REPORT ON PROCEEDINGS BEFORE

SELECT COMMITTEE ON BIRTH TRAUMA

INQUIRY INTO BIRTH TRAUMA

CORRECTED

At Macquarie Room, Parliament House, Sydney, on Monday 4 September 2023

The Committee met at 09:15.

PRESENT

The Hon. Emma Hurst (Chair)

The Hon. Mark Banasiak
The Hon. Susan Carter (Deputy Chair)
Dr Amanda Cohn
The Hon. Anthony D'Adam
The Hon. Greg Donnelly
The Hon. Natasha Maclaren-Jones
The Hon. Sarah Mitchell
The Hon. Emily Suvaal

* Please note:
[inaudible] is used when audio words cannot be deciphered.
[audio malfunction] is used when words are lost due to a technical malfunction.
[disorder] is used when members or witnesses speak over one another.

The CHAIR: Welcome to the first hearing of the Select Committee on Birth Trauma. This inquiry is examining the experience and prevalence of birth trauma across the State. The inquiry will address the growing concerns surrounding the rates of birth trauma and consider what legislative, policy or other reforms can be enacted to prevent birth trauma. I acknowledge the Gadigal people of the Eora nation, the traditional custodians of the land on which we are meeting today. I pay my respects to Elders past and present, and celebrate the diversity of Aboriginal peoples and their ongoing cultures and connections to the land and waters of New South Wales. I also acknowledge and pay my respects to Aboriginal and Torres Strait Islander people joining us today.

Thank you for attending today's hearing. Owing to the nature of this inquiry, I would like to warn those in attendance and listening to this recording that evidence presented today may contain sensitive content or themes. If you feel distressed as a result of the inquiry's sensitive content and themes, please contact one of the resources available on the Committee's website. Before we commence, I would like to mention that the Committee has received over 4,000 submissions. The Committee would like to thank all individuals who have contributed to the inquiry. Sharing your story will help inform the Committee's understanding of the issues.

Given the large number of submissions received, the Committee is prioritising the processing of individual submissions received from individuals based in New South Wales. The Committee will then move on to other submissions received from individuals based in other States. Interstate submissions will be accepted by the Committee and likely be confidential due to resourcing constraints. Today we will be hearing from a number of stakeholders, including NSW Health, birth trauma and maternity organisations, expert bodies on obstetrics, gynaecology and midwifery as well as legal experts and representative organisations and associations. While we have many witnesses with us in person, some will be appearing via videoconference today. I thank everyone for making the time to give evidence at this important inquiry.

Before we commence, I would like to make some brief comments about the procedures for today's hearing. Today's hearing is being broadcast live via the Parliament's website. A transcript of today's hearing will be placed on the Committee's website when it becomes available. In accordance with the broadcasting guidelines, the House has authorised the filming, broadcasting and photography of Committee proceedings by representatives of media organisations from any position in the room and by any member of the public from any position in the audience. Any person filming or photographing proceedings must take responsibility for the proper use of that material. This is detailed in the broadcasting resolution, a copy of which is available from the secretariat.

While parliamentary privilege applies to witnesses giving evidence today, it does not apply to what witnesses say outside of the evidence at the hearing. I therefore urge witnesses to be careful about comments you may make to the media or to others after you complete your evidence. Committee hearings are not intended to provide a forum for people to make adverse reflections about others under the protection of parliamentary privilege. In that regard it is important that witnesses focus on the issues raised by the inquiry terms of reference and avoid naming individuals, hospitals, medical facilities or workplaces unnecessarily.

All witnesses have a right to procedural fairness according to the procedural fairness resolution adopted by the House in 2018. If witnesses are unable to answer a question today and want more time to respond, they can take a question on notice. Written answers to questions taken on notice are to be provided within 21 days. If witnesses wish to hand up documents, they should do so through the Committee staff. In terms of the audibility of today's hearing, I remind both Committee members and witnesses to speak into the microphone. As we have a number of witnesses in person and via teleconference, it may be helpful to identify who questions are directed to and who is speaking. Finally, could everybody please turn mobile phones to silent for the duration of the hearing.

Dr JARED WATTS, Board Director, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, before the Committee via videoconference, sworn and examined

The CHAIR: I now welcome Dr Jared Watts, who is joining us via videoconference. Would you like to start by making a short opening statement?

JARED WATTS: RANZCOG would like to thank the New South Wales select committee for its review of our previously provided submission and the opportunity to further present to the Committee today. In regard to birth trauma, RANZCOG acknowledges the physical and emotional trauma that many women and their families have experienced during birth. As a result, and as leaders in women's health, we've undertaken a number of projects in this area with the aim to both prevent and assist women who have experienced this pain. We welcome the passion and drive of the New South Wales Government and members of Parliament to assist in this process, which we hope will result in additional funding and research as well as policy and legislative changes, and we will see a difference that extends out to all women and families in Australia.

RANZCOG believes that the solution requires continuing to listen to women, further research and a multidisciplinary team effort to address this trauma. Just like for birth, there won't be one option or one solution that fits all, but it will require multiple approaches to ensure, as the WHO states, that every woman has a positive birth experience. Whether this is a homebirth, a maternal-requested caesarean section or an unplanned emergency instrumental-assisted birth, RANZCOG has ensured this women-centred and multidisciplinary approach is now our core business. We have a network of independent consumers who are paid by the college to review all our policies and guidelines and to meet and interact with our board. We ensure our guidelines are also multidisciplinary, with our terms of reference ensuring midwifery representation on writing and review committees for each obstetric guideline and other disciplines as needed.

As the terms of reference for this review Committee also note, we also agree there are added challenges for our First Nation, rural, and culturally and linguistically diverse women, as well as transgender and gender-diverse people. We therefore undertake work in this area with the OGET project for rural multidisciplinary training, working with AIDA to ensure all our trainees have a deep and detailed understanding of cultural safety, an online program for LGBTQI+ care for all members and webinars in gender diversity.

In addition, we've listened to patients who are often given conflicting information in antenatal care and we are proudly working with Monash University and the Australian College of Midwives to develop new guidelines for antenatal care, and [inaudible] our vice-president, Dr Nisha Khot, with the Australian College of Midwives' vice-president, Dr Zoe Bradfield, as co-chairs. We would welcome the opportunity to expand these programs with health service providers, other professional colleges and government departments to immediately start addressing birth trauma as well as work on longer term changes.

As in our submission, we do note concerns with the term "obstetric violence". While we understand this is an international term, we acknowledge that language is important and can often hinder a solution. Just like the term "normal birth" has undergone significant recent change, including by the WHO, we feel the term does not correctly define the issue and does not assist in a solution. We outline the reasons in our submissions and are willing to explore today as the Committee desires.

Finally, obstetrics is a challenging area of medicine. It can be said that in our society we have neglected research into women's health and we are now seeing the consequences. The technology we have has limited specificity and pregnancies go from low to high risk within seconds and without warning. We have the conflict between legislation regarding consent and providing care, and the difficulties of working in high-stress and often emergency situations where minutes can literally mean life and death. Therefore, we welcome the Committee's review into these challenging areas and its assistance by developing recommendations to ensure every woman has a safe outcome and a positive birth experience.

The CHAIR: The Committee has passed a resolution that we will be splitting questions in a free-flow format, so I am now looking at the Committee to see who is looking to ask some first questions. Thank you, Deputy Chair, the Hon. Susan Carter.

The Hon. SUSAN CARTER: Thank you, Dr Watts, for the submission that you provided. I note in the submission that RANZCOG says obstetric specialist care models have the lowest birth trauma rates. What barriers exist to stop all women being able to receive this type of care, if it has the lowest birth trauma rates?

JARED WATTS: The research that has come from a survey by the Australasian Birth Trauma Association has shown that private obstetric care, which is, obviously, a very intense sort of program—and so we would like to see continuing care, of a single model, whether that's midwifery, whether that is obstetrician. But

it's going to need to have policy changes, increased infrastructure, resources, because at the moment we all can walk into a big tertiary hospital where there are multiple women who have been waiting to see antenatal care, and we may be seeing women only once in their pregnancy and then they see a different provider each time. So I think that it would be something that would be fantastic, to be able to have this with everyone, but it's going to need to have changes in resources to be able to do that.

The Hon. SUSAN CARTER: Can you clarify what sort of changes and resources would be required?

JARED WATTS: Absolutely. At the moment, with the number of antenatal care appointments that are required, we do have these big models of large antenatal clinics and so, therefore, we would need to have the resources so that there is a team or a dedicated person that sees the same person each time. So we would be looking at MBS item numbers that can be accessed by private providers to be able to provide individualised care. There would need to be, even from infrastructure, rooms—the amount of rooms in some hospitals being able to provide these longer consultations—and we've also looked at the number of appointments that need to be provided for each individual patient to be able to provide that one-on-one care.

The Hon. SARAH MITCHELL: Dr Watts, I wanted to ask a question in relation to your submission where you talk about making more education resources available for patients, particularly around things like evidence-based birth plans. That is a bit of a theme that has been recurring in the submissions around what information is provided before pregnancy and what are realistic expectations of what can happen during labour and giving birth. Could you talk a little bit about how you see that process working now, particularly around prenatal care and information, and maybe how we could suggest that that be improved?

JARED WATTS: Absolutely. This sort of came out of that we, at our most recent annual scientific meeting of RANZCOG, which was our largest one ever attended, had a whole session on birth trauma and we had the consumers come to speak to us. They were speaking to the amount of information that they received before, so when they were actually needing to make those decisions in labour—and sometimes it can be required that they make quick decisions—that they had that information beforehand. And so for us what it would be is—it's not a very nice thing to be talking about to women who are already maybe a little bit concerned—actually discussing with them what is a forceps, what is a vacuum and what happens in an emergency caesarean section.

In my job, I do a lot of counselling afterwards of women and they just don't—we haven't told them beforehand what could actually happen in an emergency situation, and they become traumatised by it. I can understand why they're so concerned. An example could be one of my patients who was like, "Why did there need to be so many people in the room when I needed to have the vacuum?", because the paediatric team came in as well. We thought the paediatric team coming into the room so they could resus the baby in front of the mother, so the mother sees the baby, would be the best thing to do, but obviously she didn't realise that they were coming in for that reason. When we explained this to her afterwards, she was like, "Oh, that actually makes sense", but we're not giving women the information, so they're becoming stressed at the time—you know, to explain why sometimes we have to use forceps over a vacuum or vice versa, so when you need to do that in the room it's not just sort of trying to give them, "In two minutes, we need to do that." They are empowered beforehand, so they don't have that traumatic experience at the time.

The Hon. NATASHA MACLAREN-JONES: Just following on from education, I'm interested if you have any research around the CALD and the Aboriginal and Torres Strait Islander communities, the information that's provided and what more needs to be provided to tailor to meet those community needs?

JARED WATTS: Absolutely. So with Aboriginal and First Nations women, I think that antenatal care needs to be provided by the appropriate person and hopefully we can recruit Aboriginal health workers and Aboriginal midwives to give this in a culturally appropriate way. This might be looking at gender. I work primarily in Aboriginal health and we make sure about the way it is given—without certain males in the room can be quite important. RANZCOG is actually looking at information leaflets at the moment because we have no written review of them by our consumers—they are all Caucasian women. So we're actually redesigning the forms to show Aboriginal women because Aboriginal women have sort of said to me, "Well, this doesn't apply to me. It's a Caucasian woman."

We're changing our resources to actually demonstrate Aboriginal women. We're changing the language of them because obviously the words that are used are very different and then making sure that they are appropriate languages as well because we know that we have so many languages in the Aboriginal culture. I think these ideas extend over into the culturally and linguistically diverse as well to make sure they are represented in the posters and the information as people—that they see the photos of people of their culture and everything. And also to make sure that the languages are appropriate—in their language—and they have access and they know where to receive that information.

Dr AMANDA COHN: I have two questions. The first one is about technology. Dr Watts, the submission talks about consideration of better and more updated technology in the context that CTG monitoring may be overcalling fetal distress and leading to more interventions. There are also other submissions from other bodies that talk about the CTG monitoring actually being really restrictive and stopping people from freely moving around during birth and that being part of the trauma. I'd be interested to know more, understand more, about where the research is at and what promising or emerging technologies might exist to replace CTG monitoring.

JARED WATTS: Absolutely. For a little bit of background, the CTG machine is the best that we have that detects a fetal heart rate. As a world of obstetrics, we've tried to improve over a number of years using artificial intelligence and sort of different ways of actually monitoring babies' heart rates. But we do know that it overcalls it. But, unfortunately, we don't know when it overcalls until—there is evidence that we probably do a little few more caesarean sections because we don't actually know. The machine is not good at saying, "Look, this is definitely a baby in distress." But it's the best we've actually got and we could never go back to not actually using it.

I think there are two aspects: One is to make it more appropriate for women in labour and we have now these midwives who are experts on them and they have like a sort of more of a bluetooth thing that can actually stick onto the skin, so therefore they're able to move around. Some of them are waterproof so they can actually get into the water. These are quite expensive. Once again, I work primarily in rural areas. To have access to these quite expensive technologies is very hard in small hospitals—having that availability for every woman to have this sort of available technology. The CTGs can still allow them to move around and get into positions that they feel comfortable with.

The second one is it's not the most accurate and how can we actually do it? I do know that there are groups that are looking at more direct ways of measuring fetal areas. Obviously, they're not releasing exact information because it's a sort of technical thing but it appears to be mainly measuring the lactate. If we do worry that a CTG is showing that a baby's showing signs of distress based on the CTG, we can sometimes take a little sample of blood just from the skin on their head and we measure the lactate or the pH. We believe that there is evidence out there that companies are working on technology that can maybe do this continuously. Hopefully, with the development of this we can just be so much more accurate and we can say, "Look, this is a baby that's in distress", which is great. When there is more evidence for it, we can then have our interventions based on who actually needs it and we don't overcall it because it's hard, you know, and we want to make sure that you deliver babies safely, and if it overcalls, it is an issue.

Dr AMANDA COHN: There is a number of other stakeholders who've raised concerns that the rate of various interventions has increased while perinatal mortality hasn't decreased. I was hoping for your opinion or comment on why that might be the case.

JARED WATTS: Look there are some things. One is if you look at the Australia Institute research, we see the vacuums and forceps have actually stayed the same. So if you look at the 2012 right through to the most recent one, vacuums and forceps have stayed around about 7 per cent. I think there's only about a 0.2 difference of that as an instrument. I did notice some submissions talked about increasing, but overall the rate has actually stayed the same. But, yes, caesarean sections have increased.

I think that there are multiple reasons here. One is we do have the average age of women having their first baby and that is the time—your first birth is the most likely time to potentially have a caesarean section. If you're—I hate this term—an older mother, then you're more likely to have a caesarean section. We are seeing that, with fertility advances, we are having women who are able to fall pregnant with more medical conditions and at a later stage in their life as well. There is then this evidence that there are more interventions because people are older and have more health conditions at the same time. I think that you could then say that, "Look, our outcomes are quite stable." And that's quite good. If either patients are on average getting older and have more health conditions and yet our outcomes are still stable, then, yes, maybe our intervention rates have gone up.

There's also a demand in society to have good outcomes in everything. This is one of the things that we are very stressed on: that obstetricians have this pressure that we don't want a bad outcome because of the harm to that mother, the harm to that family, so we may actually be a little bit more cautious because of this. Whether this Committee can actually make some recommendations in that area so that it allows women to have that idea—to have their birth plans that are them-centred but then also provide protection for the doctor, the midwives, that, if things do go—for people who have non-standard management care, there's not the fear of a long drawn-out process with AHPRA and medico-legal aspects as well.

The Hon. EMILY SUVAAL: Given your experience, could you describe what your experience is of women that have described birth trauma and what circumstances it's more likely to occur?

JARED WATTS: Absolutely. Once again, in my role, you spend a lot of time counselling women afterwards and it is sort of quite—there are so many different multi aspects to it. I think one is the limited information, so they don't have the opportunity to know what is actually happening at the time. Then I think the second thing is that we don't actually go in and spend time with women afterwards at an early enough stage that then they start to think about what actually happened and did they actually cause it and they start to think over and over again. I think that birth trauma is going to be managed through a few different ways. The first one would be just empowering them with information in the antenatal period so that therefore they can make the informed choices and, if things do not go the way that they wished, they understand why and they're able to journey through that process.

Then the options of once it actually happens are that we have clinics set up that women can actually meet the team within—they can meet them in hospital, meet them only two weeks later, so that they can go through the process again and process the information. What happens now as standard is that we normally meet these women at six to eight weeks down the track after they've had a less than desirable—not an outcome that they actually wished. And they've had six weeks of thinking about this, lack of sleep. It affects their bonding with their child, their bonding with their family, and we've really failed to explain to them what happened. There are so many times at that six- to eight-week point where they just go, "Why didn't I find that out straightaway?" The way that we don't have access to psychologists and opportunities to set up these clinics to counsel these women straightaway, so that they don't carry on this burden for six weeks—and sometimes they don't even get into these clinics because we don't have enough of them that it's not until the next pregnancy that we have those issues as well.

I think the other one is that we need to have these multidisciplinary teams. So often some research—a survey that I was looking at from the trauma thing was looking at that midwifery group practice, which is an incredible program. But a lot of women actually do have birth trauma come out of them from their interactions with doctors. When you see what it actually is, it is that they're in this room, they're having an amazing delivery and everything is going really right but then just last minute—it's a rare thing but the cord goes tight or gets compressed and all of a sudden the midwife calls in the obstetrics team and for the very first time they're meeting the obstetricians when, to be frank, their legs are in the air, they've never met these people before, they're doing things to them that they don't really understand.

We really need to change this to patient-centred care. This idea of obstetrician-led care, midwifery-led care—we need to come back to patient-centred care and have multidisciplinary teams, because we're all needed at different times. The last thing we actually want to see is traumatising women when we meet them for the first time when we are performing a procedure in an emergency situation. I think that's the two big things that I see: counselling beforehand with information, as soon as they have an outcome that wasn't what they desired, and then that they know all the members of their team so they're not meeting them for the first time in a traumatic situation.

The Hon. GREG DONNELLY: Thank you for appearing today. Could I take you to page 2 of your submission, where you spend some time dealing with definitional matters around obstetric violence and obstetric trauma? I'm trying to reconcile some quite strong language in there expressing concerns about the terms and, if I could use this word carefully, some concession by you that there is work to be done to mitigate the potentiality of that occurring. Can you please explain why RANZCOG is taking such a strong line on its concerns around the definitions?

JARED WATTS: Absolutely. We do appreciate that it's in the international literature; it's a term that's used by many organisations, but then we see issues with the actual term for three main reasons. We felt that they may hinder getting to the solution for what these women are actually experiencing. To speak to those in detail, the first one would be the word "obstetric". Even if you do look into the Latin or the Greek—I can't remember which one it is—it does refer to being with birth, we have seen in some of the submissions that it looks to be appearing towards obstetricians. We know from the birth study by the University of Sydney that a lot of this sort of obstetric violence has actually come from everyone that could be involved in women's care: from the doctors, the midwives, the patient care assistants when they're bringing in their meals. We've had cases where they've come in and delivered their meals when they're exposed, and they feel traumatised by that experience. That is to say that this is the whole team that needs to actually focus on this; it's not just obstetrics.

The other one then is—and I've discussed it with many of my senior midwifery colleagues, and also they've discussed it on one of their birth trauma forums that I've attended—if we use the word "obstetrics", it means the obstetricians are the ones with the solution. But they've also said, "Look, if we actually use a term that involves everyone then it's all of us that need to come together to solve this issue that, if you look at the University of Sydney's data, one in 10 women are actually experiencing". We need to define it as a term that encompasses the actual issue.

The next one is that there is also the word "violence". We spoke about the intent, and I like that one of the submissions is that no-one goes to work to cause trauma. I think that when obstetricians hear this thing about "obstetric violence", we find that that can't be us. We spend six years in med school, six years to nine years at O&G. We're trying to do the best for our women, and people turn off when you hear "obstetric violence" because it's such a term that we find so—that can't be us. If we need to come to the party and actually work out a solution for this, we need to use language that engages the doctors.

There's also some international literature I've seen about the neglect in labour. That's not going to be obstetric violence if you're left alone or you're not given food, so that's another thing—that violence is seen to be an active process. But we need to look at are we making sure women have the support while they're in labour, so there's a whole thing. There are some views such as mistreatment in labour, mistreatment in birth, that do appear to define the issue as well, and also bringing all the obstetricians and bringing all the parties together so we can come together to work out a solution for what these women experience and to hopefully resolve it.

The Hon. GREG DONNELLY: You've referred to the University of Sydney study, but no doubt you're aware of the study that is generally referred to the Keedle et al study 2022 around the birth experience, which has received publicity in this inquiry. We've also had the opportunity to look at the paper that was produced around the study and the summary of it. Are there any comments you would like to make about that study?

JARED WATTS: I do apologise that I'm remote meeting today. Could you just expand which study that is? I'm so sorry.

The Hon. GREG DONNELLY: The BESt. The Birth Experience Study.

JARED WATTS: Yes. Sorry. Absolutely. We definitely congratulate the authors. This is the biggest study that has actually had a look into it. And I think that any patient that is experiencing this trauma, we should be worried about. I think that we do need further research. This was a survey-based study where it was through social media, and I think that the patients were actually recruited. Working mostly in rural and remote areas myself—to try and make sure we actually access those Aboriginal women out in those remote communities, we do need further research rather than surveys that are based on social media. So I think it's the best we've got. I would say that, based on surveys, we probably need further research that is based on—look, here are 1,000 women. Let's ask them. Let's go into detail about what they've actually experienced in birth so we can come to some of the solutions as well.

The Hon. GREG DONNELLY: Are you actually criticising the methodology of that piece of work?

JARED WATTS: I am not criticising, because it's the best we've actually got, we would say, to look at the percentages and everything like that. It was based on recruitment through social media—people that went to see the video—so it could be underestimating the birth traumas and things like that as well. We would say this is the best we've actually got—this survey—but we would call for more research in this area to see what the actual rates are and what the actual causes of this problem are as well.

The Hon. ANTHONY D'ADAM: Thank you, Dr Watts. Have you actually read the submission from Western Sydney University that's part of this inquiry?

JARED WATTS: Yes, I have.

The Hon. ANTHONY D'ADAM: Okay. I don't know whether you've got the submission in front of you, but there's a graph on page 16 that deals with the types of birth across models of care in New South Wales, and this question is probably an extension of the question that was asked by Dr Amanda Cohn earlier. But it paints a pretty concerning picture about private obstetricians in terms of the likelihood of having a caesarean section, and it seems, from this data, that you're more likely to have a caesarean section than a vaginal birth. I wanted to give you an opportunity to perhaps offer some comments about that and whether you think that is an accurate picture in terms of the role of private obstetricians.

JARED WATTS: I am not a private obstetrician. I work purely in public. But we know that the private hospitals do have a higher rate of caesarean sections, and, quite often, there is the maternal-requested caesarean sections that do come from a lot of these patients. Patients previously trying to get a maternal-elected caesarean section in a public hospital is something that didn't exist until more recently, and RANZCOG has just released a paper about this in the last couple of weeks—or guidelines, sorry. So a lot of people would actually go to the private system where, if they wanted to have a caesarean section for the maternal-request reasons, they would actually do that.

So we do see a higher rate, and there is evidence that that would be coming also from patient requests. We also know that patients that use this service with private health insurance are older and, therefore, we do know

that the risk of a caesarean section is also higher for older mothers, and there's some physiological reasons for that. So they would be potential reasons that we are also seeing a higher rate of caesarean sections in the private sector—as two of the main reasons.

The Hon. MARK BANASIAK: Thank you, Dr Watts. In your submission, you talk about some recommendations and one of them is financial support for patients who are seeking non-standard birth plans to travel to larger metro centres. Can you provide a bit more clarity as to what you mean by non-standard birth plans? Are you talking about unassisted birth or is there a clearer definition that you could give us?

JARED WATTS: For sure. Non-standard birth plans would be a decision that a patient has made to desire a birth that would be seen as outside of the clinical recommendations, and that can change hospital to hospital. An example that I'm just going to use would be that most hospitals would be attempting a vaginal delivery after two caesarean sections. This would be what we classify as a non-standard birth plan because most hospitals would actually say that the risk associated with that would be higher, and we would recommend an elective section if you've had two before. This would be someone who would have a non-standard birth plan.

I have seen other recommendations from other groups that have said adapting the Queensland—and Queensland does have a very good guideline, actually, based on this, a non-standard management plan. This recommendation would be that quite often patients can't—if they do want to have a non-standard birth plan in a small town, there might not be the resources if things do actually go wrong. They might have lower levels of blood resources; they may not have as many staff around. So if a woman wants a plan that is outside of what we would say was the standard guidelines, that there is funding for them to go to a larger centre like a tertiary hospital where there are more doctors around and there are more midwives around and the ability to have intensive care. Therefore, they can still have the birth plan that they desire but there is also the back-up to actually provide assistance if things do not go correctly.

The other thing is that we know about the second victim. When things do go wrong, there are also the midwives and the doctors that are actually affected. In small country towns that can be a bit of an issue because everyone sort of knows everyone. So one of our recommendations would be that there would be funding to women that want to have these birth plans that are outside what we would say are the clinical guidelines so that they can have them in larger service centres where it's safer.

The Hon. MARK BANASIAK: Just as a follow-up question, how prevalent is that in our rural and remote areas? I am just looking at some stats on the National Core Maternity Indicators, and it's seeming like we have a high percentage of women in remote and very remote areas actually having unassisted births and very conventional births. How prevalent are these non-standard birth plans in our remote areas?

JARED WATTS: I can't comment directly on New South Wales, as I don't work in New South Wales. But I would say that there's definitely a few—I can't actually give you numbers, sorry. I can give you personal—in the hospitals that I work in, we would have one or two per week of women that would want to have non-standard birth plans that we would go through the process of getting them to sign the paperwork and look at how we can make that birth what they want and as safe as it can be.

The Hon. MARK BANASIAK: There's no recording of this data anywhere that you could draw Committee members to at all?

JARED WATTS: I do not know for New South Wales, I'm sorry.

The CHAIR: Dr Watts, we have talked a little bit this morning about some of the increased risks of having a caesarean section. Obviously, a caesarean section is quite important to this inquiry because many of the submissions talk about there being an increased rate of birth trauma when there is a caesarean section. You've talked about some of the factors, such as age and people giving birth at an older age, as one of the reasons why we are seeing an increase in that rate of C-sections. But some of the submissions also look at the rate of C-sections in Australia compared to other countries around the world, and Australia is much higher than most other countries. Why do we have such a high rate specifically in Australia? What other factors are relating into that other than older births and stuff, which I am assuming would be worldwide?

JARED WATTS: If we are looking at obviously the high- versus low-resource countries, caesarean sections are safer and so, therefore, we do see in the higher resourced countries a high rate of caesarean section because we have a lower threshold to do them for fetal reasons. I work, for example, quite a fair bit in Africa and there's a much lower caesarean section rate because we know that the risk of caesarean sections are so high, just for the maternal reasons. That's just with the high- and low-resource countries. With high-resource countries, we do have a system that we are—the idea of access to the models of care. We do actually have that. We could look

at individualising care to see what patients actually want and to see whether we could reduce it as well. I'm not sure of any other reason, sorry, besides those ones that we have stated before.

The CHAIR: The other countries that were compared to—the US, the UK, European countries—had lower caesarean rates than Australia. It's interesting. I am assuming that they are also higher resourced but they still have a lower caesarean rate. It might go back to what you were saying about some of those conversations with women about what they want and their own birthing plans. You talk in your submission about consent. In fact you say that consent is the bedrock. It seems that this is a point of agreement across every submission that we have received; everyone has talked about consent and the need for consent. How can we improve in this area? What is not happening? Why are some people feeling like that consent isn't there? What needs to be in place to make women feel like "I actually gave consent to this"?

JARED WATTS: The first thing would be to realise the time critical nature of some decisions that need to be made in obstetrics, so therefore we need to take the information that we give to women back to the antenatal care. That can be through birth education or it can be the one-on-one sessions. We have made the recommendation that MBS item numbers are looked at to see that there is enough time to actually make sure that you develop a plan with the women beforehand to discuss their actual individual circumstances and come up with a plan. There are two things there. One is that the woman then has enough information so that, when she is put forward, if we need to do either an instrumental delivery or caesarean section, she's been given that information a few weeks beforehand. But also because then the primary carer gets to know what that woman wants.

That is why we agree on the continuing care from a single provider as the main person, whether that's a private obstetrician or a GP obstetrician, who has looked after the woman potentially for the last 15 to 20 years of her life, or the midwifery one as well. That is because then you get to know what the patient actually wants as well because you've discussed this in the antenatal care. So therefore consent can be made because there's enough information because you've had that half an hour discussion in the antenatal care. I think that the other one then would be that we do need further training of everyone involved in antenatal care on how to actually gain consent. The Law Society of New South Wales submission spoke about not only just looking at *Rogers v Whitaker* but actually how to do consent in that quick situation. We must have other areas that we can look into to learn how to do that. A program that can be funded for the birth, trauma and care for all providers would be very important.

The CHAIR: You also said in your submission that you would like legislative support and protection for providers who support women to elect non-standard care pathways. I've read some quite concerning submissions about what has happened to healthcare providers when they have tried to support those non-standard care pathways and the difficulty they have had to do that. Can you talk us through some of the policies and procedures in the hospitals that are making it difficult for obstetricians to actually support women in making these choices?

JARED WATTS: Absolutely. I think there are two aspects to this. The first one is that, if we do support women in these choices that are patient centred but they may not be seen as what is the best evidence base—we need to be looking at what the patient actually wants—if something does actually go wrong, the obstetrician, the midwife and the care providers have that protection. There's story after story that I can tell about my colleagues. People can be angry after things go wrong. Even if there is consent, there can still be complaints placed into authoritative bodies. That can be drawn out for sometimes a couple of years and they can still find that no wrong was actually done. But it's two years of worrying, of concerns and of having to report to your employer that you have an AHPRA notification over you when you're going for new jobs. Therefore people are quite worried about their jobs and their reputation. It's so easy now to have these care sites, where patients can put opinions.

If we are going to support women to have a non-standard management plan, if things do go wrong, we must have the legislative support to say, "We counselled you correctly. This is the decision you made. If you change your mind, we are there to support you at any time," but there is protection for the obstetricians and the midwives to be able to provide that care for the patients. That is the first part. The second one, as you spoke about, was then about hospitals. I think hospitals are also in the same situation, that they need the protection, when things go actually wrong, that people can't point the finger and say, "That patient was outside the guidelines, and you let her do that." We should be saying, "We empowered the woman to actually do that." So we need to have those changes from above, those legislative changes, that the consent process—how can we do this so the consent actually stands up? So we need that education of the health service providers and the clinicians as well, so both sides of it.

The CHAIR: Thank you. I just want to go back to something you were saying before and also what's in your submission around the term "obstetric violence" and how using that term can create some sort of division. From my understanding, from some of the submissions that do use that term, they're referring to obstetrics rather than obstetricians. Are you feeling that the public will be confused about the difference between obstetrics and

obstetricians? The second part—in your submission, you talked about it sounds as though it's deliberate. From all the submissions I've read so far, they've been talking more about it being avoidable rather than it being deliberate. What sort of terminology do we need to use around this avoidable concerns that are happening in obstetrics and, as you say, across the field? Because it is quite different to the much broader term of "birth trauma".

JARED WATTS: For the first part of the question, in the world of midwifery and obstetrics, we're trying to move away from the word obstetrics because it is quite often seen by the public as you're referring to the obstetrician. We know that we're part of the team, that there's the midwives and everything as well. So we are actually trying to use the word maternity. I know in a lot of the services we're changing from "obstetrics" to "maternity". Our maternal mortality, instead of now "obstetrics", is now "maternity mortality". We're trying to use it that way. We do appreciate that that refers to anything to do with birth, but we don't believe that's the way it appears to the public. We want to be seen as a team, so we're using the word maternity. We think, in the same context here, that the term "obstetric violence" is referring to obstetricians.

In the second part of your question, definitely, reading the submissions as well, I think the terms "birth trauma" and "obstetric violence" were definitely used back and forth and sometimes crossed over in the same paragraph. There is that confusion about what the actual difference is. I think that trying to define also what happens just by birth, a third-degree or fourth-degree tear—that is birth trauma that may not have actually been anything to do with the clinician involved, compared to the actual aspect of not covering a patient up after an examination or the patient has perceived that you didn't gain proper consent. Because it's always the patient's opinion that we should care most about. Even if we feel the consent was attained, it's what the patient perceived. We prefer the terms, instead of "obstetric violence", another term that actually brings obstetricians to the party, as well. We realise there's an issue that we need to fix.

The CHAIR: Thank you. So you would look at words like harm, to say, "We recognise you might have a tear and that might be traumatic, but it might be unavoidable." But then what we're also hearing a lot about here and, I guess, what's of most interest to this Committee is what is avoidable. Because within the Parliament system there's probably not much we can do about unavoidable instances. But where there are things that are avoidable—and that can come back to funding or legislative changes, policy changes, all those sorts of spaces—how do we differentiate that from birth trauma, which is much broader?

JARED WATTS: I think that other terms, potentially not using the word violence, definitely needs to be—we definitely need to differentiate them out. I'm trying to remember the word that we portrayed in our document as well. "Mismanagement", I think, and some other terms like that actually can be put forward to differentiate between birth trauma and something that was avoidable, for sure.

The Hon. EMILY SUVAAL: Dr Watts, I just wanted to take you back. Earlier we were talking about the time-critical nature of interventions that may be required and that may also be perceived to be traumatic. Could you expand on that, about what those occasions are when interventions that may be traumatic are required to ensure the best possible outcome—say, for argument's sake, you're called in in the middle of the night to assist a woman you've never met before, who's had a non-standard care pathway and who may be in need of some intervention?

JARED WATTS: Absolutely. So examples in that situation?

The Hon. EMILY SUVAAL: Yes.

JARED WATTS: The three cases that I think about are—and in trying to get consent, like an abruption. This is when the placenta comes away from the womb. It can be extremely painful for the woman. It can be both life threatening for the baby and for the mother because of the potential bleeding. When you come into this situation—which, unfortunately, most obstetricians have done a few times in their career—you've got this woman who's in absolute agony, it's happened suddenly and you need to get her consent for a caesarean section to very much likely try to save the baby's life and potentially hers as well. It is such a difficult situation because how can you get consent from someone who is in such severe pain and is frightened because everyone is going to be rushing around them—because we all know how time critical this is as well. That is one.

The other ones I've seen are where a woman has come in, she's in labour and all of a sudden her waters have broken and the cord rushes out. Instantaneously, that poor woman is turned upside down, the midwife has to place her hand on the baby's head, through the vagina, and push that baby's head back off the umbilical cord. This has to happen so quickly, and sometimes they don't have analgesia. In these situations you have to act so quickly. I think the solution for this one is the education beforehand. It is hard because you don't want to scare women in your antenatal classes and tell them about every complication, because you wouldn't want to have a child if you

heard about every complication that could potentially happen. But the big ones we probably do need to speak about, so that if they do occur they may know what to do.

I really think the birth support people are really important, to get them involved, because by getting them involved they can reassure their partner. Obviously you can't obtain consent from them, but trying to get them involved, I really think that's quite important as well. The other one is trying to manage the trauma afterwards. So that is seeing the patient straight away after the delivery to see anything. But there is really good evidence that in the first 24 to 48 hours after delivery women are tired, they are in pain, they've got opioids on board. This counselling that we do in the first 48 hours—a few women don't remember it when I've gone back again after a few days. I think it is an acute thing we still need to do because there might be women—but then also see them early again, like in one or two weeks, as I think I spoke about before, so they don't have that night-after-night worrying about did they do the wrong thing or did they make the wrong decision.

We can actually then still see them at the more traditional six to eight weeks as well to see if they—we see women after any delivery to talk about contraception, breastfeeding and how the perineum is healing and things as well. So it is a difficult situation, but that's how I would see a potential solution—well, one solution, but there are probably many that we could come up with.

The CHAIR: I have one more question. RANZCOG is supportive of continuous maternity care from a known provider. Can you talk about some of the benefits of continuity of care and how you believe it will reduce birth trauma and improve outcomes?

JARED WATTS: Absolutely. I think that the benefit of this is that the provider gets to know you. We definitely feel that there are so many different models in this one. It should be patient centred—whether they choose midwifery, their GP, obstetrician or private obstetrician. They get to know you throughout the entire pregnancy, so they can realise when things are looking different because they will know what you were like last time; we've got their ability to pick up mental health conditions more readily and quickly if they've seen you before; they will get to know your medical history in a lot more detail, rather than seeing a different provider at every antenatal appointment; and then in labour they'll have had so many conversations with you that they'll know what you wish to have in that birth plan and what you'll wish to have in birth, so they'll be able to try to help you do that.

They'll know your past history in much detail because they'll have seen you for the last 40 or fewer weeks as well, so they'll know your past medical history. When things happen in labour, they can know things like the medications you are on and your past medical history as well. Therefore, I think we've got the psychological support detecting mental health. They know what you actually want from spending so much time with you. And they're just a familiar face as well, so when things go wrong—and I see it. You watch the patients, and they keep their face on that midwife that they might know in that traumatic situation. I say to my patients, "In the emergency, just watch me. If my face is still okay, keep going." I also see patients who do this with their midwives. In an emergency situation, they focus on that person they know they trust, and that makes the process a whole lot better. If that's their GP, if that's their obstetrician or if that's their midwife, I think it's a really important thing that we should look at.

The Hon. NATASHA MACLAREN-JONES: One of the challenges we have with health is that it is partially funded at a Commonwealth level and also at a State level. You did refer to the medical provider numbers and a few other things, and we touched briefly then on continuity of care. Has any work been done to engage the Commonwealth in stepping up to the table to provide better support and funding, particularly for GPs and also obstetricians that are outside the State system, or when they come to a hospital that is State-funded?

JARED WATTS: Absolutely. RANZCOG meets with both the Federal and State counterparts. They've met with all the State ones, I believe, in the last 12 months. This is an issue, especially for our GP obstetricians, due to the access item numbers. The midwives have also made submissions about this. Definitely, the RANZCOG also looks into the gynaecological numbers too, because we know that, looking at ultrasounds and things like that, item numbers for a female pelvic ultrasound is less refunded than male ones. These are definitely things that RANZCOG is looking at and is making submissions to the Federal Government. We need to have women's health care equal to male gender's health as well. Definitely, that's something RANZCOG is looking at, both gynaecologically and obstetrics, with the Federal Government.

The CHAIR: Thank you for attending today's hearing, Dr Watts. We appreciate your time. I know you've called in from overseas, so thank you so much for that. Committee members may have additional questions for you after the hearing. The Committee has resolved that the answers to these questions be returned within 21 days. I don't think you took any questions on notice today but, if there were any, they will be included in that as well. The secretariat will contact you in relation to these questions. Thank you very much.

(The witness withdrew.)

(Short adjournment)

Ms SALLY CUSACK, National Secretary, Maternity Choices Australia, affirmed and examined

Ms AZURE RIGNEY, National Advocacy Manager, Maternity Choices Australia, before the Committee via videoconference, affirmed and examined

The CHAIR: Would either of you like to start by making a short statement?

SALLY CUSACK: I am the company secretary for Maternity Choices Australia. Thank you to the Chair, Committee and public servants for the opportunity to give evidence today about MCA's experience over more than 30 years attempting, with little success, to improve maternity services to become evidence based and respectful of women's rights. Once a woman decides to proceed with a pregnancy, no-one else involved is literally risking their current and future health prospects to ensure the safest arrival for the baby, yet our maternity care system dismisses women's hopes and expectations for their births as fanciful and a distant second place to the system's perception of safety. This is at odds with all evidence surrounding safety and birth, including our national maternity strategy, which includes emotional safety. It is a given that women want a live baby, but if that's the main focus of maternity care, we will continue to see birth trauma. In fact, Australian maternity practices are very similar to the UK's, where a systemic review showed only 9 per cent to 12 per cent of practices are based on grade A evidence and 50 per cent based on some evidence.

Contrary to public belief, it is possible for birth to unfold smoothly, with minimal physical and emotional harm if the woman is in an environment where she feels safe. Extensive World Health Organization research conducted around the developed and developing world has led to the findings that approximately 87 per cent of women can give birth without medical intervention. It's estimated that fewer than 5 per cent of New South Wales women, though, have an intervention-free birth. Even though research has shown most women want to birth this way, intervention-free or physiological birth isn't collated or reported on in perinatal datasets. In less than 100 years, our economic system has drawn the fields of medicine, law and technology into the care given to women in the perinatal period, which has led to almost complete erasure of the physiological process that has taken over millions of years to develop.

We have seen a particular explosion in interventions in just the last 20 years, which could be forgiven if we had seen a corresponding reduction in stillbirths. Sadly, as heard earlier, we have seen no reduction in stillbirths in this same period. Instead, we are seeing rising rates of physical and emotional trauma, where we are now in the position that one in three women report having experienced birth trauma, one in four developing postnatal depression and one in 10 with PTSD, and nearly one in five babies are admitted to special care nursery or NICU. The C-section rate is now 38 per cent, and 23 per cent of those babies born this way end up in special care nursery or NICU. The NICUs and special care nurseries are highly lucrative to the wider system and the way guidelines are written mean occasionally healthy babies are separated from mum, admitted and even pick up hospital-acquired complications and infections they otherwise wouldn't have gotten.

Women don't feel empowered to speak up with the fear and more frequent reports of vexatious reporting to children's services for declining recommended maternity care, which is a woman's right regardless of the outcome. We would like more transparency on these figures and associated funding for interdepartmental referral. The third Australian atlas of unwarranted clinical variations showed maternity services have the highest rates of procedures being performed for no medical reason or maternal request.

This was found to be particularly true of low-risk women, who experienced 12-fold variations. Much of this could be attributed to the fact that C-sections are more likely to happen in birth suites where an operating theatre is available. In New South Wales we have only a handful of standalone birth centres—and actually only one completely standalone. No-one in this room actually believes 60 per cent of women want or need to be cut open in order to get a live baby. Globally respected US obstetrician from Harvard Dr Neel Shah points out higher rates do not equal better outcomes. He states in particular that "American women today are 50 per cent more likely to die in childbirth than their mothers." While our outcomes aren't tracking as badly, our intervention rates are headed in the same direction. If women are having all this pain relief and interventions, why is there still so much birth trauma?

Trauma is compounded when it is not acknowledged by providers or, in our experience as professional consumer representatives, minimised—or worse, gaslit into believing it was necessary. It is vital that women hear the measures that providers, their employers, their professional bodies, regulators and government are taking to correct the issues—that they have truly heard the women and that the massive ruptures that disrespectful violence has had on them, their babies and their families, all at this precious, transformational period that can never be re-lived. I'll hand over to Azure to go through some brief but hard stats and the case for ministerial interventions for system reform.

AZURE RIGNEY: What role should the medical system play in maternity care? If we're willing to accept the WHO's findings that only 13 per cent of women need medical care, the assumption that we're intervening with over 95 per cent of births—we're seeing a massive overservicing that's very skewed towards an obstetric model, therefore directly inverse of what women want and need. Incidentally, most of the 95 per cent of women who are treated with a drug called Syntocinon or Syntometrine, which is often used interchangeably when a hospital just doesn't order Syntocinon at all—it increases women's risk of postnatal depression by 36 per cent. The product insert, by the way, advises not to breastfeed for 12 hours after use. Ironically, 87 per cent of maternity tasks are carried out by midwives, but unfortunately most of them are strangers to the women that they serve.

The Queensland Human Rights Commissioner has pointed out our current fee-for-service funding model is a perverse incentive to overservice women for financial gain. The Independent Hospital Pricing Authority states that $1,000 per birth would be saved with funding that is allocated to the woman, known as bundle funding, rather than the intervention, known as activity-based funding. Queensland Health is currently investigating allocating funding over each of the four trimesters, rather than per intervention. I also might just note the national maternity strategy recommends that women receive care from a known provider up to 12 months postnatally. In fact, if we could have the whole 12 months, that would be great too.

When 8 per cent of women have access to a known midwife, they're serviced by 3 per cent of the midwifery workforce. If we had MGP targets in service agreements, we'd have 80 per cent of women being cared for by 30 per cent of the midwifery workforce. I ask you, do we have a midwifery workforce shortage or is it manufactured from management failures based on lobby groups' best interests and political donations? As you can see by the tabled New South Wales MP brief, co-signed by 45 other community organisations, sent to all MPs about two years ago, a known midwife saves 22 per cent per birth or $5,208. That's $450 million that the New South Wales Government could save in unwarranted intervention by offering each woman a known midwife over a stranger midwife.

The WHO states that the most abuse and mistreatment occurs 15 minutes before birth, so we do not want to endorse models of care that only provide prenatal and postnatal continuity. A known midwife in labour and birth is primary prevention. No other model of care offers continuity across the whole period, even GP obstetrics, because no GPO is going to sit there for 12 hours holding a woman's hand in labour—they're far too highly paid and highly skilled. We have far more obstetricians than are required for the 13 per cent expert modelling suggests. Even if we double that number, we find it fascinating that private obstetrics is the only medical speciality where women can get a GP referral without clinical indication, and that no NSW Health services promote to women that they can self-refer to their local birth service in their preferred model of care and place of birth—also so they can capture the stats on who is missing out on what they're actually after, in hope that the services start to meet women where they're at and what their needs are. It's a great display of the power imbalance.

We insist on a system that's centred around the needs of mothers and babies, not industry. Most women want a birth without intervention, but they also want the support of people who are experts in birthing physiology that they get to know throughout this time. Give women the midwives that they know and trust. And if they want to have a doctor they should be allowed to have a doctor, too. However, we should not continue bullying women into mandatory 36-week obstetric review appointments, because time and time again women say that they're feeling quite coerced in these appointments. Let's also let women have the care for prenatal, early labour, birth and postnatal in homes and close to home, even if they have risk factors, even if we're offering them a small amount of funding to go to a larger tertiary centre if they're wanting to have a vaginal birth after two caesareans, for example.

The system needs to acknowledge that harm is done and understand the role that standard fragmented care has played. When not in relationship-based care, disrespect and misunderstandings are more likely to happen, and women fall through the gaps. Various contributing factors reports for stillbirth also state that of unexpected stillbirths, 55 per cent were from substandard hospital care. The system needs to accept that the standard hospital birth environment is contraindicated for physiological birth and inhibits oxytocin, derailing the birth process not just for women but for the staff who work there every single day. For example, the walls are painted light colours. It's just inappropriate for the normal physiology of labour and causes further unwarranted intervention, creating more emergencies to then have to manage.

In all of our years of advocacy and working for improving birth services across the country, we've found our ability to engage meaningfully with our health system very limited. Standard 2: Partnering with Consumers has allowed us to make some slight inroads, but consumer-led influence is still very minimal. Consumer reps have been dismissed from their roles when bringing women's voices to the table. We're required to sign NDAs, which make collaboration with other representatives for broader change virtually impossible, given the systemic layers of abuse are not isolated geographically. Even when very serious complaints are rarely heard and acted on, there

is little recognition of the incidence of sex-based violence in the maternity system. Women have no bill of rights or mechanisms to action their complaints about unconsented procedures. The HCCC legislation is narrow, and women report that its and hospitals' responses are extremely offensive. MCA doesn't believe it is appropriate to complain to an abuser in any situation, including maternity services. I'll pass back to you, Sally.

SALLY CUSACK: This invisibility of women's voices has led to MCA to self-fund and create a system to generate a grassroots response to lack of Standard 2 engagement change in the maternity care system. Best Birth Finder allows women to submit their birth experiences and receive a draft feedback email to send to their birth service, and other women can read these reviews to help them to find the best local service that meets their needs. We also hope that hospitals will improve access to evidence-based, rights-respecting care and consumer-driven public oversight. I would like to table some bookmarks that I have made.

AZURE RIGNEY: The evidence supporting everything we've stated has been available for up to 50 years. The policies keep being written at State and Federal levels. We know what to do; they're just not being implemented. No further money needs to be spent. We just need political will to face the facts and change the culture through incentives for evidence-based care and fines in service agreements, further fines at the HCCC level, and criminalising obstetric violence so that victim-survivors assaulted in the birth room can access the same channels for justice as women assaulted outside of hospitals, as an unexpected finger in the anus makes a woman feel the same in both situations. The intent is control. The intent is to cause harm, and this is called torture. Harm without intent is called violence. We call on the Attorney General to strengthen the sexual violence laws to include obstetric violence—and that any funded mental health line, hospitals and HCCC begin to collect and report on obstetric violence data. Thank you.

The CHAIR: Thank you to both of you. I am now going to throw out to the Committee members. We've resolved to spread the questions across. I'll start with Dr Amanda Cohn.

Dr AMANDA COHN: My question is for Ms Rigney, who mentioned in passing the design of maternity wards in hospitals and how that's not supportive for women. I am interested in exploring that further and how we can design those wards to be better for patients.

AZURE RIGNEY: Yes, absolutely. An example is not having the same lift where a 60-year-old man is going in for a knee surgery and the woman is having contractions in early labour. So a separate lift, ideally on a ground floor, a separate standalone birth centre [audio malfunction].

The CHAIR: Sorry, Ms Rigney, we've lost your sound.

AZURE RIGNEY: Sorry. Walls should be painted dark. Beds either shouldn't be in the rooms or should not be visual to the woman—certainly not in the centre of the rooms. Every single hospital room in New South Wales should have a tub where a woman can access water immersion or water birth for the significantly improved outcomes for women and their babies, with reduced NICU rates and what have you.

SALLY CUSACK: I can pick up a little bit on this too. Dr Sarah Buckley is an obstetrician herself and her PhD is called *Hormonal Physiology of Childbearing*. You can find it on her website. In it she talks about—the simplest way to explain this is that for the most efficient labour, a woman needs to have three feelings. It's interesting and goes to show how important emotional safety is for giving birth. Those feelings are to feel private, safe and unobserved. So the interesting thing is that we bring ourselves over and over into the hospital environment where that is completely contraindicated. There's no privacy. Yes, you may be in a room, but strangers can come in and out at any time. Privacy, safety and unobserved—the maternity care system is all about measuring, assessing, observing.

Also in terms of other physiological impacts, bright lights turn off the birthing hormones and, in fact, stimulate cortisol instead. Cortisol is required later on, just prior to the pushing of the baby, but during labour it's highly counterproductive and will shut birth down—bright lights, being in the presence of strangers, engaging the prefrontal cortex, the frontal part or the thinking monkey mind that has us worried about "Who's this person and why are they flicking through all these papers and what's this computer screen about and what's that beeping machine in the corner of the room for?" The sight of technology is disruptive.

There are actually some great examples of birth centres where it's a more home-like environment. As soon as a woman goes into a foreign-feeling environment, especially one that smells of antiseptic—as the research of Maralyn Foureur and her colleagues, done here in Sydney, found even the sight of stainless steel and tiling is enough to generate that release of cortisol. A home-like environment is created, and those recommendations have been taken on board for some birth room designs. For instance, I'm from northern New South Wales and there was quite some effort that went into the design of the birth units there, where there were measures taken such as putting the resuscitation beds back out of the way and not in the centre of the room or as soon as you walk in. And

there is a bed but it's not this clinical, high, narrow bed. There is room to move and places for the woman to retreat and be out of the more public view. Instinctively, we are meant to birth in privacy.

The Hon. SUSAN CARTER: Thank you both, Ms Cusack and Ms Rigney. Ms Rigney, I just wanted to follow up on something that you were talking about in relation to funding models. It also, I think, relates to your recommendation 12 in your group submission. As I understand what you were saying—perhaps I'm just confirming that I'm understanding you—you think that the issue of birth trauma would be, in part, addressed by what we might call a woman-centred funding model. So a woman might be given, for example, a voucher for maternity services, and then she would take that voucher to the service provider of her choice. Is that sort of voucher funding model what you're suggesting?

AZURE RIGNEY: Yes, that is absolutely how I explain it, too, even though it's not exactly how the Independent Hospital Pricing Authority explains it. But why the health economists think this is a great idea as well is because then the services are more likely to become competitive. Okay, so XYZ hospital doesn't have tubs but ABC has tubs just an extra 10 minutes down the road—then the women who really want that water birth are going to go elsewhere. Follow the funding and they might start becoming woman centred. They might start improving—and hopefully less restrictions.

The Hon. EMILY SUVAAL: I've got two questions, if you'll indulge me. Thanks so much to both of you for appearing today and for travelling; I know you've travelled some distance to be here, Ms Cusack. I wanted to ask you to expand more on the comments around interventions that you made in your opening statement, in terms of the explosion in the rates of interventions. That is somewhat contradictory, I suppose, to evidence that we heard from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists this morning, who stated that it was the same since 2012. What comments do you have on that? Are there occasions when interventions that may be traumatic are required to ensure the best possible outcome for babies and their mothers?

SALLY CUSACK: I might jump into that second question and hand over the first part of the question to Azure. Yes, there are occasions when birth can suddenly take a very different course. We're familiar with the term "emergency caesarean"; it's used a lot. However, we have found—and it's not just us, but through the international research—that most of these procedures happen over a period of hours and sometimes even days in the lead-up to these caesarean sections. The better term is "unplanned". However, at the far end of the spectrum—the very pointy end of the spectrum—yes, there are some very sudden events that can develop. But we're talking in the less than 1 per cent sort of numbers. The incidence of cord prolapse, which Dr Watts referred to earlier, is like a 0.6 per cent chance. Yes, it is highly distressing and you need to act on that, and of course any woman is going to want someone to just come in and deal with that. We're talking about the other end of the spectrum here, where it's over many hours, days and possibly even weeks.

The Hon. EMILY SUVAAL: Something like pre-eclampsia, for example?

SALLY CUSACK: Yes—not that that's something that can happen to most women. That, too, is a more unusual event. No, it's things like the perception that a baby might be big or that you haven't birthed within—there's some variation there in the interpretation of the best time for a baby to be born, but there's a common obstetric view that 39 weeks is the best time for a baby to be born and that babies should be induced at around that time. For instance, in the case of Dr Sarah Buckley's research that I mentioned earlier—well, it's not just her research but she quotes it in her thesis—an intervention like the synthetic induction of labour is only going to work when the woman's uterus has sufficient oxytocin receptors in order to receive that medication. Prior to that time, all you're going to do is raise the woman's blood pressure and cause distress in the baby.

Interestingly, as a woman goes through her pregnancy she's developing these oxytocic receptors, and it's hours and maybe a day or so before birth that she gets this exponential increase in these receptors. Whenever she's ripe and ready to go is a very individual thing; it's between 37 and 42 weeks. So if a woman is induced at 39 weeks and she would naturally go into labour at 40½ weeks or something like that, it's really not going to have much effect. So it's best for Syntocinon, that induction, to wait until the woman's ready, but we don't know when that is going to be and, ironically, she will go into labour anyway.

So, yes, just talking there on that point of the—it's the lead-up to these interventions that is really what we're talking about and where consent is required. Many women are experiencing sort of antenatal education, we could call it, or some people might even call it coercion, to start thinking about induction when they're at about 36, 37 weeks—"Oh, you might want to start thinking about induction," "Oh, baby's looking a little bit big and you're looking tired." A lot of women end up choosing it simply because they live too far away from their birth service and they want some sense of control of when it's going to happen. So they may choose that for very valid reasons, but many other women are just wanting to go into labour spontaneously and they're being sort of primed for this suggestion over time. And then it might be suggested, "Oh, why don't you have an ultrasound scan late in

pregnancy. That might help us work out what's the best time for you", and then, "Oh, baby's looking rather big." One in three of those cases of suspected macrosomia turn out to be quite incorrect.

We come across countless stories every year of women who—well, I can't say countless but obviously a high number of stories every year from women who were induced due to suspected large baby, and baby turns out to be 7½ pounds and not an issue. This is where the consent issue is so important. Dr Watts talked earlier about the importance of needing time to get consent from women. I would like to point out that it's not the responsibility of the carer to get consent. It's their responsibility to give the information and for the woman to then make the best decision for herself. This is where continuity comes in. He's quite right, women need time to consider their options. In a sudden emergency situation, she can't give that level of consent. But if she's got a cord prolapse, she's going to say, "Do whatever you have to do." Really, we're talking about small numbers here, I repeat. We're talking about the rest of the scenario here. So, Azure, did you—

AZURE RIGNEY: Thanks, Sally, for explaining grooming. I was just going to give a real high oversight. We get many, many complaints every year and a lot of them are, "Look, I was told I needed an emergency C-section. I said yes because I wanted to save my baby's life," and she's sat there for three hours on the trolley waiting to go into theatre. So these sorts of things are, I guess, what we're trying to get at. To get at your first question, if I could just point to Denmark. Twenty years ago, both us and Denmark had a 17 per cent caesarean section rate. We're now at 38 per cent and they're just at 18.5 per cent—18 and a bit, can you not exactly quote me? But you know what I mean. It's like, okay, something is not adding up.

The Hon. EMILY SUVAAL: It's fair to say, though, some women may choose to have a caesarean and there are different categories of emergency caesarean sections. There is category zero and various stages of what is described as an emergency caesarean, but there may be different degrees within that.

AZURE RIGNEY: Two per cent of women have tokophobia, so, yes, absolutely we acknowledge that about 2 per cent or so do a maternal request, as is their right. We do have less complaints about that issue, about not being able to access a caesarean section on request. The main issues we get over and over again are not being able to access water birth, not being able to access a known midwife, not being able to access out-of-hospital birth and those sorts of things.

The Hon. EMILY SUVAAL: I want to ask a second question, with regard to your statements around the midwifery shortage. We've received submissions from the Australian College of Midwives, which describe the midwifery workforce as "declining", and I quote here, "data indicating that there are 1,220 less midwives nationally than there were in 2016". Do you have any comments on that?

AZURE RIGNEY: Yes, absolutely. Like I said, though, that's based on how we currently have fragmented maternity care, how we currently have midwives mostly in call models. I think only 11.6 per cent of New South Wales women have access to a known midwife. So if we scale that up to 80 per cent, the health economists state over and over again, and in their research, that there will be no midwifery workforce shortage. As well, a lot of those burnout issues will reduce and the attrition rate in universities will drop out, because I'm told time and time again from universities around the country that their student midwives are dropping out because of the trauma they're witnessing in hospitals. It's not the way that the textbooks tell them that maternity care should be delivered, so it's a moral injury.

The Hon. EMILY SUVAAL: But there is certainly a shortage of midwives nationally.

AZURE RIGNEY: If we currently have this fragmented system, yes. But what we're saying is if we had MGP targets, in-service agreements and ministerial directives to LHDs, then, no, there will be no workforce shortage for midwives.

SALLY CUSACK: There's a high attrition rate that we're experiencing in this fragmented system that most women and most of their care providers are working in. Research into continuity of care models for—research into the experience of the carers finds far higher levels of satisfaction.

The Hon. MARK BANASIAK: Ms Rigney, during your opening statement I think you mentioned women feeling coerced into getting regular check-ups, and I think you referenced the 36-week mark. Do you have any actual data or facts and figures that you could perhaps come back to us with on notice in terms of how many women have reported feeling coerced into getting check-ups? What is it specifically about the 36-week check-up that they're having concerns about? I'm just looking at some information about what happens at that 36-week check-up. I'm just wondering what's triggering that concern at that point?

AZURE RIGNEY: Yes, absolutely, and we would love more data capture on this, but unfortunately there's no funded maternity advocacy bodies who record obstetric violence stats.

The Hon. MARK BANASIAK: What are you basing that statement on, then, if there's no—

AZURE RIGNEY: The women who contact us every single day stating, "I felt coerced into seeing an obstetrician at the 36-week appointment. He didn't want me having a VBAC. He's saying that I should have a caesarean section." Then, as the consumer rep, we have to go to the hospital guidelines. We look them up. We provide them to her where it actually says, "Well, it could be a senior midwife that you see at 36-weeks. It doesn't have to be an obstetrician, but not every hospital has that." Not every hospital makes the guidelines publicly available. When we look at the guidelines, we know that only 9 per cent to 12 per cent are based on best evidence. We know that the way that the guidelines are written, it says midwives "must" do this, this and this, and obstetricians "may" do this, this and this. There's a lot more flexibility, and you can see the power imbalance in just the way that the guidelines are written. I'm happy to send you an article on that later on.

The Hon. MARK BANASIAK: Perhaps on notice, can you go away and collate some data for us in terms of—I don't know whether it comes through either a phone call or hotline or an email—how many people are saying to you that they're feeling coerced into getting obstetrician check-ups and, particularly if they're saying anything specific about that 36-week mark, what is triggering about that point? I note that there is a vaginal swab, which probably would be quite confronting, but everything else seems quite run-of-the-mill in terms of tests they perform. If you could just take on notice any data on that, it would be really helpful in trying to understand that very specific concern that obviously is coming to your organisation.

SALLY CUSACK: Yes. We would love more support in being able to capture data too, actually. We do all of this work as volunteers and so this is why we developed Best Birth Finder. It's a way to capture these stories in a central place. At the moment we don't have the system. We will go—

The Hon. MARK BANASIAK: Whatever you can give us would be helpful, yes.

SALLY CUSACK: We will do that and go back through our Facebook messages, text messages, emails and we can pull some of that data out. But we do not have a system that we can draw on to give you that information and it's not captured by the system. The other thing to just be aware of is that most women are in a fragmented system. What that means is that they're seen by a team of midwives who are overseen by obstetricians. So the standard process for an otherwise well woman is she has her monthly check-ups and in the last month or two they become two-weekly and then weekly. At 36 weeks—that's just picked as a point where the overseeing obstetrician gets to eyeball the woman. Prior to that she's just been seen by midwives.

This is a point that we've made in our submission—it points out the problem that exists for midwives being restrained from acting to the full scope of their practice. They're meant to be primary carers, the experts in physiological birth who understand when things deviate to abnormal and when to bring a doctor in. So the assumption is that the midwives who are overseeing the women just need to be—it just all needs to be checked by an obstetrician. It's not just an assumption; that's how the system works. And it hamstrings the operation.

AZURE RIGNEY: I was just going to say, if women don't want to have that 36-week obstetric appointment, sometimes they miss out on the birth centre, the publicly funded homebirth model or the what have you. There's literally research around the missing out, the qualitative stuff. I know you want more the quantitative but we might just send you that as well because it's fascinating.

The Hon. MARK BANASIAK: Yes. Any data on that—I just found it quite intriguing that women would be feeling coerced into going to get a check-up.

AZURE RIGNEY: By their non-preferred provider.

The Hon. MARK BANASIAK: Having experienced three births myself and going to every single check-up, I'm curious as to what the concern is there.

SALLY CUSACK: Well, if there's nothing that's detected by the obstetrician, then, yes, that's fine. And it depends very much on the obstetrician who's there at the time. Perhaps, certainly with second and third babies, there tends to be, if the first birth went fairly normally, an assumption that, "Oh, look, she's likely to be okay. Let's just tick that box and move her through."

The CHAIR: Just to clarify, is it that they're feeling coerced to go to the check-up or is it that they've gone to the check-up and then felt like, "Okay, I've just spent 37 weeks with this plan in mind and now I've just been given all this different information from somebody who hasn't been involved in my pregnancy until now and now I'm really confused"? What are we looking at here?

AZURE RIGNEY: Both. So women often will say, "I had this bad experience last time or I've had bad experiences with doctors in general." There's a range of reasons, so they just don't want the doctor-led

appointment; they want the midwife-led appointment. We certainly don't care what women choose, as long as they get what they want. Occasionally if a woman is getting a hard time about accessing a maternal-request C-section or accessing a doctor in the public health system, she'll contact us, but that's a very small amount of the complaints that we get compared to the ones who aren't being told that they could just have a senior midwife or their known midwife do the 36-week birth plan case review.

SALLY CUSACK: And that person brings a different perspective to physiological birth than the midwife who has developed the relationship over the weeks and months.

The CHAIR: NSW Health published in March the blueprint for action for maternity care in New South Wales and it does address some of the systemic issues regarding maternity care. Are you familiar with this document, and do you think it goes far enough or do we need greater reform?

AZURE RIGNEY: Absolutely I think the Queensland birth strategy is a thousand times better and I hear it's going to go online in the next week or so. If New South Wales would look to Queensland, I think that would be a very good idea.

The Hon. GREG DONNELLY: Thank you for coming along today to provide us with the opportunity to follow up some of the important points you make in your submission. Looking at the NSW Health submission and specifically on page 11, 3.3, NSW Maternity Care Survey. You may not have the submission with you. But I'm sure you've had a chance to look at it. I'll just summarise what it says. It talks about NSW Health commissioning the Bureau of Health Information to complete surveys. It refers to surveys in 2015, 2017 and 2019 and then refers specifically to the 2019 maternity care—

SALLY CUSACK: Sorry, which page was this again? Because I do have it.

The Hon. GREG DONNELLY: Page 11 of the document that is titled *Inquiry into Birth Trauma*. Do you have page 11?

SALLY CUSACK: Yes, I think so.

The Hon. GREG DONNELLY: And do you have 3.3, "NSW Maternity Care Survey"?

SALLY CUSACK: Oh, my goodness. I'm sorry, I'm looking at the wrong one.

The Hon. GREG DONNELLY: That's okay; I'll read these out. This is from the 2019 survey, the most recent one that's been done. It reads:

> The 2019 Maternity Care Survey reflects the experiences of 4446 women and highlights:
>
> - 94% of women rated their care during labour and birth as 'very good' or 'good'
> - 90% of women felt they were 'always' treated with respect and dignity during labour and birth
> - 86% of women felt the health professionals providing their antenatal care 'always' explained things in a way they could understand
> - 90% of women felt the health professionals were 'always' polite and courteous
> - 92% of Aboriginal women felt their emotional health was 'yes, definitely' or 'yes, to some extent' supported by health professionals during pregnancy.

So that's a report that's in the public domain; it's not that old. I'm trying to reconcile what your organisation is saying with what has been publicly researched and put into the public domain, bearing in mind the majority of women in New South Wales have their births in public hospitals. In percentage terms, those figures are quite high—in fact, arguably very high. How are a number of the points that have been made in your evidence this morning reconciled with survey results like that?

AZURE RIGNEY: It's a great point, and that's why I guess I'd prefer to defer to the experts such as the health economists at UTS who are currently developing a really rigorous and international standard of PROMs and PREMs—that is, patient-reported outcome measures and patient-reported experience measures—rather than just BHI's survey. But then, also, I've had two babies in New South Wales. I didn't realise that I'd been raped for five years. So what sorts of questions are we asking women, and do they know what's happened? I just sort of felt like something wasn't quite right, but it was only with time that I realised, "Oh, that's actually a really inappropriate thing that happened". The way that we ask questions can be perceived as grooming and minimising and gaslighting, and all these words that we hear within this—

The Hon. GREG DONNELLY: May I ask you this, then? In terms of the Bureau of Health Information work, which is done on quite a rigorous basis and in a whole range of the domains of health—and the methodology

is very clear; the questionnaire design, the sampling procedures et cetera are all there for people to see—are you casting doubt about the integrity of their survey work?

AZURE RIGNEY: It's more the questions that we're asking—less about methodology but more how are we asking questions and are women understanding. They might say, "Well, I received care, and any care is better than none", not realising that actually they didn't get access to a known midwife; therefore, perhaps their preterm birth could have been prevented, if they were Aboriginal, by literally 50 per cent. They don't know what they don't know and so, yes, that's why we have concerns when things like this aren't done independently of government.

The Hon. GREG DONNELLY: I just want to drill down a little bit here. The Bureau of Health Information isn't run by the Government. You would know that, wouldn't you?

AZURE RIGNEY: With government agencies who get government funding, though—and I sit on many of these so I actually have experience but, unfortunately, like I said, have had to sign non-disclosures—the way that those committees are formed leaves a little bit of questioning.

The Hon. GREG DONNELLY: Says who?

AZURE RIGNEY: Do you know what I'm saying?

The Hon. GREG DONNELLY: Says who?

AZURE RIGNEY: Well, it's just, sometimes the way that they structure it is to achieve a certain goal. Remember that these agencies are run by members of the medical lobby.

The Hon. SARAH MITCHELL: I just wanted to ask one quick question in relation to continuity of care, because that is something that comes up around information that women have throughout their pregnancy and giving birth. Obviously, in your submission you talk a lot about having the continuity of midwifery care. I just wanted to ask your opinion or perspective as to whether or not it is actually important to have continuity with someone who you feel comfortable with. Take this as an example: I live in a regional community and had my two babies at my local hospital, and that relationship, for me, was with my GP. And I felt really strong and confident in that. Do you think, regardless of who the caregiver can be—and sometimes there are workforce challenges around that—is the overall message that, if you can have that continuity of a trusted relationship with whoever as a woman you choose to go down that path with with your antenatal care, that continuity is the most important piece?

AZURE RIGNEY: So, member, I assume your GP wasn't there for the whole 12 hours of labour?

The Hon. SARAH MITCHELL: Not all of it, no.

AZURE RIGNEY: Therefore, it's not continuity of carer. So, unfortunately, what *The Lancet*, the Cochrane, the United Nations and UNICEF—all of the above—say is that continuity of midwifery carer is what improves outcomes. So, yes, absolutely. If you love your GP, that is fantastic that you can see your GP, and no woman should be stopped from doing that. However, women are absolutely stopped from having a known midwife, and that is what we want to put a stop to, because it's safer and it's cheaper.

The Hon. SARAH MITCHELL: Do you see that as two different levels of the support that you receive throughout the process? I just want to be clear so I understand.

SALLY CUSACK: The research supports that having continuity of midwifery-specific continuity of care delivers the best outcomes. They're the experts in physiological birth. But, as in your particular situation, there may be very little difference in terms of outcomes, because you had that very strong relationship with your GP. But, overall, we are talking about populations here.

The Hon. SARAH MITCHELL: Everyone has their own experience, but I am just interested in that continuity model and what you perceive that to mean. But that has been useful to clear up.

SALLY CUSACK: Possibly, I think, the relationship that your GP would have had with your hospital—your GP, when not there. They would be familiar with how your GP practices and his or her expectations, and the staff would work pretty synchronously with that. But the general finding is that midwifery-specific continuity of care delivers the best outcomes.

The CHAIR: Unfortunately, we have run out of time. Thank you both for attending today. I assume that Committee members will have additional questions for you after the hearing. We have resolved that the answers to these along with answers to questions that were taken on notice be returned within 21 days. The secretariat will contact you in relation to these questions.

SALLY CUSACK: I'm happy to provide more information to the member about the BHI survey.

(The witnesses withdrew.)

Ms AMY DAWES, OAM, Co-Founder and CEO, Australasian Birth Trauma Association, sworn and examined

Ms AMANDA TURNILL, Chair, Australasian Birth Trauma Association, sworn and examined

The CHAIR: I now welcome our next witnesses. Would either of you like to start by making a short statement to the Committee, just keeping it within a few minutes?

AMY DAWES: Thank you to the Committee for this opportunity. We commend the work in establishing and undertaking this inquiry. Eight years ago, I was diagnosed with life-altering injuries as a result of the forceps delivery of the birth of my first child here in a New South Wales hospital. My diagnosis occurred in an appointment with a private women's health physiotherapist. When I got home from that appointment, I googled "physical birth trauma" and nothing came up. So I googled "birth trauma", and I found an organisation in the UK that focused on PTSD as a result of the birth experience. After this, I started researching and I found out how common birth trauma actually is. Yet, despite this, there was no support for women. It was for this reason that I co-founded the Australasian Birth Trauma Association—so that other women like me would be able to find the support that I couldn't.

Since starting the ABTA, we have gone on to support over 4,000 women and parents who have experienced psychological and/or physical trauma as a result of the birth process. We work collaboratively with both parents and the range of clinicians involved in the care of birthing families to better prevent, diagnose and treat birth-related trauma. This includes obstetricians, midwives, nurses, doctors, mental health clinicians and specialist surgeons. This is in our mission to increase understanding and provide support and advocate for people impacted across the community. We have developed a range of health information and resources, and we have presented to thousands of healthcare providers to raise awareness and educate about birth-related trauma. Our aim is to develop a trauma-informed model of care to be used in a maternity setting. Birth-related trauma is under-reported, undervalued and over-represented in the community. This issue has wide ranging ramifications across society, yet it's mainly women and families that shoulder the burden of living with the impacts and finding the support that they need.

The work of the Australasian Birth Trauma Association is done by an almost entirely volunteer workforce. Everyone involved has some lived experience of birth-related trauma. We receive little to no government funding, and we rely solely on the donations and the energy of our passionate volunteers. Most of the work that we've done to raise awareness in education and support is done by people like me, with a lived experience and whose lives have been affected by birth-related trauma. From feedback within our community, we see that health system care pathways are fractured and access to care can be a lottery, depending on your postcode and socio-economic status. This shouldn't be the case, and we look forward to working together with the New South Wales Government and the maternity health systems to prevent ongoing birth-related trauma in New South Wales. This type of inquiry should be extended to all Australians.

The Hon. EMILY SUVAAL: Thanks, Ms Dawes and Ms Amanda Turnill, for appearing today. I wanted to start by congratulating you, Amy, on your recent Order of Australia, which acknowledged your service to women's health, particularly to birth-related trauma, so well done. It's true that there is no universally recognised definition of "birth trauma". I suppose that is probably our first challenge. In your submission it is referenced that one in three women experience birth trauma. Where is that figure from?

AMY DAWES: That is an Australian-based study, but it was done quite a number of years ago. We definitely need some more research in this space. Interestingly, it's come through in the surveys that we have done. But we would like population-level data. We would like that gathered by the government as well.

The Hon. EMILY SUVAAL: Are you referring to the BESt study that we heard about?

AMY DAWES: No, this was a study done a while back by Creedy. It's in the report. We can give it to you later.

The Hon. EMILY SUVAAL: We have heard a bit about interventions today and the reasons for interventions. Do you have any views on the occasions when interventions that may be traumatic are required to ensure best possible outcomes for babies and mothers? What are your thoughts on when these are required?

AMY DAWES: I think it's an interesting conversation. We heard RANZCOG speak earlier and they were saying that we can't possibly inform women about all the risks associated with birth. I think we need to stop infantilising women and we need to actually empower women with information. We know statistically that one in five women are going to end up with an unplanned caesarean section. We know that one in four first-time mothers are going to end up with an instrumental delivery. So why aren't we talking about this before women are

in the birth suite? That is the biggest thing. As we've touched on earlier today as well, birth-related trauma is not always preventable, but there is hope and there is preventable trauma. A lot of that can be done with informing and providing women with knowledge and resources and information and tools to prepare effectively for birth.

The Hon. SARAH MITCHELL: Thank you, Ms Dawes, for your submission and for sharing your story, and thank you to the many women who have provided excerpts from their experiences in your submission. I thought that was really powerful. For us as a Committee to really understand the different experiences and the different levels of trauma and impact was really useful. I want to put on the record my thanks to everybody who helped and gave you that information.

I will follow on from what my colleague just asked about. In your recommendations at the beginning of the submission in section 8 you talk about more evidence-informed information and enhancing standard postnatal information provided to families. I completely agree with you. It has been a common theme throughout the submissions that we have to be providing more information for women and families going through this process. If we were to recommend one thing that we could do to improve that access to information, is it standardising what comes in antenatal classes? Is it more public information available? Where do you see the really obvious gaps around information that women receive as part of this?

AMY DAWES: I love that question. There's a real positive to be drawn from the new LEAAP guidelines that are in development in collaboration with the College of Midwives and the college of obstetricians. Those guidelines for antenatal education are being refreshed for the first time in five years, but these are the first national guidelines for postnatal care that have ever been developed. For postnatal care, it's just non-existent. That is quite staggering. That's going to take quite a process, but I think we need to implement recommendations from these guidelines.

I think it's really important that we look at how antenatal information is delivered. What we would like to see is a collaborative care model, where midwives and doctors are working together to deliver information, and also including mental health clinicians when required. Pelvic health physiotherapists have a really great and important—they bring some knowledge into this space to help prepare women for physiological birthing and identify those that may be at risk for complications or difficulties. It's that collaborative care.

One thing that I think we have really missed or that needs to be addressed when we are talking about birth-related trauma is also how we screen women effectively for those that may be at risk of experiencing psychological trauma as a result of the birth experience. That's maybe not so much as education but how do we work with women and families to give them an environment where they can disclose information safely with their caregiver about things in their history that may influence their birth experience. That seems to be a real gap.

The Hon. SARAH MITCHELL: That was actually going to be my second question, which goes back to part 6 of your recommendation, around having that screening process for pre-existing trauma, because—you're right—I think that that's a space where more needs to be done too. So you've answered my second question in the first, as well, unless you wanted to add anything more about that pre-existing—

AMY DAWES: Yes. It talks to you thanking us for sharing the stories. We pride ourselves on learning. We've been learning from the community that we've supported for the last seven years. I'm so incredibly lucky that we've had brave women that have disclosed their pre-existing trauma of sexual assault or abuse and how that has influenced their birth experience. I've only learnt that from the community that we've supported, not from the clinicians that we're working with. So I do think that that is a gap that we need to perhaps address and look at how we can do that well.

Dr AMANDA COHN: Your submission raised not just prevention of birth trauma but treatment for trauma, whether that's accessing treatment for physical injuries or accessing psychological treatment for psychological injuries. It's something we haven't had the opportunity to discuss yet today, so I was hoping to understand in more detail some of the challenges that the people you've spoken to have had in actually accessing treatment for their injuries and the recommendations around improving that.

AMY DAWES: If we talk about physical birth trauma first, it really came through in our birth injuries report that we did last year, in 2022. The aim of that survey was really to understand the prevalence of birth injuries, how the system is at diagnosing them and the impacts of those injuries. The one thing that just came through again and again was how difficult it was to get a diagnosis. They would maybe go to a care provider and talk about ongoing pain symptoms, issues that they were experiencing. Often they were dismissed, or they were told it was a normal part of childbirth.

That further exacerbated their mental health challenges because they're navigating, remember, looking after young babies while many are unable to leave the house until they've had a bowel motion, or they're suffering

from incontinence. The psychological impacts and the physical impacts often go hand in hand. What came through and why we really advocate for pelvic health physios to be as involved in the care of birthing families as we'd like to see midwives and doctors is because it was often private pelvic health physios that were the first ones to identify any type of trauma and also signpost them to mental health support as well.

Then, with the psychological aspect of trauma, it's really complex as well because many women that we support may have symptoms of depression or anxiety, but they may benefit from specialist trauma treatment. But there is a gap in that kind of information for care providers. There's no screening done to identify those that may be experiencing PTSD symptoms as a result of their birth, so they might go through traditional mental health treatments. They might have depression and anxiety, but that could be as a result of the trauma. So often again they're struggling to get the support that quite suits their needs. That comes through a lot in the stories from the women that we support.

The Hon. SUSAN CARTER: Thank you very much for the submission, especially, the insights that you get from all the contributions that are in the submission. If I can take you back to the issue of screening or better understanding women who are presenting who may be at greater risk—therefore we might look at more support for those women—I was very interested in the comments, made in the submission, in relation to the stages at which trauma can occur and something that had not occurred to me at all before, that experience of prior termination may be something that puts women perhaps at greater risk of birth trauma. I wondered whether you had any comments as to whether that should be something that is routinely screened for. Also, I suppose the comments seemed to suggest to me that we're looking at birth trauma but perhaps there's also trauma associated with termination—and the extent to which there should be debriefing and counselling available to women post-termination.

AMY DAWES: Yes. I think one thing that we've discovered in our work as well is that all through the process of that journey to parenthood there can be challenges. Those challenges are underpinned by how we're treated. We know that many women even going through the IVF process—parents going through the IVF process—it's incredibly challenging, and yet many don't get offered counselling, and there's no support. So you would apply that for people that have to go through termination. Absolutely. Then it's also understandable that people who maybe have experienced early pregnancy loss—they are going into the pregnancy and birth experience, rightly and understandably, with a level of anxiety, but we are not necessarily picking that up and understanding why that individual in front of you is feeling a particular way. So it's working with our care providers to better screen for pre-existing conditions.

The Hon. NATASHA MACLAREN-JONES: In relation to one of the recommendations you've made, which is on page 10, in relation to NSW Health undertaking a review of New South Wales maternity care practices, you refer to "genuine birth mode choice". Could you outline what that means and what type of view you would be looking for the department to take?

AMY DAWES: Yes, providing women with an option for choice. That's the one thing we really want to see: genuine choice. There has been a lot of conversation today about caesarean section rates. What I discovered very early on in working in this space is that, often when we look at birth trauma, we are looking at vaginal birth versus caesarean, but we see it as much more than that. We see it as women not being enabled an opportunity for truly informed choice, whatever that could look like. We support women who have had incredibly traumatic caesarean sections, we support women who have had incredibly traumatic vaginal birth and we support women who have had everything in between. We need to create a model of care that enables women to have informed choice and their choices provided. That could be a homebirth or that could be a maternal-request caesarean, but at the moment, again, it's a postcode lottery.

The Hon. NATASHA MACLAREN-JONES: How does that work in the case of an emergency?

AMY DAWES: Again, it's down to the individual. If we are providing evidence-based information in birth preparation, then decisions are made. If somebody decides to have a homebirth and they're not within a reasonable distance to a hospital, that's a choice that they're making, but do we enable that choice to help reduce trauma potentially? Is that what you—

The Hon. NATASHA MACLAREN-JONES: Yes, obviously there is the element of consent, but my question is more about obviously allowing women to make that choice as to what type of birth, but how does that fit into a situation where—and we heard evidence before that sometimes a split decision needs to be made. How do you fit that into ensuring choice? You referred to homebirth. If it is identified that a woman is at risk, how do you manage the choice of taking that risk and having a child at home versus going to hospital—how do you manage that?

AMY DAWES: I don't know if I could effectively answer that question, but I can talk about risks associated, say, in a hospital, for example. Even in my own experience, it came down to a decision between a forceps delivery and a caesarean section. I didn't really know anything of the risks associated with forceps, and then I've seen the form where I've signed and agreed to that forceps delivery. What we'd like to see around choice and risk is that conversations around risk need to occur long before they're in the birth suite.

The Hon. NATASHA MACLAREN-JONES: And probably also the uniformed information about the risks, so that everyone knows quite clearly what the details are.

AMY DAWES: Yes, and I just think we need to move away from this conversation where we can't talk about risks associated with birth because that's what comes through again and again from the community that we support. Often women whom we support say, "I feel like I really prepared for birth, but nobody told me that this could happen." That is a real disservice, I think.

The Hon. SARAH MITCHELL: Just quickly following on from that, in your submission you also talk about the role of partners and their information, and there are a few fathers that you use. Do you think there is something in that space too around—particularly when you're in that moment of making decisions about what you need to do when you're in the birthing suite—having better involvement of partners in that process, because then you're able to have that again before you're in that moment, if that makes sense, and then their inclusion in the process as well? I note you say that some of the dads in this instance feel quite anxious about what happens in that space too. Is there something there that we could look to as well?

AMY DAWES: It comes down to resourcing and investing in workforce. Often, when we hear stories from fathers, or we hear from women telling their partner's experience, they're typically left aside. They feel like a spectator. They feel useless and completely disempowered. They are often left for hours wondering of the status of their partner or their baby. There's little changes that we could do if there was somebody in the room dedicated to communicating safety. There is evidence that says that PTSD can be prevented in the moment that the trauma is occurring with the application of compassionate care. That isn't occurring, so people are walking out, understandably traumatised, because they have feared for the life of their loved one or they have feared for the life of themselves.

The CHAIR: I noticed in your submission that you talked about how the New South Wales Government should set up some kind of a legal clinic, particularly around OV. Can you talk about how this would work and why a legal clinic is needed in this space?

AMY DAWES: I don't think we did have that. Was that in our submission?

The CHAIR: I believe so.

The Hon. MARK BANASIAK: I think it was the one before.

The CHAIR: Sorry about that.

Dr AMANDA COHN: I have a different question, if you need a second.

The CHAIR: I will ask another question and then throw it back to you. Correct me if I'm wrong again, in case I've made a mess of my notes, but you mentioned the economic impact of birth trauma in your submission. Do we have any rough figures on what that actually costs at a financial level? Obviously, we have got a government right now that is talking about a budget black hole. There are a lot of submissions that we have received to this inquiry with recommendations that would require funding to be put into those spaces. Could I get an understanding of the cost of the system where there is birth trauma? Will changes in some of that funding also help us save money over time?

AMY DAWES: I think this is an important part of the conversation. We know there has been—and I think we have got it in our submission. I'm sorry; I can't find it. But there's the cost of depression and anxiety. We can pick out some of the factors in relation to birth trauma—for example, the cost of incontinence. That is in our submission as well, I believe. But it's very difficult to measure the ongoing costs. We have done some work with the Australian Physiotherapy Association to try to demonstrate the benefit of accessing a pelvic health physiotherapist in the perinatal period so that women are recovering effectively from the inside out and, hopefully, preventing ongoing issues such as pelvic organ prolapse and ongoing incontinence.

We know that incontinence is the leading reason that people go into aged care, for example. But we'd like to get more understanding. There needs to be more research into the actual economic cost of birth trauma. We know that many women that we support will need multiple care providers. When you budget for a baby, you don't

budget for the cost of couples counselling, psychiatry or specialist surgeons. Typically, that element of cost is from families. There's also the cost of not being able to return to work. We see that as well.

AMANDA TURNILL: I think a lot of these economic costs are unquantified, and that's one of the reasons we are looking at extending the birth trauma inquiry and, certainly, making it Australia-wide. At the moment, we are only looking at New South Wales. Also, on an individual level, women could spend thousands of dollars looking for treatment and finding the appropriate treatments. These things are all unquantified and also depend on the socio-economic status of the individual.

The CHAIR: Absolutely. I know you mentioned C-sections before. Obviously, a lot of our submissions talk about C-section rates and the link between C-sections and birth trauma. I agree with your summary that it goes beyond C-sections. But I think you mentioned that there was, at some point, an attempt to create targets to reduce C-section rates but they were abandoned. Can you give us any insight as to why they were abandoned and whether targets are the way to go? We've heard that there are various factors to explain the increase in C-sections, such as age, but then there's not really been given any explanation as to why Australia is so high compared to other well-resourced countries. What needs to happen in that space?

AMY DAWES: I think targets around caesarean sections can be problematic, and it's interesting that the UK's low caesarean section rate was brought up. We mentioned in our submission the Ockenden inquiry, which was an investigation into 300 baby deaths and nine deaths of mothers and hundreds of incidences of lifelong injuries. That was a particular area of the NHS which took great pride in saying that they had the lowest C-section rate in the country. We don't want to echo that in Australia.

Dr AMANDA COHN: On a very different topic, if that's all right. One of the terms of reference of this inquiry is looking at exacerbating factors that can impact birth trauma for particular priority population groups. Most of the large stakeholder organisations that we have spoken to haven't had any relevant data for LGBTQI+ people. I note that you made some comments in your submission about LGBTQI+ people as a group that are more likely to report having negative experiences with health care and I'm hoping you could expand on that?

AMY DAWES: Yes. I can only talk about the support that we've provided to, say, same-sex couples, for example, and often having to really advocate for themselves in the situation where two women are there and the care provider's, "Well, who's the mum?" We actually gave that example in the submission, and stories like that we hear quite frequently. But again, there's just such a lack of research in this space and our main recommendation is that we need to start gathering research, and it's the same with culturally and linguistically diverse. What we see is—I'm sorry to say it, but seeking support for trauma does have an element of privilege. There are barriers to particular groups to even acknowledging that they've got trauma and possibly talking about it. So, yes, we need to find ways to break down those barriers and I think that is by seeking to understand it more.

The Hon. GREG DONNELLY: Thank you both for coming along today. I think you were here earlier today and heard the evidence from RANZCOG, or part thereof?

AMY DAWES: Yes.

The Hon. GREG DONNELLY: You recall there was commentary in the contribution, also answering questions, around the definitional matter of birth trauma and obstetric violence. I have some questions around the same matter. In terms of the two phrases, your submission comments mostly on birth trauma but does make some reference at the front to the phrase obstetric violence. You may recall from the RANZCOG submission there was some tepidity that the idea of using the phrase obstetric violence might have some particular downsides, at least from their point of view as an organisation. Can you tell us about your organisation's thought about the two notions, the specific way in which you define both and the utility or otherwise of using both terms?

AMY DAWES: Thank you for that question. It's a really important conversation to be had. The label obstetric violence does act as a powerful reminder that some of this birth-related trauma is preventable. I do understand RANZCOG's stance that it implies malice and intention, and I think it is really important to acknowledge. We've talked today already about the workforce: We've got midwives leaving the profession, we've got obstetricians leaving the profession. We need to work collaboratively with the caregivers that are providing the support to families to improve outcomes and also more research. I'm going to keep saying more research. We need to work with individuals that are directly impacted by trauma to find out how they feel about that terminology.

I think we noted that we don't see it used within our community, but that's not to say that they wouldn't identify as having obstetric violence. Maybe they haven't heard that terminology before because even now we get calls saying, "I've just read an article about birth trauma, I think I've got that." We are still fighting to get birth trauma recognised. In fighting to get that recognition, we want to work with clinicians involved in the care of

birthing families to improve outcomes. I think if we're going in and saying, "You're doing everything wrong", then it's going to be difficult to create change, and that is ultimately what we want out of this.

The Hon. GREG DONNELLY: Don't you run the risk of trying to walk down the line and have two bob each way? I understand your answer, but obviously there are particular groups and organisations and advocates and even academics that we will hear later today that seem to believe it's quite important to quite deliberately and emphatically use the phrase "obstetric violence". If that does become entrenched in the vernacular in terms of dealing with the matter that's before us, does that run the risk of creating some tepidity and reluctance and, dare I say, even pushback from engaging or dealing with what is clearly a set of issues that no-one is going to say, "Listen, this is all being imagined." That is just not the case at all. Is there that tension there?

AMY DAWES: I think so. Yes, absolutely. And I think it's important that we learn, and I think that there is space to use that terminology while also recognising that many people that have birth-related trauma do not identify as experiencing obstetric violence. But also, equally, a lot of trauma that we see is completely underpinned by how people were treated in that moment as well, so they go hand in hand and it is important to acknowledge both. I don't know if that answered that part of it.

The Hon. GREG DONNELLY: I think it's going to be a challenging narrative to deal with over time. Just finally—from me, anyway—the matter of consent. You deal with this in your submission, and it's quite interesting. Would you like to elucidate a bit more about the idea of trying to bring about a greater clarity and determination that consent is actually being achieved before steps are taken or procedures are enacted?

AMY DAWES: In stories that we hear, one of the biggest consistent narratives that we hear is that, "Nobody gave me informed consent. Nobody told me what was happening. I didn't know that having, for example, an induction would result in this." And it is often because these conversations are not occurring until women are actually birthing, and it's too late. There's no other medical procedure that you would obtain consent in the moment. Of course, I think that, again, the nuances lie is that birth, particularly vaginal birth, is perceived as a natural event. We don't seek to obtain consent, yet so many women will end up with an instrumental delivery. So how do we have conversations? It needs to occur earlier, and we have tried to do that as an organisation.

We developed ThinkNatal education, which was designed to cover topics that are typically under-represented in antenatal education, such as instrumental deliveries and perineal tears, for example, or recovery from caesarean. We want to give that autonomy back to consumers, because so many people that we support come out of childbirth and go, "Right, I know what I need to do to advocate for myself." We are trying to encourage them to have those conversations with their care providers sooner. As I said before, for some people that is striving to have a vaginal birth and for other people it's, "I really want to avoid an instrumental delivery but I want to try for a vaginal birth. How do I avoid that?"

I think that is where there's that opportunity for midwives and obstetricians to work together collaboratively, because midwives are incredible and they are exactly there to provide support for a physiological birth. But when things aren't going to plan, it is going to be an obstetrician that's going to come in and do the instrumental delivery or caesarean section, or in an emergency situation. And, as was touched upon earlier, it's a complete stranger if they've had no relationship prior to that point. So how do we improve our care models to have a collaborative approach so that women ultimately don't come out of birth blindsided by the outcomes?

The Hon. ANTHONY D'ADAM: Many of the submissions effectively favour or are encouraging the Committee to look to specific models of care in preference to others. Your submission doesn't appear to take a position in relation to a preferred model of care that would reduce the likelihood of birth trauma. Can you elaborate on why you've taken that approach?

AMY DAWES: Absolutely. We support women that have experienced trauma from obstetric-led care. We support women that have experienced trauma from midwifery-led care. We support women that have experienced trauma from home births. So there is something that is occurring, and although it's really important to acknowledge the vital work that continuity of midwifery-led care offers, we also see that there are opportunities to improve our care models, and that is with that collaborative approach. If we just said that midwifery-led care is the best model of care, then we are ignoring all of the stories of the many women that have experienced trauma from that model of care as well.

The Hon. ANTHONY D'ADAM: I expect that the data is contested, but it seems that certain models of care have a lower incidence of birth trauma. Obviously all models have issues, but some perhaps are better than others. Can you perhaps comment on that?

AMY DAWES: Yes. For us, what we can say is that the women that we support are struggling to get a diagnosis. The women that we support are not under any model of care, typically, when they find us. Often people

don't find us until they're pregnant the second time or they're thinking about conceiving. So how do we measure birth outcomes at the moment, and can we improve birth outcome measurement? Again, we touched upon debriefing and connecting in with women after the birth experience. What we see is that typically they don't actually want to talk about their birth when they're in the hospital. I think we mentioned it in the submission, as well. We want to see birth outcome measurements well beyond the standardised six-week check, checking in with women at three months—perhaps up to a year postpartum—to really see how they feel about their outcomes. And I think that's possibly what we're seeing. Many people simply don't identify as having trauma; I personally didn't until I was 16 months postpartum.

The Hon. GREG DONNELLY: You would be aware of the work done by Western Sydney University, specifically the BESt study?

AMY DAWES: Yes.

The Hon. GREG DONNELLY: Looking at the paper itself, at the back the acknowledgement lists a number of consumer organisations that were involved in the co-design and also the funding of the study, which raises issues itself about people funding a study. Putting that to the side for a moment, I note that the Australasian Birth Trauma Association was not part of this, or at least was not acknowledged. Is that the case? You weren't invited to participate in the study.

AMY DAWES: That is correct.

The Hon. GREG DONNELLY: Did you receive or seek any feedback about why such a well-known, highly regarded advocacy group was not involved or invited to join?

AMY DAWES: We didn't seek feedback, no.

The Hon. GREG DONNELLY: Did you receive any feedback from anyone about why you may not have been?

AMY DAWES: Only from members of the community asking why we weren't involved.

The Hon. GREG DONNELLY: And what did you say to that?

AMY DAWES: I think there's perhaps, at times, a misconception that because we don't talk about—exactly to your question—that continuity of midwifery-led care is the answer to birth trauma, it's perceived that we don't support midwifery-led care, which is completely untrue. I work with universities, particularly in Queensland, presenting to student midwives, and I see firsthand where the burnout begins. These student midwives are undervalued. They're often told that they need to do dual degrees because midwifery as a profession isn't valued enough, so they have to do nursing as well. Then they're doing their studies and they're doing their prac, which they don't get paid for, so they have to do work on the side because they need to live. I recognise firsthand where the burnout begins. We work collaboratively with hospitals across the country, but there is a misconception because of our position. But our position always comes down to the community that we support.

AMANDA TURNILL: I have something to add to the former question by the honourable member. We're really looking for a trauma-informed model of care. So it's not midwifery only or obstetrics only; it's really education and advocacy about these issues so that women and birthing people are actually aware of what could happen and how to treat it and who they can contact.

The Hon. GREG DONNELLY: That's helpful. Thank you.

The CHAIR: Thank you both for attending today. We really appreciate your time. Committee members may have additional questions for you after the hearing, and the Committee has resolved that the answers to these, along with any questions taken on notice, be returned within 21 days. The secretariat will contact you in relation to these questions. Thank you again.

(The witnesses withdrew.)

(Luncheon adjournment)

Dr HAZEL KEEDLE, Senior Lecturer of Midwifery, School of Nursing and Midwifery, Western Sydney University, affirmed and examined

Professor HANNAH DAHLEN, AM, Professor of Midwifery, Associate Dean of Research and Higher Degree Research, and Discipline Lead, School of Nursing and Midwifery, Western Sydney University, affirmed and examined

The CHAIR: I now welcome our next witnesses. Would either of you like to start by making a short statement of just a few minutes to the Committee?

HANNAH DAHLEN: First of all, we thank you for this inquiry and for the time that you've given to the voices of women in this State. We know that women have poured out their heartfelt traumas and experiences, and we hope that finally something is done about it and this is taken seriously. Over the last 20 years at Western Sydney we've been involved in more than 20 studies. We've had more than 20 PhD students and more than 100 papers and book chapters on this issue, and nothing has been done and the same things are coming up again and again and again. I thank the Committee, and I particularly thank you, Emma, for pushing this through and making this happen.

No means no, except apparently in childbirth, and it's time to change that. This is the Me Too movement of birth that is now finally coming to fruition. The intervention rates in New South Wales have risen dramatically. When I was training back in the late eighties/early nineties we were horrified at a 15 per cent caesarean section rate. We now have a 38 per cent caesarean section rate. We only have 50 per cent of women having a normal vaginal birth. We have now got a one in four episiotomy rate; that was high when I trained, went down and, due to the evidence, is going back up. Our perinatal mortality and maternal mortality has shifted slightly but not hugely in that time. We have about 13 per cent of models of care that are midwifery group practice in this State and nation.

We've become really good at saving lives but we have not become so good at protecting minds and hearts, and there is more to life than death and we need mothers and babies to be alive and well physically but also psychologically, socially, culturally and spiritually. Alive is the floor but everything else is the ceiling. I think in 2023 we owe women more than the floor when it comes to health. We're standing before you today to say we have got a problem, and we are part of the problem as health providers, but we have solutions as well and we're a major part of that solution as health providers.

There are some key things that obviously are in our submission and that many other people have raised throughout this time, but the first thing we need to do is prevent birth trauma in the first place. I think we could halve birth trauma overnight if we actually really valued relationship-based care and we had women being able to journey with a provider they knew throughout the pregnancy, the birth, and then able to debrief and be well dovetailed into appropriate services postnatally.

We need more midwifery models of care. We know the evidence says that they lead to the best outcomes when it comes to ticking all the big boxes, which is quality, which is safety, which is cost, and its something women are wanting. But we also need the right training pathways. We need the right retention strategies because midwives are burning out out there and we have a shortage of staff that is pretty horrendous, and no midwife running between several rooms can give respectful care in the way that women deserve it.

We need to embed respectful care and the understanding of consent and coercion into undergraduate and post-registration education, and that's something we are looking at at Western Sydney. We've led the way on perinatal mental health by getting doctors, midwives, social workers and psychologists to train together at undergraduate level, and now we're doing that nationally at clinical level. I want to end by saying thank you. Yes, we're going to hear about a lot of problems, but we also know there are a lot of solutions and we really hope that we can focus on the positive and take this forward for the sake of women.

The Hon. SUSAN CARTER: Thank you both for coming today and for the wealth of research and experience that you bring to this field. Thank you for providing a copy of your paper in *Violence Against Women*. I have a couple of questions in relation to the BESt study that underlies a lot of the work. So 8½ thousand responses—how were those responses obtained? Who were the women who responded to the survey?

HAZEL KEEDLE: Our survey co-designed with maternity consumer organisations was put out on different platforms in March 2021 and was live for nine months. We've written a paper about methodology, which is under review at the moment, so I pulled some stats together from that. We used a variety of different techniques, both with our consumer organisations and then also using social media. We looked at what the evidence said about social media and advertising and saw that there was an increase in getting a more varied response from women if

you used social media advertising called microtargeting. We did 10 paid microtargeting adverts, which meant we could highlight what we were looking for—the gender, the age, the location being Australia and interests in pregnancy, and also looking at different cultural groups. We had seven different languages which were from the high migrant groups coming into Australia. Each of those adverts were available in English and also in each of those different languages.

Altogether we had over 12,000 people who'd start the survey and 8,804 complete more than 70 per cent of that. But with the advertising through social media, we were able to get 51,702 accounts accessed through—well, not accessed, but advertised to through the advertising. We really did have a broad spectrum across Australia. The post was shared nearly 500 times and we also had a QR code which was on a postcard and we got about 2,600 come through that. So we did use social media but we made sure that it was an evidence-based approach and that we could really target the groups of women that we were trying to target.

The Hon. SUSAN CARTER: In terms of the survey, you have representatives of all ages and representatives of all birth experiences?

HAZEL KEEDLE: Yes.

The Hon. SUSAN CARTER: You've got regional and city?

HAZEL KEEDLE: Yes.

The Hon. SUSAN CARTER: So it's statistically reliable in terms of city/country birth experience?

HAZEL KEEDLE: Absolutely. When we looked at the rates of birthing in all the different States and Territories, we had the same, if not more, in some of the smaller States of representation. We had a good representation across the whole of Australia, in all States and Territories.

The Hon. SUSAN CARTER: When you say "same, if not more", it's my understanding that if you're putting a survey like this together, what you want is to go, all right, there are so many women who birth in a city hospital, so many people who birth in a base hospital, so many people in a regional community, and you would want, therefore, the same percentages of those represented. There'd be so many CALD women. There'd be so many First Nations women. You'd want the same percentages represented. You've got that in this survey?

HAZEL KEEDLE: We absolutely tried our hardest with that, certainly with getting the languages—

The Hon. SUSAN CARTER: So you have that in this survey?

HAZEL KEEDLE: We have slightly lower when it comes to Aboriginal and Torres Strait Islander and culturally and linguistically diverse communities, even though we did reach out to organisations and consumer organisations in that space.

The Hon. SUSAN CARTER: Is this purely self-selection or you went out to women who would not ordinarily be interested in filling in this survey?

HAZEL KEEDLE: We did work with organisations, such as refugee and health, and they did share our survey. Actually in the paper under review, we've listed all the organisations that shared the survey that would then be followed by members of that community.

The Hon. SUSAN CARTER: But perhaps what I'm trying to determine is we're specifically looking at traumatic birth. There may be a number of women who experienced no issues in birth and, therefore, perhaps wouldn't self-select to fill in this sort survey. How did you reach out to that part of the population so their views are represented in this survey?

HANNAH DAHLEN: The other thing that we did was go to places like Playgroup Australia and the Australian Breastfeeding Association. We also advertised through some of the major parenting websites like Kidspot and BabyCentre and places like that. We also got interviewed in a lot of newspaper articles and online articles and radio interviews et cetera, and asked people to contact us. So we did our best.

The Hon. SUSAN CARTER: I have no doubt. This is a very hard area to do research in, and this is a large-scale first study. But to help us understand how we can best make recommendations for birthing women in New South Wales, it's good to really understand the nature of the data that we're being offered, what the holes in it might be, how representative it truly is and, perhaps, therefore where other work may need to be done to help us and to help all of the women in New South Wales.

HANNAH DAHLEN: I totally agree. No survey is perfect, and we definitely acknowledge the limitations.

The Hon. SUSAN CARTER: It was very helpful the way you specifically address in your submission, for example, First Nation groups. Can you tell me what the sample size of the First Nations women was that you were using to draw those conclusions?

HAZEL KEEDLE: This data is from the New South Wales data. So we pulled out all the respondents that were from New South Wales and focused on that.

HANNAH DAHLEN: It was slightly below the birthing population, which sits at around 3 per cent. It was slightly below that. It was something like 2.7 per cent[1], if I remember correctly, which was quite good considering the difficulties that we have actually getting Aboriginal and Torres Strait Islander people to answer surveys. We had Aboriginal and Torres Strait Islander people and a body[2] involved in the survey design to look at the questions and make sure they were acceptable.

HAZEL KEEDLE: I can get the actual numbers for you if you like.

The Hon. SUSAN CARTER: Thank you. As I understand it, this was part of a larger, international study. Are you able to look at, for example, how the experience of giving birth in New South Wales compares to other countries, and can we draw insights from what's happening in other countries?

HAZEL KEEDLE: Yes, it's exciting that we're now part of the Birth Experience Study international collaboration. As Australia, we're leading that and we are the lead of that international collaboration. So far we have 12 other countries—and us makes 13—that are part of that collaboration. So far only one of them has data, which is the Netherlands. The others are in varying points of getting their ethics applications or putting the surveys out. But we do cross every single continent, and we've now also got low/middle-income countries as well. We'll end up with a very interesting dataset where we can compare women's experiences here and internationally as well.

The Hon. SUSAN CARTER: When might we expect that international data to be available?

HAZEL KEEDLE: I think within the next few years. We're working on one paper now between Australia and the Netherlands actually looking at birth trauma and the factors that contribute to birth trauma both here in Australia and in the Netherlands. I believe our next country to collect data is Taiwan, and that'll be quickly followed by Denmark. They will be having their surveys out by the end of this year.

HANNAH DAHLEN: Just to let you know, the birth trauma rate in the Dutch data is much less than ours. We won't give you the precise amount, but the Netherlands has midwifery care for pretty much all women right through. So there will be some really interesting exploration of that data.

Dr AMANDA COHN: I'm about to ask some sticky questions as well, but I wanted to start off by acknowledging that the work that your group has done has been really seminal. The volume of other key stakeholders who've submitted to this inquiry who cite your work as providing the key figures, particularly for the prevalence of birth trauma—you've clearly put this issue on the map. You're one of the only Australian sources of peer reviewed data on this topic, and I really greatly appreciate that and wanted to acknowledge that before I get into the weeds of talking about the research. My reading of your submission is that you're presenting raw survey results and that the different categories haven't actually been correlated with each other. Have I got that right?

HAZEL KEEDLE: Yes, we haven't done the full statistical analysis. For the timing of the report, we put together what we could for that.

HANNAH DAHLEN: That is just for New South Wales, but we have done it for the big dataset and we have done it for the longitudinal birth in the time of COVID dataset, and we found very similar trends in the outcomes.

Dr AMANDA COHN: Following on from that, I'm interested in the summary that you provided about different modes of birth that were most associated with birth trauma, and then least, because some of that appears to be contradictory. I think without that formal correlation, it's very difficult to unpick. For example, private obstetricians have some of the highest levels of intervention. Higher intervention was more associated with trauma, but private obstetricians had a much lower level of trauma. What I'm trying to do is unpick the actual causative factors there because it seems like it's not just the model that's producing that result.

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1 Correspondence from Professor Hannah Dahlen AM, School of Nursing and Midwifery, Western Sydney University providing transcript clarifications on 11 November 2023.

2 As above.

HANNAH DAHLEN: I think the tie-in thing there is it's relationship-based care. When bad things happen—or things happen that are outside your expectations—and you're in a relationship with someone you trust who informs you and can then debrief with you afterwards, no matter what happens, that leads to safer care. Yes, the intervention rates are much lower in midwifery care, and of course the lowest rates of birth trauma are in private midwifery care, with the lowest intervention and the highest continuity. There's no doubt continuity of care has got to be one of the biggest things in protecting women regardless of what happens during their birth. In the private sector, there are more women who choose private obstetric care because they are wanting to either hand over their decision-making to an expert or are actually seeking intervention. That's certainly not all of them, but there is a higher amount, and we do have that data as well to show that having a normal vaginal birth is not as important as it is to women who aren't in the private sector. There is an element of the need being met by the service as well in that.

The Hon. ANTHONY D'ADAM: On that point, that aligns with what Dr Watts was saying earlier about the profile of those who choose private obstetricians being older and therefore more likely to have interventions. That's more likely to be a question of choice. Is that fair to say?

HANNAH DAHLEN: Just to answer that, the profile or the demographics of women who choose private obstetric care are almost identical to the demographics of women who choose private practising midwives. That's the great, interesting thing about this. In fact, the women are older in that group that chooses privately practising midwives. You couldn't have two more polar opposites when it comes to intervention. Of course, women who choose privately practising midwives are much more likely to want a physiological birth and an experience where they make those choices and are in control, whereas women who choose private obstetrics are more likely to perhaps not want that.

But when we adjust all the data, as you very rightly pointed out—and we adjust for demographics, we adjust for medical risk factors and we adjust for mental health—we're actually finding that when you adjust for all of that, the best outcomes overall, in all the models of care, are private midwifery practice followed by MGP, followed by private obstetrics, followed by GP shared care, followed by standard care as being the least positive in rates of intervention and birth trauma. That's come out in two major studies that we've done. If you look at it, that really follows a trend of how much continuity you get. Continuity is again the key here.

The Hon. ANTHONY D'ADAM: If we adopted that as the, I suppose, object of this inquiry in terms of recommendations, that would totally overturn the current state of play, is that fair to say? The majority are in those latter two categories in terms of births.

HAZEL KEEDLE: Absolutely. What most women have available to them at the moment is that standard fragmented model of care where they will see someone different every time and not be able to develop the relationship-based care, one that is continuous for labour and birth and postnatally as well. What our studies and this study show is the importance of continuity of care not only in all the results we already have from our Cochrane systematic reviews that we can see with midwifery continuity of care, but now also the impact of birth trauma and obstetric violence on women as well.

The Hon. ANTHONY D'ADAM: You mentioned the Netherlands. I think in another submission they cite that the Netherlands has 28 per cent home births and it's a totally midwifery-driven system. Has that always been the case? If you're proposing a transition to a completely different system, maybe the Netherlands offers us a model of how you go from A to B. Are you able to give us any information about how the Netherlands achieved that arrangement?

HANNAH DAHLEN: The homebirth rate in the Netherlands, actually, now has dropped quite a bit. That's the honest truth. It sits at around 16 per cent, 17 per cent. It used to be much, much higher. However, the midwifery model of care continues to be very strong. It's how the government has funded. So, really, if you want to drive change in models of care in this country—and I know this is not a New South Wales specific prerogative, because this goes beyond you, into Commonwealth funding—you have to really look at the funding models that fund women. For example, in New Zealand now over 90 per cent of women have a midwife they know as their lead care provider, providing that care. That's because the funding has been given to women, for women to decide who they select, and they can go out and they can use that funding and they can then get that provider. In this country, the funding is driven by the provider and that is really shaping the models of care that are on offer. I think that's a really important point to make.

The CHAIR: I don't think Dr Amanda Cohn had finished her questioning, so I'll return to her.

Dr AMANDA COHN: No, that's all right. It's all relevant. I am still trying to unpick pages 19 and 20. It strikes me, on reflection of your answers, that the thing that private midwifery practice and private obstetrician

care have in common, as you've said, is the continuity but also that we're talking about patients with a certain amount of privilege and financial capacity to actually choose. So is it the choice that actually is the benefit of those models?

HAZEL KEEDLE: It is down to a choice, but I think it's also down to what women are actually looking for and expecting. Certainly, we do have a document, which I've brought around to you all as well, called "What Women Want" that does actually focus on a paper we've got coming out at midnight tonight in the *BMJ Open* that looked at the question in the survey "If you were to have another baby, what would you do differently?" So we've already then got women who've gone through a model of care and then are looking forward and going, "Well, what would I do? What are the changes that I would do?"

We had 6,101 comments from women to analyse, and then we could actually look at what is it about the model of care they want, what is it about the type of birth they want and what things would they do differently. There we can actually see, from the model of care, that choosing a midwife, continuity of care with a midwife, had the highest amount of comments, as did wanting to have a vaginal birth compared to choosing a caesarean. So I think that's one of the things you've got to bring into it, not only what does have lower rates of trauma and obstetric violence but measuring that against what women are actually wanting and requesting for in their next birth.

HANNAH DAHLEN: Can I just add to that and say that we have a Cochrane systematic review, over 17,500 women, 11 randomised control trials[3], where women are randomly allocated to midwifery continuity of care and other models. So these are not all the same women. These aren't women who choose; these are women who are randomly allocated, and we have stunning results with less intervention. We have less babies dying, we have 24 per cent less pre-term birth rate and we've also got cost effectiveness.

The randomised trials have been done. However, to come to your point, it is still often a privileged, white pathway into these models. It's who do you know and who's got the information? Everybody knows, once they've had a baby, once the blue line appears on the stick you need to ring up and book your place for a midwifery model of care, which means that some of the women who would most benefit from these models are not getting a look-in, and that's a real problem. There is lack of equity when it comes to accessing models of care that we know would probably make a bigger difference, because the research is now showing that, particularly with Aboriginal women, the bigger difference, the bigger bang for your buck from midwifery continuity of care would come where there is disadvantage and in more of our minority groups.

The Hon. EMILY SUVAAL: Thanks to you both for attending today. I just wanted to start with a bit of a leading question, I suppose, and seek your advice. Would you agree that, as health professionals and as elected representatives of a level of government representing the people of New South Wales, it is incumbent on us to consider evidence that is of the highest possible rigour when considering making decisions about health care within New South Wales that will impact people's lives and, indeed, the quality of the health care that they receive?

HAZEL KEEDLE: Absolutely and, as Hannah just mentioned, we already have that with the randomised control trials and then the Cochrane systematic review on midwifery models of care. So, yes, we have that. What the BESt study did was, literally, really go into the depth of what women are actually experiencing and their own experiences and their own comments around that, which is just as important when we are designing maternity services, that we actually listen to the experiences of women. We ended up with over 54,000 comments throughout the survey, which is an important part to bring in. Not only do you need that high level of evidence but you also need to be able to hear the voices of women as well.

HANNAH DAHLEN: Can I just add to that? I think also we need to look at what other government bodies are recommending, what other health bodies are recommending. If you look at the WHO, if you look at the UN, if you look at ICM [International Confederation of Midwives], if you look at FIGO, if you look at the NICE in the UK, et cetera, continuity of care is a central mandate now in all of the recommendations.

The Hon. EMILY SUVAAL: Thanks. In terms of the BESt study, which you mentioned, the study utilised a non-probability self-selection for the recruitment of participants using social media and during screenings of a birth activist documentary. The paper also states that most respondents had a combined income of more than $100,000, were university educated and married or in a long-term relationship, and that 87 per cent of

[3] Correspondence from Professor Hannah Dahlen AM, School of Nursing and Midwifery, Western Sydney University providing transcript clarification on behalf of Dr Hazel Keedle on 11 November 2023.

the respondents were women that were born in Australia. How does your analysis account or control for selection bias?

HAZEL KEEDLE: It's part of any cross-sectional survey that's out there. You try and mitigate that and we certainly did by getting surveys translated into different languages and working with organisations that represented women from those communities. We did get more than we would usually get in previous surveys from those different representations, but still not quite as much as we would like. This survey, which will be a rotating survey, we will learn from what we have got and keep on trying to get those voices out there. But you will find that that is something that's common across cross-sectional surveys, which is why we did look at micro-targeting—to really try, in different languages and in English, to get that out to women from a variety of different backgrounds.

HANNAH DAHLEN: If I can just add to that, what we do is also look at the data using statistical techniques that adjust. So that's the work we're doing now, where we're adjusting for demographics, we're adjusting for risk factors, we're adjusting for mental health, we're adjusting for a whole lot of predictors of women who go into models of care specifically. Nothing is as good as a prospective randomised control trial but they cost a lot of money and we have quite a lot of them, so really this was about having another look at another aspect of the data.

The Hon. EMILY SUVAAL: In terms of the study, results have grouped the "yes" and "maybe" responses to questions on obstetric violence together. Are you able to provide the data on the two responses separately?

HAZEL KEEDLE: We did look at that and we did put a definition of obstetric violence in the question because, as has been mentioned earlier today, it can be a term that maybe women are not familiar with. So we did put a definition in there. The "maybe" just allowed women who were maybe not sure to then be given the option to leave a comment. So if they said yes or maybe, they would be put onto the next question, which was: Would you like to tell us more about your experience? That's where the paper came from—the analysis then of those 626 comments around the yes or the maybe. Because that was a qualitative study and a qualitative content analysis, we did put all the comments together and it certainly was not visible to see any difference between a yes and a maybe. They were all experiences that were valid and could fit the definition that we had put in the question.

The Hon. EMILY SUVAAL: So are you able to provide figures on the separate responses?

HAZEL KEEDLE: I can do, absolutely, when we get back to it.

HANNAH DAHLEN: We can pull it apart.

The CHAIR: You can take that on notice.

HAZEL KEEDLE: Yes, absolutely.

The Hon. MARK BANASIAK: I've just got a couple of questions around some of the recommendations you make, and feel free to take some of the detail on notice. In section 2 it says, "Ensure midwifery regulation protects women's rights by not punishing the midwives who support them."

HANNAH DAHLEN: Yes.

The Hon. MARK BANASIAK: It seems like a bit of a loaded comment there. Can you, perhaps on notice, tell us where in the regulations you see there is a potential or there is something happening there where midwives are getting unfairly, or seemingly unfairly, punished.

HANNAH DAHLEN: Yes. I'll take responsibility for that one. These come from our book that we published in 2020 called *Birthing Outside the System: The Canary in the Coal Mine*. Myself and some colleagues put together international research on why women are avoiding our system and, analysing everything that people had written, we came up with recommendations. We've slightly adapted these. What we know from the research we've undertaken and others have undertaken is at least 50 per cent of privately practising midwives in this State have been reported to AHPRA. They've been reported often for just simply entering the doors of a hospital with an appropriate transfer, when they're transferring a woman from a planned homebirth when she needs extra assistance.

We know that there is a disproportionate reporting of midwives when it comes to models of care like privately practising midwives. We don't actually know the precise number. We know there are over a 1,000 endorsed midwives in this country. But actually practising as privately practising midwives—there's much, much less. We also know many of them have left and have been burnt out by the numbers of reports that they are getting to the regulator—some vindictive, some absolutely needed to be done. But we've got a problem where we target people who are outside the norms in our system through the use of reporting to AHPRA.

The Hon. MARK BANASIAK: The last one in that section 2 is "appoint a chief midwife in the State". Governments of all persuasions like to create titles and, when you look at them, they look like a bit of an empty vessel. Could you provide a bit more detail as to what you would want that chief midwife to be doing, what powers you would expect them to have and just a bit more meat around the bones in terms of that role? Otherwise, if we leave it potentially up to a government, it might become a bit of a placeholder but not much else. If you could provide some detail around what you would like that chief midwife to be able to do and where they fit within the system and who they report to and all those sorts of things, that would be really helpful.

HANNAH DAHLEN: We've been lobbying for this for a very long time. It's been in the UK for a while. There's a chief nurse and a chief midwife. As of last week there's a chief midwife going to be appointed in Queensland, which we're very excited about, which will report, I believe, to the deputy DG. We have a chief nurse midwife in this State that isn't a midwife but functions in both roles and they do great jobs. In fact, there are two chief nurse midwives in this nation that have midwifery. The rest only have nursing. They do a wonderful job and they have a very hard job. This is no criticism of them. But, often as a result of lack of knowledge and also dealing with a massive portfolio of nursing, midwifery gets left off the agenda and is not often prioritised or properly advocated for.

So the role of a chief midwife would be to give advice to government, would be to be looking at what's happening on the ground, would be around putting into place support programs that are around sustaining the midwifery workforce, that are about growing that midwifery workforce, that are about putting evidence into practice and advocating for that profession. We've got such a shortage of midwives—I'm sure you're all aware—not only in this State but around the world, and one of those things that would be an absolute priority would be to build back midwifery so that we can actually provide women with the care they're asking for.

The Hon. MARK BANASIAK: Do you have a preferred model in terms of the chief midwife that you're leaning towards? Obviously it might be too early to tell about Queensland.

HANNAH DAHLEN: The UK has a chief midwife and that's the first chief midwife. That chief midwife has become the chief midwife of the International Confederation of Midwives, which is even more exciting, so there's now one at that high level. But that midwife reports to the chief nurse. So I don't think it's perfect. I do think we need to have them respected equally and probably reporting to the director general.

The CHAIR: I was going to ask you about the chief midwife as well. You said one was appointed in Queensland.

HANNAH DAHLEN: They've just announced they will.

The CHAIR: We also heard this morning that Queensland had a better blueprint for action. We're hearing some quite positive feedback about Queensland's model. What can we in New South Wales be doing or learning from Queensland?

HANNAH DAHLEN: So 28 per cent[4] of models in Queensland are continuity of midwifery care and 13 per cent are—New South Wales is lagging way behind. What really has made Queensland step right ahead has been that they have dealt with the issue of endorsement. I'm an endorsed midwife, by the way, and I worked as a private-practising midwife for nearly 10 years. What they've done is opened the doors to endorse midwives, which of course came about in 2010—Medicare, insurance, all of those things that are possible. But built into that—and I was the president of the Australian College of Midwives when this actually happened—there was a mandate to find collaborative arrangements with obstetricians, which was the death knell to private-practising midwives. Obstetricians wouldn't collaborate, wouldn't sign up, and a midwife couldn't get entrance into a hospital unless she had that signed agreement. Now, there has been a recommendation recently to get rid of that; that's going to take a little while to get into place.

Queensland very smartly got the arrangements in with the hospital and not the individual provider, and they enabled private practising midwives to set their businesses up and bring those women directly into hospital and provide their care postnatally and antenatally in the community. We are way behind Queensland when it comes to that. I really hope, with the recommendations now, that we do not need a signed collaborative arrangement. It was putting the fox in charge of the henhouse, to be really honest. We're 13 years down the track, and we've proven that was a big mistake. That's not to say we shouldn't collaborate; collaboration is absolutely

[4] Correspondence from Professor Hannah Dahlen AM, School of Nursing and Midwifery, Western Sydney University providing transcript clarification on behalf of Dr Hazel Keedle on 11 November 2023.

key to safety. Women want us to collaborate; we want to collaborate. But to force a signature and make doctors feel vulnerable that they're responsible for decisions midwives make was always going to be a problem.

The CHAIR: In our submission from NSW Health, they say that they're experiencing barriers to expanding midwifery continuity of care models. Namely they're talking about the workforce shortages and also individual challenges for midwives to work in a model with on-call requirements and things like that. I want to get your response about that. How do we implement a midwifery continuity of care model? If there are legitimate barriers, how do we address them?

HANNAH DAHLEN: I might respond on that because I have a student just finishing her PhD on exactly this question of: how do we sustain midwifery group practice in Australia? She's done an amazing study and is about to publish a paper that's really going to unpick what is going on. What often happens is these models all start with great bangs, and everybody brings a cake in and sets off balloons, and we're all really excited. And then they drift; they morph. They are sometimes over-micromanaged, or they are sometimes not managed enough.

I think what we have is essentially an organic model that is about working with the woman when she needs it into a system that's all about the system. We often have managers who don't understand the way the model works. We often have higher managers, the executive managers, who don't understand the way the managers are trying to run the model. So we have a massive problem in fitting this really different way of working—that a midwife might be out gardening with her phone on her hip, and then she'll be in all night. We have a real problem in working that out.

We've also got a problem with our industrial arrangements, where you can pop across the border and get better rates in another State and so we lose midwives across the border. We're supposed to have one standard, but we don't. We also have really interesting data that will be coming out in this survey, which is looking at what's the best training pathway to have midwives enter into midwifery group practice. It's becoming increasingly obvious that the Bachelor of Midwifery, which is a three-year direct entry program, leads to the greatest number of midwives going out there and practising as midwifery group practice midwives. So we need to really start looking at: how do we expand these models that we know are leading to that success, how do we manage these models better and how do we get smarter about the way that we sustain midwives in the model? There's a lot of work to do, but we've got some very exciting results coming.

The CHAIR: I have another question that is related to that. I'm sure you've seen in the media that the Government has talked about a bit of a funding black hole and so funding is quite difficult, and obviously a lot of the recommendations that organisations have put forward will require funding. I want to get your thoughts on some of other side of that that we're also hearing about the cost of birth trauma. Are we spending more by not putting in more up-front funding? Do you have some thoughts around that?

HAZEL KEEDLE: Absolutely. There's an ongoing cost of birth trauma both for the woman, for her family and then also for those working in the system and the health system. Certainly I know ACM will be able to talk about this later on—about the impact of birth trauma on midwives and what they found in their survey. But certainly, from the women's experiences that we have collated, there is an ongoing impact. That can be psychological support that they needed and often aren't able to find, and then not being able to afford either, and the ongoing impact that can have with their next pregnancy as well. So, yes, there is the psychological impact that birth trauma can end up with postnatal depression, PTSD, and anxiety, but also untreated mental health issues as well.

HANNAH DAHLEN: Can I just add to that, because Hazel did touch on it, and I think this is a really important point. Birth trauma affects health providers as well. There are lots of traumatised midwives and obstetricians out there who are traumatised by what they work in, what they see and what they are part of. That is driving our workforce away. So solving birth trauma is, number one, about women, babies and families, but women, babies and families are not the only ones traumatised, and we need to solve this for all of us. And it is an expensive thing, after you've trained a midwife or an obstetrician, to drive them away because they no longer can psychologically deal with what they're doing.

HAZEL KEEDLE: I will also add, in my role at Western Sydney University, I'm the academic program adviser, which means that whenever a student has a problem in the Bachelor of Midwifery, they come and speak to me. So I do hear from students about the impact of witnessing and not being able to then act, not knowing what to do—of seeing birth trauma. Most of those students will go through and continue their training with the hope they are going to make a difference in the future and that they can make different choices but, unfortunately, some students are not able to work in that system and then leave.

The CHAIR: I also wanted to ask you about the term "obstetric violence". It has come up a little bit throughout the morning, and I know that you have chosen to use that term. Can you give us a bit of information about why you have chosen to use that term and what terms we can be using to differentiate something which talks about avoidable harm in comparison to trauma that is unavoidable?

HANNAH DAHLEN: I can actually understand the sensitivity because, at face value, it can sound like it's a bad obstetrician when, in fact, it's not. If you look at the Latin for "obstetrics", it actually is pertaining to a midwife. If you look at what it actually means, it is one who stands opposite the woman giving birth. That is exactly the Latin underpinning of "obstetrics". We don't have a problem with "obstetric trauma". We don't have a problem with "obstetric haemorrhage". We don't have a problem with "obstetric emergencies"; we understand that involves all of us in there, working together. Some people have a problem with "obstetric violence" because they feel that it is a direct label of a group. It is not a direct label of a group. Midwives are absolutely involved in obstetric violence. The WHO talks more about disrespect and abuse, but we also have the UN that has had a special rapporteur report that has directly used the word "obstetric violence". It's also a legal term. It's also a term that is in legislation in quite a few countries.

I actually think that our colleague, who follows shortly and who is a lawyer, is going to be much better at telling you exactly what the legal underpinnings are. However, I think, if we need to move on, I think we need to learn what environments and what language do we use in what environments, in order to get us to move on together. I'd like to say, right up-front, this is not about obstetricians. This is about all of us. It's women who suffer. The term is a legal term. It is a well-recognised international term. We once didn't like the word "domestic violence"; we preferred "domestic discord". We preferred softer words. Now nobody blinks an eye at "domestic violence", because it is what it is. Perhaps we'll come to a point where no-one blinks an eye at "obstetric violence", or perhaps we're going to have to soften and change the term to get us all on the same page. But I do not think the term should hold us back from recognising the reality of what women have told us and that we need to do something about it.

HAZEL KEEDLE: In our paper on obstetric violence, we asked women what they describe, and, certainly, their descriptions included feeling disrespected and feeling powerless, but also experiences of physical and sexual assault and trauma and violence. So if we have a look at what is being experienced by women, and those experiences were there, then the term "violence" most definitely comes in. We're also an international collaboration, so if we had one term that we use in Australia and then different terms across our 12 other countries, then there would be, maybe, an issue with our data as well. So we have to recognise that this is an international problem, and we are part of that international community.

The CHAIR: I also have a question about informed consent and informed choice. I think you referred to both, and I just wanted to get an understanding of the difference between informed consent and informed choice. We also have in the NSW Health submission that there is consent training through the My Health Learning system. I'm not sure if you're familiar with that consent training. But is that enough? When we start to look at some of the data that's coming out, I know one of the submissions said that one in five women felt that they hadn't quite consented or that they weren't sure if they had consented to things. Obviously there is this consent training happening, but why is there this gap and what can we do?

HAZEL KEEDLE: I think the legal definitions will certainly be mentioned a little bit later and not for us. From our study, we did actually look at the informed choice aspect with how involved women felt they were in the decision-making. We used some recognised, validated tools that are used across research, which are the Mother's Autonomy in Decision Making and the Mothers on Respect index. We could see that the highest score would be "high autonomy", which is having full involvement in all of the choices and the decisions that you made during pregnancy. Less than half a per cent of the women in our survey felt that they had that high autonomy and going down to 9 per cent of having very low autonomy, having very low involvement. Others can look at the definitions, but to understand that women are not experiencing informed choice in their maternity care experiences.

The CHAIR: We've seen this thing called *A Blueprint for Action—Maternity Care in NSW*, which was published in March, which has come out from NSW Health. I'm just wondering what feedback you've got on that document, if you've read it, and if you think that it's going to be enough to help us move through birth trauma.

HANNAH DAHLEN: Look, I would have preferred to have seen it much more in line with the woman-centred care strategy that has been put out by the Government; I think that's an extremely good strategy. I think there are some very good things in it. My concern is—and I've probably been in this business a little bit too long now—I've seen us moving away very much from the woman and down to the line of the baby. I am 100 per cent behind the First 2000 Days. Nothing matters more to a woman than her baby and her partner. But if

we do not put enough protection and support around women, the hand that rocks the cradle does rule the world and we will see the implications of that in the children. My only concern would be, "Let's get up the front end. Let's prevent the bad stuff happening. Let's stop always going down here and pulling people out post trauma, post us making a mess of things, post us not providing services." I think we need a little bit more focus on the prevention.

The Hon. GREG DONNELLY: Through the Chair, thanks for coming along this afternoon. I'm trying to reconcile some work done by NSW Health and testing satisfaction, if I can use that phrase—satisfaction levels or satisfaction rates with women giving birth in New South Wales—and the figures that you have in your documentation. I've just got a copy here of the report; I'm wondering if the secretariat could pass it to you. I'm sure you've read the NSW Health report. It's section 3.3 on page 11. I'll let you perhaps take a couple of moments to read that.

HANNAH DAHLEN: Yes, we're definitely very aware of it.

The Hon. GREG DONNELLY: Of course you are. Just looking at the numbers, that would suggest, it seems to me as a layperson, a high to pretty high satisfaction rate with respect to those questions asked. I don't know what the precise questions are, but they are the percentages that are attached to what's said there. If you just take the first one, the headline one:

> 94% of women rated their care during labour and birth as 'very good' or 'good'

Reconciling that with the figure in your documentation of 28 per cent of women experiencing birth trauma in New South Wales, how does one put them side by side and say that this is reflecting the same thing—that this is women experiencing the same thing in the State of New South Wales, as they experienced labour and the birth of their child?

HANNAH DAHLEN: First of all, ask very different questions. I have no problems with the PREMs and the PROMs. I think that they provide a very important service, and I think they answer a very important question. The PREMs measure, really, the process of the care provision. The PROMs measure clinical care effectiveness. It's a short survey. It's designed to be completed to meet a whole bunch of benchmarks. A classic example for me is when the results were released a couple of years ago and we had the Ryde continuity care midwifery practice and the Wyong one et cetera, which scored green, green—

The Hon. GREG DONNELLY: Sorry to interrupt. Is this the 2019 survey you're talking about?

HANNAH DAHLEN: Yes. They scored green, green, green, green—excellent for everything. Then they scored red for the appointment taking longer than 20 minutes, or longer than whatever the standard was. That's because women in that model had an hour-long appointment. So there are things in that that need to be adjusted to run with our current, contemporary models. However, the difference and the value—I'll let Hazel continue on from here—is we analysed women's comments, numerous comments. Those are not as freely available in the PREMs and PROMs.

It was the comments that enabled us to really nut down on some of the issues that are not being picked up. The questions around birth trauma—it doesn't mean that all birth trauma is caused by providers or that women aren't satisfied with the care that they got, but they're traumatised. There's a lot of subtlety. The other thing is that 90 per cent felt they were respected with dignity. That means 10 per cent didn't. That lines up a little bit with some of the stuff we found with obstetric violence. It is a different survey. It targets a hospital population in the majority. It certainly serves a purpose, but our survey was specifically looking at birth trauma and that experience.

The Hon. GREG DONNELLY: Just to confirm we're talking about the same thing, this is the Bureau of Health Information survey of 2019?

HANNAH DAHLEN: Yes.

The Hon. GREG DONNELLY: You said "a couple of years ago". That's only 2021. Are you sure we're talking about the same survey?

HANNAH DAHLEN: Yes, we are.

The Hon. GREG DONNELLY: So your answer to the question is that you can put these two side by side, and it's not irreconcilable that you actually have one survey saying 94 per cent of women rated their care during labour and birth as very good or good across the State of New South Wales but also, if you asked another question or conducted another survey asking another question or other questions, you would find that 30 per cent of women would say they have experienced birth trauma.

HAZEL KEEDLE: I think that's understandable. It also comes down to timing of when these surveys are put out. If they're put out in the immediate postnatal period, to be filled in and then sent back in—

The Hon. EMILY SUVAAL: Sorry, can I just clarify? The survey that we're referring to here is the BHI data, not the PREMs survey.

HANNAH DAHLEN: Okay, right.

HAZEL KEEDLE: First of all, you need to—

The Hon. GREG DONNELLY: That's why I've asked the question twice. So we're not talking about the same survey you referred to just in your response. Is that right?

HANNAH DAHLEN: If it's not the PREMs and the PROMs, that is the most common survey that I am aware of, that is sent out.

The Hon. GREG DONNELLY: That's why I took the time to take you through. This is the Bureau of Health Information survey.

The CHAIR: I just want to let the member know we've got some other questions so just to get to the point of the question just because of the time.

The Hon. GREG DONNELLY: I've asked the question. Clearly, we've now discovered the—

HANNAH DAHLEN: Can I suggest that we take it on notice and we get back to you with a response?

The Hon. GREG DONNELLY: Absolutely. And one final one: Was there a reason why, with respect to the BESt, the Australasian Birth Trauma Association was excluded from participation?

HANNAH DAHLEN: I'm happy to answer that. We've just been in the corridor. I had a lovely conversation and shaken hands. They will definitely be involved in the next version. The birth trauma association has moved on a long way from their original setting-up. The original setting-up was very much focused on pelvic floor trauma. Some of the discourse that was out there was very, very dominated in that area. However, there has been a significant change. They are doing amazing work. Amy Dawes and I have been out there, having a lovely conversation. They will be involved in the next survey.

The Hon. SARAH MITCHELL: I just wanted to pick up on something, I think, Professor, you said earlier about Queensland having a higher percentage rate of midwifery-led care in comparison to New South Wales. I'd be curious whether you've got any insights particularly into rural and regional communities. Obviously, there are similarities with distance and population in Queensland as there are here in New South Wales. Do you know if the rates there in rural communities also increased, or was it more in the metro parts of the State? I'm just trying to understand whether the rural element has seen growth in Queensland as well.

HANNAH DAHLEN: Better than us, but certainly not perfect. There's no doubt that rural and remote women—and I've just been in Canberra last week at a roundtable looking at the plan for rural and remote women—have less options and less models, but Queensland is doing that better than us.

The Hon. SARAH MITCHELL: Is there anything specifically that Queensland is doing that we could look to emulate, particularly in the rural communities—I mean, "better than" is useful, but anything specifically?

HANNAH DAHLEN: Privately practising midwives is something that they are doing because they've got the ability to open the doors to them. Queensland is not perfect. What they are not doing well is not providing publicly funded homebirths, may I say. That's something New South Wales does really well.

The Hon. SARAH MITCHELL: With the private-practice midwives, do they have those relationships with the local hospitals that you spoke about earlier as well in that model?

HANNAH DAHLEN: Yes, that's right.

The Hon. SARAH MITCHELL: How do they manage that with staffing as well? I'm making general assumptions here, but if you've only got one or two midwives in that, if there are multiple women who happen to be labouring on the same day—in practical terms, how does that actually work?

HANNAH DAHLEN: When I was in Parliament House for this roundtable last week, we were exposed to some incredible models where midwives, GPs and obstetricians all work together and the woman had a midwife she knew as the thread throughout that care. We've got some extremely good exemplars. We've also got an extremely good model down in South Australia, where they are dealing with incredibly remote areas, where they have turned everything over to midwife-led care, collaborating with obstetricians and GPs. We can do it. We've

got some really good examples of how to do it. We have to get past the politics and we have to also start to look at funding and access agreements.

The Hon. SARAH MITCHELL: If possible, on notice, if you could provide some information of a couple of those examples or communities that maybe the Committee can look into in a bit more detail, that would be worthwhile.

HANNAH DAHLEN: Yes, I'll send you through the South Australian example. It's extremely good.

The Hon. SARAH MITCHELL: That would be great. I have one other quick one, because I know my colleague has a question as well. In relation to page 8 of your submission, where you look at the impact of induction of labour on birth trauma and seeing that there was a higher rate of birth trauma for women who had to be induced—just some general comments on what you found in that study and why that is? Again, I'm making a very general assumption that often people who do have to be induced maybe have other underlying risks or factors, but is there anything that we can take away from that particular statistic that you think is relevant?

HAZEL KEEDLE: The induction of labour rates has increased across Australia, and we haven't always asked women how do they feel about that and what are their experiences. Not only did we see that there were higher rates of birth trauma, but in the paper coming out tomorrow we asked them—when they looked at what they would do differently, many women said that they would avoid having an induction and that that impacted on their birth trauma. Most basically, if you have a plan to be upright and mobile and have active labour and birth, then being induced really makes that very challenging. Then we've got higher rates of intervention. That cascade of intervention, as many submissions have spoken about, then starts with that first induction of labour.

HANNAH DAHLEN: And 41.3 per cent of first-time mothers in Australia—and New South Wales has very similar statistics—are being induced, and that has risen dramatically. Not enough attention has been put on the impact on women. Some big, systematic reviews of the evidence have shown us that women don't feel adequately informed or prepared for what happens.

The Hon. SARAH MITCHELL: I wonder if that's part of the broader education piece that we've been speaking about today too, in terms of what your choices are around induction and why you might or might not need to. That might be something we could explore too.

HANNAH DAHLEN: May I say, the NICE guidelines on induction from the United Kingdom—they have an extremely good section on what does informed choice mean for women having induction, and it's really worth a read. I'm happy to send that through too.

The Hon. SARAH MITCHELL: That would be great.

The Hon. NATASHA MACLAREN-JONES: I am mindful of the time, but I wanted to ask about your question around the complaints process. I'm mindful that quite a large number of people felt that they didn't need to complain; however, around 400 said that they did. I am interested to know if anything came out of the research as to what needs to be done to improve the complaints process beyond increasing education, but specifically around the Health Care Complaints Commission and what things this Committee could look at.

HAZEL KEEDLE: I think from the comments that we looked at, and we were also looking at the debriefing process as part of that paper, women often don't know what the options are, or if they go straight to the hospital they might not get a very adequate response and feel that they don't then know where else to take it. We're also asking women who've just had a baby and are very busy with caring for baby to then go for that next step of writing it down. We know, just from the submissions, that it takes a lot out of people to write down their trauma, and so that also comes out into how you would then write that letter of complaint. But a lot of it is just not knowing what the options are and what the processes are and then actually getting a response that is not defensive or tries to negate the woman's experience.

HANNAH DAHLEN: Can I just add one comment to that? The paper that's coming out tomorrow—one of the saddest things about that paper is one of the largest categories is that "next time I'll advocate for myself better" and that women are telling us that it is basically their fault that it happened to them. Women take on a lot of self-blame and they feel a lot of failure and, therefore, they often don't feel they have a right to complain because they feel it was their fault. I think we have to change the discourse. We don't want to open up the doors and say, "Everybody complain." That's not the answer, but I think we need to really start to have conversations with women as to what the pathways are and what the potential strategies are that can help them move on.

The Hon. NATASHA MACLAREN-JONES: I have one last question. It is about the survey that was conducted in 2021. When you were looking at the responses, whether or not you've actually sliced the data, and looking at it from each jurisdiction and the pre-COVID period and the COVID period—because obviously each

State and Territory were dealing very differently in response to COVID. I would be interested to know—did that affect the data, or if you've actually looked at when those women responded?

HAZEL KEEDLE: We have now had two studies going on at the same time. With BESt, we have, in future papers and the one coming out tomorrow, actually bought into the pre-COVID and during COVID—because it was never after; pre and during—so they can see the spread of those comments. But then we weren't asking particular questions about COVID. Most definitely there were impacts to it with a lack of support or being able to bring people in or changes to their models of care, but then Hannah was leading the Birth in the Time of COVID-19 study, which was looking particularly at women's experiences during COVID as well.

HANNAH DAHLEN: Yes. So, we do have a specific study which we are publishing on now, which is looking at women's birth experiences during COVID and what changed, and I can tell you that the more negative experiences were in places like Victoria.

The Hon. NATASHA MACLAREN-JONES: That's what I am interested in: if you have broken that down by jurisdiction, because obviously Queensland would be different to New South Wales and WA?

HANNAH DAHLEN: We haven't yet, but there is so much data and so much work to do. Thank you for the suggestion.

The Hon. NATASHA MACLAREN-JONES: I don't want to give you more work.

HANNAH DAHLEN: More work.

The CHAIR: Thank you both for attending today. Committee members might have additional questions for you after the hearing and have resolved that the answers to these, along with the questions that you have also taken on notice, be returned within 21 days. The secretariat will contact you in relation to those questions.

(The witnesses withdrew.)

Dr BASHI KUMAR-HAZARD, Chair, Human Rights in Childbirth, affirmed and examined

The Hon. ANTHONY D'ADAM: Chair, I would like to put on the record that I've know Dr Kumar-Hazard for a very long time. She's an old friend of mine.

BASHI KUMAR-HAZARD: When Mr D'Adam and I were at university we used to laugh about whether or not our economics degree was going to take us anywhere. Here we are.

The Hon. SARAH MITCHELL: Where else would you rather be?

The CHAIR: Would you like to start by making a short opening statement of a couple of minutes?

BASHI KUMAR-HAZARD: Yes. As I said, I am the Chair of Human Rights in Childbirth. I also have a doctorate from the University of Sydney Law School. Since my statement, or my submission, is not online, I will quickly go through the summary of observations. Human Rights in Childbirth—let me start by saying we are very grateful to this Committee for initiating this inquiry. We think that it is a conversation that it is about time that we had in Australia. But the fact that New South Wales is starting it is probably going to mean something for the rest of the country. Our organisation is an international not-for-profit legal and human rights foundation. We were founded in The Hague in 2012. I was asked to join the organisation in 2013, shortly after I commenced practice in this field, and I've recently been asked to take the chair.

Our mission is really to monitor and report human rights abuses in pregnancy and childbirth. In Australia in particular, we've been advising and advocating for women in this space. We advise women who were abused or mistreated while accessing institutional care, but we also advise and advocate for healthcare providers or support people whose employment or income is threatened for protecting women in their care. We also in particular probably support the most vulnerable amongst those women who face police inquiries or have to deal with the Department of Communities and Justice and extended hospital investigations or reports because of the healthcare choices that they made while they were pregnant.

I would like to start by making a summary of the observations in my submission. The abuse and mistreatment of pregnant women and people in maternity health facilities is a normalised, everyday event, and it is embedded in the institutional and professional culture and practice. I ask that the Committee consider this when you are dealing with somewhat defensive responses, because we do see that in our practice every day. What happens is that people have become very accustomed to doing things a particular way. When we call something into question or we challenge the way that is being done, there is definitely a response of, "But you don't understand what's happening here." From our perspective, of course, we are seeing the impact that it's having on women.

We've had clients and women come to us who have, sadly, committed suicide or attempted suicide. We've seen situations where women have rejected their infants, and it takes a lot of counselling and support to get them back on track. We've seen women who engage in, basically, substance abuse. Relationship breakdown is a very big part of what we've been seeing. Families separate, basically, because the woman who has been subjected to the abuse feels that she's been betrayed by her partner, who was equally helpless in that space. We see a lot of ongoing diagnoses of PTSD, anxiety and depression. We see a lot of women give up their careers and also struggle to re-enter the workforce. That is a very big issue because many of them have significant out-of-pocket expenses that have come as a result of that injury, either because of getting psychiatric or psychological assistance, or they have pelvic floor injuries or third or fourth degree tears. Those are the things we see.

We see a spike in domestic violence and we see women reject health care, particularly for themselves and their infants. Vaccination is especially a battleground in that respect. It's not limited to the intrapartum period. There is a lot of focus on labour and birth, but from our perspective and the work we do, we see it happen from the time a woman is initiating access to a health service. Indigenous women are particularly vulnerable in this space—refugee women as well. If women cannot speak English very well or as a first language, then they really are in difficulty. Young women—women from lower socioeconomic backgrounds are particularly vulnerable to being pursued by the police or the DCJ, and, of course, reports to the health authorities or, in fact, to the sheriff. We've seen a bit of that.

It's also not confined to the women. Anybody who stands up for the woman, we've seen, actually also—it's basically a guilt by association. They tend to get attacked, abused or sidelined. There is generally this sort of feeling of hostility that surrounds a woman who is seen as alternative. Underpinning all of that—you've probably seen it from all of the submissions that we've seen being put on the site—is that informed consent is a very big issue in the way in which health care is being delivered.

I do acknowledge that this is probably something that no-one else has looked at, which is the discriminatory laws and practices that we have in place, which I think Parliament can actually examine. This is a fine opportunity for us to look at and review some of that legislation, and also to look at the institutions that support our healthcare providers, such as the coroners and the police and DCJ and the paramedics, and the involvement they have in facilitating this kind of normalised culture.

I'll wait for you to ask me questions about the definition of obstetric violence, but let me stop there and just say that Australia does have an obligation under CEDAW to prevent gender-based violence against women. I'm hoping there are certainly a lot of specific recommendations that have been made by the Committee, and I'm hoping that this inquiry will consider them in some detail.

The CHAIR: Thank you. In New South Wales we don't have a human rights Act, while other States and Queensland do. I'm just wondering if that limits the protections afforded to women in New South Wales who are giving birth. What sort of model or legislative changes do we need in New South Wales to ensure that women are protected here in the same way as they are in other States?

BASHI KUMAR-HAZARD: Let me start by talking about the Queensland Human Rights Act. There is a tiny little provision in the Queensland Human Rights Act, under section 17 (c) of the Act, which states that a person cannot perform or provide any medical treatment to someone without true and proper informed consent. So informed consent has now been enshrined in law. Whilst there are very limited teeth associated with the Human Rights Act in Queensland, what it has done is that it's starting to make a cultural shift in our facilities. Women have an avenue to go to someone, like the Ombudsman or the Human Rights Commissioner, and say, "I was denied informed consent. My right to informed consent was not duly protected by this health facility."

If the commissioner gets enough complaints along that front, they will put it all together and provide it to the Government. The Government has to consider it and take it seriously. The Government also gives it to the Queensland Health Ombudsman, who has to take it seriously. What it has done is driven a bit of cultural change. That's not to say that it isn't a slow process. We see the same sort of resistance in Queensland to that cultural change as we may see here.

The CHAIR: You talk about someone being able to go to the Ombudsman, for example. What are the legal avenues here? Does it just require somebody to take on their own legal case? What's the difference?

BASHI KUMAR-HAZARD: I sort of break that down under part 3 of my submission. The avenues for women here are limited. In terms of complaining, women can only complain to the HCCC. Unfortunately, getting the HCCC to take these complaints seriously requires two things: One, there has to be injury to the infant; and the second is that if there's injury to the woman, it has to be permanent and/or enduring. PTSD doesn't count under those kinds of categories. So unless a complaint accompanies those kinds of elements, it's not taken seriously. Informed consent is considered a soft skill. In the last 11 years of doing this work I would probably have made, on average, about 120 complaints a year. Without doubt, I can almost anticipate the answer if the claim is about a violation of informed consent: It will be, "Thank you. We'll let the practitioner know."

The CHAIR: You talked about true and proper informed consent, and most of the submissions talk about communication and consent in some form or another. One of the questions that has come up quite a bit is what if there's an emergency and it's a doctor that the woman hasn't met before or they're in a different emergency service? What is true and proper informed consent, and how do you build legislation around that without it becoming too difficult in an emergency situation?

BASHI KUMAR-HAZARD: Informed consent, in and of itself, has a lot of law behind it. In order to be informed, the right information has to be given. It has to be freely obtained, so the practitioner has the obligation to give that information and to give the woman choices and to give her time. It has to be timely. She has to have time to think about it, free from any kind of constraints or coercion, and she can change her mind at any time. That's just not how our system is structured. Obviously, whilst the phrase is in legislation, it's open to the courts to interpret it. It also is informed by international law. We've got the international instrument for bioethics principles. We've got the convention on the elimination of violence against women. We've got the Convention on the Elimination of All Forms of Discrimination Against Women. All of them define what informed consent looks like, and it's very carefully preserved as a fundamental human right.

Within maternity healthcare facilities, we need to start distinguishing between what is called an emergency and what are essentially standardised processes. Standardised processes are more common in maternity health care than we think. A woman at the point of admission when she comes into hospital, we can almost predict now just from getting their files what the process is going to be on admission. She'll be checked. We'll probably take her vitals. Somebody will come in and assess her. The midwife will review her file, all her antenatal reports.

They'll do a vaginal examination. There are at least four or five routine processes that are already implemented in place. Now the woman doesn't know that any of these are routine and that she has a choice in relation to it. She is rarely counselled about it; she is just told it's going to happen. Those things actually build up into quite an intense period. As the labour progresses, the woman becomes more and more in distress and has more of a feeling of loss of control and violation.

At the very end—and we do concede that there are times of genuine emergency, and there are, but for the most part, certainly for the hundreds of complaints that we see, what constitutes a genuine emergency is not necessarily there. What is seen as an emergency in the facility is that they're short staffed, the doctor is running out of time, they've only got a few minutes and they're bolting from room to room, and they need to get things done. They need to sort out one woman before they get to the next, and so there is a sense of urgency and immediacy that's pushed on her. She doesn't know that this is the context in which she's trying to navigate her labour and birth.

This is not actually something that we're making up. In the special rapporteur's report on violence against women in the context of facility-based childbirth, so the obstetric violence report, the special rapporteur said that there is quite a significant abuse of the doctrine of medical necessity—medical necessity being emergency procedures—and that, because providers get to decide what constitutes an emergency, they tend to pretty much declare as much as possible, and that's not intentional. They're responding to a system that is under pressure. Usually they're the only one or it's the middle of the night or they're short staffed. They will treat it as an emergency because in their minds they're running out of time and they can't negotiate. They will not be able to give woman-centred care.

The CHAIR: Is that due to staff shortages predominantly?

BASHI KUMAR-HAZARD: Staff shortages and obviously we do think that there is an element of interpersonal issues. I think compassion fatigue really affects staff who are under a lot of constraints. It's not just staff shortages. It's the policies and the protocols. It's the fact that nobody quite knows who is in charge. Nobody quite knows who is under their care. This woman has seen probably about 10 to 15 different providers before she turns up in labour, and it's a big ask. It's a big ask for whoever is looking after her to get on top of all of those needs.

The Hon. SUSAN CARTER: Thank you, Dr Kumar-Hazard. You spoke about the Queensland Human Rights Act. Victoria, the Commonwealth and the ACT also have legislation in this area. Does any of that legislation include a right to informed consent?

BASHI KUMAR-HAZARD: No, they don't specifically refer to the right to informed consent and also they don't really have the kind of—so there is an obligation on, say, the courts to take into consideration that legislation but there is no opportunity for women to get complaints lodged on the basis of those violations. Informed consent I think has only started to rise as prominently as it has because we are trying as a society to encourage patient autonomy, and patient autonomy can't progress without some measure of respect for informed consent.

The Hon. SUSAN CARTER: You said that informed consent is very well defined and understood as a concept internationally. In the context of an unplanned forceps delivery, what would informed consent look like?

BASHI KUMAR-HAZARD: One of the examples that I give is that women will be told, probably in the five minutes before they're due to give birth—

The Hon. SUSAN CARTER: Sorry. I don't mean to stop you, and I understand the examples that you've given, but not what's happening now. If there was going to be informed consent in an unplanned forceps delivery, what would that look like, so we know what we're trying to achieve perhaps?

BASHI KUMAR-HAZARD: We know that repetition helps, so I would say that antenatal preparation would be, unfortunately, to hold up those giant tongs and say, "This is what a pair of forceps looks like and it could be that, if your labour is not progressing to a certain point or you're not pushing the baby out at a certain point, then we may have to use this." Or you show them an image of the ventouse and then you have to explain what the risks will be, including third- and fourth-degree tears, or injuries to the baby's scalp. Those are the realities that women need to know because that's the thing that they're most concerned about, which is that whilst they're there in a very vulnerable position somebody whips out this instrument and proceeds to use it on them. They need time to consider that.

But even during the labour, I would say that she needs someone to come in 10 or 15 minutes beforehand and say, "This is something that we need to do or the alternative is that we would recommend that you have a

C-section." Then you step out and give her the five minutes to think about it and talk with her partner about what she would prefer. Ultimately, if we're talking about informed choice, we need to be quite realistic and not push one agenda over the other. We do tend to see that happening a bit in this space.

The Hon. SUSAN CARTER: In a *Rogers v Whitaker* context, why aren't these warnings about possible side effects being given currently? That surely exposes healthcare providers to action.

BASHI KUMAR-HAZARD: It does. Unfortunately, though, we have a Civil Liability Act—and particularly the legislation here in New South Wales—that means that none of these cases are coming to court because of the level of injury. If it is a third- or fourth-degree tear, yes, it will end up in court. There's a failure to warn kind of element that will be thrown in. Unfortunately, what the courts would see as failure to warn would not actually translate back into practice. There are some aspects that matter to women in terms of the failure to warn. It's got to be material risks, and it takes time. The courts have to sort of say that third- and fourth-degree tears are a material risk. But nicks to the baby's scalp, arguably, won't be considered a material risk because they're not significant enough. The other aspect is that if the woman has PTSD, unless it falls under section 16—which is 15 per cent of the worse kind of injury or the most extreme kind of injury, so there has to be some kind of physical injury attached to it—they won't even get past first base in terms of filing a claim.

The Hon. SARAH MITCHELL: As a non-lawyer, unlike my colleague, I wanted to understand. Say in that scenario that you just played out where the recommendation from the doctor is to have a forceps delivery, the woman has time to consider and decides "No, I don't want to do that." If something then happens to either the mother or the child, and it goes into that area of medical liability, which you did talk a little about in your submission—in layperson's terms, if the worst happens and the child is either injured or doesn't survive childbirth, where does that liability come in, in terms of the decision that was made? Is that process something that midwives or doctors would be nervous about? That's the part that I really struggle to grapple with because I can see the importance of women making informed decisions, but then if they're also not medical professionals, where does that balance lie?

BASHI KUMAR-HAZARD: There's two aspects to that. I think you're absolutely right. We have a situation in medical liability laws—and I have to be very frank and say that I am not a fan of medical liability laws. I think they put doctors and midwives on the back foot and it means that a practice can practise defensively. In many cases we see them do that. It's not just the medical liability laws. It is the fact that it's unpredictable. You don't know whether the court's going to go in your favour or not. I was talking to a GP who said, "We look at the cases every week and we keep saying that could be us."

So there is a problem there with the medical liability laws, and nowhere is it more felt in this space. Partly because the women aren't really getting access to justice, so there's no balance. I'm sure my colleagues are not going to be happy with me saying this, but when it goes to a plaintiff lawyer, they will be saying to the woman, "We're going to run this case on the basis that you were helpless and you didn't know what was happening", and that the doctor should have taken over. That is a cultural clash with all of the policies we have of pushing towards patient autonomy. So it is holding us back in that sense. That said, in most, if not all, medical liability cases I've seen, the primary defence will be that consent was appropriately obtained, and in many cases the courts will find that. So obtaining proper consent is a defence in medical liability claims, so it is worthwhile.

The Hon. SUSAN CARTER: I have one more follow-up question. You speak in your submission extensively about the role that the guidelines play in hospitals. Is there an opportunity to amend those guidelines to put in time lines for seeking consent, and would that help in terms of improving information and the consent process?

BASHI KUMAR-HAZARD: Absolutely. I think those guidelines could be amended. When I read them, I too just think, "Well, obviously this is why the staff would do what they do." If the guideline says, "You have to perform a vaginal examination every four hours"—I have seen midwives being disciplined and losing their jobs because they didn't do that because a woman refused. The guidelines should be drafted in a way that specifies that consent needs to be obtained and allow for the documentation of the refusal of that consent so that it literally respects the woman's and the midwife's or the doctor's boundaries. The other thing, of course, is that the first thing that the woman does when she's about to lodge a complaint is she gets her files first, and she looks at her medical records. If she remembers accurately that that is what she said, often it defuses the amount of frustration and pain that they feel. What is more concerning for them is when it's retrospectively added—that she refused something—and they know that that didn't happen. Then it becomes a battleground.

Dr AMANDA COHN: I'm going to a completely different topic. Earlier, in your introduction, you mentioned the Coroner and that the current coronial processes are part of the problem. I'm interested in exploring that a bit further.

BASHI KUMAR-HAZARD: Sure. Do you want me to answer that? We have been monitoring what the coroners have been doing, in particular for those women that we consider to be very much outside the system. I know that Hannah mentioned before that there was a book published on birthing outside the system, and I was one of the co-authors for that. One of the chapters that we contributed is about how the coroners across the country approach investigations into infant deaths. Over time I think what has happened—and it's a bigger social issue as well. I think there is an assumption that women relinquish their bodily rights or their reproductive rights as soon as they've gone past that first trimester. So we have coroners saying things like, "You don't have a right. The hospital has a right to tell you what to do." They don't really, and that's not the law. We also see coroners openly criticising women for having political interests, and we don't see that kind of public attack on men who have political interests. That is the very definition of discrimination.

The Hon. EMILY SUVAAL: Thanks so much for your time today. Looking at your submission, which I acknowledge isn't online yet, there are some quite serious allegations in the submission. I was just wondering where the evidence is for these examples and if you can provide us with some specifics.

BASHI KUMAR-HAZARD: Would you tell me which ones? Because some of them would be privileged.

The Hon. EMILY SUVAAL: In the opening, point one, in terms of the prevalence, goes through to list a number of different types of abuse.

BASHI KUMAR-HAZARD: Yes.

The Hon. EMILY SUVAAL: And non-confidential care and non-consented care et cetera—there's quite a number of different examples.

BASHI KUMAR-HAZARD: Yes. We do keep a register of all the complaints that we receive, and we will get permission from the women to use extracts of whatever it is that they're saying. A lot of that is based on either the complaints or the matters that we have pursued on behalf of women who've come to us.

The Hon. EMILY SUVAAL: And are they women in New South Wales, women internationally or women in Australia?

BASHI KUMAR-HAZARD: The ones that I picked out are from New South Wales, bearing in mind that it's over the last 10 years.

The Hon. EMILY SUVAAL: Thanks for clarifying. The other question I had was around the BESt study. It's true that you were involved in the co-design and funding of the BESt study. Would you describe what your role was in that?

BASHI KUMAR-HAZARD: When the survey was finally put together by the authors, they released it to all the consumer groups and said, "We'd like your feedback." From my perspective, we just needed to make sure that none of the questions were at odds with the human rights obligations that we have. But otherwise, it's not my area of specialty so I left it to them. The other aspect, of course, is when the authors came back to us and said they would like to extend the survey to women from non-English speaking backgrounds. That is exactly the kind of thing that Human Rights in Childbirth would certainly like to see a lot more of, so the board agreed to give $500 to the University of Western Sydney, which matched it with another $500 in order to get interpreters to interpret the survey. That is where our funds went.

The Hon. GREG DONNELLY: I will return to our earlier discussion. Very helpfully, you made reference to the human rights Act, specifically the Queensland Human Rights Act 2019. I'm just looking at the provision here. I will read it out and then ask you a question. Section 17—subparagraph (c) is the relevant one—of the Queensland legislation states:

> **17 Protection from torture and cruel, inhuman or degrading treatment**
>
> A person must not be—
>
> …
>
> (c) subjected to medical or scientific experimentation or treatment without the person's full, free and informed consent.

Would you be able to explain, for the benefit of myself and maybe other Committee members, what you understand to be the meaning of "full, free and informed consent" under that legislation?

BASHI KUMAR-HAZARD: Sure. That definition is actually based on the human rights instruments that explain what full, free and informed consent means. It's enshrined in international law. There are a couple of cases that have since been examining the definition in its full scope, particularly in the context of maternity care. It's actually not unlike the education that we've rolled out for sexual consent—consent in relationships. It needs to be

full in the sense that it needs to be fully informed; it needs to be free in the sense that information is given and the woman is left to her own devices, basically, to consider it, come back and ask questions; and there needs to be an information exchange but, ultimately, it's the right of the woman to say yes or no. It can be refused and it needs to be timely. I think a big problem is that we don't give people enough time to consider their options. It's a hurried process even when it's routine care. Then, of course, it can be reversed. It must always be reversed. I think that is something that women are not told in our health systems. Often they know they're being pushed in a particular direction but they're too afraid to stand their ground, or they're too afraid after they've said something to turn around and say, "Actually, I've changed my mind. I don't want to go down that path."

The Hon. GREG DONNELLY: But, in practical terms, that might be difficult to reverse. One could relatively envisage circumstances where if they had consented and a procedure, or part thereof, has commenced, it may not be possible to reverse it. It may be possible to stop it, perhaps, but not reverse it.

BASHI KUMAR-HAZARD: I think the assumption is that the reversing happens before the procedure, obviously.

The Hon. GREG DONNELLY: Right, okay. Can we go back to your example—because I think it was an interesting one—of showing the woman the forceps prior to what might be a very short period of time before the actual need for the birth. Forgive me—I was obviously ignorant and unaware of this—but I would have thought that, for example, that may have been discussed with women in those various courses they do. As I understand, the courses are not mandated but a number of women enrol in them—and I think some of them are even paid courses or workshops—to explain to them what's ahead of them. Is there not some of this done already, just for my edification?

BASHI KUMAR-HAZARD: It depends on where you go. I think in the public sector it is actually an additional cost and a constraint, and so antenatal education is thin on the ground.

The Hon. GREG DONNELLY: Sorry, it's thin on the ground?

BASHI KUMAR-HAZARD: It's thin on the ground, yes. The best way, obviously, is when it comes from the primary care provider, so the person who is doing the antenatal appointments with the woman would be the one who would be tailoring that information to suit her. I can guarantee you that most care providers can already reasonably anticipate whether a woman is going to end up in that situation, particularly if she's got gestational diabetes, because the baby is more likely to be large, or if she is of a particular age or she has a history of very slow labours. Those are the kinds of things that would often be already something that's anticipated.

I've had the privilege of visiting midwives who work in very regional areas, very rural areas, particularly in Indigenous areas, and their skill set in terms of anticipating what is going to happen to every woman in their care is extraordinary. I do think that it's a skill set that we have really failed to capture and utilise to our best abilities as a health service. Most midwives providing that kind of antenatal care, if they are given the time and the means, will actually be providing much more in terms of that kind of education than, really, generic antenatal classes.

The Hon. GREG DONNELLY: Is it your submission that actual obstetricians and gynaecologists in their rooms with women who are going to have a baby, that isn't discussed or considered or raised?

BASHI KUMAR-HAZARD: It's not necessarily discussed, no. By that you mean the private sector, because in the public sector the women may get one visit with an obstetrician beforehand and it's probably more about deciding which path—whether she's high risk, low risk or she's going to go in for a C-section or not. We call that a screening appointment. But, generally speaking, they're dealing with the doctor in labour, you know, at the pointy end of things. In the private sector, generally speaking, they don't. Some private hospitals have antenatal education in place. I mean, I haven't sat through any of them, but from what the women tell me it's not really something that's discussed—it's considered too frightening. But I tell you what, for my clients, when those forceps are coming towards them and they're strapped to a bed, it's pretty frightening.

The Hon. SARAH MITCHELL: I just wanted to ask about—I think it's page 14 of your submission, and I don't want to seem critical and I'm sorry if it comes across that way—routine interventions. You talk about how the Department of Health guidelines mandate routine interventions and invasive procedures, and one is screening for diabetes. You mentioned before that if someone has gestational diabetes they are probably more likely to have a larger baby and might need intervention with delivery. In your submission you indicate that doing those screenings has an impact on the woman's human rights, but I would counter that by saying if you want to make an informed choice as a woman giving birth don't you also need to know if your risk factors have increased? And so, things like being screened for diabetes or having a drug and alcohol test, or whatever it is, are actually helping you to make more of an informed choice when you're in that position, if that makes sense?

BASHI KUMAR-HAZARD: Absolutely, but—

The Hon. SARAH MITCHELL: So can you explain a bit more why you put that as a concern?

BASHI KUMAR-HAZARD: Yes. What we find is that it's not that these screening opportunities are there, it's the fact that when women refuse that screening because they've been through it before or because they know that it's not going to make any difference to the choices they make, they are usually risked out of certain models of care. If you're in an MGP program or in a birth centre and you refuse the screening for diabetes, you can be sent back to the maternity ward, so it's almost like a punitive reaction to exercising a choice. These are probably women who have been through it before and didn't see that it made any difference, and there are women who just don't want that level of—they don't want to know. There are women who refuse ultrasounds as well. The problem is not that they get the information or are offered their choice and they refuse. The problem is that they're penalised.

The Hon. SARAH MITCHELL: But then wouldn't they have to go back to that model because that risk is there that's unknown? Does that make sense? Because if you know you're low risk, you're probably better to be able—or you might have more options available to you. What's coming through, certainly for me, in the course of today has been that information for women is really important so that they are making those choices with their consent, knowing what their risks or options are.

BASHI KUMAR-HAZARD: Yes. I'm probably getting out of my lane a little bit, but from what we understand with the BMI, and certainly screening for diabetes, will be that it is going to end up being that the baby is bigger or that the labour is slower, but that too can be managed. That can be managed without it being labelled as a high-risk situation. The problem is that, once the classifications come in—and this is also part of a bigger issue that we have—just because someone is labelled high risk doesn't mean that they need to go back to fragmented care.

In fact, our argument would be that those women are more vulnerable and they probably need more continuity of care than anybody else. They're probably more likely to be either readmitted or having all these incidental problems because, on top of those underlying issues, they will have some kind of emotional or physical trauma associated with the birth. There are different ways to do it. Forcing the process or imposing penalties so that it doesn't seem like a choice would not be the way to go. If you gave me as homework, you know, 10 pieces of guidelines, I could probably rewrite them in a way that respects women's human rights within maybe a couple of hours.

The Hon. SARAH MITCHELL: Yes. That was just one little example that was there but, as I said, it's just about trying to understand the risk, the information, the informed choice and how we can make that whole system work in a better way.

BASHI KUMAR-HAZARD: Yes.

The Hon. SARAH MITCHELL: That just stood out to me a little bit. Thank you.

The CHAIR: Does the Hon. Mark Banasiak have any questions?

The Hon. MARK BANASIAK: No.

The CHAIR: The Hon. Anthony D'Adam?

The Hon. ANTHONY D'ADAM: Yes. In the previous session, Professor Dahlen made some observations about what I would describe as systems obstruction to private practising midwives. I know you touch on that in your submission. Perhaps you might be able to elaborate on some of the systemic obstruction that's occurring in terms of the ability of private practising midwives to operate in the system?

BASHI KUMAR-HAZARD: Sure. I did a PhD on that, which I just handed in.

The Hon. GREG DONNELLY: Was that a Dorothy Dix question?

BASHI KUMAR-HAZARD: Is it in my covering letter? Did I make a reference to that?

The Hon. ANTHONY D'ADAM: No. It's on page 24. You actually refer to it.

BASHI KUMAR-HAZARD: Okay.

The Hon. ANTHONY D'ADAM: Oh, not to the PhD but in terms of this issue—

BASHI KUMAR-HAZARD: Okay. Yes, there are three areas that we have identified. In my research I found that there were three areas, one of which—and this is largely a Federal Government issue—is a refusal to

refer women. In order to access Medicare for the services rendered by a private midwife, women need to get referrals from GPs. We frequently hear from women who say that they cannot find a GP who is willing to write a referral. As I say in the submission, this is not to say that the woman won't access a private midwife; she can, but she will pay a lot more fees for that. So that's a lot of out of pocket; none of it is recoverable from Medicare.

The second issue has to be with the refusal to collaborate. Anecdotally—because no-one wants to come out and tell the truth about it—we know that there's probably about 20 obstetricians across the country who've agreed to enter into collaborative arrangements with private midwives, which means that, generally speaking, private midwives who need a collaborative arrangement with a doctor in order to practise will shut down their practice. This is especially a problem in rural and regional areas, where there's usually one or two private obstetricians in practice.

The third is access to public tertiary maternity wards. Private midwives are entitled to make applications for visiting rights to public tertiary maternity hospitals. They have to make the applications to the LHD, the local health district. The local health district will have a medical committee, although that has changed in New South Wales. They have a more generalised committee where the nursing unit manager or the nursing manager will sit with the medical providers. But it used to be the case, and it still is the case, that the LHDs will consult with the hospital for which the midwife has made that application. If the hospital staff do not see it as feasible then chances are the application will be rejected. Really, from a competition law perspective, what you would like to see is parity. So you would like to see at least matching numbers of private midwives as with visiting medical officers or private obstetricians, failing which you're really looking at a competition issue.

The CHAIR: Thank you so much for attending today's hearing. Unfortunately our time has expired. If committee members have additional questions for you after the hearing, we have resolved that the answers to these along with any answers to questions taken on notice today be returned within 21 days. The secretariat will be in contact with you in regard to those questions.

(The witness withdrew.)

(Short adjournment)

Dr VANESSA SCARF, Midwife and NSW Branch Chair, Australian College of Midwives, affirmed and examined

Ms ALISON WEATHERSTONE, Chief Midwife, Australian College of Midwives, affirmed and examined

Mr MICHAEL WHAITES, Assistant General Secretary, NSW Nurses and Midwives' Association, affirmed and examined

Mrs GEMMA DENG, Professional Officer, Midwifery, NSW Nurses and Midwives' Association, affirmed and examined

The CHAIR: I now welcome our next witnesses.

VANESSA SCARF: I am the Chair of the NSW Branch of the Australian College of Midwives. I am also a senior lecturer at the University of Technology in midwifery.

The CHAIR: I might start by asking if somebody from the NSW Nurses and Midwives' Association wants to give a short two-minute statement.

MICHAEL WHAITES: Thank you. I'll take that opportunity. Thank you for the invitation to give evidence at this inquiry. The NSW Nurses and Midwives' Association represents the industrial and professional interests of over 76,000 nurses and midwives in New South Wales. The association collectively advocates for our members on industrial and professional issues and also advocates on behalf of our members on human rights and social justice issues. Over 87 per cent of nurses and midwives registered in New South Wales are women. Birth trauma is an issue that affects our membership professionally and personally. Both myself and Mrs Deng are midwives. Birth trauma is a significant physical and mental health issue for women and their families. It also affects the mental health and wellbeing of midwives who care for those women.

This inquiry will be, and in some instances already has been, difficult for our members—people who strive to provide the best care possible, whose work exposes them to what can be the most positive experience in another person's life but that can also become a traumatic experience, and sometimes the line between the two is a matter of moments. It will be difficult because they may have been involved in cases where they know more, or perhaps less, could have been done. It will be difficult because of their professional and personal lived experiences. We hope this inquiry will lead to positive change and not simply lead to further trauma. Our recommendations to this inquiry are focused on four main areas: the need for universal access to midwifery-led continuity of care, improved workforce planning and design—and this includes the need for higher rates of pay and improved working conditions for midwives—improved access to education and a review of the policies that impact on care provided.

Our midwifery members strive to advocate for women in their care every day but are often constrained by workforce shortages, which are at times extreme. They can be constrained by the existing policies and, sadly, medicalised decisions that are based on a fear of litigation or complaints. Our recommendations are aimed at providing solutions that would address those constraints and ensure that our midwifery members are able to provide the highest standard of care. Our State and Federal governments must act urgently to ensure that measures are implemented to prevent the physical and mental harm associated with birth trauma. Finally, we want to acknowledge the experiences of our members and the women who have come forward to bravely share their experiences. Their advocacy will be the catalyst for the changes that need to occur.

The CHAIR: Thank you. Is one of our witnesses from the Australian College of Midwives wanting to give an opening statement?

VANESSA SCARF: Thank you. Yes, we will. Thank you for having us today to make a submission. The Australian College of Midwives is the peak professional body representing midwives in Australia. Midwives are primary maternity care providers whose scope includes the provision of women's health support, education and advice before conception; during pregnancy, labour and birth; and for the postnatal period. Midwives are also experts in sexual and reproductive health. This means that midwives' scope of practice holistically encompasses the needs of child-bearing women and their families through their life course.

The Australian College of Midwives welcomes the New South Wales select committee inquiry into birth trauma. The college asserts that the recognition that birth trauma exists—indeed, as research indicates, it affects one in three women—is the first step towards addressing this critical issue affecting so many women in our community. It is also important to acknowledge that birth trauma and witnessing or being party to instances of birth trauma have a significant impact on midwives also.

ACM surveyed its members with regard to midwives' responses to the inquiry questions and received over 200 responses. Some of the frankly distressing stories that midwives have provided are outlined in our submission. As one midwife said, people do not start their day planning how they will cause birth trauma. The key themes relating to birth trauma occurrence identified in our survey are (1) poor communication and sharing of information with the woman; (2) consent: lack of informed consent and coercion in the face of active refusal; (3) management of emergencies such as postpartum haemorrhage, medical interventions and induction of labour, for example episiotomy; and (4) workforce challenges like stress, time constraints, burnout and low staffing levels. Whilst midwifery education focuses on woman-centred continuity of care, many midwives indicated that they are unable to provide this in the existing system. It is compounded by workforce and cultural issues that can further impact on their care provision. Respect for maternity care is a fundamental right of all birthing women.

ALISON WEATHERSTONE: In our submission, the college has provided six priority recommendations for maternity service reform in New South Wales to improve outcomes for birthing women and their families. They are:

1. NSW Ministry of Health to commit to fully funding all ten goals and associated objectives of the '2023 Blueprint for Action – Maternity Care in NSW' with a completed implementation plan including benchmark targets, actualised within 6-12 months—

further, ACM would seek to be included in the key stakeholders for this implementation plan—

2. NSW Ministry of Health to review and/or implement Service Level Agreements with Local Health Districts to ensure the required structural and system level reform in maternity care as per Blueprint objectives is included, funded and actioned.
3. Every woman to have a known midwife and access to full continuity of midwifery models of care, with targets as a matter of priority as per Blueprint objectives 4 and 6.
4. Development of multi-disciplinary trauma informed obstetric emergency and consent training.
5. Priority integration of privately practising midwives into NSW maternity services, including authority to practise within hospital settings and enabling hospital admitting rights NSW-wide for Privately Practising Midwives.
6. Expansion of First Nations'-led midwifery models of care in NSW.

Evidence shows us that midwifery continuity of care with a known midwife—and, for clarity, this is not the same model of care as the MAPS model currently utilised in New South Wales—across the full spectrum provides better outcomes for women, including improved perinatal mental health, minimised birth trauma, reduced intervention at birth and increased breastfeeding rates. It also reduces preterm birth by 24 per cent, extending to 50 per cent for our First Nations women. It is 20 per cent cheaper than standard fragmented care.

ACM asserts that structural reform of the New South Wales maternity services prioritising midwifery leadership and midwifery models of care with a known midwife working to full scope, such as midwifery group practice, will have a positive impact on a woman's birth experience and, importantly, give New South Wales babies the best start to life. On behalf of the Australian College of Midwives, we would like to thank you for the opportunity to present today.

The Hon. EMILY SUVAAL: Thank you all for attending here today. I just wanted to clarify, if I could, that you are all midwives. Is that correct?

VANESSA SCARF: Yes.

The Hon. EMILY SUVAAL: Wonderful. I am going back to a comment which I had noted in your submission, Dr Scarf, about a quote from one of your members that people do not start their day planning how they will cause trauma. Could you comment on the midwives that you have worked with in your clinical settings, collectively, and the type of people that it would be fair to say they are—that extends to obstetricians—in light of this comment about people not wanting to start their day intending to cause harm?

VANESSA SCARF: I think all staff who work in maternity care certainly have the best interests of the women at heart. I think that there are a number of systemic, cultural and organisational challenges that present huge barriers to midwives, particularly, practising in a way that they would prefer and that they see would be in the best interests of the women and their families. This would include enormous workforce shortages, but also a prioritisation of intervention and a lack of recognition of physiology in labour and birth, for example. But also there are systems, even around antenatal care—antenatal clinics, for example—where midwives are not able to give the woman a satisfactory appointment because of time constraints, for example. So it's a multilayered issue and, I think, in regard to—I can't really speak on behalf of the medical staff except that, in observing them in my own practice, they're often overstretched and they're called to situations that may be deviating from normal. I think that it would benefit medical staff, particularly in their early practising years, to understand better the physiology of labour and birth rather than only being exposed to emergencies.

ALISON WEATHERSTONE: When you undertake a Bachelor of Midwifery or a Bachelor of Nursing and Midwifery, one of the first things you learn is the concept of beneficence and non-maleficence—that is, to do good but, above all, to do no harm. As students in midwifery come through, especially now with their continuity of care experiences, they are looking to come into a model of care where they can work to their full scope of practice but also protect that normal physiology of birth. And, I think, where you see midwives are the experts in normal birth physiology and because of their skill adaptation for that, they have the ability to then consult and refer when anything deviates from normal. I know, in my experience in recent times as the Chief Midwife for the Australian College of Midwives, we, as a member organisation, represent clinical all the way up through to advocating for policy with government.

We have just recently made our student membership free for the Australian College of Midwives. That was a really important strategy for us, because our students are our future workforce. When I see their submissions to engage with us at the college, you can see, in their first, second and third year of study, they are so keen to go out into the workplace and put into practice what they're learning in continuity. Unfortunately, the way the systems are at the moment, these midwives are not able to practice how they're learning. And we see that midwives are leaving within five years, but also in that five- to 10-year middle career age workforce bracket. So I think that concept of holistic care for women is definitely there from the beginning, and then it is shaped based on personal experiences and system structures.

MICHAEL WHAITES: I think each and every one of our members turns up every day to try to provide the best possible care that they can, but the constraints within the system, at the moment, particularly for the midwifery workforce, are real. We know that there are increasing shortages. You can turn up on your shift and not necessarily have midwives around you; you might have replacement staff working around you. But, also, when we look at the experience of the midwives within the system, I point you to a report in Victoria, the FUCHSIA report, that showed that the majority of midwives have less than 10 years' experience. The association routinely does a request for government information, the GIPA Act, and we see through those figures that the number of midwives with more than seven or eight years' experience has significantly decreased since 2017—in fact, nearly a 10 per cent decrease in that. So you have this atmosphere at the moment where you go onto shift as a midwife, you're short-staffed, you're looking for the experience around you and, increasingly, that experience is not there.

The Hon. EMILY SUVAAL: Mr Whaites, further to your comments in that regard, there have been recent announcements of the MOU that the Government has come to with the Nurses and Midwives' Association in terms of the safe staffing task force, which I understand extends to midwifery. Do you have any comments on how you see that as having a role in addressing some of these issues?

MICHAEL WHAITES: We welcome the current Government's commitment to implementing their safe staffing policy, part of which includes a review of Birthrate Plus, which is the tool used by NSW Health to ascertain the staffing levels needed and a commitment to deliver one to three in the postnatal wards, which will provide a significant workforce boost. I think the component that we are still needing to have further robust discussion with the Government about is the quantum of the pay, because we know that rebuilding the workload is, one, making sure that the midwives understand that a better workload tool is coming and hopefully their working conditions will be improved. That requires us to recruit and retain midwives. We know that as a midwife the remuneration both in Queensland and Victoria is better, particularly around caseload midwifery and the pay that is received for those midwives. So there's still some movement to go, but we're pleased that the Government has made that initial step.

The Hon. MARK BANASIAK: I have a couple of questions—and this one is to you, Michael, or Gemma. In your submission, you talk about a lack of adequate training in trauma-informed care, based on a survey of your membership. Can you talk about what is available at the moment in terms of that trauma-informed care through the midwifery courses or CPD? Is there anything in that space?

MICHAEL WHAITES: My understanding is that at the moment there is an online package that is available to the staff to do.

The Hon. MARK BANASIAK: But that's not mandatory? That's just optional?

MICHAEL WHAITES: That's correct.

The Hon. MARK BANASIAK: Would you like to see something mandatory put in place as part of CPD or as part of the midwifery course?

MICHAEL WHAITES: I think it needs to be core of their ongoing training, absolutely. But another mandatory online package, quite frankly, isn't going to cut it. Actually, what we need is experienced staff that can

train the skills and can provide midwives who are practising the opportunity to—it's what we call reflective practice, so to have someone with you when you're carrying out the function and to be able to sit down with you and debrief afterwards to help you improve your practice.

The Hon. MARK BANASIAK: Yes, I think anyone that has been through online training would definitely attest to the benefit of face-to-face. In terms of the continuity of care model, we heard evidence this morning that there are not actually declining midwife numbers in New South Wales and that it's actually the fragmentation of the workforce that is causing this perceived shortage. First, I just want to get some comments on that evidence. Also, do we have enough midwives at the moment to appropriately adopt this model of continuity of care or do we need to go on a mass recruitment drive to actually get those figures up? What would be those figures?

ALISON WEATHERSTONE: I think, from the Australian College of Midwives' perspective, there is definitely a maldistribution of the workforce across Australia—they are predominantly in metropolitan areas. So that can provide challenges to rural and remote areas. But also there are differences across jurisdictions and States and Territories in Australia. I believe, if you look at your maternity service reform and strengthen your midwifery leadership, that will have a flow-on effect to the maternity models of care and the midwifery continuity rollout, because you need midwifery leadership from middle management all the way up to executive. We heard previously about the request for a chief midwife. But alongside that, you really need to bolster the leadership across all levels because they understand the models, they can roll them out, and they make them sustainable. When you've got a workforce that is attractive to work in, the midwives will want to work in it. So I think it's awareness and an education piece but also looking at how you can better utilise the workforce you've got now. Part of that is actually increasing the scope of practice of a midwife.

MICHAEL WHAITES: The figures that we have available say that New South Wales dropped from 9,533 midwives with practising registration in 2021 to 8,669 in 2023. I note that there was a Federal Government workforce planning document that said—I'm paraphrasing badly here—that our workforce planning is great, and we'll be okay for the number of midwives into the future. At the same time that that came out, there was literature saying that looking at the midwifery workforce, those who are going to retire, and looking at the burnout rate, we're in trouble. Actually, that 2019 document was absolutely right. We are seeing experienced midwives—as I said, there's been a massive decrease in those numbers, and corresponding increase as a percentage, obviously, in the junior workforce. But we also know that the senior midwives are reducing their hours to part time. That is a coping mechanism. That means that you need more people to come in and fill those full-time equivalent positions if people are working part time in order to cope with the workloads and the things that they're experiencing whilst they're at work.

The Hon. MARK BANASIAK: Have you done any workforce modelling in terms of, factoring in that burnout rate and that attrition rate, what you would need to recruit and what you would need to retain to reach that optimal level? Obviously, we're accepting that 8,669 isn't the optimal level of midwives, I'm assuming. Have you done any workforce modelling?

MICHAEL WHAITES: We don't have access to the data that would help us or allow us to do that modelling. We're very keen to work with both the State and Federal governments in doing that modelling, however. I think, to expand on my answer, encouraging models of care that put the midwife at the centre of that model of care, midwifery-led models of care, allowing midwives to work to their full scope of practice, are absolutely essential in helping us rebuild the midwifery workforce into the future. But that alone won't be enough. We also need to look at the workloads. We also need to look at the remuneration. We also need to look at work-life balance for midwives who are working in those group practice processes.

The Hon. SARAH MITCHELL: Thank you to both organisations for your submissions and for coming today. I think it might have been you, Ms Weatherstone. In your opening remarks you said something about not supporting—I think it was the MAPS model. I have no idea just as a layperson. What does that mean?

ALISON WEATHERSTONE: Definitely do support the MAPS model. That is continuity through antenatal and postnatal period. It's a version of providing continuity of care to the woman. However, they have a different midwife for the labour and birth. When we look at the data that we're presenting in terms of midwifery continuity of care, those outcomes and percentages are related to the full spectrum of antenatal labour and birth and postnatal care.

The Hon. SARAH MITCHELL: Thank you. I just wasn't quite sure about that one, so I just wanted to have that clarity. Also, just going on from that, I think both submissions talk—I think you've been very passionate in your evidence today about the importance of having that continuity of care model. I want to speak briefly particularly for rural and regional communities because, obviously, I am someone who lives in a regional town.

Those workforce challenges are particularly acute, the further west you go from the capital city. I just was wondering. I know NSW Health in their submission talk about a midwifery-led practice, I think, down in Leeton. Are there things that you know from your experience—this goes across both organisations—where there've been some really good models in rural and regional communities, either here in New South Wales or in other places across the country that we should look to emulate, that has been in place in the past and that we could go back to? I'm just curious, from that rural, regional and remote perspective, what your insights are.

VANESSA SCARF: I could start with that. I know that Broken Hill had moved to a completely midwifery continuity of care model in a multidisciplinary team approach, so all women—Broken Hill has a reasonably small birth rate—saw a known midwife for their pregnancy. I think that they have had the usual challenges of the younger workforce of midwives having to take time off to have a baby themselves et cetera, but that is a model that was established a number of years ago that was very successful. We have a couple of rural midwives in the New South Wales branch committee for the college, and the reports that they give us at our meetings are the same. They ask me every time, "Has there been anything moving this forward?" Generally, the midwives are not permitted to work to their full scope of practice in rural areas. Not only is it a frustration for the midwives who are there, but it is certainly a detractor for midwives who would consider going out to rural areas.

One of the reasons for that would be that the leadership in that particular health service is generally a nurse without midwifery training. So midwives understand midwives' work. The other thing is that it is very difficult to get obstetric services in some rural areas, even to the point where it's difficult to get a locum to go out there to work with them. There are some services that have GP obstetricians. I think that there could be more of a multidisciplinary approach to that. Rural areas are also a perfect place for an endorsed midwife to be able to provide midwifery care to women in a multidisciplinary team.

ALISON WEATHERSTONE: I think it's really important to expand Birthing on Country and Birthing in Our Community models of care. In Queensland they have a Growing Deadly Families strategy, and we also had a national rural maternity workforce forum in Canberra last week where we discussed the challenges of rural and remote maternity care provision, looking at local co-design of what the community's needs are so that you don't just have a one-size-fits-all approach to the models that are being implemented in these communities but that being underpinned by the continuity of midwifery care. We also see there are hub-and-spoke-models in South Australia that work very effectively. I think one of the drivers would be that you need to have continuity-of-care targets because there needs to be either incentives for the local health districts to implement these continuity-of-care targets or a disincentive if they don't.

The Hon. SARAH MITCHELL: Did you want to add anything? It's fine if not.

GEMMA DENG: I have nothing to add.

The Hon. SARAH MITCHELL: Just a different question. In the submission from the association on page 18 you talk about the personalised alternative care and treatment framework that's in place in Queensland, just in relation to women having consent and being fully informed about their choices. I wonder whether you could tell us a little bit more about that model, if you know much more about it, and if you think it's working, effective and something that we should look at doing here?

GEMMA DENG: Yes, it's something that goes further than just signing a form to say I don't consent to having something that we have here in New South Wales—something that's documented so that women can write down their reasons for what they want within their birth. They can have that done at any time in the pregnancy, and they then don't have to repeat themselves if they are in that fractured care, or even if they are with the same care provider and anything changes. It's a living document. It can also be documentation for the medical staff as to what they've been informed of so we have evidence of what the women want and the reasons that they want that, and what the doctors have explained to them and what they've come to arrange together. It lives within their notes, and then if they come in at any point in their pregnancy, labour or birth, it's there for everyone to see.

At the moment what we have is decisions being made in clinic, so that when they come in on the weekend and that doctor is not available then that's not always upheld. It is one trial that we have seen there. I think it needs further investigation but it would be something to help respect women's choices and make them feel valued in their decision-making. Because that's not something that's always reflected in practice at the moment.

The Hon. SARAH MITCHELL: Do you know how long that's been available in Queensland? It's fine if not.

GEMMA DENG: No, I don't. I have to take that on notice.

Dr AMANDA COHN: We've heard from every witness so far today about the importance of continuity of care. In the submission from NSW Health they cite two barriers to implementing continuity of care more broadly, one being the midwifery workforce shortage but the second one being difficulty with the inflexibility of working models and working conditions, that the midwifery workforce is largely women, often with dependents, that on-call requirements are difficult. My question is to all of you in terms of suggestions that you would have for how NSW Health could offer that kind of arrangement in a way that would be attractive to midwives to work in.

GEMMA DENG: I'm happy to give my point of view. I worked in continuative care for seven years with labour and birth. I stopped having to work in that model of care because I had babies and I don't have family here that can drop everything and look after my children for me. I think child care is a really big thing. As you mentioned, mostly women in that model of care, so needing more flexible child care, even just more flexibility with terms of part-time roles. That wasn't something that was supported in the large hospital that I worked in as they felt that that would not provide women with good enough continuity if we weren't there for them and if we were working, say, a job share type role. But what that meant was groups dissolved and there was no continuity for those women. So actually enabling people to trial part-time would be important.

Remuneration, as we've heard earlier, better pay for women in NSW Health. Then they might be able to afford more child care or they may be able to afford flexible child care, nannies and such, so they might then be able to actually work in that space. And just greater acceptance and understanding of the role that we do, as there was sometimes a disconnect between what people thought you were doing. That role is very flexible. We may be in the hospital, we may be at a home visit, we may be doing admin, you know, heaven forbid—so you weren't always visible. And there was an understanding of what were those people actually doing, and appreciation for the work. When they were short staffed in the hospital, often we were pulled in to work in that framework and then obviously our model was being diminished there. I think it's just having improved staffing and models for escalation—so that there's better escalation models within the hospital so that the group practices are not being fallen back on. As I said, remuneration and perhaps child care and more flexible hours/work time.

MICHAEL WHAITES: I will add to that. I think sufficient numbers in the model so that, particularly if you are leaning into more of a team approach, but sufficient numbers in the model so that the midwives' caseload is manageable so that they can take time off, they can have days off, they do get that downtime through that team-based approach.

ALISON WEATHERSTONE: Again, going back to midwifery leadership, when your midwifery unit manager or your MGP manager understands the model, there's actually quite a lot of flexibility within it for the people working in that model of care. I do agree that there needs to be flexible working arrangements within that model of care. I think you need to be innovative in looking at how you can incorporate graduate midwives and early career midwives to be working in these models. They want to work and they're workforce ready for continuity, so looking at how you can best support that. There are some midwifery group practices in Australia that are purely run by early career midwives with the right support. Also, I have to agree with Gemma: This is an out-of-hospital setting, it's a community-based model of care and so the kneejerk reaction currently is to want to take from MGP to prop up rosters in hospitals. It needs to be the other way around.

VANESSA SCARF: I think respect for the work that the midwives are doing, in midwifery group practices particularly. If they're not seen then there's an anxiety that they're perhaps not working. But in fact, as Ali and Gemma have said, community-based midwifery is actually definitely the way that we need to go. Women like to be seen in their own community.

The Hon. SUSAN CARTER: We've heard from a number of submissions that birth trauma is not something that just affects the women giving birth. It affects families, but it also affects healthcare workers. What sort of access to do midwives have to vicarious trauma counselling or support?

GEMMA DENG: Minimal, in my experience. As a midwife, we do a whole load of things from wonderful, happy occasion births to really sad moments where people lose babies. We try to be there the best we can for all those women. We can be delivering a stillbirth and hopping next door to then deliver that woman's live birth, and you're having to switch the way you feel from one way to another. That's really difficult and it doesn't always allow time for counselling or discussion. It's really important that there's an effort placed on that. Clinical supervision—there are lots of trials about clinical supervision at the moment, and it's mandated for some professions, but it's not mandated in midwifery. That is protected time for midwives to be off the ward or aside from the ward to actually be able to talk to a professional about how they're feeling in a group situation and doing other things to help them feel more positive about how they can best cope with their workplace issues.

Midwives need to know that they can go to that and that that can be valued, because at the moment, sometimes if we are able to have time, we get pulled back—same with education, so that you can have that protected time. Just having debriefs that are about the midwife and what the midwife wants to talk about, and not just to be assigned when something awful has happened, to say, "Well, now we need to talk about that." It's actually what was happening for that midwife at the time, because right now there's not a whole lot. We had a lot of comments, and we wrote probably some through our submission, of midwives who have suffered this vicarious trauma. This has been 20 or 30 years of driving to work terrified of what might happen or blaming themselves for something that probably, drilled down, wasn't their fault, and just not having the opportunity to talk about it. This is another reason why people are leaving the profession. We really need to keep them in it. We need to look after our midwives so that we can look after our women.

MICHAEL WHAITES: Whilst NSW Health has the employee assistance program available to staff, recently we've had criticism from members about the availability and literally stories of hanging on the phone for hours, waiting for someone to pick it up—the amount of debriefing that they are able to access through that not being sufficient and also examples where if a social worker is provided to the team, they're not someone who is specialised in this area. The midwives can actually be re-traumatised because they have to explain everything to the person that's meant to be there to help them with their trauma. Certainly, the recommendations that Gemma just touched on—we would also say that the need for dedicated support staff within the public health system is greatly needed.

ALISON WEATHERSTONE: Just to add to that, I think there's an opportunity here to strengthen mentorship and mentoring in midwifery. I know there is a program in New South Wales, but I believe you should have mentoring throughout your whole career. That should be structured from early entry, all the way through to challenging you, through to midwifery leadership roles. Also, I think we need to recognise that, as midwives, we are impacted by birth trauma and vicarious birth trauma differently, so our needs will also be slightly different. While we look at individualised care for the women, I think we need to look at what supports we're providing for midwives and that is individualised. Because we also, at the Australian College of Midwives, had member surveys come back to say that they've lacked support in this area.

VANESSA SCARF: I have a colleague who is doing a randomised control trial at the moment on clinical supervision in midwifery and I think that's another way of supporting midwives in hospital settings and outside hospital settings. But just to go to Gemma's point about having time quarantined, often clinical supervision is, on paper, available to midwives; however, it is very difficult to quarantine the time.

The Hon. SUSAN CARTER: Just so that I'm clear, clinical supervision is akin to what psychologists have as part of their requirement. So, subject to the results of the trial, perhaps that's something that could be mandated as a required part of practice and time available for it.

VANESSA SCARF: Certainly.

ALISON WEATHERSTONE: In some States and Territories, the midwifery group practice has that as part of their localised agreement, so that's something that New South Wales could look at.

The Hon. SUSAN CARTER: Sorry, quite a different question now. We've talked a lot about consent and the need for women to understand what it is that they are being asked to give consent to. Are you able to give us any idea of what type of antenatal education is available to women, who delivers it, when it's delivered and what women might be told about in that process?

GEMMA DENG: What women are told about in antenatal classes can be tricky and sometimes hard to facilitate as women as individuals or families want different things from that education. Some women come in wanting to know everything and, therefore, may be able to give more informed consent. Some women and families come in and don't want to hear about what could go wrong or that negative side of it as it affects perhaps their preparation for birth, and so it can be hard to standardise what type of information women can get through the antenatal period. It's definitely one thing that came through in a recommendation that we made that more antenatal education needs to be available for all and some standardising within that, whether that's free antenatal education if that's possible.

Through COVID we lost a little bit of that face to face where online seems to be easier but not always as personable and as individualised. Even just longer times in clinic—I know different hospitals can facilitate different amounts of time for their antenatal appointments, but that can be the time where women, if we can't capture them in antenatal classes, we can capture them in their antenatal appointments. Just having specific moments set aside for that extra education, so that they do have more chance of being able to give informed consent, is important.

VANESSA SCARF: Can I just add to that, please. That's absolutely right, and I think going back to, again, continuity of care models where midwives can work to their full scope of practice, the antenatal appointment, which is usually extended, also involves talking about labour and birth over the course of the pregnancy. It may also discuss those things like interventions. Even if interventions are only touched on in this period, if that known midwife is with the woman during the birth, they have a close professional relationship and the woman trusts the midwife to talk through with her what's happening to her in that moment. Often emergencies unfold over a period of time. It's very unusual for there to be a catastrophic event occur without any sort of warning. That's obviously a big part of labour surveillance. So a woman will trust a midwife who is caring for her in labour and then they can talk through, "Do you remember when we spoke about this?" or they can talk through what's happening in the moment.

The Hon. SUSAN CARTER: I'm just exploring whether there might be an issue with antenatal education being available, not everybody either taking that opportunity up or not wanting to engage with some aspects of it, and then, because they haven't engaged, not having the information that allows them to make an informed decision. Is that something that might be happening?

GEMMA DENG: I think so, yes. I think expectations, again, was a big thing that came out through our survey and that's just talking through members, and how they're viewing what's happening in practice. Sometimes unmet expectations can be a big part of birth trauma. It's not only the physical, as I'm sure you've heard and read through all the submissions. It's not just the physical side of birth trauma; it can just be there's unmet expectations. If they're unable to access education, that leads to those expectations not being met as they may be able to be discussed as Vanessa's mentioned. If you have that partnership, that trust between you and the woman, you're then able to provide more education and discuss their expectations and give them more of an idea of what might happen for them in an individualised way to help lessen the trauma of what perhaps might happen.

The Hon. GREG DONNELLY: Thank you for coming along this afternoon. I've got a copy of the New South Wales Government's submission to the inquiry, which is submission 862. I'll pass it over. You may have had a look at the submission from the Government. I've got a couple of questions for the Nurses and Midwives' Association, firstly, going to page 11, section 3.3, which says, "NSW Maternity Care Survey". I'll just give you a few moments to read it. It's not very long.

That's now a few years old. It's a 2019 survey; I make that concession. But in terms of those figures there—and without trying to look at things through rose-coloured glasses because there are many issues that have come up over the course of the day and, I'm sure, will in the following hearing days and submissions—does not those percentages indicate that there is currently operating in New South Wales from the point of view of women and birthing quite a reasonable level of satisfaction with the way in which it's occurring in New South Wales?

MICHAEL WHAITES: The statistics that NSW Health put there may indicate that the majority of women are having positive experiences, but I would still be very concerned that 10 per cent of women—looking at that dot point—are not treated with respect and dignity during labour and birth. I would say 10 per cent is a significant number that we should be paying attention to.

The Hon. GREG DONNELLY: No, please. I'm not dismissing or discounting the percentage there at all. What I've been challenged with a little bit over the course of the hearing thus far is trying to understand, in my mind, what is the level of birth trauma. First of all, what is "birth trauma" as specifically defined so that people can clearly understand what it means, then apply that to New South Wales and have a clear understanding that's the challenge we face in New South Wales, and also we have this added matter of the reference to the term "obstetric violence", which is mentioned in the submission, and trying to make a distinction between those two. When engaging women who are going to give birth about one or the other, is there clear distinction between the two? Trying to define something is really important to measure what the issue is. That can lead to the steps taken to resolve the issue—or at least discuss what the resolution might be. Do you agree with that statement?

MICHAEL WHAITES: I think it would be, yes, of course useful to be able to measure the rates of birth trauma and obstetric violence occurring in NSW Health so that we can set targets to then reduce them, obviously.

The Hon. GREG DONNELLY: Do you have any thoughts about how that might be done or how that could be done?

MICHAEL WHAITES: I think you could ask women, in the first instance, what their experience was like and, if it was unsatisfactory, why. I think the system could be open to listening to the detail of that and not being—I'm concerned that there may be a culture of being overly defensive and fearful of the litigation rather than listening to what is being said and learning from what is being said. Of course, these are processes that could be explored.

The Hon. GREG DONNELLY: In terms of the NSW Nurses and Midwives' Association, what definition do you use as the definition that you believe is the most accurate to describe birth trauma?

GEMMA DENG: There's lots of big organisations that have tried to define birth trauma and it's self-defined. I think that's what Michael's touching on there, that it's self-defined. I can look after a lady that comes in. She has a beautiful water birth, goes home and she's traumatised by that because it was more painful than she thought. That doesn't mean that the midwife caused a problem. That doesn't mean that she had any other physical issues. That just means, "Wow, that was huge and that's something I wasn't expecting."

That's one birth trauma. There could be birth trauma where it's physical, whether it's the forceps, episiotomy or something—whatever happened down that track. Birth trauma is so huge, and that's why I think to this point, it has not been quantified.

Birth trauma has been around—every time you tell someone you're a midwife, a mum or a grandma has a story, "This happened to me. That happened to me." Birth trauma is not new. Women just have a voice now. That's why women are coming and saying, "This has happened to me," not, "Isn't that meant to happen when you have a baby? Aren't I meant to be incontinent?" It's one of those things where now women have a voice. Different organisations, as I said, are trying to put a definition to it. I don't know that we're going to be able to because it's an individual. It's about you, and I don't think that we can capture that. But we can certainly have points; we can have groupings of themes of things that we've all seen in our submissions. But I don't know that we are going to come to just one definition, because that's the point.

The Hon. GREG DONNELLY: It may be challenging but, without discounting anything of what you've said—I think that's my thinking as well—if you take that example you've given of the birthing where it seems to have gone prima facie okay and that's the feedback, but then the woman gets home and there's a subsequent sense of, "That was a traumatic experience," or what have you, if we are to establish the size and level of trauma in New South Wales with birthing, would that have to be discounted or included in the count? I know people think why am I pushing the detail to this level, but quantifying the dimension of it is pretty important because that then leads to questions of resourcing to deal with it. You say it's an individual experience and take that as the answer, but then do we accept that anyone who says, "I've had trauma," simply gets placed into the trauma subset? Is that how we address it?

GEMMA DENG: I think so, and I can only talk as personal experience of what I bring to this. I believe that if you say you have trauma, you have trauma. I don't believe anyone can tell you that you don't. I think we should then have—whether we're talking about debriefing clinics or whether we're talking about associations that can provide support to every single woman that wants to have that support. Because I can't tell you that you've not had it, and I'm not going to put you in a basket and say that you don't. So I think that it does have to be individualised and therefore systems set up to support every single woman and husband, even, or family member that is present at a birth.

MICHAEL WHAITES: Could I just add to that? I think, too, that the response to birth trauma needs to be specific to the person who has experienced it. What we don't have at the moment is sufficient staff on hand to provide a debrief for a woman in the postnatal period. It may well be that, in the circumstance that Gemma just described and that you're using for your case study there, the ability to sit down and spend time with a midwife and to talk through those issues is sufficient for that trauma to be resolved or at least to be coped with. If you don't have the staff on to do that debriefing, whether that's in the hospital setting or whether that's in the home setting, then that trauma is going to remain. So some of the solutions to this are not overly complicated. It's providing sufficient midwives with sufficient skills in sufficient numbers.

The Hon. GREG DONNELLY: There is a paragraph in your submission on page 6. I'll just take you to it. I'm trying to understand its full meaning. On page 6 the paragraph below the first part at the top that is in blue print says:

> The prevalence of birth trauma is inextricably linked to the patriarchal medical model in which the majority of women in NSW birth.

Can you explain that to the Committee?

MICHAEL WHAITES: I think there has been, perhaps, a too slow transition within how birth services are offered to women in New South Wales or Australia. It has traditionally been a very medical approach, and that medical approach has been dominated by men, an approach that says that the doctor knows best: The doctor will tell you what to do; you will be subservient to that doctor's advice. We would like to think that we're no longer in that sort of system but there's certainly a long way to go.

The Hon. GREG DONNELLY: Just going on—

The CHAIR: Sorry, Mr Donnelly, I've just recognised there are only five minutes left. Perhaps you could put some of those questions on notice. Thank you all for coming along today. We've already talked a lot about the continuity of care model, but both of your organisations specifically advocate for midwifery continuity of care whereas some of the other submissions we've heard said that it could be anyone—a GP or an obstetrician. For both of you, why is midwifery continuity of care specifically what you advocate for?

ALISON WEATHERSTONE: We've got really good evidence in Australia and internationally that midwifery continuity of care has demonstrated outcomes for women and babies. That goes from breastfeeding rates, a baby's more likely to be healthy and born at term, and a lower likelihood of stillbirth and preterm birth. This applies even to our First Nations women and families. I think if we really committed to looking at the impacts that prioritising maternity care has across the lifespan and on the chronic burden of disease—and well into aged care—we really do need to prioritise maternity care. We have a primary maternity care workforce and this is their core business. I think utilising each skill set in the interdisciplinary, multidisciplinary team to their full scope of practice will go a long way to addressing the maternity care needs across Australia.

GEMMA DENG: I'm biased because I'm a midwife. I've worked in a midwifery-led continuity of care model. I believe, too, that birthing is women's business. There was a time when men just weren't there and it was just us—not to say that was a better time. I think it's important—and Vanessa touched on this earlier—that midwives know normal. That's what we want to try and keep as best we can, is to keep women as normal midwifery as possible. Obviously there are going to be deviations and there are a lot more comorbidities. I think we need to work in models where we consult and refer, and we've got very clear guidelines around that that we can follow. But when it comes to women coming towards us as we talk about the research, there's plenty of research to say that midwifery continuity-led care has great outcomes. We want to try and promote that women's business and keep that special, and use the obstetric team to refer to when things are outside of the norm rather than making it the norm that we need to see doctors. We need to step back and learn to trust in our bodies again, and to go down that midwifery-led model.

MICHAEL WHAITES: From a budgetary view alone, it is more efficient and more effective to run midwifery-led models of care. It just seems, given what my colleagues have just said, a no-brainer.

The CHAIR: I note in the submission from the NSW Nurses and Midwives' Association you talked about a recurring theme in the feedback from your members: the use of coercive language. The submission states, "Implied or express consent given under extreme duress is not consent." How did we get to this point where this is the way that women are being treated in hospitals? It seems like quite a systemic issue. Are there certain pressures in hospital policies that are causing this? What recommendations of this inquiry can we use to deal with this?

GEMMA DENG: I think litigation is a really big issue. Lots of things are happening because we're worried about litigation rather than, perhaps—I note Hannah Dahlen mentioned earlier that just having a live baby is the floor. We want to have more than that, and I think litigation is stopping us from doing that. Definitely there's a drive with policies, as Michael mentioned, medical models through our policies that are pushing—I've lost my train of thought. What was your question?

MICHAEL WHAITES: Intervention?

GEMMA DENG: Push intervention, yes, exactly. Sorry, I've lost my train now, Mike, you might want to take over—or if you could repeat the question, maybe? Sorry.

The CHAIR: Sorry, my question was quite long. I was talking about the coercive language and that express consent under extreme duress is not consent. How did we get there and what recommendations do we need to put forward as part of this inquiry to deal with this?

MICHAEL WHAITES: I think a review of policy approaches: Are they creating too many opportunities for intervention to be required where intervention is perhaps not required? Once you intervene, you start a cascade which will lead to periods where consent was not provided but you've wound up in that situation. But I think also getting the staffing numbers right, rebuilding the midwifery workforce, making sure that there are enough doctors on the shift that they can refer to each other, that they have that mentoring support available. As my colleague said earlier, typically these things don't happen in an instant, so where is that advice and support in the build-up to the circumstances? Where is that communication with the woman early on?

The CHAIR: Yes. Thank you. I have one last question. The submission from the Australian College of Midwives mentions reduced intervention targets. This is something that has come up a little bit. There has been a recognition that more interventions and certain interventions are linked with higher rates of birth trauma and yet, at the same time, it's quite difficult to have a target because you don't necessarily want emergencies not to have

those kinds of interventions. How do we deal with that, where we're seeing that certain procedures are more likely to be related to birth trauma? There are the emergencies and then what's coming into question now is that there is this grey space where these interventions are happening where it's not an emergency. How do we deal with that?

ALISON WEATHERSTONE: Thanks for that question. I think you need to look at all of the barriers to these high intervention rates. There are international targets—for example, caesarean section rates. The World Health Organization has a benchmark for what is considered an acceptable rate for a caesarean section; Australia is almost more than double that. So I think when you look at all of the contributing factors to rising intervention, it could be workforce, it could be service capability of a health service, it could be time constraints and staffing, lack of access to certain models of care. So I think what needs to happen is that you need to tie in with some of the significant national pieces of work. There is the National Scope of Practice Review, there is a woman-centred care strategy, there needs to be a national maternity workforce piece of work completed, but all of these need implementation strategies.

For the college, it's midwifery leadership and continuity of care, for access for women, then these are going to address these intervention targets. But also you're looking at a reduced access to vaginal breech birth or there is less confidence around performing forceps, so that's going to affect the rates of instrumental births. So I think if you've got midwives making decisions for midwives, you've got consumers involved in each layer of consultation and they're designing the model of care that they're wanting for their community, then I think that's going to be a step in the right direction.

The CHAIR: Wonderful. Thank you all for attending this hearing. We have gone slightly over time. Committee members may have additional questions for you after the hearing. The Committee has also resolved that the answers to those, along with any answers to questions that may have been taken on notice, be returned within 21 days. The secretariat will contact you in relation to those questions.

(The witnesses withdrew.)

Ms DEB WILLCOX, Deputy Secretary, Health System Strategy and Patient Experience, NSW Health, affirmed and examined

Adjunct Professor MICHAEL NICHOLL, Chief Executive, Clinical Excellence Commission, NSW Health, sworn and examined

The CHAIR: I now welcome our next witnesses. Would either of you like to start by making a short statement of a few minutes to the Committee?

DEB WILLCOX: Thank you, Chair. I'd appreciate that. Can I just thank the Committee for the opportunity to appear today. I would like to acknowledge the traditional owners of the land where we are here, the Gaimaragal people of the Eora nation, and pay my respects to Elders past and present, and acknowledge any Aboriginal people here in the meeting. I'd also like to acknowledge the bravery of the women who've shared their stories. I want to acknowledge the distress that many of them have described. We are sorry this has been their experience. NSW Health commits to listening and learning from what they are telling us. I thank the Committee and the secretariat for their sensitivity in response to the submissions.

I would like to make a comment in relation to our staff in NSW Health. I've worked in and around health for about four decades, starting my career as a nurse. I've had the privilege of working alongside and observing literally hundreds, probably thousands, of staff in different parts of our public health system. There are around 170,000 staff who come to work every day to provide the very best care to their patients. As a system manager, it's our job to make sure they have the resources to do that. I think it's important to say that they would never want a patient in their care to experience harm or to have a bad experience but, sadly, we know that things do go wrong and there are times when we don't meet the expectations of an individual and certainly our community.

But we do have a very strong culture of listening and learning to enable us to continually improve care. Our staff drive this very strongly. Every day more than 200 women give birth in the system here in New South Wales and there are expectant women in our care right now or soon to come into our care. It is important that they feel safe and not fearful in light of some of the information that's appeared in response to the inquiry. So again I thank the Committee for their sensitivity to this and urge any women with questions or concerns arising from the inquiry to contact their maternity service or the health professional taking care of them.

Across New South Wales almost 100,000 women give birth every year. Maternity care in New South Wales is safe. Maternal deaths are rare and the number of stillbirths and newborn infant death rates are low. We had a Bureau of Health Information survey in 2019, to which 4,446 women who had given birth in New South Wales contributed. Some 94 per cent rated their care during labour and birth as very good or good; 90 per cent of women felt they were always treated with respect and dignity, with 9 per cent saying sometimes; and 97 per cent of women said a midwife or nurse asked how they were doing emotionally during the postnatal visit. Also 283 Aboriginal women participated in the survey, and seven in 10 said that they had confidence and trust in their care. These are obviously encouraging results but we know that these experiences aren't uniform and we have to listen and learn from the things that don't go so well as well as the positive.

Listening to, connecting with and responding to women is key to our work. This is in fact the cornerstone of the consultation that has been taken across New South Wales for our *A Blueprint for Action – Maternity Care in NSW*. In fact, its headline is "Connecting, listening and responding". Over 18,000 women and partners responded to two online surveys. A thousand individuals participated in face-to-face consultation and we received more than 500 public submissions. This feedback is already helping us reframe and reshape our maternity services. There were some things that were very clear and, I think, listening to some of the evidence today, there's a lot of alignment and consistency, which is pleasing to some extent.

It is clear that it's not okay to simply measure maternity outcomes by physical outcomes alone but also to include a woman's experience and to use this as a way of improving maternity care at an individual, service and system level. The initial areas of focus that we want to concentrate on that seem to be resonating strongly are: developing a way that we can routinely capture the experiences of and feedback from women, ensuring access to consistent information during the course of their pregnancy; strengthening guidance for clinicians on how to obtain valid consent, recognising the importance of women being adequately informed to consider their options and make their own preferences and choices; and how we better support women who may decline recommended care.

Trauma-informed care is recognised by the NSW Health system. We acknowledge the core trauma-informed principles of safety, trust, choice, collaboration, empowerment and respect for diversity. Earlier this year we released an integrated trauma care framework, "My story, my health, my future". It has four key

assumptions that underpin trauma-informed care: realising that our staff realise the impact of trauma, they recognise signs of trauma, they respond using the principles of trauma-informed care, and they seek to work to prevent re-traumatisation for patients. Trauma-informed training is available for our clinicians across the system and there are a number of online guides for staff that are pretty busy and it gives them a quick resource.

In recognition of the need for trauma-informed care, we do undertake psychosocial screening of women during pregnancy and after birth. Understanding if a woman has experienced domestic violence, migration-related trauma, previous abuses of any nature, enables the midwife of the team caring for them to really make sure that care is appropriate and they're alert for signs of distress. In New South Wales over 95 per cent of women attending our maternity services are screened during pregnancy and after birth as part of SAFE START, enabling us to provide the right care.

In relation to our services, New South Wales birthing services are networked. Our smaller hospitals are connected with tertiary, maternal and neonatal services to ensure that all women and their babies are able to receive the right care. Our teams are made up of multidisciplinary teams who work together to aim to provide women-centred care. Let me reiterate that we want women to have choice and access to care when and if they need it. We understand that continuity of care, especially with a midwife, is important to women and we are working to expand the number of different types of midwifery models of care available.

But, like all jurisdictions around the world and particularly following COVID, recruitment of all staff has proved a difficult issue that governments at all levels are very focused on. Unfortunately, midwifery staff are no different. We have rural incentive packages to attract and retain staff in rural health districts and we've had considerable success. We continue to work with local communities, the profession and the Commonwealth to see how we can better strengthen our workforce collectively. In the past seven years we've recruited an additional 500 midwives. That's full-time equivalents, so some may be working part-time. We have a retention rate of around 95 per cent.

In closing, I just want to say that we are committed to listening and learning from women who have experienced birth trauma, whether physical, psychological or both. We work with over 700 consumers and clinicians actively across the system to build continuous improvement and delivery of maternity services. Professor Nicholl will talk more around quality and safety. All of us in NSW Health, no matter our role in maternity care, are committed to ensuring women have a positive birth experience and receive safe, high-quality care. I look forward to receiving questions from the Committee.

MICHAEL NICHOLL: I, too, wish to begin by acknowledging the women and their partners, support people and clinicians who have bravely shared their lived experience of birth trauma. To all those who have experienced or witnessed birth trauma, we acknowledge and respect your feelings and experience. My name is Michael Nicholl. I'm the chief executive of the Clinical Excellence Commission for NSW Health. Prior to this, I was the senior obstetric adviser for NSW Health for over a decade. I've been a clinician for 40 years now, and 30 years of those as a specialist obstetrician and gynaecologist in New South Wales. I've been a long-time advocate for improving the safety and quality of maternity care in New South Wales. I'm also a fellow of the Australasian Association for Quality in Health Care.

At the CEC we're committed to learning from the experiences that have been shared with us. We are dedicated to working collaboratively with all stakeholders to improve the quality and safety of all clinical care, including maternity care, in New South Wales. The role of the CEC is to lead, support and promote improved safety and quality in clinical care across the New South Wales health system. We set standards for safety and monitor clinical safety and quality processes, and improve the performance of individuals, teams and systems in prioritising safety. We also have a role to play in developing workforce safety culture and their capability.

Whilst there have been systems and processes in place for many years to support the delivery of safe, high-quality maternity care in New South Wales, the CEC recognises that there is a need to continually review, adapt, innovate and invest in safety and quality to ensure the provision of contemporary, evidence-based, safe and respectful clinical care, including maternity care. At the CEC we've invested in a range of safety and quality education programs. We have a current focus on reflective clinical practice and a just and restorative learning culture to foster a skilled, informed and competent workforce. We've invested in technology to ensure that clinicians, managers and policymakers have access to near-real-time data to inform strategic and operational decision-making, to drive continuous quality improvement initiatives and to be able to benchmark performance against peers. We are committed to learning from adverse clinical events and near misses. We actively monitor adverse clinical events and provide system-wide advice, support and guidance to maternity services through our incident management system and processes.

Whilst most clinical care is delivered safely, we're all humans and capable of making mistakes. Whilst we cannot eliminate human fallibility, we can act to optimise best practice and to moderate and limit risks. Effective performance and efficiency are optimised when system factors are designed to accommodate the capabilities, limits and goals of people rather than simply requiring them to adapt. Nobody in the health system comes to work to do a bad job; nobody comes to work to do a bad job.

Human factors training that we're heavily promoting at the moment places the emphasis on considering what makes things go right, which includes ensuring that staff are enabled to do their work in ways that work best for the patient. The CEC has an active maternity and neonatal safety program with a focus on human factors training. We're also involved in supporting maternity services on the ground through initiatives such as QIDS MatIQ, which is our near-real-time data collection system, and maternity resilience assessments. These assessments are unique to New South Wales and assess the ability of maternity services to adapt following adverse events. At the CEC we look forward to the future opportunities to further improve safety and quality in the maternity space in New South Wales, and I hope that we can contribute to positive outcomes from this inquiry.

The Hon. SARAH MITCHELL: Thank you to both of you for your opening statements. I just had a couple of questions. Firstly, the collection of data is something that has come up today. Obviously, we have been speaking to various groups and we talked particularly about the BESt survey that had been done, which I am sure you are familiar with. I know my colleague the Hon. Greg Donnelly had been talking about some of the BHI data as well, but is there a need to have a better data capture of women who do experience birth trauma? Are there any suggested ways as to how we could better quantify exactly what is happening and how often?

DEB WILLCOX: I'm happy to take that question and Michael may wish to add. I think that's definitely right. Patient experience really is relatively new in terms of our focus in the health system. In 2020 we established our first Elevating the Human Experience framework, which really started to give a system-wide approach to how we understand the experiences of our patients in much more detail. We've a got a number of experience surveys that are routinely produced. Local health districts will do modest experience surveys in their wards and units, trying to capture information when people are leaving hospital and see how it was—following up with them. There are a variety of survey mechanisms going across the State.

The Bureau of Health Information is an independent part of the health system that has a very rigorous methodology around its survey collection, and we've been relying on the Bureau of Health Information independent advice around performance and experience and a range of other measures in the system for some time now. The next iteration for us, and it's evolved over time and it's certainly come out in the discussions with consumers and staff while developing the blueprint, is this area of experience measure called PREMs—patient reported experience measures.

These are questions that can be asked of patients, in real time, by the clinicians caring for them, that will then go into the electronic medical record so the patients are feeling that an experience can be captured. The next clinician that's caring for them can see the sort of issues that are emergent. But also, as a system, we can collate and theme up these issues at an individual level to a unit issue, up to a statewide collection. It will give us very rich information to understand what our patients are feeling, what they're experiencing, and what sorts of things we need to put into place. There are a number of disease areas—for want of a better term—where we have patient-reported measures currently running and, as I said, the intention is for our maternity services to be one of the next rolled out because it came out loud and clear in our consultation.

The Hon. SARAH MITCHELL: In relation to midwifery-led models of care—and, again, throughout the day there has been some evidence in relation to that and outcomes for women—I know in your submission you talked about the example in Leeton where the local council and the community were really behind it. There are two parts to my question. The first is what are some of the barriers or challenges for that midwifery-led practice and particularly for rural and regional communities? I suspect it will lead to workforce challenges. Interestingly, in the evidence given before by the Nurses and Midwives' Association, they also spoke about access to child care and how that can be a challenge. In the experience of NSW Health, what are some of the barriers to having midwifery-led practices? What are some recommendations we could make help to make that more accessible, particularly to people in rural areas, because often it is not an option? And is it the workforce challenges that are the main impediment to seeing expansion of that sort of model?

DEB WILLCOX: As I said in my opening statement, the challenges for recruitment across the health system are pretty difficult at the moment, and it's getting a lot of attention with the Commonwealth and the States. There's a health workforce task force that the Secretary of Health is chairing, and there's a whole lot of work going on with the Commonwealth Minister and with immigration, border affairs and all manner to see what we can do to accelerate recruitment into the system. It would be fair to say, in rural and regional communities, that is difficult.

We've had a number of strategies in place over many years in Health to attract clinicians to rural areas. We have a rural incentive scheme, at the moment, where there are bonus payments, assistance with housing and various things to try and attract staff into rural communities. That's had relative success. I think, at the last count, it was just over 1,000 additional staff in the last couple of years that have gone into regional communities off the back of that scheme.

There are a variety of different models—and you're obviously right to say women really do like these midwifery models of care. People want to have choice, but we get very positive feedback. Midwifery group practice does occur across the system—Michael may wish to comment on this as well—but having an on-call roster is one of the limiting factors, and that's about having enough workforce and time out for people. Because if you're on call and it's going to be continuous care, with a mum, there's some logistical issues there, which is one of the reasons why the midwifery antenatal and postnatal model—the MAPS model—became quite popular as well. We get really positive feedback from women about that. You get continuity around your antenatal and your postnatal care, and there's a core group of midwives that would be available for when you delivered. Now, it may be that the midwife you've been dealing with antenatally is the one that delivered, but it does allow a bit more flexibility for our staff in terms of being on call.

I think we've got to target this recruitment issue —continue the work with the Commonwealth, because we've got broader employment and recruitment issues. We have to really target our rural and regionals because that's where we are trying to encourage people to come; not so much in the city. We need to keep working with the professions around what are some models that we can optimise, because this consistency and continuity of care is such an important part. Again, we hear that all the time and I've heard it through some of the evidence given here this morning.

The Hon. SARAH MITCHELL: Did you want to add anything?

MICHAEL NICHOLL: Yes, thank you. Look, one of my previous roles was managing a network of maternity hospitals. Even though that was in a metropolitan setting, the issue of sustainability is a real challenge. I've been a supporter of continuity of care models for over 20 years now. I think I have a very strong track record with respect to that. However, in putting my manager hat on, sustaining services is really quite difficult. I'm not sure; there are perspectives that have been shared with the inquiry, but, generally, in continuity of care models we've traditionally had two groups of midwives—those that are early on in their career and those that are towards their more mature years in their career. Those that are in mid-career are having a family and often do not participate in these models. Whilst we've got a reasonable pipeline at that earlier end, we don't have that same guarantee at the other end of a midwife's career. Sustaining a workforce is really, really difficult. I think that was the greatest challenge that I had in co-leading a service across five maternity services.

The Hon. EMILY SUVAAL: Thanks for appearing today. My question is to Ms Deb Willcox. You've talked about the maternity blueprint and other policies and plans in your opening statements and remarks. Can you tell me what New South Wales has actually been doing over the years to strengthen and improve maternity services in New South Wales?

DEB WILLCOX: Certainly, the blueprint—because we're about to kick off with our implementation—has really been the focus in the last little while. Obviously the pandemic has sort of hampered a lot of innovation in the system outside of the work for the pandemic. But it's important for the Committee to know that we're never stationary when it comes to the continuous improvement in the health system and maternity care is no different. We have a network of services across the State, as I flagged in my opening statement, where hospitals that can do more complex care are connected to smaller services. We continue to refine those referral pathways between those smaller hospitals with the larger ones. Connection with staff, virtual care during COVID has actually been a bit of a boon and it has created greater connectivity across the system. If you're a rural clinician in a small hospital, having that virtual connection to someone in a metropolitan teaching hospital has really been strengthened.

We've done a bit of work around what we call the maternal transfer redesign. One of the things that we do know that does cause distress and trauma for women is if you have to have your baby away from home. Sometimes that's not going to be possible, but where we can keep you close to your family and your community it is obviously what we try to do. This transfer redesign initiative was really to look at a systemic approach to the consultation and the referral pathways with clinicians. What we've been able to do is strengthen relationships, as I flagged, between the larger hospitals and the rural hospitals. We've helped clinicians with— a decision-making tool that they can use to help make a better or a stronger clinical decision around whether a woman may need to move or whether that care can be managed locally.

They've implemented a test—Professor Nicholl will be far more versed in this—that assists with predicting the risk of premature birth. All of these things—your connection with your larger centres, understanding some of

the decision-making and the risk management of a woman, and having some tools that help you predict how a woman's pregnancy is going to carry through—help to make good decisions of whether you can stay or whether you have to go. The initiative's been evaluated, and the good news was that we found that less women are being transferred for non-birthing clinical indications. So that local decision-making's certainly been stronger. As I said, keeping people close to home is really important to us.

More recently we've built on that work with an initiative called Pregnancy Connect. Each local health district has had some funding to recruit an obstetrician and a midwifery lead to help coordinate the care of a woman. Again it's about getting your access to antenatal care for those women who are greater at risk, timely access, especially consultation, and increased support for those rural and regional clinicians through mechanisms such as virtual care.

We've done a lot of work on our resources, and I know we need to do more. If you look at our website—there is quite a vast array of information on the website in many languages. That's a constant bit of work we do to update that. The famous Blue Book is to be digital and well known to mums right around the State. We have fact sheets so that you can see what your local hospital provides, so that women get a bit of an idea of what they can expect, and parenting guides in many languages, and some really lovely innovations around working with Aboriginal communities. I don't know if the Committee members had benefit to see the Finding Our Way, which is a piece of work that's been done with Aboriginal communities, for Aboriginal communities, to help with decision-making around maternal care. It's apparently one of the first in the world in terms of the model and how it's been constructed.

We continue working with our staff on a range of culture and safety initiatives, as I mentioned earlier—the human experience work. There's a lot of activity in that regard. That's all about our staff feeling valued in the workplace, that they have more resilience and empathy to care for women. Again, this is just ongoing work in the system. As I mentioned, working to build on our workforce and looking at new schemes and opportunities that we can to encourage people to come into the midwifery space and certainly to work in rural areas—that's again an ongoing body of work. Thank you.

The CHAIR: We've heard a lot today about the Queensland model and things that are being implemented in Queensland. I was wondering if we've been looking at those aspects in Queensland that are being quite strongly supported and if we are looking at implementing any of those in New South Wales.

DEB WILLCOX: I might refer to Professor Nicholl, if I may, on that one. The one area that I could comment on and I'm aware of is the chief midwifery officer appointment. I'm also aware the Commonwealth—I think it was late September 2022—created a senior midwifery adviser. We do have a chief nurse and midwifery officer in the Ministry of Health. We do have a principal midwifery lead as well in the division, and a deputy to the chief nurse, who happens to be a midwife as well.

The CHAIR: That was mentioned today. The concern was that they are two enormous portfolios: Nursing is enormous, and then midwifery is enormous. I think that's why it was advocated that there be a separate chief midwife. Is there any movement in New South Wales to do the same as what they've done in Queensland?

DEB WILLCOX: We haven't started to test that question. We do have, as I said, with the senior leadership we have in the nursing and midwifery branch, good representation. But we also have a large network of clinicians around the system that work on these matters, too. It just doesn't come from the Ministry of Health. I think there are nearly 700 clinicians, which include a large number of midwives, that advise on various clinical policy and models of care through the Agency for Clinical Innovation and provide advice and support into the ministry. The nursing and midwifery branch do a lot of work around the profession and development, look at things like the MidStart and mentoring and workforce-related things, working in concert with the workforce branch and the ministry. But we do have a very large number of midwives that are actively engaged with the ministry and the local health districts when it comes to designing models of care and looking at—

The CHAIR: Sorry to interrupt. Are they involved through that chief nurse and midwife—how is that coordinated if there is no chief midwife?

DEB WILLCOX: They will engage at different levels. A lot of them will work directly with their local health districts. Within that, there will be the directors of people and culture, where they will be looking at their own workforce pressures and things that they might do bespoke to attract staff, improve training and how you retain staff; they will connect in through the Agency for Clinical Innovation where, as I said, we do a lot of work around designing models of care and providing guidelines and policy; and they will also input into the ministry in various parts of the ministry, depending on the nature of the work they are undertaking, and connecting with

workforce within the ministry would be part of that. I think it's a devolved and diffuse collection of clinicians that we have working on various parts.

The CHAIR: I think more generally about the model that has been introduced in Queensland, as well as the legislation, and getting your thoughts on that—it came up today that in Queensland, under the Human Rights Act, there is an informed consent law that doesn't exist in New South Wales. Again, is that something that is being looked into—as well as the general model of maternity care that's now being put through in Queensland and the support that is being put forward to the Committee around that model?

MICHAEL NICHOLL: From my perspective, over the last decade or so we've continually been scanning what's been happening in other jurisdictions to see if there is a better way of service delivery. As you've already alluded to, there are structural and legislative differences across the jurisdictions, which make some things easier and some things more difficult. Queensland, historically, has had a very different approach to the issue of consent, with very specific consent for individualised procedures; whereas in New South Wales we take a more holistic approach—that consent is individual to an individual situation. So there are considerable differences across jurisdictions, but, certainly, we are watching what's happening in Queensland, and if there is best practice to be learned from, we will.

The CHAIR: So you are going to be looking at some of the results from this new Queensland model and any data that comes through that?

MICHAEL NICHOLL: Yes, we are continually scanning what's going on, both across Australia—

The CHAIR: Sorry, can I just confirm what "scanning" means?

MICHAEL NICHOLL: Looking. We have meetings between jurisdictions, particularly on the east coast—

The CHAIR: So there is a formal process?

MICHAEL NICHOLL: There is a formal process. Queensland, Victoria and New South Wales meet quite regularly on safety and quality issues, for example, and a variety of clinical services that are included in those discussions, including maternity services.

The CHAIR: I just wanted to double-check because "scanning" sounds like we are just having a quick look around to see what's happening.

DEB WILLCOX: I should add, too, Chair, that the Agency for Clinical Innovation—which, as I mentioned, develops a lot of the clinical policy and models of care—has a very well-regarded, evidentiary section where they look at literature, look at research and look at models around other jurisdictions to inform practice. Certainly, clinicians are always connecting with their colleagues around the country and internationally and bringing some of those ideas back to the table as well.

The CHAIR: We've talked a little bit about some of the reasons why a midwifery continuity of care model is difficult to implement right now in New South Wales, and we've talked about workplace shortages and all sorts of different factors. I'm wondering what's actually being done to address those factors, including any shortage in midwives, so we can move towards some of these models which are going to provide that better care?

DEB WILLCOX: The work with the Commonwealth, as I flagged, is critically important because some of these recruitment issues aren't issues for us alone, and we need assistance across the country in terms of the border issues at immigration and getting workforce into the country that COVID obviously had a significant impact on. Our secretary, Susan Pearce, is chairing our health workforce task force to look at some of the barriers to recruitment and things that we can do to strengthen that. The work that we do in the ministry is around trying to support local health districts to incentivise staff to come and work particularly in the rural areas and our regional areas.

Our metropolitan colleagues, while there are difficulties there at the moment as well, it would be fair to say, are probably not of the same nature that you see in the rural and regional communities. So incentive schemes, things we can do to attract people, accommodation and child care—all of the things that the member formerly mentioned—are all really relevant if you are going to make a decision to leave where you live to go and work in a country town. We are very mindful of those, and those things are an active part of our recruitment and retention strategy. We need to—

The CHAIR: Sorry to interrupt again, when you say that they are a part of the strategy, you mean that all of those aspects are currently being implemented in New South Wales, or are they just—

DEB WILLCOX: Not active, but we have a rural incentive program that's a funded program where we can provide incentives—by the way of bonuses it might be, but it might be to find accommodation for a staff member. It's not a sort of a standard fit, it will be if we can recruit some people, here are a suite of things we have on offer to support you if you come, and that enables. So, if it is child care, it's accommodation, whatever it might be, then we can look and see whether we can support that requirement that they have in order to get them to come and work in a rural community. Those sort of incentive packages aren't new. They're things that have been going on for quite some time, but it's making sure you tailor them to suit individuals.

We also need to work with our universities. Clearly there is a pipeline of students coming through. A student can study midwifery at university straight out of school, or you can do your nursing and then do you midwifery training afterwards. We want to make sure there's a strong pipeline. Our chief nursing and midwifery officer works closely with the universities. Some of the other strategies that we have around mentoring, I think you have heard about the mid-start scholarships—they are all of the sorts of things we can do to encourage people into midwifery practice and once they come how can we keep them there to make it a supported learning environment so they stay and it becomes their career of choice.

The CHAIR: Do you think with some of these strategies we could get to a place where we can implement technically that midwifery continuity of care model?

DEB WILLCOX: Certainly, we will continue to optimise our recruitment of midwives across the State. Decisions around what the right or the preferred model of care might be in a local health district really have to come from the local health district in consultation with their community and their clinicians to understand what meets their needs and still gives women choice. I wouldn't like to say blanket-wide this is what we are going to do, but I can give a commitment to the Committee that recruitment of midwives is a priority for us and optimising choice for women, no matter where they live, is a priority. We need that local consultation with community and with our clinical staff on the ground to work out what the best models are.

Dr AMANDA COHN: I am interested in talking about what you have called human factors in your submission, such as fatigue and stress. We have received an avalanche of submissions from healthcare workers who have talked about stress, fatigue, burnout and the impact that has on things like communication, their ability to properly obtain informed consent and the impact that that has on birth trauma. Just before you, we heard from the College of Midwives and the Nurses and Midwives Association, and we had a good discussion around some of the initiatives or recommendations to support midwives in particular, and nurses.

My question is relating to medical staff, and particularly junior medical staff. In the submission from the Nurses and Midwives Association they posited or suggested that one of the reasons for poor communication and poorly obtained consent is that junior doctors are rushed and inadequately supported. I know that NSW Health is facing a class action from junior doctors for unpaid overtime and that makes me concerned that the department may not be aware of the number of hours actually being worked by junior doctors if they're not being paid for those hours. What is NSW Health doing to better support, particularly junior medical staff?

MICHAEL NICHOLL: I will defer to the deputy secretary around the question to NSW Health, but from a Clinical Excellence Commission perspective, we are very supportive currently of encouraging reflective practice, not just after events but at the beginning of days for people to express how they're feeling, whether they're feeling overwhelmed, whether they're feeling anxious, so that their colleagues are aware of their individual circumstances so that they can work better together as a team, but also reflection after and during the course of their shift. We're encouraging that as well. Clinical supervision is something that intersects with this a little bit, but clinical supervision generally has been applied to certain sectors of the workforce, rather than all sectors of the health workforce.

We see reflective practice, though, as being more holistic across the entire workforce, and that would be inclusive of junior medical staff. Supervision in maternity services is always a difficult issue. Working in maternity is complex. It's a very dynamic situation with clinicians—whether they're junior or senior, whether they're medical or midwifery—being pulled in multiple directions. But at the CEC we're hopeful that introducing training, particularly with respect to reflective practice, allows clinicians to see where they might be vulnerable and then being able to act on that with their colleagues. But the workforce issues that you allude to are not the purview of the Clinical Excellence Commission.

Dr AMANDA COHN: Perhaps a supplementary as we move to NSW Health? In the process of this inquiry, I've become aware of a base hospital where obstetrics registrars are working one in two on call—so literally every second night on call. I don't think any of us would expect that someone could provide their best quality care with that kind of roster. This is the type of thing I'm concerned about, and I would like to know what NSW Health is doing to address those kinds of unsafe rosters.

DEB WILLCOX: If there's any specific examples that you would like to bring forward, we're happy to take those and look into it. I'm not in a position to talk to industrial matters or specific workforce as it relates to the award and conditions for junior medical officers, so I'd have to take part of your question on notice. In general terms, though, I would say the issues around staff wellbeing have really been front and centre for some time, but no more so than during or following COVID. It would be fair to say almost every local health district would have a JMO wellbeing committee. In many cases they're a subcommittee of the board, or board members of the local health districts participate in that. That is specifically designed for JMOs across the local health district to come and raise their particular issues and talk through the things that are concerning them, enabling the district to respond.

That local connection is incredibly important. There will always be the sort of industrial flavour of things, or pay or conditions and all of those things, but in terms of actually hearing about the things on the ground that are actually troubling staff, impacting on them providing care—these mechanisms are very powerful. If I can speak for my previous hat as a chief executive of a local health district, one of the very simple things that the JMOs came forward with was that every trolley in the hospital was different in terms of where the intravenous cannulas were and the equipment to take blood and the like. It sounds like a modest thing, and in some respects it is, but if you're very busy working nights and going from ward to ward, something simple like that can actually decompress a lot of stress for you. Those committees are incredibly important.

In general terms, the work that we are doing around elevating the human experience—again it is not just about the patient; it is about staff. We know if staff are feeling supported and valued, their resilience increases, their empathy increases, and that a patient's experience, too, is positive. You put those two things together and you actually have outstanding outcomes, both by experience and physical outcomes for patients. We're very focused on a lot of things coming out of that work.

Connected to what Michael was talking about with reflective practice, one of the things that staff have been very engaged with—and there's about 20 hospitals, I think, now, across the State, with more to come out this year—is around the Schwartz Rounds, which are an evidence-based debriefing structure for all staff. Not just medical, not just clinical, but all staff are involved to enable them to talk about their experience. It might be that a particular day was pretty difficult or a particular person. It's a very structured debriefing mechanism which allows them to reflect on that and to talk through their stressors. With that, information comes from those sessions that can go back into the hospital executive teams or line management to better support staff, so it's sort of a learning process as well as a decompression setting for staff involved in something difficult.

Dr AMANDA COHN: To follow up, are those sessions that you've just mentioned provided on protected time?

DEB WILLCOX: It's provided within the working day, is my understanding, but I can check if there is ability to provide that outside of the workday.

Dr AMANDA COHN: Thank you, I appreciate that being taken on notice—and my earlier question.

DEB WILLCOX: There may be some variability across districts and how it runs itself. I'll follow that up.

The Hon. MARK BANASIAK: We heard from the Nurses and Midwives' Association about the lack of knowledge of trauma-informed care—that they'd surveyed their members. I note that you published a framework in February this year which details the how, the where and the why. But it probably leaves out a crucial point, which is the when. So you have strategic priorities listed there but no indication as to when you plan to achieve them or when you think you'll intend to achieve them. I am wondering, on notice, can you go back on those strategic priorities and give an indication as to when you may achieve some of them, particularly things around providing education to hospital staff or health staff around this? I think it's probably a crucial starting point. If you want people to deliver trauma-informed care, they should actually be educated on it. If you could provide some timelines as to when you plan to implement this framework, that would be helpful.

DEB WILLCOX: Certainly. I'd be very happy to take that on notice. I can tell you the work is underway, and there are already a number of training programs through our Education Centre Against Violence and through our prevention of violence, respect and neglect services as well. So there is a lot of activity underway, and I'm happy to report back to the Committee.

The Hon. MARK BANASIAK: Thank you. This is probably my final question. We obviously heard a lot about informed consent and education for women and their partners through the whole pregnancy process. You've mentioned the Blue Book and other information publications. But my concern is, if you look at some of these publications you provide, like the first one, *Having a baby*, while you provide it in all these different

languages, I'm concerned that you're not catering for the 44 per cent of adults in Australia that have low literacy. Putting my 18 years of teaching hat on, I look at that 172-page document and I tell you now, someone with low literacy is not going to read that document. They'll see the first page and just say, "Oh." So my question to you is what are you actually providing in terms of information and guidance for those adults that have poor literacy, regardless of the language they speak? Because 172 pages—most kids or adults with that low literacy would just freeze and say, "I can't handle that", and give up.

MICHAEL NICHOLL: I'll take that, if that's okay. That particular book perhaps needs to be considered more a reference book than anything else for women to go back to. Antenatal education is a dynamic thing, and it will change during the course of a pregnancy, based on particular risk factors that develop or particular needs that develop during a pregnancy. It really becomes quite individualised as you work through a pregnancy. So with somebody who has identified needs such as low literacy or if English is not their first language, then the system would certainly be using interpreter services or tailoring the information that is available to that particular woman and her family.

The Hon. MARK BANASIAK: Are there simplified versions of this information available that doctors or midwives can quickly grab and provide to patients?

MICHAEL NICHOLL: There are, at local levels. Do we have it at a State level? The answer to that is probably no.

The Hon. MARK BANASIAK: Is it standardised across those local levels, or is it just up to the individual?

MICHAEL NICHOLL: Again, context is everything. Again, if I draw on my previous experience, when I was working in northern Sydney, one-third of our women are from North Asia. That's a very different situation to, say, Murrumbidgee Local Health District or Far West. We had to tailor the information locally with the consumers to address that particular population. So context is everything. I'd be reasonably confident, though, that maternity services would use those source documents that are produced by the ministry as the guide to what should be included in any local information development. But it's all about context for me. The context across each of our LHDs is so different.

DEB WILLCOX: I'm happy to come back with some more detail around that. At a statewide level, the issue of health literacy is, to your point—it won't be surprising—a very significant issue, and one of our priorities under our future health strategy is just that. The University of Sydney with Western Sydney Local Health District have an outstanding health literacy hub that has been established, and we're about to use that partnership to improve the nature of the communication and the health literacy needs of the community. So that's a work in progress, but I'm sure we can get you some feedback from local health districts.

The Hon. MARK BANASIAK: That would be great. Health literacy becomes infinitely harder from a starting point where someone has low general literacy.

MICHAEL NICHOLL: Yes, agreed.

The Hon. EMILY SUVAAL: Further to my previous question, we have heard a lot through the submissions from women in Wollongong, where we will be later this week, and also Wagga Wagga. Was NSW Health aware of the issues, and what have you been doing to improve the situation in that case?

DEB WILLCOX: Obviously we were deeply concerned once the experiences started to emerge. I want to reassure the Committee—and obviously those local communities—that the ministry and the local leadership teams are taking this very, very seriously. I might just begin with Wagga Wagga. Clearly the Chair and members of the Committee are familiar with the issues down there. I think it is important, if the Committee would indulge me, to step through some of the things that have occurred over the ensuing months. The district and the Wagga Wagga Base Hospital are deeply committed to improving the experience there for women. In Michael's role at the Clinical Excellence Commission, a resilience assessment was undertaken. Perhaps I should ask Michael to speak a little bit to that, but that was done at Wagga Wagga Base Hospital with a range of recommendations to strengthen the capability, the policy and the work environment for the team down at Wagga Base.

Some of the things that have emerged out of that are that a new clinical director of obstetrics and gynaecology has been appointed at Wagga Base; they started in the role in April this year. They're working very closely with the consumer groups down there. I think that relationship is all the stronger for this and there's a lot of alignment around what they both think is important. They've started work together, co-designing with the consumers, on a woman-centred model of care. They've established a four- to six-week postnatal follow-up service

so that women can discuss the sort of support that might be required. It goes to this concept of the postnatal debriefing that I'm sure you will have heard a lot about during the course of today.

Wagga hospital itself is participating in a national pre-term birth prevention collaborative, which is all focused on looking at improved outcomes for women and babies. They've introduced their early pregnancy assessment service and a hyperemesis gravidarum clinic in the maternity assessment unit. An endocrinologist has just commenced to enhance their pregnancy diabetes service, and they've set up a senior steering group with members of the district, senior clinicians and consumers to oversee the implementation of all of the work that has come out of that resilience assessment. The Health Care Complaints Commission, too, has finalised its report and they've accepted those recommendations, which will form part of the body of work.

In relation to Wollongong, the local health district down there is working very hard with the local community. Again, I think strong alignment—sometimes, out of these difficult experiences, good things come. The district and the chief executive have been working very closely with Better Births in Illawarra. They're working on how they can improve their continuity of care models—the MGP and the MAPS that we've talked about here this afternoon. They're doing some more streamlining around their feedback and complaints processes so that women can more easily respond. There are formal survey mechanisms, but there are also very simple things you can do for people just on an iPad as they're leaving to document their experience. It gives the midwifery unit manager an opportunity to call a woman after they've gone home and talk through things. It's just about that ongoing connection. They're continuing to roll out their training and recruitment campaigns to try and attract more staff. It's fair to say that they remain very focused on all the improvements they want to see. They'll do that in lockstep with Better Births and their clinical teams there at Wollongong and Shoalhaven.

The CHAIR: That concludes our time today. Thank you both for attending the hearing. Committee members may have additional questions for you after the hearing. The Committee has resolved that the answers to these, along with any answers to questions taken on notice today, be returned within 21 days. The secretariat will be contact you in relation to those questions. Thank you again to all our witnesses for their time. That concludes our hearing for today.

DEB WILLCOX: Chair, is it okay if I table our Connecting, Listening and Responding framework for members?

The CHAIR: Yes, absolutely.

DEB WILLCOX: Thank you for your time and your questions.

The CHAIR: Thank you.

(The witnesses withdrew.)

The Committee adjourned at 17:00.