Beverley Walker

14.09.09

Ms Claire Moore
Chair
Senate Community Affairs Legislation Committee

By E-mail: community.affairs.sen@aph.gov.au

Dear Senator Moore

Re: Inquiry into Health Legislation Amendment
(Midwives and Nurse Practitioners) Bill 2009 and two related Bills

I write to express my concern about the above bills. I understand that these bills will enable Medicare funding, access to the Pharmaceutical Benefits Scheme and professional indemnity premium support for midwives providing care for women to give birth in hospital.

Medicare funding for midwifery care is long overdue.

It is not acceptable however to exclude homebirth from this funding and indemnity arrangement. By doing this Australia is totally out of step with nations such as the United Kingdom, Canada, The Netherlands and New Zealand.

These nations support the rights of women to choose homebirth and fund a registered midwife through their national health scheme. In New Zealand and the U.K women have a legislative right to choose homebirth.

The intersection of this legislation with the national registration and accreditation of health professionals will prevent homebirth midwives from registering.

I believe this to be an unintended consequence and ask that you take steps to include homebirth within the Health Legislation Amendment (Midwives and Nurse Practitioners) and related Bills.

I support a system where all consumers are treated equally, with the same access to funding and the same insurance protection as the medical profession.

My comments in relation ot Homebirth:

- I have observed and heard described from 1962-2009, practices in bush nursing, as well as public and private hospitals where midwives are the carers of pregnant antenatal labouring and postnatal normally healthy women for the 90% or majority of time.
- Doctors are called to be present by the midwife when the woman is ready to give birth or/and for any deviation from the normal process.
- The doctor's presence, except when required for abnormal birth, lasts long enough for congratulations, signing of the forms for the birth and a cup of tea for the doctor.
- The midwife does the work for the antepartum, intrapartum and postpartum care professionally legally and solely responsible for the woman and baby.

- It is therefore strange to me that there is such a concern about the safety of women in the care of professional and experienced midwives in the home.

- Midwives are rarely litigated against.

- REASONS;
  - It is stated to be that litigation occurs when clients are not given reasons or apologies for poor outcomes.
  - According to Victorian State health reports nurses and midwives have good communication skills.
  - The medical profession have been instructed in recent years to improve their communication skills.
  - Printed material is now handed to clients.
  - Lack of communication was the content of the majority of complaints in State Health Reports about the medical professions' behaviour.

- A doctor claiming to be a registered obstetrician/ gynaecologist continues to practise where I live.

- The past history of this man is known to me through my work in a major teaching hospital for over 9 years.

- In my opinion he should have been charged with assault.

- I am appalled that he has not been de-registered.

- I advised a friend in this area to go to Melbourne for her care without giving my reasons other than his wife chopped up his red Lamborghini with an axe.

- I knew that she would otherwise be obliged to take up an appointment with this man.

- Because she could not get to see an efficient and busy practitioner in Melbourne for 3 months she chose to be in the care of this man.

  - What ensued was appalling and predictable.

  - One year later after an unnecessary (in my opinion) - total hysterectomy – she has finally been seen by a Melbourne Physician and the problem of an inguinal hernia corrected

  - His manner was and continues to be arrogant and careless.
    - I am not allowed to name him.
    - He was not named in three cases of near death for 3 women and the death of a baby at least once during my time in his vicinity.
    - This is not an unusual story – as my 50 years of clinical practice bears witness to a number of assaults on women – the challenging of which on 3 occasions resulted in threats to my senior position.

- I need to write a book.

- I feel like screaming from the roof tops about the iatragenic (hospital) causes of why many women opt for homebirth

- I continue to try to be professional and reasonable in my approach.
- I do not promote homebirth per se but I educate women to recognise why the choice must be there.

- I learned to work in other ways to achieve better results.

- Why do many women would choose to have a baby at home?

- Is it the loss of dignity?

- for example:

    - Vaginal examinations exceeding 10 in public hospital systems for some women through out the time of conception to birth and beyond.

    - The disrespectful treatment of women in hospital settings is legion.

    - One leading obstetrician carried out vaginal examinations without speaking to the women - no informed consent before and no information given after – role modeling for student and resident doctors.

    - When I challenged this practice I was told to leave and take the students with by the then DON via this man who then standing for the President of the AMA.

    - I and students didn't leave and he did not win his desired post.

- I know of three cases of women in the last two years who were told by leading obstetricians "your baby might die if the baby is not induced"
- The scientific evidence was the newly acquired technology and skill of measuring liquor (fluid whichsurrounds the baby)
- The sword hanging over the women is 2 cms of reduced liquor..
    - Babies lose weight at term to reduce the size of the uterus which in turn enhances the fetal ejection reflex.

- Two of these babies weighed over 3.0 kgs at birth (one who escaped and became a normal birth).

- <u>In my experienced opinion the "Obstetric Cascade" of intervention has resulted in Caesarian birth rates in private hospitals move from 5% in the 1970's to 39%-45% in 2009</u>

    - The morbidity from Caesarian birth , has increased exponentially.
    - Scarring– physical
    - Mental - including depression
    - Breastfeeding difficulty
    - Role models in the medical field are present, I can name two or three.

QUESTION 1

- Tell me why women would prefer to stay at home to have a baby?
- Tell me why aboriginal women hide from the plane when they are to be taken to white womens' hospitals in out back NSW, Queensland in Australia and British Columbia, Canada.
- In far north British Columbia where I did a comparative study similar patterns of fear were present.
    - Coercion to go to a public hospital 1000's kms away.
    - Left in town of public hospital without social support to go back home.

QUESTION 2

Why do experienced professional registered midwives burn up their energy to fight government legislation for the right to give women care in the home?

QUESTION 3

- Why are midwives leaving the hospital setting?
    - Majority due to poor work satisfaction?
        - Most do not have the courage to do what is best for women in the hospital setting
        - The majority end up working in department stores.
        - Attrition must be very costly for Governments

Yours truly

Beverley Walker M. Bioeth. (Monash) B. App.Sc. (RMIT)
Wife
Mother of 4
Grandmother of 7

RELEVANT QUALIFICATIONS extracted from 4 pages of 8 font Curriculum Vitae.
Midwife 1962 – date or death!
Steering committee member of the Maternity Coalition and member to date.
Member of the Midwives in Independent Practice MIPP until 2001
Co-ordinator of Midwifery Course 1995-1998
Senior University Lecturer RMIT 1989 – 1998
Member of the State Midwife Examiners Committee of Victoria to 1993
Appointed to the Victorian Nurses Board 1993
Appointed to the Victorian Government Midwifery Advisory Committee 1993-1996
Elected to the Nurses Board of Victoria by the nurses and midwives of Victoria 1991
Elected as an Independent to the Victorian Branch Council of the ANF 1986

DOUBLE JEOPARDY – MIDWIFE AND MOTHER

Another woman remarked about lack of consent "It wasn't until some time after he was born I realised I'd had an episiotomy. *No one has asked my permission or even explained what they were doing*[1].

INTRODUCTION

I have been sitting here looking at books reading studies and former submissions. My successful Masters thesis about the autonomy of women when making a choice about infant nutrition is full of wise and wonderful words. I have taken part in campaigns, supported home birth and been a member of every professional body known to midwives. I was on the steering committee of the Maternity Coalition, and still an honorary member. Over the last 48 years of my midwifery activist life I was a Victorian State midwife examiner and Chair/Adviser to the Victorian government on the Executive Committee of the Victorian Nurses Council. I was elected to the Victorian Branch Council of the Australian Nurses Federation

ANOTHER SUBMISSION FULL OF WORDS – BLOCKAGE AND A SOLUTION I have been blocked by the thought of writing yet another submission – which does not come from my heart – but comes from my very well educated head. I am an expert and qualified observer of pregnant women and their babies. I qualified as an International Board Certified Lactation Consultant in 1995. In that capacity as a retiree I am still helping many women to successfully breastfeed and hear many stories that curl my hair.

MY DAUGHTER'S BIRTH

I recalled the papers I have given and particularly the one to a Latrobe University conference. Double Jeopardy Mother and midwife. This paper related to my daughter's complicated and fractious birth and how between us we achieved a non-interventionist birth even though at her age of 26 and mine of 66 we were not exactly best of friends. This situation did not allow me to pass on my in depth knowledge but due to her long time live in family relationship of 22 years. V. stated after the birth that she had "learned something from listening to me growing up". I had just asked V. why she stood up to the numerous requests to intervene in the timing of her birth.

A RECENT STORY

The most recent story told directly to me from a woman in my care in July 2008. Sarah was told that "if she was not induced her baby might die". The same phrase was repeated to two other women by highly qualified private obstetricians. One example more recently was based on measurements of liquor which had reduced by 2 cms. at term.

[1] Health Department of Victoria. 1990. Final Report of the Ministerial Review of Birthing Services in Victoria Having a Baby in Victoria Minister for Health. Health Department Victoria Chapter 6

KNOWLEDGE AS AN EXPERIENCED MIDWIFE AND SENIOR UNIVERSITY LECTURER IN THE SUBJECT.

Physiologically speaking reduced liquor happens when a baby is ready to emerge. Liquor is reduced to bring about change in the space within the uterus which in turn creates pressure on the foetus within the uterus to assist in the initiation labour. The foetus itself is thought to have an "ejection reflex[2]" .Fear being an obstructer. My examination of one woman and the history of the other two did not justify induction or the subsequent caesarian sections for two of these women. The husband of the other helped his wife reject the threat and they produced a 3 kg baby after normal labour commenced. Reduced liquor is considered by some to be a result of failure to be nourished. If the woman has a comprehensive assessment other factors would confirm or reject the diagnosis.

ABORIGINAL HEALTH AND THE CONSEQUENCES OF NOT BREASTFEEDING AND POOR BIRTH EXPERIENCES

I note reference to the indigenous population in your terms of reference. I have been to British Columbia Canada, Queensland and the Northern Territory. I was invited to give a paper in Darwin on the similarities and contrasts in these two groups of pregnant and lactating women and the care, or lack of it, they received. I care very much that the health of our indigenous friends is suffering due to lack of knowledge and changed life style. It does not help their emotional and social health to have the poor start in birth or breastfeeding which for many is currently the case. I was invited to and am involved with a lactation group of midwives in Gippsland and hoping to talk to young aboriginal women through our regional liaison officer.

CAIRNS HOSPITAL AND MAREEBA

The birth of our 5th grandchild and our daughter V's first child took place in the Cairns hospital Queensland in 2001. I realised at the end of this journey the reasons why my career took the path it did. The long years and my adaptation to changing knowledge brought many benefits. The second benefit was the birth of my daughter's second child in the Mareeba hospital in Queensland. A unique maternity unit run and staffed only by midwives. Aboriginal women give birth here. My friend a local of Cairns wired me in Venus Bay to let me know that this unit was in danger of closing. As a member of Maternity Coalition [MC] I asked MC and many other objectors to write letters. This effort I believe stopped the Qld. State Government from closing this Unit in early 2007.

V. my daughter was asked by the Mareeba midwives if I was coming. V stated "that she put her head in her hands" and "I said, I know what she is like". I was told by midwives that the midwives of Cairns Base had learned heaps from me. I had written letters of explanation for my "up-to-date" actions and did not have to do anything at Mareeba but sleep through V's 2nd labour and birth. It was such joy to find that midwives were acting as they should, giving their best to care to women. The standard of antenatal preparation was outstanding. Midwives educate about nutrition and rest. They both hear and listen and act if necessary on what they hear. They reassure, confirm and support. I am a midwife with midwifery in my bones .I will never stop being a midwife.

[2] Odent, M. 1992. The Nature of Birth and Breastfeeding. Westport, Connecticut USA: Bergin and Garvey Chapter Five p 29 The Fetus Ejection Reflex ISBN:0-89789-287-9

Brief History

- At the time of the first birth which I am describing I was a Mother/Grandmother.
  - 4 children ages 27-40 now 31,38, 44 and 45.
  - 5 then, now 7 grandchildren 7 months to 7 years
  - BW Midwife of 45 years plus experience
  - Senior Midwifery Lecturer l989-l998 RMIT
  - Activist ongoing till death it seems.
  - Member of Midwives Action Group of the ANF.
  - Australian Lactation Consultants Association 1 9 9 5 - 2001
  - and Maternity Coalition circa 1988 to date.
  - Midwives in Independent Practice 1998 to date.

- **V. 1 year prior to pregnancy**
- Dive Master/Resort Manager aged 23
- 2000 Lived with partner Chris and two of his friends and their partners sharing a large house in Cairns
- 2008 lives in Cairns with 7 year old daughter C. and 4 year old A.

1. Conception - First trimester

The benefits of being informed and educated and my thoughts about an unplanned pregnancy:

- Pregnancy
- Bleeding Diagnosis of aortic valve disease & carotid artery damage following ante partum haemorrhage. No management Caravan to Cairns.
- Why are we here?
  - Establishing a relationship and reassuring my daughter that the pregnancy was welcome. – The crisis of expectant fatherhood.
  - Awareness of this helped me to be a friend to the father Chris,
  - Getting to know the 5 house mates and taking over V's twice a turn a week cooking a meal.

- The first ultrasound was used to confirm pregnancy and was given to the mother of expectant father by her son. (21)
- Making sure my daughter would be left in good hands when we returned to Victoria.

……..THE STORY BEGINS at our home to which my husband and I had retired in Venus Bay in Victoria. V. was now 3 months pregnant in October 2000 and had rung me at about 11.30 pm stating that she had been bleeding. I suggested she go straight to Cairns Base Hospital. Another call from a lost daughter and her partner on how to find the emergency department – they were lost in the dark of an abandoned ward! I had heard nothing so I rang the hospital. The result was that a resident doctor stated to me "did I know that my daughter had mitral valve damage to the heart and carotid artery damage?

SERIOUS DIAGNOSES

Both these diagnoses are very serious and can result in death in a pregnant woman. Pregnancy brings extra stressors to bear on the heart. I remained calm and questioned the resident about the Echocardiograph [ECG] reading and her clinical findings. I suggested that these could be the normal murmur of pregnancy. This is a normal reading in pregnancy. A bump in the graph and the murmur sound on listening occurs due to the change in volumes of circulating fluid in the mother's system. The resident denied this rather rudely (probably did not like being questioned) and stated that she had checked with the registrar and her findings were correct. I asked about the bleeding and this "was not yet diagnosed".

CARDIOLOGIST NOT AVAILABLE FOR THREE MONTHS

My daughter had been discharged from the Cairns hospital with a letter stating V. needed an ultrasound of her heart and to see a cardiologist. There was no appointment with a cardiologist till January 2001 (in October 2000). My husband and I immediately packed our van and took off to Queensland. In the meantime I correctly diagnosed (over the phone from Melbourne) my daughter as having rectal bleeding a simple test with a tampon usually differentiates vaginal and rectal bleeding.

HELP AVAILABLE

Fortunately V. found (at my urging) an experienced General Practitioner behind a chemist shop in the Cairns Mall. Dr. G R. (whose home on an outback station we were later invited to visit) immediately arranged for the Ultrasound. I was reassured that V. was in safe hands till we arrived. This was a doctor with the intelligence to recognise my background. In the meantime I could not tell my daughter that she needed to rest – she was working – and had all the signs of fatigue associated with early pregnancy, let alone heart disease.

Untreated heart disease such as that described by the resident doctor, needs very careful management due to the possibility that the stress of pregnancy can cause death. Normal things such as avoiding constipation, nutrition enrichment for maintaining haemoglobin levels, lack of stress and for her to stop work, take

on a new meaning. None of these ideas were considered relevant or practical by my daughter.

A DIVE INSTRUCTOR

We arrived with a high level of stress, met her partner and met our daughter and her pregnancy for the first time. V. had not realised that vomiting and diarrhoea on the "pill" takes away its efficiency as a contraceptive. This was explained to V post pregnancy by the resident doctor. My daughter was surprised that we had come to Cairns so early in the pregnancy. I kept our reasons to myself. My first thought was to carry out a physical examination but I did not want to alarm her even more. On visual observation I was reassured. I had other doubts about the heart disease due to the fact that she had passed a medical for PADI scuba diving and was an internationally qualified Dive Instructor.

SKILLED ASSESSOR

I am a skilled assessor and clinician – with both clinical and technical aids. Emotional fear for her life was not conducive to rational thinking as a mother, but I was reassured by what I could see and hear. The next day at the Cairns hospital, where V. my daughter was to have an ultrasound of her heart, I had already been told to "mind my own business" by a midwife when I politely asked to speak to the midwives.

HEART ULTRASOUND READING

After leaving V. at the Ultrasound department, an intensive care nurse approached us. She stated that she could see that my husband and I were distressed. This nurse offered to help us get the ultrasound read by the cardiologist. The cardiologist agreed to ring us if the condition was as serious as diagnosed.

REASSURANCE

The technician, who was not supposed to tell me, reassured me that she could not see any evidence of the heart condition. We were then able to tell our daughter why we had rushed up to Cairns. We felt enormous relief so while V was being seen by a specialist obstetrician (of my acquaintance from Melbourne who stated "I was not here") I went to see the Director of Nursing (a male).

COMPLAINT

The D.O.N. without bias, encouraged us to complain to the Health Department via the regional health service. V gave us permission in writing to approach the issue. It was after six months of writing that the Queensland and Regional Health Department of Health reluctantly apologised for our distress. The doctor from the Department of Health then informed me that the wrong diagnosis was a result of the 'normal murmur of pregnancy'. As previously questioned by me!?

NOT THE END OF THE STORY

Due to the long distance travelled we decided to stay on the tableland and await events. We were asked to mind three homes while in the area, so our needs were met by grateful home owners, who were travelling.

The perceived need for ritualised medical care during pregnancy is more cultural than medical[3].

The belief that pregnancy is a normal physiological event disappeared with the move of normal pregnant women in to hospital in the 1900's. The barrages of technology used sometimes instead of clinical (bedside) diagnosis that has occurred in the last 4 decades is phenomenal and has added to sending "health" costs soaring. My long career means I preceded technology. In my early practice I experienced a more 'genteel' era of using clinical skills of touch sight and hearing. Technology was used only as an aid. Birth was allowed to arrive safely by trusting the woman's body to do what it has done for centuries with the aid of the baby which is thought to have its own birth initiators.[4]

2. in the Second Trimester

I established a midwifery network for support through the following connections:

- **Australian Lactation Consultants Association**.
- Gail Martin **Midwife in Charge of Private Hospital**
- Marian Idle Homebirth Midwife from Cairns
- Rita Ball **LC Cairns Base Hospital**
- Email Nationwide
- Robyn Thompson **Homebirth Midwife Melbourne**
- Pam Lister (deceased) **Midwife and Cairns friend since mid 1962**

I had given a paper at a conference, 2 years previously, in Cairns so had already made contact with a number of people. I was reassured by midwifery colleagues that there would be good care by midwives, who had been re-educated with up-to-date practice. The hospital had been refurbished with en-suites, baths and single rooms for new public funded mothers. Interventions were still high and the theatre staff (Director **of Anaesthesia) did not encourage breastfeeding at birth.**

FIRST REFUSAL BY V.

A second ultrasound (the first confirming the pregnancy) was rejected by my daughter V. Because she was "tired and did not want to wait". Nothing to do with my strong beliefs that these ultrasounds are an unnecessary and costly exercise. The woman who ran the ultrasound department was the 3rd wife of the obstetrician who was in charge of the Midwifery Unit. I had met the two previous wives who were also midwives – he was aware, as a result of the first two wives knowledge about evidence based up to date practice of meeting the needs of birthing women. This obstetric nurse was very distressed that my daughter was not "doing as she had been told". Another mother and I discussed how these frequent tests were worrying for the pregnant mother, our daughters;

[3] Thomas H. Strong. Expecting Trouble Extracted from Wolf, N. 2001 Misconceptions: Truth, lies and the unexpected on the journey to motherhood. London: Chatto and Windus 2001

[4] Odent, M. loc cit

we both agreed that if the mother was healthy and the clinical skills of the practitioner had not diminished - why was all of this anxiety producing expensive testing necessary?

3. The Third Trimester

'UNDER THE INFLUENCE OF THE MOTHER'

FRANK BREECH

I was called in by a midwife to the antenatal clinic during this trimester towards 32 weeks. According to the technology (third ultrasound) machine wheeled in by the doctor (same obstetrician from Melbourne) the baby was presenting as a frank breech. A frank breech has very stiff legs up alongside the head on palpation. Frank breeches do not usually revert to flexible presentations. The machinery and the doctor had decided that this was a frank breech. I explained that V. had a 6 week cycle and could have conceived later – therefore the foetus was probably not ready to turn until 2 more weeks. Besides which, my experienced hands knew that this baby was very well flexed. To no avail – it turned out that the hands were beside the head and these appeared and probably felt like feet on palpation and would look similar to feet on ultrasound. After C was born she had a habit of putting her hand up to her face.

APPOINTMENT WITH THE DIRECTOR OF ANAESTHESIA

Because V. may need a caesarean birth (new rule for breech births for first pregnancy) V. and I were asked to have an interview with the Director of Anaesthesia. I usually chose not to go to the antenatal clinic visits with V every time to give her space. V. stated to the director that she did not want an epidural – so I explained to V that it - an epidural - was better than a general anaesthetic – and the anaesthetist smiled and breathed out in a relieved manner. I had read in my daughter's notes that my daughter was*" under the influence of the mother".*

BREASTFEEDING AT BIRTH

During this interview at the request of the hospital Lactation Consultant, I asked the Director of Anaesthesia if it was true he did not allow breastfeeding after Caesarean birth – Because if that was true I would write another letter! By this time the file was thick with my correspondence about an explanation for the wrong diagnosis and lack of initial care. The Director then reassured me the baby would be allowed to breastfeed at birth following a caesarean birth. The lactation consultant was ecstatic when I relayed the message. A caesarean birth was not necessary.

MIDWIFERY TWO STEP. BREECH TURNED

I wrote by Email to R T. independently practising midwife and friend. R.T wrote to V. and C. and told them how to turn the baby – hands off. The baby spontaneously turned a week before our next visit. The doctor wanted to know about our midwifery 'two step' and I demonstrated the position to the midwife. The diagram at the bottom is the medical way. The midwifery method is less invasive and is to do with positioning the woman.

The point is that midwives of the calibre of R.T. homebirth midwife and others have their own body of knowledge.

MEN OF SCIENCE AND USING THE FORCE OF GRAVITY.

'Men of science' in 'developed countries' for over a century continued the practice in hospitals of positioning women in labour on their back. This position had women pushing babies out uphill and against the force of gravity. The use of forceps (sometimes necessary) became prolific when the short women of Greece and Italy arrived in the 50's and found themselves in unfamiliar and frightening positions for birth. The fear and the wrong position probably increased their inability to labour well.

POSITIONS IN LABOUR AND BREASTFEEDING

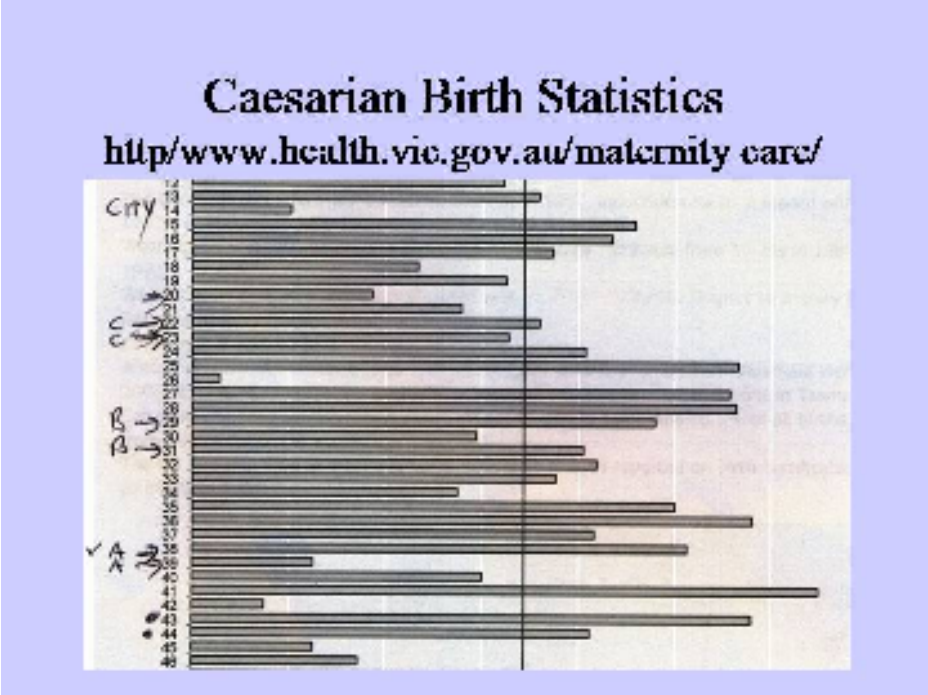
These women were used to squatting to give birth – perfectly normal in our (Australian midwives) newfound knowledge about "positions in labour". Breastfeeding practices in most Australian and Western hospitals at the time were also mistaken. These non English speaking women must have been confused. I was aware of a number becoming depressed at the time. I was working in the psychiatric unit at the Royal Melbourne Hospital in the late 1950's when a number of women were admitted with this condition. The lack of English language added to their realistic reactions. It has taken nearly 3 decades to alter entrenched mistaken practices.

INTERVENTION IN NORMAL LABOUR

My evidence-based knowledge about intervention in normal birth arose from observing changes to the way women were managed in labour as a practitioner, clinical teacher and university lecturer. I was formally and informally teaching midwives while practising at the bedside (as nurses and midwives do as well as clinical practice) in two major teaching hospitals prior to taking up a University position. The change to academia and research based evidence began in the 1970's.

At University level I became responsible (amongst every other subject midwifery related) for teaching the methodology about collecting data and analysing National Birth Mortality and Morbidity statistics. For example, discussing the stark contrast between white and aboriginal women's health. The outcomes were as evident in figures kept from 1983 – 1998 about poor aboriginal health, as they are now. Midwives also began to have access, through our professional networks, to hospital performance indicators [5](see example over page[6]).

Some midwife practitioners began to keep graphs in hospital to see who was carrying out an over use of interventions. This brought down the rate of, for example the over use of episiotomy "the unkindest cut of all". New evidence collected by midwives in the UK was demonstrating that natural small tears were preferable and that episiotomy became necessary when women were giving birth in prescribed abnormal position for birth.



VICTORIAN MATERNITY SERVICES
PERFORMANCE INDICATORS
Public hospitals indicators MAT1, MAT4 & MAT5
using combined data from 2001 and 2002.

November 2003

[6] Reference above.

In the Caesarian Birth Statistics above I have marked different hospitals i.e. city and (A) (B) and(C). I knew which hospitals these were so that I could ask and explain questions to students as to why a certain hospital would have higher rates or better rates. For example a major teaching hospital might be admitting only acute cases. Most city hospitals currently take a mixture of types of case. Other hospitals were staffed by people who were using women and baby friendly midwives together with birth centres. I was aware of most practices in Victoria. I moved widely across Victoria in my dual role of clinical supervision of midwifery students and being responsible for placing University students in most metropolitan and rural midwifery hospitals over 9 years. I could explain comparable results from different sized hospitals. The Victorian Health Department was sending polite explain letters to some of these hospitals.

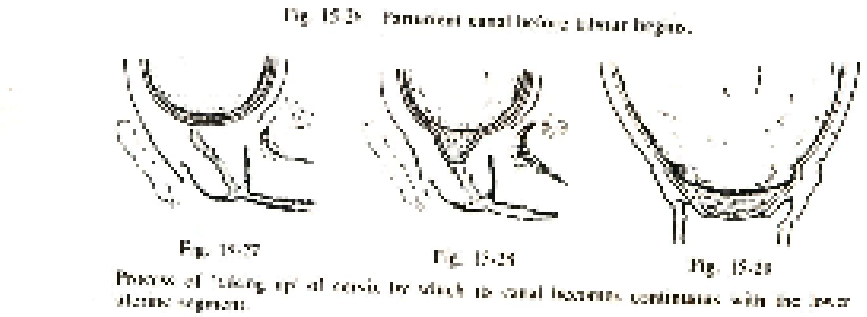
PROTECTION OF THE BABY

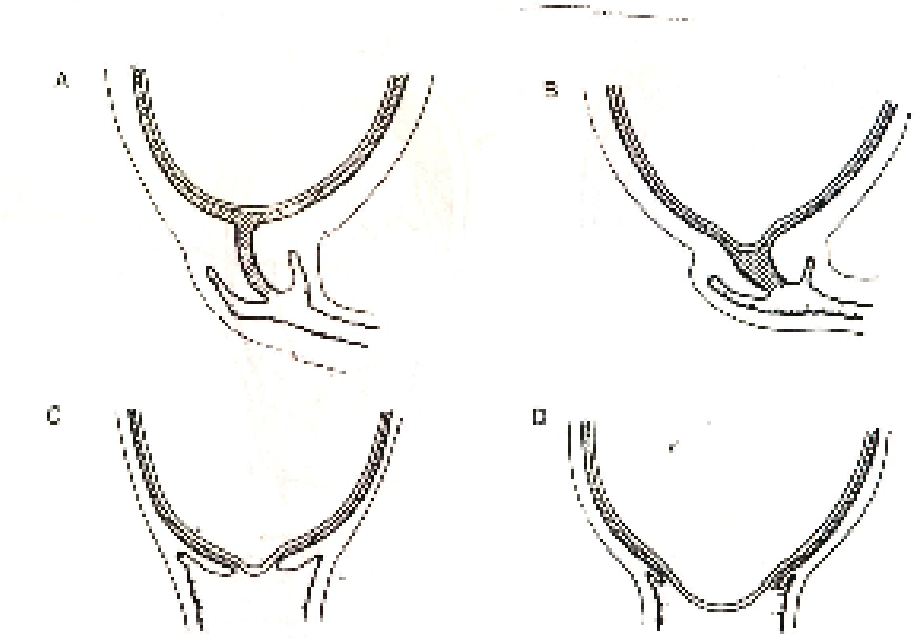
In the diagram over leaf it can be seen that an emerging bag of membranes surrounds the (absent sketch of) baby. One of the purposes of this bag is to protect the baby from harm of infection. The bag maintains hydrostatic pressures

- which keeps the baby protected from unusual pressures on major vessels
- - for example a fall or accident or ordinary every day events of pressure, for example carrying a toddler or from examiner's hands.

- Pregnant women in an advanced stage of pregnancy are encouraged to lie on their side to prevent impeding blood flow from the maternal major blood vessels.

- The large fetal vessels 2 arteries and a vein contained in the umbilical cord, supply oxygen and nutrients to the baby and excrete by-products. As can be seen in Figure 15 – 29 the uterus slowly opens up as the baby's head or other presenting part, descends. This bag of membranes forms a cushion in front of the head which gently protects the birth passage from tears and bruising.





SURGICAL INDUCTION OF LABOUR

In the distorted wisdom and sometimes unexplainable desire to speed up labour, practitioners penetrate this bag of membranes with an alligator toothed instrument to artificially rupture the sac.

The stated intent is to expedite labour. The benefit may be that the baby drops just a bit further down. This process is meant to initiate labour or induce labour.

The breaking of the barrier or membranes then causes a breach in the protection for the baby. Women complain that labour becomes very painful.[7]

In the Final Report of the Ministerial Review of Birthing Services in Victoria to which I contributed both individually and as a member of professional ~~organisations, one woman~~ had been told

"'You are not going fast enough'. She had been very confused about this. She felt good. The baby was alright. She wasn't sure how fast she had to go".[8]

This process becomes part of the cascade of intervention leading to increased caesarian birth rates. Once the membranes are ruptured then there is no turning back as the high risk of infection that results would cause problems after 24 hours without progress of the fetus in labour.

Induction Statistics

IN the diagram overleaf of induction statistics you will see that induction rates are much higher in the private than the public sector. I describe this induction method because this is what they wanted my daughter V. to agree to later in the pregnancy when she became "Overdue" Most babies left to themselves will follow a genetic pattern – some at 43 weeks and some at 37 weeks. The due date then becomes the average of the sum

– 80/2 = 40 weeks.

Caesarian rates have risen in private hospitals as a result of inductions on the whole from 15% in 2000 to 45% in one major teaching hospital in 2007 . A mix of private and public hospitals for women.

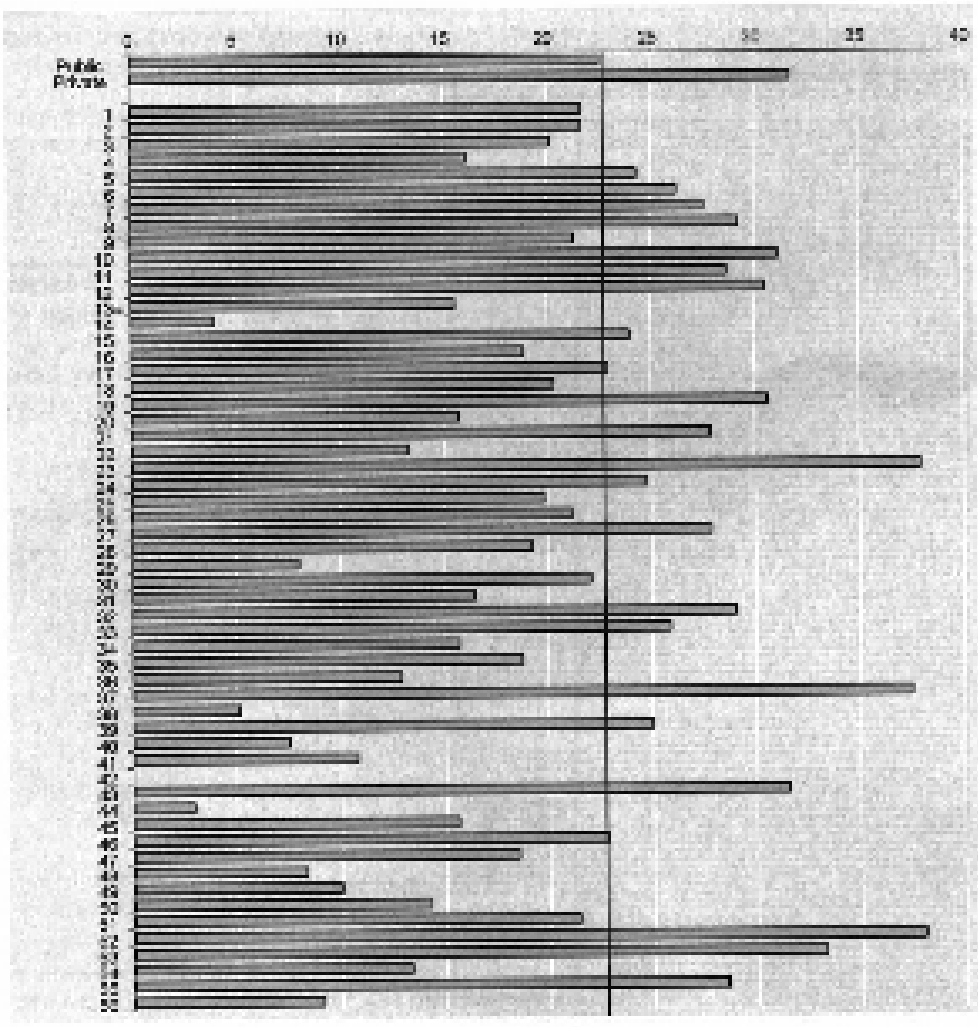
[7] Having a Baby in Victoria 1990. First Review of Birthing Services in Victoria. Victorian State Government Chapter 6

3.2 MAT-1a Induction of labour in standard primiparae

$$\% \text{ Induced} = \frac{\text{The number of standard primiparae undergoing induction of labour}}{\text{The number of standard primiparae who give birth}} \times 100$$

Public hospital average	= 2,681/11,882	22.6% (95% CI 21.8, 23.3)
Private hospital average	= 2,272/7,153	31.8% (95% CI 30.7, 32.9)

Figure 2 Inductions per 100 standard primiparae 2001 and 2002



[8] loc cit

17 DAYS OVERDUE April 2009

V. was now 17 days overdue the exacting 40 weeks. The rules of Cairns public hospital state *"10 days over and then you must be induced".* We counted that V. was told she needed inducing **by 7 different practitioners**. It was Easter Friday 2001 and the two midwives talking over the top of V. said "why isn't she booked in for an induction?" V. told me she put her hand up and said "because I do not want one". Next thing my phone rang and the female registrar asked me why my daughter was refusing induction. I gave her the reasons related to wrong dates, the baby was well, the tests done showed no stress and Victoria did not want any needles. The registrar was not happy when I said she was the **8th person to approach V.**

THE REGISTRAR rang me back and said that "*recently her son had suffered because she did not stand her ground against her colleagues*". The registrar said to me *"I have thought over what you said and congratulate you - mother you do what you think is – be the mother from hell".* I explained that my daughter had made her own decisions.

"Whew" was I grateful to that doctor. I was becoming strained as it is not easy to withstand the uniform routine and ritual of colleagues backed by my daughter's hard line stance (typical early 20's daughter if you have one).This was what was hard about trying to *be* just a mother. At the suggestion of M. I., homebirth midwife who had supported my decisions as had many of my colleagues on email; I took V .to a cranio-sacral therapist who managed with a kind of *"reiki"* therapy. By this time I was bouncing off the ceiling while the therapist's wife 'a la' flower child performed yoga and incense burning. My daughter said that she was not touched, but found a kind of heat pass through her uterus. Labour started the next day.

DRUGS TO INDUCE HARMFUL?

Induction used to be carried out by intravenous infusions of mega doses of synthetic oxytocics e.g. Syntocinon, till it was realised that hypoxia to the baby due to long and frequent (as opposed to graduating) strong contractions along with the take up in the haemoglobin of drugs, was causing jaundice of a large number of babies. Reduced oxygen is also due to drug transfer, which takes up the place of oxygen in the haemoglobin. The pain of normal (that is not induced) uterine contractions is due to a normal lack of oxygen to the smooth muscle of the uterus. Prolonged lack of oxygen causes hypoxia (low oxygen levels in red blood cells) which by a pathological process, results in newborn jaundice = yellow colouring of fatty tissue of which the brain has large amounts. shortly after birth and for varying depth and time periods up to two weeks.. The contractions were brick hard and very painful in my observation and touch experience. This method was combined with rupture of the membranes.

Currently membranes are ruptured following the insertion of a mega dose of prostaglandins combined with a gell around the cervix. This second method causes relatively low pain 30 second in length and often almost 2 minutely

spaced contractions lasting over a period of time – up to12 hours sometimes without any evidence of the softening changes needed to augment or initiate true labour. Reports from midwives and mothers are that mothers are exhausted from this process and do not labour well – so next step if the woman's labour is not fast enough an epidural is performed.

This consists of a large amount of local anesthetic inserted in an air space, outside the spinal cord in order to create pressure on specific nerves to the uterus. The aim is pain relief which in turn provides relaxation and may be increase labour progress. The goal sometimes is to be in readiness for Caesarean birth when labour does not progress. Lower Uterine Segment Caesarian Section [LUSCS] is now inevitable due to the rupture of the membranes.

4. LABOUR

ANOTHER M ACHINE

The lie of V's baby was unstable as my daughter has *a synclitic* pelvis – (uneven). I was
worried and needing to remind myself to trust V. to know her own body. When we arrived in the labour ward (birth room), V and C having gone ahead, there was the inevitable cardiotocography [CTG] machine and straps, keeping her in bed! The midwife (male) announced that the baby was "not happy". After getting her to walk around and adjusting the straps the baby was "happy". That is the baby's heart rate became normal.

PAIN RELIEF

For relief of pain the bath was not suitable for V. as the baby was *posterior* that is lying
On its back, on Victoria's back Victoria tried the bath but hopped out and assumed a position of semi kneeling – thus taking the baby off her back. As the labour advanced back pain was eased by her partner putting on hot packs. According to the resident the labour was not progressing. The stopping of labour for a short resting period is normal in normal labour. That is a labour that is not induced. Some inexperienced doctors do not **recognise this normal pause as they generally only monitor induced labour.**

LYING ON HER BACK - FOETAL DISTRESS

In order to examine V the doctor had to put V. on her back which caused pressure on the
Major vessels along V are back. That is the aorta and inferior vena cava. The baby's heart rate appeared to have stopped. This was a panic time until her position was changed. We moved V. over to her favorite position on her knees and the baby's heart rate came back. Due to this hiccup the paediatrician was called for the birth. The paediatrician, who looked to me to be about 10 years of age and the resuscitation trolley waited outside. My perception of his **age was ageist** due to **my** advancing years.

4TH STAGE
BIRTH

BABY HEALTHY

I had taken over by now and the baby was born crying and pink. A midwife appeared With an oxytocic. I put my hand up to the midwife carrying the ready filled syringe, as V asked me to explain what it was. I had not discussed this with her. The oxytocic is usually given into a vein without asking the woman. The idea is to prevent post partum haemorrhage, the side effect being that its use also expedites the separation of the placenta from the uterine wall. The injection was not given.

Referred in obstetric parlence as delivery of the secundines . Midwives refer to the expulsion of the placenta and the baby first feed at the breast.

- SPEEDING UP THE PLACENTA

There was no blood. I stopped the midwife putting her hands on the placenta because it Was not ready to release. Most hospital midwives expect to give the oxytocic which speeds up the release of the placenta – so that they can assist the resting placenta to leave the vaginal passage. This can sometimes result in abnormal consequences – an everted Uterus is one. Another intervention. I explained that the baby's action of breastfeeding would help nature, there is a greater amount of natural oxytocic released during the physiology of breastfeeding than there is in the synthetic based injection. With the help of gravity, a breast feed and a walk to the toilet, the placenta was born without intervention.

VITAMIN K
– THREATS OF DEATH FOR THE BABY

The story of Vitamin K became an issue. I have an advanced education in lactation physiology. I qualified in 1995 as an International Board Certified Lactation Consultant [IBCLC] – recognised world wide as well as being an invited lecturer on the subject to sit on the International Board of Examiners in Arizona, U.S.A. Because there is sufficient Vitamin K in colostrum and I had encouraged my daughter's diet to be high in Vitamin K I have spoken many times about the economic and unnecessary giving of this mega vitamin to the healthy newborn. The doctor insisted in describing a story about a woman with 11 children who had lost a baby by not giving it Vitamin K. I suggested to him that the mother's diet and nutritional status would be affected by 11 pregnancies – and her diet should have been supplemented. That and other babies may also have had a systemic problem such as a liver abnormality. This condition may be another cause associated with the lack of clotting in a new born – known as Haemorrhagic Disease of the Newborn (HDM). Poor breastfeeding practices in the past including not giving colostrum (which contains high and adequate amounts of Vitamin K) to the newborn is a management and education problem. Cultural, routine and ritual (South East

Asian) practices are also part of the lack of Vitamin K content of early feeding of the newborn. Poor management and lack of education are some of the muli-factoral issues which need to be part of the equation.

C. my daughter's partner, deferred to me as he told V "*your mother knows what she is doing*". I did not want to pressure my daughter so I left the room. M I. the home birth midwife was on duty and she gave the oral vitamin K to C. the new baby. C. apparently spat it out. I overheard this young doctor telling staff that V. "*was under the influence of the mother*". I wrote to him and other staff to let them understand that I had not had any influence over my daughter, except by osmosis. This was a judgement made without having any conversation with me.

BREASTFEEDING.

I have written a thesis successfully presented for A Masters Degree and that is a whole other story.

I ought to comment here however that breast feeding does not seem to threaten the safety of women or their babies or the pockets of any "body" except may be the billion dollar formulae producing industry. Of course where breastfeeding is allowed to be performed has been successfully put as legislation to decriminalize breastfeeding in public through the Victorian Parliament.

Later MP Kristie Marshal was thrown out of the chamber for daring to breastfeed there.

* * * * * * * * * *

CONCLUSION

I have demonstrated how without me, my daughter may have managed as she was strong. I have been asked many times to imagine what it must be like for aboriginal women or any one with low self esteem. Even I, who has knowledge to back my decisions and was caring for my daughter found it difficult to withstand the pressure. This is why we need continuity of care of the one person – preferably an experienced midwife who has time to give total care.

FLEXIBLE MIDWIVES

The midwives were flexible and were very willing to help with obtaining an intervention

Free birth. These midwives were up-to-date, but constrained by ritual and routine. C. is a baby born of a mother who did not use pain relief. C. was a bright baby – swinging her head around to respond to the voices of her parents who C. had been hearing for the last 9 months. Most babies born of women sedated heavily in the recent past during labour were usually asleep and hard to wake at birth.

THANK YOU

Thank you for giving me the opportunity to tell this story. I trust it is a story of hospital process which while it was not nearly as restrictive as most Australian hospitals, gave some leeway to an intervention free birth. After a 45 year period of practice it is disheartening to find similar constraints are still occurring in major teaching hospitals in Victoria.

I was invited to visit Professor D. Lowdermilk of the University of North Carolina, USA to help her to update the units in which she taught. As a result I took part in consulting with the authors of a major textbook. This invitation followed a period of a week when I organised a tour for the professor of some of our up to date hospital birth settings during the professor's visit to Melbourne in 1994 and to help her meet "home both" midwives.

I visited the Duke University in Durham North Carolina USA in 1995 and was horrified by the out-of-date attitudes to birth. High tech machinery wall to wall, and obstetric nurses with hospital gowns carrying instruments in holsters which look like guns! With the story of the struggle between conflicting attitudes to birth it is time for an overhaul. I believe my story is uniquely told by a mother who is also an experienced midwife.

THE STORY OUTLINED ABOVE GIVES EMPHASIS TO WHY SOME WOMEN PREFER HOMEBIRTH.
MANY ABORIGINAL WOMEN SAY THEY DO NOT LIKE THEIR BODIES BEING INVADED NOR DO THEY LIKE TO LEAVE THEIR COUNTRY TO GO TO MAJOR HOSPITALS.
I visited Canada Far North British Colombia Far North Queensland and Northern Territory. I wrote a Paper which compared the similarities and differences between two examples of indigenous nations. The cultural beliefs about, together with, government and medical interventions in birthing practices was startlingly similar.

EYE CONTACT
MOTHER AND BABY 12 HOURS LATER

Beverley Walker (03) 5663 7648 Mobile 0417 501 688 **Email**: bevw1@bigpond.com

Maternity Services Review

Chloe's Birth
2001

Presented by Beverley Walker

October 31st 5.00 pm
2008

Revised edition
July 12 2009

Double Jeopardy Midwife and Mother

COPIES TO: Maternity.services

2008

Maternity Coalition review@health.gov.au

Federal Politicians wilkes@maternitycoalition.org.au

McMillan Russell.Broadbent.MP@aph.gov.au

EARLY 2009

Minister for Health Nicola.Roxon.MP@aph.gov.au Faxed

JULY 2009 ROUND

Ms Claire Moore Chair Senate Community Affairs Legislation Committee

By E-mail: community.affairs.sen@aph.gov.au

Fax__ (07) 3252 7101

SYNOPSIS

INFORMED CONSENT INFORMED REFUSAL

****

Walker, Beverley: *Double Jeopardy Midwife and Mother*

"Tell your mother that she must only be a mother not a midwife is the message my 12 week pregnant daughter brought back to me waiting at our temporary home in Tropical Far North Queensland." My husband's and my presence in Queensland so early in the pregnancy was a result of an appalling misdiagnosis given over the phone in the middle of the night at our home in Victoria.

In the paper I will focus primarily on the experience I had in overcoming my daughter's generational pull against me and describe the struggle I had to be 'just' a mother. The underlying theme is about how I needed to execute a midwifery and motherhood two-step. A fine line between line dancing and a waltz. I was able with the help of outstanding resources reach a good outcome in spite of the current trend towards overwhelming technological intervention in Far North Queensland and my daughter's ambivalence. I found that forty years of professional midwifery and life as a feminist together with the wonderful women South of and in Far North Queensland combined to enable me to take some great leaps of faith. Ironically the technology of e-mail was and remains a fine tool for women's business. The gains I made as a mother and midwife were complex involving learning when to speak and when to fight. How to listen with a mother's heart and how to act with a midwife's skill. Why the art of women's ways of knowing propelled me in times of indecision along the right path. 21 months on I have still to comprehend the enormity of what was achieved and the glorious daughter/mother relationship that resulted. I will never be able to thank enough those women who channelled me away from impetuosity and back to my normal common sense.

****

DEFINITION OF A MIDWIFE

Adopted in 1992/3

(he and she inter - changeable}

This definition of a midwife was adopted by the International Confederation of Midwives (ICM) and the International Federation of Gynaecologists and Obstetricians (FIGO), in 1972 and 1973 respectively and later adopted by the World Health Organisation (WHO). This definition was amended by the ICM in 1990 and the amendment ratified by the FIGO and the WHO in 1991 and 1992 respectively and now reads as follows:

A midwife is a person who, having been regularly admitted to a midwifery educational program, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery.

She[1] must be able to give the necessary super-vision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries [assist the birthing woman] on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help.

She has an important task in health counselling and education, not only for the women, but also within the family and the community

The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care. She may practise in hospitals, clinics, health units, domiciliary conditions or in any other service.

http://www.acegraphics.com.au/articles/leap01.htm

MIDWIVES

(1) My grandmother b1880 – d 1917
Ethel Appledore on the far left at back

First district midwives circa 1903 at 111 Hotham St., East Melbourne

Beverley Walker: Graduation 1996 Portrait 2008 Miles J

Academic and wise old woman
Midwife 2008

.

C O N T E N T S