Submission No 972

INQUIRY INTO BIRTH TRAUMA

Name: Dr Erin Nesbitt-Hawes

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Submission to NSW Inquiry into Birth Trauma

My name is Dr Erin Nesbitt-Hawes and I am an Obstetrician Gynaecologist. I have the privilege to care for women who are pregnant, both throughout the pregnancy and their birth and I love my job. Currently, I practise obstetrics in the private sector only, but I have worked for many years in the public sector as well (previously in obstetrics and now only in gynaecology as the Director of Gynaecology at the).

The language around birth trauma is complex and can have a number of meanings. Birth may be traumatic in a psychological sense for the woman or her partner and this can lead to ongoing issues such as postnatal depression, anxiety or PTSD. I am sure you will see many submissions that deal with this aspect. Birth can also be traumatic physically, with pelvic floor injury, sequelae of bladder and bowel issues as well as prolapse and this can lead to long term concerns for the physical function and mental health of women. Finally, something that is rarely discussed is the trauma experienced by the clinicians, both doctors and midwives, of having adverse outcomes in our patients. Some of which may be preventable, or not preventable. This can lead to mental health burdens for health care workers themselves.

Pregnancy and birth are understandably such intimate and personal events for a couple and particularly for the pregnant woman. It is a time when external influences can have a major impact on what women believe is an ideal pregnancy and birth experience. There is a lot of information that portrays the ideal experience to be that of minimal intervention and as natural as possible. Of course, in the ideal world that would be the case for many women and we are very supportive of women who embark upon the labour with these preferences in mind. What is missing though, is the other side of the story and education around what can happen if things do not go to plan.

For a woman having her first baby, there is a high chance that she will have a complicated birth (43-57%)[1]. This could mean assistance by an instrumental delivery, emergency caesarean birth, anal sphincter injury, postpartum haemorrhage or low APGAR scores for the baby. Unfortunately, women are often not routinely given the statistics for these outcomes during birth education and antenatal care. They are set up for failure by birth educators when they are told that everything should be natural and low intervention without touching on what may happen for around half of women having their first child. I would suggest that a better model of education for women is one where they are empowered with all of the information. This should include birth statistics and possible sequelae. In our private practice, we value information provision highly in our antenatal care pathway. This includes providing women routinely with information about the possibility of intervention if needed either for maternal or fetal indications. Women are able to digest this information and ask questions in a safe space when they are not in labour so that when consent for an intervention is required in the labour process, they are already aware and it is not a surprise or shock.

A continuity of care model (either group midwifery or private obstetric care) allows for education for women over multiple time points during an evolving relationship with a trusted professional. This can better enable that professional to identify risk factors for mental health concerns antenatally or postnatally. A debrief of the delivery process can happen with a known healthcare provider to that woman and her partner. Perinatal psychological support can be offered early if needed and women can get the mental health care that they need at the time when they need it most. The major flaws in this process are access to a continuity of care model (with midwifery staffing shortages) as well as

access to perinatal mental health services, particularly for women in the public health care system. Women are often relying on private psychological care with few available providers.

As mentioned above, the chance of a woman having physical trauma (eg. Obstetric anal sphincter injury or damage to pelvic floor musculature) and then ongoing concerns such as incontinence or prolapse is another aspect of birth trauma. As obstetric medical professionals, we are at times conflicted by our role which is to protect two patients under our care at the same time, the mother and the baby. This can mean that at times we need to perform an intervention that may risk longer term harm to the mother in order to protect the baby by expediting delivery. This can be the case when an emergency forceps delivery is performed. In addition, policies such as the previous "Towards normal birth" policy influenced the way doctors performed obstetrics in order to meet targets in reduction of caesarean deliveries. At times, this could mean that a vaginal birth was performed in situations where there was a high chance of injury to the woman such as a high forceps delivery. Previously also, the autonomy of women to birth via caesarean delivery on request was denied due to these policies. This is changing, although I suspect can still be a restricted option for women in some public units. Again, I feel that the solution to this aspect of the problem relates in part to education as well as a personalised level of care for each individual. If women are aware that a forceps delivery may be required in an emergency situation and have had a chance to discuss the possible outcomes prior to the labour, they will be able to better give consent at the time if this is needed. If the outcomes are unacceptable to that woman, a discussion around the option to birth via caesarean delivery (and the possible pros and cons including risks) can be had.

In addition, I do believe strongly in the role of women's health physiotherapy for women who are pregnant. Women should have an assessment of the pelvic floor prior to birth (which is most at risk of injury during childbirth), they should have education on birth outcomes for the pelvic floor, they can be pro-active in learning and performing measures to help prepare their bodies for the birth and they should have a physiotherapist to access after the birth if there has been an injury sustained. This is routine in our private practice but is not something that is routinely accessible to women in the public sector.

One of the other issues relating to birth trauma comes down to the culture in obstetric care and the division that can occur between the carers of pregnant women. This is not universal and there are many more situations where midwives, doulas and obstetricians come together in the interests of the woman and her baby. Indeed, I experience this daily in the hospital I work at. These moments are amazing, collaborative and very special to be part of. Over the years though, I have had many experiences though where colleagues in midwifery and doulas have painted a negative role of the obstetrician in the team. This can be in the language 'keep the wolves (doctors) away from the door', or in actions (refusing on behalf of the patient to allow access for medical staff to review a woman in labour). Women who are engaging in care with non-collaborative birth attendants often have unrealistic expectations of how their labour may go, they are less likely to be educated on possible medical interventions and the reasoning behind these, apart from rhetoric around doctors and our desire to intervene in the natural course of labour.

As obstetricians, we feel attacked in the media by these 'advocates' of birthing women. The obstetrician is often portrayed as the perpetrator of trauma and the language used is 'obstetric violence'. The Cambridge dictionary online defines violence as "actions or words that are intended to hurt people"[2]. As doctors who have taken an ethical oath to do no harm, the use of the word violence is hurtful. We are not violent people. We do not intentionally harm women. By using these terms, the obstetrician is by definition, not caring. I consider myself to be a strong advocate for my patients and I aim to support all the women I care for to have a positive birth experience. And I am

not alone, I am surrounded by a community of obstetricians who feel the same way. To insinuate otherwise about our profession is disrespectful, however this is often the way that obstetricians are painted by educators, midwives, doulas and in the media. This is in itself, harmful to the mental health of doctors who are trying to do their best by two patients and achieve the outcomes of a healthy mother and baby.

When women are guided to place restrictions on the level of care or intervention they receive in labour and childbirth (often in the context of biased information and education), there can be terrible outcomes for that woman or baby. As obstetricians we see babies die, who are born in poor condition with low APGAR scores, we see women who have complications such as postpartum haemorrhage, sepsis or uterine rupture and who occasionally die too. In cases where there are preventable adverse outcomes, the whole clinical team (including midwives and doctors) can be harmed as well as the patient. Obstetricians have a high rate of suicide compared to the general community or even other medical specialties. We are in an intense role, where life and death are often in the balance and we are ultimately the responsible party, even when decisions were not made by us but by the other members of our clinical team. However, when the spotlight is turned on the mental health outcomes for doctors, they are dismissed. As reported in the Guardian in 2022 in response to a comment on obstetrician suicide by the president of NASOG: *The Maternity Consumer Network responded on Facebook: "So, regardless of your wants and needs for birth, drs say you should always put their needs in front of your own. They even had the hide to throw around the suicide card. Can't win with the patriarchal medical model, if you don't do what they want, they'll either pull the dead baby card, or the dead dr card."*[3]

This undercurrent of mistrust in the medical profession is harmful. It means women don't feel confident in their doctors and that doctors are undermined in their area of expertise.

Thank you for your time in reading this submission. I am optimistic that we can achieve the best outcomes for all parties if we empower women with knowledge, education and individualised care pathways surrounded by a collaborative clinical team.

1. Jardine J, Blotkamp A, Gurol-Urganci I, Knight H, Harris T, Hawdon J, van der Meulen J, Walker K, Pasupathy D. Risk of complicated birth at term in nulliparous and multiparous women using routinely collected maternity data in England: cohort study. BMJ. 2020 Oct 1;371:m3377. doi: 10.1136/bmj.m3377.
2. https://dictionary.cambridge.org/dictionary/english/violence
3. https://www.theguardian.com/commentisfree/2022/jul/17/birthing-women-may-feel-fear-but-it-should-not-be-about-midwives-and-obstetricians