

To Use or Not to Use the Term “Obstetric Violence”: Commentary on the Article by Swartz and Lappeman

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Abstract

Based on the article by Swartz and Lappeman, we propose in this commentary to reflect on three central components linked to the concept of obstetric violence: the withdrawal of intentionality as a founding element of its recognition, the preponderant place given to the perspective of women and those affected by it, as well as the recognition of its sexist, gendered, and systemic character. We also discuss the epistemic injustice associated with obstetric violence. We stress the importance of including both health workers and health systems in the equation, even though they may be offended by the use of the term. We conclude by recalling that significant leadership must be exercised by health care workers and institutions to put an end to this form of violence.

Keywords

obstetric violence, gender violence

We are pleased to join the discussion on obstetric violence with these comments on the article by our colleagues Swartz and Lappeman. We believe that this is an important issue and that researchers, activists, and other stakeholders should join forces to address it. It is a problem that confronts women and persons who give birth, as well as the professionals who assist at the birth, regardless of where they are. Thus, the discussion should transcend geographic borders and disciplinary boundaries. For our part,

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we offer a view from a French-speaking part of Canada (Québec). We are two university researchers trained in two different areas (public health and sexology for one, and public health and law for the other). We identify as cisgender females, and both of us have experienced pregnancy and childbirth. We have not experienced obstetric violence personally. We come to this discussion from a background of research on obstetric violence perpetrated by health care providers against women and informed consent to care. We will begin by mentioning that Québec has had a public health and social services system since 1971. The government is therefore the main provider and administrator. The system includes two universal regimes: hospitalization and health coverage combined with a mixed private–public drug coverage plan. As such, the system is largely tax funded. Accordingly, all women and persons who are pregnant and enjoy regular civil status are eligible to receive free perinatal health care, including pregnancy follow-up, childbirth, hospitalization, and postnatal care for mother and baby. However, despite the universal access and the quality of the care that is provided, women in Québec, particularly those of First Nations origin, have experienced obstetric violence when giving birth at a hospital (Bergeron et al., 2019; Regroupement Naissance-Renaissance et al., 2019).

In their article, Swartz and Lappeman propose a response to the following question: “Does use of the term ‘violence’ inadvertently disempower the women that it is meant to empower?” The empirical corpus for their article stems from a larger study on the responses of health care providers confronted with stillbirths in the labor ward of Khayelitsha Hospital (South Africa). The study is based on qualitative data: observations of the labor ward, birthing rooms, and maternity ward combined with an analysis of hospital documents and interviews with the health care practitioners who worked with the women whose babies were stillborn and interviews with the women who birthed them. In light of the results, the authors wonder whether the use of the term violence is appropriate in this particular context. In their reflections on the use of the term obstetric violence, they begin with the silence that reigned in the maternity ward and the remarkable lack of human contact. When questioned in their interviews, the physician and psychologist were actually surprised by this silence. Nevertheless, the authors suggest that the women who gave birth “were not overtly mistreated and were generally medically well attended to”. They conclude the section with the following question: “Although this silence may have caused some distress, can we label this silence a form of violence?”. We would really like to know what the women themselves would have to say on this subject. Was the silence imposed on them, and did it in fact cause any distress, as the authors suggest? Or did they find it instead a welcome rest? In short, how did the main concerned parties feel about the silence? Their perspective is sorely lacking.

Another point raised by the authors is the absence of birthing partners. When asked about this, the mothers stated that they didn’t want them there. This could be interpreted as a sense of reproductive agency and the ability to make a choice, even if this choice goes against the recommendations of the health care providers. Comparing their results (and interpretations) with the typology of violence proposed by Freedman et al. (2014) and Chadwick’s (2018) formulation, the authors interpret the absence of

birthing partners as a potential form of violence. However, for these women, the term violence did not seem to apply. In fact, they stated that they would rather not have their partners present, and the health care providers did not force the issue. The authors therefore question the use of the term “gentle violence” to characterize what they observed, arguing that identifying these women as victims of violence would be tantamount to denying them a sense of agency. Consequently, their internalized perceptions of being agency-less victims would have negative repercussions for their well-being.

Their third argument against using the term obstetric violence is that health care systems and staff would risk being labeled as violent, “as opposed to untrained, insensitive or incompetent,” which would have “far-reaching consequences for their emotional health”. The authors contend that this positioning would be counter-productive and would make health care workers resistant to behavior change interventions. They add that labeling health care organizations as violent may inhibit their opportunities to improve the care that they provide. At the same time, they surmise that acknowledging the inherent violence in health care systems can be theoretically productive. Finally, in response to their central question, they suggest that violence may be an appropriate term for sociological understandings, but that people who are unfamiliar with such usages could suffer harmful consequences. For instance, the term could disempower both women and their caregivers and stand in the way of change.

Our first commentary of this article focuses on a definition of violence, which places intent at the heart of the matter. We will try to demonstrate, following the authors, that intention is not a central component of violence, unlike the point of view of the people who are victims of it, which must be placed at the forefront of its conceptualization. Our second commentary concerns the sexist nature of this violence. We will establish why we believe that the violence that is at issue should also be recognized as a gendered, sexist, and systemic form of violence. Third, unlike the authors, we completely reject the idea that naming and thus making visible this violence could disempower women. On the contrary, we argue that when women can acknowledge and share their experiences, they can start down the road to empowerment. Denying that these forms of violence exist and denying a voice to women and persons who give birth means recreating and perpetuating the epistemic injustices that too often feature in scientific and academic research. Therefore, although naming obstetric violence as such can be harmful for health care practitioners, we believe people must be aware of a problem before it can be changed. At the end of the day, the eradication of the violence experienced by women and persons who give birth at health care establishments will require an examination of all the power dynamics and issues at play, including how the health care is delivered and organized and how the health care providers are trained.

Definition of Violence

The authors state that, “Violence is a very serious matter”. We share this view, and we will go further: obstetric violence is a very serious matter. No one denies that all forms of violence are rooted in the exercise of power, or at least, power inequality. This

inequality is present and has been widely documented in doctor–patient relationships (Goodyear-Smith & Buetow, 2001) and particularly in the field of obstetrics (Campo, 2010; Cherniak & Fisher, 2008). But how do we define violence in this specific health care context? We feel that the primary objective of a definition of obstetric violence should be to establish the operational criteria. Far from constituting an accurate diagnostic tool, the definition should instead enable observing, quantifying, qualifying, and eventually influencing behaviors and attitudes as well as the organizational and systemic parameters that shape this complex and shifting phenomenon.

We agree with the authors that the World Health Organization (WHO) definition of violence centered on intentionality is outdated and that structural violence must be integrated into the understanding of this social and health issue. And while we recognize the relevance of the ethics of care paradigm to studying health issues, we believe that using the term obstetric violence to refer to what some women and people who give birth may experience is the most ethical proposition there is. In addition to the arguments used by the authors, we believe that the WHO definition is irrelevant for two main reasons: It does not *a priori* target violence that is experienced in health care systems, and more importantly, the definition would be considered outdated in light of contemporary conceptions of violence across diverse contexts. On one hand, under the WHO definition, violence is considered a public health issue: a phenomenon that has harmful effects on the health of populations that are exposed to it. In this sense, violence is a risk factor for health, in league with tobacco consumption, malnutrition, and a sedentary lifestyle. We therefore feel that the WHO definition of violence was not meant to apply to acts committed by health care providers within a health care system. Instead, it was meant to define a public health issue, namely, situations that increase mortality and morbidity rates in populations as a whole.

On the other hand, the intentional nature of the acts (or non-acts) as defined by WHO appears inconsistent with current concepts of violence across many domains. Thus, the intentional aspect included in former definitions of intimidation and violence between children (O'Moore, 1999), violence toward women (Cantin, 1995), and workplace violence (International Labour Organization [ILO], 2019) has been dropped. The contemporary concept of workplace violence points to useful new directions for our understanding of what “violence” covers. The ILO definition of violence presents the advantage of addressing interactions within a given environment, as does the term “obstetric violence.” Thus, in Article 1 of its Violence and Harassment Convention (C190, June 2019), the ILO has adopted the following definition:

For the purposes of this Convention: (a) the term “violence and harassment” in the world of work refers to a range of unacceptable behaviours and practices, or threats thereof, whether a single occurrence or repeated, that aim at, result in, or are likely to result in physical, psychological, sexual or economic harm, and includes gender-based violence and harassment; (Emphasis added)

The ILO definition indicates that although intent remains a criterion for violence, it is not the only determining factor. To the actor's intent is added the victim's

perspective, including that of potential victims: “result in, or are likely to result in.” Thus, the central element in the ILO definition of violence is not the actor’s intent, but rather the actual or probable existence of harm, meaning the direct consequences for the victim.

Finally, many laws and legal experts on this issue have not retained the intentional nature of acts of obstetric violence (Langevin, 2020; Roman, 2017; Williams et al., 2018). Nor has the French High Council for Gender Equality (HCE), which states that caregivers “*n’ont pas forcément l’intention d’être maltraitantes*” [do not necessarily intend to cause harm] (Haut Conseil à l’égalité entre les femmes et les hommes [HCE], 2018). Thus, definitions of violence that place the accent on the intent have been largely rejected of late in favor of broader conceptions of violence that underscore the victim’s perceptions and the consequences for that victim. Obstetric violence should be no exception to this rule, and any suggestions of intent should be removed from the definition. We believe that when it comes to defining obstetric violence, the perceptions of the women and persons who have been victimized should be front and center.

Recognition of Obstetric Violence as Gendered, Sexist, and Systemic Violence

To this day, not a single cisgender man has given birth. Only women have given birth, from a perspective that includes non-binary persons and trans men. But surprisingly, this central and obvious fact of pregnancy and childbirth was not considered. Was it so obvious that Swartz and Lappeman did not think to include it in their analysis or their definition? Yet, in our opinion, this fact is key to the understanding and reporting of this form of violence. Obstetric violence is a manifestation of violence against women. In other words, it is gender-based violence, and it should be included in reports of gender inequality (Shabot, 2016). Health care, and particularly obstetric care, can be conceptualized as a patriarchal and sexist system (HCE, 2018; Rivard, 2014). Furthermore, health care and the associated patient–caregiver interactions often reflect relations that are marked by unequal power dynamics, where the caregiver holds the knowledge and authority to the detriment of the patient, who is placed in a vulnerable position (Goodyear-Smith & Buetow, 2001).¹ Finally, in many countries, including Canada, health care is subjected to pressures of performance and efficiency. Among others, the outcomes are depersonalized health care, hurried medical consultations, and staff burnout, with repercussions for obstetric care delivery.

Our conceptual analysis of the term “obstetric violence” and related concepts such as abuse and disrespect in connection with obstetric care sheds light on certain aspects of obstetric violence (Lévesque et al., 2018). First, because women (and not men) give birth, obstetric violence has been impacted by gender inequalities. Second, childbirth is viewed as a medical situation, whereby a woman is “delivered” of her child. This minimizes the woman’s reproductive agency. Third, the hierarchical relationship between health care professionals and women who give birth introduces an unequal

power dynamic. These aspects highlight the need to conceptualize obstetric violence in terms of not only the relationship between the individuals concerned but also between the systems involved—here, health care and cultural systems—and hence, to acknowledge the gendered, sexist, and systemic nature of the relationship.

Disempowerment or Re-Empowerment?

Swartz and Lappeman voice their fear that imposing the label “obstetric violence” could characterize certain acts as violent when they were not interpreted as such by the women who experienced them. More specifically, they mention the absence of birthing partners and the silence of the birthing ward. While aware of the space constraints (e.g., limited number of pages) for article publication, we feel that the authors’ justification for this fear is unconvincing. We also believe that the two presented situations are based on an empirical corpus that appears insufficient to conclude on the presence or absence of obstetric violence. Note that none of the women shared their feelings about the silence or lack of communication in the obstetric ward, and none were asked about what that silence meant to them or how they perceived it. On the absence of birthing companions and significant others, the women said that they didn’t want anyone else around. Their statements revealed diverse motivations for this, such as preferring to manage the pain on their own and not having to worry about someone else. This led the authors to assume demonstrations of agency: These women were ignoring the recommendations of the caregivers, who would prefer a birthing companion to be present. Nevertheless, they still labeled the conceptual category as “Women’s isolation and lack of support.”

We are puzzled by the authors’ premise that labeling certain acts as “obstetric violence” could contribute to disempower women. According to the experience of people working in the area of violence against women, it is just the opposite. That is, when women can acknowledge that what they have experienced is violence, and can realize that the person who committed the violence is responsible for it, they start to become empowered (Corbeil & Marchand, 2010). The women become aware that they are not at fault and that there is no reason to feel ashamed or guilty. This reassertion of power (i.e., re-empowerment) is facilitated by collectivization and shared experiences, such as denunciations on social networks (Suk et al., 2021). In Québec, stories of obstetric and gynecological violence are reported via #stopvog, and in France via #payetonuterus. It is also true that some women might prefer not to call what happened to them “obstetric violence,” or might be offended by the idea of being seen as a victim. These women can certainly choose not to use such words to describe their experiences, and they can always recast the events as obstetric violence later on, if they wish.

As researchers who have adopted a feminist epistemology, we are interested in the idea of epistemic injustice. This concept is defined at the intersection of social, ethical, and epistemic justice (Godrie & Dos Santos, 2017). People are subjected to epistemic injustice when they are insufficiently believed or improperly understood because they belong to a non-dominant social group or because the group is affected by certain biases or prejudices (Fricker, 2007). Two types of epistemic injustice are proposed: (a)

testimonial injustice, or an unfair deficit in the credibility of a speaker due to an identity prejudice that is related to bias, whether conscious or unconscious, on the part of the listener; and (b) hermeneutical injustice, which occurs when communicators are misunderstood or undermined due to biases in a society's conceptual resources (i.e., incomplete or inadequate conceptual resources to understand certain experiences). This second form of epistemic injustice occurs when a gap in the collective interpretative resources' places certain people at a disadvantage when it comes to making sense of their experiences. Based on Fricker's (2007) examples, we contend that a woman experiences hermeneutical injustice when she is unable to communicate her experience of obstetric violence as such, either because the term does not exist or because the experience is not acknowledged by the society in which she lives or the institutions that provide obstetric care. Hence, her experience is denied.

The Caregivers: Part of the Solution

The authors fear that health care practitioners would be resistant to the use of the term "violence." This fear is legitimate. We saw it materialize when we presented our research results on obstetric violence at an international conference in Dublin (Ireland) in 2016 (Lévesque et al., 2016). Before a large audience of researchers and health care practitioners, we reported the results of a critical assessment of obstetric violence. We thought, naively, that the conference, which focused on issues of violence in health care settings, would be an appropriate place to engage in a dialogue on this important topic. But we had failed to grasp that only violence against practitioners was on the agenda and that violence perpetrated by practitioners and health care systems was a taboo subject. We therefore watched the audience empty out during our presentation. The participants were angry and indignant, and for the health care practitioners, it was apparently unthinkable that their patients would describe the care that they received as violent. We were taken aback by this reaction. However, it gave us an idea of how much work lies ahead to ensure that this form of violence is recognized as a social and health care problem, addressed as such, and prevented. And despite this hostile reception, we never doubted the need to retain the term "obstetric violence," nor did we think to exclude health care providers from the equation in the fight against it.

A more recent experience provides some hope that practitioners' attitudes toward obstetric violence can be changed, and that a greater willingness to address this issue is possible, along with self-examination and eventual changes in practices. Last summer, we had the opportunity to meet with representatives of diverse professional orders and organizations associated with childbirth (patients, midwives, doulas, nurses, medical specialists, general practitioners, and researchers) to discuss obstetric violence. It was the first time in Québec that such a broad range of stakeholders in the childbirth process gathered at the same table. We pooled our thoughts on issues of obstetric violence and the priority research directions to develop scientific and social responses. Although an officially recognized definition of obstetric violence did not emerge from this first phase, which was funded by the Canadian Institutes of Health Research (CIHR), meaningful commonalities and points of cooperation were agreed upon. For example,

consensus was reached on the need for more humanized obstetric care, consideration of intersectional perspectives, and collaborative and participatory research to gather quantitative and qualitative data on obstetric violence.

Violence is made up of acts both small and large, but also acts of omission and retention. We therefore believe that everyone concerned must examine their own behaviors and attitudes. While not wishing to injure or harm others, one may perpetuate norms and values that violate the principles of respect, dignity, and equality. In this sense, they can become vectors for violence. As mentioned above, the medical model in general, and the obstetric field in particular, remains patriarchal, such that patient–caregiver relations operate within a power dynamic that facilitates obstetric violence. All health care practitioners could use critical introspection, re-examine their privileges, and remain vigilant to ensure that they provide patients with care that is high quality, respectful, and nonviolent. In sum, health care practitioners and institutions must provide meaningful leadership in the quest to end this form of violence.

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Note

1. Nevertheless, some structural changes have been observed, such that health care is transitioning toward a patient-as-partner approach whereby patients get involved in their own care, thereby revolutionizing the medical paradigm.

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