AIMS For a better birth...

Abusing language

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If you're around birth for long enough, you'll hear women tell you that they have had vaginal examinations without consent, perhaps as a form of coercion. It seems that women are frequently told things like "We need to know 'where you are' if you're to be admitted to the hospital/given access to the pool/given an epidural or even gas and air". In some case there is no explanation or justification.

Sometimes when woman consent to a vaginal examination, they will also be given a stretch and sweep or have their waters broken with the justification of "I did it while I was there".

If a person uses coercion to gain access to someone's vagina in a non-medical setting, the law recognises that as assault. If a person does a medical procedure it is well accepted by the medical establishment and the law as assault and medical malpractice. Yet for some reason it has become common practice for doctors and midwives to expect access to the vaginas of pregnant or labouring people.

When this was raised at a recent meeting between maternity service users and a hospital trust, senior midwives were extremely upset. The context for this discussion was a group activity called the 'diamond nine' exercise. Nine real life statements collected from service users were written on cards and members were asked to lay them out with the most serious concern at the top and the least serious concern at the bottom. "I agreed to a VE and without my permission, my midwife gave me a 'stretch and sweep'" was placed at the top of the diamond by one group. When asked why, they said that this was the most serious concern because it was common practice and it was an act of abuse.

Senior midwifes were upset not because they were being advised of women suffering abuse under their watch, but because "the midwives have a hard enough time of it, without being accused of abusing women".

At another meeting where there was a discussion of women who were declining care, a doctor asked how health professionals could be protected when women make unsafe decisions. Is this the crux of the issue in that midwives and doctors believe that women are not able to make safe decision about their bodies and so they feel they must do interventions, such as a vaginal examination, even if the women fails to consent?

Doctors and midwives need to be able to accept two things

- That birthing people make decisions that are right for them based on many things and are the only persons who can do so; and, rarely, will these decisions be highly risky when all aspects are considered.
- That even if a decision is highly risky that person has an absolute right to be supported in that decision.

So, is the use of the term abuse in this situation an understandable concern? Should campaigners use different language when talking about this issue with midwives in order to not have them defensively shut down the issue as they don't see themselves as 'abusers'?

Language is hugely powerful, and hearing ourselves being accused of something that does not represent our internal sense of self is generally going to lead to us being defensive. Equally, women who have been assaulted want to, and have the right to, hold ownership of their description of what happened to them. As birth campaigners – and many of us are victims of these assaults – how do we tread both these lines in a way which supports everyone being heard as well as keeping everyone listening?

Perhaps, we need also to be asking why the system is forcing midwives and doctors to be more comfortable with assault than with supporting someone to make decisions about their care which currently fall outside normal care. What is it about the culture of our maternity institutions which is supporting this sort of practice which AIMS was founded 60 years ago to try to address?

I think that it is important to use the words that women use to describe their experience of what happened to them, and we should not shy away from them. Assault, abuse, attack, violence… these are what women experienced, and it is not acceptable to downplay that in order to try to avoid upsetting people, even if the intent by the health care provider was not to assault, abuse, attack or be violent. However, there are ways to use these words which do not in turn mean that the midwives feel under attack themselves, meaning that they are then more likely to reflect on their own practice and how it feels to be a woman in their care.

These practices, which are assault, are also the normal way of working in many units. Very often

maternity staff, who may be extremely gentle and kind people, have simply never had it pointed out to them that what they are doing can cause extreme trauma. They may feel extreme pressure to conform to what is expected by the institution, pressure that may make them concerned for their job or professional registration. This does not mean that they are 'bad people'. It means that human psychology is such that the everyday normalisation of the abnormal can simply mean that even the best people do not realise, or feel unable to do anything about, the destructive power of their actions.

Let's look at how communication may be improved. If a birth campaigner says, "I want to talk about how the midwives and doctors in the trust are assaulting women during their births", instantly the maternity staff's minds jump to a different type of assault, something that they consider that they would never do. As they are thinking of something awful that they know would not be something they could ever consider doing, they are not going to be open to reflecting on the fact that their practice is actually abusive.

Instead, consider saying, "I want to talk about practices which are considered within the hospital to be completely normal, and I totally understand that they are being done with the intention of caring for the woman, and yet many women are experiencing these as being very traumatic. We know that many midwives and doctors are simply following common practice, and I know that you would all be horrified to hear that some of what feels really routine to you is causing many problems, but women are being traumatised and they need you to hear what their experience is so that this can be changed."

The health care providers may still respond defensively, and even begin to explain why it's important that these routine assaults happen. It's fine to listen to their responses so that they know that they're being heard. However, if they do this, they haven't yet understood the situation, so perhaps you could respond with something like, "I completely understand, however it's not always the checks themselves that are the problem. What we need to talk about is how women experience them when they're not given enough information to make an informed decision - a decision to decline or accept what is being suggested without feeling coerced."

When trying to work on communication, there's a fine line to tread. People's experiences must not be downplayed, but to be heard we need to be really careful about how we speak. This might be considered to be 'tone policing'. I would hope that I would never do that – everyone has the absolute right to speak about their experience as they wish to. But when it comes to communication, when we are trying to be listened to and understood, *how* we will be heard is vital. This does not mean pussyfooting around, nor downplaying the seriousness of the assault – no – that would be entirely inappropriate. But it does mean thinking about how to best put across our words in a way that the other person will actually listen. When we do this, we can really reach out to the other person and communication can start to happen. Equally, the onus is also on health care providers to listen to and respect the experiences of women as being the experiences that they actually had, even if that's hard to hear.