Submission No 204

INQUIRY INTO BIRTH TRAUMA

Name: Name suppressed

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Partially Confidential

I am a private obstetrician.

I am concerned by the number of women who experience birth trauma due to the lack of information and education about possible outcomes in the birthing process. I have a number of patients who see me for subsequent births significantly scarred by the care they received in the public system that was not necessarily medically negligent but was a result of lack of communication and patient education.

We have a health system that provides safe care for women and babies but to maintain these outcomes at times women will require intervention. Intervention in the birthing process is not necessarily a bad thing however there is much mis-information on the internet regarding the dangers of intervention and the "cascade of intervention" leading to birth trauma. Intervention in many instances results in outcomes of healthier women and babies yet women who have not been educated appropriately during the antenatal period regarding their chances of possible interventions that may result in better outcomes for them or their baby.

Induction at 39 weeks for otherwise low risk women has been shown with a high level of evidence to reduce the risk of Caesarean section, reduce the risk of post part haemorrhage and reduce the risk of poor neonatal outcomes yet many women are not offered this as routine practice and instead are advised that an induction will lead to a Caesarean section.

Growth ultrasounds in the third trimester allows an assessment of fetal growth to identify significantly growth restricted or macrosmic babies to then counsel women about the best mode of delivery and the benefits and risks of either attempting vaginal or opting for an Elective Caesarean section if there are significant outliers in fetal growth.

Reading previous submission the recurrent theme is women being unprepared or not understanding of why certain interventions were performed or needed. A vacuum or episiotomy to deliver a baby at risk of hypoxia is performed as a time sensitive procedure and often there is minimal time to explain at length the full risks and benefits, particularly to a women in the second stage of labour who is in significant distress herself.

I believe the key to reducing trauma is to ensure women are offered appropriate and scientific based education in the antenatal period. Explaining possible interventions that may be offered and why they may be needed means when the time comes a women who needs these interventions is aware of the risks and benefits and why they may be occurring. Antenatal education for the most part focuses solely on the natural birthing process glossing over the fact that many women, particularly those having their first baby, will require some sort of intervention to have the best chance of a healthy mother and baby.

Autonomy to refuse interventions is only truly possible if a woman has had the opportunity to be offered all scientific based evidence, not simply the natural birth as the best option.

A lack of resources in antenatal clinics and education has left many women to do their own research that often leads them to internet sites or support groups with a significant push for anti-science, anti-medical, anti-intervention rhetoric. If antenatal services and antenatal education were better resourced through our obstetric services this would reduce women feeling they need to seek their own educational resources and leaving them under-prepared for a successful birthing outcome.