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INQUIRY INTO BIRTH TRAUMA

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I am an experienced midwife who works in two hospitals in Sydney. From my perspective, it isn't obstetric emergencies such as a postpartum haemorrhage or shoulder dystocia that cause the majority of birth trauma. These scenarios are recognised as highly stressful and consequently, birthing women (and to a lesser extent clinicians) are usually given the opportunity to formally debrief, ask questions and find closure after these events.

It is the more insidious features of everyday practice within the hospital system that I believe contributes to the majority of birth trauma. This includes women lacking a sense of agency when navigating the maternity system, and the frequent absence of genuine choice, informed consent and individualised care. Without these, women cannot leave hospital feeling that they had an empowering experience.

I have summarised my thoughts under three key themes below, coupled with my ideas for possible solutions.

1. **<u>Informed consent and why induction matters</u>**

In the hospital system we talk a lot about offering women choice and providing "person-centred care". Any health professional will tell you that women have the right to decline anything they choose. However, the everyday reality is that most women don't have much choice about the type of care they receive during pregnancy and women who question medical authority to virtually any degree are often labelled as obstructive and ignorant. There remains a strong sense of medical patriarchy within the maternity system that results in a very unequal power relationship between the birthing woman and the health professional.

The rate of induction continues to steadily rise in this context, and many health professionals seem to have adopted a cavalier attitude toward induction. Women are reassured with studies such as the ARRIVE trial that induction is no big deal and unlikely to negatively affect their birth experience or health outcomes. They also have a limited opportunity to ask questions in what is usually a rushed consultation with a junior doctor, who is under immense pressure to see patients as quickly as possible.

Countless women I have cared for postnatally describe encountering such a scenario and consenting to an induction, only to find themselves later experiencing the classic 'cascade of intervention' during their labour. For example, their induction leads to an epidural they might not otherwise have had, which leads to a prolonged second stage of labour, an instrumental birth and greater likelihood of severe perineal trauma and long-term pelvic floor issues. They feel traumatised by an experience they felt inadequately prepared for and were told was no big deal. While studies such as the ARRIVE trial might suggest that routine induction has few negative consequences, this finding is not reflected in local hospital statistics. Women are not being presented with an accurate picture and this needs to change.

Possible solutions:

- Develop a state-wide framework to guide health professionals (both medical and midwifery) in discussing induction and its risks and benefits in an accurate and balanced way
- Introduce models of two-way professional feedback into public hospitals (the standard yearly appraisal is not effective at doing this) to give junior staff the opportunity to provide anonymous feedback on their managers. This is needed in both the medical and midwifery professions.
- Address power imbalances between the medical and midwifery arms of maternity departments by implementing medical and midwifery co-directors that are on equal footing. This would go a long way to creating a respectful collegiate atmosphere in maternity departments that encourages genuine discussion about clinical care at a department-wide level, rather than the current siloed 'us and them' structure that exists in most hospitals.
- Mandate interdisciplinary handovers in every maternity and labour ward. This should involve midwives directly discussing their own patient's clinical care wherever possible, rather than the token presence of a single midwifery manager in a room full of doctors located away from the ward. This would create a more open and transparent culture of reflecting on clinical decisions as an interdisciplinary team.
- Increase access to continuity of care, especially for women who need it the most (eg CALD and refugee women)
- Introduce different types of continuity of care models to allow midwives who cannot be on-call or who need to work part-time to be employed in these models

2. <u>Caring for CALD and refugee women</u>

The issue of lack of choice and informed consent is compounded for women from refugee and CALD backgrounds. I work with a highly diverse patient population and frequently observe women consenting to interventions and procedures that they did not fully understand. For example, I remember a woman presenting to the ward and telling me she wasn't sure what she was there for, but she was told to arrive at this time. It turned out she had apparently provided verbal consent for an induction during an antenatal visit the day before, however an interpreter had not been used and she had not understood what she was consenting to. While this is a relatively extreme example, I have cared for many more women who attended hospital for an induction, but did not fully understand the induction process until I explained it in more detail and/or using an interpreter.

Possible solutions:

- Support innovative models of care for women from CALD backgrounds, such as group antenatal care using interpreters
- Increase access to continuity of midwifery care for women from CALD and refugee backgrounds, including those with higher risk pregnancies and those who book in later in pregnancy (currently places are allocated on first come, first serve basis in most programs)
- Increase availability of face-to-face interpreters in antenatal clinics to make it easier for healthcare staff to access interpreters on demand
- Double the appointment time available for patients requiring an interpreter

- Support the training and employment of more female specialist healthcare interpreters
- Fund health services to translate written information into a greater variety of community languages, including the languages of emerging refugee communities

3. Pelvic floor and women's long-term health

A large proportion of women experience an assisted instrumental birth (vacuum or forceps), which are associated with a higher rate of severe perineal trauma. The state government has done an excellent job at implanting perineal care bundles in the public hospital system and I have observed an increased awareness of the risk of severe perineal trauma among health professionals. However, I observe very little awareness of the effect of obstetric practice on women's longer-term pelvic health and women receive little to no education postnatally on how to care for their long-term pelvic health.

I recently had a baby myself and visited a private women's physiotherapist at three months postpartum for a general check-up. While I had an uncomplicated birth, I still found this visit extremely educational and worthwhile. All postpartum women would benefit from the opportunity to see a women's health physiotherapist, and for women who had a complicated birth this should be considered essential. Unfortunately, few women can afford this service.

As a midwife I have worked with many pregnant women who are experiencing ongoing issues such as incontinence as a result of a previous pregnancy or birth. Wait times for the specialist women's health physiotherapist at one public hospital I work at are long, and at the other hospital there is no such service.

Possible solutions:

- Provide all postpartum women with the opportunity to access five Medicare-funded visits with a private women's health physiotherapist
- Provide access to Medicare-funded women's health physiotherapy during pregnancy when needed
- Collect population data on the rate of pelvic floor dysfunction in the months and years following birth (eg through GPs and physiotherapists) and feed this data back to maternity hospital management. I believe many doctors would more critically analyse the necessity of using instruments if they were more aware of the long-term health impacts for the woman.