Submission
No 34

INQUIRY INTO BIRTH TRAUMA

Name: Name suppressed

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Partially
Confidential

I am a midwife who worked in NSW at Hospital in 2017 on a short-term contract and I wanted to give my perspective on the birth trauma inquiry.

I had previously worked in QLD and WA prior to my contract in NSW health. I have since worked in over 15 hospitals in 5 states and my experience with NSW health contributed to my own vicarious birth trauma, through what others had endured that I wouldn't want done to myself.

During my time in NSW there were significant and chronic staff shortages and the midwives, including myself, raised the issue multiple times. On one occasion, the Director of Nursing attended the maternity ward, where I took the time to express that I was gravely concerned. At this point, I felt it was so unsafe that I genuinely feared for my registration and was counting down the shifts on my contract until I could get out. I distinctly remember her telling me that they would not increase staffing or do anything until a death occurred, to which I replied that a death was going to be inevitable given the circumstances.

There were often situations where there were no midwives allocated for labour ward. When a labouring woman did present it meant that the babies in special care were often left unattended or in the hands of an enrolled nurse. Vulnerable postnatal women were also often unattended and left alone in tears, recovering from caesareans and unable to breastfeed. They were left trying to work it out alone because the labouring women had to take priority. Compounding the issue, nearby towns such as Leeton hospital was on bypass and yet no additional midwives were sourced to cover the extra workload.

One night, I walked past the special care nursery on my way to labour ward after a lady presented spontaneously in labour. One of the neonates was desaturating and the enrolled nurse pulled from the nursing wards to help was turning off the alarm. When I questioned what she was doing, she said “It keeps beeping”. She had no idea that the desaturation was a sign of a deteriorating baby that needed its airway repositioned and closer observation. I remember thinking it was just luck that I had walked past when I did. Once I had finished the birth in labour ward, it was morning, I went back to the postnatal ward where I was originally allocated. I assumed that somebody would have been called to replace me. Instead, I was shocked to find one of the women in my care had not fed her baby all night, she was in tears and angry. She had rung the bell and it had been left unanswered. Nobody attended to her the entire time I was called to the birthing woman. Her baby was starving, and she was laying in soiled sheets because she was immobile from a caesarean section. I felt so heartbroken for her and felt like I too had failed. I didn't want to come back the next night, but I knew if I didn't, they wouldn't replace me, “there's no staff” would be an acceptable excuse to leave these women alone without any help. No nurse manager ever stepped up to help or did anything significant to try replacing the shortage. They weren't midwives and didn't see why healthy women needed a midwife postnatally, reciting “they've delivered haven't they” these first-time mums were alone, isolated in a hospital needing help.

I also witnessed a lot of things that fell below a respectful standard. One that really disappointed me was a lady with twins who had declined a caesarean section. She had done her research and wanted to birth vaginally. She was treated terribly; her rights weren't respected, and she was harassed endlessly via phone. She ended up failing to attend her last appointments due to the pressure and then presenting without warning fully dilated and ready to push. After the first twin was out, she was refused delayed cord clamping and skin to skin with her baby. They took her baby off her and made it have a paediatric check before the second baby was even out and against their wishes. I honestly believe this was done as a punishment for going against the directive of a caesarean section. The baby came out with Apgar's 9 and there was no clinical indication to remove it from the mother. Unfortunately, the Labor ward felt like it had a bit of a school yard mentality and there was an us against them attitude. The health professionals against the rouge and dangerous parents who declined the recommended caesarean. There was certainly a power play where the obstetric and maternity team were using their positions of power to undermine the parents and make out like they had somehow been reckless by overreacting with intervention after they did finally present. The problem with this attitude was that the health professionals determined that they were right, and they had ultimate authority. They didn't consider that there is a clear variation in healthcare solely based on one clinician's decision making. If this mother had of presented to another hospital who supported vaginal twin birth, she wouldn't have had to fight for her right to birth vaginally. She would have continued to attend appointments and been supported in her choices. It was largely the clinicians lack of experience with vaginal twin deliveries and a system that placed all power onto individual clinician decisions that caused this family to withdraw and cease all interaction with the hospital until they arrived fully dilated and pushing. Consequently, they were then treated with contempt for having the bravery to advocate for themselves and get the outcome that they would have also been offered in a different maternity unit with different clinicians.

There were a lot of other obscure things that I saw in my time, things that wouldn't happen elsewhere. There are too many scenarios for me to elaborate but variety ranged from Doctors coming into labour ward to ask for stickers to claim funding for births they never attended and were done entirely by midwives. Vacuum extractions done under general anaesthetic, which would lack maternal pushing effort and a risk of fetal entrapment means it is not practiced anywhere else in Australia. Women who declined active management only to unnecessarily receive the highest doses of medicine at the first sign of excessive bleeding. This again seemed to be another bullying tactic done with staff contributing to the bleeding by pulling on the cord to try remove the placenta and to show the women how silly it was to decline in the first place. These interventions led to an increased in blood pressure, vomiting and further observations which was portrayed as a cause of the Initial bleeding and declining of active management rather than a consequence of the health professional's excessive management of postpartum bleeding.

Despite my family residing in NSW, I have never worked in NSWs again after this experience. The attitude of senior management at the time gave me the perspective that this was not isolated to the hospital but a statewide perspective to save money and I personally left feeling like it was the most unsafe state for both women and midwives. In all the hospitals I have worked in during my career I felt like was the most unsafe and lacked any form of governance over the quality of healthcare.

Birth trauma itself is not isolated to NSWs health, it is rife throughout Australia especially in rural areas where midwives are limited in their scope of practice and unable to provide supportive care tailored to women's needs. Birth trauma happens when women feel their sense of control over their own body is taken from them. At a time when birth can be unpredictable, it is a skill to water down the traditional paternalistic medicine and tailor communication in a way which supports women's choices free of coercion, in a holistic and respectful matter suited to the individual.

The hospital structure itself is not designed in a way which allows women to go internal and do what needs to be done to birth their babies. These women are barged in on, have ward rounds done on them in Labor and then labelled as failures to progress when they don't perform in accordance with an algorithm. They don't feel safe, they don't feel comfortable, and it goes against everything we know about what is required for normal birth.

So how do we fix a system where both obstetricians and midwives aren't supported or incentivised to support women's needs?

- Australian wide or statewide Pathways for the management of women declining recommended care that absolve health practitioners from the fear of litigation and reduce coercive control
- All nursing directors that oversee a maternity unit be qualified in midwifery.
- All directors of nursing and any management overseeing midwifery should have midwifery qualifications. A common theme I see in poorly managed maternity services is that upper management have no experience in maternity or newborn care and therefore don't understand why midwifery is much more complex than mainstream nursing. Having nursing managers make decisions on maternity services is like having a GP make decisions on how a cardiology unit runs, they're both doctors but it's different. Equally having nursing management make maternity decisions just doesn't work.
- Creating chief midwifery officer role for somebody who is an endorsed midwife experienced on every aspect of maternity care.

- Having a clear goal of reducing maternity care variation by each hospital. Doing this by having Australian wide guidelines that are developed from evidence and regularly updated by a panel with equal representation of maternity and obstetric care. There should never be such a variation in maternity care that two women presenting with the exact same scenarios get offered two different pathways to birth. For example, a large baby with no other risk factors being recommended a caesarean when in the hospital the next suburb over the same clinical scenario is having no intervention. More live data monitoring would also help hold hospitals to account regarding their birth outcomes.

We know women who feel powerless and have no control over their own body exit that system. They turn to homebirth and when there's no midwife available, they'll do it without one, on their own. They want their power back which places them in situations that wouldn't happen if they felt safe and supported by the current maternity system to make their own decisions.

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