Who's in control when you're giving birth?

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Kimberly Turbin wasn't expecting childbirth to be a pleasant experience, but she wasn't expecting it to be a nightmare either.

On 4 May 2013, she was sitting on the couch at a friend's house. They had plans to go out for seafood in San Pedro, next to the Los Angeles Harbor, and 27-year-old Turbin was relaxing in the living room while her friend took a shower. Then she felt something "pop" – her water had broken. Turbin rushed home to take a shower herself and grab her things before heading to the hospital. She arrived at the Providence Tarzana Medical Center in the San Fernando Valley around 5pm.

Turbin was insured through Medi-Cal, a state programme that offers free or low-cost health coverage for people with limited income. She had received prenatal care through a nonprofit community health centre called El Proyecto del Barrio, where nurses handled most of her appointments. The day before she went into labour, two weeks before her due date, she had first met Alex Abbassi, an obstetrician who worked with Providence Tarzana.

Turbin is a two-time rape survivor, and when she arrived at the hospital, she asked the staff to be gentle and get permission before touching her. "I was scared of everything and everybody and I told them, "You have to tell me what you are doing or you are going to freak me out,"" she says.

Abbassi checked on Turbin's progress over the course of the evening, and shortly after midnight, it looked like she was ready to deliver. She was on her back in the hospital bed, immobilised by an epidural and

pushing, when Abbassi said, "I am going to do an episiotomy now."

Turbin objected: "What? Why? We haven't even tried!" More than once, she said, "No, don't cut me." Surgical scissors in hand, Abbassi explained that the baby's head was too big and that her "butthole" might "rip" otherwise. Turbin implored him, once again, not to cut her. He said, "I am the expert here… Why can't I do it? You can go home and do it. You go to Kentucky." Then, despite her refusals, he cut her perineum 12 times.

The entire episode was caught on video by her mother, standing off to the side in the hospital room.

"I didn't know he did that until I saw my video," says Turbin. "Nobody could tell me why and that's what bothered me. I was so mad he forced me to do something I didn't want to do."

After two years looking for a lawyer who would take her case, Turbin filed a complaint for assault and battery against Abbassi. Her supporters describe it as a potential turning point for the rights of women during childbirth.

Episiotomy is a surgical incision of the perineum – the area between the anus and the vulva. During the 18th and 19th centuries, physicians used this technique to speed up delivery but only in dire emergencies. At a meeting of the American Gynecological Society in 1920, however, the leading obstetrician Joseph DeLee recommended that physicians use episiotomy as a matter of course to prevent perineal tears, which can be a normal part of childbirth. The rationale was that a surgical cut is more controllable and heals more easily than a natural tear. By 1979, 62.5 per cent of all births and 80 per cent of first-time vaginal births in the US involved an episiotomy.

From the 1980s, however, clinical research began to indicate that episiotomy should not be considered routine medical practice. It can be a life-saving intervention under certain circumstances but for most births, "snipping" does more harm than good. The procedure is associated with higher levels of pain, edema, bleeding and incontinence – and actually increases the risk of severe tearing.

Today, the American College of Obstetricians and Gynecologists and the UK's National Institute for Health and Care Excellence (NICE) recommend against routine use of episiotomy. NICE's guidelines on intrapartum care state it should only be done if there is a "clinical need," such as to relieve fetal or maternal distress.

Episiotomy use varies wildly between countries. In 2010, around 19 per cent of vaginal births in England involved episiotomy. The figures were 27–28 per cent in France and Germany, 43 per cent in Spain and 73 per cent in Portugal, but just 5–7 per cent in Sweden and Denmark. Around the same time, the US rate was 14 per cent, but there is a trend downwards. There is no consensus about what constitutes an appropriate rate.

"There are cases in which episiotomy remains an appropriate thing to do, but when labour and delivery is progressing normally, there is no indication to do an episiotomy," says Dana Gossett, a professor and OB/GYN at University of California San Francisco. "Episiotomy has declined over the last three decades because physicians recognise the potential harm and that we should not routinely do an intervention unless there is a clear indication to do so."

In Turbin's case, her labour was progressing normally. She was young and healthy, and there were no apparent circumstances that made an episiotomy necessary. Even if there had been a legitimate medical reason, the doctor still needed her consent. Like most patients, Turbin

had signed consent forms when she entered the hospital. Those forms stated that she consented to "emergency treatment, medical or surgical treatments, or hospital services rendered to the patient under the general and special instructions of the physician," but also that she had "the right to consent or to refuse any proposed operation or procedure at any time prior to its performance."

Nadia Sawicki, professor of law at Loyola University Chicago, studies the ethics around doctor–patient relationships and informed consent. She says that even though patients sign consent documents when they enter the hospital, that does not mean doctors can perform surgery against their explicit will. If that were so, then anytime anyone entered the hospital, they'd give up their agency entirely.

"Every time you go to a hospital, you sign consent forms – there is paperwork involved," Sawicki explains. "But a basic legal principle that everyone understands is you need to have consent before that kind of a patient interaction. You can have a document that says, 'consent to all treatment,' but if a doctor hasn't had a conversation with the patient, that consent document isn't going to protect the hospital."

Kimberly Turbin stands about 5 feet tall, with dark hair and dark eyes, glasses, and a warm smile. Her right arm is covered in a sleeve tattoo of flowers, and she has other flower tattoos on her chest and foot. Originally from the Los Angeles area, she moved to Chicago in 2009 for college. She was working at the front desk in a dental practice when she found out she was pregnant.

"I knew something was different right away," she says. "It was my first pregnancy, but right then and there, I already knew it was a boy. I was so happy."

Turbin decided to move back to Los Angeles to be closer to her family

during the pregnancy. It was an easy pregnancy – she didn't even experience morning sickness – and she hoped her birth experience would be similarly smooth. What she got was an unwanted episiotomy.

The experience left her feeling traumatised, upset and violated, but the hospital staff said there was nothing to be done. A representative from the hospital came to her room the next day to ask if she was okay and Turbin said she wasn't. According to Turbin, the woman handed her a pamphlet about post-partum issues… and that was it.

When Turbin got home, she told family, friends and coworkers about what had happened. Many responded that episiotomies were a standard part of giving birth and she had nothing to complain about because her baby was healthy. But Turbin didn't think that was right – what happened to her couldn't be normal. She decided to post her birth video to YouTube and see if it got a reaction. Within a day, the video attracted 13,000 views. Within a few weeks, it hit 100,000. Today, it has over 500,000 views.

"I was very surprised when we hit 13,000," says Turbin. "A lot of the responses said, "Oh my God, that's horrible," like they knew something was wrong with the situation. I felt very validated. People were making it seem like I was making a big deal out of nothing, but I knew I wasn't crazy or whiny."

Turbin sent her video to a group called Birth Without Fear, which she came across while searching for online breastfeeding forums. They brought it to the attention of Dawn Thompson, the founder and president of an advocacy organisation, Improving Birth. In many ways, it was the case Thompson had been waiting for. She had tried to raise awareness about "obstetric violence" for years, but one of the biggest obstacles was scepticism that such a thing actually existed. The video meant Turbin's story could be proved. There was no doubt that she said no and the

doctor proceeded anyway.

"There are thousands of stories like Kim's, but hers was caught on video," says Thompson. "Just before she reached out to us, I had been saying that we needed to find documentation, a video, of a doctor being abusive to substantiate the case, so people would know that this is not unusual. Kim's story is an extreme version, but it's an issue everywhere."

Disregard of consent during childbirth and the use of unwarranted interventions are more common than one might like to think. In the Listening to Mothers III survey, a 2013 study of maternity care in the US, 59 per cent of participants who had experienced an episiotomy said they did not have a choice about having the procedure. Between 8 and 23 per cent of mothers also reported experiencing pressure for a range of other interventions, including labour induction, epidurals and C-sections. The same pattern holds in the UK. Over 12 per cent of women said they did not give their consent to examinations or procedures in a 2013 survey conducted by Birthrights.

Research from the Harvard School of Public Health has found that bias, prejudice and stereotyping by healthcare providers can contribute to decreased agency for patients and the delivery of lower-quality care. In the Listening to Mothers survey, about one in five black and Hispanic women reported poor treatment from hospital staff due to race, ethnicity, cultural background or language, as compared to one in 12 white women.

"Women face many violations during maternity care and it is as if their human rights – dignity, bodily and psychological integrity, privacy, equality – do not exist," says Camilla Pickles, who studies obstetric violence and the law at the University of Oxford. "Subjecting them to a cascade of medical interventions unnecessarily and without informed consent is wrong, harmful to their overall wellbeing and can be

dangerous."

In an ideal world, physicians would only recommend or perform interventions when medically necessary and the necessity of those interventions would be clear. That, however, is not the world we live in. Research shows that the prevalence of certain childbirth interventions has far more to do with where and when the physician was trained, the culture of the hospital, and even the time of day or day of the week. A labour that one doctor views as too slow, another may view as slow but safe.

"There could be ten women with the same clinical chart and they could make ten different decisions," says Hermine Hayes-Klein, founder and executive director of Human Rights in Childbirth. "There is so much medical uncertainty with childbirth – the decision-making is not black and white.

"Underneath the idea that childbirth is somehow complicated or different compared to other kinds of informed consent is the idea that somehow because a woman is pregnant, she has less authority over her body than other people."

There is a long line of precedent establishing that all competent patients, including those who are pregnant, have the right to decline unwanted medical procedures. In practice, this can be overshadowed by the idea that doctors know better than their patients what is right. If a doctor says something is best, the impulse is generally not to push back.

"We have this cultural ideal about pregnant women and women in labour as hysterical," says Holly Fernandez Lynch, professor of bioethics at Harvard. "There is a hierarchy in medicine and you don't have much control over [what happens]. Then after the fact, people say you are overblowing this. It's a symptom of how deeply ingrained the idea is that

the doctor wouldn't do anything to harm you."

Fernandez Lynch adds that there could theoretically be an ethical grey zone if a mother was refusing an intervention that would save the life of her baby, but these cases are exceptionally rare because women in labour are not, in practice, inclined to make choices that put their babies in danger. A situation may be confusing and progressing fast, but physicians still have an ethical duty to inform their patients fully and honestly about what is happening and involve them, to the extent possible, in the decision-making process.

Turbin's case did not appear to exist in this grey zone. The video of the birth does not indicate that she or the baby were in danger. This is backed up by her medical notes, in which Abbassi wrote: "She progressed as per usual… and she delivered a baby boy… spontaneously."

These records show that some of her wishes were followed: "The patient refused any surgical intervention and vacuum, so the 2nd stage was prolonged." But then, Abbassi noted, without further explanation, "it was necessary to perform episiotomy under local anesthesia."

In the months following her son's birth, Turbin struggled with emotional and physical trauma. She was in serious pain and found it difficult to do basic things, like sit down. She bought pillows to sit on and changed her entire diet so that going to the bathroom would be less painful.

"I bought a NutriBullet and basically only ate blended fruits and vegetables because I was so scared to use the bathroom," she says. "It was horrible."

After talking to Thompson and Improving Birth, Turbin filed a complaint with the hospital and met with its director of women's

services. She also filed a complaint with the Medical Board of California. Not satisfied with the responses she was getting, she decided to move forward with a lawsuit for assault and battery.

However, Turbin and her supporters couldn't find anyone to take the case. They talked to 80 different lawyers over the course of 18 months, and were repeatedly turned down. Either the lawyers thought it should just be a medical malpractice case or they were not willing to work pro bono. Some didn't think Turbin had a case at all because her baby was fine and her own injuries were not as pronounced as, say, those of Caroline Malatesta – an Alabama woman who suffered a debilitating nerve injury after nurses held her son's crowning head inside her for six minutes while waiting for the doctor to arrive. With the statute of limitations on assault and battery drawing to a close, Turbin filed the complaint herself.

And then finally, towards the end of 2015, Thompson connected with Mark Merin, a prominent civil rights lawyer in Sacramento, who agreed to accept Turbin's case. With episiotomy, Merin says, "there is a tendency to defer to a doctor as the expert about what is needed or not needed. It's rare that a woman will assert her autonomy and say no." He believes that other lawyers initially thought, "What is this woman complaining about? This is a doctor's decision, not a woman's decision."

Even Turbin's mother, who was in the delivery room with her (and filming), took the doctor's side and encouraged her daughter to allow the episiotomy, saying "He has to do his job" over Turbin's protests of "No, don't cut me." The decision, however, was Turbin's, which is why she wanted to bring an assault and battery suit rather than medical malpractice. She and her supporters felt it was a more accurate reflection of what had happened. In a medical malpractice suit, the plaintiff alleges that the doctor behaved in a way that a reasonable doctor would not – by messing up a procedure, performing below standard, or neglecting to get

a patient's full consent. Battery, in contrast, requires proof that the defendant made physical contact with the plaintiff in a harmful or offensive manner against their will.

"A battery is a pretty extreme characterisation of a doctor's actions," says Merin. But, he adds, Turbin was "restrained" and she said the procedure was "performed against her will."

In June 2016, Judge Benny Osorio ruled in the Superior Court of California that Turbin v. Abbassi was properly constituted as a battery lawsuit. In his court order, Osorio wrote that Turbin had "alleged a battery based on a deliberate decision to ignore the scope of the plaintiff's consent, not a negligent failure to disclose a potential complication." This meant Californian courts were willing to try incidents like this as potential acts of assault.

This is why it's so significant. The judge acknowledged the possibility that a doctor performing an episiotomy without the patient's consent could be committing an act of violence, as opposed to just medical malpractice. Thompson hopes Turbin's case will have national implications about legal rights during childbirth. It raises awareness about the issue of consent and authority, and shows that there are opportunities for recourse for those who believe they have been subjected to obstetric violence.

"This is one of the first cases ever of calling it assault and battery," Thompson says. "Dr Abbassi is essentially a symbol for me. Women are constantly thanking Kim for standing up for them because they weren't able to do it for themselves."

Ultimately, however, Turbin's case did not reach a full trial. By January 2017, mediation was underway and what turned out to be the last meeting in the process was emotional – the culmination of a journey that

had unfolded over many years, one that Turbin was desperate to be done with. When Merin told her that taking the case to trial could take years, she put her head down on the table in despair. The prospect of waiting for a trial and then recounting the entire experience for a judge and jury was overwhelming.

"Mentally, I was done," she recalls. "I don't even know how I got that far. I felt like crying, but I also felt like I made my point."

Abbassi and Turbin agreed to settle out of court. He had already relinquished his medical licence in 2015, having acknowledged that his cognitive functioning meant that he could not continue to safely practise medicine. Despite several attempts to contact Abbassi to hear his side of the story, I was unable to reach him either directly or through his lawyer.

Turbin's case is extreme, by any measure, but it is an extreme on a spectrum. Around one-third of women experience trauma while giving birth. A recent study published in the journal BMC Pregnancy & Childbirth asked 943 of these women from around the world about their experiences with birth trauma. Two-thirds of them said that their trauma related to the way they were treated by medical professionals. Their statements were startling.

"I begged not to have a c section, neither I nor my baby were in distress or danger, but because the doctor was ready to go home, he did a terrible section that resulted in almost a year of recovery," one woman said.

"I was steamrolled with unnecessary intervention and didn't get to speak with a doctor about my options, risks vs benefits… I feel like the nurses, doctors and hospital only did what was in their best interest, not mine… It was a nightmare," said another.

Shared decision-making is supposed to be a part of giving birth, but

pressure, manipulation and coercion are not uncommon in the delivery room. In most cases, this is not due to malicious intent. If physicians think a certain course of action is best, it is their duty to express that. However, it is ultimately the patients who have the right to decide what happens to their bodies. Pregnancy does not eclipse agency, but many of those approaching childbirth do not know this. They don't know that they can say no, or they don't understand why there might be a need to.

As Turbin discovered when sharing her experience with the people around her, this type of treatment is considered normal in some communities and there can be minimal accountability. Her refusal to accept this response, her willingness to share a deeply intimate video with the world, and her drive to keep pursuing her case through four years of rejections and dismissals all stem from a conviction that no woman should have to endure what she did, especially not without the right to hold those responsible to account. She realised that too many women go through similar experiences and never speak up, which allows the pattern to continue.

"What's most unusual about this case," says Hermine Hayes-Klein, "is that she made it into court. Thousands of women behind her did not have that kind of access."

More than four years after the birth of her son, Turbin is still coping with the physical and emotional effects. She has suffered through sustained and acute pain, struggling to find a doctor who could help her on public insurance. When she visited a family healthcare clinic that accepted Medi-Cal, looking for help with the vaginal pain, they gave her lubricant and told her to try anal sex. She has also dealt with PTSD, depression and anxiety as a result of the trauma, compounded by her memories of rape.

"My son has a sad mom sometimes or someone who gets frustrated

because she's in pain," she says. "I was supposed to be okay and it went completely upside down."

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