ACM SUBMISSION

ACSQHC

Severe (Third and Fourth Degree) Perineal Tears Clinical Care Standard Public Consultation

Date of issue: 2019

www.midwives.org.au

Australian College of Midwives

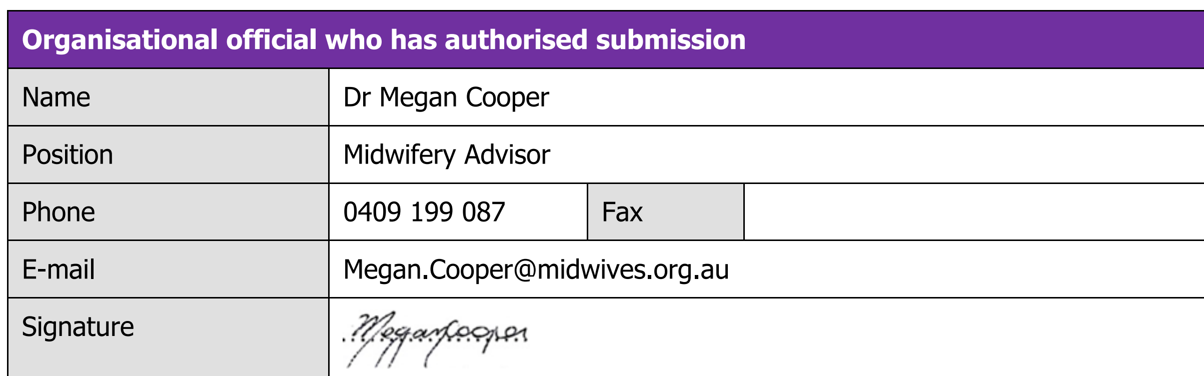
ACM Submission
ACSQHC Severe (third and fourth degree) Perineal Tears Clinical Care Standard

Australian College of Midwives

Cover Sheet

Name	Dr Megan Cooper				
Postal Address	Level 3, 97 Pirie Street				
Suburb	Adelaide	State	SA	Postcode	5000
Phone	0409 199 087	Fax			
E-mail	Megan.Cooper@midwives.org.au				
Signature	[signature]				

Is this submission being made on behalf of an organisation? (Y/N)	Yes				
Name of Organisation	The Australian College of Midwives				
Postal Address of Organisation	PO Box 965, Civic Square				
Suburb	Canberra	State	ACT	Postcode	2608
Which best describes the capacity in which you are responding?	Midwife/Other (Professional Organisation)				
Which of the following best describes where you are located?	N/A – National Organisation				



Organisational official who has authorised submission			
Name	Dr Megan Cooper		
Position	Midwifery Advisor		
Phone	0409 199 087	Fax	
E-mail	Megan.Cooper@midwives.org.au		
Signature	[signature]		

Severe (third and fourth degree) Perineal Tears

Clinical Care Standard

Consultation Feedback

We would first like to raise concern about the use of 'severe', both in the title of this document and also throughout the content. The term 'severe' is highly subjective; to emphasise this point, a woman who experiences a second-degree tear may refer to this injury as severe for any number of reasons including but not limited to the pain experienced, the circumstances associated with sustaining the tear and/or the experiences and perceptions of her support people. We strongly recommend that any reference to 'severe' be removed from this document and instead replaced with 'third and fourth degree.'

Consultation questions

For all respondents

1. ***(For each quality statement)*** **Does the quality statement adequately describe the quality of care that should be provided to women?**
   a) How could the quality statement be improved?

Quality statement		Does the quality statement adequately describe the quality of care that should be provided to women?	How could the quality statement be improved?
1.	Information, shared decision making and informed consent	No	The quality statement, even though labelled 'information, shared decision making and informed consent' includes very little emphasis on these important aspects of care. The woman's choice and autonomy are largely absent and appear to come second to the care providers preferred care and the needs of the health care facility. This quality statement needs to define woman-centred care and informed consent. Shared decision-making should be changed to decision making to reflect that a woman's choice is her own and should not be influenced by others. To support the woman's autonomy and decision making, full disclosure of balanced, unbiased, evidence-based information is required.

2.	Reducing risk during pregnancy, labour and birth	No	The clinical standard is primarily focused on care provision during the intrapartum period and more specifically, during the time of birth. There is very little emphasis on the antenatal factors that may improve perineal outcomes. While mentioned in brief in box 2 on page 15, more discussion about the quality care provision across the spectrum of maternity care, including any history of perineal trauma, is necessary to ensure that the best possible outcome can be achieved. Cherry picking of factors, is narrow sighted. We also suggest that this section could be framed more positively by referring to the improvement of outcomes rather than the reduction of risk.
3.	Instrumental vaginal birth	Partially	While we support the use of instruments to facilitate birth ***when and where there is a clear medical indication***, there is no discussion about these indications anywhere in this document. Further to this, clinical circumstances do not trump a woman's informed consent and therefore this needs to be clearly reflected in the purpose. This section also refers to the use of episiotomy in the event that an instrumental birth is recommended. However, this is presented such that the woman is not able to decline. It also does not reflect that an episiotomy may not always be necessary nor does it mention that an instrumental birth may also lead to a third- or fourth-degree tear. As such a woman may experience an episiotomy and risk an extension of episiotomy where it may not have been necessary. This information should be provided to women in order for then to make an informed choice. There is very much a focus on the risk to and safety of the baby. While this is a consideration, this should not override the decision making and informed choices of the woman, particularly when these particular interventions also have the potential to influence the woman's own risk and safety. We raise significant concerns with the respect to the statement 'You will be asked to provide consent for this type of operative care, except in the case of emergency.' Informed consent is a necessity of all care provision and is arguably more necessary in the event of an emergency. Legally, consent is still required even in the event that the woman collapses and is non-responsive, whereby a next of kin or medical power of

			attorney will consent (or decline), on behalf of the woman. In such cases where there is no one available to act on the woman's behalf, consent is fulfilled by two medical professionals who agree on the best course of action. As such, there is ***never*** a situation in which consent is unnecessary. This needs to be rectified urgently.
4.	Identifying third and fourth degree perineal tears	Partially	Reference to the woman being 'checked' or 'assessed' is vague and is open to misinterpretation and the care providers own take on what this means for their practice. Any reference to 'assessment' or 'checking' needs to be clearly defined and the information the woman receives, explicit so as to ensure that woman is able to provide informed consent or alternatively, decline. There is consistent reference to the 'appropriately trained and skilled' health professional without an explanation of what training and skills are required of a care provider to identify third- and fourth-degree tears in a timely and accurate manner. For example, are maternity care providers such as obstetricians and midwives, deemed to be trained and skilled professionals or are these professionals required to undertake further training and education to meet the level of skill referred to in this document? There is little evidence to suggest that per rectum examinations are effective, particularly in the event that the woman has an intact perineum. Further to this, a PR examination will not reduce the incidence of third- and fourth-degree tears but rather assist in the identification. However, there also needs to be acknowledgement of the fact that third- and fourth-degree tears may go undiscovered and therefore untreated, even despite the offer of and undertaking of a PR examination, which in any event, the woman may decline.
5.	Repairing third and fourth degree perineal tears	Partially	Language throughout this section is condescending and needs to reflect that the choice is actually the woman's e.g. 'Talk to the woman' Reference to 'appropriately trained and skilled' clinicians is used throughout this section. With respect to repair of 3a tears, there are specifics about who can perform the repair however, this same kind of information is not included elsewhere throughout this document. Please see comment against quality statement 4.

			Full information about the procedure should be provided to the woman. For example, there is no mention of a per rectum examination post the repair in the information for women. Reference to the use of prophylactic antibiotics is unclear and contradictory. This section opens with suggesting that the evidence base for antibiotics is limited. However, it is then stated that 'giving prophylactic antibiotics is recommended or considered reasonable for severe perineal tears.' If the evidence base is limited, it would be more appropriate to suggest that antibiotics should be considered on a case by case basis. This is particularly important given that we are contending with higher antibiotic resistance.
6.	Postoperative care	Partially	Reference to 'urinary catheters' is presented in this section when this ideally should have been discussed in earlier sections with supporting evidence to reflect best practice and suggest why a catheter may be required. The statement 'Before leaving hospital, you should see a physiotherapist who can let you know what to do or what to avoid while recovering' creates an expectation on health services that all women with a 3rd & 4th degree tear will see a physiotherapist before discharge. This does not take into account the wishes of the woman to be discharged over a weekend when a physiotherapist may not be on staff, or women who birth at a service that does not have a physiotherapist on staff. Further it does not value the skill or knowledge of the midwifery profession who have the capacity to provide pelvic floor care advice to women nor that there are midwives who have specialised in pelvic floor/continence care. A suggested change to make this more inclusive of options available would be to change the physiotherapist to 'suitably qualified health professional' and also to note that in instances where the health professional they need to see is not available prior to discharge that they will be provided with a referral. For equity in access consideration needs to be made to how women will access physiotherapy after discharge such that women are not required to travel long distance or pay exorbitant frees to see private practitioners. We further note that not all physiotherapists have knowledge and skill related to the care and management of women's pelvic floor disorders following birth and as such it is imperative that if physiotherapist is identified that they are a women's health

			physiotherapist with the required skills and knowledge to provide advice. There is reference to a physiotherapist providing advice with respect to breastfeeding. This is outside of their scope of practice. Midwives are ideally positioned to provide this support as this is within the scope of a Midwife. This section should reflect that a multidisciplinary approach is needed. Further to this, there is reference to the breastfeeding implications that may arise with respect to a perineal tear however, there is no elaboration of what these implications include in the information for women. The information for women and clinicians should be crosschecked to ensure that there is consistency.
7.	Follow-up care	Mostly	There is no specific reference to a midwife's role in supporting women post birth and up to six weeks postnatal.

For consumers:

2. Are there aspects of care related to perineal tears that are not covered by this clinical care standard that should be included?

Yes.

a) Please describe these aspects

There is insufficient focus on preventative strategies that may reduce perineal tears. Instead, the focus is largely on intrapartum care and more specifically, what can be done by the care provider at the time the woman is giving birth. There is very little importance placed on:

1. The woman eating a healthy, balanced diet throughout her pregnancy
2. Maintaining a healthy weight range

The above factors are known to reduce the possibility of diabetes, hypertensive and other medical disorders during pregnancy which in turn influence the weight of the baby, comorbidities and reduce the possibility of interventions.

3. Discussing interventions that may increase the likelihood of perineal tears

Induction of labour, epidural anaesthesia and instrumental births as examples are associated with increased likelihood of perineal tears. Full disclosure of information that assists women to make informed decisions about these interventions should be provided during pregnancy.

4. Remaining active during labour and birth and positions that reduce the potential for perineal tears

Women remaining active and in an upright position during labour and birth, not only facilitates descent of the baby but also opens the pelvic outlet by up 28% compared to a supine position.

5. Continuity of caregiver namely, a midwife

Continuity of caregiver not only improves physical outcomes but also facilitates women's sense of control and trust over their body and the experience of giving birth. The woman is therefore able to listen to her body's cues and to be supported through spontaneous pushing in second stage.

3. Is the fact sheet for consumers useful?

a) How could the fact sheet be improved?

Please see our comments in response to Q7 below.

For clinicians and health service organisations:

4. The quality statements target areas of care that could benefit from quality improvement. Are there additional aspects of care that should be included in the quality statements?

No, we do not feel that additional target areas need to added to this clinical standard however, those that are included need to be revised and strengthened. There are significant shortfalls that must be rectified in order for this document to reflect quality care that is woman-centred, safe and evidence-based.

a) Please describe and provide evidence to support your response

At present, the document reads very much like a guideline rather than a clinical standard. As a clinical standard is ultimately about upholding safe, evidenced base care, there is a need to underpin the standards with ethical and moral principles, that being the woman's bodily autonomy and a care providers duty to ensure that women receive the information they need in order to exercise autonomy and make informed decisions. The document fails to uphold these important principles across many areas. Further to this, the document refers to person-centred

care. This should be replaced with woman-centred care to align with the newly released *Woman-centred care: strategic directions for Australian maternity care* and to reflect that this is a maternity related issue that affects women giving birth.

We have also included a comprehensive list of feedback under question 11.

5. If implementing this clinical care standard, what would be the implications for:

a) Your practice (health care providers)?

There are implications for the care provider if ethical, moral and professional principles are not upheld. Health care professionals risk doing more harm than good and where women have not been supported to make informed decisions following full disclosure of information and in the absence of coercion, harassment or bullying and/or the care providers preference, there is the risk of litigation. This is particularly significant given the growing incidence of birth trauma and psychological sequalae that can be attributed to the woman's perceived lack of control and autonomy with respect to decisions that affect both herself and her baby.

There is also the potential that emphasis will be placed on the intrapartum aspects of care that may minimise the woman's chances of perineal tears if the importance of factors such as those listed under question two (see above) are not reflected in the clinical standard.

b) The health service organisation?

The suggestion that aspects of the clinical standard may not be achievable in all venues is counterintuitive to the fact that this is labelled a clinical standard. This raises issues of inequity where the quality statements cannot be upheld in all settings that offer maternity care.

Reference to the 'appropriately trained and skilled' clinician needs to be clarified to ensure that health organisations are able to ensure that staff providing services are sufficiently trained and skilled to provide care in line with that provided in this clinical standard. At present, this is vague and open to interpretation which lends itself to variation in practice and therefore, inequity of service provision.

6. The clinician fact sheet lists the quality statements for clinicians. Is the fact sheet for clinicians useful?

The woman is completely absent from quality statement three. There is reference to the safety of the baby and clinical need, but there is no mention of the woman's informed decision making and choices. This needs to be included.

Quality statement four is poorly written. While the opening suggests that the woman's consent will be gained, this is followed by 'a woman is examined.' This implies that the woman has no choice and that the examination will be undertaken regardless of her decision. This need to be rectified. Alternative wording could be: After discussion with the women, and with her consent, an appropriately trained clinician may undertake a vaginal and PR examination to exclude the possibility of a third- or fourth-degree perineal tear. Tears are classified using the Royal College of Obstetricians and Gynaecologists classification and are documented in the healthcare record.

7. The consumer fact sheet describes what the clinical care standard means for patients and consumers. Is the fact sheet for consumers useful?

The fact sheet could be useful if the following are addressed:

The final paragraph under the section 'What is a perineal tear?' should be presented before the description of third- and fourth-degree tears to reflect that most women will not sustain major perineal trauma. In this paragraph, it should also refer to the woman i.e. 'Most women will not experience major perineal trauma' to reflect that the woman is more than just her vagina.

Quality statement one

Refrain from suggesting that the clinician 'will talk to' the woman. This suggests that the woman should just sit and listen rather than be actively engaged. We suggest that the following statement 'your clinician will talk to you about your birthing options such as a vaginal birth, an instrumental-assisted birth or a caesarean' be changed to 'The clinician will discuss the birthing options that are most suited to your personal circumstances' or something to that effect.

The statement 'The option you choose will be based on your clinical need and personal preferences' suggests that the clinical need will trump the needs and preferences of the woman. It could be implied from this, that the woman's preferences are limited to what the clinician views as necessary thereby limited the woman's choices while contravening the premises of informed decision making and consent. The sentence is superfluous and we would suggest deleting it completely.

Reference to 'level of risk' is vague in the second to last paragraph. This should be specific to the risk of perineal tears. With regards to the following statement, 'Your clinician will also discuss the importance of being checked soon after your baby is born to make sure you do not have this type of injury', there is no explanation of what it means to be 'checked.' The meaning of 'checked' needs to be explicit in this document.

Quality statement two

The inclusion of pregnancy-related factors that are likely to reduce the possibility of a perineal tear are welcomed but need to be extended further (see previous comments to question 2).

The recommendation of an episiotomy should be supported with a statement that it will only be performed post the woman providing informed consent.

The reference to an instrumental vaginal birth and caesarean section should suggest that information will be provided about the need and consent gained. The information in quality statement three is much better.

Quality statement three

The second paragraph needs to put the discussion with the woman as first and foremost rather than as an addition at the end of the sentence.

We raise significant concerns with the respect to the statement 'You will be asked to provide consent for this type of operative care, except in the case of emergency.' Informed consent is a necessity of all care provision and is arguably more necessary in the event of an emergency. Legally, consent is still required even in the event that the woman collapses and is non-responsive, whereby a next of kin or medical power of attorney will consent (or decline), on behalf of the woman. In such cases where there is no one available to act on the woman's behalf, consent is fulfilled by two medical professionals who agree on the best course of action. As such, there is ***never*** a situation in which consent is unnecessary. This needs to be rectified urgently.

Quality statement four

The explanation of 'check' is welcomed in this section however, as stated previously this needs to also be reflected in the clinical standard itself.

Quality statement five

The statement 'The clinicians will try to make sure your baby and support person remain with you during the surgery' should be rephrased to suggest that every attempt will be made. For example, 'Every attempt will be made to ensure your baby and support person remain with you

during the surgery.'

Quality statement six – Ideally, the use of a urinary catheter should be explained and presented in quality statement five as part of the repair discussion. Language is pitched to high without sufficient explanation and as such, the document is not woman-centred.

The statement 'your clinician will discuss your experience' reads poorly. It would be better if it was replaced with 'you will have an opportunity to discuss your experience with the clinician' or something similar.

The statement 'Before leaving hospital, you should see a physiotherapist who can let you know what to do or what to avoid while recovering' creates an expectation on health services that all women with a 3rd & 4th degree tear will see a physiotherapist before discharge. This does not take into account the wishes of the woman to be discharged over a weekend when a physiotherapist may not be on staff, or women who birth at a service that does not have a physiotherapist on staff. Further it does not value the skill or knowledge of the midwifery profession who have the capacity to provide pelvic floor care advice to women. A suggested change to make this more inclusive of options available could be 'Ideally, before leaving hospital, you will be seen by a suitably qualified health professional who can let you know what to do or what to avoid while recovering. In the even that this is not possible, a referral will be made to a suitably qualified health professional.' We further note that not all physiotherapists have knowledge and skill related to the care and management of women's pelvic floor disorders following birth and as such it is imperative that if physiotherapist is identified that they are a women's health physiotherapists with the required skills and knowledge to provide advice.

Quality statement seven – Midwives are not included in the list of those who are able to support women after birth with recovery. For example, the following statement talks only of GP's and physiotherapists 'Your general practitioner and a physiotherapist with expertise in women's health will have a key role in looking after you and will help you get the care you need.'

Paragraph 3 under 'What this means for you' includes Continence Nurses but there are also Continence Midwives so we would suggest this be changed to 'Continence Nurses or Midwives'

We are pleased to see that the physio has been well defined in this Quality statement as being 'a physiotherapist with expertise in women's health' and suggest that this needs to be defined earlier/throughout the document.

For all respondents:

8. **Would you like to provide comments on the indicators?**
   Yes.

9. **Are the proposed indicators useful for monitoring the care described in this clinical care standard?**
   a) **How could the indicators be improved?**

   The indicators fail to recognise the woman's experience as a pivotal aspect of care. The *Woman-centred care: strategic directions for Australian maternity care* released in November 2019 calls for emphasis on woman-reported outcomes asserting that they are essential to underpinning and informing quality care provision. This is particularly pertinent given that psychological trauma related to or associated with pregnancy and birth are increasing.

   The use of 'delivery' should be replaced with 'birth' throughout these indicators.

   The use of 'person-centred' should be replaced with 'woman-centred' throughout these indicators.

   Indicators that capture aspects of antenatal care that are likely to influence the woman's chances of experiencing a perineal tear should also be included to ensure that there is greater understanding of the multitude of factors that may have led to the tear; not just those that are reflected in the perineal care bundle. This will reduce the likelihood of the perineal tear being attributed to the actions or inaction of the care provider.

10. **Do you know of any current or planned initiatives that could support implementation of this clinical care standard?**
    Yes. The recently released *Woman-centred care: strategic directions for Australian maternity care* reflects the goals and targets of Australian maternity care into the future. This clinical standard should reflect the strategies outlined in this document and most importantly, reflect the importance of ensuring care provision is woman-centred. This extends to the language that is used, through to the information that is provided and decision making that is free from coercion, harassment and/or bullying.

11. **Do you have any other comments you would like to make about this clinical care standard?**
    Yes. Please see the below dot points that raise key issues identified throughout the document that we feel need to be addressed.

    Clinical Standards

    - Clinical care standards aim to outline systems required by health services to review and make improvements in care. However, these clinical standards read more as a directive in that they outline specifics of care provision which would be better included in a guideline or would be incumbent on the health service determining the requirements based on their capacity and resources.

    Language

    - This document is not aligned to the recently released *Woman-centred Care: Strategic directions for Australian maternity services* in that the woman about who this care is for is not central to all aspects of care and further 'the woman' is largely missing in the language used throughout. For example, the use of 'person-centred care' or directives from the perspective of the health provider or health professional.
    - We recommend that the term 'delivery' is replaced with 'birth' throughout the document.
    - There is an abundance of ambiguous and inappropriate language:

  - The term 'severe' as a descriptor of the perineal tears is highly subjective and needs to be changed throughout the document to 3rd and 4th degree tears.
  - There are suggestions that third- and fourth-degrees tears are common without rationale.
  - Using the term 'Suitable environment' without definition or clarification.
  - Using the term 'Checked' without outlining what this entails.
  - Requiring an 'Assessment' without clearly outlining what is meant. We believe this refers to PR examination but this is not explicit nor does it explain what is involved for the woman or the clinician.
  - Using language such as 'Talk to the woman' which suggests that the woman is passive and will be told what to do. All communication with the woman should be a two-way conversation where information is shared and the woman is able to ask questions and make an informed decision free from coercion, manipulation, harassment or bullying.
  - There is emotive and subjective language throughout the client information.
- A grammatical review of the document is required.

Women's informed choice and decision making

- 'Shared decision making' suggests that the care provider has equal ability to make the decision. This is problematic because the decision should be ***made by the woman*** after full disclosure of all available information in a non-biased and non-coercive manner.
- Women's choice and decision making are largely absent throughout the entire document. This is particularly disappointing given the recent release of the 'Woman-centred care: strategic directions for Australian maternity care'.
- Women should be able to decline any care offered without fear of consequence. At present, this is not explicit throughout the document.
- Individualised care is largely absent – this does not speak to woman-centred care nor does it speak to the legal requirement to gain informed consent.
- Quality statement 1 ultimately needs to clearly discuss what is meant by information, decision making and informed consent.
- The document refers to 'the women needing to reconsider options of care if circumstances change' without any indication as to what this means or in what circumstances would this apply. Further, this statement is redundant if the woman does not agree and/or does not provide consent to the options of care on offer.

Person-centred vs. woman-centred care

- Replace 'person-centred care' with 'woman-centred care' throughout.
- This standard concerns women receiving maternity care and therefore the document needs to be specific to the context and audience that it is written for.

Care provision

- Appropriately trained and skilled clinicians are not defined with respect to this clinical standard. There is also suggestion that a physiotherapist can support a woman with breastfeeding which is outside of their scope of practice. This is the scope of a midwife.
- Limited reference to the multitude of factors that could and/or are likely to influence the possibility of perineal trauma – this includes the support that women receive throughout the antenatal period as well as care during labour and birth including continuity of carer.
- 'Midwives and women's heath nurses' are combined as defined health professionals. Midwives are a recognised health profession and as such should be recognised as a separate profession in this list.

- On page 13 the document states that 'The procedural and surgical skills required to identify, classify and repair severe perineal tears must be considered in the context of the clinical service capacity of the organisation'. We would like clarity as to what is meant by this statement and what implications there will be on services that may not have the capacity to repair noting that identification and classification are likely not the barriers in this statement.
- The circumstances surrounding an indication for an episiotomy are vague. They should be explicit and ensure that unnecessary episiotomies are not performed and that in all instances consent from the woman is obtained.

Equity

- Page 12 states that 'It should be used to provide high-quality, evidence-based care, taking into account the context in which care is provided, local variation in care, and the quality improvement priorities of the individual health service organisation'.
  - This is contradictory and suggests that where the health service itself has variation then this document becomes redundant. Above all else, care provision should be informed by the preferences and needs of the woman and not by any of the needs or requirements of the health service.
- We are concerned that a clinical standard is being defined that does not have the necessary supporting structures or resources in place to ensure that the clinical standard can be upheld and functional. For example:
  - 'Not all care settings can offer all care options' which will result in inequitable access and inability to work to the standard.
  - A clinical standard needs to reflect best practice and where it is best practice, it should be made available to all women e.g. Midwifery Continuity of Care, or midwifery led care.

Evidence base

- Information is only focused on the mode of birth and specific care options that may be used during labour and birth rather than on other modifiable antenatal and other intrapartum factors that may influence or increase the potential for perineal trauma e.g. induction of labour. These factors must be considered and discussed as they will impact on perineal outcomes.
- The requirement for all women to have a per rectum (PR) examination is not evidence-based and there is no literature to suggest that such an approach would reduce rates of third- and fourth-degree tears. What will reduce the rates is the information that women receive about minimising their risk through the antenatal period and during labour and birth.
- There is a lack of clarity around the need for prophylactic antibiotics and whether or not they are recommended or whether it is based on clinical discretion. Any recommendation with respect to antibiotics needs to be specific and evidence based particularly given increasing antibiotic resistance.
- Episiotomy for women with a history of third- and fourth-degree tears in not evidence-based or supported by the literature.
- Repair of 3a tear in the birthing suite is not evidenced based. This recommendation is particularly concerning given that tears are commonly under classified.

Litigation

- There is reference to 'assuring women about care', for example, 'assessments can assure that a tear is not missed'. This language is misleading as there is always the possibility that a tear may go undiagnosed.
- The use of subjective language throughout the document is concerning as terms such as 'severe' are personally interpreted and will have different implications and meanings for every individual.
- Informed consent must be central to any procedure that is performed on a woman. There are a number of issues with respect to sharing of information and obtaining informed consent that are of concern and could result in legal action particularly where interventions are not fully explained and/or breach women's rights.