BYO MIDWIFE

Hospital visiting access for independent midwives

Joy Johnston

The young anaesthetics Registrar stood up, having injected the drugs into the epidural catheter.

"So what's with this BYO midwife deal?" he quizzed.

I didn't have the opportunity to say more than a few words then. My commitment was to the woman, and there was no time for chatting about midwife visiting access to hospitals. Now that I have time to reflect I am able to talk about the BYO midwife.

The woman had employed me in early pregnancy as her primary care provider. The only way I can do this is to plan homebirth, so that's what we did. The woman had several scars – on her womb, on her abdomen, and in her mind. She had talked to me about homebirth a few years ago, in her first pregnancy. But she was persuaded then to 'go private'. She got the private induction, the private caesar, and the private nightmare of complex breastfeeding problems.

Labour began spontaneously about 10 days after the calculated due date. The woman at first eagerly engaged in her body's powerful surges. After some hours, having sought relief in the birthing pool, she knew she wanted to move from home to hospital. This decision was made without regret by the woman herself. I wrote a request for medical consultation, called the hospital, and explained to the midwife on duty that we were on our way. The hospital does not provide a booking facility for women planning homebirth, so they had to manage the admission in the same way that they do for women who are occasionally transferred from small outlying hospitals.

Some midwives find it difficult to say the 'h' word – homebirth. Several at the hospital said to me "would you do 'it' when they have a scar?" This was a serious question. These midwives consider me incredibly brave, and possibly foolish for attending homebirths - even without a scar.

"TRIAL OF SCAR" was written across the partograph. After several more hours, and an epidural that did not remove the pain, I thought it quite possible that surgical assistance may be the eventual course of this journey. But I really should stick with being a midwife, and leave prophesy to others. Embracing uncertainty is an essential element of the with woman partnership. The baby was birthed beautifully, in spite of the hospital midwife's obsession with keeping the little red heart on monitor screen flashing, in spite of the epidural that didn't do what it was supposed to do, and in spite of my earlier doubts. The woman looked ecstatic as she inhaled the intoxicatingly beautiful smell of her newborn who she clasped against her breast. After a few hours' rest the proud family went home again.

I mentioned that one of the scars from the previous birth was to do with breastfeeding. I was thrilled to be told five days after the birth that I was no longer needed.

That part of the story has a happy ending. The other theme, the BYO midwife, is urgently needing resolution. The goal of the Midwifery Campaign, "to achieve for all women the right to choose a midwife as their primary caregiver during pregnancy and birth …" can only be achieved when midwives are able to practice, whether they are employed by the woman or the hospital. The exclusion of independent midwives from hospitals should not be tolerated by the midwifery profession, by the women who employ us, or by the community. We must break this restrictive monopoly.

BYO Midwife Part 2

This is another story from my practice, to illustrate the urgent need for access of independent midwives and our clients to public hospitals. It is appropriate that midwives provide primary care, and that every pregnant woman has access to emergency obstetric services. When a woman needs the secondary or specialist level of care it is only reasonable that her known midwife continues with her through what can be a daunting and distressing sequence of events.

My client had experienced a small and painless bleed vaginally at 35 weeks, in her first pregnancy. I am her midwife, and the plan had been for homebirth. I listened to the baby, and heard a steady and healthy heartbeat. I wondered what was happening. The bleeding had happened only briefly, and had stopped. Did she have a placenta previa, or was labour about to start?

The woman and her partner were happy to go from my office to the hospital. I wrote a note to the doctor, photocopied the early pregnancy blood test reports, and phoned to let the hospital know my client was on her way. It seemed important to the three of us that a specialist assessment be made.

Upon arrival at the hospital the cardio-tocograph monitor was used, and after 20 minutes of perfect trace the monitor straps were removed. Then, without any warning, there was another, larger bleed. The baby's heartbeat could not be detected. Ultrasound confirmed that the baby had died.

The obstetric Registrar called me, giving me what information he could. The staff at the hospital did all they could to support the young couple through their sadness. There was no-one to blame. Even the choice to plan homebirth, which has been described as 'suboptimal' care by those who oppose independent midwifery, could not be given as a contributing factor in the death of this baby.

This tragedy could not have been predicted. Had there been any means of acting to save this little life, it would have been done. The bleeding had come from a vessel in the membranes (vasa previa) which burst. The blood on the sheets was the baby's lifeblood.

This account illustrates a good working relationship that exists between the hospital, which is a tertiary referral centre, and independent midwives working in Melbourne's Eastern suburbs. We can provide safe and appropriate midwifery services because we can access expert specialist services at all times, usually without fear of criticism or punitive action. The next step, by which the independent midwife can be officially recognised to practice midwifery within the hospital, should not be a major hurdle. Visiting access, clinical privileges, practising rights, or whatever else it is called should not be difficult to

achieve. The woman who wants a BYO midwife is the one who is disadvantaged by the refusal of hospitals to grant visiting access to midwives. That woman is being told that she is not allowed to have control over who is with her, who touches her, and with whom she shares some of the most intimate moments of her life.

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