LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH, AGEING AND COMMUNITY SERVICES
Ms Bec Cody MLA (Chair), Mrs Vicki Dunne MLA (Deputy Chair)
Ms Caroline Le Couteur MLA

Submission Cover Sheet

Inquiry into Maternity Services in the ACT

Submission Number: 13

Date Authorised for Publication: 05.02.2019

Date: 12th January 2019

To: The Committee Secretary
Standing Committee on Health, Ageing & Community Services
Legislative Assembly for the ACT
GPO Box 1020
CANBERRA ACT 2601

[redacted]

Inquiry: Maternity services in the ACT

Dear Committee Secretary,

I have experienced 3 births within the ACT, the first in 2010 and the last in 2016. My first birth was conducted in the public system and subsequent births in the private system with the same provider. I include my comments on the 2010 birth as this initial experience generated constraints that I believe are still relevant to individual choices under the current birthing infrastructure, despite welcome improvements to birth services in the ACT over this time frame.

My comments mainly impact:

(1) Models of care and gaps in care models
(2) Management of patient flow, specifically capacity constraints
(3) Management of patient birthing preferences, professional advice and practices associated with birthing emergencies.
(4) The impact of understaffing on both staff and patients
(5) Efficiency and efficacy
(6) Patient satisfaction

Models of Care

- It is essential to ensure equity of access to information regarding care models in order to reduce women's dependence on individual provider information.

For example, during my first pregnancy in 2009 I received very little information from my GP regarding different care models. I was not an Australian citizen at this time and had no experience of the health system here. If information was more readily available, or more care models existed as they do now, I would have chosen very differently.

- The importance of MidCall and MACH services in providing post-partum care

I am uncertain which model of care these services are aligned with but I believe they are available to all. The mid-call (midwife visit to the home after the birth) service was offered to me under the public system for free. Due to medical conditions I received free fortnightly and subsequently monthly MACH calls to my home for a 4-month period following my second and third births. These visits were highly beneficial to me and greatly reduced my need for further expensive medical appointments.

Capacity constraints & birthing emergencies

I experienced these issues in 2010 when I was a patient at Calvary Hospital using the public maternity service (Standard or GP Shared Care). Although procedures and policies may have updated since that date, the legacy of prior birth events still influences women's choices if they are considering children in the present. At Calvary after I was admitted in labour the hospital informed me they had gone onto by-pass and were directing women to the Canberra Hospital. Initially I was accommodated on the ward, where I was shouted at for bleeding on the carpet. The birth suite was full and I was next installed in a room on the ward with a wipe clean floor to deliver. My confidence in this room was high as appropriate equipment was available and I was not aware that I was not in the actual birth suite. Unfortunately the choice of this room to accommodate me resulted in a loud verbal confrontation regarding appropriate protocol between staff, which occurred over my body whilst I was in my first obstructed labour. I obtained my birth notes a year later, which recorded facts such as the full birth suite and room location on the ward but no record of the extra staff present or the conflict exists, presumably such events are not considered medically relevant despite their impact on patient health. Eventually I was admitted to the birth suite and scheduled for an emergency c-section, with relatively little explanation of why this was required. Following the c-section I was accommodated in a single room on the private side of the ward for a few hours due to lack of space anywhere in the public ward, then moved into a 4-bed public ward, where I received care from multiple midwives, one of whom worked a 16 hour shift.

Impact of understaffing on patients & staff

- Understaffing did contribute to a negative disempowering birth experience, I felt I'd been undeservedly treated like a criminal and my only crime was to go into labour on a night the hospital entered by-pass.

- Staff conflict caused by lack of physical infrastructure hugely contributed to my distrust of their competence and the overall negative experience.

- Poor provider performance from a small number of staff during my initial maternity experience led me to question the constraints, motives and morals of all subsequent health providers, leading to high patient anxiety and waste of competent provider time.

- Medical staff causing patients to suffer unnecessary trauma potentially put themselves and their families at risk of receiving threatening behavior in the future from traumatized patients.

Management of patient birthing preferences, gaps in care models & professional advice

For my second (2014) and third births (2016) I wanted to experience both continuity of care and attempt a VBAC. In 2014 I believed that my only option to combine these wishes was with a private practitioner. Although I was aware that I could have considered a VBAC as a public patient at either hospital, I thought (perhaps mistakenly) that I would be unable to access continuity of care in 2014 unless through the Birth Centre, which I believed I was automatically excluded from due to a prior c-section. I do not know if the information I received at the time from the Birth Centre and the Antenatal clinic at Calvary was correct, either it was and my birth options were limited, or I was misinformed and sourcing accurate information is difficult. My preferences were very important to me so I chose a private practitioner at Calvary Hospital (my geographically closest hospital).

In the private system I felt that professional advice was unavoidably biased due to the logistical and emotional constraints of any provider involved. However, in 2016 I was again forced to choose the private system, as I believed the public system would not support an attempted VBAC after 2 prior c-sections. In my particular case the private doctor was both willing and competent to support my wishes if no limiting medical factors were involved.

- I had to pay for the privilege of continuity of care and birth choice and I feel both aspects of care should also be offered within the public system, the latter when medically appropriate. Choices should be equitable and accessible between the two systems.
- Can the Birth Centres, both at CHWC and at Calvary provide continuity of care for public patients attempting VBAC? Can the eligibility criteria be altered to accommodate this? What proportion of VBAC women wanting to birth in the public system are excluded from simultaneously accessing continuity of care and the option to VBAC?
- To date I am still confused about whether options existed in 2014 to accommodate my wishes, or even if they exist now. The CaTCH program, which I never heard of in 2014, was supposedly established in 2011 according to website information and should have been able to meet my needs if I had been able to obtain a place. At the time I was searching (in 2013) this information was not apparent, which highlights the need for better access to information on care models.

Efficiency and efficacy

Media claims that birth services in the ACT are poorly resourced and understaffed (May 2018) concerned me. Evidently workplace cultural issues exist related to effective communication with senior management, escalation policies and appropriate

recruitment and management of a work force with widely divergent beliefs in how the same goal should be achieved. However, none of this public broadcasting of dysfunction enhances the confidence of women experiencing their first pregnancy.

- How will this inquiry enhance confidence in the efficacy of maternity services in the ACT? Will the public be informed of future recommended actions?

I was surprised to read in other submissions of the large number of perinatal and post-natal services which I would have been eligible for that I never heard mentioned. My referral from my GP lists my other medical conditions and my eligibility for additional perinatal services was high. In actual fact I was provided with no information at all and privately booked and paid for an appointment with a specialist. I am surprised that no other service was offered to me under the private system, although this may have been because there was no perceived need for such services at that time.

- Linkage between different medical specialist services seemed to be better under the public system than the private system.

Additionally, under the public system I received updated immunization for measles and numerous information leaflets on community care services prior to discharge, whereas no such public health guards or information was delivered under the private system.

Patient satisfaction

Although some care providers deliver an exceptionally high quality service, sadly I believe negative birth experiences affect a large number of women but are underreported due to public bias caused by stigmas regarding social shame, fear and humiliation and post-traumatic influences. Patient satisfaction surveys conducted at the time of hospital discharge may occur when patients are still intimidated and requiring care and may not accurately reflect patient's subsequent emotions.

[redacted]