

Linguistic manoeuvres: obstetric violence camouflages harm and loss of consent from birth

The recent inquiries into birth trauma in New South Wales (NSW) and the United Kingdom (UK)^{1,2} have led to increased scrutiny of maternity care standards. These inquiries found that a failure to listen, poor communication, and care that lacked balanced information, adequate pain relief and kindness were hurting birthing women. Women also experience harm from unsolicited interventions. The antenatal provision of good quality information is critical to consent at birth. Informing women about available choices during pregnancy, or the decoding of the birth experience after birth, risks being hindered by hyperbolic discussions focused on “obstetric violence”. In this article, we problematise the term “obstetric violence” and suggest that it may confuse harm done to women by the promotion of “normal birth”. In this article, “woman” represents all women and birthing people.

Missing the woods for the trees

Birth trauma — both physical and psychological — carries lifelong impacts.³ Causes include complications in pregnancy, psychosocial circumstances, safety concerns, fear, loss of control, poor clinical communication, lack of respect, unmanaged pain in labour and birth injury.⁴

There is no consensus regarding the definition of obstetric violence.⁵ Latin American and Caribbean definitions focus on the medicalisation of what is argued to be the natural (by default, good) process of childbirth.⁶ However, this privileging of the natural obscures trauma that women report from the intentional denial of access to information or interventions during birth.

Birthing women must own the narrative regarding their experiences and name them as they wish. Obstetric violence includes instances of verbal, physical and emotional abuse by clinicians⁷ and is not restricted to care provided by obstetricians. Confusingly, obstetric violence appears to malign obstetric practice while obscuring the contribution of others. When women report bullying by midwives as found in this notably small study,⁸ it would appear that some female carers risk internalising the very misogyny that they argue they have rejected.⁹

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists states that the term “obstetric violence” is “incorrect and in fact may limit opportunities to reduce patient experience of birth trauma”.¹⁰ Linguistically, obstetric violence — when conflated with “intervention” — furthers an anti-medicalisation/anti-intervention agenda that may compromise patient safety and leave poor behaviour unaddressed. It also raises an important question:

what of the violence that results from the promotion of “normal birth”?

Normality-centred care

For context, the NSW inquiry occurred in the shadow of the “Towards Normal Birth” policy implemented there.¹¹ This NSW directive sought to increase the rate of vaginal births and decrease the rate of caesarean deliveries.¹¹ Employing a “spectrum of birth” philosophy, the “Towards Normal Birth” policy encouraged a more permissive approach to forceps-assisted births¹¹ despite data linking such interventions to birth trauma.¹² The magnitude of harm accrued from the failed “Towards Normal Birth” policy — before it was rescinded — remains unknown.

A national survey of clinicians reiterates what many submissions to the NSW inquiry presage: that “normality-centred care” in Australia compromises patient autonomy and safety.¹³ Obstetric insistence on vaginal births (and thus denial of “maternal-request caesarean”) could “induce additional stress and possibly increase the risk of peri-partum anxiety and depression”.¹⁴ Herein lies the catch: initiatives to decrease the primary caesarean delivery rate often compromise transparency.¹⁵ The “high rate of injury associated with operative vaginal deliveries (eg, 25.3% rate of maternal trauma following forceps delivery)” is — we argue — purposefully underplayed.¹⁵

The information void that birthing women encounter is evident in submissions to the inquiries. The *Montgomery v Lanarkshire Health Board* case in the UK¹⁶ merits discussion here. Nadine Montgomery — a woman of small stature with type 1 diabetes — expressed concerns about her baby being big during her pregnancy. Her concerns were discounted and the birth was complicated by shoulder dystocia, resulting in preventable harm to her child. *Montgomery v Lanarkshire Health Board* has shaped the law on informed consent in the UK since 2015. There is an Australian legal precedent (*Rogers v Whitaker*, 1992),¹⁷ which mandates disclosure of material risks. Despite *Montgomery v Lanarkshire Health Board* and *Rogers v Whitaker*, information provision on material risks at birth remains patchy. We argue that this occurs because normality-centred care in maternity services prevents informed choices.¹³

Ideology in clinical practice

The “Towards Normal Birth” directive,¹¹ which aimed to increase “the proportion of women who have a vaginal birth” and to “reduce the use of” analgesia in labour, is an example of how health organisations skew care away from evidence, based on ideology. Failure

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to give birth “normally” results in disappointment and trauma, particularly when women hold strong expectations about birth.³ It compounds the “birth dissonance” that arises from the woman’s expectations of an unmedicated “normal” birth not being met.³ The differences in epidural-spinal rates at private and public hospitals in NSW (84.1% *versus* 54.9%)¹ tell a clear story — women accessing public care are at a distinct disadvantage when it comes to pain relief at birth.

In submissions to the inquiries, midwife-led continuity of care (MCOC) enjoys vociferous support, but can it reduce birth trauma? A recent Cochrane publication¹⁸ offers the most detailed evidence on MCOC with modest conclusions. MCOC clients are “less likely to experience a caesarean section and instrumental birth”¹⁸ — a reduction by 1%, for each compared to other models of care for childbearing women. MCOC clients may be “less likely to experience episiotomy” with “little to no difference in intact perineum”.¹⁸ Women are “more likely to experience spontaneous vaginal birth and report a positive experience”.¹⁸ Critically, a “majority of the included studies did not include”¹⁸ women at high risk of complications and no studies focused on women from disadvantaged backgrounds.

The updated review on MCOC has, hearteningly, deleted prior¹⁹ references to the undergirding philosophy of “normality and the natural ability of women to experience birth without routine intervention”. Mothers and babies have been harmed by the mandated implementation of MCOC in the UK.²⁰ The Ockenden Report²⁰ recommended the suspension of the further rollout of MCOC (unless trusts could demonstrate safe, minimum staffing requirements). The report also demanded a “thorough review of the evidence that underpins continuity of carer to assess if it is a model fit for the future”.²⁰ There is a profound and salient lesson for Australia in this.

Doing better

The implementation of trauma-informed care will help improve patient experiences.²¹ Provision of evidence-based information reduces decisional conflicts for women. Obstetric colleges publish information resources for pregnancy; easy accessibility to these via digital platforms could be transformative.

Evidence-based pain relief at birth is non-negotiable. Unmedicated births — a central pillar of “normal birth” — have placed women at risk of trauma. Multiple submissions to the inquiries suggest an overlap of poor care, casual cruelty and negligence. Recommendations to further research into “the benefit and difficulties of legislating with respect to the birthing experience”¹ may do little to help when the primary issue of effective pain relief is disregarded.

Language matters. The maternity lexicon is replete with labels that appear unprofessional. Referring to care that is not MCOC as “standard fragmented maternity care”²² — being care provided by obstetricians and midwives rostered to various clinics

and wards — is one example of how language delegitimises mainstream maternity services. Violence is a serious accusation suggesting deliberate intent to cause harm. In some instances, terms such as obstetric violence are no less a “form of violence against healthcare professionals”.⁵ The term “normal birth” pedestals a woman’s ability to give birth vaginally. Women who cannot or choose not to birth this way, have a right to not feel like failures.²³

For a positive birth experience, continuity is key. We suggest that multidisciplinary continuity will lead to a better experience for women. We propose that moving from a normality driven, low risk focused MCOC model, to a continuity model that includes all women, accessing all types of care, will likely lead to better care experiences. There is little evidence that MCOC can support higher risk women during birth. We must accept that continuity “doesn’t necessarily reside in continuity of carer”.² Instead, it could be that: “Everybody has an understanding of trauma, that everybody is compassionate and kind, that there is continuity of information-sharing so that people don’t have to keep on reiterating their trauma, telling their stories over and over again to different people”.²

Conclusion

It is time to acknowledge that there is an increased risk of harm driven by the promotion of “normality-centred” care. The NSW and UK birth trauma inquiries have identified this through the submissions but have failed to state it in plain language. Change that is desperately overdue in maternity services will not arrive unless we unambiguously state what is needed.

Clinicians must provide unbiased information to women. True collaboration prioritises women over ideological mores. Honest attempts at reducing birth trauma require clinicians to respect maternal choice, including opting for, or declining, interventions. Failure to do so only creates further trauma. Ultimately, bespoke care provision will occur when the birthing woman can direct her care, to suit her individual needs.

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