Submission No 823

INQUIRY INTO BIRTH TRAUMA

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Date Received: 6 August 2023

I have been a Registered Midwife for 9 years where I worked most of this time in a busy teritary Birthing Unit. Throughout my career I have witnessed countless acts of obstetric violence.

In this submission I will be addressing a number of the terms of reference such as causes and factors contributing to obstetric violence, the importance of informed consent, the barriers to the provision of continuity of care and the information available to women and families regarding maternity care options.

I have witnessed women being withheld pain relief such as having to endure procedures that should be undertaken in the operating theatres such as manual removal of placenta and severe perineal trauma repairs, being done in birthing unit. Merely to save doctors from having to organise going to OT.

I have witnessed women being threatened with FACS if they do not comply with recommendations and guidelines and witnessed women be made to feel like policy is law and that they do not have any other choice.

I have witnessed women be blatantly lied to about the risks of a procedure, for example an obstetrician telling a mother that a forceps delivery would absolutely not cause any harm or injury to her baby.

Hospital policies provide a biased opinion and do not support true evidence based practice. It has been shown that it takes 7 years for evidence to make it into policy. I have witnessed women be told time and time again that they "have to" get certain tests done, be induced, have ultrasounds and procedures without being informed of the risk and the current evidence-based research. Women are being told what the policy recommends but not what the research shows, thus not allowing them to provide true informed consent. There is pressure to follow policies and instructions from those in charge even if they are not evidence based, in the woman's best interest or against what the woman wants.

One particular incident of obstetric violence that stands out for me was when I was caring for a young 16 year old girl who had been admitted with us for about a week. She was 24 weeks pregnant and they had found her to be fully dilated with the bag of waters protruding from her vagina. We had been caring for her in the trendelenberg position (on bedrest with the foot of the bed higher than the head), to try and prolong her pregnancy for as long as possible. I was caring for her on her 16th birthday when she suddenly was feeling more pain that she had previously and her waters broke. The obstetric registrar came to assess her and advised that he had to do a vaginal examination to see where baby was. It seemed that birth was imminent and the neonatal ICU team was called.

The obstetric reg performed a vaginal examination and was instructing the girl to push while using his fingers to push down on her perineum. When he was not seeing a result, he continued to perform a vaginal examination despite the girl yelling at him to stop over and over again, to which he responded "its ok, its ok" without ceasing the exam. I remember the NICU team and the student midwife I was working with all looking at me in horror. I had to

insist that he stop what he was doing before he finally did so. I left the room shaking after witnessing such a profound and disgusting act of abuse. I was later told by other members of the obstetric team that I may have been overreacting to the situation and that he was just doing his job. I was thankful that my manager at the time supported me and replied that I was doing my job in advocating for the patient. This young 16 year old girl eventually birthed her baby not long after this incident which would have been traumatic enough given her extremely premature baby's tough, long road ahead.

Since working in the birthing unit, I have moved onto working in Midwifery Group Practice providing continuity of care to women and families. Continuity of care is the gold standard which has been shown by research to have better outcomes, better experiences and higher satisfaction for women and families as well as being more cost effective for hospitals. Yet continuity programs are constantly having to prove that they have a place in hospitals rather than be supported to succeed. 10% of women in Australia have access to continuity of care, there are not enough models and midwives available to women. This can be for a variety of reasons such as lack of support from management and executives, lack of funding and a lack of support from our obstetric colleagues. Women are also being discouraged from seeking continuity of care from private midwives in the homebirth setting, I have been a victim to this even as a midwife myself, where my GP encouraged me not to birth at home and then kept delaying giving me a referral to a private midwife. Another reason that families are not accessing continuity of care through private midwives is the lack of education that is provided pre-pregnancy and also from GPs as many women do not even know that private midwifery may be an option for them.

Continuity of care IS the answer to birth trauma and obstetric violence. It is not always about the outcome, and there is definitely a place for obstetrics and medicine in pregnancy and birth. However continuity of care allows women and families to build trust with their care provider who will keep them informed, educated and most importantly respected, every step of the way, even if the outcome is less than favourable.

Thank you for taking the time to read my submission.

I would prefer not to given evidence at a hearing.