Submission No 976

INQUIRY INTO BIRTH TRAUMA

Name: Name suppressed

Date Received: 11 August 2023

Dear Ms Emma Hurst, Ms Susan Carter and members of the Select Committee on Birth Trauma,

My name is . I am a registered midwife with over 16 years of experience. I work privately providing birth education courses to help couples feel informed and aware of their options and rights through their childbirth experience. I am making this submission about my experience supporting my sister with her birth at in 2019.

This submission relates to the following terms of reference:
(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")
(b) causes and factors contributing to birth trauma including: (i) evaluation of current practices in obstetric care (ii) use of instruments and devices for assisted birth e.g., forceps and ventouse (iii) the availability of, and systemic barriers to, trauma-informed care being provided during pregnancy, during birth and following birth
(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.
(e) the role and Importance of "Informed choice" in maternity care
(f) barriers to the provision of "continuity of care" in maternity care
(g) the information available to patients regarding maternity care options prior to and during their care

Our Story
My sister, was pregnant with her first baby. She was allocated MGP with the intention to birth at a free-standing birth centre as she was considered low-risk. At approximately 39 weeks of pregnancy, my sister had an ultrasound for suspected fetal growth restriction. The ultrasound confirmed the clinical suspicion, and she was advised to attend Public Hospital Birt Unit for a review.

We arrived at the birth unit and were seen by a registered midwife. The allocated MGP midwife was on a day off and the backup MGP midwife was unable to attend. It was unsettling to enter the hospital without her support. The birth unit midwife scolded my sister for not having her yellow antenatal card with her. She went on and on about it. In the end, I stepped in and said “Ok we haven’t got the yellow card, there isn’t anything we can do about it. We will remember next time. Can, we move on?”

The midwife took my sister's blood pressure which was now elevated and asked if she could do a “check”. My sister consented until I asked her whether she knew what that involved. She thought it was a check of her baby's heart, but the midwife was referring to a vaginal examination (VE). My sister declined the VE. A CTG was then performed, which was normal.

We waited hours for an obstetric registrar to explain the results and offer her recommendations. She advised us that induction of labour be commenced that night as her baby might die if not born soon. My sister was exhausted physically and emotionally exhausted and declined to be induced that night, instead opting to return the following afternoon.

The following day we arrived at the Maternity unit at approximately 4 pm. The MGP midwife was there initially but did not stay for the balloon catheter insertion. Ward midwives came to perform observations and abdominal palpations at various times. There were inconsistencies in the palpation assessments between midwives, some midwives reported the baby's head was still "very high" and others said it was engaged. This inconsistency in clinical assessments was unsettling for my sister and placed doubt in her mind. The ward midwives voiced their irritation at the MGP midwife not being present to do the admission and balloon catheter as they were all busy.

Finally, at approximately 11 pm my sister was transferred to the birth unit for a balloon catheter. She was exhausted by this time. The midwife inserted a cannula and took blood. The cannula remained painful after the insertion, but the midwife dismissed my sister's experience and insisted it was in the correct position. There was a beautiful student midwife in attendance, and she provided such warmth and care.

Not long after the cannula insertion an obstetric registrar came to do the balloon catheter. My sister was placed in stirrups and a vaginal examination was performed. The examination was roughly performed and intensely painful for my sister. She closed her eyes and focused on her breathing but was groaning in pain through the procedure. Midway through the examination, the registrar picked up the balloon catheter and then firmly and abruptly instructed my sister " open your eyes, this is the catheter and I'm going to fill the balloon with water". My sister struggled to open her eyes but did as she was told.

I live with the regret that I sat there and witnessed that abuse and didn't yell "Stop". In the moment I was doing everything I could to support my sister with her coping strategies and couldn't gather myself to advocate for me sister. I felt powerless. As someone who has worked in the medical system it left me feeling shocked and disillusioned about how anyone could stand up to the medical dominance.

My sister went into shock. She was shaking and lost the ability to regulate her body temperature. She needed multiple heat packs and massage techniques to reduce the shaking and eventually feel warm again.

We returned to the maternity ward where my sister had intense contractions all through the night. The positioning of the balloon catheter was painful even at rest. My sister was unable to move independently. Every time she went to the bathroom, she needed to fully weight bare on me as it was just so painful. She barely had any rest that night.

In the morning the MGP midwife arrived, and we were moved to the birth unit at 6.30 am. We questioned whether the catheter should be in for longer as it was initially explained that it would be in for 12 hours. The midwife advised that an Artificial Rupture of the Membranes (ARM) would be performed at 7 am despite the catheter only being in for about 7 hours, not 12. It seemed that there was an agenda to get things done at a set time rather than considering our individual situation.

On entering the room that looked like the one from the night before where the traumatic balloon catheter insertion had occurred my sister and I both felt physically sick. It took every ounce of mental strength to refocus on turning the experience around to be a more positive one.

A lovely doctor came in and gently explained the ARM process and the expected interventions with Syntocinon. She was so warm and caring and performed the vaginal examination and ARM very gently, there was not a flinch of pain from my sister. I could see how important it was for my sister's mindset to be treated like this after the previous night. It reaffirmed her belief that she could do this.

The Syntocinon was commenced and for the rest of her labour, my sister laboured without medical pain relief, only using her breath and mental focus to birth her baby. When it came to the pushing phase, she worked with her natural urges. After an hour or so there were decelerations of her baby's heart rate and no visible progress. The MGP midwife left the room to get a doctor and I suggested to my sister to change position. In an upright kneeling position, her baby's head was visible and 15 minutes later her baby was born. My sister recalls how she pushed with much force in the last 15 minutes because she was scared the doctor from the previous night would come in and "assist".

After the birth, when speaking with different midwives, there was a recognition that the obstetric registrar who had inflicted the abuse the night before had a reputation for this kind of "care". There was eye-rolling from staff who confided it was not an isolated experience.

This experience scarred us both. My sister may or may not have decided to have another child, but two things are certain. It caused her to lack trust in medical care providers competence and caused emotional trauma that she is still seeking professional help with today. For me, it made me question my work as a birthing educator where I felt that having knowledge and awareness of rights and tools to work with care providers made a difference. It reaffirmed that I would never again enter the system again as midwife.

Recommendations
Communication and Informed decision making

- A focus on re-educating all staff that women have the right to consent or decline any treatment.
- Clear guidelines that stimulate there is never a place for pressuring or coercing the woman even if her decision is different to what they would recommend.
- Clear guidelines that outline what must be provided when seeking informed consent including that at any time, a woman can stop an intervention or procedure and that information about benefits, risks and alternatives to interventions always be provided.
- Education about communication skills including the importance of warmth, compassion, empathy and acknowledging the woman and her family as an individual.

- Education to ensure Staff refrain from language that implies there is no option or choice such as “We do not allow……” in all of its variations. (It is rare for me to hear a birth story without this language being reported).

Continuity of Care

- When a woman is in a continuity of care model that her midwife or another team member provides care at any stage in the pregnancy, birth or postpartum even if complications arise.
- Enable all risk MGP models.
- Increased Medicare rebates for women her choose to birth with a privately practicing midwife to enable more women to access this option.
- Improved staffing rations and supernumerary team leaders.