Submission by

HUMAN RIGHTS in CHILDBIRTH

to the

Australian Human Rights Commission

Submission to:

Free & Equal: An Australian Conversation on Human Rights

29 November 2019

Endorsements/Acknowledgements of Support

PUBLIC HEALTH ASSOCIATION AUSTRALIA

MATERNITY CHOICES AUSTRALIA

SAFE MOTHERHOOD FOR ALL

GRIFFITH UNIVERSITY

UNIVERSITY OF WESTERN SYDNEY

HOMEBIRTH AUSTRALIA

TRANSFORMING MATERNITY CARE COLLABORATIVE

MATERNITY CONSUMER NETWORK

PREGNANCY BIRTH & BEYOND MEDIA

THE AUSTRALIAN MOTHERHOOD INITIATIVE FOR RESEARCH AND COMMUNITY ENGAGEMENT

HYPNOBIRTHING INTERNATIONAL

HOMEBIRTH NSW

SOCIETY FOR INDEPENDENT MIDWIVES

LITTLE SPARKLERS

LAMAZE INTERNATIONAL

HOMEBIRTH QLD

BREASTFEEDING ADVOCACY AUSTRALIA

FRIENDS OF THE BIRTH CENTRE

ASSOCIATION OF RADICAL MIDWIVES

HOMEBIRTH CONSORTIUM AUSTRALIA

SOROPTIMIST INTERNATIONAL MORETON NORTH INC

WAMINDA, SOUTH COAST WOMEN'S HEALTH & WELFARE ABORIGINAL CORPORATION

Table of Contents

About Us 4

I Respect *4*

Recognising the SRHR of Pregnant and Birthing Women 6

(a) Conditions and constraints of the health system 10

Violations of the Fundamental Human Right to Informed Consent 12

(a) "Bait & Switch" 12

(b) Mandating 'routine' interventions without prior disclosure 12

(c) Utilising state enforcement mechanisms to obtain medical compliance from pregnant women 14

Direct Forms of Abuse and Disrespect 16

(b) Discriminatory laws and practices, and harmful stereotypes 16

Racial profiling in the provision of maternity health care 19

(c) Power dynamics and the abuse of the doctrine of medical necessity 21

II Protect *25*

Making a Complaint 26

The Civil Justice System 28

Medical Malpractice Law 29

The Problem with Medical Malpractice Law 31

The Criminal Justice System 34

Human Rights Justice System 36

III Fulfil *36*

Attachment 1: Letter of Support from the Australian College of Midwives

Attachment 2: Letter from CEO, Waminda, South Coast Women's Health & Welfare Aboriginal Corpn

About Us

Human Rights in Childbirth (**HRiC**) congratulates the Australian Human Rights Commission (**AHRC**) for initiating this much needed conversation on the role that human rights must play in Australia's future. We are grateful for this opportunity to present, from a human rights perspective, a significant yet often overlooked subset of violence against women in the provision of reproductive health care and the failure of state and legal accountability mechanisms to respect, protect and fulfil the sexual and reproductive health and rights of women in the provision of health services, including where those services are provided by private actors.

Human Rights in Childbirth (**HRiC**) is an international, non-profit legal and human rights advocacy and reproductive justice organisation founded in The Hague in 2012 and operating with a diverse board of stakeholders from Australia, Latin America, Eastern Europe, USA and India. We work in partnership with consumer organisations nationally or established umbrella organisations to support, advocate and educate women on their human rights in pregnancy and childbirth. We monitor human rights abuses in pregnancy and childbirth around the globe and develop resources to build regional capacity, and train women and gender non-conforming people to advocate for their rights. In this respect, we have worked closely with the World Health Organisation to provide grassroots engagement on the introduction of trained, accredited midwifery in India. Historically, the reproductive rights movement has marginalised young women, women of colour and low-income women from leading change in a sphere that has profoundly affected and continues to affect us. We are working to change this through multidisciplinary research, leadership and capacity building, movement building and by putting the lived, personal experiences of childbearing women at the center of our discourse.

HRiC has long recognised that the realisation and protection of women's reproductive rights is not a cherry-picking exercise. For low-income women, Aboriginal and Torres Strait Islander women, immigrant women and women of colour in particular, the full spectrum of women's reproductive rights must be defended, together with advocacy to develop the conditions for the realisation of women's human and reproductive rights. These include:

(a) the right to have a child or to not have a child;
(b) the right not to be separated from our children;
(c) the right to be able to care for our children in accordance with our cultural, spiritual and community norms, consistent with the human rights of women and children; and
(d) the right to control our birthing options, including the right to decide our care providers, birth companions, treatment options and the circumstances of our birth.

Without exception, efforts to elevate any one of these rights at the expense of the other is to place arbitrary limits on a woman's right to bodily autonomy and informed consent, with serious consequences for women and babies, some of which are described in this submission.

This submission seeks to introduce an understanding of and support for the recognition of the sexual and reproductive health and human rights (**SRHR)** framework for women in pregnancy and childbirth in Australia and for the introduction of a human rights based approach to the provision of all reproductive health services, in particular maternity health care in Australia. In this submission, we outline the manifestations of abuse and mistreatment of women seeking maternity and reproductive health services in Australia, the root causes of such mistreatment and the steps that need to be taken to promote a rights-based approach in the provision of maternity and reproductive health care.

I Respect

Women's sexual and reproductive health rights (**SRHR**) are indivisible aspects of their human rights, and deeply linked with the fulfillment of all other civil, political, economic and social rights.[1] To put it simply, healthy happy women, girls and mothers make for healthy, happy and sustainable communities.

Despite acknowledging the contributions of women and mothers to our ability to thrive as a nation, the continued lack of express state recognition of the SRHR of pregnant and birthing women in Australia is, in our view, a significant and ongoing barrier to any sustained improvements in the endorsement and development of women's human rights, and the mitigation of violence against women, in this country.

This includes the recognition of rights that indisputably enhance the socio-economic status of women, such as the right to information and informed consent, the right to the highest attainable standard of physical and mental health, the recognition of the mother/infant bond in all matters concerning the "best interests of the child", the right to be free from discrimination, the right to bodily autonomy, the right to be remunerated for our work as primary carers of children, the sick and the elderly, and the right to elevated workplace protections for being either pregnant or the primary carer of young children, such as through paid maternity leave – all of which contribute to the protection of the family as a fundamental unit of society.[2] As a European Commission Study has found:

> *"A frequently recurring theme across the countries is the ways in which gender shapes parenthood and makes motherhood different from fatherhood both in everyday family life and in workplaces. The transition to parenthood appears to be a critical "tipping point" on the road to gender equity. On becoming parents, decisions have to be made at the household level about how to manage work and family demands. Even in countries with a strong egalitarian ideology, the experiences of motherhood and fatherhood are very gendered, shaped by structural, cultural and practical factors. Socio-economic status is also important, influencing supports and constraints for combining parenthood and employment.*
>
> *The study confirms that gender and class are still major factors that structure and shape experiences of working and parenting across the countries as found by many other studies. Although levels of inequality differ across the countries studied, social inequality is a very persistent aspect of European society, and may be exacerbated by the growing gap between core and peripheral*

---

[1] Gates, Melinda, "Valuing the health and contribution of women is central to global development" (2015) Vol 386 *The Lancet*, Issue 9999, p. e11-e12; The Lancet Editorial, "Women are the key to sustainable development" (2015) Vol 386 *The Lancet,* Issue 9999, p. 1110.

[2] Schiller, R, "Maternity Rights are not an Optional Extra" The Guardian News (31 Aug 2016) at https://www.theguardian.com/commentisfree/2016/aug/31/maternity-rights-discrimination-blights-women-lives.

workforces. Structural inequalities persist amongst parents in workforces, affecting their prospects of even taking up policies."[3]

As we discuss below, that same "tipping point" is affecting women and girls in Australia. HRiC is concerned that the SRHR of women and girls are being seriously undermined in Australia through the systemic dehumanisation and consequent normalization of rights violations in the provision of facility based reproductive health services, including and especially in the provision of maternity health care. The dehumanisation is affecting the health and wellbeing of women and their families, and is contributing to the gendered social inequity that develops from that tipping point.

Recognising the SRHR of Pregnant and Birthing Women

Women have been advocating for their right to birth in a safe and respectful environment for over 55 years.[4] Despite the consistency over decades in the composition and content of complaints by women of systemic and procedural forms of abuse and disrespect, successive governments have refused to acknowledge, let alone address, that mistreatment and violence taking place in childbirth facilities.[5] Ignoring women's complaints about their treatment in childbirth has become as normal as the process of abusing and disrespecting women in pregnancy and childbirth.[6] It forms a part of the continuing cycle of abuse in the provision of reproductive and maternity health care. For Aboriginal and Torres Strait Islander women who have only been "allowed" to access mainstream maternity services over the last 30 years, the intergenerational impact of trauma caused by mistreatment - past and present - continues, and repeated calls for the universal implementation of *Birthing on Country*[7] Initiatives as a healing mechanism to address the mistreatment that they experienced both *without* and *within* health facilities are simply not being heard.

Health and human rights should go hand in hand in Australia, but this partnership is rarely reflected in the provision of maternity and reproductive health services in Australia. While we note that successive governments in Australia (state and federal) pay lip service to statements such as "woman centred care" and "respectful maternity care", real change at the facility and practitioner level is rare, and accountability mechanisms are virtually non-existent for human rights violations. As we will discuss further below, hospitals are particularly resistant to change and careproviders face no incentive to adjust practice

[3] European Commission Directorate-General Research, 'Gender, parenthood and the changing european workplace: Young adults negotiating the work-family boundary: TRANSITIONS' (Research Paper, Project HPSE - CT-2002-00125 No EUR 22086 EN, DG Research, EC, February 2006) 13-14.
[4] Goer H, "Cruelty in Maternity Wards: Fifty Years Later" (2010) 19 *J. Perinatal Education* 33.
[5] Kerreen Reiger, *Our Bodies, Our Babies: The Forgotten Women's Movement* (MUP, 1997).
[6] R. Reed, R. Sharman and C. Inglis, 'Women's descriptions of childbirth trauma relating to care provider actions and interactions' (2017) 17(1) (2017/01/11) *BMC Pregnancy Childbirth* 21.
[7] *Birthing on Country* is described as '...a metaphor for the best start in life for Aboriginal and Torres Strait Islander babies and their families' which provides an appropriate transition to motherhood and parenting, and an integrated, holistic and culturally appropriate model of care for all', see Joint Position Statement between the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) and the Australian College of Midwives (ACM) and CRANAplus (2016) at < https://www.catsinam.org.au/static/uploads/files/birthing-on-country-position-statement-endorsed-march-2016-wfaxpyhvmxrw.pdf>

methods to conform with the provision of human rights[8] by reason of the lack of accountability or compensatory mechanisms for violations of women's SRHRs.

The close relationship between governments (state and federal), the medico-legal industry and the medical profession has all but precluded meaningful engagement with pregnant and birthing women on assessing and improving the quality of reproductive health services. In Australia, consumers are used to either rubber stamp policies developed by stakeholders or cherry-picked to promote a particular government political cause. A majority of the maternity health care policies HRiC has reviewed deploy coercive language or language that precludes any understanding of the fundamental human right to informed consent. In the private sector, providers are asserting property rights to trump the human right of a woman to a birth companion of her choosing. Real, sustained change in the provision of maternity health care to the kind of care that has been requested (and denied) the majority of women in Australia is unlikely under the current socio-political dynamic, despite women's requests reflecting the standards and models of care endorsed by the WHO as the gold standard in the provision of maternity health care.[9]

Women should not only have the right to access appropriate reproductive health services, including maternity health care, but to also be treated with dignity and respect when they access such care. Concerns around the mistreatment of women during pregnancy and childbirth both within health care institutions[10] and in social spaces generally in Australia[11] have been widely documented in research and the media, but appear to have had limited impact[12] on reforming a health system more focused on constraining spending, avoiding liability and protecting provider interests. Aboriginal and Torres Strait Islander[13], migrant and refugee[14] pregnant women are particularly vulnerable to mistreatment within our health systems but are regularly overlooked in consultation or quality assessment forums. As a result, there appears to be an overwhelming operational assumption in reproductive health care, in the application of laws, policy and practice, that SRHRs do not apply in policy or practice to women who have voluntarily elected to maintain a pregnancy to term.

[8] Pamela Laufer-Ukeles, 'Reproductive Choices and Informed Consent: Fetal Interests, Women's Identity and Relational Autonomy' [2011] 37(4) *American Journal of Law and Medicine*.

[9] Petra ten Hoope-Bender et al, 'Improvement of maternal and newborn health through midwifery' [1226] (2014) 384(9949) *The Lancet* 1226-1235.; Tarik Jašarević, 'Individualized, supportive care key to positive childbirth experience, says WHO' (News Release, World Health Organisation, 15 Feb 2018).; WHO, 'WHO recommendations: intrapartum care for a positive childbirth experience' (Research Paper No Licence: CC BY-NC-SA 3.0 IGO., World Health Organisation Geneva; WHO, 'WHO recommendations on antenatal care for a positive pregnancy experience' (Working Paper, World Health Organisation Geneva.

[10] Elly Bradfield, 'Australia's maternity care at 'crisis point' with birth trauma rates increasing', *ABC NEWS* (Online report, 1 Nov 2019) <https://www.abc.net.au/news/2019-10-31/birth-trauma-ptsd-feminisms-forgotten-issue/11649116>.; M. Simpson et al, 'Postnatal post-traumatic stress: An integrative review' (2018) 31(5) (2018/01/18) *Women Birth* 367-379.

[11] Derya Iner, 'Islamophobia in Australia (2016-2017)' (Research Paper, Centre for Islamic Studies and Civilisations, Charles Sturt University.

[12] M. Simpson and A Cater, 'Birth Trauma: The noxious by product of a failing system' 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 12.; I. Olza et al, 'Women's psychological experiences of physiological childbirth: a meta-synthesis' (2018) 8(10) (2018/10/21) *BMJ Open* e020347.

[13] 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.; C. Felton-Busch, 'Birthing on country: an elusive ideal?' (2009) 33(2) (2009/11/26) *Contemp Nurse* 161-2.

[14] 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., V. S. Rao, H. Dahlen and H. Razee, 'Indian migrant women's experiences of motherhood and postnatal support in Australia: A qualitative study' (2019) (2019/10/22) *Women Birth*.

Disrespectful and abusive maternity care is impacting women's physical and psychological health and the health of their newborns.[15] In high income countries like Australia, undue emphasis on low maternal and infant mortality rates are shielding the rise in maternal and infant morbidities[16], including severe morbidity that is, at present, inadequately monitored[17], such as post-natal depression, undiagnosed PTSD and maternal suicide following childbirth.[18] In addition to physical co-morbidities[19] and the long term sequelae[20] suffered by both mothers and babies as a result of birth injuries, women who experienced a distressing birth *consistently* report depression and suicidal thoughts, marital and family breakdown, sexual dysfunction, emotional detachment from the baby, flashbacks and nightmares, hypervigilance with regard to the baby, social withdrawal and difficulty maintaining employment.[21] Some women also report fear of becoming pregnant, which contributes to a lack of intimacy and conflict with partners, and voluntary infertility. Women who have experienced a traumatic childbirth tend to 'reframe' birth as frightening and dangerous.[22] For Aboriginal and Torres Strait Islander women in Australia, the exacerbation of cultural harms and the impact of mistreatment on their connection to country, culture, family and kinship is profound and simply cannot be justified.

Women have responded to States' failures to provide human rights centered safe and respectful birthing environments in different ways.[23] A greater percentage of women are requesting elective Cesarean sections in order to avoid the pain and suffering now associated with facility-based childbirth.[24] As we note below, these requests are met with very little resistance in privately funded for-profit health facilities, with medical professionals purportedly defending "women's right to choose". With the advent and growth of the provision of women-centered maternity care practice led by independently practising midwives, a growing number of women are seeking to birth away from health facilities with a skilled midwife by their

---

[15] Reisz S, Brennan J, Jacobvitz D & George C, "Adult attachment and birth experience: importance of a secure base and safe haven during childbirth" (2019) 37:1 *Journal of Reproductive and Infant Psychology* 26-43, DOI: 10.1080/02646838.2018.1509303.; A. Horsch and S. Stuijfzand, 'Intergenerational transfer of perinatal trauma-related consequences' (2019) 37(3) (2019/06/21) *J Reprod Infant Psychol* 221-223.

[16] Geller SE, Koch AR, Garland CE, MacDonald EJ, Storey F & Lawton B, "A global view of severe maternal morbidity: moving beyond maternal mortality" (2018) 15 (1) *Reproductive Health* 98 https://doi.org/10.1186/s12978-018-0527-2.

[17] The leading cause of maternal death in Australia is maternal suicide. The WHO recommends that maternal deaths from psychosocial causes be categorised as directly attributable to the pregnancy. This recommendation has not yet been widely adopted and could be contributing to an under-reporting of late maternal suicide. See C. Thornton et al, 'Maternal deaths in NSW (2000-2006) from nonmedical causes (suicide and trauma) in the first year following birth' (2013) 2013 (2013/09/12) *Biomed Res Int* 623743.

[18] White R, Matthey S, Boyd K & Barnett B "Postnatal depression and post-traumatic stress after childbirth: Prevalence, course and co-occurrence" (2006) 24: 2 *Journal of Reproductive and Infant Psychology* 107-120, DOI: 10.1080/02646830600643874.

[19] L. L. Peters et al, 'The effect of medical and operative birth interventions on child health outcomes in the first 28 days and up to 5 years of age: A linked data population-based cohort study' (2018) 45(4) (2018/03/27) *Birth* 347-357.; Hannah G. Dahlen et al, 'Rates of obstetric intervention and associated perinatal mortality and morbidity among low-risk women giving birth in private and public hospitals in NSW (2000–2008): a linked data population-based cohort study' (2014) 4(5) *BMJ Open* e004551.

[20] Kendall-Tackett K, Cong Z & Hale T, "Birth Interventions Related to Lower Rates of Exclusive Breastfeeding and Increased Risk of Postpartum Depression in a Large Sample (2015) *Clinical Lactation*, 6(3), http://dx.doi.org/10.1891/2158-0782.6.3.87

[21] J. Fenwick et al, 'Women's perceptions of emotional support following childbirth: a qualitative investigation' (2013) 29(3) (2012/11/15) *Midwifery* 217-24.

[22] J. Patterson, C. Hollins Martin and T. Karatzias, 'PTSD post-childbirth: a systematic review of women's and midwives' subjective experiences of care provider interaction' (2019) 37(1) (2018/08/18) *J Reprod Infant Psychol* 56-83.; M. A. Kealy, R. E. Small and P. Liamputtong, 'Recovery after caesarean birth: a qualitative study of women's accounts in Victoria, Australia' (2010) 10 (2010/08/20) *BMC Pregnancy Childbirth* 47; P. Slade et al, 'Establishing a valid construct of fear of childbirth: findings from in-depth interviews with women and midwives' (2019) 19(1) *BMC Pregnancy and Childbirth*.

[23] Arcia A, "US nulliparas' perceptions of roles and of the birth experience as predictors of their delivery preferences." (2013) *Midwifery,* DOI: 10.1016/j.midw.2012.10.002; Y. L. Hauck et al, 'Association between childbirth attitudes and fear on birth preferences of a future generation of Australian parents' (2016) 29(6) (2016/05/29) *Women Birth* 511-517.

[24] Helen M Haines et al, 'The influence of women's fear, attitudes and beliefs of childbirth on mode and experience of birth' (2012) 12(55) *BMC Pregnancy & childbirth* 1; J. Fenwick et al, 'Why do women request caesarean section in a normal, healthy first pregnancy?' (2010) 26(4) (2009/01/02) *Midwifery* 394-400.

side.[25] Women understand that the risk of suffering harmful interventions and other forms of obstetric violence during the birth process are significantly lower in a home environment.[26] While planned home birth is a safe option for low-risk pregnancies in well integrated health systems[27], access to the service remains elusive as incumbent stakeholders resist this option in Australia. The refusal to properly integrate home birth as a birthing option into the existing health network is a violation of the fundamental human right to the highest attainable level of physical and mental health, and the right to privacy in Australia – the fundamental right to choose how, where, when and with whom a woman chooses to give birth[28].

More recently, Australian researchers have begun documenting the rising incidence of "freebirthing". This is where women choose to birth without a careprovider or to seek the support of an unregulated careprovider against medical advice.[29] In most cases, these choices were made because the women believed they were safer[30] outside a facility that had violated or was violating their SRHR.[31]

Globally, discussions around the SRHR of pregnant and birthing women have been the subject of UN Human Rights Committee and World Health Organisation (**WHO**) inquiries in recent years. In 2016, following a systematic research review pointing to mistreatment of women in facilities around the globe[32], the WHO published a statement noting that the mistreatment of pregnant women in facilities:

> *… not only violates the rights of women to respectful care, but can also threaten their rights to life, health, bodily integrity, and freedom from discrimination.*[33]

Shortly thereafter, in its Thematic Report to United Nations General Assembly, the UN Working Group on the Issue of Discrimination Against Women in Law and in Practice expressed concern that:

---

[25] Catling C, Dahlen HG & Homer SE, "The influences on women who choose publicly-funded home birth in Australia" (2014) 30(7) *Midwifery Journal* 892 -898.

[26] See for instance https://www.birthplacelab.org/homebirth-an-annotated-guide-to-the-literature/ The Birth Place Lab, in the Division of Midwifery at the University of British Columbia facilitates multi-disciplinary research, community-based participatory research, and knowledge translation around access to high quality maternity health care across birth settings.

[27] Olsen O & Clausen JA, "Planned hospital birth versus planned home birth." (2012) 9(9) *Cochrane Database Syst Rev* :CD000352, doi:10.1002/14651858.CD000352.pub2 (Available online at http://www.ncbi.nlm.nih.gov/pubmed/22972043); E. K. Hutton et al, 'Perinatal or neonatal mortality among women who intend at the onset of labour to give birth at home compared to women of low obstetrical risk who intend to give birth in hospital: A systematic review and meta-analyses' (2019) 14 (2019/11/12) *EClinicalMedicine* 59-70.; Caroline S. E. Homer et al, 'Birthplace in New South Wales, Australia: an analysis of perinatal outcomes using routinely collected data' (2014) 14(1) *BMC Pregnancy and Childbirth*; Caroline S. E. Homer et al, 'Maternal and perinatal outcomes by planned place of birth in Australia 2000 – 2012: a linked population data study' [e029192] (2019) 9(10) *BMJ Open*.; ibid.

[28] Ternovszky v. Hungary (2010) ECHR (Strasbourg) (Application no. 67545/09) <http://hudoc.echr.coe.int/app/conversion/pdf/?Library=ECHR&id=001-102254&filename=001-102254.pdf> at p22.; . Cole et al, '"Trying to give birth naturally was out of the question": Accounting for intervention in childbirth' (2019) 32(1) (2018/05/08) *Women Birth* e95-e101.

[29] EC Rigg et al, 'A survey of women in Australia who choose the care of unregulated birthworkers for a birth at home' (2018) (2018/12/07) *Women Birth*.

[30] L. Holten and E. de Miranda, 'Womens motivations for having unassisted childbirth or high-risk homebirth: An exploration of the literature on 'birthing outside the system'' (2016) 38 (2016/04/09) *Midwifery* 55-62.; . Cole et al, '"Trying to give birth naturally was out of the question": Accounting for intervention in childbirth' (2019) 32(1) (2018/05/08) *Women Birth* e95-e101.

[31] H. G. Dahlen, M. Jackson and J. Stevens, 'Homebirth, freebirth and doulas: casualty and consequences of a broken maternity system' (2011) 24(1) (2010/12/18) *Women Birth* 47-50.; Heather Sassine and H. Dahlen, 'Identifying the poisonous gases seeping into the coal mine: what women seek to avoid in choosing to give birth at home' 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 6.

[32] M. A. Bohren et al, 'The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review' (2015) 12(6) (2015/07/01) *PLoS Med* e1001847; discussion e1001847.

[33] *The prevention and elimination of disrespect and abuse during facility-based childbirth*, WHO/RHR/14.23) (WHO Statement) ('*The prevention and elimination of disrespect and abuse during facility-based childbirth*').

"...many national laws and policies provide for overmedicalization of certain services that women need to preserve their health without a justified medical reason. These include requirements that only doctors can perform certain services, such as pharmaceutical termination of pregnancy or obstetric care. In many countries, women are not given a free choice between different ways of giving birth. Caesarean sections, when medically justified, can be crucial in preventing maternal and perinatal mortality and morbidity. However, studies conducted by WHO demonstrated that performing caesarean sections on more than 10 per cent of women does not lead to improvement in mortality rates. Caesarean section rates of 30 per cent in some countries demonstrate overmedicalization of childbirth, with the risks of obstetrical complications and health problems."[34]

As these issues gained prominence at the global health policy level, the UN Special Rapporteur on Violence Against Women (**Special Rapporteur**) continued to receive reports from women in medium to high income countries about mistreatment and abuse in the provision of reproductive health services. This, in turn, prompted a review and report to the United Nations General Assembly in July 2019 on the issue of mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence.[35]

In her report, the Special Rapporteur highlighted 3 issues that manifested in all the consultations and submissions received on the issue of obstetric violence, all of which are pertinent to the manner in which pregnant and birthing women are treated in Australia. In summary, the Special Rapporteur noted the following root causes of mistreatment and violence against women in childbirth:

(a) conditions and constraints of a health system;[36]
(b) discriminatory laws and practices and harmful gender stereotypes;[37] and
(c) power imbalance in the provider-patient relationship and abuse of the doctrine of medical necessity[38].

We will deal with each of these root causes in the Australian context below.

(a) Conditions and constraints of the health system

Women are abused and disrespected in health systems during pregnancy and childbirth through:

[34] Human Rights Council, *Report of the Working on the issue of Discrimination against Women in law and in practice*, A/HRC/32/44, 32 sess, Agenda Item 3, UN Doc GE.16-05771(E) (8 April 2016) ('*Report of the Working on the issue of Discrimination against Women in law and in practice*'). at para 74.
[35] 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) ('*A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence*').
[36] Ibid. at para 39.
[37] Ibid. at para 42.
[38] Ibid. at 48-49.

(a) Systemic mechanisms: the use of structures, policies, rules and state support mechanisms (police, courts, child protection services) to dehumanize, bully, control and coerce pregnant women; and

(b) Direct action: physical actions, verbal abuse and threats, neglect, random punishments, cruel and inhuman treatment, discrimination.

Within medical facilities, direct and systemic forms of abuse and mistreatment work in a symbiotic and integrated fashion to achieve the end result, which is a process of coercion and control of pregnant and birthing women to achieve an outcome.[39]

Systemic structures such as the use of institutional policies to override bodily autonomy and violate informed consent, denying labouring women water or food in (undisclosed) anticipation of surgery, the arbitrary use of time limits to limit or control access to health services, threats to call child protection services and/or neglecting women who have been physically restrained and/or connected to foetal monitoring equipment are amongst the complaints HRiC receives on a regular basis. These systemic mechanisms create the context in which a culture of dehumanising[40] pregnant women, and consequently, "normalising" abuse and disrespect of pregnant and vulnerable women, can thrive.

In Australia, systemic mechanisms for controlling women are further embedded through direct, provider actions informed by racism, discrimination, neglect, and the use of indiscriminate "punishments" that are now endemic and self-sustaining, both within and across health facilities.[41] Such a culture is so prevalent that facility personnel who do not adapt, perpetrate or deliberately blind themselves to the abuse and disrespect are quickly managed out of the health system. This trend, as we discuss further below, is adversely affecting young midwives and physicians who seek to provide person centered care.

A good example of the symbiotic relationship between systemic mechanisms and direct forms of abuse is presented in the case of an unscheduled Cesarean section recommended because labour is "not progressing" as planned. HRiC has found that it is extremely rare to find a woman, who is not already a careprovider, who knows or understands that she is attending a hospital which imposes strict time limits on different stages of labour. That is because time restrictions on stages of labour *are rarely, if ever, disclosed to women before their attendance at a facility.* When that time limit presents itself during a woman's labour, she is unhelpfully labelled a "failure to progress" and subsequently bombarded with requests to consent to medical interventions until she concedes. Women are suddenly told that "they are out of time" or "not allowed to keep labouring" or that "their baby will die" if they do not submit to interventions. Women report feeling shocked, unprepared, terrified or bamboozled by the sudden, intensive change in approach, which was more often than not preceded by hours of neglect. Any decision, in this grey area of whether to continue labouring or to proceed with an unscheduled Cesarean section, is hardly made on an informed basis when one party is using undisclosed policy or guidelines to

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

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

[41] Omar Sultan Haque and Adam Waytz, 'Dehumanization in Medicine' [176] (2012) 7(2) *Perspectives on Psychological Science* 176-186.

mandate responses from women. The "consent" that is finally given is more of a concession, where women simply give up after hours of badgering, taunting or abuse.[42] [43]

Violations of the Fundamental Human Right to Informed Consent

Full and informed consent is only given if the health care provider explains the health status of the woman and her foetus, and provides complete and unbiased evidence-based information regarding her health care options and its risks. It includes the option to decline treatment.[44] The woman should be given time, without pressure, to consider her options and decide independently of any influence and she has the right to change her mind at any time.

As noted above, despite the ethical and legal obligations of facility-based health care providers to obtain full and informed consent to medical procedures, it is rarely observed in practice in maternal health. We have found, in our work, that informed consent is not standard practice, and worse, women who attempt to refuse medical treatment are often badgered or bullied and some forced against their will to undergo procedures, including surgical interventions of their bodies.

Systemic coercion and mistreatment of pregnant women can only be repeatedly achieved through the concealment of, and failure to provide, information and choice. The fundamental human right to informed consent, based on notions of bodily autonomy and integrity, is rarely used in the provision maternity health care in Australia. The following is a summary of the manifestations of systemic mistreatment and abuse that are reported in Australia:

(a) "Bait & Switch"

Misrepresentation or concealment of the health care provider's or the facility's intentions, practices and preferences, in order to gain women's trust and custom during the course of the pregnancy. Careproviders then impose a highly interventionist model during the last weeks of pregnancy, around the time when women find it difficult to change provider or facility. This practice is aided by governments refusing to mandate that hospitals and careproviders, including private facility providers, disclose, clarify or explain intervention and complication rates.[45]

(b) Mandating 'routine' interventions without prior disclosure

The use of hospital policies or protocols that were not disclosed prior to booking to mandate routine interventions and invasive procedures during labour at a facility[46], including but not limited to:

---

[42] Betrán AP, Ye J, Moller AB, Zhang J, Gülmezoglu AM & Torloni MR "The Increasing Trend in Caesarean Section Rates: Global, Regional and National Estimates: 1990-2014." (2016) 11(2) *PLoS One*. e0148343; doi:10.1371/journal.pone.0148343.

[43] Clesse C, Lighezzolo-Alnot J, De Lavergne S, Hamlin S & Scheffler M, "Statistical trends of episiotomy around the world: Comparative systematic review of changing practices" (2018) 39(6) *Health Care for Women International* 644-662, DOI: 10.1080/07399332.2018.1445253.

[44] The American College of Obstetricians and Gynecologists, 'Refusal of Medically Recommended Treatment During Pregnancy', *ACOG.org* (Committee on Ethics Opinion No 664, June 2016) <https://www.acog.org/-/media/Committee-Opinions/Committee-on-Ethics/co664.pdf?dmc=1&ts=20191111T0051085108>.

[45] Kate Aubusson, 'Hospital complication rates 'veiled in secrecy' and marred by flawed definition of 'preventable': Grattan report', *The Sydney Morning Herald*, 4 February 2018).; 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.; Stephen J Duckett et al, 'All Complications Should Count: Using our data to make hospitals safer' (Report No 2018-01, Grattan Institute, February 2018).; Dahlen et al (n ; Hannah G. Dahlen, 'Is it Time to Ask Whether Facility Based Birth is Safe for Low Risk Women and Their Babies?' (2019) *EClinicalMedicine*.; Kristjana Einarsdóttir et al, 'Neonatal complications in public and private patients: a retrospective cohort study' (2013) 3(5) *BMJ Open* e002786.

[46] Thompson R & Miller YD, "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 at <http://www.biomedcentral.com/1471-2393/14/62>.

(a) Mandatory periodic vaginal examinations, CTG scans, blood tests for drug and alcohol screening and pitocin induction of labour;

(b) Prioritizing the foetus over the woman;

(c) Denial of access to a support person of the woman's choosing;

(d) Demanding prior acceptance, on arrival at hospital, to all forms of medical and surgical interventions at the careprovider's discretion and without explanation;

For instance, the following advice, downloaded from the Department of Health (Victoria) website on 7 June 2019, provides a fine example of blanket demands for prior acceptance:

> *"If you are in a high-risk group, health care professionals have an obligation to put your health and the health of your baby above your preferences. Understand that some decisions might therefore be out of your control."*[47]

Separate attempts to contact then Victorian Minister for Health Jill Hennessy MP received no acknowledgment and no response.

(e) Placing women in the supine position to labour for the convenience of the careprovider;

(f) Strict observation of reduced time limits for stages of labour;

(g) Routine episiotomy and the application of "the husband stitch"[48] without consent;

(h) Denying food and water for women profiled as most likely to have a Caesarean-section;

(i) Expedited cord-clamping and cutting;

(j) Removing the newborn to expedite management of delivery of the placenta;

(k) Denying mother and baby skin to skin contact immediately after or in the first few hours of birth;

(l) VBAC bans[49], twin vaginal delivery bans and breech vaginal delivery bans.[50]

Hospitals protocols, particularly when undisclosed, cannot and should not trump the fundamental human rights of any person. In addition, the mandating of procedures and protocols, and the failure to disclose them prior to the engagement of a service, is in itself a breach of the consumer protection provisions under the *Competition and Consumer Act* 2000 (Cth) in Australia (and equivalent state legislation), in addition to being a violation of women's human rights. This inconsistency between careprovider practices, state policies and adherence to basic legal principles, that most men and non-pregnant women take for granted in Australia, is concerningly prevalent in the provision of maternity care, which HRiC submits is based on discrimination and

[47] See Dept of Health website: <betterhealth.vic.au> under "Birthing Options".
[48] Mamabirth, "The Husband Stitch" (2013), viewed 10 May 2019, at http://www.mamabirth.com/2013/07/the-husband-stitch.html. See also Šimonović, note 35 at para 29.
[49] 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 Childbirth* 206.
[50] Sheena Meredith, *Policing pregnancy : the law and ethics of obstetric conflict* (Routledge, 2016).

inequitable treatment targeted at women on the basis of their pregnancies. We note too careproviders are either oblivious to the rights violations they commit or resistant to advice of the same or both. We will explain why further below.

(c) Utilising state enforcement mechanisms to obtain medical compliance from pregnant women

HRiC has observed an increased willingness by careproviders, particularly in publicly funded facilities, to access state enforcement or child protection services in order to coerce pregnant and labouring women to submit to medical treatment, including:

1. Pre-natal Reporting

In NSW, until recently, the government mandated pre-natal reporting to child protection services of pregnant women who refused to comply with health authority mandated ante-natal care or who do meet health facility "standards". In other words, this was a strategy of removing *at birth* the newborn infant by reason of its mother's failure to comply with health authority decrees *before the birth*, i.e. during the pregnancy.[51] This includes unrealistic demands on already vulnerable pregnant women to submit to treatment requirements or to leave partners that facility providers consider to be a threat to the unborn infant. This is a violation of a woman's 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 cruel or inhuman treatment. Aboriginal and Torres Strait Islander women were (and still are) especially vulnerable to prenatal reporting which subsequently permanently placed them on a Child Protection Services "watch" list. Pre-natal report was having a significant impact on Aboriginal and Torres Strait Islander women who already feel unsafe in what is perceived to be a Western biomedical model of care lacking in cultural sensitivity and integrity. Despite the fact that pre-natal reporting created a significant deterrent to pregnant Aboriginal and Torres Strait Islander women accessing much needed antenatal care, the practice persisted for a substantial period and was being actively facilitated by non-Indigenous maternity health care providers.

In a coronial inquest concerning the death of a newborn whose mother refused to attend hospital, it was revealed in court that the local medical practitioner, who had obtained a late term ultra-sound report at the woman's request, subsequently used that report (without prior consent) to notify the woman to child protection services for declining to attend a hospital for a Caesarean section. At the inquest, complaints were made that Child Protection Services had not done enough to control the mother *before* the birth.[52] The woman was a new immigrant from a poor socio-economic background with a limited grasp of spoken English. Submissions to the Coroner reflected the extent to which there is a substantial confusion amongst careproviders as to their role in facilitating compliance of pregnant and birthing women on behalf of the state. Careproviders and state enforcement services showed very limited understanding of the connection between the use of surveillance and coercion, and the violation of the fundamental rights and freedoms of pregnant women.[53] In the same way the AHRC notes that there is an

[51] Hazard, B, "Respectful Maternity Care for Indigenous Mothers" (2017) *Aust Midwifery News*, Practice Matters, p37.
[52] MacKenzie B, "Concerns about plans for high-risk home birth not acted on: inquest" *ABC News* (Updated Mon 27 Jun 2016, 5:32pm.)
[53] *Inquest into the death of NA File number: 2015/60842* (14 September 2016) NSW Coroners Court (Deputy State Coroner Harriet Grahame).

absence of training for public servants on their human rights obligations, so too is there a significant gap in the understanding of the health care profession of the need to observe, respect and protect the SRHR of women and girls – whether pregnant or otherwise.

2. Police Reports

Reports of careproviders engaging the sheriff or the local police to enter a woman's home without a warrant, conduct an immediate search also without a warrant, and/or forcibly retrieve the pregnant woman for coerced surgical delivery at the facility, have also been received. In South Australia and Victoria, criminal legislation has been introduced to prohibit anyone who is not a registered practitioner from attending a woman in childbirth. Both the State of South Australia and Victoria dismissed the potential for this legislation to increase the surveillance and control of pregnant women rather than protect them from harm.[54] In Nov 2018, HRiC received a request for assistance in relation to a woman in South Australia who reported that her midwife had abandoned care at 42 weeks (mandated), just two hours before she went into labour. Her midwife refused to attend to her at home and referred her to the tertiary hospital for medical treatment. The woman, by reason of previous trauma experienced at the hands of the hospital she was being made to attend, refused to leave her room. Her husband called an ambulance which, in turn, called the police. The woman reported that, instead of receiving medical assistance, the police entered the premises without permission, conducted a search for an unregistered birth attendant, and proceeded to question the mother in her bedroom about her intentions *whilst she was delivering the placenta*.

3. Utilising ambulance services to report and coerce women/careproviders

Women who call an ambulance to expedite a transfer to hospital report abuse and disrespect by both ambulance personnel and receiving hospital personnel directed at them and, if the women are professionally supported, their careproviders as well. This includes calling the police and/or media prior to arrival[55], dismissing or ignoring handover advice from midwives[56], demanding that independent midwives breach the privacy of their patients by handing over file notes, misreporting midwives to the Australian Health Practitioner Regulation Agency for continuing to protect women's human rights to informed consent (which is rebranded in the reports as "obstructing medical practice")[57] and providing falsified or inaccurate evidence to support complaints against independent midwives.[58]

4. Abandonment of Care

[54] E. Rigg et al, 'Not addressing the root cause: An analysis of submissions made to the South Australian Government on a Proposal to Protect Midwifery Practice' (2015) 28(2) (2015/01/22) *Women Birth* 121-8.
[55] Australian Communications and Media Authority (ACMA), Investigation Report No 2813 – Channel Nine News Broadcast by NWS (16 February 2012) File No 2012/722.
[56] Welles J, "Coroner refers midwife to complaints commission over baby's death after failed home birth in Taree" (2014) *ABC News Online* (14 Sept 2014), https://www.abc.net.au/news/2014-09-15/coroner-refers-midwife-to-complaints-commission-after-baby-dies/5744998.
[57] R Jenkinson and D. Fox, 'Maternity care plans and respectful homebirth transfer' 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 15.
[58] H. Dahlen and J Hunter, 'The modern day witch hunt' 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 11.

> Facility careproviders either threaten to or actually abandon women in the late stages of pregnancy or during labour if the woman does not agree to submit to careprovider instructions in relation to accepting tests or surgical interventions. This practice appears to be endorsed by the coronial courts, which have called for the censure of careproviders who do **not** abandon women in the provision of maternity health care for refusing tests or rejecting recommended treatment.[59]

Direct Forms of Abuse and Disrespect

In a facility environment designed to dehumanise, coerce and deceive pregnant and labouring women, it is not at all surprising that HRiC has received reports of the following actions in facilities which constitute violations of the rights to health, life, privacy and freedom from discrimination and cruel or inhuman treatment. Manifestations of mistreatment are especially felt by refugee, immigrant and Aboriginal and Torres Strait Islander women, women with disabilities, gender non-conforming persons and those from a lower socio-economic background. Examples include circumstances where careproviders:

1. exert power and authority over women with limited appreciation for the impact it is having on the mental wellbeing of women, particularly women in labour;
2. react to perceived challenges to that power and authority with a range of defensive measures, from jokes, verbal abuse, threats, taunts and crude attacks on women's sexuality, to public shaming and the use of physical restraints;
3. engaging in punitive measures to discipline 'misbehaving' or defiant women, including:
   (a) performing painful procedures on women without consent or pain relief;
   (b) denying or ignoring simple requests for water or pain relief;
   (c) isolating women by either excluding their partners and support persons, or by attempting to co-opt their partners or support persons into punishing the women;
   (d) utilising invasive and/or interventionist procedures without securing informed consent.

The failure of health systems to recognise the importance of respecting women's attempts to protect themselves points to either a limited understanding of the aetiology of trauma and avoidance[60], or a measure of the true social value attached to pregnant women's rights to the highest attainable level of physical and mental health in Australia.

(b) Discriminatory laws and practices, and harmful stereotypes

In the absence of a human rights based approach to the provision of reproductive and maternity healthcare, a pregnant woman entering a facility to birth is expected to:

[59] See, for example, Parkinson, *Inquest into the Death of Joseph Thurgood-Gates* (COR 2010 04851) (2013), Coroners Court Victoria (Coroner Parkinson); Olle, *Inquest into the Death of Thomas Fremantle*: COR 2010 4201 (8 April 2014) Vic Coroners Court (Coroner J Olle).

[60] Thomson G & Downe S, "Widening the trauma discourse: the link between childbirth and experiences of abuse" (2008) 29:4 *Journal of Psychosomatic Obstetrics & Gynecology* 268-273, DOI: 10.1080/01674820802545453.

(a) meet (undisclosed) health standards of what constitutes "normal" (ie not too fat, not too thin, not too old, not too young, not of Aboriginal and Torres Strait Islander, South Asian or African descent, and presenting with no prevailing medical conditions);[61]

(b) perform obediently as against undisclosed careprovider interests and mandated facility-based policies; and

(c) meet social expectations of feminised behavior and adhere to harmful stereotypes of what constitutes a "good mother".[62]

This is a heavy burden for anyone to bear, let alone a pregnant woman, in labour, facing a team of uniformed, health professionals – most likely for the first time - in a well-coordinated facility designed to support provider convenience.

"You don't want your baby to die, do you?"[63]

Despite extensive legal and human rights commentary warning of the implications of pitching a woman against her own body,[64] medical education and facility based training in obstetrics and maternity health care continues to position pregnancy as an abnormal condition during which the needs of the mother are seen as being in conflict with the needs of her unborn infant.[65] This medico-legal fiction, coined "The Obstetric Dilemma", is embedded in obstetric education and training.[66] Underpinning this medical construct is the belief that an unborn fetus is entitled to a right to life which competes with and/or overrides a woman's rights to self-determination, life and the highest attainable level of physical and mental health. As one prominent foetal rights philosopher noted, there is purpose behind maintaining this artificial construct:

> *"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*

[61] Helga Kristin Hallgrimsdottir and Bryan Eric Benner, ''Knowledge is power': risk and the moral responsibilities of the expectant mother at the turn of the twentieth century' [7] (2013) 16(1) *Health, Risk & Society* 7-21.
[62] Claudia Malacrida and Tiffany Boulton, 'Women's Perceptions of Childbirth "Choices"' [748] (2012) 26(5) *Gender & Society* 748-772.
[63] Damien Leggett, '"At least you have a healthy baby": Birth trauma, manufactured crises, and the denial of women's experience in childbirth.' (Honours Thesis, University of Manitoba, 2014).
[64] Mackenzie TB, Nagel TC & Rothman, BJK "When a Pregnant Woman Endangers Her Foetus" (1986) 16 (1) *Hastings Center Report* 24, 25; Karpin I, "Legislating the Female Body: Reproductive Technology and the Reconstructed Woman" (1993) 3 *Columbia Journal of Gender and Law* 325 at 329; Mattingly SS, "The Maternal-Foetal Dyad: Exploring the Two-Patient Obstetric Model" (1992) 22(1) *Hastings Center Report* 13.
[65] Julie Jomeen and Lura L. Pethtel, *Choice, Control and Contemporary Childbirth* (Routledge, Ist ed, 2011). at 16-18.
[66] McLean S & Petersen K, "Patient Status: The Foetus and the Pregnant Woman" [1996] 2(2) *Australian Journal of Human Rights* 229.

maternal autonomy that may, in concrete circumstances, result in the prioritising of one over the other."[67]

From a rights-based perspective, the conflict does not exist between pregnant woman and unborn foetus. The conflict exists between the woman and the stakeholders that stand to gain or lose legally and financially from the birth, and needs to be correctly characterised as the "maternal-stakeholder" conflict.[68] Providers are legally required to offer treatment to the pregnant woman - the consumer - who stands before them and to explain their reasons and motivations for their treatment recommendations. This legal and human rights obligation is not being served when providers are, without adequate disclosure, elevating the status of the unborn foetus at the expense of its mother, irrespective of any altruistic or religious claims to the contrary.

The UN Human Rights Committee has recently confirmed that the human right to life is triggered from the moment of birth.[69] It cannot be used to subordinate the rights of one human being for another, regardless of whether it is for altruistic, religious or financial reasons. This should not come as any surprise. The idea[70] that a foetus may need protection from the mother whose body, brain, values and life choices have been redirected to prioritising her pregnancy and her unborn baby belies any rational thought and is based on archaic and dangerously misogynist attitudes towards women, their bodies and their role in society. With state endorsed power and authority, however, medical and facility based careproviders are protected from having to disclose financial, personal or religious preferences that undermine or conflict with women's human rights and from the consequences of violating women's human right to equality before the law, informed consent, bodily autonomy and freedom from discrimination by states and governments.[71] The undisclosed beliefs about the supremacy of foetal rights can put pregnant women in such care at serious risk. In circumstances where careproviders have engaged the law to override women's right to bodily autonomy, grave consequences have followed for the mother.[72] HRiC is concerned that Australia may well be following that trend given the paucity of human rights approaches to the provision of maternity and reproductive health services.

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, in direct violation of a pregnant woman's human rights. Deployment of increasingly mechanised care supplemented by real-time

---

[67] Casey, G "Pregnant Woman and Unborn Child: Legal Adversaries?" (2002) Vol 8 (2) *Medico-Legal Journal of Ireland* 75 at http://www.ucd.ie/philosophy/staff/casey/PregWomUnbrnChld.pdf> downloaded 2014.

[68] Martine Hollander and Jeroen van Dillen, 'Women Refusing Standard Obstetric Care: Maternal Fetal Conflict or Doctorpatient Conflict?' (2016) 03(02) *Journal of Pregnancy and Child Health*.; M. van der Garde et al, 'Women desiring less care than recommended during childbirth: Three years of dedicated clinic' (2019) 46(2) (2019/02/09) *Birth* 262-269.

[69] 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*').

[70] Savulescu J & de Crespigny L, "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.

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

[72] *In re A.C.* 573 A.2d 1235, 1990 D.C. App. LEXIS 90 (D.C. Apr. 26, 1990); *Pemberton v. Tallahassee Memorial Regional Center*, 66 F. Supp. 2d 1247 (N.D. Fla. 1999); Luisa Cabal and Amanda McRae, 'Torture or Ill-Treatment in Reproductive Health Care: A Form of Gender Discrimination' in Anti-Torture Initiative Center for Human Rights and Humanitarian Law (ed), *Torture in Healthcare Settings: Reflections on the Special Rapporteur on Torture's 2013 Thematic Report* (American University Washington College of Law, 2014) 51.; Kukla R & Wayne K, "Pregnancy, Birth, and Medicine" in Zalta EN (ed), *The Stanford Encyclopedia of Philosophy* (Spring 2018, Edition) <https://plato.stanford.edu/archives/spr2018/entries/ethics-pregnancy/>. see Chapter 3.2 Overriding Autonomy: Forced Interventions During Pregnancy.

surveillance[73], withholding information essential to enabling informed choice and consent[74], and “shroud waving”[75] are just some of the many tactics currently employed to manage and coerce pregnant women into submission or accepting treatments they do not want or need. In facilities, through the aforementioned systemic mechanisms and tactics, careproviders can easily assert themselves as the only “expert” capable of speaking on behalf of the unborn fetus. In HRiC’s view, it is only a matter of time before careproviders commence legal proceedings in Australia to override women’s bodily autonomy in pregnancy and childbirth.

Racial profiling in the provision of maternity health care

HRiC has received several complaints from women and careproviders concerning provider practices which seek to incorporate racial profiling of women during the provision of maternity health care. Specifically, complaints related to the practice of putting Sudanese refugee women under general anaesthetic, without their knowledge or consent, for the purposes of performing a Caesarean section, also without consent, in public facilities in the state of Victoria. HRiC is especially concerned that, in one particular case, the mother was expecting her fifth baby, was not offered an interpreter and had never experienced the invasive treatment options utilised in Australian facilities. HRiC was notified that, unbeknownst to the woman, facility personnel put a sedative in her IV drip, placed her under general anesthetic without her knowledge and performed a Caesarean section without consent. HRiC is especially concerned that the Sudanese mother’s subsequent attempt to fatally injure herself and her infant may have been linked with her traumatic birth experience.

We note that the AHRC has already recorded evidence of the mistreatment of asylum seeking pregnant women seeking access to health services in Australia:

> *“In July 2014, a [asylum seeking] mother of an 11 month old boy on Christmas Island spoke about her experience of having her son. The woman said that she and her husband were transferred from Christmas Island to Darwin in preparation for the birth. When the woman left to go to the hospital,* ***her husband was not allowed to accompany her in the ambulance. Although she did go into labour naturally, the woman was told that she had to have a caesarean. She explained that there was no interpreter present when she signed the consent form for the procedure****. She said that there was a Serco officer outside her hospital room at all times.*[76]

---

[73] Kirsten A. Small et al, 'Intrapartum cardiotocograph monitoring and perinatal outcomes for women at risk: Literature review' (2019) *Women and Birth*.; Edvardsson K, Mogren I, Lalos A, Persson M and Small R, “A routine tool with far-reaching influence: Australian midwives’ views on the use of ultrasound during pregnancy” (2015) 15 *BMC Pregnancy and Childbirth* 195, <DOI 10.1186/s12884-015-0632-y>.

[74] Kirstie Coxon, Jane Sandall and Naomi J. Fulop, 'To what extent are women free to choose where to give birth? How discourses of risk, blame and responsibility influence birth place decisions' [51] (2013) 16(1) *Health, Risk & Society* 51-67.

[75] The practice of repeatedly telling women, without basis, that their babies are going to die if they do not comply or that their actions are contributing to the deaths of their newborns, also known as “waving the dead baby card”, see Hall, WA, Tomkinson J & Klein MC, “Canadian Care Providers and Pregnant Women’s Approaches to Managing Birth: Minimizing Risk While Maximizing Integrity” (2012) 22(5) *Qualitative Health Research* 575–586, doi: 10.1177/1049732311424292.

[76] 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>.

Separating the pregnant woman from her family when she is due to give birth, in labour pain and does not speak the language of her captors is cruel and inhuman treatment. Mandating a caesarean section – clearly without consent – is a violation of her human rights to health, dignity, bodily autonomy and informed consent. Forcing her to submit to procedures in pregnancy without the assistance of an interpreter is committing a gender-based violence akin to torture and a violation of the right to be free from discrimination. But this extract is also important because it sheds light on a practice that HRiC knows to be commonplace for all pregnant women in facility based maternity care throughout Australia: facility based providers assume and adopt the practice that the consent process is not much more than obtaining a signature on a standardised form – even if signed in the dark, or by a woman weeping in fear, or by a woman who is in extreme pain or by a woman who is being bullied and badgered into submission.

Race is a social construct and should not be used to supplement the social determinants of health that careproviders need to take into account when advising women of their options in reproductive health services in accordance with women's human rights.[77] It is discrimination (more aligned with eugenics) to assume that South Asian or African immigrants require different or more aggressive treatment options on the basis of race.[78] Use of retrospective data to justify and develop standardised treatment options on the basis of race is a dangerous precedent to set and fails to take into account women's individual needs and human rights.[79] As it is, migrants are unduly affected by over-servicing, with no discernible improvement in outcomes, in the provision of maternity health care in high income countries. In 2013, researchers in Australia conducted a meta-analysis of seventy-six studies across the globe comparing the Caesarean rates between international migrants and non-migrants and found consistently higher overall caesarean rates for Sub-Saharan African, Somali and South Asian women in all the studies. The authors could find no evidence to explain the differences in treatment.[80] HRiC receives regular requests from women of colour seeking access to careproviders who will not subject them to standardised treatments based on racial protocols. The practice of racial profiling in maternity health care has nevertheless continued with limited consideration given to the impact that surgery or high interventionist practices may have on first generation, socially isolated immigrant women struggling to care for a newborn in circumstances perceived to be racially hostile to her and her family.[81]

The extract below was shared by a young migrant woman from Victoria, who aptly describes the terror and lack of control that manifests in migrant women when subjected to treatment without consent in a new country:

> *"Images still haunt me to this day of being "shackled up" to a hospital bed, my legs placed into those awful stirrups whilst I have painful needles inserted into my vagina. I feel I could forgive some of the trauma that was inflicted upon me*

---

[77] Z. Obermeyer et al, 'Dissecting racial bias in an algorithm used to manage the health of populations' (2019) 366(6464) (2019/10/28) *Science* 447-453.; Richard Fielding et al, 'Racial Bias in Perceptions of Others' Pain' [e48546] (2012) 7(11) *PLoS ONE*.

[78] J. B. Ward et al, 'How do we assess a racial disparity in health? Distribution, interaction, and interpretation in epidemiological studies' (2019) 29 (2018/10/22) *Ann Epidemiol* 1-7.

[79] See, for example, M. Reddy et al, 'Maternal Asian ethnicity and obstetric intrapartum intervention: a retrospective cohort study' (2017) 17(1) (2017/01/07) *BMC Pregnancy Childbirth* 3.

[80] Merry L, Small R, Blonde B & Gagnon AJ, "International migration and caesarean birth: a systematic review and meta-analysis" (2013) 13 *BMC Pregnancy and Childbirth* 27, http://www.biomedcentral.com/1471-2393/13/27.

[81] Rao, Dahlen and Razee (n 14); J. Chen et al, 'A systematic review of prevalence and risk factors of postpartum depression in Chinese immigrant women' (2019) 32(6) (2018/12/19) *Women Birth* 487-492.; A. Hernandez-Martinez et al, 'Postpartum post-traumatic stress disorder: Associated perinatal factors and quality of life' (2019) 249 (2019/02/18) *J Affect Disord* 143-150.; J. Joseph, W. Brodribb and P. Liamputtong, '"Fitting-in Australia" as nurturers: Meta-synthesis on infant feeding experiences among immigrant women' (2019) 32(6) (2018/12/26) *Women Birth* 533-542.

if anybody had only pretended to care about how frightened I was and had talked to me or explained what was happening, instead I was left in a terrified state wondering if my baby would die and what they would do to me next.

The result of the abuse I experienced at this labour ward where my right to privacy (my genitals were at one stage exposed to a whole congregation of male students who were following a female OB who attended to me, without being asked whether this would be ok with me), informed consent and physical autonomy were taken away from me and where I was in the end treated like a " piece of meat" and not like a human being left me to suffer from PTSD for almost 2 years. Not only did this birth trauma cause me to suffer from nightmares and flashbacks, it almost destroyed my marriage and our young family." – T.K.

Racial profiling has especially affected Aboriginal and Torres Strait Islander women in the provision of maternity health services, with negative health effects for mother and infant. Careproviders feel a greater pressure to intervene when women are racially profiled as being part of a "vulnerable cohort", even where to do so is clearly in violation of fundamental human rights to informed consent and bodily autonomy.[82] HRiC has received reports of careproviders ignoring or dismissing women's pain and requests for culturally sensitive support, using antenatal visits to threaten to report women to child protection services, coercing Aboriginal and Torres Strait Islander women into accepting treatments they do not want and threatening women's partners or family members for seeking to protect their distressed womenfolk. This creates a self-perpetuating cycle of mistrust and fear for both parties, and, aside from being racially discriminatory, is a significant deterrent to Aboriginal and Torres Strait Islander women seeking care. In addition, women are denied the basic dignity and respect that underpins a rights based provision of maternity health care and that they perceive to be offered to non-Indigenous groups of women.[83] This is a strong reflection of the lack of empathy and lack of training afforded to health care providers on cultural safety, compassion and kindness towards those already vulnerable when engaging with health services.

(c) Power dynamics and the abuse of the doctrine of medical necessity

In her report, the Special Rapporteur for Violence against Women noted from submissions received that the power dynamics in the provider-patient relationship are another root cause of mistreatment and violence, compounded by gender stereotypes on the role of women in society:

---

[82] Hartz et al (n 13); Josif, C., Barclay, L., Kruske, S., Kildea, S. "'No more strangers': Investigating the experiences of women, midwives and others during the establishment of a new model of maternity care for remote dwelling aboriginal women in northern Australia" (2014) 30(3) *Midwifery* 317-323; Kildea, S., Hickey, S., Nelson, C., Currie, J., Carson, A., Reynolds, M., Wilson, K., Kruske, S., Passey, M., Roe, Y., Tracy, S., et al (2018). "Birthing on Country (in Our Community): a case study of engaging stakeholders and developing a best-practice Indigenous maternity service in an urban setting" (2018) 42(2) *Australian Health Review* 230-238.

[83] Kildea S, Tracy S & Sherwood J, "Improving maternity services for Indigenous women in Australia: moving from policy to practice." (2016) 205(8) *Medical Journal of Aust* 374-79; Sue Kildea et al, 'Reducing preterm birth amongst Aboriginal and Torres Strait Islander babies: A prospective cohort study, Brisbane, Australia' (2019) *EClinicalMedicine*.

> *"The health provider has the power of authoritative medical knowledge and the social privilege of medical authority, while the woman is largely dependent on the provider for information and care. A woman during childbirth is also particularly vulnerable. Although providers do not necessarily have the intention of treating their patients badly, "medical authority can thus foster a culture of impunity, where human rights violations do not only go unremedied, but unnoticed"[84]."*[85]

It remains the case that in Australia, as with the USA, the influence and power of (male dominated) medical institutions to control the discourse around pregnancy and childbirth and the health literacy of women, and through these controls, to greatly influence the mechanisms for accountability, have not abated. Equally, it should come as no surprise, given that the dissemination of information is entrusted to those with vested financial interests, that women, for the most part, in Australia, lack the knowledge and understanding of their human rights in pregnancy and childbirth and therefore find it difficult to assert them.[86] Aboriginal and Torres Strait Islander women, migrant women and refugee women not only lack the knowledge about their human rights in pregnancy and childbirth, they are terrified of the consequences if they do speak out.

HRiC notes, in Australia, the particular resistance of obstetric medical institutions and state and federal governments to engage with human rights lawyers in shaping government policy on maternal and reproductive health and health care through a human rights lens. Consumer engagement is at times offered but is carefully maneuvered to advocates with a limited understanding of funding, legal and human rights accountability structures, or those seen to be sympathetic to the political strategies of the prevailing government. The result is often the development of ineffectual guidelines or policy initiatives with no funding, no measurable evaluation requirements, and no accountability mechanisms for improvement or redress or assessment by reference to human rights standards and Australia's international obligations. Worse, toothless policy statements are used to promote health services (particularly in the private sector) and subsequently deployed to raise women's expectations that their human rights will be protected when they arrive at a facility, only to find that they have been tricked or cheated into putting themselves in the same unsafe situation that has now functioned for decades, from which they are unable to extract themselves.[87] This, in itself, is a form of abuse.

Nowhere is the exercise of this power imbalance more evident than when members of the medical fraternity use their social privilege to publicly attack and ridicule women who reject mainstream maternity health care. HRiC has noted, in Australia, a concerning preoccupation amongst the medical fraternity with attacking and ridiculing the personal health choices of women rather than reflecting on provider practices or acknowledging systemic problems that push women away from reproductive health services. Similar

---

[84] Joanna N. Erdman, 'Commentary: Bioethics, Human Rights and Childbirth', *Health and Human Rights Journal* (Commentary, 2 June 2015).
[85] Šimonović, UN Doc 19-111859 (E) 130819 (n 35 at para 49.)
[86] Campo M, "Trust, Power and Agency in Childbirth: Women's relationships with obstetricians." (2010) 22 *Outskirts Journal*, online edition, <http://www.outskirts.arts.uwa.edu.au/volumes/volume-22/campo>.
[87] Jomeen, J "The paradox of choice in maternity care" (2011) 18 *Journal of Neonatal Nursing* 60-62.

trends are observed in Ireland[88] and in the USA[89], where the obstetric medical profession is financially vested in maintaining control over the provision of pregnancy and childbirth health care services.

In Australia, polarised debates[90] over women's desire to homebirth are steeped in judgments aimed at reinforcing harmful gender stereotypes about women.[91] Leaders of medical fraternities, supported by a media hungry for salacious reporting, have publicly called women "selfish", "stupid" and "irresponsible"[92] for seeking alternate spaces that they perceive to be safer than the facilities in which those women were previously mistreated or abused.[93] No other profession has the ability, in spite of its role as a 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:

> *"There is no excuse for women who do not meet sensible inclusion criteria for homebirth to take unacceptably high risks with the potential of their unborn child. These women, these couples are not stupid, they are selfish," said WA Australian Medical Association President and obstetrician Dr Michael Gannon.*[94]

Representatives of the profession have also engaged in open attacks on anyone seen to be supporting women's choices to birth outside traditional settings or persons who seek to advocate for the human rights of women to self-determination and bodily autonomy. It often requires decades of evidence, a number of witnesses and a rare, intelligent and intrepid journalist to investigate and pursue these complaints in support of women's human rights.[95] In effect, statements attacking women are deliberate – and aimed at reinforcing the view that women are expected to suffer mistreatment and abuse in childbirth as part of their enduring, selfless maternal sacrifice or be socially isolated and censured for failing to be

[88] F Mullins, 'The Doctor used a Hacksaw on Me During Labour: Ireland's Women Speak Out', *The Telegraph UK* (online, 11 Feb 2015).
[89] L Hall, 'Doctors Violate American Women's Rights in Delivery Rooms Every Day', *LearnLiberty*, 17 July 2017).; R Grant, 'Ethics of the Delivery Room: Who's in Control when you're Giving Birth?', *Independent*, 18 Dec 2017).
[90] C. Homer, 'The homebirth debate in Australia - a clash of philosophies?' (2010) May/June(98) *Precedent* 38.; Lachlan H, "There is no moral imperative for women to give birth in hospital" (2014) *The Conversation* February 8, 2014 1.32am AEDT < https://theconversation.com/there-is-no-moral-imperative-for-women-to-give-birth-in-hospital-22732>.
[91] Ella Kurz, Jenny Browne and Deborah Davis, 'Trial by media; the vilification of homebirth' [15] (2017) 30 *Women and Birth* 15-16.; M. Sternadori, 'Birthing narratives in the news: Gendered notions of "real" womanhood.' (2010) 38(3) *Media Report to Women* 6-11, 19-22.
[92] Gartry L & Arrow B, "Women ignoring medical advice on homebirths 'selfish', peak medical body says" *ABC News Australia* (18 June 2015) at https://www.abc.net.au/news/2015-06-18/women-choosing-homebirths-selfish-peak-medical-groups-says/655566; Schetzer A, "Free Birthing trend on the rise, and it has medical experts worried" *News.com.au* (31 August 2017) https://www.news.com.au/lifestyle/parenting/pregnancy/free-birthing-trend-on-the-rise-and-it-has-medical-experts-worried/news-story/b7e033d2415c6a28f4fb64fa5280d891.
[93] 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) (2012/02/04) *Midwifery* 561-7.; Keedle et al (n 49); E. C. Rigg et al, 'A survey of women in Australia who choose the care of unregulated birthworkers for a birth at home' (2018) (2018/12/07) *Women Birth*.
[94] Katsambanis K, "Home birth will always be a game of Russian roulette" *Opinion, Sydney Morning Herald* (4 April 2016) at <https://www.smh.com.au/opinion/karalee-katsambanis-home-birth-will-always-be-a-game-of-russian-roulette-20160403-gnx6wi.html.>
[95] See report by Davey M, "Sydney obstetrician said women should sign a consent form for vaginal births" *The Guardian* (7 Nov 2019) https://www.theguardian.com/australia-news/2019/nov/08/sydney-obstetrician-said-women-should-sign-a-consent-form-for-vaginal-births.

“good mothers”. In some cases, this harmful gender stereotyping is being reinforced – and recommended - by the coroner’s courts.[96]

From a human rights perspective, even if these repeated statements from health professionals attacking women for their personal and self-protective choices[97] in childbirth are subsequently removed or corrected, they serve their purpose of reinforcing harmful stereotypes about public ownership and control over women’s bodies. They have proven highly effective at silencing women’s objections to mistreatment and abuse in the mainstream health system and preventing women from holding successive Australian governments to account for failing to properly integrate homebirth services into the health system network. Questions abound, and remain, over poor implementation of collaboration guidelines[98], competitive neutrality for privately practising midwives, and integration of homebirth services with acute, ambulance and allied health networks[99]. As the Report of the Working Group on the issue of discrimination against women in law and in practice noted:

> *Women’s non-discriminatory enjoyment of the right to health must be autonomous, effective and affordable and the State has the primary responsibility to respect, protect and fulfil women’s right to health in law and in practice, including where health services are provided by private actors.*[100]

It really is that simple.

Then there is the most obvious deflection: the blanket prohibition by medical practitioners on attending or supporting homebirth, which is in itself inconsistent with any professed claim to be concerned with respecting women’s choices and autonomy:

> *“You need three things in order for women to be free to choose home births," says Dr Leonie Penna, a consultant in foetal medicine and obstetrics at King's College hospital. "You need women who want a home birth, you need a supportive infrastructure and you need midwives who are happy to deliver it. Unfortunately, we obstetricians undermine the first two – and sometimes even all three. By our nature, we are very risk averse. Many of us blow out of proportion the risk inherent in home births, counselling women against it in a*

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

[97] E. Burns, 'The Meaning of Home: Spirituality and Domestic Space in Australian Home Birth Experiences' (PhD Thesis, University of Western Sydney, 2016).

[98] Rachele Meredith, Caroline S. E. Homer and Christine Catling, 'Private midwives and collaboration: What are their experiences?' [15] (2017) 30 *Women and Birth*.; P. K. Halverson, G. P. Mays and A. D. Kaluzny, 'Working together? Organizational and market determinants of collaboration between public health and medical care providers' (Pt American Public Health Association) (2000) 90(12) *American Journal Of Public Health* 1913-1916.

[99] McLelland G, McKenna L & Morgans A & Smith K, “Paramedics׳ involvement in planned home birth: A one-year case study” (2016) *Midwifery Volume* 38, July 2016, Pages 71-77.

[100] Council, UN Doc GE.16-05771(E) (n ; see also Ternovszky v. Hungary (2010) ECHR (Strasbourg) (Application no. 67545/09)<http://hudoc.echr.coe.int/app/conversion/pdf/?Library=ECHR&id=001-102254&filename=001-102254.pdf> at p22.

very paternalistic way. The fewer women choose it, the more the infrastructure is weakened. Then midwives begin to lose confidence, and suddenly the entire structure becomes shaky."[101]

These public attacks on women also serve to deflect from the serious behavioural and professional failures that have manifested (and been protected) [102] in medical facilities in Australia, the majority of maternal and newborn fatalities that also occur in medical facilities in Australia, and any investigation into or understanding of the number of maternal suicides that occur in Australia and its relationship with the harmful racial and gender stereotyping that women experience in pregnancy and childbirth.[103]

The result of this power imbalance, as endorsed by the states and judiciary, is the discrete relegation of pregnant women to a second-class status, decreed through healthcare policies and administered by facility based careproviders. Unlike non pregnant women and men, pregnant women are being required to sacrifice themselves, together with their rights and freedoms, for the sake of another. It is in this context that violations of a pregnant woman's basic human rights to the rights to life, privacy, personal autonomy, self-determination, freedom from discrimination and the highest attainable level of physical and mental health have become a commonplace and regular occurrence in Australia.

The power imbalance we describe does not occur in a vacuum. As we discuss in the next section, the medico-legal industry and governments have also worked to protect this imbalance in favour of providers by restricting women's access to accountability and redress for violations of their human rights.

II Protect

In Australia, women who have suffered harms in the provision of maternity health services can make a complaint, file a legal claim or do nothing. As we discuss below, the mechanisms for individual and consumer redress are not developing consistently or in sync with women's human rights. As a result, current accountability mechanisms fail to acknowledge or provide redress for violations of women's SRHRs, thereby contributing to the normalisation of rights violations in the provision of maternity health care.

In HRiC's view, the gap in accountability mechanisms is fueling the ongoing mistreatment and abuse of Australian women in the provision of reproductive health services.

[101] Hill A, "Home birth: 'What the hell was I thinking?" (2011) *The Guardian* (16 Apr 2011) https://www.theguardian.com/lifeandstyle/2011/apr/16/home-birth-trial-or-rewarding; See also, Wallace E & Davies-Tuck M, "Homebirth in Australia: eminence- vs evidence-based care" (2016) 46 MJA Insight (28 Nov) https://insightplus.mja.com.au/2016/46/homebirth-in-australia-eminence-vs-evidence-based-care/.
[102] Cresswell A, "Doctors "shielded Butcher of Bega" (2008, 29 February) *The Australian*. Retrieved from http://www.news.com.au/. . .butcher-of-bega/storye6frfkvr-1111115674252.; Pesce A, Davis C, & Tippett C, "Doctor doesn't deserve vendetta" (Letter to the editor) (2007, 9 October) *The Chronicle* (Toowoomba).
[103] Davey M, "'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>; Davey, M "Review finds deaths of seven babies due to 'key failings' at Melbourne hospital" (2015) The Guardian News (16 Oct) at https://www.theguardian.com/australia-news/2015/oct/16/review-finds-deaths-of-seven-babies-due-to-key-failings-at-melbourne-hospital, downloaded 5 July 2019; Davies G, *Queensland Public Hospitals Inquiry Report* Govt Printer, Brisbane, 2005: <http://www.qphci.qld.gov.au/final-report/Final-Report.pdf>

Making a Complaint

HRiC notes that significant barriers are raised against effective accountability or resolution for women whose human rights have been violated in pregnancy and childbirth in Australia. For instance, consumer complaints mechanisms are often lauded as an effective teaching tool to enhance patient satisfaction and improve practice within facilities. This does not, however, match the reality of women's lived experiences in Australia.

HRiC has reviewed hundreds of complaints from women to professional bodies and we note that women's complaints about human rights violations are either dismissed, ignored or retrospectively substantiated by an abuse of the doctrine of medical necessity. This occurs because:

(a) Practice standards focus on and develop 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 for protection against liability and to minimise the cost of insurance premiums[104];

(c) The practice standards by reference to which women's complaints are assessed have been written by health and/or medico-legal professionals who generally recommend the type of care that supports rights violations.[105]

> *..[I] was belittled, laughed at, ignored and told I had "issues" by delivery staff, the hospitals' risk manager, the hospitals' CEO, and ...the board that is supposed to regulate hospitals. These people DID NOTHING. – V. M.*

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.[106] Instead, the complaints are viewed as coming from patients who are inexpert, distressed or advantage-seeking. Staff assume that their role is to reinforce themselves as either the authority in decision making and to just be an empathetic listener.[107] Most women report the same, saying their attempt to explain their pain and injuries and the impact of abuse and mistreatment is viewed either as a waste of time or treated suspiciously as someone's attempt at extracting compensation. The many hospital written responses HRiC has viewed simply reinforce the views of the person who actively violated the woman's human rights, usually with a false, retrospectively shaped narrative that involves an abuse of the doctrine of medical necessity to justify human rights violations. We note too that hospitals in Australia will cancel any request for a meeting if advised that a human rights lawyer is going to be present with the complainant.

---

[104] Reiger KM, "Knights" or "knaves? Public policy, professional power, and reforming maternity services" (2011) 32(1) Health Care Women Int. 2-22, doi: 10.1080/07399332.2010.529218.
[105] Davey M, "A decade after the Butcher of Bega, red flags are still being missed" (2018) *The Guardian Au* (27 June) <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>.
[106] Marta Spranzi, 'Humanity and "Ordinary Abuse": Learning from Hospital Patients' Letters of Complaint' [264] (2018) 61(2) *Perspectives in Biology and Medicine* 264-278.
[107] Adams M, Maben J and Robert G, "'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) *Health* 603–623.

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.[108] When asked, the following is just some of the explanations HRiC has been provided:

> *"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." – A.W.3*

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

> *Several months afterward, I asked to meet with the doctor and midwives who attended my birth, but the hospital denied my request. The hospital did allow me to meet with the head of [xx]. .. Both of the hospital officials expressed sympathy for my trauma and said they were sorry I was unhappy with my care. However, they firmly stated that all women deliver on their backs in the hospital, and if a woman is not on her back when the doctor wants her to be, she will be forcibly moved into that position. They said they were sorry there had not been time for the doctor to explain that this was the way their hospital worked. They promised to implement new training to help midwives be gentler when they forced women on to their backs. I did follow up to see what sort of new training they had implemented, but they would not give me any information. – J. R.*

A significant reason for the failure to protect women's SRHRs in the provision of reproductive health services is the over-reliance on service providers to self-assess consumer complaints in maternity care and to substantially influence the outcome of court proceedings through the self-protective assertion of "expertise" and adherence to the reinstituted "Bolam defence"[109]. As we show below, providers shape and drive the policy directives, adherence to outcomes, practice standards and the education and training of medical and facility personnel which, in turn, are underpinned and driven by financial incentives, liability concerns and recommendations from insurers – with very little to consideration for women's human rights. These mechanisms encourage the treatment of pregnant women as a "means to an end" in facilities for childbirth, in violation of women's SRHRs.

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

[109] *Civil Liability Act 2002* (NSW) ss 5O, 50A, 5P; *Civil Liability Act 2003* (Qld) ss 20–2; *Civil Liability Act 1936* (SA) s 41; *Civil Liability Act 2002* (Tas) ss 21–2; *Wrongs Act 1958* (Vic) s 59; *Civil Liability Act 2002* (WA) ss 5PA, 5PB. The common law continues to apply in the Australian Capital Territory and Northern Territory.

The Civil Justice System

Access to justice has always proved challenging for women in Australia, 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 defense over civil prosecutions. Privately funded lawyers are price prohibitive for most new parents and would be considered an indulgence for most – particularly if the woman is planning on taking unpaid maternity leave.

The contingency fee structure, if available in a state, 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 in Australia. The contingency fee structure's efficacy is predicated on the promise of sufficient returns to address both compensation and damages to cover the costs of bringing the case. Contingency fee lawyers – particularly in Australia - will only take the cases they expect to award significant damages in maternity care. Women of color and other marginalized communities, in particular, suffer from inequitable access to redress and accountability for violations like forced surgery. With the impunity that arises from this gap in accountability, careproviders have become very comfortable with the notion of abusing and mistreating women of colour and women from marginalised communities. This is the process of normalisation of abuse and mistreatment of pregnant women that HRiC referred to earlier.

Privilege and socio-economic status do not necessarily protect women from experiencing mistreatment and abuse in childbirth. Women with greater socio-economic power and privilege find it easier to engage lawyers willing to advocate on their behalf, but are often reluctant to take on what they perceive to be a very powerful and defensive medical profession[110], and with good reason. The following is an extract from an article about Dr Emil Gayed and one of his patients, Vicki Cheadle, who describes how the profession was more concerned about protecting itself at the expense of her right to the highest attainable standard of physical and mental health:

> *"[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*

[110] Elizabeth Kukura, 'Contested Care: The Limitations of Evidence-Based Maternity Care Reform' (2016) 31(1) *Berkeley Journal of Gender, Law & Justice* 247; Elizabeth Kukura, 'Obstetric Violence' (2018) 106(3) *Georgetown Law Journal* 721.

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.[111]

HRiC is not at all surprised by this report as we commonly receive requests for help – particularly in rural and regional areas – where women are unable to find a provider willing to acknowledge the mistreatment and abuse at the hands of a colleague, to whom they are most likely dependent for referrals and professional support. Women need access to forms of accountability that do not require the permission of stakeholders with vested financial or professional interests.

Medical Malpractice Law

While we are undertaking more research in the Australian context, our efforts to drive human rights based litigation in this field in Australia have experienced the same barriers associated with medical malpractice litigation in maternity health care reported in the USA and the UK. Access to redress for maternal injuries is hampered by a number of factors:

(a) Gender bias in the legal system

Precedent findings in medical malpractice cases tend to downgrade maternal injury and prioritise foetal injury. Consequently, limits on potential damages as well as the statutory barriers make maternal injury cases less attractive to lawyers.[112] This constitutes a barrier to access to justice that prevents a legal remedy even before courts have a chance to examine the claim.

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 surgeries becomes a significant barrier and undermines patients' efforts to seek redress.

Winning is rare in maternal injury only claims and often is justified only because of serious or permanent maternal injury. In a recent US case for assault and battery for a forced Caesarean section resulting in a perforated bladder[113], for instance, a mid-level New York Appeals court ruled, somewhat astonishingly, that "***the state interest in the well-being of a viable foetus is sufficient to override a mother's objection to medical treatment***".

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

Medical malpractice lawyers in Australia appear to have a limited understanding of human rights and law and tend to believe in, and weigh on the side of, physician value-sets such as "doctor knows best" and "naïve or ignorant patient". Doctors also subscribe to this view as against the general public.[114] In most cases, these value-sets can be used to the advantage of patients.

---

[111] Davey, note 103.

[112] Diaz-Tello F, "Invisible Wounds: Obstetric Violence in the United States" (2016) 47 Reproductive Health Matters 56, 57; P Stewart and A Stuhmcke, 'Lacunae and Litigants: A Study of Negligence Cases In The High Court Of Australia in the First Decade of the 21st Century and Beyond' [2014] (2014) 38 *Melbourne University Law Review* 151.

[113] *Dray v Staten Is. Univ. Hosp.*, 160 A.D.3d 614 (N.Y. App. Div. 2018).

[114] Ostherr K, "The Shifting Aesthetics of Expertise in the Sharing Economy of Scientific Medicine" (2018) 31(1) *Science in Film and the Deficit Model* 107-127, https://doi.org/10.1017/S0269889718000054, published online: 27 March 2018.

However, when the value-set is used in the context of the fictional “materno-foetal” confict (described earlier), these values lend themselves to a culture of overriding informed consent, and the systematic subordination of one set of patient’s interests as against the fictional “other” (which as we described earlier, is really the provider’s interests). The harms to women are compounded, as they are repeatedly gaslighted into believing that the problems lay not with poor quality practice and provider interests, but with their ubiquitously deficient bodies.[115]

In Australia, women report that malpractice lawyers will request, particularly in the case of PTSD or psychological harm, that the woman find a practitioner who will prove the link between the mistreatment in birth and the psychological injury before they will accept her case. Psychiatrists specializing in this field rely on obstetricians to refer women to them for treatment. Not surprisingly, it is incredibly difficult for Australian women to find a psychiatrist who (a) understands the link between mistreatment, human rights violations and resulting harms; and (b) is willing to give evidence in support of women as opposed to referring practitioners.

Many women are also 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.[116]

“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.

(c) Foetal-centric focus in assessment of damages

Courts and lawyers tend to privilege claims for damages to fetuses or babies over those of mothers:

In the few cases where birthing women have prevailed in maternal harms cases, it is generally through a foetal injury derivative claim where - even in these cases - courts still have to press heavily to maintain the viability of a stand-alone maternal harms claim and defense counsel remains incredulous.[117]

(d) Mothers downplay their own physical injuries, while the courts and the law downplay psychological harm[118]

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

[115] Sara Cohen Shabot and Keshet Korem, 'Domesticating Bodies: The Role of Shame in Obstetric Violence' (2018) 33(3) *Hypatia* 384.; Sara 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).
[116] Beck C, “Birth trauma: in the eye of the beholder” (2004) 53 *Nursing Res*. 28-35).
[117] Abrams, JR, “Distorted and Diminished Tort Claims for Women” (2013) 34 *Cardozo L. Rev.* 1955-1980.
[118] Givelber, Daniel, “The Right to Minimum Social Decency and the Limits of Evenhandedness: Intentional Infliction of Emotional Distress by Outrageous Conduct” 82 *Columbia L. Rev*. 42, 44- 60 (1982).

In many cases, however, that psychological harm is also hampering 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.

The Discriminatory Impact of Medical Malpractice Litigation

Harms arising from human rights violations, unless associated with deviations from accepted medico-legally endorsed practice, are not recognised[119] and therefore devalued and dismissed as unimportant in medico-legal culture and practice.[120]

A good example of this is the disconnect between human rights and common law, on the one hand, and actual provider practice, on the other, in relation to obtaining informed consent. It is confirmed human rights law that a pregnant woman's human right to make informed choices about her own body according to her values is essential to securing the highest attainable standard of physical and mental health.[121] These principles are reflected in the common law shared between Australia and the UK which assumes, as a starting point, that all adults have the right to refuse medical treatment or to determine what happens to their body.[122] As a result of reliance on medico-legal pathways over a human rights approach to the provision of health services, however, providers have become both insulated and indoctrinated by a care paradigm that prioritises facility and insurance protocols at the expense of human experiences in facility practice.[123] For example, if the facility decrees a vaginal examination every four hours (as most of them do), whether or not it is medically indicated, a provider will badger and bully women into submitting to these treatments to avoid being disciplined or, worse, blamed for a later adverse outcome even if that outcome had little to do with mandated vaginal examinations. The failure to treat in accordance with facility protocols is associated with medical negligence - *whether or not the woman consented to the treatment.* It takes away provider incentives to defend or protect a woman's rights to informed consent and bodily autonomy in relation to any medical treatment.

---

[119] V. Tonei, 'Mother's mental health after childbirth: Does the delivery method matter?' (2019) 63 (2018/12/31) *J Health Econ* 182-196; Daniel P. Kessler, Nicholas Summerton and John R. Graham, 'Effects of the medical liability system in Australia, the UK, and the USA' [240] (2006) 368(9531) *The Lancet* 240-246.

[120] A Barrett and A. J. 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.; Beth A. Burkstrand-Reid, 'The Invisible Woman: Availability and Culpability in Reproductive Health Jurisprudence' (2010) 81 *Uni of Colorado Law Review* 97.; Elizabeth Kukura, 'Revisiting Roe to Advance Reproductive Justice for Childbearing Women' (2018) 94 *Notre Dame Law Review Online* 20.

[121] Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, UN Doc. E/C.12/2000/4 (2000), para. 8.; I. V. v. Bolivia, Report No. 72/14, Merits, Inter-American Commission on Human Rights, Case 12.655 (August 15, 2014), para. 186.

[122] In Re F (Mental Patient Sterilisation) [1990] 2 AC 1 (per Lord Donaldson); In re MB (medical treatment) 1997 EWCA Civ 3093; *Montgomery v. Lanarkshire Health Board* [2015] UKSC 11, 11 March 2015.

[123] Haque and Waytz (n 41).

By contrast, when it comes to issues of causation and damage in medical malpractice, the courts have relied on the illusion of a pregnant woman's right to assert her human rights to bodily autonomy to determine cases against her. In the case of *Harriton v Stephens*[124], a 25-year-old woman with severe congenital disabilities caused by her mother's infection with rubella while pregnant, sued her mother's medical provider for failing to warn her mother of the infection. Harriton's mother asserted that she would have terminated the pregnancy if she had been properly counselled of the infection at the appropriate time. The High Court of Australia rejected Harriton's application for relief, asserting a pregnant woman's right to decide whether or not to keep a pregnancy makes it unlikely for the so-called damage (i.e Harriton's birth) to be caused by the provider's failure to warn:

> *Such decisions are bound up with individual freedom and autonomy. 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. These circumstances can be expected to make it difficult for a court to assume that a possible conflict between the interests of mother and child would be "exceptional" and to complicate the task of a court in formulating normative standards of conduct against which breach of such a duty of care could be assessed.*[125]

In fact, as HRiC reported in Part 1 above, a woman's right to autonomy and bodily integrity, seemingly sacrosanct in the letter of the law, is frequently challenged by providers – particularly through the sphere of medical negligence - when it comes to childbirth. In addition, contrary to the expressed concerns of the High Court of Australia, that artificially constructed conflict between mother and unborn foetus in fact *underpins* medical and facility based training in the provision of maternity health care.

Aside from diminishing the importance of SRHRs of pregnant and childbearing women, the dominance of a medico-legal culture in reproductive health has created an "us vs them" mindset. Providers have now developed a vested interest in gaslighting the complaints of women in order to maintain the current practice structures and minimize liability exposure, even if they are knowingly violating the human rights of women. As noted earlier, personnel who do not support the workplace culture, particularly, newcomers or junior staff within the system, are at risk of being managed out of the system for not complying with the dominant voices:

> *"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. I don't know what questions to ask to make it better, I don't know if new or reformed laws would help, or if there needs to be more rounded education at university level -*

[124] *Harriton v Stephens* [2006] HCA 14; (2006) 226 CLR 52 (9 May 2006)
[125] Ibid, at para 248 (per Crennan J for the majority).

and if it's the fear of normal, because they are surrounded by abnormal every day, which drives some Obs, how do we change that?" – S.M

"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? This is coercion and a play on the woman's most vulnerable moment of her life and language that I have never felt comfortable with. How do we move forward to change this?" – G. M.

In recent years, and through global economic downturns, tort reform has proven to be the favourite political undertaking of states, in order to reign in perceived pro-plaintiff excesses of the civil justice system. Of the austerity measures imposed under that umbrella, caps on non-economic damages or strict time limitations on claims are the favored approach and it has had an enormous impact on birthing women's access to justice and, in our view, contributed to the rise in abuse and mistreatment of women in pregnancy and childbirth.[126] Legal restrictions vary among states, but some are so extreme that recovery is considerably hampered for childbearing women. As was noted in 2002:

"Health professionals have often actively lobbied for caps on non-economic damages, whereas consumer advocates have generally held that such limits ... are unfair to injured parties and especially create burdens for those with more serious injury. Further, caps may provide a disincentive for lawyers to take clients with meritorious cases and reduce incentives for deterring harm."[127]

Despite reforms, medical malpractice liability and defensive medicine continue to feature heavily in the practice of careproviders in medical malpractice jurisdictions across the globe.[128] Successful compensation claims turn into insurer's recommendations for practice which turn into hospital policies and practice standards.[129] Doctors commonly assert that liability hangs, like the sword of Damocles, above their heads, and that the prospect of a liability claim encourages overuse of interventions[130] in maternity care, the overriding of informed consent[131] and the focus on the foetus as a patient.[132] The reality is somewhat more complex, as research has indicated that these perceptions aren't the only factors to drive

[126] Field A, ''There must be a better way': Personal Injuries Compensation since the "Crisis in Insurance"' (2008) 13(1) *Deakin Law Review* 67.
[127] Carol Sakala et al. "Maternity Care and Liability: Least Promising Policy Strategies for Improvement" 23 *Women's Health Issues* e15, e17-18 (Jan. 2013).
[128] Natalie Malak and Y. Tony Yang, 'A re-examination of the effects of tort reforms on obstetrical procedures and health outcomes' [108626] (2019) 184 *Economics Letters*;
[129] 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.
[130] K. A. Wallis, 'No-fault, no difference: no-fault compensation for medical injury and healthcare ethics and practice' (2017) 67(654) (2016/12/31) *Br J Gen Pract* 38-39.
[131] J. R. Bean, 'Defensive Medicine: Rational Response to Irrational Risk' (2016) 94 (2016/08/16) *World Neurosurg* 568-569.; V. Gomez and M. Raimondo, '"Primum Non Nocere": are we getting carried away?' (2013) 45(6) (2013/05/07) *Dig Liver Dis* 462-3.
[132] C. T. 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.; D. Wilkinson et al, 'Protecting Future Children from In-Utero Harm' (2016) 30(6) (2016/02/13) *Bioethics* 425-32.

interventionist or defensive practice.[133] Even with tort reforms providing greater protection from liability, doctors have not necessarily reduced their intervention rates.[134] In Australia, intervention rates are well and truly on the rise[135], with Australia having one of the highest Caesarean section rates amongst developed nations.[136] As we have noted throughout this report, far more serious and profound matters are at play.[137] These include, but are not limited to:

(a) meeting changing regulatory requirements;

(b) endorsing the more restrictive practices of colleagues[138] to boost the volume of deliveries and/or recover higher reimbursement rates while also maintaining the "Bolam defence" that is now legally provisioned in some Australian states; and

(c) scheduling procedures for the sake of convenience.

Regardless of the reasons given for mistreating women in pregnancy and childbirth or for violating fundamental SRHR, the aforementioned systemic practices and the medico-legal liability structures that reinforce them have now become standard issue in Australia. Women do not feature as the priority in the treatment assessments conducted during the provision of maternity health care or in the development of maternity health care policy. This much was affirmed by one coroner who recently stated:

> *"…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.*[139]

Such extraordinary statements indicate that the pervasiveness of the medico-legal culture which, in the provision of maternity health care favours highly interventionist and coercive practices in violation of human rights, are recommended *legal* practices being endorsed by the courts. It has become so commonplace, even judicial officers are failing to recognise the obvious violations of a woman's human right to bodily autonomy and informed choice.

The Criminal Justice System

Cases can be brought for assault and battery in childbirth in Australia but the courts and the police force are overwhelmingly reluctant to accept complaints brought by birthing women of violence in health

---

[133] 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, https://doi.org/10.1007/s10754-016-9202-8.

[134] Lancet The, 'Medical negligence: there are no winners' [2079] (2018) 391(10135) *The Lancet* 2079.

[135] *National Core Maternity Indicators Canberra* (AIHW, ('*National Core Maternity Indicators*').

[136] Chen BK and Yang C-Y, "Increased Perception of Malpractice Liability and the Practice of Defensive Medicine" (September 2014) 11:3 *Journal of Empirical Legal Studies* p 446-476 <http://dx.doi.org/10.1111/jels.12046>; Y. W. Cheng et al, 'Litigation in obstetrics: does defensive medicine contribute to increases in cesarean delivery?' (2014) 27(16) (2014/01/28) *J Matern Fetal Neonatal Med* 1668-75.; D. J. Murphy, 'Medico-legal considerations and operative vaginal delivery' (2019) 56 (2019/03/05) *Best Pract Res Clin Obstet Gynaecol* 114-124.

[137] Currie J & Bentley MacLeod W, "First Do No Harm? Tort Reforms and Birth Outcomes" (2008) 123 *Q. J. Econ.* 795; Louise M. Nash et al, 'Perceived practice change in Australian doctors as a result of medicolegal concerns' [579] (2010) 193(10) *Medical Journal of Australia* 579-583.

[138] D. M. Studdert and T. A. Brennan, 'No-fault compensation for medical injuries: the prospect for error prevention' (2001) 286(2) (2001/07/13) *JAMA* 217-23.

[139] *Inquest into the* Death *of Thomas Fremantle*: COR 2010 4201 (8 April 2014) Vic Coroners Court, per Coroner J Olle at para 54.

services. If anything, the police force in Australia appear more interested in increasing investigations, forced medical treatment, monitoring, incarceration and the policing of pregnant women, allegedly for the purposes of protecting the unborn.[140] These strategies overwhelmingly affect women who are already vulnerable, and serve limited to no purpose given that we already know, from the experiences of *The Stolen Generation* in Australia, that these views are driven by outmoded and dangerous beliefs about racial superiority.

HRiC has represented women who have been inappropriately restrained or detained during childbirth, threatened by members of the police force while in labour, locked in theatres or denied access to their loved ones, and held down by personnel or security staff while doctors perform unwanted vaginal examinations or invasive cephalic maneuvers during labour without consent. We acknowledge that these are shocking and extraordinary reports of events taking place in public health facilities in Australia. What is more extraordinary, however, is the refusal of members of the police force to treat these occurrences as assault and battery because they were committed by health care providers. It is now established that women are much more vulnerable to experiencing domestic violence when pregnant.[141] What hope do pregnant women have of protecting themselves in domestic violence situations if providers are abusing and mistreating them in the presence of their domestic abusers *with state endorsed impunity*?

HRiC strongly advocates for the introduction of accountability measures dealing directly with violence against women in pregnancy and childbirth, including and specifically, violence committed in the course of providing medical treatment in pregnancy and childbirth. There are precedents for such mechanisms in other states. In 2006, following complaints from civil rights groups, Venezuela incorporated the concept into its legal framework, defining Obstetric Violence as:

> "*the appropriation of the body and women's reproductive processes by health care personnel, that is expressed in a dehumanizing treatment, in an abuse of medicalization and pathologization of natural processes, bringing with it loss of autonomy and ability to freely decide on their bodies and sexuality, negatively impacting in the quality of life of women*"[142]

Argentina, Panama, certain Mexican states, Bolivia, Brazil and El Salvador have followed suit. A number of academics are now calling for similar legislative provisions to be introduced to developed nations. Given the difficulties Australia's police force have with recognizing violence against women in maternity health facilities, there may be some merit in introducing specific legislative and criminally sanctioned requirements for addressing obstetric violence in Australia.[143]

---

[140] Queensland Police Union, "Submission to the Child Protection Inquiry re Rights to the Unborn" (201<http://www.childprotectioninquiry.qld.gov.au/__data/assets/pdf_file/0009/172692/Queensland_Police_Union.PDF>; Paltrow LM & Fravin J, "Arrests of and Forced Interventions on Pregnant Women in the United States, 1973–2005: Implications for Women's Legal Status and Public Health" (2013) 38(2) *Journal of Health Politics, Policy and Law*, DOI 10.1215/03616878-1966324.

[141] H. G. Dahlen et al, 'The relationship between intimate partner violence reported at the first antenatal booking visit and obstetric and perinatal outcomes in an ethnically diverse group of Australian pregnant women: a population-based study over 10 years' (2018) 8(4) (2018/04/27) *BMJ Open* e019566.

[142] English translation of Section 15(13) "Ley Orgánica Sobre el Derecho de las Mujeres a una vida libre de Violencia".

[143] Camilla Pickles and Johnathan Herring, 'Childbirth, Vulnerability and the Law: Exploring Issues of Violence and Control - Introduction' in Camilla Pickles and Johnathan Herring (eds), *Childbirth, Vulnerability and the Law: Exploring Issues of Violence and Control* (Routledge, 2020).

Human Rights Justice System

In Australia, claims for civil and human rights violations can be brought before the courts and through the AHRC. The restrictions imposed on the AHRC's powers of investigation mean that the human rights violations that women suffer at the hands of reproductive health care providers often go unrecognised. This too contributes to a normalization of the rights violation culture that we described earlier. Complaints brought before tribunals and the lower courts are tested by reference to a simplistic and meaningless comparative analyses, such as that used to assess discrimination on the basis of sex,[144] i.e., because the human rights violations potentially affect all women in pregnancy and childbirth, and are, for the most part, imposed by a feminised workforce (midwives and nurses), pregnant women are not being discriminated against on the basis of sex.

In the EU, a number of cases are being prepared to defend women's human rights in the context of pregnancy and childbirth which, while having mixed success, are slowly but surely creating a body of human rights law and precedent that reaffirm a pregnant woman's human right to privacy, life, health, bodily autonomy and informed consent, and the right to the preservation of her family unit. In 2010, the European Court of Human Rights declared that the circumstances of giving birth incontestably formed part of a person's private life for the purposes of Article 8 of the European Convention on Human Rights.[145] The Court found that the applicant, Ms Ternovsky, was in effect not free to choose to give birth at home because of the permanent threat of (criminal) prosecution faced by health professionals who sought to assist her, in this case, an obstetrician-turned-midwife who specialised in providing homebirth intrapartum care. The Court noted the absence of specific and comprehensive legislation on the issue of home birth in Hungary and expressed concerns about the mistreatment of women in birthing facilities.

III Fulfil

HRiC and the organisations that have endorsed this submission would welcome the opportunity to further discuss the dimensions around this constantly overlooked subset of state endorsed violence against pregnant and birthing women.

HRiC recommends the following steps to address the lack of human rights literacy in the provision of reproductive health care for all women:

1. Development of publicly funded programs to protect pregnant and birthing women in Australia, including but not limited to:
    a. Access to state-funded reproductive health services (including integrated access to abortion services) for all women, in all states;
    b. Paid parental leave for all women for one year, with access to a second year of leave for women who have suffered injuries or rights violations in pregnancy and childbirth (including for women who suffered stillbirths);
    c. Access to free, independent, human rights based, culturally sensitive antenatal and parenting education and support for pregnant women, together with information on accountability mechanisms and access to locally based resources to support women up

[144] *Wilson v Western Health* (Human Rights) [2014] VCAT 771.
[145] Ternovszky v. Hungary (2010) ECHR (Strasbourg) (Application no. 67545/09) <http://hudoc.echr.coe.int/app/conversion/pdf/?Library=ECHR&id=001-102254&filename=001-102254.pdf> at p22; Pojatina v Croatia (2019) ECHR (Application no. 18568/12); Dubská and Krejzová v. the Czech Republic (2014) ECHR Strasbourg (Applications nos. 28859/11 and 28473/12).

to two years after a birth, including support for women who have experienced miscarriage;

d. Establishment of a separate complaints mechanism with the Australian Health Practitioner Regulation Agency dealing specifically with rights violations in the provision of health, together with mandatory reporting mechanisms for abuse and mistreatment in facilities and by individual providers;
e. Mandatory review of all health policies – specifically maternity health care policies - through a human rights lens and by reference to WHO recommendations which promote the provision of publicly funded midwifery led maternity health care and human rights based antenatal, intrapartum and postpartum care;

2. Creation of the following targeted programs under a national framework:
    a. Develop a no-fault compensation scheme for injuries arising from the provision of maternity health services due to negligence;
    b. Develop a plan for costing and integrating all options for models of care in pregnancy and childbirth, including the removal of obstacles to access to birth centers, homebirth and Aboriginal and Torres Strait Islander *Birthing on Country* initiatives;
    c. Develop state - based institutions for the independent monitoring, advocacy and protection of SRHRs which include the recognition of obstetric violence as a form of gender-based violence against women, under a national reporting framework;
    d. Requirement that federal funding for state and healthcare systems is subject to oversight by independent human rights lawyers with expertise in the provision of SRHR laws to review and report on healthcare education programs, facility-based induction and training, policies, guidelines and professional standards, through a human rights lens;
    e. Incorporate age appropriate sex education, including elements of the physiology of childbirth as a healthy, undisturbed human life event, in primary school education – to be initiated as early as possible and provided on an ongoing basis;
    f. Development of racial literacy and cultural sensitivity in school curriculums, including an understanding of Aboriginal and Torres Strait Islander history (from the perspective of Aboriginal and Torres Strait Islander peoples and the intersectional issues faced by Aboriginal and Torres Strait Islander women) and the impact of colonialism on Aboriginal and Torres Strait Islander peoples today;
    g. Require the disclosure by careproviders, health facilities and states of all intervention practices and rates, and adverse events, whether or not evidence based;
    h. Mandatory inclusion in all medical, nursing and midwifery syllabi of human rights in childbirth and maternal rights education and training.

3. Access to justice measures:
    a. Developing measures for accountability in relation to all forms of violence against women regardless of perpetrator, including access to justice for women subjected to violence in health facilities, where both individual provider and health facility will be held accountable; and
    b. Develop and impose human rights based accountability mechanisms at the provider and professional level through the Australian Health Practitioner Regulation Authority, with separate cultural integrity and safety oversight mechanisms managed solely by Aboriginal and Torres Strait Islander representatives; and

c. Provide funding to publicly funded legal services for commencement of action for women who endure violence and abuse in the provision of health services.

Human Rights in Childbirth
Sydney
29 November 2019

Sources

Aubusson, Kate, 'Hospital complication rates 'veiled in secrecy' and marred by flawed definition of 'preventable': Grattan report', *The Sydney Morning Herald*, 4 February 2018)

Barrett, A and A. J. 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

Bean, J. R., 'Defensive Medicine: Rational Response to Irrational Risk' (2016) 94 (2016/08/16) *World Neurosurg* 568-569

Bohren, M. A. et al, 'The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review' (2015) 12(6) (2015/07/01) *PLoS Med* e1001847; discussion e1001847

Bradfield, Elly, 'Australia's maternity care at 'crisis point' with birth trauma rates increasing', *ABC NEWS* (Online report, 1 Nov 2019) <https://www.abc.net.au/news/2019-10-31/birth-trauma-ptsd-feminisms-forgotten-issue/11649116>

Burkstrand-Reid, Beth A., 'The Invisible Woman: Availability and Culpability in Reproductive Health Jurisprudence' (2010) 81 *Uni of Colorado Law Review* 97

Burns, E., 'The Meaning of Home: Spirituality and Domestic Space in Australian Home Birth Experiences' (PhD Thesis, University of Western Sydney, 2016)

Cabal, Luisa and Amanda McRae, 'Torture or Ill-Treatment in Reproductive Health Care: A Form of Gender Discrimination' in Anti-Torture Initiative Center for Human Rights and Humanitarian Law (ed), *Torture in Healthcare Settings: Reflections on the Special Rapporteur on Torture's 2013 Thematic Report* (American University Washington College of Law, 2014) 51

Chen, J. et al, 'A systematic review of prevalence and risk factors of postpartum depression in Chinese immigrant women' (2019) 32(6) (2018/12/19) *Women Birth* 487-492

Cheng, Y. W. et al, 'Litigation in obstetrics: does defensive medicine contribute to increases in cesarean delivery?' (2014) 27(16) (2014/01/28) *J Matern Fetal Neonatal Med* 1668-75

Cohen Shabot, Sara, '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)

Committee, United Nations Human Rights, *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

Council, Human Rights, *Report of the Working on the issue of Discrimination against Women in law and in practice*, A/HRC/32/44, 32 sess, Agenda Item 3, UN Doc GE.16-05771(E) (8 April 2016)

Coxon, Kirstie, Jane Sandall and Naomi J. Fulop, 'To what extent are women free to choose where to give birth? How discourses of risk, blame and responsibility influence birth place decisions' [51] (2013) 16(1) *Health, Risk & Society* 51-67

Dahlen, H. G., M. Jackson and J. Stevens, 'Homebirth, freebirth and doulas: casualty and consequences of a broken maternity system' (2011) 24(1) (2010/12/18) *Women Birth* 47-50

Dahlen, H. G. et al, 'The relationship between intimate partner violence reported at the first antenatal booking visit and obstetric and perinatal outcomes in an ethnically diverse group of Australian pregnant women: a population-based study over 10 years' (2018) 8(4) (2018/04/27) *BMJ Open* e019566

Dahlen, H. and J Hunter, 'The modern day witch hunt' 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 11

Dahlen, Hannah G., 'Is it Time to Ask Whether Facility Based Birth is Safe for Low Risk Women and Their Babies?' (2019) *EClinicalMedicine*

Dahlen, Hannah G. et al, 'Rates of obstetric intervention and associated perinatal mortality and morbidity among low-risk women giving birth in private and public hospitals in NSW (2000–2008): a linked data population-based cohort study' (2014) 4(5) *BMJ Open* e004551

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

Duckett, Stephen J et al, 'All Complications Should Count: Using our data to make hospitals safer' (Report No 2018-01, Grattan Institute, February 2018)

Einarsdottir, K. et al, 'Increase in caesarean deliveries after the Australian Private Health Insurance Incentive policy reforms' (2012) 7(7) (2012/07/31) *PLoS One* e41436

Einarsdóttir, Kristjana et al, 'Neonatal complications in public and private patients: a retrospective cohort study' (2013) 3(5) *BMJ Open* e002786

Erdman, Joanna N., 'Commentary: Bioethics, Human Rights and Childbirth', *Health and Human Rights Journal* (Commentary, 2 June 2015)

Field A, ''There must be a better way': Personal Injuries Compensation since the "Crisis in Insurance"' (2008) 13(1) *Deakin Law Review* 67

Felton-Busch, C., 'Birthing on country: an elusive ideal?' (2009) 33(2) (2009/11/26) *Contemp Nurse* 161-2

Fenwick, J. et al, 'Women's perceptions of emotional support following childbirth: a qualitative investigation' (2013) 29(3) (2012/11/15) *Midwifery* 217-24

Fenwick, J. et al, 'Why do women request caesarean section in a normal, healthy first pregnancy?' (2010) 26(4) (2009/01/02) *Midwifery* 394-400

Fielding, Richard et al, 'Racial Bias in Perceptions of Others' Pain' [e48546] (2012) 7(11) *PLoS ONE*

Grant, R, 'Ethics of the Delivery Room: Who's in Control when you're Giving Birth?', *Independent*, 18 Dec 2017)

Gomez, V. and M. Raimondo, '"Primum Non Nocere": are we getting carried away?' (2013) 45(6) (2013/05/07) *Dig Liver Dis* 462-3

Gynecologists, The American College of Obstetricians and, 'Refusal of Medically Recommended Treatment During Pregnancy', *ACOG.org* (Committee on Ethics Opinion No 664, June 2016) <https://www.acog.org/-/media/Committee-Opinions/Committee-on-Ethics/co664.pdf?dmc=1&ts=20191111T0051085108>

Haines, Helen M et al, 'The influence of women's fear, attitudes and beliefs of childbirth on mode and experience of birth' (2012) 12(55) *BMC Pregnancy & childbirth* 1

Hall, L, 'Doctors Violate American Women's Rights in Delivery Rooms Every Day', *LearnLiberty*, 17 July 2017)

Halverson, P. K., G. P. Mays and A. D. Kaluzny, 'Working together? Organizational and market determinants of collaboration between public health and medical care providers' (Pt American Public Health Association) (2000) 90(12) *American Journal Of Public Health* 1913-1916

Haque, Omar Sultan and Adam Waytz, 'Dehumanization in Medicine' [176] (2012) 7(2) *Perspectives on Psychological Science* 176-186

Hartz, D 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

Hauck, Y. L. et al, 'Association between childbirth attitudes and fear on birth preferences of a future generation of Australian parents' (2016) 29(6) (2016/05/29) *Women Birth* 511-517

National Core Maternity Indicators Canberra (AIHW,

Hernandez-Martinez, A. et al, 'Postpartum post-traumatic stress disorder: Associated perinatal factors and quality of life' (2019) 249 (2019/02/18) *J Affect Disord* 143-150

Hollander, Martine and Jeroen van Dillen, 'Women Refusing Standard Obstetric Care: Maternal Fetal Conflict or Doctorpatient Conflict?' (2016) 03(02) *Journal of Pregnancy and Child Health*

Holten, L. and E. de Miranda, 'Womens motivations for having unassisted childbirth or high-risk homebirth: An exploration of the literature on 'birthing outside the system'' (2016) 38 (2016/04/09) *Midwifery* 55-62

Homer, C., 'The homebirth debate in Australia - a clash of philosophies?' (2010) May/June(98) *Precedent* 38

Horsch, A. and S. Stuijfzand, 'Intergenerational transfer of perinatal trauma-related consequences' (2019) 37(3) (2019/06/21) *J Reprod Infant Psychol* 221-223

Hutton, E. K. et al, 'Perinatal or neonatal mortality among women who intend at the onset of labour to give birth at home compared to women of low obstetrical risk who intend to give birth in hospital: A systematic review and meta-analyses' (2019) 14 (2019/11/12) *EClinicalMedicine* 59-70

Iner, Derya, 'Islamophobia in Australia (2016-2017)' (Research Paper, Centre for Islamic Studies and Civilisations, Charles Sturt University,

Jackson, M., 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) (2012/02/04) *Midwifery* 561-7

Jašarević, Tarik, 'Individualized, supportive care key to positive childbirth experience, says WHO' (News Release, World Health Organisation, 15 Feb 2018)

Jenkinson, R and D. Fox, 'Maternity care plans and respectful homebirth transfer' 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 15

Johnson, C. T. 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

Jomeen, Julie and Lura L. Pethtel, *Choice, Control and Contemporary Childbirth* (Routledge, Ist ed, 2011)

Joseph, J., W. Brodribb and P. Liamputtong, '"Fitting-in Australia" as nurturers: Meta-synthesis on infant feeding experiences among immigrant women' (2019) 32(6) (2018/12/26) *Women Birth* 533-542

Kealy, M. A., R. E. Small and P. Liamputtong, 'Recovery after caesarean birth: a qualitative study of women's accounts in Victoria, Australia' (2010) 10 (2010/08/20) *BMC Pregnancy Childbirth* 47

Keedle, H. et al, 'Women's reasons for, and experiences of, choosing a homebirth following a caesarean section' (2015) 15 (2015/09/05) *BMC Pregnancy Childbirth* 206

Kessler, Daniel P., Nicholas Summerton and John R. Graham, 'Effects of the medical liability system in Australia, the UK, and the USA' [240] (2006) 368(9531) *The Lancet* 240-246

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

Kildea, Sue et al, 'Reducing preterm birth amongst Aboriginal and Torres Strait Islander babies: A prospective cohort study, Brisbane, Australia' (2019) *EClinicalMedicine*

Kukura, Elizabeth, 'Contested Care: The Limitations of Evidence-Based Maternity Care Reform' (2016) 31(1) *Berkeley Journal of Gender, Law & Justice* 247

Kukura, Elizabeth, 'Obstetric Violence' (2018) 106(3) *Georgetown Law Journal* 721

Kukura, Elizabeth, 'Revisiting Roe to Advance Reproductive Justice for Childbearing Women' (2018) 94 *Notre Dame Law Review Online* 20

Kumar-Hazard, B, '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

Kurz, Ella, Jenny Browne and Deborah Davis, 'Trial by media; the vilification of homebirth' [15] (2017) 30 *Women and Birth* 15-16

Laufer-Ukeles, Pamela, 'Reproductive Choices and Informed Consent: Fetal Interests, Women's Identity and Relational Autonomy' (2011) 37(4) *American Journal of Law and Medicine*

Malak, Natalie and Y. Tony Yang, 'A re-examination of the effects of tort reforms on obstetrical procedures and health outcomes' [108626] (2019) 184 *Economics Letters*

Mayra, Kaveri 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

Meredith, Rachele, Caroline S. E. Homer and Christine Catling, 'Private midwives and collaboration: What are their experiences?' [15] (2017) 30 *Women and Birth*

Meredith, Sheena, *Policing pregnancy : the law and ethics of obstetric conflict* (Routledge, 2016)

Mullins, F, 'The Doctor used a Hacksaw on Me During Labour: Ireland's Women Speak Out', *The Telegraph UK* (online, 11 Feb 2015)

Murphy, D. J., 'Medico-legal considerations and operative vaginal delivery' (2019) 56 (2019/03/05) *Best Pract Res Clin Obstet Gynaecol* 114-124

Nash, Louise M. et al, 'Perceived practice change in Australian doctors as a result of medicolegal concerns' [579] (2010) 193(10) *Medical Journal of Australia* 579-583

Obermeyer, Z. et al, 'Dissecting racial bias in an algorithm used to manage the health of populations' (2019) 366(6464) (2019/10/28) *Science* 447-453

Olza, I. et al, 'Women's psychological experiences of physiological childbirth: a meta-synthesis' (2018) 8(10) (2018/10/21) *BMJ Open* e020347

The prevention and elimination of disrespect and abuse during facility-based childbirth, WHO/RHR/14.23) (WHO Statement)

Patterson, J., C. Hollins Martin and T. Karatzias, 'PTSD post-childbirth: a systematic review of women's and midwives' subjective experiences of care provider interaction' (2019) 37(1) (2018/08/18) *J Reprod Infant Psychol* 56-83

Peters, L. L. et al, 'The effect of medical and operative birth interventions on child health outcomes in the first 28 days and up to 5 years of age: A linked data population-based cohort study' (2018) 45(4) (2018/03/27) *Birth* 347-357

Pickles, Camilla and Johnathan Herring, 'Childbirth, Vulnerability and the Law: Exploring Issues of Violence and Control - Introduction' in Camilla Pickles and Johnathan Herring (eds), *Childbirth, Vulnerability and the Law: Exploring Issues of Violence and Control* (Routledge, 2020)

Rao, V. S., H. Dahlen and H. Razee, 'Indian migrant women's experiences of motherhood and postnatal support in Australia: A qualitative study' (2019) (2019/10/22) *Women Birth*

Reddy, M. et al, 'Maternal Asian ethnicity and obstetric intrapartum intervention: a retrospective cohort study' (2017) 17(1) (2017/01/07) *BMC Pregnancy Childbirth* 3

Reed, R., R. Sharman and C. Inglis, 'Women's descriptions of childbirth trauma relating to care provider actions and interactions' (2017) 17(1) (2017/01/11) *BMC Pregnancy Childbirth* 21

Reiger, Kerreen, *Our Bodies, Our Babies: The Forgotten Women's Movement* (MUP, 1997)

Research, European Commission Directorate-General, 'Gender, parenthood and the changing european workplace: Young adults negotiating the work-family boundary: TRANSITIONS' (Research Paper, Project HPSE - CT-2002-00125 No EUR 22086 EN, DG Research, EC, February 2006)

Rigg, E. C. et al, 'A survey of women in Australia who choose the care of unregulated birthworkers for a birth at home' (2018) (2018/12/07) *Women Birth*

Rigg, E. et al, 'Not addressing the root cause: An analysis of submissions made to the South Australian Government on a Proposal to Protect Midwifery Practice' (2015) 28(2) (2015/01/22) *Women Birth* 121-8

Sadler, M. 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

Sassine, Heather and H. Dahlen, 'Identifying the poisonous gases seeping into the coal mine: what women seek to avoid in choosing to give birth at home' 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 6

Shabot, Sara Cohen and Keshet Korem, 'Domesticating Bodies: The Role of Shame in Obstetric Violence' (2018) 33(3) *Hypatia* 384

Šimonović, Dubravka, *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)

Simpson, M. and A Cater, 'Birth Trauma: The noxious by product of a failing system' 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 12

Simpson, M. et al, 'Postnatal post-traumatic stress: An integrative review' (2018) 31(5) (2018/01/18) *Women Birth* 367-379

Slade, P. et al, 'Establishing a valid construct of fear of childbirth: findings from in-depth interviews with women and midwives' (2019) 19(1) *BMC Pregnancy and Childbirth*

Small, Kirsten A. et al, 'Intrapartum cardiotocograph monitoring and perinatal outcomes for women at risk: Literature review' (2019) *Women and Birth*

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

Sternadori, M., 'Birthing narratives in the news: Gendered notions of "real" womanhood.' (2010) 38(3) *Media Report to Women* 6-11, 19-22

Stewart, P and A Stuhmcke, 'Lacunae and Litigants: A Study of Negligence Cases In The High Court Of Australia in the First Decade of the 21st Century and Beyond' [2014] (2014) 38 *Melbourne University Law Review* 151

Studdert, D. M. and T. A. Brennan, 'No-fault compensation for medical injuries: the prospect for error prevention' (2001) 286(2) (2001/07/13) *JAMA* 217-23

ten Hoope-Bender, Petra et al, 'Improvement of maternal and newborn health through midwifery' [1226] (2014) 384(9949) *The Lancet* 1226-1235

The, Lancet, 'Medical negligence: there are no winners' [2079] (2018) 391(10135) *The Lancet* 2079

Thornton, C. et al, 'Maternal deaths in NSW (2000-2006) from nonmedical causes (suicide and trauma) in the first year following birth' (2013) 2013 (2013/09/12) *Biomed Res Int* 623743

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

Wallis, K. A., 'No-fault, no difference: no-fault compensation for medical injury and healthcare ethics and practice' (2017) 67(654) (2016/12/31) *Br J Gen Pract* 38-39

Ward, J. B. et al, 'How do we assess a racial disparity in health? Distribution, interaction, and interpretation in epidemiological studies' (2019) 29 (2018/10/22) *Ann Epidemiol* 1-7

WHO, 'WHO recommendations on antenatal care for a positive pregnancy experience' (Working Paper, World Health Organisation Geneva,

WHO, 'WHO recommendations: intrapartum care for a positive childbirth experience' (Research Paper No Licence: CC BY-NC-SA 3.0 IGO., World Health Organisation Geneva,

Wilkinson, D. et al, 'Protecting Future Children from In-Utero Harm' (2016) 30(6) (2016/02/13) *Bioethics* 425-32