Submission
No 1061

INQUIRY INTO BIRTH TRAUMA

Name: Name suppressed

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Partially
Confidential

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

10 August 2023

To the Members of the Select Committee on Birth Trauma

As a NSW based trainee in obstetrics, I would like to comment on my experience and understanding of the issues around birth trauma.

My first comment is to state that birth trauma is an understood phrase and "Inappropriate, disrespectful or abusive treatment before, during and after birth" is not acceptable in any form from the treating team or patient, extended family or friends.

Secondly, the trauma experience is not limited to patients themselves but the entire team. Take into consideration the rate of junior doctor suicide in Australia – with more than 50 % of doctors still in training either committing suicide or dropping out of the profession due to expectations and stress.

Committee members must be aware that no health care worker ever goes to work in the morning to inflict pain on their patients. In fact, they are missing out their own family birthdays, social events, school athletic days and sporting activities all because they are committed to work in a profession that is available to help others at any time day or night.

"Obstetric violence" is misleading language, as it implies that care providers, in this case, the obstetricians, have in fact deliberately caused physical and/or psychological damage to a patient. This is despite the chance that all care providers can contribute and can be affected.

The main responsibility of any committee is to investigate appropriately the entire case and take into consideration the impact on all personal involved as trauma affects everyone, not only the patient and the patient's family but the care givers, including:

- Midwives
  - Including student Midwifes private and public midwifes, Midwife group practice, public.
- GPs
  - Including GP obstetricians.
  - Medical students.
- Other doctors
  - Including obstetricians, private obstetricians, trainee obstetricians, resident and unaccredited including locum registrars.
- Other teams
  - Anaesthetics, paediatrics, aboriginal liaison officers, social workers, theatre nurses, nurses, trainee nurses and other specialist teams.

In their deliberations, the committee needs to take into account contributing factors of Birth trauma.

1) Patient Expectations & Beliefs

Many patients expect nothing to go wrong with their birth experience and are encouraged to make birth plans with unrealistic expectations.

Many patients do not receive culturally appropriate counselling about the birth process and the possible complications. This education can only be delivered by health care workers familiar with the complications.

2) Communication & Education

Autonomy can be maintained if women are given the opportunity to develop a full understanding of their choices for care, whether they choose to have care or decline recommended care needs to be covered, including instrumental delivery, Caesarean sections, timing of birthing, augmentation, mode of delivery, pain relief support services and more.

Patient education of what birth involves and not just by GP and midwife but by doctors that actually perform the instrumental deliveries in indeed necessary.

3) Models of Care

Midwifery group practice and other community lead midwife programs are excellent in providing care especially to outreach patients however these models of care often lack some aspects of education due to the lack of access to trained obstetricians.

In these cases, doctors may only meet a patient minutes before they have to assist a birth, time is usually very limited and emotions are very high. That does not allow for continuity of care or patient centred education using the clinically proved talk back method.

4) Indemnity

Legislation that allows women to make informed decisions for their own care and protects them and health care providers needs immediate development.

5) Co-founding Factors to Birth Trauma

- Inability to access obstetric treatment and specialist even when a client asks for one
- Adequate analgesia often denied by care givers other than doctors.
- Inability to meet maternal requests for caesarean section especially necessary in the treatment of women with previous trauma ie sexual abuse.
- Emergency caesarean section not available in a timely manner.
- Instrumental delivery, especially when a client has a lack of understanding of reasons why intervention may be needed, contributed to a lack of antenatal education.

My Recommendations

Holistic care that would limit trauma should be conducted in a team environment. STOP trying to divide the care givers INSTEAD implement a team environment (as it was in the past) were every care giver works together to ensure adequate care and education opportunities for all including diverse population, ATSI and other cultures. MGP should include doctors in their model of care. A team.

There needs to be improved access to private obstetric care. The public system is over stretched leading to more women seeking to choose the private model of care in order to forgo some of the co-founding factors listed above. But costs and lack of access to private care often push them back into the public sector.

When things go wrong, publicity should be avoided. Being publicly named in the media increases doctor suicide rate. Even though the majority of doctors are found innocent of wrongdoing, public naming in the media leads to a reputation being destroyed even before the doctor has an opportunity to defend themselves, this should not be a legacy of Australia! its ends careers, prevents others from entering the health professions, reducing available doctors, and the circle goes round and round. Health negligence legislation needs to protect patients and healthcare providers alike.

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