

Introduction

'Stichting GeboorteBeweging¹' -GB Foundation- is a grass roots originated foundation aiming to secure women's human rights in Dutch maternity care during pregnancy, childbirth, and postpartum period.

Among other things, we inform and support women who ran into the limitations of the Dutch integrated maternity care system. Our Facebook platform has over 2500 members and grows every day.

Gb foundation will herewith report on mistreatment and violence against women during reproductive health care and childbirth in the Netherlands.

As a foundation that has been battling obstetric violence for almost a decade now, we are very grateful to the UN Special Reporter for drawing the attention to this type of violence against women (VAW). We hope this will eliminate the mistreatment that pregnant women all over the world go through in childbirth.

In case of questions about this report or our organization, please don't hesitate to contact us at info@geboortebeweging.nl

On behalf of the board of GB foundation,
Mira Westland

¹ Translated: Birth Movement, for more information www.geboortebeweging.nl

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1. Please indicate whether in your country there are cases of mistreatment and violence against women during reproductive health care, particularly facility-based childbirth. If so, please specify what kind of cases and describe your country's response and any good practices, including protection of human rights

With its relatively low caesarean rate (15.2% ²) and home-birth (12,7% ³) as a legal option, the Dutch maternity system is a well-known outlier in the Western world. Notwithstanding The Netherlands' reputation for women-friendliness, since our foundation in 2010 we receive many stories of obstetric violence each year. Stories about violations of basic human rights, about women being left alone, misinformed or disrespected, women being coerced, or even forced, to comply with protocols in a highly standardized supply-driven system.

The Netherlands are a small country - In 2017 163.826 women gave birth to 166.440 babies⁴. Human rights are highly valued and secured in Dutch legislation.

Still, our 2016 'Break the silence' campaign⁵; urging women to share their experiences with obstetric violence on social media, became Twitter's trending topic on the first day. We received 600 hundred submissions in only two weeks and thousands more added their stories.

Many others told us offline they did not dare to share their story online. Some had not been able to speak about their experience for years. In total, the Facebook page counted 1,5 million interactions.

In our call we mentioned various forms of obstetric violence including: physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination, abandonment and detention. The submissions that followed show all these categories of disrespectful and abusive care still exist in the Netherlands today. (See appendix for examples.)

Even though physical abuse is perceived as highly unlikely in the Netherlands, more than a few women send in stories of direct violence, like unnecessary or extended episiotomies and using physical force to restrain the woman for an intervention she explicitly did not want. The campaign also showed that non-consented care -where women aren't informed or asked for their permission in advance- and non-confidential care - violations of privacy during delivery or privacy of medical history- are much more common and partly standardized⁶ in our current system of maternity care.

² <https://www.perined.nl/publicaties1/publicaties/jaarboeken>

³ <https://www.perined.nl/publicaties1/publicaties/jaarboeken>

⁴ <https://www.perined.nl/publicaties1/publicaties/jaarboeken>

⁵ Translated: '#Genoeggezwegen'

⁶ Since the implementation of the EDP (electronic Patient Dossier) we frequently hear that information is shared by default within the obstetric cooperation. Women can 'opt out' instead of giving their permission before their medical information is shared with any other caregivers.

The stories most of these women shared were very clearly non-emergency situations. They were confirmed by caregivers reflecting on their own behavior by sharing their experiences with obstetric violence under the hashtag #handineigenboezem; 'look nearer home'. Still the responses - both on social media and offline, from laymen and respected healthcare providers - suggested that they must have been emergency situations in order to justify the violence. Women were portrayed as ignorant, ungrateful and even accusatorial towards their caregivers. This painfully revealed that many forms of obstetric violence are socially accepted in the Netherlands.

Notwithstanding the media attention our action generated, narratives without numbers carried no political weight either. The black book summarizing the action was received without much interest by our (at the time, female) minister of health and ended up in a bottom drawer soon thereafter.

In response to our parliamentary questions, we received a letter from the state secretary, that no extra measures were necessary according to the professional organizations, who simply dismissed the incidents as excesses or necessary measures to save babies. No political or legal measures to prevent obstetric violence in the Netherlands have been taken since.

Rather scarce research from Australia, Italy, the UK and the US confirms the suggestion that disrespect, abuse and misinformation in maternity care are common, even in countries with a high standard of health care. Our action suggests this counts for the Netherlands too, it just has not been investigated systematically – or barely at all.

There is endless research on birth outcomes for babies. From the numbers of articles it appears that the mother's physical – let alone mental or emotional – short and long-term outcomes are of much less interest.

The research that includes the mothers' experiences into the equation, rarely succeeds in getting women to talk about obstetric violence, as the knowledge base can be heavily influenced by the type of questions that get asked – and those that do not⁷.

⁷ We describe the following studies: The 'Wonderstudy'(Why women want Other or No Delivery care) which studied the phenomenon of birthing outside the system, and the TEACH study (Traumatic Experiences Associated with CHildbirth), which investigated why women experienced childbirth as traumatic. Both studies demonstrated associations between certain birth complications and traumatic experiences. But they didn't make a distinction between trauma as a result of obstetric violence and trauma after complications.

The latest study: Birthing outside the system, trauma and autonomy in maternity care, opposed to previous studies, asked women what could have prevented their trauma.

The results of a survey included in this study show women attribute their traumatic childbirth experience primarily to lack and/or loss of control, issues of communication, and practical and/or emotional support. This study shows that, although a traumatic childbirth experience is often associated with certain birth complications, it is not the occurrence of the complication in itself that causes the experience to be a traumatic one, rather, a lack of communication and support from the provider.

Although this study has eye for the actions of caregivers (or the lack thereof), it is no quantitative study into mistreatment and obstetric violence. Even though, lack of communication and loss of control are both associated with OV, there is no mention of obstetric violence or rights violations. By portraying women's experiences as individual and subjective, we find little or no acknowledgement of the system that causes rights violations, structurally.

For that reason, in collaboration with our foundation, the department of Midwifery Science of the University of Amsterdam started a PhD trajectory that we hope will result in the actual numbers of obstetric violence in the Netherlands.

But, the lack of scientific research on the subject is not the only reason, why obstetric violence remains unnoticed and undiscussed in the Netherlands. It is extremely hard to discuss, or investigate, because there is no accurate Dutch translation for it. The English noun 'violence', means so much more than just 'behaviour involving physical force intended to hurt or damage someone'. Whereas the Dutch translation: 'geweld', is limited to just that.

Since physical abuse is not the most common, or accepted, form of obstetric violence in the Netherlands, and there's almost never an intention to harm women, this word cannot be used to start a constructive conversation on the subject.

Additionally, this narrow Dutch translation makes discussing Obstetric violence, using the English words, harder too.

Because obstetric violence almost always involves, rights violations, the Dutch word 'rechtenschending' would be the better alternative, which we commonly use.

But this translation is not only less accurate than its English counterpart, it still touches a raw nerve in most Dutch, since human rights are taken extremely seriously here.

As the next chapter will show, we can simply not believe human rights could be violated in The Netherlands. So whether we use 'Obstetric violence', 'geweld' or 'rechtenschending', the main response, even from women who have actually experienced it themselves, is: 'this doesn't happen here, because it was not intended as a violation'.

Alas, the lack of a Dutch word or political consequences, our action was felt to be supportive by so many women and we managed to break the taboo surrounding on a negative birth experience and injustice during childbirth⁸.

Nowadays more women share their experiences with obstetric violence in social media groups like ours and even encourage each other to stand up for their rights in (disciplinary) courts.

Over the last year alone, several cases involving women's human rights during childbirth have been processed (and mostly dismissed) by Dutch (disciplinary) courts. Before reporting on those lawsuits, we will specify how informed consent is embedded in our minds, laws and health policies.

⁸ <http://geboortebeweging.nl/dag-9-emails/>

2. Please specify if full and informed consent is administered for any type of reproductive health care and if these include childbirth care;

Basic human rights are part of the Dutch constitution and they are specified in our health laws. Informed choice - implicating both consent and refusal, although they are not mentioned separately - is an existing right that all health practitioners underwrite fully.

The Netherlands are - or at least think of themselves as - a historically open and liberal society. All Dutch say that human rights are very important to them and they should be respected, always. This has led to progressive legislation on reproductive rights for women. Despite of several right-winged and/ or Christian organizations aiming for that to change⁹, in case of abortion this is still the case - both in legislation and in practice. But when a woman decides to proceed with the pregnancy, something extremely “un-Dutch” happens; she has to turn to a system full of very conservative morals towards birth, motherhood and women in general.

Although informed choice is taken care of legally, and these laws are applicable to reproductive care and childbirth, in practice there are many violations. Most of which are not even seen as such by women, their caregivers and society as a whole.

The Dutch system, that is said to serve as an example to the world of obstetrics, is currently being used to violate basic human rights to informed choice, bodily integrity and privacy.

The Dutch government has willingly implemented measures that contribute to this development. Even though the assumption that these measures will lead to better fetal outcomes has not been supported by scientific research.

Instead of facilitating women in exercising their human right to self-determination, women are forced into the ‘integrated maternity care’ system.

Integrated maternity care – Risk assessments vs. women’s rights

In 2010 the Dutch government started to (urgently) encourage care providers to cooperate throughout the entire supply chain. So called ‘obstetric cooperation’s¹⁰ emerged and were urged by the government to develop protocols, in which they capture their local collaboration agreements based on joint risk assessments.

⁹ Women are offered subsidized informational meetings about their options in case of an unwanted pregnancy. These meetings are offered by three organizations. Among them is Siriz, the Christian organization that originated from the ‘Protection of the Unborn Child Association’.

Women are also increasingly harassed and intimidated by anti-abortion protesters at the entrance of abortion clinics. We find this extremely worrying, because women must be able to count on independent information.

<https://www.humanistischverbond.nl/abortus/>

¹⁰ In Dutch; Verloskundig SamenwerkingsVerband (VSV).

To women, this risk based system implies that, except for some ultrasounds, standard examinations are not up for debate. Standard testing and interventions are usually presented as a given, in the information women receive (written and otherwise).

Women are not usually informed about their right to consent to or refuse tests or treatments. It is not standard to tell them what the (dis)advantages and alternatives of the proposed interventions are.

This goes for blood tests and ultrasounds. But also for vaginal exams during labor, artificial breaking of the membranes and oxytocin shots after the child is born are usually not up for debate.

But, the tendency not to fully inform women about their (legal and medical) options and alternatives is not limited to standard or prophylactic treatments. Not seldomly does it also apply to elective or acute interventions, such as an episiotomy, instrumental delivery or cesarean section.

Although women in the Netherlands can choose whether they want to give birth at home or in an outpatient clinic, research shows they cannot make this choice unconstrained¹¹.

The information women are given regarding this choice is incomplete at best, sometimes downright untrue. As a result of their rigid application, guidelines and protocols determine the place where Dutch women give birth, and usually not the women themselves. More information about this research and a few examples can be found in the appendix.

Last decades' system reform has intensified the restriction of informed consent and freedom of choice in practice. Starting 2015, integration is being enforced through joint funding of obstetric cooperation's, making it increasingly difficult for care providers to work independently or deviate from medical standards and local protocols.

This also means that, although out of hospital birth is still a legal part of our system, this option is not available to all women. There are only a few midwives who are willing to offer true hands off childbirth assistance at home to 'low risk women'. The ones that facilitate out of hospital births for "high risk women" can be counted on one hand.

A few of them charge extra (creating an extra financial barrier). Many of these midwives are under constant scrutiny of the health inspection and have difficulties holding up financially. They are threatened with exclusion from the hospital collaborations, preventing them from getting paid.

As this is perceived very intimidating, many have discontinued their practices. Client-led instead of guideline-led caregivers have become so scarce that, even if a woman decides she doesn't want to comply to compulsory medical advice, it is nearly impossible to find an alternative caregiver.

¹¹ Pregnant women will be incompletely informed about the different options and their freedom of choice regarding the birth place. This ignores the core values as described in the Medical Treatment Agreement Act (WGBO), in which information provision and freedom of choice are two important key points.

Because online information provision is playing an increasingly important role in the current health care system, we asked two graduating midwifery students to research at how pregnant women are informed on websites about the options they have with regard to the place of delivery.

Thanks to the implementation of joined funding, women's rights have become paper rights. Local protocols are considered law instead of medical advice. Since these protocols were primarily designed to record working agreements, human rights or Dutch law are no part of them and remains largely unknown to all parties involved.

Although the local protocols all adhere to the national guidelines, joint funding has also enhanced regional differences - in terms of both assessed risks and their consequences for treatment. Consequently, women with the same condition can be offered different standard care and options, depending on local customs and preferences.

Local differentiation of this thoroughly standardized, supply driven, integrated system does not only violate human rights of individual women, but it also leads to increasing legal uncertainty for all women in the Netherlands.

Legal ignorance and popular misconceptions

Although we have mentioned and discussed the trends described above with all parties it may concern, including the parliament, they still believe (not based on facts), that an 'integrated' system is going to lead to better care and less infant mortality. Women's rights can be trumped when necessary (when the care provider deems it necessary).

To this day, women in the Netherlands, hear hardly anything about their rights to make their own decisions in pregnancy and childbirth. On our Facebook group, we get asked questions about these rights on a daily basis. We find it even more alarming that most caregivers are not aware of the applicable laws either.

Two most common examples: Caregivers are led to believe that they are responsible for the outcome of the care they give (perinatal mortality), instead of the care itself (including informed consent and refusal).

Secondly, they think they have a legal contract- a medical treatment agreement¹² - with the unborn baby as well as the mother. When in fact, under Dutch laws, children have no rights until they are born. This is again in line with popular opinion, that unborn children should have rights. There's even a trend towards limitation of informed consent legally¹³.

These popular misconceptions were recently confirmed by dr. M.H. Hollander Ob-Gyn in her thesis; Birthing outside the system, trauma and autonomy in maternity care¹⁴.

(Breaking) Trends

A few attempts to break this trend of further chain integration and disguised budget cuts at the expense of freedom of choice and basic human rights for pregnant women have been made over the last couple years;

¹² In Dutch Geneeskundige behandelovereenkomst <https://wetten.overheid.nl/BWBR0007021/2006-02-01>

¹³ A group of prominent Rotterdam gynecologist proposed to use financial legislation to give unborn children legal status, to get around a woman's bodily integrity and make forced caesareans possible.

During the symposium that was held on the subject, 30% of the audience (mostly care givers) was in support of this proposal. We are still waiting for the first time that this is attempted in practice.

¹⁴ <https://books.ipskampprinting.nl/thesis/528107-hollander/14/> p. 263 "Chapter 2 outlines the legal and ethical intricacies of situations where pregnant women and their maternity care providers disagree on a birth plan. Women may opt for a birth in a setting that is against recommendations, for instance a home birth in a high risk pregnancy. Alternatively, they may request to have a hospital birth with a community midwife, in a situation in which this is against medical advice, for instance a breech or twin birth, or they may refuse certain items of recommended care, such as continuous fetal monitoring during a trial of labor after a previous caesarean section. In these situations, medical professionals may feel as if there is a conflict between the wishes of the woman and the best interests of the baby she carries. This may lead providers to resort to measures such as coercion, or actual force, such as a court-ordered caesarean section. In this chapter, we outline the positions of various professional organizations pertaining to coercion and force, and illustrate that it is actually the professional the woman is in conflict with, and not the baby she is carrying. We conclude by stating that, in the great majority of cases, actual shared decision making will resolve the issue, and if not, the autonomy of the woman should always prevail."

A guideline about 'out- of guideline maternity care' has been written and implemented. It addresses how to provide demand-driven care, even when women refuse standard care or request care that is different from what protocols describe.

Main goal of this guideline is to provide clarity on the rights of pregnant and birthing women. It emphasizes communication between the attending midwife and the hospital in case of a referral or complications during labor - since women are often scolded when they come to a hospital during a planned enhanced or high risk home birth.

Unfortunately even when this guideline is known to caregivers, it is often used as a means and lessen their own accountability, or forced information sharing against women's wishes, instead of really give women options. As we will show in the appendix, it has already been used in several lawsuits, resulting in less rights or choice for pregnant women.

With our support, Women's rights organization Bureau Clara Wichmann¹⁵ started a legal procedure¹⁶ to stop compulsory integral funding of birth care organizations. The lawsuit was recently lost.

Again, with Clara Wichmann we also supported 'Sophie' - 37 weeks pregnant – in a lawsuit against her hospital. The hospital didn't allow her to give birth with her chosen midwife, because the midwife was prepared to offer Sophie and alternative to their proposed treatment.

Even though a so called 'poliklinische' or outpatient childbirth¹⁷ is a valid legal option to pregnant women in the Netherlands, the hospital refused this midwife access to the hospital because she wasn't affiliated to their obstetric cooperation.

Although this is against a women's right to self-determination and freedom of choice, the lawsuit was lost. The judge ruled that the hospital is not obligated to conclude an admission agreement to a midwife that does not wish to comply with the provisions contained in their protocols.¹⁸

Although Sophie has already given birth by now, we are still awaiting the appeal.

15 A women's rights organization that strives for a better social and legal position for women in the Netherlands by promoting and influencing the law, regulations, legal practice and the application of legislation that directly affect fundamental women's rights issues.

¹⁶ <https://www.clara-wichmann.nl/rechtszaken/keuzevrijheid-in-de-geboortezorg>

¹⁷ Where the midwife 'rents' a room within the hospital for the woman to give birth supported by her.

¹⁸ <https://uitspraken.rechtspraak.nl/inziendocument?id=ECLI:NL:RBZWB:2018:1745>

3. Please specify whether there are accountability mechanisms in place within the health facilities to ensure redress for victims of mistreatment and violence, including filing complaints, financial compensation, acknowledgement of wrongdoing and guarantees of non-repetition. Please indicate whether the ombudsperson is mandated to address such human rights violations.

As opposed to general (medical) knowledge and opinion, caregivers, under Dutch law, are not only obligated to provide care¹⁹. Providing all relevant information and alternatives (including doing nothing) is also mandatory.

There are basically four legal options open to women in case their caregivers do not adhere to the law.

1. A woman can file a formal complaint with the hospital or association of caregivers. All hospitals and associations are obligated by law to have an independent officer and commission for complains.

In practice these boards are not as independent as they should be and we regularly hear that procedures are not being followed. (Two examples can be found in the appendix.)

2. This is why in January 2016, the Dutch Healthcare Industry Complaints Act -Wet kwaliteit, klachten en geschillen zorg (Wkkgz)²⁰ - has been implemented. The Wkkgz applies to all healthcare institutions and all healthcare professionals and obligates them to be affiliated with independent dispute resolution body.

From now on, healthcare providers must also report all forms of violence to the Healthcare Inspectorate. Although, this is a significant improvement of women's positions, this has mostly been a paper measure so far, since by our knowledge, no obstetric violence has been reported by healthcare professionals yet.

Still, we are hopeful about this relatively new opportunity for women. The law aims to minimize the threshold for complaints in order to improve the quality of care. It has improved the clients position and made it easier to file for damages (although there's a €25000 maximum).

Since the consequences for individual care givers aren't as severe as disciplinary actions, this law hopefully increases a victims' chances of getting recognition, punitive damages paid or even change the system.

3. Women can take disciplinary actions against the specific caregiver. A jury of peers will then decide whether the caregiver has adhered to the medical standards. Basically, they will judge based on what they would have done in a similar situation. The disciplinary board can take disciplinary measures against individual caregivers that did not adhere to professional

¹⁹ Women report to us regularly that their caregiver will no longer help them if they don't agree to the proposed treatment.

²⁰ <https://zoek.officielebekendmakingen.nl/stb-2015-407.html>

standards. This would be a beautiful system, if only the law was part of the professional standards.

A few recent example showed that lack of informed consent is common practice and allowed, as long as there were medical reasons. It does not even have to be an emergency. We fear, as long as obstetric violence is embedded in the system and therefor common practice, disciplinary boards are not inclined to judge otherwise, creating even more jurisprudence on the subject.

4. Her last option is filling a private liability suit. Usually, the hospital (or sometimes an individual caregiver) is held accountable for (physical, mental and financial) damage done to a woman.

But in this case the burden of proof is inverted. The woman has to proof the damage was done by the doctors or midwives actions, instead of the doctor or midwife proofing the necessity of his/ her actions or interventions.

In practice, not also does she have to proof causality between the caregivers actions and her damages, which can be hard to do. Usually, it also means a woman has to successfully proof that she would have gone against medical advice, if she had been given the choice.

When she does so successfully, this immediately puts the woman herself on trial. She basically has to show she was not crazy for doubting the doctors decisions. That's a very hard thing to do, since medical practitioners are still perceived as authorities (both inside and outside the courtroom). As far as we know of, it has not been done successfully (yet, because there is at least one case in preparation for several years now.)

4. Does your health systems have policies that guide health responses to VAW and are these in line with WHO guidelines and standards on this issue

There are definitely policies to combat VAW in the Dutch healthcare system. As this report shows, the Dutch are excellent policy makers and VAW is taken very seriously. But, in the Netherlands, obstetric violence is not recognized and acknowledged as such. There isn't even an accurate Dutch translation.

When advocates try to raise awareness to this type of VAW, most caregivers feel attacked, misunderstood in their good intentions and wrongly accused of being perpetrators. This does not help our changes to change the system.

Secondly, our integrated maturity care system is ironically called 'woman centered'- like in the WHO guidelines. Just like the WHO guidelines, it is said to be '*organized around women's health needs and perspectives*²¹', while in practice there's no room for individual needs and perspectives.

Opposed to the guidelines, it disempowers women, doesn't provide women with information or support to make informed choices and decisions. Although it aims the opposite, our

²¹ 1.3. *What is a woman-centred health response?*

Care and health services for women who have been subjected to violence should be woman-centred – that is, they should be organized around women's health needs and perspectives.

A woman-centred health response offers care that:

- *takes actions to enhance women's safety;*
- *minimizes or does no harm and maximizes benefits of how services are designed and delivered;*
- *takes into account women's perspectives;*
- *responds to women's needs and concerns in humane and holistic ways;*
- *provides women with information and supports them to make informed choices and decisions;*
- *empowers women to participate in their own care.*

Two fundamental principles guide woman-centred care: • respect for women's human rights; and • support for gender equality.

Source: "Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence A manual for health managers: Page 8"

<https://apps.who.int/iris/bitstream/handle/10665/259489/9789241513005-eng.pdf%3bjsessionid=87D2C09FA4E78A6C623ADA9989B2E34E?sequence=1>

current system is designed and delivered to minimize costs and risks for the fetus at the expense of women's human rights and freedom of choice.

Protocols are often used to override informed consent. Victims are perceived as ignorant, and ungrateful for their healthy babies. And the legal options women have to fight this are very limited in practice.

On top of those consequences for individual women, it has led to more inequality based on medical, social or financial in our society as a whole.

We fear that, as long as policy makers are in denial over obstetric violence, the abuse described in this report will continue. Therefore we urgently ask the counsel to;
Explicitly define obstetric violence²² as a category of VAW, and have its characteristics and measures to prevent it added to manuals on the subject.

²² A definition of 'Obstetric Violence' is *"the appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanized treatment, an abuse of medication, and to convert the natural processes into pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women"* Perez DR. Obstetric violence: a new legal term introduced in Venezuela. Int J Gynaecol Obstet. 2010;111(3):201–2.

Appendix

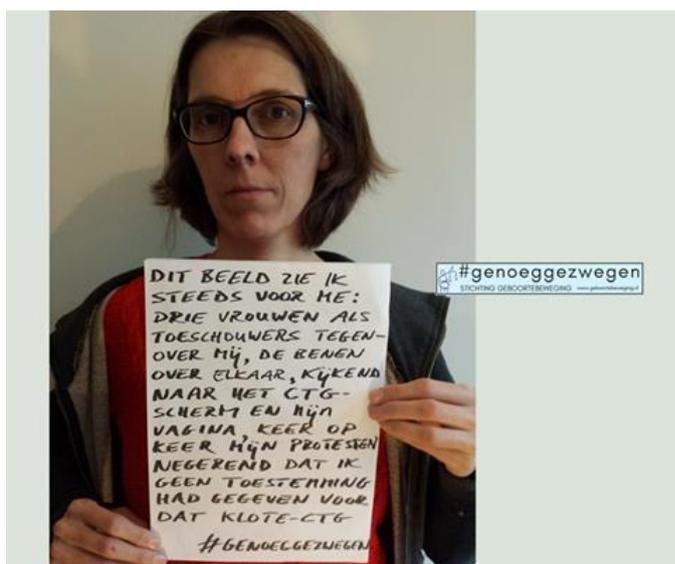
#genoeggezwegen - the Dutch 'Break the silence'- campaign



"No means no"



"During the caesarean I panicked. Instead of calming me down, I was anesthetized completely. I woke up a few hours later, alone and scared. I didn't know what happened. The first few hours with my twins were taken from me, and I will never get them back."



*"I'll never forget this image: three women opposite to me, like spectators. Their legs crossed, looking at the ETG- screen (electronic foetal monitor) and my vagina. Neglecting my protests; I had never given them permission for that f*cking ETG."*



She: would you rather bleed to death than get an oxytocin injection?

Me: I want neither.

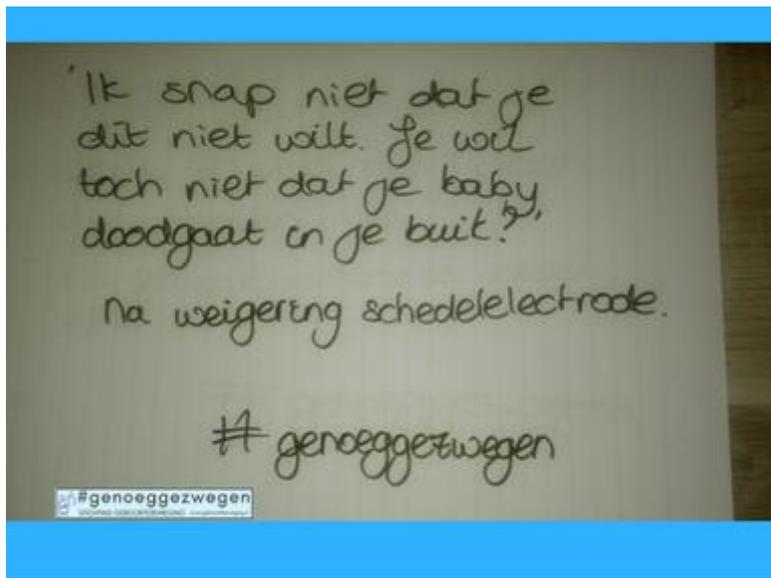
She: That's not an option.

Me: I forbid you to give me oxytocin.

She: So you'd rather endanger your child?

Me: of course not, but I only want oxytocin after 30 minutes and solid deliberation.

She walks away.



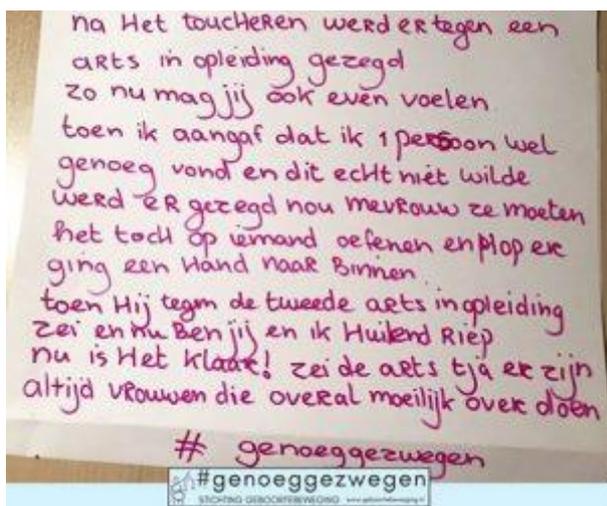
I don't understand why you don't want this. You don't want your baby to die inside you, do you?

After me refusing foetal monitoring with an electrode on my babies skull.

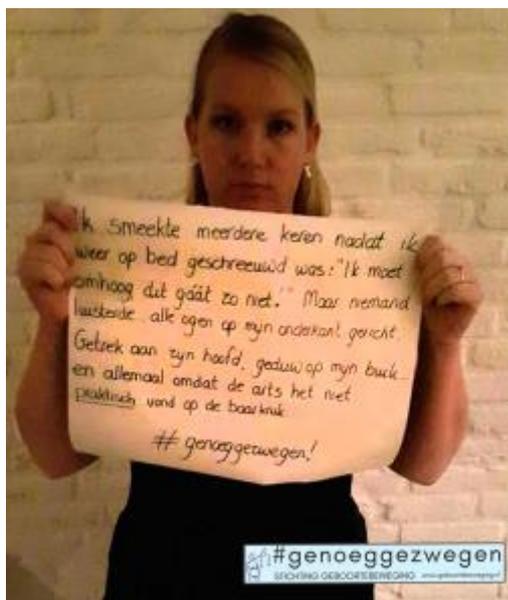


I am 38 weeks pregnant when I tell my new gynaecologist, I don't want a caesarean at 41 weeks. The response was: "afterwards you will sit opposite us in the courtroom, discussing your dead child and we will have to say 'Madam, was stubborn'".

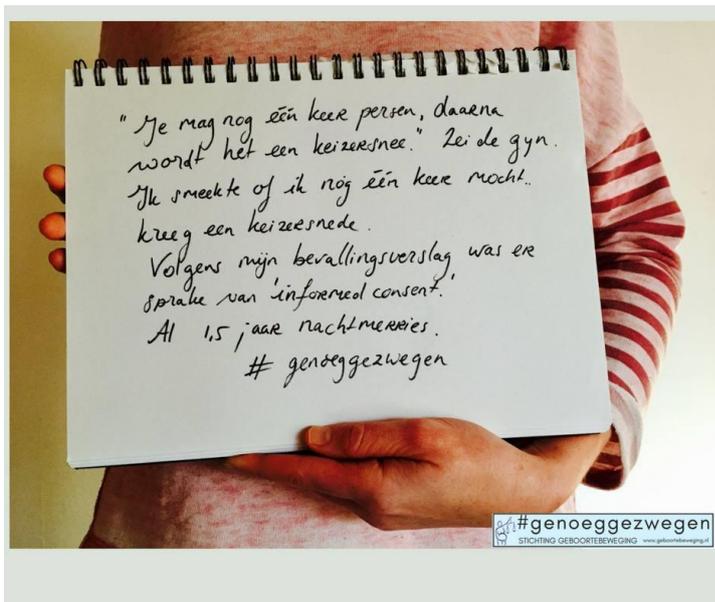
I can't get this image of my dead baby girl out of my head.



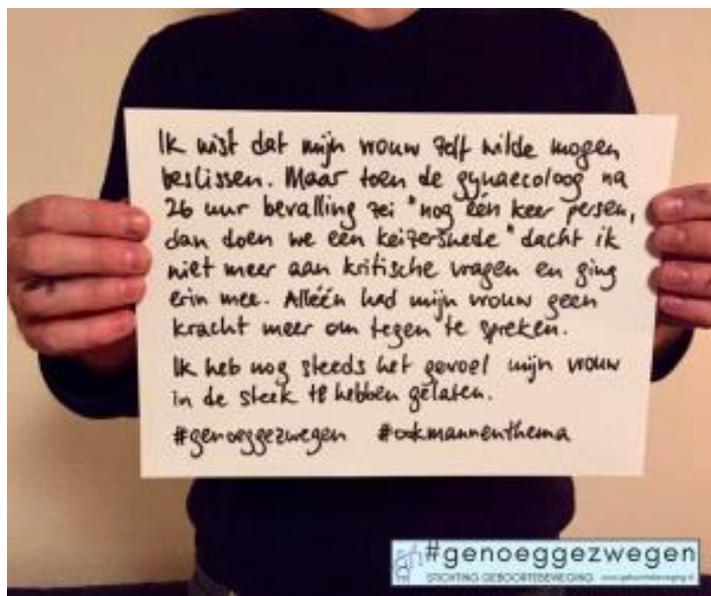
After examining me vaginally, they told the doctor in training: 'all done, now you can feel for a moment'. When I told them I really didn't want them to, because one was more than enough. They said: ma'am, they have to learn somehow" and I felt another hand go in. Than he told a second one: "your turn". I yelled crying: "enough!" and he said: "it is always the women making everything so difficult."



After being yelled at and commanded to get back on the bed several times, I begged: "I need to get up, it doesn't work like this." But no one listened, all eyes remained focussed on my bottom part. Pulling his head, pushing my stomach, all because the doctor found the birthing stool unpractical.



"One more push, and we'll perform a c-section" said the gynaecologist, as I begged him for one more try. I got a caesarean section instead. According to my medical records this was 'informed consent'.



I knew my wife wanted decide for herself, but when - after 26 hours of labour - the gynaecologist said: "one more push, and we'll perform a c-section". I didn't think about asking critical questions and went along with it.

My wife didn't have the strength to go against it on her own. And I still feel I let her down.



The Ob-Gyn, whom I hadn't met before, came in to turn my daughters head, internally. During a contraction, I was lying on my side and wasn't able to remove my panties in time.

While I was asking him to wait, he turned me over on my back, pulled my panties off and pushed his hand inside me. My screaming, or my husband crying, wasn't enough to make him stop.



The irreverent doctor came in without any respect for my wife. He was being completely indifferent to the process she was in. He brutally inserted his hand to turn my daughter inside her. Furiously, I told the nurse to get this man out of my side. We never saw him again.



During my six weeks of hospitalization I discussed my birth plan several times, with several Ob-gyn's. Despite my birth plan, and all those conversations, I still had to yell: "I am not giving permission for this" for five different interventions.

#handineigenboezem – ‘look nearer home’



Midwife: Eight years after giving birth for the first time, she asks me what that pelvic floor assistance was for. She says she will still be able to feel my fingers inside her, when she's eighty years old.

I regret all those times, I provided unasked-for "assistance".



'Kraamverzorgende'- maternity nurse:

I took the mothers temperature, rectally, even though she wasn't feeling warm at all. She hated it, but I didn't dare to go against protocol.

Examples of compulsory language in written information;

Pregnant women are incompletely informed about the different options and their freedom of choice regarding the birth place. This ignores the core values of the Medical Treatment Agreement Act (WGBO), in which information provision and freedom of choice are key. Because online information provision is playing an increasingly important role in the current health care system, we asked two graduating midwifery students²³ to research how pregnant women are informed on websites about the options they have with regard to the place of delivery.

The following is a summary of their research; *“Home or Outpatient: Freedom of choice within the limits of the guidelines.*

Qualitative research into the written information on midwifery websites about the place of delivery”

Three themes were studied; the information about the place of birth: was it complete? Accordance with the WGBO: where was woman informed about their right to choose? And the wording that was used: was coercive language used to limit or steer woman's choice according to the protocol?

Almost all websites indicated which options were available with regard to the place of delivery. But, on many websites, the following information, for example the information about 'safety'²⁴, was incomplete.

Most websites indicated that women can choose where they want to give birth, after which this choice is immediately limited by setting. There was no mention of women having the final say themselves.

The words used on the websites varied. Some practices formulated the information advisory style, whereas other practices used directive wording to set conditions. A few examples:

“You can only give birth at home if everything goes as it should during pregnancy and childbirth. If we think it is not justified you should go to the hospital to finish the delivery there.”(Practice 23)

“Sometimes you are not allowed to give birth at home! We will always discuss this with you, so that you know this in advance.”(Practice 29)

“There are a number of reasons for you to have to give birth in the hospital, because of an increased risk of complications. In some cases this means that your own midwife may supervise your birth and in other cases you will be transferred to the gynecologist.” (Practice 30)

Some practices described that in some situations, giving birth at home is *“not allowed by them”* or just *“not allowed”* in general, after which examples of those situations were given.

²³ Feline van Bladel en Irene Koopmanschap - 29-06-2017

²⁴ Most websites indicated that, for low risk women, home birth is just as safe as an outpatient hospital birth, but none of them explained how safety is measured.

When the distance to the hospital is enlarged²⁵, sometimes a home birth was "*discouraged*" on the website, while other websites simply stated that midwives "*don't do home births*" or women were "*not allowed to give birth at home*".

When websites mentioned it may be necessary to be referred to the hospital, words such as "*must*" were often used; The woman "*must be referred*", or "*if they think it is not safe, you have to go to the hospital*" or in the event of a medical indication, women simply have "*To continue delivery in the hospital*".

Conclusion: "*Midwifery practice websites currently offer pregnant women insufficient support to make their own choices regarding the place of delivery. The protocols and guidelines seem to influence the information described and the client's freedom of choice.*"

²⁵ Dutch guidelines advise women who live over 30 minutes from the nearest hospital, not to birth at home.

Examples of Formal Complaints filed by victims of obstetric Violence

1. A hospital board of complaints about what is expected from a gynecologist, even when that leads to forced induction and a caesarean without informed consent:

“A caesarean is chosen when it is medically necessary that labor ends. Because of the high caput, abnormal CTG and meconium in the amniotic fluid, continuing a vaginal birth is considered high risk for the baby. The board of complaints believes this is an indication for a caesarean section. Because there was an indication, there were no alternatives to be mentioned. ..

A gynecologist is expected to prevent life threatening situations from happening. In other words he has to act before an emergency situation for the mother and or the child occurs. In this case the fetal reserves were decreasing and there was imminent fetal distress. Indeed, the file does indicate there was no fetal distress at the moment. But because of the high caput, abnormal CTG and meconium in the amniotic fluid a continuing vaginal delivery would have been a risk to the baby. The indication for a caesarean is therefore correct. ...

According to the board of complaints there were there were medical reasons to justify these actions, the complaint (lack of informed consent) is denied.”

2. A hospital board of complaints on AROM without consent, demonstrating know knowledge of the law whatsoever:

‘By agreeing to be hospitalized (for a 24 hour observation period after a car accident) the patient agreed to letting the doctor do everything necessary to ensure that she and her baby would not be in danger. Even if this meant it would be traumatic for her. For the doctor there was no way of knowing that it would.’

Examples of Disciplinary Suits filed by victims of obstetric Violence

This appendix contains a few (but not all) examples from disciplinary cases, showing that, although informed consent is in fact a legal right, in both medical and legal practice it is not adhered to.

1. This example is from an appeal in a disciplinary suit²⁶ against a gynaecologist (in training) who forced a woman to give birth lying on her back against her wishes. The woman wrote explicitly in her birth plan, she wanted to choose her own position during childbirth, but this ruling shows just how easily regulations are used to limit laboring women's right to bodily autonomy.

"This means that a woman's 'fundamental right' to decide how to labor does not apply under all circumstances. This right should be respected, but it should also be made clear that there are limits to adhere to. A caregiver cannot ignore all applicable regulations to implement these wishes and must clarify (professional) boundaries."

2. The following example is from recent appeal to the disciplinary court by a woman who had a c-section against her will²⁷.

This quote is a response to the woman's referral to her right to informed consent. It shows that a woman's right to informed consent is believed to be unworkable in childbirth. And consent can easily be bypassed, or considered to be given implicitly.

"Apart from the fact that this (rather rigid) explanation of the informed consent (obligation to provide information and requirement to ask for consent) for every action, being not consistent with current (and workable) practice. Particularly in the supervision of childbirths, that also concern the health of the child.

The defendant could and may also deduce from the complainant's behavior that she (tacitly) agreed to his (treatment) action aimed at carrying out a caesarean section (cf. art. 3: 33-3: 35 BW). Especially, with regard to the possibility of a caesarean section being discussed with the complainant in advance and it is not known from the medical file that she did not necessarily wanted to prevent this (but did prefer a natural, vaginal birth). "

3. The following judgment shows this interpretation of a woman's right to informed consent during childbirth is not uncommon for healthcare professionals and their peers in the disciplinary counsels.

²⁶

https://tuchtrecht.overheid.nl/zoeken/resultaat/uitspraak/2016/ECLI_NL_TGZCTG_2016_227?dateperiodstart=21-06-2016&dateperiod=op&DomeinNaam=gezondheidszorg&Pagina=1&ItemIndex=1&fbclid=IwAR3olhN9GhbvwY84TsMV9LcG005mevk9vbp7ShzpHdHleozPLXuNthWvf2w

²⁷ https://tuchtrecht.overheid.nl/ECLI_NL_TGZRAMS_2018_54

These are quotes from a disciplinary case²⁸ a woman filed after having an episiotomy without her knowledge.

'Furthermore, the commission shares the defendant's view that counselling and information on the one hand and permission on the other hand is a two-unity (like trinity but then two), all the more so in a situation of a second stage labour that has no progression, and in which some action must be taken.'

It seems that to inform a woman ('I am cutting an episiotomy now') is enough for consent. According to this court's ruling, telling someone action must be taken, automatically results in consent for the proposed action.

'Pursuant to Article 7: 450, paragraph 1 of the Dutch Civil Code, the patient's consent is required for interventions following a treatment agreement. Although the Medical Treatment Agreement Act (WGBO) does not explicitly regulate, permission can also be given implicitly or tacitly.'

If a person does not say 'no', according to this disciplinary counsel, a health care provider may assume that she said 'yes' (to in this specific case, cutting an episiotomy in a woman's vagina). This type of behavior is considered criminal by ALL Dutch citizens in ANY other form of violence against women.

"The complainant was - in her own words - approachable during the birth and mentally able to make a decision. Within a period of approximately 30 minutes – prior to the cutting of the episiotomy - the complainant had had sufficient opportunity to let her (the clinical midwife) know that she did not want an episiotomy – both during the mention 'failure to progress' and when the defendant injected the anesthetic. Under the given circumstances the defendant could legitimately trust that the complainant agreed (implicitly) to an episiotomy."

Considering the value human rights have in The Netherlands, one would expect this ruling to be overthrown in appeal²⁹, but it didn't. Instead, even more arguments why informed consent doesn't apply during childbirth were found;

"At the hearing on appeal, the midwife described the usual steps for initiating an episiotomy. If, as in the case of the complainant, no progress is made, the midwife will share this with the client and offer her a mirror as an incentive. The midwife also offered a mirror to the complainant for that purpose, but the complainant did not want to make use of this offer."

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http://tuchtrecht.overheid.nl/zoeken/resultaat/uitspraak/2017/ECLI_NL_TGZRAMS_2017_134?zoekterm=%20%20%20%20%20%20Verloskundige&Pagina=1&ItemIndex=3&fbclid=IwAR1hagyAwwslrutWkDSrdHYcvNMWHGqY2qLCLYIOreY7zu84clSVSYxUr9mM

29

https://tuchtrecht.overheid.nl/zoeken/resultaat/uitspraak/2018/ECLI_NL_TGZCTG_2018_298?zoekterm=infor%20med%20consent&Pagina=1&ItemIndex=3&fbclid=IwAR1CGRX9BMc-M1RzO0iH-6iYLkeHeBeUQu35pOqxzvmxxD6NeJuNOMRf7AU

“If then, there is still no progress, the clinical midwife tells her client that the baby has descended far enough and that if there is no progress, an episiotomy (cut) is indicated, possibly followed by a vacuum extraction. At the hearing, the midwife indicated that this announcement also sometimes provides sufficient incentive to push the baby out. If progress is nevertheless not made, the midwife explains that a cut is necessary to make room and she makes preparations, such as administering anesthesia.”

“At the hearing, the complainant stated that she had not drawn up a birth plan in which she set out her wishes with regard to an episiotomy. She also did not inform the defendant before the delivery that she did not want an episiotomy, in principle. At the hearing, the defendant outlined convincingly how she is used to acting in similar circumstances and how she informs her patients. However, the defendant has also stated that she cannot specifically remember the present birth.”

“The midwife explained at the hearing, without being contradicted by the complainant, that in the first-line practice where the complainant was guided during her pregnancy, the birth and possible complications were discussed with pregnant women. During an information meeting, visited by this woman, the moment when an episiotomy is indicated is explicitly mentioned (with a slide). All this to prevent a woman from having to face choices during delivery that she had not taken into account in advance. The complainant was also informed in this way by the midwifery practice where she received her primary care.”

“Pursuant to Article 7: 450, paragraph 1 of the Dutch Civil Code, the patient's consent is required for interventions following the treatment agreement. The clinical midwife stated at the hearing in the appeal that in the case of an episiotomy she does not assume implicit consent, but that she directed the birthing woman to take part in the process described above under 4.4 that leads to an episiotomy.

The Central Disciplinary Court finds that, since the midwife did not receive any signals from the complainant or her husband during that half hour prior to the episiotomy, that there was no consent to the episiotomy. There were no signals from which the midwife should have understood that what she said did not or insufficiently penetrate the complainant, she could and was allowed to deduce the informed consent of the complainant from these behaviors. This is all the more true now that the first-line practice has informed the complainant well in advance about the possible complications during the birth and the treatment that can be expected in this regard.”

Thus;

- because this was all part of a standard process leading to an episiotomy,
- which she had been made aware of at an information meeting she had visited during her pregnancy,
- the woman could and should have been aware of the chances she had of having an episiotomy.
- And she should have taken the time she had been given to say ‘no’ to it.

The fact that this clinical midwife was allowed to deduce her informed consent by her not objecting (to something that was not even mentioned to her at the time) is exactly the opposite of what is stated in Dutch law, to which both the disciplinary counsel and the midwife were referring.

Moreover, in view of the documentation obligation which is the midwife did not adhere to either, it is highly remarkable that the commission completely ignored her statement; that she always requests informed consent, but cannot remember this specific case. This is discussed further under the following example.

4. Healthcare providers in the Netherlands have the obligation to record all actions, including requesting permission in their medical files.

Failure to comply with this documentation obligation is often included as an indictment in disciplinary cases. Yet, it happens in almost all 'informed consent'- cases, known to us, that the caregiver has not met this obligation, but is nevertheless acquitted of all charges.

That is practically impossible. Either permission has been requested and given, but incorrectly documented. In that case the documentation requirement has not been met. Or the permission has not been requested, then the documentation obligation was met, but the right to informed consent was indeed violated.

This irrefutably proves the double standards used in Dutch disciplinary courts; the documentation requirement has not yet been successfully used by a woman who's informed consent was violated during standard interventions. But it has, on more than one occasion, been successfully used to reprimand or remove midwives from the profession, who have granted a request for care outside the guidelines to "high risk" women.

The following quote from such a case³⁰ explicitly states, that documentation is more important than a 'good memory' or the habit of asking permission. It needs to be on paper.

"5.5 It is established that due to the breech position there was an indication for referral to the second line (hospital), but the client nevertheless indicated that she wanted to give birth at home. This fell under the Guidelines "Obstetric care outside guidelines". With such a request, it is essential that the choices made by a client and the considerations that - after adequate information about the risks - have led to these choices are recorded in the file in consultation with the client.

30

http://tuchtrecht.overheid.nl/zoeken/resultaat/uitspraak/2018/ECLI_NL_TGZRZWO_2018_147?zoekterm=verloskundige%20stuit%20thuis&Pagina=1&ItemIndex=1

Good reporting will make clear what has exactly been discussed and agreed upon. The practitioner will then be able - when necessary - to account for the policy pursued. Sufficient recording can also prevent the care provider from forgetting the agreements in situations where consultation is no longer possible.

Contrary to what the defendant seems to assume, a care provider's memory does not outweigh the reliability of a record of wishes, information, considerations and agreements made in consultation with a client.

..... The file creation does not meet the requirements to be met. This can be charged to the defendant in the disciplinary sense."

The following quote proves that, in case it is impossible to know whether or not the client has been informed about the alternatives from the file, **this can be charged to the defendant in the disciplinary sense.**

"As considered above, the very brief file does not show exactly what has been discussed. In her report ..., which, according to the defendant, was also read by her client, the defendant provided more information about what she had discussed with the client. However, this also does not show that the respondent extensively informed the client about the differences between homebirth and childbirth in the hospital, such as (...).

Now that the defendant has failed to proof exactly what information was provided in her defense, the Commission can only assume that complete information has not been provided. This can also be charged to the defendant in the disciplinary sense. "

In cases of obstetricians acting against the wishes and consent of their clients, but in accordance with the guidelines, documentation requirements are not taken seriously.

Why can the commission "*only assume that complete information has not been provided*" when women make choices outside the guidelines? But do they find a description of ones habits sufficient to get others acquitted in informed consent cases? Even when "*the defendant has also stated that she cannot specifically remember the present birth.*"

In Dutch disciplinary courts protocols are clearly valued over human rights in childbirth.