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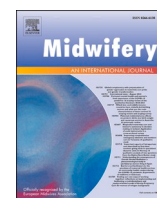
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Commentary

The forgotten patient. Do we really care what the birthing mother thinks, feels, and needs?

Shelley O'Connor



(Coxon et al., 2024) Editorial focused on a recent report published by the United Kingdom (UK) All Party Parliamentary Group (APPG) on Birth Trauma detailing findings from a national inquiry into birth trauma (APPG, 2024). Report findings showed that irrespective of the UK, as one of the largest economies in the world, maternity care is substandard and that serious failings are putting expectant and new mothers at risk of inadequate care and preventable tragic outcomes.

By my experience navigating the complexities of pregnancy and birth and the ensuing years, was like no other voyage I had embarked upon previously. I was a 40-year-old woman and had somewhat good mental health. I was overjoyed, but anxious at the prospect of becoming a mother for the first time. Fast forward two years, I bear the marks of a mother with physical and emotional scars following a traumatic birth. This is my story.

Becoming a first-time mother, I knew little about trimesters, fetal growth charts, and colostrum harvesting, so I read extensively and accepted sage advice from experienced mothers. This, however, did not equip me for the road ahead and subsequently, my journey to motherhood was fraught with problems from the offset. I was in my second trimester when I found out I was pregnant, and I could not secure an appointment with a midwife at my GP, due to staff sickness, unobtainable appointments, and problematic clinician caseload. When I finally saw a midwife, I was referred to the maternity services at a local hospital due to my age and diagnosis of cardiomegaly and was informed that all future appointments would be at the local hospital, rather than with a community midwife. It was here that I was under a cardiac consultant and my pregnancy was deemed high risk.

Psychological trauma began as early as the antenatal tests and checks. I recall a healthcare assistant say that I had missed the all-important combined screening test for Down's syndrome, Edward's syndrome and Patau's syndrome and could only be screened for Down's syndrome which does not provide accurate results but tends to increase with maternal age. I am an over thinker and manifested this anxiety at every scan. Many times, I recall the sonographer(s) state that the baby's head is measuring big, or the limbs appear short, or they could not get a clear picture of the heart or kidneys and had mentioned 'soft markers'

but did not expand on this or offer further explanation or show compassion. And other times, I had sonographers question why I needed so many scans, with one deeming it "unnecessary". Moreover, a young couple I know, had undergone counselling due to the emotional upheaval of having a baby with down syndrome. There was no indication at the screening tests or scans, although the birth was successful, they recollect not being supported by the healthcare staff, and were discharged without a conducive plan but instead were handed a crumpled-up leaflet and instructed to contact the numbers and social groups. They did not feel supported, and neither did I.

Coxon et al. (2024) state that the UK maternity policy focus has been on compassionate care since 2016 (National Maternity Review NHS England, 2016) but despite this, compassionate care is still lacking. Krausé et al. (2020) sought to determine what characterises compassionate care in childbirth, through a qualitative study and found:

'[it is] a process of making meaningful connections with women through recognising their needs, initiating individualised understanding of each woman's needs and desiring to ease it, which is subsequently manifested in action through emotional, instrumental and informational care and support'. (Page 1). And those meaningful connections should encapsulate good interpersonal skills, conduct based on dignity and respect and establishing trust, which should be extended to cultural competence.

When it comes to antenatal classes, this is a postcode lottery of health! I lived outside boroughs that provided regular antenatal classes and therefore I either did not qualify to attend or could not attend due to distance. I did however attend an antenatal education session one Saturday morning via an online platform and was met with a single healthcare worker and other couples. I don't remember much from the session and didn't find it particularly informative, but I was lucky enough to have access to a laptop, WI-FI and a quiet space- *do all expectant mothers have this privilege? How do expectant mothers in marginalised communities' access antenatal classes?* Instead, I searched for pregnancy related classes in my local area and came across *Pool of Life Yoga Birthlight pregnancy yoga*, ran by a local yoga teacher. Despite my lack of yoga knowledge *and flexibility*, I found this to be a supportive environment where we could share stories and normalise our anxieties

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encouraging a discussion of physical and mental health issues on a safe space.

Due to my high-risk pregnancy, I was not given a birthing option, despite requesting a discussion on a planned caesarean (Bell et al., 2022; Shareef et al., 2024; HealthTalk.org 2024). I was told that I would undergo one of the most common obstetric procedures in the world, *an induction of labour (IOL)* (Marconi, 2019). The National Institute for Health and Care Excellence (NICE) guideline [NG207] state that: *'an induced labour may be more painful than a spontaneous labour' and 'their hospital stay may be longer'* (NICE, 2021, 11.3).

Reasons for induced labour, vary from heightened health risks to the mother/and or baby, to a mother's preference (World Health Organization 2011). Yet my experience of the induction process was nothing less than harrowing- a horrific membrane sweep that resulted in heavy bleeding and no offer of pain relief, pessaries that needed reinserting and restarting the labour process, being lefts for hours each day without any communication and a deterioration in my mental health. The IOL was not a success, and I recall asking a midwife what the success rate was, to which the response was "very low, if at all any".

My trauma was further compounded by an emergency caesarean, suspected pulmonary embolism, treatment for Group-B strep disease, delayed antibiotics (going from 8pm to 2am), suspected meningitis, hourly observations for both my baby and I that were never in sync affecting our sleep, mood, and recovery, staff not administering prescribed medication timely (due to staff shortages), missing me off meal rounds and an absent feeding team (in the first crucial days which lead to dehydration). I would question here whether antenatal education would have minimised my birth trauma experience. Would I have managed some degree of self-efficacy and empowerment to mentally accept what had happened to me? Could I negate the potential of Post Traumatic Stress Disorder (PTSD) or other postpartum mental health illness?

In reflection of my experiences of birth trauma, I would have wanted the healthcare staff to listen to me, show me compassion and empathy and offer me small talk. I found that most of the healthcare staff either had no time to or chose not to engage in any communication. For example, I recall the moment I was woken at 3am <24 h following the birth, to be informed that my baby may have meningitis and needed a lumbar puncture. I was all alone, and no-one came to reassure me. As the days blurred into one, I did not know whether I was coming or going. I knew that my mental health, which has largely been good my entire life, was deteriorating. No-one spoke to me about being a first-time mother. There was an assumption that you just get on with the job. There was no small talk, no active listening. No-one seemed to really care or had the time to care. I felt like I was forgotten.

In total, I was in hospital for 10 days and my baby 7 days before I pushed for us to be discharged. The interrupted sleep, a perceived lack of compassion from healthcare staff and contradictory information did nothing to support my mental health. I needed to care for my baby in an environment that would be supportive to me. I needed my home. I once was a sprightly, out-going woman, two years on, I now suffer with PTSD, debilitating back pain and diastasis recti.

Birthing mothers yearn for small talk and regular check-ins and mental health plays a pivotal role in birth mother's experiences. Without the support from the healthcare team, some mothers may develop

mental health conditions such as PTSD that may go unnoticed or exacerbate existing mental health conditions. Should focus therefore be on the expectant mother's entire journey from pregnancy to postpartum rather than just birth trauma, to improve clinical outcomes? And is there a need to introduce mental health literacy education for healthcare staff, expectant mothers, and birthing partners, to spot disorders, gain knowledge of risks, and knowledge on treatment and services?

In retrospect, becoming a mother was a journey like no other. You could spend every waking minute preparing ourselves mentally for the road ahead, however, plans change, and you are thrown into chaos and unpredictability. By situating ourselves, and using our stories, we are enabling a future where practice can be improved. I encourage more mothers to share their stories and address their traumatic experiences to improve policy, evidence-based learning, and future midwifery education (NMC, 2019; 2023). Together we could end the era of the forgotten patient.

CRedit authorship contribution statement

Shelley O'Connor: Writing – review & editing, Writing – original draft, Visualization, Validation, Supervision, Software, Resources, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization.

Declaration of competing interest

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