The Maternity Consumer's Guide to Informed Consent

MATERNITY CONSUMER NETWORK

Written for consumers by consumers

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Informed consent

Your care provider must always get your informed consent before they do any medical treatment or test.

They must do this when you are:
Pregnant
In labour
After your baby is born

The only time your care provider can do something to you without informed consent is to save your life if you are so sick that you have fallen unconscious.

Even then, you can set up an "Advanced Healthcare Directive" to decline life-saving treatment.

It is your right to decline or revoke consent for any medical treatment at any time, even if doing so may result in harm to you or your baby.

Informed consent is:

Voluntary

You agree of your own free will.

You do not feel coerced, pressured, or scared into agreeing.

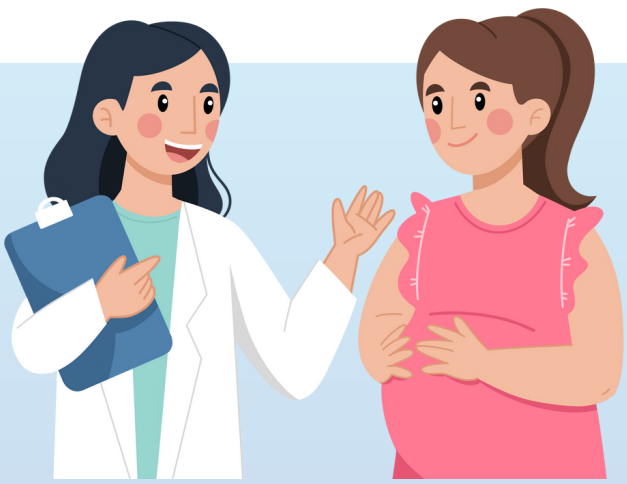
You have had time to ask questions and think about your decision.

Informed

You have a full understanding of what you are agreeing to.

You have been given all the information you need to make a decision, including:

Why it is being recommended.
The benefits.
The risks.
What is likely to happen if you don't do it.
The costs.
The process of performing the test/treatment.



Informed Consent is not:

General information sheets

These are useful to help you make a decision, but your care provider must still discuss your individual situation.

A signed consent form

These are intended to record your decision to give informed consent. However, they are only as good as the discussion that happened before you signed it.

If your care provider pressures you into into signing a form, you have not given informed consent.

A guideline

Guidelines are general advice to care providers about what interventions to *offer* in different situations.

Some state health guidelines incorrectly say that a care provider can ignore your consent if a doctor thinks your baby is in danger. These guidelines go against Australian case law and women's human rights.

"Shared decision making"

You are the only person who has the right to make decisions about what happens to your body and baby.

Some guidelines refer to a concept called "shared decision making". This makes it sound like your care provider has a say in what can be done to your body. They do not.

Informed consent in practice

Discuss your preferences early in pregnancy

Having a detailed conversation about an intervention during labour is difficult. This means that it is important to discuss possible interventions with your care provider during your pregnancy.

You should discuss your wishes early your pregnancy to make sure you and your care provider understand each other before you go into labour. These discussions are not informed consent by themselves - they are simply useful to help you make quicker decisions while you are in labour. Do not let your provider avoid these topics and say they can discuss things during labour.

If your preferences do not align, you can change care provider

Sometimes you may find that your care provider would prefer to intervene in your labour more or less often than you would like them to. In this case, you may choose to change your care provider to one whose preferences align more closely with yours. This can be done by finding a new provider in the private sector or sending a request off to your local public hospital asking for a different midwife or doctor for your care.

Informed consent in practice

Guidelines and practice differ

While by law, the provider is supposed to give informed consent, sadly in practice, women often must fight to get the information they need.

It is not a guarantee however that a care provider will tell the truth. This is why it is important to seek independent information on birth physiology, birth interventions, and the risks involved.

Health care workers and policies

Hospitals and their staff have to work within local health district's maternity guidelines and policies. These are mostly based on “consensus” rather than scientific evidence. Further, some guidelines illegally instruct providers to assault women with medical interventions under the guise of ' medical emergency'.

A care provider who delivers truly evidence-based practice may risk their license. Such providers are very rare, and are usually private midwives and obstetricians who support vaginal birth after caesarean.

Informed consent in practice

Create a birth plan

A birth plan is a good way to consider your options and record how you would like to proceed in different situations.

It is important to consider your options for as many scenarios as you can, including for interventions you do not intend to have. For example, you may consider having the curtain lowered to witness the birth of your baby in the case you consent to an emergency caesarean.

You may choose to share your birth plan with your care provider during your pregnancy. Their response can help you to understand whether their general approach to birth aligns with your preferences. If the provider tries to make you to change your plan, or starts modifying it to suit their preferences, this may indicate that the provider does not respect your right to give informed consent. Your birth plan is a written record of your personal medical decisions, and it is not your problem if your provider disagrees with them.

You are not obligated to share your birth plan with your provider. You may simply give it to your assigned midwife during birth to read. If they disagree, it is their problem not yours; they must still get your informed consent before doing anything to your body. Simply ignore your provider or request a new one if they disrespect your birth plan.

Alternatively, if you wish to have a more thorough and legally binding document, you may choose to create an Advanced Healthcare Directive. Templates are generally available from your state's health website.

Strategies for Decision Making

When your care provider recommends an intervention, there are tools that can help you make an informed decision. These can be used in the prenatal period as well as in labour.

BRAIN Tool

Ask your care provider and yourself these questions before making a decision.

Benefits - What are the benefits of the suggested course of action? Consider benefits to both you and your baby.
Risks - What are the risks associated with this decision? Any side effects? Different people will weigh the advantages and disadvantages differently.
Alternatives - What are the other options available?
Intuition - How do I feel about the suggested course of action? Our subconscious quietly analyses the information in a way that our conscious brain can't. If nothing else, acknowledging your feelings makes them easier to process.
Nothing - What is likely to happen if I do nothing? What if we wait for an hour, a day, or a week?

Once you have done this, it is your right to ask for time alone or with your support person to consider your next action.

IDECIDE tool

Use the steps in this acronym to make sure you have covered the important aspects of decision making.

I – Identify the urgency with which the decision should be made.
D – Details of the current situation. What is the diagnosis and/or why is the intervention being recommended?
E – Exchange objective and subjective information. You could use the BRAIN tool here to ensure you have the information you need.
C – What Choices are available to me?
I – I (the woman) confirm my understanding and seek any further clarification I need.
D – Make your Decision, and the care provider should record it.
E – Evaluation should take place a few days/weeks later using a recorded experience measure.

What is Obstetric Violence?

Obstetric violence is when maternity care providers mistreat women, or disrespect their rights to informed consent. This includes being forced or coerced into procedures against your will.

It is your legal right to decline any intervention that is recommended, and to tell your care provider to stop at any time. If a provider does not stop the intervention or does a medical procedure without your permission, this is medical malpractice and/or negligence. Studies have found that between 1 in 10 to 1 in 3 women experience obstetric violence in Australia.

However, research does not include covert obstetric violence nor includes postpartum obstetric violence from the postnatal ward, NICU or by maternal health nurses and paediatricians. Furthermore, consider many women may not recognise or identify that they are victims of obstetric violence and are groomed by society to think medical abuse is okay

The Obstetric Violence Power and Control Wheel is designed to help you recognise obstetric violence.

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Understanding Obstetric Violence

The United Nations defines obstetric violence as: "A form of gender-based violence, exercised by those in charge of health care for pregnant women accessing services during pregnancy, childbirth and post-partum."

The Maternity Consumer Network defines obstetric violence as : "Misogynistic based maternal medical violence against women and mothers by healthcare professionals that is enabled and excused by society in order to keep women into socially defined archaic roles of obedience, compliance and trauma bonding to oligarchal medical systems."

There is a narrative that obstetric violence is caused by under-staffing and a demoralised medical workforce. While these are certainly issues, it does not make obstetric violence acceptable. Private hospitals do not have these staffing issues and have the same amount medical violence towards women.

It is important to remember that abuse is about power and control. Providers who abuse women in pregnancy, birth and post-partum have made a conscious decision to do so and do so with intention.

The next pages will give several example scenarios of obstetric violence.

Antenatal Obstetric Violence

Elle is told she has to have an induction because she has reached 41 weeks. When Elle declines the induction, her provider tells her that, her baby will die and she will be responsible.

This is not informed consent. This is coercion.

The provider should explain the benefits and risks of induction, respectfully discuss the risks of stillbirth and respect Elle’s right to decline the procedure.

Chiyo made an informed decision to decline to remain part of the gestational diabetes clinic as her sugars have remained stable after 2 weeks of finger prick tests. Her MGP midwives do not tell her that this disqualifies her from their care until she goes into labour. Chiyo is left with a an unknown midwife she had not planned for.

This is bait and switch. Chiyo's midwives should have been upfront about the requirements of staying on an MGP program at Chiyo's booking appointment.

Luca makes an informed decision to decline GBS screening in pregnancy. At following appointments, she is constantly ‘asked’ for a GBS swab. Sometimes the providers have the swab kits ready and instruct Luca to take off her pants despite her refusal.

This is maternal disrespect and abusive pressure tactics. Luca’s midwife should have provided Luca with information regarding GBS and why they recommend screening. Her refusal should have been documented and acknowledged and not brought up at future appointments.

Miriam makes an informed choice to have no ultrasound scans in pregnancy. When Miriam discloses to her provider she won’t be having a morphology scan, her provider threatens to report her to child protective services, and tells her that the hospital will take her baby away and give it to social workers if she doesn’t have the scan.

This is coercion. Children's protection do not get involved over women’s medical choices in pregnancy nor do healthcare providers have any knowledge or say about whether a child is removed from a parent in a child protection investigation. Hospitals have no statutory power to remove a child from a parent. Only the police and a child protection officer may remove a child from a parent's custody when that child is at risk of significant harm and when that child is born separate from its mother.

How to address these situations

Lodge a complaint

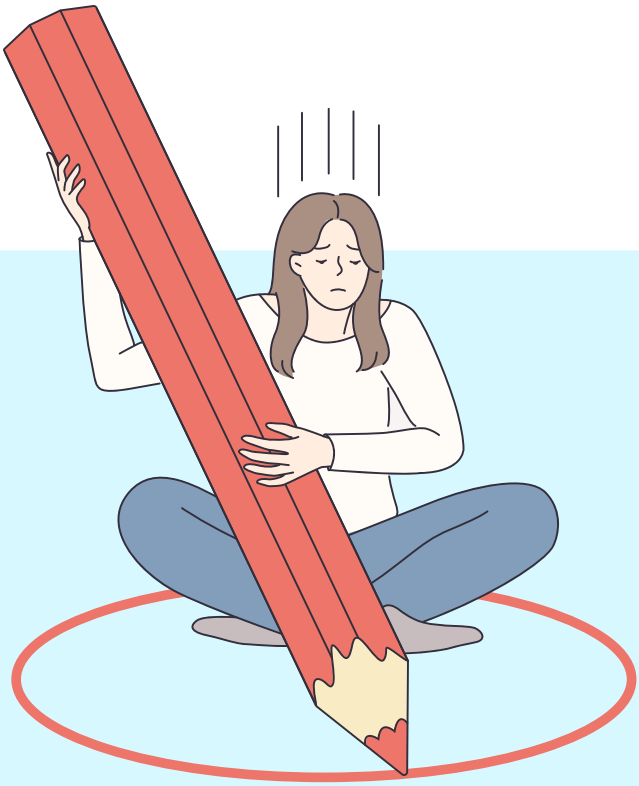
The women in these scenarios should document what happened to themselves in a time stamped email on the day the abuse occurred, and lodge a complaint to the hospital's patient liaison department. This can be done themselves, or through an advocacy organization such as the Maternity Consumer Network.

The concerns should be kept simple.

- What happened
- Who was involved
- How it made them feel
- That the clinician cease this behavior and respect their rights
- Request the abusive practitioner is removed from their care

A birth advocacy organization may add an additional letter to the complaint citing codes of ethics, conduct and professional standards as well as guidelines the clinician/hospital must adhere to.

It is important to document and lodge complaints early. This creates a paper trail in case the disrespect escalates, and helps to set boundaries and expectations before the birth.



If the disrepect does not stop

- Request a meeting with the head of obstetrics, midwifery and clinical director
- Put in writing to the hospital you will be disengaging until you receive respectful maternity care and will see them on birth unit (unless you choose to go to a different hospital or homebirth). Mention you will be resuming antenatal care privately.
- Sometimes hospitals may try to call child protection on the matter. Child protection in most cases will ignore, but sometimes may ring for a welfare check and offer services such as transport to hospital or child-minding during labour. They may also try to help advocate for your needs with the hospital.
- Occasionally, some providers may make false accusations to child protection so for the purposes of a welfare check, they may ask more questions than unusual in order to close their case

Child protection cannot force you into medical treatment in pregnancy or birth.

Obstetric Violence During Birth

Fatima has some concerning readings on a non-stress test during a routine third trimester appointment. Fatima is new to Australia and is learning English. Without permission a clinician grabs her arm and inserts an IV and another clinician puts a consent form in front of her saying she must sign as she is wheeled to theatre. Fatima does not understand what is going on and signs the consent form for an emergency caesarean as sedatives is injected into her IV.

This is a form of medical assault and battery.

The providers should make sure Fatima has an interpreter of her choice and the risks of a concerning non-stress-test are explained to her. Consent for caesarean forms should be explained to Fatima with an interpreter before the non-stress-test and Fatima will herself decide to sign them or not. The benefits and risks of an emergency caesarean and everything it entails should also be discussed before the non-stress test. Fatima's consent through the interpreter should also be gained for an IV line and any drugs administered. Fatima also has the right to decline a caesarean and take on the risks associated with that choice.

Lucy desires a Vaginal Birth After Ceasarian, a choice her provider does not support. Her provider lies to her about her baby's position being transverse and schedules a caesarean section. As Lucy after the birth reads her clinical notes, she finds out her caesarean was recorded as elective and her baby was in the correct head down position.

This is obstetric violence by omission to trick a patient into surgery to meet a provider's agenda. Lucy's provider should have explained they are not competent to support VBAC and should have referred her to a provider who would have.

Jane is pushing during childbirth and her baby is about to crown. Her provider recommends an episiotomy as they feel Jane may risk severe perineal tearing. Jane declines the episiotomy. Her provider performs the episiotomy anyway. This is assault. The provider should have respected her choice.

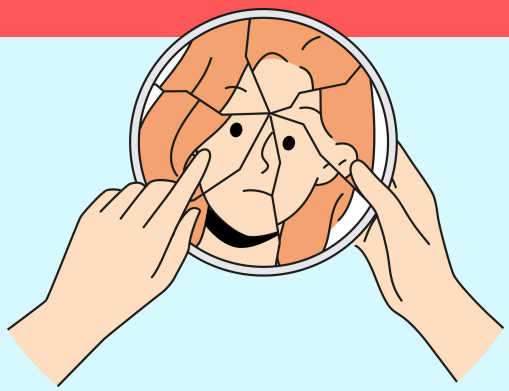
Sara is in the pushing stage and declines an episiotomy. Her provider then continues to question her about why and repeats the request for episiotomy. Feeling exhausted and wishing to push her baby out in peace, Sara ‘consents’ to the episiotomy. This is assault via coercion. Her provider should have only made sure Sara understood the risks amd left her alone.

Ming is in early labour and declines to have her waters broken. Her provider then gets 'consent' from Ming's partner and does the procedure anyway. This is assault. Consent can only be obtained from the patient and no one else.

Gupreet is at a routine third trimester antenatal appointment and consents to a vaginal exam to see if her cervix is ripe for an induction. Gupreet finds the vaginal exam unusually painful and very rough. The provider removes their fingers and tells Gupreet “I gave you a stretch and sweep while I was in there.” This is medical sexual assault. Gupreet had only consented to a vaginal examination, not a stretch and sweep.

Sally consents to an emergency caesarean due to foetal distress. The surgeon makes a few practice cuts, but Sally reports she can feel everything. The surgeon decides timing is more important and proceeds with the caesarean without adequate pain relief. This is medical assault and a breach of Sally’s human right to pain relief under article 5 of the Declaration of Human Rights

Araluen requests an epidural as she cannot cope with contractions. Her provider delays and makes excuses not to get the anesthetist because they have beliefs about natural childbirth. This is obstetric violence by denying the woman her human right to pain relief to serve clinicians own agenda



These situations require by-stander intervention to handle

By-Stander Intervention in Maternity Care

Bystander intervention is when a woman's birth support advocate, question, de-escalate, stop and document situations involving obstetric violence and mistreatment.

Many people tell women that they need to advocate for themselves during birth, despite this being very difficult due to the physiological process of labour.

Ideally medical staff should not abuse women; however this is unfortunately common.

It is unrealistic to expect women to protect themselves from medical assault when they are in a vulnerable position such as being in labour. A support person can help advocate for the provision of respectful maternity care.

Research on by-stander intervention is almost absent in maternity care, but we can get an idea of how affective it is and how it works by looking at by-stander intervention for sexual violence.

For by-stander intervention to work, the by-stander needs to:

- Recognize the abuse
- Understand they need to take action
- Take responsibility
- Make a plan to intervene
- Have the confidence to do so

By-Stander Intervention in Maternity Care

Bystanders tend to feel more confident if they feel supported and prepared. Partners and birth support should seek education to help them recognise obstetric violence, and should prepare strategies to intervene. If the woman is working with a doula, her partner and the doula can work together; however it is important that the partner is also prepared.

Doulas do tend to recognize obstetric violence in many situations, but women's birth support should also undertake education on what obstetric violence is so that they too can recognize it.

Bystander intervention is most likely to be required during the birth process. It needs to be utilized strategically, as providers can accuse the bystander of being aggressive and interfering with medical practice, and may call for security. Therefore, it is very important the bystander remain calm.

It is not a guarantee bystander intervention can stop obstetric violence, but it is important to try. Knowing that someone was advocating for her, even if unsuccessful, may help the woman in the aftermath. By-standers should be aware their advocacy will be met with hostility and may run the risk of being escorted out by security. Always remain calm and polite.

Example 1: Episiotomy

The provider is pressuring the woman to consent

The bystander can politely ask the provider: "She has clearly declined. You should respect her informed medical decision."

The provider is taking out scissors and preparing to cut the woman's perineum:

The by-stander can say *"She hasn't consented to that/? She was very clear no episiotomy in her birth plan. Perhaps get her consent? '* If the provider responds, they usually retort about a medical indication, so this is the perfect opportunity to direct them to go into risks and benefits for the woman. Alternatively you can warn the woman what is happening and ask if she consents to this.

If the provider ignores you and cuts the woman anyway, advise the woman of this after the birth. With the woman's permission request the clinician is removed from the room and someone else provide medical care. Document the assault immediately and call an attorney or a birth advocacy organisation as soon as possible for a paper trail. Make a police report as soon as possible with the woman's permission.

Example 2: The Provider is trying to gain consent from someone other than the woman

Sometimes providers try to get consent from women's birth support or try to talk to women's support alone, usually her partner, to get them to pressure the woman to agree to an intervention.

If the by-stander (partner) is asked to give consent, the by-stander can say *"I'm sorry I am not your patient and I cannot make those medical decisions."* This should be repeated even if the provider tries to use fetal safety as an excuse. The woman's autonomy is morally and legally more important than the birth outcome of a fetus.

If the provider tries to talk to the birth support alone, *"I'm sorry if you wish to talk, we can talk together with the patient as I don't have her consent to talk with you alone. You can talk to the woman if she gives consent to speak to you alone though."*

This is redirect tactic to have the provider focus on the patient rather than birth support, It's important to have conversations with the woman before birth about this possible scenario so that you are both on the same page when it comes to making sure consent is obtained from the woman alone.

Example 4: Outright Physical and Sexual Violence

Sometimes providers ignore the word no and any redirection and choose to engage in physical violent acts like forced forceps deliveries.

The provider is having midwives hold down the woman for a forceps delivery without consent

The by-stander can say "T*his is illegal as the woman hasn't consented and you need her consent even in an emergency as she is still conscious. Fetal concerns do not override her autonomy."*

If they do not stop and its obvious physical violence being inflicted, the by-stander should call the police. They may not come, but calling them is important for a paper trail. Ask for a receipt of the phone call from the police phone operator. It is also important the by-stander beforehand takes down the names of the clinicians in the room especially the main one committing assault. This will make it easy for advocacy organizations to search the provider's up on Australian Health and Practitioner Regulatory Authority website.

The next option is to ring an attorney. But this depends on what time the woman is giving birth, availability, and financial feasibility. It can also be used in an attempt to stop behavior and the by-stander can say:

"*Hey this doesn't seem right. I'm just going to get some legal advice."* However, this does need to be followed through. Most lawyers will give quick free legal advice on the phone.

In all these scenarios, the by-stander should remain calm and watch the tone of their voice and their mannerisms. Be politely assertive and try not to words things like a threat. This is to avoid being accused of being aggressive

Most states have laws against recording, but if a case of obvious criminal activity such as medical assault is occurring, use your own judgement if you feel the need to record (privately) and get legal advice after. Do not release on to social media or police. The recording is for private legal court use only.

These situations are tricky to navigate, and you may not be able to do more other than call out the legality and immortality of the situation. However, there are still options for aftermath intervention.

Aftermath By-Stander Intervention

As soon as possible, the by-stander should document what they saw in a time stamped email or on a written hand note that is photographed and sent in email, again for time stamping purposes.

The documentation should include, what happened, who did it, what time it occurred, what the woman said, reacted, did or how she looked. It may have more legal clout if the email is sent to a birth advocacy organisation like us, contacting us with concerns. When the woman is able to, she should document her version of events.

For example:

"On the 21st of June around 12:pm, my client Jane was beginning to push her baby, but the provider put their fingers inside Jane's anus. Jane told her to remove her fingers as did I. The provider argued that this was to prevent perineal tearing, however Jane continued to plead for the provider their fingers out. The provider ignored her and Jane became very distressed. The provider only removed their fingers when I said 'I think this is wrong and I might call an attorney as this seems to be a violation of her human rights and assault.' After this, Jane gave birth to a baby girl…I am documenting this as I believe a sexual assault occurred. Can your organization advise on what to do next. This happened at St Mary's Hospital. The provider's is name is x".

This is an important step for a legal paper trail so the woman has written evidence from witnesses that are time stamped, otherwise most cases involve a 'he said, she said' issue with little opportunities for the woman to seek justice during a complaint process.

Aftermath By-Stander Intervention

After the birth, encourage and back up the woman to have the abusive provider removed from the room and a different provider be the one to resume medical treatment. You can simply ask her if she wants someone else to treat her after what just occured. She may not agree at the time. Warn the woman privately the abusive provider or other staff may try to come to her room on the post-natal ward for a 'debrief.'

Advise her to decline this (privately). Debriefs are not evidence based and are used by hospitals to gaslight women and document interactions to avoid litigation.

Declining debriefs on the post-natal ward can be overwhelming and scary after a traumatic birth. A simple 'I/We do not wish to talk. Please leave." Repeat if they ask why and if they do not cease, the woman or support person can say "If you do not leave I/we will contact a birth advocacy organisation. Please leave."

It is important the by-stander documents what happens to an attorney or a birth advocacy organization. This is because sometimes hospitals try to document false narratives that the by-stander is abusive or aggressive. If the by-stander is male, be aware the hospital may try to make a false report to child protection regarding domestic violence.

Do not worry about this. Child protection will either ignore or do a welfare check and the bystander or the woman can simply explain the situation and show them documentation they took, and tell them of any birth advocacy organizations involved.

If you are a doula who has intervened to stop obstetric violence, there is a risk that you may be reported to a health regulatory authority for interfering with medical practice. If this happens, make sure you keep accurate documentation of what happened that is time stamped, contact us and we can help assist with your clients in providing supportive statements. Always seek legal advice regardless. In most cases, the accusations are dropped as they are unfounded. Advise your client not to engage with the regulatory authority as they are not obligated to give information if you are the one being investigated.

Post-Partum Obstetric Violence

Obstetric violence does not end at birth but is on a continuum and extends into the post-natal ward, NICU and Special Care Nursery.
This type of abuse usually involves:

- Baiting
- Breastfeeding Sabotage
- Maternal Surveillance
- Proxy neonatal violence
- Post-Natal ward negligence

Unfortunately, the medical community expects women to fit into social constructs of how a 'good mother' should act like around healthcare professionals when her baby needs medical treatment. This means women are expected to be docile, agreeable and unquestioning in regard to the treatment involving their babies.

When women do not fit into these expectations and try to assert their parenting choices, they are often threatened with child protection, have child protection get involved and in turn their babies may be mistreated by medical staff in order to bait them into losing their composure and look 'unfit.'

To navigate these situations, its best to check our manual on post-partum obstetric violence:

"Navigating Motherhood under Obstetric Adversity'

Complaint Processes

There are consumer organizations you can turn to, for support in lodging a complaint or providing advocacy services. The two current organizations that provide these services in Australia are:

Maternity Consumer Network
https://www.maternityconsumernetwork.org.au/

Maternity Choices Australia
https://www.maternitychoices.org/

For legal assistance in a complaint:

Human Rights in Childbirth
https://www.humanrightsinchildbirth.org/

Or any relevant legal firm of your choice.

If you need help dealing with your birth trauma, it is best to seek out psychological services that specialise in perinatal psychology.

It is important to ask the perinatal psychologist if they are trauma informed and by that they mean that trauma is a natural response to stressful life events and not something abnormal like 'mental illness.'

Complaint Processes

There are options for independent birth debriefs mostly offered by independent private midwives. They can go through your clinical notes and spend a few hours discussing your birth to help understand what happened and assist you in processing your birth experience.

Sometimes these debriefs are also offered by doulas, but it is important to be sure about what kind of debrief you are looking for as not everyone offering these services has training in psychological first aid or are trauma informed. The best individuals to offer birth debriefs are independent private midwives, preferably with additional mental health qualifications.

Hospital birth debriefs where any trauma occured should always be avoided.

Birth debriefs are not a replacement for therapy or perinatal psychology services. They are however good as a first step to understand your experience and decide how you wish to navigate any trauma you may be feeling after a birth.

Some doulas or midwives who offer debriefing services may offer to assist you through the complaint process. While it is your choice to go through this process with them, we advise that this is better done through a maternity consumer organisation like the Maternity Consumer Network or Maternity Choices Australia.

This is because consumer organisations have extensive experience navigating complaint process and can provide advice on what to write as well as what to expect from healthcare complaint responses.

Making a Complaint

There are several options for making a complaint.

If you wish for policy changes and an apology you may make a complaint to the hospital. Hospitals may invite you along for a discussion and a meeting and may enact policy changes and apologize for the way you feel about the experience.

They will not take accountability or outright admit to negligence or abuse due to litigation reasons. The purpose of a hospital complaint is to get an explanation and have your complaint used as feedback for policy changes and staff training.

You can also escalate complaints to the local health district clinical executive who can review your matter.

However, if you wish to seek damages for trauma - whether physical or mental - inflicted upon you from the birth, as well as hold the hospital or clinician accountable, whether criminal and civil, we do not recommend making complaints to hospitals or having meetings without the advice of a lawyer. Such complaints should remain strictly with your chosen legal representative.

Other options for complaints involve going to third party regulatory authorities.

If your complaint is against a clinician, you can lodge a complaint with the Australian Healthcare Practitioner Regulatory Authority (AHPRA).

If your complaint is against a hospital due to the treatment and practice of multiple clinicians, you can lodge a complaint with your state's regulatory authority such as the:

Healthcare Ombudsman
Healthcare Complaints Commission

Anything requiring compensation or justice must be done through a medical malpractice or human rights lawyer through the judicial system.

A Word of Caution

Complaints to hospitals and medical regulatory authorities often yield very poor responses that minimise or justify the situation. They require overwhelming evidence to action a reprimand of some sort. A regulatory authority cannot give you the justice or recognition a court will.

Most regulatory authority reccomendations or coronial inquests are not legally enforceable.

In our experience as a consumer advocacy organisation, many complaints are not dealt with sufficiently and responses often involve minimisation of what has occurred. Complaint processes though are beneficial for paper trails for any future litigation proceeds or for mass maternity consumer complaints and for documentation for child protection investigations regarding medical neglect.

In regard to obstetric violence and the legal system:

Criminal court requires a high standard of evidence (beyond all reasonable doubt) to determine the guilt of a clinician for medical battery, which will be decided by a jury. The conviction rate of obstetric violence in Australia is almost 0.

Civil court requires a lower standard of evidence than criminal court (balance of probabilities) and is usually where most women seek their ‘justice’ via compensation. The downside to civil court is that it will require evidence of ‘harm’ to the woman and not just the ‘act of violence.’

Conclusion

Pregnant women in Australia have the same rights to respectful medical treatment as everyone else.

You do not lose your bodily autonomy because you are pregnant.

You have the right to decline medical treatment even if it results in your death or the death of your unborn child.

Medical practitioners are always required to obtain your informed consent/refusal before performing any procedure.

Silence is not consent.

The only time your consent is not required is in an emergency where you are so sick that you have fallen unconscious.

Australian maternity care does not use an evidence or human rights-based approach. Many clinicians do not understand consent, and some think that they are the advocates for fetuses. It is difficult to hold such people accountable in the aftermath of obstetric violence, which is why it is important for women and their birth support to stand up for their rights.

We must remind maternity care providers exactly what their role is: to provide a medical service, not to make decisions for women.

Your rights in childbirth include:

The Right to access healthcare
The Right to Informed Consent
The Right to Respectful Maternity Care
The Right to a high and competent standard of care
The Right to safe health care
The Right to pain relief during birth

Understanding your rights is the first step to recognizing when those rights are being violated and to know when to seek help.

References and Resources

https://www.safetyandquality.gov.au/our-work/partnering-consumers/informed-consent

https://www.ahpra.gov.au/Resources/Code-of-conduct/Shared-Code-of-conduct.aspx

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