



A review of the Joint position statement: 'Substandard and disrespectful care in labour – because words matter'.

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This is the joint statement of the European Association of Perinatal Medicine (EAPM), the European Board and College of Obstetricians and Gynaecologists (EBCOG), and the European Midwives Association (EMA).



By Gemma McKenzie

I read the article in the title with a cup of tea and a raised eyebrow. It comprises yet another attempt by health care practitioners to silence women and their use of the term 'obstetric violence' when describing their own knowledge and experience. As someone who researches obstetric violence and who has been subjected to it, I find the article both startling and confusing. There are a lot of linguistic gymnastics used as a way of (unsuccessfully) arguing that 'violence' should not be used in the terminology. I do note with some relief however that no British obstetrician or midwife has signed their name to the piece; my hope is that anyone who was approached, recognised the authors' argument for what it is: out of touch, one

dimensional and misinformed.

Before we dive into the article under review, let's ask a basic question: who has the right to decide what should be labelled 'violence'? When we discuss other forms of violence, we do not ask the perpetrators or their institutions what language they prefer. If they offered a suggestion, we would certainly not be under any obligation to use it. And that is doubly true if we are the victim/survivor. While there may be many more articles written by health care practitioners on their distaste of the term and the labels they would prefer to use, no one is required to follow their attempts at instruction.

Importantly, there is power in language. Suppose we refrained from using the term 'domestic violence' and instead replaced it with 'marital disharmony.' Or if we dropped the term 'rape' in favour of 'non-consensual sexual relations'. Perhaps a more appropriate example reflecting the insidious nature of obstetric violence would be to swap the word 'racism' to 'unfavourable treatment'. If these changes were pursued, the seriousness of the acts would be undermined, resulting in a minimisation of the victim/survivor experience. Ultimately, we need to ask whose needs are served when violence is minimised. Whilst the authors may consider this a good way to forge collaborative working "between individuals and institutions" in aid of improving women's experiences, I consider it a way for the medical establishment to dictate the narrative and silence women.

Obstetric violence versus 'substandard and disrespectful care'

Obstetric violence is a nebulous term. Academics who study the phenomenon are still grappling with the creation of a specific definition and the ways in which it can manifest. One thing that muddies the waters is when authors substitute the term for other phrases, such as 'disrespect and abuse', 'D&A', 'mistreatment' and even sometimes 'birth trauma'. The authors in the article under review have introduced an additional term: substandard and disrespectful care in labour.

There are several problems with the authors' use of this term and their description of what it constitutes. Let's begin with substandard care. This is described as:

- The use of healthcare interventions that are not considered best practice.
- Inadequate use of interventions.
- Situations where best-practice interventions are not offered or are withheld from patients.

What the authors are describing here is medical negligence. In the UK, laws already exist regarding this. An additional example the authors provide for substandard care is:

- The performance of healthcare interventions without adequate informed consent.

In England and Wales, this is not simply 'substandard care' – this is a criminal assault. A non-consensual vaginal examination, episiotomy, stretch and sweep, forceps birth, and all other non-consensual interventions are forms of battery. Laws already exist against this, and assault and battery are legally recognised forms of violence.

The authors' use of the term 'disrespectful care' creates an even more incoherent picture. Although in their title, the authors contend that "words matter", the term 'disrespectful care' is an oxymoron. Care is the very opposite of disrespect and it is difficult to think of an example when both can co-exist.

According to the authors, 'disrespectful care' includes "disrespect for ethnic, cultural, religious, gender or other beliefs". It is interesting that this language is used. Are the authors actually referring to behaviour that would be better described as racist, homophobic, sexist, misogynistic, transphobic or incorporating forms of religious discrimination such as antisemitism or islamophobia? The dangers attached to these types of discrimination go far beyond the concept of 'disrespect'.

The authors also state that 'disrespectful care' includes verbal, emotional, physical and financial abuse. Again, such behaviour can amount to a criminal act. Notably, verbal, emotional, physical and financial abuse are forms of domestic violence. Within that sphere, we do not describe those acts as simply 'disrespectful'; we correctly describe them as forms of violence. Yet the authors perceive the label of 'disrespect' as appropriate when such violence is carried out on pregnant women by health care practitioners.

The authors do provide a definition of 'violence'. There are (feminist) scholars who have spent their whole careers exploring this term, its meaning and the way it manifests. Sadly, the authors did not engage with this literature, preferring instead to simply refer to the dictionary. Bizarrely, the authors' definition of violence includes "the use of physical force so as to injure, abuse..." yet this is exactly what they describe as simply 'disrespectful care' and argue should **not** be termed violence.

So why is obstetric violence a more appropriate term?

It is unfortunate that the authors believe obstetric violence is simply healthcare practitioners' substandard or disrespectful 'care'. This limits their understanding of the concept to the idea that it occurs simply during one-to-one interactions. This is not the case with obstetric violence. Of course, there are 'bad apples' in medicine – as there are in all professions – but obstetric violence is not just about individuals not following guidelines. To make an analogy, that would be as simplistic as saying sexism only occurs when men hit women.

Obstetric violence does not require a 'bad' midwife or doctor who deliberately harms people in their care. It can exist even when health care staff have the best of intentions. For example, obstetric violence can be institutional. A hospital may insist a woman be 6 cm dilated before she can move to the delivery ward. This requires the labouring woman to submit to a vaginal examination and undermines any notion of real informed consent. It is likely that the midwife who undertakes the vaginal examination has no

intention of violating the woman concerned, but her act is a violation of both the woman's rights and her body.

Obstetric violence can also be structural and emanate from wider social inequality and discrimination. For example, the maternity system operates within a capitalist and patriarchal society that reveres scientific and medical knowledge and the people who claim to possess it. In capitalist countries without free maternity care, women may be subjected to over-medicalised births because they are financially more lucrative to the health care practitioner and the institute in which they work. In patriarchal societies like our own, there is a power imbalance weighted against women and this does not suddenly disappear once they enter the maternity system.

With regards to scientific knowledge, this assumption is evident in the article under review. The authors write that some doctors may have "judgemental or paternalistic" approaches and allow this to reflect in their behaviour "particularly in situations where they hold the power of knowledge and decision". It is important to consider here, when do doctors hold the "power of knowledge and decision"? In other words, when do pregnant women and people have no knowledge and no right to decide? Beyond situations in which women do not have mental capacity, for example, if they are unconscious, it is difficult to conceive of such a situation. Even in an emergency situation, if a woman has mental capacity, she can decline a medical intervention.

In addition, women always possess some form of knowledge, for example, of their own bodies, preferences, needs, previous life history and family lives. These are all important forms of knowledge that impact decision making. When health care practitioners do not recognise this, they have fallen foul of social assumptions that there is a knowledge hierarchy, and their medical knowledge is at the top. It is this very attitude that permeates maternity care and fuels obstetric violence. It also flies in the face of what the authors are claiming they want to achieve: individuals and organisations coming together to improve maternity care.

A final note

I wanted to make one final point with regards to this review. The authors simply do not understand the impact obstetric violence can have on a woman's life. They claim that it can leave her with "negative feelings" and she may "feel mistreated, humiliated ... abused". Negative feelings minimise the reality of women experiencing post-traumatic stress disorder (PTSD) and post-natal depression (PND), not to mention stress and anxiety linked to obstetric violence. These are recognised mental health conditions and are not simply "negative feelings".

Further, when people use this turn of phrase about *feeling* mistreated or abused, it avoids any contrition from the abusers, their institutions and systems. It is similar to the type of apology that begins "we are sorry you feel that we..." In other words, the fact that you *feel* abused does not mean that you actually were. This type of approach smacks of the dehumanisation that is central to obstetric violence. If the maternity system and its practitioners cannot empathise with the people they are supporting, then

obstetric violence will continue unabated.

And finally

Everyone is entitled to call their own knowledge and experiences what they want – especially victims/survivors. Some victims/survivors may hate the term obstetric violence, and that's fine. Others may feel it appropriately reflects their experience. As to health care practitioners' attempts to stop people using the phrase, the horse has already bolted, and the genie is well and truly out of the bottle. We do not need health care practitioners' blessing to use the language we feel most appropriate.

Whilst it would be great to have as many medical professionals aligned with the views of organisations such as AIMS, it is not entirely necessary. Vast improvements to the culture of maternity care, and in particular that which enables obstetric violence to thrive, will only come from pressure outside of the system. The problems fuelling obstetric violence are too ingrained socially, institutionally, structurally and culturally. It is up to us as women, pregnant and birthing people, activists, researchers and all others who want to challenge obstetric violence, to use our voice, to use the language that feels right for us, and to share our knowledge and experiences in the ways we feel best.

For more information on obstetric violence see:

[Obstetric Violence – What is it?](#)

[AIMS Information Page – Obstetric Violence](#)

[AIMS Position Paper on Obstetric Violence](#)

[Obstetric and Gynaecological Violence in the EU](#)

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