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INQUIRY INTO BIRTH TRAUMA

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Submission to NSW Legislative Council regarding Birth Trauma

My name is Lynn Townsend. I am a Fellow of the Royal Australian College of Obstetricians and Gynaecologists (RANZCOG) and am a consultant working in private practice as an Obstetrician, Gynaecologist and Sonologist (sub-specialist in O&G Ultrasound).

I am writing as a representative of myself and also as a committee member of NASOG (National Association of Specialist Obstetricians and Gynaecologists).

I will be addressing the nomenclature used in the submission, the role of the Obstetrician in birth care and in addition, the role of private Obstetrics in the Australian health care climate.

The term “birth trauma” has multiple meanings which is problematic when people from disparate backgrounds attempt to discuss dissimilar issues. Trauma can be physical, to indicate the damage extended to the body in the process of labouring and delivery. These outcomes are measurable, for example, major perineal trauma involving the anal sphincter (OASI) is such an outcome. The other meaning of birth trauma is the psychological distress that some people feel when their birth expectation deviates from their intended outcome. People adamant in achieving a vaginal mode of delivery can feel that they have experienced violence if they require a Caesarean section. Even in situations when there are signs of fetal distress, they may feel that their autonomy is not being respected. This can occur in an absence of understanding how there may be fetal distress within their worldview. They may feel disenfranchised from the process of delivering their baby and this indeed can have significant psychological outcomes.

Unfortunately, the use of the term “birth trauma” in the psychological sense is directed almost exclusively towards obstetricians. This is because obstetricians are health professionals who are able to intervene in a material sense when there are concerns. Instrumental and operative deliveries can only be performed by doctors.

The role of the obstetrician is that of safety gatekeeper. Pregnant people are not considered unwell unless there are direct illnesses in addition to the pregnancy status which may be as a consequence of the pregnancy or independent of the pregnancy. In the public healthcare system, it is entirely possible that some pregnant people may never require obstetric review. Some may only encounter an obstetrician when there are complications either antenatally or in labour. This often engenders some antagonism as the obstetrician is thus associated with a plan that is not proceeding as initially envisaged.

There is a widespread expectation about birth that is not reflected in actual measurable outcomes. Recent Mother and Babies' reports in 2022 confirm that 1 in 3 pregnancies are delivered by Caesarean section. Nearly 80% of labouring people choose intrapartum analgesia. However social media, mothers' groups and pressure from some heath professional groups suggest that operative delivery or use of analgesia is associated with maternal failure. The prospect of a healthy mum and healthy bub are lost in the efforts of "Towards Normal Birth".

Antenatal education is thus key in pregnant people's understanding of the process and outcomes at delivery. When education is facilitated by non-doctors, there is often less discussion about instrumental and operative delivery, and the education sometimes portrays that the intervention process "hurries up labour" for the obstetrician's benefit rather than the clinical needs of either the mother or the baby. This is neither true nor respectful. If obstetricians are going to come to the table to join in the conversation about improving pregnant peoples' experiences, then basic respect and acknowledgement between health care teams is paramount.

Much has been discussed about women centred care. We are well aware of the benefit of one-on-one care where the pregnant person is cared through the antenatal journey to birth and then to the post-partum period by an individual or a small team. This is reflected in the development and implementation of the midwifery team model. However, obstetricians too provide one-on-one care with each visit, delivery, and post-partum care being provided by a single obstetrician or small obstetric team. In addition, the obstetrician is always cognisant of having the ultimate medicolegal responsibility for the pregnancy. Being risk adverse is a critical necessity of obstetrics in Australia, from a medicolegal perspective and also from ensuring that the optimal outcomes are achieved.

Obstetricians, particularly those working in the private sector, are often maligned by a view that in chasing the dollar, convenience for the doctor is more important that the welfare of the pregnant person. This cannot be further from the truth. These families become fellow travellers in trying to achieve true autonomy, based on knowledge and an honest understanding of the challenging risk/benefit ratio that underpins all obstetric decisions. This is the meaning of true informed consent: to fully understand the implications of one's choice, from information provided by a trusted expert who discloses all possible outcomes so that individual can make a considered choice. To think that a Caesarean section is an opportunity to destroy a planned calm vaginal delivery is to consider that the obstetrician has ideals based in pure malice.

If we as a community are to move forward, we need to understand that obstetrics has a valid role in pregnancy healthcare and that obstetricians provide lifesaving interventions that, when not available in the past, resulted in devastating outcomes. We just need to ask our grandmothers how terrifying and uncertain was their generation's experience of childbirth. There's an old saying that "at no time is a woman closer to death than on the day of her first delivery". Whilst we live in an environment where we are fortunate to not experience these poor outcomes, we should also be aware that obstetric interventions are largely responsible for improved outcomes, not a blind belief in the physiology of a body "knowing what to do".

Private obstetric care elevates the idea that education and skill can provide beyond the greatest good for the greatest number, and instead provide the greatest good for the individual person. We obstetricians are invested in our people's outcomes and experiences. We are aware of their medical and personal histories. We learn about their dreams and fears, their families and their life goals, and we are enmeshed in their lives. Their joy is our joy. Their sorrow is our pain. To be including in their journey of parenthood is an honour and privilege. This is what individual obstetric care means to my colleagues and myself.

Many thanks to the commission for their consideration of my comments. I am always happy to discuss them further as required.

Lynn Townsend

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