TRANSCRIPT

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Melbourne — 18 September 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 Andrew Watkins, Neonatologist.
The CHAIR — I welcome to these public hearings Dr Andrew Watkins, neonatologist at the Mercy Hospital for Women. Thank you for attending here today. All evidence taken by the committee at this hearing 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 of the transcript. I would now invite you, Andrew, to make a 10 to 15-minute statement, and we will follow up with some questions.

Visual presentation.

Dr WATKINS — Good. First of all I would like to note that my submission was a personal submission and not representative of either of my employing hospitals. I am a neonatologist. I have been practising in one capacity or another for 37 years in the neonatal intensive care system in Melbourne and Victoria for quite a while. I have been practising as director of unit for some time, although I am no longer director of unit. I have also been involved at the policy level in the department with various committees. I thought that the main thrust of my submission should be on the neonatal intensive care bed state, because that is something of a running sore. I thought I should give this short supplementary presentation to give an idea of the scale of the task, some of the history of neonatology and what has been important in the improved survival which we have seen.

I think this photo, in a sense, says it all. This is a 23 to 24-week infant who is, as you can see, incredibly fragile, with very thin skin, which is very easily torn. All of the rest of that baby’s organ systems are similarly fragile, and it is not hard to see how that baby (a) has a very high chance of dying and (b) will require very specialised care for quite a long time.

So a short history of neonatal intensive care: we started off just looking after babies by keeping them warm and feeding them, and premature babies very commonly died. In the 1970s we started providing some sort of intensive care. The other thing was that it was beginning to integrate with obstetrics, and it was shown that if we gave mothers steroids intramuscularly before birth, the babies were less likely to die of their lung disease. A Victorian follow-up showed that babies born outside major tertiary centres had a higher mortality and a much higher disability rate, and so in the 1980s there was an extreme focus on regionalisation of major intensive care and in particular on avoidance of babies being born outside tertiary centres if at all possible, which required a high level of integration of obstetric and paediatric care.

In the 1990s surfactant was introduced, which is a chemical which we put down the endotracheal tube of a baby and which replaces the chemical that the babies do not make that keeps your lungs and my lungs open. This revolutionised intensive care and revolutionised survival, and there were other interventions in terms of improvements in ventilation. Through the late 1990s and into the 2000s we have then moved into a less invasive pattern of care with more use of non-invasive respiratory support, a focus on being nice to babies for once, a focus on breastfeeding and increased milk banking and generally a less intensive model. But this, to succeed, requires a high level of nursing skill, numbers and attention to detail.

One of the reasons we focused on regionalisation is highlighted in this study by William Tarnow-Mordi from the UK. What they did was they looked at risk-adjusted morbidity and mortality in the early 1990s and compared it between Scotland and a pool of Australian units. At that time they were using the same toys we were. They had surfactant available. We were using essentially the same tools and had the same knowledge and same skills. The risk-adjusted mortality in Scotland was between one and a half and two times what it is in Australia. The difference is that in Australia we have had a pattern of regionalisation of care with a focus on care for very low birthweight infants being provided predominantly, at least initially, in large regional intensive cares with high turnover, high expertise and a lot of experience. This is in fact still reflected in the risk-adjusted perinatal mortality ratios in Victoria in which the level three, four and five centres commonly have a risk-adjusted perinatal mortality ratio of about one and a half times what it is in the tertiary centres.

There has been a significant improvement in survival through this time. These are survival rates for my own institution over a four-year period some time ago. You can see that at 23 weeks the survival rate is approximately 50 per cent and by the time you get to 28 weeks the survival rate is above 90 per cent, so there has been a massive change. In the past, 23-weekers were basically not treated because it was felt that the survival chances were so low that it was not ethical to do so.
A recurring theme through most of my professional life has been the fact that Victoria has historically had a lower provision of neonatal intensive care beds per 1000 live births than all of the other states. This is a snapshot we took in 2011, which was the last time the data were available, but this reflects basically the pattern of the last 20 or 30 years of my life. You can see that Victoria is the lowest in terms of provision of neonatal intensive care beds per 1000 live births.

The other thing that has characterised my professional life has been occupancy and a constant running bed-state crisis. For most of my life, particularly when I am on for either the transport service or intensive care, a fairly large slab of that has been devoted to fighting about where the next baby will go and where the next mother will go. Of course babies have a habit of coming out of mothers, so you have got to be able to plan for both simultaneously and they have to be able to be managed in perinatal centres.

You can see that over this 11-year snapshot the median occupancy of intensive care — and by that I mean babies with respiratory support and non-invasive ventilation and babies who are too sick to be managed elsewhere, as in non-ventilated NICU — has generally been between 100 and 105 or 106 per cent, and it is reaching a peak of about 114 per cent. That is median occupancy — median — which means that on at least 50 per cent of occasions units are working above their rated capacity. We can sometimes find the staff to make it work, we can sometimes find the equipment to make it work, but the infrastructure is designed for less than 100 per cent. And it has been shown worldwide in a number of studies in adult neonatal and paediatric intensive care that as occupancy goes up and the relationship between baby number and acuity and nurse skill mix and number and medical staff skill mix and number goes off, morbidity, mortality and infection rates go up.

So this has been the defining issue of my professional life: the constant battle to get adequate bed capacity. You can see this from a snapshot taken in the first four months of 2012. You can see that on most days on the VicPIC website overwhelmingly all four units declared themselves closed because they felt that they could not safely manage another admission. The response to this in two hospitals — after, I think, some byplay with the department — was that they were told that they were no longer allowed to declare themselves as closed on the VicPIC website. When you rang them up — the VicPIC website said ‘We are still open’ — they said, ‘No, we can’t take the baby’. The VicPIC website has been the tool that we have used for many years to run bed state and make our transfer decisions.

This is a bitty slide. Recently the department has put intensive care on the REACH website and is no longer using the VicPIC website, which has been a valuable tool because (a) it has given a good running idea of who has got beds and who has not and (b) it includes maternity data, as in who has got capacity to deal with the mother. And of course babies have a habit of coming out of mothers. The REACH website, which is the website used for adult intensive care, coronary care, ambulance services etc, does not contain any evidence about obstetric care — it does not contain any information about obstetric capacity — so when we are looking on the computer to see where to put the mother, where to put the next baby or when we are negotiating where to put them, we do not have that information or we can only get it by a fairly cumbersome ring around.

I am sorry that the slide is not projecting very well, but you will see the level 6 is defined as intensive care. If you look at the occupancies — 32 per cent, 52 per cent, 52 per cent — it looks as if there is not an intensive care problem. If on the other hand you look at the total numbers in the nursery — 100 per cent, 100 per cent, 107 per cent, 97 per cent occupancy — it is clear that there is a problem. The reason that this arises is because extremely low birthweight babies, like the ones I showed in my first slide, when they are ventilated, they come off the ventilator and they go into non-invasive care, when it is argued by some in the department that they could then be managed in level 2 centres, or level 3, 4 or 5 centres, as they are called now. They still require total parenteral nutrition, they still require extremely skilled nursing services and they may still require one-to-one nursing. There is nowhere else to put those babies, so they sit in beds which are not labelled intensive care beds receiving intensive care, but from the point of view of the department they are not intensive care babies. So we come under pressure, saying ‘You’ve got empty intensive care beds’. Note the labelling of that column: empty beds. Those beds are not empty; they have got babies in them. They just do not have babies in them with a tube in their nose. And so administratively hospitals are under pressure to admit babies because it is deemed that there is a contract between the hospital and the health department to provide so many intensive care spaces, and we are under pressure to admit to those beds even if there is already someone in that bed. So the REACH website has been a major problem.
Ms BRITNELL — Excuse me; can I just ask a question? So the high-dependency beds are not there that are necessary for them to be able to move from the intensive care beds?

Dr WATKINS — Yes. You take the tube out of the baby’s nose. He might still be on inotropes. He might still be needing one-to-one nursing. He is still in the bed, but the bed has been relabelled — or his status has been relabelled — so that it is deemed to be an empty bed even if it has got a baby in it, which is Orwellian. So there is a significant problem with the information we collect. The other thing that VicPIC has done over the years is to produce very reliable information about bed-state capacity.

Ms McLEISH — Very reliable?

Dr WATKINS — Yes, it is reliable. Because it is such a useful tool, people have filled it in pretty conscientiously. So it provides an ongoing running score over years. In my time on the newborn services advisory committee, after much argy-bargy it was finally admitted by the department that the only reliable information on neonatal bed-state capacity they had was the information generated by VicPIC, because their own figures were basically not fit for purpose, shall we say.

You can see that these are the criteria that are currently used for transfer to a regional centre. You have got to be 32 weeks corrected. So if you are a 24-weeker, you have got to sit around in intensive care for eight weeks or thereabouts. There are also problems that often the level 2 centres do not have the capacity because their nurseries are full. There has been a big thrust, as I said in my submission, from the department for provision of more CPAP in level 2 centres, or level 3, 4 or 5 centres, but these centres often do not have the capacity or often do not have the capacity to do it safely and reliably or may not have the capacity on the day. As I said in my submission, this was put to the department repeatedly by the clinician members of the committee, and it was basically ignored. So in summary, the bed state is not just about assisted ventilation, because these babies have complex ongoing needs that need to be provided in centres of expertise. We need also to be able to integrate the care of the mother, because, as the previous witnesses have mentioned, these mothers are often sick themselves and need intensive care or highly skilled management.

We aim to keep babies and mothers together as much as possible, because it is a horrible experience for a mother to have her baby in the Mercy or the Women’s and then have her baby moved to the Children’s or to wherever because there is no capacity in that unit. That mother is not particularly portable for three or four days after birth, is in pain. Childbirth is a very good time to be a boy. We have not found a way to make it painless and to make you mobile afterwards, however you have your baby. And so mothers are separated from babies or have to go through a lot of pain in order to be with their baby if we cannot provide care for them in the centre in which the baby is born. We have to be able to plan to keep mothers and babies together, which means that we need information about obstetric capacity and we need adequate obstetric capacity in the perinatal centres as well. I think that is probably enough, because you have also got my submission in which I made many of these points.

The CHAIR — Thanks for that presentation, Dr Watkins. We might start asking some questions of you, if that is okay. We have seen from your statistics and your submission that Victoria has always had a lower number of NICU units per 1000 live births, and the median occupancy is 100 to 110 per cent. My first question is: why do you think Victoria has always lagged behind in those statistics?

Dr WATKINS — NICU is expensive. There has been at times a reluctance to prioritise it. I think the department’s planning capacity is suboptimal. Despite the department having a number of very good individuals in it, I think as a whole the department has functioned in a fairly dysfunctional way and has got a long track record of not listening to clinicians. To be fair, doctors are not immune to a bit of shroud-waving if they want to build their empires too, so there is a need for an element of cynicism or inquiry about whatever we say.

I think it was shown by Andrew Ramsden, who unfortunately died a year or so ago and who was probably the master of neonatal figures, that there has been a significant lack of capacity for a long time, that there is not the capacity to care for more babies in level 3, 4, 5 centres to the level that they need in many cases and that even if more babies were moved out to 3, 4, 5 centres, which is the thrust of the department, those that are able to — that meet those criteria I showed you — are such a small number that they would not impact on the basic problem. My experience of sitting on various committees — and I think that is duplicated by others — is that the department arrives with a pre-prepared plan that is then talked through and argued about, and the plan just keeps resurfacing and resurfacing and resurfacing in much the same form. That ultimately culminated in the
newborn services advisory committee actually refusing to sign off on the department’s plan for neonatal services in 2011, which caused some tooth sucking, but we felt that it was so important an issue that we had to take a stand.

The CHAIR — Thanks. Just a second question: with your experience — I am just asking you for a personal opinion — can the perinatal mortality rate be lowered from 9 per 1000 babies to lower? If so, is there somewhere we can look to in Victoria for the best practice to do that?

Dr WATKINS — There needs to be a close look at the determinants of the perinatal mortality rate. I am an intensivist, not an epidemiologist, and it would be very easy for me to say that this problem can be solved by lots and lots of nice shiny new intensive cares, but that is probably not true. It would certainly be helped. There are deaths which are occurring now because of a lack of intensive care capacity or overworked and understaffed units, but we also have to look at the facts of intergenerational disadvantage and the socioeconomic determinants of obstetric morbidity and mortality, some of which were addressed in the previous submission.

A lot of it goes to addressing economic disadvantage, making high-quality antenatal care available to people and providing also support for diagnosis of other intergenerational disadvantage issues, such as family violence, which comes up very commonly in pregnancy. The time in a woman’s life when they are most likely to be assaulted by their partner is when they are pregnant. All of these intergenerational family issues of poverty, family violence, disadvantage, chemical dependency et cetera do feed into this problem because we are dealing with a high-risk population. The other issue is the ageing population and the increased level of general medical risk in the population.

The CHAIR — So it is not just a case of if we increase the neonatal intensive care units, we would have better outcomes. It is a whole gamut of social —

Dr WATKINS — Yes. There is no magic bullet. In order to make a truly regionalised system work — where, for example, I in my tertiary centre, or whatever it is called these days, can develop a seamless relationship with the other units in a particular region — the international consensus is you need to be running at an occupancy of somewhere around about 80 per cent. So when somebody rings up from Wangaratta at the moment and says, ‘Andrew, you’re my regional unit. Can you take the baby?’, I have to say, ‘Well, I’d love to help you, but no’.

If on the other hand on 80 per cent of occasions when Wangaratta or Bendigo or whatever rings us up and says, ‘We’d like to talk about this mother and baby. Can you take her or what do you think?’, I can say, ‘Yes, send her down’. That builds a network of relationships which provide better care in the community and does increase the possibility that that woman will be able to be managed for a larger percentage of her pregnancy or that baby will be able to be managed for a large percentage of his postnatal stay in Wangaratta or Bendigo or wherever. But while Melbourne is in a state of chronic meltdown on the bed-state front, those relationships cannot develop.

Ms EDWARDS — Thank you for coming in, Dr Watkins, and thank you for your submission. You mentioned that in the majority of cases you try to keep the mother and baby together and that they are not separated should either or both need intensive care support. How often would you say that mothers and babies are separated during that process?

Dr WATKINS — We are a 60-bed unit with an official rated capacity of 20 to 22 intensive care cots. We have almost always got three or four mothers waiting elsewhere to get a bed here or to be discharged from the other hospital in which they had their baby so that they can come in and spend time with the baby.

Ms EDWARDS — What would be the period of time of that separation? Does that vary depending on —

Dr WATKINS — Yes. It varies depending on our maternity bed state and also depending on the needs of the woman. If she has had a vaginal delivery and is reasonably fit, she can often be discharged, and in fact many mothers will just sign themselves out at their own risk in order to come to see the baby — which is suboptimal — because they want to be with their baby. If you had a vaginal delivery, you can usually be discharged safely one or two days after having a baby, assuming that you are medically well.
Of course the problem for us is that a lot of the reasons for prematurity can produce mothers who are sick. Mothers die of some of the things that lead to their babies being premature, like pre-eclampsia or obstetric haemorrhage. Some of these mothers are too sick to discharge and need to stay in the hospital in which their babies were born. All other things being equal, if you have had a vaginal delivery and are healthy, you can probably be discharged one or two days after having the baby, and in many countries you are discharged on the same day. After you have had a caesarean section, it is usually four to six days, but that is a matter for obstetric expertise, not for me to put my expert’s hat on, because I am not an obstetrician.

Ms EDWARDS — For women whose babies are required to be in ICU and that separation occurs, is there any research or data on the impact on mothers of that separation?

Dr WATKINS — I am not aware of any. It is an interesting question. There is certainly a lot of data that shows if you have had your baby in intensive care, the business of bonding and parenting is more difficult, but I have not seen it separated or subdivided between the issues of separation from regional birth and birth in a tertiary centre. One of the themes that does come out in the literature, both in the qualitative parent narrative literature and also in some of the quantitative literature, is the issue of separation though.

Ms EDWARDS — What support is available to the mothers who are separated from their babies?

Dr WATKINS — We facilitate photographs. We obviously provide regular updates. We do not have a facility at the moment for video links. There are some units around the world where the baby has a video camera above their unit, and that is beamed through to the mother’s room so that she can see her baby in intensive care all the time. So there is a techno fix for some of it —

Ms EDWARDS — In terms of emotional support?

Dr WATKINS — but it is fundamentally about getting the mother together with the baby.

Ms EDWARDS — You mentioned the workforce in the NICU area. Do we currently have the skilled workforce capacity to meet the NICU beds that we currently have, and if not, what do we need to do to address that?

Dr WATKINS — At the moment because of some workforce blundering in various quarters we have a significant excess of neonatologists, as in people like me, because we have trained too many for reasons which probably do not bear examination. The issue is mostly in the provision of trained neonatal intensive care nurses, because of some of the issues which were addressed in the previous submission — the cost of doing the course, the availability of the course and what you get for your money if you do the course. If you do the course, you get a more interesting job, but you get a lot more stress and not much more money. There is an issue of retention. We have noticed at the Mercy that a lot of our older staff are now moving on to less demanding jobs and we have got a lot of young staff coming through, who are the future, but some of them are still quite wet behind the ears. There has been a significant exodus of senior, experienced staff from the system, and this often accelerates after periods of high workload. People just decide —

Ms EDWARDS — So would you say, just to sum that up, that there is a shortage of neonatal intensive care nurses currently —

Dr WATKINS — Yes, basically.

Ms EDWARDS — and that you cannot meet the demand of the NICU beds that we already have?

Dr WATKINS — We can meet just about the demand for those we have got, but we need significant planning and significant input of resources to allow for an expansion.

Ms McLEISH — Thank you, Dr Watkins, for coming in. I have got a couple of questions, first of all, about VicPIC. Can you explain exactly what that is? You have said it is very reliable if used conscientiously. Who has the authorisation to review the data, the big picture?

Dr WATKINS — It was housed on the NETS or PIPER transport service website. I think it is funded and administered by the department. It provides two basic screens — one for neonatal intensive care capacity and one for midwifery capacity — in all of the various hospitals. The software behind it records all of the updates,
so it is possible to go back. Some of the data, for example, which I have shown today has been generated by going back over VicPIC for the last five or 10 years and looking at occupancy and numbers of ICU beds and numbers of babies. It keeps a record of the number of babies in the system in each hospital. That is searchable and analysable, and you can give trends for occupancy, workload etcetera, days closed and the sort of data I have presented.

It is (a) a valuable data-gathering tool, but (b) it is a useful management tool. For example, at times when things are tight, at 11 o’clock we have a teleconference. We have a ring-around of all the units. Everybody is on a teleconference, and we are all sitting there looking at VicPIC so that we can say, ‘Is there going to be capacity at the Women’s?’ The Women’s or whatever may say, ‘No. We have got two 24-weekers coming and we cannot take it’, and you can have those sorts of discussions.

We are not using REACH much in those teleconferences any more because it is so useless for that purpose. It is basically not fit for purpose. It is there in a tokenistic way, but it is not accorded much credibility by the clinicians.

Ms McLEISH — So anyone with access to VicPIC can do the data analysis?

Dr WATKINS — Yes, if you have got the passwords. Each unit has at least one person who can go back and do the research. I asked our data wonk — because I am computer incompetent — to go back and produce some of these figures, and he was very easily able to just do that. It was an afternoon’s work for him.

Ms McLEISH — And do you know if the department looks at it and does data analysis?

Dr WATKINS — They have used it, but they have preferred to use their own figures I think. I do not know if that has changed. Since I have not been on the newborn services advisory committee in recent years, I do not know if that has changed, but they did acknowledge in 2011 that it was the only reliable source of information they had.

Ms McLEISH — So they acknowledged VicPIC was the only reliable source, but they choose to use —

Dr WATKINS — They acknowledged that it was the only reliable source of information they had.

Ms McLEISH — What advice have you got for the department?

Dr WATKINS — Listen to clinicians. They have been getting a fairly consistent message for a long time, and most of it has not been listened to. As I said, you have got to listen. Everybody has got their interests and their little barrows to push. There has to be a leavening of cynicism and inquiry. I think the other thing that I have noticed over the years is that the people who are making the decisions in the department are overwhelmingly not clinicians, and the turnover is such that by the time somebody does get their head around the issues they are moved on or they move on to another job.

We had an example recently when a REACH website like the one I have showed you was put up, and the department representative in a conference said, ‘It’s clearly not a level 6 problem. We have a problem at level 3, at level 4 and at level 5’, when the website was quite clearly showing that the units were well over capacity. It is just that the level 6 numbers were below 100 per cent. I think that a number of the people making the decisions in the department have no idea of how brutal life is at the coalface and also of the human reality of what it is like for the babies and for the families when they are horse traded round Melbourne, quite apart from the effect on the staff as well.

Ms BRITNELL — I am trying to think of what the word is, but I think it is quite disturbing to be listening to your report today. It is not surprising, actually, but still very disturbing, and disturbing because of what you are saying about the fact that we have had this information for a very long time and it is not improving and is obviously getting worse because demand is getting higher. I am acutely aware of the challenge that it does present the staff, as you have just highlighted.

My questions are just for a bit of clarity around a couple of things. With our improved capacity in getting neonates and improving them from younger week gestations — so down to 23 weeks at 50 per cent improved survival rates — is that making the problem worse? Because 24 weeks was not so long ago where we drew the line. Now we have got 23 weeks and a 50 per cent survival rate. Is that an increasing problem as well?
Dr WATKINS — Absolutely. When I started in neonatal intensive care as a baby doctor, of the patients admitted to intensive care only 50 per cent of them would need any care for more than a week, because they would die. The rest of them would then go through the system. Now we are looking at between 70 and 95 per cent of infants who are admitted to intensive care needing care until roughly term corrected. So if you are a 24-weeker, generally you go home at roughly your due date. If you have had a particularly disgusting first couple of weeks of life, you go home usually three or four weeks after you were due. If you have had a relatively gentle course through intensive care, you may go home two or three weeks before you were due. But a 24-weeker on average will need about 16 weeks of care somewhere.

What we try to do is to do the care that needs to be in a tertiary centre in our tertiary centre. We then explore whether it can be managed closer to home. If the woman lives just around the corner, it is stupid to send them to a level 2 centre or a level 3, 4 or 5 centre to convalesce when they have already got a relationship with us. The relationships you build with the people who look after your extremely premature baby are very strong and are very important in building the foundations for parenting later on. If on the other hand the parents live a fair way away, the tasks at the last 4 to 5 weeks of the hospital stay are far more around mothering and parenting, and if by moving that baby closer to home the mother can do four or five breastfeeds a day rather than two or three, it is obviously in everybody’s best interests for that baby to go closer to home.

All of the tertiary perinatal centres have teams of nursing staff dedicated to managing discharge and to managing the relationships with the level 4 and 5 centres so that babies can go closer to home if it is appropriate for the family, if the family consents to it — because it is necessary for the family to consent to it, although there have been some arguments from some quarters that the transfer should be able to occur without consent, about which I have significant reservations — and if it is appropriate. So the units do put a lot of effort into trying to get babies closer to home if it is appropriate for the baby and the family.

Ms BRITNELL — The survival rates, I noticed, were 70 per cent of 24-weekers. Is there a figure on any disabilities around that?

Dr WATKINS — We are fortunate in Victoria in that the follow-up program that we have in Victoria is one of the best — probably the best — in the world. I am no longer directly involved in it, so I am not banging my own drum here. They enrol cohorts periodically of infants under 1000 grams and also enrol controls. So at the time that the premature baby goes home, a control-term infant matched for sex, ethnicity and broad social status is recruited also as a control, and they are then followed up developmentally. What we have shown is that under 1000 grams the incidence of severe disability is between 7 and 10 per cent and the incidence of mild to moderate disability is about 20 to 30 per cent. By mild to moderate I mean mild cerebral palsy, learning disorders, coordination and clumsiness issues — issues such as that, issues which will not stop you having a life but mean that you need a bit of help. The severe, hardcore disability is defined as cerebral palsy so severe that you are not walking at two, mental retardation with the IQ three standard deviations below the mean, or blindness, which is a very hardcore disability, which raises questions in some minds about whether that is a quality of life worth having — but that is an argument for another day.

The other difficulty with those sorts of judgements is that in terms of the ethical debate about disability there is evidence that doctors on the whole rate the quality of life of disabled survivors as very low, the parents of disabled survivors rate their quality of life significantly higher than the doctors do and the survivors themselves rate their quality of life that they are living even higher than their parents do. So judgements made by doctors based on quality of life need close examination. There are also some strands of opinion that if bed state is tight, we just should not treat 23-weekers. The people who run that argument argue that if you have got a 50 per cent chance of some disability and a 50 per cent chance of dying, that is a threshold beyond which it is not reasonable to treat and it is reasonable to not offer treatment so the baby dies. If you do the numbers on that, if you have got 12 babies and you follow that policy, you end up with 12 dead babies. If you on the other hand offer treatment to the 23-weeker, you end up with six dead babies, three disabled survivors and three normal survivors — if you accept the validity of those statistics. So by making decisions like that you are accepting the death of three normal survivors in order to avoid producing three disabled survivors, and that is a very interesting ethical question. The numbers are hard, and it is a very difficult area.

Ms BRITNELL — Thank you for that very succinct and detailed answer. The other thing I wanted to talk to you about was given the growth rates, given the improved technologies around the weeks that we can work on
survival rates — which you have articulated perfectly well there — what is your recommendation on the beds needed to be planned for?

**Dr WATKINS** — I think there are two issues: bed numbers, which I have addressed, and bed distribution. What has been glaringly obvious for many years is that there is a significant shortage of neonatal intensive care and high-level obstetric capacity — and those things go together — in the western suburbs. The current government, pre-election, made a commitment to develop the facilities at Sunshine, which I think has been a very good decision, and that is something on which we should build. In other words, to move fairly rapidly to development of fully functional neonatal intensive care with a high-risk perinatal obstetric program at Sunshine would significantly ease capacity in the system and also significantly ease the issues of access, travel and continuity of care for women in the western suburbs.

**Ms BRITNELL** — Do the regions not have enough demand? And does the service we offer centrally in the city cover the needs from a baby’s best outcome — parent’s best outcome — that we would not need to consider Bendigo or Ballarat?

**Dr WATKINS** — That is why I made the point that I made earlier about the Scotland study. I practised in Britain in the late 1980s when the provision of intensive care was very equipment based. The Lions Club would buy a small regional centre a ventilator, and that baby would be ventilated and would count in the national statistics as a baby receiving intensive care despite the fact that there was no neonatologist — a third-year resident and a generic midwife looking after the baby. It was not a nice experience. I saw more of the complications of neonatal intensive care in those two years than I had seen for some years beforehand. That was, I think, because of the fact that these babies, who are demanding and difficult babies, were being managed in the centres which did not have a critical mass and enough throughput to generate work and practice and skills for enough staff to maintain a viable roster.

It is not adequate to have one neonatologist in a level 4, 5 or 6 centre because that person, if they want to stay mostly sane and mostly married, cannot be on call 24 hours a day, seven days a week. And yet you need somebody with the skill to drain a pneumothorax or the skill to intubate a small baby, and in order to make a viable, safe roster which is compatible with remaining mostly sane and mostly married you have got to have three or four people so that people can practise in a safe manner. I grew up in the days when we worked 100 hours a week, and I do not want to go back there. If you have not slept for 24 hours, which was common in my life, you are effectively practising with a blood alcohol level of 0.1 per cent.

If I turned up at work and blew 0.1 per cent, I would be in front of the medical board so fast my feet would not touch the ground, and so I should be. But if I turn up at work having worked for 24 hours, I am some sort of a hero. There is a significant cultural problem in medicine, and there is sometimes a significant administrative problem in getting the willingness to address that.

**Ms BRITNELL** — That leads me to my last question. You have quoted the Auditor-General’s report of the department being highly dysfunctional, and that report was done in 2011. Have there been any changes that that report resulted in that have approved improved the situation?

**Dr WATKINS** — There has been some increase in beds, but I think you saw from the figures that I showed you that that has not been sufficient to meet the demand. The other thing that has happened is the commitment by the current government to develop resources at Sunshine. I am not involved enough in the engine room of the department to know whether they have fundamentally addressed their inability to predict things like birthrate and the demand for services.

**Ms BRITNELL** — Your message has been received loud and clear that we need to make sure the department is a bit more responsive to the clinicians.

**The CHAIR** — Thank you so much for coming in, Doctor. I would just like to take you up on one thing, and that is that you said you were computer incompetent. I think you have navigated the presentation very well today, so thank you for that. Thank you for your submission. We have got a fair few points to think about and discuss. Thank you.

**Dr WATKINS** — It is mostly to do with being innumerate. Thank you for your attention.