**Submission No 478**

# INQUIRY INTO BIRTH TRAUMA

**Name:** Name suppressed

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Hi my name is a 3rd year student midwife completing my training within the next few months. I have predominantly completed my training at a level 5 hospital in sydney. The comments in this inquiry are in reference to the experiences I have witnessed and been involved with at this hospital.

A) The experience of birth trauma has become all too normalised in our health services. I have lost count of the number of times a woman has detailed horrific experiences during the perinatal period and then stated at least my baby is alive. But should that be our standard or can we do better. Does the mothers wellbeing not matter, does her baby's well being not matter. We need to ensure mothers and babies are emerging from the transition to motherhood psychologically, spiritually, physically and socially well, not simply alive. My very first birth I ever witnessed in the birth unit was the worst case of obstetric violence I have witnessed. The woman arrived obviously in active labour and progressing well. However, the midwife felt the need to assess where she was at through a VE. Consent was not obtained but rather the midwife told the woman they were going to do a VE and proceeded with the same. The woman yelled at the midwife to stop but they continued. The woman then hit their hand away. The midwife then insisted on the use of a CTG and forced it onto the woman's belly whilst she told them to stop. The woman quickly proceeded to the birth of her baby at which point she experienced a clitoral tear. Following birth the obstetrician informed the woman this required suturing which she consented to. However, upon suturing the midwife experienced significant pain and told the obstetrician to stop suturing repeatedly. The obstetrician ignored this request and continued suturing and told the woman over and over "it's not that bad", "the hard part is over", "stop complaining". At the time I felt uneasy and knew this was wrong, but by not ever witnessing a birth before I wondered if this was normal and required for the women's safety. I have since learned this is absolutely obstetric violence and in speaking with the woman the next day it was evident she was in shock. Whilst this is the most extreme example I have witnessed, I have heard too many women describe similar stories.

e) Informed choice in maternity care is highly subjective to the care provider. Our current policies and guidelines limit the ability for care providers to truly provide informed choice to women as we must remain within these bounds. I have witnessed numerous care providers (in continuity of care models) provide women with all information regarding available options so that they can make a choice most suitable to their needs. However, more often than not women are presented with the standard option of care and not given the option otherwise. For example, here is a GBS swab can you do this before your next appointment, we will give you anti D at 28 weeks because you are negative blood group. These statements are not followed up with any information in regards to the recommendations. Additionally, I have witnessed countless consent forms signed for induction of labour where the clinician says to the woman we need to induce you for x reason can you sign this form without detailing risks, benefits, alternatives or any other relevant information. Recently in birth unit I had a woman arrive for an induction of labour but she was unaware what her plan of care was or what an induction involved. Her consent form had been signed suggesting she had been informed of this however, evidently she had not. She was not aware that it was optional and she could choose, she didn't know what the process involved, she did not know the risks and she did not know why she needed it. Upon discussion the obstetrician informed her that it was recommended as per policy for her to have an induction due to her IDGDM. However, they agreed that her baby was well and there was no concerns at present after discussion and decided to discontinue the induction and go home. Had this discussion not occurred the woman would have proceeded with an induction without informed choice.

(f) Within the hospital I work, women are not able to access a continuity of care model unless they sign up for continuity of care within the first 8 weeks of their pregnancy due to lack of availability. This presents a barrier for many women who may not realise this and may not even be booked in for perinatal care by this gestation. Additionally, less than 10% of the women in our hospital have access to continuity of care despite the demand being significantly higher. This is alarming as women who experience continuity of care are more informed and experience better birth outcomes at the hospital I train at.

g) At the hospital I train at we are trained to tell women at their booking in appointments antenatally their maternity care options in regards to care providers and models of care. However, by this point many women have either deliberately chosen our service or if they have not thought about their options, choices are limited due to lack of accessibility such as MGP programs being booked out and Privately practising midwife being unavailable. Regardless, we present the options to women. Through this discussion I have been told by multiple women that they have tried to get onto the MGP program but were unsuccessful. I have also had numerous women tell me they wanted to have a privately practising midwife however they could not afford it. Whilst, there are options offered to women from the beginning of their pregnancy some of these are still unattainable for them.