# The Reproductive Justice Story Project

**October 29, 2018**

Dear Elena, Sally-Ann, and Sandy,

Thank you again for taking the time to meet with me to discuss your response to the patient feedback survey that you received in June of this year. As I mentioned in an earlier communication, I will be sharing this letter publicly for any community members (including the 410 people who took the survey) who may be interested in the improvements you've made since receiving the report. I will share some quotations from your formal letter in **bold**, and try to unpack what we discussed in-person for readers who were not present.

In your formal written response to the survey report, you shared that **"[a]ll patient rooms on the Family Birthing Centre unit are now equipped with communication boards, a tool that helps our teams understand our patients' priorities and engage better in developing care plans together"** In our meeting, you explained that these "communication boards" are dry-erase whiteboards. When asked, you were not able to describe how these particular whiteboards differ from the whiteboards that were already in place in all patient room for quite some time. It was also unclear exactly what would need to be written on the whiteboards by the patient in order to ensure these wishes are incorporated into their care. For example - staying grounded in the feedback from the survey - if a patient would prefer *not* to be given an episiotomy without their knowledge or consent, is that something they should be outlining ahead of time on their whiteboard?

As a Catholic teaching hospital, the cultural aversion to informed consent and bodily autonomy in your childbirth unit makes sense, however, some patients raised this culture as an area of concern in the feedback survey. You shared in your letter that you are **"continuing to seek learning opportunities that expand care providers' understanding of what obstetrical [sic] violence is and ways we can ensure patients don't experience this under our care"** In the meeting it was stated that "ideally we need to embed it into some standardized classes" but you were not able to speak to whether "obstetric violence" or "patient mistreatment" are terms that had come up at all yet, even in less formal conversations and huddles on the unit.

However, you expressed with certainty that there have still been no *formalized* discussions or training around what constitutes obstetric violence, and how to interrupt the cycle of obstetric violence in your Family Birthing Centre. It was also unclear whether the experiences of abuse and mistreatment some patients shared in their survey responses have been addressed in a comprehensive way.

**“We have also launched an online survey to collect feedback that can be completed on the TVs in every patient room”** As you know, this project was created in response to the lack of dedicated feedback mechanisms in place for patients of the Family Birthing Centre, this sounds like an important tool for patients to communicate compliments and concerns.

You explained that your survey has been live for about three months and that so far, you’ve received 30 completed responses. This, I believe, works out to a response rate of about 3.5% based on the 3,400 folks you said give birth each year at the centre? It was unclear whether midwifery clients who choose to return home three hours after birth would have access to the survey, currently, as it is only offered on the televisions in inpatient rooms. I suggested that it also be made available on your website for patients to complete from home. You said you would bring this idea to corporate communications to see what they can do. Thank you!

You did confirm that the survey is only offered in English and that the need for a language interpreter would have to be initiated by the patient. In other words, if a patient can not read English to see that there is a survey available, it isn’t clear how they would know to request interpreter services from their nursing team in order to complete it. Presumably, you should already be booking language interpreters for patients who require one in order to complete your thorough postpartum mood screening and discharge briefing, perhaps the survey is something that could be incorporated into that process if the patient is interested in participating in order to ensure a representative sample size?

On this note, you confirmed that there is no dedicated health equity plan for the Family Birthing Centre at the moment and that no staff training around anti-oppressive practice has taken place. This came up in patient feedback as an area for growth and was included in the report’s recommendations. You explained that the department “did a lot more sort of work around diversity in the community and reaching out to disenfranchised groups” long ago, but currently the focus is elsewhere. You were not able to share whether there will be a formalized plan or timeline for health equity initiatives coming together soon within the unit. Knowing what we know about health disparities across different populations, and about the many marginalized folks that call our community home, perhaps this is something your team will make time to look into soon?

**“We’ve implemented fetal health surveillance training that is mandatory for all physicians, nurses, and midwives to complete. By enhancing interprofessional education, we’re helping improve the relationship among the care team’s different disciplines which contributes to better patient quality of care.”** You explained that this fetal health surveillance training is a formalized certification around a clinical skill. You also explained that sometimes different care providers have differing opinions on what the course of care should be, and at times, patients are exposed to the battle between the care providers’ interpretation of these strips. If the interprofessional friction your patients identified is only related to these clinical skills, your new standardized training should be a helpful solution. However, responses from some of your patients in the survey point to the possibility that there *could* be more to the cultural climate in the unit than differing opinions around fetal heart tracings. As you saw in reading the survey report, most patients did not identify this as an issue central to their experience.

You touched on this when you spoke to the “variability in staffing” in terms of staff behaviour, assuring me that when staff are acting inappropriately, or not “properly doing consent” you should be following up around that through your HR processes.  You shared that you are still working towards a culture in which staff will be able to come forward with their concerns about coworker misconduct without fear of retribution. Thank you for being upfront that this is still something you are working towards. You did not speak to specific initiatives or trainings in the works to address these cultural concerns in the unit, stressing that these things don’t just “happen overnight”. I will gently add that these things don’t just happen - period - if they are not addressed in the full light of day. How can you begin working to change something that you have not yet named?

It is my understanding that there are some strides being made to address problematic behaviour and this “variability in staffing”. For example, the recent suspension of the elective surgery privileges of one obstetrician whose name came up with staggering frequency in connection with allegations of non-evidence-based and non-consensual care, both in the survey results and in less formal community consultations. Thank you for taking this step to protect patients from further harm.

When asked about the delay in implementing full scope of practice for the midwives who have privileges at the hospital, you simply said there are “a lot of political pieces that I can’t get into”. It’s seems there’s been some resistance to giving midwives full privileges for epidural and exogenous oxytocin for augmentation or induction of labour for quite some time. Why does it need to be so complicated? Is it true that folks who choose midwifery care for their pregnancies are not forced into a transfer of care at *any* other hospital in Toronto? Has your hospital administration taken a look at any of the current research on the impacts of continuity of care on health outcomes and patient satisfaction?

Continuity of care is simply good for patients, no matter who they've chosen as their primary care provider. There were comments in the survey report from patients who caught glimpses of what one might describe as systemic disdain for midwives. There is an undeniable interprofessional tension that sometimes bubbles up to the surface where patients have noticed and it's time you took some real steps to address it by expediting the implementation of epidural and oxytocin privileges for midwives and by allowing them autonomy in decision making around privileging and patient care.

While the disconnect between your interprofessional teams is palpable, you have taken some great steps to connect with patients. For example, you shared that the Patient Care Manager of your Family Birthing Centre now tries to check in with all patients who had unplanned C-sections to offer her contact information should they want to get in touch.

You shared, as well, that the Patient Care Manager recently had a group of staff from the unit come forward hoping to form a committee to address the need for updated language in documents at the centre. They had offered to spearhead this work to create a more inclusive and equitable environment for patients. However, you struck down their proposal, citing the need for change to come from the top down, rather than led by frontline workers who are best positioned to advocate on behalf of their more vulnerable patients.

**"We have also taken steps to enhance education about trauma-informed care through presentations called grand rounds which bring experts in to speak with our teams - this is an area where we are looking at plans for more formalized training"** For readers who are not familiar with the language, it is my understanding that rounds are meetings that take place every Friday morning at the Family Birthing Centre. Grand rounds are simply rounds that all staff members are invited to attend, however attendance is not mandatory.

You explained that so far, there has been only one (1) grand round dealing broadly with the topic of trauma: a short presentation on the impacts of previous sexual trauma on childbearing. It focused exclusively on ciswomen who have a history of childhood sexual abuse or sexual assault. This is such important information for your team to have, and the presentation was a great starting point! However, it did not delve into the need for trauma-informed care as a universal approach or address the many other forms of trauma and adverse experiences that can have a profound impact on pregnant and birthing folks during an already vulnerable and unpredictable time.

As I'm sure your experts at the hospital are aware, research confirms that one does not even need to have a history of trauma to have a traumatic birth experience, and that this trauma can be lessened or even prevented with good communication, patient-led decision-making, and a

dedication to patients' bodily autonomy and informed consent throughout their care. Without a focus on practical strategies for frontline staff to employ in lessening the risk of traumatic birth (for patients who have disclosed trauma histories and those who have not) this single grand round presentation did not arm your staff with all the skills they will need. You were not able to speak to plans for more of these informal, optional grand rounds, and confirmed that you do not have formalized plans or timelines for embedding essential skills around trauma-informed care into mandatory training.

You explained that there has been some talk of "compassion training" for staff, however there are no formal plans yet and no timeline for when that training will happen either. On a more positive note, you have **"introduce[d] new programs including having all of our nurses take part in customer service and communication-focused training that has created a framework for our teams to communicate with patients and their families as well as one another."** Thank you for taking this step to improve skills where they're needed most!

**"We are also conducting weekly safety huddles where we meet with patients and families to ask them about their experience and ensure they have the contact information for the unit's manager and patient relations should they want to connect with us at any time during their stay or when they go home."** In our meeting, you confirmed that these meetings do occur twice a week and sometimes up to five times per week after group feeding classes on the unit. As I'm sure you've found, not everyone who gives birth on the unit attends these classes, as some may come and go during days when there is no class available, and not all families choose to or are able to breast/chestfeed for a variety of reasons. It sounds like these meetings have been a valuable tool so far for hearing feedback from *some* patients in real time, however, I raised concern during our meeting about the many folks who you won't be hearing from in these sessions; people who are not comfortable raising their hand to share personal thoughts aloud with a group of strangers, those who have not had time to process their experience so soon after giving birth, and others whose potentially distressing or traumatic experience may be ongoing.

I urge you to look into the research that suggests processing birth experiences can take time; that many people are not able to articulate and critically reflect on their experiences until weeks, if not months after; that you are unlikely to get all the feedback you need to hear the most if it's only being gathered in-person, and on inpatient television sets. I hope you will continue to look for ways to improve this process and seek opportunities to invite even more feedback, especially that which may be difficult for you to hear.

This survey initiative has been an incredible learning opportunity for me and the collaborators who made it possible. I am grateful to all of the patients who shared their difficult experiences in the survey, and for all of you at St. Joseph's Health Centre for providing such an in-depth education on the challenging process patients face in trying to have their voices heard. Our next survey initiative (currently in the works) will be aimed at exposing obstetric violence and traumatic childbirth experiences province-wide and it would not have been possible without the many lessons you've shared on the subject.

Thank you again, so much, for taking the time to look at the survey report and for acknowledging all the work ahead in making care better for your patients.

Best of luck!

Kate Macdonald

**Founder, The Reproductive Justice Story Project**
**reproductivejusticestories.org**
**@ReproJusticeSP**