Submission No 966

INQUIRY INTO BIRTH TRAUMA

Name: Name suppressed

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I am a registered midwife working in the public health system and occasionally within the private health system in NSW.

I have over 20 years of experience as a midwife in NSW and overseas.

On commencement of my career as a midwife in NSW I was shocked by the paternalism and hierarchical relationships that continue to exist between obstetric Dr's and midwives. It is embedded into health culture and exists historically because women historically consider that obstetricians are the experts in childbirth. Midwifery is misunderstood. Midwives are autonomous practitioners yet they are often called nurses and lack recognition in their own right. A chief Midwife is required at state level to address midwifery and enhance the profile of midwifery in NSW.

Naively women choose private care and consider this a safer option without realising that with pregnancy risk factors they may in fact be at risk for choosing to birth in private hospitals that do not have out of hours support (timely theatre access, onsite neonatal support as examples), women are not informed that they are birthing in a hospital without the supports they may require. Women are recommended interventional procedures that suit the needs of the obstetrician rather than the wellbeing of the woman and her baby.

In public hospitals increases in intervention, lack of equipment, increased expectations to do more with the same or less resources, an aging and resigning workforce without numbers to replace them lead to increased risk of intervention.

RM's (not dual registered as a nurse) are being told by after hours hospital managers to accept and care for general medical/surgical patients on maternity wards which is outside of their scope of practice and means midwives are not able to provide adequate care for the women and babies who require their care.

Lack of ratios on maternity wards mean RM's are caring for both mothers and babies (often with significant risk factors) the equivalent of caring for and managing 8-10 high risk patients (observations, medications, breastfeeding assistance, education, psychosocial support). Discharging women to the community without adequate support, meaning women represent back into the ED within the first week of birth for analgesia due to pain, bleeding, high blood pressure and for having an unsettled baby.

Midwifery continuity models of care are not seen as financially beneficial by executive boards who lack understanding of midwifery, despite research-based evidence to the contrary that not only are they cost effective they also reduce intervention and increase positive outcomes. Models of care should be available to all women and midwifery should be funded for the same.

Midwives are uniquely placed to provide population health intervention at a teachable time where women and families are more motivated to change yet this is being used to target midwives with more work with inadequate antenatal capacity to provide the same.

Women sit in antiquated waiting areas some not fit for purpose, waiting two hours for a 15 minute appointment with a different Dr or midwife who they have to retell their traumatic story or complex history to, and hope that the Dr/midwife is across their care to recommend (loose term) appropriate ongoing care that may or may not meet the needs of that woman. Women are being told they need an IOL or a C/S, women are told to have tests because they are routine (GBS, USS) without being told that it may mean intervention, without having the reason explained or any risk associated with the process before agreeing to the same. Tests are being undertaken without consent or without it being known.

Cognitive bias and embedded cultural practice seeps across all aspects of maternity care. Midwives and Dr's are fearful of speaking up for fear of being bullied, targeted or managed out risk of loss of job.

Women are experiencing birth trauma at alarming rates. No consent, not being told about risks, denied treatment, threatened, coerced, told they are making ridiculous dangerous choices, judged for seeking care when their home birth midwife escalates appropriately and transfers the woman to hospital (and the home birth midwife gets judged and bullied and questioned and reported for providing compassionate care). Judged for choosing care outside of guidelines. If you are from minority populations (cultural and indigenous) you are more likely to experience poor outcomes and are less likely to speak up about your experience. There is an unknown number of women with pregnancy and birth related trauma that have never spoken up.

Maternity services in NSW require significant review and funding to meet the needs of the women and families of NSW, to meet the needs of our future generations, to meet the evidence presented within the first 2000 days and NSW blueprint Connecting Listening and Responding. If the Government and executive boards at LHD's invest in maternity services, morale and outcomes would improve and women would receive the respectful care that they deserve.