Submission No 409

INQUIRY INTO BIRTH TRAUMA

Organisation: Human Rights in Childbirth

Date Received: 17 August 2023

Select Committee on Birth Trauma
c/o The Hon. Emma Hurst MLC
Chairperson
NSW Parliament House
14 August 2023

We are grateful to the Committee for providing us with this rare opportunity to share our knowledge and experience in relation to the mistreatment of women and pregnant people accessing maternity services in NSW.[1]

Human Rights in Childbirth (**HRiC**) is an international, not-for-profit legal and human rights organisation founded in The Hague in 2012 to monitor and report on human rights abuses in pregnancy and childbirth. We report such abuses to the World Health Organisation and the UN Special Rapporteur on Violence Against Women. The organisation is led by a board comprising obstetricians, midwives, consumers and human rights lawyers from Australia, Latin America, Eastern Europe, USA and India.

In Australia, we advise and advocate for women who were abused or mistreated while accessing institutional maternity care, health care providers and support persons whose employment or income is threatened for protecting women in their care, and women who face police, the NSW Department of Communities and Justice (**DCJ**) and extended hospital investigations and reports for the health care choices they made while pregnant. We do not receive any funding or fees for our work.

Summary of Observations

(a) The abuse and mistreatment of pregnant women and people in maternity health facilities is a normalized, everyday event that is embedded in institutional and professional culture and practice.

(b) Abuse and mistreatment in childbirth has, amongst other things, caused women to suicide or attempt suicide, self-harm, reject their infants, suffer PTSD, anxiety and depression, suffer relationship breakdowns, lose their jobs, lose their homes, relinquish their careers, struggle to re-enter the

[1] For inclusivity, we use the words "women" and "pregnant people" interchangeably.

workforce, incur significant out-of-pocket costs seeking psychological or psychiatric care or specialist care for nerve damage, pelvic floor injuries, surgical complications and third to fourth degree perineal tears, endure faecal incontinence, terminate pregnancies, reject providers and vaccinations, become isolated and suffer domestic violence.

(c) Disrespect and abusive treatment are not limited to the intrapartum period (ie labour and birth). Incidences of abuse have been reported from the moment a woman's pregnancy has passed its first trimester to well after the infant has been delivered. It is driven by hospitals and providers, and facilitated by the police, ambulance services, primary health networks (ie GPs), and DCJ;

(d) Abuse and disrespect are not confined to the woman. They is also directed at any person seen to be supporting a woman perceived as non-compliant to provider demands. Indigenous, refugee and immigrant families, trauma sufferers, people with disabilities, and women who engage the services of doulas and/or privately practicing midwives are especially vulnerable to such abuse.

(e) Many providers show limited to no understanding of the legal and reproductive health rights of competent, adult women, and rely on discrimination, harmful gender stereotypes, the doctrine of medical necessity and institutional power to justify abusive behaviours;

(f) Discriminatory medical liability laws, legislation and professional regulators shield providers who violate human rights and diminish the significance of abusive behaviours unless they are accompanied by physical injuries to the infant;

(g) The Coroner's court, police and child protection services have helped to foster a culture of impunity around facility-based abuse and normalize gender-based violence and associated violations of women's fundamental human rights;

(h) Australia is obliged, under the Convention on the Elimination of All Forms of Discrimination Against Women, to:

1. Provide quality health-care services i.e. services that are delivered in a way that ensures that a woman gives her fully informed consent, respects

her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives;[2]

2. Adopt legal and policy measures to protect pregnant women from and penalize obstetric violence, strengthen capacity-building programmes for medical practitioners and ensure regular monitoring of the treatment of women in maternity healthcare centres and hospitals;[3]
3. Take all appropriate measures to modify or abolish not only existing laws and regulations but also customs and practices that constitute discrimination and the endorsement of harmful gender stereotypes against women;[4]
4. Establish, publicise and implement a Patients' Bill of Rights, with access to effective remedies in cases in which women's reproductive health rights have been violated, including in cases of obstetric violence;[5]
5. Provide specialized training to judicial and law enforcement personnel to recognise structural discrimination based on harmful gender stereotypes regarding pregnancy and childbirth;[6] and
6. Provide obstetricians, midwives, other health professionals and administrative bodies with adequate professional training on women's reproductive health rights, obstetric violence, harmful gender stereotypes and adherence to the Patients' Bill of Rights.[7]

We have attached, to this correspondence, our observations and responses to the Terms of Reference for this inquiry.

We would be happy to share any further information or respond to any questions the Committee may have in relation to our submissions or our work.

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[2] UN Committee on the Elimination of Discrimination Against Women (**CEDAW**), *CEDAW General Recommendation No. 24: Article 12 of the Convention (Women and Health)*, 1999, A/54/38/Rev.1, chap. I, available at: https://www.refworld.org/docid/453882a73.html [accessed 16 August 2023].

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

[4] UN General Assembly, Convention on the Elimination of All Forms of Discrimination against Women New York, 18 December 1979 (Res 34/180 of 18 December 1979, Entry into force 3 September 1981), Art 2(f), 5.

[5] *N.A.E v Spain* [2022] CEDAW C/82/D/149/2019, [16(b)(v)]; *S.F.M v Spain* [2020] CEDAW C/75/D/138/2018, [8(b)(iv)].

[6] *N.A.E v Spain* [2022] CEDAW C/82/D/149/2019, [16(b)(iv)]; *S.F.M v Spain* [2020] CEDAW C/75/D/138/2018, [8(b)(iv)].

[7] *N.A.E v Spain* [2022] CEDAW C/82/D/149/2019, [16(b)(iii)]; *S.F.M v Spain* [2020] CEDAW C/75/D/138/2018, [8(b)(iii)].

Yours sincerely

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HUMAN RIGHTS in CHILDBIRTH

NSW Legislative Council Inquiry into Birth Trauma August 2023

General Observations

In international law, "Obstetric Violence" is defined as:

> …the mistreatment and violence against women experienced during facility-based childbirth… [which] has been shown to be widespread and systematic in nature.[8]

The phrase "violence against women" is defined, under Article 1 of the Declaration on Elimination of Violence Against Women, as:

> …any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.[9]

In its *General Recommendation No 35 on Gender Based Violence Against Women*[10], the Committee which monitors the implementation of rights enshrined in the Convention on the Elimination of All Forms of Discrimination against Women (**CEDAW**), to which Australia is a contracting party, defines gender based violence as '*violence which is directed against a woman because she is a woman or that affects women disproportionately*'. Such violence constitutes discrimination and a violation of women's fundamental human rights.[11]

Those human rights include, but are not limited to:[12]

- right to dignity and equality
- right to life
- right to the highest attainable level of health
- right to privacy

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[8] *N.A.E v Spain* [2022] CEDAW C/82/D/149/2019, [15.4]; *S.F.M v Spain* [2020] CEDAW C/75/D/138/2018, [7.3].

[9] Declaration on Elimination of Violence Against Women, GA Res 48/104 (Adopted 20 Dec 1993) <https://www.ohchr.org/en/instruments-mechanisms/instruments/declaration-elimination-violence-against-women>.

[10] Committee on the Elimination of Discrimination against Women, General recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19, UN Doc CEDAW/C/GC/35 (26 July 2017).

[11] Committee on the Elimination of Discrimination against Women, *General recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19*, UN Doc CEDAW/C/GC/35 (26 July 2017), [1]

[12] Rajat Khosla et al, 'International Human Rights and the Mistreatment of Women During Childbirth' (2016) 18(2) *Health and Human Rights Journal* 131-143.

- right to bodily autonomy and informed consent
- freedom from discrimination
- freedom from torture, or cruel or inhuman treatment.

The Committee went on to say the prohibition on violence against women is non-conditional and:

> "[t]he opinio juris and State practice suggest that the prohibition of gender-based violence against women has evolved into a principle of customary international law."[13]

I. The Prevalence of 'Obstetric Violence' in Australia

Like the phrase 'domestic violence', the phrase 'obstetric violence' takes its meaning from the setting in which the violence manifests.

Obstetric violence hurts and damages women and families, at times irreparably. We have had clients and complainants who suicided or attempted suicide, engaged in acts of self-harm such as cutting and substance abuse, rejected their infants, suffered years of PTSD, been treated for anxiety and depression, been stalked or relentlessly pursued by tabloid journalists, suffered relationship breakdowns, lost their jobs, lost their homes, relinquished their careers, incurred significant out-of-pocket costs in seeking psychological care or specialist care for nerve damage, pelvic floor injuries and third to fourth degree perineal tears, endured faecal incontinence; developed acute phobias about hospitals and the smell of disinfectant, chosen abortions over another pregnancy, become distrusting of all medical treatments and providers - including vaccinations, withdrawn from family and friends, and endured domestic violence following their childbirth experiences.

Obstetric violence broadly falls into two categories[14]:

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[13] Committee on the Elimination of Discrimination against Women, *General recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19*, UN Doc CEDAW/C/GC/35 (26 July 2017), [2].

[14] MA Bohren et al "The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review (2015) 12(6) *PLoS Med* e1001847.

- Interpersonal behaviours of individuals manifested through physical and verbal mistreatment, humiliation, lack of information and consent, the abuse of medicalization and the pathologizing of natural processes; and
- Dehumanising systemic actions, structures and policies[15];

that lead to women's loss of freedom, autonomy, and the ability to freely make decisions concerning their body and sexuality.

The two categories share a symbiotic relationship. The abusive interpersonal behaviours of providers are structurally and systemically reinforced, in that they are enabled and sustained by a number of institutions, policies and guidelines, and medical liability laws and legislation.

Manifestations of mistreatment are disproportionately experienced by refugees[16], (non-European) immigrants[17] and Indigenous women[18], women with disabilities, gender non-conforming persons and those from a lower socio-economic background, particularly if they are young. Presentation with substance or alcohol abuse, mental health issues or "alternative" values and appearances appears to exacerbate mistreatment and abuse.

The following are examples of some of the everyday health care practices that manifest as obstetric violence in NSW.

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[15] M Sadler et al, 'Moving beyond disrespect and abuse: addressing the structural dimensions of obstetric violence' (2016) 24(47) (2016/09/01) *Reprod Health Matters* 47-55.

[16] Australian Human Rights Commission, *National Inquiry into Children in Immigration Detention 2014, Inquiry team visit to Christmas Island Detention Centres*, File Note,17 July 2014 at <https://www.humanrights.gov.au/our-work/6-mothers-and-babies-detention#a6-2>.

[17] R Small et al, 'Immigrant women's views about care during labor and birth: an Australian study of Vietnamese, Turkish, and Filipino women' (2002) 29(4) *Birth* 266-77; J Yelland et al, 'Maternity services are not meeting the needs of immigrant women of non-English speaking background: Results of two consecutive Australian population based studies' (2015) 31(7) *Midwifery* 664-70; J Chen et al, 'A systematic review of prevalence and risk factors of postpartum depression in Chinese immigrant women' (2019) 32(6) *Women Birth* 487-492; T Shafiei, R Small and H McLachlan, 'Immigrant Afghan women's emotional well-being after birth and use of health services in Melbourne, Australia' (2015) 31(7) *Midwifery* 671-7; Kaveri Mayra and B Kumar-Hazard, 'Why South Asian women make extreme choices in childbirth' in H.G Dahlen, B Kumar-Hazard and V. Schmied (eds), *Birthing Outside the System: The Canary in the Coalmine* (Routledge Research in Nursing and Midwifery, 2020) Chapter 9., VS Rao, H Dahlen and H Razee, 'Indian migrant women's experiences of motherhood and postnatal support in Australia: A qualitative study' (2020) 33(5) *Women Birth* 479-489

[18] H Fox et al, 'Evidence of overuse? Patterns of obstetric interventions during labour and birth among Australian mothers' (2019) 19(1) *BMC Pregnancy Childbirth* 226; D Hartz et al, 'Why Aboriginal women want avoid the biomedical system: Aboriginal and Torres Strait Islander Women's Stories' in H.G Dahlen, B Kumar-Hazard and V. Schmied (eds), *Birthing Outside the System: The Canary in the Coalmine* (Routledge Research in Nursing and Midwifery, 2020) Chapter 16.

Physical Abuse

- Authorising security guards to physically restrain a woman resisting a forceps delivery;
- Mandating or enforcing continuous fetal monitoring which physically immobilises and confines women to the bed;
- Withholding food and water during labour in anticipation of performing a Caesarean Section (**CS**);
- Withholding pain relief to obtain compliance;
- Forcibly removing women from the shower or bath (used as pain relief) because the doctor wants them on the bed;
- Forced treatment such as:
  - manual revision of the uterine cavity without pain relief;
  - forcing a fist and arm into the cervix without pain relief;
  - attempting to sterilise a migrant woman during a CS;
  - collective or repeat digital vaginal examinations for refusing a CS;
  - vaginal examinations without consent;
  - episiotomies without consent;
  - expedited cord clamping without consent;
  - requiring Indigenous women, immigrant and refugee women to follow protocols incompatible with their cultural background;
- Isolating or confining women to a room as a means for obtaining compliance to treatment;
- Withholding pain relief as a punishment or form of trade-off for compliance.

Disrespect and Verbal Abuse

- Reacting to perceived challenges to a provider's power and authority with a range of defensive measures, eg storming out of the room, eye-rolling, jokes, verbal abuse, threats, taunts and infantilising statements: eg
  - "You silly, stupid girl"
  - "It's time you got a reality check"
  - [To an Indigenous woman] "I think you need to learn how to say please and thank you";
- Asking family members, spouses or doulas to get a non-compliant woman under control and blaming them for 'interfering' if they refuse;
- Shroud waving:
  - "Your baby is going to die and that's on you"
  - "You don't want your baby to die, do you?"

  - "A baby died in this room yesterday, let's not make that happen again - understood?"
  - "I don't have time for this. Call me when she is ready to save her baby's life";
- Badgering to get the desired response:
  - "You've had five minutes to think about this, are you ready now?"
  - "What's the problem? Why are you wasting everyone's time?"
  - "The doctor is waiting!";
- Scolding for doing something the staff don't approve of, such as getting off the bed, moving around the room, asking for water, crying or vomiting:
  - "This is really unnecessary – tone it down!"
  - "That's disgusting. Why did you do that?"
  - "You stay there, young lady. You better not move until I say so"
  - "Do you have any idea what you are doing? You are going to be a mother!";
- Threatening or ejecting fathers or doulas for trying to protect a distressed woman:
  - "Calm down please or we will have to ask you to leave"
  - "You can either help or get out, now".

Non-confidential care

- Refusing to close the birth suite door;
- Complaining at the nurses' station about particular women;
- Sharing personal information about women refusing care with local GPs, the police and DCJ, without their knowledge or consent;
- GPs 'reporting' women planning homebirths to hospitals and the local sheriffs (a feature of regional hospitals);
- GPs obtaining a woman's personal information, including her home address, from hospital staff and corresponding with the woman against her wishes;
- Hospital staff gossiping about women who transfer from a homebirth, particularly in regional hospitals of small communities.

Non-consented care

- Mandating CSs, inductions, forceps, continuous fetal monitoring and vaginal examinations;
- Performing procedures *before* consent is given;
- Abusing the legal principle of implied consent;

- Deploying routine procedures such as continuous fetal monitoring, cannulas, vaginal examinations, strict time limits on labour, active management of third stage; without prior disclosure or consent;
- Forcing women who refuse treatment to undergo psychiatric assessments;
- Threatening to call or calling DCJ if women don't accept treatment.

False and misleading information

- Biased information, particularly in relation to VBAC (Vaginal Birth After Caesarean);
- Evasive responses to questions about VBAC, waterbirth, delayed cord clamping, skin to skin with the newborn, continuity of midwifery care;
- Withholding information to disable the capacity to give true informed consent;
- Withholding resources or referrals (eg in relation to breech birth);
- Abusing the doctrine of medical necessity;[19]
- **Bait and Switch**: the practice, particularly in the private sector, of promising to support a woman's requests until the 28th week of pregnancy when Medicare, the private insurer and the woman have paid the (substantial) pregnancy planning fee following which, the provider withdraws support for her preferences or mandates an alternate treatment.

Discrimination

- Failing to secure an interpreter where needed;
- Ignoring or mistreating refugee women who are not fluent English;
- Forcing or mandating treatment on the basis of race or migration status;
- Profiling and treating women differently by reason of race, sexuality, gender, disability;
- Assuming that Indigenous people will be intoxicated, incapable of caring for their infants, will cause trouble, are dishonest and/or need to be controlled;
- Assuming that DCJ should be notified because the woman is Indigenous;
- Disrespecting simple requests for cultural sensitivity for eg a Muslim woman requesting female careproviders so she can remove her hijab and labour comfortably;

[19] The doctrine of medical necessity limits the provision of medical intervention without consent to situations where the intervention is urgently required to avoid serious harm to the person affected.

- Ignoring or dismissing 'unseen' disabilities like trauma, anxiety, mental health issues or chronic pain.

Abandoning care

- refusing to provide care because a woman's birth choices are outside hospital policies;
- storming out of the birth suite without further discussion and refusing to provide follow up care.

The Fundamental Human Right to Bodily Autonomy and Informed Consent

The Special Rapporteur for Violence Against Women (**Special Rapporteur**) observed in her Report, *A Human Rights-Based Approach to Mistreatment and Violence Against Women in Reproductive Health Services With a Focus On Childbirth and Obstetric Violence,* to the UN General Assembly (**OV Report**):

> … the main issue at the core of obstetric violence is the systematic deprivation of women's right to autonomy once they are in contact with a health-care facility.
>
> That deprivation can take many forms, going from the most obvious, such as the practice of an operation despite the lack of the woman's consent, to some more insidious forms like the application of so-called 'hospital protocols'….[20]

The right to informed consent is underpinned by the fundamental human rights to bodily autonomy and bodily integrity.

Autonomy and consent are recognised legal principles in Australia, and often used as a defence in medical liability claims, such as in *Harriton v Stephens*[21], where Crennan J, for the majority, said:

> Such decisions are bound up with individual freedom and autonomy.

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[20] Dubravka Šimonović, A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence, A/74/137, Report of the Special Rapporteur on Violence against Women, 74 sess, Agenda Item 26(a), Supp No A/74/50, UN Doc 19-111859 (E) 130819 (11 July 2019) (***OV Report***).

[21] (2006) 226 CLR 52.

> The duty of care proposed to the foetus (when born) will be mediated through the mother. The damage alleged will be contingent on the free will, free choice and autonomy of the mother.[22]

More recently, the UK Supreme Court in ***Montgomery v Lanarkshire Health Board***[23]*, again* affirmed the right to consent to or refuse treatment:

> An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken.[24]

Informed consent is defined in Article 5 of the *European Convention on Human Rights and Biomedicine* 1997 as follows:

> An intervention in the health field may only be carried out after the person concerned has given free and informed consent to it.
>
> This person shall beforehand be given appropriate information as to the purpose and nature of the intervention as well as on its consequences and risks.
>
> The person concerned may freely withdraw consent at any time.

In NSW, providers in both public and private sectors operate on the assumption that:

- they do not need to obtain informed consent for routine or minor procedures;
- the requirement for consent in relation to 'major' procedures such as CSs is satisfied when women sign a consent form; and
- pregnant women do not have the right to refuse treatment.

These practices violate the fundamental human right to bodily autonomy and integrity, the legal right to choose or refuse treatment, the right to privacy and self-determination and, especially in cases of unconsented surgery, constitute cruel and inhuman treatment. The Special Rapporteur observed in her Report:

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[22] Ibid, [248].

[23] [2015] UKSC 11 (***Montgomery***); see also *Re MB (Caesarean Section)* [1997] EWCA Civ 3093, [30]; *Society of N.Y. Hosp. v Schloendorff* (1914) 211 N.Y. 125; *Secretary, Dept of Health and Community Services v JWB and SMB* (Marion's case) (1992) FLC 92-293, 79,172; *Mallette v Shulman* (1990) 67 DLR (4th) 321, 336.

[24] Montgomery n17, [87].

> Women are frequently denied their right to make informed decisions about the healthcare they receive during childbirth and other reproductive health services; this lack of informed consent constitutes a human rights violation that could be attributed to States and national health systems.

II. Causes and Factors Contributing to Obstetric Violence

In her OV Report, the Special Rapporteur identified four root causes of mistreatment and violence against women in maternity health facilities:

a) conditions and constraints of a health system;[25]
b) harmful gender stereotypes;[26]
c) discriminatory laws and practices; and
d) power imbalance in the provider-patient relationship and abuse of the doctrine of medical necessity.[27]

We address each of these causes in the NSW context below.

1. Conditions and Constraints of a Health System

As noted above, abusive behaviours by health care personnel could not exist without the structural mechanisms that support and reinforce them. Systemic actions, policies and guidelines support provider mistreatment by creating structures to enable the dehumanisation of pregnant women seeking maternity care. These structures have, in effect, normalised the abuse and disrespect detailed above in everyday health care practices and created a culture of impunity amongst health professionals.[28]

We expect that most of the submissions received on behalf of providers will raise concerns about limited or declining resources. There is certainly support for this but, in maternity care, it is not necessarily about resources *per se*. A significant portion of the already high healthcare budget is dedicated to funding

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[25] Šimonović n14, [39].

[26] Šimonović n14, [42].

[27] Šimonović n14, [48-9].

[28] A Waytz & J Schroeder 'Overlooking Others: Dehumanisation by Omission and Commission' (2014) 21(3) *TPM*– Special Issue 1-16.

maternity health care. The problem is not so much about resources as with *resource allocation*. We have below provided just some examples of a highly standardised, process driven and consequently dehumanising standard of care that produces and sustains a culture of abuse and disrespect for which women are told every day to be grateful. This assembly line[29], which promotes forcing the birth process and the replacement of interpersonal care with technology and neglect, is celebrated by government and the professions as a cost-effective, high quality standard of care. It is a system that is guarded and protected by the Health Care Complaints Commission and its professional boards.

"I was treated like a cow on a conveyor belt"

From the perspective of women, a costly health system has not translated into a quality health system. Priority is given to technology and resources to minimise risk over investment in personnel. Time and again, women say they want continuity of care and carer.[30] That is, one careprovider who leads their maternity care from conception to at least 6 weeks after the baby is born, is networked into the health system and receives the respect they deserve for providing such gold-standard care. Medical professionals do not attend the labour until a woman is close to giving birth. This means that the current system depends on a highly fragmented structure for delivery of a care, including antenatal care by one group of doctors and/or midwives, hospital birth with another group of midwives, a new doctor (or two) who turns up at the end of the labour, or when called, who feels out of the loop, anxious to take control and ready to blame everyone else if there is a problem. Then another group of midwives who will provide postnatal care and another doctor who will conduct a final check before the woman is discharged. There is no one provider who can confidently say that they have been with the woman, know and understand her needs and wants, and are able to navigate and coordinate care that is respectful to her. In such a fragmented framework, the opportunity to manage minor issues before they become major problems are often missed. Without a relationship with the woman, it is easy to dehumanise and mistreat her – as we show below.

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[29] M Hansson et al, 'Veiled Midwifery in The Baby Factory - A Grounded Theory Study' (2019) 32(1) (2018/05/02) *Women Birth* 80-86

[30] D Walsh, 'Subverting the Assembly-Line: Childbirth in a Free-Standing Birth Centre' (2006) 62(6) *Soc Sci Med* 1330-40.

Since doctors are unwilling to attend women in labour, the government needs to step up and invest in continuity of midwifery-led care. Midwives, in particular those who are not inculcated into a hierarchical nursing culture, are educated and trained to provide woman-centred care for the full episode of care. They are taught to build patience, compassion and consent into their practice and provide antenatal, intrapartum (labour and birth) and postnatal care for mothers and newborns, particularly in the desperately needed post-natal sphere, that most women can only dream about in NSW. Yet, most of this education and training is beaten out of them once they enter the health system.

'As a midwife working in hospital, how do I navigate around a consultant obstetrician/registrar telling a woman her baby will 'die' or 'do you want to keep your baby safe' if she doesn't partake in a certain action?'

Recruiting and *supporting* adequate numbers of appropriately educated and trained midwives to work in models of care that both respect their professional independence and the human rights of women sits low on the scale of health system priorities. Retraining hospital midwives to practise in birth centres and midwifery group practices presents a real challenge both logistically and culturally, and requires both leadership and commitment from government, particularly in the face of a powerful medical lobby. Respecting the full scope and independence of the midwifery profession, instead of treating them as waiting staff for medical personnel, also requires commitment and leadership. In the long run, the cost analysis is clear – it is much cheaper to invest in midwives and medical providers who support *genuine* woman – centred care than it is to maintain the current technical, technology-driven and highly interventionist system – even for women with complex pregnancies.[31] Yet we only have to look at how much push back there has been on NSW birth centres and homebirth programs to understand exactly who has control over resource allocation.

Quality woman-centred care will also be much, much more cost effective for women and families.[32] At some stage, government needs to both assess and take

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[31] Vanessa Scarf et al, 'Costing Alternative Birth Settings for Women at Low Risk of Complications: A Systematic Review' (2016) 11(2) *PLoS One* e0149463; SK Tracy & MB Tracy, 'Costing the Cascade: Estimating the Cost of Increased Obstetric Intervention in Childbirth Using Population Data' (2003) 110 *BJOG: an International Journal of Obstetrics and Gynaecology* 717–724; H Fox et al,'*A review of the impact of financing mechanisms on maternal health care in Australia' (2019) 19(1) BMC* Public Health 1540; J Toohill et al, 'Socioeconomic differences in access to care in Australia for women fearful of birth' (2019) 43(6) *Aust Health Rev* 639-643

[32] PS Moran et al, 'Economic burden of maternal morbidity - A systematic review of cost-of-illness studies' (2020) 15(1) *Plos One* e0227377

responsibility for just how much the current system of obstetric-led care is costing the overall health system and families *after* women are discharged and dealing with iatrogenic injuries to them and their babies.[33] Those with means will seek counselling and psychiatric support, and treat physical injuries through specialists and/or their GPs. Perinatal psychologists specialising in birth trauma are extremely scarce and expensive.[34] Most psychologists and, in particular, psychiatrists, are reluctant to even acknowledge the significant of birth trauma.

'I thought perhaps you'd know what to do to highlight this issue among psychiatrists generally? They just don't get it - they seem so much like RANZCOG in prioritising their loyalty to medical colleagues over patient care.'

The remainder will struggle and attempt to seek support from the public health system, particularly for their babies. These network effects – suffered by consumers – are a hidden cost which is impairing women and families' ability to establish and care for their families.

We set out below some of the systemic and structural healthcare mechanisms we have observed as contributing to obstetric violence in NSW:

a) 'Routine' Interventions Without Prior Disclosure

Department of Health hospital guidelines, policies and protocols are written in ways that mandate routine interventions and invasive procedures during labour and birth, with little regard for the fundamental human rights of women such as:

- Repeat vaginal examinations at least every 4 hours, following a change of shift, whenever there is disagreement between providers or just because the obstetrician does not believe the midwife[35];

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[33] J Adams et al, 'Substantial Out-Of-Pocket Expenditure on Maternity Care Practitioner Consultations and treatments During Pregnancy: Estimates from a Nationally-Representative Sample of Pregnant Women in Australia' (2017) 17(1) *BMC Pregnancy Childbirth* 114; Emily Callander & H Fox, 'Changes in Out-Of-Pocket Charges Associated with Obstetric Care Provided Under Medicare in Australia' (2018) 58(3) *Aust N Z J Obstet Gynaecol* 362-365; EJ Callander, H Fox and D Lindsay, 'Out-of-pocket Healthcare Expenditure in Australia: Trends, Inequalities and the Impact on Household Living Standards in a High-Income Country with a Universal Health Care System' (2019) 9(1) *Health Econ Rev* 10; EJ Callander et al, 'Out-of-pocket Expenditure on Health Care by Australian Mothers: Lessons for Maternal Universal Health Coverage from a Long-Established System' (2020) 47(1) *Birth* 49-56

[34] V *Tonei*, 'Mother's mental health after childbirth: Does the delivery method matter?' (2019) 63 *J Health Econ* 182-196.

[35] S *Cohen* Shabot, 'Why 'Normal' Feels So Bad: Violence and Vaginal Examinations During Labour – a (Feminist) Phenomenology' (2021) 22(3) *Feminist Theory* 443–463; Rebecca Brione, 'Non-Consented Vaginal

- Anal examinations without consent;
- Electronic Fetal Monitoring[36];
- Blood tests for drug and alcohol screening;
- Screening for diabetes and BMI[37];
- Prophylactic antibiotics[38];
- Pitocin induction of labour[39];
- Episiotomies[40];
- Placing women in the supine position to labour for the convenience of the provider[41];
- Strict observation of reduced time limits for stages of labour;
- Expedited cord-clamping and cutting[42];
- Denying mother and baby skin to skin contact immediately after or in the first few hours of birth (this is a particular problem in privately funded facilities where women who have had CSs are not informed that they may be

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Examinations: The Birthrights and AIMS Perspective' in Camilla Pickles and J Herring (eds), *Women's Birthing Bodies and the Law : Unauthorised Intimate Examinations, Power and Vulnerability* (Hart Publishing, 1st Ed, 2020).

[36] Kirsten Small et al 'My Whole Room Went Into Chaos Because of That Thing in the Corner": Unintended Consequences of a central Fetal Monitoring System' (2021) 102 *Midwifery* e103074; Kirsten A Small et al, '"I'm Not Doing What I Should Be Doing as a Midwife": An Ethnographic Exploration of Central Fetal Monitoring and Perceptions of Clinical Safety' (2022) 35(2) *Women and Birth* 193-200; KA Small et al, 'Midwives Must, Obstetricians May: An Ethnographic Exploration of How Policy Documents Organise Intrapartum Fetal Monitoring Practice (2022) 35(2) *Women Birth* e188-e197; KA Small et al, 'The Social Organisation of Decision-Making About Intrapartum Fetal Monitoring: An Institutional Ethnography' (2023) 36(3) *Women Birth* 281-289.

[37] Rae Thomas, Clair Heal & Julia Lowe, 'Are You at Risk of Being Diagnosed with Gestational Diabetes? It Depends on Where You Live' *The Conversation* (The Conversation Media Group, 6 Mar 2019) <https://theconversation.com/are-you-at-risk-of-being-diagnosed-with-gestational-diabetes-it-depends-on-where-you-live-112515>.

[38] T Tapiainen et al, 'Impact of intrapartum and postnatal antibiotics on the gut microbiome and emergence of antimicrobial resistance in infants' (2019) 9(1) *Scientific Reports* 10635; M Reyman et al, 'Impact of delivery mode-associated gut microbiota dynamics on health in the first year of life' (2019) 10(1) Nature Communications 4997.

[39] DHE Hargreaves, 'Induction of Labour in Nulliparous Women at Term: Factors influencing a High Caesarean Section Rate' (2018) 58(1) *Australian and New Zealand Journal of Obstetrics and Gynaecology* 3-25.

[40] C Clesse et al, 'Statistical trends of episiotomy around the world: Comparative systematic review of changing practices' (2018) 39(6) *Health Care for Women International* 644-662.

[41] HG Dahlen et al, 'From social to surgical: historical perspectives on perineal care during labour and birth' (2011) 24(3) *Women Birth* 105-11; A De Jonge, TAM Teunissen and ALM Lagro-Janssen, 'Supine position compared to other positions during the second stage of labor: A meta-analytic review of Birthing positions' (2004) 25 *Journal of Psychosomatic Obstetrics & Gynecology* 35–45.

[42] H Rabe et al, 'Effect of timing of umbilical cord clamping and other strategies to influence placental transfusion at preterm birth on maternal and infant outcomes' (2019) 9(9) *Cochrane Database Syst Rev*. CD003248.

separated from their infants for at least 2 hours after the surgery, which contributes to significant problems with breastfeeding)[43];

- VBAC bans[44], twin vaginal delivery bans and breech vaginal delivery bans.[45]

Providers are placed in a difficult position: disrespect a woman's human rights or face disciplinary action at work.[46]

The Department of Health, LHDs and regulators expect staff to comply with policies and guidelines above all else, even where it overrides women's rights. It is considered the only way to maintain a level of quality care when the system itself consists of fragmented care and personnel churn. As noted above, it is not unusual for women to deal with at least 3 different unknown midwives and 2 different unknown doctors during labour and birth alone. After the initial discussion with the woman on admission, changeover staff will rely only on what is documented on the file and their guidelines. A changeover midwife dealing with 3 women in labour at the same time is neither interested nor wants to tailor care to suit each woman's needs. She sticks to her guidelines, even if it means forcing treatment, and keeps her job. An inexperienced obstetric registrar will stick to the guidelines even if the woman expressly objects or has offered a birth plan. If it is not on file or stipulated in a guideline, a new midwife or doctor will refuse to honour a prior arrangement. This creates conflict. The woman who was relying on an assurance or an arrangement to manage a chronic disease suddenly finds she is dealing with a new staff member who will not honour that

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[43] J Stevens et al, 'Immediate or early skin-to-skin contact after a Caesarean section: a review of the literature' (2014) 10(4) *Matern Child Nutr*. 456-73.

[44] H Keedle et al, 'Women's reasons for, and experiences of, choosing a homebirth following a caesarean section' (2015) 15 *BMC Pregnancy Childbirth* 206; H Keedle et al, 'From coercion to respectful care: women's interactions with health care providers when planning a VBAC' (2022) 22(1) *BMC Pregnancy Childbirth* 70; I Lundgren et al, 'Clinicians' views of factors of importance for improving the rate of VBAC (vaginal birth after caesarean section): a qualitative study from countries with high VBAC rates' (2015) 15 *BMC Pregnancy Childbirth* 196.

[45] CSE Homer et al, 'Women's experiences of planning a vaginal breech birth in Australia' (2015) 15(1) *BMC Pregnancy and Childbirth;* A Bisits, 'Risk in obstetrics - Perspectives and reflections' (2016) 38 *Midwifery* 12-3; A Kotaska, 'In the literature: combating coercion: breech birth, parturient choice, and the evolution of evidence-based maternity care' (2007) 34(2) *Birth* 176-180; A Kotaska, 'Inappropriate use of randomised trials to evaluate complex phenomena: case study of vaginal breech delivery' (2004) 329(7473) *BMJ* 1039-42.

[46] Elaine Jefford, Julie Jomeen and Margie Wallin, 'Midwifery Abdication – Is It Acknowledged or Discussed Within the Midwifery Literature: An Integrative Review' (2018) 2 *European Journal of Midwifery* 6; GB Kruger and TV McCann, 'Challenges to Midwives' Scope of Practice in Providing Women's Birthing Care in an Australian Hospital Setting: A Grounded Theory Study' (2018) 18 (2018/11/14) *Sex Reprod Health* 37-42; DL Davis and CS Homer, 'Birthplace as the Midwife's Work Place: How Does Place of Birth Impact on Midwives?' (2016) 29(5) (2016/10/25) *Women Birth* 407-415; Kerreen Reiger, 'The Politics of Midwifery in Australia: Tensions, Debates and Opportunities' [53] (2014) 10(1) *Annual Review of Health Social Science* 53-64.

assurance or was not informed about the arrangement. The more exhausted and distressed the woman is, the higher the incidence of conflict. Staff who have learnt to adapt to an abusive culture have also developed compassion fatigue. They have learnt to ignore the distress and pleas of the woman or they get angry and impatient with her, and will stick to their guidelines.

Staff that struggle with overriding women's choices are managed out of hospitals and/or reported to Ahpra. This is especially the case with midwives, who are more likely to be reported by colleagues and managers who have adapted to an abusive, hierarchical workplace culture.[47] The Nursing and Midwifery Board of Australia (**NMBA**) is quick to assume that hospital midwives who do not follow policy or guidelines are incompetent and/or require professional retraining, even where the midwife is asserting that the woman refused or requested an alternative. We have, on several occasions, been asked by women to help them provide evidence to show that the midwife was simply doing as they asked. The NMBA has either ignored or rejected that evidence. The consequences can be severe – the midwives concerned have both lost their jobs and had restrictions placed on their registration. This is, in effect, a license to other providers to disrespect and abuse women to protect their employment.

By contrast, complaints from consumers about doctors and midwives mandating procedures and overriding consent are rarely acted upon. We will say more about this in the next section.

It is one thing to have routine processes in place, it is quite another to *not disclose those routine processes* to women. Every hospital has a number of routine procedures, mandated by the Department of Health and/or the Local Health District (**LHD**). Personnel know they are going to use these procedures on women on admission. They know that a broad majority of women will either object to or become manifestly distressed by these routines processes. Yet there is an overwhelming culture of concealing this information from women and, in many cases, providing evasive or misleading statements to women who expressly seek that information.[48] In addition, women who expressly seek assurances are falsely informed that their requests will be met, and human rights protected. These false assurances constitute unconscionable and false and misleading conduct for which

[47] K Harvie, M Sidebotham and J Fenwick, 'Australian Midwives' Intentions to Leave the Profession and the Reasons Why' (2019) 32(6) (2019/01/13) *Women Birth* e584-e593.

[48] R Thompson R & YD Miller, "Birth control: to what extent do women report being informed and involved in decisions about pregnancy and birth procedures?" (2014) 14 *BMC Pregnancy and Childbirth* 62.

providers and facilities should be held accountable. Despite obvious violations of the law and human rights, this practice is near universal in Australia.

To be clear, hospitals protocols cannot trump the fundamental human rights of any person. In addition to being a violation of women's fundamental human rights (which we elaborate on further below), the failure to disclose routine processes prior to the engagement of a service is a breach of the consumer protection provisions in Australia.

'If we told women what we actually do to them, they wouldn't come here.'

When women first contact us for assistance, they nearly always say that they want other women to know what happens in their local hospital because "they don't want anyone else to go through what they did". We, as a society, hold the medical profession in high esteem. Women want to trust their providers and most see the mistreatment as a profound betrayal of trust. These complaints are so consistent that we have asked facilities why they do not simply tell women what to expect before they enter that facility. We have not, to date, received any responses. We acknowledge, however, that were a facility to actually disclose its practices, it would lead to a parliamentary inquiry, much like the one before this Committee. As one retiring medical practitioner explained: "If we told women what we actually do to them, they wouldn't come here."

b) Education And Training That Dehumanise Women And Enforce Fetal-Centric Care

The education and training of medical and facility personnel appears to encourage the treatment of pregnant women as a means to an end in childbirth. Through the use of structures set up to support, protect and prioritise the interests of the facility, including its personnel, careproviders have developed education and practice through the process of dehumanisation by omission.[49]

[49] OS Haque and A Waytz, 'Dehumanization in Medicine' (2012) 7(2) Perspectives on Psychological Science 176-186.

Dehumanization by omission occurs when the dehumanisation process is passively triggered by contextual and individual suppression of the humanity of a particular sub-group.[50]

Dehumanisation is not about treating someone as not human.[51] It is about treating a person as *sub-human* or a human of lower stratification through discriminatory references to, for example, race, skin colour, socio-economic status, disability and sexuality.[52] In maternity care, that discriminatory stratification is, first and foremost, based on sex and pregnancy – ie that pregnant women are purely a means to an end, the end being the extraction of an intact infant. Disappointingly, careproviders – even the most highly educated and intelligent amongst them - appear susceptible to system conditioning towards treating pregnant women as a means to an end.

The primary factors identified below as contributing to dehumanisation by omission reflect the typical context and behaviours of careproviders in childbirth facilities:

(i) Outcome Irrelevance

A common feature of routine practices and fragmented care is that careproviders devote less resources to the relationship with, and consequently seek less personal information about, individuals with whom they do not expect future interaction.

In large tertiary facilities designed to operate like a rapid throughput assembly line, careproviders develop coping mechanisms which are similar to dehumanisation strategies. This will mean careproviders have even less inhibition when deploying control and punishment mechanisms. This is typical of large maternity wards in NSW. A change of shift, as noted above, results in a woman in labour having to deal with a new personality and preferences. It is no different in private facilities. While the private obstetrician may be known to the woman, they do not attend the woman until either they are called in or the

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[50] A Waytz & J Schroeder 'Overlooking "Others": Dehumanisation by Ommission and Commission' (2014) 21(3) *TPM (Special Issue)* 1-16.

[51] Smith, David L., "The Essence of Evil: You Dont Have to be a Monster or a Madman to Dehumanise Others. You Just Have to be an Ordinary Human Being" (2014) Aeon Online https://aeon.co/essays/why-is- it-so-easy-to-dehumanise-a-victim-of-violence.

[52] N Kteily *et al*, The Ascent of Man: Theoretical and Empirical Evidence for Blatant Dehumanization' (2015) 109(5) *J Pers Soc Psychol* 901-31; S Trawalter et al 'Racial Bias in Perceptions of Others' Pain' (2012) 7(11) PLoS ONE e48546.

birth is imminent. The midwives who provide care for the duration of her labour are all strangers to her, working shifts and providing fragmented care like in public hospital maternity wards. The only difference is that, while public hospitals have to operate under Department of Health mandated guidelines, women in private care are cared for in according with their treating obstetrician's guidelines. In both cases, the woman is never apprised of the existence of these guidelines. All it takes is one provider who is abusive and disrespectful to put the woman in complete distress.

'The new midwife told me to get out of the shower because "we don't do that here". But I was doing it before she turned up and no one said anything'

The typical maternity ward operates on a standardised process, utilising routine care, and is designed to get the women in, get the baby out as quickly as is physically possible and send the woman home also as quickly as possible. Once a woman is discharged, there is no follow up, home visits or postnatal care. There is no expectation she will return and, if she tries, she will be redirected to her GP, the hospital admissions and emergency department, or a local health nurse. Maternity ward staff are therefore shielded from the damage they cause including, and in particular, depression and anxiety, post-traumatic stress disorder, struggles with breastfeeding, and physical injuries such as untreated second-degree tears, bruises and cuts on the newborn's head, surgical nicks on the bladder, infections on the CS wound, pinched nerves, severe post-surgery pain, back pain and incontinence. These are injuries considered too minor to result in litigation so maternity providers are simply not interested in hearing about it. Women are left at a complete loss when these things happen. This is a terrifying reality for migrant women, women without family support and Indigenous women who were forced to travel a long distance to get to a hospital.

(ii) Social Connection

Careproviders who develop social connections with their dominant group (i.e. facility personnel) attribute fewer mental states to others, and report that others were less worthy of moral concern because these "others" lacked or falsely portrayed feelings and emotions.

There are several dynamics at play in NSW maternity wards. Medical professionals tend to band together and support each other, particularly as against midwives. Midwives, on the other hand, do not typically exhibit the same degree of professional loyalty to each other. However, when it comes to the

woman, providers are generally united in their attempts to control and coerce a particular outcome.

This is especially reflected in the defensiveness and lack of engagement by careproviders when called to account for abuse and disrespect. When women resist, raise questions or ask for more time, it is not unusual for a large group of practitioners, in hospital garb, to descend on the family and a labouring woman all at once, where one will take charge while the rest bear witness, take notes, check the woman's vital signs and express disapproval. The families are usually 'ordered' to put away their phones or any other form of recording device. Doulas are threatened or told to leave. Fathers are sidelined. The person in charge will proceed to berate the woman and the family for being ungrateful or stupid and/or wasting everyone's time. Families, often already fearful and in a state of heightened senses, become overwhelmed by this, particularly if language is a barrier or they are young. Some will have overheard corridor discussions between staff about needing the bed and the birth suite. If the family resist or react in fear, they are threatened with security and/or engagement with DCJ. If the woman cannot be persuaded by the entire team to do as they wish, a social worker can be sent in "for a chat". That social worker is, in fact, screening the woman's mental health to decide whether to refer the matter to the hospital psychiatrist or to initiate a child protection investigation. Often, the woman will capitulate in response to threats. To be clear, all this happens before the baby even exists as a legal person. This form of coercion and abuse is a normal, routine process in maternity wards. We deal with such complaints on a weekly basis and, during the pandemic, addressed such complaints at least 4-5 times a week.

(iii) Goal Instrumentality

Whereas birthing women are often afforded little attention because they are outcome irrelevant or socially irrelevant, when they become necessary to fulfill a goal (such as when they are pushing out the baby) they are afforded a great deal of attention, not for their intrinsic value as humans, but instead to their extrinsic utility of completing the goal of producing a live baby.

Because the care provider's attention is limited and finite, this focus on instrumentality leads to a passive neglect of a woman's essential humanity, seen to be outside the scope of the focal goal of extracting the infant. In other words, pregnant women, instrumental only for the purposes of extracting the baby, are treated like tools used to fulfill that purpose. Most of the abuse that occurs during the final stages of childbirth is driven by goal instrumentality. Providers will do whatever is necessary to the woman's body, without consent, in order to extract

a live, intact baby, including perform episiotomies, strap women down, put their legs in stirrups, insert cannulas, perform repeat vaginal examinations, shout at the woman, inject medicines and apply forceps – all without consent and, at times, alongside verbal abuse.

Most of these behaviours actually constitute assault and battery but are later justified as falling under the doctrine of medical necessity. The doctrine of medical necessity requires evidence of an emergency. In reality, there is nothing unusual or urgent about the circumstances. They are an everyday occurrence where the urgency has more to do with the time constraints on the facility and the attending medical practitioner than any genuine emergency affecting the woman.

'Suddenly, all these people burst into the room and surrounded her. They started doing things to her and she was screaming 'no' repeatedly. I froze. I couldn't move. Then her mother stood up and said, "That's enough!'

Women repeatedly tell us that the labour was going well when, suddenly, out of the blue, a team of providers will burst into the room and tell them that the baby has to come out NOW. They are bamboozled by the hyperactivity around them, i.e. questions being asked, things being done to them by several people at once, all without consent. Fathers retreat because it all looks like an emergency, unaware that this happens *everyday* as a normal occurrence for the facility.[53] Many women say they were bullied into agreeing to have an "emergency CS" as if it was a matter of life and death, only to find that they are left waiting for hours for the so-called 'emergency CS". On review of their medical files, we discover that they were in fact misled or given false information which disabled their ability to give true informed consent. The emergency CS was not in fact performed because it was a genuine emergency. According to RANZCOG, any CS performed after the commencement of labour is deemed an Emergency CS, and the decision-to-delivery interval is determined by the following classifications:

Category 1: Urgent threat to the life or the health of a woman or fetus;

[53] E Daniels, E Arden-Close and A Mayers, 'Be quiet and man up: a qualitative questionnaire study into fathers who witnessed their Partner's birth trauma' (2020) 20(1) *BMC Pregnancy Childbirth* 236; J Etheridge and P Slade, '"Nothing's actually happened to me": the experiences of fathers who found childbirth traumatic' (2017) 17(1) *BMC Pregnancy Childbirth* 80.

Category 2: Maternal or foetal compromise but not immediately life threatening;

Category 3: Needing earlier than planned delivery but without currently evident maternal or foetal compromise; and

Category 4: At a time acceptable to both the woman and the CS team, understanding that this can be affected by a number of factors.

Category 3-4, and arguably Category 2, would not satisfy a dictionary definition of an emergency, let alone common sense. Under this classification structure, providers can induce a woman to commence labour, decide that her labour is not progressing as quickly as they would like, declare the need for an "emergency CS", schedule it at a time that is convenient to the facility and receive the highest reimbursement from Medicare, private insurers and out-of-pocket fees. Under the current Medicare/insurer reimbursement scheme, suppliers are incentivised to overtreat and to coerce or mislead women into accepting overtreatment.[54] It is reinforced by medical liability laws (discussed below) and is especially rife in the private sector.[55] The person who bears the brunt of supplier-induced demand[56] and who is left in pain and suffering is the woman.

(iv) Possession of Resources such as Status, Power and Money

Careproviders enjoy relatively higher status, power, and money which encourages thinking and behaviour to reflect perceived superiority, less cognitive attention to others and greater narcissism, all of which can contribute to the process of dehumanization.[57] Consequences include increased unethical behaviour, reduced prosocial behaviour, feelings of powerfulness and greater disengagement during social interactions. Powerful people tend to objectify others and consider them more in terms of extrinsic utility than intrinsic worth as

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[54] M Hensher, J Tisdell and C Zimitat, "Too much medicine": Insights and explanations from economic theory and research" (2017) 176 Soc Sci Med 77-84; YD Miller, SJ Prosser and R Thompson, 'Going public: do risk and choice explain differences in caesarean birth rates between public and private places of birth in Australia?' (2018) 28(5) *Midwifery* 627-35; H Fox et al, 'Evidence of overuse? Patterns of *obstetric* interventions during labour and birth among Australian mothers' (2019) 19(1) *BMC Pregnancy Childbirth* 226.

[55] K Einarsdottir et al, 'Increase in *caesarean* deliveries after the Australian Private Health Insurance Incentive policy reforms' (2012) 7(7) (2012/07/31) *PLoS One* e41436; D Coates et al, 'Women's experiences of decision-making and attitudes in relation to induction of labour: A survey study' (2020) *Women Birth*.

[56] Also known as second degree moral hazard ie where providers know that consumers are insured and are therefore more likely to overtreat to *increase* their revenue from third party payers.

[57] Caragh Brosnan et al, 'Experiences of Medical Students who are First in Family to Attend University' (2016) 50(8) *Medical Education* 842-851.

humans. A final pervasive resource that seems to influence careprovider perceptions is money. People exposed to money are more likely to believe social advantaged groups should dominate disadvantaged groups and that victims deserve their fates.[58]

In Australia, it is well-established the specialist medical providers – in particular privately funded obstetricians - occupy the top income tax bracket and enjoy significant socio-political prestige. Less than 10 percent of medical students come from lower socio-economic backgrounds, reflected in the difficulty government has with persuading obstetricians to practice in rural, regional and lower socio-economic areas.[59] Unlike most industries, the profession is very closely connected with government and claims to speak for or on behalf of its consumers. Such is the power and prestige that is associated with medicine and its specialists, that we appear as a society to overlook the fact that, like lawyers, accountants and engineers, they are, first and foremost, running a business and, like everyone, striving to make a profit.

'If you like Dr Google so much, get him to deliver your baby'

The process of asserting that the provider is more knowledgeable than the woman is about what is going on in her body is fuelled by that power and privilege. Women have told us their providers will sneer when they disagree with the provider's assessment or ask questions, and respond with statements like, "If you like Dr Google so much, get him to deliver your baby" or "Last time I checked, social media doesn't give you a degree in medicine" or "If you think you know better, why are you even here?" or "It's people like you that make me want to give up medicine". These are people who, in this day and age, are likely not fit to be health care providers. Yet, such behaviours are dismissed as incidental to the provision of care by Ahpra, the HCCC, hospitals and the professional boards.

When pressed, careproviders often seek to justify abuse and disrespect by asserting that they are themselves the victims of a system with poor working conditions and limited resources. There is no doubt that disrespect and abuse are driven by difficult situations – real or perceived – in the health system as

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[58] Rodante van der Waal, Veronica Mitchell, Inge van Nistelrooij & Vivienne Bozalek (2021) Obstetric violence within students' rite of passage: The reproduction of the obstetric subject and its racialised (m)other, Agenda, 35:3, 36-53

[59] Ian B Puddey, Denese E Playford and Annette Mercer, 'Impact of Medical Student Origins on the Likelihood of Ultimately Practicing in Areas of Low Vs High Socio-Economic Status' (2017) 17(1) *BMC Medical Education* 1;

well as the broader socio-cultural environment. There are both financial and structural constraints on providers. Few are willing to admit that abuse is their responsibility or due to their own attitudes, beliefs and temperament. Most health care providers will attribute their attitudes to stress and exhaustion, lack of motivation, ignorance, lack of training or difficult situations.

But external stressors alone cannot explain why and how a collective of, arguably, the brightest and most privileged cohort in our society decided to respond to perceived difficulties by abusing the most vulnerable person in the room. Nor does it explain why providers are able to engage in different behaviours when it comes to friends, colleagues, the very wealthy (e.g. Sara Murdoch), the famous (e.g. Elle McPherson), politicians, members of the judiciary and journalists. It suggests a behavioural discretion and, with it, an intention to behave in a particular manner towards particular groups of women.

c) Distrust and Disrespect towards Women Engaging Independent Midwives

In circumstances where facility providers are complaining about limited resources and excessive workloads, a rational response would be to welcome any initiative that takes the pressure off health facilities. Women and pregnant people who utilise the services of privately practising midwives (**PPMs**) are a case in point. Unfortunately, that has not been the case. Since PPMs were given the ability to access Medicare reimbursements, and obtain visiting and prescribing rights, health facilities and private providers have adopted a 'gatekeeping stance' against them and behaved in a hostile manner towards the women who hire them.

We have received reports in relation to the following:

- Women who are abused and disparaged when they tell their GPs that a PPM is going to manage their pregnancy and birth. This occurs even after the woman has provided information about the PPM, her practice and her contact details;
- Women struggling to find a GP – particularly in regional areas – who will agree to write a referral to a PPM. This does not mean that the women cannot access PPM services. It does mean, however, that women who utilise PPM services are denied Medicare reimbursements and will be required to pay a higher fee than a woman who sees a GP for antenatal and postnatal care. This could constitute anti-competitive conduct prohibited by the *Competition and Consumer Act 2010* (Cth);

- Women who arrange to transfer to hospital:
  - face abuse and disrespect on arrival for 'inconveniencing' the facility;
  - are told to 'wait their turn';
  - face abuse and criticism from ambulance personnel; and
  - are made to endure tests and diagnostics without consent so hospitals can collect evidence to report their PPMs to the HCCC and the NMBA;
- Women who are distressed to learn that their PPMs were reported to the HCCC following a transfer to hospital.

These attacks are in fact a reflection of how normalised abusive culture is in facilities. Hospital staff resentment toward PPMs is extended to anyone associated with that PPM. Both the woman and her PPM become "the other" and are treated with suspicion. Hospital staff behave in strange ways towards PPMs, seemingly in response to the threat PPMs pose to their dehumanising culture. PPMs do not force treatment or pursue routine guidelines and are therefore assumed to be dangerous or incompetent midwives.[60] A PPM who will not coerce women into transferring to hospital at a time that is convenient to the facility is often reported for just that – this mistaken notion is also endorsed by the NMBA. Hospital staff object to the strong relationship between PPM and the woman, and will accuse the PPM of obstructing their ability to control the woman. They also resent PPMs providing information that challenges or contradicts any biased or misleading information being put forward by facility staff. In one particular case, the medical practitioner and Midwifery Manager lodged a complaint against a PPM for "obstruction". According to the woman, she kept shouting 'no' but the doctor continued to put on his gloves and attempt a vaginal examination as if she wasn't conscious. The PPM put her hand in front of the woman and asked the doctor to stop. To be clear, these are situations where there are several people in the room, some of whom are aware that what they are doing is against the law, but the only one brave enough to say anything is the PPM. PPMs regularly pay the price for trying to protect women from facility based assault. They are scrutinised by the NMBA for several months, the costs of which are personally borne and can be profound. They do not have insurance, which usually covers legal representation, and most cannot afford legal representation.

[60] D Fox, A Sheehan and C Homer, 'Birthplace in Australia: Processes and interactions during the intrapartum transfer of women from planned homebirth to hospital' (2018) *57 Midwifery* 18-25.

We have dealt with many complaints, especially from hospitals with a high number of privately practising Visiting Medical Officers (**VMOs**) or practitioners who work in both the public and private sectors, about PPMs allegedly 'getting in the doctor's way'. That government facilities are willing to enable complaints by VMOs against their competitors highlights the tendency for regulatory capture between government and the medical industry and, consequently, just how much power and impunity these VMOs and the facilities that support them enjoy as against consumers. These are not unfounded assertions. The inquiries into Roman Hasil[61], Graeme Reeves[62] and Emil Gayed[63] revealed the extent to which facilities would go, at times over decades, to protect obstetricians that were practising while intoxicated, performing procedures without consent, engaging in sexual misconduct, committing serious medical errors in surgery, and performing hysterectomies without consent. According to the consumer complaints we received, many of these poor practices were preceded by verbal abuse and the use of harmful gender stereotypes to harm and coerce women. The tolerance of such behaviours for such long periods of time reinforces to medical providers that they can behave with total impunity, provided they do not cause the kind of physical harm that would attract external scrutiny. For instance, investigations into Emil Gayed only commenced after intrepid journalist, Melissa Davey, published a story about his string of abusive practices in *The Guardian.*[64] By contrast, most PPMs are immediately reported by facilities for allegedly not providing adequate handover or assuming care for what the facility deems to be "high risk women".

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[61] NZ Health and Disability Commissioner, *Dr Roman Hasil and Whanganui District Health Board 2005 - 2006: A Report by the HDC* (Opinion No 07HDC3504, HDBNZ, Feb 2008) <https://clarolaw.co.nz/wp-content/uploads/Whanganui-DHB-and-Dr-Roman-Hasil-HDC-report-2008.pdf>, 11, 20–1.

[62] Diedre O'Connor, *Review of the Appointment, Management and Termination of Dr Graeme Reeves as a Visiting Medical Officer in the NSW Public Health System* (Report, Dept of Health, NSW: 2008) <http://www.health.nsw.gov.au/resources/news/pdf/oconnor_2.pdf>, 2; 3–5.

[63] Gail Furness, *Section 122 Health Services Act: Independent Inquiry Relating to Dr Emil Gayed* (Report, NSW Dept of Health, 2019) <https://www.health.nsw.gov.au/patients/inquiry/gayed/Documents/gayed-report.pdf>, 15; Furness GB, *'Review of Processes Undertaken by the Medical Council of New South Wales pursuant to Part 8 of the Health Practitioner Regulation National Law (NSW) with respect to Dr Emil Gayed'* (Report, Medical Council of NSW (previously Medical Board), 7 Jan 2019) <www.mcnsw.org.au/sites/default/files/full_deidentifed_medical_council_-_7_january_2019.pdf.>

[64] Melissa Davey & Carly Earl, 'Exposing Emil Gayed, the Obstetrician Who Mutilated Scores of NSW Women' (*The Guardian,* Online Report, *Guardian News & Media Limited*: 8 May 2023) < https://www.theguardian.com/media/2023/may/08/exposing-emil-gayed-the-obstetrician-who-mutilated-scores-of-nsw-women>.

'You are nothing more than a doula around here, so I suggest you get out of my way'

Many doctors have pulled PPMs out of the birth suite and warned them not to communicate with their clients because staff depend on the provision of limited or misleading information to produce a specific outcome. Facility personnel have also made repeat, anonymous complaints about a PPM before a woman is due to deliver in an attempt to force the PPM to cease care for that woman. Nearly all facilities will claim that they did not receive adequate handover of information when, in fact, the PPM either gave them everything she had (which, from our review, usually carries much more personal information about the client than typical hospital notes) or she was present with the woman in hospital every day, and could have debriefed virtually every single staff member on ward during those times. What we see, however, is hospital personnel, by reason of their social connections with their dominant groups, avoiding any direct contact with PPMs.

We have no doubt that facilities will deny this. Unfortunately, the problem is so significant that it prompted (just) one facility in NSW, the , to introduce a local operating procedure which requires, amongst other things, that:

- The staff of the should remain respectful of the relationship between the woman and her homebirth care giver/s; …
- has an agreement with the NSW Ambulance Service in the event of a life-threatening situation where the woman will be transferred to the closest medical facility.

Sadly, such collaborative leadership is scarce in NSW. In one complaint, a woman sought advice from us about the way she was treated by a regional public hospital. She lost her baby approximately twelve hours after being admitted to the facility, alongside her PPMs. She claimed that her hospital records included false and misleading information aimed at concealing hospital neglect and incompetence, retrospectively added after the baby died. Hospital personnel denied responsibility and the LHD instead distributed material which defamed both the woman and her PPMs. The woman reported the hospital to the HCCC for malpractice and neglect, which declined to investigate the complaint. The hospital reported the PPMs to the HCCC claiming, amongst other things, that the PPMs failed to properly brief staff on transfer. Staff forgot to mention the fact that the PPMs remained by the woman's side for the 3 days she

was in hospital but no one would speak to them during this time. The HCCC nevertheless chose to investigate the PPMs.

'I went in for help with our newborn, but instead they admitted me, put me on a bed, did a vaginal exam and took bloods. When I asked why, they said my midwife was incompetent and they needed to make sure I was safe. When I refused any more tests, they threatened to call child protection.'

Women have also told us that hospital personnel will conduct forensic tests on them and their infants without consent for the purposes of collecting evidence to support a complaint against their PPMs. We have seen these hospital complaints, based on additional investigations conducted without the woman's knowledge or consent. This is an extraordinary violation of a woman's right to autonomy and privacy. Hospital personnel, especially in regional hospitals, appear to have forgotten that their remit is to serve women and pregnant people, and not the other way around. It is not a matter for hospital personnel to conduct forensic tests on human beings to serve their own purpose. That said, it appears that the health system shares the hospital's view. When our client raised these concerns with the HCCC, she was informed that, while obtaining consent would have been 'good practice', it was all done to preserve her safety and was therefore acceptable. We are not aware of any Australian legal or human rights principle that endorses experimentation without consent on human beings to preserve their safety.

2. Harmful Gender Stereotypes

The Special Rapporteur identified harmful gender stereotypes common in the provision of maternity care that constitute a root cause of obstetric violence. These include provider beliefs about:

(a) women's natural role in society and motherhood; and

(b) women's decision-making competence.

a) Women's Natural Role in Society and Motherhood

Stereotyping women is based on strong religious, social and cultural beliefs and ideas about sexuality, pregnancy and motherhood.[65] We have, as a society, a profound problem with respecting 'informed consent' which, in turn, has overwhelmingly translated into violence against women and girls in all spheres of their lives. Our facilities are, unfortunately, made up of members of the same society, carrying all the same values, ideas and beliefs. We set out some of the most common refrains which reflect such harmful gender stereotypes about women, pregnancy and motherhood.

"At least you have a healthy baby"

This claim is based on the belief that pain and suffering in childbirth is the rite of passage for all 'good mothers'. Women who speak up about mistreatment will be told that they are very lucky to be giving birth in one of the safest countries in the world and that they should be grateful for a healthy baby.[66] The belief that women must sacrifice everything, including their personal and psychological safety, to be considered good mothers is a harmful gender stereotype observed in countries rich and poor. Note that the statement does not deny the pain and suffering the woman has endured during labour and birth. On the contrary, using the words "At least" at the start of the sentence is an admission that what happened was traumatic for the woman but, in the larger scheme of things, the message is clear: the woman's own physical and emotional health is no longer valued.[67]

Diminishing the pain and suffering of women at the hands of careproviders is obstetric violence.[68] It is no different to blaming women who were sexually assaulted. Most women do not know what they are getting into when they enter a maternity ward and, as noted earlier, there is no attempt to warn them about the abuse and disrespect they may experience. It is not and can never be their fault that they have endured abuse at the hands of someone they trusted. Some

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[65] International Federation of Gynecology and Obstetrics, *Ethical Issues in Obstetrics and Gynecology: Harmful Stereotyping of Women in Health Care* (London, 2012),), 28.

[66] Šimonović n 14, [46].

[67] Rebecca J Cook and Simone Cusack, *Gender Stereotyping: Transnational Legal Perspectives* (Philadelphia, University of Pennsylvania Press, 2010), 34.

[68] S Cohen Shabot, 'Amigas, Sisters! We're Being Gaslighted: Obstetric Violence and Epistemic Injustice' in Camilla Pickles and Johnathan Herring (eds), *Childbirth, Vulnerability and the Law: Exploring Issues of Violence and Control* (Routledge, 2020).

health services will blatantly deny having abused or disrespected a woman and make her question herself, even where she is obviously in distress. Some will tell her that it was for her own good. Others will ignore her complaints. A small portion will send her a standard form, conditional apology, such as "We are sorry that *you think* that we behaved in a way that violated your rights…". The hundreds of women we have spoken with could not *all* be mistaken about the mistreatment they experience at a facility, in some cases, at the hands of a protected repeat offender.

We would add just one exception: if the woman or the infant has sustained a physical injury that could interest a medical liability lawyer, the facility will go to some lengths to meet with and apologise to the family. Anything less than an actionable claim for damages, however, is dismissed or ignored.

'As doctors, we must constantly advocate for the best interests of our patients, including babies who cannot speak for themselves'

This statement, published by obstetricians in leadership positions in an obstetric journal, is premised on two claims. The first claim is that the woman and unborn fetus have equal rights in law and practice. The second is that the doctor can presume to speak for a woman's unborn infant. Neither of these claims are consistent with the recognition or protection of women's fundamental human rights.

These claims are nevertheless embedded in medical education and facility based training in obstetrics and maternity health care. They are based on a medico-legal fiction coined as "The Obstetric Dilemma"[69] i.e. the belief that pregnancy is an abnormal condition during which the needs of the mother conflict with the needs of her unborn infant.[70] Underpinning this medical construct is the belief that an unborn fetus has the same legal and human rights that either compete with and/or override the pregnant woman's rights.

The first claim is at odds with both Australian law and human rights laws. The UN Human Rights Committee recently confirmed that the human right to life is

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[69] S McLean & K Petersen, "Patient Status: The Foetus and the Pregnant Woman" [1996] 2(2) *Australian Journal of Human Rights* 229.

[70] Julie Jomeen and Lura L. Pethtel, *Choice, Control and Contemporary Childbirth* (Routledge, Ist ed, 2011). at 16-18.

triggered from the moment of birth.[71] This is articulated in Australia as the 'born alive' rule at common law. An unborn fetus cannot be used to subordinate the rights of a living human being, regardless of whether it is for altruistic, religious or financial reasons. If every competent adult is entitled to choose whether or not to accept medical treatment, providers are not entitled to construct a second patient in order to override the rights of the competent adult.

The human right to autonomy and the laws on informed consent means that a woman seeking maternity services is entitled to be treated as an individual in her own right, the sole beneficiary of the service provided by the practitioner and fully competent to make decisions concerning her own health.

This is a matter of a woman's right to equality before the law.[72]

When pregnant people are forced to surrender to or accept treatment they don't want or need because providers are concerned with the welfare of the unborn, providers are denying women their constitutional right to equality before the law and in practice. It is not only contrary to the law, it sends a dangerous message – that pregnant women are not entitled to the same rights as everyone else. That the right to equality and equal treatment can be set aside, at the whim of healthcare providers. To be clear, overriding the rights of pregnant people requires legal and constitutional consideration by our democratically elected parliamentary representatives, who we can scrutinise and hold accountable for their decisions. Such authority has no place in the hands of facilities or providers, behind closed doors.

The second claim is also based on dangerous misconceptions about women's right to autonomy. The idea[73] that a foetus may need protection from the mother - whose body, brain and life choices have been redirected to prioritising her pregnancy and unborn baby - belies any rational thought and is based on archaic and dangerously misogynist attitudes towards women and their bodies. There appears to be, amongst some Australian commentators, a desire to

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[71] United Nations Human Rights Committee, *General Comment No 36: Article 6 re Right to Life*, HRI/GEN/1/Rev.9 (Vol 1), CCPR/C/GC/36, 124 sess, 1834 mtg, UN Doc GE.19-15012(E) (3 Sept 2019) annex 1915012 ('*General Comment No 36: Article 6 re Right to Life*').

[72] UN Human Rights Council, *Report of the Working Group on the Issue of Discrimination against Women In Law and in Practice*, A/HRC/32/44, UN General Assembly 32 sess, UN Doc GE.16-05771(E) (8 Apr 2016), [86].

[73] J Savulescu & L de Crespigny, "Should it be a crime to harm an unborn child" (2014) *The Conversation* (21 Mar), <https://theconversation.com/should-it-be-a-crime-to-harm-an-unborn-child-24407>.

elevate the status of the fetus, or to give the fetus recognition at law, so as to undermine the legal status of pregnant women. [74]

As one philosopher argues, there is a purpose behind maintaining the medico-legal fiction:

> "Broadly speaking, if the unborn child is accorded little or no legal personality, then considerations of maternal autonomy almost invariably trump foetal autonomy. To the extent that the unborn child is accorded substantive legal personality then the road is open to a balancing of foetal autonomy and maternal autonomy that may, in concrete circumstances, result in the prioritising of one over the other."[75]

In reality, the conflict is not between the woman and her infant, but between the woman and the provider who is using a fictitious second patient to force a treatment on her.[76]

Pitting the interests of mothers against the interests of their unborn infants in the provision of care, whether for religious or financial interests, or liability concerns, has undoubtedly exacerbated the abuse and mistreatment that women experience in pregnancy and childbirth.

We ask the Committee to also consider the implications of careproviders overriding women's rights in the presence of spouses and family members who may already be perpetrating violence against that woman. To so brazenly and publicly commit such violence – whether intentional or otherwise – is to effectively give perpetrators of family violence a license to behave as they do.

b) Women's decision-making competence

Women consistently report that their express requests are either flatly denied or ignored, apparently in their best interests because, in the provider's view, they are not making the right decisions. This infantilising of adult women is

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[74] D Johnsen "The Creation of Foetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy and Equal Protection" (1986) 95 *Yale Law Journal* 599.

[75] G Casey "Pregnant Woman and Unborn Child: Legal Adversaries?" (2002) Vol 8 (2) *Medico-Legal Journal of Ireland* 75.

[76] Martine Hollander & Jeroen van Dillen, 'Women Refusing Standard Obstetric Care: Maternal Fetal Conflict or Doctorpatient Conflict?' (2016) 3(2) *Journal of Pregnancy and Child Health* 1-4.

especially evident in provider responses to birth plans.[77] Women rely on birth plans and spend a significant amount of time considering their need to be *feel* safe and healthy during pregnancy, labour and birth, which they set out in their birth plans.[78] Birth plans, at law, are an offer from the woman, setting out the types of care she wants, in return for which a public hospital will receive the Medicare funds which would ordinarily be received by the woman or a private provider will receive payments for providing that service. They are, in effect, evidence of the terms on which the woman is agreeing to accept medical treatment and the closest thing to a record of consent.

Personnel at both public and private hospitals behave in evasive or misleading ways when presented with birth plans. With rare exceptions, they will not expressly reject the birth plan or honestly declare that they are unable support the plan. Most will accept the document without reviewing it or say they are placing it in the woman's file. In reality, there was never any intention to follow an individualised birth plan which, by its very definition, is at odds with mandated routine procedures and assembly line care. With alarming consistency, we hear time and again from women who say that hospital staff or the private obstetrician took the birth plan and either 'lost it' or ignored it once the woman presented in hospital. Others will deny that the birth plan was ever received or claim that the person who received the plan no longer works at the facility.

These evasive practices deny women the opportunity to make informed choices before they are in labour and have nowhere else to go. Public hospitals know that women need time to adjust their plans because they are either restricted to that hospital's catchment area or are located too far away from another hospital. Alternative plans need to be made *before the last trimester* and well before the woman presents in labour. In regional areas, the reluctance to disclose information that will encourage women to pursue alternate arrangements is, in part[79], financially driven. In NSW, if regional facility booking numbers are sufficiently low, the Department will move to dismantle the service altogether. Declining numbers also mean less revenue for that facility in the next budget.

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[77] Hannah Dahlen and Bashi Kumar-Hazard, 'Don't Throw the Birth Plan Out with the Bath Water!' (2016) *Ethics Centre*, Sydney <https://ethics.org.au/dont-throw-the-birth-plan-out-with-the-birth-water/>

[78] PT Simkin, 'Birth Plans: After 25 Years, Women Still Want to Be Heard' (2007) 34(1) *Birth* 49-51

[79] Another driver is the harmful gender stereotypes that many providers hold in relation to women. These will be discussed below.

Financial incentives also drive, in part, the reluctance to disclose in private care. Women report that private providers will accept a birth plan without disclosing that they have already mandated routine processes and guidelines they expect staff to follow at the private hospital in which they practice. As one manager at advised:

"The patient is **not** our client. The doctor is our client."

Women who discover that their private provider has 'suddenly' had a change of heart will also struggle to change providers after 28 weeks' gestation. This is because there is no incentive for another provider to accept a woman into their care after the significant Medicare, insurer and out-of-pocket pregnancy planning fee has been paid to someone else.

What is especially concerning is the culture of vilifying women for the choices they make in childbirth, even after they have lost a child. White, male doctors are frequently asked by conservative media pundits or religious groups to be the authoritative voice on women's choices. The responses they give, in this day and age, have been disappointing, to say the least. These are just some of the statements we have seen in news reports:

> 'These women, these couples are not stupid, they are selfish', said WA Australian Medical Association President and obstetrician Dr Michael Gannon.[80]
>
> Australian Medical Association WA president Dave Mountain said there should be [criminal prosecutions] to encompass the 'wild extremes' of homebirths, foetal alcohol syndrome and unborn babies affected by their mothers' drug use.[81]
>
> As a Wodonga obstetrician, Dr Pieter Mourik, says, the natural birth lobby 'has been advocating dangerous practices and I believe the media has a responsibility to publish these cases when a totally

[80] Laura Gartry and Belinda Arrow, 'Women Ignoring Medical Advice on Homebirth 'Selfish': Peak Medical Body Says', *ABC News* (online, 18 June 2015) <http://www.abc.net.au/news/2015-06-18/women-choosing-homebirths-selfish-peak-medical-groups-says/6555662>.

[81] K Campbell, 'Charge Reckless Mums: Doctors' Union', *The West Australian* (online, 27 February 2012) <https://thewest.com.au/news/wa/charge-reckless-mums-doctors-union-ng-ya-328979>.

> avoidable baby death occurs … so gullible, pregnant women are not persuaded to follow these risky practices'.[82]
>
> But sadly the minority who choose to be different seem to never accept the blame for their ridiculous decisions when things go wrong.[83]
>
> …as one of the most extreme proponents of home births, Joyous Birth has been influential in persuading pregnant women to shun medical intervention in childbirth. It describes as 'birth rape' doctor intervention that saves the lives of mothers and babies…[84]

Abusing and disrespecting pregnant women has been fair game in NSW and Australia. According to these statements, women are selfish, ungrateful, gullible, ridiculous, irresponsible and extreme, and they should be subject to criminal prosecutions for harming themselves and publicly vilified for their personal preferences. We are not aware of any such extraordinary public attacks on men. Such statements devalue the status of women to little more than reproductive vessels that need to be controlled. Providers understand that such sensationalised statements are likely to make the front page of the news and it serves a purpose – to receive social endorsement for the control and coercion pregnant and birthing women face in maternity wards every day.

Social commentary and critique about homebirth are largely driven by opinions ignorant of the human and legal rights implications of denying reproductive choice and control. Determining the circumstances of one's birth is a reproductive and fundamental human and legal right.[85] More importantly, attacks on homebirth or other models of care are a convenient distraction from the real issue – the obstetric violence women face in facility based care. When consumers experience abuse and violence in institutional care, many perceive it as a

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[82] Ibid.

[83] K Katsambanis, 'Karalee Katsambanis: Home Birth will Always Be a Game of Russian Roulette', *The Sydney Morning Herald* (online, 14 April 2016) <https://www.smh.com.au/opinion/karalee-katsambanis-home-birth-will-always-be-a-game-of-russian-roulette-20160403-gnx6wi.html>.

[84] M Devine, 'Homebirth is Not a Safe Birth', *The Sydney Morning Herald* (online, 9 April 2009) <https://www.smh.com.au/lifestyle/a-home-birth-is-not-a-safe-birth-20090408-a0s3.html>.

[85] *Ternovszky v. Hungary* [2002] ECHR 2010-XII (Application no. 67545/09). See also F Diaz-Tello and B Kumar-Hazard, 'What are Women's Legal Rights When It Comes to Choice in Pregnancy and Childbirth?' in HG Dahlen, B Kumar-Hazard and V Schmied (eds), *Birthing Outside the System: The Canary in the Coalmine* (Routledge, 2020), Chapter 14; F Diaz-Tello, 'Invisible Wounds: Obstetric Violence in the United States' (2016) 24(47) (2016/09/01) *Reprod Health Matters* 56-64; LM Paltrow, 'When Becoming Pregnant Is A Crime' (1990) 9(1) (1990/01/01) *Crim Justice Ethics* 41-7.

profound betrayal of trust. That betrayal, combined with the trauma they have suffered, makes it almost inconceivable that they would utilise facility-based care again. Consumers who homebirth consider it a safeguard from the obstetric violence[86] perceived to be a common feature of institutionalised and/or standardised Australian maternity health services.[87] In fact, abused and traumatised consumers who cannot afford a PPM will go to extraordinary lengths to protect themselves, even if it means putting themselves in risky situations and/or birthing without any assistance. In their minds, anything is better than the abuse they experienced at the hands of controlling strangers.[88] This is no different to someone who is unable to return to a place at which they were sexually assaulted. It is both unconscionable and unethical, in particular for providers who are perpetrators, to ridicule, shame and threaten pregnant women for seeking to protect themselves from such institutional abuse.[89] Those who do so are either denying the abuse that women face in institutional care (an act which is in itself a form of abuse) or forcing women to conform to harmful gender stereotypes about suffering and sacrifice in pregnancy and childbirth.

3. Discriminatory Laws and Practices

a) HCCC Complaints

HRiC has reviewed hundreds of complaints from women in various jurisdictions. In NSW, complaints to health care regulators about obstetric violence, unless accompanied by injuries to the infant or major and enduring injuries to the

[86] Melanie K Jackson, Virginia Schmied and Hannah G Dahlen, 'Birthing Outside The System: The Motivation Behind The Choice to Freebirth or Have a Homebirth with Risk Factors in Australia' (2020) 20(1) *BMC Pregnancy and Childbirth* 254; H Keedle et al, 'Women's Reasons For, and Experiences of, Choosing a Homebirth Following a Caesarean Section' (2015) 15 (2015/09/05) *BMC Pregnancy and Childbirth* 206.

[87] Hazel Keedle, Warren Keedle and Hannah G Dahlen, 'Dehumanized, Violated, and Powerless: An Australian Survey of Women's Experiences of Obstetric Violence in the Past 5 Years' (2022) *Violence Against Women* 10778012221140138; H Keedle et al, 'From Coercion To Respectful Care: Women's Interactions With Health Care Providers When Planning a VBAC' (2022) 22(1) *BMC Pregnancy Childbirth* 70; Hazel Keedle, Bashi Hazard and Hannah Dahlen, '1 in 10 Australian Women Report Disrespectful Or Abusivecare In Childbirth', *The Conversation* (Comment, 6 Dec 2022) <https://theconversation.com/1-in-10-australian-women-report-disrespectful-or-abusive-care-in-childbirth-186827>.

[88] M Jackson, H Dahlen and V Schmied, 'Birthing outside the system: perceptions of risk amongst Australian women who have freebirths and high risk homebirths' (2012) 28(5) *Midwifery* 561-7; EC Rigg et al, 'A Survey of Women in Australia who Choose the Care of Unregulated Birthworkers for a Birth at Home' (2020) 33(1) (2018/12/07) *Women Birth* 86-96.

[89] Michelle Oberman, '"Mothers and Doctors" Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts' (2000) 94 *Nw U L Rev* 451, 472.

woman, are either dismissed, ignored or retrospectively substantiated by the doctrine of medical necessity. This occurs because:

(a) Practice standards are focussed on and developed around medico-legal outcomes, not human rights;

(b) Women's complaints are referred back to professional bodies with a vested interest in maintaining the current practice standards as a defence to medical liability claims (see below) and to minimise the cost of insurance premiums[90];

(c) The practice standards are written by health or medico-legal professionals who recommend the type of care that requires rights violations.[91]

Complaints about obstetric violence have had little to no impact on quality or standards of care in NSW. Recent studies indicate that facility personnel rarely see complaints as an opportunity for improvement in quality of care. Personnel are already well aware of the human rights abuses that will be the subject of any discussion but do not regard these complaints as relevant to their standard of practice.[92] Instead, the complaints are viewed as coming from patients who are inexpert, distressed or advantage-seeking. Staff assume that their role is to either reinforce themselves as the authority in decision making and to just be an empathetic listener.[93]

There is also a general reluctance to engage with, or acquire knowledge about, women's fundamental human rights. To date, every hospital that has agreed to meet has cancelled when informed that a human rights lawyer will be supporting the family. The Department of Health does not respond to correspondence about human rights abuses unless litigation is anticipated. Professional bodies such as RANZCOG, the ACM, and individual providers are also reluctant to engage directly with human rights lawyers. In Queensland, since the introduction of the

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[90] Kereen M Reiger, "Knights" or "knaves? Public policy, professional power, and reforming maternity services" (2011) 32(1) *Health Care Women Int.* 2-22.

[91] Melissa Davey, "A decade after the Butcher of Bega, red flags are still being missed" *The Guardian Au* (27 June 2018) <https://www.theguardian.com/australia-news/2018/jun/28/a-decade-after-the-butcher-of-bega-red-flags-continue-to-be-missed?CMP=share_btn_link>.

[92] Marta Spranzi, 'Humanity and "Ordinary Abuse": Learning from Hospital Patients' Letters of Complaint' (2018) 61(2) *Perspectives in Biology and Medicine* 264-278.

[93] M Adams, J Maben and G Robert, "It's Sometimes Hard to Tell What Patients are Playing At': How Healthcare Professionals Make Sense of Why Patients and Families Complain about Care' (2018) 22(6) (20170822) *Health (London)* 603-623.

Human Rights Act 2019 (Qld) we have been invited to speak to facilities about the human rights of women in the provision of maternity care. On every occasion, unless mandated, medical professionals were apparently 'too busy' to concern themselves with the human rights of the women in their care.

In our experience, women pursue complaints for altruistic reasons. They turn first to their careprovider for a discussion and, if not satisfied, resort to formal complaints. Many pursue complaints in the belief that they can help protect others from suffering these harms in the future:[94]

"I've tried to write my story to [**]. Every time I try though, I hear [the doctor's] voice jeering at me telling me I'm just a baby crying for not getting her way. If writing my story helps just one woman avoid the abuse I've experienced, it was worth the pain of remembering."

"I hope change is made in how doctors treat women during childbirth. It is an absolute disgrace what is happening now."

A significant reason for the failure to protect women from obstetric violence is the over-reliance on service providers to self-assess complaints in maternity care. Policy directives, adherence to outcomes, practice standards and the education and training of medical and facility personnel are underpinned and driven by liability concerns and recommendations from insurers. These mechanisms encourage the treatment of pregnant women as a means to an end in facilities for childbirth, at the expense of fundamental human rights. Even if women are successful in getting the HCCC to investigate a complaint, abuse and disrespect is treated as a "soft skill" and, at most, women will be informed that the provider was 'urged' or 'encouraged' to improve their bedside manner.

b) Medical Liability Laws and Practice

Medical liability and defensive medicine feature heavily in the practice of providers. As noted above, successful compensation claims turn into insurer's conditions for practice which turn into hospital policies and practice standards.[95]

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[94] RC Boothman et al., "A Better Approach to Medical Malpractice Claims? The University of Michigan Experience" (2009) 2 *J Health & Life Science Law* 125, 133.

[95] Tim Draycott, Rachel Sagar and Susannah Hogg, 'The role of insurers in maternity safety' (2015) 29(8) *Best Practice & Research Clinical Obstetrics & Gynaecology* 1126-1131.

Doctors commonly assert that liability mandates the overuse of interventions in maternity care, the overriding of informed consent and the focus on the fetus as a patient.[96] The reality is somewhat more complex. Tort reforms were introduced in 2002 in NSW[97] which severely curtailed consumer rights to redress for certain harms, such as by reintroducing a modified *Bolam Principle,* preventing certain claims for personal injury and death, imposing cost penalties on small claims, restricting claims for psychological harms, and placing caps on damages. The intervention rates in NSW have nevertheless continued to rise. In 2011, 26.5% of women in NSW had an induction. In 2021, 35.5% of women in NSW had an induction.[98] In just 10 years, NSW Caesarean Section rates have risen from 31.3% to 37.8 percent.[99] The WHO recommendation for an optimal CS rate is between 10-15 percent.

Economic indicators suggest these perceptions aren't the only factors to drive interventionist practice.[100] As we have noted throughout this report, far more serious matters are at play, such as the adoption of the more restrictive practices of colleagues to boost volume of deliveries and receive higher reimbursements, and scheduling procedures for convenience or profit.[101]

(i) Gender Bias in Medical Liability Laws

Harms arising from human rights violations, unless associated with deviations from accepted medico-legally endorsed practice, are not recognised[102] and

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[96] CT Johnson et al, 'Malpractice and obstetric practice: the correlation of malpractice premiums to rates of vaginal and cesarean delivery' (2016) 214(4) (2016/01/16) *Am J Obstet Gynecol* 545-546.

[97] The Hon Justice Ipp, *Review of the Law of Negligence* (Final Report, Cth: Sept 2002).

[98] Australian Institute of Health and Welfare (Cth), *Australia's Mothers and Babies* (Web Report, Canberra: 29 June 2023) https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/labour-and-birth/onset-of-labour.

[99] Australian Institute of Health and Welfare (Cth), *Australia's Mothers and Babies* (Web Report, Canberra: 29 June 2023) https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/labour-and-birth/method-of-birth.

[100] Cano Urbina J & Montanera D, "Do Tort Reforms Impact the Incidence of Birth by Cesarean Section? A Reassessment." (2017) 17(1) *International journal of health economics and management* 103-122.

[101] Joshua S Gans and Andrew Leigh, 'Born on the First of July: An (Un)natural Experiment in Birth Timing' (2009) 93(1) *Journal of Public Economics* 246-263; Joshua S Gans and Andrew Leigh, 'IZA DP No 6165: Bargaining Over Labor: Do Patients Have Any Power?' (2012) 88(281) *Economic Record* 182-194.

[102] V Tonei, 'Mother's mental health after childbirth: Does the delivery method matter?' (2019) 63 (2018/12/31) *J Health Econ* 182-196.

therefore devalued and dismissed as unimportant in medico-legal culture and practice.[103]

First and foremost, this is because damages are the gist of a claim in medical negligence. It is designed to compensate women and babies for physical harms caused after the clinician is shown to have breached established standards of care or peer practice, and those breaches caused the injury sustained by the woman or infant. Psychological injury alone has not been enough to substantiate a claim, particularly since amendments were introduced into the *Civil Liability Act 2002* (NSW) to cap damages and recoverable costs. For this reason, the mental health injuries and post-traumatic stress disorders caused by abuse and mistreatment are of no consequence to health care facilities and providers.

Second, even if damage can be proven, another significant barrier to justice for women comes from the modified version of the Bolam Principle in relation to diagnosis and treatment, reinstated under sections 5O(1) and 5O(2) of the *Civil Liability Act 2002* (NSW) (CLA). Under these provisions, a provider will not be negligent if the treatment provided was based on a peer accepted practice. For example, a woman may have endured fourth degree perineal tears because an obstetrician performed an episiotomy she did not consent to while performing a forceps delivery. If it can be shown in defence that (a) the woman consented to the forceps delivery and (b) peer accepted practice is to perform both the episiotomy and forceps as part of the same treatment, that provider will not be negligent for the fourth degree tears even if it can be shown that the episiotomy caused the fourth degree tears. Following a court ruling to that effect, it will become standard practice to perform an episiotomy when applying forceps without the need for additional consent. In other words, the prevailing provider practice get the last word on how the woman will be treated. In this way, sections 5O(1) and 5O(2) of the *Civil Liability Act 2002* discriminates against pregnant women, disincentivises improvements in care, and encourages providers to continue to violate fundamental human rights. What would normally constitute assault and battery is now a peer-accepted standard of care.

"You can't get sued for a C Section"

[103] F Diaz-Tello and B Kumar-Hazard, 'What are Women's Legal Rights When It Comes to Choice in Pregnancy and Childbirth?' in HG Dahlen, B Kumar-Hazard and V Schmied (eds), *Birthing Outside the System: The Canary in the Coalmine* (Routledge, 2020), Chapter 14; A Barrett and AJ Kotaska, 'Obstetricians discuss the Coal mine and the Canary' in H.G Dahlen, B Kumar-Hazard and V. Schmied (eds), *Birthing Outside the System: The Canary in the Coalmine* (Routledge Research in Nursing and Midwifery, 2020) Chapter 20.

Finally, medical malpractice in maternity care relies on maintaining harmful gender stereotypes. Cases are run on the basis of physician value-sets such as "doctor knows best" and "naïve/ignorant/helpless woman". When such value-sets are used in the context of the fictional maternofoetal conflict (or the "Obstetric Dilemma" as it was described earlier), they lend themselves to an endorsement of the systematic subordination of one set of patient's interests as against the fictional "other" – *at the behest of the doctor*. In a society where women hold less intrinsic value, and injuries to the infant are taken more seriously, there is a tendency to hold that the 'doctor knows best' even if it was to force or coerce the woman into submitting to a procedure in the interests of producing a live infant. A perverse result follows – whereas human rights principles emphasise the independence, agency and equality of women, medical malpractice presupposes an ignorant patient, dependent on an expert who was expected to take control of her care in order to secure an optimal outcome. The expert will be found to have breached their duty of care if they *didn't take control of her care and didn't impose treatments the expert believed to be necessary, irrespective of consent*.

(ii) Gender Bias in Legal Practice

Access to justice has always proved challenging for women, let alone those who have suffered human rights violations. This challenge is greater if they are economically or racially disadvantaged.

Access to justice requires either the availability of a publicly funded lawyer, funds to retain a privately funded lawyer, or reliance on a contingency fee structure. Publicly funded lawyers in Australia prioritise criminal defence over civil prosecutions. They do not (yet) recognise obstetric violence as a human rights violation.

Privately funded lawyers are price prohibitive for most new parents and would be considered an indulgence – particularly if the woman is on unpaid maternity leave.

The contingency fee structure is assumed to provide solutions to access to justice concerns and a means of redress for the most vulnerable and most injured. Unfortunately, it also presents significant access challenges for women. The contingency fee structure's efficacy is predicated on the promise of sufficient returns to both compensate and cover the costs of bringing the case. Contingency fee lawyers will only accept cases in which they expect a significant damages award.

Precedent findings in medical malpractice cases tend to downgrade maternal injury and prioritise fetal injury. Winning is rare in maternal injury only claims and often justified only because of serious or permanent maternal injury.

Consequently, precedents, caps on damages and the s50 Bolam defence make maternal injury cases much less attractive to contingency fee lawyers. This constitutes a barrier to access to justice that prevents a legal remedy even before courts have had a chance to examine what could be a meritorious claim. The failure to seek redress for such claims reduces incentives for deterring harms, as reflected in facility based practice and culture today.

Gender bias also discourages health care professionals from accepting the views of birthing mothers, such that the challenge of proving the harms resulting from forced or abusive treatment becomes a significant barrier and undermines patients' efforts to seek redress. For example, Vicki Cheadle, a former patient of Emil Gayed said:

> "[The surgeon told me] Dr Gayed had botched my procedure, and that basically I would have died if I had been made to wait any longer for surgery to fix it."
>
> Cheadle immediately sought legal advice. She asked the surgeon who treated her infection to support her case with a statement, and to her shock, he told her he would not.
>
> "He threatened me, and told me he would make sure no doctor in Taree would treat my sons or myself if I took legal action against Gayed," she said. "That he would get on the stand and lie, because I was lucky any doctor operated on me and that I should respect Gayed's training and experience."
>
> Word that she was considering legal action also got back to her GP, who advised her not to proceed.[104]

We have received many similar reports from women, particular in rural and regional areas, where medical practitioners are scarce.

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[104] Melissa Davey, "'I Still Feel Mutilated': Victims of Disgraced Gynaecologist Emil Gayed Speak Out" *The Guardian* (Wed 24 June 2019 23.25 GMT) <https://www.theguardian.com/australia-news/2018/jun/25/i-still-feel-mutilated-victims-of-disgraced-gynaecologist-emil-gayed-speak-out>.

(iii) Gender bias in the broader socio-economic system

Sadly, as with sexual assault and domestic violence, women blame themselves for the violence they experience and suffer in silence. That shame is reinforced by our society. Women are told, by friends and family, that injury and suffering during childbirth is inevitable, and that a mother should be grateful to have a healthy baby. This is constantly reinforced by both careproviders and loved ones.[105]

I talked to my husband about it, and while he was so supportive and kind, he ultimately told me I got my healthy baby and that we were all ok, and that was what I needed to focus on. Everyone told me that. It made me so sad." – M.H.

Mothers also downplay their own physical injuries, while the courts and the law downplay psychological harm[106]:

I have not sought any legal action because I don't have serious medical complications from the birth, unless you count a scarred, torn urethra... – A C #1

Psychological harm also hampers a distressed new mother's ability to pursue redress:

I did not take any legal action. I was busy healing and nursing round the clock and I was so so SO angry and sad about the whole thing that I could barely even talk about it without crying. ... I still don't think anyone at the hospital would care how I was treated. I was a home birth transfer, some ignorant hippy or whatever, so clearly the Dr was just doing what needed to be done and I was hindering his care for myself and my baby, who I had placed in grave danger by not coming straight to the hospital when I began labor. It's all my fault – apparently" – P. B.

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[105] C Beck, "Birth Trauma: in the Eye of the Beholder" (2004) 53 *Nursing Res.* 28-35.

[106] Daniel Givelber, "The Right to Minimum Social Decency and the Limits of Evenhandedness: Intentional Infliction of Emotional Distress by Outrageous Conduct" (1982) 42 *Columbia Law Review* 44- 60

c) Coronial Investigations and Findings

We have observed alarming reinforcements of harmful gender stereotypes, over-reliance on the medico-legal framework, support for violations of women's human rights and the elevation of foetal personhood in coronial investigations and findings into women who choose out-of-facility birthing options. These findings give credence to facility and provider beliefs about infringing human rights and perpetrating obstetric violence.

The inquest findings set out below concerned women who either free birthed, chose unregulated birth workers or hired registered PPMs because they were desperate to avoid a maternity health facility that has abused or mistreated them. Evidence was presented to the coroner of that abuse and mistreatment, including the lengths the women went to negotiate with facilities, research alternate options and prepare themselves for adverse outcomes and mitigate their risks. For these women, the core issue was the profound breach of trust and trauma they had suffered, which was enough to create a strong aversion – in effect, a debilitating phobia – against maternity facilities and providers. These mothers were terrified that, at the end of another abusive birth, they would not be in any position to function physically or mentally, let alone parent their children.

I deliberately chose a homebirth against my gp's advice after a devastating experience in hospital for my second birth….I wouldn't send my dog to hospital. There are no choices for women. In order of importance it is doctors/legalities first, baby second, mother last.

From a human rights perspective, several concerning themes emerged from our review of the investigations and findings which, in effect, legitimise and endorse the abuse and mistreatment by providers in facilities. As shown below, these findings endorsed the very human rights violations that women said had made them flee systemically abusive, standardised care.

(i) Distrust for Women's Agency and Decision-Making Capacity

In Dillon & Hadley's "*Manual for Coroners*", the authors (one of whom is a NSW Coroner) declared their pre-conceived views about women who choose homebirth:

> "Home Birth Issues

> The safety of home births is a controversial issue that tends to generate passionate views on both sides of the question. Unfortunately, sometimes, midwives and parents err on the side of "natural birth" when it is unsafe – even obviously unsafe – to do so."[107]

This statement is revelatory. It implies either that adult competent women are not able to make decisions for themselves or that adult *pregnant* women are *not competent* to make decisions for themselves. This infantilising of women is discrimination on the basis of sex and pregnancy. It also constitutes a breach of Australia's obligations as a contracting party to CEDAW.

Of course it's a woman's right to choose, but….

But the authors did not stop there. They went on to cite two publications which apparently supported the claim that pregnant women owed a moral responsibility to society to prevent injury to the unborn infant by birthing in hospital.[108]. The first is a sensationalist opinion piece from a lifestyle e-magazine ('Mamamia').[109] The second is a controversial publication by a conservative ethicist and an anti-homebirth obstetrician arguing that harming a fetus by having homebirth should constitute a crime (*Savulescu Article*).[110]

Coroner Dillon cited these two publications in the *Inquest into the death of Bodhi Eastlake-McClure*, and repeated his claim that "women and midwives had a moral responsibility to prevent injury to the unborn infant".[111] While doing so, the Coroner may have overlooked Professor of Applied Philosophy Hugh Lachlan's response, which highlighted the flaws in the *Savulescu Article* and, consequently, the Coroner's claim:

> Their conclusion is highly debatable on two grounds. It is not clear that home deliveries are riskier than hospital ones. Even if they are riskier,

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[107] H Dillon & M Hadley, *The Australasian Coroner's Manual* (The Federation Press, Leichardt, 2015), 154-155.

[108] Ibid, 155-156.

[109] Mammamia News, "Homebirths killed three babies. It's official" (June 10, 2012) at <https://www.mamamia.com.au/home-birth-killed-three-babies-coroner-says-they-could-have-lived>

[110] J Savulescu & L de Crespigny, "Should it be a crime to harm an unborn child" (2014) The Conversation (21 Mar), https://theconversation.com/should-it-be-a-crime-to-harm-an-unborn-child-24407

[111] H Dillon, Inquest *into the death of Bodhi Eastlake-McClure* (2014) *State Coroner's Court of New South Wales, Glebe,* [77-8].

> it doesn't follow that it is morally wrong for women to choose to have them.
>
> …There might also be particular risks associated with hospital deliveries. For instance, mothers and babies might be more exposed to infectious diseases there. They could also run the risk of injury or death in a road accident on their journey to and from the hospital. These risks are slight but so too are the risks of disability that Crespigny and Savalescu talk of. It is not clear that it is irrational for a woman to choose to have a baby at home rather than a hospital. It isn't possible to avoid risk if one chooses to have a baby. And it isn't obvious that one could possibly know that, all things considered, one choice was riskier than the other.[112] (Emphasis added, Lachlan, 2016)

It would be useful for women if coroners declared such views at the commencement of their investigations into homebirth. It would save women who try to explain that the real problem lies with facility-based mistreatment, or that they are, in fact, entitled to decide whether or not to access a treatment option, a lot of time.

(ii) Devaluing the Significance of Facility-based Mistreatment

Australian women have taken to online forums to describe stories of unwanted, painful, traumatic and violating medical interventions in childbirth. These stories highlight the discord between their desire to be respected for their choices and their reality of facilities forcing the birth process, denying their requests and experiencing abusive and inflexibly applied hospital policies and practices.[113]

Coronial inquests about out-of-hospital births have consistently received evidence of the violence and disrespect mothers experience in facilities. Sadly, the complaints by mothers and fathers are concisely recorded in the findings and then superseded by lengthy, written explanations about the undue medical risks the women took, women's questionable decision-making capacity and their

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[112] Hugh Lachlan, "There is no moral imperative for women to give birth in hospital" (2014) *The Conversation* (8 Feb, The Conversation Media Grp, 1.32am AEDT) < https://theconversation.com/there-is-no-moral-imperative-for-women-to-give-birth-in-hospital-22732>.

[113] L Cole et al, "Trying to Give Birth Naturally was out of the Question": Accounting for Intervention in Childbirth (2019) 32(1) *Women and Birth* e95-e101.

childlike proclivity towards being so easily misled by errant midwives or social media or both.[114]

Underpinning these views are the discriminatory, harmful gender stereotypes that women are not capable of making decisions in their best interests and must sacrifice their physical and mental health to produce a live, healthy baby.

(iii) Publicly Vilifying Women Who Complain About Obstetric Violence

The lack of consideration given to trauma and the prior harms suffered by the women has serious implications for the coroner's assessment of the women's choices in childbirth. In the *Inquest into the Death of Roisin Frazer*, Janet Fraser, who made the decision to freebirth her baby, told the coroner that she had experienced a traumatic birth in hospital which she was desperate to avoid again.[115] To cope with the abuse she suffered at the facility, Mrs Frazer created a website entitled "Joyous Birth" which contained details of the actual abuse Mrs Frazer suffered at the hands of her careproviders. Her anger and frustration at being violated and betrayed by her providers was manifested in the words she used to describe her experiences. Like many women experiencing symptoms of PTSD, she attempted to reframe her experiences by imagining what she would do if she was given another chance to confront the perpetrators. Coroner Mitchell dismissed the significance of her words and the trauma which drove the creation of her website. He was more concerned that Frazer's written objections to specific and clear examples of assault and battery apparently constituted a threat to unnamed providers everywhere. This is the clearest example we have yet seen of a judicial endorsement of gender-based violence against women:

> "Another piece appearing [on the website] is entitled "Birthrape, Birthrape, Birthrape, Birthrape, Birthrape." Here medical and nursing staff are warned – one might well say threatened, should they 'shove an arm in a woman who's screaming 'no', rupture the membranes because you have to tick the box and comply with 'protocol' even

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[114] Schapel, *Inquest into the deaths of Tate Spencer-Koch, Jahli Hobbs and Tully Kavanagh*: File Number 17/2010 (0984/2007, 0703/2009) & 45/2011 (1628/2011) Coroners Courts of SA, (2012), (Deputy State Coroner E Schapel); Olle, *Inquest into the Death of* Thomas *Fremantle*: COR 2010 4201 (8 April 2014) Vic Coroners Court (Coroner J Olle); B Kumar-Hazard, 'The role of the coroner in Australia: listen to or ignore the canary?' in H.G Dahlen, B Kumar-Hazard and V. Schmied (eds), *Birthing Outside the System: The Canary in the Coalmine* (Routledge Research in Nursing and Midwifery, 2020) Chapter 14.

[115] Mitchell, *Inquest into the Death of Roisin Frazer:* File No 0817/2009 (28 June 2012) NSW Coroners Court (Deputy State Coroner Mitchell), [31].

> when the woman screams 'no,' slash a woman's vagina with scissors and she's screaming 'no.'" The piece goes on to say that "your green gown – Your stupid hospital gowns" will not protect you" and "I will charge you."[116]

Coroner Mitchell also used gendered notions of what constitutes a "good mother" to scold and shame Mrs Frazer for apparently putting her personal and political interests before her unborn baby.

The Committee should know that, following Coroner Mitchell's discriminatory attacks on Mrs Frazer, she was stalked for many years by a Newscorp journalist. He told her that he would follow and expose her "baby killing activities" for the rest of her life. She and her partner separated, she sold her home to pay for her legal fees and had to move to another region, hours away from Sydney, in order to give her children some privacy. She is now a single parent and full-time carer of a hospital-born child with learning difficulties – one of her motivating factors (the other being the abuse she faced) for avoiding future facility-based births. All this happened because of the choices Mrs Frazer made in relation to her own body. We are not aware of any instances in Australia where this has happened to a man.

(iv) Denying Women's Human Right to Bodily Autonomy

In the *Inquest into the Death of Thomas Fremantle* (Fremantle Inquest), Coroner Olle erroneously asserted that:

> "…the wishes of parents should be considered and where possible, accommodated. However, the safety of the child is paramount, and it follows, in cases of identified high risk, the wishes of the parents always secondary to ensuring the safest birthing process. (Emphasis added)[117]

This statement is both legally incorrect and in violation of a pregnant woman's human rights. There is no child at law – there is only the pregnant woman and her body. To assign personhood to the unborn fetus and to give it non-existent legal rights is to override the pregnant woman's right to life and privacy and her legal right to informed consent and autonomy. To decide that her wishes can

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[116] Mitchell, *Inquest into the Death of Roisin Frazer:* File No 0817/2009 (28 June 2012) NSW Coroners Court (Deputy State Coroner Mitchell), [29].

[117] Ibid, [54].

be overridden is to endorse the violation of her right to bodily autonomy and integrity, and freedom from discrimination. To equate her bodily integrity with the so-called rights of the father is discrimination and a violation of her right to equality and health. These are all rights that are stipulated under CEDAW, which our governments and our courts are obliged to take into account when making such determinations. Finally, to claim that providers can decide the 'safest birthing process' is to endorse assault and battery, apparently in order to protect a fictitious person not recognised at law.

d) Police Investigations

In cases involving serious facility-based physical abuse or sexual assault, our clients have attempted to make reports to NSW police. Our clients have been turned away and we are told that it is not possible for medical providers to commit criminal assault if they are trying to save a baby – a statement that is both untrue and manifestly discriminatory. No effort is made to even investigate the complaint.

By contrast, when an ambulance is called to expedite a homebirth transfer to hospital, the police will attend as if a crime has been committed. Women have reported police entering the property without authorisation, turning all the lights on, several male police personnel standing over the mother while she is delivering the baby, conducting unauthorised search and sweeps, arresting and detaining PPMs, and questioning everyone present. Some members of the police force can barely contain their apparent disapproval of the woman's choice to birth in the privacy of her home. This happens regardless of whether or not there has been an adverse event. The following description was given by a woman whose baby was stillborn at home:

When we got out of the ambulance, there were two policemen waiting for us. The hospital didn't have a bed for us, so J and I sat with bub in the staff waiting room, with an armed policeman outside the door.

Staff members kept coming in, looking shocked and leaving very quickly until I asked the cop to stop them from coming in. He didn't really care. He just kept rushing us to say goodbye to our baby, telling us that it was late and that he was waiting to send the body to the pathologist as there would be an inquest. I asked why and who decided that, but no one would answer me. All the staff just avoided looking at us.

When I had to go to the toilet, I was made to keep the door partially open so the cop could keep an eye on me. We were later 'escorted' home in a police car, and then we stood outside while the police entered the house, took everything as evidence, they searched our fridge, pantry, clothes, bedrooms and collected all these samples. They even raided the garbage bins. They put yellow crime tape around the house as the neighbours watched to mark it as a crime scene.

All I wanted to do was climb into bed and cry, but then they questioned us for hours. We were treated like criminals. My punishment for choosing to give birth in the privacy of my home.

Police investigations of homebirths and freebirths on behalf of the Coroner urgently require scrutiny and transparency. No crime has been committed. The Police, however, behave as if crimes were committed. They will tell family members that statements to the coroner are required and that police are entitled to enter the premises, to search and seize evidence (without a warrant) and question anyone who is present – often within minutes of a woman giving birth. They will question the role of everyone at the birth as if aware that something suspicious was happening behind closed doors. No one tells the family that they can, for religious or personal reasons, refuse an autopsy and an inquest, that they do not have to provide statements and that the police cannot enter the premises or take anything without a warrant. The point here is these families are denied procedural fairness ordinarily afforded to someone who has committed a crime, all because *an adult competent woman is asserting her right to bodily autonomy*.

These police behaviours support a misconceived and self-perpetuating belief that pregnant women are not entitled to the same rights as everyone else. We are aware that the coroner and facilities have a protocol in place for reporting and collecting information about an adverse birth event. A similar protocol needs to be developed and published for women who choose out of facility births.

e) The Department of Communities and Justice (DCJ)

We regularly advise women who inform us that their GP or the local hospital has notified them to DCJ because they have refused a particular medical treatment.

We receive at least one such report a week.

I declined a cesarean section in August 2021. [DCJ] and a police officer showed up to my house saying I had to go or they would hand cuff me in front of my children. To avoid this, I reluctantly went in. I was then locked in a room with a security guard posted outside my door and the [DCJ case worker] came in and told me if I didn't consent to a CS that my other children would be taken away from me.

Out of fear I agreed.

I was forced to see Brighter Futures for 8 months after the birth. I was told by DCJ it was so they could monitor me and check in any time. I was told by Brighter Futures that DCJ had told them my baby was failure to thrive. Which she was never diagnosed with and was always a healthy chunky baby who met all her milestones. It seems I was being punished for my birth choices or that they were intimidating me in case I figured out what they did to me was illegal and wrong.

In my next pregnancy I was keen on a VBAC. The Ob at [x] Hospital verbally abused me when I declined so I made a complaint to the Maternity Consumer Network who wrote to the hospital to be discharged so I could find care somewhere else.

Child protection called me again asking about my birth plans, but I knew my rights a bit better this time and quoted the NSW Health Consent Manual at them…. 6 months after the birth of my child at [x], DCJ visited me again saying they were there because I put my child at risk for my birth choices.

Section 25 of the *Children and Young Person's (Care and Protection) Act 1998* (NSW) (the **Act**) provides that a person who has reasonable grounds to suspect, before the birth of a child, that the child may be at risk of significant harm after his or her birth *may* make report to the DCJ.

Pre-natal reports are not mandatory. An unborn fetus is not a person or a child under the Act. It is questionable as to whether section 25 of the Act is consistent with the principle of equality before the law in the Australian Constitution.

To enliven DCJ powers under section 25 of the Act, the reporter must have (a) *reasonable grounds* to suspect (b) risk of *significant harm* (c) to the child ***after*** *the birth*. The words "after the birth" are not, in their natural and ordinary meaning, the same as "during the birth" or "as a result of the birth". Providers are making pre-natal reports against women in circumstances where they could not possibly

have formed reasonable grounds to suspect that the infant is at risk of significant harm *after the birth*. There are no reasonable grounds for assuming that an adult competent woman who declines treatment before the birth is going to put her child at risk of significant harm after the birth. Even if a provider believes the woman should have a treatment, they are not entitled to force that decision on the woman. We need to remember that providers can, and regularly do, get things wrong. Providers may also, like everyone else, be driven by harmful gender stereotypes about women and believe that they are entitled to control and coerce women. These beliefs and interests cannot and should not form the basis for reasonable grounds to suspect significant harm.

While section 25 of the Act gives the DCJ the authority to receive a pre-natal report, it does not give the DCJ the authority to coerce pregnant women into enduring medical treatments.

Administrative bodies are required, under the stewardship of government, to ensure that their actions do not infringe the human and legal rights of women. The DCJ is obliged, as an administrative body acting on behalf of the government, to ensure that it does not violate the human rights of pregnant women. It has been misusing its very limited remit under s25 to threaten and coerce pregnant women, on behalf of facilities and GPs, into accepting treatments they do not want. This discriminatory law has, unsurprisingly, overwhelmingly affecting Indigenous women and facilitated the removal of a record number of indigenous infants under the previous NSW Government.[118] Section 25 is a violation of the human rights to bodily autonomy, equality, privacy, self-determination, protection of the family as a fundamental unit of society and to be free from discrimination, and degrading or inhuman treatment.

The DCJ has publicly insisted that it has the power to protect unborn children and does so on a regular basis, but has not been able to point us to the legislative provisions it is apparently relying on to coerce pregnant women into submitting to medical treatment.

[118] Hazard, B, "Respectful Maternity Care for Indigenous Mothers" (2017) *Aust Midwifery News*, Practice Matters, 37.

4. Power Imbalance in the Provider-Patient Relationship and Abuse of the Doctrine of Medical Necessity

"I've recently seen an example of what I would call obstetric violence, and it showed me that sometimes it doesn't matter how educated or empowered the woman is, sometimes obstetricians just feel as though their medical training gives them authority over a woman's body during labour and birth. We can make reports and we can escalate them, but this perceived authority seems to be a culture amongst a significant proportion of obstetricians."

No other profession has the social legitimacy, in spite of its role as a profit-making service provider, to publicly and morally censure women through the use of harmful gender stereotypes with impunity and, at times, with state and judicial endorsement. Members of the profession feel confident and secure enough to speak on behalf of women, openly attack anyone who makes health choices they do not approve of, dismiss consumer concerns about mistreatment, reframe social debate around human rights and risk, publicly disparage their competitors and behave in ways that raise barriers to entry for new entrants in the private maternity health services market.

This is the power that medical practitioners carry into the birth room, even before they assert their expertise and training as against a labouring woman. Once in the birth room, the asymmetrical relationship is reinforced by a team of people, devices, technological aids and resources designed to support the doctor, while the labouring woman only has a fearful and equally powerless partner at her side.[119] This is the power dynamic that most families face in the birthing room. They do not stand a chance against a bullying, coercive practitioner. In fact, providers have become so accustomed to this power imbalance that the presence of anyone familiar with hospital processes, such as doulas or midwives, appears to offend them.

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[119] Ellen D Hodnett et al, 'Home-like versus conventional institutional settings for birth' (2005) *Cochrane Database of Systematic Reviews* 1; JD Harte et al, 'Application of the Childbirth Supporter Study to Advance the Birth Unit Design Spatial Evaluation Tool' (2016) 9(3) *HERD: Health Environments Research & Design Journal* 135-61.

In this context, when a medical practitioner insists that there is a medical emergency and uses it as a basis to override consent, the woman's ability to resist is utterly undermined. When women later discover that there was no emergency or that the urgency was overstated for the convenience of the facility, their sense of betrayal and distrust is significant and contributes to the trauma they suffer. It is this dynamic that encourages women to choose out-of-hospital birth, regardless of the personal risk they face. It is especially unconscionable, given this dynamic, for providers, administrators and the judiciary to then abuse or mistreat women for attempting to protect their physical and mental health as best they can in a hostile, rigid system that treats them as reproductive vessels.

III. The Physical Emotional, Psychological and Economic Impacts of Birth Trauma

For too long, victims of obstetric violence and their families have suffered in silence. The providers who seek to protect and defend them have also suffered in silence. We have represented clients and complainants who, following their birth trauma:

- attempted or committed suicide;
- self-harm, particularly with alcohol abuse;
- rejected their infants;
- suffer complex PTSD, anxiety and depression;
- suffered relationship breakdowns;
- lost their jobs;
- lost their private midwifery practice;
- lost their homes to cover their legal fees;
- relinquished their careers;
- struggled to re-enter the workforce;
- became permanent carers for infants with injuries;
- incur significant out-of-pocket costs seeking psychological or psychiatric care or specialist care for nerve damage, pelvic floor injuries, surgical complications and third to fourth degree perineal tears;
- endure faecal incontinence;
- terminate pregnancies;
- reject medical providers, especially vaccinations;
- become isolated; and

- suffer domestic violence.

IV. Recommendations

The following recommendations are based on Australia's obligations under CEDAW and supporting caselaw.

(a) *The obligation to provide quality health-care services i.e. services that are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives.*[120]

- Dept of Health to review, and instruct the LHDs to review and amend all maternity health care policies and guidelines which do not respect the human rights of women and pregnant people;

- Department of Health to review and oversee applications for accreditation and visiting rights by PPMs to publicly funded facilities, independently of the LHDs;

- All providers (public and private) to, at the time of booking, give the woman a form listing routine procedures used and relevant policies applied at the facility and/or by the provider with check boxes so women can use that form as a birth plan if they wish;

- NSW Government to remove "catchment restrictions" on public hospitals providing maternity care;

- Private providers to have the pregnancy planning discussion with women before 28 weeks, *before* the bulk of the private fees are due;

- Private providers to disclose their intervention rates and practice preferences prior to the first booking;

- Dept of Health to issue mandatory guidelines to facilities, LHDs, ambulance and the police force on facilitating respectful home to hospital transfer for women regardless of the circumstances of their birth and a

[120] UN Committee on the Elimination of Discrimination Against Women (**CEDAW**), *CEDAW General Recommendation No. 24: Article 12 of the Convention (Women and Health)*, 1999, A/54/38/Rev.1, chap. I, available at: https://www.refworld.org/docid/453882a73.html [accessed 16 August 2023].

requirement that staff remain respectful of the relationship between the woman and her support persons or PPMs at all times;

- Develop a phone app which enables women to choose the model of care that suits their choices and preferences, which includes information provided by LHDs on each facility's admission and intervention rates, and any unique services they offer such as breech birth, birth centres or midwifery group practice or homebirth;

- Aim to implement midwifery continuity of care as the minimum standard of care throughout NSW by 2028;

- Reduce or remove restrictions on consumer intake into birth centers and midwifery group practice;

- Double the number of birth centres and Midwifery Group Practices until midwifery continuity of care is fully implemented.

(b) *The obligation to establish, publicise and implement a Patients' Bill of Rights, with access to effective remedies in cases in which women's reproductive health rights have been violated, including in cases of obstetric violence.*[121]

- Develop legislation containing Health Care Consumer Bill of Rights (in consultation with women and human rights lawyers) which:

  - includes provision for the protection from obstetric violence and recognises the right to informed consent and the right to choose or refuse treatment;

  - authorises consumer video and/or audio recordings in birthing suites;

  - provides consumers with an avenue to complain against providers and/or facilities for breaches of the Act to HCCC for investigation; and

[121] *N.A.E v Spain* [2022] CEDAW C/82/D/149/2019, [16(b)(v)]; *S.F.M v Spain* [2020] CEDAW C/75/D/138/2018, [8(b)(iv)].

- gives consumers standing to commence proceedings against facilities and individual providers for rights violations, including obstetric violence.

(c) *The obligation to adopt legal and policy measures to protect pregnant women from and penalize obstetric violence, strengthen capacity-building programmes for medical practitioners and ensure regular monitoring of the treatment of women in maternity health-care centres and hospitals.*[122]

- Legislation containing the Health Care Consumer Bill of Rights to give the HCCC the power, independent of all professional bodies, to:

  - monitor and report on rights violations and violence against consumers;

  - commence investigations against individuals and facilities following a complaint or of its own initiative;

  - issue strict liability penalties against facilities or providers found to have engaged in (defined) 'minor' violations;

  - commence proceedings, on behalf of consumers, against facilities for (defined) major or repeat violations;

  - refer serious or repeat incidences of obstetric violence to the police;

(d) *The obligation to take all appropriate measures to modify or abolish not only existing laws and regulations but also customs and practices that constitute discrimination and the endorsement of harmful gender stereotypes against women.*[123]

- Repeal section 25 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) or amend the legislation to make it clear that section 25 does **not** authorise the DCJ to coerce pregnant women into accepting medical treatment;

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

[123] UN General Assembly, Convention on the Elimination of All Forms of Discrimination against Women New York, 18 December 1979 (Res 34/180 of 18 December 1979, Entry into force 3 September 1981), Art 2(f), 5.

- Ensure that all consumers are provided with the Health Care Consumer Bill of Rights including avenues for complaint, prior to their consumption of said health services;

- Mandate annual professional training for obstetricians, midwives, ambulance personnel and other health professionals on women's reproductive health rights, obstetric violence, harmful gender stereotypes and adherence to the Health Care Consumer Bill of Rights.[124]

(e) Provide specialized training to judicial, administrative (i.e. DCJ) and law enforcement personnel to recognise structural discrimination based on harmful gender stereotypes regarding pregnancy and childbirth.[125]

[124] *N.A.E v Spain* [2022] CEDAW C/82/D/149/2019, [16(b)(iii)]; *S.F.M v Spain* [2020] CEDAW C/75/D/138/2018, [8(b)(iii)].

[125] *N.A.E v Spain* [2022] CEDAW C/82/D/149/2019, [16(b)(iv)]; *S.F.M v Spain* [2020] CEDAW C/75/D/138/2018, [8(b)(iv)].