Submission No 1167

INQUIRY INTO BIRTH TRAUMA

Name: Ms Linda Deys

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Submission to the Birth Trauma Senate Inquiry, NSW

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PhD Candidate at

I will be addressing all of the Terms of Reference in my submission

I would like to be given the opportunity to give evidence at the hearing and share my clinical and academic knowledge and experience

Dear Committee,

I have been a midwife for 32 years, I have worked across the whole scope of midwifery practice in this time, in the private and public health system and for an Aboriginal Maternal Infant Health Service. All of this has been in NSW, around 6 years in Sydney metropolitan, but predominantly in the regional and rural sector of the south coast. I make this submission as both a clinician with substantial experience and an academic researcher.

As a clinician I have witnessed and been an unwilling participant to obstetric violence perpetrated on women in labour and birth. The vast number of midwives are women, caring for an all-female clientele, in a hospital system which is ruled by patriarchal history, culture and policy. Midwives, as women, are subjected to similar power and control issues within the maternity space. Some of us fight against this as 'midwives', while others submit to becoming 'obstetric nurses', the latter being a passive group who do as they are told in an attempt at self-preservation. Neither is an easy path.

Vicarious trauma is rife within maternity care. Midwives work 'with women' as our title defines, and we are governed by registration standards to provide safe, respectful and quality care that is woman-centred (1). This means focusing on each individual woman and her unique needs, hopes and expectations, including physically, socially, emotionally, psychologically, spiritually and culturally. Her rights to bodily autonomy, informed choice and control, over both herself and her baby are paramount. Our standards acknowledge that the woman alone has the right to make decisions about both herself and her baby and that the baby is not an independent being, separate from the mother (2). However, we are unable to fulfill these standards in the current maternity system. Despite often knowing the women intimately, emotionally and physically, the care we provide is always trumped by obstetric input in even the most normal and physiological circumstances. Obstetric care is an essential role within maternity services when pregnancy, labour, birth or post-partum events step outside the normal range. It saves lives. However, it should have no part of the 'normal', as medical doctors are not trained in normal. Midwives are trained to support the typical and therefore recognise abnormal and refer on as per our clearly defined National Midwifery Guidelines for Consultation and Referral (3).

As a midwife I have held women's hands and looked into their eyes while they are restrained to have their bodies cut and babies pulled from their bodies. Their partners, other midwives or health professionals also enlisted to help hold them down as they screamed for the doctor to stop, while the doctor has told them to 'shut-up'. Hand holding is not enough.

As a midwife I have tried to explain why a doctor has decreed an induction of labour or a caesarean section is warranted, knowing there is often no medical indication and that the evidence they have cited to the woman is out of date, statistically biased or has been refuted. I have advised the woman she has the 'right' to say no, that it is her body, her baby, her choice but I know she does not have that power or right in the current system. I have often heard doctors tell women that if they don't do what they say their 'baby could die' or that they would refuse care or send them to another facility.

As a midwife I have heard the stories of women who are so traumatised by their previous birth that they are choosing care outside the system for their next birth. They fear the health system and do not trust any of us working within it.

In my current leadership role I specialise in lactation support. This includes antenatal clinics for women who have experienced previous breastfeeding challenges or are expecting them with their current pregnancy/baby. I have sat with so many women who described birth trauma, obstetric violence, and loss of bodily autonomy with previous pregnancies which have then resulted in poor breastfeeding outcomes. Much of the traumatic birth experience centred around being separated from their baby soon after birth, particularly at caesarean section. This heightened the fear and trauma as they often did not know what had happened to their newborn. There is very little evidence to show how maternal separation impacts women emotionally which has led to me doing a PhD on the subject.

My research is titled *"Where's my baby?" Understanding the maternal experience of unnecessary separation of women from their babies at caesarean section birth*. I commenced this is 2020 and am currently writing up my findings papers. I interviewed 15 women who had a caesarean section birth, well mothers and babies, elective and emergent procedures, whose babies were removed from their care, sight and proximity shortly after birth. Their support persons were sent with the baby. They were not reunited for many hours and there was no medical indication for the separation. This is despite many hospital policies which supported keeping mothers and babies together.

The birth experience for these women has been profound. I only looked at women who had birthed in the previous 10 years, but other research has shown that women remember their birth experience for much longer than this. Keeping mothers and babies in immediate and uninterrupted skin-to-skin contact after birth has the potential to improve the overall experience and is protective for both mothers and babies emotional and physical well-being. My published literature review on this topic explains the evidence further (4). And yet, in 2023, they are still being separated and traumatised further.

My background as a midwife, my experience of caring for women experiencing obstetric violence, and my clinical and academic knowledge of the long term impacts of separating mothers and babies at birth makes me feel very responsible for the 15 participant stories in my data collection. Fifteen one to two hour interviews of traumatised women who cried, swore and expressed anger and frustration at what had been done to them. This impacted their decisions to have further children, changed their relationships with partners and infants, and negatively impacted their mental health and well-being. They had no power and control and did not give informed consent for many of the procedures that were done to them during pregnancy, labour & birth, and post-natally. They were coerced and threatened with risk of harm to their babies and had interventions initiated which were mostly not necessary and caused a further cascade of emergent procedures. I attach below a word cloud of the emotional responses from those interviews to highlight how these women felt both at the time of birth and separation and in the days, months and years since (appendix 1). All of these

women identified their own vulnerability and lack of power and control. They knew it should not be up to themselves to fight for what they needed and wanted during their birth.

I have presented my preliminary findings at an international midwifery conference this year (Virtual International Day of the Midwife) which includes some quotes from the participants and this can be viewed here - https://www.youtube.com/watch?v=is7ho3NoP4w&ab_channel=VirtualMidwives. I have draft papers in progress which I hope to have published in the coming months as well as further conference presentations. This will add to the growing body of evidence of birth trauma and obstetric violence in our current maternity health system. It has to change, we cannot continue to so negatively impact the lives of women in our community as these women are the ones caring for our children and future. Trauma is generational, now is the time to make change and protect our future.

In summary, my recommendations for making a change are as follows:

- True woman-centred care with a known midwife caring for all women, independent of risk or cultural identity, in a continuity of care model
- Support currently publicly funded Aboriginal Maternity care services to expand to full continuity of care models
- Trust midwives to work within their scope of practice and professional standards
- Increase midwife numbers – recognise this is a profession distinct from nursing and acknowledge the unique skills they have to care for pregnant, birthing and post-natal women – continuity of care cannot happen without sufficient midwives
- Work within our medical systems to change the patriarchal and hierarchal culture – equality for women truly starts here
- Informed consent for all women throughout their perinatal journey, and a medical system which understands a woman has the right to decline recommended care
- Understanding that a woman is not a vessel to incubate a baby – her rights will always eclipse those of an embryo, foetus or baby – her choice, her body, her baby – if we support women they will make the choice that is right for them and their baby
- Provide birth debriefing for all women so they have the opportunity to understand what happened during their birth and why certain things happened – only women have the option to say if they have experienced birth trauma, there is no criteria or box ticking to define birth trauma
- Be mindful in language that excludes women in any decision or outcomes from this inquiry – the majority of people having babies are women/mothers, removing this language further impacts the rights of women
- Be aware that some people having babies do not identify as women and that some people who are breastfeeding may not be biologically female – all need respect and care which is centred around their specific needs, including the language that defines them

Kind regards

Linda Deys

References and suggested reading for the committee:

1. Midwife standards for Practice (AHPRA) - https://www.nursingmidwiferyboard.gov.au/codes-guidelines-statements/professional-standards/midwife-standards-for-practice.aspx
2. Providing woman-centred care (Aust. Government) - https://www.health.gov.au/resources/pregnancy-care-guidelines/part-a-optimising-pregnancy-care/providing-woman-centred-care
3. National Midwifery Guidelines for Consultation and Referral (NSW MOH) - https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2020_008
4. Deys L, Wilson V, Meedya S. What are women's experiences of immediate skin-to-skin contact at caesarean section birth? An integrative literature review. *Midwifery* 2021; **101**: 103063.

Appendix 1