NSW Parliamentary Inquiry into Birth Trauma

Questions on notice from Maternity Choices Australia

1. You highlight in your submission that 'informed consent' practices in NSW maternity care are lacking. Can you expand on some of the problems you see in this space?

Qld Centre for Mothers and Babies (now defunded) Report: *Having a Baby in Queensland*, 2010 stated of 3500 respondents that:

- only 48% of women who had a planned c-section were informed and had consented to their procedure, (MCA commentary: not a single informed consent document women sign state the increased risk of sexual dysfunction 5 years post c-section or increased risk of stillbirth for a following pregnancy)
- 70% of women who had epidurals were informed and consented (MCA commentary: this is according to women, however not a single guideline explains the risk of breastfeeding difficulties and consequent increases to maternal and childhood cancers from early cessation) and
- 26% had not been informed or consented to their episiotomies. (Given there is no research on the size of womens erect clitoris in labour, and we know that nerves are being severed, never to regain their function, not a single woman is being given an opportunity for full free and informed consent as almost all clinicians we have asked have not been aware of these facts around reduced sexual function. So we want to highlight the difference between affirmative consent 74% and informed consent 0% with this example)

What MCA is trying to demonstrate is if we included this commentary and other research (which wouldn't pass ethics as it would be considered a leading question), would the study results for interventions with enthusiastic affirmative, full, free and informed consent be closer to 0%?

Many studies verify the issues with informed consent in our maternity care system:

Maternity care providers' perceptions of women's autonomy and the law, (Kruske, et al, 2013) showed professionals inconsistently supported autonomous decision making in pregnancy and birth.

The impact of a perineal care bundle on women's birth experience in Queensland (Barnett, 2023) found that the co-called Perineal Protection Bundle© had a largely foreseeable impact on women's autonomy and human rights, yet was nonetheless implemented by the Australian Commission for Safety and Quality in Health Care (ACSQHC) in spite of

consumer (and academic) outrage. The Chief Midwifery Officer of the ACSQHC refused to review the policy earlier without a ministerial directive to review and remove any elements lacking evidence or compatibility with human rights. This is just one example of how ‘independent’ agencies take directives from government. It should be obvious all health policies should have greater preventative attention prior to implementation, yet the Perineal “Care” Bundle was rolled out swiftly to **27** hospitals in 2017 and ACSQHC sent a directive for their severe perineal trauma clinical care standards to jurisdictions who sent out directives to their hospitals.

Consent during labour and birth as observed by midwifery students: A mixed methods study, (Lee, et al, 2023), has revealed that consent during labour and birth is invalidated by a lack of disclosure of risks and alternatives. The authors state that health and education institutions should include information in guidelines; theoretical and practice training with human women (NOT AI, as poor evidence in = not fit for purpose algorithm) on minimum consent standards for specific procedures.

A pre-post implementation study of a care bundle to reduce perineal trauma in unassisted births conducted by midwives, (Lee, et al, 2023); most bundle components have limited or conflicting evidence for improved outcomes, and some potentially harmful. Why and how the bundle was introduced at scale without a research framework to test efficacy and safety is a key concern.

We've been told about hospital responses such as “a woman assumed a position of consent, for being bent over the bed”, “implied consent, for being naked and on the bed”, or of clinicians commentating as they are performing the procedure, none of which amount to informed consent. Similarly the common practice of “consenting a woman”, ie a clinician asking if they can do a procedure is not informed consent. All procedures have risks, and only the mother is able to assess and weigh up the risks, benefits, alternatives, or simply waiting. Unless a woman is unconscious, even if she is in the grip of labour, she is capable of understanding what is being said to her, and she will be capable of responding if clinicians attending her simply wait a minute or so for her response in between contractions.

Right now, like the Queensland example above, NSW maternity clinicians have a poor understanding of the law (i.e., the baby is not a legal entity until born alive), and/or they do know, but are so fearful of overreaching and unscritinised agencies such as AHPRA and the Coroner. By comparison, clinicians also do not have little concern of breaching the *Anti-Discrimination Act* (NSW) and ACSQH's Standard 2: Partnering with Consumers as pursuing actions is so difficult for individual women to navigate these complex and narrow systems. This legislation and health policy is also not designed to protect an individual's bodily autonomy, especially not in a wellness model like maternity.

2. What do you think needs to change from NSW Health to ensure women are empowered during birth and able to give genuine informed consent?

Each LHD must have one or more maternity hospitals (level 2-6), a stand alone birth centre (level 2), and publicly funded homebirth. A business case must be made for any LHD's who cannot adhere to these basic requirements must be made public and include alternative local options at no cost to the women, such as NSW Health paying for private midwifery care ($7000, less medicare) or a hotel room as a pop up birth centre ($250), up to the average care cost across the continuum ($25,000) to ensure they are meeting their consumer engagement, human rights, anti-discrimination, etc obligations.

Women must be able to self-refer to the hospital/model of care of their choice, and include a tick box to auto generate a complaint if there is no access to what place of birth or model of care she is seeking.

Women must be able to access the most evidence based and cheapest model of care and be provided with an image at booking such as the Queensland MGP infographic (see attachment), if women are unable to access through the local public hospital, or as above having private care paid for, the LHD's service agreement should state that the LHD must report their lack of service to the HCCC for failure to provide a safe service, with their business case for not supplying it and CC the woman in the communications.

HCCC legislation must be widened to physical AND emotional safety specifying access to model of care/place of birth and procedural; informed consent with no physical harm must also be specified e.g., for anal exam.

The HCCC should no longer refuse to investigate complaints on the grounds of being “in line with procedure or medically necessary” as we know that the guidelines staff are following are mostly inconsistent with evidence.

Sexual consent laws must be revised to remove the phrase “proper medical procedure”. Hospitals and HCCC must investigate complaints and should not use phrases like “women's expectations not met” or “communication deficit” when responding to traumatised mothers.

The Health Minister must set a directive for consumer-led informed consent training to be mandatory, i.e., via Maternity Consumer Network’s Better Births with Informed Consent training programme.

Public health promotion is required for informing the public about human rights in childbirth, as well as how to decline recommended (but not necessarily evidence based) maternity care. The more bodily autonomy a woman has the better her outcomes. (See response to Question 8 for more discussion on this point.) Unless a woman an enthusiastic “yes”, it's a “no”.

Informed consent needs to be treated as an advanced health directive and Birth Mapping (as developed by Catherine Bell, PhD candidate) as legal documents needs to be offered to 100% of women.

3. In your submission, you highlight serious concerns about so-called ‘routine obstetric procedures’, such as use of forceps, inductions, episiotomies, c-sections, and their relationship to increase rates of birth trauma. Can you provide some more detail about your concerns, and outline what recommendations we should be making as a committee to avoid birth trauma caused by these ‘routine interventions’?

Bundled Funding is required to stop incentivising OVERUSE of harmful interventions but to also give women more autonomy. This kind of funding structure (rather than Activity Based Funding) will incentivise hospitals to offer more options than fragmented care and hospital based care, both of which are accessible compared to continuity of midwifery carer and out of hospital birth, which is very difficult to access. If hospitals are too far away, women can use their allocated funding (NDIS Style: choice and control) to a private provider and pay any gap herself. With time public hospitals will slowly become women centred and offer birth centres, publicly funded homebirth and will reinstate the many level 2 hospitals in regional, rural and remote areas that have been closed in the past 25 years, but also in metro areas.

Until Bundled Funding is introduced, women must be informed of approximately how much the hospital is making from each intervention i.e. $750 on average per episiotomy.

Women must be informed of data available from the Australian Institute of Health and Welfare, showing the variance in hospital outcomes, but also in the model of care outcomes. This will enable them to make informed decisions to reduce unwarranted interventions and maternal trauma.

All clinicians need training in informed decision making and human rights in childbirth, as mentioned in the previous question. Women might give affirmative consent in the moment to have a syntocinon injection for the estimated 99-95% of cases, but they are not being told it increases PND by 36%. This means they are not giving informed consent and is therefore in breach of their rights. And most women are mostly unaware they even have rights. For those who are and are in a privileged position to make a complaint, they are beat down by the process during every step and gaslit to believe it was their ‘expectation’ that caused the trauma. When they are just trying to have their rights upheld for next time through systemic reform and for other women.

NSW Health must start tracking women’s expectations for their births and their outcomes and publicly report on this data. (More discussion on this in the BHI Survey report section, below.) Currently NSW Health keeps no data on the number of women who experience

intervention-free physiological birth, but estimates are at around only 2%, most of which takes place under the care of a private midwife.

The purpose of the Perineal Protection Bundle and clinical care standards was to reduce 3/4th degree tears after a damning report by the ACSQH on unwarranted variances[1]. However most elements of the bundle lacked evidence, most women don't have consent, some don't have affirmative consent and the guidelines are written in a way to incentivise and reduce risk of $4000 fine and risk of litigation, as only a few areas are covered by medical negligence laws. A further deficit of the bundle is that the model of care is self reported, and data analysts tell us not many staff update models of care when they change (not that there should be any changing or risking women out). (The NSW perinatal dataset must start recording outcomes per model of care so women can see risk of intervention per model.)

It should be mandatory that each woman be sent her hospital records by 6 weeks so she can find out the procedures done to her. Too many women are unaware of everything that happens during their births. Many women report to us how difficult it is to obtain their records; this must be streamlined.

4. Do we need a review of hospital policies and procedures to ensure these interventions are only done when necessary, and with full informed consent – rather than as a 'standard'? If so, please explain why?

We completely agree that a review of federal/state/hospital guidelines be reviewed for compatibility with evidence, human rights, discrimination and ACSQHC's Standard 2.

The need to respect women's rights to informed consent is discussed in detail in Question 8, below.

5. We've received evidence that skin-to-skin contact is very important in the first hours after birth - can you explain why, and also what in the current maternity system is preventing women from having skin-to-skin contact immediately after birth?

The myriad benefits of skin to skin contact immediately after birth and for the first hours has been studied extensively around the world and is integrated into international policies such as the UNICEF Baby Friendly Initiative that is recommended for all hospitals to adopt.

In brief, the benefits are that it:

[1] Australian Commission on Safety and Quality in Health Care and Australian Institute of Health and Welfare. The second Australian atlas of healthcare variation. Sydney: ACSQHC; 2017

- calms and relaxes both mother and baby (and reduces the risk of postpartum haemorrhage)
- regulates the baby's heart rate and breathing, helping them to better adapt to life outside the womb
- stimulates digestion and an interest in feeding
- regulates temperature
- enables colonisation of the baby's skin with the mother's friendly bacteria, thus providing protection against infection
- stimulates the release of hormones to support breastfeeding and mothering

This research has been recognised widely for more than a decade and reading through this list it's hard to believe that any maternity care system would get in the way of immediate skin to skin being the standard of care. Yet it plays second fiddle to the routine weighing, measuring and wrapping of babies. Those that are believed to need resuscitation have their umbilical cords cut and are separated from the mother to be placed on a resuscitation table over the other side of the room or sometimes elsewhere in the hospital, whereas most common resuscitation techniques can be carried out on the mother's chest, while the baby receives all the benefits of skin-to-skin contact.

Many interventions increase the perceived need to separate babies from their mothers for resuscitation, such as epidural and syntocinon as they can affect the responsiveness of babies. This leads to more routine separation.

As the last Mothers and Babies Report showed, the c section rate is now at 38% and 23% of those babies require care in Neonatal Intensive Care Unit (NICU) or Special Care Nursery (SCN), leading to more separation. NICU/SCNs are not family centred in design, meaning babies are kept separate to their mothers in incubators. Women who have had c sections and whose babies are in NICU/SCN are not roomed together, in fact are in separate wards sometimes on completely different floors to each other. Further, postnatal wards do not routinely support these women who have just had major abdominal surgery to visit their babies, let alone have skin to skin time with them. Ambulances and air transport does not routinely support keep mothers and babies together even though these dyads are most in need of this simple 'intervention'.

Contrary to standard hospital design here, St Joseph's Hospital in Berlin is an exemplary example of what is possible for NICU care. There, mother/baby dyads are roomed in together with the baby spending maximum time on their mother (or partner's) bare chest. Even the tiniest, most fragile babies are given this opportunity and they have found that their babies can go home much sooner, more are exclusively breastfed on discharge. We encourage you to watch the documentary "The Milky Way" 2014, www.milkywaymovie.com. Sweden also provides family centred NICU so the micro premmie babies go home at 33-35 weeks and millions in expenditure is saved, while the risks of infections and complications are decreased.

NSW Health's Hospital Design Guidelines need updating for labour, birth, postpartum, particularly NICU/SCN to reflect what the evidence shows is needed to optimise and protect these processes and post birth recovery. We have sat on numerous committees for hospital

redesigns and have asked for evidence based spaces, but the design guidelines (and lack of understanding by participating clinicians) inhibits the design of evidence based spaces.[2]

Supplementary questions: Ms Sally Cusack, National Secretary, Maternity Choices Australia

6. Regarding the term “birth trauma”:
a. what is Maternity Choices Australia's preferred definition of the term?
b. why is this the preferred definition?

Birth trauma is defined subjectively by the woman who experiences it. The trauma can be physical or psychological. It can be intrapersonal or systemic i.e., due to policy.

7. Regarding the term “obstetric violence”:
a. what is Maternity Choices Australia preferred definition of the term?
b. why is this the preferred definition?

MCA agrees with the World Health Organisation’s definition of “obstetric violence” as meaning:

> “outright physical abuse, profound humiliation and verbal abuse, coercive or unconsented medical procedures (including sterilization), lack of confidentiality, failure to get fully informed consent, refusal to give pain medication, gross violations of privacy, refusal of admission to health facilities, neglecting women during childbirth to suffer life-threatening, avoidable complications”

This definition is accepted internationally.

8. Can you explain why “informed consent” is necessary for women with respect to decisions for their pregnancy?

Women have the same rights to bodily autonomy as any other person, as acknowledged by the Universal Declaration of Human Rights, 1948. Women also hold the human right of the

[2] Foureur, et al, *The relationship between birth unit design and safe, satisfying birth: developing a hypothetical model*, Midwifery, 2010

highest attainable standard of health[3]. Failures to not recognise a woman's right to informed consent have been ruled as violations of women's fundamental human rights in international case law and instruments.[4]

The Convention (women and health), the Committee on the Elimination of Discrimination Against Women stated:

"Acceptable services are those that are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives." (para 22)

Intertwined with women's rights to informed consent is the so-called and long-established "Born Alive Rule", which states that a foetus is not a fully recognised separate human being with their own separate human rights until they are born alive. This allows for a woman's individual rights to bodily autonomy, highest attainable standard of her own health and informed consent are recognised in law, regardless of the opinion a clinician may have about her decisions.

The Born Alive Rule also prevents a woman from being forcibly restrained and subjected to procedures against her will, which has been clearly articulated in cases where this has in fact occurred, such as in the case of *I.V. v Bolivia* (2016) where a woman was sterilised against her will[5]. This ruling also protects women who are seeking care but are denied it because the placed priority on foetal health over maternal health, as in the case in 2012 of Savita Halappanavar in Ireland who was denied an abortion after her waters had broken at 17 weeks' gestation. Halappanavar's body did not expel the foetus and as a heartbeat was still present the hospital would not perform an abortion, causing her to develop septicaemia and die within one week. After a nationwide outcry, this led to a change in the law in 2018.

However, it is also important to remember that mothers are generally not known for putting themselves first. Once a woman decides to proceed with a pregnancy, she is the only one in any conversation about procedures in pregnancy, who is literally risking her current and future health prospects in order for the safe arrival and ongoing nurturance of the baby.

Aside from the need to recognise women's human rights, international research into safety and quality in health care has found that all health procedures result in better outcomes when health consumers are actively involved in the decisions for their care. This means we are more likely to experience adverse medical events if we simply do what the doctor says. OECD policy *The Economics of Patient Safety* (2017) clearly points out the financial benefits of preventing iatrogenic harms by involving health consumers in decisions regarding their healthcare. The Preventing Overdiagnosis International Conference is held each year to

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[3] Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, UN Doc. E/C.12/2000/4 (2000), para. 8

[4] Further reading on rights to informed consent in maternity care: http://humanrightsinchildbirth.org/index.php/2021/02/17/shared-decision-making-in-maternity-care/

[5] Many other cases are cited here: Paltrow, Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973–2005: Implications for Women's Legal Status and Public Health*, J Health Polit Policy Law (2013) 38 (2): 299−343

raise awareness of the impacts of unquestioned implementation of medical procedures and tests.

In Australia this research has led to the Choosing Wisely campaign for “reducing unnecessary tests, treatments and procedures” and the establishment of the *National Safety and Quality in Healthcare Standards* in 2010 (which include Standard 2: Partnering with Consumers).

Additional questions taken on notice

These questions were taken on notice, as per the transcript, but were not included in the supplementary questions document sent to MCA.

What are the shortcomings that you see of the BHI’s Maternity Care Survey?

As stated by Sally Cusack in the transcript at the end of our evidence, we have also provided below further information about our opinion of the data obtained by the BHI about women’s birth experiences in the maternity care system.

The Maternity Care Survey by the Bureau of Hospital Information (BHI) is carried out every two years. In the last survey reported on, 2019, almost 4,500 women of the total 94,000 women completed the survey. This amounts to a total of 4.7% of all women who gave birth in NSW in 2019. The surveys are mailed out to women in the early weeks after birth and each survey is marked with a unique identifier.

The survey is comprised of 98 questions, all of which are multiple choice except for the final two questions that ask “What was the best part of the care you received from the hospital where you gave birth?”, followed by “What most needs improving about the care you received from the hospital where you gave birth?”

Virtually no emphasis on ascertaining levels of informed decision making

In the Antenatal Care section, most of the questions are about checking that their attending clinicians practised according to clinical guidelines, e.g., “Did the health professionals give you advice about the risks of exposure to tobacco smoke while pregnant?” or whether staffing levels were sufficient, e.g., “How much time did you usually spend waiting to be seen?”.

Unfortunately there was very little focus in the survey on actions taken by the service to ensure informed decision making took place during any part of the perinatal period. Three questions that came the closest to this were: “Did the health professionals providing your antenatal care explain things in a way you could understand?”, “Did the health professionals discuss your worries and fears with you?” and “Did the health professionals discuss with you what was important to you in managing your antenatal care and birth?”

While these questions are important for understanding that staff are meeting their most basic obligations, these do not enquire explicitly about whether informed decision making was facilitated for women by the staff. Important questions are missing from the BHI, such as "Did any health professionals explain to you what informed decision making is?" and "Did any health professionals explain that continuity of midwifery-led care results in the best outcomes for mothers and babies and why?" While women remain in the dark about their rights and the safest options for the perinatal period, they don't know what is missing from their care..

In an effort to allow women to share their experiences of maternity care, MCA has developed Best Birth Finder (www.bestbirthfinder.org.au). As we understand the importance of informed decision making for optimising outcomes, we asked the simple question "Did you feel you could say "No" at any time to treatments/care offered (or change your mind about your choices) at any time? As we have only just launched BBF, our dataset is still small (n 90), but 33% of respondents have replied "No" and 23% did not answer. Of those who replied "No", when asked "How might the service be improved?" almost all chose the option of "Training for staff in informed decision making and human rights in maternity care".

The only opportunity provided by the BHI survey to ask how the maternity service could be improved is a free text box at the end of the 98 question survey. Most women using maternity services are inexperienced with being inpatients, so don't know their human rights or the obligations of health services to uphold them, let alone involve them in the design of their care. For this reason, BBF offers suggestions to the question "How might the service be improved?" to get women thinking about what should have been available to them. BBF also offers a free text field so women can make other suggestions for improving the health service.

No focus on understanding women's plans

The antenatal section of the BHI survey also does not ask what the women were hoping for their births, nor does it ask what kind of birth preparation they were given by midwives, e.g., pain management strategies. While birth cannot always go to plan, the survey indicates there is no priority placed at the policy level (the efforts of individual clinicians aside) on informing women of their choices and their human rights, or on helping women achieve their goals.

Conversely BBF asks what choices women sought for their births in pregnancy, as well as their outcomes. When combined with lack of informed decision making in care, disparity between goals and outcomes can lead to birth trauma. It is well documented from studies conducted here and overseas that most women want an intervention-free vaginal birth[6] and that those who experience interventions, operative births or c sections are more likely to experience trauma. The fact that the BHI and NSW Health do not capture women's plans for their births and their outcomes and study the disparities is arguably in breach of their duty to

[6] *Stemming the global caesarean epidemic (2018) Lancet, Vol 392, Issue 101055,*
Downe, S., et al, (2018) What matters to women during childbirth: A systematic qualitative review, PLOS ONE, Public Library of Science

the mothers and babies of NSW in achieving their human rights to the "highest attainable standard of health"[7]. This lack of interest in women's goals is, however, in keeping with clinicians' unfortunate and widespread dismissal of women's birth plans[8].

Very little focus on understanding women's outcomes

As for reporting outcomes, the BHI survey captures very little data in this regard. There may be the assumption that this is all captured by the hospital, but hospital stays are so short that lots of complications can arise in the days and weeks after birth that are lost to any future analysis. One of the few questions regarding outcomes was "Was your labour induced?". Interestingly, the responses to this question have not been included in the 2019 Supplementary Data Tables.

The 2017 survey did include a question on Complications: "During your hospital stay or soon afterwards, did you experience any of the following complications or problems? Please tick all boxes that apply to you:

- An infection
- Excessive bleeding/haemorrhage Perineal/vaginal tear
- Complications as a result of an operation or surgical procedure
- A negative reaction to medication
- A bed sore or pressure wound
- A blood clot in the leg/DVT
- Any other complication or problem "

Ten percent of women indicated they had experienced one or more of these complications and 18% of those women described their complication as "very serious". It is also interesting to note that the Complications section of the survey was omitted in the 2019 survey.

Women are surveyed before they are equipped to express their experience

The final, and perhaps most important points to note regarding the BHI survey are that it is issued to women in the early weeks after birth when for many women they are simply relieved to have survived the ordeal. This comment can be made with confidence given the research into the levels of tocophobia (extreme fear of birth) among women and the general social anxiety surrounding birth.

As experiences go, giving birth is uniquely powerful and transformative. And as extensive research shows, women's brains undergo a huge transformation during the perinatal period,

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[7] Committee on Economic, Social and Cultural Rights, General Comment No. 14, *The Right to the Highest Attainable Standard of Health*, UN Doc. E/C.12/2000/4 (2000), para. 8

[8] Keedle H, Peters L, Schmied V, et al. *Women's experiences of planning a vaginal birth after caesarean in different models of maternity care in Australia*. BMC Pregnancy Childbirth 2020;20:381.
Batsis JA, Boateng GG, Seo LM, et al. *Development and usability assessment of a connected resistance exercise band application for strength-monitoring*. World Acad Sci Eng Technol 2019;13:340–8.

which can delay a woman's ability to interpret and understand everything that happened to her. Their inexperience with the policies, procedures, having their genitals on display, being physically examined and handled along with the explosive hormonal releases is highly disruptive and takes months, sometimes even years to integrate. This is complicated by the fact that most women don't receive their notes unless they know to ask for them, which they often need to fully understand everything that happened to them. This is all compounded by the high levels of exhaustion new mothers are going through with the 24/7 care of their newborns. All of these factors can make the further step of being able to express their experience in writing even more challenging.

In her evidence, Amy Dawes from the Australiasian Birth Trauma Association (ABTA) admitted it took her 16 months to realise that she had experienced trauma in her birth. So presenting women with a survey that has the primary focus of ensuring that health services are meeting their most basic of obligations (with no questions about expectations, outcomes, whether informed decision making was facilitated) when they are still finding the words to express their experience will yield only limited results.

> "We want to see birth outcome measurements well beyond the standardised six-week check, checking in with women at three months—perhaps up to a year postpartum—to really see how they feel about their outcomes. And I think that's possibly what we're seeing. Many people simply don't identify as having trauma; I personally didn't until I was 16 months postpartum." Transcript from Sydney Hearing, 4 September 2023.

Without detailed research that follows women up for much longer than just the newborn period, the complications women experience from their births continues to slip away unnoticed and unaccounted for by NSW Health. The Australian Birth Experience Study (BESt), 2021, developed by Hazel Keedle, PhD and Hannah Dahlen, PhD, is an important step in addressing this problem.

From the trauma documented in the BESt, as well as the evidence given at this Inquiry, we are also left wondering what percentage of traumatised women were capable of completing the BHI survey. Recalling trauma is very taxing, especially for women in the perinatal period, so it is possible many traumatised women cannot face completing the survey with everything else going on for them at this time, and of course this can skew results.

In fact, the 94% of women quoted in the NSW Health submission that rated their care during labour and birth as "very good" or "good" and the 90% who felt they were 'always' treated with respect and dignity during labour and birth, could be seen as evidence of traumatised women not completing the survey. These results are also strangely at odds with the findings of the BESt and others like it that continue to find birth trauma rates at approximately 30%[9], which is perhaps further evidence that traumatised women are not completing the survey.

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[9] Between 9-50%: *Developing a woman-centered, inclusive definition of traumatic childbirth experiences: A discussion paper*, Leinweber, et al, Birth, 2022

For this reason, we believe that BHI would need to conduct follow-up with women at least 18 months postpartum, and even again 5 years postpartum in order for NSW Health to gain a true picture of women's and babies' outcomes after using their maternity services. This view is supported by the findings of the BESt, in which the largest group of women surveyed were 1-2 years postpartum and 85% of women stated they would make different choices if they had another baby, including advocating better for themselves (the "Next time I'll be ready" group), the type of birth, and model of care. Only 10% of women said they would not make any changes to their care if they had another baby.

Another important finding of the BESt was that among the Next time I'll be ready group, these women appeared to blame themselves for system failures, which added to their trauma. This theme has been found in previous birth trauma studies, as well as other studies into traumatic assaults on women.[10] It is reasonable to speculate that this response could cause some women to withhold a more descriptive expression of their experiences if surveyed too soon after birth, and gives further weight to the need to follow up early surveys.

Culture of reporting in the health system

It is important to acknowledge the reality that BHI staff and board members are embedded within the culture of NSW Health. While BHI is an independent statutory body, it is funded by Health and this is reflected in the culture of reporting only on positive findings, rather than enquiring into the negative. This is reflected in the NSW Health submission where only high levels of positive findings are quoted.[11]

We also note that while Inquiry member, Mr Donnelly MLC, asked MCA, Dr Keedle, Dr Dahlen, the NSW Nurses and Midwives Association, the Australian College of Midwives and women from Day 2 of the hearings in Wollongong how they can reconcile the positive findings of the BHI study with their understanding of the levels of birth trauma experienced by women, he did not ask NSW Health how they can reconcile the findings of birth trauma research that show very different levels of satisfaction with services provided by the maternity care system.

We also note that the BESt was criticised in the transcript for recruiting respondents through social media, even though a common method of recruiting respondents for surveys prior to the advent of social media was through the press. Social media is now the usual method for advertising a survey and was also used by ABTA for their Birth Injuries survey of 2022, yet this, nor their lack of process regarding academic ethics, was not highlighted.

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[10] *What women want if they were to have another baby: the Australian Birth Experience Study (BESt) cross-sectional national survey*, Keedle, et al, BMJ Open, 2023

[11] *Inquiry into Birth Trauma*, NSW Health, 23 August 2023, p11

Reports from women to MCA of coercion that occurs in the 36 week appointment

Women's perceptions of influence of obstetric interference in midwifery practice as being negative (especially in the late stages of pregnancy) is well documented, such as this recent academic paper cited in comments below: *Getting kicked off the program: Women's experiences of antenatal exclusion from publicly-funded homebirth in Australia*, Coddington, et al, Women and Birth, 2023. The women surveyed in this study were:

> "anxious about 'Jumping through hoops' to maintain their low-risk status. After being 'Kicked off the program', women carefully 'negotiated the system' in order to get the birth they wanted in hospital. Some women felt bullied and coerced into complying with hospital protocols that did not account for their individual needs. Maintaining the midwife-woman relationship was a protective factor, decreasing negative experiences."

Other similar research includes:

- Jenkinson, et al, *Women's, midwives' and obstetricians' experiences of a structured process to document refusal of recommended maternity care*, Women and Birth, 2016 and
- Jenkinson, et al, *The experiences of women, midwives and obstetricians when women decline recommended maternity care: A feminist thematic analysis*, Women and Birth, 2017

A 2016 review[12] of how midwives' and obstetricians' perceptions of risk impact their care for low-risk women in labour found that obstetricians tend to assume abnormality in the birthing process leading to unnecessary intervention and surveillance. From other research that demonstrates clinicians increase their assessment of risk when they don't know women in the care, the 36 week standard obstetric appointment (in which women meet the obstetrician for the first time) is further fertile ground for interventions being recommended and women feeling coerced.

[12] *Midwives' and obstetricians' perceptions of risk and its impact on clinical practice and decision-making in labour: An integrative review*

The many types of obstetric violence that have been studied are described in this infographic by Maternity Consumer Network.

At MCA we frequently hear from women who have experienced late stage obstetric interference in their midwifery care. For the most recent stories we have heard from women, see screenshots of responses to our Facebook post on 5 September 2023: https://www.facebook.com/profile/100064429762020/search/?q=36%20week

“Coercion in Obstetric review appts.

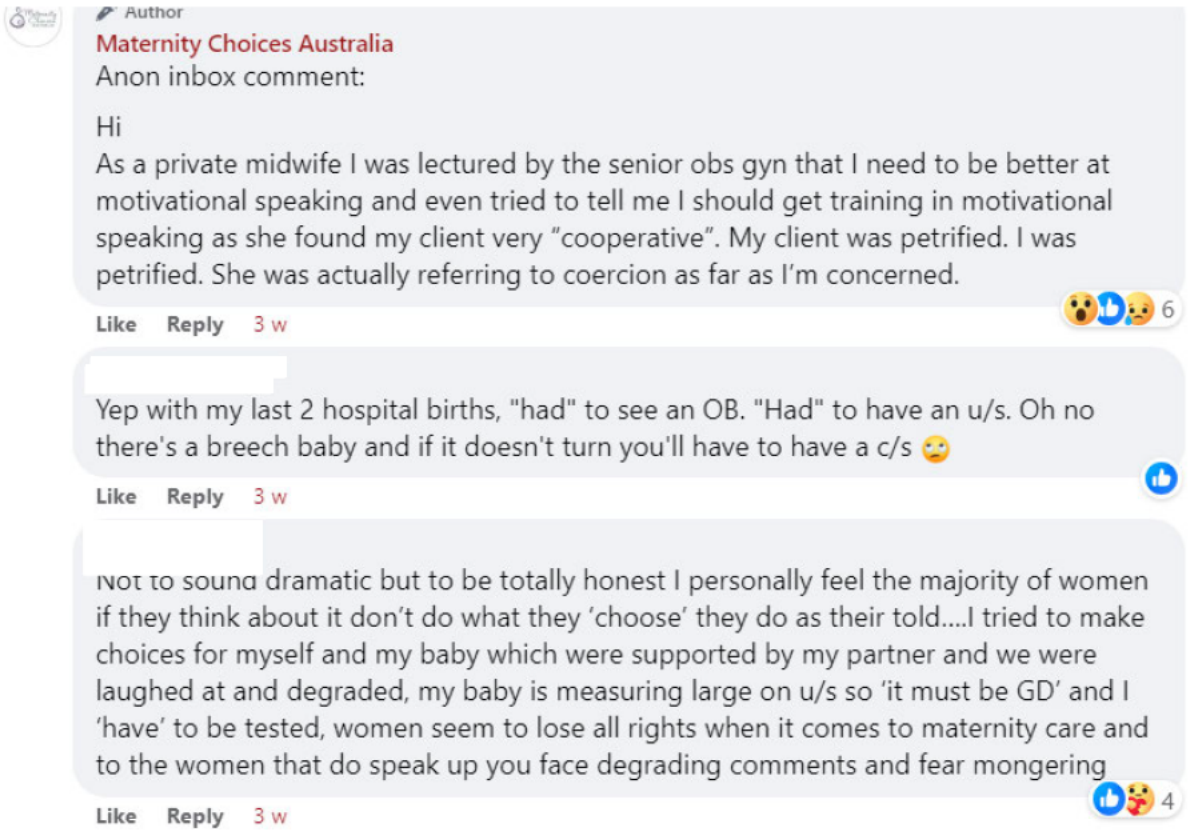
Please comment if you felt coerced into seeing an obgyn around 36 weeks (or if your in PFHB/BC model and the review to access this model was done earlier)?

Would you have been happier to have the appt with just your midwife or allocated midwife?

Were you told some hospital guidelines state that 36 week reviews can be done with a senior midwife and would you have preferred this to be offered?

Did you feel coerced into certain tests like GTT/GBS swap/weighing yourself/blood tests/scans/vaginal exams in order to continue to access waterbirth/BC/PFHB/MGP etc.

Pls don’t comment on anyone else’s comment, we are just after comments about women feeling coerced or groomed at any point antenatally based on hospital policy.”



This happened to me with my last baby, they tried coercing me into IOL, it destroyed and drained the joy and happiness out of my last four weeks of pregnancy, the last four weeks that I'd ever be pregnant again in my life! I was also in an MGP model - I may as well not have been! For reference, I am also a midwife - so it happens to people who work and know the system as well, O+G holds no boundaries 😐 the system is broken 😔

Like Reply 3 w

3

so sorry to hear this and of the impact it had on the weeks preceding birth. It's not ok. Have you been able to relay some/all of this to the service where you have birth?

Like Reply 2 w

Top fan

My beef as a midwife is that I have to offer lots of "programs" and information to wonen. Like GHiP. I detest it! Lots of wonen feel it is weight-shaming, and I would probably feel that way too. If we don't do enough referrals, we are reprimanded for not meeting the KPI.

And I'm currently being performance managed for "not following the medical model of care." Women where I work have NO choice at all.

5

Like Reply 3 w

I would argue that this info graph is not actually accurate.
Despite the clinical picture & research evidence ultimately it's a woman's choice, even if her choice is not supported by research or even if her clinical picture says this may not be a favourable outcome.
It's the woman's decision, so ultimately the sweet spot is with the woman and the decision she makes despite how uncomfortable that may make others feel.

Like Reply 3 w

4

100% agree. Quite an odd graphic. The sweet spot is what the woman wants!

Like Reply 3 w

2

I saw a public obstetrician for breech baby. Was coerced into an Xray of my pelvis (and baby) to access vaginal breech birth. Was told if I came to hospital with breech in labour, I would be cut (episiotomy), and have a forceps routinely, even if everything was progressing normally. The other option was CS. So I drove 1000kms to birth in Sydney to access respectful and evidenced based obstetric care.

Like Reply 3 w Edited

5

Top fan

Was told that I had to see the obgyn at 37 weeks to 'approve' my birth plan. Wasn't allowed to book an appointment with my midwife.

Like Reply 3 w

2

Yep sure did! I was told I wouldn't qualify for the home birth program if I didn't follow the rules and agree to all the testing requirements and the rule of the OB

Like Reply 3 w

i think this graphic should simply say 'what the women wants'

5

Like Reply 3 w

Amy Vesper I reckon what a woman wants will change, based on the information available to her about the clinical picture and available research evidence. Information is an essential part of consent.

3

Like Reply 3 w

Yep. Despite vomiting my entire pregnancy, and being extremely low risk for GDM, I was forced to do a GTT in order to be "allowed" to remain in the homebirth program. It was a horrible experience that was completely unnecessary and made me feel powerless. I know it's not a "big deal" in the scheme of things, but the problem is being forced/coerced into doing something I didn't want to do, rather than the fact it was "only" a GTT. In retrospect, I regret not taking more of a stand about it. But at the time I felt vulnerable and worried about having my chosen place of birth taken away from me by refusing.

2

Like Reply 3 w Edited

I was offered a stretch and sweep by the OB at a 38 week appointment told I would be offered a stretch again at my next one with her at 40 weeks. It was normalising the idea in my head which is likely a subtle long game coercion tactic. This was MGP.

On a separate note, after looking at my file she said "yep, I'm happy for you to give birth", I looked at her stunned and she corrected herself "I'm happy for you to give birth - at home"

Like Reply 3 w

100% I felt coerced and I'm a midwife!

3

Like Reply 3 w

Author

Maternity Choices Australia

Alexis can you pls clarify what component?

Like Reply 3 w

Was part of 'caseload' (for babies 3 & 4) but expected to be 'signed off' by doctors. Got given grief for refusing to consent to thyroid checked (history of graves disease but had been medication free for years and symptomless and know the condition well). Got given grief for refusing OGTT and GBS swabs.

Even though I had a caseload midwife was forced to consent to a VE to get in the bath. Then when they did the VE it caused a small fresh bleed, so then I was refused the bath! It was only a small bleed and I'm tipping it was caused by the VE!!

3

Like Reply 3 w

https://www.sciencedirect.com/.../pii/S1871519222001093...

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Getting kicked off the program: Women's experiences of antenatal exclusion from publicly-funded homebirth in Australia

2

Like Reply 3 w

I wish i had known i could simply decline OB care as i was automatically booked with ob and scared into a strip and stretch. It brought back all my sexual trauma and caused (most likely caused) PROM. it led to a powrtlessw, scared, doubtful prelabour that ongoing knock on effects. I was told by a man i had never met before if i didn't accept it my baby had double the chance of dying.

7

Like Reply 3 w

BOOM

Like Reply 3 w

ATTACHMENT
Queensland Health *Benefits of Continuity of Midwifery Models* Infographic
https://www.health.qld.gov.au/__data/assets/pdf_file/0034/837916/continuity-of-carer.pdf