

Mistreatment and violence against women during reproductive health care with a focus on childbirth:

The case of Sweden

Submission to the United Nations Special Rapporteur on violence against women
by the civil society organization Födelsehuset
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Födelsehuset (“The Birth House”), an NGO concerned with rights and choices for women and families around pregnancy and childbirth, on behalf of its members and users, together with a fast growing number of invested parents and various birth activists’ groups, hereby reports on the Swedish Government for failing to act to protect women’s human rights in childbirth, in particular when it comes to obstetric violence. Further we consider the Government’s failure to provide options for out of hospital birth (birthing centers as well as assisted homebirth), despite the proven superior safety of such options, and their potential to mitigate the problem of obstetric violence experienced by many women in facility-based childbirth. In our view these failures are reflective of misogyny, by which women’s immediate and long-term mental and physical health is not being prioritized.

1. Cases of mistreatment and violence against women during reproductive health care, particularly facility-based childbirth

Obstetric violence and mistreatment of women in childbirth

Women in Sweden today have little options on how to give birth, where and with whom. There is only one kind of obstetric unit in Sweden, which results in an unnecessarily large group of women becoming exposed to **unnecessary interventions and iatrogenic injuries**. Thereby putting an increased risk to their health, at a higher cost - but with no difference in outcome for the baby. This goes directly against article 12 of CEDAW, and is also harmful to women’s general health, both in short and in long term perspectives.

A major disadvantage of the Swedish maternity care system is the constraint to **birth in the company of strangers**. Swedish women see one midwife during pregnancy at a local health care unit. But they give birth with medical personnel at high-risk hospital units or in-hospital maternity wards, whom they first see when they arrive to the hospital in active labour. At the same time, research shows that about

95% of women wants to give birth with a midwife they have got to know prior to birth (Hildingsson et al., 2019).

Women lack choice in terms of **their place of birth**. Birth care in Sweden today is almost completely centralised in high-risk hospital units and there is virtually no alternative to this: home birth is marginal with about 100 planned home births out of 30 000 births in total in Sweden per year. There is *no single birth center/out of hospital maternity unit* run by midwives in Sweden. *Lack of financing* constitutes a systematic obstruction of women's right to give birth at home. Swedish women who do not want an intervention prone hospital birth, and who pay for everyone else's hospital births through their high taxes, cannot get financing for their own birth if they should choose to birth outside of a hospital. Because there are no publicly financed alternatives to hospital birth, all midwives are forced to make a living in the hospitals, thereby making unavailable the presence of a skilled midwife for a home birth should you be wealthy enough to afford one. This has increased the number of women who choose to give birth at home unassisted by midwives (Födelsehuset, 2016).

Moreover, even if a midwife is present at a homebirth, she *lacks the possibility to prescribe* necessary emergency medicines to use for out of hospital births in case of postpartum bleeding is another such systematic obstruction. This in spite of the fact that Swedish midwives have wider prescription rights than midwives in any other country, a prescription right that includes strong hormonal contraceptives and morning after-pill.

The lack of financing and the lack in prescription rights function as a direct obstruction of midwives' and women's autonomy in that many women and midwives, who would otherwise consider birthing or caring for birthing women at home are prevented either by economic or practical limitations of home births' otherwise well documented superior safety, both of which limitations are in fact nullifying their formal rights to have an out of hospital birth.

Swedish legislation insist on all midwives' obligation to perform abortions, without any exemption on religious or other grounds, because it ensures that safe abortions are free and available as a vital part of women's reproductive freedom. The abortion legislation reflects acknowledgement of women's right to choose if, when and with whom to have children. But where, how and with whom to give birth is an equally important part of women's freedom to choose. The consequences of not having access to a skilled midwife for home birth are the same as of not having access to qualified personnel for abortion. It makes both abortions and home births unsafe. (Födelsehuset, 2016)

The **kind of facility-based midwifery care** set up in Sweden is a different type of concern. Midwives are in charge of normal births in Sweden and they refer pregnant and birthing women to a doctors only if complications arise. Therefore international recommendations on the benefit of midwifery-led care in normal birth are hereby largely perceived as being met. However, midwives provide care within high-risk hospital units, which affects the kind of care they provide. The definition of normal birth differs essentially between the medical profession and the midwifery profession. Despite midwives' attendance at birth, the midwife's professional scope is limited by local doctor-written guidelines, which prescribe various, not necessarily evidence based, interventions, contingent upon narrow medically defined interpretations of what constitutes abnormalities in birth. This is one of the reasons the handling of healthy women's births in high-risk units inadvertently *increases the incidence of interventions* and thus also iatrogenic injuries (Födelsehuset, 2016).

Another concern is the *lack of one to one care* in high-risk labor wards. It is documented (that continuous presence of a midwife during a woman's active labor is the most significant factor in terms of diminishing interventions and in terms of ensuring an overall good birthing outcome psychologically and physically (Hodnett et al., 2012). The widely disseminated DRG reimbursement system in place, by which labor wards receive money per complication or per intervention according to a specific code, inadvertently hampers normal birth by being overly rewarding of interventions instead of rewarding the one to one ratio of midwifery care required to keep birth uncomplicated. Normal birth, which requires more presence of a midwife, decreases the labor wards' income from interventions and figures merely as an expense because salaries are taken from another budget. In sum, when "Midwifery Care" is organized and regulated by doctors around a medical risk aversion paradigm rather than around professional midwifery's own salutogenic "watchful waiting" paradigm, the benefit of midwifery care is lost.

Lack of evidence-based care is also pervasive in this regard. In the 2018 recommendations “Intrapartum care for a positive childbirth experience”, WHO states: “Routine cardiotocography is not recommended for the assessment of fetal well-being on labour admission in healthy pregnant women presenting in spontaneous labour. (Not recommended)” and further adds:

“Evidence shows that cardiotocography (CTG) on admission in labour probably increases the risk of caesarean section without improving birth outcomes. In addition, it increases the likelihood of a woman and her baby receiving a cascade of other interventions, including continuous CTG and fetal blood sampling, which adds to childbirth costs and might negatively impact a woman’s childbirth experience.” (WHO, 2018: 64).

Nevertheless, all hospitals in Sweden administer routine CGT on admission and every 20 minutes during the entire labour and birth.

A similar situation occurs with regard to WHO’s recommendation number 36: “Women in the expulsive phase of the second stage of labour should be encouraged and supported to follow their own urge to push. (Recommended)” (WHO, 2018: 133). As most of the obstetric violence cases presented in this rapport show, directed or forced pushing is a widespread practice in Swedish hospitals.

Physical consequences of childbirth over-medicalization often lead to **birth injuries**. The level of birth injuries is high in Sweden. One of the cases of such an injury is the story of a uterine rupture of Malin Trulsson (see Annex 1). On 16 May 2015, Malin Trulsson was induced with “Propess” (Dinoproston) at Kristianstad Hospital maternity ward. She was not informed of the potential risks of this medication, nor of any treatment alternatives, and her consent was not obtained. The induction resulted in an extremely urgent caesarean section due to life-threatening intrapartum haemorrhage and a suspected uterine rupture. As a result, Malin has suffered extensive and lasting anxiety, PTSD and flashbacks to the bloody bathroom where she nearly died. Malin was administered a contraindicated pharmaceutical without informed consent, resulting in serious physical and psychological injury. Her injuries could have been prevented by exercising due care and constitutes a clear case of obstetric violence. This story illustrates that over-medicated hospital births due to doctor-written directives and routines have negative consequences not only for **women’s physical health** but also for **women’s mental health**. More examples of obstetric violence cases are presented below.

Women’s experiences of obstetric violence

In the wake of the MeToo movement, many stories about obstetric violence started to surface in social media groups where women feel safe enough to share their **devastating experiences**. Stories of trauma and birth injuries, mistreatment, misinformation, lack of informed consent or total lack of consent. We are now sharing with permission some of those stories, some women wish to be anonymous. (see also Annex 1).

Nathalie Gustavsson Vedin, Östersund Hospital

Nathalie gave birth to her first child in June 2018 at Östersund Hospital in Östersund Municipality (Jämtland County). With Pitocin (Syntocinon) drip and epidural in place she was forced to lie on her back (lithotomy position) and push for a very long time. She remembers pushing without pause to the point of not having any time to even breath in between. The doctor then decided to use vacuum extraction. They applied the vacuum extractor, while Nathalie V. was asked to continue with the forced pushing and another staff member applied strong pressure to her uterus (Kristeller maneuver). The baby was not breathing and Nathalie started bleeding abundantly while they took the baby to another room. Nathalie was told she needed short surgery to repair a tear, and that it would take 20 to 30 minutes. She was actually sedated and the doctors operated on her for two hours. She had suffered third/fourth-degree tears extending to the rectum. She has now healed, but it has been difficult for her to get the proper postnatal care. She filled a claim for compensation for her injury to Löf (Landstingens Ömsesidiga Försäkringsbolag) and received the equivalent to approximately 400 euros, which is less

than half of what Swedish authorities pay out for “abuse against person lying down” (Brottsövermyndigheten.se).

Anneli N., Helsingborg Hospital

Anneli N. gave birth at Helsingborg Hospital (Helsingborgs lasarett) in July 2016. She suffered a third-degree tear during childbirth following mistreatment and a total lack of consent during her labour and birth. She had to endure hearing that “We [the doctor in charge and the attending midwife] have discussed if you are going to rest or if we are increasing the Pitocin drip and we have decided that we’re increasing the Pitocin drip”. They took the decision without requesting or obtaining consent and performed this intervention without providing pain relief or support of any kind. Anneli pushed for more than two hours until the doctor decided to perform a vacuum extraction, even though the baby was feeling well. Anneli recalls the awful moment “they were pulling my baby out while I was screaming telling them to stop, I could feel how I was tearing apart”. Then the doctor sutured the tears without pain relief. Anneli still has memory gaps when recalling her birth.

Anonymous, Blekingesjukhuset in Karlskrona

Another woman, who we can call C due to her request for anonymity, suffered a third/fourth degree tear after a deeply traumatic birth at Blekingesjukhuset in Karlskrona. C still remembers how nasty, unpleasant and unhelpful the midwife was, telling her things like “Stop whining, it does hurt to give birth!”, “You’re making it worse”, “WHAT do you want NOW?!”. The midwife would sigh audibly, making C feel powerless and inadequate. C did not receive information about any of the procedures that were being carried out. Instead she had to endure hearing the midwife saying over her head that her baby’s heartbeat was dropping. C was ignored when she asked what was going on with her and her baby. This combination of not having support and the fear for her baby’s health made C to feel stressed and led her to push too hard and too fast, this being indicated as the main reason for her third/fourth degree tear extending from the vaginal wall and perineum to the rectum. The increased risk of such injuries due to stress and fear are well founded in science.

Anonymous, Hudiksvall Hospital

We also have the story of a woman who gave birth at Hudiksvall Hospital (Hudiksvall Municipality, Gävleborg County) in March 2018. She was induced due to high risk pregnancy (Type 1 diabetes). She had, however, agreed on a planned c-section if any complications would arise. She remembers that at some point the doctor entered the room and without introducing himself or asking for any consent started to perform “a manoeuvre”: He took her legs and pressed them into her belly and then pushed them away hard towards the floor. She remembers that he took her firmly and fast while she was screaming “Please, STOP!”. She panicked and vomited all over herself. She remembers speaking to the midwife who was also in the room afterwards. The midwife told her “I was in shock. It felt as if “I was witnessing an assault”. She suffered a fourth-degree sphincter rupture and her baby an obstetric brachial plexus injury. The baby was born with no pulse nor heartbeat, yet they succeeded in reanimating her.

The day after the birth, the doctor visited her and she confronted him and asked how things could be done this way. He interrupted her and said “Wait wait, don’t you understand that giving birth is not risk-free?”. The chief physician completed a non-conformance report so that the County would carry out a full investigation. The investigation, which was only based on the medical records, did not give her any positive resolution. The doctor was not employed by the Hospital and was a locum physician, so the hospital terminated his contract. She is in the process of presenting a complaint to the Health and Social Care Inspectorate (IVO) and filing a claim for compensation for her injury to Löv (County Councils' Mutual Insurance Company).

Nathalie K., Norra Älvsborgs Länssjukhus in Trollhättan

This is the story of Nathalie K. who in 2014, then 23 years old, gave birth to her son at Norra Älvsborgs Länssjukhus (NÄL) in Trollhättan. She suffered postpartum depression after being repeatedly mistreated during labour and birth by the obstetrician in charge. This same obstetrician prescribed Pitocin drip to augment labour for more than 8 hours, and the same obstetrician operated on her to repair Nathalie’s injury after birth. This doctor failed to repair the third/fourth degree tear injuries. Nathalie thus needed to be re-operated four months later by the SAME doctor, which was re-traumatising for her. She asked for another doctor, but was told that this doctor was the only option she had. Nathalie is still suffering from her injuries and is fighting to recover from the trauma.

Anonymous, County Hospital in Sundsvall

This woman, who wishes to remain anonymous (referred to as "N"), suffered fourth-degree injuries in connection with the birth of her child in 2017 at the County Hospital in Sundsvall. She underwent surgery shortly after birth. N's contractions stopped after she received an epidural. She was then induced, and the Pitocin drip gradually increased up to the maximum level. The contractions exhausted her totally and the labour was ineffective. Staff decided to perform a vacuum extraction (VE). She was never told that the baby was in any danger. The pain became intolerable when the obstetrician positioned the vacuum extractor, which became dislodged again and again. N repeatedly screamed "STOP" and "You're tearing me apart!" when they started pulling, but several people held her down and the obstetrician just continued.

The nurse who was holding one of her legs said that she should stop screaming and focus. The pain when the doctor pulled out the baby was indescribable. N wanted to die and felt intensely how her perineum was torn apart.

She had major difficulties and significant pain in the first weeks after the birth. She could barely go to the toilet – a single visit could take several hours in the first few days/weeks.

When N spoke to the maternity ward staff afterwards, and asked if she should perhaps be put on sick leave after an injury of this kind and ensuing surgery, she was mocked. The answer she was given was that she had simply given birth like many other women and that she was fit to work. The reality was that N could not get into bed or turn around independently. She was unable to walk upright, and had to move around in a bent-over position. She was also disabled in looking after her child independently.

Anonymous, Nyköping's BB, Nyköping

A woman who gave birth at Nyköping BB (an in-hospital maternity ward) in 2016 is still suffering the consequences of multiple birth injuries. She was forced to remain in a lying/semi-sitting position in bed while forced to push following the midwife's directions. All evidence indicates that forced pushing increases the risk of birth injuries. Forced pushing is, however, a widespread practice in all hospitals in Sweden.

Anonymous, Halmstad Hospital in Halland County

A woman who wishes to remain anonymous gave birth at Halmstad Hospital in Halland County in 2014. She was at the hospital for three days before the baby was finally born due to her water breaking without contractions and positive Group B streptococcus (GBS). The doctors and midwives told her that she needed to be induced and that Cytotec (Misoprostol) was the best way to start labour. She was not informed about the possible side effects. She also received continuous Pitocin IV drip throughout the birth. She had continuous cardiotocography (CTG). When she was in positions that felt good to her, the continuous CTG would show a decrease in the the baby's heart rate, and would stabilise if she was laying on her back being examined. The midwife told her she had to stay on her back "for the sake of the baby". The midwife never used another method to check the baby, for example a Doppler ultrasound device or a Pinard foetal stethoscope.

She cannot remember if she felt the contractions as she was about to push, but the midwife proceeded with forced pushing: the midwife told her when to and when not to push. She suffered third-degree tears. It was, however, the midwife who did the stitching in the same birthing room. A third-degree tear should have been treated by a doctor in the operating theatre. She suffered from pain for a year after giving birth and still has problems with incontinence, haemorrhoids and occasional pain and discomfort during sex.

Anonymous, Malmö

A woman who gave birth in Malmö in 2017 share her story. She was given Pitocin drip to augment labour, without informing or asking for consent. When she was fully dilated, she asked them to stop the epidural which they said they did. The midwife left the room with the words "push if you feel like it". The woman and her partner were left alone in the room for over five hours. During that time, the midwife only checked on them once and said again to the woman that she could push when she felt like it. The woman said she still could not feel anything since receiving the epidural. After five hours, the woman and her partner realized that the epidural was still in, on a continuous drip. As her partner went to get the staff, they came rushing into the room and told them they were losing the baby's heartbeats. She was then informed that they were going to use the vacuum extractor to which she said she did not want, that she had written it on her birth letter, that she rather preferred a caesarean

birth. She was not listened to. They informed her they were going to perform an episiotomy. She said absolutely no, that she did not want an episiotomy. They did not listen to her and proceeded with the episiotomy and the vacuum extraction without her consent.

After using the vacuum, they placed the baby on her, which she recalls in this way: “they threw something on top of me, only later I understood that it was the baby”. They cut the umbilical cord, grabbed the baby and took it away without a word to the panicked mother. For over ten minutes, she did not know if the baby was even alive. It was not until she asked for the Apgar score that anyone paid her any notice. She was then informed that the score had gone from 5 at birth to 10 after ten minutes. Even though the Apgar score was low in the beginning, the baby had no trouble breathing so there was no medical reason to separate the baby from the mother.

When the midwife was doing the stitching, she refused to tell the mother how many stitches she received.

The mother was forced to stay in the hospital overnight even though she did not want to and was forced to share a room with a stranger. That meant that her husband was not allowed to stay, which traumatized her even further.

She did not receive any postnatal care and even though she was in great pain from the episiotomy, she had to ask to receive even the lowest dose of painkillers. The fact that she was not bonding with the baby and crying went unnoticed. She did not manage to sleep at all and had been awake for 72 hours when she was finally allowed to go home the next morning. Something she was ridiculed by the staff for wanting. They did not perform a pelvic exam before she was released from the hospital.

She had been promised to get to speak with the midwife about the traumatic birth, but that was also ignored. Upon insisting, she was finally granted a meeting four months later. At this meeting the midwife simply stated that everything that had happened was the mother's own fault.

The mother suffers from several birth injuries including prolapse, PTSD (post-traumatic stress disorder) as well as trauma-induced depression. It has been one year and ten months and she has not received any treatment. Injuries that the child may have suffered remain unknown.

Sweden's response to mistreatment and violence in childbirth, including protection of human rights

Obstetric violence is one of the reasons why an increasing number of women prefer to give birth at home. However, state policy is discriminatory towards those women. It is legal to give birth and to provide midwifery care at home, but there is no state funding available to cover the costs of homebirth for women. As a result, women, having already paid taxes towards the state healthcare system, will also need to cover the cost of a home midwife, while women who give birth in high-risk labor wards have all their costs covered by the governmental system - albeit exposed to the increased risks of emotional trauma and injuries.

The Swedish government has not been doing much in recent years to address the described problems. Rather, the opposite is true. Until recently, a very limited homebirth system has existed only in Stockholm County (Stockholms län) and certain parts of Västerbotten County (basically in Umeå). However, on 14 May 2019, politicians at Stockholm County Council took the decision **to terminate the existing homebirth system in the whole of the Stockholm region**. This means that women in Sweden have only one option: to give birth in high-risk hospital units. This decision goes against women's rights in childbirth and contradicts best practice as determined by several organs such as NICE, as well as extensive scientific evidence.

In order to try to meet the need of women to **give birth in hospital with a midwife known to them, two pilot programmes** of caseload midwifery have recently started. One is called “Barnmorska hela vägen” (in Sollefteå (up north Sweden) and another “Min Barnmorska” (“My Midwife”) at one of the hospitals in Stockholm (Karolinska Huddinge).

2. Is full and informed consent administered for any type of reproductive health care, including childbirth?

The concept of woman-centered care, is all but unheard of, and informed choice and consent to treatment, concepts that entered the law only in January 2015, are concepts which have not yet been assimilated into the paternalistic medical culture which pervades obstetrics. Consequently, most doctors and midwives fear non-compliance with various local doctor-written directives more than they fear violating the women's right to informed consent to treatment or to routine interventions.

Hospital routines such as synthetic oxytocin injection after birth, cord blood testing or vitamin K shot are many times performed on women and their babies without asking for consent. Usual forms of “informing” about medical interventions and routines are the following:

- “This is how we do it here” (when routine cardiotocography (CTG) is performed, every 20 minutes),
- “We do not work at this pace here” (when setting the pitocin drip to augment labour),
- “Now it is time to break the water bag”,
- “I will set this scalp electrode so we can watch your baby closely”,
- “You get this little shot now” (when synthetic oxytocin is administered by routine after birth), etc.

These common examples of delivery ward-jargon demonstrate that the decision on the part of a woman is undesired. Instead, routine **interventions without clear information** and consent are common.

There also exists a practice of writing a **birth plan** ahead of time. Patients are encouraged by their maternity care midwives to write such a document and bring to the hospital when labor starts. However, these birth plans are frequently not adhered to, if they are even read.

3. 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.

The individual's first hand choice of contact is the caregiver to report complaints and/or mistreatments. The responsibility of investigating, analyzing and sorting out mistreatments and wrongdoing that has been done to a patient lies in firsthand on the care giver in the local ward, reception etc. which is responsible for the mistreatment (Socialstyrelsen, 2019a). Within the care system, all staff are held responsible to investigate and report mistreatments or events that has harmed a patient or could have harmed a patient (Patientsäkerhetslagen 4 §, 2018, Socialstyrelsen, 2019a).

Further, the caregiver's responsibility includes to take action to prevent the event from happening again, answer and inform the patient about the event, causes and consequences and what is to be done and which rights the patient has. Such as reporting it further to IVO and eventually get replacement/financial compensation (Socialstyrelsen, 2019a).

How every caregiver is investigating these matters differs a bit between regions, but one uses a tool and strategy to get an overlook of the risks and consequences of the situation. In Swedish a so called *Riskanalys* or *Händelseanalys* (“Analysis of risk or event”, Socialstyrelsen, 2015).

An alternative instance for the individual is to contact *Patientnämnden* (Patient board). It is an instance that is neutral and represented in every region and its aim is to support and help patients in this matter. They guide them to the right instance and work as a diplomat between patient and caregiver (Socialstyrelsen, 2019b).

There is the possibility to report irregularities or register a complaint to the Health and Social Care Inspectorate (IVO), which is a government agency responsible for supervising healthcare and social care services and staff. This inspectorate takes action when it's clear that care-related damage or mistreatment has happened. All regions and private sector is under the insurances Patientförsäkringen and Läkemedelsförsäkringen which can give economical replacement, support and help when a wrong is found. (Johansson, 2018; Socialstyrelsen, 2019b).

The County Councils' Mutual Insurance Company (LÖF) is a nationwide Swedish insurance company whose main task is to insure publicly financed health care providers. LÖF's final customers are the patients who have suffered an avoidable injury caused by health care. According to LÖF it has, between 2012 – 2018, been in average 459 mistreatments a year from The Women's wards that has been replaced/financially compensated nationally in Sweden (Landstingens Ömsesidiga Försäkringsbolag, 2019).

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

Choice of birthplace is not in line with WHO's guidelines.

The use of routine cardiotocography (CTG) on admission and continuous CTG during labour in hospital births are not following WHO's recommendations. The negative impact it may have on the birth process and outcome is not informed to the birthing person.

Recommendations:

With the purpose of **preventing and combating obstetric violence**, ensuring women's right to choose the circumstances of birth, and improving overall maternal health, we suggest that the Swedish Government take the following legislative measures to strengthen midwives and consequently strengthen women's autonomy in birth:

1. The Government must legislate for free access to a skilled midwife as part of the tax funded Public Maternity Services, regardless of where the woman wants to give birth. This, therefore, includes public funding of home birth.
2. To ensure women's right to choose out of hospital safe midwifery care, midwives' prescription rights must be expanded to include emergency medicines in case of bleeding and local analgesics for suturing of minor birth tears.
3. To ensure the safety of the baby, midwives' authorization must be expanded to include thorough examination of the newborn baby, which can currently only be performed by pediatricians in hospital, thus constituting yet another obstruction for out of hospital birth.
4. To ensure safe transfer of care, procedures for midwives collaboration with hospitals must be legislated for, both with regards to routine examinations and in the case of complications arising during pregnancy and birth.
5. To limit dangerous birth interventions, legislation must ensure equal representation of midwives on all levels governing birth. In regional councils and in the management of high-risk labor wards, midwives must partake in determining core principles for care and in the writing of guidelines governing normal birth, thus maximizing the protective benefit of midwifery care, even for women giving birth in hospitals.

6. To adopt the principle of one to one care, thereby reducing unnecessary interventions, the labor wards' reimbursement system must be modified to reflect the higher value of physiologically undisturbed birth. By putting economic incentives in place which reward Midwifery's core principle of one to one care; better staffing ratios will be prioritized even in hospitals thus helping outbalance the current heavy economic incentives to intervene in birth.

7. To ensure that birthing women's right to informed consent is better respected, The Swedish Government should legislate to encourage a system of periodic oversights of patient files, with specific attention to documentation of information given to the woman.

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Annex 1: Cases of obstetric violence

Uterine rupture of Malin Trulsson

SUMMARY

On 16 May 2015, Malin Trulsson was induced at Kristianstad Hospital maternity ward. She was expecting her fifth child and had had a prior caesarean. The drug Propess was used to induce her. She was not informed of the potential risks of using Propess, nor of any treatment alternatives, and her consent was not obtained. The induction resulted in an extremely urgent caesarean section due to life-threatening intrapartum haemorrhage and a suspected uterine rupture. As a result, Malin has suffered extensive and lasting anxiety, PTSD and flashbacks to the bloody bathroom where she nearly died. Malin was administered a contraindicated pharmaceutical without informed consent, resulting in serious physical and psychological injury. Her injuries could have been prevented by exercising due care and constitutes a clear case of obstetric violence.

CONTRA-INDICATIONS

Malin's treatment with the prostaglandin analog Propess contravenes the recommendation of the Swedish Society of Obstetrics and Gynecology (SFOG), the American College of Obstetricians and Gynecologists and the Royal College of Obstetricians and Gynaecologists. It is contraindicated by the package insert. It is also against common clinical practice for the use of prostaglandins for induction or previous caesareans due to the increased risk of uterine rupture.

The Swedish medical information database FASS warns that "Propess should be used with caution in women that have given birth to more than three children...Uterine rupture has been reported in connection with the use of Propess, mainly in patients where contraindications are present. Propess should therefore not be administered to patients who have previously undergone caesarean section or uterine surgery as it implies a potential risk of uterine rupture and ensuing birth complications."

In Malin's case the reasonable course of action would have been to await spontaneous labour. The indication for induction was that the child was large. The child's weight was estimated at 4,500 g in week 41. But Malin had previously birthed large children of 5,050 quickly and without difficulty. So how much more were Malin's doctors expecting the baby to grow in less than a week? Instead, she was threatened with caesarean section if her baby continued to grow in the womb. This was presented to her as a non-negotiable fact. Malin was only 41+0. She had a further full week for her cervix to continue to ripen and for spontaneous birth to start, which was her express wish.

BREACHES OF THE PATIENT ACT

During antenatal check-ups, Malin stated that she expressly did not want induction and wanted the birth to start spontaneously. Malin was expecting her fifth child and had had a prior caesarean, constituting a clear contraindication. Malin should have been informed of the risks and Propess should not have been administered. Malin's womb was detrimentally overstimulated by the contraindicated use of Propess which resulted in uterine rupture. The handling of Malin's case is in breach of Chapters 3, 4, 5 and 7 of the Swedish Patient's Act (Patientlagen) regarding informed consent. No information was given nor consent obtained, neither orally nor in writing.

According to Malin herself, and according to her journal notes, she received:

- no information about the risk of rupture in connection with induction with a previous caesarean, only information about the risk of caesarean if the child would continue to grow larger.
- no information about treatment options, e.g. await spontaneous labour, primary amniotomy or balloon catheter.
- no information about the contraindication of using prostaglandins in cases of sectio antea in many Swedish maternity wards and internationally due to the risk of rupture.
- no information about the clinic taking a gamble by administering the Propess inlägget despite the patient having 2 of the 6 contraindications on the packing leaflet of the medicine.

WHISTLE-BLOWING MIDWIFE

The midwife present at her birth who tried to prevent the situation from arising and protect the birthing woman's rights and safety was ignored, harassed and eventually pushed out of her job.

When the whistle-blowing midwife inquired from a colleague about the lack of information and consent, she discovered that patients were routinely not informed about the increased risk of uterine

rupture from induction in cases of previous caesareans because the ward did not wish to frighten patients. (!!!)

The whistle-blowing midwife made the following recommendations to the clinic, which were not followed up:

1. Report a side effect of Propess to the Swedish Medical Products Agency (Läkemedelsverket)
 2. Start including notes confirming that information had been given to patients and consent obtained in the patient journal.
 3. Reserve ward space for cases such as this one and institute clearly defined monitoring routines for induced patients.
 4. Make a careful, evidence-based and individualised risk assessment when making decisions regarding induction, which would reduce the number of inductions made on doubtful indications.
- The whistle-blowing midwife was excluded from the inquiry without being informed.

A case of shoulder dystocia; suppression of whistle-blower midwife; mistreatment of newborn

SUMMARY

A multiparous woman was induced without indication, causing an overstimulated uterus with severe contractions, and was not monitored, resulting in shoulder dystocia. The whistle-blower midwife was reported for disruptive behaviour as a result of attempting to change the course of events and assist the birthing woman, and the child was deprived of 30-40% of its blood volume without indication.

COURSE OF EVENTS

This case relates to a multiparous and small woman with poorly managed diabetes, with a large child (4,800 gram), at 40+2 weeks, in the first stage of labour when arriving at the hospital at 4-5 am.

Spontaneous contractions started at around 8-9 am.

After 5 hours on the ward she'd progressed well and opened to 7 cm by 10.30, but she then remained at 7 cm for a few hours.

Despite the good progress and spontaneous labour, she was given an amniotomy as the journal stated "weak contractions" – the contractions simply cannot be described as weak as she dilated from 4 to 7 cm in only 5 hours, some of which during the first stage of labour.

There was no attempt to get the woman to empty her bladder to speed things up, and only 1.5 hours after the amniotomy she's was placed on an IV induction drip.

The CTG then indicates severe overstimulation for many hours with 6-7 contractions/10 min.

Because of understaffing and high patient volumes, there was no midwife in the room with this woman as all staff was busy attending births in other rooms.

Because there was no coordinator during evening and night shifts, NO ONE had an overview of what was happening.

The whistle-blower midwife looked through the window occasionally, when running past while attending her own births and patients –she observed a woman on her back in stirrups, immobilised by pain and continuously inhaling nitrous oxide.

When the birthing woman buzzed for the midwife because the baby was crowning, the whistle-blower midwife entered the room briefly.

The birthing woman was uncontactable on nitrous oxide and the whistle-blower midwife reduced the strength of nitrous oxide and helped her into a hands-and-knees position to increase the pelvic space.

The designated midwife then entered the room and the whistle-blower midwife returned to attend to her own birth.

Just under an hour later, the alarm was raised due to shoulder dystocia.

Everyone on the ward rushed in and the whistle-blower midwife reports that the birthing woman was once again on her back.

It was not until THEN that the IV drip was switched off and the HELPERR procedure started.

The whistle-blower midwife assisted using Mc Roberts, suprapubic pressure and the Trendelenburg manoeuvre.

The designated midwife tried to rotate the child manually but didn't succeed, then a second midwife tried and finally the senior obstetrician.

ALL THREE tried their own version of an internal rotation manoeuvre a total of three times, and all the while the woman was still lying on her back after a full 4-5 minutes!!!

The next manoeuvre in the HELPERR series was then due, the GASKIN manoeuvre (hands and knees).

During the entire HELPERR process, the whistle-blower midwife repeatedly asked for the GASKIN manoeuvre to be tried.

The whistle-blower midwife was later reported for her repeated requests to try the GASKIN manoeuvre for having "acted in a disruptive manner" during the birth.

But it was not until all three birth attendants had all tried the same (!!!) manoeuvre and failed that the birthing woman was finally placed on her hands and knees.

The birth attendants now once again tried to rotate the baby – first the more experienced midwife, then the senior obstetrician and not until all three had given up the senior obstetrician asked the whistle-blowing midwife to try.

The whistle-blower midwife was ONLY NOW given the chance to try the GASKIN manoeuvre – which is indicated as a part of HELPERR – before clavicle fracture, which would have been the next step.

The whistle-blower midwife experienced this as an attempt to frame her for the now almost certain clavicle fracture or Zavanelli before emergency caesarean.

This whole situation was entirely iatrogenic in origin.

The iatrogenic cause does not refer to individual practitioners, but to a systemic failure in Sweden's childbirth services in terms of how maternity care is organized.

High pressure on the ward is turned into "weak contractions", and is noted in the journal as an indication for speeding up labour through induction.

Due to a shortage of ward spaces and personnel, this diabetic woman in entirely normally labour with a large child was induced with a non-indicated amniotomy and overstimulation lasting several hours, merely so that hospital routines could be followed.

Safe one-to-one care is so under-prioritised in Sweden that not even a high-risk woman can be assured of having a midwife present during birth.

The baby's arm was stuck behind its back with the hand across the shoulder blade in a twisted position.

Despite several hours of overstimulation, the CTG fortunately indicated an exemplary foetal heartbeat – even in the period the time the boy was stuck.

After 1 and a half minutes the whistle-blower midwife succeeded in releasing the baby's arm so that its hand lay flat against the hip and the baby was then born easily after a 7 minute shoulder dystocia.

The shortage of resources caused poor judgment when prescribing an excessively early amniotomy and a rapidly ensuing induction.

Why else the urgency, if it wasn't to move the birthing woman along due to a shortage of ward space?

The same shortage of space also caused the neglect of this woman during several hours of overstimulation, evident from the CTG record, which NO ONE monitored during the many hours the patient was alone in the room.

If there had been time and opportunity to monitor the CTG, the 6-7 contractions every 10 minutes due to overstimulation would have been discovered.

The induction was initiated without any substantial indication and without ensuring that there was sufficient staff to administer the treatment safely.

A present midwife would have discovered the 6-7 contractions every 10 minutes and would have been able to correct the overstimulation, and assisted the woman to move into a hands-and-knees position to increase the pelvic space.

This, and other more pain-relieving positions would have resulted in fewer and better-coordinated contractions, which would have reduced the risk of shoulder dystocia.

The lack of a present midwife caused constant back pain from iatrogenous overstimulation, which forced the birthing woman into a position on her back, minimising her pelvic space.

She could only reach the nitrous oxide on her back – needed to alleviate the intense pain caused by her treatment!

No individual midwife can compensate for or address the risks caused by Sweden's understaffed and over-medicalised maternity services.

This birth was mismanaged DESPITE the presence of a highly competent and responsible midwife.

Because of understaffing on the ward, the midwife was unable to prevent a severe and life-threatening shoulder dystocia from occurring.

Her absence, alongside the rushed and non-indicated amniotomy, constant overstimulation and the immobilising back position, are all the result of systemic shortcomings, which midwives are far too frequently held *personally* responsible for.

MISTREATMENT OF WHISTLE-BLOWER MIDWIFE

The whistle-blower midwife was not invited to perform the GASKIN manoeuvre until after the senior obstetrician and two other midwives had given up after multiple more or less identical and unsuccessful attempts at rotation.

The GASKIN manoeuvre is indicated as a part of the HELPERR protocol – before clavicle fracture, which would have been the next step.

The whistle-blower midwife experienced to ignoring of her repeated requests and very late invitation to astry the GASKIN as an attempt to frame her for the now almost certain clavicle fracture or Zavanelli before emergency caesarean.

The whistle-blower midwife was later reported for her repeated requests to try the GASKIN manoeuvre for having "acted in a disruptive manner" during the birth.

This whole situation was entirely iatrogenic in origin, and the appropriate treatment had been brought to the team's attention by the whistle-blowing midwife, who was not only ignored, but reported for disruptive behaviour.

The whistle-blower midwife was also reported for attempting to return some of the baby's blood volume from the umbilical cord, which had been cut without indication.

This illustrates the systemic nature of obstetric violence in Sweden: it is perpetrated against women, babies and the midwives who try to protect them.

OBSTETRIC VIOLENCE AGAINST THE BABY

Once the baby was born, despite quickly vocalising and with good tonus, the umbilical cord was immediately cut and the baby was to the NEO room, where he was given a little neopuff to achieve APGAR 6- 10- 10.

Not bad for a 7 minute shoulder dystocia, some might say.

But the whistle-blower midwife states that this baby would have had an APGAR score of 10 10 10 and not needed to be NEO-puffed if the ward had not taken 30-40% of his blood after only 5-10 seconds by means of immediate cord clamping.

Given the baby's CTG, it's impossible for the baby to have been asphyxiated, despite several hours of severe overstimulation.

The FHR was constant at 140 throughout the birth, and even when the shoulder was trapped it "dropped" to 110 bpm, which is still in the normal range.

This baby had the right to retain his own blood and it was removed from him, potentially endangering him, entirely unnecessarily.

This represents a case of obstetric violence against the baby.

Especially as this baby needed the extra oxygen-transporting blood cells and stem cells to repair any potential micro-injuries caused by a potential oxygen shortage.

There was NO BASIS for cutting the cord so soon in this case.

Having failed to prevent the cord being cut, the whistle-blowing midwife ran to collect the remaining blood from the baby's umbilical cord to compensate this entirely unnecessary blood loss, which corresponded to the equivalent of 2 litres of adult blood.

She was then reprimanded for this, as it deviated from the hospital's outdated routines. (!!!)

All the up-to-date research shows that what happens to the child in the period after birth and until the placenta is born, is much more important for an asphyxiated child's future health, that what immediately preceded it, because the increased blood volume and the increased volume of blood components and stem cells are significant to the baby's immediate survival and long term health, as the stem cells have major repair characteristics to compensate for any potential micro-injuries caused by asphyxiation.

The NEO staff refused to return the baby's blood to him!

Just under 24 hours later, the baby was transferred to the NEO was for treatment due to increased temperature and CRP.

There were no signs of intra- or postpartum infection neither on the CTG or in the mother.

According to Judith Mercer et al. a compromised immune system is one of the (/milder) results of iatrogenous hypovolemia, which does not appear until a little after birth, and is therefore often not connected to the extreme stress of the large blood loss the baby is exposed to and which is caused by too rapid cord-cutting.