Supplementary Submission No 252a

INQUIRY INTO BIRTH TRAUMA

Organisation: Australian Medical Association (NSW)

Date Received: 20 February 2024

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The Hon. Emma Hurst, MLC
Chair, Select Committee on Birth Trauma
Parliament House
Macquarie Street
SYDNEY NSW 2000

via email: BirthTrauma@parliament.nsw.gov.au

To The Hon. Emma Hurst (Chair),

Further to our correspondence requesting an additional opportunity to provide evidence before the Committee, we provide a statement from AMA (NSW). While we again note that the time for submissions has passed, we believe that evidence related to the impact on the unborn child is significant and should be considered by the Committee.

We look forward to your response to this submission and our request for Dr Staub to appear.

Yours sincerely,

Fiona Davies
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Select Committee on Birth Trauma

AMA (NSW) seeks to make a further submission to the NSW Parliament Select Committee on Birth Trauma. While we note the time for submissions has closed, we have requested consideration of this further submission on the basis of the need to ensure appropriate evidence is put forward regarding the clinical needs and rights of the unborn child.

AMA (NSW) submits that there must be consideration for the babies whose length and quality of life can be impacted enormously by the decisions made in the planning for a birth.

Obstetrics is one of the few areas of clinical practice in which doctors, nurses and other healthcare workers need to consider the clinical needs and personal rights of two (or more, in the case of multiple births) patients. While there are complex legal frameworks around these rights, AMA (NSW) believes it is critical for the Committee to hear submissions on behalf of those charged with caring for infants after the delivery.

AMA (NSW) requests that the Committee call Dr Eveline Staub to provide evidence. Dr Staub is an AMA (NSW) Councillor and a neonatal intensive care physician based at Royal North Shore Hospital. She trained and worked in Switzerland as well as in the US and Australia. She heads the department of neonatology at Royal North Shore Hospital and leads a team of 20 doctors, over 120 nurses and allied health care professionals in charge of a 29-bed neonatal intensive care unit. Dr Staub oversees the management and care of all the infants admitted to the Neonatal Intensive Care Unit or NICU. The NICU provides comprehensive intensive care medicine for the sickest and most critical babies in Northern Sydney and the state.

NSW has NICUs in all quaternary public hospitals. NICUs are responsible for the care and management of prematurely born infants, from 23 weeks gestation (as small as 500 grams) as well as critically unwell full-term babies. Other public hospitals will have paediatric services which would include special care nurseries to look after late preterm infants and those born at term that require some extra care, but not requiring an intensive care unit. A number of private hospitals with obstetric services would have similar facilities. Decisions regarding the appropriate location for care are often influenced by the services available in a facility to support the child, either by the timely transport of the still pregnant mother to a service with a NICU or moving the baby itself. For the latter, neonatal and paediatric services in NSW are supported by the Newborn and Paediatric Emergency Transport Service (NETS), which provides remote clinical advice, and retrieval services to move infants to higher level care facilities when required. NETS has a critical role in maintaining safety for mothers and babies in NSW.

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Around 40% of the 500 – 550 admissions to the Royal North Shore NICU are infants born *at or shortly near full term*, who develop unexpected, but critical medical issues that require urgent and intense care. The reasons for the admission of a full or near full term baby to the NICU would include problems with breathing, signs of oxygen deprivation around birth, infections and low blood sugar levels.

An admission to the NICU is a difficult situation for a family. While there are times the admission will be expected as part of the pregnancy management process, in most instances, the requirement to admit a baby to a NICU is unexpected. Admission to a NICU means separation of the parents and baby, sometimes for many weeks and months. While NICUs and paediatric units are focused on the care of the baby, those working in the units seek to support distressed parents as part of the care.

A neonatologist or paediatrician will be called to a delivery when the baby is expected to require medical support after being born. This includes whenever babies are about to be born preterm or when it is a multiple birth (twins or triplets).

One of the most frequent reasons for paediatric attendance at birth, however, is when it is determined that the baby is in or has the potential to be in distress. The term *in distress* is used by doctors, nurses, and other healthcare workers to signal a concern. It is an expression designed not to overly alarm mothers and partners, however, what it most commonly means is that the baby is no longer receiving sufficient oxygen. The assessment of a baby in distress is made in a range of ways, usually using a monitoring device such as heart rate monitoring or measurement of baby's acid level in the blood via a probe in the presenting part of the head.

Many submissions have raised concerns regarding the use of monitoring devices and the impact in labour. There is mixed evidence regarding the use of such devices, however, speaking directly regarding the unborn baby, these are the most effective options available for the monitoring of the baby's heart rate – a vital sign of the baby's health and the best indicator of whether the baby is in distress.

While there are various ways to identify the level of distress a baby is in during delivery, it is ultimately not predictable which baby will need extensive measures of resuscitation and which ones will be okay after brief interventions. For this reason, it is important to get paediatric or neonatal staff alerted and prepared as soon as signs of distress appear in order to support the baby after birth. In approximately 10% of neonatal resuscitations, no warning signs were present during delivery and the need for resuscitation not anticipated.

Hypoxic ischemic encephalopathy (HIE) is the most common type of brain damage during childbirth. It is classified as brain damage caused by decreased blood flow and/or oxygen levels to the brain. HIE leads to destruction of brain cells and tissue. Classically, it causes damage in the area of the brain controlling movement and motor functions, leading to cerebral palsy. But other areas of the brain can be affected, resulting in problems of other

areas of brain function, such as learning problems or intellectual disabilities, epilepsy, problems with hearing and vision, speech delays, behavioural and emotional problems. The longer the period of oxygen deprivation and/or decreased blood flow to the baby's brain, the higher the risk of relevant damage to the brain and, consequently, lifelong problems.

Occasionally, the brain damage is so severe that the baby cannot be resuscitated after birth, or the lifelong disabilities are feared to be so dire, that the parents, in discussion and agreement with the medical team, choose to not continue the life support and to let nature take its course, so that the baby dies in the first days after birth. The direct association between duration of hypoxic insult and outcome for the baby is the reason why interventions during delivery need to be timely and swift and therefore don't leave much time for extensive discussions with the birthing parents around risks and benefits.

Once a baby suffers from brain injury as a consequence of birth asphyxia the clinical management is to lower the baby's core temperature to 33 degrees for 72 hours. The so-called cooling treatment cannot undo damage which has already occurred, but it can stop further injury and significantly improve the outlook for the baby in terms of expected disability. This treatment requires nursing the undressed baby on a chilled mattress. The baby is given significant sedation because the cooling process is distressing.

Dr Staub noted that most parents who experience a NICU admission express distress about the lack of warning they were given during the ante-natal period that their child could end up with significant complications from birth.

Dr Staub indicated that in Switzerland, it was routine for neonatologists and paediatrics to be involved in ante-natal education to advise parents about the potential for unplanned outcomes and the care that would be provided as a result. She noted that in Australia, there is a significant reluctance to present information about adverse outcomes and that neonatologists and paediatricians are often accused of scaremongering.

It is noted that as with many areas of advances in healthcare delivery, the reduction in the incidence of complications makes parents less aware of the risk of delivery.

AMA (NSW) submits that the Committee should ensure an appropriate consideration of the rights and care of the unborn child in any recommendations.

This should involve increased education for parents regarding all aspects of maternity. Such education should include the prevalence of risks which could result in lifelong injury to the baby or worse, risks that in many cases can be avoided.

The Committee should also refrain from changes to consent requirements which may create a significant risk of harm by risking further delay in the provision of critical medical care.