Submission No 566

INQUIRY INTO BIRTH TRAUMA

Name: Name suppressed

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To whom it may concern,

I would like to share my experience of birth trauma in the hopes that current practices in hospital systems are reevaluated, and foremost let that continuity of care is given greater funding and consideration in maternity care.

I am writing regarding my antenatal care and the birth of my second child, [redacted] at the [redacted] Hospital [redacted] in April 2020.

Having had positive experiences with the Midwifery Group Practice and excellent obstetric care with my first birth at [redacted] Hospital, I had high hopes for a positive experience at [redacted] Unfortunately this was not the case.

Despite my pregnancy being uncomplicated, the fact that this birth was classed as a VBAC categorically excluded me from having any option for continuity of care. I feel this exclusion is hugely detrimental, considering that women attempting a vaginal birth after cesareans are, if anything, in greater need of having a rapport with their caregivers. While a designated VBAC program has merit, my experience of the program at [redacted] was that it did not provide me with any benefit, and merely took away any possibility for me to be known by my caregivers. During antenatal appointments I had no continuity with midwives at (fleeting) appointments and each time had to re-tell the context of my previous pregnancy and birth. I felt entirely lost in the system.

Additionally, being diagnosed with gestational diabetes (GD) - but entirely diet controlled - I spent an inordinate amount of time in hospital waiting rooms with my very active two year old, only to be told in the space of 2-3 minutes that my blood sugars were indeed of no concern and to 'continue doing what you're doing'. I am so greatly appreciative of the expert medical care available to women who truly need it; however I question the efficacy of a system that treats all women with GD alike, convoluting their care, wasting both their time and hospital resources.

I presented in established labour around 11.30pm on April 15th and after being introduced to the midwife allocated to me and examined, my husband and I were largely left alone throughout my labour. My labour progressed rapidly upon our arrival. I sought midwifery support as my labour became more challenging, and with little relief from tepid water in the bath and shower and little in the way of emotional support or suggestions for non-medicated pain management, I opted for gas and air, before an epidural. While the midwife was reasonably friendly, she made no efforts to support me emotionally or suggest anything to support my labour - such as positioning, breathing techniques or massage. I felt helpless and disappointed to be choosing this intervention when I was 9cm dilated.

As often happens, the epidural slowed down the pace of my labour and halted my 'progress' in the early hours of the morning. I was approximately 9cm dilated with little change at this time for 3-4 hours. Continuous CTG monitoring reflected that my baby showed no signs of distress, and I was feeling well in myself.

At 8am a shift change occurred in the obstetric and midwifery team. Dr [redacted] and her colleagues took over my care. Within minutes of arrival and a single vaginal examination reflecting that I was now fully dilated (the seventh examination in 10 hours), they had strongly suggested that I was transferred to theatre for an instrumental delivery, if not a caesarean. Despite being exhausted, I assertively questioned this decision, however was told that a theatre list has been pushed back for me and that it was their recommendation to be in theatre. I was told repeatedly that there was only a 30 minute window and I needed to make a decision. I reluctantly signed the consent form but I do feel that I was coerced to do so.

I was transferred to theatre 52 minutes into the second stage of my labour. The Australian College of Midwifery guidelines clearly stipulate that after an epidural, up to two hours of active pushing should be allowed. I am unclear as to why the OBs felt this was a necessary choice when there were no indications towards it.

During the transfer to theatre, I was instructed to actively push in order to avoid the use of forceps in theatre. This felt threatening to me and so I did my best to push my baby out in the halls of the hospital in full view of other patients, porters and staff. Unsurprising, being under so much pressure for a hasty delivery, my baby's head could be seen by the time we reached theatre and the obstetric team were ecstatic that all that was needed was a kiwi cup (vonteuse) to assist her delivery. I question the necessity of this considering I was still within a normal time frame for second stage of labour.

A vacuum was inserted into my vagina and the obstetrician pulled my baby out. Bradycardia is noted in my medical records as a reason for assisted delivery, however on examining the CTG it is evident that this is a normal deceleration associated with head compression in a natural vaginal birth. My baby was exceptionally well on arrival and PH from the cord gases reflect this. Foetal and maternal distress were not evident.

Upon reviewing my medical notes and seeking third party knowledge, I believe that had the doctors followed protocol, I would have been left in the birthing suite for the full two hours allowed to second stage, and I could well have peacefully delivered my baby without the intense stress that I did experience in theatre. On arrival in theatre I had numerous people in my face, starting social conversations with me, and each other. Prior to this I'd been in a quiet birthing space for 12 hours and this occurred just minutes from having my baby. There was very little respect for the sanctity of childbirth in that environment.

Having had a positive caesarian delivery (due to footling breech) with my first baby, I am in no way opposed to medical intervention when it is required. However, I strongly feel that in the case of [redacted]'s birth, this was not the case and my right to a supported and peaceful birth was taken away from me, and ultimately I was coerced into a rushed and stressful birthing experience. Personally I have invested much time and money to recover psychologically from my experience, and I can only imagine how other women with fewer resources must feel.

The key issues I am drawing your attention to here are the dire need for continuity of care in pregnancy and childbirth, the treatment of women by the maternity team, and the unnecessary use of medical intervention. If I had felt truly supported or listened to in my labour, I would not be writing this letter. I believe that a better MGP program at [redacted], as well as options for continuity of care in VBAC - or other higher risk - scenarios is essential for the wellbeing of mothers and babies.