Submission No 898

INQUIRY INTO BIRTH TRAUMA

Name: Name suppressed

Date Received: 11 August 2023

Submission by a now widowed husband to a wife who experienced Birth Trauma and other complications generated by non typical female sex organ anatomy.

The relevant events, experiences and incidences follow listed in near chronological order.

1. Circa Valentines Day 1982 I met up with my wife to be at a local Bistro. More or less instantly I noted she (-------- (surname omitted for respect and family privacy purposes) exhibited child bearing hips.

2. After several meet ups and outings together invited me inside her accommodation. Due to my lack of sexual approach she queried me as to why I didn't make a sexual move on her. I informed her because of her child bearing hips I expected a young child to come out of a bedroom complaining he or she couldn't get to sleep due to our lounge room conversation. In response informed me that several years previous she had desired to become a single mother and so had a one night stand conceiving with a local single male. During her pregnancy she became aware the biological father had an inherited degenerative nervous condition which would subsequently cause him (and any male offspring) to become wheel chair bound invalids. Subsequently, aided by considerable pressure from her younger sister and mother, elected to have a late stage abortion.
During these same discussions also informed she lost her virginity at a relative late age of 28 year old (yo) (especially relative to her elder half sister who was a mother at 15 yo and her younger sister who I was informed was sexually active at 14 yo). (also informed at about the same instant she had lost her older half brother at some 27 yo by suffocation during an epileptic fit whilst a client at a . (Unfortunately no further information or details were declared due to the sensitivity in relation to the actual loss of her half brother and discussion about same.)

3. The actual abortion was conducted apparently at a Sydney Clinic. Apparently she was strongly hassled by anti abortion protesters and /or religious groups during her approach and entry into the Clinic. (Unfortunately no further information or details were declared due to the sensitivity in relation to this abortion or discussion in relation to same.)

4. Possibly more or less immediately post the abortion returned to work and apparently did not perform the necessary post 'birthing' exercises to normalise her muscular skeletal condition post her near full term child bearing status.

5. Post the abortion was inserted with an IUD device.

6. During our courting discussed her desire when married to have a pigeon pair of children in close succession prior to her turning 40 yo. During our courting discussions including description of our joint grandparent physics it became evident would give birth to relatively large offspring. Shortly post our meet up ceased smoking.

7. Early December 1983 and I wed and conducted our honeymoon / study leave in Japan from December 1983 to late June 1984.

8. More or less immediately on our return from our honeymoon elected to go to her gynecologist to have the IUD removed. (This gynecologist had apparently regularly examined during her aborted pregnancy and subsequent to the abortion inserted the IUD.)

9. conceived the very next ovulation cycle post removal of the IUD.

10. Ultra sound testing identified the embryo was correctly placed, was relatively large and male.
11. During the pregnancy had regular visits to the gynecologist. However, I was never invited to attend with her. In the later stages of pregnancy she also attended regular new mother meeting held in local Council motherhood clinics with, in the final stages, me in attendance for new father information and education.

12. Mid May 1985 in final stage of heavy child bearing attended Hospital Birthing clinic twice as false alarms. These false alarms were elevated in anxiety due to the birth being some two weeks overdue.

13. Early evening (circa 17:00) on the 17th May water broke and complemented by other evidence we confidently attended Hospital Birthing clinic. She was admitted post considerable hesitation by the admission staff suggesting she was experiencing another false alarm. Post the hesitation she was admitted and placed in a birthing room bed.

14. On reclining in the birthing bed a junior, recent qualified University trained, nurse attached a skin stress sensor to thumb (or wrist) connected to a freestanding bedside monitor. The monitor simply indicated a trace moving along the screen base. With the trace cycling the junior nurse departed bedside. Immediately the junior nurse departed bedside she commenced to experience serious thrusting yet the monitor displayed a base trace. Hence I informed I considered the skin / muscle stress sensor was incorrectly installed to her thumb (or wrist). strongly disputed my statement along the lines of what would I know about such medical non engineering sensors.

15. Initially nurses would regularly enter the room peer at the 'base' trace on the monitor and simply depart without calibrating the trace to actual thrusting effort and body / muscle / skin stress.

16. As the night wore on and in the early morning no nurses attended . At approximately 3:00 the baby commenced crowning. For some three hours was thrusting extremely hard yet the extent of the baby's crown did not significantly increase.

17. As the change of night to day shift occurred the supervising nurse conducted a routine check on simply by looking at the monitor trace. On noting a base screen trace she immediately commenced to leave the room. However, I intervened to inform the nurse that the baby had crowned. On that information the nurse lifted the sheet covering to observe the baby's crown. The nurse then raised hand with the sensor attached to immediately identify the sensor was not properly attached confirmed at the instant by observing first hand extremely hard thrusting. The nurse then attached the sensor correctly to . Immediately the trace went off scale at the top of the monitor screen. The nurse then raised the alarm and effected the necessary arrangements to have gynecologist attend and effect the actual child birth.

18. Luckily a healthy 10lb baby son some 21" long (and accompanying large placenta) was born at approximately 8:15 on 18th May 1985 post some 5 minute attendance by her gynecologist. Luckily also was deemed to be in perfect health void of any damage to her female organs and uterus.

19. Post the actual child birth left nipple caused suckling difficulties due to it's initial inversion.

20. subsequently copiously and enthusiastically breast feed the child for some eighteen months.

21. Whilst breast feeding our first child experienced a miscarriage wherein it was reported the fertilised ova had not successfully attached to her uterus wall.

22. On or about third ovulation cycle post terminating breast feeding our first child she fell pregnant with our second child. At the time was nearing 40 yo and was very concerned this second child may be born with down syndrome. Further by employing the 'Billings' method she was keen for the second child to be female. So at the appropriate pregnancy stage eagerly had the necessary Epidural injection to extract uterus fluid for testing. Subsequently the test confirmed negative for down syndrome and that the embryo was female. So with utter delight continued with the pregnancy.

23. For her second pregnancy elected to change gynecologist's.

24. At the appropriate week of pregnancy with the second child had her first examination with her elected gynecologist opting for me to be in attendance.

25. Post the gynecologist examining the gynecologist promptly returned to his desk at which I was seated and informed almost in whisper tone, whilst was redressing behind a screen:

'Did you know your wife has a reverse angle vagina, it occurs in women about on a one in ten thousand basis.
It means having sex with her will be uncomfortable and difficult in some positions.'

With that information declared I immediately leaned over the desk to inform the gynecologist:

'What do you mean some positions its all positions; she as a repertoire of one - missionary!'

26. Immediately post my reply to the gynecologist joined us at the gynecologist's desk. Much to my surprise the gynecologist did not introduce to our conversion along the lines:

I was just informing your husband that you have a relatively unusual vaginal condition referred to as reverse angle vagina and this may be causing you discomfort and difficulty whilst conducting sex.'

Instead the gynecologist informed us the embryo was correctly positioned and all appeared well.

Subsequent events suggest indeed the gynecologist never informed of her vaginal details nor recorded same on her medical records.

Opportunity here is taken to compare the foregoing communication exchanges to that expected had being examined by a female gynecologist. Namely, due to the high confidence between females, during the actual vaginal examination the female gynecologist may have stated:

do you know you have an anatomical deviation it is referred to as a reverse angle vagina. Approximately one in 10,000 possess the deviation. May I suggest you experiment with different sex positions for improved enjoyment and comfort. '

Further then on returning to her desk whilst redressed informed me:

'. do you know your wife has an anatomical deviation it is referred to as a reverse angle vagina. Approximately one in 10,000 possess the deviation. May I suggest you experiment with different sex positions for improved enjoyment and comfort.'

This simple discussion difference would have presented opportunity for us to experience sexual activities long term so greatly reinforcing a strong, most meaningful and enjoyable marriage.

27. At approximately 22:30 2nd May 1998 our second child a healthy daughter was born at 21" length and slightly under 10lb weight (complemented by a relatively large placenta) with minimal delay and difficulty from water breaking to delivery some three years younger than our son. Luckily again incurred no organ or uterus damage.

28. subsequently copiously and eagerly breast fed our daughter for at least fourteen months possibly eighteen months. Throughput both pregnancies and breast feeding terms never consumed alcoholic drinks (or took any drugs). recommenced light social drinking post breast feeding our second child.

29. Post both above stated child births, with unhindered work free opportunity, enthusiastically conducted extensive walking exercise to normalise her body as best can post the actual pregnancy / child birthing events. was a most dedicated mother throughout electing to purchase a house directly opposite our children's desired primary school, whereas, she most punctually and reliably dropped and collected our children at high school using the family vehicle.

30. Throughout our marriage on a particular day I would awake to and throughout the day observe my wife in a most sensitive state and indeed in heavy tears. On asking her why she was so sad and sensitive her reply would be:

'It would be her (aborted) son's birthday and state the particular age.'

Unfortunately that annual anniversary never departed

31. In all missionary sexual activities with foreplay involved a thorough full body massage followed by difficult finger penetration foreplay with actual penis penetration effected progressively and with copious lubrication. Sex in missionary position was so uncomfortable and difficult that I would often think to myself:

'If sex for other couples is so uncomfortable and difficult as it is for me the human race is doomed for extinction!'

32. Some three years post the arrival of our second child when our sexual activities returned to more or less normal post usual full body massage foreplay activity I suggested to that we experiment with a cowgirl reverse sexual penetration position. I was confident with my knowledge of reverse angle vagina that she would discover this penetration arrangement comfortable and enjoyable. However, refused to even experiment with the position as she

was very conscience of her extensive child bearing hips and the dislike of having her back to my face.

So uttered to my request: '*Why do you want to try that position?*'
My answer: '*Because you have a reverse angle vagina I informed*'
reply: '*Who told you that?*'
My answer: '*Dr ..... your gynecologist*'
reply: '*Rubbish your a liar I was there*'

(Yes she was in the room but she was behind a screen redressing and the discussion was held in very quiet voices!)

33. Our sex activities ceased post this incident and hence obviously I did not have opportunity to experiment with other sex positions consistent with the adage: '*variety is the spice of life*!' Most sadly and considerable disappointment departed this world calling me a liar and also prompted our children to call me a liar (without knowing the reason why their mother elected to incorrectly call me a liar).

34. By shear coincidence to the decease of elder half brother it was epileptic fit complications that caused manipulated (her live support was turned off) decease on 21st January 2014. In addition similar complications also nearly caused the decease of our son who incurred his first epileptic fit when he was five yo. Luckily my son is now on the correct medication for the particular type of Epilepsy thanks to the . (This separate issue has been taken up with the NSW Health Complaints Commission.)

35. Whilst driving from an interstate work commitment simultaneous to listening on the vehicle radio to Triple J Hack program the coincidence occurred that a female teenager phoned in to report that contrary to the reports from all her friends that sex is enjoyable she reported sex was painful and hence enjoyable. Due to lack of mobile coverage it was not possible to contact the radio station to suggest to the teenager caller that she most likely had a reverse angle vagina. This disappointment was further compounded by the fact the presenting radio hosts failed to provide the caller with adequate explanation for the caller's adverse sex experience.

Recommendations

Sex education should inform that all persons sexual organs, of a particular sex, are different from birth. These differences may range from purely cosmetic, to physical and to functional. In terms of physical that some females may possess a reverse angle vagina. Due to physical differences couples engaged in sex activities should experiment with different sex positions to identify a position rendering maximal sexual comfort and enjoyment.

A greater number of females should be encouraged to study to become proficient competent practising gynecologists and so exploit the confidence women share between each other especially in regard female child bearing sex anatomical components.

Gynecologist or qualified registered medical personnel whom identify a female to possess a reverse angle vagina should be required to directly inform the patient of her condition at the earliest appropriate opportunity especially mature age sexually active females.

Gynecologist or qualified registered medical personnel whom identify a female to possess a reverse angle vagina should be required to record this condition on their medical records.

Gynecologist or qualified registered medical personnel whom identify a female to possess a reverse angle vagina should be required to inform patients, with the condition, of suggested or recommended sexual positions to experience elevated sexual comfort and enjoyment.

Gynecologists, qualified registered medical personnel and midwifes should be educated as to necessary alterations to normal birthing procedures to minimise possible birthing difficulties and damage to the offspring and the mother's vulva, vagina and uterus.

Gynecologists or qualified registered medical personnel effecting a medical or birth control procedure involving manual or instrument penetration of a patient's reverse angle vagina should be required to remind the patient of her vaginal condition (or deviation) at the earliest appropriate opportunity.

All medical sensors attached by junior nurses should be quality control checked by a more senior or supervisory staff for proper fitment and operation before leaving the patient bedside. Especially sensors installed to imminent birthing mothers in birthing units or Departments. Furthermore the same should be confirmed by thorough calibration with the patient's actual status.

All females electing late stage abortions should receive appropriate counselling immediately post the procedure and be fully informed of available ongoing counselling and support resources.

Submitted with utmost sincerity (on this day 11th August 2023) (Extended 22nd August 2023.)