, thereby exposing them to public infamy when the ensuing judgment was based solely on the claimants’ allegations.

## SUMMARY

The evidence is unequivocal, there is not, and never has been, any valid argument for closure of small rural obstetric units on grounds of safety or smallness. It is inevitable that such closures will lead to increasing morbidity and mortality for rural women and their babies.

The State Government needs to provide a clear policy direction on this matter to hospital boards and the rural communities they serve, and follow this with funding support to maintain services and facilities. Additionally the State Government needs to ensure appropriate studies are undertaken to investigate these issues, and continue its support of practitioners providing this service with indemnity arrangements and improved assistance for CME.

## Attachments

### 7. REFERENCES for Position Paper

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