Submission No 261

INQUIRY INTO BIRTH TRAUMA

Name: Name suppressed

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Partially Confidential

I'm a midwife and had significant experience in a major teaching hospital before I had my children. I feel like I was incredibly empowered because of my profession and knowledge base but still had negative experiences birthing in the Australian system.

I had two births where we engaged a private midwife and one solely public when there was no private midwife in our area.

My first birth was a successful homebirth but our son required transfer to a SCN when he was around 4hrs of age when he had a dusky episode at home before our midwife left. The ambulance staff were great but the admission process to the hospital was horrendous. I expected it and was strong but it made me so angry to be bullied over giving prophylactic IV antibiotics in the absence of any clinical signs of infection, and to give formula over donor breast milk or IV fluids and wait for my own milk to come in.

We declined IV antibiotics and later blood cultures came back clear, confirming no infection was present.

We strongly declined formula, and later gave donor EBM after one midwife told me no-one had ever fed donor milk in their hospital and they never would. Arrogant much? The World Health organisation lists the order of priority for milk for human babies to be:

1 directly BF,

2 EBM from mother

3 surrogate BF or EBM from another mother

4 formula

It's the last choice, donor EBM is a valid evidence based choice if insufficient milk is available from the biological mother. It's not wheatgrass. It's not poison. It was MY choice.

During that admission I was also told not to touch my child. He was too sick, my touch fatigued him. Bullshit. He was my baby. There's plenty of evidence showing direct contact mother to baby reduces stress experience for both, normalises HR, RR and all other clinical observations and lessens duration of admitted care.

I was so angry at the poor care we received having worked in a better tertiary nursery and knowing what evidence based practice was (and yet staff here weren't meeting the standard), it took 6 weeks for my milk to come in. I had no physical reason that I couldn't lactate. My baby could BF but I had barely any milk until I wrote an extensive complaint letter to te hospital, had a formal apology, they changed their jaundice management protocol overnight to align with the tertiary centre in the network and I finally relaxed.

I kid you not, the tertiary centre had a new jaundice protocol - 6 weeks old, but their level 2 facility we were admitted to, was still trying to use their old protocol from 20yrs ago. The consultant was trying to use it to say my baby was close to needing an exchange transfusion, the new protocol chart was different and he was far from requiring that intervention. How ridiculous. All hospitals in the network need to use the same policy and it obv should be the latest evidence based one from the tertiary hospital, not someone's preference from when they first trained. And it certainly shouldn't be wielded like a weapon.

I BF my son with a supply line, donor EBM, my own piddling amount of EBM, medication to boost my supply, acupuncture (for me) and Chiropractic care for us both, we released his tongue tie that the SCN refused to acknowledge. (the paediatrition said tongue ties don't affect BF'ing - they do), and after 6 weeks, one day I suddenly felt breast fullness heard him gulping at the breast and was able to stop supplementation and never look back.

I tandem BF with him and his next brother, and then our last daughter. I never again had supply issues. I think it was purely related to the stress and trauma of the admitted care in the nursery. I am a good clinician myself, I knew what good care was and was angry we weren't receiving it.

As a clinician I have seen abhorrent situations. It's like no-one believes a woman can birth without interventions. She must do the diabetic test, she must have gbs swabs, she must be induced at only 40+ anything to suit the hospital rather than await and encourage natural labour.

Women are bullied into having care with a lens of risk, undermining their own confidence, ability and choice, often without a known and trusted provider because there are so few continuity of care models available and it all makes them more vulnerable and unable to engage their hormones to do as they should, labour and birth safely. When women don't feel safe, they don't go into spontaneous labour when they're meant too, and it can iterruot the course of labour increasing the chance of labour stalling and greater interventions being offered / forced and poor outcomes with PPH, BF'ing etc.

It's very hard to decline interventions offered because if the clinicians think they're needed, they will use very strong language to make women feel they must employ them otherwise they're putting their baby at risk. I understand the gravity in some situations. Where that is true and warranted, but this is much less often than when it's occurring. Esp given the example of routine GBS swabbing. The latest evidence published in the UK refutes that practice, yet most drs in Australia still persist in the practice and give a hard time to women trying to decline.

My second labour never established properly at home, with our private midwife. I had a few contractions and got to 8cm, but he was malpositioned and labour stalled after never really establishing as regular strong painful contractions etc. We decided to transfer, this time to the tertiary facility as I was NOT going back to the level 2 hospital after my last experience. They were great.

The ideals of the obstetric consultant on-call and myself didn't align, but she listened and we negotiated. I wanted syntocin to bring on more uterine power with an epidural to relax me and my strong reflex to clench with the abnormal contraction pains while he was msl-aligned (deflexed OP and asynclitic). She wanted me to have a caesarean straight up to avoid risk of uterine rupture.

I understood that was a risk but didn't agree I was a multipatous woman who had gone out of labour (big flag), I'd never established properly. I wanted to be given a go. We were in a facility that could run for an emergency caesarean if signs of uterine rupture developed. To me, a successful vaginally birth was a better outcome for us both, than negating the risk and having a caesarean then, not forgetting that operative procedure comes with its own risks - maternal death being one of them.

She agreed we could try the syntocin for 2 hrs and expect to be deliverable, fully dilated, after that time, if not she'd want to head for a caesarean. I agreed and considered that reasonable. My son was born after 1½ hours of syntocin with only 3 pushes. I just needed the power of the uterus increased to push him into a better position to be born.

I have lots of friends who hearing that story said they would have had the caesarean when the obstetrician recommended it, they wouldn't have thought they could decline and ask for a different intervention. That included many registered nurses who felt whatever the obstetrician said was gospel to be followed.

She was actually great, and respected my opinions and choices and listened to my private midwives assessment of me, but she was trained to focus on the risk and opt for the quickest way to birth a live baby, not to consider the location and facilities capacity to manage an emergency and choose the perhaps riskier route that could offer the greater benefit, knowing crash caesarean could be done quickly if an emergency transpired. Thankfully it didn't, and my use of resources was minimised be avoiding theatre.

I could go on, if you want to read my 14,000 word complaint letter about my first SCN experience I could send it in, but the crux of the matter is we need clinicians who believe for most well, healthy pregnant women, birth works. Women need to have their foundational health supported, be educated about the physiology and the process, their choices and how particular choice may impact outcomes. We need more continuity of care to support this and

ensure women are cared for by a known provider actively involved in the education and planning.

We need appropriate levels of clinicians caring for women, not private obstetricians charging through the roof caring for midwifery level patients but failing to spend the time bruising the relationship and trust with the education process, deploying more interventions than required and then saving the day with their heroic feats yielding families so grateful they come back for more failing to recognise the unnecessary intervention that started it all caused the drama in the first place.

So often from private women I'd hear 'my obstetrician doesn't do twins vaginall'. Or insert other opinion based inconvenient thing... Why? Yes, there's some presentations where attempting a vaginal birth is not safe, but a blanket rule laid out before 20 weeks? Stike him/her.

Same for those that don't 'let' woman have a trial of labour for VBAC and instead insist they have a repeat caesarean. Whose choice is it? Who gets to be at home alone with that surgical wound and two young children after dad goes back to work while she can't drive for 6 weeks post op? If women want a VBAC and there's no medical indication to suggest it's unsafe it should be her choice, not her drs.