**Submission No 1032**

# INQUIRY INTO BIRTH TRAUMA

**Name:** Name suppressed

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I'm a research scientist, born in Cuba and an Australian citizen. I will be addressing terms of reference (b (i) evaluation of current practices in obstetric care), 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 and potentially as well as terms of reference e- g. I'm also open to provide evidence at a hearing if necessary.

The journey of myself and my partner to become parents was not an easy one and we had trouble getting pregnant, finally conceiving through IVF. As potential parents, we always heard fantastic things about the public health system in Australia, hence it was an easy decision to proceed with public maternity care. I was quite surprised that induction of labour was advised as early as week 14 (first antenatal appointment) because of IVF pregnancy. This led to my husband (also a scientist) and I searching for evidence-based practices for inductions in IVF pregnancies. To our surprise the evidence was not that clear and different guidelines are followed between countries (Bay et al., 2019; Henningsen et al., 2014; Marino et al., 2014). This is why when we were repeatedly asked to give consent for induction during antenatal care, we tried to discuss with the medical team the evidential basis for this practice in Australia. Unfortunately, we felt that our requests were not taken seriously nor were adequately addressed. As it was our desire and hope to have a completely physiological birth, I repeatedly refused consenting for the induction of my labour.

At 39.4 weeks I had a bleeding that settled by itself while in hospital. Next day, a routine ultrasound showed that blood flow between baby and placenta looked compromised. After asking again for an explanation, we were told this was related to the middle cerebral to umbilical artery ratio, that as far as we understand, is considered a predicative measure for negative outcomes but is not a standard practice across ultrasound clinics in Australia (Oros et al., 2019; Paoletti et al., 2021; Srikumar et al., 2017). We then asked why a c-section wasn't planned an option, but doctors recommended induction instead. The midwives checked the favourability of the uterus, but it was not favourable, so the medical team went ahead and inserted a Folley catheter that night.

Next day, my waters were broken by a midwife and I was administered Syntocin. Within the first hour of its action, I reached continuous contractions (every minute). When my birth doula arrived (an hour or so later), I was in extreme pain despite the Syntocin being given at the minimum dosage. She requested the medical team stop all medication since my contractions were not only too strong but also uninterrupted for what was still only early labour. The medical team agreed. In retrospective, this made us wonder why they didn't take that decision earlier and had to wait for my birth doula to request it. Even though the Syntocin was stopped, my uterus kept contracting without much rest in between, so 6 hours after induction was initiated, I requested an epidural even though it had been against my birth plan and wishes. Once the epidural was in place the medical team resumed Syntocin stimulation at even higher levels, but I was not completely aware of it nor my husband, only hours after, once the epidural started failing, did we realize that I had been put back on Syntocin.

Sometime in between, the midwife informed us that the heart rate of our baby had increased from baseline, my temperature was rising and there was blood in my urine. When the medical team next did their rounds, we asked what the plan of action for our baby given that I had given my consent for induction only because I was told our baby was already in distress and that the induction process had actually added more stress to both me and our baby. They said they would reconvene and come back to us. After a total 14 hours of labour and no progress in dilation, the head of the medical team did not

inform me, but to the midwife in my birth suite that he was calling it out for a c-section. Right after a registrar came to obtain my consent for an emergency C-section.

We were two nights in hospital after a C-section with no obvious complications. However, we felt that the continuation of care was not ideal as I had history of recurrent UTIs and overactive bladder (which was closely monitored during antenatal appointments). However, the medical team failed to prescribe prophylactic antibiotics after the bladder catheter was taken out. Within 48 hours, I developed a bladder infection and recurrent UTIs for months after the birth. Together with a painful C-section recovery, I then developed pelvic nerve pain, which only increased my chances of developing postpartum depression in the first few postpartum months. Even my post-natal midwife was surprised that no mention had been made of any bladder conditions (nor the drugs I was taking to combat the issues) when she visited, which I have found to be highly symptomatic of my later experiences dealing with the hospital records department as mentioned below.

Even though a year has passed and my UTIs have settled (with the help of my GP and urologist) and I am recovering well from pelvic nerve pain (thanks to the advice and treatment from a pain specialist and a pelvic physio), I am still very much in recovery of postpartum depression strongly linked to PTSD related to the birth and birth trauma and the whole experience and recovery process has added significant emotional, physical and economic burden to our family. The main feeling I took away from my birth experience was that I was not informed properly regarding the likelihood of an induction leading to complications. As a result, the feeling of being constantly pushed by the medical team towards an induction (especially towards the end when I had spent two days in hospital after the bleed and was exhausted) ultimately turned to a feeling of deception. The difficulties accessing my records from the birthing unit have further heightened these feelings. My GP, as requested by me, has tried several times to obtain my medical records pertinent to antenatal, birth and postnatal files and the hospital has repeatedly failed to provide them in their entirety. This has become particularly time consuming and emotionally charged for me. During my last phone call to the hospital, they suggested that a particular form needs to be fill out by me and a fee needs to be paid for all the ‘available’ records to be released. This again made me wonder why this information hadn’t been shared with my GP when we first requested my medical records almost a year ago.

I believe my case could help the practices around pregnancy and birth be improved. For example, the medical team needs to be up to date with the evidence related to induction safety and efficacy in general and in IVF pregnancies. It is important to tell women that inductions do not work in all cases and that it is not their ‘failure to progress’ what made them more likely to end up in an emergency C-section, like myself or instrumental delivery, but short comings in the methods that are used to speed up labour. This removes the weight of perceived failure from a birthing mother and, as it should, puts it back into the evidence-based practice and how little technological and scientific advances have been made regarding labour procedures in the last few decades (which should be addressed in my opinion). Regarding consent and informed decisions, the medical team should have made sure my partner and I understood everything that was being done. In my experience as a scientist who performs experiments in human participants, it is our duty of care and ethical responsibility to always inform our subjects on all procedures being made without any perceived deception (unless your experiment requires so). I also believe there is room for improvements in the continuity of care. It is most critical that the postpartum care isn’t disconnected from the antenatal care, so underling conditions like mine are not missed but properly addressed and complications prevented.

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