ANMJ
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JUL–SEP 2025

BURNOUT, HOPE AND CHANGE:

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Annie Butler

ANMF Federal Secretary

The Australian Nursing and Midwifery Federation (ANMF) welcomes the return of the Albanese Government following the federal election in May, and we extend our congratulations to the Prime Minister and his team.

We now look forward to working with the government to fulfil its election commitments to nurses, midwives, and the broader health and aged care sectors — commitments that recognise the essential role of our workforce in delivering safe, high-quality care and driving real reform.

Throughout the election campaign, the ANMF was proud to take a clear and political stand- not on behalf of any one party, but on behalf of our members.

We assessed and shared where each party stood on maintaining gains made in healthcare and where they stood on current issues that matter to nurses and midwives.

We unveiled which parties were prepared to deliver for our professions and for the future of healthcare in this country. That work allowed you – our members – to make an informed choice at the ballot box.

Elections matter. Being political matters – because the decisions made by governments shape the conditions in which we work, live, and care. Our members know that voting is a powerful act, and the ANMF will continue to advocate for the policies that support safe staffing, fair pay, secure jobs, and a health system that puts people first.

With the government now returned, the hard work begins. The ANMF stands ready to work constructively with Ministers and decision-makers to implement the reforms that were promised—reforms such as funding a state-run, nationally consistent RUSON/RUSOM program, developing a single national employment check for nurses and midwives (in collaboration with states and territories), acting on recommendations from the scope of practice review, and, especially relevant to this midwifery-focused issue: appointing a Commonwealth Chief Midwife and funding the development and implementation of a National Midwifery Strategy.

While we remain focused on achieving these improvements at home, we cannot ignore the escalating humanitarian crisis unfolding in Gaza.

Nurses, midwives and other health professionals there are delivering care under unthinkable conditions — in bombed-out hospitals, without clean water, electricity, medical supplies or personal safety. In addition, the people of Gaza are suffering mass starvation with very little aid being allowed through in the region.

In response, the ANMF has published a statement on behalf of our members condemning the attacks on healthcare and calling for an immediate and lasting ceasefire.

We continue to demand the protection of all civilians and health workers, and urgent access to humanitarian aid. We extend our call not only for Gaza, but all countries severely impacted by war such as Ukraine, Afghanistan and many others.

Our statement is only the beginning. Over the coming weeks, we will be coordinating further activities that members can join to show solidarity and provide support. We know that our members want to act to show support to their overseas colleagues and we are committed to creating those opportunities for meaningful engagement.

Nurses and midwives are united by a commitment to care, dignity and justice- values that must extend beyond our own borders.

As we look to the future with a renewed federal government and a mandate for reform we do so with a strong sense of responsibility: to hold our leaders to account, to improve our own health system, and to stand in solidarity with our colleagues around the world.

I encourage you to continue speaking out and taking collective action on the issues that matter. Together, we will lead the change our professions – and our world – so urgently need.

Elections matter. Being political matters – because the decisions made by governments shape the conditions in which we work, live, and care.

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Madi with Emma and Charlie.
Credit: Fiona Stanley Hospital

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Moving state.

Transfer your ANMF membership

If you are a financial member of the ANMF, QNMU or NSWNMA, you can transfer your membership by phoning your union branch. Don't take risks with your ANMF membership – transfer to the appropriate branch for total union cover. It is important for members to consider that nurses who do not transfer their membership are probably not covered by professional indemnity insurance.

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FOCUS

The *ANMJ* acknowledges the Traditional Owners and Custodians of this nation. We pay our respects to Elders past, present and emerging. We celebrate the stories, culture and traditions of Aboriginal and Torres Strait Islander Elders of all communities. We acknowledge their continuing connection to the land, water and culture, and recognise their valuable contributions to society.

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IMPACT OF ENDOMETRIOSIS LAID BARE

The rate of endometriosis hospitalisations among females aged 20-24 has doubled in the past decade, a new Australian Institute of Health and Welfare (AIHW) report has revealed.

Endometriosis, an inflammatory condition where tissue similar to the lining of the uterus, grows outside the uterus, can be painful, affect fertility and lead to reduced participation in education, work and social activities.

Around one in 7 (14%) of women born in 1973-78 were estimated to have been diagnosed with endometriosis by age 44-49, according to the report. Endometriosis remains the third leading cause of non-fatal disease burden among females due to reproductive and maternal conditions, after genital prolapse and polycystic ovarian syndrome.

An estimated $293 million was spent on endometriosis in the Australian health system in 2022-23. Since 2013-14, total spending on endometriosis has more than doubled, from $142 million to $293 million in 2022-23.

Almost all (95%) endometriosis-related hospitalisations involved a procedure, with surgical procedures used in treatment including removal of lesions via laparoscopy (key-hole surgery) or laparotomy (abdominal surgery) and in severe cases, removal of the uterus (hysterectomy) or parts of the bowel. In 2022-23, there were 44,200 endometriosis-related hospitalisations.

The Albanese Government has taken significant steps to improve women's health treatment, including endometriosis. This has included the expansion of specialist clinics and medicines being added to the PBS, significantly reducing the annual cost of treatment.

New Aged Care Act delayed

The new Aged Care Act which was due to be implemented on 1 July will now be delayed to 1 November.

The delay – the fourth since the legislation's inception in 2023 – has been announced in response to advice from the sector that it needed more time to deliver the major reforms.

In an open letter to the aged care workforce, new Minister for Aged Care and Seniors, Sam Rae, has highlighted the government's commitment to working together with frontline aged care staff following the deferment of the start of the new Act by four months.

Minister Rae said recent discussions with older people, their families, carers, aged care providers and workers revealed that the sector needed more time to understand and prepare for the introduction of the new Act, including new ways of working to ensure continued safe and quality care for elderly Australians.

According to Minster Rae, the government will use the extra time to work with the workforce and employers to:

- Help build capability and support in understanding new requirements
- Prepare older people for the change so they know what they can expect from each aged care worker
- Finalise systems and processes for governance and reporting
- Develop guidance and training modules for key changes

"The aged care workforce is at the frontline of aged care, and we share a common goal in getting these once-in-a-generation reforms right so we can deliver a high-quality, sustainable and world-class aged care system for all Australians," he said.

Student and early career nurses speak out for health of the planet

Members of the International Council of Nurses' (ICN) Nursing Student Steering Group have expressed their deep concern over the global environmental crisis and its escalating impact on human health.

Their message is clear: the impact of environmental degradation and the climate crisis is not a future concern – it is reshaping healthcare now.

"These are not distant threats," said the statement.

"But real events that are rapidly shaping our clinical environments, influencing the communities we serve and affecting our mental health and wellbeing."

The group has called for:

- Recognition of student and early career nurses as essential to advancing planetary health
- Integration of planetary health into nursing education
- Nursing curricula that prepare nurses to advocate for sustainable, equitable and climate-resilient health systems

"We offer our perspective as the future of nursing – with hope, integrity and a deep sense of responsibility," the group stated.

"We are ready to learn, lead and act – grounded in the ethics of our profession and inspired by the vision of a healthy and sustainable world. Because there is no health without a healthy planet and there is no future of health without the education of nurses who are prepared to protect it. Nurse the planet. Heal the future."

New podcast launched in Digital Health series

Listen Now! The latest episode of the ANMF Podcast, presented in partnership with the Australian Digital Health Agency, is now freely available on Soundcloud.

Unlocking New Digital Tools in Clinical Practice: Leaders in Nursing & Midwifery Discuss brings together senior leaders in nursing and midwifery to explore how digital health, especially Artificial Intelligence (AI), is reshaping clinical roles and care delivery.

The discussion emphasises the importance of nursing and midwifery knowledge, curiosity, inclusion, and human judgment in successfully integrating digital tools such as AI into nursing and midwifery practice.

Participants include Alison McMillan (Commonwealth Chief Nursing and Midwifery Officer), Kellie Wilton (Senior Midwifery Advisor), Annie Butler (ANMF Federal Secretary), Karrie Long (Victorian Chief Nurse and Midwifery Officer), and Alicia Graham (Digital Health Educator with the Australian Digital Health Agency).

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Nurses contribute to accessible quality care in medicare urgent care clinics

An evaluation report of Medicare Urgent Care Clinics (UCCs) shows they provide treatment for urgent but not life-threatening illnesses and injuries and reduce visits to hospital emergency departments, as intended.

The interim report, by the Department of Health and Aged Care, shows nurses' contribution in UCCs providing accessible quality healthcare. Medicare UCCs employ an average of four full-time equivalent nursing staff per clinic.

The report evaluated all 75 clinics operating in the first 15 months of the program against nine measures of success including timely treatment; safe and quality treatment; coordinated care; and cost effectiveness.

Key findings from the report include:

- UCCs have prevented 334,000 emergency department presentations a year
- Average wait times were 14.5 minutes long (compared to between 24-31 minutes for comparable ED wait times)
- Majority of patients presented to UCCs with conditions appropriately managed there.

While nursing staff are integral to the operation of the clinics, the report focuses predominantly on challenges related to GP recruitment. The report identifies opportunities for more flexible workforce models, including interdisciplinary care.

The ANMF, along with other peak nursing and midwifery bodies, has called on the federal government to implement recommendations from the *'Unleashing the Potential of our Health Workforce Scope of Practice Review'* Final Report, including blended funding models that support nurses and midwives working to their full scope of practice.

Nationwide scorecard on tobacco and vapes

A nationwide scorecard reveals a stark divide in states and territories in tackling tobacco and vapes, one year on from the federal government introducing world leading reforms.

The Australian Council on Smoking and Health (ACOSH) scorecard measured progress across nine key areas, from cracking down on illegal sales and enforcing vape laws, to protecting kids from marketing and ensuring smoke and vape-free public spaces.

While South Australia and Queensland are leading the charge, the Northern Territory and Western Australia have yet to prioritise urgent updates to state tobacco laws which give authorities the power to shut down illegal vape shops and introduce tougher penalties to deter offenders.

In South Australia, there have been over 500 inspections conducted with closures of retailers and government taskforces have seized millions of dollars' worth of illicit cigarettes and vapes. Significant penalties have also been introduced in Queensland with large-scale seizures and stronger enforcement.

Though some reforms have been made in New South Wales, Victoria, the ACT and Tasmania, stronger and more comprehensive action is required. ACOSH will redo the scorecard in 2026.

The Thoracic Society of Australia and New Zealand has launched new *Guidance for the Management of Electronic Cigarette Use* designed to equip healthcare professionals with strategies to prevent vaping initiation and support individuals who are trying to quit. The open access position statement is published in peer-reviewed journal *Respirology*.

New Federal Vice President brings fresh voice to the ANMF

By Natalie Dragon

Meet newly appointed ANMF Federal Vice President Astrid Tiefholz – based in Tasmania, Astrid is a passionate advocate for nurses and midwives across the country.

Astrid brings a rich and diverse background to the role, shaped by years of experience in midwifery, advanced nursing practice, and perinatal mental health. With a deep commitment to the profession and a clear vision for the future, she's ready to amplify the voices of nurses and midwives on the national stage.

"It's important that we have diversity of voices from across the nation," she says. "It is really important to me to be able to represent Tasmania and be part of the national voice in nursing and midwifery."

Astrid completed a nursing and midwifery double degree at La Trobe University in Melbourne. "In retrospect, I'm really glad that I did both nursing and mid because it's given me a lot of opportunities to expand my sphere of practice.

"For a long time, I worked mainly in antenatal intrapartum and post-natal care, which I loved. As time went by, I found that I became more interested in other subspecialties of midwifery."

About 10 years ago, Astrid went back to become a lactation consultant. "Something that really struck me was that I felt inadequately prepared to meet the psychosocial and mental health needs of families. I started working in a mother baby unit and then went back and did a Masters on Mental Health Nursing focusing on women's and children health."

For the last five years, perinatal mental health from conception to 12 months post birth has been her specialty. "I've also been increasingly interested in mental health nursing for not just mothers' but also partners, non-birth parents, same sex couples. The multitude of ways that people go into family formation and the amount of support that is needed."

A member of the ANMF for 20+ years, Astrid joined the union when a student at La Trobe University. "I'm passionate about making sure that we can band together and make our voices be heard. When it comes to any kind of negotiation in the workplace about pay entitlements, workplace safety, and standards, we are always stronger as a united voice than as individuals."

Having moved back to Tasmania in 2011, Astrid worked in Member Support at the ANMF Tasmanian Branch in 2012 and was a Workplace Rep at the Royal Hobart Hospital from 2013 for five years. She has been on the ANMF Tasmanian Branch Council since 2017.

As ANMF Federal Vice President, Astrid wants to bring her voice to the table around key issues including the underutilisation of the workforce and working to full scope of practice.

"There are a lot of barriers for advanced practise nurses to upskill to become NPs. There is a lot that we can do within the ANMF as well as aligning with the Australian College of Nurse Practitioners. Expanding the scope of practice and developing a larger NP workforce is really important."

Likewise, there is limited capacity for mental health nurses to upskill and provide Medicare rebate services for ongoing counselling and support, says Astrid.

"There are so many scenarios where mental health support is required but isn't always accessible or available. I think we're really missing out on the use of our existing workforce to provide that additional care that is so sorely needed. That's what I'm really passionate about and wanting to represent further."

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Delivering against the odds: Midwives speak out on burnout, support, and hope for change

Midwives are at the heart of care for the 315,000 mothers who give birth in Australia each year. Yet a landmark report has described the profession as being 'in crisis'—marked by burnout, chronic understaffing, limited career progression, and a sense of being undervalued.

Still, midwives continue to deliver round-the-clock, personalised care, even as that very commitment strains the workforce to breaking point. To secure the future of midwifery, we must attract and support new recruits – but just as urgently, we must listen to, value, and care for the midwives we already have. **Fernanda Fain-Binda** reports.

CONTINUITY OF CARE IN ACTION

"The moment I walked in, I knew it was where I wanted to have Charlie," says Emma Eddy, 34 years old, remembering her first visit to Fiona Stanley Hospital's Family Birth Centre in 2023.

"It's more relaxed than a hospital, with less equipment and the midwives wear their own clothes, rather than scrubs. The rooms are big, so you can move around in labour."

This physiological approach to birth mattered to Emma.

"I've worked as a nurse in Emergency wards for 13 years. I absolutely love my job," she says. "I also like to be active, so I wanted my birth to be as physiological and natural as possible."

Emma had heard about Midwifery Group Practice (MGP) from her friends and colleagues.

At the Family Birth Centre, midwives look after low-risk pregnant women across the whole scope of their experience. Emma and her husband Tim were booked into appointments with Madi (Madisen) Morton. Madi worked opposite shifts with Jane, her 'Buddy' midwife.

Every four weeks, Emma and Tim met Madi to go through education tailored for their stage of pregnancy and individual needs which includes comprehensive antenatal checks. Each appointment lasted between an hour and ninety minutes.

"The education we give our women equips them for one of life's most pivotal moments," explains Madi. "We develop a trusting relationship. Because care is individualised, there's better birth outcomes for babies, improved postpartum care, increased breastfeeding rates and more mental health support for women."

Madi with Emma and Charlie.
Credit: Fiona Stanley Hospital

Emma and Charlie.
Credit: Fiona Stanley Hospital

"New Zealand has a program where every new graduate is assigned a mentor to support them through the first 12 months. It could also keep experienced midwives engaged."

Jasmine Kirk, ANMF Strategic Lead – Midwifery

Emma and Tim had previously experienced pregnancy loss, so consistency of care meant that they didn't have to repeat the story to a new person at every appointment.

"It had only been 12 months ago, and I was still so shaky with it," says Emma. "That's another reason why it was so nice to have Madi: we only had to talk about it once."

A MODEL WORTH STRIVING FOR

Emma's experience reflects what many women hope to receive – and what many midwives strive for. According to *Midwifery Futures*, a large-scale report into the workforce published in October 2024, midwifery-led continuity of care models are essential for educating, preparing and retaining Australia's future midwives. Eighty percent of newly qualified midwives want to provide pregnancy, labour, birth and postnatal care this way, but only 13% find jobs that offer this model.

The report also found that 37.5% of currently practising midwives would prefer to work in MGPs – such as those offered by the Family Birth Centre – over traditional hospital or private practice settings.

The report, which draws on insights from more than 3,000 midwives, 300 midwifery students, 70 educators, and nationwide focus groups, identified expanding access to MGPs as a key strategy for retaining midwives in the workforce, along with a recommended 20% increase in student midwife enrolments to meet future demand.

A SECTOR IN CRISIS

Also identified in the report are other systemic issues within the sector with one in three midwives, including many well before retirement age, considering leaving the profession due to high levels of burnout, stress, anxiety, and low job satisfaction.

Without action the report warns of a looming crisis in the sector, citing widespread local staffing shortfalls – especially in non-metropolitan areas – which could have a 'catastrophic impact' if workforce attrition continues to rise.

The report reinforces what the ANMF has long known.

"Midwives have been raising the alarm about the workforce crisis in Australia for years," Naomi Riley, a Strategic Lead at the Australian Nursing and Midwifery Federation's (ANMF) Federal Office says. "We've consistently advocated on behalf of almost 20,000 midwife members to address these critical, workforce challenges."

Throughout 2024, the ANMF contributed to the *Midwifery Futures* Project as part of both the Working Advisory Group and the Expert Advisory Group. Many of the report's recommendations reflect the ANMF's ongoing advocacy for midwives across the country.

THE HUMAN COST OF CRISIS

Jasmine Kirk, a Brisbane-based clinical midwife, and also a Strategic Lead for the ANMF Federal Office says better support for midwives would help alleviate issues leading to high attrition rates in the sector.

Highlighting her own experiences as an example, Jasmine says her first two years on the job were a reeling reality check between the philosophy of midwifery versus the actual practice of midwifery in regional Australia.

Recalling a traumatic birth following the decisions made by the on-call obstetrician she says the mother wasn't immediately traumatised. "But witnessing it meant that the father was, and so was I."

Jasmine added no psychological support was offered post the event.

Naomi, sees the lack of emotional support as a result of a long-held 'stiff upper lip' mentality.

"There's this idea that it's happened to the woman or person you are caring for, not you," says Naomi. "We are both honoured by what our job involves and confronted by some very stressful situations. It is so busy, there is not the time to nourish or repair, or to be the midwife you want to be.

"It is critical employers, put in place services to support midwives to stop, reflect and regroup from the realities of providing care," Naomi says.

She argues hindering this process is time and money. "But it costs more in the long run because we lose midwives. Caring for midwives is a long-term investment in giving people in Australia the best start to life."

REACHING BREAKING POINT

It took an overseas holiday for Jasmine to see that she was burning out.

"I was having flashbacks of my working day when I was trying to sleep, sometimes even waking up with them. I felt irritable and anxious," says Jasmine. "I worried that I was losing my empathy."

After this, Jasmine sought therapy. She also applied for a job with ANMF.

Jasmine believes that structured, professional mentorship could provide crucial support for midwives.

"New Zealand has a program where every new graduate is assigned a mentor to support them through the first twelve months. It could also keep experienced midwives engaged."

Madi has also alluded to the difficulties of the profession.

"It's hard," says Madi, "Midwives delivering this model of care often don't have a family of their own yet. We're on-call for 24 hours at a time, usually for multiple days in a row. Even if you're at home, you have the mental load of knowing you could go into work at any minute. You get the emotional reward at the end, when you get a hug from your woman, or a card that says they couldn't have done it with you. But, any work-life balance is a real challenge."

The Midwifery Futures report identified that attracting and keeping midwives like Madi, 27 years old and four years into her role, is key to fighting the workforce's crisis. 'Continuing to do the same and expecting different results is no longer possible', the report says.

Naomi echoes the report's concerns.

"We're losing that middle band of expertise, after the five-year-mark, with women who are between 25 and 40 years old,"

"They're proficient midwives, getting more responsibility based on their years in the job. At the same time, their personal lives expand, perhaps with children or caring for parents. Things start to get hard to balance work and personal demands, you come home like a worn-out rag. They go from permanent to casual. It's like quiet quitting."

OPTIMISM FOR URGENT CHANGE

Naomi and Jasmine argue that the midwifery workforce urgently needs change. In addition to stronger support for midwives, they highlight the need for improved information sharing and clearly defined career pathways.

The Leads also stress the importance of implementing other recommendations outlined in the *Midwifery Futures* report.

The first recommendation of this report is for the Australian Government to fund the development of a National Midwifery Strategy and implementation plan – a 2025

Credit: Fiona Stanley Hospital

pre-election commitment made by the Labor party.

The Labor Government also committed to appointing a Commonwealth Chief Midwife. This has sparked optimism for meaningful change. Naomi and Jasmine believe this would be a pivotal step in recognising midwifery as a distinct and essential health profession. The role would elevate the profile of midwives, strengthen support for midwifery-led models of care, and ensure midwifery expertise informs national health policy, decision-making, and advocacy.

A SUPPORTED BIRTH EXPERIENCE

Back at the Family Birth Centre, Madi talked Emma and Tim through their prenatal education. She used the BRAIN (Benefits, Risks, Alternatives, Intuition, Next Steps) acronym to share information so that the couple felt informed and empowered.

Whenever Emma had questions or concerns, she could contact Madi by mobile phone and know that either her, or Jane, would quickly reply.

"It was so reassuring to know they were always right there," says Emma.

When Emma's due date passed, she was booked in for an induction. Madi reassured her that she was being offered choices rather than forced into a decision.

"Rudely, Charlie decided he was ready to go on the only day Madi had off," says Emma.

Labour started at 4.30am, and the first stages at the Family Birth Centre went naturally. Jane helped Emma into the pool. Several hours in, however, meconium was detected, and Charlie's heart rate dropped. At roughly 8.30pm, Emma was taken to the Birthing Unit. More midwives appeared, as well as the obstetrician on duty. Suffering intense pain, fatigue, and vomiting, Emma could barely talk.

Thanks to Madi's prep, Tim was able to advocate for Emma in a birth that didn't go to plan. Emma remembers how the Ward Coordinator came and sat with her, holding her hand, and talking calmly as they prepared for a caesarean section.

Charlie's first cuddle came from his father, Tim, as Emma was being sutured. When he got to his mother, Charlie went straight to Emma's breast.

"It was incredible," Emma says. "Just beautiful. Not very glamorous, of course!"

I can't believe I missed all the action, Madi texted Emma in the morning. She made her way to the hospital to meet baby Charlie.

"It felt like a friend was coming to visit," Emma remembers. A friend with useful advice – Madi was able to remind Emma about the exhaustion ahead, how her newborn would cluster feed and sleep only lightly, plus a reminder that she'd visit the family at home.

When Emma felt able to go home, Madi advocated on her behalf with the doctors on duty. She believes that continuity of care midwives can hold more authority with other medical professionals because they are confident in the woman's wishes.

A VISION OF CHANGE

At Fiona Stanley Hospital (WA), there are plans to expand midwifery programs to a greater number of future parents. The hospital is piloting an all-risk model of care (ARC), that would see midwives collaborating with medical teams to help high-risk pregnancies and women wanting a vaginal birth after a caesarean. Fiona Stanley Hospital is also extending patients' interaction with midwives via their Maternity Antenatal Postnatal Service, offering newborns and their families further opportunities to engage with the range of a midwifery services.

These families can also be a valuable source of information for maternity hospitals. Fiona Stanley has a Maternity Advisory Group which meets monthly, including an Aboriginal and Torres Strait Islander person and a representative for gender and sexual diversity.

Baby Charlie, born by emergency c-section in January 2024, is a toddler now. His parents are besotted.

"My care was wonderful," says Emma. "Midwives are just wonderful. They do so much more than deliver our babies."

If you need support, please reach out to **Nurse Midwife Health Program Australia**, a national confidential free support service for midwives and nurses on **1800 001 060**

"Midwives have been raising the alarm about the workforce crisis in Australia for years. We've consistently advocated on behalf of almost 20,000 midwife members to address these critical, workforce challenges."

Naomi Riley, ANMF Strategic Lead – Midwifery

Why AI can never replace the human touch in nursing

By Ahmad Mousa

Artificial Intelligence (AI) may be highly advanced and tireless, but it will never fully replace certain jobs that require qualities beyond software capabilities, such as empathy, a human touch, or the ability to make complex decisions. At a time when jobs are being outsourced to robots, nurses cannot be replaced. This article delves into the reasons AI alone will never replace nursing.

EMPATHY

Empathy is the capacity to recognise and to some extent share feelings that are being experienced by another nurse is central to nursing. Nurses not only provide care but also help patients and their families emotionally. For a lot of people, this compassionate connection matters and can play an essential part in creating trust that makes patients feel cared about.[1]

Advanced algorithms or data processing does not enable AI to genuinely empathise. AI may seek to imitate empathy in programs, but it is not capable of experiencing human emotions and experiences. A nurse can provide that warmth and comfort a machine cannot.[2]

ETHICAL DECISION-MAKING

Nursing makes some of the most complex ethical choices, and these decisions take place within human values, ethics and cultural background. Nurses can find themselves in the difficult position of balancing medical protocols with patient individual needs and wishes. The need to navigate between these decisions may not be clear-cut, and dependent on the individual patient.

As AI follows previous programmed algorithms it is unable to deal with these types of moral grey areas. The presence of human judgement and moral reasoning that characterises the practice is important in their conduct, a hallmark of holistic patient care.[3]

PATIENT CARE

Patient care is multifaceted and extends beyond medication administration/procedures. Physical, emotional, and social needs are reviewed by nurses who can alter care plans due to direct observation and interaction. This real-time personalisation is difficult for an AI to mimic. AI can monitor vital signs and help in the managing of medical records, but it will never be able to replace the critical thinking skills and adaptability that nurses demonstrate every day on their jobs. One hallmark of skilled nursing care is the capability to react to unforeseen changes in a patient's condition and respond with prompt, knowledgeable choices.[4]

HUMAN INTERACTION

Human interaction is the foundation of our nursing practice. A caring nurse can offer reassurance and comfort at a time when the patient is feeling vulnerable, anxious or both. The nursing-patient relationship is built on communication, trust and mutual respect.[5]

As intelligent as AI is, it still lacks the ability to have a genuine human conversation. Body language, tonality and non-verbal cues are nuances that machines will never understand. Healthcare providers cannot lose what makes care effective by a technology platform. The human connection and interaction that nurses build with their patients is unique, important to the care they receive and not replaceable by tech solutions.[6]

INTUITION AND EXPERIENCE

Intuition and clinical experience inform the decisions experienced nurses make about patient care. This kind of acquired instinct, honed over time through practice, serves to help nurses spot small signs that a patient is deteriorating or improving.[7] Whereas AI can process immense numbers of data sets, it does not have the hands-on experience necessary to use intuitive insight. This ability to predict ahead of time what can go wrong and intervene proactively is in the complexity territory that AI will not be able to mimic after considerable years caring for patients.[8]

AI can be useful for automating nursing tasks and providing data-driven insights, but it cannot replace the human elements that are central to nursing care.

AI lacks the ability to understand empathy, ethics, and the nuanced decision-making required in patient care - critical aspects that define the essence of nursing practice.

As technology continues to evolve, it is crucial to recognise and value the unique qualities that only a nurse can bring to the care of another person. While AI can serve as a valuable ally to nurses, it can never replace the deeply human element of compassion and connection in caring for others.

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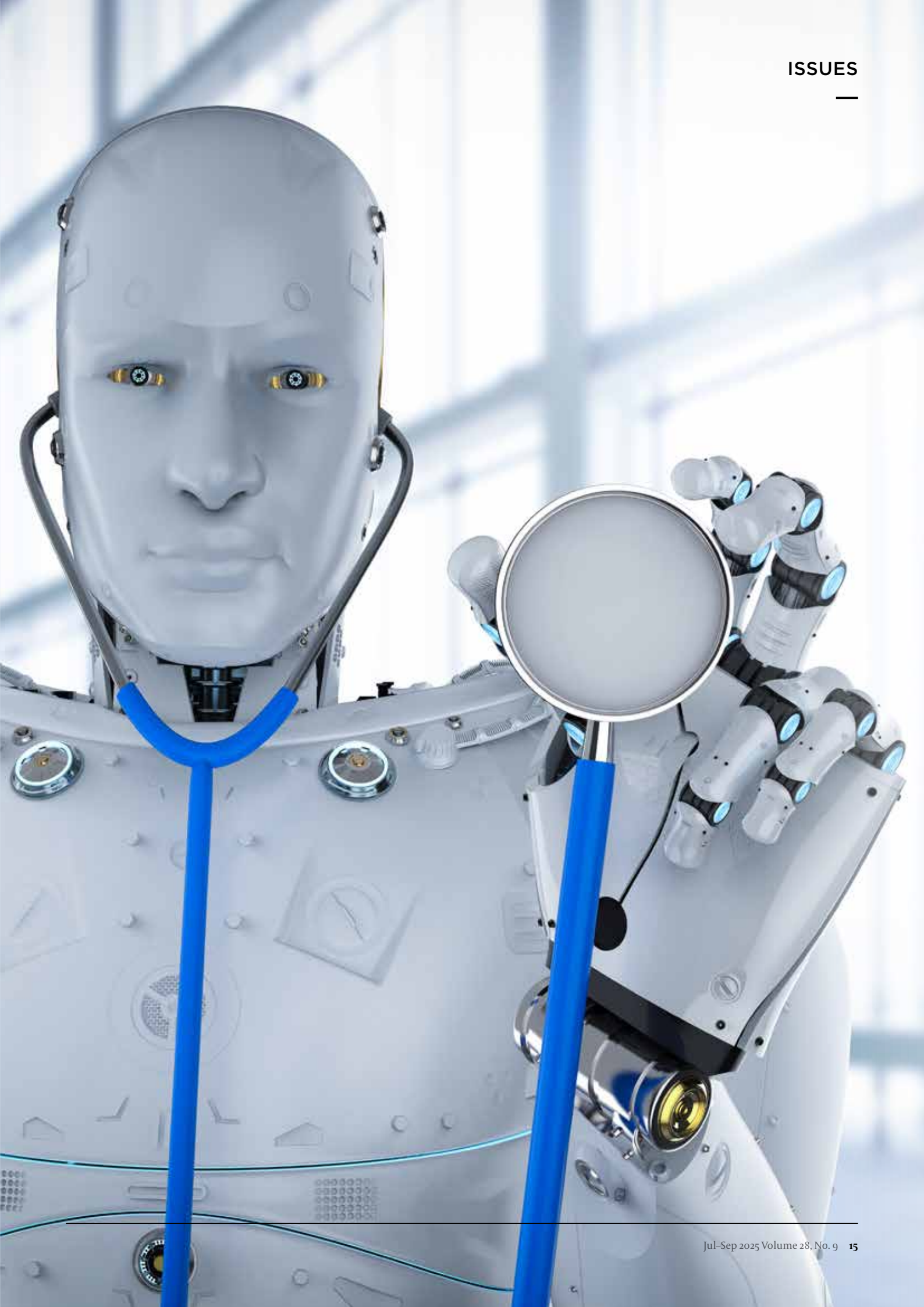

Paul Yiallouros

ANMF Federal Industrial Officer

Non-compete clauses and other restraints of trade

Even to those who follow the political cycle, one of the more unexpected announcements in the Federal Budget was the news that the Albanese Labor Government plans to ban non-compete clauses in employment contracts. Between tax cuts and student debt being slashed, you could have missed this tiny detail.

WHAT ARE RESTRAINTS OF TRADE?

In the context of employment, a restraint of trade usually occurs where an employment contract includes a clause that would prevent an employee from engaging in other work.

For example, a contract might restrain an employee from working for a competitor organisation for a defined period of time after resigning or prevent that worker from finding a new job in the same city or region.

Restraints can also be used to prevent a worker from inviting a colleague to join them in their new workplace, or from bringing clients with them. They can also be used to block a worker from setting up their own business.

In recent years, these clauses have become commonplace, drafted by employment lawyers and bundled into lengthy employment contracts, the terms of which are offered on a 'take it or leave it' basis. Workers rarely have a say in the drafting of their own employment contracts.

Workers search for new jobs for any number of reasons: better pay, better hours, or sometimes to escape a toxic work environment. A restraint can trap a worker from seeking greener pastures.

ARE THESE CLAUSES LEGAL?

Yes and no.

Under current laws in Australia there is nothing to prevent an employer from including a restraint clause in an employment offer. While a prospective employee can turn down an employment offer or try to negotiate better terms that remove the restraint clause, if the employer refuses to budge, an employee is more likely to reluctantly agree to the contract than let it become an impasse to securing a new job.

However, at law, restraints on workers are presumed to be against the public interest and therefore are usually unenforceable, unless an employer can establish through court proceedings that the restraint is reasonably necessary to protect their business interests.

In other words, an employer has to sue one of their workers if they want the restraint to stick.

Whether a restraint on a worker is "reasonable" is a question of scale and degree. The broader the restraint, the less likely it is to be lawful. A narrow restraint preventing an employee from working for a competitor within a 100m radius of their old workplace is more likely to be enforceable that a ban on a worker seeking employment anywhere in their city, state or country where they live.

Most restraints would be laughed out of court.

SO WHY DO EMPLOYERS STILL USE THEM?

Most worker restraints are presumed to be legally unenforceable, but because some are considered "reasonable" in the eyes of the law, some employers might hold out hope that the contractual restraints they have with their own employees are among the very few lawful ones.

But aside from the question of legality, what makes a restraint clause so powerful is the fear it creates amongst workers who may want to find a new job in their field. Some workers may not be aware that most restraint clauses will be struck down by the courts. But even those who are aware of this may still be frightened at the prospect of getting sued by their own workplace for daring to seek employment elsewhere. This fear can become even more heightened when the worker starts receiving threatening letters from their employer's lawyers, or court proceedings are filed against them. The fact that the employer's case will likely fail is cold comfort for the worker.

WHY IS ALL THIS CHANGING?

Last year, the Federal Treasury held a public review into the use of non-competes and other restraints in employment. Feedback from ANMF members was that these clauses were rife and being misused, such as aged care workers who were told that they could not jump ship to another aged care provider in the same state. The ANMF provided a submission to this review, calling for a total prohibition for all worker restraints, with very narrow exceptions.

On Budget night this year, Federal Treasurer Jim Chalmers announced that the Albanese Labor Government would legislate to ban worker restraints, other than for high income earners. With the dust settled on the election, the ANMF looks forward to reviewing new laws that would consign worker restraints to the history books.

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Recovery and revaccination of people experiencing chest pain post-mRNA COVID-19 vaccination in 2021

By Rebecca Johnson, Renee Reynolds, Patrick Cashman, Jody Stephenson, Kirsten M Williamson, Nicholas Wood and David N Durrheim

Vaccine adverse event surveillance systems include reports of people experiencing chest pain following mRNA COVID-19 vaccines, but medical investigations did not support a myocarditis/pericarditis diagnosis. We describe their recovery and revaccination experience.

METHODS

Cases of chest pain reported to the Hunter New England Public Health Unit, New South Wales, from March to December 2021 were investigated and interviewed. We describe the case characteristics, vaccination re-uptake and outcome following revaccination.

RESULTS

Seventy of the 127 reported cases of chest pain (n=70/127) were interviewed. The majority were 20-39 years of age (51.3%, n=36), female (65.7%, n=46/70), received Pfizer-BioNTech vaccine (81.4%, n=57/70) and experienced their chest pain following dose 1 (64.3%, n=45/70).

At follow-up, 64.3% (n=45/70) reported symptom resolution. Nearly half (48.6%, n=34/70) had a subsequent COVID-19 vaccination and most (67.7%, n=21/31) did not experience recurrence of symptoms. Of the 10 who experienced symptoms upon revaccination, two had follow-up testing with normal results.

DISCUSSION

We found that most non-myocarditis/pericarditis chest pain cases reported returning to their usual level of health and were revaccinated without recurrence of symptoms.

INTRODUCTION

In Australia, two mRNA COVID-19 vaccines were granted provisional approval by the Therapeutic Goods Administration (TGA) in 2021, tozinameran BNT162b2 (Pfizer-BioNTech) and elasomeran (Moderna mRNA-1273).

There is a recognised small increased risk of myocarditis and/or pericarditis following receipt of an mRNA COVID-19 vaccine. The rate of reported cases varies based on age, sex, dose number and vaccine product. The highest number of reported cases have been recorded following dose 2 elasomeran in males aged 18-27 (299.5/ 1 000 000). The lowest number of reported cases have been recorded following dose 1 tozinameran in females (3.9/ 1 000 000).[1,2]

People who experience symptoms suggestive of myocarditis/pericarditis following an mRNA COVID-19 vaccine are encouraged to seek medical assessment. Symptoms may include chest pain, palpitations, and/or shortness of breath. Initial investigations for suspected myocarditis/pericarditis should include electrocardiogram (ECG) and cardiac troponin levels.[3,4]

Chest pain and other symptoms suggestive of myocarditis/pericarditis following an mRNA COVID-19 vaccine are considered an adverse event following immunisation (AEFI). AEFIs are listed as notifiable conditions under the NSW Public Health Act (2010) and NSW Public Health Units (PHU) are required to investigate reported AEFI cases.[5] During the 2021 COVID-19 vaccination program, the Hunter New England Local Health District Public Health Unit (hereafter 'HNE PHU') received reports of AEFI cases from people who experienced chest pain following an mRNA COVID-19 vaccine, who were examined by a medical officer and discharged from clinical care following a normal ECG and normal troponin levels.

Throughout the initial stages of the COVID-19 vaccination program there was high public health interest in understanding the symptomology and sequela for vaccinated cases that were diagnosed with myocarditis and/or pericarditis with abnormal clinical findings such as elevated cardiac troponins and ECG abnormalities.[6] Our study followed up the cases who presented with chest pain and had a normal ECG, normal troponin and were discharged home.

The aim of this paper is to describe the clinical course of persons who reported experiencing chest pain following an mRNA COVID-19 vaccine with normal ECG and normal troponin levels on medical assessment. The secondary aim is to describe the experience of revaccination against COVID-19 within this group.

METHODS

AEFI cases were reported to the HNE PHU via passive clinician reporting and syndromic surveillance through the NSW Public Health Rapid, Emergency, Disease and Syndromic Surveillance System.[7] The number of cases reported to the HNE PHU discussed in this paper should be considered in the context of mass community vaccination with predominately mRNA COVID-19 vaccines from March to December 2021.

A case report form developed by the National Centre for Immunisation Research and Surveillance (NCIRS) for myocarditis and pericarditis follow-up was localised and approved by the HNE PHU AEFI team for use with cases that reported chest pain but did not have clinical findings of myocarditis/pericarditis. Cases were investigated by a Public Health Nurse and clinical findings were compared to the Brighton Collaboration Criteria for myocarditis/pericarditis.[6] We included cases that did not meet the Brighton Collaboration Criteria for a diagnosis of myocarditis/pericarditis. Cases were interviewed by a registered nurse and interview responses were recorded in RedCAP.[8,9] Case ECG reports, troponin levels and medical discharge reports were reviewed by a Public Health Clinical Nurse Consultant at the time of notification and case interviews occurred between five- and 10 months following symptom onset. The variation in interview time point was due to factors such as reporting delay and competing operational needs of the Public Health Unit.

Cases were eligible for inclusion (Figure 1) if:

1. They reported chest pain as a symptom following an mRNA COVID-19 vaccine
2. They did not meet the Brighton Criteria based on objective findings for a diagnosis of Myocarditis or Pericarditis[6]
3. They did not have COVID-19 infection documented between the dates of vaccination and symptom onset on the NSW Health Notifiable Conditions Information Management System (NCIMS)

Ethics approval was granted by the Hunter New England Local Health District Human Ethics Research Committee.

ANALYSIS

Baseline cardiac enzyme results for troponin, c-reactive protein (CRP) and erythrocyte sedimentation rate (ESR) were assessed by a Public Health Nurse skilled in AEFI assessment and categorised as normal or elevated. Subsequent vaccination details were obtained from the Australian Immunisation Register (AIR).

Descriptive statistics were used to describe the characteristics of the sample; days between date of vaccination and onset of symptoms; symptom profile at baseline; diagnostic testing performed at baseline; subsequent vaccination and chest pain; medications prescribed; cardiologist follow-up and diagnostic testing performed at follow up. Data analysis was conducted using R (R Foundation for statistical Computing) version 4.3.1.[10]

FIGURE 1. Case selection from HNE PHU AEFI reports in 2021 that meet the criteria for chest pain following mRNA COVID-19 vaccination

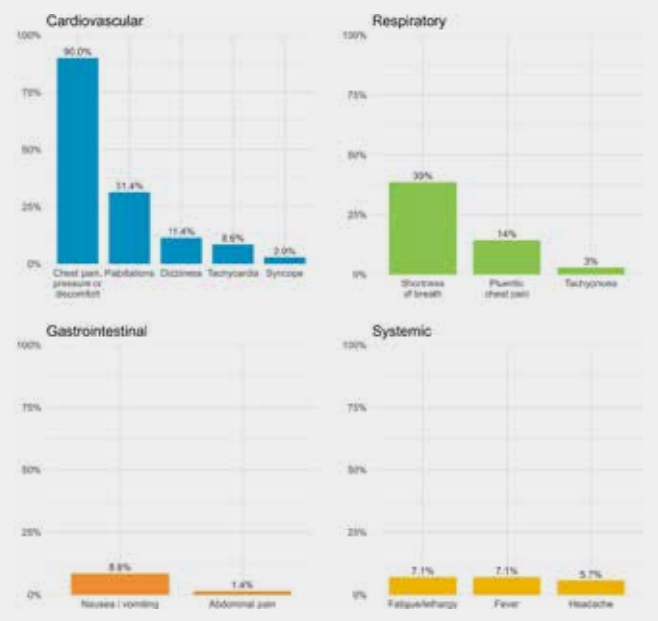


Figure 2. Symptoms experienced by study participants following mRNA vaccination

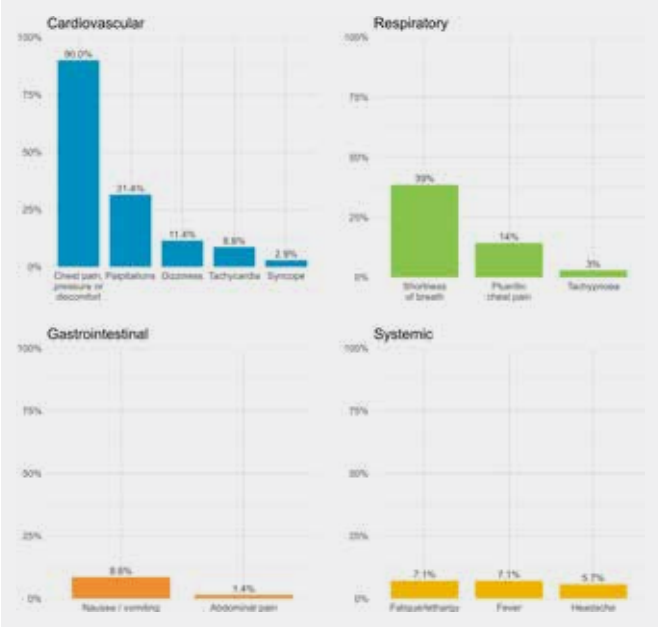
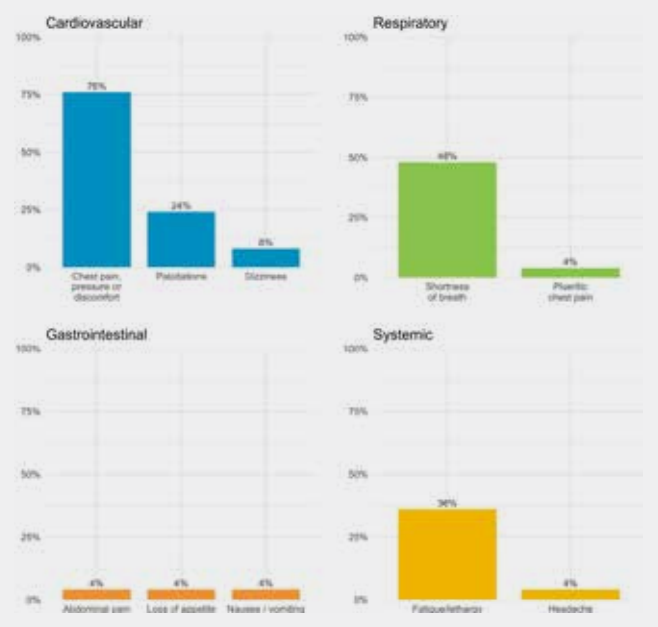


Figure 3. Symptoms of study participants who had not returned to usual level of health at the time of follow-up



RESULTS

The characteristics of those eligible for the study are depicted in table 1. The majority were 20-39 years of age (51.3%, n=36), female (65.7%, n=46), did not identify as Aboriginal or Torres Strait Islander (94.3%, n=66) and received the Tozinameran-BioNTech vaccine (81.4%, n=57). Most of the chest pain reports occurred following dose 1 of an mRNA vaccine (64.3%, n=45).

The median time between the date of vaccination and the date of symptom onset was three days (interquartile range (IQR): eight days) with a range of the same day as vaccination to 43 days following vaccination.

Initial presentation for medical assessment was either at an emergency department (92.9%, n = 65) or general practice (7.1%, n =5). The most common symptoms at initial presentation were chest pain, pressure, or discomfort (89%, n=63), shortness of breath (39%, n=27) and palpitations (30%, n=22). Only a small number of people experienced gastrointestinal or other general symptoms at their initial presentation (Figure 2).

The majority of cases had an ECG (90.0%, n=63) and had their troponin levels assessed (85.7%, n=60); just under half had their C-reactive protein (CRP) levels assessed (42.8%, n=30), and a small number underwent an echocardiogram (10%, n=7) or had an erythrocyte sedimentation rate (ESR) (8.6%, n=6) (Table 2).

All echocardiograms were normal and troponin levels were within normal range. Of those who had an ECG, the majority (73.0%, n=46) were normal, four people had an ST elevation or ST abnormality (nil diagnosed with myocardial infarction), one person had an atrial, supraventricular, or ventricular arrhythmia and 16 people had another abnormality, of which none were sufficient to be diagnostic of myocarditis/pericarditis. Seven people had elevated CRP levels and one person had an elevated ESR.

Values are presented as number (%).
CRP = C-Reactive Protein, ESR = Erythrocyte Sedimentation Rate

Just under half of the cohort (48.6%, n=34) went on to have another COVID-19 vaccination. Of these, 31 (91.2%) had another mRNA vaccine and only one of these people switched mRNA vaccine brands (switched from Elasomeran to Tozinameran-BioNTech). Three cases (8.8%) switched from an mRNA vaccine to a viral vector vaccine Vaxzevira. The majority 22/32 (68.7%) did not experience a reoccurrence of symptoms following another dose of COVID-19 vaccination. The question about revaccination was answered inaccurately so vaccination details obtained from AIR were used to calculate subsequent vaccination requiring adjustment of the denominator and two cases did not have subsequent vaccination symptom details entered. Of the ten cases who reported experiencing a recurrence of symptoms following subsequent COVID-19 vaccination, the symptoms reported were chest pain, pressure or discomfort (90%, n=9), palpitations (10%, n=1), dizziness (40%, n=4), shortness of breath (30%, n=3), and fatigue (20%, n=2).

At the time of follow-up, 64.3% of cases (n=45) reported that they had returned to their usual level of health. Of these, 26.7% (n=12) took less than one week to return to their usual level of health, 24.4% (n=11) one week to less than one month, 28.9% (n=13) one month to less than three months, and 20.0% (n=9) three months or longer.

Of the 25 cases who reported they had not returned to their usual level of health at the time of interview, the most common symptoms experienced at follow-up were chest pain, pressure, or discomfort (76%, n=19), shortness of breath (48%, n=12), fatigue (36%, n=9) and palpitations (24%, n=6) (Figure 3).

Of the 70 people surveyed, 22 (31.4%) had a follow-up appointment with a cardiologist after their initial chest pain, five had not had a follow-up appointment at the time of the survey but they had an appointment planned, and the remaining 43 participants did not have any follow-up planned.

Of the 22 people who had a follow-up appointment with a cardiologist at the time of follow-up with the HNE PHU, 21 had an echocardiogram, 18 had an ECG, 12 had their

TABLE 1. Characteristics of study participants

CHARACTERISTIC	INCLUDED (N=70)
Age group, years	**n (%)**
10–19	14 (20.0%)
20–29	16 (22.8%)
30–39	20 (28.5%)
40–49	12 (17.1%)
50+	8 (11.4%)
Gender	
Male	24 (34.3%)
Female	46 (65.7%)
Indigenous Status	
Neither Aboriginal or Torres Strait Islander	66 (94.3%)
Aboriginal	4 (5.7%)
Vaccine brand when chest pain reported	
Tozinameran-BioNTech	57 (81.4%)
Elasomeran	13 (18.6%)
Vaccine dose when chest pain reported	
Dose 1	45 (64.3%)
Dose 2	25 (35.7%)
Dose 3	0 (0.0%)

TABLE 2. Diagnostic tests for study participants at time of medical assessment for chest pain

INVESTIGATION	TOTAL	MALE	FEMALE
Electrocardiogram	**N=63**	**N=22**	**N=41**
Normal	46 (73.0)	17 (77.3%)	29 (70.7%)
ST elevation or ST abnormalities	4 (5.7)	1 (4.7%)	3 (7.3%)
Atrial, supraventricular or ventricular arrhythmia	1 (1.6)	1 (4.7%)	1 (2.4%)
Other	16 (25.4)	7 (29.2%)	9 (22.0%)
Echocardiogram	**N=7**	**N=4**	**N=3**
Normal	7 (100%)	4 (100%)	3 (100%)
Troponin	**N=60**	**N=22**	**N=38**
Normal	60 (100%)	22 (100%)	38 (100%)
Elevated	0 (0%)	0 (0%)	0 (0%)
CRP	**N=30**	**N=12**	**N=18**
Normal	23 (76.7%)	11 (91.7%)	12 (66.7%)
Elevated	7 (23.3%)	1 (8.3%)	6 (33.3%)
ESR	**N=6**	**N=4**	**N=2**
Normal	5 (83.3%)	3 (75.0%)	2 (100%)
Elevated	1 (16.7%)	1 (25.0%)	0 (0%)

Values are presented as number (%). CRP = C-Reactive Protein, ESR = Erythrocyte Sedimentation Rate

troponin levels assessed and two had a cardiac MRI. All follow-up diagnostics were normal.

DISCUSSION

Most AEFI cases interviewed who experienced chest pain which did not meet the diagnostic criteria for myocarditis/pericarditis following an mRNA COVID-19 vaccine returned to their usual level of health. However, 22 of the 70 cases interviewed reported that it took at least one month for them to return to their usual level of health, and this is not insubstantial. There was a considerable range in the reported duration of symptoms, but the majority resolved over time.

Just under half of the cases interviewed chose to have subsequent COVID-19 vaccination. Most of these cases, who chose to be revaccinated, did not experience a recurrence of symptoms.

Limitations of the study should be considered when interpreting the results, including: a relatively small sample size, a large variation in the onset of symptoms and follow-up (five to 10 months) and the study was a case series without a control group, therefore other factors aside from recent vaccination may have contributed to the symptoms described.

We demonstrated a subset of patients who were revaccinated without recurrence of symptoms. Our findings highlight that chest pain experienced after an mRNA COVID-19 vaccination that was not due to myocarditis/pericarditis can still impact on subsequent vaccination uptake. The results provide useful reassuring information to assist providers with risk versus benefit discussions with patients who have experienced similar symptoms.

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[α]Pooled patient-level analysis of ORION-9, -10 and -11 phase 3 trials of LEQVIO vs placebo in 3,660 adult patients (3,655 in safety population) with HeFH, ASCVD or ASCVD risk equivalents (T2DM, FH and 10-year risk of a CV event >20% as assessed by Framingham risk score) and LDL-C above target of 1.8 mmol/L, on a background of maximally tolerated statin (unless intolerant or contraindicated) ± ezetimibe. Co-primary endpoints: placebo-corrected reduction from baseline in LDL-C at Day 510 (17 months) of 50.7% (95% CI -52.9, -48.4; p<0.0001); placebo-corrected time-adjusted reduction in LDL-C from baseline between Day 90 (3 months) and Day 540 (18 months) of 50.5% (95% CI -52.1, -48.9; p<0.0001).[2]

ASCVD, atherosclerotic cardiovascular disease; CI, confidence interval; CV, cardiovascular; FH, familial hypercholesterolaemia; HCP, healthcare professional; HeFH, heterozygous familial hypercholesterolaemia; LDL-C, low-density lipoprotein cholesterol; T2DM, type two diabetes mellitus; TEAE, treatment-emergent adverse event.

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NOVARTIS

By Traci Travers

As an Indigenous travel nurse working across many nations and countries, what Australia has to offer, working remotely in Aboriginal and Torres Strait Islander communities has brought privileges, most are not fortunate to experience.

The unique challenges bring their own rewards that require an experienced skill set of patience, flexibility, understanding and most importantly a great sense of cultural responsiveness.

However, during my travels throughout the Northern Territory and Far North Queensland I have encountered situations that have left me unsettled: cultural bias among my peers.

As a First Nations nurse working for Aboriginal and Torres Strait Islander communities, this is an uncomfortable reality, but one that needs addressing if we are truly going to meet the equitable health needs of First Nations people, regardless of the nurse's background.

It's a privileged position working in community. Although more times than not, I am not on my own Country. Over time, I have noticed my role swaying towards voluntarily serving as a bridge in assisting nurses to connect more genuinely with Aboriginal and Torres Strait Islander patients, in terms of cultural practices vs clinical education.

As well as my clinical load, I often felt an increase in cultural load. More times than not my cultural responsibility found me advocating for the community values and traditions, to other nurses who may not fully understand or appreciate the ways of living.

An example I have observed many times is nurses directly informing the patient, on what they believe the patient must do, or even a sense of dismissiveness in communication. This is not primary care; this is not holistic care. This is cultural bias in presuming the patient does not know what the nurse is talking about and often the nurse spoke their own version of pidgin English, to convey their message.

This is a deep assumption that where English is a second, sometimes third language that the patient does not understand, which leads to disrespect for the patient and culture whilst being on their Country. The fact remains, First Nations people understand English.

Cultural bias here in this example, that does not just reflect a "simple misunderstanding" of language but reveals a greater failure in the sense that the nurse did not see the patient as someone who understands, leading to the patient being compromised for potential unequal treatment. This situation was not an isolated incident, I would see this often during the day, every day. This was a generalised response when communicating with Aboriginal and Torres Strait Islander peoples.

What happens in these moments is the subtle erasure of cultural respect with the assumption that the patient is not understanding and now is placed in an inferior position by the cultural bias of the nurse. I have finished many shifts with the thought, does the patient leave the clinic with a feeling of being unheard or even undervalued? If so, would this suggest there is a divide caused by cultural bias. Does cultural bias contribute to increasing the divide?

While I have the utmost respect for remote nurses, at no time am I saying that all remote nurses come with cultural bias, I would like to stress again – this has been my observation whilst working as a travel nurse. It's incredibly important – more like essential that nurses who work with First Nations peoples have a clearer perspective on how Aboriginal and Torres Strait Islander people perceive healthcare, something which is bound in identity, spirituality, history and cultural context on Country. The one size fits all approach does not work – it may cause harm.

While I'm not responsible for educating every nurse, there is a sense of cultural duty to ensure First Nations peoples receive culturally safe care. As a First Nations nurse navigating cultural bias and as a First Nations nurse this isn't just about tackling cultural bias, it's about creating a space where patients can be culturally respected.

This will require the nurse to firstly recognise that their practice could do better in terms of much self-reflection and self-awareness in recognising their own cultural bias and assumptions that perpetuate stereotypical behaviours. This is known as cultural responsiveness; however, I think to address this, nurses should adopt an approach of cultural humility which includes a willingness to learn from the patient.

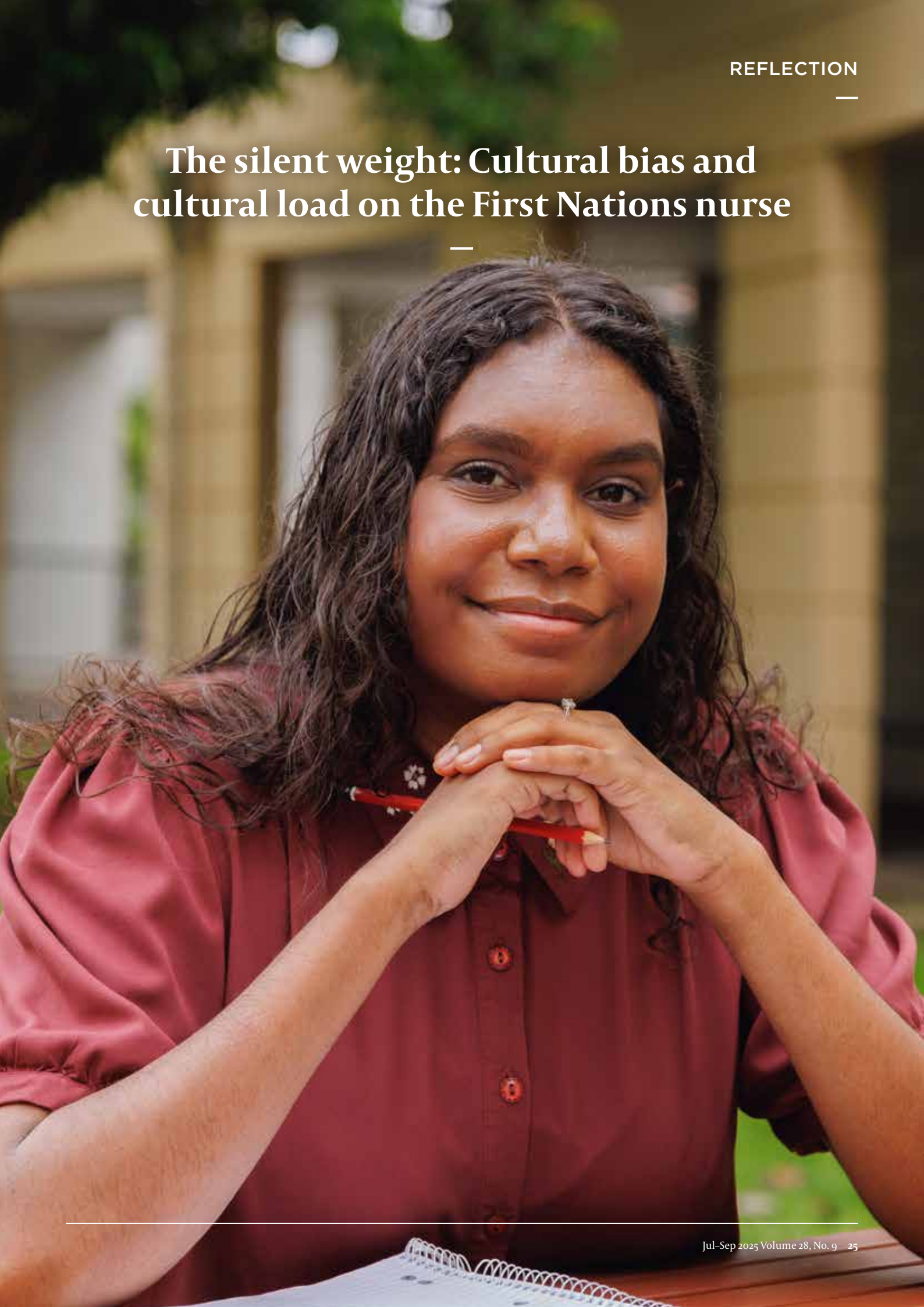
Through my journey in working in remote locations within Australia as a First Nations nurse, I have come to understand and observe – that our role extends far from just providing clinical care. It is about assisting in the healing and bridging of cultures. Overall, I do believe that with every conversation, every piece of reflective work, with every patient interaction, I remain hopeful that a healthcare system that is more culturally respectful, culturally inclusive and without cultural bias is possible in all parts of Australia.

Author

Traci Travers Assoc Dip Aboriginal Studies, RN, BN, Grad Dip Corrections Health and Forensic Nursing, Grad Dip Sexology, Grad Cert University Learning and Teaching is Lecturer in Nursing in the Discipline of Nursing/School of Health/Faculty of Medicine and Health at the University of New England, NSW Australia

As a First Nations Academic from Biripi, I acknowledge and pay respects to the Anaiwan, the Traditional Owners of the land on which I live and work, and their neighbours, the Gumbaynggirr, Dunghutti, and Gomeroi. I also pay respects to cultural knowledge holders and Elders, past, present, and emerging, and acknowledge my Elders of the Biripi Nations.

The silent weight: Cultural bias and cultural load on the First Nations nurse



Dr Micah D J Peters

Associate Professor Dr Micah DJ Peters is based in the ANMF National Policy Research Unit (Federal Office) in the Rosemary Bryant AO Research Centre, UniSA Clinical & Health Sciences, University of South Australia.

Why Australia needs a Commonwealth Chief Midwife

As the Labor Government begins its second term, midwives across Australia are rallying around a historic step: the appointment of a Commonwealth Chief Midwife.

This proposal, championed by the Australian Nursing and Midwifery Federation (ANMF) and allied organisations, has gained momentum following the Albanese Government's firm commitment to this role. In contrast, the then Opposition Leader Peter Dutton and the Coalition failed to respond to this election ask—revealing a pattern of political ambivalence toward the nation's health and wellbeing, particularly in relation to women and maternal care. Many believe this failure contributed to Labor's landslide re-election, as voters increasingly demand a government that takes women's health seriously.

The appointment of a Commonwealth Chief Midwife would represent a defining moment in the elevation of midwifery as a distinct, essential health profession. It enhances the visibility of midwives, strengths recognition of midwifery-led models of care, and brings midwifery expertise to the forefront of national health decision-making and policy.

Australia already has a precedent for senior nursing and midwifery leadership. In 2008, under the leadership of then Prime Minister Kevin Rudd, Dr Rosemary Bryant AO was appointed as Australia's first Chief Nursing and Midwifery Officer. This office has had a significant impact over almost 25 years. A dedicated Chief Midwife role is the next necessary step and acknowledges midwifery as a profession unique from nursing, with its own scope, philosophy, and models of care.

So, what exactly would a Commonwealth Chief Midwife do?

The Commonwealth Chief Midwife would serve as a senior advisor to the Australian Government, providing expert guidance on midwifery workforce development, clinical practice, education, and maternal health policy. Their leadership would ensure that midwifery perspectives are embedded in national health strategies, particularly those that impact the care and wellbeing of women, babies, and families. Drawing from both frontline experience and evidence, this leadership would shape and implement policies that support safe, respectful, and culturally responsive maternity care.

Workforce planning will be a key area. Midwives are a cornerstone of the health system, yet their contributions are often overlooked or conflated with those of nurses. A Commonwealth Chief Midwife would help ensure targeted strategies to address workforce challenges including shortages, maldistribution, limited training pathways, and burnout. This includes attention to rural, remote, and underserved communities, where access to quality maternity care remains unequal. Working in tandem with state and territory governments, national midwifery leadership will drive greater consistency in practice standards and education and equitable access to high-quality care.

The Chief Midwife would play a central role in upholding and strengthening professional standards. In collaboration with regulatory bodies such as the Nursing and Midwifery Board of Australia and the Australian Health Practitioner Regulation Agency, this role will enhance the standards that underpin safe, ethical, and woman-centred midwifery care. This leadership is especially vital as midwifery adapts to new challenges, evolving technologies, and calls for greater consumer involvement and choice.

The Chief Midwife's responsibilities would include advocating for evidence-based maternity care models including continuity of care which improves outcomes for both mothers and babies. Their work will also strengthen culturally safe practices for Aboriginal and Torres Strait Islander and culturally and linguistically diverse women.

The Chief Midwife would be a national voice for midwives, championing their expertise in government forums, contributing to interdepartmental collaboration, and engaging with international partners. From working with organisations such as the Australian College of Midwives, the World Health Organization, and the International Confederation of Midwives, to coordinating across federal portfolios like Health, Education, and First Nation's affairs, this role would cement midwifery as a key stakeholder in shaping Australia's health system.

As Australia faces the challenges of a stretched, underutilised maternity workforce, the establishment of a Commonwealth Chief Midwife is essential. This role will provide the leadership and coordination needed to ensure that every mother and baby receives the highest standard of care, no matter who they are or where they live. With political will now in place, it is time to give midwifery the national leadership it deserves—and the women of Australia the care they have always needed.

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Give peace a chance: Nurses and midwives can play crucial role in fostering global peace in a fractured world

By Robert Fedele

As trusted frontline health professionals in every corner of the globe, nurses and midwives are uniquely positioned to lead collective international efforts for lasting peace.

NSW registered nurse Pumla Coleman is passionate about global peace.

On top of clinical care, nurses and midwives can play a significant role in helping bridge divides – including cultural, political and social – through their daily advocacy and action.

The UN International Day of Peace was established in 1981 by the United Nations General Assembly to promote peace among all nations and peoples. Each year on 21 September, the reflective day of global ceasefire and non-violence aims to strengthen those ideals and reduce conflicts around the world.

Amid escalating geopolitical tensions and ongoing conflicts, including the Russian invasion of Ukraine, the Gaza war, and tensions between India and Pakistan, just to name a few, there has never been a better time for health workers like nurses and midwives to step up as torchbearers for global peace.

The International Council of Nurses (ICN) is among many peak global bodies leading the collective movement for change.

In response to global conflicts, particularly the war in Ukraine, ICN launched its #NursesForPeace campaign, condemning the violence and showing solidarity and support for the nurses of Ukraine. It quickly expanded and now raises awareness and funds to support nurses working on the frontlines in crisis zones worldwide.

Speaking at a World Health Organization (WHO) Member State meeting in 2023, ICN Chief Executive Officer Howard Catton revealed that as the #NursesForPeace campaign grew, a strong link emerged between the work of all nurses and promoting peace. Giving one example, he said when supporting the health of migrants and refugees, issues of discrimination, marginalisation, sexual violence, can be laid bare. In these moments, nurses can build relationships through their trusted advice and care, which, as a byproduct, supports peace efforts.

"It became clear that nurses' holistic approach and their concern for people's wellbeing is also a bridge to peace: through their work, nurses address the root causes of ill health and the risk factors that lead to conflict."

In January, three years on from the start of the conflict in Ukraine, ICN published an updated statement on healthcare in conflict, calling for peace in combat zones around the world.

"This anniversary is a stark reminder that war continues to devastate lives across the world, and that nurses bear a profound burden as they continue to serve their communities in the face of unimaginable hardships," Mr Catton said.

An anti-war protest rally for Ukraine held outside the UN Headquarters in New York in 2022. Photo: United Nations

"As peacemakers, nurses play a critical role in healing wounds – both physical and societal – helping to rebuild trust and stability in war-torn areas."

Originally from the town of Soweto in Johannesburg, South Africa, New South Wales Nurses and Midwives' Association (NSWNMA) member Pumla Coleman, a registered nurse currently working in mental health, understands the importance of peace all too well – conflict almost cost her life.

Pumla followed the footsteps of her mother to become a registered nurse and midwife in the 1970s.

Before fleeing to Australia in 1992, she lived through the Apartheid – a system of institutionalised racial segregation and discrimination enforced by the white minority government from 1948 to the early 1990s.

"It was a very brutal system. I lost a father and two brothers, and I'm not alone in that," says Pumla.

"The government just killed as they pleased, and African people were confined to certain locations. We weren't allowed to be in the town after six o'clock. My mother, who was a registered nurse, earned a third of a white nurse's wage for the same job."

Pumla was working as a community development worker for the University of South Africa, training nurses in primary healthcare to meet demand post-Apartheid, when she became a government target. It coincided with Nelson Mandela being released from prison, which triggered black-on-black violence in the streets.

"I was one of those [the government] had on their hit list to kill," she says matter-of-factly.

Deciding that enough was enough, Pumla moved to Australia with her husband and family.

An activist in South Africa for decades, Pumla has continued to support social justice causes in Australia, including advocacy for global unity and peace.

"I firmly believe nurses play a crucial role in promoting world peace by providing compassionate care, advocating for health equity, and being committed to the community's wellbeing. That goes a long way for world peace," she says.

In a fractured world, she considers it critical that health workers remain at the forefront of the collective movement for global peace.

"Nurses can help people to collaborate and understand their cultural differences. It's about people feeling accepted and valued. It sounds like airy-fairy stuff but each person that you meet, you treat with compassion – there's a ripple effect."

Pumla's message to global leaders is simple: nurses and midwives are best-placed to lead collective action towards peace and better health outcomes.

The United Nations International Day of Peace is held on 21 September

‘I’ve been hurt a lot’: Surplus suffering in health services for people living with Functional Neurological Disorder

By Chloe Sinclair, Katherine Gill, Fiona Orr, Mark Goodhew and Jo River

Functional Neurological Disorder (FND) is a common condition accounting for 15–30% of acute neurological presentations to hospital.[1]

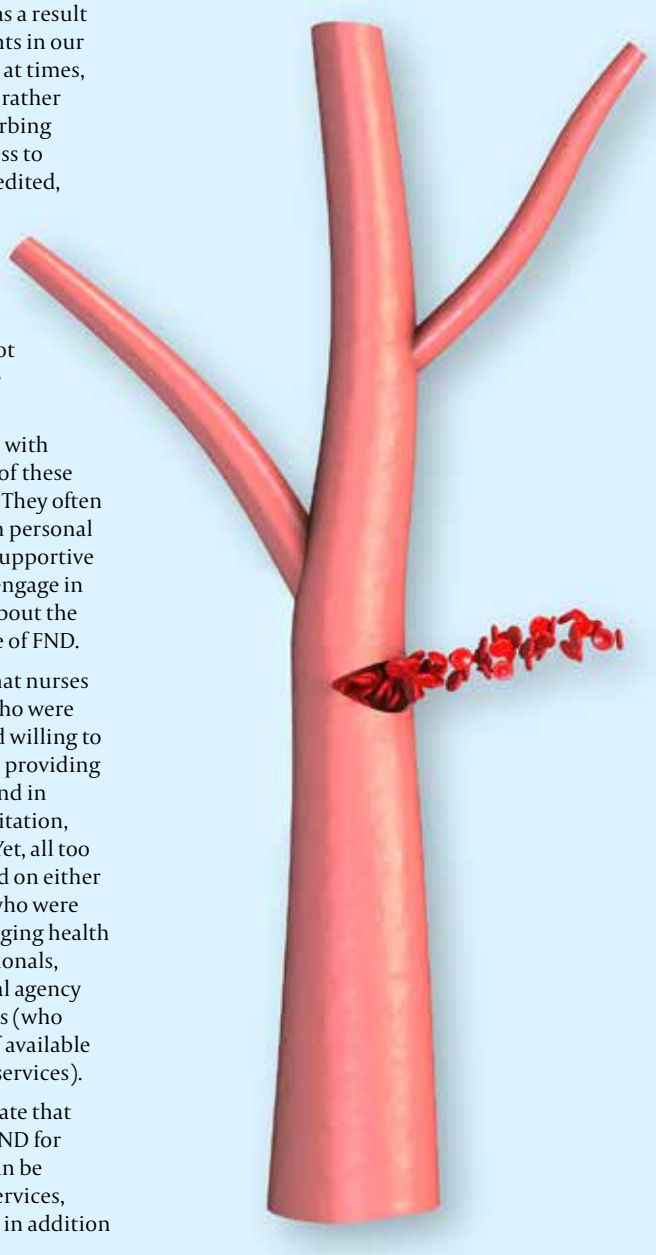
It develops due to problems with the functioning and connectivity of the central nervous system without structural damage, and leads to involuntary motor, sensory, and/or cognitive symptoms, such as seizures, tremors, weakness, gait problems, communication difficulties, visual impairment, pain, fatigue and/or brain fog.[1,2] People with FND face multiple disadvantages when accessing services, often falling in the gap between neurological and psychiatric services.[3,4]

Although research undertaken in partnership with people with lived experience is vital to ensure health services are responsive to the needs of service users,[5] existing research on FND has rarely involved people with lived experience and has been criticised for being deficit-based and exacerbating negative perceptions of people with FND.[2] To address this gap, we developed a research partnership between people with lived experience of FND, nursing, and public health academics.

Using a substantive co-design methodology,[5] and a strengths-based approach to qualitative inquiry, we collaborated through all stages of the research, including co-designing, co-conducting and co-analysing 17 interviews with people living with FND, which explored their challenges and skills in navigating health services.

Findings from a thematic analysis of interview data suggest that people with FND experience stigma and discrimination in health services- a point noted previously in the research literature.[6]

Extending earlier work, our research suggests that rather than being supportive, health professionals and services can create a “surplus suffering” for people living with FND.[7] Surplus suffering is defined as suffering that is created in addition to the original suffering of illness, and as a result of seeking healthcare.[7] Participants in our study also reported that services, at times, could be experienced as harmful rather than helpful. This included disturbing experiences of being denied access to services, having symptoms discredited, and being verbally abused and physically harmed. These kinds of experiences were linked to the ongoing perception that people with FND were ‘making it up’ – that FND symptoms were not real – and that FND patients were manipulative and malingering.



Our study also found that people with FND were not passive in the face of these negative healthcare experiences. They often went to great lengths – often with personal and financial costs – to seek out supportive health professionals or skilfully engage in educating health professionals about the involuntary and disabling nature of FND.

People with FND also reported that nurses and other health professionals who were knowledgeable, or interested and willing to upskill, could be instrumental in providing respectful and supportive care, and in advocating for linkage to rehabilitation, psychological or social services. Yet, all too often, any access to support relied on either the efforts of people with FND (who were already trying to manage challenging health issues) to educate health professionals, or on the dedication and personal agency of individual health professionals (who were often hampered by a lack of available education, resources, or referral services).

In conclusion, our findings indicate that the rights of people living with FND for respectful and supportive care can be severely undermined in health services, which creates a surplus suffering in addition

to FND symptoms. There is an urgent need to resource services that are responsive and respectful to the healthcare needs of people living with FND, as well as to improve the training of nurses and other health professionals in FND care, and thereby reduce the burden on people living with FND to educate health professionals and to receive supportive and respectful services.

Authors

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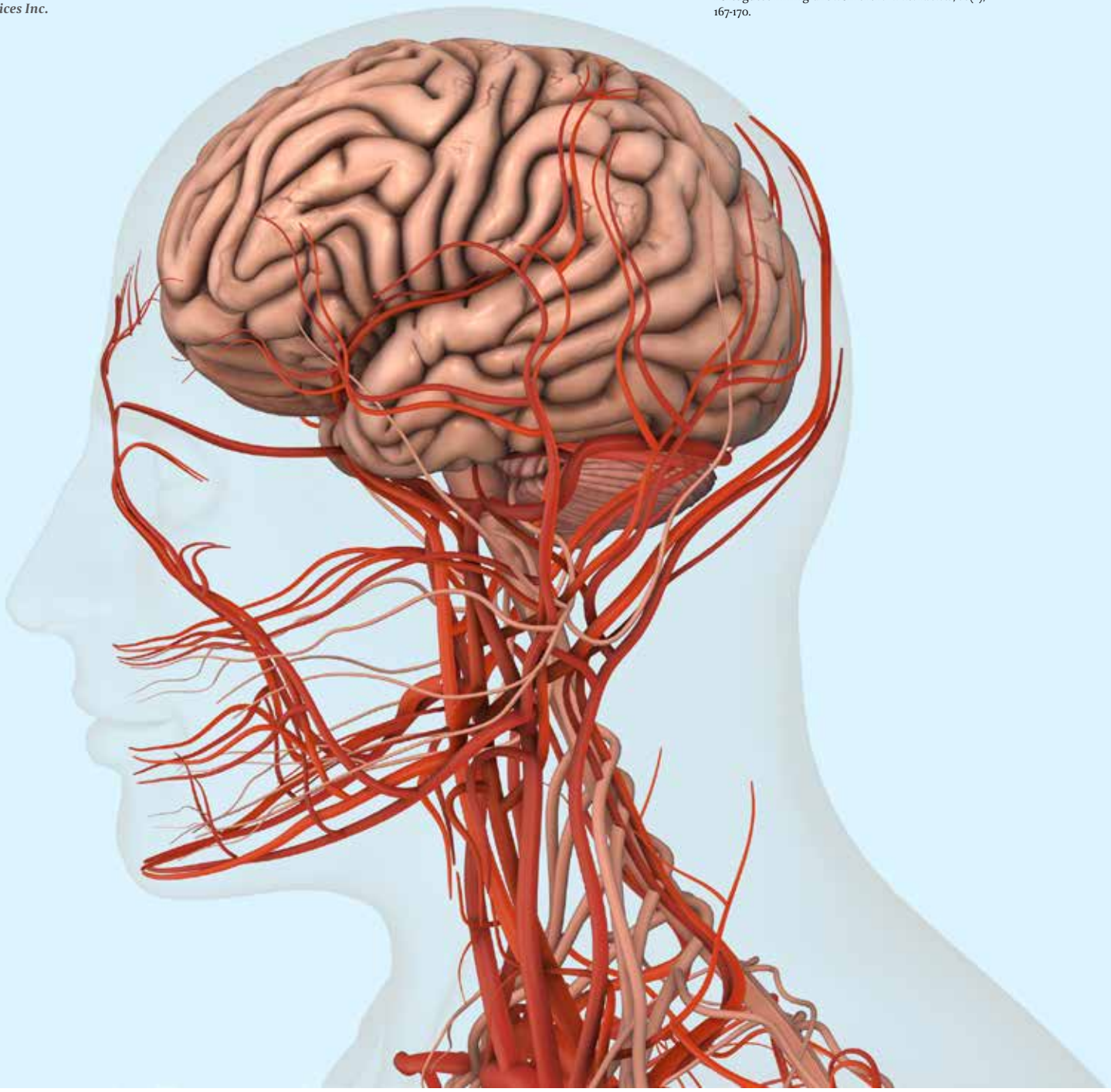

Rebecca Millar

Rebecca Millar is a forensic mental health nurse and lawyer and is in the nursing program in the school of Health and Biomedical Sciences at RMIT

Privacy in nursing and midwifery workplaces

If you are in a public place whilst reading this, particularly if you are in a metropolitan city, chances are you will be sitting in a place where your every move – and word – is being captured by CCTV.

Disclaimers may be plastered all over the walls stating that you are giving up any rights to privacy. Your mere existence in that place at that time, resulting in an implied acceptance of the disclaimer. Many of us are used to a life of CCTV in public places, but what about our workplace?

Is there a right to privacy in the context of nursing practice? I've previously written about privacy in the context of digital existence – the extent and perpetual nature of your exposed online existence. However, with 89.9% of Australia's population owning smart phones with video and audio recording capabilities,[1] privacy in the workplace is increasingly at risk.

Covert and overt recording of another person in healthcare is often considered in the context of patient privacy and confidentiality, with reference to the need to ensure consent is obtained from patients[2] and data security promoted.[3]

Often patient privacy is a concern in mental health units[4] and emergency department settings[5] where CCTV is used to promote the safety of patients in settings where there is a risk of aggression or violence. With the advancement of technology, privacy principles are being tested to the extreme with pilot projects already underway where nurses and emergency department staff use body worn cameras on shift to promote their safety.[6] Similar advances are also evident in the operating theatre. Although recordings of laparoscopic procedures for surgeons' private self-evaluation post operation have been used for decades,[7] video recording is now being used in general surgery to record the performance of the multidisciplinary team for purposes of reflection and learning.[8]

What is clear here, is that the purpose of the recording is significant. Whilst the *Privacy Act 1988* (including the recent amendments) doesn't specifically cover surveillance in the workplace, the Australian Privacy Principles set out stringent, limited circumstances where an employer can record an employee in the workplace. Many will be surprised to learn that a patient recording a nurse or a student recording an academic is permitted by law, providing that surveillance only records a private activity to which the recording person is a party. Although nurses and midwives or nursing and midwifery academics are in their workplaces, a patient or student nurse, in most jurisdictions, is not prevented by law from filming their interactions with a nurse or midwife (sections 3 and 7 of the *Surveillance Devices Act 1999 (Vic)*. Section 11(1) of the *Surveillance Devices Act 1999* does, however, make it an offence for a person to 'knowingly communicate or publish a record or report of a private conversation' obtained from a recording, unless the consent of all parties involved has been obtained. Whilst a conversation with a patient may be considered 'private', it is the patient's privacy that is protected – not that of the nurse.

Although privacy is legislatively governed on a state-by-state basis, in most jurisdictions video recording (in the circumstances outlined above) is permissible (except in South Australia and Western Australia).

Although not required, clinicians will often give consent to be recorded for private use only. Although there are no legislative protections to prevent being recorded, safeguards are in place to manage the use of the recording, such as the admissibility of evidence and the ability to seek civil law remedies of injunctions to have published material removed.

Often by the time these remedies are applied, there may have been significant and serious consequences of the publication of the material, such as reports to professional bodies and imputations to nurses' and midwives' reputations.

Studies have found that nursing and midwifery staff are, to say the least, uncomfortable about the prospects of being video recorded by their patients. Similar concerns have been raised by nursing and midwifery academics, who are increasingly recorded by their students. Risks to clinician safety and welfare as well as increased clinician stress have been cited as reasons against permitting patients video recording requests.[9] In many ways, the issue of healthcare services or nurses filming patients is relatively simple to work through. CCTV conflicts with nurses and midwives legal and ethical obligations to protect their privacy of their patients.[10] We are required to promote private surroundings for private and confidential consultations and discussions to take place.[11] However, there are no such safeguards protecting the privacy of nurses or nurse academics' practice.

With existing legislation focusing on the protection of patient confidentiality and in the context of high availability of recording devices and quick access to publication methods, attention needs to be turned to protecting nurses and midwives' privacy in their workplace. Whether in clinical practice or teaching, consider if your workplace has a policy on student or patient recording of staff and start a workplace privacy conversation.

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Nurse navigation – Steering the patient onto the right course

By Rong Jiang and Juliana Friedrich

Falls are prevalent within Residential Aged Care Facilities (RACFs), leading to significant hospitalisations, injuries, and mortalities.

In response to a South Australian Coroner's Inquest in 2011, a recommendation was made to transfer aged care residents with suspected head injuries on blood thinners to hospitals for assessment. While these guidelines broadly address the older people, they lack specific insight for the complex RACF population, often resulting in unnecessary hospital transfers that can cause adverse events and significant healthcare costs.

This case study examines the journey of an 81-year-old RACF resident, Mr AG, who faced frequent hospitalisations due to falls. The study highlights the role of the Comprehensive Aged Residents Emergency, Partners in Assessment, Care and Treatment (CAREPACT) Nurse Navigator (NN) program, which facilitated a person-centred approach, aligning medical interventions with the resident's goals and preferences, and focusing on symptom management for falls. This approach ultimately reduced hospital presentations and improved his quality of life.

The case study demonstrates how the NN model can integrate person-centred care and bridge gaps in the healthcare system to support individualised fall management in RACFs for aged care residents with complex needs. The findings advocate for a shift from a risk-averse culture to one that embraces the dignity of risk, ensuring that residents' autonomy and quality of life are prioritised.

INTRODUCTION

Falls are prevalent within Residential Aged Care Facilities (RACFs), where 60% of all residents fall each year and 10% are transferred to hospital for investigation and treatment.[1,2] They are one of the leading causes of hospitalisations, injury and death among aged care residents.[3] Falls represent a significant health concern for vulnerable residents and have been increasingly viewed as a marker of quality of care in RACFs.[4]

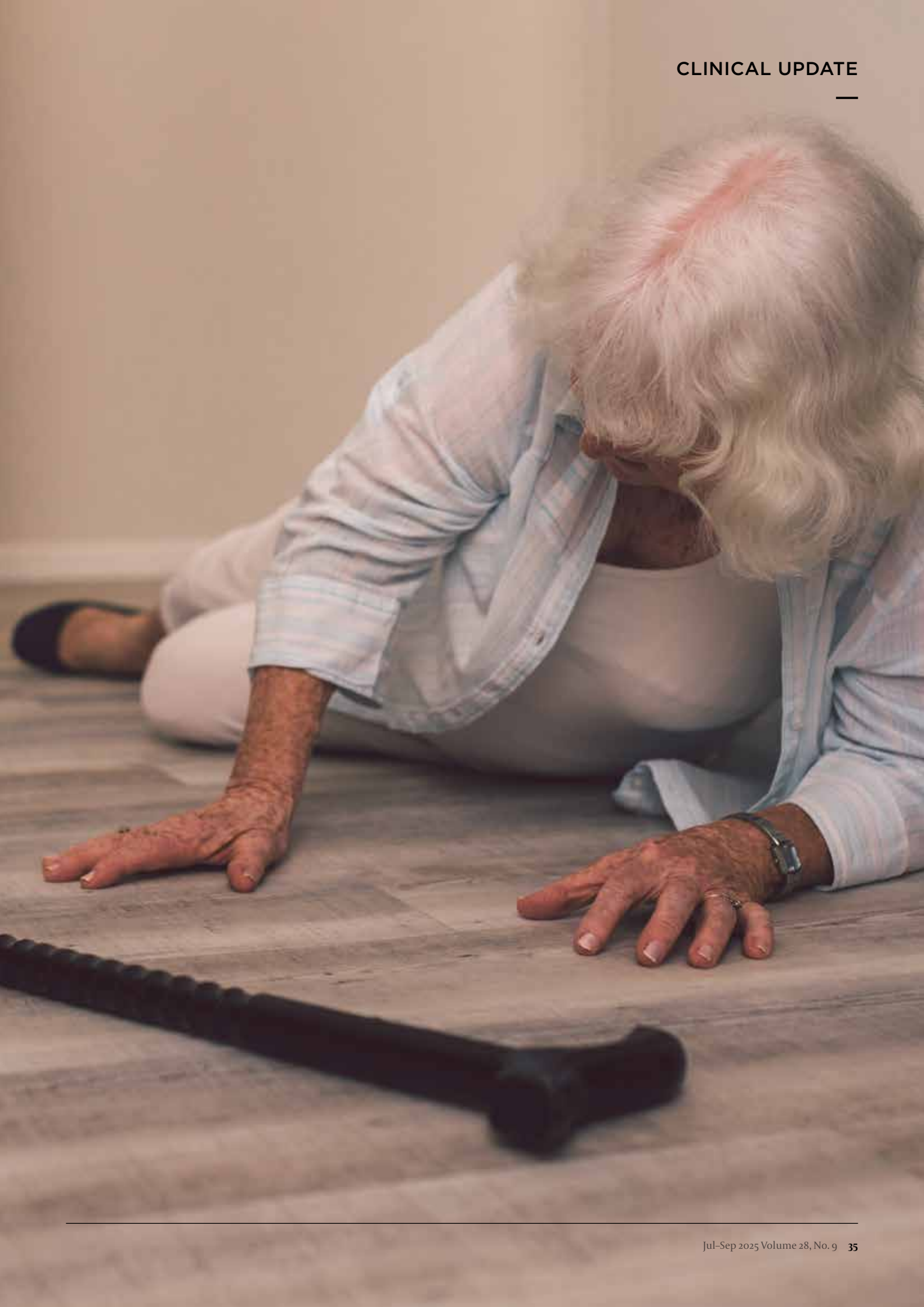
In 2011, following a South Australia Coroner's Inquest into an aged care resident who died following a fall from a chair, a recommendation was made that the aged-care sector consider transferring all residents who have a suspected head injury to hospital for assessment while on blood thinning medications.[5] Subsequently, RACFs falls guidelines have reinforced this recommendation by sending residents who fall with a suspected head injury or an unwitnessed fall to hospital.[1,6]

While these directives broadly address the older people in general, they lack specific insights tailored to the RACF context and individual patient. RACF residents are an increasingly older and vulnerable population, often with dementia and complex comorbidities.[7] Several studies including a systematic review, indicate that a substantial portion of RACF residents transferred to Emergency Departments (ED) do not yield significant benefits and causes a considerable burden for residents.[3,8,9] Moreover, these transfers are associated with adverse events such as delirium, pressure injuries, medication errors, nosocomial infection, further falls and potentially unnecessary invasive interventions.[3,10] These fall-related hospitalisation not only distress residents but are also costly to the healthcare system.[11]

The introduction of Advanced Care Planning and the Statement of Choice forms into RACF aim to ensure that medical interventions align with resident's and their family's goals and preferences, especially toward the end of life.[12,13] These documents have improved medical decisions at the end of life for residents, resulting in reductions in hospitalisations[12] However, they rarely address the issue of falls directly, and therefore documentation of residents' preferences does not guarantee translating the patients 'goals of care into appropriate medical action for falls management in RACFs.[14]

The application of residents' goals and treatment preferences is further complicated by fear around legal responsibilities among aged care providers.[15,16] The government and statutory bodies are mandated to promote the wellbeing of the aged care community. While their actions might be perceived as undertaken in good faith, they reinforce a preference for risk aversion in aged care organisations.[16] The individual resident may have specific goals that assist them to reach their desired quality of life, however, tension arises for RACF staff and management who want to support the residents' choices but struggle to balance the risks arising from these choices with the duty of care requirement to protect people from harm. As a result, service providers accept a relatively low level of risk and adopt a conservative or defensive approach to care provision in the practice.[16] The Aged Care Quality and Safety Commission enacted the dignity of risk principle in aged care, allowing "consumers have the right to make their own decisions about their care and services, as well as their right to take risks".[17]

Consequently, limiting residents' decisions about the way their care is delivered because of the possibility of risks is not in line



with the existing legislation and can undermine their autonomy, negatively impact their psychological wellbeing and physical health.[15]

The following case study explores the journey of an 81-year-old Mr AG, who struggled to meet his needs and achieve good quality of life due to frequent hospital presentations with falls. It examines how the Nurse Navigator CAREPACT (Comprehensive Aged Residents Emergency and Partners in Assessment, Care & Treatment) positively impacted his healthcare journey by supporting his preferred goals and reducing hospital presentations through advocating person-centred shared decision-making and facilitating broader system connections.

BACKGROUND

Nurse Navigators (NN) were employed by Queensland Health in 2016 to provide an integrated and person-centred approach for patients with complex health conditions to transition effectively through the healthcare system.[18] The NN role was subsequently introduced in the Metro South CAREPACT (Comprehensive Aged Residents Emergency, Partners in Assessment, Care and Treatment) service in recognition of the significant challenges experienced by vulnerable residents living in the Residential Aged Care.

The CAREPACT program is a Residential Aged Care Facility Support Service (RASS) that provides emergency and gerontology specialist assessment and management for 97 RACFs within the Brisbane Metro South Health catchment area. The aim of the program is to improve quality of care and reduce ED and hospital admissions of RACF residents. CAREPACT delivers a multifaceted program that works in partnership with RACFs and GPs by providing a centralised contact for acutely unwell RACF residents to allow specialist review or consultation. The model includes emergency support service and clinical care planning, inpatient resource and early discharge service, nurse navigator mediated case management, mobile emergency assessment team service, and Geriatrician specialist support.[19]

CASE STUDY

Mr AG moved to a RACF after experiencing a stroke, as his wife found it increasingly difficult to care for him at home. His stroke resulted in right-sided weakness and dysarthria. His mobility was also reduced, requiring the use a four-wheelie walker for short distances and a wheelchair for long distances. In addition to the stroke, Mr AG had a history of abdominal aortic aneurysm,

ischemic heart disease, peripheral vascular disease, T-cell non-Hodgkin's lymphoma, gastroesophageal reflux disease, hypertension, and dyslipidaemia.

TRADITIONAL TRAJECTORY

Since his admission to the care facility, RACF staff have noted that he was impatient and often did not wait for assistance with mobility and transferring to the wheelchair, leading to frequent falls. He also displayed agitated behaviours, such as throwing his lunch plate at nursing staff when his lunch was not served immediately. Mr AG had no diagnosis of dementia, thus staff attributed his behaviours and frequent falls to impulsive movements and individual personality.

Mr AG was on clopidogrel due to his history of stroke. Despite implementing falls prevention strategies and frequent physiotherapy review, Mr AG continued to fall many times each week, often resulting in bruises and lacerations. Although Mr AG's advance care planning indicated that he would not want life prolonging treatments and preferred to focus on quality of life and dignity, the RACF staff felt obligated to send him to hospital in accordance with the organisation's falls policy.

Mr AG would spend an average seven to 10 hours in ED, undergoing invasive or non-invasive investigations including blood and urine tests, X-ray, CT head, and then being discharged back to the RACF with recommendations for implementing more falls prevention strategies to minimise fall incidents. After 12 ED presentations for falls in 12 months, the hospital referred him to the nurse navigator.

THE NURSE NAVIGATION JOURNEY

The NN CARE-PACT commenced navigation in January 2020. During interviews with Mr AG and his wife, who was his Enduring Power of Attorney (EPOA), they expressed confusion about why Mr AG was falling so frequently. Conversations with RACF staff revealed their frustration with the hospital for not performing thorough investigations of Mr AG's frequent falls and often requesting the facility to implement more falls prevention strategies.

Following a detailed case review, the NN facilitated a rapid geriatrician review for diagnosis and specialist support. A formal diagnosis of advanced dementia was made after the Geriatrician review. The NN then worked closely with RACF staff and their multidisciplinary team to refer Mr AG to appropriate behaviour supportive services, trial different mobility aids, relocated him to a different room to increase supervision, and implement a daily social outing program to minimise boredom and low mood. Mr AG's fall incident rate reduced, although he continued to have an average of three to four falls per month.

Recognising these recurrent falls are symptoms of advanced dementia.[14,20] The NN liaised with the CAREPACT Geriatrician, GP, RACF clinician, and EPOA to facilitate a case conference to discuss future management for recurrent falls. The goals of care discussion with the EPOA focus on Mr AG's diagnosis of advanced dementia, the expected clinical course of the disease, his prior wishes for care in the advanced stages of the disease, the likelihood of injury and alternative treatment options following falls, and the potential for adverse effects of hospital presentations.[1] Following the discussion with the EPOA, an alternative clinical pathway for fall management was implemented. This pathway utilised CAREPACT and after-hours GP services instead of transferring to hospital, and it was documented in the RACF care plans and hospital electronic systems (ieMR). This alternative approach to care not only reflected Mr AG's wishes for a focus on comfort but also educated and supported the RACF staff to shift their approach from a fall prevention paradigm to a symptom management, comfort and dignity for those individuals with advanced dementia.[14]

After 18 months of navigation, AG's current RACF was sold to a different company and residents were relocated, posing a challenge to continuity of care plans. The NN continued to support the EPOA and new RACF staff when Mr AG relocated to the new facility, ensuring he received consistent care and management plans. Four months later, Mr AG was admitted to ED with foot ischaemia. The NN facilitated the sharing of information for the hospital treating team to provide a holistic overview of his care needs. The treating team reviewed various medical options and had discussions with his wife about his prior wishes. A palliative pathway was then made jointly between the treating team and his wife to align with Mr AG's prior wishes. He passed away one month later at the RACF with his family and familiar RACF staff after his last hospital admission.

During Mr AG's 24 months navigation journey, despite falling every week, the incidence of injury-related falls was reduced, with only five hospital presentations unrelated to falls. The RACF clinician and the hospital treating team provided goal-concordant care. The RACF clinicians felt supported without fear of repercussions, and the EPOA expressed gratitude for the RACF team and NN's service.

DISCUSSION

This case study provides a valuable insight into how the NN facilitates a patient-centred approach to falls in individuals with advanced dementia by addressing barriers to patient care and reforming organisation practices. What is evident in this case is the significant reduction in ED admissions and hospitalisations for Mr AG following person-centred goals of care discussions with the EPOA and the implementation of appropriate fall management in the RACF. The success of the navigation program also extended to improving Mr AG's quality of life, with treatment plans driven by his wishes and preferences. RACF staff gained increased confidence and the ability to manage his recurrent falls.

Dementia is a progressive and terminal illness, with a high mortality rate reported for people with advanced dementia.[21] Falls are common in patients with dementia and may be impossible to prevent in pre-terminal stage.[20] The Gold Standard Framework[22] identifies a serious fall as an event that often occurs near the end of life for those with dementia. Recurrent falls, once fully assessed may prompt the implementation of a palliative care approach to focus on symptom management.[14] Falls can be planned and managed in RACFs safely through sensitive discussions about the prognosis of diseases with residents and their decision-makers, followed by the implementation of care plans based on the discussed goals.[14] When residents and substitute decision-makers possess a clear understanding of the poor prognosis and expected clinical complications in complex commodities, they are more inclined to forego hospitalisation, focusing instead on quality of life and symptom management for residents within RACFs.[23]

Although early and effective goals of care discussion for recurrent falls with residents and their decision makers are recommended, such discussion remain uncommon in practice.[23] Hospitals often assume that GPs and RACF clinicians are the best professionals to conduct these discussion due to their understanding of the patients and their illness.[24] Conversely, clinicians at RACFs often struggle to recognise the prognostication of dementia and may feel a "sense of therapeutic failure" when resident falls.[25] Another barrier identified is the institutional culture of reporting falls as a quality indicator. Aged care staff often feel a strong duty and pressure to prevent falls in a person with dementia and are concerned about medicolegal risks.[4] Consequently, some organisational fall policies and practices fail to recognise the residents' needs and goals, treating all residents the same by sending those who fall to the hospital.[26] Supporting residents in exercising their decisions for falls management within aged care context requires clear guidelines about who will be responsible for potential risks that may follow a dignity of risk decision. Involving residents, their substitute decision-makers, aged care staff and management, GPs and hospital clinicians in goals of care discussion will achieve positive understandings of risks and ensure that all stakeholders are prepared to take accountability for the associated risks.[27] As central points in the patient journey, NNs have a holistic understanding of patients, their families, and their disease trajectory. Hence, they are well placed to facilitate goals of care discussions with patients' families and aged care service team, guiding decision-makers to make treatment decisions that reflect the individual's wishes and best interests in fall management.[24,28] Additionally, NNs enable aged care clinicians to confidently implement fall management plans by adopting a systematic approach and

ensuring consistent communication and good documentation across care settings. This collaborative and partnership-based environment allows the organisational culture to deliver care that aligns with the resident's goals and preferences.[29]

The value of the navigation also transcends traditional system boundaries and builds partnerships with key stakeholders across settings to support aged care residents experiencing complex healthcare needs.[28-30] The NNs identify service gaps within a fragmented and subspecialised system, working to negotiate care and connect patients, aged care service providers and hospitals. The NNs link patients and aged care service providers with expertise and resources in both hospitals and communities, educating and supporting aged care clinicians to improve practice and drive system change.[28]

A further lesson from this case study is the improvement of patient outcomes with falls in dementia by providing a patient-centred care approach throughout the patient care journey.[18,30] Current research[20,31] has shown that some effective interventions for reducing falls in advanced dementia primarily focus on identifying patients' needs and addressing symptoms, rather than attempting to modify the underlying medical condition. The needs of patients with dementia vary greatly, necessitating individualised and co-partnered care planning specific to falls. It is particularly valuable that care plans are consistent with the patient and decision maker's preferred wishes and also involve addressing the physical, psychological, social and spiritual care needs of the person with dementia.[14,31]

CONCLUSION

The case study demonstrates that individualised fall management in this vulnerable population can be achieved within RACFs through person-centred shared decision-making alongside hospital utilisation. The influence of the navigation model steers a new course at an individual level by building partnerships and organisational integration. Importantly, these changes will persist within the organisation, as the influence extends beyond the care of the individual patient and continue to support future patients. Implications for future practice will need to examine when to initiate goals of care discussions and implement stage-appropriate care plans for fall management in dementia at RACFs. The evidence generated from this case will encourage reform towards more person-centred policies and guide clinicians in appropriately applying dignity of risk principles in aged care organisations.

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The power of starting a green group

By ANMF Climate Change Officer Catelyn Richards

Why collective action is one of the best ways to lead change in your workplace and community.

It started with cold curry in my lunch box and a ward office full of nurses. Our sustainability Clinical Nurse Consultant was clicking through slides about PVC recycling while we crammed in our lunch, knowing we all had to be back on the floor in less than 30 minutes.

It wasn't glamorous. It wasn't strategic. But in the midst of the presentation someone posed the question, "should we just start a green group?"

And someone else nodded.

That moment, wedged between shift work and leftovers, was the beginning.

The beginning of a conversation that became a group … that became our mini movement.

And the first nursing/midwifery green group I ever joined.

Across Australia, a quiet revolution is happening. Nurses and midwives are forming green groups. We're not waiting for permission. We're starting where we are: with gloves, with bins and with our voices. Green groups might seem inconsequential, but their impact is anything but. Wondering how they really make a difference? Let's take a closer look.

WHAT IS A GREEN GROUP?

A green group can go by many names: 'sustainability group', 'climate action group' or 'green committee'. At its core, it's a collective of people working together to create more environmentally sustainable practices, whether in hospitals, homes or the broader community. In healthcare, this might look like a ward-based team reducing single-use plastics, a hospital-wide sustainability committee, or a national advocacy group driving policy change. No matter the name or context, green groups usually share two common threads: 1) they exist to foster environmental responsibility and 2) they bring people together around the shared vision, to make change collectively.

WHY GREEN GROUPS MATTER

You're probably doing things already: recycling where possible, speaking up about unnecessary waste, or using active transport. But doing this work collectively, has the potential to have a bigger impact.

Research shows that environmental action is more successful and more sustainable when done as a group.[1] Initiatives embedded into teams, not just driven by individuals, are more likely to stand the test of time. They shape workplace culture; help normalise environmental responsibility[3,5] and makes sustainability in nursing and midwifery more visible.

Being in a group also brings resilience. The friendships I've made in climate and health have helped me keep going when the challenge feels intractable. We share the load and keep each other inspired to move forward.

This is why, when nurses and midwives ask me, "What's the single most effective thing I can do to tackle environmental problems?", my answer is always the same: "Join or start a green group."

There's something deeply empowering about being part of a collective.

WHAT KIND OF GROUP COULD YOU START?

There's no one-size-fits-all approach to what kind of group suits you and/or your work. Some groups start with garnering support from or with their unit manager and hospital administration. Some conduct a small sustainability audit of their ward. Some do a desktop audit – where they collect meaningful reports, guidelines and strategy documents from their organisation and run an in-service to teach others. Others link in with existing groups or start informal lunchtime catchups. Some campaigns grow into formal committees or state-wide networks. It might take a bit of reflection to work out what you think your organisation needs.

If you can't find a group that fits, you can start one. You don't need to be an expert. Just a person who's willing to gather with others and ask, "What could we do together?"

GROUPS YOU CAN JOIN

If *starting* a new group isn't your style, many others are already walking this path. You might:

1. Join your union and join any environmental sustainability committee or group that they may already have
2. Search for hospital or state-based nursing green groups on Facebook like the *Green Nurses and Midwives Facebook Group*
3. Take a look at, or join 1 million Women
4. Become a member of Climate Action Nurses or become involved with the Nursing and Midwifery Planetary Health Collaborative
5. If advocacy isn't your cup of tea, and you want to try something more hands on, you could volunteer with your local Landcare or local council tree planting group

You'll find likeminded people. And you might even find yourself reinspired.

BRINGING IT ALL TOGETHER – BUILDING SOMETHING BIGGER

I've lost count of how many times I've turned to my climate network after reading an incredible article I just HAD to share or followed up on a documentary recommendation from a green-group-peer that turned out to be exactly what I needed. Some of my closest friendships have come through my climate networks. There's a powerful sense of shared humanity that runs through these connections, a feeling that we're in this together and a reminder of what we are fighting for.

- Nature rarely works alone. Trees connect through roots. Birds migrate in flocks. Bees thrive in hives.
- Nature thrives when it works in connected groups and so do nurses and midwives.
- Maybe we're not meant to tackle this climate challenge solo either.
- Maybe the first step is finding each other … and then getting to work.

WANT TO LEARN MORE ABOUT COLLECTIVE ENGAGEMENT?

- Check out the ANMF Federal and *ANMJ* website.
- Read *Right Here, Right Now* by Natalie Isaacs. In this book, Natalie Isaacs shares the powerful story behind building a movement of more than 950,000 women and girls engaged around taking climate action. The book ends with practical steps you can take.

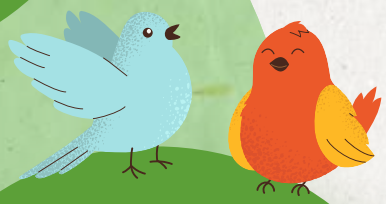
'WHAT IS A GREEN GROUP'

They also serve as a hub for information. You are able to learn strategies.

Things that work and don't work.

You learn tips for your own home life.

You soundboard new things you want to try and can set up workplans for making it happen.

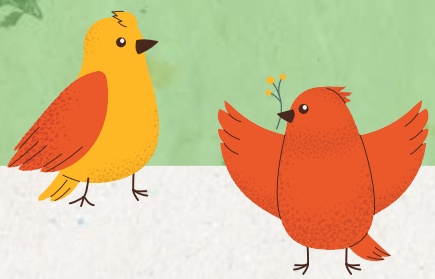


THINKING OF STARTING YOUR OWN GROUP?

1. Start small: one meeting, one topic
2. Choose a shared project: an audit, a bin system, reusables, climate education
3. Use available tools that others have already shared
4. Invite a range of people: nurses, midwives, doctors, students, cleaners, admin
5. Track your progress – how will you know when your team is winning?
6. Celebrate your wins, however small

WHAT THE RESEARCH SAYS

- Collective action in workplaces improves uptake and longevity of sustainability initiatives[1]
- Working alone can lead to feelings of ostracisation[2]
- Group-led change helps shift norms and embed environmental values into organisational culture[3,4,5]



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Jasmine Kirk

ANMF Strategic Lead - Midwifery

Have you ever thought of a midwife as a climate worker?

Midwives are critical climate workers, that play a pivotal role in ensuring health equity, safety, resilience, and sustainability for the people they care for.

The ongoing effects of climate change in Australia present more than just environmental challenges – they also have the potential to become public health emergencies.

In pregnancy, women and birthing people and their newborns are particularly vulnerable to the effects of bushfires, drought, and flood.

Heatwaves are becoming longer and more severe, posing a direct threat to maternal and foetal health. Exposure to high temperatures during pregnancy has been linked to increased risks of preterm birth, stillbirth, congenital abnormalities, and gestational diabetes.[1]

Recent catastrophic flooding in Queensland, New South Wales, and Victoria have resulted in massive disruptions to healthcare access. During the 2022 floods in Queensland and New South Wales, maternity services were disrupted for weeks, forcing emergency evacuations and care disruptions. Midwives were seen providing essential care in shelters, via telehealth, and even by travelling on foot or via boat to reach women isolated by floodwaters.

The 2019-2020 Black Summer bushfires exposed millions to toxic smoke for weeks, including pregnant women and birthing people. There are links between smoke exposure and pregnancy complications, including low birth weight, prematurity, and changes to foetal DNA.[2]

Midwifery care provided during evacuations due to fire proved a vital source of physical and emotional support to new families.

Midwifery-led models of care align with climate conscious, sustainable principles – improving birth outcomes while reducing unnecessary interventions and hospital admissions.

Midwives, particularly those in rural and remote work, often provide care with minimal reliance on high-emissions equipment, aligning with low-carbon, low-resource strategies. Through health promotion work, such as breastfeeding and vaccination midwives help build community resilience against climate-related disruptions.

Although many think of midwives as strictly birth workers, midwives are also essential to family planning. The ANMF recently advocated for endorsed midwives to have access to a Medicare Benefits Scheme item number to insert long-acting reversible contraception, currently the most environmentally friendly contraception method available.

Midwives are trusted advocates within communities. We are well-positioned to raise awareness about environmental impacts on pregnancy and infant health, such as the importance of hydration and cool environments during heatwaves, or how to reduce infection risks during floods.

In Aboriginal and Torres Strait Islander communities, midwives work with Aboriginal health workers to incorporate traditional knowledge and culturally safe practices, promoting both health and ecological stewardship. This approach is critical in addressing the compounded effects of climate change, colonisation, and systemic health inequities present prior to birth.

As trusted health professionals, midwives can also influence policy by highlighting the connections between environmental degradation and maternal outcomes. The ANMF has recently onboarded a climate officer to engage in climate-health advocacy, emphasising the need for nurses and midwives to be included in emergency planning and environmental health discussions.

To fully embrace our role as climate workers, midwives need targeted support and education. Incorporating environmental health into midwifery curricula, including topics like the effects of heat stress and pollution, and sustainable practices, will ensure future midwives are climate-literate and prepared.

In practice, this means investing in mobile midwifery units, community birthing centres, and telehealth – particularly for climate-vulnerable regions. Public health and emergency management plans must include midwives as essential personnel, especially in remote communities where they may be the only health professionals available during a crisis.

In the face of Australia's climate emergency, midwives are not just birth workers – we are climate workers. We stand at the intersection of health, justice, and environmental resilience, caring for families during floods, heatwaves, bushfires, and droughts. Our work is essential to building sustainable healthcare systems that can withstand the challenges ahead.

Recognising and supporting midwives as climate workers in Australia isn't just about improving maternal health – it's about safeguarding community wellbeing and environmental justice in a rapidly changing world.

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MIDWIFERY AND MATERNAL HEALTH

PART 1

Culturally safe maternity care for Indigenous women: Bridging gaps for health equity

By Nina Sivertsen, Tahlia Johnson, Grete Mehus, Tove M Ness and Susan Smith

An international, pan-Indigenous, and cross-cultural research team has examined Indigenous women's dissatisfaction with birthing experiences across both the Northern and Southern Hemispheres.

A recently published scoping review includes data from 1,437 women, 36 Elders, 14 fathers and family members, and 91 healthcare professionals, highlighting widespread dissatisfaction with birthing in mainstream maternity hospitals in Australia, Aotearoa (New Zealand), Canada, the US, Kalaallit Nunaat (Greenland), and Sápmi (Norway).

The findings reveal a critical need for culturally safe, trauma-informed care, inclusive communication, active decision-making, and greater integration of Indigenous perspectives in maternity care. The research also advocates for the involvement of Indigenous birth support workers and the inclusion of Birthing on Country models of care where appropriate.

Despite the safety benefits of medicalised births, the evacuation of Indigenous women for childbirth causes cultural, geographic, and social disconnection. This disconnection leads to distress and contributes to ongoing dissatisfaction with maternity experiences. The review underscores the urgent need for enhanced cultural safety education, improved communication, and the integration of cultural practices into maternity care, with Indigenous birth support workers playing an essential role.

Birth outcomes for Aboriginal and Torres Strait Islander women continue to be significantly worse than for non-Indigenous populations, despite advancements in maternity care. This scoping review highlights systemic inequities and cultural safety concerns in mainstream maternity hospitals, exacerbated by the medicalisation and evacuation of Indigenous women for childbirth. A consistent preference emerged for birthing within Indigenous communities, where women feel connected to their cultural practices and supported by family. Many women reported feelings of isolation and disconnection when relocated for childbirth, particularly in rural or remote areas. The lack of culturally safe care erodes trust in healthcare providers, contributing to higher dissatisfaction and poorer health outcomes.

A key finding is the strong preference for the Birthing on Country model, which integrates traditional practices, supports holistic wellbeing, and provides continuity of care – especially when midwifery teams include cultural support and Indigenous birth workers. However, mainstream maternity services often fall short of meeting these needs, revealing a significant gap in cultural understanding and safety within the healthcare system.

The research stresses the need for cultural safety training for healthcare professionals. Effective and inclusive communication, and active decision-making are essential for improving the birth experience for Indigenous women. Such education enables healthcare providers to challenge cultural stereotypes, build trust, and enhance clinical care, leading to better maternal health outcomes.

This research calls for a transformative approach to maternity care that prioritises Indigenous women's voices and cultural needs. By integrating traditional knowledge and practices into mainstream care, maternity services can become both medically safe and culturally empowering for Aboriginal and Torres Strait Islander women. Healthcare professionals must create inclusive, respectful environments where all women, especially those from marginalised communities, feel heard, valued, and supported in their maternity care.

Addressing these gaps in care and advocating for systemic change is not just a professional responsibility – it's a moral imperative. Ensuring that Indigenous women have access to culturally safe and responsive care is critical to closing the health equity gap and improving outcomes for mothers and their babies across the globe.

You can read the full review via this link: **frontiersin.org/journals/public-health/articles/10.3389/fpubh.2025.1495197/full**

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What could clinical supervision do for you?

By Naomi Riley, ANMF Strategic Lead – Midwifery

Clinical supervision is a wonderful form of continuing professional development aimed at enhancing care received by health consumers by assisting health practitioners to reflect, think deeply and critically, gain clarity and develop strategies to enhance their practice and care provided.

Clinical supervision can be viewed as a supportive model of reflective practice. Unlike other forms of supported practice, it is practitioner led. The supervisor assists the practitioner to critically reflect on aspects of their practice of their choosing, incorporating how the practitioner may feel and think about what they do or have done, and how they have related to others whilst providing care and the outcome/s. It can be deeply personal exploring a practitioner's thinking and feelings about their practice and work environment that they are finding most thought provoking including the sometimes uncomfortable and/or distressing realities of healthcare provision. It is a protected time when practitioners can be heard, to be understood by another professional and not judged.

Increasingly, clinical supervision is being recognised as an essential modality of professional support for contemporary midwifery practice. However, many midwives haven't heard of clinical supervision or been given the opportunity to explore if this can support their practice. So, what are the midwives who have had clinical supervision saying about it?

I had the opportunity to speak with Susan Gee who is a midwife, Clinical Midwife Consultant and Complex Care Coordinator at Launceston General Hospital. She has been engaging in clinical supervision for the first time in her many years as a midwife since the middle of 2024.

According to Susan, clinical supervision offers her an invaluable opportunity to reflect on how she responds in clinical practice and explore options for her responses in similar experiences in the future. Since commencing clinical supervision, Susan reports improved job satisfaction and increased recognition of her strengths and positive steps she has taken in her practice. As well as enhanced confidence and knowing she has the strategies to manage challenges in her practice and interactions with other staff and clients.

Susan's experience supports the evidence that engaging in regular supervision with a trusted clinical supervisor may assist midwives to feel more satisfied in their role and develop greater awareness of their skills and knowledge, and risks in the workplace to enhance their clinical practice and clinical practice environment.

What could clinical supervision do for you?

For further information on clinical supervision for nurses and midwives please see the *Position Statement: Clinical Supervision for Nurses and Midwives* accessible at: **midwives.org.au/common/Uploaded%20files/Clinical%20supervision%20-%20Joint%20Position%20Statement.pdf**

Many thanks to Susan Gee for her time and sharing her experiences of clinical supervision.

Are we well on the way to parenthood? Promoting maternal mental health and wellbeing

By Lesley Pascuzzi

The mental health and wellbeing of mothers raising the next generation of children is a national priority[1]. Despite the priority profile, pregnant women in Australia are provided little or no mental health promotion opportunities during routine maternity care.

In Australia, midwives offer routine screening of mental health using self-report questionnaires[2-3] focused on detecting a woman's risk of anxiety and depression. The burden of mental illness is significant and researched heavily with pregnant women[4-5] and mothers[6-7].

Data tells us one in five women experience mental health difficulty in pregnancy[8] suggesting four in five women may have better mental health. Midwives develop a unique relationship with pregnant women and mothers during the perinatal period[9] and are well placed to promote mental health. However, there is little known about how to support midwives to fulfil this professional scope of practice.

I'm thrilled to be undertaking doctoral research to explore promoting maternal mental health and wellbeing. Taking a participatory co-design approach, my research seeks to address the gap that exists within routine maternity care. Bringing together midwives, pregnant women and mothers with maternal child health and obstetrician colleagues in a *project design* group is engaging those with expert lived and living experience in exciting, creative workshops to produce something new! To ensure our project produces sustainable and equitable outcomes, the research has an *expert advisory* group of industry experts from mental health promotion, public health in primary care, maternity health service leadership, perinatal mental health promotion and lived experience.

Top 5 reasons why this research matters:

- Women are motivated in pregnancy to adopt health-related behaviour change however, currently most enter a "detect-risk of disease" screening of mental health difficulty, resulting in opportunity costs to routinely promote mental health and wellbeing.
- Our research shows women lack a mental health vocabulary to confidently identify and discuss their mental *health and wellbeing* with partners, family or healthcare professionals, instead explaining increased ease in describing mental illnesses including anxiety and depression.
- Midwives recognise the importance of mentally healthy mothers; are well placed to promote mental health during antenatal and postnatal care but are currently not well equipped to do so.
- The potential to utilise the mental health promotion capacity of midwives is currently unrealised in Australia.
- Improved knowledge and skills within midwifery practice could play a role in optimising perinatal emotional wellbeing outcomes for women and infants.

My research aims to address these gaps, and the creation of our project outcomes is currently underway. In 2026, we plan to "real world" test our project within business-as-usual maternity care delivered by midwives in Western Australia.

For more information about our research please email: **lesley.pascuzzi@postgrad.curtin.edu.au**

Acknowledgement: Supervision team from Curtin University A/Prof Zoe Bradfield and A/Prof Karen Heslop with Professor Helen Skouteris, Monash University, Victoria.

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Lesley Pascuzzi is a PhD candidate within the School of Nursing, Curtin University, Western Australia supported by an Australian Commonwealth RTP Scholarship. She is a trained Applied Psychologist (UK) and holds postgraduate qualifications in Perinatal Mental Health (University of South Australia). Lesley's PhD research focusses on optimising mental health and emotional wellbeing of women in Australia on their journey to parenthood.

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Project design group members including pregnant women and mothers in Western Australia discussing potential mental health promotion solutions

Gender affirmation, surrogate leave, among new progressive conditions won during enterprise bargaining

By Erica Visser and Justina Beltrame

What began in 1970 as the Family Planning Alliance of South Australia continues to lead the way advancing workplace conditions, thanks to an ANMF (SA Branch)-negotiated Enterprise Agreement that has introduced several progressive new provisions.

Nurses and midwives at the organisation, now known as the Sexual Health Information Networking and Education South Australia (SHINE SA), are celebrating the new Enterprise Agreement (EA), which for the first time, includes paid leave for gender affirmation, surrogacy and in the event of stillbirth.

Menstruation leave has also been included to the agreement, recognising that nursing and midwifery are female-dominated professions. Members at SHINE SA can now access six days paid leave per annum for healthcare needs relating to painful periods, or due to symptoms of perimenopause and menopause.

ANMF (SA Branch) members played an active role in negotiation meetings, and consultations leading up to the successful agreement making process.

Sexual health nurse and ANMF (SA Branch) member Kelly Vernon (pictured) was among the enthusiastic members who sat at the bargaining table.

"It was important to me because reproductive conditions affect a huge majority of the nursing workforce," Kelly said. "Having experienced the debilitating effects of these conditions and having many colleagues who have also experienced similar, it is wonderful to work for an organisation that recognises this and is providing real support to the workforce.

"This is a positive step forward in bridging the gender pay gap."

The collaborative approach aligns with the important work SHINE SA nurses and midwives do in providing inclusive and safe care to the South Australian community.

Clinics, both in person and via phone, are staffed by ANMF members who provide sexual and reproductive health advice to people from diverse cultures, sexual orientations, genders, sexes and abilities.

SHINE SA Sexual health nurse and ANMF (SA Branch) member Kelly Vernon

Recent initiatives include a pilot program for a cervical self-screening, supported via the telephone helpline.

The continuing professional development of nurses and midwives has also been considered in the comprehensive offering of education and training available through SHINE SA.

Kelly said she hopes many of these new conditions are just the beginning for further changes and improvement.

ANMF (SA Branch) Director, Nursing & Midwifery, Professional Practice Adj Associate Professor Jackie Wood highlighted this achievement as a powerful example of how union members can drive meaningful changes within their organisations.

"ANMF (SA Branch) members played a pivotal role in these negotiations, working closely with their employer to secure an Enterprise Agreement that prioritises the wellbeing of all staff," Professor Wood said.

"Leave entitlements such as menstruation, stillbirth, surrogacy and gender affirmation, are becoming increasingly recognised by employers. This shift reflects a growing awareness of the need to support diverse and inclusive workforces, ensuring a more equitable workplace for all."

Authors

Erica Visser is a Senior Media and Communications Manager with the South Australian Branch of the ANMF

Justina Beltrame is an Industrial Officer with the South Australian Branch of the ANMF

Nurse practitioner led abortion clinic: Providing accessible, safe abortion and reproductive healthcare

By Marina Mickleson

Nurse Practitioners (NP's) are integral members of the healthcare team with the scope to provide comprehensive care to women seeking to have an abortion.

Every woman in Australia has the right to make their own choice about whether to have an abortion or continue their pregnancy, with specific guidance provided by each state or territory's legislation.[1]

Abortion is legal in all states of Australia, although individual state and territory legislation has varying gestational limitations. In Western Australia (WA) the Abortion Legislation Reform Act 2023,[2] changed the law to allow women to have an abortion up to 22+6 weeks gestation. From 23 weeks, two doctors must independently consent to the women having an abortion. This new legislation came into place in March 2024.

As long as within their scope of practice, NPs or endorsed midwives (EMs) can prescribe medical abortion medication to women up to nine weeks gestation (63 days). The Women and Newborn Health Service (WNHS) in WA runs a comprehensive Pregnancy Choices and Abortion Care Service, with two outpatient clinics a week providing holistic care for women seeking medical and surgical abortions. These clinics comprise of a multidisciplinary team (MDT) of nurses, midwives, gynaecologists, psychologists, social workers, a nurse practitioner, sonographers, pastoral care staff and Aboriginal liaison officers. Women have access to all members of the MDT as needed.

As an NP and midwife, I oversee the medical termination clinic for women under nine weeks gestation at WNHS. I also provide a long-acting reversable contraception (LARC) clinic for women post abortion care. I am working with WNHS to further support the capacity of endorsed midwives in this area of practice, allowing them to be trained in providing abortion and LARC services, increasing women's access to these essential services.

This will help fill a crucial gap in abortion services in WA. WNHS currently employs 50 endorsed midwives with many more currently undertaking their endorsement qualification. The services I provide in my practice setting demonstrate the potential for endorsed midwives and NPs to provide comprehensive, accessible and holistic sexual and reproductive healthcare for all women in Australia.

Author

Marina Mickleson MNP, BNursing, Grad Dip Midwifery is a Nurse Practitioner, Clinical Midwife, Credentialed Diabetes Educator Nursing & Midwifery in the Obstetric & Gynaecology Department at the Women and Newborn Health Service at King Edward Memorial Hospital in Subiaco WA

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Considered collaboration in research: An example from the birthing community

By Caitlyn Atkinson

Set against the backdrop of Australia's dominant biomedical maternity system, freebirth is a growing phenomenon and an emotive topic.

Caitlyn Atkinson, a privately practicing midwife and researcher at Edith Cowan University, is undertaking a project exploring women's experiences of care when planning to freebirth, and how it impacts their experience of pregnancy, birth and postpartum.

WHAT IS A FREEBIRTH?

Freebirth is commonly defined as when a woman deliberately chooses to give birth at home without the presence of a registered maternity professional such as a midwife or doctor.[1] Other terms include unassisted birth, sovereign birth, or wild pregnancy and birth.[2]

WHY DO WOMEN CHOOSE TO FREEBIRTH?

According to previous research, women freebirth to achieve physical, emotional and psychological safety during childbirth.[3-6] Motivators for women to reject mainstream maternity models and choose freebirth are previous traumatic childbirth experiences, and concerns that coercive measures will be used to perform unnecessary childbirth interventions and undermine their reproductive autonomy.[7,8] As shown in the 2024 NSW Birth Trauma Parliament Inquiry, birth trauma is a harmful outcome experienced by a significant number of Australian women.[9]

WHY RESEARCH WOMEN'S EXPERIENCES OF CARE?

Women who freebirth have diverse care experiences. From self-implemented activities such as extensive research, resuscitation courses, selective engagement with maternity professionals, to hiring unregulated birth workers for support.[8,10-13] Freebirthing women often face vilification and stigmatisation.[2,12,13] Listening to their experiences may improve our understanding of their self-reported needs when planning to give birth and improve the care provided to this often-misunderstood population of women.

HIDDEN FROM THE MAINSTREAM GAZE

Freebirth, by nature, excludes midwives and is largely hidden from the mainstream gaze. Acknowledging the autonomy women seek, and possible previous negative experiences or trauma within the institution of mainstream maternity care, careful methodological consideration has been given to ensuring the participants of the research do not feel their authority is undermined by institutional academic research being done "on" or "for" them.

ASKING FOR TRANSPARENCY WITH TRANSPARENCY

Power disparities between researchers and participants are a known phenomenon,[14] not dissimilar to the power dynamics at play within hierarchical systems that freebirth women intentionally avoid. The research team have attempted to address this imbalance using the participatory power of a 'community group' of women, dubbed 'lived experience experts', who have previously planned to freebirth, to add meaningful value to the design, conduct and outcomes. These women will work alongside the research group in a collaborative approach, their knowledge and insights contributing to material development such as recruitment flyers, reviewing interview questions to fill assumed gaps in knowledge, and offering suggestions for the use and sharing of results.

Valuing the lived experience experts within a community group heightens a project's sensitivity to the needs and wishes of the participants and wider population.[15] In the case of freebirthing women, mitigating research-based power disparities wherever possible aims to offer transparency for transparency; to explore this phenomenon and the women's experiences with the spirit of openness, curiosity, and respect and gratitude for the women's involvement in increasing our knowledge.

Author

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Midwifery in motion

By Alison Weatherstone

For many years, midwives have championed the benefits of midwifery continuity of care, backed by extensive research proving time and again that this model delivers the best outcomes for women and their babies.

Over the past 18 months, focused advocacy has captured the attention of governments and policymakers, leading to significant wins for the profession:

- **Paid student prac placements** from July 1, 2025.
- **Removal of collaborative arrangements** from November 1, 2024.
- **Creation of a Chief Midwife Officer** position in Queensland.
- **Introduction of publicly funded homebirth services** in Queensland.
- **Expanded prescribing rights** – 44 new medicines now available to Endorsed Midwives with expansion into sexual and reproductive health, including long active reversible contraceptives and medical abortion.
- **$56.5 million in funding for outstanding MBS items from the 2020 MBS Review Taskforce**, improving women's access to primary midwifery care.
- **A long-awaited Midwifery Professional Indemnity Insurance** solution allowing Endorsed Midwives to provide intrapartum care at home.
- **Scope of Practice Review recommendations** that will enable midwives to better serve all communities, particularly in rural and remote areas.
- **Opening of an Endorsed Midwife-led birth centre** in Perth.
- **Development of a 2nd edition National Rural Maternity Care Consensus Framework and strategy**.

These policy shifts and funding commitments highlight the growing recognition of midwives as essential healthcare providers. Recent reviews – *Midwifery Futures* and *Unleashing the Potential of Our Health Workforce Scope of Practice* – have underscored workforce retention challenges and the need for systemic changes to ensure midwives remain in the profession. They have also identified the untapped potential of midwives in improving equity of access to maternity care, particularly in regional and rural areas, as well as expanding their role in sexual and reproductive healthcare.

Midwifery is finally in the spotlight, and while these hard-fought gains mark significant progress, there is still work to be done. The NSW Birth Trauma Inquiry found that **one in three women experience birth trauma**, underscoring the urgent need for continued reform. Until every woman in Australia has access to respectful, evidence-based, best-practice maternity care, advocacy groups, the ANMF and peak bodies like the Australian College of Midwives will continue to push for lasting change. **midwives.org.au**

Author

Alison Weatherstone, Chief Midwife, Australian College of Midwives

The FUCHSIA study goes NATIONAL

By Naomi Riley, ANMF Strategic Lead – Midwifery

The ANMF is pleased to be funding a study called The FUCHSIA study: Future proofing the midwifery workforce in Australia. Not dissimilar to the Victorian FUCHSIA study (report released in 2022), this study aims to gather accurate, up-to-date evidence to map and gain insights into the health and wellbeing of the midwifery workforce, and its sustainability.

To achieve change for the midwifery workforce, we need hard data identifying the critical factors that affect the retention and attrition of midwives in the Australian maternity care sector. This is your chance to contribute to that change!

All midwives, regardless of their context of practice, are encouraged to complete an online survey led by researchers Professor Della Forster and Ms Robyn Matthews at La Trobe University that is distributed via your workplace. Please get in touch with your manager or contact your ANMF Branch if you have not received the survey by August 2025 to have your say.

Words matter: Power of terminology in fertility care

By Amanda Mackay, Selina Taylor, Emma Anderson and Beverley Glass

What does the word 'infertility' mean to you? It's a term commonly used in nursing as we are caring for patients who have had fertility treatments to achieve pregnancy or may have an infertile partner.

With one in six Australian couples experiencing difficulty with fertility, it is likely that every day you will come across patients who have experienced fertility challenges.[1,2] Even though it is faced by so many, there is still debate amongst health authorities and governing bodies as to the actual definition of infertility and its application. There are many different reasons for fertility challenges and not all descriptors are appropriate for all individuals or couples (see figure 1).[3]

The World Health Organization describes infertility as "a disease of the male or female reproductive system".[5] Other professional health organisations refer to infertility as a 'medical term', 'condition', 'disorder', or a 'problem'.[3,4,6-8] In 2023, The American Society for Reproductive Medicine's committee described infertility as a disease, condition, or status (see figure 2).[9]

Along similar lines an article by Maung describe infertility sub-types as having different terminology and debated the use of the word 'disease'.[7] It begs the question, if there is so much confusion from professional bodies and researchers as to how to refer to infertility, how do we know whether we, as health professionals, are getting it right?

The medical world regularly uses terms such as 'infertility' or 'infertile', however a study currently investigating fertility care has highlighted the negative impacts of this terminology. Health professionals have discussed that the use of the term 'infertility' or 'infertile' or 'infertility diagnoses' can provoke feelings of insufficiency, failure and hopelessness and emphasised that how we use terminology in fertility care needs to be considered carefully.

Health professionals working in fertility care explained that terminology that was more appropriate and considerate of patients was the use of 'fertility journey', 'people experiencing fertility challenges', and the use of 'fertility care' rather than infertility treatment.

As a nurse or midwife, it is desired to use language that makes patients feel safe and cared for and this research has identified the need to rethink how we use the term 'infertility' in practice. Irrespective of the cause, or the classification being a disease, condition or problem, being empathetic to the sensitive nature of infertility and the impact it can have on a person's life and future is important. When caring for patients, their partners, and families, the language we use plays a crucial role in effective communication. Thoughtful terminology demonstrates respect for their journey, strengthens rapport, and helps minimise emotional distress. These considerations can significantly impact the patient experience.

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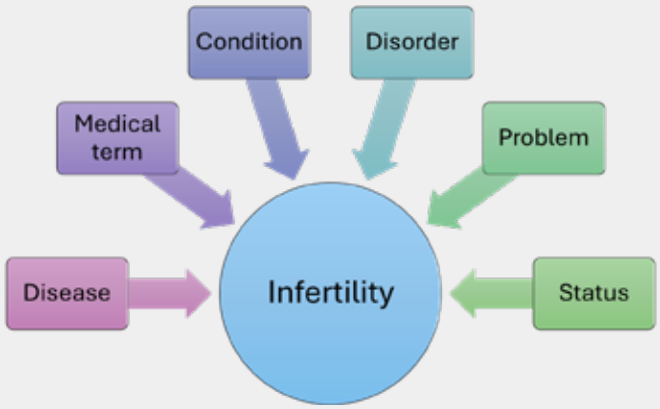
FIGURE 1 – Factors associated with fertility challenges.[4]

FIGURE 2 – Terms used to describe infertility.



Welcome to Healthy Eating

Each issue we will be featuring a recipe from Maggie Beer's Foundation, which ensures research, education and training will lead to better outcomes and the delivery of nutritious and flavoursome meals to our ageing population in nursing homes. Maggie's vision is not only to improve nutrition and wellbeing for the aged, but also for all who enjoy good wholesome food.

Leek, mushroom and tarragon bread pudding

Prep time 25 mins **Cook time** 45 mins **Portions** 8–10 serves

INGREDIENTS

200g whole grain bread crusts cut into 2 cm cubes

2 tbsp olive oil

1 tbsp unsalted butter

50g good quality bacon, finely diced

250g leeks, sliced thinly (white part only)

3 tbsp olive oil

500g flat mushrooms, sliced thinly

1 tbsp sherry

125ml stock, chicken or vegetable

200g light whipping cream

100g light sour cream

2 eggs

¼ tsp fresh nutmeg

1 tbsp fresh tarragon finely chopped

Sea salt flakes and pepper

80g grated cheese; mozzarella or similar

METHOD

1. Preheat a fan-forced oven to 180°c.
2. Place the cubes of bread on a baking tray and bake for 10–15 minutes or until dry, set aside.
3. Grease a 35 x 25 cm baking tray or similar.
4. Place the oil and butter in a large pan over medium heat. Add the bacon, cook for 2 minutes, before adding the thinly sliced leek and large pinch of salt, cook for 8–10 minutes or until soft.
5. Meanwhile heat a frying pan over high heat, add the mushrooms and sauté until lightly coloured and tender, add to the leek mix.
6. Pour in the sherry, allow to evaporate, then add the stock and simmer until reduced to a quarter. Season the mix with salt and pepper.
7. In a large bowl whisk the creams, eggs, nutmeg and tarragon, add the bread and then the leek mix. Pour into the prepared baking tray and top with grated cheese.
8. Bake for 35–50 minutes or until golden, moist and cooked through (remember it will continue to cook as it cools).

Food styling + photo by Erika Budiman © pixelsandpaper.studio

We invite you to try and make Maggie's recipe.

Send a photo of you and your creation from this issue, and in a sentence, let us know what you liked about It. If we pick your entry, we'll publish it in the next *ANMJ* and reward you with a $50 Maggie Beer voucher. Send your entry to: **healthyeating@anmf.org.au**

Nicely done, Lesley, on making Maggie's house braised beans, published last issue. We hope you enjoy your $50 Maggie Beer voucher.

"Delicious, nutritious Maggie meal, with beautiful subtle flavours warming up winter for us" says Lesley.

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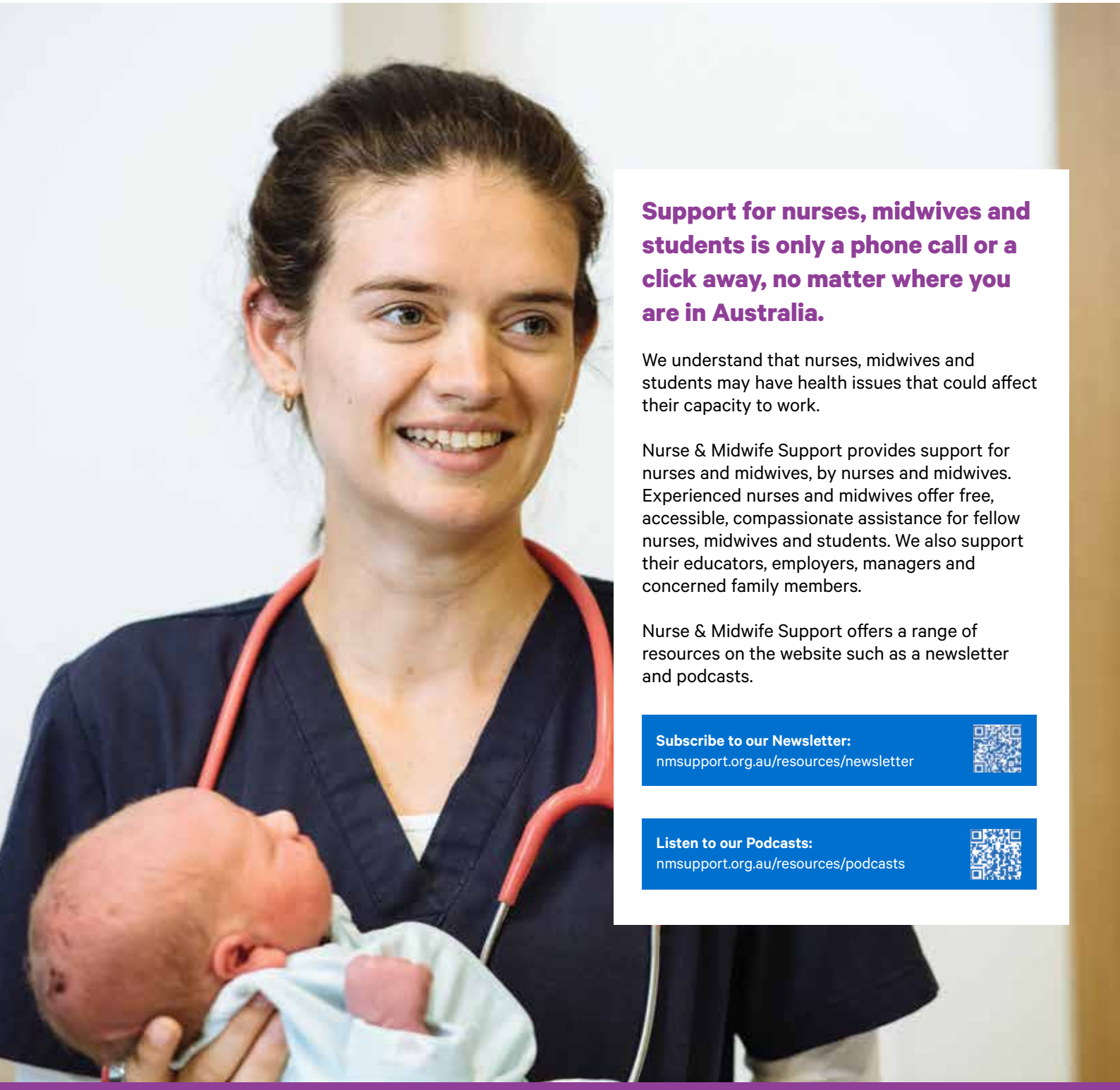

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