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INQUIRY INTO BIRTH TRAUMA

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First born at Hospital, Sydney
Second born at home, Sydney

Introduction

I had my first baby in the birth suite at in 2005. Although this is a long time ago, it has had a lasting impact on me and my family and in the 18 years since, little has changed in maternity care. This experience has also shaped the work that I do as an advocate for women's choices in birth. I've had the benefit of being able to interview midwives, academics, doulas and of course many women and some of their partners about their birth experiences, and how these have gone on to shape their lives too. I've learned that birth trauma is far too common and mostly caused by a woman feeling a lack of control over what's happening to her. These conversations and years of other research has led me to have a highly developed understanding of how the maternity care system fails women and their babies. But this learning journey all started with my first birth.

In this submission I describe my first birth, which I've come to see was a standard vaginal birth in the hospital system. I then compare it with my second birth experience where I had the benefit of continuity of carer in my home. Finally I make recommendations for improving outcomes in the maternity care system.

A standard birth in the system

Allow me to reiterate here that I hear stories just like mine over and again in my work as a maternity services advocate. I have decided to retell it here because the themes here remain as relevant as they were 18 years ago.

I had hoped to have my son in the birth centre, but when it came to birth, the only two beds there were full so I had to go to the more medicalised birth suite. The midwives were mostly nice enough and none were outright unkind towards me, just indifferent. None of them knew me. It was busy there and I could see they were overworked. The gold standard of maternity care, continuity of carer, was not offered, but I didn't know then what an impediment that would be for me.

I went into spontaneous labour at 39 weeks, but progress was slow and the team of midwives weren't able to give me much guidance about when I should come in for birth. We transferred after several hours but I know now I wasn't sufficiently established in labour. They let me stay overnight but the next morning I went home. I have to say it was a very defeating experience to have to do that, like I was making the whole thing up and wasting their time.

When I look back, I felt a kind of deep sadness that I kept to myself as I staggered back up the corridor to the midwives' station again. They could see me coming but no one came forward - they were busy. Here I was primed and ready to do a most incredible act, to undergo the greatest transformation of my life, yet I had "chosen" to do it with a bunch of strangers who would have preferred I hadn't turned up on such a busy night. This alone goes to the core of how incompatible our system is with not only women, but to her family as a whole.

By this time I was thoroughly exhausted and unfortunately they had no rooms available, so I had to wait in a small brightly lit utility store room. They found I was dehydrated and had high ketones (which I now know shouldn't really be a problem) so they gave me a peanut butter sandwich and orange drink. I tried to eat some but I vomited it all straight back up.

Eventually I was taken to a room and continued labouring on the floor. At some point my waters were broken to help speed labour up. Soon, I started pushing but the midwife said "don't push, your cervix isn't dilated enough!" I couldn't stop pushing, my uterus was doing it spontaneously and with huge power. In fear that I was going to crush my baby and unable to communicate, I managed to whisper "epidural". I'd never dreamt of having an epidural but I thought they had to do whatever was needed, cut me open there on the spot, in order to save my baby. I literally didn't worry if I would die, I just needed to make sure he was safe. I know this sounds overly dramatic but I couldn't speak and they weren't giving me any information, so my mind was going to the worst possible outcome.

An anaesthetist was eventually found but keeping still for him was almost impossible. He got the anaesthesia in place and after two days I could finally have some rest. I slept for two hours and fortunately when I woke I was at the prescribed dilation of 10 cm. The midwife instructed me to push, which was very difficult when paralysed. She did ask if I wanted to lower the dose but I was terrified of being in that pain again.

I do now wish I understood what that decision meant because the two hours of extreme pushing I had to do (rather than the uterine pushes that are more effective and protective against pelvic floor damage) led to permanent nerve stretch injury, which has left me with weakened pelvic floor and reduced sexual function, all these years later.

Many more poor practices ensued including immediate cord clamping, strenuous kneading of my stomach to remove the placenta, administration of syntocinon in my thigh without warning, moving my son immediately to the other side of the room to check him and wrap him up, rather than putting him straight to be chest. It was then time for a change of shift and about two hours after he was born, I was still in my blood soaked t-shirt when the new midwife asked "how's feeding going?" to which I said "what feeding?". I was in a complete daze and exhausted. I could tell by my midwife's face that she was worried by my response.

I had no idea of what this could mean but this marked the beginning of the most difficult three months of my life as I tried to establish breastfeeding.

My son was drugged from the epidural and so was not very responsive to being put to my breast at first. Over the following days I was subjected to having my nipples grabbed at and shoved in his mouth. I was sent home after three days with breastfeeding still not properly established. I ended up returning to hospital one day later because my son was vomiting blood.

This absolutely terrified me but it turns out that this was caused by my nipples being so damaged that he was drinking blood as well, which made him nauseous. I was fortunate to have several days in hospital getting some more guidance but unfortunately all of this interference (and likely transmission from the hospital environment) meant I acquired a staph infection in my breasts (nipple impetigo) that could not be diagnosed for three excruciating months.

The pain from the infection lasted for hours after each feed but no one could tell me what was wrong. I found expressing into a bottle helped manage the pain somewhat but it was exhausting doing all the expressing, sterilising, feeding, as this gave me only at most an hour's rest in between feeds. By pure luck I found a doctor with experience in nipple impetigo, and she was able to treat me straight away with anti-biotics. I was disappointed in this because it meant my son would get it too and at such a young age, but went ahead with it.

The whole experience left me feeling bewildered and wondering where I went wrong. As for the birth itself, it felt like I was trying to peer through a paling fence at something powerful and transformative that lay beyond. Even though I had just passed through the experience, birth was still a mystery to me. Was I even capable of giving birth without a team of experts? The epidural made me feel I was observing it rather than really doing it. It was a very disconnecting experience and left me feeling a deep loss and confusion that I couldn't express.

This birth was not particularly traumatic when compared with so many women. *The sad fact is I experienced a pretty standard birth that most women are forced to endure*: no continuity of care, syntocinon, pethidine, epidural, pelvic floor damage (ongoing), nipple damage, extensive breastfeeding difficulties, staph infection, significant sleep disturbance, postnatal depression and anxiety.

I know now that nothing was actually wrong during the whole ordeal, but the interventions were "needed" because I was taking too long and was exhausted.

A second opportunity

Two years and nine months later, I had my second child, but I was fortunate enough to "discover" homebirth when I was 6 months pregnant. This birth was completely different and explained what was wrong first time round:

- My labour was one third of the duration of the first birth. Yes, that could be explained by it being my second birth, but I was actually held up psychologically this second time because I had acquired beliefs from my first experience that I may not be able to give birth. It hadn't occurred to me the first time that I might not be able to do it.

- I didn't have to transfer to give birth this time. First time round, the two transfers halted my progress. Exposure to lights, strangers, having to explain things all inhibits birthing hormones and had staff suggesting all sorts of augmentation methods.

- My postpartum bleeding was barely more than one day, compared with the first time when I bled consistently for 6 weeks. The midwife at my first birth pulled on the umbilical cord, rather than waiting for me to birth the placenta, resulting in a "ragged" placenta. This led to extensive clotting that needed monitoring in the days after.

- My relationship with my midwife in the three months leading up to the second birth meant I could ask lots of questions and become much more informed than what I learned from books the first time. This streamlined all aspects of labour, birth and postnatal care.

- My husband was also traumatised by the first birth, unlike the second one, which he described as the best day of his life. This time he was involved and included by the midwife, stepping forward to catch the baby, while she gave the odd quiet instruction or explanation. By contrast with the first experience, he felt like a "frightened passenger on a runaway train".

- When labour first started to happen, my midwife was available by phone to help me understand if this was going to become established or not. (Once again I was at 39 weeks.) First time round, I just needed reassurance that all was normal, rather than just the vague message "come in if you're concerned". That's not clear enough for a first time mum. A woman needs guidance from an experienced woman she knows who can come and see how she's going and help time the transfer to hospital.

- With our established relationship, my midwife was comfortable to let me start pushing spontaneously without waiting for her instruction, or cervical checks. Just prior to pushing, I did ask her for a cervical check for reassurance that I was progressing. After for checking for dilation, said "You're at about 6-7cm but the cervix is extremely thin and pliable and will stretch easily right over baby's head." So different from the hospital situation where they want your body to be following a certain script. I wonder if the first time round if my cervix was in a similar state (6-7 cm, rather than the policy of 10cm) when I spontaneously started pushing. If not, and my cervix was thicker, this was likely due to my extreme exhaustion and dehydration, all of which would not have happened if I had had a midwife looking after me during my labour at home.

- The lack of understanding and support for the "golden hours" immediately after my first birth meant that the precious window for establishing breastfeeding easily was almost completely closed for us. By contrast, after my second birth, my midwife kept us both together, not rushing anything, not pulling on the umbilical cord, letting the placenta emerge naturally, keeping the baby with me as much as possible.

- Rather than being made to feel like I was taking up space at the maternity unit, and that the birth was just something to just try and get through, my second labour was anticipated with a gentle excitement. My sister and mother in law gathered in support, followed by the midwife and the house felt full of just the right support and care, just for me, my baby, my family. I felt privileged and grateful.

- With my second birth I was able to experience the full power and transformation that lies within the experience of birth. That drab paling fence that had been blocking my view was blown away as I was transported to the other side of the universe with each contraction. I was so surprised by how psychedelic it was, but I suppose this is what Dr Sarah Buckley and other birth experts are talking about when a woman's brain is literally rewired through the process of birth. She can be either rewired for trauma or rewired for expansion and growth, in order to nurture her child in the most responsive way. This experience had been taken away from me in my first experience, but I am so grateful I had a second chance. Few women get this opportunity to reshape their feelings about themselves and birth generally.

- If given the right support and sensitive guidance, a woman's body will push her baby out efficiently and without damage most of the time. (The WHO established that in two huge studies in the developed and developing world, 87% of women will give birth normally[1].)

- Through the months of recovering from my first birth, I experienced (undiagnosed) depression and anxiety, which caused a massive disturbance to my ability to fall asleep and stay asleep. I hardly slept for months and sought all sorts of help to correct it. What didn't help was the postnatal advice that I should "teach" my baby to sleep on his own in a cot. What a loss to both of us this process of "control crying" was, and it compounded my problems with sleep. The disturbed birth I experienced rewired my brain for trauma and distress. Instead, second time round, I learned about safe co-sleeping methods, had her in the bed with me from the beginning and my broken sleep, together with my rewired brain, fixed my sleep overnight.

- In spite of the upfront cost of engaging a private midwife, I had no expenses for repairing damage from her care, unlike what happened to me in the public system. My first birth cost the health system thousands of dollars, unlike my second, which cost the system nothing.

In spite of these challenges, with the benefit of a night and day experience in birth, I discovered many silver linings. I began advocating for women's choices in birth 14 years ago with Maternity Choices Australia, as well as running a radio show "Pregnancy, Birth and Beyond" which later became PBB Media with the express goal of getting information out to women that is not in the mainstream about their choices. I also serve on numerous maternity committees such as the NSW Maternity Alliance (an initiative of the NSW Nurses and Midwives Association) and within my Local Health District in NSW.

[1] World Health Organization. WHO recommendations: intrapartum care for a positive childbirth experience. 2018. [cited 2022 February 14]. Available from: https://who.int.

Recommendations

From my experiences I have a detailed understanding of how the maternity care system overservices many, many women, most of whom want to give birth with as little intervention possible. There is so much unnecessary damage caused by simply not supporting labouring women's physiology. I also understand the importance of women feeling confident in their new roles as mothers, and that the key to this is having the kind of birth experience that rewires them for nurturing their child.

Unfortunately standard maternity care does not prioritise this and our society suffers as a result. Birth is treated as something we just need to endure and get done in whatever way possible. It is not treated as being, at its heart, a social, emotional and spiritual event. Even women experiencing complex births need to have this view of her birth prioritised, so it can be celebrated and she can be truly centred in it.

1. All staff working in the system need to accept that once a woman decides to proceed with a pregnancy, no one is more vested in the safe arrival of the baby than her. No one else in any conversations about assessing risk is literally putting her current and future health prospects on the line for this child. This foundational belief will go towards reducing strict adherence to hospital policies, preventing coercion and encouraging systems of informing women of their choices.

2. All staff need thorough training in respectful maternity care, informed decision making and supporting women who decline recommended care, so that her choices are genuinely supported. This is a key requirement for reducing trauma.

3. Providing continuity of carer models for all women, regardless of her so-called "risk" profile. Unfortunately continuity of carer is usually only available to "low risk" women, whereas it is the women with complex needs who benefit the most from a sustained relationship through their perinatal journey. These models allow for greater levels of informed decision making, allowing care to be tailored to a woman's needs as her clinician/s come to know and understand her and reduce the need for costly interventions that can lead to poorer outcomes.

4. Changing the default view of birth as a medical event to one where for most women does not need to become medicalised. Much of the need for medicalisation is caused by the lack of emotional support and detailed information shared with women over time by trusted carers. Relationship based care is key to reducing birth trauma.

5. Recognising the importance of protecting the mother/baby dyad in order to get best possible outcomes for both. This means eliminating policies and practices that lead to separation of mothers and babies and encourages bonding and boosts women's confidence in their abilities as mothers.

6. Recognising that birth is at its heart a social, emotional and spiritual event, rather than by default a medical event. This involves preserving a woman's choices in recognition that her experience is important and deserves to be valued.

7. The activity based funding model of delivering maternity care needs to be eliminated. This has the unfortunate flow on effect of a hospital being geared for administering expensive treatments, rather than supporting a woman's physiology.

8. Health funding needs to be linked to individual women. As funding is activity based, this places the emphasis of data on procedures performed rather than who receives what treatment. This has the effect of not being able to easily follow the cascade of interventions that women receive. For example, a hospital keeps data relating to numbers of inductions, numbers of c-sections, etc, but the data doesn't facilitate an understanding that a woman who has an induction has x% chance of ending up with a c-section. This of course has been studied, but it was not aided by hospital data collection. If, on the other hand, budgets are allocated to individual women, it is much easier to follow the impacts that procedures have.

9. Midwives need recognition as the primary carers they are. Currently the maternity care system gives them the responsibility of obstetric nurses, i.e., ultimately having to follow the instructions of obstetricians. This has them practising to a lower level of their skill base and not being able to practise in a woman-centred way. Instead, they are having to follow the more restrictive practices prescribed by doctors, rather than honouring women's wishes. Midwives are also discouraged from truly being "with woman" and having the freedom, as the experts in physiological birth, to guide women with optimal positioning techniques and pain minimisation strategies, as appropriate.

10. Government support is needed to increase the numbers of midwives in the maternity system and services need to be re-designed to optimise labour women's physiology. This means creating home like environments with invisible clinical equipment, dimmable lighting, the freedom to move around and not be on a bed, birthing pools, continuity of carer and homebirth programmes. This is all made more possible when maternity services recognise the vast array of international and domestic evidence that shows that most women will give birth normally, given the right support of their physiology.[2]

[2] Foureur, M, et al, *Developing the Birth Unit Design Spatial Evaluation Tool (BUDSET) in Australia: A Qualitative Study,* 2010, https://doi.org/10.1177/193758671000300405