Submission No 991

INQUIRY INTO BIRTH TRAUMA

Name: Name suppressed

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Introduce self and organisation
Many terms of reference are included in this submission: 1a, 1bi- 1biii, 1c, 1di, 1diii, 1e, 1f, 1g, 1h, 1i, 1j,

I am registered nurse and midwife for the last 12 years in NSW and ACT hospitals.

I have worked in tertiary referral hospitals and rural areas in every area of the midwifery scope of practice and I have advanced practice experience in continuity of midwifery care group practice. I hold a masters degree in advanced practice with experience in roles of education and management within tertiary referral hospitals. I have witnessed culture within the workplace where colleagues have become emotionally 'broken' and unable to practice in the profession of midwifery or obstetrics any longer. Some colleagues have left the profession altogether and grieve the loss of this role they loved. Some colleagues have experienced such trauma at the workplace that they have taken their life. The flow on affect of this is palpable in the workplace and the ripple affects of these events are extensive and life changing.

I am also a mother to 3 children (6, 3.5, 1) and because of my advantageous position of knowledge I was able to access continuity of midwifery care. Many women have never ever considered care provider options in pregnancy and many people assume that because a private obstetrician is the most expensive option, then it must be the best option with the most qualified person. I feel this is miscommunicated. If the public are well informed about their options for maternity care providers then they can make decisions that are best for their physical and emotional wellbeing. Sometimes this will mean a private obstetrician is the best expert for their care, as the expert in complicated birth. The midwife is "with woman", and the midwife is the expert in physiological birth.

I have had 3 extremely positive birth experiences. I had continuity of care midwifery where I felt safe and supported throughout each pregnancy and birth experience. I experienced 3 waterbirths with no perineal trauma and no ongoing issues. I identified my fears early in my pregnancies as fear of hospital and fear of intervention. In the 6 years prior to having my first child I had been professionally exposed to high, what I felt was unnecessary levels of intervention and ineffective epidurals that only work in some parts of the body.

Due to the fantastic care we received from our continuity of care midwives, my husband felt safe and supported and involved in each pregnancy labour and birth process. I feel that every woman and her family should have access to continuity of care midwifery practice as it has been well documented that improved outcomes occur with this continuity of midwifery care. I feel that this model of care, despite being so clearly beneficial to individual experiences and society, is dismissed as not the gold standard that it is.

Our first child was born in the birth centre of my workplace at the time in a major Syndey hospital and my biggest fear at the time was to go into hospital "too early" as I had "seen what we do to women".
Upon reflection, I recognise that excessive intervention and defensive practice (often well meaning) obstetric intervention regularly occurred within the delivery suite where I worked. I felt that my work in the delivery suite could be likened to a production line where women were put into hospital for many many reasons of induction of labour. I have personally witnessed the cascade of intervention in many women's experiences. This cascade of intervention refers to the necessary ongoing intervention that occurs when the first intervention is accessed- e.g. induction of labour includes a synthetic oxytocin drip which often causes more painful contractions, which means a woman is more likely to require analgesia like epidural, when she has an epidural the baby is less able to move down the birth canal and the birth is more likely to require forceps, ventouse or caesarean section.

It should be noted that very often women are not able to be informed about the longer-term implications of things like pelvic floor injury associated with forceps delivery like levator ani injury where muscle is quite literally detached from the bony structures. This often leads to women having ongoing, sometimes lifelong pelvic structural injuries. Pelvic organ prolapse, urinary and faecal incontinence are also associated outcomes with the use of forceps. These issues carry on into the lives as older women and then as we age, pelvic organ prolapse and incontinence are linked to increased likelihood of falls and subsequent morbidity and mortality in the elderly, adding to the cost of the health system. Support birthing people and their families to have better outcomes and reduce this incidence of birth trauma and we will save the country money.

These are factors that matter. Many of our obstetric colleagues may feel that intervention is worth the risk as it leads to a healthy baby. A healthy baby is incredibly important. However, if a mother is left with significant emotional and

physical injury following these escalating interventions, she is less able to care for her baby and more likely to have ongoing chronic physical and deteriorating mental health. Neither mother or child, or extended family will thrive in this circumstance.

People from culturally and linguistically diverse (CALD) backgrounds, in my professional experience, often seem to experience significant birth trauma. Although I feel these people would be very unlikely to ever report their experiences as trauma. This may be due to language barriers, culturally inappropriate care provision. I have not seen interpreters accessed for all cultural groups when they should have been and I can only imagine what kind of emotional trauma these women have experienced as a result. For example when a CALD woman required a forceps delivery, the consent was obtained in slowly spoken English when as the junior midwife at the time, I knew the woman was just nodding but did not understand what was being said.

Reforms likely to prevent birth trauma:

- Every pregnant woman receives continuity of midwifery care, regardless of 'risk' in pregnancy. This would mean that every woman, whether the woman requires a booked caesarean section or is appropriate for homebirth, gets her own allocated midwife or small team of midwives through the duration of her pregnancy, labour, birth and postpartum. This would not only improve birthing outcomes in the context of physical and mental wellbeing, but also improve public health measures like breastfeeding and family planning.
- The continuity of midwifery care models need to be structured in a way that collaborate with our obstetric colleagues so that referrals are established where appropriate to keep women and their families safe.
- Obstetric, midwifery and consumer groups leaders need to work together, collaboratively to find an outcome moving forward that keeps birthing people and their families physically well and emotionally safe.
- Invite consumer groups have input into policy writing within the hospitals to improve the patient experience.

References:

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