

TRANSCRIPT

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Melbourne — 27 November 2017

Members

Mr Paul Edbrooke — Chair

Ms Cindy McLeish — Deputy Chair

Ms Roma Britnell

Dr Rachel Carling-Jenkins

Ms Chris Couzens

Ms Maree Edwards

Mr Bernie Finn

Witness

Dr Wendy Pollock.

The DEPUTY CHAIR — I would like you to introduce yourself and begin your 8-minute submission.

Dr POLLOCK — I am Wendy Pollock. I made a submission only last week. I am not sure if you have had time to access or read it as yet, but I am an adult intensive care nurse and also a midwife, and I undertook a PhD on critical illness in pregnancy. So my perspective is very much at that very extreme end and relatively rare part of birthing where women experience a life-threatening event. For the last 16 years I have also been a member of the CCOPMM maternal mortality and morbidity subcommittee so I have been involved in reviewing maternal deaths across the state and also six years of maternal deaths across Australia, so overall hundreds of maternal deaths I have been privy to examine the circumstances of. My particular focus from a clinical perspective though is on when women survive. My concerns relate particularly to a service gap that exists when women are in hospital and insufficient follow-up and support for women when they get home.

Primarily at the moment my position as such is that I run my own business called Maternal Critical Care. I offer professional education and also research services around this topic area. I have honorary appointments with two universities and supervise three PhD candidates, and I sometimes do clinical shifts as a casual nurse midwife in maternity high dependency or general intensive care.

The service gap that exists in the clinical setting relates to a lack of any focus on professional education around illness in pregnancy. With the mandatory curricula for general nursing that is overseen by AHPRA for universities to be accredited to provide the program, there is no mandatory maternity segment in that education any longer. There used to be historically; there has not been for a long time. So nurses that now graduate and become registered nurses may not have done any theory or certainly any clinical rotation to any maternity event or services.

For midwives, whether they take a three-year bachelor of midwifery or a graduate diploma of midwifery or a double degree of nursing and midwifery, the focus of midwifery is 'normal, healthy bub. That is the domain and the whole philosophy and structure of the curriculum: to ensure that midwives are capable of caring for women through the normal life experience of birth but in a healthy, well framework. So when women experience illness — whether that is something like they were born with a congenital heart disorder, for example, and they have now survived into adulthood and they have then chosen to have a child; there are women in increasing numbers that have very severe cardiac disease and that go on and have children — you do not really have any skilled nurses and midwives who have been specifically prepared to cater for that group of women. Moreover, though, most women that experience illness were actually previously well and healthy and the illness has not been predicted. So for most women that experience a complication it is related to either pre-eclampsia, which is a condition of pregnancy, or bleeding associated with birth, obstetric haemorrhage. Those two things occur out of the blue. They can occur anywhere, at any time, and the system of care needs to be coordinated and organised to identify a deterioration in the woman's clinical state promptly and then to have the right response in place to then minimise the effect of the illness for the woman.

At the moment even the big tertiary services do not cater for sick women very well. Even though Royal Women's Hospital has co-located with Royal Melbourne and Mercy has co-located with Austin, they are separate institutions. A woman gets discharged from one to go to the intensive care of the other. There is no continuity of care across the two hospitals unless you might get the obstetrician popping in. Nurses and midwives provide 24-hour surveillance and monitoring of clinical condition, and they provide support and care. The ICU nurse, for example, may have no idea what a fundus is and certainly does not understand how to establish lactation, for example. But the midwife over here cannot come across. Also, coming and going is not enough anyway because the role of a nurse and midwife is different to that of a doctor: it is 24 hours, it is hands-on all of the time. At the moment, without doubt, there is a significant service gap for caring for these women when they are in hospital.

Ms COUZENS — Does that include diabetes as well?

Dr POLLOCK — Diabetes is incredibly rarely life-threatening to the mother.

Ms COUZENS — Yes.

Dr POLLOCK — It is very common —

Ms COUZENS — And it is growing in numbers.

Dr POLLOCK — It is hugely common, but diabetes in pregnancy is something that is now routinely screened for. It is usually identified during pregnancy. There is quite good endocrinology support and links. There are diabetes educator midwives, and there is a lot of material to support it. That is certainly the case in the major centres. I am not quite sure about more remote or regional places. As you are probably aware, a lot of the Victorian countryside no longer has maternity services so women have to travel large distances for antenatal care, and those women may not have the same sorts of outcomes with diabetes as the women that access services more readily. But certainly in my line of work gestational diabetes or insulin-dependent diabetes is not a major force for illness in pregnancy.

For the mums once they go home they have no specific special set-up or circumstance at all. They can have a massive haemorrhage, have an emergency life-saving hysterectomy, have lost their fertility, and their baby may have survived or died in that process, and they then go home and there is nothing extra special. They might have term healthy twin babies and they have to suddenly then take the care of them. There is no support service or extra stuff to kick-in to help them go through the process. Their postnatal check might even have been delegated to their GP so they do not even go back to the maternity service to understand what actually happened and why that event occurred. That is pertinent for the next pregnancy potentially because if you have a postpartum haemorrhage after one birth, that increases your likelihood for the next time. Definitely the woman needs to communicate to the maternity care in the next pregnancy that that has occurred because it might change how they approach the birthing event.

For women that have had pre-eclampsia it is very important again for the woman to understand the implications for a subsequent pregnancy because something like low-dose aspirin is suitable and may prevent that condition developing again in that next pregnancy. Unless they are aware of that they are not able to communicate that with their clinician and their clinician may not be aware then on how to provide the best care for that next pregnancy either.

As far as postnatal depression, post-traumatic stress disorder, anxiety and other mental health things are concerned, we have no idea of the implications for women that experience these illnesses. There is no data, there is no follow-up. We do not understand the influence on these women's wellbeing or their infant bonding or their partner relationship or anything into the future. There you go; that is about it.

The DEPUTY CHAIR — Thank you very much. We greatly appreciate your providing a submission and coming and speaking to us today.

Dr POLLOCK — Certainly please contact me if you need any other details.

The DEPUTY CHAIR — Terrific. Thank you.

Witness withdrew.