Termination of Pregnancy (Live Births) Amendment Bill 2024

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Australian College of
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Inquiry into the termination of pregnancy (live births) amendment bill 2024

ACM Submission

Issued May 2024

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The Australian College of Midwives

The Australian College of Midwives (ACM) is the peak professional body for midwives in Australia; and welcomes the opportunity to provide a written submission to the ***Inquiry into the termination of pregnancy (live births) amendment bill 2024***. ACM represents the professional interests of midwives, supports the midwifery profession to enable midwives to work to full scope of practice (SoP), and is focused on ensuring better health outcomes for women, babies, and their families.

Midwives are primary maternity care providers working directly with women and families, in public and private health care settings across all geographical regions. There are 33,594 midwives in Australia and 1,195 endorsed midwives[1]. ACM is committed to leadership and growth of the midwifery profession, through strengthening midwifery leadership and enhancing professional opportunities for midwives.

Terms of Reference

This submission will address the proposed amendment bill.

The priority opportunities for ACM include;

1. Add wording to the Amendment Bill clarifying that there is **an obligation** on health professionals to provide comfort measures (including palliative care medications if necessary) and afford dignity to an infant born alive as a result of termination
2. Add wording to the Amendment Bill clarifying that there is **no obligation** on health professionals to provide life-sustaining measures to an infant born alive as a result of a termination of pregnancy, but this decision should be made based on the individual's condition in consultation with the parents and the medical team
3. Include legislation that feticide must be performed prior to termination of pregnancy at any gestation when a live birth may occur
4. Prioritise scale up of MCoC for all women in QLD
5. For women undergoing a termination of pregnancy who have not commenced antenatal care, regardless of gestation, these women should be allocated to a midwife or nurse in a continuity of care relationship for the duration of the experience and for follow-up care
6. Ensure that babies born alive as a result of a termination of pregnancy are included in midwife-patient ratios as part of the roll out of the Health and Other Legislation Amendment Bill (No.2) 2023
7. Ensure that all women undergoing induced labour for termination of pregnancy are cared for in a one-to-one ratio for the duration of the labour and birth
8. Provide training in counselling, bereavement, and specific clinical skills related to caring for a woman and baby during a termination of pregnancy to all midwives and nurses, both in pre-registration programs and as Continuing Professional Development offerings
9. Ensure that all midwives caring for women undergoing termination of pregnancy are offered free counselling and debriefing support
10. Ensure that women and their families undergoing termination of pregnancy are offered free counselling and social work support before and after termination

ACM position on proposed amendment

The ACM supports the rights of all women to reproductive healthcare, including the choice to terminate a pregnancy. If a baby born as a result of termination shows signs of life, but it is considered unlikely that they will survive, the ACM supports legislation stipulating that comfort measures should be provided to the baby until they are no longer alive, and that the infant should be treated with respect and dignity at all times. If the baby is showing signs of distress, seizures or air hunger, palliative care medications should be considered and administered. Medications should be titrated to achieve optimum symptom control, with minimal side effect.

The ACM agrees that health professionals should not be restricted from escalating situations in which life-saving measures may be indicated to babies born alive as a result of termination, if the long-term prognosis for the individual baby is deemed to be positive by the multidisciplinary team. However, it should be clearly stipulated in the Bill that there is no obligation on health professionals to provide life-sustaining treatment to babies born alive as a result of termination.

Babies born severely premature are at significant risk of life-long disability and have high care needs, often throughout their life [2,3]. When a baby is born severely premature not as a result of a termination, the decision to provide life-sustaining treatment is made in consultation with the parents. In the case of a baby born alive as a result of termination, this decision would be complex, and include multiple considerations. Women who commence premature labour spontaneously are given antenatal corticosteroids, which reduce the newborn's risk of respiratory distress syndrome, intraventricular haemorrhage, necrotising enterocolitis and systemic infections. In the case of a termination, this will not have been administered, and this increase in risk of health complications is one aspect that must be considered in any decision to administer life-sustaining treatments. Legislation should not act to sustain life at all costs, even if the quality of life preserved is deemed by experts to be incompatible with a fulfilling life.

A further important consideration is that many late terminations are carried out because of a medical diagnosis of a foetal condition which is not compatible with long-term survival, or of a severe disability. Careful consideration needs to be given on a case-by-case basis to whether prolonging the life of a severely premature baby with pre-existing disability and / or a poor long-term prognosis is in that child's best interests. The emotional wellbeing of the parents must also be considered.

In the case of a baby born alive following a termination and receiving life-sustaining treatments, the parents may not wish to assume custody of the baby. Consideration must therefore be given to ensuring that appropriate immediate and ongoing guardianship of the baby is established, with involvement of social work and counselling support for the parents, and a view to kinship care as a first preference, or alternatively permanent adoption for the baby.

It is worth noting that not all health services in QLD have the capacity to provide appropriate resuscitation measures to a severely premature baby. It is important to ensure that no repercussions occur for health professionals who are unable to provide life-sustaining treatment.

An important aspect of late termination care is feticide, which ensures that the fetus is dead prior to commencing the induction of labour. This is performed to save suffering for both mother and baby, and is recommended as part of standard care for terminations after 22+1 weeks in the QLD Clinical Guideline

– Termination of pregnancy. Effective use of feticide, accompanied by appropriate assessment of the success of the procedure, makes the incidence of a live birth following a late termination extremely unlikely. This procedure is performed for the majority of terminations after 22 weeks' gestation[Rosseretal,2022], however legislative policy could transition this recommendation into law, effectively removing the chance of a live birth following termination. According to the Termination of pregnancy (live births) amendment Bill 2024 Explanatory Note, a percentage of babies in QLD were born with signs of life under 20 weeks gestation. This requires further investigation to determine the earliest gestation at which babies are born with signs of life, and both the QLD Clinical Guideline and the amendment bill should reflect an appropriate earlier gestation to perform feticide prior to termination of pregnancy.

Recommendations

- Add wording to the Amendment Bill clarifying that there is **an obligation** on health professionals to provide comfort measures (including palliative care medications if necessary) and afford dignity to an infant born alive as a result of termination
- Add wording to the Amendment Bill clarifying that there is **no obligation** on health professionals to provide life-sustaining measures to an infant born alive as a result of a termination of pregnancy, but this decision should be made based on the individual's condition in consultation with the parents and the medical team
- Include legislation that feticide must be performed prior to termination of pregnancy at any gestation when a live birth may occur

Other considerations in relation to the Bill

Conscientious objection

It should be noted that all health professionals have the right not to be involved in the care of a woman and infant undergoing termination of pregnancy via a conscientious objection. This includes students and allied health workers.

Midwifery Continuity of Care

Midwifery Continuity of Care (MCoC) is a maternity care model where women see the same midwife or small team of midwives throughout their perinatal experience. Midwifery Continuity of Care is known to be the gold standard of maternity care[4]. Women and babies experience reduced interventions and better outcomes, both physically and psychosocially[5,6,7]. MCoC improves satisfaction with the birthing experience and can reduce birth trauma[8]. Midwives are also more satisfied working in MCoC models[9], with lower levels of burnout and psychological distress[10]. In addition, MCoC costs the healthcare system 22% less than other models of care[11]. Midwives provide MCoC in publicly funded models and in private practice. In remote areas where there is genuinely not a safe referral pathway for women experiencing intrapartum complications, an adapted MCoC model which excludes intrapartum care is an option which provides effective primary maternity care during the antenatal and postnatal period. This model of care, known as Maternal and Postnatal Service (MAPS), has demonstrated positive outcomes, is well received by women[4]. It is the ACMs position that the majority of women in Australia should be cared for in a full MCoC model, and that all women for whom this service is not available should be offered care in a MAPS model. The ACM cautions against health services assuming MAPS is an acceptable replacement for full MCoC and defaulting to MAPS models of care due to assumptions about midwives' preferences or challenges setting up MCoC models.

Any decision to terminate a pregnancy is difficult and emotional. For women undergoing a termination of pregnancy at a late gestation (when it is possible that the baby may survive for some time), the experience can be especially traumatic. Some of these women will already have been receiving antenatal care. In this context, MCoC would provide the family with a known and trusted caregiver who could support them through this difficult experience emotionally, physically and practically. MCoC reduces the need to repeat painful and distressing information to multiple caregivers, and the MCoC midwife knows the family and is able to refer to appropriate ongoing services and support. This includes contraception advice if required.

Recommendations

- Prioritise scale up of MCoC for all women in QLD
- For women undergoing a termination of pregnancy who have not commenced antenatal care, regardless of gestation, these women should be allocated to a midwife or nurse in a continuity of care relationship for the duration of the experience and for follow-up care

Midwifery Staffing and Ratios

It is important to determine and plan an appropriate workforce to facilitate the care of a baby born alive as a result of termination. The midwifery workforce is under immense pressure in Queensland. Currently, care of live babies born as a result of a termination is provided by midwives in many facilities across Queensland. These maternity departments are busy and already understaffed. Midwives are required to support babies at the end of life as well as provide physical care and emotional support to the woman and her family, and at times this process can take hours. An appropriate workforce to provide care for babies born alive after termination is imperative to ensure adequate support for women and babies.

The recent Health and Other Legislation Amendment Bill (No.2) 2023, which includes newborn babies in midwife patient ratios, is to be applauded. According to a Government statement, the new ratios are being rolled out in a staged approach. The ACM encourages the implementation of the new ratios across all QLD health services as soon as possible, so that all QLD midwives, mothers and babies can benefit from this nation-leading legislation. Importantly, the Bill includes stillborn babies. No mention is made of babies born alive following a termination of pregnancy. It is important to ensure these babies are included in patient ratios as part of the roll out of the Bill.

Queensland midwives are reporting high levels of burnout, with nearly half of QLD midwives considering leaving the profession, according to a poll of 20,000 midwives by the Queensland Nurses and Midwives' Union. Factors compounding burnout include heavy workloads, vicarious trauma, high levels of complexity and acuity, and lack of staffing. Some solutions to address these factors are increased clinical supervision, mentoring, and increasing midwives' autonomy, which increases job satisfaction. Crucially, more midwives are urgently required to provide the staff needed to meet the patient ratios laid out by the new Bill, on top of meeting the staffing shortages already experienced by health services across the State. Without adequate midwifery staffing, implementation of the Termination of Pregnancy (live births) Amendment Bill 2024 will fall to an already over-stretched and burnt-out workforce. While some health services have a specified bereavement midwife, this midwife usually works during office hours only, may not work full time, and not all health services employ a bereavement midwife. In some instances, staffing arrangements mean that women undergoing induced labour for terminations under 20 weeks are cared for in the general maternity ward, meaning the midwife may be caring for multiple other women and live babies at the same time as supporting a family through a late termination. This results in inadequate time to provide appropriate support for the woman and baby, and emotional distress and burn out for the midwife.

Recommendations

- Ensure that babies born alive as a result of a termination of pregnancy are included in midwife-patient ratios as part of the roll out of the Health and Other Legislation Amendment Bill (No.2) 2023
- Ensure that all women undergoing induced labour for termination of pregnancy are cared for in a one-to-one ratio for the duration of the labour and birth

Emotional Impact

Caring for a family undergoing a termination of pregnancy can be emotionally challenging, and without appropriate support, negative effects on the midwife can be long-lasting[12]. Grief, compassion fatigue, burnout, and secondary traumatic stress are frequently experienced by midwives providing care for women undergoing late pregnancy termination[13]. Caring for a baby born alive as a result of a termination adds an additional layer of emotional impact to an already challenging experience. Midwives describe feeling unprepared to deal with the experience of caring for women undergoing late terminations, and informal mentoring by more experienced midwives is common[13]. More formal clinical mentorship programs would support midwives caring for women during this difficult experience. It is noted that Nurse and Midwife Support is currently offered nationally and provides brief telephone counselling support and referral, and that the new National Nurse and Midwife Health Service is due to roll out in 2024 and will offer telehealth and face-to-face services.

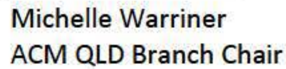
Women choose to terminate pregnancies for a wide variety of reasons, but the experience has a significant emotional impact regardless of the reason. In addition to Midwifery Continuity of Care, women and families undergoing termination of pregnancy should be offered counselling and social work support. In particular, women should be counselled before the termination about the possibility of a live birth, and should be informed about how the baby would be cared for in this instance.

Recommendations

- Provide training in counselling, bereavement, and specific clinical skills related to caring for a woman and baby during a termination of pregnancy to all midwives and nurses, both in pre-registration programs and as Continuing Professional Development offerings
- Ensure that all midwives caring for women undergoing termination of pregnancy are offered free counselling and debriefing support
- Ensure that women and their families undergoing termination of pregnancy are offered free counselling and social work support before and after termination

Conclusion

The care provided to an infant born alive as a result of termination is a complicated and emotional landscape. Multiple considerations must be taken into account when enacting legislation related to this issue. Priority considerations include the distinction between comfort measures and life-sustaining treatment, feticide, staffing, the importance of Midwifery Continuity of Care, counselling and social work support, and ongoing guardianship for a child who lives after a termination of pregnancy.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Consent to publish

ACM consents to this submission being published in its entirety, including names.

Consent to provide further information

ACM is available to provide further expert opinion and advice if required.

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