Select Committee into Birth Trauma

c/o The Hon. Emma Hurst MLC

Chairperson

NSW Parliament House

5 October 2023

Dear Committee Members,

Re: Supplementary Questions

We thank the Committee for taking the time to consider our initial submission and to raise supplementary questions to enhance your understanding of the human rights principles we have raised. Your questions and our responses are set out below.

(1) NSW Health says they have the 'NSW Health Consent to Medical and Health care Treatment Manual' and the 'Consent requirements for pregnancy and birth' which enshrine protections regarding informed consent. Do you believe these documents are working to protect women from non-consensual procedures in the maternity care setting? If not, why not?

The Consent Manuals have failed to have any impact on the behaviours of maternity health care providers and there are several systemic reasons for this.

HRiC is familiar with both NSW Health Consent Manuals, which we often use to try to advocate for women who seek our assistance. If, as NSW Health claims, these documents enshrine protections regarding informed consent, the Committee would not have received the thousands of submissions it is now reviewing from women about mistreatment in childbirth. We have reviewed many of the submissions from individuals and, without exception, they all refer to some violations, and in some cases, major violations of informed consent.

We have not, in the last 11 years of providing legal services in this field, seen an NSW provider being disciplined for breaching the consent guidelines during the provision of maternity care, even in the face of repeated complaints from women. There are several reasons for this:

(a) The consent manuals are *treated* as discretionary guidelines. There are no consequences for ignoring them. As a result, staff are either mostly unaware of the manuals or dismiss them as inconsistent with the policies/protocols which mandate routine care/procedures;

(b) Violations of informed consent are normal and embedded in our maternity health system. Our observation is that directors of maternity wards are medical personnel who have, themselves, practised in ways that sideline the need for consent to meet logistical constraints and are, consequently, sympathetic to colleagues who do the same. As such, complaints about consent violations are of no concern to the directors we have spoken with unless the facility is under media scrutiny, there is a coronial investigation under way, or a lawsuit is imminent;

(c) As we discussed in Topic 4 'Power Imbalance in the Provider-Patient Relationship and Abuse of the Doctrine of Medical Necessity' (see page 53) of our initial submission, providers nearly always seek to justify consent violations through a retrospective application of the doctrine of medical necessity. This doctrine permits providers to perform procedures in exceptional circumstances i.e where a woman is not competent to give consent *and* it is an emergency. The Special Rapporteur on Obstetric Violence noted in her Report described in her Report two ways in which providers abuse the doctrine of medical necessity.

First, providers are disguising their logistical need to manage (too) many women under their care as an emergency. An "urgent need to get the job done" is not the same as a genuine medical emergency. We appreciate that, from a provider's perspective, convenience and logistics are important considerations. They are not, however, to be confused with genuine medical emergencies.

Second, providers assume that a purported emergency entitles them to bully, coerce or badger a woman into conceding to a preferred treatment. It does not. For as long as a woman is conscious and competent, providers are legally obliged to follow the same legal process for seeking informed consent.

Incidentally, this deception leads to a profound breach of trust and leads to some women paying (even if it is beyond their means) for an independent midwife. It is also the reason why women become angry, distressed and extremely fearful of childbirth, in extreme cases, choosing to freebirth. These incidences are being caused by the very health service that is subsequently bullying women into attending hospital;

(d) There are no mandatory multidisciplinary annual training programs (if any) to teach staff about the laws of consent and how to implement it as a critically important, shared responsibility between doctors and midwives; and

(e) Any reference to consent in training programs is usually packaged as part of medical liability training and delivered by a medical liability practitioner (or insurer) who reinforces the need to prioritise protocols to protect the facility, not the woman.

(2) What do we need to change around informed consent procedures in NSW - are there other states in Australia we can look to who are getting it right, or at least doing a better job?

It is our view that the introduction of legislation which counteracts these discriminatory policies and practices, and shifts the balance to consumers will facilitate the much needed change in health care practice and attitudes to pregnant and birthing women.

We canvassed in our initial submission the way that medical liability laws discriminate against and pitch the interests of pregnant women against their unborn infants. These laws perpetuate the myth that pregnant women do not have the same rights as everyone else, and have negatively influenced HCCC, coroner, police, paramedic and provider behaviours and attitudes towards pregnant women. Given the scale of the problem, laws to counteract these discriminatory practices are the only feasible avenue for change.

New Zealand and Queensland have introduced legislation which gives regulators the power to impose or investigate complaints of human rights violations.

Queensland

The State of Queensland has implemented the *Human Rights Act 2019* (Qld) which, amongst other fundamental rights, provides:

> **17 Protection from torture and cruel, inhuman or degrading treatment**
>
> A person must not be—
>
> (a) subjected to torture; or
>
> (b) treated or punished in a cruel, inhuman or degrading way; or
>
> (c) subjected to medical or scientific experimentation or treatment without the person's full, free and informed consent. (Emphasis added)

The legislation overall has had an impact on maternity health provider culture and practice. Section 17 in particular has been influential in obliging providers to learn about and understand how to respect informed consent. In fact, section 17 has been instrumental in revealing the dearth of understanding about, and resistance towards, respecting informed consent in childbirth. Our observation has been that many providers really struggle with basic consent issues, such as a woman's right to refuse a vaginal examination. Queensland Health District and Professional Development training initiatives now focus on informed consent, not for the purposes of protecting the facility from liability, but for the purposes of training staff to view and respect consent through a human rights lens. The difference in provider attitudes towards women is also palpable, particularly in regional areas where internationally trained providers are especially vulnerable to complaints of mistreatment. In addition, complaints about violations of section 17 are assessed by the Human Rights Commissioner, who is not embedded in provider or facility culture and/or influenced by medical liability laws. This is an effective means for providing a counterbalance to the discriminatory laws and practices that underpin medical liability laws. The Commissioner also reports on rights violations to the Queensland Government which, in turn, influences and drives changes in policy.

We do not, however, think that the ability to complain alone will adequately deal with the epidemic of abuse being reported to this inquiry in NSW. In our experience over the last 11 years in NSW, women's repeated requests to be treated with kindness and respect have largely fallen on deaf ears. **Asking nicely has not produce the outcomes expected**. Receiving respectful care is still very much like winning

the lottery in NSW. It is entirely arbitrary and dependent on a woman being at the right facility, at the right time, during the right provider's shift.

New Zealand

The New Zealand Patient Code of Rights has been in operation for quite some time. Under the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, anyone using a health service is protected by the Code of Rights which protects:

1. The right to be treated with respect.
2. The right to freedom from discrimination, coercion, harassment, and exploitation
3. The right to dignity and independence.
4. The right to services of an appropriate standard.
5. The right to effective communication.
6. The right to be fully informed.
7. The right to make an informed choice and give informed consent.
8. The right to support.
9. Rights in respect of teaching or research.
10. The right to complain.

The Health and Disability Commissioner has the power to receive and act in relation to complaints about breaches of those rights. Practitioners are required to consider and improve their practice in response to complaints under the supervision of the Commissioner.

Accountability

While both human rights systems are reasonably effective, in our view, they will **not** be sufficient to address the scale of the problem in NSW. At law, violation of some human rights, such as the right to informed consent, constitute assault and/or battery and should be easily actionable. Unfortunately, limited access to justice, financial constraints, health issues and the discriminatory influence of medical liability laws on the judiciary prevent women from holding providers accountable for that assault and battery which, in turn, has fostered the impunity that has resulted in the thousands of complaints now brought before this inquiry. This is at odds with Australia's international "*obligation to adopt legal and policy measures to protect pregnant women from and penalize obstetric violence*".[1]

There needs to be a mechanism which enables women to lodge complaints which, if proven, results in the imposition of a pecuniary penalty on a facility or a provider, or both. Pecuniary penalties, like parking fines, can be very effective in driving behavioural changes in such circumstances, because they create tangible incentives to improve communication and quality of care and are not dependent on the goodwill of a provider. Legislation which gives consumers standing to commence proceedings for breaches of their human rights in the provision of care will also be very effective at facilitating change.

(3) NSW Health says that women who have concerns about the care they received can make a complaint to the HCCC. Is this an easy or viable option for most women who have experienced obstetric violence?

It is easy enough for women to lodge a complaint with the HCCC about mistreatment in childbirth. That does not mean it is a viable, let alone worthwhile, option. In fact, it is largely a waste of a woman's time and only compounds her distress.

The problem lies with the remit of the HCCC. Both the HCCC and the professional boards operating alongside it are concerned with the preservation of practice standards. Women who lodge complaints about violations of informed consent or obstetric violence are not concerned about the practice standards *per se*. They are concerned about the provider forcing procedures on them for convenience/logistical reasons, to protect themselves or to meet protocols. They are concerned about being forced to accept routine treatments without any regard for her bodily autonomy or bodily integrity, or in ways that are harmful to her and her infant. Women are also concerned about the way they were misinformed or

[1] *N.A.E v Spain* [2022] CEDAW C/82/D/149/2019, [15.5].

misled or coerced into accepting treatments because the provider was determined to pursue a particular avenue.

In our experience, complaints about facility-based mistreatment which did not result in enduring physical injury to mother or baby, are dismissed on grounds that the provider was (apparently) well intentioned and/or meant no harm, even where there are a number of breaches or more than one complainant. This narrative is not unlike the narratives once used to excuse domestic violence or marital rape.

For women, being told that the violence they experienced at the hands of a provider was not sufficiently important having regard to the outcome is a devastating experience and compounds the injuries they experience. They are, in effect, being told that they don't matter.

From a public interest perspective, it is especially concerning because the HCCC is in fact condoning abuse and violence towards pregnant women and signalling to providers that the end (ie maintaining practice standards) justifies the means (ie deploying coercion or rights violations). This is just one of the many ways providers are given the license to violate rights with impunity.

(4) What reforms would you like to see to the HCCC framework in order to see genuine redress for women who have experienced poor treatment during birth?

To be effective, the HCCC will need powers to:

(a) require all maternity care providers to provide consumers with information about their rights;

(b) enforce a Code of Rights/human rights legislation either through a complaint or of its own initiative;

(c) provide consumers with direct access to a specialised division within the HCCC, *independent of the professional boards,* for complaints concerning violations of their rights;

(d) accept and use consumer video and/or audio recordings of health care treatment without breaching the *Surveillance Devices Act 2007* (NSW);

(e) implement a range of accountability measures such as strict liability pecuniary penalties for minor (as defined) violations, disciplinary proceedings for repeat offenders, legal proceedings for rights violations against facilities and/or providers;

(f) depending on the nature of the complaint, refer incidences of obstetric violence to the police, the Anti-Discrimination Board or any other facility that can more appropriately deal with the subject matter of that complaint;

(g) monitor and report on rights violations to NSW Health and to Parliament on an annual basis.

In addition, **consumers** need:

(a) the right to video or audio record appointments and/or the birth and use that evidence without violating the *Surveillance Devices Act 2007* (NSW);

(b) receive information about the Code of Rights/human rights legislation from providers and the HCCC, including information about the ability to complain;

(c) seek the assistance of the police where needed;

(d) the power to request a range of resolution options such as pecuniary penalties, evidence to commence proceedings for assault and/or battery; a mediation and/or disciplinary proceedings.

(5) Another witness argued there should be an 'obstetric violence legal clinic' funded to support women who experience this treatment in the medical system – is this something you think would be beneficial? If so, why?

This would be highly beneficial to both consumers and providers and will also restore some balance to the provider/patient relationship.

Women have no access to legal services aside from us and we are unable to meet the demand for our services because we receive no funding. This is yet another of the many ways providers are given the license to violate rights with impunity.

Currently (to the best of our knowledge), the only not-for-profit groups that receive funding in NSW are PANDA, the Gidget Foundation, Beyond Blue and, to a lesser extent, the Australian Birth Trauma Association, all of which only focus on remedial referrals to health services for birth trauma. While important services, they are unfortunately purely band-aid measures. They provide a very important referral service for women already harmed, but they do not protect women from being harmed, they do not hold providers accountable for harming women and infants, and they do not build capacity in consumers by educating them about defending their rights in pregnant and childbirth.

For consumers, prevention is key to facilitating change in such behaviours. In our experience, consent is so lacking that many providers do not understand or show compassion to a bamboozled or distressed woman. They assume she is being precious (as one midwife told me – they need to learn to "suck it up") or demanding. They try to force the birth process even more in the hope they can get her out the door faster and minimise any negative impact.

For providers, once the harm has been done, they are at odds with a consumer and become defensive, anxious and resentful. This is because mistreatment is so normalised in our facilities that an individual provider will perceive a complaint as targeting them for doing what everyone else appears to be doing with impunity.

A vast majority of 'minor' infractions could be managed before the harm is done by engaging with the facility as soon as the woman raises a complaint. Telephone advice to consumers or engaging with the health service or DCJ early has been very effective in reminding them of a woman's rights and/or resolving a situation to both parties' satisfaction.

Over time, these strategies will evolve into best practice to minimise disputes and subsequent legal challenges.

In addition, a specialised clinic could:

(a) Provide advice to consumers, share information about relevant legislation and rights, support decision making and advocate on behalf of consumers;

(b) Develop and disseminate knowledge and understanding of the rights framework for pregnant and birthing women;

(c) Provide CPD training for medical liability lawyers, police, paramedics, DCJ, coroners and the judiciary on obstetric violence and the human rights of pregnant women;

(d) Give providers the early opportunity to listen to women and reflect on their particular style of practice without having to also legally defend themselves;

(e) Commence proceedings on behalf of vulnerable consumers for breaches of human rights;

(f) The clinic could also be a focal point for collecting evidence and monitoring trends in violence to share with NSW Health and the HCCC as needed.

We recommend that such a clinic operate independently, either through a university law school or under the Legal Aid framework.

(6) You note in your submission that indigenous women, and migrant and refugee women, have been forced to follow birth protocols that are incompatible with their cultural background - can you give some examples of this?

(a) Staff wanted a Muslim woman in labour to remove her hijab because she was overheating. She agreed to do so provided no man would enter the room without prior warning. The midwives agreed to support her request (misleading promises). The VMO did not. He marched into the room after the hijab had been removed and told her that a baby had died in that same room the day before and that she needed to stop fussing about nothing if she wanted to avoid facing the same outcome (breach of privacy, verbal abuse, shroud waving, threats and misinformation).

(b) An unpartnered Indigenous woman attended hospital holding what looked like dirt wrapped in tissues. It was, in fact, a handful of soil from the woman's country because the woman wanted desperately to connect her child to <u>her</u> country and traditions, as opposed to the absent father. To mitigate her pain, she brought a handful of soil which she wanted to keep in her hand for the moment she touched her baby. She asked that no one touch her baby when he was born so his first physical contact was 'with country' and her skin, before the cord was cut. A change of shift midwife discovered the tissue in her hand, took it without asking while she was pushing and said to the woman, as if she were a child, that the midwife would throw away all that dirty stuff (verbal and physical abuse, discrimination). Another unknown midwife picked up the baby when it was born, cleaned out his mouth, checked his vitals and wrapped him in a blanket before handing him back to her (violation of baby's right to skin on skin, undisturbed golden hour). When the woman complained, she was told it was 'protocol', performed for her and her baby's safety (false and misleading, discrimination).

(c) During COVID-19, a migrant woman of Thai descent went into early labour at home. She contacted the hospital and said, because of the visitor restrictions, that she would come in after her family had performed a ceremony the following morning. The hospital objected and falsely claimed that she was 'required' to come in as soon as she was having contractions (coercion, misleading and

deceptive conduct, discrimination). At about 1am, four police officers knocked on the apartment door and demanded that she accompany them to hospital. She was detained at the hospital without grounds (false imprisonment) and falsely informed that her baby had severe jaundice (misleading and deceptive conduct). She was told that it was 'protocol' to take him to the paediatric ward without her (false claims, violation of her and baby's rights to not be separated). In fact, her baby had been taken away in anticipation of a DCJ visit. She was also reviewed by a psychiatrist (breach of informed consent). All this was done while she was alone and just after she had given birth. When we contacted the hospital, they refused to communicate with us but subsequently discharged both mother and baby.

(d) A Sudanese single mother of 4 was labouring with her fifth child in hospital. Her previous 4 children were born naturally, without incident – two of them in a refugee camp. Hospital staff decided that, by reason of her refugee status, the protocol was to 'recommend' a Caesarean Section, which she did not want (discrimination, racial profiling). She could not speak any English but no translator was secured (breach of protocol, false imprisonment). Her 16-year old eldest child, left at home to care for her remaining children, tried to advocate on her behalf over the telephone as best he could. She was alone, incredibly distressed and fearful of an all-white staff that could not communicate with her. Staff followed 'protocol' - she was given a general anaesthetic without her knowledge, followed by a Caesarean Section without consent (assault, battery, misleading and deceptive conduct, coercion, violation of informed consent). When she awoke, she blamed and rejected her baby girl.

(e) A young Lebanese woman became extremely distressed because the midwife was insisting on performing a vaginal examination in front of a male doctor. She was told that vaginal examinations were protocol and that she would have to have a Caesarean Section if she refused (false imprisonment, misleading and deceptive conduct, coercion). She started screaming and protesting as they held her down to do the VE so staff put her under a general anaesthetic in front of her partner who was also terrified, and performed a Caesarean Section (assault, battery, misuse of doctrine of medical necessity, violation of informed consent). When she came to us for a consult, she was refusing to breastfeed, and would not look at or hold her baby.

The Committee should know that these are the types of experiences that prompt women to choose to homebirth or even freebirth in their subsequent pregnancies. In such circumstances, hospital staff abuse of women and private midwives who have no choice but transfer from a homebirth to hospital is especially unconscionable.

(7) You note in your submission that early separation between mother and baby can cause breastfeeding issues - can you explain why this is the case? And if this is a concern, why do you think separation between mother and baby after birth is occurring?

The key to successful breastfeeding for all women is an undisturbed 'golden hour' where the neonate is given the opportunity – without any intervention – to instinctively perform the 'breast crawl'. At present, the only women who enjoy the privilege of a 'breast crawl' are women who have a homebirth and are cared for by an independent midwife.

It is well established that the "golden hour" immediately following birth is a critical time for mother and baby. This is where a mother has uninterrupted skin-to-skin contact with her newborn in the first hour of birth. It helps regulate the baby's temperature, control their respiration, and lower the risk of low blood sugar. For the mother, it can prevent postpartum haemorrhage (PPH), promote uterine involution and result in lactation amenorrhea, which is a useful form of contraception.[2] For both mother and baby, it initiates early and enduring breastfeeding.

Without external interference, an infant will autonomously crawl over the mother's belly, locate the nipple and self-attach to her breast. It is an extraordinary expression of pure instinct. The breast crawl makes breastfeeding feel more natural by tapping into the neonate's instinct to find milk autonomously. The self-attachment serves as an imprint for both baby and mother. This imprinting appears to form multi-sensory stimulations and early attachment for mother and baby, in turn promoting parasympathetic nerves and increasing newborn colostrum and milk intake. There is little to no pain or discomfort. The United Nations International Children's Emergency Fund (UNICEF) recommends that the

[2] International Federation of Gynaecology and Obstetricians, *Harnessing the Golden Hour: Breastfeeding Recommended within the First Hour of Life* (Statement, 28 July 2023) <https://www.figo.org/resources/figo-statements/harnessing-golden-hour-breastfeeding-recommended-within-first-hour-life>.

"breast crawl is the preferred method for mothers to begin breastfeeding their neonates".[3] The American Academy of Paediatrics (AAP) recommends that "all healthy infants should begin skin contact with their mothers immediately after delivery until the first feeding naturally occurs".[4]

Interference with the breast crawl, even if the infant is given skin to skin, can cause the neonate to lose some innate abilities, thereby affecting the structural or functional integrity of the brain and body.[5] When denied the opportunity to have both skin on skin and to breast crawl, neonates are prone to breast and nipple rejection, which leads to breastfeeding failure.[6]

Like delayed cord clamping, this is a simple process that costs nothing and requires little more than personnel patience and gentle support. Sadly, most facility staff are unaware of the significance of the breast crawl (most have never even witnessed it) and think that any type of skin on skin (even with the father) is sufficient. It is not. Women consistently report that, following separation, when they are eventually returned to their rooms, a baby is held by the back of the head and 'shoved' onto the breast. Both mother and baby find this traumatic and the only imprinting that occurs is the enduring trigger of the mother's fear and pain, and the baby's desire to push away from the breast. Mothers are then told they are doing it all wrong or that the baby is having difficulty latching. It is one of the key reasons many tertiary educated women reject facility-based birth altogether.

Separation of mother and neonate occurs after surgery, even routine surgery, for logistical or convenience reasons. In most cases, there isn't someone there to attend to both mother and baby post-surgery or the hospital does not have a separate mother/baby post-surgery recovery unit. This is especially the case with private hospitals where there is more concern about a crying baby affecting other non-maternity patients in recovery over the golden hour and its benefits for mother and infant. These hospitals also do not disclose, prior to performing surgery, that they cannot accommodate mother and baby together in a post-surgery recovery unit. Women report crying or calling for their babies during recovery and being told to wait or be quiet. Most report not seeing their baby for at least two hours post Caesarean Sections. Not surprisingly, higher income women who utilise private obstetric care are more likely to experience breastfeeding difficulties.

(8) In your submission, you say some health care providers had experienced disciplinary action as a result of supporting a women's birth choices – how prevalent is this kind of disciplinary action? What recommendations would you like to see made to improve this situation?

It is important to note that this form of disciplinary action appears to overwhelmingly affect midwives. This is because medical professions are trained to and expected to adhere to practice standards over all else, and their practice standards are crafted with this in mind. In addition, once registered to practice, medical professionals enjoy significant autonomy over their decision making. Midwives, however, face a conundrum. Their practice guidelines require them to honour and support, as far as possible, a woman's birth choices or honestly convey to the woman that the facility cannot meet those choices. They are called professionals but lack autonomy, are closely scrutinised by both management and medical personnel, and expected to set aside their professional practice guidelines in favour of hospital protocols. Where respect for women's choices clashes with the facility protocols and the midwife elects to support the woman, that midwife will inevitably be both disciplined and reported to the HCCC. Many will exit the system because they find the lack of autonomy and scrutiny both unfair and exhausting. We call this 'burnout' but it is entirely preventable. We need to either acknowledge and honour their professionalism or remove their professional status altogether. At present, they have the worst of both worlds.

That said, we also know of at least 5 medical practitioners who, over the last ten years, have been the subject of repeat complaints to Ahpra and the HCCC for advocating for women, at least two of whom (both women) were forced to relinquish their medical registration to preserve their personal health. We are also aware that bullying and negative interpersonal relationships significantly affect providers who openly defend women's right to autonomy.

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[3] P Gangal, 'Breast Crawl: Initiation of Breastfeeding By The Breast Crawl' (UNICEF, 2007) <http://www.breastcrawl.org/index.shtml>.

[4] LM Gartner et al, 'Breastfeeding and the Use of Human Milk' (2005) 115(2) *Paediatrics* 496–506.

[5] Y Pang et al, 'Effect of Neonatal Breast Crawl on Breastfeeding: a Prospective Cohort Study' (2023) 8 *Frontier Pediatrics* 11.

[6] A Sharma, 'Efficacy of Early Skin-To-Skin Contact on the Rate of Exclusive Breastfeeding in Term Neonates: a Randomized Controlled Trial' (2016) 16(3) *Afr Health Science* 790–7. See also J Bergman & N Bergman, 'Whose Choice? Advocating Birthing Practices According to Baby's Biological Needs' (2013) 22(1) *The Journal of Perinatal Education* 8–13.

We are not aware of an independent midwife who has **not** been the subject of a complaint following a transfer to hospital in NSW. Independent midwives expect to be targeted by hospital staff and will brace themselves for either a confrontation or forensic examination on presentation to hospital. Most of the complaints against independent midwives that we have reviewed are eventually dismissed, but not before the independent midwife's livelihood, reputation and wellbeing have been compromised. In addition, facility staff know that regulators escalate the investigation of complaints based on the number of previous complaints a provider has on file. Even if a complaint has not been progressed on this occasion, the HCCC will retain a log of such complaints and re-examine them every time another complaint is lodged. At some stage, the complaints will "stick" and the midwife will find her practice subject to an audit and investigation. Facilities seeking to exclude a particular independent midwife from using their facility will lodge repeated complaints about an independent midwife for the smallest infraction, with the knowledge that repeat complaints will eventually force that midwife out of practice. They are, in effect, competitors using legal and regulatory frameworks to strategically impose barriers to entry for the purposes of eliminating a competitor.

(9) Regarding the term "birth trauma":

a. what is the Human Rights in Childbirth preferred definition of the term?

'Birth Trauma' is a diagnostic term for the **injuries** that arise from childbirth, and includes physical, emotional and psychological injuries and damage to mother and baby.

b. why is this the preferred definition?

The term is used to define childbirth related injury in medical liability claims and to diagnose and treat those injuries.

(10) Regarding the term "obstetric violence":

a. what is the Human Rights in Childbirth preferred definition of the term?

"Obstetric Violence" refers to **acts or behaviours** that result in, or are likely to result in, physical, sexual or psychological harm or suffering to women who are pregnant, giving birth or have recently given birth, including threats of such acts, coercion or arbitrary deprivation of liberty, in facility-based maternity health care.

b. why is this the preferred definition?

The term and associated definition are recognised in international law as a form of gender-based violence towards pregnant women. Courts and lawyers are expected to use the term as defined by CEDAW and the United Nations. The Federal Government has also published a consumer-friendly explanation for the term at https://www.pregnancybirthbaby.org.au/obstetric-violence.

(11) Can you explain why 'informed consent' is necessary for women with respect to decisions they make regarding all aspects of their pregnancy?

Informed consent in relation to pregnancy and maternity care is *essential* for legal, ethical, health and public interest reasons and to preserve the equal status of ALL women in our society.

Legal Reasons

The rule of law in Australia applies to everyone equally. In addition, everyone is entitled to equal treatment before the law. This means that, legally, women have the right to be treated the same as everyone else, pregnant or otherwise.

The law is very clear on how providers are to deliver care to pregnant patients in a manner that protects their constitutional right to equal treatment before the law. Put simply, the law states that, until the infant is born and physically separated from the mother's body, providers are to treat the pregnant woman as a patient in her own right and as the **only** person capable of making decisions about her body and unborn infant. This means a pregnant woman enjoys autonomy and the right to informed consent *like everyone else*.

Policies promoting patient autonomy reflect our civil and criminal laws on assault and battery and apply equally to everyone, pregnant or otherwise. Informed consent acts as a defence to *any* physical contact – actual or attempted – that would otherwise, without that consent, constitute assault or battery. It follows that providers who fail to afford informed consent or who override a pregnant woman's refusal are in fact engaging in assault and/or battery.

The fact that providers can override a pregnant woman's right to informed consent and do so with impunity because they are shielded from accountability by regulators, administrators and the courts

means that we, as a society, have accepted that pregnant women are not entitled to equal status before the law. This is in breach of Australia's international obligations under CEDAW.

Providers have, in effect, been given de facto powers by regulators, administrators, and the judiciary to undermine the rights of pregnant women. Only Parliament can exercise and delegate such powers.

In addition, when providers override a pregnant woman's wishes or deny her right to informed consent in order to secure what they believe to be an optimal outcome for the neonate, they are, in effect, relegating pregnant women to the status of a second-class citizen. In this case, the pregnant woman is treated as someone whose legal rights can be subordinated to protect the interests of another that the provider has deemed more important. No other person in Australia is subject to such enslavement. The legal and constitutional implications of such actions are profound. Again, this is a matter for Parliament only. It is not a matter for either a health care provider or NSW Health.

Ethical Reasons

On the question of ethics, patient autonomy is based on the view that, no matter esoteric medicine can be, every patient is more than capable of assessing a provider's advice and deciding what is best for them, even if their decisions are at odds with the provider's recommendations or could compromise their health or wellbeing. When patient autonomy is respected and facilitated for all competent adults except for pregnant women, providers are engaging in unethical and discriminatory behaviour by, firstly, treating pregnant women as subordinate to the interests of the unborn infant, and secondly, by assuming a pregnant woman is incompetent by reason of her pregnancy. This conduct is also illegal.

Health Reasons

On the question of health, women often inform us that, on becoming pregnant, they are no longer treated as a human being but as a vessel and a means to an end (ie a live baby). It has a profound effect on them. Many say they feel like they have been sexually assaulted. Women who are survivors of sexual assault say that the coercive hospital treatment often triggers the trauma they experienced during the assault. In part, this is because providers are dealing with and exposing parts of women's bodies that we have been primed to protect from a very young age, more so if we have been victims of sexual assault. Providers are particularly insensitive to the impact that invasive repeat or routine practices like vaginal examinations have on women's wellbeing. We have observed that many providers are disrespectful and dismissive when women express their discomfort. In some cases, they are mistreating women who are survivors of sexual assault or child sexual abuse.

Proper informed consent, sought with respect and the timely provision of adequate information, can mitigate the sensitivity and shame most women experience when anyone – regardless of who they are – is attempting to touch those areas of her body. Informed consent gives women a sense of control over what is happening to them and their bodies, especially those who are survivors of assault and abuse. It is a way for practitioners to deliver good outcomes both physically and psychologically. It is a reflection of the quality of the health service in question.

It follows that affording informed consent can be a litmus test for assessing the quality of any maternity health service. Why are providers misleading women or concealing information about routine procedures unless they already know that such procedures are usually disliked or rejected? Why don't providers consciously examine these processes and reflect on better ways to deliver care that is responsive to patient needs? If the patient is not happy with her options, why are there no alternatives? Why do providers deceive women about birth plans unless it is because they do not wish to change their behaviours? Reflecting on improvements in practice can only be undertaken by providers who engage honestly and openly with patients prior to and during the delivery of care. If providers can easily get away with limiting the provision of information, or deceiving, coercing or misleading in order to secure compliance, there is simply no incentive to improve the quality or delivery of care. That is the perception of NSW consumers about our maternity health systems – both public and private - today.

Finally, there are very important public interest reasons why it is necessary to protect women's right to informed consent in pregnancy and childbirth. Australia is currently facing an epidemic of gender-based violence in the form of sexual assault, domestic violence, and child abuse. **Underpinning all these social issues are some profoundly misguided, discriminatory beliefs about consent and the ownership of women's and children's bodies.** Our providers, who already occupy a privileged position in our society, should know and do better. They should be leading by example given their education, means and influence. We need to expect more from them and to hold our providers to account in the same way we are holding other perpetrators of gender-based violence to account. In short, we need to all be the change we want to see.

We hope that our responses are helpful to the Committee. We are incredibly grateful to the Committee and the NSW Parliament for taking the initiative to investigate and understand a systemic problem that has, to date, escaped scrutiny.

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[PhD: *Midwives, Medicos, Markets and Maternity Care: Assessing Anti-Competitive Behaviours in Privately Funded Maternity Care*]

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