Submission No 684

INQUIRY INTO BIRTH TRAUMA

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I have been a registered midwife since 2014, and throughout my career have worked across Qld, NSW, and Victoria, in a range of settings from 'low risk' rural MGP teams to tertiary centres.

In my experience, birth trauma is extremely prevalent for women and birthing people. When discussing pregnancy, birth, and postpartum experiences with families (both professionally and socially) the overwhelming majority of stories shared contain themes of fear, lack of support, inadequate information sharing, and a loss of control.

The Terms of Reference specifically list 'current practices in obstetric care' and 'use of instruments and devices for assisted birth' as factors contributing to birth trauma. I agree that these issues are key considerations in birth trauma, however it is the culture and systems within which these practices are used that allows for the abuse and violence against consumers of perinatal services.

Current practices in obstetric care are often not, as it is widely suggested, 'evidence-based'. I will not explore this in great detail- local policies/procedures/guidelines about continuous fetal monitoring, water immersion for labour and birth, and perineal care are all excellent examples of guidelines that are not supported by robust evidence. However, in my experience, the presence of poorly written guidelines alone does not create birth trauma. The risk of trauma to women and pregnant people is when these guidelines are enforced in a manner that does not align with true information sharing and informed consent. This may be as subtle (and insidious) as health professionals omitting or skewing the information they provide, to coerce women into agreeing to a particular plan of care. Or this may also be as violent as performing physical intervention without consent, which is assault. This is nearly always done under the guise of safety, which is often simply not supported by evidence, and in all cases is never reason enough to override a person's bodily autonomy.

I have witnessed, on more than one occasion, instrumental births, episiotomies, perineal stretching, fundal massage, and vaginal examinations being performed without consent, including occasions when the woman has asked the professional to stop and they have not. This is assault. I have witnessed women being told they cannot access warm water or analgesia unless they agree to a vaginal examination. This is coercion and does not meet the minimum standards for informed consent. This is assault. I have witnessed women being told they must agree to an induction of labour or caesarean section otherwise their baby will die. This is coercion.

Current guidelines and vacuums/forceps alone do not cause trauma. It is their use within a system and a culture that enforces the idea that the medical industry 'knows better', that does not respect autonomy, and uses coercion, threats, and violence that causes trauma.

The impacts of this trauma are widespread. I will not detail the consumer impacts as their own words will be far more valuable. For myself, I have experienced vicarious trauma through bearing witness to the abuse suffered by women and birthing people in mainstream perinatal services, including the recognition of knowing I have been complicit in this violence through my own inaction in these situations. I experience physical symptoms of anxiety when required to advocate for women and families, as I know the repercussions from when I have not advocated strongly enough in the past. I am undertaking counselling with a birth trauma specialist, which is financially costly. I also intend on leaving the public health system, as I can no longer serve organisations that do not have consumers as their priority. I am not alone in this choice, and I fear this will impact the care available for women and birthing people who do not have the health literacy or finances to seek alternative care options.

Continuity of midwifery care is not readily accessible for all families, and this is unacceptable. The evidence supporting midwifery continuity of care is substantial, and yet facilities refuse to implement these models of care. The reasons cited are often financial, though research indicates these models can decrease health services' costs. For services that offer continuity of midwifery care, accessibility is dictated by local procedures that restrict access to the model based on risk profiles, that again, are not well founded in research. Midwifery continuity of care has a myriad of benefits and no increase in 'poor outcomes'. It is a political and patriarchal issue that all women and birthing people cannot access this type of care. However, this alone cannot reduce birth trauma unless the culture within which midwives are expected to practice also changes.

Thank you for your time in reading my submission.