**Submission No 718**

# INQUIRY INTO BIRTH TRAUMA

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**Date Received:** 14 August 2023

The Hon Emma Hurst MLC

Chair, Select Committee on Birth Trauma

NSW Parliament

Dear Ms Hurst and Committee members.

I read with sadness and frustration the recent media publications surrounding birth trauma at various sites throughout NSW health and feel compelled to contribute to the inquiry.

As a background, I have worked as a GP Obstetrician in regional NSW for 12 years. For much of that time the majority of my workload has been pregnancy-related care. On rough estimate, I delivered about 1000 babies either as the woman's primary carer, while working on the hospital ward or assisting colleagues. However it is worth stating that I feel my largest and most valuable contribution to maternity care was as the woman's primary carer throughout their pregnancy, birth and beyond. In most part, as per terms of reference point 1.(f), it is this 'continuous care' aspect that I wish to address with this submission.

Birth trauma – both physical and mental – is bound to occur despite the best efforts of passionate & well-trained medical and midwifery teams. It is my strong belief that many of the instances would be dealt with much better (or not necessarily considered 'trauma' at all) if women were more frequently afforded the opportunity of genuine continuity of care.

Moreover I suspect that the reported incidence of birth trauma episodes would be lessened, not because fewer instances of physical 'damage' actually occurs but rather those instances fail to reach the definition of 'birth trauma'.

This is not a sneaky or underhanded way to alter the statistics. Women who are well supported before and after traumatic events through;

Ready access to healthcare (both physical and mental)

A trusted healthcare provider

A set of reasonable expectations as to the likelihood of certain 'traumatic' events occurring (established through education, the aforementioned trusted relationship & the power of informed decision-making )

are less likely to feel that the events they've endured are traumatic at all or , at worst, will recover with less interventions and over a shorter period of time.

I've taken the opportunity to read some of the submissions already made and it is no surprise to me that some repeated themes borne out by the contributors are;

not feeling heard

feeling disempowered

a misunderstanding of the nature & necessity of some birth-related interventions (reflective of a self-sabotaging healthcare system that is ill-equiped to provide the education needed to thwart such misunderstandings)

It is hardly a surprise then that a recently published article by Keedle et. al surrounding the controversial term 'obstetric violence' framed patient feelings in the subcategories of dehumanised, violated & powerless.

It was also of little surprise to me that a large majority of the submissions detailed interactions with a healthcare professional (HCP) not previously known to the woman or her partner.

Of the 100's & 100's of babies I delivered I had my share of complications. Every practitioner does. Patients & HCPs are human. Mistakes happen, misunderstandings and misinterpretations occur and what's right for one patient can be catastrophic for another. To believe that individuals, treated within a system that often derides individualised care, will have the best possible outcomes because they are managed according to non-individualised, risk-averse guidelines is a totally unrealistic expectation.

I feel very fortunate to have had such profound and valuable relationships with many of the patients that sought my care that when complications did occur , they trusted me enough to help them understand the reasons they occurred & the way forward that would result in the best possible outcomes.

Hence I believe we should embrace the imperfection and uniqueness of the patients seeking our care. In doing so we are not only more likely to reduce the incidence of complications but are also more able to predict, account for & manage the complications that inevitably, will occur.

The HCPs best placed to deliver this type of care are those that are allowed to practice continuous care. The specific model (e.g GPO or MGP) isn't necessarily important. What is important is that the various medico-political & bureaucratic obstructions that currently prohibit true care-continuity are dismantled.

Regardless of a HCPs individual role in the system (including medical administrators) they must be encouraged to promote unity, collaboration and consultation and avoid the temptation to design contracts around ever-narrowing scope of practice guidelines that attempt to account for every possible clinical scenario at the expense of care continuity and service delivery. This is just the type of medicine we should avoid practising in the pursuit of quality and sustainable maternity services, particularly in regional & rural centres.

In summary then, it should not be the primary goal of this inquiry to reduce the incidence of birth trauma episodes per sè. Rather, it should make recommendations that improve & facilitate longitudinal, continuous & individualised care that in turn leads to birth trauma becoming not just less frequent but more importantly, better understood & managed by all concerned.