Submission No 1444

INQUIRY INTO BIRTH TRAUMA

Name: Name suppressed

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Trauma is the experience of deep distress experiences by an individual. Birth trauma encompasses trauma that may be experienced due to distressing events surrounding the antenatal period, birth and/or postnatal period. The cause of birth trauma can be multifactorial and heterogeneous in origin. It cannot be defined clearly as it is specific to the individual experiencing it.

Working in the field of women's health as a health care worker, is a beautiful career. It can be an emotional rollercoaster – witnessing birthing experiences, managing fertility issues, postmenopausal health and gynaecological care. The aim of pursuing this profession for most is to provide an excellence of healthcare to women and improve outcomes for women. Never in a million years would I or any colleague I know, midwifery or medical, seek to voluntarily traumatise women in any aspect of their care. Yet to see so much trauma resulting from this part of life/birth, is truly terrifying. Clearly there are issues – which are multifactorial and cannot be pin pointed to blame one person or one profession.

Some of the issues include:

- Historically, medicine and obstetrics has been hugely paternalistic – outcomes and direction of care presumed based on what the clinician thinks is correct. I certainly hope this is changing and definitely feel like informed consent and practice is improving, acknowledging more needs to be done (this may be region specific as well). This includes care provided where intervention is recommended and also care where women may want intervention that is declined (e.g. maternal request elective caesarean sections being declined). Policies such as 'Toward normal birth' is also to partly to blame for these views where hospital performance outcomes are measured by types of deliveries rather than patient informed care and patient satisfaction.

- Antenatal classes: the expectation and message painted in many, not all, classes of "birth being perfect/orgasmic", "our bodies being designed to do this", "women have been doing this for years", "epidurals lead to a cascade of medical intervention" implying that 'you needing an epidural leads to you needing intervention'. These messages are on another extreme spectrum but essentially can instil fear, unrealistic expectations around labour/birth and guilt for seeking simple relief such as analgesia. The burden of this is extreme. The lack of any realistic or objective discussion around analgesia, indications of when intervention may be medically indicated, create a further divide on "normal" birth versus any degree of intervention, including analgesia.

- The lack of continuity of care (both medical and midwifery) in the public hospital setting creates a disrupted patchy service for women. Continuity in all aspects of care needs to be improved, particularly birth and postpartum services. In a resource limited public hospital setting with chronic staff shortages and rotational shift work rostering, women are suffering as a result of lack of follow up, debriefing postnatally and subsequent post partum period. In a MGP group setting or private obstetric model, the same care provider can provide care for antenatal, birth, postnatal period. In an ideal world, this should be the goal. However, in a public health model with limited resources and staffing, how can we make this work?

- While women have been 'doing this for millennia', there is a significant difference in maternal and neonatal morbidity and mortality in this time. Even in current times, there is a stark difference of outcomes based on country of birth. We can look at the statistics between Australia and Papua New Guinea (PNG) for comparison sake, where maternal mortality is 1 in 10,000 in Australia versus 1 in up to 20 in PNG and similar stark differences in neonatal

morbidity/mortality outcomes. The trauma for these women and families (including subsequent inter-generational trauma) cannot be fathomable. This is obviously heartbreaking and hard to imagine occurring in this current era, but adds some perspective. While comparatively in Australia, achieving this reduced morbidity/mortality has resulted in increased intervention (operative, instrumental assisted delivery, antibiotics, screening in pregnancy); there does now exist a question of how much intervention and what is unnecessary? This is sometimes impossible to answer - the alternative to intervention may be no intervention and a 'normal' outcome but can also result in a poor outcome, which is also unacceptable, so what is the alternative?? There is no correct answer.

Some ways we can aim to better address these issues in order to reduce the trauma women experience:

- Continuity of care: antenatally to postnatally. In the public system, MGP groups are great, however should not be limited to just 'low risk pregnancy' models. Higher risk pregnancies that require more frequent follow ups, would also benefit from ongoing continuity at both a midwifery and medical level. Medical continuity with obstetric 'teams' antenatally and postnatally.

- Antenatal education with a holistic approach. Non-judgemental education with focus on antenatal, birthing and also postnatal education. The option of providing education sessions in a public hospital setting for women and having midwifery, obstetric and anaesthetic input so women can have their questions answered in an objective, non-judgemental way and have facts/data reviewed over anecdotal stories.

- Postnatal follow up and debriefing services for all types of birth (unassisted, assisted, operative births, perceived low risk and high risk births). Women can choose not to follow up. Having provision for this service allows women to have their questions answered once they have time to process their birth experience.

- Increased access to antenatal services such as lactation consultants and women's health physiotherapists

- Increased access to postnatal/perinatal psychologist/mental health services

In reporting cases of birth trauma in this way, there will clearly be a bias – based on reporting bias (based on those who reach out to report), those with an alternative agenda, including creating a divide between the medical and midwifery models of care, political agendas just to name a few. While looking into how to submit this claim, there are other websites of non-government organisations that exist in encouraging women to submit their personal stories of birth trauma. Whilst on face value this seems helpful and encouraging, the language used in these sites are instructive, one sided, divisive and promote emotive language. It is difficult to see this for simple an instructive informative resource.

As with any situation, working in a cohesive multidisciplinary team has huge benefits – providing different perspectives of care, efficiency, education and support. There is a lot of work to be done to improve care around birth for women. Working together with women as a team of midwives AND obstetricians rather than midwives OR obstetricians is what we need, without political agendas and media manipulation.