Submission No 858

INQUIRY INTO BIRTH TRAUMA

Organisation: National Association of Specialist Obstetricians and Gynaecologists (NASOG)

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NASOG
National Association of Specialist Obstetricians and Gynaecologists

Select Committee on Birth Trauma
Parliament of NSW
Macquarie St
SYDNEY NSW 2000

14 August 2023

The National Association of Specialist Obstetricians and Gynaecologists (NASOG) appreciates the opportunity to provide a submission to the Parliament of NSW Standing Committee on Birth Trauma.

NASOG is a not-for-profit professional association representing specialist obstetricians and gynaecologists across Australia. The association is overseen by a National Council of practising specialists at all stages of practice and actively lobbies Government and other stakeholders on maintaining access and affordability for O&G services, for the benefit of patients and providers.

Australia is recognised as one of the safest countries in the world to give birth, or to be born. NASOG strongly supports a collaborative, proactive model of obstetric and midwifery care for all women giving birth in Australia. The overall safety and success of this model of care is confirmed by research from Australia and around the world.

However, increasingly, Australian women are suffering birth trauma and this has an impact on everyone involved in the birth of a child; the mother, infant, their extended family and the entire healthcare team.

In addition to our own submission to the Inquiry, I would like to take this opportunity to endose the submissions from the Australian Medical Association (NSW), the Australasian Birth Trauma Assocation and A/Prof Gino Pecoraro.

The NASOG team looks forward to an opportunity to discuss our submission with the Standing Committee.

Yours sincerely,

Claire Leonard
CEO

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1. Obstetricians in NSW

There are a total of 583 General Obstetricians & Gynaecologists (O&G) practising in NSW https://www.medicalboard.gov.au/News/Statistics.aspx). This group practice across private and public settings.

Of this group, NASOG membership shows that approximately 52% are female. We understand that In the current O&G trainee cohort, over 75% are female.

Full qualification as a specialist O&G can take anything from 14 to 20 years. This includes an undergraduate degree, a post-graduate medical degree and specialist training through the Royal Australian & New Zealand College of Obstetricians and Gynaecologists.

Most specialist O&Gs have had their own families and wide life experience before they finally qualify.

Specialist O&G's pay up to $100,000 per annum for professional indemnity insurance. This premium reflects the real level of risk involved in helping mothers deliver healthy children. Even pregnancies assessed as straightforward with a likely low risk birth can quickly change to a high risk emergency requiring medical assistance and intervention to save the lives of both mother and child. Only Obstetricians have the skills to manage complex or high-risk pregnancies and births and can perform interventions and caesareans when necessary.

In 2021, an international study, the *Medscape National Physician Burnout & Suicide Report* showed that 19 per cent of obstetricians report having suicidal thoughts — amongst the highest of all medical specialties.

For all of these reasons, the decision to specialise as an O&G is not one made lightly by graduates from medical school. It is a genuine vocation, involving years of commitment and personal sacrifice that includes time away from their own families in order to be there for others.

With their vocation firmly placed in bringing healthy new life into the world, O&G is not a specialist group that sets out to harm or humiliate patients.

2. Continuity of Maternity Care

Continuity of care is a measure of the one-to-one care provided by the same named caregiver through the whole duration of the maternity period, meaning that designated carer provides or coordinates the majority of care for the antenatal, intrapartum and postnatal periods.

The Australian Institute of Health and Welfare *Mothers and Babies Report 2022* found that over one-third (37%) of models have no continuity of carer in any stage of the maternity period, which means there is no named carer assigned to each woman and care is given by different providers. Around one-third of models have continuity of carer for some part of the maternity period, for example the antenatal period only (17%), or the antenatal and postnatal periods (13%). Just under one-third of models (31%) have continuity of carer (https://www.aihw.gov.au/reports/mothers-babies/maternity-models-of-care/contents/what-do-maternity-models-of-care-look-like/continuity-of-carer)

Continuity of care is essential for positive maternity outcomes. Consistent contact with a lead caregiver, whether a obstetrician or midwife, builds trust for the patient and their family. The model provides many opportunities to discuss expectations around the birth process, allows better monitoring of existing or developing health issues and ensures that there is clear understanding between expectant mothers and team members around what may happen if the birth does not proceed as anticipated.

With a majority of patients not engaged in a model that allows for continuity of care there is no opportunity to build rapport and trust with a known caregiver. When they are seeing a different person at every visit, patients may not be comfortable asking questions or seeking clarification around things that could go wrong.

This lack of opportunity to ask questions and clarify problems can lead to unrealistic expectations, resulting in shock and trauma if/when something goes wrong or doesn't exactly follow a prescriptive birth plan.

Additionally, where a woman is under the care of a Midwife Group Practice, she will have no interaction with an obstetrician at any time during the antenatal period. Therefore, when a doctor is needed in an emergency situation, the woman is meeting them for the first time in very fraught circumstances.

NASOG recommends that considerable funding be made available to restructure the model of care in NSW Birthing units to re-establish doctor-led teams that include all the health professionals who form part of the care of the mother and baby. Expectant parents are allocated to a team and stay with the same group throughout their entire pregnancy, birth and post-natal journey.

3. Use of the term 'Obstetric Violence'

In Australia, the term 'Obstetric Violence' is often taken to be directed at an actual Obstetrician involved in a traumatic birth. Therefore, using this term has the sense of effectively ignoring the involvement of other members of the care team and placing the blame for any birth related trauma firmly with the medical staff.

The World Health Organization (WHO) defines Obstetric Violence as the:

> *Outright physical abuse, profound humiliation and verbal abuse, coercive or unconsented medical procedures (including sterilization), lack of confidentiality, failure to get fully informed consent, refusal to give pain medication, gross violations of privacy, refusal of admission to health facilities, neglecting women during childbirth to suffer life-threatening, avoidable complications, and detention of women and their newborns in facilities after childbirth due to an inability to pay.*

In the context of International Human Rights law, the term appears to be used most in relation to state sanctioned actions around childbirth and control of a women's reproductive abilities. (https://www.humanrightspulse.com/mastercontentblog/obstetric-violence-in-international-human-rights-law)

NASOG believes that the term 'Obstetric Violence' should be used with caution in discussions around Birth Trauma.

Greenfield et al. (*What is traumatic birth? A concept analysis and literature review, Br. J. Midwifery, 2016*) define traumatic birth as:

> *The emergence of a baby from its mother in a way that involves events or care that cause deep distress or psychological disturbance, which may or may not involve physical injury, but resulting in psychological distress of an enduring nature.*

Other literature reviewed by Watson et al in their 2020 paper, *Women's experiences of birth trauma: A scoping review* (https://www.sciencedirect.com/science/article/abs/pii/S1871519220303346?via%3Dihub#preview-section-references) observes that whether or not a woman has had a traumatic birth experience lies with the woman alone and ultimately can only be defined by her.

With over 45.5% of Australian women reporting experiencing traumatic birth events, NASOG believes that management of communication and building trust with the full care team from early pregnancy are key.

4. The Role of Informed Choice

There is no doubt that women should be the key decision makers around their care during pregnancy and childbirth. It can be observed through the increasing rate of birth trauma that the sense of control and involvement in the decisions made during this time can have a long-lasting impact on women's physical and mental health and wellbeing.

Caregivers have a responsibility to provide patients with all the information they need to make appropriate decisions about their care. In relation to childbirth, this can sometimes be confronting. Every birth is unique and unpredictable and even when a pregnancy has been completely uneventful, things can take a turn once labour starts and may no longer neatly follow an articulated birth plan.

Making an informed choice should mean that the patient has received all the information about benefits and risks around a range of circumstances that will require their authorisation. This includes the possible need to use instruments or progress to caesarean section.

To manage expectations there needs to be improved patient education and clearer communication. Patients need a realistic understanding of what could go wrong and have the opportunity to build their preferences into their birth plan, with agreement about when clinical intervention will occur.

NASOG is particularly concerned that expectant mothers are increasingly approaching childbirth with unrealistic expectations around their experience and outcome articulated in their birth plans. Information is increasingly being sourced from social media and online groups whose images and commentary do not take into account individual circumstances such as age, health status, access to care etc.

The language around natural birth particularly, adds to the apparent lack of awareness that in the case of an emergency, doctors will need to make quick decisions about the best way to save mother and/or baby.

In those circumstances, it will not always be possible to follow the steps in a birth plan, if nothing is articulated about how to deal with emergency situations, the healthcare team must use their best judgement (based on experience and education) to preserve life and health.

The most effective model to achieve good informed choice is with continuity of care. When rapport is built up with a care team the full range of decisions that may need to be made can be discussed and built into birth plans.

NASOG recommends that funding is made available to develop a full range of education material for parents. Additional funding should also be put in place to train selected care team members in how to deliver the education thoroughly and appropriately to diverse audiences.

5. Significant Contributing Issue: Declining Private Obstetric Practice

NASOG believes that the decline in the use and availability of Private Obstetric Practice has implications for increasing levels of birth trauma across Australia more broadly.

The Australian healthcare system relies on a steady balance of public and private services. Without a robust private sector to provide care for women and careers for young specialists, greater and greater pressure will be applied to already overstretched public hospital maternity units. Full training and careers in obstetrics will contract and supply of care in outer metro and regional areas will almost cease altogether.

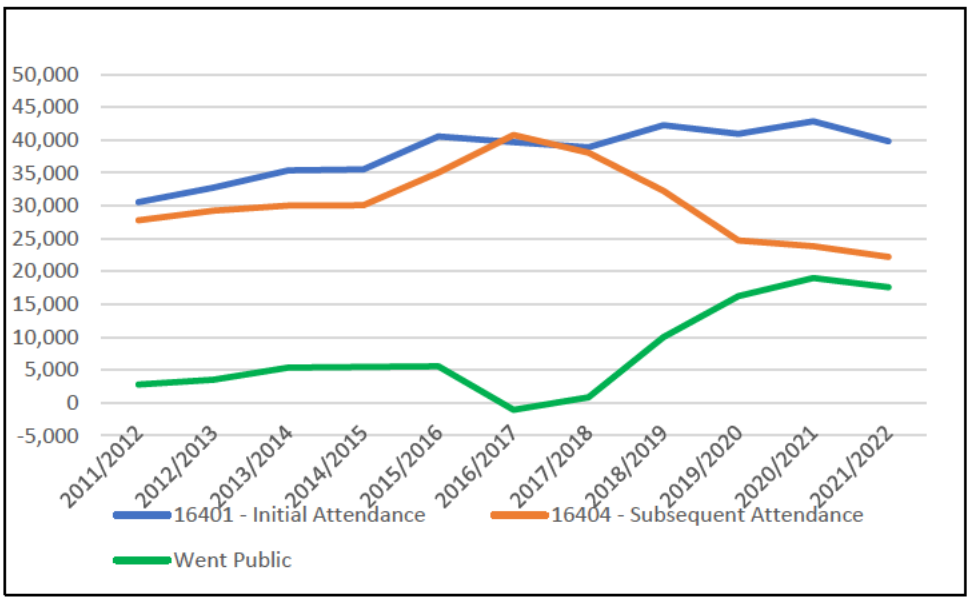

TABLE 1: Trend in Patients Using Private Obstetric Care in NSW 2011 - 2022

Table 1 shows that. like the rest of Australia, the number of expectant mother in private obstetric care in NSW has been steadily dropping since 2017. Prior to that year, on average only 13% of women who had an initial consultation with a private obstetrician did not pursue private care.

By 2021/22 this percentage had increased to 44%, meaning that an assumed 17,607 women did not pursue private care and were instead cared for by public hospitals1.

Obviously, this annual increase of maternity patients is placing greater pressure on the public system. At this rate, the State government will need to incur significant additional capital costs to provide the necessary infrastructure to meet the increased demand for public obstetric care. This will include restructuring healthcare teams and ensuring there are enough staff and wards to accommodate the demand.

But there is clearly an ongoing appetite for private obstetric services so the cause for the reduction in use (affordability) needs to be addressed in order to relieve the pressure on the public system.

NASOG advocates that a review of MBS rebates will assist with managing out of pocket costs and encourage patient uptake of private providers. Out of pocket costs are usually levied on the pregnancy planning and management fee (MBS item 16590).

[1] Calculated from MBS data obtained from medicarestatistics.human.services.gov.au. The number of claims for item 16404 (subsequent attendance) was subtracted from the number of claims for item 16401 (initial attendance). This number is indicative only and does not account for loss of pregnancy, patients moving interstate or overseas or other variables that would prevent a birth in NSW.

Under the Defence Joint Health Command contract with Bupa for Australian Defence Force health services, a fee of $3,000 was negotiated for item 165902.

As this precedent exists, NASOG proposes that the MBS fee for item 16590 is increased from $384.40 to $3,530 – providing a patient rebate of $3,000 (85% of the fee for an out of hospital service).

Patients would only receive this rebate when obstetricians accepted the MBS rebate as full payment for item 16500 (i.e. bulk billed) and the patient's health insurer's schedule fee for items 16519 and 16522.

Raising the MBS fee for item 16590 to $3,530, in order to "guarantee" out of pocket costs for private obstetric care will increase Commonwealth MBS expenditure.

However, NASOG believes that without this Federal investment, the cost to the State government for the increased demand on public hospital obstetric care could be a far greater amount.

We therefore believe that despite the significant fee increase for MBS item 16590, the cost to the Australian Health System will be less overall and there will be a meaningful increase in the use of private obstetric services.

An additional issue with access to private obstetrics is that womens' reproductive health is currently only covered in top level Gold health insurance policies. The most expensive option with waiting periods in place before cover is granted.

NASOG has been lobbying the Federal Government for several years on these issues. We would be pleased to provide a full briefing to the NSW State Government.

6. In Closing

NASOG believes that Continuity of Care models and full Informed Choice are the key elements in the management of Birth Trauma.

It is known that Public Hospital birthing units do not provide Continuity of Care for pregnant women. The opportunity for informed choice through education and discussion with known and trusted caregivers is therefore diminished.

Without appropriate communication and consultation around all the issues impacting childbirth, Birth Trauma rates are likely to continue to climb.

NASOG requests involvement in the development and implementation of a range of communication and education materials to increase the knowledge of the birth process and experience for expectant parents.

NASOG calls on the NSW State Government to prioritise funding for maternity care across public and private sectors. With key focus on the healthcare workforce structure and expansion, action on MBS funding, and a significant investment in the development of accurate and appropriate education materials about pregnancy and birth for a range of diverse audiences.

[2] Bupa Health Services *Medical and Surgical Specialist Schedule of Fees – ADF Services*. Price effective from 1 November 2020.