Submission No 1045

INQUIRY INTO BIRTH TRAUMA

Name: Name suppressed

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Dear Committee members,

Thank you for the opportunity to provide a submission to the inquiry into Birth Trauma 2023. This submission reflects my experience as a registered midwife of 10 years, working in a high-risk birth unit setting, in a tertiary referral hospital in NSW. I have witnessed adverse events in the workplace, of varying degrees of severity; whether it is hearing how information is delivered with bias and a lack of clear evidence preventing proper informed choice, or actual physical obstetric violence towards women in the birthing setting. Thank you for investigating the prevalence of this issue and potential opportunities for improvement. I will be addressing the terms of reference (b)(c)(e)(f) and (i).

(b) Causes and factors contributing to birth trauma

I believe that one of the biggest contributors to women's experience of birth trauma is the attempt to process individuals, with their nuanced physical and psychological histories, through a standardised system of care. Of course, it is necessary and appropriate to have overarching systems, policies and procedures that guide the smooth functioning of a large and competent maternity system. However, it is sometimes hard to focus on the individual at the same time, and the over-medicalisation of women can occur to accommodate, for example, the bed management of a busy unit.

It is difficult for birthing people to navigate this system in a way that leads not only to a physically well mother and baby at the end of the day, but also a psychologically well mother and baby. Engaging a continuity of care midwife can assist birthing families in navigating the system, and will improve actual outcomes [The Lancet: 'Supporting midwifery is the answer to the wicked problems in maternity care', Dahlen, H. et al, July 2022]. Continuity of care can help to prevent birth trauma by giving the control back to the women, as there is greater space for thorough education and trust, leading to informed decision making and consent. In this model of care, both the woman and care provider can proceed with an un-biased and un-fearful manner when women make their own choices.

Also of note, is the potential effects Covid has had on women's experience of birth trauma. The denial of support people into the birthing space, extra precautions and procedures, delays in provision of care, and the general tension in society can only have enhanced trauma in those experiencing it.

Lastly, and hardest to articulate, is witnessing actual events of un-consensual procedures being carried out during labour and birth, either through lack of adequate information provision, lack of adequate pain relief when performing emergency procedures, or lack of any consent at all. This, of course, results in trauma to the woman experiencing the event and the staff witnessing it.

(c) The impacts of birth trauma

Personally, I have come to realise I have at times experienced vicarious trauma through witnessing isolated events of what I interpret to be abuse of women giving birth. Of course, this is not a regular occurrence, and I must stress that I experience much joy and satisfaction in my work and place much respect and faith in the vast majority of my co-workers. However, there have been a few situations that have repeatedly been returning to my thoughts, and I feel distressed at the powerlessness that I felt at the time to step in and protect the women from the 'higher powers' at play. These feelings of powerlessness within the system resulted in guilt and anxiety in the workplace, which I can see if left un-checked could lead to burnout and leaving the profession. This anxiety also fed into my own

subsequent (third) pregnancy, fearing I could come to the same fate, leading me to birth outside the system.

A common theme of candid debriefs in the workplace has been that it is hard to know how to escalate these specific situations we witness, particularly when the common denominator can be the actions of an individual health professional. There is a fear of repercussions on our personal employment or workplace treatment should our concerns reach the accused or colleagues. I fear that this barrier has held many, like me, back from reporting inappropriate workplace behaviour, leaving unchecked the risk of women experiencing birth trauma from specific individuals.

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

Informed choice is extremely important, as women are far less likely, from my observations, to report trauma, regardless of actual obstetric outcome, if they feel safe, heard, in control, and that they always had a choice. The difficulty comes when the 'informing' various so greatly in content and delivery, based on the care-provider and situation. Two care providers may present the same statistic of risk differently, eg: "If you have a VBAC your chance of experiencing a uterine rupture is up to 37 times higher than someone labouring with no uterine scar." Or, "Uterine rupture with no previous caesarean occurs in approximately 0.5-2.0 per 10,000 births. Whilst uterine rupture for a woman having a VBAC can occur in approximately 22-74 per 10,000 births" [*RANZCOG Best Practice Statement: Birth After Previous Caesarean, March 2019*]. The difficulty lies in the lack of accountability in appropriate delivery of even the same statistics as this example shows.

Factors that could contribute to women receiving incomplete information preventing a well-informed choice include a lack of knowledge around the most up-to-date research available on any given topic, and practitioner fear. It's very difficult as a clinician to stay on top of and correctly interpret all emerging research, and the 'evidence to practice gap' [*BMC, March 2016, Achieving change in primary care—causes of the evidence to practice gap, Lau. R et al.*] can also hinder the provision of current evidence-based care even when abiding by hospital policies. In addition, a culture of fear in the workplace prevails; fear of litigation, 'it will come back to you', 'the hospital won't back an individual', 'you have to cover yourself'. This fear can lead to many culture-based practices in the workplace, as opposed to standardised policy or even evidence-based practice, for example in the case of "admission CTGs". Ideally informed choice needs to occur in the context of detailed discussion in a pressure-free setting, with a known care provider.

(f) Barriers to the provision of "continuity of care" (COC) in maternity care

From my personal perspective as a midwife witnessing colleagues in different work-place settings, I perceive staffing as a barrier to entering a COC model as a midwife, even though the evidence of the benefits to women and midwives of this model of care is clear. If a team of COC midwives is not adequately staffed this results in insufficient back up within the teams and inadequate rostered time off-call. I believe more staff would enter COC models if they could be guaranteed a level of stability and the assurance of regular leave/time off, a reasonable expectation. In addition, the option of entering COC with a part-time load would increase interest amongst midwives with young families, comprising a large proportion of the current workforce.

Furthermore, when personally investigating the option of entering private practice, the absence of professional indemnity insurance to cover homebirths is off-putting. This is a missed opportunity to lower the burden on public hospitals and improve outcomes for childbearing women, by shifting the focus of normal birth from hospitals into the home when appropriate and chosen by women.

(i) Legislative, policy or other reforms likely to prevent birth trauma

Without a doubt, supporting midwives and women to enter continuity of care models is the clear answer to reducing birth trauma.

In addition, moving birth away from hospitals when obstetric input is not required, would automatically reduce a number of the factors that currently contribute to trauma, such as the over-medicalisation of birth. This could look like more stand-alone birth centres, the provision of indemnity insurance for private midwives providing care for homebirths, and support for hospital-based continuity of care models as discussed in (f) above.

Public education/promotion of the outcomes of birthing in different models of care, including likelihood of experiencing birth trauma, is advisable. This information can be accessed for those who are looking, but to the average woman entering the maternity system in Australia I find that word-of-mouth often leads them to their decisions of care-provider, rather than a well-informed choice.

Thank you again for your time,

Yours sincerely,

Registered Midwife