CRIMINAL LAW (COERCIVE CONTROL AND AFFIRMATIVE CONSENT) AND OTHER LEGISLATION AMENDMENT BILL 2023

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From: [redacted]
Sent: Saturday, 4 November 2023 11:20 AM
To: Legal Affairs and Safety Committee
Cc: [redacted]
Subject: Coercive control and affirmative consent legislation
Attachments: favicon.ico; PIIS1871519223000379.pdf; favicon.ico

Dear Committee,

Thank you for your work, I'm sorry not to have had the opportunity to make a submission until now, however I wonder if you will consider the following.

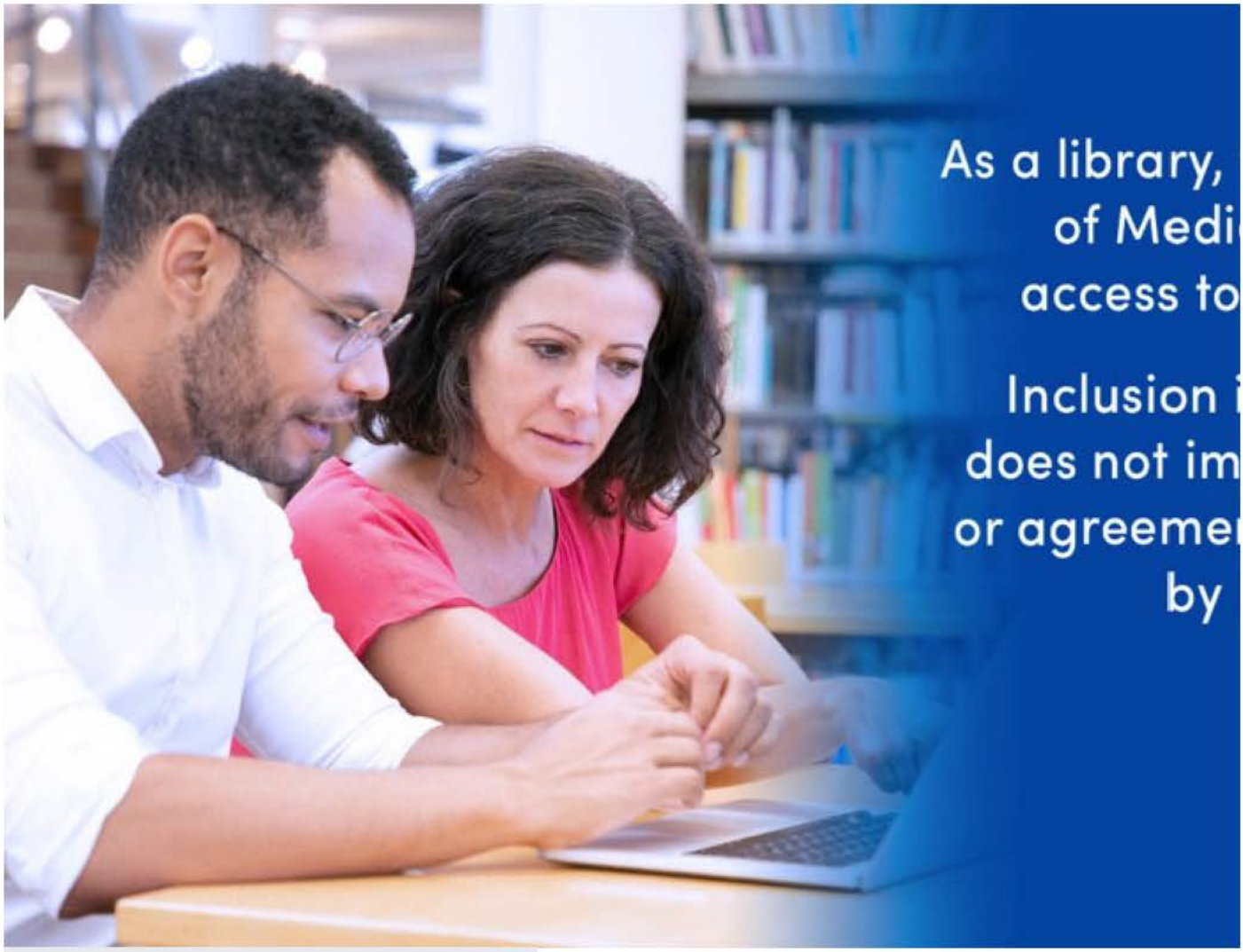
Recently NSW passed similar legislation but there was an exception for 'proper medical and hygienic procedures', this has had a devastating impact on maternity service users who routinely have their vagina and anus or penetrated without consent. Clinicians do this as they are following policy, but the policy is not based on evidence. A dangerously high level of women's vaginas and clitoral tissue is being cut open without affirmative consent, and not a single woman is being offered informed consent. Qld researchers have regularly reported on health care providers having a poor understanding of the law of consent, and this being most prevalent in Maternity Services due to mothers vulnerability.

Maternity care providers' perceptions of women's autonomy and the law
scholar.google.com.au

Women report to Maternity Choices Australia, Maternity Consumer Network and various local groups they had explicitly said no, yelled no, attempted to close their legs or had their partners stand inbetween their vaginas and the provider approaching with scissors. Women report having an epidural and reviewing their medical notes to find out they had endured 5x vaginal exams in 20 minutes, providers have threatened 'if you don't push your baby out in an hour, I cut you'. Some examples of womens experiences of obstetric violence are in this video

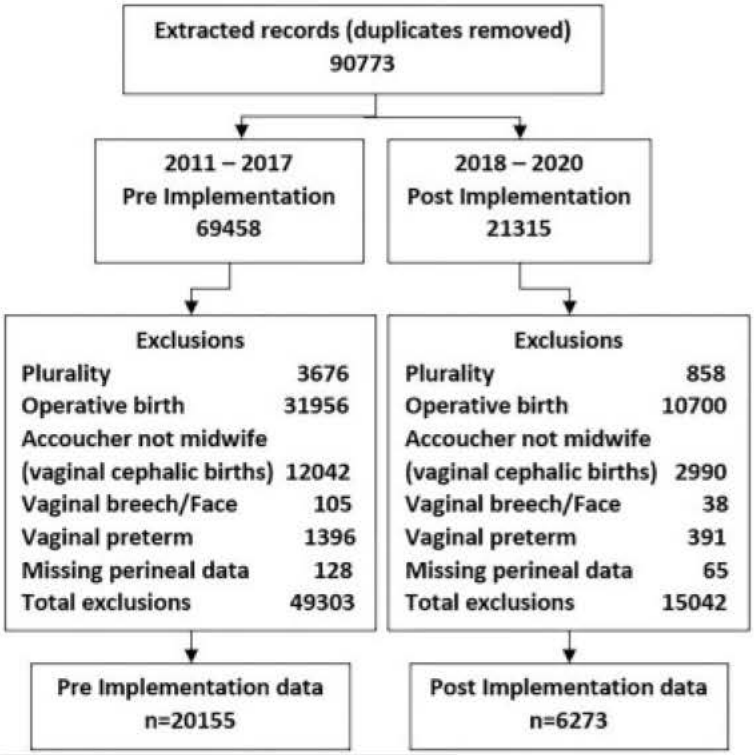
Our Voices: Obstetric Violence
youtu.be

Here is the research:
1.



The impact of a perineal care bundle on women's birth experiences in Queensland, Australia: A qualitative thematic analysis - PubMed
nlm.nih.gov

2.
https://www.womenandbirth.org/article/S1871-5192(23)00037-9/pdf
3.



A pre-post implementation study of a care bundle to reduce perineal trauma in unassisted births conducted by midwives
womenandbirth.org

4.
https://journals.sagepub.com/doi/10.1177/10778012221140138

5.

September 2023 Volume 49 Is

JOURNAL OF MEDICAL ETHICS

Journal of the Institute of Medical Ethics

jme.bmj.com

IME

BM

Setting a human rights and legal framework around 'the ethics of consent during labour and birth: episiotomies'
jme.bmj.com

6.

Report on a human-rights based approach to mistreatment and obstetric violence during childbirth
ohchr.org

We are asking that you ensure there is no exception in Qld's new coercive control and affirmative consent legislation in order to protect mothers in maternity services. Ideally, this legislation Will specificity that Obstetric violence, a form of sexual violence, is prohibited.

Thank you for your time.

[redacted]
Maternity Choices Australia [redacted]
[redacted]

Sent from my iPhone

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Consent during labour and birth as observed by midwifery students: A mixed methods study

Nigel Lee [a,*], Lauren Kearney [a,b], Emma Shipton [b], Glenda Hawley [a], Peta Winters-Chang [a], Catherine Kilgour [a], Susannah Brady [a], Ann Peacock [a], Loretta Anderson [a], Tracy Humphrey [a]

[a] Level 3 Chamberlain, Building, School of Nursing Midwifery and Social Work, University of Queensland, St Lucia, Queensland, Australia
[b] Level 6 Ned Hanlon Building, Women's and Newborn Services, Royal Brisbane and Women's Hospital, Metro North Health, Queensland, Australia

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ABSTRACT

Background: While consent is an integral part of respectful maternity care, how this is obtained during labour and birth presents conflicting understandings between midwives' and women's experiences. Midwifery students are well placed to observe interactions between women and midwives during the consent process.
Aim: The purpose of this study was to explore the observations and experiences of final year midwifery students of how midwives obtain consent during labour and birth.
Methods: An online survey was distributed via universities and social media to final year midwifery students across Australia. Likert scale questions based on the principles of informed consent (indications, outcomes, risks, alternatives, and voluntariness) were posed for intrapartum care in general and for specific clinical procedures. Students could also record verbal descriptions of their observations via the survey app. Recorded responses were analysed thematically.
Findings: 225 students responded with 195 completed surveys; 20 students provided audio recorded data. Student's observations suggested that the consent process varied considerably depending on the clinical procedure. Discussions of risks and alternatives during labour were frequently omitted.
Discussion: The student's accounts suggest that in many instances during labour and birth the principles of informed consent are not being applied consistently. Presenting interventions as routine care subverted choice for women in favour of the midwives' preferences.
Conclusions: Consent during labour and birth is invalidated by a lack of disclosure of risks and alternatives. Health and education institutions should include information in guidelines, theoretical and practice training on minimum consent standards for specific procedures inclusive of risks and alternatives.

Statement of significance

Problem

Informed consent may be invalidated if such discussions do not consistently address all the required principles of beneficence, nonmaleficence, autonomy and justice.

What is already known

Research presents conflicting accounts of how informed consent during labour is presented by midwives and experienced by birthing women.

What this paper adds

The observations and reflections reported by midwifery students of the consent process between midwives and birthing women suggest that, while midwives treated women with respect, less than 50% considered that midwives generally informed women of risks and alternatives.

Introduction

Consent is an integral component of respectful maternity care, a key

* Corresponding author.
E-mail addresses: nigel.lee@uq.edu.au (N. Lee), lauren.kearney@uq.edu.au (L. Kearney), Emma.Shipton@health.qld.gov.au (E. Shipton), glenda.hawley@mater.uq.edu.au (G. Hawley), p.winterschang@uq.edu.au (P. Winters-Chang), c.kilgour@uq.edu.au (C. Kilgour), s.brady@uq.edu.au (S. Brady), a.peacock2@uq.edu.au (A. Peacock), loretta.anderson@uq.edu.au (L. Anderson), t.humphrey@uq.edu.au (T. Humphrey).

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indicator of high quality midwifery practice, and a fundamental right for birthing women [1,2]. Consent comprises four ethical principles: beneficence, to act for a person's benefit; nonmaleficence, to prevent harm; autonomy, personal power to make choices and justice, fair and equitable treatment. [3] Informed consent requires that the person providing consent has the capacity to do so, receives full disclosure, comprehends the information provided and acts voluntarily [3].

Legal rulings in the Australian High Court [4] and, particularly relevant to maternity care, the United Kingdom Supreme Court [5] shifted the emphasis of consent away from what a reasonable practitioner may consider clinically essential information, to that which is of particular relevance and importance to the 'patient' (woman). The change in focus and the subsequent requirement for consent to consist of a dialogue between the clinician and the woman that explores the risks and benefits from both perspectives underpins the concept of shared decision making [6]. However studies have highlighted continuing barriers to an active role in decision making for birthing women such as lack of information on rights of consent and the pervasiveness of the risk avoidance discourse [7].

Research into how consent is obtained during labour and birth presents tension between the understanding of the concept by care providers, such as midwives and obstetricians, and women's experiences. In a qualitative study of the practice of consent during pregnancy, all midwifery and obstetric participants voiced support for the practice of informed consent [8]. Whereas the experience of women participants reflected a more one sided and formulaic approach to consent [8].

Labour and birth present a particularly vulnerable time for women with intimate procedures such as vaginal examination often being considered by clinicians as routine [9]. Research also highlights the possibly haphazard approach to consenting for procedures such as episiotomy compared to other surgical procedures [10]. Time pressures, such as those often associated with episiotomy and operative birth, and the experience of pain present challenges in providing informed consent [11]. However, such clinical factors are not the only contributors to the complexity of intrapartum consent. Lack of training and guidelines on how to undertake informed consent and engage in shared decision making effectively limits the ability of clinicians to navigate these requirements. These issues are exacerbated in fragmented models of care where there may be little opportunity for pre-emptive discussion regarding labour and birth interventions [7].

Some research suggests that the disparity between the clinicians and women in their experience of consent increases during labour and birth. A mixed methods study of women's interactions with clinicians during birth revealed themes of coercion and the prioritising of the care provider's agenda which contributed to women's experiences of birth trauma [12]. For other procedures such as intrapartum perineal massage performed by some clinicians during birth, there is no research detailing how consent is obtained.

Arguably, some research approaches that could directly and prospectively explore differences between cultural expectations and individual actions may not produce authentic findings. Essentially, clinicians are more likely to answer such inquiries with acceptable theoretical responses rather than an authentic account of practice [13]. Therefore, this study sought to address this potential limitation to midwives recounting their own approaches to gaining informed consent by exploring midwifery students' observations and experiences of how midwives undertook consent during labour and birth. Midwifery students are motivated to observe the actions of clinicians; however, they are also largely 'invisible' in the clinical area in such a way that clinicians do not routinely alter their practice in their presence.

Methods

Study aim and design

We aimed to explore midwifery students' observations and experiences of midwives obtaining consent from labouring women. We advised the students to focus on their encounters with midwives rather than maternity care providers more broadly (e.g. obstetricians) as we considered that the students spend the majority of their time with their midwifery preceptors and it is these experiences that are likely to be reflected upon in considering their own practice. The study used an explanatory concurrent mixed methods approach [14,15]. The study employed an online questionnaire designed specifically for the research to collect quantitative data. The survey included an embedded application which offered the capacity for voice recorded responses. This feature enabled students to recount experiences of consent to specific procedures during labour and birth and reflect on how these influence their understanding of consent and respectful care.

The questionnaire was divided into five sections. (i) Seven questions that collected demographic data. (ii and iii) Five point Likert scale statements regarding student's observations of midwives practice of consent both in general less invasive procedures such as abdominal palpation and for specific procedures such as vaginal examinations (VE), artificial rupture of membranes (ARM), intrapartum perineal massage and episiotomy. We defined perineal massage as both the digital stretching of the perineal and vaginal tissues by the midwife in an attempt to reduce perineal injury and the digital pressure placed on the vaginal wall to direct maternal pushing effort. The Likert scale statements were based on the principles of consent, specifically beneficence (information on the indications and benefits of a procedure), nonmaleficence (risks involved), justice (alternatives) and autonomy (time to ask questions and consider). Students were offered the opportunity, via the voice recording application, to describe an episode of consent they had observed related to a particular intervention and/or describe how this illustrated the answers they gave in the Likert questions. Students were advised not to include any names of midwives, other clinicians or identifying information in their verbal descriptions. (iv) Factors that may influence midwives' approach to consent and (v) using the recording application to reflect on how their observations might shape their own concepts of consent and midwifery. The questionnaire was provided to midwifery academic staff and midwifery students for testing for face validity and functionality. This resulted in only minor grammatical changes to the questions. Formal assessments of validity were not undertaken.

Participants and distribution

The inclusion criteria for the study was midwifery students in their final year of an Australian university course that led to registration as a midwife. Final year students were chosen as, being at the completion of their course, were more likely to have undertaken sufficient clinical practice placement to provide observations of midwifery practice in obtaining informed consent. A link to the questionnaire was posted on Facebook and distributed via email to Heads of School in Australian universities that provided a midwifery program. The email detailed the rationale for the research, study information and link to the questionnaire for students. Universities that agreed to support the study then distributed the study information and questionnaire link amongst their final year midwifery students. The distribution process occurred initially in November 2021 and repeated in April 2022.

Consent and ethics

The use of midwifery students as proxys or 'other raters' to provide prospective observation data of the practice of midwives observed during practice placement has potential ethical challenges [16]. Particularly given the power differential and relationship between midwifery students and midwives. Asking participants to recall and reflect on a collection of past experiences does not carry the same ethical dilemmas. Therefore, it was explicit in the participant invitation and questionnaire instructions that the data provided was to be retrospective

(i.e. from observations of past placement experiences) and that there was no expectation that the students should observe individual midwives prospectively.

The introductory page of the questionnaire detailed the purpose of the study, the inclusion criteria, and the voluntary nature of participation. While the first question asked respondents to confirm that they were final year midwifery students there was no prescribed process for confirming if respondents met the inclusion criteria. There was no formal consent process required, it was considered that if potential respondents followed the link from the introduction to the commencement of the survey this implied an acceptance of the invitation to participate.

Ethical approval for the research was provided by the University of Queensland Human Research Ethics Committee. Some of the universities approached had process for site ratification of the original ethical approval, or other committees or processes for reviewing external requests for student involvement in research. Where required this process was completed prior to distribution of the questionnaire.

Data analysis

Quantitative data were analysed using Stata statistical software (StataCorp. 2015. Stata Statistical Software: Release 14. College Station, TX: StataCorp LP). Descriptive statistics were calculated for all variables including percentages and mean ranked scores as appropriate. In the Likert scale questions we considered the responses of 'All of the time' and 'Most of the time', to be positive, 'Some of the time' to be neutral and 'Occasionally' and 'Never' as negative.

Qualitative data from the verbal responses provided by students were analysed using reflexive thematic analysis that employs a creative, exploratory, flexible and iterative approach. [17,18] Reflexive thematic analysis is commonly used in applied health research or mixed methods research [19]. The recorded data was mechanically transcribed by the application and checked for accuracy against the original voice recording. The first author (NL) led the data analysis. The transcripts were read and reread, and meaningful phrases were coded. NVivo qualitative data analysis software (QSR International Pty Ltd. Version 12, 2018) was used to facilitate the coding of the transcribed text prior to thematic analysis. Codes were then synthesised into themes with quotes as illustrative data [17]. Codes and themes were then shared amongst the co-authors. Discussion with and feedback from co-authors challenged interpretations and prompted a return to the data for exploration of differing viewpoints [20]. The discussions and iterative process contributed to the reflexivity and triangulation of the analysis resulting in a richer and more nuanced understanding of the data. An audit trail was kept to record the development of thematic structure during the analysis. [20] Thick description in the form of participant quotes, has been used to evidence both the credibility and transferability of the findings to similar settings. The format […] indicates where quotes were edited to maintain focus on the issue under discussion.

Findings

Two hundred and twenty-nine students responded to the survey. Of these, 34 provided only demographic data without responding to the questions regarding consent, their data was not included in the analysis. Not all 195 participants included in the data responded to all the questions, numbers for missing data (unanswered questions) are presented in the relevant tables. Twenty respondents provided qualitative data.

Demographic data is presented in Table 1. The majority of respondents were Bachelor of Midwifery students (53.3 %), and 73.8 % resided in a major city. The majority of students agreed that in the course of routine non-invasive procedures that midwives treated women with respect and practiced informed consent. However, less than 50 % considered that midwives generally informed women of risks and alternatives (Fig. 1).

Table 1
Participant demographics.

Participants *Age, years,*	Survey responses n (%) *(n 195)*	Audio recorded data n (%) (n 20)
<20	1 (0.5)	1 (5)
20–24	120 (61.5)	16 (80)
25–29	23 (11.7)	0
30–35	24 (12.31)	0
36–40	13 (6.6)	3 (15)
>40	14 (7.1)	0
Course type		
B Mid	104 (53.3)	6 (30)
Dual Degree	74 (37.9)	12 (60)
M Mid	10 (5.1)	1 (5)
Post Graduate	7 (3.6)	1 (5)
State		
NSW	25 (12.8)	0
QLD	114 (58.4)	16 (80)
Vic	16 (8.2)	2 (10)
SA	11 (5.4)	0
WA	16 (8.2)	1 (5)
ACT	10 (5.1)	1 (5)
NT	3 (1.5)	0
Geographic region		
Major city	144 (73.8)	15 (75)
Inner regional	39 (20.0)	4 (20)
Outer regional	10 (5.3)	1 (5)
Remote	2 (1.0)	
Placement type		
Block Placement	56 (33.3)	5 (25)
Integrated placement	130 (66.6)	15 (75)
Placement area (multiple options) (n 195)		
Birth Suite	191 (97.9)	18 (90)
Birth Centre	65 (33.3)	3 (15)
Private MGP	1 (0.5)	0
Public MGP	108 (55.3)	15 (75)
Public and Private MGP	10 (5.1)	0
Private homebirth	3 (1.5)	0
Public Homebirth	11 (5.6)	0

*Missing data (n = 1); (n = 2) respectively; % calculated on completed data.

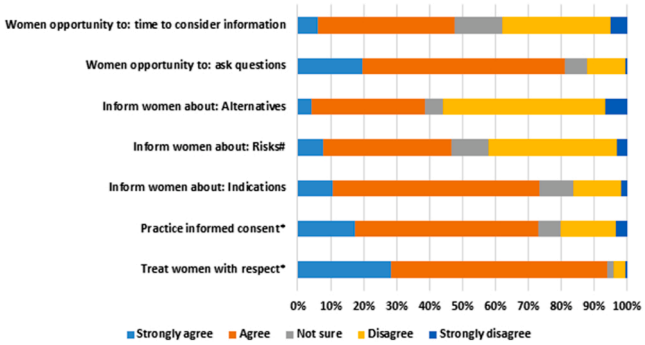

Fig. 1. Aspects of consent for general non-invasive procedures. Legend: *Missing data (n = 1); (n = 2) respectively; % calculated on completed data.

For the VE, ARM and episiotomy, many students (40–70 %) were positive in their responses with regards to information provided to women about indications and outcomes. However, across the same procedures responses were mostly negative regarding the discussion of risks and alternatives. In some procedures, such as VE, up to 79 % of students reported alternatives were only discussed some of the time, or never. In VE and ARM the issue of providing an opportunity to ask questions or time to consider consent was approximately equally divided between positive and negative responses. The ability to ask questions and consider consent was much less likely to occur with episiotomy.

Intrapartum perineal massage received a majority of negative responses across all the domains of informed consent. Fewer than 7 % of

positive responses were provided for either risks, alternatives, time to ask questions or consider consent and 74 % reported that risks were never discussed (Table 2).

Participants were also asked to rank 1–6, with 1 being the most important, issues that they considered might influence how midwives approach consent. The urgency of the situation was ranked as being most likely to influence the consent process (mean score 2.10). Other options in order of rank were: intervention being considered routine (mean score 2.71); midwives were obligated by policy to undertake the procedure (mean score 3.07); the woman distracted by pain (mean score 3.94); midwives being too busy (mean score 4.23) and the woman's first language not being English (mean score 5.10).

Table 2
Aspects of consent for specific interventions.

	All of the time	Most of the time	Some of the time	Occasionally	Never	Missing data
Vaginal Exam						
Indications	36 (18.4)	70 (35.9)	67 (34.3)	19 (9.7)	1 (0.5)	2 (1.0)
Outcomes	15 (7.6)	63 (32.3)	67 (34.3)	45 (23.0)	4 (2.0)	1 (0.5)
Risks	8 (4.1)	12 (6.1)	40 (20.51)	60 (30.77)	74 (37.9)	1 (0.5)
Alternatives	4 (2.0)	6 (3.0)	29 (14.9)	81 (41.5)	74 (37.9)	1 (0.5)
Ask Questions	18 (9.2)	49 (25.1)	60 (30.77)	56 (28.7)	11 (5.6)	1 (0.5)
Time to consider	15 (7.6)	35 (17.9)	66 (33.8)	53 (27.2)	25 (12.8)	1 (0.5)
ARM						
Indications	46 (23.5)	86 (44.1)	43 (22.0)	11 (5.6)	1 (0.5)	8 (4.1)
Outcomes	32 (16.4)	94 (48.2)	41 (21.0)	18 (9.2)	1 (0.5)	9 (4.6)
Risks	16 (8.2)	55 (28.2)	44 (22.5)	58 (29.7)	14 (7.1)	8 (4.1)
Alternatives	5 (2.5)	20 (10.2)	48 (24.6)	71 (36.4)	43 (22.0)	8 (4.1)
Ask Questions	21 (10.7)	90 (46.1)	43 (22.0)	31 (15.9)	2 (1.03)	8 (4.1)
Time to consider	22 (11.2)	49 (25.1)	61 (31.2)	45 (23.0)	10 (5.1)	8 (4.1)
Perineal Massage						
Indications	5 (2.5)	19 (9.7)	40 (20.5)	57 (29.2)	61 (31.2)	13 (6.6)
Outcomes	4 (2.0)	19 (9.7)	42 (21.5)	49 (25.1)	67 (34.3)	14 (7.1)
Risks	1 (0.5)	7 (3.5)	13 (6.7)	17 (8.7)	144 (73.8)	13 (6.6)
Alternatives	2 (1.0)	9 (4.6)	21 (10.7)	38 (19.4)	112 (57.4)	13 (6.6)
Ask Questions	1 (0.5)	12 (6.1)	28 (14.3)	40 (20.5)	101 (51.7)	13 (6.6)
Time to consider	5 (2.5)	7 (3.5)	20 (10.2)	39 (20.0)	111 (56.9)	13 (6.6)
Episiotomy						
Indications	38 (19.4)	53 (27.1)	62 (31.7)	21 (10.7)	9 (4.6)	12 (6.1)
Outcomes	32 (16.4)	50 (25.6)	55 (28.2)	39 (20.0)	7 (3.5)	12 (6.1)
Risks	10 (5.1)	21 (10.7)	47 (24.1)	50 (25.6)	55 (28.2)	12 (6.1)
Alternatives	9 (4.6)	20 (10.2)	28 (14.3)	63 (32.3)	63 (32.3)	12 (6.1)
Ask Questions	15 (7.6)	30 (15.3)	44 (22.5)	51 (26.1)	43 (22.0)	12 (6.1)
Time to consider	9 (4.6)	19 (9.7)	36 (18.4)	53 (27.1)	66 (33.8)	12 (6.1)

Data is n(%).

Qualitative findings

Twenty respondents provided qualitative data via the voice recording application. Most students were aged between 20–24, lived in Queensland cities, and were undertaking a dual degree program (Table 1).

Three themes were identified from the data – Uninformed consent, Continuity of care and Reflections on practice. Sub themes were generated for Uninformed consent and Reflections on practice themes (Table 3).

Theme: uninformed consent

Uninformed consent, where consent did not include some or all of the required elements, was a dominant theme in the data. Contributing factors to uninformed consent identified and discussed by the participants are described in the sub-themes; Standard care that must be done, Limited discussions of risks and alternatives, The time crunch, and; They just decided to do that.

Standard care that must be done

A number of students commented on how procedures, such as VE, were often presented as routine or standard care which subverted the need for consent:

> It's [VE] not really discussed as a question. It's more we talked about that we need to do this, so now I'm going to do this. SM2

Students were also conscious of the vulnerability of women during labour and birth. With particular reference to perineal massage one student describes how the timing of the initial presentation of the intervention impacts on the opportunity to consider consent:

> I feel perineal massage is presented in a way that it is standard care that must be done[…] instead of presenting it as a question that is open for consent. Whilst the womans in such a vulnerable position in second stage, I find it's very easy for them not to question it. SM9

Some students observed that a labouring woman's vulnerability also derived from a lack of information and reliance on the recommendations made by their midwives regarding routine care.

> I feel when women are unsure of their options, they take any recommendation as routine and tend to not question the reasoning or question the idea as to whether they can consent or not. SM9

Other students considered that the concept of routine care was also

Table 3
Qualitative analysis coding and thematic structure.

Initial codes	Themes	Subthemes
Routine procedures		Standard care that must be done
Assumption of knowledge and/ or information		
Lack of discussion of risk		Limited discussion of risks and alternatives
Lack of discussion of alternatives	Uninformed consent	
Misinformation		
Time pressures		The time crunch
Coercion		
No attempt at consent		They just decided to do that
Influence of Continuity of care	Continuity of care	
Positive interactions		
Being impressionable		
Student reflections on hospital practices	Reflections on practice	It's the system
Student reflections on own practice		The midwife I want to be

used to avoid discussion around informed consent when the midwives themselves were uncertain of how to justify particular aspects of care:

> Like they [midwives] just don't have the information to back up what they're saying. Like they literally read off of a pamphlet and say yes, this is policy, this is what needs to be done. SM14

Limited discussion of risks and alternatives

Most students commented that while aspects of procedures such as indications and outcomes were often included in consent discussions, the risks and alternatives were often not presented to women as part of the consent process. Other students remarked that even when risks were included in consent conversations with women this was often lacking information and depth. Students again related this to inadequate information sharing that limited women's understanding of the possible consequences of the interventions.

> Well I haven't ever seen a midwife explain the risks of a vaginal exam to any kind of labouring woman. SM 16

> When midwives would perform vaginal examinations, there's limited discussion prior about risks […] And if it is, it's very surface level. SM4

Some students also commented that when alternatives were discussed, these options were not presented with the same degree of information or legitimacy, possibly to influence the woman towards the clinician's preferred option.

> But if there is one that I find is lacking, it's definitely alternatives. […] I find they [midwives] only briefly discuss alternatives and they make the alternatives seem like the worst decision. SM5

The time crunch.

A number of students recognised that time pressures could influence the way that consent was sought. This could be as a consequence of the rapid decision making that may occur during labour.

> So when it comes to offering an episiotomy in a more time constrained scenario during the second stage, there is very little time [for] the woman to consider. SM6

The workloads of midwives on a busy birth suite was also seen by some students to effect the way that interventions such as ARM were presented to women.

> Like they [midwives] can get impatient with the women I find and a lot of the times they're really like persuaded [the woman] into just doing the ARM to get the procedure done. I think at the end of the day, it's all about the time crunch that hospitals are experiencing. SM5

However, time was also seen by students as a means of limiting the opportunity for women to consider their consent. One student described how consent was sought from women for ARM during vaginal exams:

> The conversation is rushed because they are already doing the VE. They don't withdraw from the VE and continue to explain the procedure [ARM]. And it's so rushed that women don't get the time to properly consent or decline. SM11

They just decided to do that.

Some students described situations where there was no attempt to gain consent prior to an intervention being performed on the woman. A number of these observations concerned intrapartum perineal massage initiated by midwives during the birth. The students recalled how despite the discomfort and distress this sometimes caused women there was no attempt to discuss the procedure as an option or gain consent prior to the midwife inserting their fingers into the woman's vagina.

> And a lot of the time that [perineal massage] isn't consented, they [the midwife] just decided to do that. SM16

> So I have seen midwives just do it [perineal massage] and then say "I'm going to put my fingers inside now and it's going to help you to push better" […] rather than it being a discussion or an option for the woman. SM 18

> They [the midwife] just put their hands in […] and for some women this is quite distressing or obviously looks quite painful for them, and they never get an opportunity to say yes or no. SM1

Some students also recounted how the perceived immediate need for an intervention, such as an episiotomy, would occur without any real discussion of any aspects of consent with the woman.

> Anyway they cut the episiotomy, […] but there wasn't really a discussion over risks, alternatives, or proper time for the doctor to say "can I cut an episiotomy" and ask for verbal yes or no, it was just this is what we're gonna do, we're doing it, which was a bit upsetting. SM 17

Theme: continuity of care

A number of students observed how continuity of midwifery care could have a positive impact on the process of gaining consent during labour and birth. Some students commented on the overall environment where continuity of care midwives could practice.

> I'm currently practicing my placement in a birth centre environment and I found that in that environment they always give women the opportunity to ask questions and obtain consent before they do it and provide any other alternatives. SM8

Some students also commented that for interventions, such as vaginal examination, that were often presented as routine care with little opportunity for women to consider consent, that continuity of care models facilitated the provision of information and options for women to decline consent.

> I've noticed that the MGP midwives are a little bit more sensitive to that, like they will tell the woman that they can decline VE, it's only recommended every four hours. SM8

Other students related how time pressures around consent, often associated with procedure such as episiotomy, had also been mitigated by the relationship between the MGP midwife and the birthing woman.

> The midwife told her the decision to have an episiotomy was not urgent and had a long discussion with the midwife and with the doctor. she was able in her own time to decide what she'd like to do. SM1

One student reflected on their own experiences of continuity of care during their program and how that empowered their sense of empathy with regards to a lack of consent.

> We've had to follow 30 continuity of care experience women and that's given me an eye opener as to the woman's perception, […] of the impact that lack of consent has on her. SM 18

Theme: Reflections on practice.

The final audio question asked students to reflect on their observations of the consent process undertaken by midwives and how this might influence their own practice and approaches to consent. The theme is explored through two sub-themes: It's the system and The midwife I want to be.

It's the system.

Some students saw the issues around the consent process as part of a broader system failure. This related to the health systems and the institutions that provided their training as student midwives.

> Like that's just, in my opinion, a fault in the system, in the way that they teach us […]. That is exactly the whole point of being a midwife. It is to be with woman, not to be with obstetrician, it's not to be with the hospital, is not to be with policy. […] the woman quite literally trumps everything and anything that the hospital system whoever can say to her. SM14

The student goes on to recount a time when they tried to advocate for a woman declining an episiotomy during an assisted vaginal birth but felt her and the woman were unsupported by the midwife. The student considered that the midwife lacked the skills to advocate and communicate the woman's choice and that this was a result of a broader systemic failure within hospitals and midwifery training.

> The midwife in my opinion failed the woman and the system failed the midwife because she was not equipped to handle a situation where she was able to really advocate for her women. SM14

Another student discussed their observations of inadequate informed consent, relating this to human rights as a consequence of the pressures imposed on midwives by 'the system'.

> The lack of consent that I've seen is just disgusting and appalling and I genuinely believe it's a human rights issue. It's really influenced the way that I feel like I can't fit into the system. And because of this, I will be working outside of the system […] because I refuse to be put under such pressure. SM12

The midwife I want to be.

A number of students reflected on how their observations of midwives gaining consent from labouring women had influenced their perception of the midwife that they wanted to be upon completion of their program.

> My observations of such poor gaining of consent and I would even say coercion in birth have made me feel really passionate about how I would like to be as a midwife. SM12

> So for me as a student, um I've seen how important consent is and how it can influence the woman during labour and birth and how it can influence your relationship and your trust with the woman as well it's been reflected as so highly important, like not only for the safety of the woman, but for us as well. Um so yeah, it's heavily influenced into my practice now. SM8

One student reflected on the how the negative and traumatic experiences they had observed in relation to the consent process had evolved into a positive influence on their growth and expectations as a midwife.

> I don't even have a specific moment where this sort of like this revelation became it for me, it's like even throughout my degree […] Like all of those little moments have come together and moulded who I am and who I'm going to be as a midwife. But unfortunately some of the areas have created pretty traumatic experiences for these birthing women and I am as grateful as I am to have experienced that. It's still really sad that these women have had to have experienced that for me to have figured out what type of midwife I want to be in the future. SM14

Discussion

The findings from the survey and qualitative data suggests that, as observed by midwifery students, the consent process involving women during labour and birth is often incomplete. In particular, the discussion around risks and alternatives for all four clinical procedures explored was reported by most students as being inadequate or absent during the consent discussions. Our findings support those of previous studies that intrapartum consent is often sub-standard [11] and that discussions around consent that largely omit references to risks and alternatives appear to subvert maternal choice in favour of clinicians' preferences [12]. Understanding of indications, benefits and risks, and voluntariness to choose between alternatives are the primary components of informed consent. These elements are rooted in the understanding that intellect and free will are essential to our self-perception of humanity. [21] Modern interpretations of consent emphasise information provision, however voluntariness is often reduced to simply agreement. Particular to health care, Alderson and Goodey describe 'Functionalist' consent as a largely ceremonial transfer of risk from the clinician to the patient where refusal or non-compliance is viewed as irrational [21].

In the sub-theme 'They just decided to do that,' midwifery students recounted how in a number of instances consent was not sought at all prior to an intervention. In both the survey and the qualitative data this occurred most commonly during intrapartum perineal massage which, similar to a vaginal examination, involves the midwife inserting their fingers into the woman's vagina. Unlike many other body parts, the vulva and vagina are afforded a unique social and sexual significance. Even in a medical context non-consensual touching of the vulva and vagina is potentially tied to the violation and dehumanisation of women [22]. The student's observations of women's pain and distress during perineal massage without the option to refuse are stark illustrations of harm, be it unintended. Under the Australian law of trespass, in the absence of clear consent, such procedures are also unlawful [23]. Students paraphrased midwives discussions with women as perineal massage was undertaken with statements such as "I'm going to put my fingers inside now and it's going to help you to push better," which some midwives may have intended as part of a consent process. However, as Nelson points out, when information is termed in vague and euphemistic instructions, particularly framed around an expectation of compliance, the procedure is unconsented [24]. Furthermore, the epistemic dominance of midwives may mask their recognition of the potential for obstetric violence associated with unconsented vaginal procedures [25]. This apparent blindness to the absence of consent and implications for obstetric violence may also be influenced by the obstetric and institutional dominance of midwifery. Recent studies have illustrated how institutionally supported obstetric guidelines can impact midwifery practice where there is an implicit expectation that both the woman and the midwife will comply [26–28].

The presentation of interventions such as vaginal examination as routine care was commonplace in the qualitative findings and a likely contributing factor to the limited discussion of risks and alternatives highlighted in the survey data. Students referred to midwives quoting guidelines and women appearing unsure but accepting of the midwives advice. The assumptions of benefit embodied in the use of routine care, given credence by practice guidelines, contribute to a sense of paternalism where, again consent is viewed as an agreement process rather than choice [29]. The broad application of routine care and guidelines without consideration of individual circumstance and bodily autonomy works to assert power and silence women [30]. Midwifery domination as a form of power is discussed by Fahey and Parratt as a means of rendering a labouring woman docile to the midwife's guidance [31]. This power is often subtle and not evident to the woman until they consider disagreement [31]. When women attempt to question routine care, this can illicit visible expressions of frustration in care providers that contribute to an uncomfortable environment for women that further inhibits or silences dissent [29].

The timing of consent was another factor considered by the students. This was illustrated in descriptions of midwives seeking consent for ARM while undertaking a VE. While VE and ARM are common procedures in midwifery practice, the sexual significance of the vagina and the pervasiveness of sexual assault characterise the act of seeking consent for an ARM during a VE as coercion and firmly within the definition of obstetric violence [22,25]. Shabot argues that while many women experience these as bodily traumatic they do not recognise them as violence due to the benevolent setting and context in which they take place [25]. Exploiting a women's aversion to vaginal examination to circumvent the consent process for another procedure is further example

of 'midwifery domination' power and silencing.

The concept of shared decision making implies extensive discussions and information sharing between clinicians and women regarding possible interventions, rationales, and alternatives. However this can be difficult to achieve given intrapartum scenarios that may require timely decisions [32]. Further complicating factors is the lack of preparedness expressed by both women and clinicians to undertake such conversations [7,32]. A frequently cited solution is to pre-emptively discuss a range of common intrapartum scenarios during the antenatal period and a number of tools have been proposed to facilitate and assess such shared decision making and identify areas of conflict [32–34]. Other authors have highlighted the success of this approach to shared decision making is often contingent on the establishment of a trusting relationship between the woman and a known carer [35].

In the qualitative data some students discussed how the consent process was more likely to be complete with midwives working in a midwifery continuity of care (MCoC) model. Pivotal early research introduced the concept of trust and 'professional friendship' fostered in the relationship between MCoC midwives and birthing women [36]. A recent systematic review and meta-synthesis of what women value in MCoC also highlighted women's experiences of trust and empowerment [37]. Trust and respect for women's autonomy are essential factors in discussions of informed consent and addressing mistreatment of birthing women [38].

A number of students reflected on the observations of the consent process and how this influenced their own self-perception as future midwives. Some students reflected not only on consent specifically but how this was situated in and was part of broader systemic issues in midwifery and maternity care. Some students reacted against negative experiences and perceptions of a system that applies pressure to midwives to conform and perpetuates control over women and midwives. Similar sentiments have been reported in the motivations of privately practicing midwives [39]. Other students transformed negative experiences into positive motivations and directions for their own midwifery philosophy and future practice. In particular, the students positioned effective informed consent as an essential component of developing a sense of respectful care for women in labour and birth consistent with current exploration of the issue globally [40].

Strengths and limitations

Our study had a number of strengths and limitations. Based on Australian government reports [41] approximately 1400 midwives graduate in Australia each year. Our survey sample size of 195 respondents would be sufficient of a 95 % confidence level with a 7 % margin of error (Qualtrics, Provo, UT). We have no way of knowing precisely how many universities distributed the questionnaire or how many midwifery students actually received the study information and invitation or viewed the Facebook posts. Though the survey was tested for face validation with academic staff and students it had not been assessed formally for validity. Therefore we do not have statistical evidence for reliability or internal consistency. While using a voice recording feature enabled data to be collected from a diverse range of students we were not able to explore the student's experiences of consent more deeply as might occur during an interview process. The qualitative sample was based solely on the number of respondents and not on any analytical or thematic considerations. Students who had observed negative interactions between midwives and women may have been more motivated to undertake the survey and/or contributed to the qualitative data than those who had more positive experiences. We cannot account for scenarios where discussions of interventions aimed at shared decision making took place prior to the students observing the interactions between midwives and women during labour and birth. The students observations were recorded retrospectively and therefore may be subject to recall bias. While we included only final year midwifery students we could not determine their degree of experience and knowledge which might affect their ability to interpret the scenarios witnessed.

Implications for practice, education, and research

As our findings suggest clinical guidelines cited by clinicians during consent discussions as justification for some interventions, they could also play a role in improving consent standards.

Institutional and State practice guidelines should include sections that detail minimum criteria and information that would facilitate shared decision making, including risks, alternative treatments and recommended timing for such conversations. While continuity of care may support effective consent discussions the process should be consistent across all models of care.

Educational institutions should ensure that standards for informed consent are detailed within theoretical and practical courses and assessments. Criterion for informed consent should be tailored for individual procedures and interventions rather than just an underlying theoretical concept. Future research should explore the effectiveness and sustainability of consent education for students and clinicians. Each of the above recommendations should be co-designed with maternity consumer representative groups to ensure they are relevant and representative of a shared process.

Conclusion

The findings of our mixed methods study suggests that the consent process undertaken by midwives during labour and birth is incomplete and therefore frequently invalid. Consent discussions appear to focus on indications and outcomes of procedures under an assumed acceptance of routine care rather than a process of fully informed consent and shared decision making. Complete and effective consent as an essential component of respectful woman-centred care would reduce the potentially harmful impact of non-consented procedures during labour and birth.

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Author agreement

I can confirm that the manuscript entitled : 'Consent during labour and birth as observed by student midwives: A mixed methods study' is an original work of the authors, has not been published elsewhere, nor is it currently under consideration by another journal. That all authors have seen and approved the final version. The authors abide by the copyright terms and conditions of Elsevier and the Australian College of Midwives.

Ethical statement

Approving ethics committees. The study protocol was approved by the University of Queensland Human Research EthicsCommittee (LNR) 2021/HE001761 23rd August 2021.

Author contributions

NL conceived the study and drafted the protocol, initial survey design, led the analysis of the data and writing of the manuscript. **TH, LK, ES, SB, AP, GH, PWC, CK**, and **LA**, reviewed the protocol and ethics submissions, contributed to the survey design, pilot testing and to the data analysis and interpretation. All authors contributed to the review and editing of the manuscript.

Conflict of interest

I can verify that neither I nor any of the co-authors have any conflict of interest concerning this research.

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Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.wombi.2023.02.005.

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