

# TRANSCRIPT

## FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

### Inquiry into perinatal services

Melbourne — 16 October 2017

#### Members

Mr Paul Edbrooke — Chair

Ms Cindy McLeish — Deputy Chair

Ms Roma Britnell

Dr Rachel Carling-Jenkins

Ms Chris Couzens

Ms Maree Edwards

Mr Bernie Finn

#### Witnesses

Dr Michael Rasmussen, clinical services director, Mercy Hospital for Women (Mercy Health).

**The CHAIR** — I welcome to these public hearings Dr Michael Rasmussen, clinical services director, from the Mercy Hospital for Women. Thank you for attending here today; we very much appreciate your time. All evidence at this hearing taken by the committee is protected by parliamentary privilege as provided by the Constitution Act 1975 and is subject to the provisions of the Parliamentary Committees Act 2003 and other relevant legislation. Any comments you make outside the hearing will not be afforded such privilege. It is a contempt of Parliament to provide false evidence. These proceedings will be recorded, and you will be sent a proof copy of the transcript. I now invite you, Dr Michael, to make a 10 to 15-minute statement, and we will follow up with some questions.

### **Visual presentation.**

**Dr RASMUSSEN** — Thank you, and do interrupt me if I am running over time. So I am Michael Rasmussen, and I am an obstetrician/gynaecologist. I am the clinical director of obstetrics and gynaecology and paediatrics for the Mercy hospitals which work under the auspices of Mercy Health, which is an Australia-wide charitable organisation.

In terms of women's and children's health and in terms of perinatal services, the Mercy is the Mercy Hospital for Women in Heidelberg and the Werribee Mercy Hospital, operating from two sites quite a distance apart, it has to be said, and that is relevant to how we function. The Mercy Hospital for Women, based in Heidelberg, has a tertiary obstetric and neonatal and gynaecological service, and one of four neonatal intensive care units in the state. It also has a large maternal-fetal medicine or perinatal subspecialist unit. It has the state's first breastmilk bank. It has a telemedicine unit up and running, albeit in its infancy, with regular links with Darwin, of all places, to begin the initiative.

The Mercy serves the state in its tertiary role, but it also serves the region, caring for women with normal births and normal pregnancies living in the area — in the north-east. It is a large teaching hospital and specialist referral centre. It operates in close relationship with the hospital on the left there — the taller building — which is the Austin. We share services with them and meet regularly with them, and our patients move freely from one side to the other. We also work closely with the Northern Hospital in serving the women of the north-eastern corridor. We work closely with GeNE, which is Genetics in the North East, a genetics initiative partnered between Austin, the Mercy and the Northern, and we work closely with our local GPs.

We delivered just under 6000 births in 2016–17. The hospital has the lowest perinatal mortality rate in the state. Werribee Mercy is a general hospital sitting in Melbourne's western corridor. Its history, I am sure, you are aware of — Jeff Kennett tried to close it. That is an abbreviation of the historical events — the community uproar — the community fought to keep a local hospital. The Mercy took it on in the early 90s and it has just absolutely grown dramatically, and continues to grow since. It is a lower level of service: it is a level 4 maternity and neonatal service, so it cares for women at 32 weeks pregnancy and onwards and women without a range of complex obstetric morbidities.

In 2016–17 there were 3700 births at Werribee Mercy Hospital. Werribee works in close relationship with Sunshine, which would be a larger partner in the relationship. It also relies on the Women's and the Mercy hospital in Heidelberg for support for its tertiary services. That is the Werribee today: it is just growing dramatically. The birth numbers have increased 20 per cent year on year, from 2012–13 to 2016–17, and birth numbers that were around 1200 to 1400 just a few years ago are now at 3700. We all have our projections, but it is projected that by 2026 there will be over 5000 births for the hospital to serve. It is of note that the proportion of ineligible patients has risen also, from 1 per cent in 2012–13 to 2.3 per cent in 2016–17.

That is the Werribee Mercy now: the top four floors there are being built. That is new, and is set to open in mid-2018. There are plans for further expansion up above that. As I said, there is a general hospital, so the building you are looking at there will be the general hospital. The obstetric wing is a newer wing out the back.

In terms of the patients we care for, there is undoubtedly increased demand on the obstetric and paediatric service out in Werribee, and we are seeing an increased complexity and morbidity in our patients — increasing incidences of diabetes; obesity in particular is a big issue for us. We only have capability to deal with women up to a certain weight at the moment, and women who exceed that weight have to transfer their care to Sunshine or the Women's or the Mercy. It used to be an uncommon event; now it is a not uncommon event and it is an issue throughout the state.

This hospital does not have a maternal foetal medicine unit, a perinatal subspecialist unit. It utilises Sunshine for that, although the Mercy hospital in Heidelberg is increasingly fulfilling that role, albeit with the tyranny of distance. Our aim as a hospital is to provide the best perinatal, obstetric and paediatric care that we can, with the best outcomes to offer informed choice, evidence-based choice and safe and deliverable choices to our families and women in a health system that is sustainable, deliverable and is going to survive.

We all present in different ways, but just for the purposes of the time available I thought I would highlight some issues that I think are critical for the future. One is access to perinatal services statewide; the other is just to briefly mention the new genetic services that were alluded to by Ryan, and how dramatically that field has changed; to talk about NICU demand, intensive care demand; safety and quality issues; about birth options and choice and consent in obstetrics; and workforce — all important issues.

Firstly, when I say ‘access’, from our hospital we see how critical access to specialist services are. It is critical in rural and remote areas in particular. It is critical in outer suburban and growth areas such as the outer north-east above the Northern Hospital, and in the west we are coping with that growth in increasing demand and complexities that are critical. That is where we more commonly encounter families of non-English speaking backgrounds. Language, communication and health literacy are a huge area in the outer growth corridors. Indigenous families likewise must be guaranteed access. And access to what? Access to specialist perinatal services, especially early on in pregnancy, as Ryan was alluding to.

Just to clarify, those women are receiving care at the moment, but the care is with their GP and often fragmented and less coordinated than it may be under the model Ryan was suggesting. I quite support that initiative to get women into specialist services earlier: access to services for bariatric patients — as I alluded to, to specialist ultrasound because the quality of ultrasound services across the regions does vary enormously; access to genetic services because they are limited; and to subspecialist foetal maternal medicine services. Perinatal mental health — accessibility to that does differ across the state. The promulgation of initiatives to prevent and manage stillbirth is an evolving area and something we need to do together as a state service. Breastfeeding support remains critical.

Domestic violence support — I put there that increasingly we are aware of the importance of pregnancy as a time when domestic violence can declare itself and can be a salvageable situation. At Werribee Mercy we have a lawyer in our outpatients department, which I did not like at the outset but it has actually been a fantastic initiative. We recognise if a family is in need and needs urgent help, there is a lawyer that we can put that family in contact with. There is no mark on the door. It is an anonymous offer, respecting the privacy of the patient — they are often very sensitive situations. That has been a fantastic initiative at Werribee.

The new genetics — when my children were born we did not have an ultrasound; four pregnancies, no ultrasound, and my children are not that old — it has just evolved so rapidly. It has evolved faster than most doctors can keep up with, and it is certainly evolving faster than the public can keep up with. The ability for us to care for a foetus in the uterus is evolving — the ability for us to diagnose an expanding range of conditions, the accuracy of ultrasound — but in particular the field of genetics is exploding in its ability to detect a range of abnormalities, ranging from the lethal to the not-so lethal to marginal impact.

Of course there is a range of conditions that most doctors and patients will know about that lend themselves to genetic testing, but there is a whole new array of genetic conditions that many couples who have had a child born with special needs are not aware of. With modern testing you are able to now detect that there is in fact a genetic abnormality in a sequence of the DNA, and that is something we are able to counsel on, test for, screen for and so forth.

There is this issue in genetics of course of the required versus the possible. I mean, it is possible to do a microarray on every child. It will cost a fortune, and what does it tell you? At the other end of the spectrum there are some antiquated methods that are costing us money. I think finding out where we sit in the spectrum of genetic testing is a critical issue for us all and for the health service. In principle community education in this field of genetics is critical — workforce education too, GP education, midwifery education.

The field of genetics is critical. Women need the best available genetic screening, particularly early in pregnancy. Screening for any foetal abnormalities is normal obstetric practice; 85 per cent of women avail of some form of screening test for genetic problems. The test that they receive will vary across the state according

to their access to services. It will vary according to their ability to self-fund the more recently available testing, such as NIPT. We would always be pushing for uniformity of practice in that area.

Access to second-line specialist confirmation is important. Support for women with a diagnosed abnormality — it needs to be quick and accurate and senior and rigorous — really needs to be a focus. There does need to be some oversight from the state as to what we are doing with genetics. Oversight perhaps? I do not know. At what point do we test for these tiny microarrays? At what point do we do a genome-wide sequencing? Because they are expensive tests, they will send the system broke if there is not some sort of governance over their use. But there are some real savings in their use — there are amazing possibilities and help that can be provided to selected families.

I mentioned NICU because it is just so busy. There is a high demand in NICU occupancy at the Mercy. NICU in 2016–17 was 121.7 per cent, so there are more babies than beds. The acuity of the patients is increasing. The doctors will say more often that the unit is full, and I am sure you are aware of that. Why is that? There are more and more treatments that we can do to help babies these days with improved outcomes. There is also the lower gestation at which babies can survive — it has just come down and down and down. When I was in New Guinea the limit for survival was 32 weeks. In Victoria it is 24 weeks, and some bubs at just under 24 weeks are able to survive. These babies stay in the hospital for a long, long time.

There is an issue about the safety of large units in paediatrics. It does appear that there is some benefit in having larger central units with specialist services as opposed to trying to fragment them too much and move babies out to smaller centres too early. That is an issue we can discuss later. The issue of palliative care is a big issue in neonatal intensive care.

In relation to access to quality, safe and effective care, there is a vast array of fantastic work being done out there with the support of the state government, with CCOPMM, Safer Care Victoria, the Victorian prenatal mortality reports and so forth. Some of those figures were alluded to — Ryan showed one of the charts. There is a huge amount of stuff out there, and the potential for it to improve and expand and grow is unlimited. Units need to be pushed to utilise their own maternity indicators. It is incumbent on us to keep pushing for a statewide dashboard of obstetric and paediatric indicators so we can better assess how we are doing and better compare between units and so forth. The improved audit of obstetric interventions is an increasing issue.

As a hospital and as a service we see it is important to offer choice in obstetric care, in the antenatal options you provide for a woman expecting a baby. Private care is there; team midwifery care; midwifery group practice, which is a dedicated one-on-one relationship between midwife and patient, taking them through the pregnancy and delivery; and shared care for some. It is important that these options are available and that they are affordable and safe, and that the public are informed of their existence.

Likewise options for birth. I think the only point I would make there is the one that Ryan from Monash did allude to, which is that increasingly it is clear that the way forward is collaboration: collaboration between the obstetric workforce and the midwifery workforce. There was a move towards a siloed workforce, so that you had midwifery care until something went wrong, and then you had obstetric care. I think the safer way forward is the collaborative model, where midwives and obstetricians remain caring for women with a range of complexities across the pregnancy, mindful of the autonomy of midwifery decision-making and mindful of how different a profession we are under the surface.

The workforce is everything. The medical workforce is a huge issue, particularly in the west — finding doctors to work. I live in Kew, and there are more doctors than patients in my street. Doctors live in Kew. Getting doctors out to where the patients are is a huge issue, and to a large extent the market will drive this. It has happened already in anaesthetics, and paediatrics to a lesser extent, that the doctors have to go where the work is. It is not a perfect science. Certainly it is an issue for us recruiting staff and hanging onto staff. The recent government changes to the 457 visa arrangements may I think impact on us at hospitals such as Werribee. We very much rely on overseas-trained specialists, it has to be said, to staff our hospitals. With the change in those 457 rules there will be some challenges coming.

With the midwifery workforce, the midwives are everything. None of us can work without the midwives, and as a profession it is changing. It really does need some help in coming up with sustainable career models for a young woman to be attracted to midwifery and to stay in midwifery and to survive in midwifery. The midwifery

workforce is getting older, and there are more leaving at one end than there are coming in at the other end. It is a constant challenge, and the midwives really need help, and they can speak to that better than I can.

How do we train them, how do we mentor them, how do we support them, particularly in those early years? Because these are very high-stress jobs that women — young women largely — or midwives are going out to deal with some most stressful situations and adverse outcomes that do occasionally occur and so forth. They can really scar a young midwife in her career.

**The CHAIR** — Michael, are you happy to take some questions from here on in?

**Dr RASMUSSEN** — Yes. Just in conclusion, to reiterate the points I have made.

**The CHAIR** — I will let you go ahead with that.

**Dr RASMUSSEN** — We are an outcome-driven service. Equity of access is important, the new genetics give challenges, and the NICU demand likewise, and so forth as we have spoken to. But yes, of course, Chair, I am delighted to take any questions.

**The CHAIR** — Thanks, Michael. Can we get a copy of your presentation as well?

**Dr RASMUSSEN** — Yes.

**The CHAIR** — In relation to what you were talking about, every service we talk to speaks to us about the challenge of expanding their services to meet the demand. Indeed the previous witness spoke of that as well. Here is someone that works in the workforce and has done so for how many years, Michael?

**Dr RASMUSSEN** — Twenty five.

**The CHAIR** — Twenty five years. And sitting across from five people that are not in the workforce. What would be a solution to dealing with what we are hearing is a bit of a —

**Ms BRITNELL** — Not that workforce, anyway.

**The CHAIR** — Just from people who are not making decisions in that sector, what would be a solution that you could, if we put you on the spot right now, give us to ensure that this developing crisis with the shortage of midwives is solved?

**Dr RASMUSSEN** — I think at the moment hospitals see their circumstance. They see one or two or three years ahead. It does not matter to the Mercy how the midwives are going out at Sunshine. It does not matter to Sunshine how the midwives are going at the Women's. It needs to be a coordinated issue. It needs to be put onto the colleges to present their plan for a sustainable workforce. It needs to be put on the hospitals to coordinate their actions in securing a sustainable workforce, particularly in those early years, and provide some support for initiatives.

The particular issue it seems to me as a doctor — you would need to ask the midwives — is that in midwifery the really critical time is in those first two years from graduation where you can make or break. You can win over a midwife for life with good experiences and support or you can end a career and have her leave the hot coalface. So I really think it needs to be put on the professions and the hospitals to show some support for their staff in those early years.

It is more complicated in medicine because you have the public service and the private practice. To an extent the marketplace is determining that because as more graduates come out and the ability to survive in private practice alone is diminishing, there are more now looking for work in the public system. If you make your public system attractive, not in terms of salary but in terms of conditions, authority, respect and so forth, then the doctors will come. In obstetrics my phone is beginning to ring with people looking for work.

To me, midwifery is the biggest concern. There are particular issues in the outer suburban and rural areas and it is mainly in those areas that are growing, that are having rapid growth. In those years we had at Werribee of the 20 per cent year on year, when your funding comes in after you have done the work, sort of thing, not as you plan to grow, the lack of any sort of support for growing was difficult.

**Dr CARLING-JENKINS** — Thank you, Michael, for coming in. My electorate office is actually in Werribee, so I drive past and see all of the construction work happening there. It is looking very exciting. I would like to ask you a little bit more about the perinatal palliative care, which is an initiative that Werribee Mercy prides itself on. Your submission, or the submission of Mercy Health, says that maternity health services must address that palliative care of babies. So I just wonder if you can expand on what your service looks like and what other hospitals can learn from that model.

**Dr RASMUSSEN** — There are both sides. There are babies that are born who, despite the best intentions, are not going to survive, and the time that a family spends with that baby in those last days or perhaps longer is critical. So to be able to offer a live-in facility for that family, to be able to offer them privacy, to be able to offer them time and counselling is critical. Babies cannot speak for themselves, self-evidently, so the issue of suffering in babies and relieving suffering when you cannot see the suffering is something that we are critically aware of and is part of the process. I think it is something that is done well at a lot of centres, and it really is part of the workload of any of the major services out there at the moment.

**Dr CARLING-JENKINS** — Is this a service that is funded independently or something that your hospital picks up because you realise the value of that?

**Dr RASMUSSEN** — I probably would not be in a position to answer that. There is always an element of people picking up stuff because there are demands there that you will need to meet and you have got to find the staff from somewhere. So there is always an element of picking up the load certainly. I could not give a better answer than that, I am sorry.

**Dr CARLING-JENKINS** — Not a problem, thank you. I also noticed on your slides you spoke about the prevention and management of stillbirths under your initiatives tab, and you described that as an evolving area and something we need to do together as a state. That shows me that we need to do better as a state in that area. Can you expand on those comments and perhaps give us some suggestions on how we should be looking at that on a statewide level.

**Dr RASMUSSEN** — We have come a long way. It was not long ago that stillbirth was not spoken of, but it is recognised now as a not uncommon event, even despite the very best of care. Victoria is still — let us be clear — one of the safest places to have a baby, but stillbirths are still occurring. There is a huge amount of work that can be done antenatally, simple things, just the frequency of visits, tape measures to assess growth, information we give women on fetal movements and so forth is all known. It is all known. It is all out there, but it does need to be more coordinated in terms of —

**Dr CARLING-JENKINS** — So a consistency?

**Dr RASMUSSEN** — Just consistent practice within services, across services and within models of care even. Then there are issues around fetal monitoring, getting women to the fetal monitor soon, getting that trace interpreted correctly, escalating any problems you have with the trace, and an investigation of stillbirths to find a cause. That has improved significantly recently with the three centres managing all post-mortems, but that is still something that is improving. It is a public health issue that would have a big return for a small investment, and it is pretty simple stuff. It is not a lot of genetics or science — as I say, movements, tape measures and awareness, and having someone to ring if you are worried, and being seen quickly.

**Dr CARLING-JENKINS** — And then following up when they occur —

**Dr RASMUSSEN** — Following up when they do occur.

**Dr CARLING-JENKINS** — with what actually occurred. Fantastic; thank you very much.

**Ms McLEISH** — Thank you very much for your informative presentation, Michael. One of the key issues you had on your slide earlier was about statewide access; in fact I think it was the top point that you had there. Could you talk about telehealth — the benefits and the limitations of telehealth?

**Dr RASMUSSEN** — Telehealth is not a panacea and it is not everything it is cracked up to be. Your children do it all the time, I am sure. It is a laptop with a camera here, and I am talking to the doctor who is on their laptop with their camera here, and the patient is usually alongside that doctor. Their ultrasound machine may be with them, and the way we do it with Darwin is that our perinatal specialist sits in a room, introduces

themselves to the patient, talks to the patient, talks to the doctor. A scan is performed in Darwin. Those images are relayed directly from the machine to our screen — so not the camera, to the screen — and an opinion can be made on an issue that has been recognised. So there is a complex perinatal situation that has been picked up, and there is clarity needed or an opinion given about the management, or should this patient be sent interstate to Adelaide or where have you — usually to Adelaide, historically — or can they remain in Darwin and so forth.

The success of it really depends on the people at each end. You cannot have an inexperienced person at one end of the telehealth and an experienced person down here in Melbourne dealing with repeated consultations. There cannot be a great disparity in knowledge at each end of the thing. You cannot have a plumber at one end of your television and a professor of obstetrics at the other. It just does not work. There needs to be an equivalence of comprehension and understanding. In certain remote situations for certain high-risk uncommon scenarios and some specialist scenarios it does have a potential, but it will probably remain a niche, a small initiative, and it will not replace the need for specialist doctors in rural and remote areas.

**Ms McLEISH** — That leads nicely into my next question as well. You talked about ultrasound, and you said access across the regions is limited. Can you tell me in what way it is limited and how we can work on fixing that?

**Dr RASMUSSEN** — If I said ‘limited’, I am sorry. That may have been a little bit unfair. Access to ultrasound varies. Some hospitals are able to provide ultrasound services completely in-house, other hospitals rely on outside private providers. Some patients are not paying for their ultrasound services, some patients are paying an out-of-pocket fee for their ultrasound services. The quality of ultrasound does vary. The quality of your screen ultrasounds and your specialist ultrasounds does vary for all sorts of reasons.

When Albury-Wodonga recently lost a specialist ultrasound provider, that was really hard on the area. One ultrasound specialist had been there doing their complex paediatric scans and, when they had gone, it really left the area underresourced. That to a large extent has been picked up. That was one of the issues we did use telemedicine for to give some support to Albury-Wodonga through the —

**Ms McLEISH** — Through the intervening period?

**Dr RASMUSSEN** — Yes.

**Ms EDWARDS** — Thanks, Michael. Sorry I was late for your presentation. Forgive me if you have covered this, but the rise in the number of Medicare-ineligible women attending the services at Werribee Mercy seems to have increased. I just wondered if you could perhaps tell us, A, why, and B, what the impact is of that?

**Dr RASMUSSEN** — The first thing is you are a hospital. You care for anyone who walks in the door. You do not turn anyone away. We do try and manage our numbers, however, and the birth numbers that we book each month do not account for the ineligible. They are at surplus to that number, so it is extra work that we do. Some of those ineligible are privately insured students, overseas students visiting here who have private insurance, and to an extent they are invoiced and that invoice will be received — not always. But there are families out there without Medicare cards and without insurance for a range of reasons, immigration-related and otherwise, and that is a cost to us, a cost that we wear. I am pretty sure the hospital sends them a bill. We do not tell them to tear up the bill. I think it is ridiculous to invoice some of these families the cost of medical care. So it is something we are aware of. It is something we need to keep an eye on. It is something we have seen. The proportion of ineligible at Werribee because of where it is located has been rising, and it is a cost to the service.

**Ms EDWARDS** — Does the service provide any support outside of the hospital for those people — follow-up services to support them to perhaps apply for Medicare card or in turn for the referral service —

**Dr RASMUSSEN** — Absolutely. It is only at my level that you would know the patient is ineligible. Any care they receive is as anyone would receive without —

**Ms McLEISH** — Question?

**Dr RASMUSSEN** — Absolutely, without question. So yes, they are a family in need, their social work supports are there, the interpreters are called for every consultation, the social workers will be on to that, and there will be support for them to get whatever help can be arranged.

**Ms EDWARDS** — Do have a particular support within the maternity and newborn services for women from Aboriginal and Torres Strait Islander backgrounds?

**Dr RASMUSSEN** — Yes, at both sites. We have had an Aboriginal service at Heidelberg, since we were located in East Melbourne. The staff have gone from one full-time to now, I think, three full-time workers; I would have to be sure of that. As a service that is available five days a week for anyone who identifies as Aboriginal, which is to make use of it. It has links with the Victorian Aboriginal Health Service as well. At Werribee I think it was about two years ago that we appointed a full-time Aboriginal health worker.

**Ms EDWARDS** — And you would have similar supports for women from CALD backgrounds?

**Dr RASMUSSEN** — From?

**Ms EDWARDS** — Culturally and linguistically diverse backgrounds.

**Dr RASMUSSEN** — Got me. I apologise. My ignorance. Absolutely. We have a full-time African liaison officer at Heidelberg. We do not at Werribee, but we should and we will, and then at each site circumstances will dictate. So at Werribee there is a large number of Karen women, and that is identified. We are very mindful of our responsibilities there.

**Ms EDWARDS** — Just in relation to your NICU and the capacity, which is obviously well over 100 per cent now, and the shortage in the workforce capacity, do you think the new REACH system is working?

**Dr RASMUSSEN** — Look, there some problems with it. It would be my paediatric colleagues you should be talking to. They have voiced some problems with it. I do think there has been a slight improvement, yes. There is no perfect solution to the problem of when we are all at capacity where does the patient go. There is no perfect solution, but it does appear to me to be better than it was before. That would be my observation. The instances of the ridiculous transfers has fallen and interstate transfers, you would know, but I think that has fallen as well.

**Ms McLEISH** — Just following on from Maree with the culturally and linguistically diverse backgrounds, are there any cultures that are quite suspicious or reluctant to have the range of services that are available?

**Dr RASMUSSEN** — That is a good question. There has been a specific issue with Jehovah's Witness patients not declaring themselves as such until the last minute. I think we are still evolving in our understanding of the particular needs of some of the African communities in particular. Certainly there are a large number of patients. I do end up in our clinic out at Werribee once a week, and it is a very, very different experience to the clinic in Heidelberg. Certainly there is an issue with people not admitting to needing an interpreter, because people are embarrassed to say they do not speak English. They speak a bit of English but not enough, and we have got to be careful of how we put the question to them and how we flag them as needing an interpreter. If they need an interpreter, then they will always need an interpreter. These are things that we instil. I do not think there is any particular group that we are missing, no, but your question is valid and one that we ask ourselves every day.

**Ms McLEISH** — My final question is with regard to homebirthing. Do you have an opinion about homebirthing — any particular opinion?

**Dr RASMUSSEN** — If the numbers of women asking for homebirth is increasing, I think we are not giving them what they need in the hospital. That would be my view. The safety of homebirth is something we can debate. The numbers will never be enough to have an accurate assessment of maternal risk. There have been numerous reports from Europe, in particular from Holland, purporting the safety of homebirth in their circumstance. I do not know that we can transpose that here to our circumstance with distances and so forth. We do not facilitate homebirth at either site at the moment. We do not have plans to. Our door is open for women who are attempting to birth at home. Where things go wrong, our door is open and we will continue their care when they do arrive. In all honesty, I think we have tried to put our focus on providing homelier and more women and family-friendly services within the hospital than trying to introduce a homebirth service as well.

Maybe in the future circumstances will change, but as an obstetrician I have some concerns about its safety given the unpredictability of haemorrhage in particular and the unpredictability of needing help for a baby that is suddenly born flat. You are very isolated at home, and that worries me, but that there is a request out there for



it means it is something we have to respond to and listen to. We have tried to do that through our MGP — midwifery group practice — programs and through our team midwifery care and through how we have set up our labour ward. I am happy to discuss it further.

**Ms McLEISH** — That is fine. Thank you very much.

**The CHAIR** — With that I thank you, Michael, for your time.

**Dr RASMUSSEN** — Thank you.

**Witness withdrew.**