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Obstetric Violence – What is it?

AIMS Journal, 2022, Vol 34, No 2

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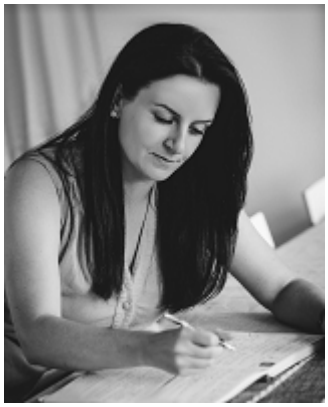

It feels as if violence against women is everywhere. Whenever I turn on my TV, I feel bombarded with the many and varied ways in which women and their bodies are abused and violated. Whether it appears in a news broadcast, on a Netflix crime docuseries or in the form of comedy, I often find myself shuddering at the cruelties experienced by women in our society.

One recent show depicting violence against women has caught my attention: The BBC's*This is Going to Hurt*. It is based on a true story about a former obstetrician, Adam Kay, and the traumas he experienced whilst working for the NHS in the early noughties. In one scene a labouring woman is racist towards a member of staff; as a form of punishment, Adam unnecessarily cuts through the woman's tattoo during caesarean surgery and seemingly with intention, sutures her in a way that the tattoo image becomes distorted. As a result, one of his midwifery colleagues, Tracey, reports him to the General Medical Council. During a confrontation between Adam and Tracey, she states:

> You *assaulted* your patient. That's what it is if you cut someone's tattoo.

She lists the various unethical acts Adam has carried out and continues:

> It's pride. It's dishonesty. It's arrogance and it's entitlement. You think that you are the cleverest person in the room. And that makes you dangerous.

Although the term is not used in the show, Tracey is effectively calling Adam out for acts of obstetric

violence. Regardless of his disgust at the woman's racist attitude, Adam – an obstetrician – physically assaults someone who trusts him and who he is meant to be caring for. He abuses the power dynamics and takes advantage of the pregnant woman's vulnerability. Irrespective of the woman's views, he has no right to physically assault her. This is a particular form of cruelty and another insidious example of violence against women.

The point of this anecdote and short article is to explore the term obstetric violence and to highlight that this type of abuse does not have to be as overt as what is seen in *This is Going to Hurt*. In fact, obstetric violence is often not as obvious as the scene in this show. Rather, it is typically more complex than this and frequently harder to pinpoint a specific person as a perpetrator.

What is Obstetric Violence?

'Obstetric violence' is a term that is gaining traction in both the UK and abroad. As alluded to above, it refers to instances when pregnant women or people have been subjected to abusive encounters with health care professionals, most typically during birth. However, the types of behaviour that could be considered obstetric violence remain unclear. There is no set list of acts, or even a settled definition. Throughout South America, for example, there are laws prohibiting this type of violence, yet each country has formulated its own description of what it is.

To add further confusion, obstetric violence is not a term used by everyone who is concerned with the phenomenon. For example, the World Health Organisation (WHO) employs the phrase "disrespect and abuse during facility-based childbirth." Other terms writers have used include 'mistreatment' and sometimes people have employed the more general umbrella phrase 'birth trauma.'

One of the clearest - although still not perfect – definition comes from WHO. It prohibits[1]:

> …outright physical abuse, profound humiliation and verbal abuse, coercive or unconsented medical procedures (including sterilisation), lack of confidentiality, failure to get fully informed consent, refusal to give pain medication, gross violations of privacy, refusal of admission to health facilities, neglecting women during childbirth to suffer life-threatening, avoidable complications, and detention of women and their newborns in facilities after childbirth due to an inability to pay. (p.1)

The United Nations Special Rapporteur has also written a report on obstetric violence. It summarised a range of abuses, including the overuse of episiotomies (cutting of the perineum i.e. skin between the anus and the vulva) and caesarean sections, application of non-evidenced based procedures such as the Kristeller manoeuvre (pressing on the abdomen during childbirth), symphysiotomy (surgical widening of the pelvis during childbirth) and forced abortions and sterilisations (pp.7-12).[2]

The type of abuse these organisations describe is overt. They reflect what we might typically understand as violence - acts which create direct harm. These are similar to the tattoo example in *This is Going to Hurt*;

the health carer physically or verbally abuses the person in their care.

Yet the 'violence' in obstetric violence does not only include wilful, overt and direct cruelty. It does not solely mean that staff must want to hurt pregnant women and people vindictively and intentionally. Obstetric violence also includes structural violence that is normalised within maternity services. In some cases, it can even be carried out unintentionally, leaving the health carer oblivious to the harm they have caused.

Normalised, structural and unintentional obstetric violence

I recently watched a Panorama documentary entitled A Cow's Life: The True Cost of Milk. It explored the treatment of dairy cows in the UK. There was a scene in which a hoist was used to lift up a "stricken" cow by its hips. As the farm worker used the equipment, the cow was raised completely into the air, its face and front hoofs dragging across the concrete floor. It was dragged this way until the farm worker was satisfied that it had been moved to an appropriate place.

For me, this undercover footage was disturbing. An academic and a lawyer on the documentary were clearly appalled by the incident. Yet what was interesting, is that a farm vet who was also interviewed appeared nonplussed. He described it as "fairly common practice". In his view, the animal needed to be moved and even though he conceded there was "potential for damage," this was short term pain for the benefit of being moved to a "nicer" area.

This is a good example of a professional who has become desensitised to abuse. So frequently does he see these incidents, that they no longer strike him as problematic. Such scenes have become a normal part of his everyday role, whilst outsiders, unused to such acts, feel dismayed and shocked. In essence, the violence has become normalised and the professional no longer sees the abuse attached to his or her act. This is exactly what is meant when people suggest midwives and obstetricians may carry out acts of obstetric violence and yet not understand that their behaviour is problematic.

Health carers may also not recognise obstetric violence if it is structural in nature. Sometimes, in these cases, a midwife or doctor may not be directly responsible for the abuse. Take for example the expectation that pregnant women and people birth on their backs. Research shows that this can make birthing more difficult.[3] Of course, there is plenty of good practice within the NHS where health carers will actively encourage a person in labour to move around and find a comfortable position. However, if a hospital room contains a bed at its centre and no alternative space for adopting different positions, a pregnant woman or person is left with little choice but to give birth on that bed. Whilst a person could theoretically kneel on the mattress to birth, the emphasis of a bed in the room certainly privileges – or even promotes - the idea of laying down or reclining during birth. The lay out of the room can therefore channel people into adopting positions that make their labours and their births more difficult. The additional pain and birthing difficulties become the violence. The room layout is the structural problem and the frequency at which people birth on their backs in such circumstances is what has normalised this abusive situation.

A further example of structural, normalised and unintentional obstetric violence is the requirement for a person in labour to be at a certain level of cervical dilation before they are either admitted to hospital or can be moved to the delivery suite. The typical way of determining how dilated a person's cervix is, is by a midwife carrying out a vaginal examination. This is an intimate procedure that a pregnant woman or person may wish to decline, as is their right; but equally they might feel compelled to undergo it so that they can satisfy the requirements of the maternity ward. Being channelled into submitting to an invasive vaginal examination for this reason does not constitute informed consent and is therefore unethical. In essence, in this situation vaginal examinations have been normalised and midwives and doctors become complicit in acts of obstetric violence – even when they believe they are providing appropriate care.

Challenging obstetric violence

It is often difficult for pregnant women and people to challenge obstetric violence. Not everyone subjected to the acts described above will immediately recognise their experiences as a form of abuse. For example, some people may wrongly believe they have to endure all medical interventions proposed by their health carers and that they are not allowed to say 'no' or 'stop'. In other cases, people may not have the confidence, ability or even opportunity to challenge a midwife or doctor. They may feel afraid or confused as to what they have experienced, unsure as to whether they are overreacting or have misunderstood what was happening. This may be compounded by the fact that most people will only give birth a small number of times. Typically, therefore, they will not have much experience of the maternity system. Consequently, some of the best people to challenge obstetric violence and to advocate for pregnant women and people are healthcare professionals.

The role of health carers in challenging obstetric violence

There is a book available online by the midwife Sarah Stone who practised in rural Georgian Somerset. It was written in 1737 and is entitled A Complete Practice of Midwifery. At the time, midwifery was not an

official profession. Instead, childbirth was very much an informal female event in which women gave birth at home surrounded and supported by other women. During this era however, men began to get involved in childbirth. Stone witnessed the rise of men-midwives whom she argued overused medical instruments in ways that could be damaging to both mothers and babies. In one passage she noted that this overuse had resulted in "infants being born alive with their Brains working out of their Heads" (xiii).

The point of this is to highlight that there is a long history of health carers calling out the abuse of pregnant women and their babies. In eighteenth-century England, a woman like Sarah Stone would not have enjoyed many rights. Yet she used her small platform to challenge abusive practices she witnessed in her own work environment. It must not have been easy to do so, and likely Stone was taking considerable risk when she published her opinions.

As Tracey discovered in *This is Going to Hurt*, it is always difficult to call out any form of unprofessional behaviour, especially of colleagues. However, obstetric violence will continue to poison the maternity system unless midwives and doctors practice ethically, actively resist structural forms of obstetric violence and challenge any bad practice they witness. It is hugely problematic if health carers do not understand how abusive practices can become normalised. Short of being subjected to a medical negligence claim, this awareness can only materialise if it is pointed out - and professional colleagues and peers are the obvious people to do this.

Concluding thoughts

I wanted to hate *This is Going to Hurt*. But the truth is that I didn't. Yes, the show provided more examples of violence against women to a viewing audience that are no doubt saturated by scenes of abuse. However, it also highlighted what AIMS has been campaigning about for 60 years – namely, that there need to be improvements in the maternity services. Obstetric violence will thrive when abusers go unchecked. It will perpetuate when structures channel midwives and doctors into becoming complicit in the abuse. Importantly, health carers have been challenging abusive practices for centuries and the requirement for them to continue to do so remains as pressing as ever.

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Information for pregnant women and people

It is a sad indictment of NHS maternity services if pregnant women and people need to prepare ways to try to avoid being subjected to obstetric violence. However, the reality is that whilst there are excellent levels of NHS care in Trusts throughout the UK, obstetric violence does exist. One way to pursue a respectful birth is for pregnant women and people to empower themselves with knowledge of their rights. AIMS has various publications that can help with this, and these are listed here:

AIMS Guide to Giving Birth to Your Baby

AIMS Guide to Resolution After Birth

Making Decisions About Your Care

AIMS Position Paper on Obstetric Violence

AIMS Position Paper on Decision Making in Maternity

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[1] WHO 'The prevention and elimination of disrespect and abuse during facility-based childbirth' - https://apps.who.int/iris/bitstream/handle/10665/134588/WHO_RHR_14.23_eng.pdf

[2] United Nations General Assembly 11/007/2019 'A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence : note / by the Secretary-General' - https://digitallibrary.un.org/record/3823698?ln=en#record-files-collapse-header

[3] Cochrane review 24/05/2017 by Gupta JK, Sood A, Hofmeyr G, and Vogel JP 'Women's position for giving birth without epidural anaesthesia' - www.cochrane.org/CD002006/PREG_womens-position-giving-birth-without-epidural-anaesthesia