Submission No 238

INQUIRY INTO BIRTH TRAUMA

Organisation: Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)

Date Received: 11 August 2023

Submission

NSW Legislative Council - Inquiry into Birth Trauma

Thank you for inviting the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) to make a submission to the NSW Legislative Council on the Inquiry into Birth Trauma.

RANZCOG is the lead standards body in women's health in Australia and New Zealand, with responsibility for postgraduate education, accreditation, recertification and the continuing professional development of practitioners in women's health, including both specialist obstetricians and gynaecologists, and GP obstetricians.

Background

There have been significant improvements in maternity outcomes over the last century in both Australia and New Zealand. While there have been many factors that have contributed to this improvement, modern midwifery and obstetric care has been central. This has included access to safe anaesthetics, caesarean sections, instrumental deliveries with complex and detailed antenatal care. These improvements have occurred while other medical advances have allowed older mother's and those with medical co-morbidities to become pregnant.

Neonatal outcomes have also significantly improved though both maternity and neonatal improved care. Worldwide, pregnancy and birth still however remain a high-risk activity. The WHO estimates 223 women per 100 000 live births die and a further 2.4 million children die within their first month of life, 75% within the first week and the majority from birth complications. The WHO states that 'scientific and medical knowledge are able to prevent most maternal deaths.'[i] Therefore, as the leaders in Obstetrics and Gynaecology (O&G), RANZCOG strives to educate and support our members to deliver the best and most appropriate and culturally safe maternity care to all women across Australia and New Zealand.

Specific Feedback

RANZCOG welcomes and supports the current inquiry into Birth Trauma that is experienced by many women and their families. RANZCOG respectfully proposes that the inquiry considers the core and primary issues that lead- to this 'trauma' being experienced. This will ensure that solutions suggested by the inquiry are able to address and reduce both the risk and burden of birth trauma for all women and neonates, whilst also ensuring the high standard of care and maternity outcomes in Australia are maintained.

Please see RANZCOG responses to some of the specific issues raised in the Terms of Reference as follows:

1.(a) the experience and prevalence of birth trauma (including, but not limited to, as a result of inappropriate, disrespectful or abusive treatment before, during and after birth, also referred to as "obstetric violence")

The term 'obstetric violence'

RANZCOG notes that the term 'obstetric violence' is well entrenched in high and low impact journal publications, social media sites, podcasts and webpages. A simple google search itself populates over 87.000 search results. Thus, the Lancet definition: ' Obstetric violence refers to harm inflicted during or in relation to

pregnancy, childbearing, and the post-partum period. Such violence can be both interpersonal and structural, arising from the actions of health-care providers and also from broader political and economic arrangements that disproportionately harm marginalised populations.' [ii]

On the other hand, both Cambridge and Oxford English dictionaries define violence (noun) with the prescription of *'Intention'*. For instance: *'extremely forceful actions that are intended to hurt people or are likely to cause damage'*[iii]*; 'violent behaviour that is intended to hurt or kill someone'*[iv]

Thus, it is apparent that the word 'violence' has a grounding in the social and political philosophy literature, with a paradigm of victimhood and oppression by a powerful privileged group who deliberately cause suffering.

RANZCOG strongly believes that the term 'obstetric violence' is incorrect and in fact may limit opportunities to reduce patient experience of birth trauma. Whilst RANZCOG acknowledges that interventions can cause harm, or psychological stress to the patient, the term 'obstetric violence' implicates that the obstetrician 'intended' the harm – which is unfair and vastly incorrect.

Conversely, the majority of the obstetricians choose the profession that often requires long, stressful hours, simply with a good intention of doing what is right for their patients. The interventions are often carried out where the health care provider is of the opinion that the intervention is needed to prevent harm to the mother and/ or baby. To this end, RANZCOG flags that the maternity care providers do not 'intentionally' harm their patients - women or their babies. Thus, RANZCOG is of the view that this terminology is incorrect and proposes consideration to vary the terminology.

The term 'obstetric trauma'

The term 'obstetric trauma' has a few definitions such as: 'a deeply distressing or disturbing experience'[v] - 'physical injury'[vi],-'an emotional response to a terrible event like an accident, rape or natural disaster. Immediately after the event, shock and denial are typical.'[vii]

As such, whilst RANZCOG acknowledges that even though childbirth may cause significant physical and psychological damage to women, it is quite extreme and incorrect to assume that 'intentional violence' is being perpetrated by Australian and New Zealand maternity care providers towards women and the babies in their care.

Moreover, the term explicitly directs the 'harm caused' towards obstetricians, whereas the 'trauma/ harm' felt by woman may be a result of the care provided by all maternity providers, including anaesthetic and midwifery professionals. Thus, in RANZCOG's view all the maternity care providers/ multi-disciplinary team members have a role to play in reducing birth 'trauma/harm' and using the term 'obstetric' implies that only obstetricians are able to assist in addressing the issues. Therefore, considering all the above factors, RANZCOG is of the view that the term 'obstetric trauma' is restrictive and is inaccurate and proposes consideration of variation of this terminology.

1. (b) causes and factors contributing to birth trauma including:

(i) evaluation of current practices in obstetric care

(ii) use of instruments and devices for assisted birth e.g., forceps and ventouse

(iii) the availability of, and systemic barriers to, trauma-informed care being provided during pregnancy, during birth and following birth

RANZCOG is of the view that trainees must be supervised and credentialled to protect pregnant women from harms. Furthermore, RANZCOG notes that the obstetric specialists care models have the lowest birth trauma rates as their patients may be more informed about all possible risks/interventions and as such, potentially may experience minimal 'trauma/harm', if an intervention is needed.

In addition, RANZCOG is cognisant that the women and their support persons need to be educated and provided all the relevant and appropriate information (including explanation of any interventions that may be required), in a culturally safe manner. Antenatal education which tends to focus on the normality of birth would result in lack of understanding of the need to timely intervention at times of 'obstetric emergencies' where time is of essence. Therefore, RANZCOG is of the view that the appropriate antenatal education and informed consent are pivotal considerations in reducing birth harms.

1. (c) the physical, emotional, psychological, and economic impacts of birth trauma, including both short- and long-term impacts on patients and their families and health workers

As mentioned previously, the health care providers are bound by the codes of conduct and professional and ethical considerations in maternity care. As such, the maternity care providers do not anticipate to intentionally cause harm to women or the babies that they care for. As such, any obstetric harm caused by the health care provider may potentially result in a number of short and long terms impacts for the maternity care providers. For instance, reputational damage, loss of income, significant insurance costs as well as the time and cumbersome appearances at various enquiries with health boards, hospitals as well as regulators. The health care providers are also emotionally impacted and are subjected to undue stress throughout the inquiry and beyond.

In addition, RANZCOG notes that the short- and long-term physical impacts of obstetric harms are well documented in the literature. Nevertheless, RANZCOG acknowledges that there is a dearth of information regarding psychological harms on women experiencing obstetrics harms and its impact on their families. Thus, RANZCOG highlights the need to collect mental health research data in this space.

1. (f) barriers to the provision of "continuity of care" in maternity care

RANZCOG is of the view that maternity models with stratification of risk assists in continuity of care.

Additionally, RANZCOG flags that the Australian intrapartum technology requires to be further updated. For instance, the Cardiotocography (CTG) which may overcall fetal distress, is the current technology that is in use. Hence, RANZCOG proposes consideration of better and most updated technology in maternal care, in addition to continuing education in the interpretation of CTGs such as the Fetal Surveillance Education Program.

1. (h) whether current legal and regulatory settings are sufficient to protect women from experiencing birth trauma

In RANZCOG's view, 'consent' remains the bedrock for improving women's birthing experiences. Complications with childbirth can occur quickly and suddenly. To prevent and manage these complications require immediate and decisive action. Health Care providers spend considerable time and funding for training and simulation, to ensure their staff are able to respond promptly, when needed. Thus, in RANZCOG's view, some of the vital consideration in this regard are:

- Consent in an 'emergency situation';
- Education of all possible options/risks/benefits in an emergency – (which may at times would not be feasible due to time constraints);
- Issues with consent when patients are already in pain, discomfort, emotion distress;

RANZCOG encourages shared decision making to ensure that choices on care options are made based on the best available evidence about benefits and risks, involving discussion and collaboration between the woman, her family and the clinician. In addition, RANZCOG strongly believes that maternity care providers need continuing education in ethical and legal concepts of 'consent' in maternity care. Moreover, we believe that pregnant women and their families need to be directed by the maternity care providers to reliable, accurate sources of information such as informative websites and literature on birthing experiences, where the women and their families will be able to make informed choices as to their birthing options.

Summary

RANZCOG welcomes and supports the current inquiry into Birth Trauma that is experienced by many Australian women and their families. We have provided specific feedback into the Terms of Reference sections *a, b, c, f and h.* Furthermore, RANZCOG would like to present the following recommendations for consideration of the NSW Legislative Council:

Recommendations:

- Comprehensive multidisciplinary antenatal education that discusses all aspect of births, including possible interventions that maybe required in emergencies, such as instrumental delivery.
    - Proposes due consideration to be given to Culturally and Linguistically Diverse Communities (CALD) as well as First Nations etc.
- Support for continuous maternity care from a known provider, including all models such as midwifery, GP Obstetrician or specialist obstetrician.
    - GPs care for patients for life and obstetricians often care for women over multiple pregnancies, and gynaecological issues later in life. To this end, RANZCOG considers that it is important that the patients are seen by obstetricians earlier in their pregnancy, thereby potentially undertaking first trimester care.
- Support for multidisciplinary antenatal care team – so that patients do not meet the doctor for the first time in an emergency.
- Medical item numbers to reflect the time and effort needed to council woman regarding birth options and consenting/education for possible emergency interventions, if required.
- Legislative support and protection for maternity providers that support woman who elect non-standard care pathways, after detailed and comprehensive counselling.
    - Legal protection for health care provider in the event of 'harm', including social media or physician rating sites.
    - Swift review of complaints by authorities such as the Australian Health Practitioner Regulation Agency (APHRA), to reduce psychological stress to health care providers awaiting an outcome.
    - Standard national consent documentations and guidelines for intrapartum care, especially around intrapartum emergency care.
- Support for multidisciplinary education and training for all members of a women's care team. Especially training around labour ward culture and ensuring woman-centred care.
- Government investment in research and development for intrapartum care monitoring. Aiming for improvement in the sensitivity and specificity of fetal monitoring.
- Improved antenatal care, to ensure women going into labour are as well optimised and healthy, requiring less intervention for excellent outcomes.
- Funding for early intervention and counselling for women and their families that experience an emergency, unexpected or complicated birth. Funding needs to be provided for in hospital counselling and following discharge, especially involving the multi-disciplinary team of health care providers.

- Making publicly available free patient education resources around evidence-based birth plans and expected realistic outcomes.
- Financial support for patient travel to larger or metro centres who are seeking non-standard birth plans, to able to provide financial assistance to a larger team and infrastructure, in case of an emergency.
- National standard evidence-based requirements and consent processes for Vaginal Birth After Cesarean Section (VBACs).

RANZCOG acknowledges with thanks, the contribution of for this submission.

Yours sincerely,

Associate Professor Boon Lim
Vice President

References

[i] World Health Organisation. Maternal mortality. 2023. Available at: Maternal mortality (who.int)

[ii] O'Brien Elizabeth, Rick M. Obstetric violence in historical perspective. The Lancet. Volume 399, ISSUE 10342, P2183-2185, June 11, 2022. Available at: Obstetric violence in historical perspective - PubMed (nih.gov)

[iii] The Cambridge Dictionary. Violence. 2023. Available at: https://dictionary.cambridge.org/dictionary/english/violence

[iv] The Oxford Learner's Dictionary. Violence. 2023. Available at: https://www.oxfordlearnersdictionaries.com/definition/american_english/violence

[v] Oxford Reference. Trauma. 2023. Available at: https://www.oxfordreference.com/display/10.1093/acref/9780199534067.001.0001/acref-9780199534067-e-8554

[vi] Ibid.

[vii] Medical News Today. What is Trauma Bonding. 203. Available at: https://www.medicalnewstoday.com/articles/trauma