Submission No 1132

INQUIRY INTO BIRTH TRAUMA

Name: Name suppressed

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Parliamentary enquiry into birth trauma
Submission by a woman who gave birth in the NSW Health System in 2023.

Problems

- Terrifying statistics on cesarean rates
- Disturbing rates of birth trauma
- Intergenerational trauma
- High chance of unnecessary interventions and unnecessary bodily harm
- Treatment of birth as a medical condition (rather than a physiological event that occasionally needs intervention).
- Lack of continuity of care
- Risk adverse system - that puts hospital liability in front of women's welfare
- Classification of informed consent - what is considered informed consent is not always actual informed consent when you are in labor/birth.
- Need for more midwifery group practices and midwifery lead care.

After reading the statistics on intervention and cesarean rates I felt scared to birth in the system.
Australian cesarean rates well above the World Health Organisation (WHO) recommendations and have more than doubled in one generation, since my mum gave birth to me.
By looking at hospital data i worked out that **my sister and i had 4 x the chance of our mother to have a cesarean based on the hospitals we were birthing at.** This terrified me. I also saw this reflection within my own family, the number of my female cousins who had cesarean births far outweighed the number of aunties in my family who had cesarean births. I personally did not want to have major abdominal surgery unless it was a life threatening situation.

The data showed me that women's best interests aren't at the forefront. My personal experience reflected this also. **Birthing in the NSW Health system felt like hospital risk and liability was put in front of my own welfare.**

I personally had a number of friends and family who had who had birthed within NSW Health and experience birth trauma.

In my case, I was in a **midwifery group practice (MGP). I felt far safer with midwives than obstetricians.** As, in general they had experience physiological birth. The MGP was intended to support continuity of care, however I did not receive it. **I didn't know where i was birthing, or who i was birthing with**. This created worry as i did not feel safe or secure. The smallest sign I outside the narrow parameters or if I went over my due date I would have been referred to another hospital. Birth is such a delicate hormonal balance. Feeling safe and secure and having trust with those in the room plays a significant psychological and physiological roll during birth. I did not have this in the system. And sadly, not even within a MGP.

The parameters of normal are so narrow inside the system. But psychologically the parameters of birth are so broad. I understand why our risk adverse system wants them to be narrow. **Birth in general birth is not a medical condition and should be treated very differently than the rest of the medical system.**

During pregnancy women are particularly vulnerable. There were a number of events, comments and advice that happened during my pregnancy/birth/postpartum period that were detrimental to me and my baby.

While pregnant I was recommended drugs by a GP who in the same sentence said it was “out of my scope” and to “follow up with an obstetrician asap”. After the 2 months wait to see an obstetrician, I was informed that there was no need for the medication. This event created so much unnecessary stress and effects on my body and baby.

During pregnancy some of the **detrimental language** used to me included:
“you will have to be induced because you are over 35”.
“if your hips aren’t big enough it may result in a hospital transfer”.
“don’t have a homebirth”

For me, **my trauma was also prevalent in my post birth/postpartum period when I had a neonate.**

Traumatic breastfeeding demonstrations with my baby and body. Aggressive shoving of my screaming baby’s head onto my breast was traumatic for both me and baby. I was too shocked and sleep deprived at the time to say anything.

After birth, before even leaving the hospital we were **given advice to give formula despite baby being within healthy weight gains. Advice without the associated warnings. Advice without being properly informed. Advice without the methods of mitigation.** Advice that abruptly ended my breastfeeding journey when my baby developed a bottle preference. This advice dramatically changed my hormones, the baby mother bond, my sleep, our daily lives and ultimately our plans for the year. I can’t begin to describe the effects this had on us. This outcome could have been prevented if the advice came with a warning about bottle preference and ways to mitigate it.
I know now that bottle preference is something that lactation consultant’s and counsellor from the Australian Breastfeeding Association (ABA) see all too frequently. But apparently **this information is not reflected within NSW health**.

My baby was given antibiotics after birth which created a significant cascade of events that changed the course of their first year of life. *I birthed a healthy baby but was sent home with a sick baby.* As a neonate, they were given fluro pink oral flucloxacillin. This is the third preferred antiobiotic for neonates. I still do not have an answer as to why we received the third best option. Also the unnecessary additives were scary. Giving a 4 day old baby fluro pink liquid after I spent 9 months growing and caring for his digestive tract was devastating. And lead to devastating consequences. Which effected both my health and my babies health.

I found the postpartum and child and family services disconnected and difficult to navigate. I was referred to lactation consultants, then sleep consultants, obstetricians, community nurse, GP’s, only for everyone to tell me I had a “healthy baby” even though my baby was in extreme discomfort.

Potential Solutions

- **Reframe, re-categorise and treat birth as a physiological event** (that occasionally needs intervention) **rather than a medical condition**. A birthing 'client' is not a sick 'patient'. She should be able to birth unassisted, without intervention, if she chooses to. The NSW Health system uses the 'between the flag' program to respond to patient deterioration in sick patients. In birth the flag concept can be applied in a different manner. *Birth should be like swimming at a safe patrolled beach. You are swimming alone. But there a 'lifeguards', trained by-standers watching you, in case you put your hand up and need help*.
- **Widening the parameters of what is physiological normal** at each stage of pregnancy. Considerations into how to better **balance hospital risk and liability with support of women's desired birth** - e.g. options for women to sign a risk waver prior to birth (to reduce risk of hospital liability).
- **Goal to have NSW birth statistics in align with WHO recommendations. NSW Health goal to reduce cesarean rates to 10% by 2033**. WHO_RHR_15.02_eng.pdf
- Reconsiderations of **what informed consent actually means when you are birthing** – even though you are conscious, women are often in a position where they are unable to make proper informed consent.
- Connectivity of postpartum services and child, family and health services. Create and facilitate better information sharing between associated services and NSW Health.

- **Training for medical professionals:**
- Training and experience in physiological birth (some medical professionals have never witnessed birth without intervention - this changes the mindset of what is 'normal').
- Training in the how intangible elements affects birth – e.g. how emotions come into play, how hormones can start/stop labor, how feeling safe effects birth, how knowing and trusting the people around you effects birth, what environment is optimal for a physiological birth, etc.
- Training of medical professions in birth communication - particularly in a non-pressure, non-fear manner. Respect for a "no", "i don't want that".
- Training how to show respect and support for women's birth plans and desired birth outcomes.

- **Fund research into the evolutionary effects and predicted trajectory of populations with high cesarean rates** - how this **changes women's bodies over multiple generations** and ultimately changes us on an evolutionary trajectory.
- Research into women's feelings of 'safety' with midwives in comparison to obstetricians. To develop and fund more MGP and midwifery lead practices.
- **Look at how emergency cesareans put pressure on the system, put patients at risk and impact other emergency obstetric work**. I experienced this personally when i needed emergency surgery for a ruptured cyst and associated hemorrhage. I had a prolonged wait due to emergency caesareans and lost significant blood in the process, which caused my vitals to go outside the flags and put me at much higher risk for surgery. These are some of the flow on impacts for high emergency cesarean rates.

The author of this submission is happy to give evidence at a hearing.