T R A N S C R I P T

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Wangaratta — 25 October 2017

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Witness

Dr Will Twycross, procedural GP in obstetrics, anaesthetics and accident and emergency.

The DEPUTY CHAIR — I welcome to these public proceedings Dr Will Twycross, procedural GP in obstetrics, anaesthetics and accident and emergency. Thank you, Will, for attending here today. 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 in contempt of Parliament to provide false evidence. These proceedings will be recorded and you will be sent a proof copy of the transcript. If you would like to make a 10 to 15-minute statement, that will be followed up by some questions from the committee.

Dr TWYCROSS — Okay. Thanks very much, and I thank the organisers for helping us to get here and present the submission. I thought I would try to do something which might be a little bit different to what you might have heard so far. I have had a look through the other written submissions and realised that there is not a lot from small rural hospitals. My position is as a VMO at the Mansfield hospital. I have been there for 30 years or so. I have pretty great love of obstetrics. It is one of the great part of being a rural GP. I have got a little illustration of that to show you.

Visual presentation.

Dr TWYCROSS — You can see 'Dr Will' there with his curly hair looking as though it is probably about 25 years ago. The only person missing in that, notably, is the father. That was done by one of my patients just after she had had her third baby. I just wanted to put to you something for your amusement: the obstetrics dilemma — which I think is actually more of a paradox than a dilemma — is that homo sapiens uniquely evolved to walk on two legs, which narrowed the birth canal. Despite this, the brain kept getting bigger. These two evolutionary processes necessitated a skull structure with separate bony plates that could slide over one another in the birth canal to mould the head. Delayed closure of the fontanelles allow rapid continued expansion of the brain after birth, and that is in a sense why we are here today. The evolutionary process has been very successful for the species but not always successful on an individual level. I think it is quite good to look back at the history of our species and how we got to this point.

That is actually borne out in the figures worldwide. In the developing world prenatal mortality rates were around 70 per thousand in the 20th century. They have actually got down to around 40 now because of a bit better control of infection, prematurity, abnormalities, better antenatal care. Interesting enough, in that sort of context the best interventions are really simple, with things like giving everyone folic acid to prevent abnormalities; treating infections, which are often asymptomatic; and better antenatal care. So if you are at that sort of level and you have those sorts of perinatal mortality rates, that is what you are actually looking at as the best intervention. In the developed world — for instance, in Australia and New Zealand — the perinatal mortality rates are down at around seven or eight, and the best in the world consistently over the last 10 years or so has been Japan, which is at about six.

So in addition to respecting the submission that you just had on really important things like depression and other morbidities, the two questions I thought that were pertinent to this inquiry in terms of perinatal mortality, which in a way is the bottom line, are: how do you get from eight to six? — in other words, from where we are to where Japan is — and how do you avoid individual and tragic clusters of deaths? I think these are different problems with very different solutions, interestingly enough. I do want to make sure that I am looking at your terms of reference. You might think I am straying a little bit by going into this sort of context, but I am trying to make it a bit interesting, I suppose, as well, and looking at some different things that may be of interest.

The submissions, I thought, were terrific. I have read half of them, and I was interested in the one from the college, the ones from the big hospitals and the ones from action groups like the Save Healesville Hospital action group, which was terrific with a lot of anecdotal things from women in the area, but I want to do something just from the aspect of small rural hospitals. The things I want to concentrate quickly on are geography, training and models of care and then just a question at the end. I know you are meant to ask me the questions, but I am asking one, if that is okay.

Geography is pretty interesting. There are 42 'small rural' hospitals. One thing that I have a lot of trouble with is when people talk about rural and regional, because rural and regional are two completely different things and I do not think they should ever be in the same phrase. That is the way the health department does it, and I think that should be changed, but that is another matter; that is probably a bigger question than just about perinatal issues. There are 42 small rurals. I think they are loosely defined as having catchment populations of under

12 000. You can see in the middle there, for instance, the Mansfield hospital urgent care presentations. The Mansfield hospital is sort of up there with the more busy of the small rurals. Kilmore is sort of a one-off, really, because it is almost part of Melbourne these days, or is certainly in the Melbourne growth corridor. But Mansfield is a busy rural hospital, with lots of visitors as well. Interesting enough, though, is that of all those small rurals these are the only ones that are actually delivering babies.

So if we go back again, we have got 42 small rurals, and here are the ones that are still delivering babies in this area. There are not a lot. Kilmore, again — because Seymour obstetrics is closed — is collecting a lot of that and also getting the growth up from the north of Melbourne. That is almost an outlier, really. But Mansfield is the busiest apart from Kilmore. Just in terms of where those small rurals are in the state, I thought you would be interested just from the point of view of the inquiry to know where these places are that are still delivering babies even though they are quite small hospitals. There they are there. They are the ones that were on that previous slide — Cohuna, Foster, Kilmore, Kyneton, Mansfield, Orbost, Terang and Yarrawonga. I assume Orbost is almost closed down by now if it has only had six this year. You can see Orbost is fairly close to Bairnsdale, although it is probably further from Bairnsdale than Mansfield would be, for instance, from Wangaratta, so it is all about the same distance. But obviously it is struggling to keep that service open. There, again, among that list of small rurals, they are the ones that are delivering babies. Mostly you will see that they are the hospitals that are also fairly busy in their casualties — in other words, they are the busier small rural hospitals.

In terms of what I want to say to you, I think it is really important for someone from a hospital not to come along to the inquiry and just bark on about their own hospital. I think this is about supporting what I would like to see as one of the outcomes, which is that the state commits through the health department to continue to support the small rural services.

The chair asked me just before at lunch, 'How far is it from Mansfield to Wangaratta?'. It is about an hour and a half, and that is just a little bit too long if you are really in trouble. The thing about obstetrics, as we know, is that it is all fine until it is not fine, and then it is very not fine. Obstetrics produces emergencies very quickly, and they can be quite serious. We are effectively too far away from Wangaratta for people to safely travel in labour. Most of the time they will be all right, but some of the time they will not be. Also just in a geographical context for the interest of the members from further away, if you look at the places there, Seymour obstetrics is closed, Yea I cannot remember having obstetrics service' it probably did.

The DEPUTY CHAIR — Yes.

Dr TWYCROSS — Okay, the chair was born there, excellent. Alexandra is closed; Healesville is closed. There is nothing, really, between Melbourne metropolitan and Wangaratta, apart from Mansfield sitting there and Benalla a bit up the road, but they offer the same service as us, and Benalla is not a small rural; it is a larger district hospital serving a larger population.

I just want to tell a few little anecdotes. Probably someone along the way has shown you a CTG, I imagine. They have not? Okay. This is a CTG. This is a baby's heartbeat, and down the bottom you can see some contractions. Down the bottom is the tocograph, which is the maternal contractions, and up the top is the baby's heartbeat. This is a woman who was being looked after at the Mercy maternity hospital, one of the best in the state, and she came to our hospital. She was on holidays. We had just delivered a local woman by caesarean section 2 hours earlier. This was on Australia Day a few years ago. She came in and she said, 'I have not felt my baby move for two days'. So we put her on the CTG, and even with the tiniest of contractions — she could not feel those contractions; they were just Braxton Hicks contractions, they were just common or garden, nothing, contractions — we knew this baby was in difficulty. In other words, the heartbeat is dropping, just with a little bit of a contraction. We delivered her 20 minutes after the end of that by caesarean section, and she had a severely compromised placenta. She would not have made Melbourne. Having small hospitals dotted around the state is pretty important in terms of saving those sorts of lives.

Another woman just two months ago was delivering a baby in Mansfield. She had had three babies before. As the baby came down the birth canal, but was still probably an hour away from delivery, there was a similar pattern to that but much worse. The fetal heart dropped down to 60 and stayed there. We rushed that patient to theatre and delivered the baby — you can deliver a baby in 3 minutes if you are in a hurry when it is that severe — and she had a true knot in the baby's cord. In other words, the baby had done a loop inside, there was a knot in the cord and as the baby was coming down it just tightened the cord. That baby was going to die in the

next few minutes. This is not common, but it is the sort of thing that can happen, and unless you have hospitals that can get women out of trouble in those situations, then it is problematic.

We had someone just a couple of years ago who was 28 weeks who came in bleeding and in labour. We had to call NETS, which you are familiar with because I am sure you have had lots of submissions about NETS and the need for those services. It is now called PERS. We delivered that 28-week baby by caesarean section. We had to do what we call a classical caesarean section — up and down, because there is no lower segment, so you have to actually do this incision instead of the sideways incision — and that baby survived and the mother survived. The point of telling you the story is that that woman two years later was living in Healesville, whose service has been closed down by Eastern Health in their wisdom. There are 36 traffic lights between Healesville and Box Hill, and at the 24th traffic light she delivered her next baby, which was highly risky because she had already had a caesarean section previously.

I suppose the only point I am really making here is that geography is critical in providing safe services to women. When you do not have access to a hospital and you live a way away from the nearest hospital, you really have got to either go there and wait there or you are going to end up delivering at a place a long way away from home, your relatives are all going to have to go there — it is very disruptive. It also disempowers local communities if they lose their maternity hospital in a way. In other words, people have confidence in their communities if they have good education and if they have good health, and the ability to deliver your baby locally or at least approximate to where you live is a very important part of feeling happy about living in the country, which is something that I think as Victorians we are all trying to achieve. We do not want everyone huddling into Melbourne.

Training I will talk about very briefly, but training is largely a federal responsibility, as you would be aware. Doctors are largely trained through federal programs, and I do not really want to talk about that, because it would go on to long, but I do want to say that midwife training has changed in the last 10 years. In other words, what has happened with midwives is that now instead of actually going and becoming nurses, young women and young men leave school and are going to midwifery school. They come out as midwives; they do not come out as general nurses. So unless we have models of care which can employ those women in smaller hospitals as midwives, then we cannot actually maintain midwives in the country.

So the way we have solved it in Mansfield is that we have a midwifery-led model of care. The midwives are involved in the antenatal care and they are involved in the postnatal care, and the midwives who work as midwives do not work in the rest of the hospital because they are not trained to do that. I am not sure how hard they thought it through when training changed to be that, but it has in a way put at risk the retention of midwives in small rural areas for obvious reasons. You need a certain number of midwives to run a service, and if they are only midwives, if they cannot also be employed as general nurses, that can be problematic. So you have to have that sort of model of care, and that model of care I think is a little bit more expensive to run than the old model of care, where you worked as a midwife and if there were not any babies in the hospital at the time, you went off into the general ward.

The last thing there I had was a query, and the query was about your terms of reference 6, which is:

> disparity in outcomes between rural and regional and metropolitan locations …

The first query I have is why 'rural and regional' is put as one phrase, because I do not believe it ever should be. The second query I have is that it is unclear to me what the disparity is. I can tell you that in our hospital we have not had an avoidable perinatal death for 30 years. In other words, it is a very safe hospital, and I believe that all those other hospitals that I showed you are very safe hospitals as well. So I actually do not think there is a disparity. We are not dealing with high-risk deliveries. Women who have diabetes or have hypertension or are about to deliver twins, they will rightly go to a larger service, but for low-risk women delivering in their local communities, those hospitals are delivering very safely. I sort of have an issue with that. If that is meant to mean that there is a problem out in the bush, I do not think it should be phrased that way. I do not know if it is phrased that way because they think there is a disparity. I do not know what the figures are, but I think that small rurals are actually very safe. That is my own experience, and that is what I would like to tell the committee.

So, again, how do we get from eight to six and how to we avoid individual and tragic clusters? We will get from eight to six by doing the effective interventions and having good antenatal and postnatal care which is accessible. That is about geography. Geographical distribution of services; good tertiary services, which I am

sure you have heard a lot about; good training and best practice, which is largely a federal responsibility as far as doctors are concerned; models of care, which is about midwife-led models of care in small rural hospitals and them being funded properly; and public health — of course smoking, obesity, diabetes and the things that we all know about. Unless they are taken care of, then we have got a problem.

To highlight the fact that there could be a problem, I just point you to the lower right there: maternal deaths in the US are on the rise. This blue line is developed countries generally, which is falling between 1990 and 2013, but in America maternal deaths are actually rising. I would contend that that is probably because of obesity. Public policy in terms of obesity, diabetes prevention — those sorts of things — is actually going to be very crucial to making sure that things get better and not worse in terms of maternal mortality and indeed perinatal care as well. In fact it may be, even if you look at the developed world, just here, you see 2005, and there is a slight trend upwards by 2013. We actually may have seen the best of maternal mortality unless we can do something about obesity. Obesity is really about public policy, with respect, if you will forgive me. Obesity or the politics of food is really at the place where the politics of tobacco was 20 or 30 years ago.

How to avoid individual and tragic clusters? This is a more political question in a way. I imagine this is why we are here, because there was a tragic cluster in Bacchus Marsh some years ago, which we are all aware of. I would just like to put a question on this. This is actually the accreditation certificate for that health service. So in other words, the health service which ran into trouble some years ago was fully accredited. The inquiry which was led by Debora Picone, I think, actually looked into that a bit but agreed that it had been fully accredited. But I do not think that, for what it is worth, the Australian Council on Healthcare Standards has ever really been called into account over that. I believe that this possibly should be something that should be looked into, because the Australian Council on Healthcare Standards are effectively almost a monopoly in terms of accrediting public hospitals in Victoria. There are only three public hospitals in Victoria that are not accredited by the Australian Council on Healthcare Standards. I have no reason to believe that they are not a highly respectable body et cetera, but they are basically run by the medical profession. If you look at their board, it is the who's who of the medical profession in Australia. It is an Australian thing. They are also responsible for what happened in Bundaberg, which also received a full accreditation.

I would just like to pose that as a question, because I do not believe that anyone else will have raised that question, and I believe they did not raise it because there is a conflict of interest there. That might be putting it strongly. They are very respectable, well-meaning people, but I have a problem. They would say, 'Well, we subcontract out the accreditation', but I just do not think that that has been properly analysed — their failure in terms of that health service.

That is pretty much all I want to say. On your terms of reference 1, I just wanted to speak about the record of small rural hospitals, which I think is excellent. On the impact of that loss of commonwealth funding, you heard from the previous presenters; I do not need to elaborate on that. The adequacy of services — that is really all about geography, as far as I am concerned. Quality and safety — when we get equipment in our hospital, we have to fundraise for it; we do not get it from the state. That is a bit of an issue for us, but I do not want to go into our own hospital politics. I do not think that is helpful, but we would like a little bit more help in that regard. Shared care is really about workforce and how I think midwifery needs to be organised. And the disparity in outcomes — I do not think there is a disparity in outcomes in terms of the way small rurals look after their communities. Identification of best practice — best practice is delivering locally with good secondary regional services and tertiary Melbourne services support when necessary.

I go back to my previous slide, which is that midwifery and obstetrics generally is a great thing to be in. I think we should be proud of our services in Victoria. I think that what happened a couple of years ago at Bacchus Marsh was an outlier and really, as long as we are willing to look at those sorts of things and analyse them properly, I think the only thing that has not been analysed in that regard properly is the fact that ACHS is almost a monopoly with regard to providing accreditation. That is all I have got to say. Thank you.

The DEPUTY CHAIR — Thank you. We greatly appreciate your time in coming here today and your experience as a GP obstetrician and anaesthetist in a small country town and looking at the challenges. I am very interested to drill down a little bit about maintaining birthing at rural hospitals. I absolutely take your point about the clear differences between Bendigo being regional or Wodonga, for example. On the one hand, I have heard in the past that the small rural hospitals are under pressure with deliveries because the boards are worried about the risks — the high risk of something going wrong — but also the difficulty in getting GP obstetricians,

that specialist ability and capability in the towns. How easy do you think it is to recruit GP obstetricians, first of all?

Dr TWYCROSS — I think that is a really good question. Doctors have the same anxieties that boards have. Young doctors coming into medicine often look at obstetrics and think, 'Well, that's a pretty risky area to go into'. One of the great things for us has been the VMIA, which is the Victorian Managed Insurance Authority, which we actually take a fair bit of comfort from. That is certainly who I am insured through. I actually do not worry about insurance at all myself. In other words, all I do, and what I tell my registrars to do, is to do your best. You will not always, always get a perfect outcome, but as long as you are doing your best, if there is a bad outcome, then the person needs to be looked after by insurance. That is what you pay your premium for.

As I say, we have not ever had a bad outcome while I have been practising, but it can happen of course. We are aware of that. So the difficulties are: having proper insurance, which I think the state has covered really well; having good training, and through the MCCC, which is Murray City Country Coast, the new manifestation of what used to be for us the Bogong regional training group, we can send our GP registrars away to, say, Wangaratta to train for a year and then come back. Then we have good links with Wangaratta, so our registrars go back to Wangaratta if we are not busy. We have 80 deliveries a year; we try to get them to come back to Wangaratta for a week a year to keep their skills up. That works really well.

We have close links to Wangaratta. In fact our mortality and morbidity meetings are run by one of the Wangaratta obstetricians, so it is independent from us. But clearly the fact is that there are less hospitals. We saw the number of small rurals that are still delivering compared with the number of small rurals. There is a problem, but I think, hopefully with better systems in place for training registrars and keeping them confident in what they are doing, and there is a lot of work going on in that, we can actually keep those hospitals going at a good level. We are certainly confident that we can do that in Mansfield.

The DEPUTY CHAIR — I will just note that in my electorate of 10 000 square kilometres, Mansfield is the only place where people can birth, which is interesting in itself.

Ms BRITNELL — I am just thinking about the challenge that you are talking about: to keep small rural hospitals birthing. It appears that we have got a cohort of doctors in their late 50s and early 60s and we are not encouraging the younger 30 to 40-year-olds. They do not have the ability to come out and practice because there are not many hospitals, and the ones that are practising do not have many births and those that do are covered by doctors such as yourself. So it looks to me like we are coming to a bit of a climax where we have got a real problem where we are just going to have very few. My question is: how do we support doctors and how do we encourage them? What sort of system can we put in place to actually support doctors, because the risk and the reward seems to be the prohibitive driver?

Dr TWYCROSS — Yes, I probably can encourage you a little bit in that regard in that, say, if you took Mansfield at the moment, there is me — I obviously have grey hair — but we also have two registrars who have both done their training, one at Shepparton and one in Perth. They are both working, they both have young families and they are in their 30s. They are coming through and training and doing well. I think the same would be, say, for instance, at Foster. Certainly Benalla, which is not a small rural but is a district hospital, has got some young registrars. So there are training systems in place, but you are probably thinking of your own local area and thinking, 'Well, how are they going at —

Ms BRITNELL — Warrnambool?

Dr TWYCROSS — Warrnambool must be right, surely. Yes, so there is a challenge, but all the rural training groups now have training places — for instance, at Traralgon, at Wangaratta, at Shepparton. To one of the people that applied to come to Mansfield two years ago, I said, 'You can come to Mansfield, but you've got to get a training place somewhere else'. They went to Perth and then they came back. So there is a bit of interstate movement as well.

Ms BRITNELL — It is still not going to meet the demand, though; it is sort of ad hoc and depending upon whether someone feels the need. Are there any sorts of incentives that we could encourage people with?

Dr TWYCROSS — There are some training incentives. There is a rural training incentive, which is generally applied to rural doctors who have been working rurally for more than five years. I am just trying to

remember, but it might be about $15 000 a year if you have been working rurally for more than five years, not just in obstetrics but generally. There are also training grants if you go off and do education — for instance, if you went to an obstetrics conference, which is clearly procedural, you would get a grant for that as well. Again, I think these are mainly federal responsibilities, and, to me, they are reasonably well covered or they are getting better.

The DEPUTY CHAIR — Will, can you just let me how many GP obstetricians there are in Mansfield all up?

Dr TWYCROSS — There are two practices in Mansfield and there are two at one of the surgeries and four at the other.

The DEPUTY CHAIR — On top of the registrars?

Dr TWYCROSS — No, that includes registrars.

The DEPUTY CHAIR — That includes the registrars. What do you not deliver and at what point do you refer somebody onto a high-level hospital?

Dr TWYCROSS — We try not to deliver twins, although that would not be a problem if we had to. We try not to deliver women with severe gestational diabetes, although those with mild gestational diabetes we do. We try not to deliver women with severe hypertension. We try not to deliver women who demonstrably have small-for-dates babies — if the babies are not meeting growth milestones. We are regarded as a low-risk facility, and there are very strict criteria around that that the health department have set. At all of our morbidity and mortality meetings — and, fortunately, at these meetings while I have been there there have been a couple of mortalities but they have been unavoidable; they have been severe birth defects and that sort of thing, or babies delivered at 25 weeks unexpectedly — those sort of things are all analysed and are reportable to the health department of course. If we were to look at Mansfield and the number of women who have babies every year, it would be about 105 and the number of women who deliver in the hospital would be about 80, although it is a bit confused now because we are doing quite a lot from Alexandra and some from Yea and even some from Seymour.

Ms BRITNELL — Can I ask how much the insurance is per annum, and is that on top of your GP insurance? Would you be able to run your business, for want of a horrible word to use in health care, without the maternity element of it? Is that the driver, that you enjoy the work? Tell me about the business around it.

Dr TWYCROSS — The work actually costs me money. For the time I put into it, I could earn more money doing something else. That is a bit of a problem, but the emphasis is — this might be an outlier view and I would like to convey this — that there is such pleasure in obstetrics and delivering babies that it does not matter that it costs money to do it. It does not cost a lot. If I do a caesarean section, I think I get $800, but if I did antenatal care in Melbourne and delivered a baby I would get $15 000. So there is a pretty big discrepancy there even though the skill level is not a lot different. I think you also asked me about insurance. You would probably have to ask my practice manager because I do not know what the insurance is, but it is probably about $10 000 and I think half of it is paid by the hospital.

The DEPUTY CHAIR — My final question is regarding the registrars, which you mentioned earlier. You said if there is an opportunity, they will go back to Wangaratta for a week and do their birth rate increases. Do other hospitals do that sort of thing, do you know?

Dr TWYCROSS — I know Benalla do. I only really know about here. But of the small rurals that I showed you before — I am sorry if anyone has just come and did not see that — in places like Foster, Kilmore, they probably have the same system, I would think. It is a really necessary system for a young doctor. I probably did not want to elaborate on this, but I learned in Africa. I ran a birthing unit in Africa with 3000 deliveries a year for five years so none of this is any problem to me. For those who have been here for a year, I support them but they do need to keep their numbers up. I would think that every small rural should have that system in place. One good outcome of the increase in governance is that I think a really good model for governance is a model we have here, which is that the director of medical services in Wangaratta is the director of medical services in Mansfield, and the senior obstetrician in Wangaratta runs the M and M meetings, the morbidity and mortality meetings, so we have a really close link to Wangaratta. When we ring them up, we know who we are talking to.

I think that also links the registrars into that system. It is a really good question, because I think if they are not doing it they should be doing it.

The DEPUTY CHAIR — Is there a required number of births that the obstetricians or the registrars need to have every year to maintain accreditation?

Dr TWYCROSS — There is not, but there is an accreditation process that the hospital has which is run with the director of medical services here. I suppose really until three or four years ago we only had two or three doctors doing deliveries, so we always thought 'Oh well, we are doing enough'. I probably should not say this, but obstetrics is a little bit like riding a bicycle: if you have done enough of it for long enough, you are probably okay at doing it still. But it is a good question because you would not want to be getting down to 10 deliveries a year or something like that.

The DEPUTY CHAIR — Which jeopardises the service here.

Dr TWYCROSS — Yes.

The DEPUTY CHAIR — Thank you, Dr Twycross, for coming in today. It has been particularly enlightening and it is great to have somebody from the type of background you have and representing small country hospitals.

Dr TWYCROSS — Thank you very much to the committee, the Hansard reporters and also the organisers.

Witness withdrew.