Submission No 1450

INQUIRY INTO BIRTH TRAUMA

Name: Name suppressed

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Dear Committee Members,

I am writing as a junior doctor to tell you of the disrespectful, bullying and obstructive actions I have witnessed by midwives who disregarded patient choices, lied to the labouring woman and refused to provide planned and requested analgesia which resulted in birth trauma for the labouring woman. I am also a friend of multiple women who have gone through the public health system and suffered during their births due to the actions of midwives. These are not isolated incidents. This a profession-wide practice by midwives underpinned by anti-medication, anti-intervention dogma which actively goes against best evidence-based practice and patient care that I have witnessed as a medical student, junior doctor and friend to women who have birthed babies in the public system over a 10 year period.

As a medical student at the Hospital in , I witnessed first hand that midwives lied to patients, over-riding their personal informed choices and birth plans when it came it to analgesia. This took the form of telling them that the Anesthetist was busy and couldn't come down yet, when this was false: they had never called the Registrar. When I offered to make the call to see where the Anaesthetics Registrar was up to, they told me no, there is no need, "she'll be fine."

As an intern at Hospital in , on my first shift in Birth Suite, I went to all the labouring women to introduce myself and see if there was anything I could do for them. One woman told me she was waiting on her epidural: it was in her birth plan, she had been assessed in the Anaesthetic Obstetric Clinic and the plan was for the Registrar to be called when she arrived to Birth Suite. This woman told me it had been 2 hours and she still hadn't received her epidural. She said she was in pain, and would like an epidural. I assured her I would look into it. I called the DECT phone for the Anaesthetics On-Call Registrar. Apologising for disturbing him, I asked if he had an idea of how long he'd be to do my patient's epidural. The Anaesthetics Registrar informed me he had never been called, had no idea, and was free, actually, and could come down now. I went back to tell the patient that the Registrar was on his way, omitting the fact he had never been called. The Registrar came down, did the epidural successfully and left. I stayed for the procedure, for my own learning. On the way out of the room, the woman's allocated midwife approached me. She asked who that was, and what was going on. I told her that it was the Anaesthetics Registrar, leaving, having put in an epidural as requested by the patient. She was visibly displeased and told me that "she would have been fine!". I chose not to engage further but said the patient was happy. From that day on, I was bullied by the midwives in that Department, as I had advocated for my patient in getting the analgesia and birth experience she had wanted.

Again, as an intern in Hospital in , I was working in Obstetrics. We had a woman who had experienced late second trimester intra-uterine foetal death. This was her third intra-uterine foetal death, but the first two had happened late in the first trimester/early in the second, and she had been able to have a dilatation and curettage procedure under anaesthesia. This would be her first time giving birth, and her baby was dead. I was tasked with admitting her, discussing analgesia, and broaching the topic of genetic testing, as this was the third baby with the same partner to have died, and the underlying cause was unknown. I was sitting in the staff station, and writing up her analgesia options, all "on request" (known as PRN in medical terminology). I had written up a suite of options, and as was the practice, numbered them, indicating order of escalation. This included non-opiate analgesia, as well as different types of opiate analgesia via different routes (intramuscular, intravenous, oral). I had also included a benzodiazepine, as an

anxiolytic, having discussed the option with the patient. Additionally, I included two different anti-emetics, so if the patient experienced nausea, she could be treated. The Midwife in Charge that day took my patient's medication chart and berated me. "What is all this? Cross this out! She doesn't need this! Some paracetamol and temazepam and she'll be fine!" She was standing over me, as I was sitting. I was shocked, and appalled. For a labouring woman about to give birth to a dead child, this midwife had no compassion at all. I explained that she was the lady in the Butterfly room who giving birth to the dead baby. This changed nothing, not that it really mattered, because my prescribed PRN analgesia was all within normal prescribing limits and correctly done. This midwife insisted, and said she wouldn't give the medications even if I had written them up. To my shame, I allowed myself to be bullied into reducing my PRN options. Later, my senior supervisor, a Fellow in Obstetrics and Gynaecology, found me and berated me for having no compassion and writing up insufficient analgesia for the woman. I explained the interaction with the midwife and my Fellow's response was, rightly, that I'm a doctor, and need to back myself.

At this same department, we had a woman of South Asian heritage give birth to twins via C-section. She had a wonderful supportive family, and her mother-in-law was particularly attentive. The midwives commented that this woman who had just had major abdominal surgery was "...needy, and a lot of work. She's a princess who expects me to hand her her babies and not even have to get up for them!" The midwives laughed, sat down and had tea and biscuits while that woman's call light went unattended. She had needed help mobilising to the bathroom. Understandable, ,at day 1 post-op, that she would be exhausted, unsteady on her feet, in pain from the surgery and needing help. This patient's choice to have a C-section was also disparaged and it was implied she was too lazy to give birth vaginally. Some comments with implied racist undertones were also met, about her family's involvement and support of her.

At a department meeting, for planning before a public holiday, when the unit has fewer staff members available and there is increased risk to patients, the case of a woman with pre-eclampsia was being discussed. This woman had almost exhausted medical management (maximum doses, maximum combinations tried, she was on two antihypertensives and Obstetric Medicine was contemplating adding a third). The Consultant Obstetrician was making a plan, that if the third medication failed to bring down her blood pressure in the next 24-48hours, she would be booked for C-section. The treatment for pre-eclampsia is delivery. The risks of pre-eclampsia include progression to eclampsia, with seizures, disrupted blood supply to the baby and mother, and maternal and foetal death. If the blood pressure is not brought down, the woman may have complications. The Obstetrics team had kept her in hospital for weeks, and she had passed the 34 week mark now, so the risks of early delivery to baby were minimised. The midwives argued that the Consultant Obstetrician had "no confidence" [in his skills] and "wouldn't allow a woman to labour". This woman was not in labour. She was hypertensive, failing medical management, and at risk of serious harm. The Obstetrician did not argue but instructed us, his juniors, to book theatre. I worked the weekend. This woman failed medical management. She went to C-section. She and the baby remained healthy. Her blood pressure remained elevated post-delivery. She was kept in for 2 weeks post-delivery to wean her off antihypertensives until she was only on one type of antihypertensive tablet, and stable enough to be discharged to the community, for blood pressure monitoring with her General Practitioner. This was a clear-cut case. The plan being discussed was necessary for the safety of the woman and her unborn child. .The midwives had such a strong anti-intervention bias that they tried to obstruct appropriate care.

These are selected examples of common, daily interactions with midwives and daily, routine, attitudes towards patients and their choices. In my experience, midwives do not respect a woman's

choice. They only support and respect a woman's choice when it aligns with their anti-intervention, anti-pain-relief, anti-operative intervention agenda. If a woman chooses to have analgesia, if a woman chooses to have a C-section, and even if a woman must have those things to ensure the safe delivery of her child and her own personal health and safety, midwives in my experience as a junior doctor actively obstruct their care and try to force their own views on the labouring woman. They lie to patients and they deny patients their informed decision making. Midwives have propagated a "natural is best" dogma and shaming culture which makes women feel like failures if they do not have a drug-free, vaginal birth. This is highly damaging to women, and absurd! The entire goal of modern medicine is to improve quality of life, length of life and reduce unnecessary deaths. If a woman has complications during pregnancy, as many do, it's a miracle that we can now manage this and deliver baby safely while keeping the mother safe and alive. This is nothing for the woman to feel shame about! Receiving treatment you need isn't shameful!

There is absolutely unacceptable territorialism between midwives which results in dangerous patient care. The Hospital in allowed "Midwifery Group" private practice. These midwives would bring in their private patients to give birth in the Hospital birth suites. They would not communicate with the midwives from the Department, or with the Obstetrics team. They did, however, rely on us to save their patients' lives when something went wrong. I personally experienced a urgent MET call for huge post-partum haemorrhage on one of these women, when we as a Department had not been notified she had even given birth. The private practice midwife said "oh, yes, she birthed 2 hours ago". We were under the impression that she was still in labour. The medical team jumped in and stabilised the patient, providing fluids, blood and analgesia. The patient was taken to theatre. Her life was saved, by the doctors of Hospital.

This is not an isolated incident. This was not isolated to the group midwifery patients. In-department midwife-led care patients were also "hidden" from the Obstetrics team, up until the point that something went wrong, and we had to save their life. The Obstetrics team, namely the Obstetric Consultant on that day, gets all the responsibility for the end-patient outcome, yet is actively excluded by the midwives from up-to-date information, and even obstructed from providing care to shared-care patients by midwives who advocate for dangerous continuation of non-intervention.

Midwives also actively attempt to exclude the patient's General Practitioner from their care. Communication with the GP during prenatal care is close to non-existent. Midwives actively discourage women from seeing their GP in the prenatal and post-natal period. I have heard midwives saying to patients post-partum "oh, there's no need to see your GP, your midwife can do that" regarding the 6 week baby check. I had to step in and say, actually, "you need more than a 6 week baby check, you've had anaemia, and blood loss, and are on iron-supplements. You'll need your bloods done and checked at the 6 week mark, to adjust your supplementation dose as needed. We also discussed contraception, and you've said you'd like to see your GP for a Mirena, so that can also be done then. Plus, if there is anything that needs looking into with baby, your GP can make those referrals for you, including imaging." The midwife was livid and took me aside to berate me for minimising the role of the woman's private midwife, who did not attend the birth, and was not involved in that patient's emergency C-section for foetal distress. I responded that the midwife had no role at this point, and the woman needs to see her GP for multiple reasons, and that the midwife's dismissal of the GP's central role in this woman's ongoing care was inappropriate.

This anti-doctor attitude is widespread in midwifery and is inappropriate, dangerous for the woman and baby, and disrespectful not only to the doctors involved, but to the patient and their right to appropriate medical care.

This was also something I have seen as a friend to labouring women.

I have two friends, who have also chosen to make submissions to this enquiry, who suffered birth trauma at the hands of midwives who disregarded their choices, lied to them about having called for the Anaesthetics Registrar to do their epidural, and forced them to experience painful, traumatic births. The first friend had wanted multiple children and a large family, and found her birth so traumatising that she has decided to not have any more children. The second, is herself a General Practitioner who had worked at the hospital in which she was giving birth and whose then-husband was a Consultant Physician at that same hospital. Even two highly educated medical professionals familiar with the system, process and risks, were unable to advocate for themselves and have their birth plans respected. My friend did not get her epidural either time. The midwives had not called the Anaesthetics registrar. Again and again I see the same blatant disregard and disrespect for a woman's choices when they do not agree with the midwifery agenda.

A 10 year study from the in (attached) which took into account 44 557 patients showed that there is no benefit to midwifery-led care over Obstetrics-based care for low-risk women and women with all levels of perinatal risk cared for under traditional obstetrician-led models of care.

The public system marginalises Obstetrics and allows midwives to set an essentially anti-woman agenda which results in birth trauma. I don't understand how this has been allowed to happen, but the high volume of low-quality research by midwives advocating for their model of care certainly plays a part. This enquiry itself, with the way it is worded, is biased against necessary medical intervention and I believe, is another political attempt to establish the midwifery dogma as universal truth.

To quote the AMAQ Queensland Maternity Services Discussion paper (attached): "It is clearly inappropriate for an obstetrician to only be made aware of a labour problem once it has become acute or serious, sometimes many hours after it began to develop. The obstetrician is then expected to assume all responsibility for the care and outcome of the mother and baby. This scenario is reported to be frequent in our public hospitals and results in potential inappropriate delay to definitive care. The current public hospital maternity services model could best be described as midwife-led with obstetrician rescue."

With my professional and personal experiences, I will never allow a midwife to provide my personal pregnancy care. I plan on paying for private insurance and going with a GP/Obstetrics shared care model, with a private delivery. I believe this will give me choice, respect for my choices, and better outcomes than care in a midwife-led public system. However, I am appalled that I will have to pay for what should be my right as a taxpayer and public patient, to receive appropriate, respectful pregnancy care.

I strongly urge the members of this Committee to stand up for women and their choices and put into legislation the Obstetrics-led pregnancy model which respects a woman's informed choices.