Submission No 68

INQUIRY INTO BIRTH TRAUMA

Name: Name suppressed

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I would like to share some of my experience of a traumatic birth and some thoughts for the committee to consider.

My experience, in short:

1. Despite using my local Midwife Group Practice service I did not receive continuity of care which affected how safe and supported I felt when vulnerable in labour.

2. The midwife who attended me offered almost no support to help me manage labour - she focused almost entirely on the CTG reading. I felt lost and completely unable to manage my pain.

3. Procedures were recommended to me with very limited information, while I was in significant pain and struggling to hear even that. No benefits, risks or alternatives were explained to me or my support persons for procedures (for me this was for a external monitoring/CTG, then a scalp clip monitor, manual breaking of waters, intravenous fluids and later - for a general anaesthetic). This is NOT informed consent. It was stated like "we need to break your waters" followed by silence. I felt very pressured to agree and felt I had no choice.

4. This was also the case for pre-labour 'cervical sweeps', which is likely the cause of the infection that subsequently developed. I was absolutely encouraged to have a sweep and not told any risks or reasons to avoid this.

5. I felt exposed and violated during labour. I was mostly naked. The door was frequently opened and as I was struggling with the pain, staff would enter and discuss things (eg the CTG) while watching me, without talking to me at all. No introduction or any information. No-one protected my privacy. Although the pain meant I was UNABLE to consciously focus on this, I was certainly aware it was happening and so it felt out of my control. There was no curtain or screen to allow staff to come and go without exposing me. At one point the midwife lifted the towel that was covering my bottom/genitals (I assume to check for visible progress?), without asking or saying anything to me. It felt as if because I was struggling with the pain and therefore struggling to communicate, she stopped even trying to talk to me and just exposed me as she saw fit.

6. After my epidural was inserted (which I requested as I felt completely overwhelmed and alone and unable to cope) and the first dose of medication given, my baby went into a 'severe prolonged bradycardia' with a heart rate as low as 52 that did not recover. The emergency buzzer was pressed and many staff entered the room - approximately 8 to 10 people. I made direct eye contact with the midwife and expressed my fear - she looked at me, said nothing then looked away. She was not making any decisions, as that was the role of the senior medical staff, and I feel at least one staff member if not the midwife, should have been able to communicate with me. A decision was made that I needed and urgent caesarean. Instead of being told this, the bed I was on was rushed out of the room and to theatre so I assumed I was having a csection. As we entered the theatre I heard someone telling my partner that I would be having a general anaesthetic. No-one directly told me this and I was shocked, but as I only overheard it I was not sure what was happening.

7. In theatre I was panicking and asked a nurse next to me what my baby's heart rate was now. She said 'Oh I can't see the monitor'. I was terrified now, not knowing if there was still a heart rate at all. This was the first direct communication I had had during the emergency and I felt it was an inappropriate response.

8. A mask was then put over my face, and I overheard the anaesthetist say to someone 'So, have you done many intubations?' In my panic I assumed that someone inexperienced was going to be intubating me. I asked 'Have you???'. The anaesthetist looked down at me and did not answer. The nurse then said 'we're putting you to sleep now' - the second direct communication I had during the emergency.

9. Outside the theatre my partner was given theatre scrubs to change into, so she assumed should would be able to come in. Partway through changing, a clerk then handed her a pamphlet on 'reasons

why you can't go into theatre' without speaking to her. Fortunately, a midwife we knew from MGP now arrived and explained this to her appropriately. If that hadn't happened, communicating with my partner by silently handing her a pamphlet is inappropriate and lacking in empathy. Similarly, my mother who was left behind in the labour room, was only told 'they won't be coming back, you need to pack everything up'. She then attempted to clean up the messy room and find somewhere to wait for an update.

10. When I woke in recovery, a doctor came to speak to me saying 'baby needed some help but didn't need CPR'. When I asked if the baby was ok now she said 'Oh I don't know they're in the NICU'. I was in recovery for 6hours due to high BP, tachycardia and fever and was not told if my baby was ok until my partner was finally allowed to see me.

11. Recovering on the ward the next day, I asked for one more dose of pain relief before getting out of bed for the first time. The young nurse who I spoke to made comments and expressions that strongly implied I didn't need the pain relief. I felt judged for wanting relief despite the fact I had just undergone major abdominal surgery, which is completely inappropriate. When I was discharged 4 days later, I was told to take panadol and nurofen only.

12. My hospital notes say I was 'debriefed' by the medical staff. This consisted of them telling me they weren't sure what happened but it was likely a placental abruption. I was given very minimal information about what this is and no follow up. I did receive some emotional support from my MGP midwife.

13. Aside from a screening for PND I was offered no guidance on how to process my birth or long term follow up. I did not even know the term 'traumatic birth' at that stage or realise that was what had happened to me.

14. 8 months later I requested my hospital notes and discovered through that, that my placenta had been tested and diagnosed as 'acute chorioamnionitis' ie infection. I contacted the hospital myself to confirm this and that I did NOT have a placental abruption. If I hadn't, I would have never known the true diagnosis which could have had a significant impact on my care during my second pregnancy.

Some thoughts I would like the committee to consider:

1. Midwives roles need to be more clear to patients. I was under the impression that more emotional support would be offered not strictly clinical care. I have learnt from others' stories that this is not an isolated issue. I would have considered a doula or other support person if I had known.

2. I have been an emergency nurse for 15 years. Aside from this birth experience, I KNOW that training on consent in healthcare is absolutely inadequate. Violations of privacy and insufficient non-biased information are every day occurrences. In labour and birth, this is particularly common and apparent. I believe this needs immediate action. I have learnt about the B.R.A.I.N acronym (see attachment) and believe something along these lines should be standard even for minor procedures. Further staff education about privacy is also needed, and structures such as curtains/screens that retain privacy when doors are opened.

3. In my role as an ED RN, I have been involved in countless emergency situations like the one I experienced in my labour. I KNOW that the focus of the team was on ensuring the survival of my baby and I am eternally grateful they were able to. However, I also know that communication with me during the emergency was absolutely possible, especially with the number of staff who were present. Supporting patients during such events is extremely important. I feel it would have greatly REDUCED the emotional trauma I suffered, as a result of feeling disempowered, loss of control, ignored/invisible, vulnerable, violated, alone, panicking/terrified and confused. It has taken my years to come to terms with everything. I believe that staff training for those who are involved in emergencies like this can be very beneficial for many reasons including patient communication. I had had similar training when

working with trauma teams at a trauma hospital, and I have noticed that other staff such as obstetric staff, resuscitation teams, theatre staff do not all receive similar training to better manage such situations.

4. A significant improvement in follow up care is needed - not only for pathology results that clearly should be communicated to the patient, but follow up for physical and emotional impact of health events. Immediate and long term debriefs by staff with sufficient training (to ensure inclusion of debriefing psychological impacts as well) would improve post partum care. I would urge the committee to be aware, particularly in birth, that even births without obvious emergencies or physical trauma, can still have profound emotional trauma that has significant long term impact on health. One brief screening for PND is insufficient as it is different to PTSD/trauma symptoms and may not pick this up. Awareness among all maternity staff, including GPs and early childhood staff, that birth trauma can cause PTSD like other types of traumatic events is essential.

5. I believe that training around pain management is also very inadequate in maternity care, as well as all areas of healthcare. There seems to be extreme inconsistency with caesarean pain management especially when compared to other abdominal surgery - both immediately post surgery and on discharge from hospital. This should include training on non-pharmacological options. In general, staff attitudes to pain relief also need addressing.

Thank you for your time and consideration.