Submission
No 1129

INQUIRY INTO BIRTH TRAUMA

Name: Ms Victoria Winters

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Att: Legislative Council,

Re: Parliamentary inquiry into birth trauma

The excitement that I felt during pregnancy was offset by fear and apprehension towards the medical culture underlying Australia's elevated obstetric intervention rate (e.g. 36% national caesarean rate; AIHW, 2021) and harmful treatment of women. In response to this ambiguity, my husband and I became better informed about pregnancy and birth, obstetric interventions, and women's healthcare experiences. I felt physically strong, well-supported and empowered during my pregnancy. I was 32 years old, no pregnancy complications, and I continued exercising regularly. I was treated as low risk up until my daughter was found to be in breech position. I understood that breech birth is a variation of normal, however, it is largely not treated as such in the contemporary clinical context. The conceptualisation of 'risk' in my birthing context was underpinned by cultural factors, such as the medicalisation of pregnancy and birth, rather than evidence-based practice.

Experiences of health professional mistreatment began when my care moved beyond the midwifery group practice program. Under the midwife's care, I was treated with respect and warmth, encouraged as an autonomous decision-maker, and received high-quality care. The discovery of my daughter's breech position led to interactions more broadly within the hospital's obstetric department and continued when I transferred to a breech clinic at another hospital. Across both hospitals there were times where I felt mistreated, dehumanised, and that my autonomy and decision-making capacity were undermined. I also had many positive health professional interactions marked by compassion, empathy, competence, and thoughtful provision of information.

Ultimately, I felt heavily pressured into a caesarean without sufficient evidence of its need. In a birth debrief with my obstetrician, I asked if any neonatal health outcomes were identified that confirmed the need for the intervention—he responded that there were no further risk factors identified, other than what was already known and understood to be variations of normal: My daughter had a low birth weight (2.74 kg), and I had low amniotic fluid. However, both factors were within the 'normal' range (i.e. someone in the community needs to be small / have low fluid within population-based data sets with normal distributions). A generation prior, my husband's mother gave birth to his sister in breech. She weighed less than my daughter did, and the pregnancy and birth were treated as low risk and 'normal'. I relayed this information during a consult with the obstetrician. He agreed that there has been a generational shift; he acknowledged the emergence of "*a culture of fear*". He said that if I chose to continue with the vaginal birth and my daughter is stillborn, "*all hell would break loose*". It would be demanded, "*why wasn't she pressured into a caesarean?*"

The caesarean intervention in its context had acute and long-term detrimental impacts on my mental health. I experienced psychological distress in the week prior to- and several weeks after birth. Acute experiences of distress were exacerbated by my interactions with health professionals and the care that I received. For example, I did not sleep at all the night of my daughter's birth because I felt unsafe and psychologically harmed by the surgery and my overall treatment. My body carried a stress response that was insurmountable to fatigue, physical trauma from major abdominal surgery, and pain medication. During a nurse-check, I disclosed my inability to sleep. Rather than being asked about my perspectives and experiences, I was told that if I did not sleep that night, I should be sedated, and my daughter would be given formula. This response felt threatening and compounded my existing sense of being unsafe and dehumanised. Additionally, I did not feel adequately debriefed about the birth, although I was invited by the obstetrician to return for a discussion whenever I wanted—I arranged a debrief almost six months later.

Summary of healthcare experiences

The initial identification of my daughter's breech position let to an immediate transfer to a 'high-risk clinic'. I had one clinic consult during which it was assumed that I would be having a caesarean with no other options presented to me. I transferred to a breech clinic at another hospital, which was better equipped for vaginal breech births. The obstetrician overseeing my care spoke openly about the adverse effects of the medicalisation of breech births and associated loss of training and knowledge in supporting women to birth babies in breech. For example, a baby can change positions at any time during birth—if health professionals are not trained in how to assist women to deliver breech babies there is a risk of harm (e.g. a more 'hands off' approach is required in breech contexts). Additionally, the decision to have an emergency caesarean due to breech position poses greater risk than a vaginal breech birth and is not warranted if no evidence-based risk factors are identified.

At the second hospital, a routine scan led to the re-categorisation of my pregnancy as 'high risk' following the discovery that my daughter's pattern of weight gain had changed and my fluid was at the lower end of normal. I was told that this scan would not involve a weight measurement at this late point in the pregnancy, due to the significant error margin of this test. However, the staff member conducted the measurement anyway. Following this discovery and subsequent categorisation as 'high-risk', I experienced several negative interactions with health professionals. For example, during fetal heart rate monitoring, I spoke with the nurse taking the CTG measurement and opened up about my distress in feeling pressured toward a caesarean. Rather than talk to me about my feelings or perceptions she told me "*oh, you'd never forgive yourself if something happened*", alluding to the death of my baby. This response compounded the pressures placed on my decision-making and the sense that my health and wellbeing were not viewed as important.

I consented to caesarean surgery, which was being treated as an emergency, yet recorded as elective. I was instructed to fast the night before surgery and not consume water the morning of. At the hospital, the staff awaited the return of my covid test result from a large public testing facility. My husband's result was returned, however, several hours later mine was still pending. We waited around 7 hours at the hospital before being sent home because of the unreturned covid test result. I was full-term and went a day without food and barely any water, which made me feel sick and weak. The adherence to hospital covid policy invalidated the 'emergency status' of my pregnancy, a confusing and irrational situation that led to further dehumanising practices.

The next day, I grieved and cried frequently in the lead up to the surgery. The anaesthetist asked me why I was upset in the room immediately prior to administering the epidural. I read the irritability in her tone and approach. I did not feel like I had the emotional resources to summarise the complexity of my experiences; I responded something like "*it's so clinical*".

She immediately countered, "*well it's a surgery, it needs to be clinical*". The interaction felt demeaning and if not for my severe distress, I might have felt humiliated by the subtext and being belittled. It was awful to have an epidural and lose the sensation in my legs. I had maintained their strength during pregnancy and saw them as a source of power during birth. It added another layer of loss, experiencing my legs being erased. Lying on the operating table with my numb legs splayed, a catheter inserted, my arms strapped down, about to have my abdomen pulled apart, my uterus cut open and robbed of childbirth was among the worst experiences of my life.

My husband promised that he would be with me the entire time, however, he was immediately locked outside the door while the obstetrician attempted an EVC under epidural. This further diminished our sense of control and was distressing for both of us. Yet, I was grateful that the obstetrician was still trying to turn my daughter into a cephalic position right up until the final moments. It gave me more tangible evidence that he was dedicated to exhausting options towards a vaginal birth within the constraints of the hospital's culture/policies.

I was told that after my daughter was removed from my body she would immediately be taken for tests before I could meet her. I expressed a deep desire to touch my baby as soon as she emerged and was told that it was against protocol. The biggest help during the surgery was the obstetrician instructing the nurses to give my daughter to me immediately (as she showed no signs of poor health). It was a powerful form of healing to touch her straight away (on my face and chest as my arms were strapped down). After the surgery, it felt dehumanising to be left with the remaining hospital staff who completed my stiches while chatting about their Christmas plans and splattered with my blood.

It was difficult leaving my daughter and waiting for her alone in recovery. When she arrived, it was just the two of us for the first time. She straight away wanted to breastfeed and I was blown away that it was happening immediately. I took a photo of her breastfeeding to treasure and show my husband who was not permitted inside. The nurse made a shaming comment and said that I shouldn't be using my phone. It was crushing to experience the cumulative impacts of disrespect and mistreatment in tandem with the first intimate moment shared with my daughter.

Psychological adjustment

My daughter is now over 1.5 years old, and I carry on-going grief, distress, and fears of potential mistreatment by health professionals in future obstetric settings. I sought professional psychological support to help with adjustment—I have come to accept that a deep sense of loss, disbelief, and pain may always be inside me. I will never know for certain if the caesarean was warranted, however, this is less relevant than the unethical decision-making context that defines women's experiences of mainstream obstetric care. That is, if the culture were different, and evidence-based practices were routinely implemented, and if there were not global and national concerns regarding the overuse of interventions, then I would not have been in that distressing situation. i.e. Grappling with the decision; unable to to trust the information provided, the recommendations of health professionals or the policies/practices of the wider healthcare system. *How do women make informed choices within a health model that systematically disempowers, dehumanises, and harms women?*

Clinical context

In Australia, obstetric intervention rates are rising in parallel with a growing body of research documenting women's experiences of mistreatment, disempowerment, and violence by health professionals within obstetric settings (Keedle et al., 2022; Fox et al., 2019; Roberts et al., 2000). For example, the 36% national caesarean rate (AIHW, 2021) is alarmingly high given that population rates above 10-15% are considered excessive (Betran et al., 2015; Ye J et al., 2014). Globally, there is growing concern over the increasing number of mothers and babies experiencing morbidity and mortality associated with caesarean section compared to vaginal birth (Sandall et al., 2018). Furthermore, adverse obstetric experiences associated with mistreatment and abuse have acute and chronic long-term effects on women's mental and physical health, their relationship with their child and infant health outcomes (Annborn & Finnbogadóttir, 2022). Research supports the urgent need for clinical practice reforms and workplace interventions targeting cultural factors underling the overuse of interventions and chronic disempowerment and violence towards women in Australian obstetric settings.

A recent data linkage study by Fox and colleagues (2019) analysed 186,789 Australian maternal records and 189,909 records of their resultant babies. Analysis revealed that mothers in the wealthiest quintile had significantly higher odds of having a caesarean, induction, episiotomy, epidural and instrumental vaginal birth than mothers in the poorest quintile. This result remained after adjusting for (holding constant) clinical risk factors. Results suggest a pattern of overuse, as has been demonstrated internationally and is increasing acknowledged as a global concern (Boerma et al., 2018). Compared to mothers who have vaginal births, mothers who have a caesarean are at greater risk of haemorrhage requiring a hysterectomy, uterine rupture, complications associated with anaesthetic, renal failure, obstetric shock, cardiac arrest, venous thromboembolism, and major puerperal infection (Sandall et al., 2018; Liu et al., 2007; van Dillen et al., 2010; Pallasmaa et al., 2008). In the long term, mothers who have a caesarean section have an increased risk of experiencing pelvic adhesions (Berghella et al., 2013), bowel obstruction (Abenhaim et al., 2018), future subfertility (Gurol-Urganci et al., 2013; O'Neill et al., 2013), decreased satisfaction with the birth, lower rates of breastfeeding and less positive reactions to their baby after birth compared to those who have a vaginal birth (DiMatteo et al., 1996).

Little systematic work has been done to examine Australian mothers' preferences regarding birth and obstetric intervention. Please read the following exert from Fox and colleagues (2019, p.6-7):

"*One study conducted in 2007 suggests that few mothers want a caesarean section in the absence of a clinical need for it [46]. Some pregnant mothers may choose, or agree to birth via Caesarean section due to non-medical factors. Fear of birth [47–51], previous birth experience [47, 51], concerns about the safety of a vaginal delivery [52], health provider influence [46, 47, 53, 54], misinformation [47, 53], and social norms and expectations [55, 56] may all play a part in the decision to have a caesarean delivery. In Australia, 24% of pregnant mothers experience fear of birth [57], with multiple Australian studies [49, 50, 58] reporting a greater likelihood of having a caesarean section for mothers who experience fear of childbirth during pregnancy. Consideration should also be given to the influence that care providers may have on a woman's decision to have a caesarean section [59, 60]. Currently, there is a lack of research that reports on the interactions between women and their care providers and the information provided to women when they choose to have a caesarean birth. One Australian study [38] that surveyed pregnant women on their recollection of* *discussions with health providers on the risks and benefits of caesarean section for themselves and their baby reported that women who preferred to have a caesarean section were typically poorly informed about the associated risks for themselves and their baby."*

Australian women's fears related to childbirth must be examined within their contemporary socio-cultural context. Gender norms and social attitudes towards femininity associate women with weakness and encourage women and health professionals to view women's bodies through a lens of deficiency. This is reflected in- and reinforced by obstetric practices and policies that collectively disempower women and have forced a disconnect from traditional knowledge of birthing practices (e.g. the importance of environmental factors in birthing, the need to feel safe and a sense of privacy, and specific birthing positions that work with gravity and open the pelvis rather than laying on one's back). A cultural shift in such harmful discourses, attitudes and gender norms may lower women's fear of childbirth and encourage them to view their bodies as powerful, competent, and complete.

Important considerations

When reading the submissions please keep in mind that the number of submissions is not reflective of the scope of obstetric intervention misuse and associated harms to women in Australia. The multiplicity of women's workloads creates challenges for participation (e.g. domestic, caregiving, paid employment). Drafting this submission required caregiving support, internet/computer use and significant time and emotional resources that many women may not have access to. In particular, it required the emotional capacity to revisit a painful experience and examine it closely. Submissions should be considered in light of national and international research demonstrating women's systemic mistreatment and experiences of obstetric violence (e.g. Avci et al., 2023; Brazy-Nancy et al., 2023; Keedle et al., 2022; (Annborn & Finnbogadóttir, 2022).

Cited literature was attached to the submission.