Submission No 123

INQUIRY INTO BIRTH TRAUMA

Name: Name suppressed

Date Received: 29 July 2023

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28 July 2023
Select Committee on Birth Trauma in NSW

Subject: Submission to the Select Committee on Birth Trauma

Dear Members of the Select Committee,

I am writing to submit my views and experiences regarding the issue of birth trauma in NSW, with a specific focus on my first child's birth at Hospital in April 2021.

My name is , and I am a resident of and was formerly living in in Sydney catchment area) for my first pregnancy/birth. I would like to address all of the terms of reference outlined in the inquiry, as well as offer potential solutions and recommendations for consideration.

I am currently 39 weeks pregnant with my second child, this time in regional NSW, so will also provide some insight into my second experience with an upcoming planned homebirth as a result of the trauma of my first birth, as well as the limitations of maternity care in a regional NSW town. As an affected parent, I believe it is essential to share my perspective in relation to the terms of reference for this inquiry.

To further illustrate my traumatic experience, I have attached the exact copy of my birth plan that was given to my care team at Hospital and have highlighted which of my requests were either denied, ignored or I was coerced out of. As you will note, there are some significant issues with how the birth of my child was handled despite my extremely clear requests.

I will now proceed to discuss each of the terms of reference and how they relate to my personal experiences:

a) **The experience and prevalence of birth trauma (including, but not limited to, as a result of inappropriate, disrespectful or abusive treatment before, during and after birth, also referred to as "obstetric violence")**

   During my first pregnancy, I was fortunate to be accepted in the Midwifery Group Practice (MGP) at Hospital, which provided exceptional care in the lead up to the birth. Continuity of care was important to me and I was glad to have been assigned two dedicated midwives and a student midwife through this program. Their support, combined with my thorough research and (self-funded) hypnobirthing classes, prepared me well for a physiological birth.

Upon entering the public hospital while in labour however, my experience took a negative turn as I faced coercion and obstetric violence by the external "care team" of rostered midwives and an obstetrician. Despite my well-communicated birth plan and strong advocacy from my birth support team, the hospital's prescribed timeframes and "hospital policies" led to a cascade of interventions that contradicted my preferences.

b) Causes and factors contributing to birth trauma including:

- **evaluation of current practices in obstetric care**
- **use of instruments and devices for assisted birth e.g., forceps and ventouse**
- **the availability of, and systemic barriers to, trauma-informed care being provided during pregnancy, during birth and following birth**

The experience of birth trauma can be deeply influenced by various factors within the current obstetric care system, as exemplified by my own birthing journey. Despite my initial preparation and support, my birthing experience took a traumatic turn due to systemic barriers and inappropriate practices.

During my pregnancy, I had produced a clear and informed birth plan, outlining my preferences and declinations for various procedures. My aim was to have a physiological birth, avoiding all medical interventions such as cervical checks, augmentation of labour, episiotomy, instrumental delivery, coached pushing, and I specifically requested a physiological third stage (delivery of the placenta), amongst many other things.

As a first-time mum, I eagerly awaited the arrival of my baby, knowing that going past my due date was an entirely normal occurrence for many women. As my due date approached, I was made aware of the "timeframes" and "hospital policy" that my pregnancy had to fit within for it to still be able to go ahead physiologically, as I desired. Hospital policy prohibited pregnancies from progressing to 42 weeks, so at 41 weeks pregnant, I was left with no choice but to schedule an induction at 41 weeks and 5 days gestation, and agreed to a stretch and sweep to “try and get things moving”. This policy-driven intervention created undue stress and anxiety over the coming days.

At 41 weeks and 3 days, thankfully, my labour began with a spontaneous rupture of membranes, though this unfortunately led to me being "put on the clock”. Once again, I was faced with more “hospital policy”, which mandated a 24-hour timeframe for delivery after the rupture of membranes. This left me feeling rushed and anxious that my body had to perform to a particular standard.

After labouring comfortably at home for 14 hours until I reached 6cm dilation (determined by a cervical check I was encouraged to have), I experienced a disheartening stall upon entering the hospital environment. This sudden halt in progress is a commonly observed occurrence when labouring women are removed from their familiar and comfortable environments at home. The shift in surroundings and the introduction of a hospital setting can negatively impact a woman's birthing experience and often leads to further interventions[1].

Despite my well-informed birth plan and the fierce advocacy for it by my MGP midwives and birth supports, their efforts were hindered by prescribed timeframes and rigid "hospital policies," often leading to coercive measures by other hospital maternity staff when my

[1] Lothian J. A. (2004). Do not disturb: the importance of privacy in labor. *The Journal of perinatal education*, *13*(3), 4–6. https://doi.org/10.1624/105812404X1707

labour was perceived to be taking too long. The implementation of synthetic oxytocin to restart my labour demonstrates the impact of these systemic barriers and interference with the physiological birthing experience.

Before being administered synthetic oxytocin, neither myself nor my birth support partners were provided with the risks or safety information about using synthetic oxytocin for myself or the baby, such as it crossing the placenta[2], hypoxia, postpartum haemorrhaging, hyperstimulation of the uterus, or any of the potential affects after birth such as its impact on bonding and breastfeeding[3]. All that was communicated was that I needed to have it because my labour had stalled.

Due to the onset of intense contractions attributed to the synthetic oxytocin, I had been immersed in the birth pool to assist with pain management. After some time had passed, I was abruptly moved from my preferred birthing space (the birth pool, where I was able to move freely) and onto a hospital bed in lithotomy position – on my back with my legs in stirrups – to do yet another cervical check.

It was at this point that the experience got extremely intense as a series of significant medical interventions took place in quick succession. I faced coercion when it came to accepting an episiotomy – something that I very explicitly stated I did not want, as I had a preference to naturally tear. The ultimatum given by the rostered obstetrician was, "I'll only perform an episiotomy if I think it will be a 3rd or 4th-degree tear," putting me in a vulnerable position to agree to the procedure at a particularly stressful and time-sensitive moment. Without any further communication, my vagina had been cut.

During this pushing stage, apparent shoulder dystocia was diagnosed, while I was laying on my back in a lithotomy position and being coached through pushing. These circumstances are completely unnatural for a labouring mother, as it limits the potential for optimal pelvic opening and increases the risk of perineum tearing[4]. In this position, the body has to work against gravity and it forces the baby into an unnatural angle in the pelvis[5].

An emergency button was hit by one of the midwives, and within seconds all the lights were on in my birthing suite and I had approximately 8 hospital staff suddenly surrounding me. I was never encouraged to turn onto my side or onto my hands and knees, which could have facilitated a more natural and less traumatic birthing experience[6]. Subsequently, my birthing journey culminated in a ventouse delivery, further adding to the distressing experience.

When my baby was placed in my arms, I was in a state of shock and felt dissociated from my baby, my body and the experience that had just unfolded. It is an extremely painful thing for me to admit and I am still trying to come to terms with it, but I did not experience the overwhelming oxytocin rush that most mothers speak of when meeting their baby for the first time. It took me over a month to feel truly connected to my baby, and this has come

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[2] M.R. Odent. (2013). Synthetic oxytocin and breastfeeding: Reasons for testing an hypothesis. *Medical Hypotheses*. Volume 81, Issue 5. Pages 889-891. https://doi.org/10.1016/j.mehy.2013.07.044

[3] Buckley, S. (2019). *Synthetic Oxytocin (Pitocin, Syntocinon): Unpacking the myths and side-effects*. Retrieved from Dr Sarah Buckley: https://sarahbuckley.com/pitocin-side-effects-part1/

[4] Dekker, R. (2012). The Evidence on: Birthing Positions. Retrieved from Evidence Based Birth: https://evidencebasedbirth.com/evidence-birthing-positions/

[5] Simkin P., Handson L., Ancheta R. 4 th ed. John Wiley&Sons; Hoboken: 2017. The labor progress handbook: early interventions to prevent and treat dystocia. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6839002/

[6] Dekker, R. (2012). The Evidence on: Birthing Positions. Retrieved from Evidence Based Birth: https://evidencebasedbirth.com/evidence-birthing-positions/

with a tremendous amount of guilt and grief, which I attribute to the way the birth was handled and the many interventions that occurred.

Despite the numerous interventions, basic after-care instructions were not provided for healing from the episiotomy and resulting stitches.

At a time when I needed rest, recovery and an environment conducive to bonding with my first born child, I was moved to the maternity ward and placed in a room with 3 other women who had had far more traumatic and medicalised experiences than I. As a result, there was a lot of activity in the room throughout the day and night, which prevented me from being able to sleep for more than an hour, following my own 28.5 hour labour.

When I realised I had bled through my clothes and sheets during the night, and sought assistance from one of the rostered midwives, I was met with a look of indignance and an unenthused comment that "there are blue underpads in the second drawer". This comment seemed to imply that I should either re-make the bed myself or use more blue underpads to prevent any further leaking through to the sheets, which made me feel unsupported and as though I was an inconvenience to her.

During one of the breastfeeds throughout the night, I had a midwife tell me I was holding my baby's head wrong and that he would die of suffocation if I continued that way.

The next day after birth, I endured over 8 hours without anti-inflammatory pain relief despite multiple requests. This delay occurred due to the maternity ward doctor being occupied and needing to sign off on the pain relief, despite the obstetrician who performed the episiotomy having already documented pain management options in my medical file. I ended up pushing to be released from the hospital's maternity ward within 36 hours of birth, as I felt I could manage my pain better at home in a supported environment with my husband and mum.

c) The physical, emotional, psychological, and economic impacts of birth trauma, including both short and long term impacts on patients and their families and health workers

While I credit my hypnobirthing preparation for aiding my psychological resilience following the birth, I am still left with fears and self-doubts regarding my ability to birth another baby without medical interventions.

The trauma experienced during childbirth has deeply impacted my trust in the medical system, leaving me feeling vulnerable and unsupported during this profound life event. As I approach my upcoming birth, I have a profound fear of being transferred to hospital and facing the same kinds of interventions, I'm terrified of tearing in the same area where I had my episiotomy and I also worry about the postpartum healing process. My traumatic experience has led me to seek a homebirth with a private midwife, incurring additional financial costs of $6250 due to the lack of trust in the care provided by NSW hospitals.

d) Exacerbating factors in delivering and accessing maternity care that impact on birth trauma generally, but also in particular:

- **people in regional, rural and remote New South Wales**
- **First Nations people**
- **people from culturally and linguistically diverse (CALD) backgrounds**
- **LGBTQIA+ people**
- **young parents**

With my second pregnancy, I now reside in regional NSW, which presented unique challenges in accessing compassionate care. Unfortunately, my local GP lacked knowledge about various maternity care options, including homebirthing, leading to feelings of being unsupported and let down by a NSW medical professional once again.

The absence of a Midwifery Group Practice in my local hospital, I felt left me with no choice but to opt for a homebirth with a private midwife as I am not prepared to have less continuity of care than I did in my first birth.

e) The role and importance of "informed choice" in maternity care

Informed choice plays a crucial role in maternity care, allowing expectant parents to make decisions based on comprehensive and accessible information.

However, I found myself undertaking extensive research and paying for a $600 hypnobirthing course to gain the knowledge needed to make those informed decisions. Empowering individuals with clear and easily accessible information is essential to improve the decision-making process during pregnancy and birth.

f) Barriers to the provision of "continuity of care" in maternity care

Continuity of care midwifery models during pregnancy and birth is recommended by the World Health Organization[7], yet only 15% of pregnancies in Australia receive this type of care[8].

In my first pregnancy in Sydney, I had the privilege of experiencing the Midwifery Group Practice program, ensuring consistent and supportive care from a dedicated team of midwives. However, living in regional NSW for my second pregnancy, this option was not available, highlighting the disparities in access to continuity of care models.

g) The information available to patients regarding maternity care options prior to and during their care

Throughout both my pregnancies, I felt that the information provided by my individual GPs regarding maternity care options was insufficient. As a result, I was unaware of various care models, such as the Midwifery Group Practice, until I called the hospital to register my first pregnancy/book in.

Clear and comprehensive information about all available care options is crucial to enable expectant parents to make informed decisions about their birth preferences.

h) Whether current legal and regulatory settings are sufficient to protect women from experiencing birth trauma

The current legal and regulatory settings, in my opinion, are not adequate in protecting women from birth trauma. On the contrary, some of these settings contribute to preventing women from having physiological births, resulting in increased instances of birth trauma. There is a need for comprehensive reforms to address these shortcomings and ensure a safer

[7] World Health Organization. WHO Recommendations: Intrapartum Care for a Positive Childbirth Experience. World Health Organization; 2018. https://apps.who.int/iris/bitstream/hand le/10665/260178/9789241550215-eng.pdf
[8] Australian Institute of Health and Welfare. (2022). *Maternity models of care in Australia, 2022* . Retrieved from https://www.aihw.gov.au/reports/mothers-babies/maternity-models-of-care

and more respectful childbirth experience for all.

i) Any legislative, policy or other reforms likely to prevent birth trauma

To prevent birth trauma, I believe several crucial reforms must be implemented:

- Emphasise women-centred care across all maternity settings

  Women-centred care, as recommended by the World Health Organization (WHO), is paramount in all maternity settings, including public and private hospitals, Midwifery Group Practices (MGPs) and homebirths. This approach prioritises the individual needs, preferences, and values of the pregnant woman, ensuring she plays an active role in decision-making throughout her pregnancy and birth journey, regardless of where she chooses to birth.

  When healthcare providers prioritise women-centred care, they can better support physiological births, respect birth plans, and provide personalised care that aligns with each woman's unique needs and desires. By fostering a supportive and empowering environment, women feel more confident and informed, leading to improved birth experiences and reduced birth trauma rates. Implementing women-centred care across all maternity care settings can significantly contribute to reducing birth trauma and enhancing overall maternal and neonatal outcomes.

- Physiological birth education for midwives and OBs

  Provide better education for midwives and obstetricians to understand and support physiological births, and most importantly, encourage pregnant women to have them.

  Education should include optimal birthing positions (e.g. avoiding the lithotomy and supine positions), avoiding cervical checks and coached pushing, and understanding the physiological processes of a woman’s body while in labour, recognising the influence the birthing environment – including attending staff – have on this process.

- Avoid pathologising normal variations

  It is crucial to shift the approach towards birth and stop pathologising completely normal variations experienced during pregnancy and labour. For example, a baby's position in the pelvis (e.g. breech, posterior, etc), the duration of labour, and other natural physiological processes should not be unnecessarily labelled as "complications" or "abnormalities." Educating healthcare providers and birth attendants about the wide range of normal birthing experiences and variations will enable them to better support women during labour without resorting to unnecessary interventions.

  Instead of viewing variations as problems to be fixed, it is imperative that obstetric care fosters a mindset that appreciates the natural diversity of birth to empower women and reduce the occurrence of birth trauma caused by unnecessary medical interventions. By embracing the physiological aspects of birth and acknowledging the uniqueness of each birthing journey, we can create a more supportive and positive birthing culture that respects the innate abilities of women to birth their babies safely and effectively, as has been done for many thousands of years.

- Addressing potential complications

  Implement education on how to handle legitimate medical complications, such as true shoulder dystocia. Midwives should be well-versed in birthing positions that naturally widen the hips, avoiding immediate resort to coercive interventions like episiotomies and instrumental deliveries, which are often performed under duress.

- Reviewing membrane rupture policies

  Ditch outdated policies that unnecessarily rush childbirth, such as limitations on the duration of membrane rupture before administering synthetic oxytocin. Instead, trust the natural progression of labour, avoid interventions when not medically indicated and educate midwives and OBs on how to naturally support and mitigate any risk of infection once membranes have ruptured (i.e. vitamin C, no cervical/vaginal checks, rest and relaxation, good hygiene, monitoring for signs of infection such as fevers, etc).

By enacting these legislative, policy, and educational reforms, we can create a more compassionate, respectful, and supportive maternity care system that reduces the incidence of birth trauma and prioritises the well-being of birthing individuals and their families.

j) Any other related matter

Nothing else to add.

In support of my submission, I have cited relevant reports and research papers, and attached a highlighted copy of my first child's birth plan to provide additional context and evidence for my views and recommendations. These documents further substantiate the need for action and change in addressing birth trauma in NSW.

I request that my submission be published publicly but without names included. Should the committee require further information or clarification, I am more than happy to provide it though given the proximity to my upcoming birth and delicate postpartum period, I will not be able to provide evidence in a hearing.

In conclusion, I sincerely thank the Select Committee for providing the opportunity to contribute to this important inquiry. It is my hope that my submission, along with others, will facilitate meaningful discussions and actions to so desperately address birth trauma and improve the birth experience.

Kind regards,

Citations & Enclosure:

Australian Institute of Health and Welfare. (2022). *Maternity models of care in Australia, 2022.* Retrieved from https://www.aihw.gov.au/reports/mothers-babies/maternity-models-of-care

Buckley, S. (2019). *Synthetic Oxytocin (Pitocin, Syntocinon): Unpacking the myths and side-effects*. Retrieved from Dr Sarah Buckley: https://sarahbuckley.com/pitocin-side-effects-part1/

Dawson, K., Forster, D. A., McLachlan, H. L., & Newton, M. S. (2018). Operationalising caseload midwifery in the Australian public maternity system: Findings from a national cross-sectional survey of maternity managers. *Women and birth : journal of the Australian College of Midwives*, *31*(3), 194–201. https://doi.org/10.1016/j.wombi.2017.08.132

Dekker, R. (2012). The Evidence on: Birthing Positions. Retrieved from Evidence Based Birth: https://evidencebasedbirth.com/evidence-birthing-positions/

Huang, J., Zang, Y., Ren, L. H., Li, F. J., & Lu, H. (2019). A review and comparison of common maternal positions during the second-stage of labor. *International journal of nursing sciences*, *6*(4), 460–467. https://doi.org/10.1016/j.ijnss.2019.06.007

Lothian J. A. (2004). Do not disturb: the importance of privacy in labor. *The Journal of perinatal education*, *13*(3), 4–6. https://doi.org/10.1624/105812404X1707

M.R. Odent. (2013). Synthetic oxytocin and breastfeeding: Reasons for testing an hypothesis. *Medical Hypotheses*. Volume 81, Issue 5. Pages 889-891. https://doi.org/10.1016/j.mehy.2013.07.044.

World Health Organization. (2018). WHO Recommendations: Intrapartum Care for a Positive Childbirth Experience. Retrieved from The World Health Organization: https://apps.who.int/iris/bitstream/hand le/10665/260178/9789241550215-eng.pdf

A copy of my birth plan, highlighted to illustrate which of my specific requests were either ignored, denied or I was coerced out of:

Birth Preferences for

To our Midwives / Obstetrician / Doctor

Please find attached a copy of our Birth Preferences.

We have chosen to use hypnobirthing techniques for a calm and gentle natural birth. We trust that you will do your utmost to help us to attain a positive, healthy and satisfying birth experience.

We also want you to know that should special circumstances arise, this may cause us to deviate from our original birth preferences and you will have our cooperation should a medical need arise. In the absence of an emergency, we ask that you provide us with a clear explanation of the special circumstance, and advise of the risks and benefits of any suggested interventions. We also ask that you provide us with any alternative options available and give us the opportunity to discuss these privately.

We have included a handout on how you, our midwives and doctors, can help us with hypnobirthing, to achieve a natural, calm birth. We thank you for taking the time to read this.

We look forward to sharing this very special time with you.

Kind regards

&

Birth Preferences

We request:

Prior to Admission

For Admission

- It is important to us that our birthing team supports and encourages hypnobirthing practices and a natural, physiological birth.

- The atmosphere of the room to be quiet, subdued lighting and blinds/curtains closed.
- To have relaxation music/tracks playing in the background.
- To have the following persons present during my birthing: (husband), (mum – COVID restrictions pending)
- Please – no references to pain, pain tolerance or pain levels. We will be referring to contractions as 'surges' and discomfort as 'pressure' or 'sensations'.

During Labour

- No unnecessary talking – please speak to birth partner/s. As I will be using self-hypnosis, I may not be immediately responsive to questions, especially during surges.

- Please no references to "pain" or "hurt".
- Please do not offer any medication (due to using self-hypnosis I am very open to suggestion) – I will ask if I need it. and is aware of my pain management order of preferences.

- To take fluids and light foods during labour. If labour is prolonged – to take nutritional snacking.

- Please do not inform me of my progression in dilation unless I am complete, however, you are welcome to share this information with my birth partner/s privately.

During Birthing

- Use ventouse, rather than forceps if assistance is medically necessary.

- Myself / to help receive the baby.

- Initial exam to be made whilst baby is in my arms.
- Allow vernix to be absorbed into baby's skin; delay "cleaning or rubbing"; use soft cloth when rubbing is appropriate but please retain as much vernix as possible.

- Delay cord clamping and cutting until after pulsation has ceased and the cord has turned white/after placenta is birthed. will cut the cord.

Baby skin to skin with mother. No hat on baby.

- In the case that the oxytocin injection is required - clamp cord before injection given.
- Please do not discard the placenta. We would like to keep it for encapsulation.
- Allow us 1-3 hours of uninterrupted bonding time together before any weighing/measuring etc.
- Injections/immunisations: Please do not administer Hepatitis B injection to our baby – this will be delayed and done with our family doctor. Please administer Vitamin K orally, unless the baby is showing signs of any bruising or an instrumental birth was required in which case we would like the baby to receive the Vitamin K injection.

In Case of an Emergency Caesarean

It is my strong wish to give birth vaginally. If it is determined that a caesarean is medically necessary, we request (health and circumstances permitting):

- The option to obtain a second opinion from another obstetrician/doctor if time allows.
- The atmosphere of the room kept calm, with no unnecessary chatter.
- Delayed cord clamping.
- Drapes lowered as baby emerges.
- Vaginal swab be taken and smeared over baby (mouth and body) immediately at birth; so baby is exposed to a similar bacteria environment as if born vaginally.
- Baby placed on my chest immediately for skin-to-skin contact, for us to stay together during repair and recovery and to breastfeed during the initial recovery period.
- My partner to remain with our baby at all times.

Thank you for taking the time to read our Birth Preferences. We look forward to sharing this very special time with you.