Submission
No 894

INQUIRY INTO BIRTH TRAUMA

Name: Ms Sarah Gell

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Partially
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15th August 2023 Sarah Eve Manning Gell

Committee Secretariat
Select Committee on Birth Trauma
NSW Parliament
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Re: Inquiry on Birth Trauma

Dear Chair and committee members,

My name is Sarah, I live in NSW. I'm 29 years old and I have two boys; a 10 year old and a 2 year old. I am a passionate advocate in my local maternity consumer group 'Better Births Illawarra' and I have also been a support person/doula at friends' births. Although I am passionate about research and evidence-based maternity care, I am not a midwife or other health professional, however I am considering a PhD in this area in the future and am very well educated in this topic; in part due to the traumatic experience of my first birth. I am happy to have my submission shared and would love to be invited to any based hearings.

My Birth Story

Firstly, for both of my children I applied for the public Midwifery Group Practice (MGP) program at hospital, unfortunately I was not successful in getting a space in either pregnancy. At only 19 years old with my first pregnancy, I desired continuity of care and so I did GP shared care for awhile before finding a student midwife to follow my case. I desired a natural birth, with minimal interventions and was very well informed through both education and research.

I had an extremely normal, natural labour starting spontaneously at 40 weeks and 4 days. My baby was born with very little intervention, I experienced the fetal ejection reflex (spontaneous pushing, not coached or directed) and a wholly uncomplicated and empowering 1st and 2nd stage of labour. Once baby was born, the midwife proceeded with immediate cord clamping and active management of my 3rd stage without consent; including cutting the cord too soon, administering IM Pitocin and removing my placenta via controlled cord traction. This was directly in conflict with my verbal and written requests to have a physiological 3rd stage, delayed cord clamping and minimal interventions.

I believe I received disrespectful, inappropriate, and abusive treatment. My baby was not allowed the time to receive his blood from the cord and placenta, which was a conscious choice I made as research shows this can have a significant impact. The placenta was forcibly removed from me, which made me feel violated and disrespected as there was no medical need in my situation.

I will never forget the photo of one of my support team holding my pale, minutes old baby, while in the background you see me naked and bleeding on the bathroom floor. It haunts me still, 10 years on.

I did not make a complaint at the time, I didn't know who to contact or where to go. I also felt that the midwife would have simply defended herself by saying that it was policy and that I didn't say no. I believe there is a lack of law policies & legislation protecting women and birthing people from birth trauma and obstetric violence. It is my experience that hospital policies and obstetric standards are considered more important than informed consent, maternal wellbeing and individualised care.

A note on 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") – Go to any mothers groups, parenting forums and playdates, and you will hear birth stories filled with fear, coercion, disrespect and abuse. I can not cover all the variations and intricacies in this submission, but I wanted to mention that for every story and submission that you receive and read, there are thousands if not millions more unwritten just from the last 5-10 years in NSW. Those that are too raw to share, or who's experiences have been so normalised, justified and buried for self-preservation and to emotionally cope may not be included but cannot be ignored. Society expects mothers/parents to get on with it and focus on the positives, so they often hide the feelings and consequences of their birth trauma.

A note on 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 – The impacts are extensive, from immediate stress at the time (and the consequences on labour progression for example), to the longer impacts such as Mother/baby bonding, partner bonding and support capacity, breastfeeding success, PPA/PPD, physical healing of tears, cuts or surgery, and babies future health as described in the 'First 2000 days of life' report.

I have given a brief example from my own experiences below;

	Cause	**Short-term impacts**	**Long-term impacts**
Physical	Immediate cord clamping and lack of skin to skin Synthetic oxytocin	My baby was described as "cold and pale" In my situation, this increased my risk of postpartum haemorrhage and other side effects	Fatigued and slow to feed, and impacted his long-term health Synthetic oxytocin – potential side effects, impacts on breastfeeding
Emotional	Birth trauma	Violated and stressed. Impacts on sleep, breastfeeding and bonding with my baby	Ongoing anxiety when discussing birth, maternity system, and statements such as "all that matters is a healthy baby"
Psychological	Obstetric violence – lack of consent	Postpartum Anxiety, difficulty trusting and asking for help	Anxiety around my body and that of my children, impacts on my relationships with partners, family and friends
Economic*	All of the above	Cost of the unnecessary oxytocin In some cases, the resulting PPH would have cost a significant amount more	Breastfeeding: Significant support cost to help with breastfeeding, cost of mix feeding, cost of increased risk of allergies and asthma Cost of psychological support, Impacts on economic contribution

*The economic cost of my homebirth was significantly less than that of my hospital birth, in part due to the physical and emotional wellbeing that it created.

A note on the role and importance of "informed choice" in maternity care – Almost every parent who has discussed their pregnancy, birth and postpartum with me has used the words "I wasn't allowed to" or "they wouldn't let me do that", this is echoed by those who are still pregnant "am I allowed?" or "my doctor told me I need to do this". I believe that we are so far from informed choice, that many do not even realise what this truly means. Birthing people and their support (may that be partners, family or friends) are operating under the assumption that they must to do what they are told by clinicians, that there isn't choice and autonomy in Australian maternity care. This has become so culturally normal that many people will be unable to even recognise that informed consent is not occurring.

A note on the barriers to the provision of "continuity of care" in maternity care – MIDWIFERY CoC is absolutely an essential part of the process of reducing Birth Trauma rates (however it not a silver bullet). Promoting a supportive, respectful and collaborative environment is going to help maintain midwife wellbeing and continue in their profession. See the [Continuity of Care Models – A Midwifery Toolkit]

On the issues recruiting and retaining midwives, I believe that many of the issues contributing to birth trauma are also impacting on our healthcare workers. I don't believe that most midwives and obstetricians go to work each day intending to be abusive and cause traumatic experiences. We need to develop, prototype, and implement programs that help our healthcare workers recover from their own trauma, to start preventing the traumas that they are complicit in causing.

A note on the information available to patients regarding maternity care options prior to and during their care – Firstly many regional or remote families do not have much if any choice of models-of-care. The vast majority of people only believe in Public hospital or Private hospital maternity care, and that the experience of paying for a private obstetrician will mean having a better experience, known provider at the birth and better resources. However, the real implications of this decision is not often realised until they feel it is too late to change.

MGP options are few and far between, with restrictions and limitations often causing stress about being 'dropped' from care in late pregnancy or even in labour. When I called to inquire about MGP applications in my 2nd pregnancy, I was told over the phone that there was so few places compared to interest, and that my chances of having 2 midwives available for a homebirth when the time for labour came were slim to none.

I also want to expand on this issue of options: both models of care and options during care. I believe that midwifery continuity of care provides some accountability for the treatment of parents in pregnancy and birth; it is easier to be abrasive and rude when you know you will not be providing care for that family again.

In mothers groups and online forums, I often hear the term "Bait and switch", where a hospital/obstetrician/midwife will promise a certain treatment or allowance will be possible in early appointments but once they hit the late 3rd trimester or arrive in labour, those things are then revoked. It then often feels too late to change providers/plans and the parents are left continuing with the model of care feeling betrayed and unsupported. Examples:

In early pregnancy or pre-birth	In late pregnancy or in labour
"We support waterbirths"	"You can labour in the tub but you can't birth there" "Your BMI is too high, I wouldn't be safe (for us)" "You need CTG monitoring so you can't use the bath" "The only person trained isn't on shift"

“We use intermittent monitoring”	“You just need to be on the CTG for 20 minutes at admission” “You were induced so now you need CTG” “We are busy and can’t keep coming back in, you need to be on CTG so we can monitor you centrally”
“We support natural birth”	But only if you: - Spontaneously go into labour between 37 and 39 weeks, then we will start pressuring you to be induced - Are a healthy BMI, don’t put on too much weight and don’t lose too much weight - Consent to all the ultrasounds, tests and procedures we want you to do during pregnancy - Consent to cervical checks so we know you are “progressing” - Can manage that in a cold bright room, with constant interruptions and questions - Don’t have gestational diabetes (even if its diet controlled which is proven to be safe) - Happen to get lucky and get a midwife/OB that is supportive
“We support breastfeeding and strong bonds/attachment”	But we won’t - Do infant resus on mum to allow the cord to stay intact - Delay all non-essential exams until parents are ready - Use 24hr weights over birthweights to account for excess fluids from labour interventions - Allow partners or support people to stay as much as possible to provide the necessary support - Ensure midwife ratios to provide the necessary support - Ensure consistent and accessible qualified lactation support antenatally AND postnatally - Support co-sleeping; where it is the parents’ informed choice
“Shared decision making” “We support evidence-based care”	Proceeds to use coercive language that bullies or places blame on the pregnant person if they disagree “Fine, but its your fault if things go wrong” “Your baby could die” “That goes against our policies and I can’t support you if you do that”

A note on the exacerbating factors in delivering and accessing maternity care that impact on birth trauma generally, but also in particular:
(i) people in regional, rural and remote New South Wales
(ii) First Nations people
(iii) people from culturally and linguistically diverse (CALD) backgrounds
(iv) LGBTQIA+ people
(v) young parents

As a young parent in a regional city with my first pregnancy, I found it difficult to understand the options and choices available to me, it was also a severe drain economically and physically to travel to appointments and see a different provider every time.

I'd also like to raise the issue of privilege in accessing midwifery models of care. With MGP, you need to be aware of your pregnancy quite early, know of the programs existence and benefits, then how and where to apply. The massive inequality this introduces is extremely concerning as many in the groups mentioned are not as likely to meet one or more of these criteria. For example with my 2nd planned pregnancy, I confirmed my pregnancy at 3 weeks + 5 days, for my 1st unplanned (teen) pregnancy it was not until weeks later.

A note on the causes and factors contributing to birth trauma – refer to research, such as the BESt study and Connecting, listening and responding: A Blueprint for Action – Maternity Care in NSW have so many fantastic insights and suggestions.

Language; as per the examples given above, informed consent cannot be given when the language used denies the importance of consent. Standard language and clear messaging in maternity wards could help encourage a shift along with other suggestions for training and cultural change processes.

Rushed; this is an issue in all areas of maternity care, many women feel like an inconvenience and minimise their issues so as not to feel like burdens on the midwives and other professionals. This is leading to adverse outcomes and lack of informed decision making.

Environment; while supporting friends in labour, I experienced midwives/nurses asking questions while she was mid-contraction, turning on lights and other disrespectful treatment. This wasn't traumatic, but did not support the birthing environment

Trauma-informed; a significant number of new parents will have experienced a sexual assault, abuse or other related trauma in their lives. Maternity care needs to assume a standard of trauma-informed care rather than responsive.

Whether current legal and regulatory settings are sufficient to protect women from experiencing birth trauma – I think it will be clear from this and other submissions that the current legal and regulatory settings are insufficient. However as this is not my area of expertise, I implore you to contact Bashi Hazard (http://twitter.com/bashazard), and groups such as Human Rights in childbirth https://www.humanrightsinchildbirth.org/

My respectful and healing homebirth with a Private Midwife - Finally I would like to share that for my 2nd child, I engaged the services of a local private practice midwife. We developed a trust and respect filled relationship over the course of my pregnancy. I birthed my baby peacefully at home, where I felt safe and supported. Myself, my husband and our beautiful baby all emerged from that birth physically and emotionally well. This experience was so incredibly different, despite the ongoing trauma from my first birth, by having a trusting relationship with my private midwife I could relax and be totally vulnerable while birthing.

I hope that the inquiry will consider recommending Medicare rebates for the attendance of private midwives at homebirths, to ensure that this model of care an affordable option for those who choose it.

Any legislative, policy or other reforms likely to prevent birth trauma – many changes are already detailed in Connecting, listening and responding: A Blueprint for Action – Maternity Care in NSW they just need an action plan with Specific, Measurable steps with transparency and accountability for both professionals and consumers. Consistent, valued and compensated engagement with community and consumer groups also needs to be implemented at all stages of this transformation.

Summary of changes I believe will decrease Birth Trauma

1. Mandate continuity of midwifery care as standard; for both private and public maternity services, with obstetric and other provider collaborations where relevant
2. Mandate Medicare rebates for the attendance of private midwives at homebirths
    a. Consider supporting private midwifery in other ways such as pathways for new private midwives. Acknowledging this model of care through inclusion in documentation, surveys and reports.
3. A State-wide publicity campaign around informed consent, autonomy and choice in women's healthcare and particularly maternity care
    a. This could be expanded to primary/secondary school education syllabus on informed consent, autonomy and choice
    b. The recent campaign around options for pap smears could be used as a model
4. Mandate the use of standard information on Benefit, Risks, Alternative, do Nothing (BRAIN)
    a. Models of care
    b. Due dates; accuracy, what's normal and risk factors (both comparative and absolute)
    c. Inductions; options, consequences
    d. Breech; options including ECV, vaginal breech birth, elective c-sections
    e. Monitoring; Intermittent (doppler), CTG, fetal scalp monitor
5. Investigate a cultural change program for medical providers modelled off the 'MATE bystander' program for gender-based violence
    a. Starting with Obstetricians and Midwives, but rolling out to nurses, GPs, child health workers, students and so on
6. Introduce or increase the number of Medicare rebated sessions available antenatally and/or postpartum for:
    a. Psychology services
    b. Women's Health Physiotherapy
    c. Lactation consultants
7. Access to specialist clinics in pregnancy for:
    a. Hyperemesis Gravidarum
    b. Gestational diabetes
8. Access to culturally safe and respectful care for all:
    a. Birthing on country
    b. Specialist interpreter services
    c. Staff who have undergone cultural awareness training

Thank you for your time reading my submission and all others who have shared their stories.