

Submission  
No 1417

## INQUIRY INTO BIRTH TRAUMA

**Name:** Name suppressed

**Date Received:** 13 August 2023

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Partially  
Confidential

I have experience as a NSW health staff member, a mother using the same hospital to give birth twice in the past few years, for care during miscarriage and friend to other mothers using both public and private hospital services. During both pregnancies I applied for the midwifery group program (MGP) prior to 12 weeks and did not get a spot.

Entering the service as a pregnant person I had a lot of anxiety around the possibility of requiring a caesarean section as I knew rates are very high both public and private (WHO suggest rates should be close to 10% if evidence used for decision making yet figures are closer to 40-50% from memory).

My fear around caesarean section is related to practices in our hospital and possibly influencing reduced breastfeeding rates, maternal-infant bond, NICU admission and so on. It is routine to wrap the baby with no immediate skin to skin in the operating theatre, there is often (particularly for emergency caesarean) no midwife available following the delivery to allow the newborn to stay in the post anaesthetic care unit (PACU) with the mother and therefore skin to skin and breastfeeding is often delayed. It seems like babies are more likely to be sent to NICU for issues that may have been prevented by adequate skin to skin time like temperature regulation and blood sugar monitoring/control. Mothers are often kept in PACU for an extended period without the newborn to return to a state of “between the flags” because they don’t receive timely active warming, or are hypotensive related to blood loss (which would be reduced with early breastfeeding) or spinal morphine administration. Once they leave the PACU, if their baby has been admitted to the NICU their ability to then visit the newborn is dependent on the availability of staff on the ward to facilitate the visit.

For my first birth, my water broke at home before labour started and I was instructed to come to the hospital for a check. I was pressured to have an induction immediately by the obstetrics doctor (within a few hours of waters breaking), with very little discussion of benefits vs risk or alternative options. I believe you generally should be able to wait 24 hrs (I was GBS negative) and then possibly continue further with provision of antibiotics. I resisted the immediate induction and was sent to the maternity ward to sleep for planned induction in the morning. When I arrived the midwife in my section explained there were many caesareans scheduled for the following day and I should have accepted the induction. Thankfully my labour naturally progressed very rapidly after that point and my baby was born with no interventions as desired that morning.

We requested to be discharged same day, and unfortunately a day or two after discharge were asked to return to treat my daughter’s jaundice, during the phone call asking us to present for light therapy we were told my daughter would need formula feeds. When I was upset by the suggestion of formula they said a doctor would discuss the reasoning when I arrive. I was very upset when the doctor came, crying when he mentioned we would be needing to give my daughter formula feeds. My concerns were around the idea that it may hinder my ability to breastfeed successfully long term as my entire extended family seems to have trouble and always resort to 100% formula feeding – the health and bonding and long-term benefits were all extremely important to me. The doctor failed to have a conversation about the benefits vs risks entirely and simply stated it was necessary to try improve the removal of jaundice waste products, and he then went on to assume the reason I was crying is that I may have heard of nipple confusion (which wasn’t actually a concern of mine) and said it isn’t real. I assumed as there was no conversation around an alternative, or benefits vs risks this was the only option for my baby.

Following my admission I looked at the NHMRC guidelines, health protocols, UK's NICE guidelines, WHI guidelines, and ALL of them either advised strongly against the use of formula for treatment of jaundice for breastfed babies or simply didn't list it as a treatment or reason for formula use unless indicated for other reasons (low supply, low weight etc, which were not problems we had). I expressed milk after every single feed to try and increase my supply to reduce the formula as quickly as possible. The transition to reducing supplemental feeds was difficult, I'm unsure if it was the cause but my daughter at that point used to cry for hours during the early evening feeding constantly I assume because she was used to the higher volumes. I assume this scenario for other mothers would drive many to transition to exclusively formula feeding.

For my second birth I decided to stick with the public hospital as I very much wanted midwifery-lead care rather than obstetric-lead and think the public hospital's emergency care is superior to the private hospital. I was quite fearful of entering the service again as there were multiple indicators that best evidence wasn't always used.

During the antenatal process I had an ultrasound showing the abdominal circumference was small and told to get an urgent second scan at their preferred site. The scan showed similar results and I was instructed to go to the hospital in Sydney for a third scan and more specialised opinion. The scan was done by an obstetric fellow using a more advanced machine, and reviewed by their specialist who stated the baby was well within normal parameters, there was no evidence of risk, and using the measurements given from the original scans that different growth charts are being used as despite growth of the abdomen since the initial scans showed the foetus was well within normal parameters originally as well. My partner has an ethnicity with smaller average birth weight compared to white Australians, and my previous healthy baby was also small with no serious health issues.

Following those scans my antenatal clinic appointments changed to obstetrician appointments rather than midwife for the reason of ongoing monitoring of the abdominal size with the suggestion that "After the next scan we should be able to return you to the midwives as you wish", which did not happen. I was repeatedly sent for growth scans. When I asked what the purpose was, e.g. if there is any pathology they could even change, any value the information could provide, I was met with "We just want to make sure" with the different junior doctors I had at every appointment and no explanation of risks and no option for alternatives. After looking up as much information I could find myself it appeared that reduced abdominal circumference lead to increased early induction rates despite no improvement to neonatal outcomes so I became fairly emphatic that I didn't want continued scans unless there was purpose, however I was simply urged to continue without explanation and so I complied despite significant financial costs and concerns for unnecessary interventions downstream. I feared that if I stopped attending scans it would reflect poorly on me as a mother, as I was instructed to go by health professionals. Eventually the foetus grew to more acceptable proportions, however I was then given an appointment with a junior doctor who decided to continue growth scans with no apparent reason (nothing written on the referral to indicate the scan) and was misdiagnosed with gestational diabetes, which she did not actually tell me she thought I had, but merely referred me to a gestational diabetes clinic where she said I would be seeing an endocrinologist. When I called the receptionist asked "Is this the first time you've had gestational diabetes?" And stated "this is where you attend a public information session for managing your diabetes". After checking my own results it was obvious I did not have gestational diabetes, but when I called the clinic to check they said the doctor had documented that I had gestational diabetes, was not aware of the provisions of the clinic, and the staff there could not see any reason I should be continuing growth scans. They agreed that I did not have gestational diabetes (not even close). During this call I complained and had them return my appointments to the midwifery team which then GREATLY improved my care overall.

By this point I was no longer trusting of the ability of the health service to give me evidence based care, and anxiety lead me to research evidence based birthing information from WHO and other trusted sources so I would be prepared for any conversations during labour and delivery. I created a birth preferences sheet, however, as staff were so unprepared to discuss things with me previously and did not request anything of the sort I felt very embarrassed to show staff, and this itself was a point of anxiety.

I was extremely lucky that my labour was extremely rapid and I changed to midwifery care where they were able to ensure I was no induced prior to 41 weeks (a desire of mine to try preserve natural birth).

#### RECOMMENDATIONS:

High risk pregnancy should not remove midwifery components of care and the midwifery group program (MGP) as the focus of obstetrics vs midwifery and the experience of senior midwives and junior doctors are completely different.

MGP should be standard model for all unless the woman and family desire something else.

NICU should be restructured for mother or parent rooming-in as per evidence. The idea that because a baby is unwell or requires more monitoring ensures that the baby is afforded lower quality bonding and care from mothers or parents is absurd.

Breastfeeding education should be given antenatally +++ (benefits and methods, hands on demonstration, should be lead by ABA as they have extensive evidence based resources and staff/volunteers) and lactation support services should be emphasised prior to discharge.

Mothers with support person(s) should be given the option to have healthy newborns in the Post Anaesthetic Care Unit (PACU) without midwifery care – the PACU is due to mother recovering from surgery. Partners and support people are considered competent carers immediately following vaginal delivery.

Birth preferences should be extensively discussed and documented during antenatal visits and reassessed during labour, it is unreasonable to expect a woman to give informed consent to interventions under pressure during labour with information provided with time constraints by junior medical staff. Birth plans and preferences should be encouraged, not shamed, with the ability to set expectations and flexibility prior to birth. If explained well, no mother would assume that a rigid birth plan would be able to be 100% adhered to in the face of complications, and they would have a greater chance of being mentally prepared and supported for this.

Interventions should always be based on evidence of improved outcomes or patient preference rather than “just in case” as there is growing evidence of potential iatrogenic harm. It is naive to assume that healthcare organisations have full awareness of the implications of interventions imposed if not necessary or desired.

More information and access for home birth needs to be provided to mothers open to the idea with a safe home space to do so available.

Support people should have more opportunity for involvement, e.g. my partner was not able to attend any antenatal clinic appointments or ultrasounds beyond 12 weeks due to inflexible “no children” policies and only weekday business hours appointment availability. History of miscarriage at 13 weeks with sonographic discovery left me fearful of no support for future potential miscarriage discoveries.

I will very happily be contacted by the government or health service to provide further suggestion and conversation for care improvement.