LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH, AGEING AND COMMUNITY SERVICES

(Reference: Inquiry into maternity services in the ACT)

Members:

MS B CODY (Chair)
MRS V DUNNE (Deputy Chair)
MS C LE COUTEUR

TRANSCRIPT OF EVIDENCE

CANBERRA

TUESDAY, 15 OCTOBER 2019

Secretary to the committee:
Dr A Cullen (Ph: 620 50136)

By authority of the Legislative Assembly for the Australian Capital Territory

WITNESSES

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Amended 20 May 2013

The committee met at 1.04 pm.

KIRK, MS MARY, Executive Officer, Canberra Mothercraft Society

THE CHAIR: Good afternoon, everyone, and welcome. I declare open this fourth public hearing of the Standing Committee on Health, Ageing and Community Services inquiry into maternity services in the ACT. Before we proceed, I take a moment to acknowledge that we meet on the lands of the Ngunnawal people. I pay my respects to elders past, present and emerging and the continuing contribution of their culture to this city and this region.

Today the committee will be hearing from the Canberra Mothercraft Society and from Ms Natasha Shahidullah. On behalf of the committee I thank witnesses for making time to appear today. We will now move to the first witness appearing today, Ms Mary Kirk from the Canberra Mothercraft Society. On behalf of the committee, thank you for appearing today. Ms Kirk, I remind you of the protections and obligations afforded by parliamentary privilege and I draw your attention to the pink coloured privilege statement next to you on the table. Could you confirm for the record that you have read and understood the privilege implications of the statement?

Ms Kirk: I have.

THE CHAIR: I also remind witnesses that proceedings are being recorded by Hansard for transcription purposes and are being webstreamed and broadcast live. Before we proceed to questions from the committee, do you have a brief opening statement that you would like to make?

Ms Kirk: Yes. On behalf of the Canberra Mothercraft Society I would like to give you a short statement. The Canberra Mothercraft Society thanks you for the opportunity to appear today and apologises for not having provided a written submission, but we have been really busy. Thank you for opening it up again, because we will provide a written submission based on what is said today.

First of all, we would like to comment at a macro level, rather than talking about specific services. The Canberra Mothercraft Society has referenced its comments on the ACT Health territory-wide health services framework 2017-27. We formed the view that there are gaps in that that would prohibit a reliable, evidence-based maternity service for the ACT.

In relation to effective care, the clinical governance framework states that an effective healthcare system is one that promotes and supports evidence-based, effective and reliable care provision. There should be no variation in the quality of care, which should be provided in an atmosphere of mutual trust where staff members can talk freely about safety problems and how to solve them.

The safety and quality of care has been found to be seriously compromised during transitions of care where consumers have moved between health professionals and clinical settings and where the management of treatment plans is not effectively communicated. Effective care is characterised fundamentally by the alignment of

evidence-based health care to evidence-based delivery and a culture that supports continuous improvement and monitoring for improvement.

While the above are critical elements of any effective healthcare system, the Canberra Mothercraft Society argues that it does not go far enough. The framework goes on to describe how effective care can be realised. It talks about clinical reliability tools; introduction, use, monitoring and evaluation of clinical pathways; and monitoring of practice variants using tools such as audit, data measurement, peer review processes et cetera.

CMS's view is that these are worthy but they do not in themselves inform a contemporary territory-wide maternity service that reflects reliable evidence to achieve the health outcomes that women and their families deserve. CMS believes that the WHO definition of universal coverage should inform the committee in its deliberations. We specifically say that because there is no mention of it in the territory-wide framework.

CMS is certain that the health workforce is central to attaining, sustaining and accelerating progress on evidence-based ACT maternity services for women. CMS suggests three guiding questions for decision-makers around maternity services. What health workforce is required to ensure effective coverage of an agreed schedule of maternity services for the ACT? What health workforce is required to progressively expand the coverage of options of care, based on reliable evidence, to all women over time? How does the ACT produce, deploy and sustain a maternity services health workforce that is both fit for purpose and fit to practise in support of accessible, acceptable, affordable and quality care that is close to where women live?

To answer these questions, CMS notes the WHO's statement that health services are only as effective as the persons responsible for delivering them. In the evolution of maternity services in the ACT, we therefore propose a conceptual framework that speaks to the key principles of both the right to health and social protection floors—that is, the availability, accessibility, acceptability and quality of health services.

By availability, we mean the availability of quality maternity services which are based upon reliable evidence and the sufficient supply and stock of appropriately skilled and qualified maternity service providers with the relevant competencies that correspond to the health needs of birthing women and their families.

Accessibility relates to the equitable access to maternity services in terms of location, transport, opening hours, the corresponding maternity service health workforce attendance and whether the infrastructure is friendly to women.

Acceptability relates to the characteristics of the maternity service environment and the ability of the workforce to treat every woman and her family with dignity, create trust and enable or promote demand for services—demand for services is important—and provide a quality and enabling environment with the requisite facilities, equipment and clinical governance to provide respectful maternity care based upon reliable evidence by maternity healthcare providers with the required competencies, skills, knowledge and behaviour.

For the majority of women, birth should be a normal physiological process. Therefore, the principles and practices of primary health care, as defined by WHO, should be the foundation of maternity services in the ACT. Nowhere in the ACT Health territory-wide health services framework are the principles and practices of primary health care mentioned. They talk about primary care. When they talk about primary care, they mean the early intervention and management of disease, not primary health care. Therefore, by definition, evidence-based maternity care may not be achievable based on this plan.

CMS calls on the ACT government to show political commitment and leadership to provide governance and policy frameworks that are contemporary and do reflect reliable evidence, adequate funding and equitable allocation of resources, the engagement of the community, models of care, prioritised primary health care in relation to maternity services—rather than "acute" being the priority—engagement with the private and non-government sectors, active engagement, real engagement, respectful engagement, a workforce that is fit for purpose, and an appropriate physical infrastructure for people to do their work in an enabling environment.

The other really important thing we would like to bring up is integrated health care. When we look at this plan, the true integrated nature of maternity services in the ACT is absent. It looks like it is only about public health services run by the ACT government. We believe that CMS is an example of why the ACT government needs to look closely at its model of integrated care. There is no mention of the importance of other sectors and the fact that they deliver critical maternity services to our community.

At the macro level of senior managers and policymakers, integration truly happens when decisions on policies, financing, regulation and delivery are appropriate. This means bringing together different services but also considers the whole of the network of public, private and voluntary health services rather than looking at the public sector in isolation.

MRS DUNNE: Could I go to the issue about timeliness and the appropriateness of service? I am reflecting on the fact that babies are not born Monday to Friday in office hours and that people do not have setbacks only in office hours. A lot of the recommendations we are seeing are about access to services out of hours. Would you expand on that and also the point you made about the appropriateness and respectfulness of the services?

Ms Kirk: I think we have tripped into a space where we deliver services that meet the needs of the services rather than putting the woman in the centre and asking what is right, what does the woman need and what does the woman want. Mostly people want what is best for them.

MRS DUNNE: Sometimes they do not know.

THE CHAIR: Particularly with the first baby, you are not across everything.

Ms Kirk: Exactly. Therefore, we have an absolute responsibility to be transparent, and that is good primary health care. The people have a health need; they seek out

support and guidance in relation to that. You put out for them all the good options that are available for them and have a partnership—working with people, not to people and not about people—to explore the best options for them. That is truly working in partnership.

If I go back to this plan it talks sometimes about working with people. Hello! It is their body and their health and they want what is best for them and their families, but they need to understand. Therefore, we as service providers have a responsibility to make things transparent and to work with them. The reliable evidence—and I use that word really carefully—says that where people are actively engaged in their care and understand their care, the outcomes are better. It is our responsibility, as the providers, to make things transparent and to work truly in partnership with them rather than being on top.

People need health professionals on tap, not on top and we have a system of on top. It is not serving us well; it is not serving women well. It is just serving. We can do better than that. We are a jurisdiction of really clever people. We are a jurisdiction where it is easy to communicate. We are a jurisdiction where collaboration and cooperation should be a snap. There is no excuse for it not happening. This is the place where reliable evidence should be applied and this should be the example for the country, in my view.

MRS DUNNE: When you say reliable evidence, what do you mean?

Ms Kirk: It is really important because there is evidence about lots of things, but the best quality evidence is reliable evidence that is able to be replicated.

MRS DUNNE: How do we recognise it?

Ms Kirk: I have great sympathy because I can sit in a room with my very own medical colleagues and they will turn around to me and say, "That is your evidence." I can produce population studies over tens of thousands of people and they will say, "Oh, that's your evidence." For policy planners and whatever to make decisions around that is fraught, and I accept it is fraught. The good researchers will be able to sit down and say, "Yes, that's a small study on a small scale for a small population and has weaknesses here, here and here." But reliable evidence will go beyond that. I do not pretend to be a researcher.

MS LE COUTEUR: You said we should be prioritising primary care rather than acute, which seems quite sensible. If we accept that, what should we be doing differently?

Ms Kirk: I am using terminology really carefully—primary health care as defined by the World Health Organisation through the declaration of Alma-Ata. We so often dismiss the work that comes from there and say, "Oh, that's not about us; that's about emerging nations," and blah, blah. It is all about us.

We know that—again there are massive, reliable studies on this—for 85 per cent of pregnant women birth is a normal process; therefore they should be cared for in a primary health model of care. Wrapped around that should be really good pathways

for consultation and referral. The majority of women should be cared for at the level of care they need.

I will admit a bias—I am a midwife. For the vast majority the primary care should be at the midwifery level. If they need care beyond that, there should be really good pathways of consultation and referral for them to have access to medical care, all sorts of medical care. When people with comorbidities get pregnant they need their rheumatoid arthritis managed while they are pregnant and whatever.

A good system allows for what is normal and healthy to stay normal and healthy and be sustained as normal and healthy. When they need the other, that should be readily available and able to be accessed. But they should not have to have all their care tripped into that space if they do not need it. It is expensive care, and what community can afford it? Nobody can afford it.

MS LE COUTEUR: How would you see our system changing? More midwives at the hospital, midwives in GPs' practices? I am just trying to get a handle on where—

Ms Kirk: I do not suppose I know. We purposely went at the macro level because we believe that unless it is embedded in policy that there is a commitment to providing primary health care we can fiddle and diddle and provide little bits here and there, and that is what we will achieve. If we at the policy level, at that highest level, have an absolute commitment that every woman will have access to primary health care and will have access to other care if that is what she needs, behind that comes: "How do we do that?"

We have an appropriately skilled and qualified workforce who can operate in an enabling environment and who can be as close to the woman as possible. That does not necessarily mean that every woman has to go to either Calvary or the Canberra Hospital; they can stay at home if they so choose. That is what primary health care is. Primary health care means that you listen to the woman—that the safest place for a woman to birth is where the woman feels safest. You could look at me and say, "You just want every woman to have a birth at home." Well, 85 per cent probably should. But that does not mean that for 85 per cent that will be the safest for them, because they may not feel that. Therefore there should be options around how woman birth.

THE CHAIR: And you are saying that that does not currently happen?

Ms Kirk: No.

THE CHAIR: Women are not able to have babies at home?

MS LE COUTEUR: No—we know that.

Ms Kirk: We know that.

THE CHAIR: There is the home birthing trial.

MRS DUNNE: It is a trial.

Ms Kirk: It is a trial, and exclusions—

MS LE COUTEUR: It has had fewer than 20 people in it so far and it excludes most people. We absolutely know that.

THE CHAIR: But then they are able to. It is just that it is a trial service.

MS LE COUTEUR: A very small number.

Ms Kirk: We come then to that fundamental point of accessibility. Do they really have access? Is it available to them? You are saying it is available: 20 women have got it. Is it accessible?

MS LE COUTEUR: Clearly not.

MRS DUNNE: If you live in Banks it is not.

Ms Kirk: And is it equitable? No, it is not, because the exclusion criteria are so through the roof that—good luck.

THE CHAIR: But I could have been assessed as being able to give birth at home, and I then ended up having a traumatic, revolting birth and was lucky I was in hospital.

Ms Kirk: You could have and you probably—

THE CHAIR: Home births did not exist. But I was classified as a wonderful, perfectly healthy, low risk second pregnancy.

Ms Kirk: A good system would have consultation referral processes where that could be managed and managed effectively. In a jurisdiction like this, I am afraid to say, there are no excuses. The evidence would say there are no excuses.

THE CHAIR: I ended up having to have a caesar because the baby was in so much distress. If I had been at home, that would not have been able to happen. So there have to be options for—

MS LE COUTEUR: There are ambulances.

THE CHAIR: Yes, but there have to be safeguards in place when women are giving birth outside of hospital.

Ms Kirk: That is what we call the consultation and referral process: that you have a network around to be able to support that, that you do not leave people. It should not be linear. Even this plan reads as very siloed, linear—it should not be linear. A woman should be able to move through the system as her needs require. Best practice says that her care should be as close to home as possible. That is what best practice would say.

THE CHAIR: But that is not for every woman, surely?

Ms Kirk: I suppose that is why I said the safest place for a woman to have her baby is where a woman feels safest. For some people that might not be an option. But for many others, why not? And right now it is not. To get into the birth centre is very difficult.

MRS DUNNE: The criteria, again, are quite strict.

Ms Kirk: That is right. And the demand far outweighs the capacity. So accessibility is not there.

MS LE COUTEUR: In home births we are behind, for instance, New South Wales. I know that because my daughter has recently given birth in New South Wales.

Ms Kirk: Yes. There is great opportunity and we are sitting in a jurisdiction where communication and collaboration should be a snap. There are no excuses for us.

MRS DUNNE: Correct me if I am wrong, but you said that we should be creating demand for service. Could you elaborate on that? Is it that sometimes mothers do not know what is available or what they need and you end up in the sausage factory, in a sense?

Ms Kirk: Exactly. If we have a community that is not well informed, that does not know what to ask for, there is not the counter-pressure to expect that. We know how important it is for us when we are providing services that we do respond to what people need. I believe we have an obligation to inform them of what is best practice and then have that counter-pressure back. That is okay; we expect it. Why have we not got it? We do not do that, and I believe we should. If we set it up that people expect best practice, we will deliver best practice. That counter-pressure is very important.

MRS DUNNE: What do you think is the missing ingredient? What you have described is a system that is not delivering best practice, although it has the rhetoric that says it wants to deliver best practice. Where is the disconnect?

Ms Kirk: I think that where there is no vision the people perish. I do not think we have the vision for it, and without the vision then we do not have the will to deliver. I think we are in a moment of drought. I am sitting here representing an organisation that was Canberra's longest serving health service provider and is not doing it anymore.

I have to say that we have a problem with policy and planners and leaders who are not embedded in health and committed to health. I am afraid to say that in our public service there may be an attitude that any manager can do anything across any portfolio. I would dispute that. I think health needs people who understand and know health to deliver the best health care, and if we have people who are not immersed in health pulling together policy for health, managing health services, I think we have a fundamental problem.

MRS DUNNE: If you ruled the world, how would you reshape maternity services in your image?

Ms Kirk: The first thing I would do is put the woman in the middle of the table. If any decision is made that is not in the best interest of the woman, it cannot be made. I think that is what we have lost track of: we have lost track of what is best for the woman and her newborn. That is the very first thing I would do.

The next thing I would do is have a good look at who is determining what our health policy is and who is advising and providing that advice. Are they truly immersed in health? Do they truly understand health? Do they know the services that are being provided under their portfolio? I would look at CMS and say we are the canary in the cage. We probably, as an NGO, had the most to lose and therefore could not risk staying in there any longer. But what is going on underneath that? I would pull together people who are absolutely committed to implementing reliable evidence.

I am not naive. Health is so political. There are many stakeholders. There are stakeholders who personally would have a lot to lose from a monetary perspective if it were to change. I understand that. But the first thing we need to do is to have a guided discussion with the key stakeholders and the women, and listen to the women—to have that conversation with the woman in the centre of the table and with the rule being: "If it is not best for the woman, forget it. We are not doing it."

MRS DUNNE: You also talked about the current policy seeming to be about the delivery of public health services through public infrastructure—

Ms Kirk: Yes.

MRS DUNNE: and that there is no integration or communication across the sector in the not-for-profits, in the private sector et cetera.

Ms Kirk: Yes.

MRS DUNNE: Would you like expand on that?

Ms Kirk: When we went through the territory-wide health services framework—it still has "draft" on it, but it is what is sitting up there as the public document—it made no mention of the cross-sector approach. We know that in this town there are more non-government providers providing public services than there are private services. But there is no mention of that in here. I do not think that is helpful. It has even got a section about integration, with no mention of this. There are lots of ways to interpret integration, but there is no mention of a truly integrated approach to maternity services.

Whilst we have people managing policy around maternity services who do not know what the providers are providing, we are fraught. This may explain why there is not a culture of curiosity about what they are paying for. That is another thing. But I think there needs to be a broader look at what an integrated approach is. How might we do it? How might we all do it together rather than saying, "Okay, we have figured out a contract for you. You go away and do that in glorious isolation and you do this in glorious isolation." In my view, there is not a truly integrated approach to providing, and this document would support that.

MS LE COUTEUR: You said that as an NGO you had the most to lose. Are you in a position to say more about that?

Ms Kirk: Probably not.

MS LE COUTEUR: I was thinking that probably was the answer I was going to get.

Ms Kirk: You can ask me at the end of November but not now.

MS LE COUTEUR: I thought I should at least ask.

MRS DUNNE: There is something I would like to ask about and I hope we can be brief. Most of the submissions we have heard from individuals are the horrible cases. They probably represent the 15 per cent who do not have a seamless birth. In a sense, what we are seeing is the hard cases where there has not been coordination. It often has not been woman and baby centred.

Ms Kirk: Yes.

MRS DUNNE: Sometimes it feels, irrespective of the gender of the person delivering the service, extraordinarily patronising. How do you make those connections better? Again, is it putting the woman and their baby in the middle of the equation?

Ms Kirk: I would say that in those cases we should sit down and have a conversation and talk about whether our health professionals work in partnership with that woman, about whether she is truly a partner in her care. Don't get me wrong; I know as well as anybody that the throes of labour and pushing a baby out is no time for us all to sit back and have a chat.

MRS DUNNE: Yes, just get it out.

Ms Kirk: Yes, that is right. But if those conversations are had before the baby is born, before those sorts of situations arise, it is a completely different sense of satisfaction and achievement at the end, because at the end there is a sense of, "We did it together," rather than, "You did it to me." That is the difference. It is truly about working in partnership. To truly achieve partnership, number one is that health professionals need to be trained in how to work in partnership. Health professionals are trained by and large to be on top, not on tap.

MRS DUNNE: And to respond: "X is happening; therefore, a, b and c should happen."

Ms Kirk: Yes. "We talked about this before. Do you remember when we talked about blah, blah? Well, now is the time. Our choices now are this and this. If we go along a bit further it will be this." That is the time for that sort of conversation.

MRS DUNNE: But you have to have that conversation first—

Ms Kirk: You have to have had it first.

MRS DUNNE: and what you are doing then is a reminder.

Ms Kirk: It is a reaffirming.

MRS DUNNE: It is reaffirming that we are at a crossroad now.

Ms Kirk: Yes, that is right. Way back here the conversation is had around, "This is what I can do. This is what I have to offer. This is the platter that I have to offer. This is where I begin and I end. The beauty is that we have also got beside us"—I am talking through the lens of a midwife—"the obstetrician, the anaesthetists and whatever. But this is where I begin and I end. This is how we can work this." The same then goes for this professional and that professional. Those conversations should be had beforehand.

THE CHAIR: You are saying they are not being had?

Ms Kirk: That then comes back to that comment about an enabling environment. People have to work in an enabling environment. They have to have a relationship. We need to understand each other. That takes a bit of time and it also takes an environment where that can happen so that there is no little bit of practice that happens in isolation of other things. The onion needs to keep being peeled off to figure out: "Why is this so? What do we need to do together to make this different?"

I would say that the biggest single thing is truly working in partnership. Most health professionals who are not absolutely immersed in primary health care are used to being on top, not on tap. They need to be reminded and trained about working in partnership. It is not a threat. It is an opportunity. Actually, you will save time by doing it, and grief.

MRS DUNNE: The other thing that we heard is that when things go wrong people need to be debriefed soon afterwards. You cannot always anticipate everything—

Ms Kirk: Yes.

MRS DUNNE: but then you cannot then just sort of walk away and say, "Gee, that was a bit rough," but not do anything about it.

Ms Kirk: Yes. I must admit that in running QE for all those years we saw many, many, many, many women who were scrambled. It all came back to a traumatic birth. They did not understand, and in some cases it was not understandable. Sometimes you can say that.

MRS DUNNE: We just do not know why.

Ms Kirk: We just do not know. It is not understandable. People go, "So it is not just me. I understand that." Debriefing is not a panacea, though—

MRS DUNNE: No.

Ms Kirk: and it is not an instant cure. It is something that has happened; it is quite traumatic; it needs to be managed. The biggest single thing that is important with people who are traumatised is that they do not have to tell their story to different people, that they are not put in a situation where they have to tell you and then you go and put me on to you. Every time the woman has to regurgitate it, she is being retraumatised.

Whoever does it needs to be the point that does it. You can hear it, you can hold it and then you can get them to somebody who can be part of their life for a little while while they truly sort it out for themselves, but not a system where there is a one-off with that one and then you find yourself at your GP because you are still in trouble or you end up in QE and that is the first time anyone says, "Are you okay?" Then out it all comes.

But with any model like that, if that person is not prepared or available to have a relationship over time, it does not have to be an extended period of time, to have a system where they have to keep telling their story is actually increasingly harmful. It has to be done really well and they need to be in a situation where they have to repeat themselves as little as possible. Every time the woman keeps telling the story, she is retraumatised.

THE CHAIR: Ms Kirk, thank you so much for chatting with us today. We really appreciate it. We have come to the end of our scheduled time. When available, a proof transcript will be forwarded to you to provide an opportunity to check and to suggest any corrections, should they be required. Again, on behalf of the committee, I would like to thank you for coming here today.

Ms Kirk: Thank you.

SHAHIDULLAH, MS NATASHA

THE CHAIR: Thank you, Ms Shahidullah, for appearing today and for your written submission to the inquiry. The committee acknowledge that preparing your submission would have been very difficult and we thank you for the time and energy that went into making the submission. Your contribution is valuable to this inquiry.

The hearing process has a range of formalities. The committee is aware that appearing before a parliamentary committee is not something that people do every day and that you will be talking about a very personal experience. Please be assured that the committee is mindful of making you feel as comfortable as possible during that time.

I remind you of the protections and obligations afforded by parliamentary privilege and draw your attention to the privilege statement next to you on the table. Can you confirm that you understand the privilege implications of the statement?

Ms Shahidullah: Yes.

THE CHAIR: The proceedings are being recorded by Hansard for transcription purposes and are being webstreamed and broadcast live. I understand that you have advised the committee that, in lieu of making an opening statement, you would like to go straight to questions and have an opportunity to make closing comments.

Ms Shahidullah: Yes.

THE CHAIR: The committee has decided not to disclose the names of medical officers, including midwives or doctors, and we ask that all witnesses refrain from identifying medical officers while giving evidence. The committee has also decided not to publish the names of children. If you wish to disclose the name of your child please remember that your evidence is being published on the Assembly's website.

In your submission you made a couple of points and some recommendations for improvement, which was lovely. Thank you; we like that. One of the things you talked about was the continuity of care of midwife models. Can you expand on that a little for the committee?

Ms Shahidullah: What the continuity of care model is?

THE CHAIR: What you experienced and your ideas on how to improve that.

Ms Shahidullah: It is actually really good. I have limited feedback on what would be better models of continuity of care because it was so excellent. I am aware of all the global health research that shows that continuity of care models lead to better health outcomes for mothers and babies. I do not think that is in question.

I want more women in the ACT to benefit from that because that was like the shining, great thing that came out of my experience with Canberra Hospital. Whenever my midwife was there—or any of the midwives from the CatCH program when my personal one was not there—it was like everything went fine. I had an advocate who

understood me and my medical history but also was focused on the best outcomes for me and for the baby. That is so valuable. It is really hard because I have no medical background.

MRS DUNNE: Except being a consumer.

Ms Shahidullah: Yes, that is right. You are relying on all these experts in the health system. When I was kid I thought doctors were infallible. I know better now. There are a range of opinions. It is like any other workplace with a range of workplace politics to work through, whether good or bad. They know the system; they can negotiate and advocate on your behalf.

I read all the other submissions to the inquiry and that was a theme that was really strong, and that is unsurprising. Whenever people felt they had an advocate, whoever that advocate was—somebody they had hired or a friend or family—they had better health outcomes and better mental and emotional wellbeing out of it. That is such an important aspect of the process as well.

There are some things you could maybe do to expand it. It was a team of four and it is geographically split, so it was pretty good. Everybody in my team was really good. I have spoken to some other women and not everybody had the same experience when their personal midwife was there. But I cannot see why we could not expand that further. I imagine it is the health budget and it is probably more expensive. As a territory and a government we need to decide if we want optimal care. If the answer is yes, optimal care is continuity of care.

THE CHAIR: You also spoke about the early pregnancy assessment unit and train and educate emergency department medical officers. Are you okay to talk about that?

Ms Shahidullah: Absolutely. I am not emotional about my miscarriages at all. I have now had five; I had had four when I went in. I feel I know better than all of them now, so I do not even bother going to emergency. EPAU is very limited, in my experience. I had some phone conversations way after one of my miscarriages. They were also very focused on a certain stage of gestation. Some part of me understands that. Again, I know it is about limited resources.

You cannot really stop a miscarriage. I have done all the research. You can make it a better experience for the woman and we can help manage that process, but there is no way to prevent it, unfortunately. So if it is a choice between helping women at the end of their labour versus early, I would say put the resources there. But we need more of a cultural shift.

I definitely think more training and development is needed to deal with anybody who presents at emergency with these symptoms, how to assess them and what is appropriate in those situations. Frankly, my experience of the medical community and how they view women's pain is not great. That is going back decades. That sometimes also feeds the narrative of the judgement that is being made on how much pain a woman is in or what she is experiencing.

One of my miscarriages was in the ED, in the toilet. The one thing I learnt from that is

that if I ever go back to ED I am going to make a massive fuss even if I am not in a terrible place. I know that sounds terrible, but I could not actually stay in the ED room because I was screaming so much. I kind of took myself out of it and then I got a lot of attention up until the moment I miscarried. After that I understood why I was deprioritised, but there was no actual advice and no consideration of what was best to do for me then, which was perhaps to go home and rest. All the medical advice I got was, "You shouldn't leave. There might be something more wrong. The doctor will see you." But I never ended up seeing the doctor.

I miscarried around 10. I think I went to ED around 8 and I went home at 2 in the morning without seeing a doctor. I could have gone home at 10 and had a good night's sleep and probably gone to work the next day or whatever. I would have been in a better state. They are not equipped or interested. I know there are people with more important, life-threatening situations presenting at ED. I know ED in the ACT is hard because of our primary healthcare system and stuff, but they definitely need more development. And the follow-up: I had to chase up EPAU. Why do I have to chase them? They should be chasing me. But maybe that has improved; I am talking about 2015 and 2016.

The one I had last year was actually a protracted miscarriage which took two months to complete. I would never have bothered going to TCH. It was never-ending. At one stage my doctor thought I would have to go in because my pregnancy hormones went down, but then they started going up. It was a lot of weekly blood tests and I am not good with needles. I would never have bothered going to TCH because there was nothing they could do.

MRS DUNNE: You actually started your submission with a big swag of recommendations. Thank you.

MS LE COUTEUR: Thanks.

MRS DUNNE: Thank you for making our life a little—

Ms Shahidullah: I think some of those have actually been addressed—

MRS DUNNE: Yes.

Ms Shahidullah: in the system now. They are better.

MRS DUNNE: You sort of touched on this. You said that when the midwives that you dealt with in the CatCH program were there, everything went well.

Ms Shahidullah: Yes.

MRS DUNNE: Can you reflect on the times when they did not go well?

Ms Shahidullah: Oh my god! So the worst—the very, very, very worst for me was when I got kicked out of the birth suite halfway through my pregnancy where I—

MRS DUNNE: Halfway through—

Ms Shahidullah: Sorry, halfway through my birth—

MS LE COUTEUR: Through your labour, probably.

Ms Shahidullah: Sorry, yes; through my labour. That is right. Really what it comes down to is a lack of respect for the patient. I am not familiar with what doctors' codes of conduct and stuff are. I am sure they have breached it.

MRS DUNNE: Why were you kicked out of the birthing suite?

Ms Shahidullah: I am still not clear. My main midwife was not there. The backup midwife, who was excellent, was there.

THE CHAIR: Can I double-check? Is this when you gave birth to your daughter?

Ms Shahidullah: Yes. It was two days I was there before I actually ended up giving birth. This was on the Sunday when I went in. I had premature rupturing of membranes but no labour started. I did not want to be induced.

MRS DUNNE: Not at that stage.

Ms Shahidullah: Yes, I was trying to resist that. I only bought myself a little bit of time, because I was also GBS positive.

MS LE COUTEUR: What is GBS?

Ms Shahidullah: I cannot remember what the acronym stands for but they test it at 37 weeks. It is rare. Even if you are positive, you have maybe got a less than 30 per chance of getting it. But it is something like a disease that affects the baby. A lot of babies die from it. Even though the chances of getting GBS are low, the impact of that is quite severe.

MRS DUNNE: It is group B streptococcus, known as group B strep infection.

Ms Shahidullah: Yes, that sounds right; group B strep.

MRS DUNNE: It is a bacterial infection that can be found in pregnant women et cetera.

Ms Shahidullah: Yes, that is about right. But because I was GBS positive and my waters broke, that increased the chance generally of infection.

MRS DUNNE: Yes.

THE CHAIR: Yes.

Ms Shahidullah: So they did not want to leave me too long if labour did not start. But I negotiated—Bec knows I am good at that.

THE CHAIR: Yes, you are.

Ms Shahidullah: But so was my midwife. I bought myself 24 hours, until Monday morning, to give labour a chance to start. The midwives negotiated; the OB was very reasonable as well. The agreement I had with the OB, including late in the afternoon when my midwife left, was that I would stay in the birth suite all night because that is where we would start the induction the next morning, at 8 o'clock in the morning. I would try to get labour started and we would see how we went. Also, I had limited choices of induction. I would have to go straight to the most severe because my waters had broken.

THE CHAIR: Is that the drip?

Ms Shahidullah: Yes, it was terrible. They doubled the dose every 30 minutes. I never want to do that again. It was right up there with my top five worst experiences of my life. The first half an hour was okay. Then it was like pretty [expletive deleted]. So my midwife left, of course. She was going to come back and do the induction with my normal midwife in the morning. We kept trying to do lots of things. We still kept trying all day with walking, going up and down stairs and all these things they asked me to do.

Then the evening shift changed over. Around seven or eight o'clock, the midwife said that the doctor had decided that I could not stay in the birth suite. I was like, "Well, is there a shortage of rooms? What is the situation?" We had already brokered this agreement. They said that the only way I could stay was if I agreed to be induced that night—like then. So, effectively—I put this in my submission—whoever he or she was, they were trying to blackmail me. Effectively, they were blackmailing me. I tried to understand why. I said to him, "I talked to the OB." I had personally talked to the OB that was on duty. But she was already gone because the shift changed. Again, I think this was a theme in the other submissions: new doctor and new rules.

Then I asked to speak to this doctor. I do not know who this [expletive deleted] is. Excuse my language. But they refused to see me; right. They literally would not come and talk to me. Again, the midwife—this is the birth suite midwife; this is the other problem with the lack of continuity of care; I really feel for all those other women that probably just have to put up with these terrible midwives, because not all of them are brilliant that you encounter in births—look, she did not really care. She was just doing what the OB, registrar or whatever had told her to do. She was just a go-between. So I was like, "I want to talk to this person." She said, "They are not going to talk to you. They will come and talk to you if you agree to do the induction."

MS LE COUTEUR: That is outrageous.

Ms Shahidullah: I have a new midwife. I am having another baby in March next year. I am back in the CatCH program. I saw my notes. This [expletive deleted] of a doctor, their name is not even in my notes. They did not even put their name in my notes. I really want to know who this doctor is, because I do not want the doctor anywhere near me. I do not want to see them. I want to throw things at them if I ever see them again. Their name is not even in my notes.

I finally agreed to go. I know what I should have done and I know why I did not do it. This is my great 20/20 hindsight. I finally agreed to go. At this stage I had not really slept because Saturday night, in the middle of the night, my waters broke. So I had not really slept in a day. I thought that my husband needed to be rested because I did not know how labour was going to go. Hopefully, it would be over like that. Of course, that is not what happened. But I knew he needed a good night's rest. He also did not want to leave me. I did not want him to leave me, frankly. I did not want to be alone. I could not physically leave because I was hooked up to antibiotics because of the GBS. I would have happily gone home. I live 10 minutes from hospital. It is no big deal. I said I would go if they were able to get me one of those rooms where my husband could also stay. Finally, that is what they said. Then I got down to the rooms and that is not what happened.

MRS DUNNE: Uh-oh!

Ms Shahidullah: Yes. By the way, I had such bad luck. Three times I was admitted to either antenatal or postnatal in those five days. All three times I got a shared room. With the whole breastfeeding thing at the end, I was just like, "I am going home. I cannot do this." That was the worst. But I was so tired. Now I think that if I had known it was going to get worse before it was going to get better, what I should have done was call my midwife. But some of it is gendered, right. You do not want to make a fuss. I am not somebody who kind of advocates for myself. My husband is not somebody who kind of advocates for us, either. You think, "We are just going to be reasonable." But it was so ridiculous. I left the birthing suite between 11 and midnight. It was really late. Then I was back there the next morning in eight hours to start this induction.

MRS DUNNE: It is not as though they were using—

Ms Shahidullah: No, they did not need it. There were plenty of empty rooms.

MRS DUNNE: It was not that you were not labouring and there were people who were labouring and they needed the room.

Ms Shahidullah: And I would have understood that even more, because I asked her specifically, "Do you need the room?" And she said no. Of course they did not need the room, because they were willing to let me stay if I was willing to be induced. I am still really, really, angry.

And my husband—there was nobody in the shared room. This is the other thing. I was in the shared room all night with another bed. But we were not allowed to use the other bed because that is hospital policy, and I do not think my husband was actually even allowed to stay all night. He was not. We were lucky. In the shared room you are not allowed to stay, normally, beyond 10 or 11 pm. It was already past that by this stage, and the nurse said he could stay, sleeping on the floor or something, but if somebody showed up in the middle of the night he would have to leave then.

What I should have done was go home. I should have just said, "Keep your antibiotics. I'll see you in 10 hours." I have educated myself about GBS a bit better now and I am more willing to manage my own risks. But all you get, really, is fearmongering in

hospitals, and you want to do what is best for your baby. I made the point that none of what the doctor, whoever that [expletive deleted] is, did what was best for me or the baby. You go into labour, a pretty tough one, and on Monday morning, with no sleep and no rest, how are you supposed to—and then in the morning when the midwife showed up, she was so angry.

MRS DUNNE: On the Monday it was your principal midwife from the CatCH program?

Ms Shahidullah: Yes, and my backup one from Sunday. They were both there to set up the induction. Once she was there it was fine. Obviously my labour did not go to plan. I ended up with a caesarean. But [expletive deleted] happens, right? I was prepared for things like that. I cannot blame the hospital for that.

Everything that happened during that process was amazing. I had such a good midwife. She was very experienced. When I wanted an epidural—I remember that in the morning this doctor came to see me to tell me when I could have it and when I could not, and then I did not last very long—I said to her, "I know I'm not four centimetres yet. Can I have an epidural? I know he said I couldn't have it till then." She said, "What does he know. He's not the one having this baby." She said, "You can have it if you want it," and she got the anaesthetist. I was very lucky he was available. Every anaesthetist I saw was incredible. To be honest, except for that doctor who I do not know, all the ones I saw during the day and the next day and who came to see me later on were brilliant and caring and reasonable, including the ones who let me go home when my daughter had lost 14 per cent of her birth weight—and she was only 2.7 to start with. They were all great.

But culturally and the hospital administration and the policies—I go back to that doctor. That is just a fundamental lack of respect for me, the patient who you are making decisions about. What is the difference between that person making a decision about my care and all of you guys doing it? He or she did not come to see me. They did not come to talk to me. They did not give me any options. They just made a decision. I have seen the notes; they are pretty brief. That is just wrong. And then, not only that but they overturned the decision that had been brokered and agreed to by their colleague previously. If somebody did that to me in the workplace, I would be pretty [expletive deleted]. You make one agreement and you come back and it is something different. It is really hard on the midwives.

I found the birth suite to be just a constant negotiation between the people who want to do the right thing or can see that there are other priorities versus the limited resources of the hospital or people who are just being [expletive deleted] like that guy. I do not know if it was even a guy. It was probably a woman—who knows? It could have been anybody. I do not even know. But that was pretty awful.

THE CHAIR: We have gone over time. But do you have anything else to add, Natasha?

Ms Shahidullah: Just generally, culture takes a while to change. I made the submission because there were so many good things that happened, and that needs to be replicated and expanded. And the terrible things—

MRS DUNNE: Need to be avoided.

Ms Shahidullah: Yes, that is right. Some of that is hospital administration, like the whole coercing me out the door sort of thing. The thing is, I hate hospitals. I did not want to stay. I had already been there four days by then. But it was such a basic thing that I did not know that I should have had my baby weighed before I left. I would never let that happen next time. But why did that have to go wrong just because it was my midwife's day off, just because there was nobody looking out for me? The health system should be looking out for me.

Even from the nice people there is this attitude—particularly every time I was placed in a shared room, which was all three times. That night when I got kicked out of the birth suite, the person in charge, the nurse or whoever, in charge of antenatal said, "Look, this is a public hospital." And I thought, "Yes, and? I pay taxes too. Am I supposed to expect suboptimal care because it's a public hospital? I would have thought the opposite." We should be setting higher standards. If we believe in public health care then that is what we should be doing, so that there is no need for the private health system. That is all I have to say for now. Everything else is in my very lengthy submission. Thanks so much for calling me to your inquiry.

THE CHAIR: Thank you so much, Natasha, for coming in and for your submission. It is wonderful. When it is available, a proof transcript will be forwarded to you to provide an opportunity to check the transcript and suggest any corrections, if required. On behalf of the committee, thank you for appearing.

The committee adjourned at 2.05 pm.