NEW SOUTH WALES NURSES AND MIDWIVES' ASSOCIATION
AUSTRALIAN NURSING AND MIDWIFERY FEDERATION NEW SOUTH WALES BRANCH

IN REPLY PLEASE QUOTE:

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4 October 2023

The Honourable Emma Hurst
Chair
Select Committee on Birth Trauma
By email: birthtrauma@parliament.nsw.gov.au

Dear Ms Hurst,

Select Committee on Birth Trauma – post hearing responses

We thank you for the opportunity to provide further information to the Committee. Please see below responses to each of the supplementary questions

1. ***You argue in your submission that "The number of 'places' in midwifery-led care models of care (e.g. Midwifery Group Practice) must be exponentially increased to facilitate widespread access." Can you please explain how widely available Midwifery Group Practice is in NSW, what the benefits are, and some of the challenges women currently face to get a place in one of these practices?***

Midwifery group practice has been proven in the research to being the gold standard of care.

The Australian Institute of Health and Welfare ('AIHW') reported in 2022 that there were 291 different models of care available in NSW, but only 13.1% of those models were made up of midwifery group practice. This by comparison is extremely low compared to 25.7% in Queensland and 22% in South Australia. Due to this, many women continue to face challenges getting accepted.

At present, the AIHW data available only outlines the number of models of care available but does not extend to how many women are engaged in each of those models.

The challenges faced by women start with the limited availability in the numbers of MGP service available and several large hospitals in NSW do not have any MGP or other midwifery led continuity of care model.

While MGP is available in many areas of NSW, there are limited spots, and not all pregnant women can access it due to high demand. Securing a place in an MGP is competitive and booking early in pregnancy is essential for those who wish to participate. Those who do not have a knowledgeable GP, friend or family member who have experienced the model, or those with language barriers often miss out on the early booking step and are therefore unfairly denied access.

In rural and remote areas, access to MGP services may be more challenging due to the geographical barriers due to distance required to travel to a participating hospital. Often MGP services are only available to women with low-risk pregnancies, so high-risk pregnancies or those with certain medical conditions may not be eligible for MGP. These women unfortunately would benefit greatly from MGP as the continuity stops them having to

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repeat their 'story', prevents them missing out on care due to poor communication and often makes them feel more empowered and heard in such a medicalised system.

The benefits for MGP are seen widely in the research and center around benefits for women, midwives, and the health service. MGP provides women with consistent care from a dedicated team of midwives throughout their pregnancy, childbirth, and postpartum period.

This continuity enhances trust and communication. It tailors care plans to meet each woman's unique needs, preferences, and cultural considerations and in doing so fosters a more Individualised approach to care. Women in MGP often report feeling more empowered and engaged in their healthcare decisions. Midwives encourage informed choices and shared decision-making, promoting a sense of control. The research indicates that MGP can lead to lower rates of medical interventions, including cesarean sections, epidurals, episiotomies and improve rates of breastfeeding while maintaining safety standards and the presence of a familiar midwifery team provides emotional support, reducing anxiety and stress during labor and birth.

A recent evaluation of a Victorian midwifery-led continuity of care model found that 98% of women were still breastfeeding at 19 weeks postpartum.[1] This is significant compared with the national percentage of a breastfeeding rate of 66% at 4 months.

Benefits for Midwives include enhanced relationships. Midwives in MGP develop strong, trusting relationships with the women they care for, contributing to professional fulfillment. Being part of a woman's childbirth journey is deeply rewarding for midwives. MGP enables midwives to practice a holistic, woman-centered approach to care, aligning with the core principles of midwifery. Participation in MGP often includes opportunities for ongoing professional development and education, ensuring midwives stay current with best practices and research.

Benefits for the health facility begin with potential cost saving, although this should be seen as a positive outcome rather than the primary motivation for implementing MGP. The model can be cost-effective for healthcare systems in the long term due to potentially lower rates of costly interventions, improved outcomes for mothers and babies and reduced hospital stays which overall reduces the burden on the healthcare system.

Although the implementation of MGP may require initial investments in midwife training and resource allocation for providing continuous care, these costs are outweighed by the savings associated with fewer medical interventions and reduced occupancy.

In our submission to the Committee, the NSWNMA recommended to the Committee that urgent workforce planning must occur and that competitive remuneration for NSW midwives working in caseload models must be addressed. Since this submission, further research has been undertaken regarding the challenges of the MGP workforce which has found that flexible practice agreements, organisational support and appropriate workloads are vital for recruitment, retention and sustainability of MGP.[2]

2. Regarding the term "birth trauma":

a. what is the NSW Nurses and Midwives' Association preferred definition of the term?

[1] https://www.castlemainehealth.org.au/maternity/wp-content/uploads/2023/03/Castlemaine-Health-mMoC-Evaluation-Report_Final-20230117.pdf
[2] Leonie Hewitt et al. *Women and Birth*, https://doi.org/10.1016/j.wombi.2023.09.002

The NSWNMA does not have a single preferred definition of the phrase. Birth trauma is a description of something experienced by an individual and can only really be defined by that person.

We are helpfully informed of the breadth and scope of birth trauma by considered interpretations and definitions available largely from consumer-led or consumer-centric organisations.

Recently, academics have discussed the development of a woman-centred, inclusive definition which was ultimately described as:

'*a woman's experience of interactions and/or events directly related to childbirth that caused overwhelming distressing emotions and reactions; leading to short and/or long-term negative impacts on a woman's health and wellbeing'.*[3]

The Gidget Foundation defines Birth trauma as:

'Birth trauma can involve a physical trauma such as a pelvic floor injury or it can be psychological. Often it is both. Birth trauma is very subjective, meaning that it does not have to be life threatening or medically traumatic to have a psychological impact. It is just experienced to be traumatic by that woman.'

The Australasian Birth Trauma Association ('ATBA') refers to both birth-related physical and psychological trauma. The ATBA outlines physical trauma as birth injuries which may or may not be identified straight away, and outlines psychological trauma as:

'The shock of what actually happened during your birth experience can bring about a number of mental health challenges, including anxiety, depression, and other disorders. Some people experience severe emotional distress after a traumatic birth, even though there was no physical trauma'.

PANDA – Perinatal Anxiety & Depression Australia – states that '*trauma can result from what happens during labour and childbirth, but also how a mum feels about her birthing experience'.*

b. why is this the preferred definition?

The NSWNMA prefers not to have a single definition that may limit the scope of what may be considered 'birth trauma' and instead will have reference to the thoughtful guidance above informed by the experience of women receiving care.

3. Regarding the term "obstetric violence":

c. what is the NSW Nurses and Midwives' Association preferred definition of the term?

The NSWNMA does not have a single preferred definition of the term 'obstetric violence', for the reasons outlined above. The reference to 'obstetric violence' in the NSWNMA submission to the committee was in response to the use of the term in the Committee's Terms of Reference at 1. (a).

[3] Leinweber J., et al. (2022). *Developing a woman-centered, inclusive definition of traumatic childbirth experiences: A discussion pape*r. Birth 49 687–696. 10.1111/birt.12634

d. why is this the preferred definition?

The concept of violence and its application to a particular interaction is subjective. Violence is something that is ordinarily inflicted and experienced, though there may be differing perceptions from each party/parties about whether something that occurred could be characterised as 'violence'.

Whilst there have been suggestions about matters implied by the use of the term (e.g. intent), not all definitions of 'violence' include a reference to intent. Additionally, the reference to 'obstetric' could potentially refer to either the context in which the harm occurred, the category of health practitioner or both. Such speculation is unhelpful and only takes the focus away from concerted efforts to improve the experiences of women receiving care.

4. Can you explain why "informed consent" is necessary for women with respect to decisions they make regarding all aspects of their pregnancy?

Informed consent is necessary for any person who receives health care or treatment of any kind. Birthing women are included in this.

The Nursing and Midwifery Board of Australia defines 'informed consent' as:
'*a woman's voluntary agreement to healthcare, which is made with knowledge and understanding of the potential benefits and risks involved'.*[4]

Although the principles of informed consent and the requirements for obtaining this are well documented, the processes around obtaining this and documenting this are inconsistent at best.

Within the context of policies that apply to NSW Health and its clinicians, the requirement for informed consent is articulated in at least the following:

- *Consent to Medical and Healthcare Treatment Manual, NSW Health, 2020.*
  This Manual outlines a specific requirement [at 4.3.4] that consent for healthcare must be informed. In reference to pregnancy and birth related matters, there is a single reference to 'informed consent' [at 10.2] and this is noted as being a principle that underpins discussions regarding tests, procedures and interventions.

- *National Safety and Quality Health Service Standards:*

  Australian Charter of Healthcare Rights – consumers have a right to:
    - make decisions with their healthcare provider, to the extent that they choose and are able to.
    - receive clear information about their condition, the possible benefits and risks of different tests and treatments, so they can give their informed consent

  Action 2.03 – consumers must be provided with information about their healthcare rights.

  Action 2.04 – organisations have informed consent processes that comply with legislation and best practice and must Adopt a comprehensive policy and associated procedures on informed consent by patients in clinical decision-making.

- *Code of conduct for midwives* [2.3] and *Code of conduct for nurses* [2.4], Nursing and Midwifery Board of Australia.

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[4] *Code of conduct for midwives*, Nursing and Midwifery Board of Australia, 2018

- *Good medical practice: a code of conduct for doctors in Australia* [4.5], Medical Board of Australia.

The decision of *Rogers* v *Whitaker* [1992] HCA 58 provides a helpful legal authority regarding information that must be provided for consent to be valid. The Court outlined what information must be provided:

> *'That relationship [doctor-patient] also gives rise to a duty to provide information and advice. That duty takes its precise content, in terms of the nature and detail of the information to be provided, from the needs, concerns and circumstances of the patient.'*

In our survey of members, 83% of respondents agreed that they felt that they had a comprehensive understanding of the concepts of express consent, implied consent and informed consent. This only represents position of midwives and nurses who responded. It does not give any indication of the position of other health professions.

There may be a disconnect between the self-identified understanding of those principles and the experience of women receiving maternity care about whether they felt that they were able to give informed consent.

Many of the submissions made to the Committee have been by women who felt that they were denied their right to exercise informed choice in birth and detailed the harm they have suffered due to that experience.

In the absence of informed consent, treatment and interventions imposed on women may reach the threshold of the criminal offence of assault, or the tort of battery. Any practitioner who makes a threat to a woman of an intervention during birth without their consent may also civilly liable for assault. This is in addition to any professional discipline complaint that they may be subjected to.

There is very clearly a legal and policy framework that fundamentally requires women to give informed consent before receiving any treatment or intervention. Upholding those requirements is essential to ensure that women receive the highest quality of care. High-quality care includes a genuine partnership in decision-making that respects the bodily autonomy and capacity of women.

It is the position of the NSWNMA that women who receive midwifery-led continuity of care, have free access to structured antenatal education as well as specific 1:1 education with their midwife would be best placed to feel confident and comfortable to give informed consent for any treatment or intervention that may be recommended.

Response to question on notice – Page 54 – to Mrs Gemma Deng from The Hon. Sarah Mitchell:

Do you know how long that's [the personalised alternative care and treatment framework] been available in Queensland?

The personal alternative care and treatment framework in Queensland is outlined as a 'Guideline – Partnering with the woman who declines recommended maternity care'.[5] That particular document was published in 2020.

[5] https://www.health.qld.gov.au/__data/assets/pdf_file/0022/736213/maternity-decline-guide.pdf

In November 2016, the Clinical Excellence Division of Queensland Health held a Maternity Services Forum.[6] In that Forum, clinicians and consumers requested education and information for women who decline recommended care.

The Guidelines were piloted in 2019 and were implemented in 2020 together with additional resources available to consumers and clinicians.[7] These guidelines also had reference to a qualitative study in QLD undertaken in 2016 regarding the use of a structured process to document refusal of recommended maternity care.[8]

The NSW Health Consent to Medical and Healthcare Treatment Manual requires [at 10.2.5] that '*Health Services must implement a local level policy to support women and staff when a woman is declining recommended medical treatment*'.

The Manual requires that the local level policy require a capacity assessment. Such a requirement undermines the fundamental right of women to make decisions about their own their own care and treatment and implies that women who make decisions that could lead to 'serious risks' lack capacity. This being a strict policy requirement only compounds negative perceptions of women who attempt to exercise their right to withhold consent.

Unfortunately, local level LHD policies are not publicly available (with the notable exception of SESLHD). Whilst the local SESLHD procedure implemented does provide clear guidance, it is not nearly as comprehensive as the QLD resource.

The NSWNMA has concerns about the requirement that each LHD develop their own guidelines around this which may cause a lack of consistency in approach. It is recommended that the Committee consider recommending the implementation of a state-wide consistent approach to providing information, advice and documenting the decisions made.

Yours sincerely

<u>SHAYE CANDISH</u>
General Secretary

[6] https://clinicalexcellence.qld.gov.au/sites/default/files/docs/improvement/maternity-services/communique-maternity-forum-2016.pdf
[7] https://www.health.qld.gov.au/consent/clinician-resources/pwdrmc
[8] Jenkinson, B., Kruske, Sue., et al., *Women's, midwives' and obstetricians' experiences of a structured process to document refusal of recommended maternity care*