Submission No 252

INQUIRY INTO BIRTH TRAUMA

Organisation: Australian Medical Association (NSW)

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The Australian Medical Association of New South Wales (''AMA (NSW)'') provides their submission to NSW Parliament regarding the Inquiry into Birth Trauma.

Vice President of AMA (NSW), Dr Kathryn Austin, obstetrician, and maternal fetal specialist, will represent AMA (NSW) at the associated inquiry hearing.

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NSW Parliamentary Inquiry into Birth Trauma

The Australian Medical Association of NSW (''AMA (NSW)'') welcomes the inclusion of maternal and reproductive healthcare on the Premier's key priorities for New South Wales and is grateful for the opportunity to make a submission to the Upper House inquiry into birth trauma.

AMA (NSW) is a medico-political organisation that represents more than 8,000 doctors-in-training, career medical officers, staff specialists, visiting medical officers, specialists, and general practitioners in private practice. Doctors working in maternity care are highly trained and care deeply about their patients and improving the system of care available to them.

AMA (NSW) acknowledges the experience of birth trauma experienced by women across the state. There are myriad reasons for trauma, and steps could be taken to address the genuine and often unexpected feelings of trauma reported by women in this inquiry. AMA (NSW) also acknowledges the impact of trauma not only upon the patients but upon the health care professionals working in birthing services.

Australia has among the world's lowest rates of infant/maternal mortality. This is thanks largely to a strong health system but also due to the multiple forms of intervention available to medical professions to address a multitude of birth impacts.

While achievements in mortality rates should be commended, there is work to be done to address the reported rates of trauma.

AMA (NSW) believes that significant resources are required for continuity of care, collaborative care with a multidisciplinary approach, staffing levels, retention of staff and a review of the rates and item numbers in the Medical Benefits Scheme.

Based on extensive research and the experience of members, AMA (NSW) strongly advocates for substantial funding for birth education, primarily before but also during and after the birthing process.

Currently there are significant health literacy limitations within the pregnancy space. AMA (NSW) feels that there are many factors which cause large numbers of expectant parents to enter into birth with unrealistic expectations of the control they will have over the experience. Doctors are forced to make split second decisions to save mother, baby, or both. Often parents do not understand why decisions are taken, because they have not been fully educated about the potential need for intervention before birth.

Birth by nature is painful and unpredictable, but that does not mean it has to result in trauma, especially where women are well informed and have trust in their care providers.

One of the most influential reviews into maternity services internationally is the Ockenden 'Independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust'. The final report of the Ockenden review was published in March of 2022, highlighting essential actions for maternity services.

AMA (NSW) supports the findings of the Ockenden review; that there is no such thing as a "normal birth" and instead the focus should be on a healthy and supported birth, with whatever supports are required for a safe mother and baby.

The role of medical practitioners:

Medical practitioners play a pivotal role in maintaining health and safety from preconception to postnatal care. Obstetricians provide private and public specialist services across all sectors of health and are able to provide care for all pregnancies and deliveries, from low to high risk. General practitioners also provide care to those considering having children, throughout antenatal and shared care programs as well as non-obstetric related health care during pregnancy. AMA (NSW) also acknowledges the significant contribution of other healthcare workers including midwives, nurses, physiotherapists, psychiatrists, and sonographers, noting best practice care is multidisciplinary and holistic.

Informed Choice:

Informed choice should be expected in maternity care, meaning women are provided with all relevant information to their individual circumstance that may impact on their pregnancy care and birth enabling an informed health decision (RANZCOG, 2017). Women-centred care focuses on the unique needs, expectations, and aspirations of the individual, acknowledging that both the mother and unborn baby exist within specific social and emotional environments which should be incorporated in the provision of care (DHAC, 2020).

Currently our health system has room to improve in the provision of pregnancy and birth care to ensure expectant parents are adequately prepared regarding the associated risks with birth.

AMA (NSW) believes an acknowledgement should be made that no birth comes without risks. Birth impacts occur in almost every delivery, with or without intervention. Messaging from social and mainstream media often delivers a false perception that a woman will have a high percentage chance of following a 'birth plan' and achieving a 'normal' or 'perfect' birth. Birth can be daunting, as there is minimal control an individual has within this period, which can be confronting and traumatic, particularly when it is unexpected. The incidence and scope of potential injury is similarly not largely understood, exacerbating psychological impacts after physical damage is sustained.

AMA (NSW) would like to emphasise that whilst health practitioners endeavour to accommodate an expectant parent's birth plan, sometimes these are not medically safe. Following a suggested plan could compromise safety or increase risk to an unacceptable level. Additionally, unexpected complications may arise, or a person's decisions may change through pregnancy, which may lead to changes in the model of care chosen.

AMA (NSW) respects a family's wish to follow a prescriptive birth plan, but it is incumbent upon health workers to put the safety of the mother and child first.

Informed choice has measurable outcomes. It minimises the process of recovery, reduces the chance of injury or dysfunction, and minimises the feeling of isolation (Dawes et al., 2022).

Recommendations:

AMA (NSW) supports the notion that standards surrounding consumer antenatal education content and curriculum should be developed, acknowledging the role and importance of informed choice (Dawes et al., 2022).

AMA (NSW) calls for a funding model to allow medical practitioners time for what can be difficult and ongoing conversations with parents about the realities of birth, the prevalence of serious and lifelong birth impacts, and to address unrealistic expectations of control. Providing patients with adequate time and information so that they are appropriately prepared for what can quickly turn into a high-risk situation in which they have no control is paramount and requires resources to underpin it.

Further funding is necessary to ensure that adequate information is conveyed equally including to young parents, people from culturally and linguistically diverse backgrounds, First Nations people and those in regional, rural, and remote New South Wales.

Intervention:

Health professionals, particularly in maternal health, are focused on achieving the best possible outcome for both the mother and the child. Birthing teams are proud of their ability to pivot in moments and make split second life-saving decisions based on ever changing circumstances. This could mean that a desired plan cannot be followed, that extra equipment is required, or more dramatic medical interventions are necessary.

Research from the Australian Institute of Health and Wellbeing reports that in NSW in 2021, 51.0% of women who gave birth had a non-instrumental vaginal birth, 4.3% a vaginal birth assisted by forceps, 7.1% vaginal birth assisted by vacuum, and 37.6% had a caesarean section birth (AIHW, 2023). The proportion of women who delivered vaginally with no instruments has decreased, whilst the proportion of caesarean section births has increased, with the use of assisted births via vacuum or forceps remaining stable (AIHW, 2023). It is important to note that these numbers are different for first time births when compared to subsequent. For example, there is approximately a 20% rate of requiring an instrumental birth for a first birth as compared to less than 5% for a second or greater birth.

It is important to note and represent that not all births involving instruments or medical intervention result in birth trauma. Instrumental births are essential tools in obstetrics. These can include forceps deliveries, vacuum assistance, episiotomies and when necessary, emergency caesareans. An emergency caesarean requires time to arrange and facilitate a theatre team, and without the advances in medical instruments and devices for assisted births, outcomes would not be as positive.

Recommendations:

That prospective parents are given a more comprehensive understanding of the potential need for intervention. Information should include detailed discussion of each form of intervention including forceps, vacuum, and emergency caesareans.

This again requires a significant investment in resourcing to allow doctors time to fully explain the pros/cons/potential necessity of all forms of intervention. This again, can be a

challenging task, particularly when engaging with patients who hold firm views against all forms of medical intervention, despite the risk to their life and the life of their child.

Mortality rates:

With modern medical intervention in Australia maternal death rates sit at around 0.00055% (down from 0.0109% in 1950) with the infant mortality rate at 0.002732% (AIHW, 2022). Australia's maternal mortality ratio has been decreasing over the past two decades, in comparison with other high-income countries such as the United States (Morong et al., 2017).

The difference in maternal mortality between the two high income western countries is, the publicly funded universal health care system in Australia and the point at which women begin receiving antenatal care (Morong et al., 2017). In NSW, 80.9% of women who gave birth in 2021 had their first antenatal care visit at less than 14 weeks gestation (AIHW, 2023). Of the women who gave birth in NSW, 95.1% had five or more antenatal care visits in 2021 (AIHW, 2023).

Antenatal care is associated with positive maternal and child health outcomes, with fewer interventions in late pregnancy and positive child health outcomes (AIHW, 2023). Often a general practitioner will be the first health professional one will seek when arranging antenatal care (Healthdirect, 2022). An initial consultation with a general practitioner will ensure all women have information regarding access to the obstetric model of care that is suitable for their needs.

Recommendations:

That all women are encouraged to seek antenatal care, from the earliest stage of pregnancy. That funding is made available to ensure all women are able to receive regular antenatal care throughout their pregnancy and that workforce and care provision are appropriately resourced to provide relevant services.

That extra funding is put in place to ensure equal access to antenatal care across regional, rural, and remote parts of the state.

Collaborative care:

An integrated and multidisciplinary approach to maternity care, provides the greatest benefit to mother and baby and the greatest safeguards against birth trauma.

From research, we know that a collaborative, multidisciplinary approach to care enables early recognition of risk factors that may cause pregnancy or birth complications.

For too long, midwives and maternity doctors have been pitted against each other, this causes disruptions within the workforce as well as confusion among the public.

The most successful outcomes are achieved when we move away from any single model of care towards a doctor-led *team-based* model of care, with each profession supporting and respecting the opinion and approach of others.

A study completed by the Australasian Birth Trauma Association, analysed the 73% of participants who identified seeking treatment as a result of complications from birth. 50% of these sought treatment from a women's health physiotherapist (Dawes et al., 2022). Half accessed treatment privately, 29% through public hospitals, and 7.9% using a care plan (Dawes et al., 2022). With half of those who received treatment accessing it privately, this highlights that the costs of birth injuries are a heavy burden.

A very successful example of collaboration is that of medical professionals and physiotherapists. Physiotherapy is the main form of treatment for women experiencing physical symptoms postpartum (Dawes et al., 2022). Supporting a collaborative model of care *from the beginning of pregnancy*, could provide significant safeguards to prevent birth impacts including trauma (Dawes et al., 2022).

However, measures need to be put in place to ensure that information provided by non-medical advisers does not contradict evidence-based medical care. AMA (NSW) obstetricians have often heard from patients who have been warned not to let a doctor use forceps because they may cause damage or perform an emergency caesarean because it is "unnatural". This could lead to both danger and confusion if an instrument like forceps, or a procedure like an emergency caesarean is required to save a baby's life.

Recommendations:

An exploration of methods which integrate and support multiple health teams leading to the creation of a greater model of collaboration of care.

That evidence-based medical care provides the basis for care plans with the support of allied health services to the extent that is safe and practicable.

That prospective parents are made aware of the benefits of collaborative care.

That prospective parents receive education in relation to the difference between medical and non-medical advice.

Sustainable well-resourced funding models are established to support the workforce and resources for care provision across all models of care.

Mental Health Support:

Diagnosed and undiagnosed mental health issues can have enormous bearing on a woman's experience of birth.

Similarly, unexpected outcomes from a birth experience can cause mental anguish including PTSD.

Adverse childhood experiences, including various forms of child maltreatment, together with mental health history (e.g., post-traumatic stress disorder, depression, dissociation) contribute to complex pregnancy outcomes (e.g., preterm birth, low birth weight), poor postpartum mental health, and impaired or delayed bonding (Sperlich et al., 2017).

Trauma-informed care can be tailored to address labour-related needs using themes such as; need for control, difficulties with disclosure, struggling with dissociation, hoping for healing, coping with remembering, and the discomfort that comes with vulnerability.

Interprofessional approaches to trauma-informed care from mental health and other health care settings could also be successful in maternity care.

Few trauma-informed models of obstetric care and trauma-specific interventions have been developed and tested for pregnant and postpartum women.

Recommendations:

AMA (NSW) believes there must be robust mechanisms in place to identify psychological distress, and clear pathways to access emotional support and specialist support where needed.

Access needs to be timely and should be delivered by practitioners who have experience in the maternity care sector.

Care and consideration of the mental health and emotional wellbeing of mothers must be given greater weight from the earliest stages of antenatal care.

Further research and collaboration are required to explore evidence-based models to address issues associated with pregnant patients with mental ill health, particularly previous trauma.

Funding must be put in place to create better models to support patients with mental ill health from conception through to postnatal care.

Emotional wellbeing supports must be developed and researched to provide holistic care to women during pregnancy and postpartum.

Continuity of care:

Continuity of care refers to a model in which a patient sees the same practitioner or team throughout their pregnancy and birth.

AMA (NSW) acknowledges that continuity of care within maternity care, ideally from the earliest stages of pregnancy, enables individuals to build a trusting relationship and increase confidence within their treating team. Continuity of care creates more opportunities for patients to discuss options and better understand their benefits and risks, as a trusting and safe relationship has been fostered (Sandall et al., 2016). This form of care has been associated with lower rates of preterm birth, infant mortality, and the need for an episiotomy (Sandall et al., 2016).

Continuity of care ensures that the patient's care team is unified, and all healthcare management is directed towards a shared medical goal. Within NSW in 2022, 34.4% of maternity care models had no continuity of care, 25.8% had continuity of care during the whole maternity period, 19.6% had continuity of care in the antenatal and postpartum periods and 18.2% had continuity of care in only the antenatal period (AIHW, 2022).

Out of the 11 major maternal care model categories, 3 provide continuity of care for the duration of the maternity period. These models are; midwifery group practice caseload care, private midwifery care, and private obstetrician (specialist) care (AIHW, 2022). It is important to note that in any non-medical model of care if intervention is required in labour and delivery this will be undertaken by a medical team.

The most common model of maternity care category in Australia in 2022 was public hospital maternity care, with 52.6% of NSW expectant mothers choosing this model (AIHW, 2022). Importantly, this model of care operates in variations and can appear different depending on the risk nature of the pregnancy. Overall, this model is based on a multidisciplinary approach, incorporating midwives, doctors, and public specialist obstetricians within the public hospital system (AIHW, 2022). An integrated and multidisciplinary model of care enables the provision of seamless, effective, and efficient care that meets the needs of the whole person (ACI, 2023). Despite public hospital maternity care being the most common model category used in NSW, the level of continuity of care within this model is low (AIHW, 2022)

While continuity of care is the gold standard, no public model can guarantee continuity of care. In the case of an instrumental birth or the requirement for a caesarean section these cannot be performed by midwives, and obstetricians in the public system are on call for public patients.

Continuity of care is supported through workforce expansion and staffing ratios, as highlighted in the Ockenden Review. The report found that until safe staffing levels are achieved, barriers to continuity of care will remain (Ockenden, 2022).

While recognising the issues raised in this inquiry, there is a significant risk that the process of conducting the inquiry could increase the distress of those working in the health system or cause doctors to reduce their commitment to the public hospital system. This would be a tragic unintended consequence and one which should be avoided.

Recommendations:

AMA (NSW) is calling for greater support for health workers. The provision of the highest quality healthcare relies on the skills of those working within the system, the resourcing available to the system and the sense of satisfaction. Workforce planning, reducing attrition of maternity staff and providing the required funding for a sustainable and safe maternity workforce is essential (Ockeden, 2022). Safe staffing levels across the multidisciplinary teams that encompass maternity services must be addressed promptly as this is a key barrier preventing continuity of care. This must include urgent measures to address staff retention.

Support too must be provided for the private system, in which 40% of obstetric care is delivered. Women choosing to give birth in the private system should have the same options to use aspects of multidisciplinary care and continue to use the private system to do so.

AMA (NSW) notes that rural and remote maternity services have unique and complex challenges which require personalised solutions. The challenges of staff shortages,

workforce recruitment, upskilling and training within rural and remote areas must be a priority reform target actioned by the Government.

The COVID-19 crisis had a significant impact on the health workforce. Maternity services continued throughout COVID, and doctors, nurses, midwives, and allied health providers rose to the challenge of providing safe care to mothers and babies in challenging circumstances. This has left many staff burned out and many units under resourced. The health and wellbeing of our health workforce needs to be acknowledged and made a priority.

Medical Benefits Schedule:

As outlined on the Medicare Benefits Schedule (MBS), for routine antenatal consultation with an obstetric specialist, MBS item 16500, the scheduled fee provided is $51.65. Within the past financial year, 371,318 MBS 16500 item codes have been processed within NSW, the highest amount compared to any other State or Territory (Services Australia, 2023). For an initial antenatal consultation with a midwife, lasting at least 40 minutes, MBS item 82100, the scheduled fee provided by medicare is $58.50, with 1,775 codes processed in the past financial year in NSW (Services Australia, 2023). A postnatal consultation with either a midwife, obstetrician or general practitioner, MBS item 16408, has a scheduled fee of $58.50, with 484 consults being processed in the past financial year (Services Australia, 2023).

Recommendation:

AMA (NSW) believes MBS item codes available for maternity and obstetric care rarely cover the costs of providing services. Addressing the interplay of medical and psychological components of pregnancy care must be factored into all MBS funding arrangements given the time-consuming nature of expertly delivered women-centred care. New and more appropriately remunerated MBS item codes will greatly improve access to maternity and obstetric healthcare for women across NSW.

Conclusion:

AMA (NSW) is calling on the State Government to place a greater priority on funding of maternity healthcare in both the public and private sector. Women's health care is essential as it is the foundation supporting our growing population, but it needs to be done right.

Addressing the interplay of medical and psychological components of pregnancy care must be factored into funding arrangements given the time-consuming nature of expertly delivered women-centred care.

Both private and public obstetric care services require additional focus and resources from the State Government. The focus areas should include; workforce expansion, workforce support, progress towards increasing multidisciplinary maternity workforce requirements, improving training capacity, increasing the Medicare Benefits Schedule for maternity and obstetric services, greater mental health support and a significant injection of funding to increase education regarding the prevalence and range of potential birth impacts, the frequency of and necessity for medical intervention and the rights of prospective parents throughout the process.

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