**Submission No 242**

# INQUIRY INTO BIRTH TRAUMA

**Organisation:** NSW Nurses and Midwives' Association

**Date Received:** 15 August 2023

# Submission to the Legislative Council Select Committee Inquiry on Birth Trauma

AUGUST 2023

**NSW NURSES AND MIDWIVES' ASSOCIATION**
AUSTRALIAN NURSING AND MIDWIFERY FEDERATION NSW BRANCH
www.nswnma.asn.au
50 O'Dea Avenue
Waterloo NSW 2017

# Foreword

The New South Wales Nurses and Midwives' Association (NSWNMA) is the registered union for all nurses and midwives in New South Wales. The membership of the NSWNMA comprises all those who perform nursing and midwifery work. This includes: registered nurses; enrolled nurses and midwives at all levels including management and education, and assistants in nursing and midwifery.

The NSWNMA has approximately 77,000 members and is affiliated to Unions NSW and the Australian Council of Trade Unions (ACTU). Eligible members of the NSWNMA are also deemed to be members of the New South Wales Branch of the Australian Nursing and Midwifery Federation.

NSWNMA strives to be innovative in our advocacy to promote a world class, well-funded, integrated health system by being a professional advocate for the health system and our members. We are committed to improving standards of patient care and the quality of services of all health and aged care services whilst protecting and advancing the interests of nurses and midwives and their professions.

We welcome the opportunity to provide a submission to this Consultation.

This response is authorised by the elected officers of the New South Wales Nurses and Midwives' Association

## CONTACT DETAILS

**NSW Nurses and Midwives' Association**
50 O'Dea Avenue
Waterloo, NSW 2017

# Recommendations

(a) Midwifery-led Continuity of Care must be accessible for all birthing women, especially those who are deemed 'high-risk'.

(b) The number of 'places' in midwifery-led care models of care (e.g. Midwifery Group Practice) must be exponentially increased to facilitate widespread access.

(c) Implementation of a new staffing model in all maternity units must be undertaken to ensure there are sufficient midwifery staff of an appropriate skill-mix to provide high quality midwifery care to all women and their families.

(d) Resources and education must be developed and provided to the community and to general practitioners regarding models of care available to women, which include the benefits and risks of each of those models. Such resources must be available in a range of community languages.

(e) Comprehensive and culturally appropriate antenatal education must be offered to all birthing women and their families free of charge.

(f) A standard curriculum for the provision of antenatal education must be implemented.

(g) Additional antenatal 'education' appointments and/or longer antenatal appointments must be resourced so that midwives can provide tailored education to birthing women.

(h) A review of NSW Health policy regarding induction of labour be undertaken to ensure the threshold for intervention is evidence-based and the importance of informed consent is a paramount consideration.

(i) Education regarding the importance of informed choice and informed consent must be provided to medical practitioners caring for birthing women.

(j) Education must be provided to all health practitioners working in maternity services to ensure they have the knowledge and skill to provide culturally safe maternity care to first nations women, culturally and linguistically diverse women, women or people who identify as LGBTQIA+ and women with disabilities.

(k) Education on trauma informed care must be provided to all health practitioners working in maternity services. Such education must include the identification of and care planning for women who have previously experienced birth trauma.

(l) Access to 'Debriefing Clinics' must be available for all birthing women.

(m) Introduction of protocols to ensure that midwives are offered the opportunity to have a 'hot debrief' either following an adverse event or when identified as needed by the midwife.

(n) Clinical supervision must be available for all midwives and accessible in protected time.

(o) Implementation of a 'Personalised Alternative Care and Treatment' policy within NSW Health to support women who choose to decline recommended or routine interventions.

(p) Urgent workforce planning, in consultation with academics, regulatory bodies, professional and industrial representatives, and employers, must occur. Particular attention is needed to increase the number of Aboriginal and Torres Strait Islander midwives being trained, registered and employed.

(q) Competitive remuneration for NSW midwives working in caseload models must be addressed in order to recruit and retain suitable numbers of midwives into this model of care.

# Introduction

*The terms 'woman' and 'women' are predominantly used throughout this submission. This is not intended to exclude people who birth but do not identify as women. The discussion and debate regarding gendered language related to pregnancy and birth is complex.[1]The acknowledgement of the identity of women is important, and so too is the acknowledgement that some people accessing maternity services are negatively impacted by the use of gendered language when receiving those services.*

The NSWNMA actively pursues our members' rights and supports member empowerment to influence decision makers for a fair and just society. It is the position of the NSWNMA that a fair and just society is one in which women who birth are provided with equality of access to midwifery-led continuity of care and who are empowered and supported to make informed decisions about their care.

The NSWNMA is required to develop position statements and guidelines that support human rights and ethical standards.[2] It is the position of the NSWNMA that it is essential the human rights of birthing women are acknowledged and upheld.

The NSWNMA advocates for equity and social justice in resource allocation, access to health care and other social and economic services.[3]

Nurses and midwives exercise their right to a voice on professional issues through the NSWNMA. The incidence, prevalence and impacts of birth trauma are a significant professional issue that midwives face in their practice.

Midwives understand the adverse consequences that ethical and human rights violations have on the health of women and infants, and will work to eliminate these violations. Midwives participate in the development and implementation of health policies that promote the health of all women and childbearing families.[4]

In addition to being a significant issue that affects our members professionally, birth trauma is also an issue that broadly affects many women. The midwifery and nursing professions are female dominated and so too is our membership.

Whilst this submission is primarily based on the professional views of our midwife members, we also advocate on behalf of those members of ours who have personally experienced birth trauma.

## SURVEY OF MEMBERS

In July 2023, the NSWNMA undertook a survey of members to seek input regarding their professional and personal experiences of birth trauma. The survey sought to gain insight into their views about the major causes or contributing factors of birth trauma, as well as changes that they feel would reduce the prevalence of birth trauma.

The feedback received from our members was devastating, though sadly not surprising. Their professional and personal experiences demonstrate the enormity of the societal and structural issues that contribute to the

[1] Gribble, K., Bewley, S., Bartick, M., et al., Effective Communication About Pregnancy, Birth, Lactation, Breastfeeding and Newborn Care: The Importance of Sexed Language, Frontiers in Global Women's Health (2022), Vol 3

[2] *The ICN Code of ethics for nurses*, International Council of Nurses, 2021

[3] *The ICN Code of ethics for nurses*, International Council of Nurses, 2021

[4] International Code of Ethics for Midwives, International Confederation of Midwives 2008

experience of birth trauma. Throughout this submission, our members' words (in blue) are provided to give an honest, first-hand account of their professional and personal experiences.

The professional and personal experiences of our members must be considered as a significant and influential voice of people whose invaluable expertise is essential when considering recommendations for reform to reduce the incidence of birth trauma.

## RESPONSE TO THE TERMS OF REFERENCE

***(a) the experience and prevalence of birth trauma (including, but not limited to, as a result of inappropriate, disrespectful or abusive treatment before, during and after birth, also referred to as "obstetric violence")***

Birth trauma, including the concept of 'obstetric violence', is a significant issue that has gained recognition in recent years. It refers to the psychological and physical trauma experienced by women during the childbirth process, and it is said to affect one third of birthing women.[5] For the birthing person, it may result from feeling unheard, disrespected, or coerced into medical interventions without their informed consent. Trauma can also be triggered by a lack of autonomy or communication during the birthing process, particularly in cases of emergency procedures or complications. Some women may also experience physical trauma (e.g. prolapse) due to medical interventions, such as episiotomies or instrumental deliveries.

> *'I had an incident where a doctor felt he could do anything to a woman because she had signed a consent form for instrumental birth/ LSCS. At the time the woman was clutching on to me and screaming for me to help her, while the doctor was cutting an episiotomy, applying vacuum and forceps, all without communicating to the woman. I eventually told him it was enough and he then tried to push the babys head back into the pelvis.'*

Birth trauma can have long-lasting effects on women and their families. It may lead to post-traumatic stress disorder (PTSD), depression, anxiety, and/or difficulties with bonding and breastfeeding. 90% of our members surveyed reported they had observed or been involved in an incident that may have resulted in birth trauma, and 80% felt unable to successfully advocate for the women in their care. Unfortunately, birth trauma does not discriminate, and the survey results also showed 73% of the members had themselves been victims of birth trauma showing that simply having knowledge cannot end birth trauma.

> *I had declined an episiotomy during birth. I was refused analgesia and the episiotomy was performed without consent.*

Various factors contribute to the occurrence of obstetric violence. These may include communication issues between healthcare providers and birthing women, and cultural and systemic norms that prioritise medical intervention over individual preferences and informed choice. Time pressures and busy birth suites lead to rushed decision making and inadequate informed consent processes and finally, a lack of proper training or understanding of the emotional and psychological aspects of childbirth among healthcare providers. This last point is supported by the results in our survey, finding 82% of members had not received any professional

[5] Keedle, H., Bell, M. V., Keedle, M. W., & Dahlen, H. (2022). Factors contributing to women's experiences of birth trauma in Australia. *Women and Birth : Journal of the Australian College of Midwives*, 35, 31

training in the provision of trauma informed care, and the same proportion of members had not received any education on caring for a birthing person who has previously experienced trauma.

---

*'When you're not informed of the risks with induction, then you have a doctor demand that your baby be delivered by midday, so they up the synto to where I was hyperstimulated, dilated rapidly, then proceeded to have a shoulder dystocia delivery with bub born flat and raced off to NICU'*

---

The prevalence of birth trauma is inextricably linked to the patriarchal medical model in which the majority of women in NSW birth. The relentless subjugation of women in our society combined with paternalistic policies and attitudes that suggest birthing women are incapable of making reasoned and rational decisions has created a culture whereby women are expected to comply with any recommended intervention. This expectation is framed around what is best for the baby, i.e. prioritising foetal wellbeing ahead of maternal wellbeing.

---

*'I have personally restrained doctors hands when they were about to do a vaginal examination without consent. Multiple different occasions. I have stopped a doctor, who, having gained consent for vaginal examination, then went to insert her whole hand to perform a manual rotation without consent, then looked at me like I was insane for insisting on a separate consent for that.'*

---

A recurring theme in the survey data obtained refers to the coercive language used when discussing proposed interventions. Many examples were provided of women being threatened their baby would die if they did not agree to the intervention. Implied or express consent given under extreme duress is not consent.

---

*'Hearing doctors tell women the only safe option for their baby to have its greatest chance of surviving is to have an induction breaks my heart on too regular a basis. Such fearmongering language used by doctors needs to be removed from the equation. Informed consent is not often gained as there is only one side of the information being portrayed. Midwives need to feel empowered to remain in the profession rather than leaving in droves due to ongoing increases in intervention and often resultant birth trauma.'*

*'There is so much to share. The way the system works and tries to rush women through birth and just all the unknown parts that instil fear. Having a traumatic birth and remembering the sound of the episiotomy, having your baby ripped out using vacuum delivery, having your baby taken away as it was not waking. Everything happened with little conversation with myself and no risk or benefits explained. I sought private birth trauma debriefing at my own cost.'*

---

***(b) causes and factors contributing to birth trauma including:***

***(ii) use of instruments and devices for assisted birth e.g., forceps and ventouse***

According to the Mothers and Babies report 2021[6] (2023), the rate of instrumental births in Australia has remained relatively stable at just under 12% of all births. While instrumental births pose a risk for physical birth trauma, there has been no sharp increase to explain the extensive birth trauma rates. However, the reported contributors to birth trauma, as communicated by our members, are centred around inadequate antenatal education, communication, and the consent process related to instrumental deliveries.

Approximately 90% of our member respondents expressed concerns about barriers faced by birthing women and their families in accessing sufficient antenatal education. The lack of access to appropriate and tailored education results in a lack of awareness regarding emergency procedures and interventions that practitioners may feel are clinically indicated. Education must ensure that risks and benefits of potential interventions are appropriately communicated having regard to the level of health literacy that the woman possesses. The level of relative risk is something that is essential to be clearly communicated with regard to instrumental deliveries (e.g. 1:1000 vs 2:1000 being verbally described as 'double the risk' in order to obtain 'consent'). Visual presentations of relative risk in education may be more accessible resources to utilise in maternity education.

The loss of autonomy and lack of participation in decision making increases the risk of birth trauma. We recommend the introduction of free hospital antenatal classes for all and extending clinic appointment times to improve educational support.

The survey also sought the professional opinion of our members regarding the leading causes or contributing factors to birth trauma. Apart from antenatal education, coercion and a lack of consent were frequently reported, particularly concerning vaginal examinations, episiotomies, and instrumental births. Members observed inexperienced doctors might rush during emergencies, focusing solely on the problem rather than considering the wellbeing of the woman experiencing the emergency. This results in poor communication during critical situations, and some members mentioned staff resorting to threats to obtain consent for procedures. To address these issues, we propose implementing multidisciplinary education and support from more senior staff to improve emergency management.

Another issue highlighted by the members was the lack of trust exhibited by certain health professionals in a person's capability to undergo labour and deliver a baby. Numerous accounts were shared of unnecessary interventions, often influenced by the fear of litigation and the pressure faced by the ward due to staffing or hospital bed availability.

The survey also revealed if women opted for care that deviated from hospital guidelines, more than 70% of members believed these women were not treated with the same level of respect as those who accepted all recommended care. This lack of respect for personal choice and individualised care is contributing to a rise in birth trauma.

By restricting choices and neglecting woman-centred care, the likelihood of birth trauma continuing to increase becomes evident. Addressing these concerns and promoting a more trusting and respectful approach to childbirth decisions is essential to reduce the prevalence of birth trauma and improve the overall birthing experience for women and their families.

***(iii) the availability of, and systemic barriers to, trauma-informed care being provided during pregnancy, during birth and following birth***

The availability of trauma-informed care during pregnancy, birth, and postpartum periods is a critical aspect of promoting positive birthing experiences and supporting the emotional wellbeing of women. Trauma-informed care recognises the impact of past trauma and seeks to create a safe and supportive environment that fosters healing and empowerment. However, there are systemic barriers that can hinder the widespread adoption and provision of trauma-informed care in maternity settings.

[6] New South Wales Government. (2023). *NSW Mothers and Babies 2021*

Many healthcare professionals, including obstetricians and midwives, have not received adequate training in trauma-informed care. In the survey, 48% of members said their understanding of the concept of trauma informed care was fair or poor, and 83% of members said they had not received any professional training on how to care for someone who has previously experienced birth trauma. Without proper education on how to recognise trauma, communication effectively and provide culturally appropriate care, they may inadvertently contribute to the re-traumatisation of women. Health practitioners working in maternity services should receive ongoing education on trauma-informed care, which includes recognising trauma signs, implementing sensitive and appropriate communication, and understanding the impact of trauma on birth experiences on future care.

Midwives often face time constraints due to poor staffing, skill mix and high workloads. This can limit the opportunity to engage with women to identify trauma, discuss emotional concerns, and individualised care plans. This is exacerbated by workforce replacement strategies that are seeing Registered Nurses and assistants in midwifery replacing midwifery positions on postnatal wards. Such strategies are being employed despite the guidance of the Nursing and Midwifery Board of Australia that *'the substitution of health workers for nurses or midwives must not occur when the knowledge and skills of nurses or midwives are needed*'.[7]

The number of midwives with practising registration in NSW dropped from 9533 in 2021 to 8669 in 2023.[8] A Victorian report revealed 61% of surveyed midwives in that state had fewer than ten years experience[9]; the NSWNMA's own data reflects a 9.7% decrease in the number of midwives with seven years or more experience and a corresponding increase of those with six years or less experience between 2018 and 2022. The lack of appropriate numbers of staff and the numbers of experienced clinicians, leaves women feeling unheard or rushed. It places a greater burden on experienced staff to intervene where birth trauma is occurring, or has occurred, potentially leading to greater burnout rates as a result of moral injury. The precipitous decline in experienced midwives is leaving junior midwives struggling for mentorship and guidance, when navigating through the professional and emotional complexities of birth trauma. Students and new graduate midwives would benefit from mentorship programs to ensure they feel confident in advocating for women in their care. There is an urgent requirement for State and Federal governments to work together with academics, regulatory bodies, professional and industrial representatives, and employers on workforce planning and design.

*'It was clear some of the midwives were wanting to do more, but did not have the capacity with workload.'*

Medical interventions and protocols are being prioritising over individualised, trauma-informed care. This focus on standardisation can overshadow the importance of emotional wellbeing and personalised support for women. Advocating for policy changes that prioritises trauma-informed care and emotional wellbeing in maternity settings is a start towards making improvements.

Mental health stigma can discourage open conversations about past trauma and emotional struggles during pregnancy and birth. As a result, some women may hesitate to disclose their trauma history, leading to potential oversights in providing appropriate support. Access to mental health services, debriefing, counselling, and support groups is essential for trauma survivors during the perinatal period.

[7] Nursing and Midwifery Board of Australia, *Decision-making framwork for nursing and midwifery* (2020)

[8] Nursing and Midwifery Board of Australia, *Nurse and Midwife Registration Data Table – March 2021* and *Nurse and Midwife Registration Data Table – March 2023*

[9] Matthews, R., Forster, D., Hyde, R,. et al, FUCHSIA, Future proofing the midwifery workforce in Victoria: A state-wide cross-sectional study exploring health, well-being and sustainability, La Trobe University (2022)

*'There were no support services offered. There was no recognition that perhaps my birthing experienced was negative. When I cried, I was told to be quiet.'*

Unfortunately, not all regions or communities have sufficient resources in place to meet these needs, leaving some women without the support they require. In the survey, members reported on their own personal birth trauma and 78% disclosed even though there were support services available they did not access them. This shows the need to evaluate the accessibility and reasons why people are not engaging with the services already on offer.

***(c) the physical, emotional, psychological, and economic impacts of birth trauma, including both short and long term impacts on patients and their families and health workers***

The firsthand experiences reported by our members of their birth trauma were harrowing. Many refer to a lack of compassion and respect in their decision making, having procedures conducted without their consent and being unnecessarily separated from their babies. Another prominent theme was the lack of debriefing following a traumatic birth, and conversely for those who had a debrief, how beneficial that was for them.

*'Home visits from my known continuity of care midwife after birth made a huge difference in being able to debrief and process my birth experience.'*

In the short term, depression, anxiety, breastfeeding, and bonding issues were commonly reported. But the long-term impacts were astounding. Many women who provided insight into their trauma recounted experiences from over 20 years ago and some even over 50 years ago. The fact that these women have carried this enduring burden of physical and emotional trauma must be recognised, and much more can and should be done to ensure that affected women receive the necessary care and support.

*'I consequently have suffered from significant long-term pain in my pelvis, lower back and hips for the past 23 years as a result of this birth experience. It has caused a significant effect on my quality of life and that of my family and I have spent thousands of dollars on various health care professionals to seek relief.'*

Our members refer to the importance of access for all to midwifery-led continuity of care and better antenatal education as the key factors that would lead to a reduction in the prevalence of birth trauma.

Interestingly, 40% of our members who were health practitioners at the time of giving birth did not feel their professional knowledge made pregnancy and birth easier to navigate. Similarly many felt neglected in their care, because their care providers had assumed a level of knowledge or understanding on their part because of their occupation.

This statistic speaks to the level of complexity and barriers that exist for women who access maternity services. If 40% of women who are health practitioners do not feel they had any advantage in navigating those complexities, then that is indicative of the even greater barriers that exist for women who do not possess a high level of health literacy.

*'I think that because I am a midwife it was assumed I would not need the same level of support as others might.'*

*'I know my body. The doctors and midwives wouldn't listen. If even I, as a midwife myself (and they knew I am), can't be respected for the personal and professional knowledge I hold, how can anyone else expect to be taken seriously!'*

The impact of birth trauma for midwives who witness this can manifest in both the short term and the long term and can have significant emotional, psychological, and economic consequences. Exposure to an instance or repeated instances of birth trauma is a serious psychosocial hazard, the risk of which must be eliminated by employers where reasonably practicable.[10]

Witnessing traumatic births can take an emotional toll on health practitioners leading to vicarious trauma and feelings of helplessness or stress. In our survey, 58% of members said their psychological health had been negatively impacted after caring for a woman experiencing birth trauma. Moral distress is also an issue, with 80% of the members reporting feeling unable to successfully advocate to prevent birth trauma.

*'I do advocate on their behalf…but it doesn't come without fear or anxiety. Often, I'm left with a feeling of despair or 'letting women down' when I'm not listened to. The only thing I could then do was internalize and blame myself'*

Experiencing multiple traumatic births and witnessing women in distress can contribute to burnout and job dissatisfaction among midwives.

*'I used to drive to work every shift with a sense of dread'*

Midwives carry the emotional burden from witnessing traumatic births, impacting their psychological health, overall wellbeing and job performance.

*'I haven't accoucheured a birth in 18 months now and I feel overwhelming anxiety when I walk into a birthing unit.'*

*'I burnt out and required 3 years of intensive psychology and psychiatry to treat PTSD to deal with work-based trauma'*

*'We deal with women who are losing their babies. Some of our staff have put 58 babies in mortuary bags in the last year. All pregnancy losses should have one on one care. We have done one on 6. It's not good enough, it's barely human.'*

Themes identified through most of the survey were inadequate levels of staffing, poor skill mix and inadequate access to debriefing or clinical supervision for midwives. 35% of respondents said they 'never' have access to clinical supervision in protected time and 29% said they rarely have access. 'Protected time' is paid time provided in addition to meal breaks, without interruption, for the midwife to participate in structured clinical supervision. Midwives participating in clinical supervision in protected time are not able to be recalled to the unit to fill staffing shortages.

[10] Section 17 *Work Health and Safety Act 2011* (NSW)

*'I think that staff need better support, birth trauma also significantly affects professionals' mental health and is also very traumatic for staff involved and there is minimal support for workers.'*

To decrease the impact of vicarious birth trauma for midwives, the opportunity for hot debriefing, and ongoing support such as clinical supervision[11] in protected time must be implemented.

*'At times when I have been involved in a traumatic event there has been no support…no debriefing… the midwives are forgotten…I am carrying a lot of trauma…and I don't feel it's recognised or acknowledged.'*

***(d) exacerbating factors in delivering and accessing maternity care that impact on birth trauma generally, but also in particular:***

***(i) people in regional, rural and remote New South Wales***

Delivering and accessing maternity care in regional, rural, and remote areas of New South Wales can be challenging and may exacerbate factors that impact birth trauma.

In rural and remote areas, there are a scarcity of maternity care facilities, including hospitals with obstetric units and skilled health practitioners. This limited access can lead to delays in receiving essential care during pregnancy and birth, increasing the risk of complications and trauma.

Geographical distances and limited transportation options can make it difficult for women to reach healthcare facilities quickly, and long travel times to access care can result in delays in care.

In cases where birth complications arise and transfer to a higher-level facility is necessary, the distance and logistics of emergency transfers can lead to delays in receiving specialised care and separation from loved ones, potentially exacerbating birth trauma. Social issues may also be present where women are traumatised as a result of being forcibly separated from their partners and/or other children in order to receive care.

Rural and remote areas faced with challenges in recruiting and retaining health practitioners and even with financial incentives, appointments may be transient. Workforce shortages lead to reduced access to regular antenatal care and limited availability of birthing options, increasing the risk of birth trauma.

This lack of health practitioners also reduces accessibility to antenatal education. This can lead to a lack of awareness about birth options, available resources, and coping strategies during labor, contributing to feelings of anxiety and loss of control.

Rural and remote communities may have unique social and cultural norms that influence perceptions of childbirth and medical interventions. These factors can impact the decision-making process during childbirth and may contribute to a reluctance to seek medical care, even in critical situations. Adding to this, access to mental health resources, including counselling and support for trauma survivors, may be limited in rural and remote areas. This can impede the availability of specialised care for women experiencing birth trauma.

[11] Catling, C., Donovan, H., Phipps, H., et al, *Group Clinical Supervision for midwives and burnout: a clister randomized control trial*, BMC Pregnancy and Childbirth (2022), 22(1)

Access to education for health practitioners in regional, rural and remote areas is also comparatively limited. There are fewer opportunities for face-to-face education and lack of resourcing in those areas impacts access to education.

To address these factors more funding needs to be allocated to improve access to education, care and support for pregnant women.

Further, consideration must be given to additional ways in which the scope of the midwifery practice can be extended for midwives in rural and remote practice to provide emergency care for those at risk of complications. Telehealth could be better utilised to bridge the gap in accessing antenatal classes, mental health services as well as culturally appropriate education for local communities to empower women to make informed decisions.

### *(ii) First Nations people*

The provision and access to maternity care for Aboriginal and Torres Strait Islander women can be affected by a range of factors that increase the risk of birth trauma. These include a lack of access to culturally safe and appropriate care, lack of access to appropriate antenatal education, racism, socio-economic disparities and disparities in health outcomes.

The intergenerational effects of historical trauma have led to mistrust, causing some Aboriginal and Torres Strait Islander women to avoid or hesitate seeking medical attention during pregnancy and childbirth. Additionally, the lack of cultural sensitivity and awareness among healthcare providers can lead to suboptimal care and increases the risk of birth trauma.

In our survey, 60% of respondents stated their employers had not provided sufficient training on providing culturally safe care to Aboriginal and Torres Strait Islander women, highlighting the significance of this educational gap. Without health practitioners having appropriate knowledge, skill and confidence to provide culturally safe care to Aboriginal and Torres Strait Islander women, the prevalence of birth trauma being experienced will not decline.

Addressing these challenges requires not only educating health practitioners about the higher rates of chronic health conditions in First Nations communities but also about culturally safe and appropriate care. Specific midwife-led continuity of care teams, as well as increasing the overall number of Aboriginal and Torres Strait Islander midwives and medical practitioners would improve the provide care provided to this community. Urgent workforce planning, in consultation with academics, regulatory bodies, professional and industrial representatives and employers, is needed at the federal and state levels.

However, the current shortage of Aboriginal and Torres Strait Islander midwives necessitates further funding for programs that enable supported education pathways to midwifery.

In some Aboriginal and Torres Strait Islander communities, particularly those in remote or rural areas, accessing quality maternity care is hindered by geographical distance, limited transportation, and minimal health services. Engaging with these communities and involving community leaders and elders in healthcare planning is essential to identify specific needs and barriers to care. Educating communities about specific midwifery-led continuity of care models available can encourage engagement with the service. Providing appropriate antenatal classes and support during pregnancy and birth may then help reduce the risk of birth trauma.

### *(iii) people from culturally and linguistically diverse (CALD) backgrounds*

The delivery and accessibility of maternity care for people from culturally and linguistically diverse (CALD) backgrounds can be impacted by various exacerbating factors that contribute to birth trauma. These factors

are rooted in language barriers, cultural differences, and systemic challenges, resulting in disparities in healthcare access and experiences.

Language differences can impede effective communication between healthcare providers and women, leading to misunderstandings about medical procedures, informed consent, and birthing preferences. In obstetric emergencies, accessing interpreter services can be challenging due to time constraints, which may further exacerbate the issue of obtaining true consent from CALD women. This difficulty (or perception of difficulty) with interpreter services can also result in exclusion from access to midwifery group practice ('MGP'), as appointment times agreed with interpreters might be cancelled last minute due to midwives having to attend other women at short notice. To address this, culturally sensitive care models need to be introduced, and more funding should be allocated to recruit interpreters for both telecommunication and in-person services.

Health practitioners' lack of cultural awareness and understanding of the traditions, beliefs, and practices of people from CALD backgrounds can lead to insensitive care that disregards cultural preferences and values. 67% of respondents to our survey reported inadequate training on culturally safe care for CALD women, underscoring the significance of this educational gap in contributing to birth trauma. Cultural competence training should be provided to healthcare providers to enhance their understanding of diverse cultural practices and beliefs, enabling them to offer more sensitive and respectful care.

Some women from CALD backgrounds may have experienced stigma or discrimination within the healthcare system before, which can deter them from seeking medical care. Engaging with CALD communities and involving community leaders can break down barriers to care, leading to more tailored and effective services. Educating CALD communities about the specific tailored services available at their local hospitals can also enhance their understanding of the care options and encourage seeking appropriate care when needed.

---

*CONSENT! If a woman says no, or stop, or that hurts, or physically tries to remove herself from a situation, then consent does not exist! regardless of if the clinicians feel they need to continue with whatever they were doing! When did it become ok for a pregnant woman to lose control of her body? Why do clinicians feel it's their right to dictate what is done?*

*As a clinical midwife I was working in birth suite looking after a woman I had previously birthed (2 years earlier). The doctor walked into the room (unannounced and without knocking and waiting to be invited into the space) during the beginning of 2nd stage and demanded that I get him the episiotomy scissors as this woman would need to be "cut". I asked him to politely meet with me outside of the birthing room where he continued to demand for the scissors and tell me that if I didn't get them, he would report me to the NM for interfering in care.*

*I asked the doctor why he felt the woman needed an episiotomy and his response was "because she's Asian". He would not listen to me when I tried to explain that I had birthed her previously and she birthed intact and that there was no current indication for an episiotomy (the head wasn't even on view yet). Luckily for the woman, the doctor was more interested in reporting me for obstructive behaviour and he left to find the manager and in the meantime the woman in my care birthed beautifully with an intact perineum.*

---

***(iv) LGBTQIA+ people***

Delivering and accessing maternity care for LGBTQIA+ people can be influenced by various factors that impact birth trauma. These factors arise from societal biases, lack of understanding, and systemic challenges, leading to disparities in healthcare access and experiences.

Healthcare settings are not fully inclusive and welcoming to LGBTQIA+ people and their families. This lack of inclusivity can lead to discomfort, fear, and hesitancy in seeking maternity care. In the survey, 78% of respondents stated that their employers had not provided sufficient training on culturally safe care for LGBTQIA+ individuals which was the highest of all minority groups. This lack of education means the use of non-inclusive language or assumptions about family structures are made and can contribute to a sense of invalidation for LGBTQIA+ individuals during maternity care.

To improve this, engaging with LGBTQIA+ communities and involving LGBTQIA+ advocates in healthcare planning can help identify specific needs for example implementing inclusive language, LGBTQIA+-friendly birthing classes and therefore reducing the incidence of birth trauma amongst this community.

***(v) young parents***

Numerous factors impact the delivery and accessibility of maternity care for young parents, stemming from social, economic, and healthcare-related challenges. These factors contribute to disparities in healthcare access and experiences for this population, potentially leading to birth trauma.

Young parents often face limited access to prenatal education and support, which can result in inadequate knowledge about pregnancy, childbirth, and postpartum care. This lack of preparation may lead to feelings of uncertainty, anxiety, and vulnerability during the birthing process. Addressing this issue requires targeted education at schools, providing information about pregnancy models of care, and ensuring that young women are aware of appropriate services when they become pregnant.

Financial constraints, social stigma, and isolation can further contribute to young parents' vulnerability and increase the risk of birth trauma. These barriers can make it challenging for young parents to access the resources and support needed during pregnancy and childbirth. To address these challenges, there is a need for initiatives that provide financial support, reduce social stigma, and create supportive communities for young parents.

Additionally, communication barriers with health practitioners and limited decision-making autonomy can hinder young parents from feeling respected, in control, and able to give informed consent. To improve the birthing experience for young parents, the implementation of midwifery-led continuity of care or specialised young person's clinics can be crucial. Currently, only 37% of health services surveyed had specialised clinics, indicating a gap that needs to be addressed to ensure equitable access to services like birthing classes and midwifery-led continuity of care for young parents.

***(e) the role and importance of "informed choice" in maternity care***

Informed choice plays a crucial role in maternity care by empowering pregnant women to make well-informed decisions about their healthcare options during pregnancy, childbirth, and postpartum. It ensures women and their families have access to accurate, comprehensive, and unbiased information about various aspects of maternity care, enabling them to actively participate in decision-making processes that affect their health and the health of their newborn.

Informed choice respects autonomy and empowers birthing women to make decisions about their care in the hope to reduce anxiety and stress associated with uncertainty and lack of control and therefore reduce birth trauma. In the survey, 71% of respondents felt women who exercised their right to makes choices outside of recommended care were not shown the same level of respect as those who accept all recommended care.

This demonstrates not only the importance of informed choice, but then respecting the choices made recognising diversity of cultural, religious, and personal beliefs.

Access to information allows pregnant women to make informed decisions about medical interventions, such as caesarean sections, epidurals, and induction of labour. In the survey, 72% of respondents believed birth trauma is increasing due to the increasing intervention rate, so allowing women to make informed choices may help reduce interventions or procedures they don't fully understand.

It is the experience of many women that they are denied the opportunity to exercise many of their basic decision making rights during childbirth. This may potentially commence with not having the ability to exercise decision making over whether to become pregnant, and could extend to whether to terminate the pregnancy, who their care provider(s) may be, where they receive their maternity care and what diagnostic or medical interventions they receive.

This experience is often exacerbated when women are birthing in facilities where the applicable policies and recommended guidelines for care are used to coerce women into making decisions without being able to have informed choice in relation to that decision.

It is also the experience of women, and the observation of many of our members, that when women attempt to exercise their decision making rights in childbirth, those decisions are often not respected and women can be branded as being 'difficult'. Such attitudes can cause irreparable harm to the therapeutic relationships that are necessary for women to feel safe and supported by their caregivers.

---

*'I have witnessed obstetricians conducting invasive examinations despite the woman saying 'no', 'stop', conducting vaginal examinations without asking consent or even introducing themselves to the labouring woman, before sticking their fingers in roughly.'*

---

Informed consent is a critical concept in maternity care that ensures pregnant women have the necessary information to make educated and voluntary decisions about their healthcare options. It is a legal and ethical requirement that empowers women to participate in their own care and treatment.

---

*'I spend a lot of time debriefing students and grads, and also experienced midwives who felt that they weren't able to adequately advocate for a woman who was coerced into consent'*

---

The qualitative data obtained from the survey reported coerced consent as one of the main drivers of birth trauma. This was explained by reasons such as inexperienced doctors rushing in emergency situations, focusing on the problem and not the woman, the fear of litigation, concern for wider hospital issues and 'health professional knows best'. The members even reported threats made.

---

*'He became inpatient and literally held up the pair of forceps up in front of the woman clanging them together loudly several times, and spoke to her aggressively saying, 'see these forceps, I need to put these on your baby's head and when I do you need to push."*

---

Informed consent safeguards against coercion or undue pressure from healthcare providers or others. Pregnant women should never feel forced into making decisions that do not align with their wishes. Further support for inexperienced health professionals and continual education around consent and communication needs to be factored into continuing professional development.

### *(f) barriers to the provision of "continuity of care" in maternity care*

A Cochrane review conducted[12] by Sandall et al. advocated midwife-led continuity of care should be the standard practice for women with both low and high-risk pregnancies. Over the past 14 years, subsequent Cochrane reviews (Sandall et al., 2013 & 2015) along with numerous other studies have further endorsed the benefits of midwife-led care. However, it is evident that widespread adoption of this approach has not been sufficiently supported or funded by health services in order to provide access to all women.

Despite being the gold standard, only a small fraction of women in NSW who birth are able to access this model of care and access is almost always contingent on the woman possessing a high level of education and awareness that the model of care exists and early booking (at 4-5 weeks) is necessary as well as being sufficiently 'low risk' to be eligible for a place.

While continuity of care has many documented benefits, there are known barriers impeding its widespread implementation and to reduced birth trauma these barriers need to be overcome.

A significant barrier reported by our members was the culture within health services, which included a lack of support for the model impacted largely by negative attitudes of obstetricians towards midwifery-led continuity of care.

Another significant barrier identified was resourcing of midwives. Shortages of midwives employed within current models were widely reported. More midwives need to be employed in order to increase access to midwifery-led continuity of care to all.

There are workforce challenges for employers and personal barriers for midwives who work in a continuity of care model (e.g. MGP). Midwives in these models usually have unpredictable on-call hours which can be impossible to balance with carers responsibilities. This is especially the case for single mothers or those with young children who rely on childcare services that are inflexible or unavailable. On top of this, our members report a lack of understanding from their employers about workload, and comparatively uncompetitive renumeration in NSW.

Caseload midwifery is a role that is unique and unpredictable in its time-based demands and one that requires midwives to have and maintain specific additional skills across a broader scope of practice compared with facility-based midwives. The role is largely autonomous and therefore carries additional professional responsibilities. For these reasons, recruitment and retention can be challenging. To facilitate broader access to continuity of care models for all, the NSW government must review the remuneration of caseload midwives.

Organisations frequently express concerns over the perceived costliness of continuity of care models. However, research suggests this concern may be unfounded. A study conducted by Fox et al. in 2023[13] highlights the potential for cost savings through reduced intervention rates, shorter hospital stays, and decreased reliance on post-birth follow-up from other healthcare professionals.

---

[12] Sandall, J., Hatem, M., Devane, D., Hora Soltani, H., & Simon Gates, S. (2009). Discussions of findings from a Cochrane review of midwife-led versus other models of care for childbearing women: continuity, normality and safety. Midwifery. 25(1) pp 8-13

[13] Fox, D., Scarf, V., Turkmani, S., Rossiter, C., Coddington, R., Sheehy, A., Catling, C., Cummins, A., & Baird, K. (2023). Midwifery continuity of care for women with complex pregnancies in Australia: An integrative review. *Women and Birth.*36(2) pp e187-e194

Another barrier emerges from the resistance of private obstetricians and GPs to recommend midwifery-led continuity of care. A wider adoption of midwifery-led continuity of care might translate into reduced revenue for GPs due to a corresponding reduction in GP shared care.

Similarly, private obstetricians might experience a similar decline. To address this challenge, birthing women should be equipped with comprehensive information to make informed decisions about their birth preferences and care providers.

The notion of midwife-led continuity of care is often perceived as only appropriate for low-risk births. However, as the birthing population presents an increasing prevalence of comorbidities, fewer women are deemed suitable for this model. To extend continuity of care to all, with the objective of curbing interventions and subsequent birth trauma, it becomes imperative to explore high-risk models. Although further research is required, Fox et al.'s 2023 integrative review of Australian studies posits the merits observed for low-risk women, such as relationship cultivation, trust-building, and reduced interventions, render this approach potentially beneficial for high-risk women as well.

### *(g) the information available to patients regarding maternity care options prior to and during their care*

The information available to patients regarding maternity care options prior to and during their care is crucial for empowering women to make informed decisions about their pregnancy, childbirth, and postpartum experiences. From finding out you are pregnant, the journey to having your appointment can be confusing.

Given the lack of community education on different models of care, a pregnant woman's initial encounter with a general practitioner (GP) may increase the likelihood of entering a GP shared care model. Similarly, private obstetricians might be recommended based on prevailing health service norms, often lacking evidence-based justification. Enhancing the information provided to pregnant women necessitates educating GPs about the benefits and risks of each model of care.

At the outset of care, GPs should present clear, consistent, unbiased, evidence-based information regarding different models of care, thereby enabling the woman to make an informed decision. However, time constraints hinder GPs from delivering personalised care. To address this, information pamphlets outlining the risks and benefits of each model of care, translated into multiple languages by NSW Health, could be devised for use by health practitioners. These resources should also be accessible online, supplemented by videos to accommodate varying learning preferences and accessibility requirements.

Informed choice emerged as a central theme from the open-ended inquiries on birth trauma. Consequently, opportunities for continuous education regarding maternity care should be woven throughout the pregnancy journey. Longer antenatal appointments should be provided to facilitate discussions about place of birth, mode of birth, birth plans, pain management, and common interventions. This is vital given that unmet expectations also emerged as a recurring theme in relation to birth trauma.

Standardised information must be available for pregnant women and health professionals ensuring families are equipped to make informed choices contributing to a more empowered experience.

### *(h) whether current legal and regulatory settings are sufficient to protect women from experiencing birth trauma*

The current legal and regulatory frameworks that govern the conduct of health practitioners are based around professional codes and standards for their profession(s). These codes and standards together with organisational policies and accepted peer professional practice dictate the acceptable and unacceptable standards of conduct for health practitioners. These codes and standards are largely nationally consistent and

operate to provide guidance to health practitioners, but do not contain any specific reference to birth trauma. These frameworks are sufficient to outline to practitioners the expectations of the community and their peers with regard to accepted professional conduct.

The responsive aspects of legal and regulatory frameworks following a complaint or adverse event are less effective. What is considered an appropriate and proportional regulatory response can differ greatly depending on the registration type of a practitioner, but also may also differ within a particular profession when considering like complaints.

The guiding principles of the *Health Practitioner Regulation National Law (NSW)* state the protection of the health and safety of the public must be the paramount consideration. This guiding principle is often used as the underpinning motivation to bring disciplinary action against practitioners on the assumption that bringing that action will not only specifically deter that practitioner but will also have a general deterrent effect to other practitioners. Such actions are often very slow to come about and there is no mechanism by which actions taken in NSW are routinely communicated to other practitioners.

A more effective action to protect women from birth trauma would be to recommend the mandatory inclusion of education regarding culturally safe care and birth trauma into all programs of study leading to registration for practitioners who may work in maternity services.

The introduction of improved and consistent policies and processes for medical practitioners to obtain informed consent would potentially create a change in the culture of how informed consent is obtained and support given to women in their decision-making.

***(i) any legislative, policy or other reforms likely to prevent birth trauma***

Implementing a policy and process for women be able to access supported care in labour and birth whilst exercising their fundamental human right to decline interventions is much needed policy reform in maternity care.

It is recommended that NSW Health implement a "Personalised Alternative Care and Treatment".[14] framework.

Our members are of the view that the highest cause of the documented increase in the rate of interventions is attributed to obstetricians' fear of litigation and/or complaints. Such fear should not trump clinical indication or the autonomy of women.

Due to the known physical and psychological risks to women of facility-based childbirth[15] and the limitations of access to privately practising midwives, some women elect to 'freebirth' as an alternative. 'Freebirthing' refers to the practise of women birthing without the care of a registered health practitioner.

Women must have access to facility-based care without the fear of coercion or interventions being carried out without their consent.

One mechanism that has been trialled in Queensland is the Personalised Alternative Care and Treatment (PACT) framework which creates a structured approach to communication and documentation where women wish to decline recommended care. This allows women to access care of health practitioners in a facility and preserves the therapeutic relationships that may be negatively impacted when women decline recommended care in labour.

[14] Jenkinson, B., Kruske, S., and Kildea, S.,(2018) Refusal of recommended maternity care: Time to make a pact with women?, *Women and Birth*, 31 (2018) 433-441

[15] World Health Organisation, The prevention and elimination of disrespect and abuse during facility-based childbirth, 2015 WHO/RHR/14.23

"*While the emphasis on woman-centred care in system-level policy goes some way in supporting women's rights to refuse, further articulation is required to clearly protect women's access to maternity care irrespective of their birth intentions. The PACT framework therefore operationalises high-level policy affirming women's rights to refuse recommended care*.

"*The PACT framework offers the opportunity to appropriately respect a woman's right to refuse recommended care and support clinicians to provide care within the confines of her consent. Its utility lies in recognising that while clinicians may justifiably refuse to perform an intervention which they perceive will do more harm than good, "the provision of care during birth is not an intervention*."[16]

Creating policy frameworks that support and empower women to make informed choices about their pregnancy, labour and birth will reduce the prevalence of trauma experienced by women throughout the perinatal period.

---

[16] Jenkinson, B., Kruske, S., and Kildea, S.,(2018) Refusal of recommended maternity care: Time to make a pact with women?, *Women and Birth*, 31 (2018) 433-441

# Submission to the Legislative Council Select Committee Inquiry on Birth Trauma

AUGUST 2023

**NSW NURSES AND MIDWIVES' ASSOCIATION**
AUSTRALIAN NURSING AND MIDWIFERY FEDERATION NSW BRANCH
**www.nswnma.asn.au**
50 O'Dea Avenue
Waterloo NSW 2017