Submission No 1398

INQUIRY INTO BIRTH TRAUMA

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I began working as a midwife at 21 years old but through study have been exposed to birth and the birthing environment since I was 18. I love this job, and I love being able to support women for what can be an extremely empowering and uplifting experience in their lives. There is downsides, like any job, and the ones we expect e as midwives can be some of the worst. It was only when I started working in a continuity model of care that the extent of birth trauma and how rampant it is became evident to me. I had heard podcasts prior to starting working on my hospitals midwifery group practice (MGP). A lot of these stories focused on pelvic floor issues postnatally and the pain associated with birth, or the fear of emergencies, so I altered my practice to focus more on the issues within the immediate postnatal period. When I started working with MGP however, whereby in the process you get to know these women before their birth, my perspective changed. I am able to better support women in this process, but I am now intimately tied to their births, and to their trauma. It has also meant that the downsides to work are felt more deeply and closely, and I too now have my own trauma arising from my birth experiences.

For the first part of this submission I will focus on some of the women I have cared for, who themselves have said, or have exhibited signs of trauma after their births. I will start by saying that these stories are of course not mine to tell, I will therefore not include any details of the women beyond pseudonyms*.

Sarah* was having her second baby, her first was an emergency caesarean after attempts to prepare her cervix for induction were unsuccessful at 42+1. She was immediately excited to be welcomed onto MGP because she was aware of the success rates with vaginal birth, and was desperate for a chance to have vaginal birth after caesarean (VBAC). We spoke a lot about this in our appointments and how to best achieve it. This pregnancy was different, there were a lot more positive signs that baby was headed to a spontaneous labour onset. We spoke about the alternative if baby was not to come, Sarah would prefer an elective caesarean than an induction. Fast forward to the birth, I was on a day off. My colleague Liz* cared for Sarah. She went into labour spontaneously with her waters breaking and contractions following soon after. On arrival to hospital her cervix was dilated to 2cm, she continued to labour for some time before asking for an epidural, her cervix had progressed to 6cm. Over the course of the next few hours Sarah reported being bullied and coerced into a caesarean section for “failure to progress” I.e. her cervix was not dilating any further, and a vaginal birth was unlikely and only adding stress to her and her baby. She acknowledged how wonderful her student midwife was in supporting her, but ultimately after 10 hours of fighting she reluctantly agreed. She has a healthy baby, as she would often reflect “so I can’t be that sad”. A rhetoric I see often at work but ignores the major component of midwifery and the birth process, to empower women through their pregnancy. I would tell them “it is normal to mourn the birth experience you thought you would have”. When I saw Sarah postnatally for the two weeks she had worked her way to a place of acceptance, I offered her a debrief at 6 weeks postpartum with the obstetrician who was overseeing her care, to ask any follow up questions which she accepted. I should note there is not a formal process for this, women are booked into our hospitals gynaecology clinic alongside women having IUDs inserted and abnormal Pap smears investigated. This is similar at a number of other hospitals. When Sarah returned, she was mad. The point of acceptance I had left her at was long gone and she was angry. We spoke to the doctor together, she laid out her points, every answer provided by the doctor (as valid as it was from a medical/midwifery perspective) was dismissed by Sarah. Sarah spoke of the bedside manner of the registrar attending her care, how she felt patronised and that no one ever explained to her why they wanted her to have a caesarean. She spoke of no one informing her about epidurals slowing down your labour, and how syntocinon

infusion would not be offered to her, she spoke of afterwards being told she would be going to a shared room on the maternity ward and that her partner could not stay, and wanting to rip out her catheter and walk out of the hospital. She was listened to, validated, acknowledged. I met with her informally after the appointment “I don’t know what I got out of that”. I suggested having her voice heard can sometimes be healing, but that there probably is more work she needs to do, she would decline my suggestion for mental health resources or third party debriefs. She left that appointment not in a better space, she left with information about how to submit a formal complaint and with intention to do so. I carried the burden of her birth experience for a long time, wishing I had been there to better support her through that, until I stepped back and realised that there are systemic and real things that can be done that would have stopped Sarah feeling she had been cheated out of her birth. Birth classes designed for women who have had negative previous birth experiences, policy based on evidence on what is considered failure to progress and how we care for women undergoing VBACs, education and subsequent supervision of how junior doctors communicate to patients recommendations for medical intervention, a rigorous and complete debriefing process - to be offered to all women regardless of mode of birth, who show any signs or symptoms of birth trauma. These things may or may not have made an impact to Sarah, but the fact that I came out of this single experience with four, very attainable suggestions on how we could do better, was astounding.

I have focused a lot on Sarah’s story, there are a number of others I wished to write about but for the sake of length I will only communicate my further recommendations:

- there needs to be an increased public health understanding on the risks of caesarean section and why vaginal birth is sought after. Women who emerge from birth trauma often go “I wish I had just had a caesarean” not understanding what this means for their recoveries, their babies, and their future pregnancies

- medical staff involved in debriefing need to understand it is not just instrumental and emergency births that women emerge with birth trauma. Normal vaginal birth AND elective caesareans can be traumatising and have lifelong impacts.

- women need to hear good stories about birth, or they enter labour fearing an outcome that may never come. Women need the opportunity to voice their trauma and their negative experiences also, but in all the attention given to birth trauma there needs to be disclosure into birth still being a really incredible process for women.

I want to focus briefly on my own experience with birth trauma, not as a woman birthing but as a midwife. I want to highlight that the current debrief system in the hospital systems are incorrectly set up to debrief after birth and obstetric issues.

Toni was a woman I was looking after who was high risk for developing preeclampsia (PET). Her pregnancy was uncomplicated until she developed gestational diabetes, which she was relatively quickly commented on insulin to manage. Over the coming weeks her insulin requirements were dropping, and there was a question into if she had gestational diabetes at all. I saw her a week after this conclusion was made by an obstetrician endocrinologist and an obstetrician registrar, I had not seen her at this point of care. Toni was exhibiting obvious physical signs of a rapidly progressing PET when I saw her, she was oedematous to the point it was difficult to breathe and talk. I immediately

assed her blood pressure which within the space of 30 minutes got to a spot of 180/115, a normal range being 140/90 and below. I went home after her blood pressure had been stabilised and was called back 12 hours later being informed she was going to have a caesarean as her blood pressure had not been stabilised and her baby was now distressed. We were walking to the operating theatre, Toni was talking to me about what had happened overnight, there were gaps in the story I could not piece together. Toni was moving herself onto the operating table from the bed when she began to seize. It started off with her arms shaking, I remember the nurses talking to her asking her to keep trying to move. “She is having a fit” I said, I had experienced my first eclamptic fit only a month before, I could not believe that this was happening to me again. The code was called and the room was fully, it was chaotic, and all I could do was try and find the fetal heart rate. In the chaos someone had taken the monitor out of the room, obviously not knowing what it was without being trained in midwifery or obstetrics, I yelled out I need my CTG where is my CTG, someone says back it’s in the corridor, and it gets brought back in. “We need to pause, can anyone find a pulse” the anaesthetist said, they were talking about Toni, not the baby. I took a step back and looked at her blue and lifeless body as nurses were attaching the defibrillation pads to her. “We now need to decide if our best step forward is a perimortem”. I could not believe what I was hearing, perimortem caesareans were for women who showed up dead to EDs after car accidents, they were meant to happen in movies and tv shows on floors, not for an inpatient who I was talking to 15 minutes ago. They found a pulse, they got an airway, we had time. The baby was born, Toni was unconscious, they were preparing to put in a tracheotomy, when I walked out of the operating theatre with the baby, we walked past her partner. 30 minutes ago I told him to wait right here and I’ll be back when Toni is all set up. This time I told him, just stay with your baby, I will tell you about how Toni is doing soon.

I stayed at work that day, whenever anyone came up to me I said “don’t ask or I will cry, I’m saving it until I get home”. Life went on, and then I went home, and then I crumbled. My partners shoulder has soaked up tears before but the screams that accompanied sobs were a different kind of hurt. I took a few days off, I was conviently rostered already to do so. I came back to work feeling ok, grateful to have time off but ever keen to see Toni and her baby, Toni was in the ICU, her tracheotomy was in place and she could not talk but had been communicating on a white board, completely neurologically intact, she was healing well, no further seizures, her blood pressure was ok. Her baby was small, likely stopped growing around 33 weeks but was born at 33+6, but doing remarkably well. He had been stepped down to the lowest level of intensive care. I was so relieved, I rode this high of “thank god”. Everytime I saw a new face I was met with that must have been so scary, please tell me what happened. And I did, everything was going to be ok therefore I had nothing to fear. And so I did over and over and over again. A seizure is a novelty in obstetrics, and a tracheotomy is unheard of, I was told “sounds awful but at least you saw a trachy put in”. I realise now I was traumatising myself over and over. That day ended with a “cold debrief”, a debrief that happens a week after the event with all the staff that was involved. I was the only one who was available from NICU/Obstetrics, the other 20 people in the room were all anaesthetics and theatre staff. The anaesthetist leading the debrief started with “let’s hear from someone who was very intimately involved in the care”, and then deflected to tha anaesthetist who had worked the night shift when Toni got sick. She spoke about her concerns and how she wasn’t listened to by the obstetric team, her thoughts were echoed and everyone in the room got a chance to weigh in on how she was obstetrically mismanaged. I am not a confrontational person, the idea of it makes my body shake, but even surprising to myself I spoke up. I said that I thought the point of the debrief was not to place blame but to update everyone on the progress and go over the acute management. I reminded everyone of most eclamptic seizures happen postnatally so all their efforts to say this

could have been avoided were most likely inaccurate, and in fact if they had, she would have likely died without the immediate anaesthetic intervention she had access to in operating theatres. I reminded everyone of how quickly this preeclampsia had evolved, given her bloods returned normal initially, and then became abnormal in the hours to follow, and how I only knew that because I met her when she was 12 weeks pregnant, and then I left. I found my friend/colleague, and then I cried, in the middle of the hospital with one million people passing me by. My boss later found me and sent me home, she told me how teary I was now was indicative I was traumatised and I wasn't dealing with it appropriately, that I needed to go to EAP and talk to the counsellor. I went home, and I still have not spoken to EAP or anyone privately. This trauma lives with me, rears it's head everytime someone has preeclampsia, otherwise just exists. I haven't spoken to anyone professionally yet because a lot of the anger I hold to the situation was actually the blame contest that followed. I should mention here no one actually spoke to Toni about her birth. When I saw her 5 days after her birth when I returned to work after my days off, her first question she wrote on her white board "what actually happened and where is my baby". In the time spent pointing fingers and combing through notes, no one had spoken to her. Toni declined a debrief, she can't remember what happened and is home with her baby who is healthy and breastfeeding. She may have questions and she has my phone number to call, but otherwise the trauma of her birth lives with me. This story I have less suggestions about how we can improve, hopefully this inquiry finds them, all I know it has to be better than EAP, incident reports to prevent lawsuits and blame games. I assume this experience has impacted others who were there, they were not afforded the same privilege I was in seeing them healthy and at home, perhaps that needs to be addressed as well.

I hope my words and stories have not been too tedious or emotional. This is of course an innately emotional issue but I have tried to remain fact based. As mentioned before I consent to my experience being published but do not wish to cause harm for the women who's stories I have included and so don't want those details to be published. I hope real change can come from this.