Monday 8th January, 2024

Select Committee on Birth Trauma: Post Hearing Responses

Ms Rebecca Quiring: Midwife
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We would like to begin our supplementary written response by reiterating our gratitude for this opportunity. We cannot stress enough that the most important voices in this matter are the women, pregnant and birthing people, and families, and we hope to amplify their voices. We also humbly acknowledge that our perspective will not always align with the lived experience of every consumer, and we are here to listen, learn, and respect the choices of each individual.

Thank you for the opportunity to expand on the evidence we provided at the Hearing on December 12th, 2023. The following document will explore:

- Question taken on notice, discussing midwives' experiences working in continuity of care models.
- The well-established evidence that midwifery continuity of care leads to better physical, emotional, psychological, and social outcomes. No other model of care, including continuity from a general practitioner, obstetrician, any other type of health care provider, is supported by this level of research evidence.
- The proposal that midwifery continuity of care be the default care option for all women, regardless of perceived risk status, postcode, or finances.
- Discussions of decision making, consent processes, and trauma-informed care.

Question on Notice

As per the transcript from Tuesday December 12th, 2023:
"The Hon. EMILY SUVAAL: Thanks so much to you all for appearing today. My first question is to the Leeton midwives—thanks so much for your opening statements. In previous hearings we've heard that some midwives struggle to fulfill the requirements of the 24/7 on-call roster in terms of that midwifery continuity of care which you provide. How do you propose that we respect midwives' personal caring commitments and their own circumstances that may preclude them from working those on-call requirements as part of the MGP, but also ensure that we provide that enhanced ability for women to access midwifery group practice if that's what they desire?".

The "Work, Health, and Emotional Lives of Midwives" (WHELM) is a body of work by the Transforming Maternity Care Collective. The studies undertaken within this program use validated tools to measure rates of anxiety, stress, depression and burnout within the midwifery workforce (Transforming Maternity Care Collective, 2024). This is an international body of work, however the research articles summarised below are specific to the Australian context.

Personal, professional and workplace factors that contribute to burnout in Australian midwives (Fenwick et al., 2018b)

> Data was collected from Australian midwives via an online survey. This survey utilised a validated tool to assess burnout, and collected information on variable personal and professional factors including age, parenthood, role, years working, model of care, and work life satisfaction. Principle area of work showed a statistically significant association with burnout symptoms. Midwives working in rotation/shifts and management had higher levels of burnout, while those working in continuity models and administration/research had lower levels. For midwives working in caseload models, 9.5% reported personal burnout and 5.3% reported work-related burnout, while those not working in caseload midwifery had a personal burnout prevalence of 35.5% and work-related of 23.2%. This study also demonstrated that having children was a significant factor in reducing burnout, and it was suggested that this was due to the grounding effect of having an additional focus of family activities. A factor that contributed to burnout was work experience of less than ten years, and it was suggested that this was due to the dissonance between current midwifery education (which is grounded in the philosophy of woman centred care and promotes evidence-based, midwifery continuity of care) and the current maternity services and workplace culture.

The emotional and professional wellbeing of Australian midwives: A comparison between those providing continuity of midwifery care and those not providing continuity (Fenwick et al., 2018a)

> This research used an online survey to assess burnout, depression, anxiety, stress, and perception of empowerment, using a number of validated tools/scales. The data was compared between midwives working in continuity models, and those working

in shift-based/fragmented care. The continuity group had statistically significant lower levels on the burnout, anxiety, and depression scales, and significantly higher levels on the perception of empowerment scale.

Midwifery empowerment: National surveys of midwives from Australia, New Zealand and Sweden (Hildingsson et al., 2016)

This study compared midwives' sense of empowerment across Australia, New Zealand, and Sweden. Australian midwives were significantly less likely to report a sense of empowerment and sense of identity when compared to their counter parts in New Zealand and Sweden. This is likely a result of midwives in New Zealand and Sweden having the opportunity to work within a healthcare system that supports midwives as autonomous, primary health providers.

Australian midwives' intentions to leave the profession and the reasons why (Harvie et al., 2019)

This study utilised both quantitative and qualitative data to determine the incidence of Australian midwives intending to leave the profession and explore their reasons for this. Almost half of the midwives surveyed had considered leaving midwifery in the preceding six months. This was more likely for early careers midwives. The two most common reasons for intention to leave were "dissatisfaction with the organization of midwifery care" (65.7%) and/or "dissatisfaction with my role as a midwife" (50.8%). Comparatively, family commitments were a contributing factor for 19.4% of participants. The qualitative analysis further supported the dissatisfaction with work organisation and current midwifery roles. Concerns identified included unrealistic workloads, task orientated care, a hierarchical workplace culture, pressure to meet organisational needs rather than women's needs, risk adverse environments, non-evidence based workplace procedures, and lack of recognition of the value of midwifery care.

Responses to birth trauma and prevalence of posttraumatic stress among Australian midwives (Leinweber et al., 2017)

An online survey was used to collect information about birth trauma events and subsequent emotions and trauma response symptoms in Australian midwives. The survey invited participants to recall a traumatic birth event they had witnessed, and this event was the basis for questions around the characteristics of the event, as well as emotional and/or trauma response symptoms experienced during or after the event. Trauma events were characterised as non-interpersonal and interpersonal. Non-interpersonal birth trauma was represented by death or injury, while interpersonal birth trauma was represented by abusive care, poor care, and interpersonal disrespect. The majority of midwives (67%) identified their trauma event involved at least one interpersonal care related feature, and 38% recalled an event that consisted of interpersonal care related trauma features only. Midwives who witnessed abusive care with significantly more likely to exhibit severe posttraumatic stress symptoms.

Additional Relevant Research

The following two articles are not part of the WHELM body of work, but also explore midwives' experiences working in different models of care, and add value due to the longitudinal nature of the studies.

Comparing satisfaction and burnout between caseload and standard care midwives: Findings from two cross-sectional surveys conducted in Victoria, Australia (Newton et al., 2014)

> Two study sites were selected that had recently introduced caseload midwifery models. Midwives working in the caseload models as well as midwives working in standard care were surveyed at the commencement of the caseload model and then again two years later. At commencement, both caseload and standard care midwives reported similar levels of personal and professional burnout, and levels of professional satisfaction. After two years, the midwives working in the caseload model scored more highly in the areas of professional satisfaction and professional support, and lower in all categories of burnout. Free text responses were used to further understand the data, and after two years, caseload midwives were more likely to report improved lifestyle and job satisfaction as positive aspects of their role.

Understanding the 'work' of caseload midwives: A mixed-methods exploration of two caseload midwifery models in Victoria, Australia (Newton et al., 2016)

> This article explores in depth interviews that were undertaken with the caseload midwives from the previous study, six months and two years after commencement of the caseload model, and explores these responses in conjunction with the previous survey responses from both the standard care and caseload midwives. Two themes emerged from the data. Caseload midwifery was seen as a 'different way of working' in terms of activity-based work, working on-call, fluid navigation between personal and work time, and avoiding burnout. Caseload midwives also perceived this way of working to be 'real midwifery', facilitating relationships with women, and requiring responsibility, autonomy, and legitimacy. Survey responses indicated that family commitments were a deterring factor for standard care midwives to transition to caseload care, however the majority of the caseload midwives interviewed had children living at home, and experienced higher levels of family time due to the flexibility and autonomy of their workload. The caseload midwives did report a period of adjustment to being on call, however the majority found ways to make it 'work for them'. These strategies included awareness of the cyclical nature of busier and quieter periods of work, supportive colleagues as back up, and relationships with the women that supported boundaries around after hours calls.

Relevance to the Inquiry

The above evidence shows that working in continuity models improves work satisfaction and burnout levels for midwives. Concerns have been raised about family commitments, however the midwives surveyed found that having children was a protective factor against

burnout, and caseload midwives were able to spend more time at home due to flexible work arrangements. The key to this statement is flexibility- when midwives are empowered to work in a true partnership with women, rather than dictated by organisational demands. We acknowledge that caring for children remains a factor for many midwives and propose increased access to childcare services and flexible work arrangements, not only for midwives, but across all industries, as increasing opportunities for all parents to have an active role in family life will reduce the burden on women as the default parent.

Early career midwives are more likely to exhibit burnout symptoms and are more likely to consider leaving the profession, citing dissatisfaction with the organisational structure of maternity care. By providing opportunities for midwives to work autonomously and responsively, as demonstrated in successful continuity models, this will assist in sustaining the midwifery workforce. From personal experience in midwifery continuity of care, this autonomy is achieved by the ability to self roster planned midwifery appointments at times that suit both the women and the midwife. Supportive managers who respect the midwives' work ethic, understand the cyclical nature of midwifery workload, and prioritise meeting the needs of the women and families over meeting the requirements of a time sheet are also key to a balanced work culture.

It is noted that most of the comments during the Inquiry regarding concerns about the impact of continuity models on midwives, and subsequent lack of implementation of these models, have come from an executive or organisational level, and not from midwives providing current clinical care. This rhetoric around difficulties of on call rostering may be secondary to a broader resistance to changing current practices and moving away from thinking of midwives as a subspecialisation of nursing, as well as an organisational resistance to support a more flexible, autonomous work culture.

In terms of birth trauma, midwives are also heavily affected by traumatic events. The events causing the most distress for midwives are those related to care based concerns such as disrespectful care and abuse as opposed to clinical outcomes. This is aligned with research about women's experiences of birth trauma, where two thirds of women report their trauma as being related to care provider actions and interactions (Reed et al., 2017). This is evidence that a significant proportion of trauma for women, birthing people, families, and midwives is avoidable, and the societal and workplace cultures that sustain disrespectful and abusive behaviour need to be challenged.

References

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Additional Information

Evidence for Midwifery Continuity of Care

The evidence supporting midwifery continuity of care (where a woman and her family receive care from a known midwife during their pregnancy, birth, and postpartum period) is well established. A Cochrane review of 15 randomised controlled trials demonstrated clear clinical benefits for women and babies, including increased rates of spontaneous birth, with reduced intervention in the form of epidurals, episiotomies, and instrumental births. There was also reduction in preterm birth, stillbirth, and neonatal deaths. There were no increased adverse outcomes for women or babies who were supported by midwifery continuity of care (Sandall et al., 2016).

Midwifery continuity of care also improves emotional outcomes for women and birthing people. Women who received continuity of care from a known midwife reported feeling more positive, in control, and proud following their births (McLachlan et al., 2015). For women who previously experienced birth trauma, midwifery continuity of care was an option they actively sought out due to the positive benefits of that support (Tafe et al., 2023).

An additional benefit of midwifery continuity of care is the reduced cost to health services as demonstrated by Tracy et al. (2013) and Tracey et al. (2014). Cost savings for the service were between $566 to $1590 per woman in midwifery caseload care, compared to 'standard care' or private obstetric care.

Midwifery continuity of care leads to better physical, emotional, psychological, and social outcomes. No other model of care, including continuity from a general practitioner, obstetrician, any other type of health care provider, is supported by this level of research evidence. This evidence is robust and longstanding, and it is unacceptable that only 14% of models of care nationwide offer midwifery continuity of care (Australia Institute of Health and Welfare, 2023). Midwifery continuity of care is often discussed in research as the "gold standard of care". We propose that midwifery continuity of care be the default care option for all women, regardless of perceived risk status, postcode, or finances, not an aspirational model only available to a select few. As discussed, there is exhaustive research supporting this model as providing the best clinical, emotional, cultural, social, and financial outcomes. It is recklessly irresponsible to continue ignoring this evidence in favour of maintaining the status quo.

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Strategies to Support Midwifery Continuity of Care

In our evidence, we discussed organisational changes to reflect Midwives as primary care providers and enable Midwives to work to their full scope of practice, without medical oversight. Collectively, Midwives believe in pregnancy and birth as a normal physiological process and are considered experts in caring for women and their babies throughout the continuum, consulting and referring to the multidisciplinary team as needed. Midwives utilise a range of resources, including the *National Midwifery Guidelines for Consultation and Referral* to guide the consultation process, consistent with the woman's wishes. It is reasonable to expect Midwives to counsel women and order routine screening tests, like the morphology ultrasound. Midwives have the necessary skills and knowledge to interpret these results and consult or refer if deviations from normal are identified.

We suggest that additional education deemed necessary by the Australian Health Practitioner Regulation Agency (AHPRA), the Nursing and Midwifery Board of Australia (NMBA), and the Australian Nursing and Midwifery Accreditation Council (ANMAC), that will support midwives to work as primary care providers be added to current university programs leading to registration as a midwife. Currently registered midwives can then upskill through certified education programs.

There is Australian precedent as a similar program was used for Enrolled Nurses (ENs). Prior to 2010, ENs could undertake additional education to become 'Endorsed Enrolled Nurses' to expand their scope of practice to administer medications. From 2010, this education requirement was included in the NMBA approved Diploma of Nursing leading to registration as an EN. This has led to the removal of the title 'Endorsed Enrolled Nurse', as all ENs are able to administer medications. The exception to this is any ENs registered prior to 2010, who did not subsequently undertake the additional unit of study. These ENs are identified with a notation stating this.

Currently, Registered Midwives do have the opportunity to become Endorsed Midwives, by undertaking additional postgraduate education, which facilitates the ability to order pathology tests, ultrasound examinations, prescribe medications, and facilitates women receiving Medicare rebates for certain midwifery services. There are many Midwives in Australia who have graduated from these programs, however, have not applied for Endorsement via AHPRA, or are not working as Endorsed Midwives as there is a limited scope and support within the public sector.

Women continue to be admitted to our public facilities "under a Doctor" which does not acknowledge the role of the Midwife as the primary care provider. This places many barriers to rural continuity of care models as Midwives are expected to be the autonomous primary clinician, however a Doctor is expected to support women being "admitted under them" without assuming primary responsibility. This further enhances the belief of Midwives working "under" a medical officer. This continues to contribute to the closure of rural units as GP Obstetricians retire, and there is no Doctor to "admit under", even though there are Midwives in the community working as primary care providers. This also increases the workload of medical officers across all centres, decreasing timely accessibility to specialist Doctors when needed. Recognising Midwives as autonomous primary care providers by

changing legislation to allow the ordering of routine screening tests, and admission to public hospitals under Midwife care for routine labour and birthing, would decrease strain on our healthcare system, allow Midwives to work to their full scope of practice consulting and referring as needed, and enable rural units to stay open and provide safe care to local women. This would decrease trauma by having a known midwife as a primary care provider throughout the continuum, enhancing emotional support and decreasing unnecessary intervention.

A system-wide reform was pioneered by New Zealand, championed by the then Prime Minister Helen Clark. Called the Nurses Amendment Act 1990, legislation was passed on 22nd August 1990, completely dismantling an organisation-focused maternity system that was failing women, and rebuilding one that is woman-centred and consumer focused, legislating a woman's autonomy to choose her Lead Maternity Carer. We strongly urge the Committee to explore this further as we believe it could be the foundation of legislative changes that could alter the childbirth landscape in Australia forever.

Decision Making and Consent

We would like to suggest an alternative view on the way consent and decision-making is being discussed throughout this Inquiry. There has been a focus on 'gaining consent', however, the use of this language creates a bias towards an outcome-based approach, where the goal of the interaction is to obtain the consent for the procedure. This can lead to specific choices in the language used and information shared by providers in order to achieve this specific result. Rather than focusing on 'gaining consent', the focus should be on sharing options and supporting the woman/birthing person's decisions.

Current health service procedures and education modules focus on the criteria required for consent and the written and/or verbal requirements. While this information is important, it does not fully acknowledge the power dynamics that can occur for people accessing health services and engaging with health professionals. It is not uncommon for women and birthing people to provide a verbal "yes" or sign a consent form, in response to pressure or coercion from care providers, which can be subtle (offering limited options or information) or overt (using statements such as "your baby will die"). The NSW Crimes Act, section 61HI while specific to sexual assault, outlines that the person should "freely and voluntarily agree". Section 61HJ precludes valid consent where "…because of force, fear of force or fear of serious harm of any kind to the person, another person, …" or "…because of coercion, blackmail or intimidation,…". This is extremely relevant to this Inquiry due to the intimate nature of examinations undertaken in maternity care, the numerous submissions from women stating their examination was sexual assault or rape, and submissions where women were told "their baby would die" if they didn't consent. The Maternity Consumer Network currently facilitates consent training for healthcare professionals, called Better Births with Consent. While we acknowledge a three-hour workshop will do little to alter the society-wide culture surrounding consent, its popularity demonstrates that clinicians themselves feel further education in the field is needed.

There also needs to be an increased focus on full bodied or somatic consent. Health workers need additional education in observing for and talking about full bodied consent. A practical, anecdotal example is a woman saying "yes" to a vaginal examination, while looking away and shifting away from the clinician. These signals may indicate that the woman has agreed to a procedure in response to external pressure. Clinicians need to be better versed in providing safe spaces for open discussions and for women to feel safe to make their own choices.

It is noted that many of the examples raised regarding consent throughout the Inquiry have referred to "emergency" instrumental births or "emergency" Caesarean sections. The use of the word emergency is misleading, as this is an administrative term used to describe a procedure that was not booked or was unplanned at the time of admission. This is not necessarily reflective of clinical urgency, acknowledging that logistical urgency (e.g. an operating theatre is available, or change of shift) is different to clinical urgency. Genuine life-threatening situations are uncommon in maternity care and organisations have processes in place to communicate urgency during these events. True statistics are not readily available as most reporting only discusses outcomes, not indication for interventions. The constant reference to an "emergency" as an excuse for inadequate

communication, lack of respect for a woman's bodily autonomy, and lack of appropriate consent, is inexcusable.

Another component of decision making is the way risk is discussed as part of information sharing. While some outcomes can have statistical probabilities assigned to them based on data, it is only the woman/birthing person making the decision who determines what level of risk is considered acceptable for them, and what level of intervention they find acceptable to negate that risk (noting that all intervention carries elements of risk).

For further exploration of the use of language around "risk" in maternity care, we suggest the Committee explore the work of Newnham et al. (2015) comparing language used in brochures for consumers about epidurals and waterbirth.

References

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Trauma Informed Care

Trauma-informed care was discussed in various submissions. We would like to put to the Committee, that all care provided in Australia must be trauma informed. In addition to respecting each person's prior trauma history and responding appropriately, trauma informed care should also be about prevention of trauma for all people. Our interpretation of trauma-informed means true informed decision making, that is respected by the clinician and the organisation, with all interactions or interventions always remaining respectful and person-centred. Anything less than this, leads to trauma and is unacceptable. Education programs for clinicians on trauma-informed language, and procedures, particularly around intimate examinations should be prioritised.

We again express our thanks in being given this opportunity to influence a change in the maternity care systems in NSW. We look forward to the Committee's findings and a future where birth is not experienced as traumatic, but as an empowering, transformative experience.