Obstetric Violence in the United States:

the Systemic Mistreatment of Women during Childbirth

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Abstract

While the term “obstetric violence” is not commonly used in literature and dialogue in the United States, the mistreatment of women during childbirth has received growing public attention in recent years. Often alluded to in literature as “dehumanized care” or “medicalization,” reports of women feeling objectified, disrespected, or otherwise violated during pregnancy and childbirth are far from uncommon. This project explores why obstetric violence exists in the United States and the structures and systems in place that allow this violence to continue to occur. It examines how obstetric violence is linked to the pathologization and medicalization of pregnancy and childbirth, to power dynamics between men and women created by American patriarchal society, and to the development and use of authoritative knowledge in obstetrics.

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Introduction

In 2014, the nonprofit consumer advocacy organization Improving Birth launched the social media campaign #BreaktheSilence that aimed to expose stories of trauma and abuse in American maternity care. Hundreds of women shared deeply disturbing stories of disrespect and mistreatment during pregnancy and childbirth, a phenomenon which Improving Birth called a "widespread, largely ignored problem" (Improving Birth, 2015). Women reported being denied food and drink, being forced to lie supine during labor, receiving repeated and rough vaginal examinations, being told they are not allowed to give birth vaginally after a Cesarean section, having their membranes ruptured without consent, and being given episiotomies after explicitly refusing, among a host of other transgressions. The stories that the women shared were varied, but overwhelmingly reflected themes of maternity care in which birthing women are not fully involved in the decision-making process, are not listened to by care providers, and receive care that is not grounded in the best available evidence and research.

The vast majority of women who give birth in American hospitals leave the hospital with what appears to be the desired outcome: a physically healthy mother and baby. Yet many women report low satisfaction with giving birth in American hospitals. Almost one in five women report post-traumatic stress disorder (PTSD) symptoms following birth, and up to 34% experience a birth that they describe as "traumatic" (Creedy, Shochet, & Horsfall, 2000; Soet & Brack, 2003). As obstetrician and researcher Neel Shah writes, "In our intense focus on mortality rates, we often overlook the obvious fact that childbearing women have goals other than emerging from birth alive and unscathed" (2017).

In 2015, the World Health Organization acknowledged the severity of the mistreatment of women during childbirth when it released a statement on the prevention and elimination of disrespect and abuse during facility-based childbirth, calling abuse, neglect, or disrespect during childbirth a "violation of women's fundamental human rights" (WHO, 2015). The statement calls for support of research to define and measure "disrespect and abuse" in health facilities worldwide, as well as to study the effectiveness of interventions that aim to prevent this type of mistreatment. The statement also points out the link between maternal mortality rates and ensuring access to high-quality, respectful maternity care. According to the WHO, this includes, but is not limited to, "social support through a companion of choice, mobility, access to food and fluids, confidentiality, privacy, informed choice, information for women on their rights, mechanisms for redress following violations, and ensuring high professional standards of care" (2015). When women are denied high-quality care, and are subjected to disrespect and abuse at the hands of their care providers, there can be "direct adverse consequences" for both the mother and child (WHO, 2015). While maternal mortality is seen as mainly an issue of low-income countries, the United States' maternal mortality ratio more than doubled between 1990 and 2013 (WHO, 2015). The reasons for this rise are not entirely known, but the statistics are indicative of underlying problems within American maternity care that deserve further research and investigation.

The mistreatment of women during childbirth is an issue that has been discussed more thoroughly in some Latin American countries, where the term *violencia obstétrica* (obstetric violence) was coined in the early twenty-first century. In 2005, Venezuela became the first country to explicitly define and prohibit this particular type of violence

against women. In Venezuela's Organic Law on Women's Right to a Violence-free Life, it is defined as:

> "...the appropriation of a woman's body and reproductive processes by health personnel, in the form of dehumanizing treatment, abusive medicalization and pathologization of natural processes, involving a woman's loss of autonomy and the capacity to freely make her own decisions about her body and her sexuality, which has negative consequences for a woman's quality of life."

While the word "violence" typically carries connotations of physical force, this legal definition of obstetric violence references the lasting consequences of a lack of informed consent, coercion by medical professionals, and dehumanized care, classifying all of these experiences as violent acts. The term "obstetric violence" is not commonly used in literature and dialogue in the United States, but the mistreatment of women during childbirth has received growing public attention in recent years. Often referred to in literature as "dehumanized care," "mistreatment," or even "birth rape," reports of women feeling objectified, disrespected, or otherwise violated during pregnancy and childbirth are far from uncommon. During a time of intense vulnerability, women can be subjected to lack of respect, acts of coercion, and outright abuse, often at the hands of their trusted care providers. These violations of a woman's trust and rights can have lasting implications.

Stories of women feeling violated or powerless during childbirth are widespread, but obstetric violence has not been thoroughly measured, researched, or discussed through formal methods. The prevalence is unknown; healthcare professionals do not know who is most at risk or what the short- and long-term health consequences are for women and babies. A 2014 survey of North American labor and delivery nurses, doulas, and childbirth

educators found that almost two-thirds of respondents had witnessed a care provider "occasionally" or "often" engage in a procedure without giving the woman time to consider the procedure, while over half of respondents had seen a care provider engage in a procedure explicitly against the woman's will (Roth et al., 2014). Other studies have examined the role of birth trauma in the development of postpartum post-traumatic stress disorder, noting that degrading treatment during labor and delivery can have lasting consequences for a woman's mental health and emotional well-being (Beck, 2004).

What is it about the American healthcare system and culture that allows disrespectful treatment of women during pregnancy and labor to be tolerated and continued? It is certainly not an issue of economics: the United States spends nearly twice as much as other "developed" nations on maternity care. Yet our outcomes for mothers and babies continue to be poor – and worsening. In 2015, the U.S. was ranked 27th in the world in infant mortality, and 46th in maternal mortality (WHO, 2015). Globally, a shift from focusing on medical interventions to issues of quality of care is beginning to take place, as researchers, women, and healthcare providers begin to think about how individual women's experiences in the healthcare system are connected to broader dimensions of maternal health. This paper addresses the ways in which the systemic subjugation of women has contributed to a culture of over-medicalization and pathologization in which power dynamics play out in the delivery room.

Types of Obstetric Violence

What, exactly, is obstetric violence? The legal definition of obstetric violence in Venezuelan law is just one example of how the term has been defined. As the feminist

philosopher Sara Cohen Shabot writes, “Like most cases of structural violence, obstetric violence is hard to define and pinpoint because it is subtle, pervasive, naturalized, normalized, and institutionalized” (2015).

In 2015, Bohren and colleagues created a typology of mistreatment of women during facility-based childbirth. This typology consisted of seven domains: (1) physical abuse, (2) sexual abuse, (3) verbal abuse, (4) stigma and discrimination, (5) failure to meet professional standards of care, (6) poor rapport between women and providers, and (7) health system conditions and constraints. This typology recognizes two important underlying dimensions of the mistreatment of women during childbirth: that violence can occur on an interpersonal level as well as on a structural level.

A 2010 report by the Harvard School of Public Health that explored “disrespect and abuse” in facility-based childbirth revealed seven categories of disrespect and abuse that are similar, yet notably different, from those identified by Bohren: (1) physical abuse, (2) non-consented care, (3) non-confidential care, (4) non-dignified care, (5) discrimination based on specific patient attributes, (6) abandonment of care, and (7) detention in facilities (e.g. prisons). The researchers acknowledged that there is a continuum of care that spans “dignified, patient-centered care, non-dignified care, and overtly abusive maternal care” (p. 3).

Under both of these definitions and typologies, violence does not have to be overt physical force (e.g. slapping or hitting a woman in labor) in order to constitute a fundamental violation of a woman’s human rights. Examples of obstetric violence might include repeated and rough vaginal examinations that are not medically necessary; providers dismissing women’s concerns and anxieties about the labor; lack of

communication about risks and benefits of procedures; loss of autonomy that renders women "passive participants" in their own birth experiences; a provider performing an episiotomy without first obtaining the patient's explicit, informed consent; or offering pain medication less to Black women versus White women based on providers' stereotypes and prejudices (Harvard School of Public Health, 2010).

When looking at the care of women during childbirth through an evidence-based lens, the overuse of medical interventions (such as episiotomy, restricting movement during labor, cesarean sections, and routine inductions) is not merely unnecessary or indicative of sub-optimal practices by practitioners, but rather a reflection of dangerous societal and institutional attitudes toward women. The ways in which women are treated during labor and birth mirror perceptions of women in broader society. It is critical to consider the underlying patterns of structural, gender-based violence that allow for non-evidence-based obstetric practices to continue to be performed.

The Medicalization of Childbirth

The Venezuelan definition of obstetric violence refers to medicalization as "abusive." Physicians, midwives, childbirth experts, and health organizations have long argued that childbirth in the United States has become unnecessarily medicalized, standardized, and regulated. In 1996, the World Health Organization (WHO) released "Care in Normal Birth," a practical guide for physicians, midwives, and nurses that established recommendations for the use of medical intervention in labor and delivery. The guide lists 14 interventions that are labeled as "frequently used inappropriately," including restriction of food and fluids during labor, electronic fetal monitoring, repeated or frequent vaginal examinations,

oxytocin augmentation, and pain control by epidural analgesia or other systemic agents. Despite the WHO's recommendations for limiting the inappropriate use of these interventions over 20 years ago, Childbirth Connection's 2013 *Listening to Mothers III* survey found that the routine use of interventions, including those that the WHO labels as "frequently used inappropriately," is still characteristic of American hospital births. The survey found that 79% of women experienced restrictions on eating or drinking during labor, 89% experienced electronic fetal monitoring, 51% received repeated vaginal examinations, 31% were administered artificial oxytocin (Pitocin) to augment labor, and 67% received epidural analgesia (Declerq et al.).

Many of the routine interventions in hospital births are not evidence-based nor medically indicated. In February 2017, the American College of Obstetricians and Gynecologists (ACOG) released "Approaches to Limit Intervention During Labor and Birth," a committee opinion containing recommendations for physicians to limit the use of interventions. According to the statement, many common, routine obstetric practices are "of limited or uncertain benefit for low-risk women in spontaneous labor" (p. 1). The recommendations note that in particular, continuous electronic fetal heart monitoring, continuous infusion of IV fluids, and stripping of a woman's membranes may not be necessary and do not improve health outcomes.

A growing body of research suggests that the routine use of such interventions can lead to increased complications and lasting consequences both for mothers and babies (Lothian, 2014). The use of routine intervention has the potential to interfere with the physiologic processes of labor and birth, which can lead to a cascade of further interventions, ultimately increasing the risk of complications for women and babies

(Lothian, 2014). This cascade of interventions is documented in the *Listening to Mothers III* survey (see Appendix B).

While these interventions are not inherently violent when used appropriately, the overuse of such interventions reflects a systemic philosophy of the expectation of complications and danger (Lothian, 2014). This philosophy toward pregnancy and childbirth is relatively new; birth has not always been seen as an event that is inherently risky and dangerous, nor has it always been treated as a pathology. The association of the concept of "risk" with pregnancy and childbirth was largely introduced by the takeover of maternity care by male physicians in the late nineteenth and early twentieth centuries (Goode and Rothman, 2017).

The birth of obstetrics (and the destruction of midwifery)

Midwives attended nearly every birth in the American colonies in the early days of the United States. Many of these midwives were enslaved West African women who attended the births of other Black women as well as White women (Rooks, 2012). After the abolition of slavery, both Black and White midwives continued to care for women during pregnancy and childbirth, and attended the vast majority of births.

Medicine was not professionalized in the United States until the end of the nineteenth century. Medical education, and particularly obstetric education, was poor. In 1910, the Flexner Report, a review of physician care in the U.S., offered a scathing critique of American medical education. In particular, the report noted that of the various medical specialties, obstetric education made "the very worst showing" (Flexner, 1910). A 1911 follow-up report noted that most obstetricians only attended one birth during their

medical education (Kahn, 1998). This was due to the fact that midwives still attended the majority of births. In order for obstetric education – and thus the reputation and position of obstetricians in the U.S. – to improve, physicians would need to have the opportunity to attend more births. In order to increase the number of births that obstetricians in training could attend, hospitalization for all deliveries was recommended. To encourage this, many obstetricians supported the abolition of midwifery (Rooks, 2012).

By 1910, midwives attended roughly 50% of births, with physicians attending the other half (Ehrenreich and English, 1973). Midwives continued to care for impoverished women, rural women, and women of color; physician-attended births were largely for urban, White, middle- and upper-class women (Ehrenreich and English, 1973; Rooks, 2012). The atmosphere between midwives and physicians was not one of collaboration and mutual respect, and the debate was a gendered one. Obstetricians ridiculed midwives, who were often illiterate and lacked formal education, as dirty, ignorant, and incompetent (Ehreinreich and English, 1973). As women, and many of them women of color, midwives lacked the formal authority and institutional power that obstetricians and other physicians held. Under pressure from the medical profession, many states passed laws that explicitly outlawed midwifery practice and restricted maternity care to physicians (Ehrenreich and English, 1973). By asserting their social power, physicians essentially usurped the traditional role of midwives.

In his 1915 paper “Progress Toward Ideal Obstetrics,” Dr. Joseph DeLee, an influential American obstetrician in the early twentieth century, belittled midwives, calling them a “relic of barbarism” and a “drag on the progress of the science and art of obstetrics.” Midwives, he argued, perpetuated a philosophy of childbirth that was fundamentally

flawed. “If the profession would realize that parturition [childbirth], viewed with modern eyes, is no longer a normal function, but that it has imposing pathologic dignity, the midwife would be impossible even of mention,” Dr. DeLee wrote.

Dr. DeLee, and other male physicians of his time, laid the foundation for the “pathology-oriented medical model of childbirth” that remains today in the United States (Rooks, 2012). This philosophy lies in direct contrast to the midwifery philosophy and model of care, which views childbirth as a normal, natural physiologic process. Aligned with the vision of childbirth as a distinct pathology, and not as a normal and natural part of a woman’s life, Dr. DeLee proposed a series of routine interventions to be used in labor and delivery, including the use of sedatives, episiotomies, and forceps. The use of such interventions, without any true need, reframed childbirth as an inherently risky and dangerous event in which intervention is necessary to prevent problems and control the course of labor. By applying these interventions to every laboring woman, the field of obstetrics attempted to control the process of childbirth and reconceptualized childbirth as an event requiring risk management. In this context, birth was now something to be *managed* rather than *attended* (Goode and Rothman, 2017).

Despite attacks on the reputation of midwifery care in the early twentieth century, data from the time-period supports the fact that midwife-attended births were safer than physician-attended births. Even Drs. DeLee and J.W. Williams, arguably the two most influential obstetricians in early twentieth-century America, acknowledged that “more women die during confinement in the hands of doctors than among midwives” (DeLee, 1915). Data from 1903 to 1912 in Washington, D.C. notes that as the percentage of midwife-attended births shrank from 50% in 1903 to 15% in 1912, infant mortality in the

first day, first week, and first month of life all increased. Despite the safety and relative quality of midwifery care, midwife-attended births dropped to just 10% of all births by 1935 (Goode and Rothman, 2017). Drs. DeLee and J.W. Williams used the fact that more women died under the care of obstetricians than midwives to justify further training for obstetrics, not more resources for midwives: "The energy directed toward the training of midwives would bring greater results if spent on doctors" DeLee argued (1915).

Certainly, the field of obstetrics has contributed invaluable knowledge and technology that have saved or improved the lives of countless mothers and babies. The development of the Cesarean section, treatments for complications such as obstetric fistula and hemorrhage, improved sanitation practices, and other important techniques have an important place in maternity care when used appropriately. Yet it cannot be forgotten that the male, physician takeover of American maternity care was not a passive process, nor was it grounded in evidence that physician-managed childbirth was safer for mothers or babies. Much of the reasoning for the rise in hospital births and obstetrician-managed deliveries stemmed from the perceived need for improved obstetrics education and training. As historian Monica Green (2008) writes, the rise of obstetrics:

> Can be called a 'masculine birth' not only in the sense that it became a field dominated by men, but also in...that it occurred largely without the input of women and, indeed, without any concern to involve them except in their roles as subordinate midwives...and, of course, compliant patients. (p. 291)

Today in the United States, women make up 55% of practicing obstetricians (Association of American Medical Colleges, 2015). Yet the medical profession is "gendered male" by its history and development (Squire, 2009). Female doctors practicing within the

biomedical paradigm are socialized through obstetrical training that developed and flourished at the expense of midwifery. While midwifery was never fully abolished, and midwives continue to care for women and attend births today through the development of nurse-midwifery and certified midwifery programs, midwives attended just 8.2% of total births in the United States in 2013 (American College of Nurse-Midwives, 2015). Midwives continue to face legal restrictions to practice in the U.S. While certified nurse-midwives, who have a nursing education and a Registered Nurse license in addition to their midwifery education, can legally practice in all 50 states, several states still require physician supervision. Certified midwives, who complete the same certification examination as certified nurse-midwives but do not undergo the same nursing education, can only legally practice in four states. Pregnancy and childbirth has become an event in a woman's life that is overwhelmingly managed by the field of medicine.

Fetal heart monitoring: a loss of control through medicalization

The Lancet's 2016 Maternal Health Series describes the state of American maternity care as often providing care in a manner that is "*too much, too soon*" – medically unnecessary inductions of labor, episiotomies, Cesarean sections, and other interventions. The researchers concluded that this type of care may "cause harm, raise health costs, and contribute to a culture of disrespect and abuse." Dr. Neel Shah writes, in medicine, "providing more care is often mistaken for providing better care" (2017). Despite the rates of these clinical interventions increasing in the U.S. over the past several decades, there have been no dramatic improvements in perinatal and maternal mortality and morbidity to match the increased use of these interventions (Sadler et al., 2016). Beyond clinically

measurable harm, the "routine misappropriation of care" in U.S. hospitals can lead women to feel deprived of their basic dignity during a profound and life-changing moment in a woman's life (Shah, 2017).

The over-medicalization of labor and birth manifests itself as a loss of control for women. One example of a situation in which women lose control at the hands of their providers is in the use of fetal heart monitoring (FHM). While such monitors can be used to obtain important information about the status of the fetus, fetal heart monitors are routinely used in hospitals without any medical indication that the fetus is doing poorly. When fetal heart monitors are used continuously, women's own observations and claims about their experience in the labor tend to be "discredited, dismissed, and often altogether ignored" (Freeman, 2015, p. 52). Attention is literally directed away from the mother and her own embodied claims while medical personnel and providers focus on the information coming from the monitor. As Freeman writes, "Such instruments transfer control over the means of observing the pregnancy and birth process from the woman to the medical personnel. The woman's experience of these processes is reduced in value, replaced by the more objective means of observation" (2015, p. 52). By replacing the woman's embodied claims with more "objective," medical observations, the provider now has a sense of control over the laboring woman.

Additionally, when FHMs are in use, women must lie immobile on their backs, a position which is known to increase the perception of pain and slow the progression of labor (Lawrence et al. 2009; De Jonge, Teunissen, & Lagro-Janssen, 2009). When lying immobile on their backs, laboring women are prone to a cascade of medical interventions: Pitocin is frequently used to increase the frequency and intensity of contractions, which

become difficult to manage and often lead to the use of an epidural, which increases the risk of Cesarean section. Thus, the excessive use of monitoring can render women passive and subject to interventions that would have likely been unnecessary in other contexts (Freeman, 2015). As the bioethicist Erdman writes, contrary to intuition, "over-medicalization can harm women and constitute a human rights violation as much through neglect and abandonment as coercion or intrusion" (2015).

The Cesarean section: medicalization and non-evidence-based care

The most common surgical procedure in the United States is Cesarean section (C-section): nearly one in three American babies is born via C-section (CDC, 2017). While the C-section is an important and potentially life-saving procedure that protects the lives of many mothers and babies worldwide, it is criticized for being overused within the American maternity care system. In the U.S., giving birth vaginally and via C-section are both overwhelmingly safe, but Cesarean delivery is associated with higher rates of both maternal morbidity and maternal mortality (CDC, 2015). Women who received a Cesarean were significantly more likely to suffer from a ruptured uterus, need an unplanned hysterectomy, and be admitted to the intensive care unit (ICU) compared to their counterparts who gave birth vaginally (CDC, 2015). Women who experienced a vaginal birth after Cesarean (VBAC) had significantly lower rates of these maternal morbidities compared to women with repeat Cesarean deliveries (CDC, 2015). Despite the fact that vaginal birth after Cesarean is safer for the mother than receiving a repeat Cesarean, the *Listening to Mothers III* survey found that 46% of women who were interested in giving

birth vaginally after having a Cesarean delivery were denied the option of doing so (Declerq et al., 2013).

In 2014, the American College of Obstetricians and Gynecologists released a statement called "Safe Prevention of the Primary Cesarean Delivery," in which they offer evidence-based recommendations for reducing the rate of C-section among first-time mothers. According to ACOG, the rapid rise in C-section rates between the 1990s and today, without evidence of maternal and infant mortality rates declining, raises "significant concern that cesarean delivery is overused" (ACOG, 2014, p. 1). Researchers estimate that about fifty percent of C-sections are performed in situations in which the baby could be safely delivered vaginally (Haelle, 2017).

Additionally, the variation in C-section rates across geographic areas indicates that clinical practice patterns affect C-section rates. C-section rates among low-risk, first-time mothers vary dramatically across geographic regions, from 14% in South Dakota to 32% in Kentucky (Haelle, 2017). Within smaller geographic areas, such as within the same city, wide variation exists in C-section rates between hospitals (Appendix C). In Chicago, for example, 31.1% of low-risk deliveries occur via C-section at John H. Stroger Jr. Hospital of Cook County, compared to 13.8% at Saint Anthony Hospital (Consumer Reports, 2016). These hospitals are less than two miles apart.

Researchers argue that the geographic variation in C-section rates is indicative of a troubling culture in which physicians do not always use the best available evidence to inform their care recommendations, but instead rely on methods that are rooted in tradition and convenience. There is a lack of specific obstetric practice guidelines regarding when C-sections should be performed; even at hospitals in which specific, formal guidelines

do exist, studies suggest that they are only followed in about half of cases (Clark, Belfort, and Hankins, 2007). Patterns of decision-making by physicians "approach randomness" rather than relying on evidence-based indicators that a C-section is necessary (Clark, Belfort, and Hankins, 2007). Women are subjected too frequently to major abdominal surgery, often thinking that they have no other option because they have not been given one.

Hierarchies in Healthcare

Obstetric violence is a form of violence against women, the essential feature of this type of violence being that it stems from women's subordinate position to men in society. This systemic subjugation devalues women's lives and rights (Cohen Shabot, 2015). Explanations of violence against women must be contextualized within the patriarchal paradigm that acknowledges the gendered social arrangements and distribution of power within Western society. The subjugation of women is reflected in social structures, including health care facilities and systems; biomedicine and the American health care system were built almost entirely by men. As Erdman writes, "A health system wears the inequalities of the society in which it functions. The same is true of institutional maternity care" (2015, p. 48). Studying patterns of violence in childbirth uncovers the structural injustices that women have historically faced.

Authoritative Knowledge and Violence

The structure of the U.S. healthcare and hospital system is a hierarchical one. In the hospital setting, a power imbalance exists between the provider and the pregnant woman.

The provider is the expert; the pregnant woman is the patient. Philosopher Lauren Freeman refers to the relationship between physicians and women as a situation of "epistemic injustice," in which pregnant women's desires and requests are "systematically undermined, overlooked, or ignored" and, as a result of being unheard, pregnant women are "demoted to a position of powerlessness" within their own birth experiences (2015, p. 44-5).

Anthropologist Brigitte Jordan refers to the position of power and authority that physicians and other maternity care providers hold as one that is reinforced by their "authoritative knowledge" (Jordan, 1997). Authoritative knowledge is defined as knowledge that is considered by a particular community or culture to be legitimate, official, and appropriate for justifying actions. An important feature of this type of knowledge is that it is socially constructed through an ongoing process, one in which power relationships are both built and reflected. This type of knowledge then comes to be perceived as natural (Jordan, 1997). In hospital rooms, authoritative knowledge is hierarchically distributed among physicians, nurses, and other hospital staff, with the physician placed in the position of utmost authority. The laboring woman's feelings, experiences, desires, and requests do not hold the same amount of authority as the physician's.

An example of the manner in which physicians assert their authoritative knowledge over laboring women is when it comes time to push. Women in unmedicated labor – and often even medicated labor – typically experience a powerful, overwhelming urge to push when their cervix reaches complete dilation. Yet despite this strong bodily sensation, it is common for women to be told to refrain from pushing until the physician gives her a

vaginal examination to ensure that her cervix is fully dilated. Once the physician has determined that it is appropriate for the woman to push, then she is "allowed" to do so. Until then, women are often encouraged to use breathing techniques to resist the overpowering urge to push, or simply told that they "can't" push yet. As Jordan (1997) writes:

> What the woman knows and displays, by virtue of her bodily experience, has no status in this setting. Within the official scheme of things, she has nothing to say that matters in the actual management of her birth. Worse, her knowledge is nothing but a problem for her and the staff. What she knows emerges not as a contribution to the store of data relevant for making decisions but as something to be cognitively suppressed and behaviorally managed. (p. 64)

In this scenario, authoritative knowledge is concentrated in the hands of the physician, who occupies a position of often unquestioned authority. This unequal power dynamic between the physician and patient that reflects patriarchal power relations, in which one group maintains power over another (Hennig, 2016). This prestige and power can afford physicians and providers the ability to use non- evidence-based practices, grounded in tradition and convenience rather than evidence or patient preferences, that become normalized routines. Due to social expectations, women expect that their care providers will act in their best interest and make only medically necessary recommendations. In return, the expected behavior from the pregnant or laboring woman is obedience and submission to the provider's recommendations, with the woman expected to comply with the provider's recommendations in the best interests of her child (Hennig, 2016).

Both Freeman and Jordan write about what the interactions between providers and women would look like if they shared a more equitable relationship. According to Freeman, the ideal patient-provider relationship would be one in which the woman and her provider are "epistemic peers." In this type of relationship, both the woman and the provider are able to hold legitimate knowledge about the pregnancy and labor, and are taken seriously by one another. This mutually respectful relationship creates a supportive space for open dialogue, in which women feel empowered and comfortable to ask questions and engage in discussion, and providers take time to carefully listen and seriously consider the woman's claims (Freeman, 2015). According to Jordan, the possession and use of authoritative knowledge must move from the present situation in which this knowledge is hierarchically distributed, to a situation in which it is horizontally distributed – all participants "contribute to the store of knowledge on the basis of which decisions are made" (Jordan, 1997, p. 17).

Informed Consent

Informed consent is a right given to patients in the United States. According to the American College of Obstetricians and Gynecologists, informed consent is a "process of communication whereby a patient is enabled to make an informed and voluntary decision about accepting or declining medical care" (ACOG, 2015, p. 1). In addition to being a legal right in the U.S., obtaining informed consent from patients is an ethical requirement for physicians, midwives, and other healthcare providers. Obtaining informed consent reinforces patient autonomy and allows the patient to be a fully included and respected decision-maker in their own healthcare. Despite these legal and ethical requirements in U.S.

healthcare, informed consent in maternity care is often restricted and not implemented consistently for all women in all locations (Goldberg, 2009).

Why are violations of informed consent and a patient's autonomy so pervasive in maternity care? The American healthcare system was founded on a paternalistic model of medicine in which the physician held a complete authority over medical decisions and information (Goldberg, 2009). It was not until the mid-twentieth century that the focus of health care shifted to include a patient's right to involvement in their own health-related decision-making. In their 2009 Committee Opinion on Informed Consent, the American College of Obstetricians and Gynecologists acknowledged the issues with the paternalistic model in maternity care that play out in present-day delivery rooms, acknowledging that "such broad social problems as the historical imbalance of power in gender relations and in the physician-patient relationship" can constrain individual choice and informed consent (American College of Obstetricians and Gynecologists, 2015, p. 4). Although informed consent is now a legal right, the legacy of the paternalistic model of care and its relationship with gender has not entirely been erased.

It has been suggested that much of the overuse of unnecessary medical intervention in labor and delivery could be prevented by adhering to the basic principles of informed consent (Sadler et al., 2016). Existing research into the American maternity care system indicates that women experience a significant loss of autonomy during pregnancy and childbirth (Diaz-Tello, 2016). Childbirth Connection's *Listening to Mothers III* survey found that 25% of mothers who received a Cesarean section and 25% of mothers who received an induction felt pressure to do so. Additionally, 63% of women who received a primary C-section identified their physician as the "decision maker" (2013). The #BreaktheSilence

campaign from Improving Birth featured stories from hundreds of women who reported being bullied or coerced into interventions, and sometimes unconsented procedures such as vaginal examinations or episiotomies. Care providers are frequently able to get women to "agree" to interventions due to the imbalance in power between the physician and the patient (2015). A 2010 meta-ethnography of traumatic birth found that a key theme in traumatic birth experiences was a feeling of powerlessness and invisibility that stemmed from being subjected to "authoritarian decision-making" on the part of the care provider (Elmir et al., 2010).

A person's right to make informed decisions about their own healthcare is a crucial component of patient autonomy, and taking this right away is a critical violation of a person's autonomy. In the case of pregnant women, the issue of patient autonomy becomes particularly muddled when the provider feels a sense of responsibility to make decisions for both the mother and the unborn child. A 2016 committee opinion released by ACOG on the "Refusal of Medically Recommended Treatment During Pregnancy" notes the ethical dilemma that arises when a woman refuses treatment that is recommended by her physician: the physician has an ethical responsibility to safeguard and respect the pregnant woman's autonomy and decision-making, while also maintaining responsibility for the health of the fetus (ACOG, 2016). Several cases of pregnant women receiving court-ordered C-sections have stemmed from this ethical dilemma; hospitals in more than a dozen states have secured court orders to essentially force unwilling women to undergo surgery (Collier Cool, 2005). There is no other situation in which patients are legally compelled to undergo a major medical procedure in order to benefit another person – in this case, the fetus. As the obstetrician Howard Minkoff notes: "You don't have to donate your kidney, your bone

marrow, or your blood, even if someone else might die without it… [Legally required C-sections are] saying pregnant women have fewer rights than anyone else, including a fetus" (Collier Cool, 2005).

In their committee statement, ACOG emphasized the importance of patient autonomy, noting that providers must recognize the "interconnectedness of the pregnant woman and her fetus" while maintaining respect and consideration for the pregnant woman's autonomous decision-making (ACOG, 2016, p. 7). The authors write that "pregnancy does not lessen or limit the requirement to obtain informed consent or honor a pregnant woman's refusal of recommended treatment" (ACOG, 2016, p. 7). Despite this call for obstetricians and other physicians to respect pregnant women's autonomy and right to refuse treatment, violations of informed consent occur in hospitals across the country.

Future Directions

How can maternity care in the United States improve? How can we ensure that women and families have access to respectful, culturally competent, low-intervention, evidence-based care throughout pregnancy and childbirth? How can we hold providers accountable for their actions, and end violence against women during childbirth?

Research Implications

First, research to explicitly define and measure obstetric violence is necessary. Without a definition, it is difficult to measure the prevalence and incidence of obstetric violence within American hospitals and birthing centers. In their 2015 statement addressing the issue of obstetric violence, the World Health Organization called for

governmental support for research to define and measure violence within healthcare institutions. Additionally, research to study the effectiveness of interventions that are developed to prevent violence is necessary in order to ensure that hospitals and clinics are taking the best steps possible to reduce experiences of violence (WHO, 2015).

Policy development to end other types of violence against women has benefitted from efforts to define and measure violence and its influences (Jewkes & Penn-Kekana, 2015). Similarly, mixed-methods research that attempts to both quantify experiences of violence within American maternity care, as well as provide a space for women to describe their experiences giving birth in U.S. hospitals, could bolster efforts to end violence against women during childbirth. Survey questions that allow women to describe their experiences in their own words are important, as many women are unaware of their rights during childbirth. The Harvard School of Public Health's 2010 landscape analysis of disrespect and abuse during birth found that a core theme that emerged from interviews with women was the "normalization of disrespect and abuse" for women who had never known any other system of care (p. 15). Thus, allowing women the opportunity to discuss their experiences is important in order to capture women's experiences of disrespectful, abusive, or non-evidence-based care that they may not even perceive as being such.

Currently, Childbirth Connection's *Listening to Mothers* survey is arguably the best attempt in the U.S. to paint a picture of American maternity care and highlight women's experiences throughout pregnancy, childbirth, and the postpartum period. However, the survey has limitations, perhaps most importantly that the survey results include responses from a disproportionately large percentage of white non-Hispanic mothers, and disproportionately low percentages of Black and Hispanic mothers.

Research that attempts to define obstetric violence and give voice to women's experiences with violence within institutional healthcare may also help researchers and maternal health advocates better understand the reasons why obstetric violence exists. By identifying those contributing factors, interventions and policy may be developed to best address the roots of the issue.

Resources for maternal health

In May 2017, National Public Radio and ProPublica released the results of a six-month long journalistic investigation of maternal mortality in the United States. According to their research, only six percent of block grants for "maternal and child health" is used to improve the health of mothers, with the vast majority of funding (78%) dedicated to infants and special-needs children (Martin & Montagne, 2017). Infant mortality has fallen to its lowest point in U.S. history, and yet maternal mortality is on the rise (CDC, 2017). Rising maternal mortality is a phenomenon that is not seen in other "developed" countries – the U.S. is alone in this (Martin & Montagne, 2017). Martin & Montagne note that at Maternal-Fetal Medicine Units Network, a federally-funded research center in the U.S., only four of 34 initiatives primarily target women – while 24 of those initiatives aim to improve health outcomes for infants. Additionally, while Medicaid provides women with healthcare coverage for just 60 days postpartum, infants are covered under Medicaid for a full year. The allocation of funding in our society indicates where priority is placed. In the case of maternal health, it is clear that higher priority is assigned to the health outcomes of the infant than those of the mother.

According to Jewkes and Penn-Kekana (2015), "the essential feature of violence against women is that it stems from structural gender inequality" (p. 1). The subjugation of women in American society systematically devalues women's lives, thus enabling the "inappropriately low allocation of resources to maternity care" (p. 1). Thus, efforts to increase funding specifically for maternal health must be rooted in efforts to improve the social position of women.

Addressing Institutional Attitudes

Establishing guidelines for "humanized birth" and respectful, low-intervention maternity care is one step toward preventing the unnecessary medical interventions that can contribute to experiences of violence and traumatic birth. ACOG's "Approaches to Limit Intervention During Labor and Birth" is an excellent starting point, and can serve to not only educate providers on best practices in low-intervention labor and birth, but to stimulate dialogue between women and their providers about expectations and wishes for labor and delivery. But establishing these best practices and creating methods of holding providers accountable for following these guidelines is just the beginning. Research from Latin American jurisdictions in which obstetric violence is legally prohibited (Venezuela and four states in Mexico) indicates that legislation brings only limited change without preventative strategies to address the attitudes and culture that lead to obstetric violence in the first place (Diaz-Tello, 2016). As previously discussed, institutional and provider attitudes toward patients contribute to the culture of high-intervention delivery, a culture which has been shaped and solidified over the course of the past 100 years of obstetrics

education and practice. It is these deeper patterns of inequality that can lead to acute manifestations of violence (Zacher Dixon, 2015).

Researchers suggest several methods for attempting to address these patterns of gender inequality that are manifested within healthcare settings. First, educating obstetricians, physicians, nurses, nurse-midwives, and other healthcare personnel on human rights in childbirth is essential. In particular, this education should be built into the curriculum of educational institutions – not simply provided as optional "continuing education." Additionally, this type of education should emphasize the gender-related dimensions of obstetric violence. According to Sadler et al., this curriculum is necessary because "many aspects of obstetric violence are not questioned, they are taken for granted and naturalized" (2016, p. 53).

Additionally, interventions that attempt to shift the power dynamic between patients and providers can help to reframe and rebuild the relationship between women and their healthcare providers (Freeman, 2014). In recent years, the "provider-patient power differential" has been increasingly discussed, as "patient-centered care" becomes a more popular topic. This power differential, which mirrors gender dynamics in wider society, is of the utmost importance within the context of labor and delivery. Specific interventions have been created to help physicians "share power" with their patients in a more equitable and respectful way (Dwamena et al., 2012). These interventions, with the addition of a clear emphasis on the complexities of gender and pregnancy, may be helpful for providers to better understand the ways in which they address and use their power within their interactions with patients.

Conclusion

Childbirth is an incredibly significant event in a woman's life. During this momentous time, women deserve to receive care that is grounded in evidence, adherence to informed consent policies, and respect for natural processes and patient choice. In order to explain experiences of trauma and obstetric violence within U.S. healthcare, we must examine patterns of gender inequality that contribute to a culture of maternity care that allows for disrespectful and non-evidence-based care of women during childbirth. Women's dignity and autonomy during pregnancy and childbirth must be respected in order to minimize experiences of violence and trauma. High-quality maternity care is respectful, evidence-based, humanized care.

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Appendix A

Bohren and colleagues' typology of mistreatment of women during childbirth (2015).

Table 1. Typology of the mistreatment of women during childbirth.

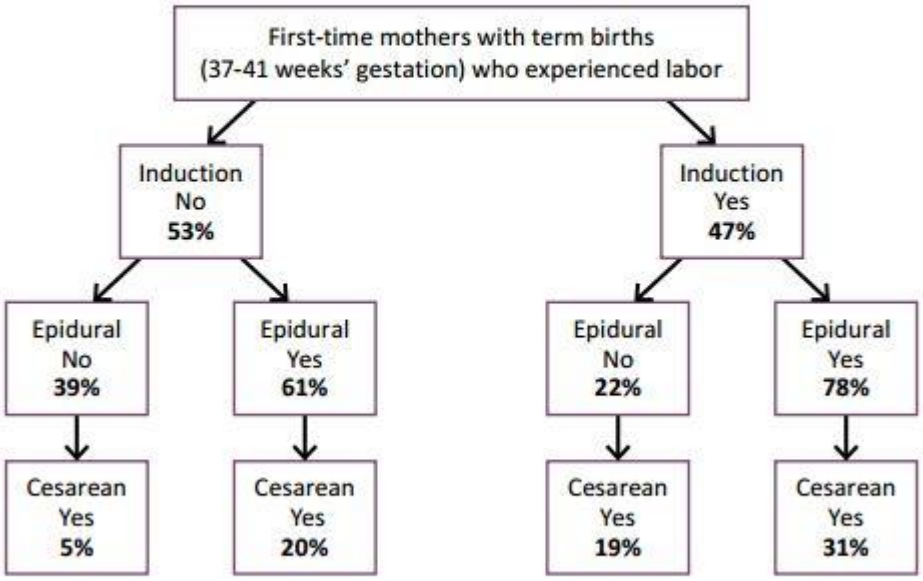
Third-Order Themes	Second-Order Themes	First-Order Themes
Physical abuse	Use of force	Women beaten, slapped, kicked, or pinched during delivery
	Physical restraint	Women physically restrained to the bed or gagged during delivery
Sexual abuse	Sexual abuse	Sexual abuse or rape
Verbal abuse	Harsh language	Harsh or rude language
		Judgmental or accusatory comments
	Threats and blaming	Threats of withholding treatment or poor outcomes
		Blaming for poor outcomes
Stigma and discrimination	Discrimination based on sociodemographic characteristics	Discrimination based on ethnicity/race/religion
		Discrimination based on age
		Discrimination based on socioeconomic status
	Discrimination based on medical conditions	Discrimination based on HIV status
Failure to meet professional standards of care	Lack of informed consent and confidentiality	Lack of informed consent process
		Breaches of confidentiality
	Physical examinations and procedures	Painful vaginal exams
		Refusal to provide pain relief
		Performance of unconsented surgical operations
	Neglect and abandonment	Neglect, abandonment, or long delays
		Skilled attendant absent at time of delivery
Poor rapport between women and providers	Ineffective communication	Poor communication
		Dismissal of women's concerns
		Language and interpretation issues
		Poor staff attitudes
	Lack of supportive care	Lack of supportive care from health workers
		Denial or lack of birth companions
	Loss of autonomy	Women treated as passive participants during childbirth
		Denial of food, fluids, or mobility
		Lack of respect for women's preferred birth positions
		Denial of safe traditional practices
		Objectification of women
		Detainment in facilities
Health system conditions and constraints	Lack of resources	Physical condition of facilities
		Staffing constraints
		Staffing shortages
		Supply constraints
		Lack of privacy
	Lack of policies	Lack of redress
	Facility culture	Bribery and extortion
		Unclear fee structures
		Unreasonable requests of women by health workers

Appendix B

The Cascade of Interventions during Childbirth: *Listening to Mothers III*

Figure 9. Cascade of intervention in first-time mothers with term births who experienced labor

Base: first-time mothers with term births who experienced labor *n=750*



In this group, which included 85% of first-time mothers, the overall epidural rate was 69% and overall cesarean rate was 21%.

Appendix C

C-section rates within Chicago (Consumer Reports, 2016).

Hospitals listed by C-section rate

Better ◄——► Worse

Hospital Name	Avoiding C-Section Rating	C-section rate (First-Time Mothers, Low-Risk Deliveries)
Saint Anthony Hospital	●	13.8
Roseland Community Hospital	●	13.9
Northwestern Memorial Hospital	●	16.7
Norwegian American Hospital	◓	18.5
Mercy Hospital and Medical Center	◓	18.7
Swedish Covenant Hospital	◓	20.7
Presence Saints Mary & Elizabeth Medical Center	◓	22.1
Rush University Medical Center	○	26.7
Presence Resurrection Medical Center	◒	27.5
Jackson Park Hospital and Medical Center	◒	29.5
University of Chicago Medical Center	◒	29.8
Presence Saint Joseph Hospital	◒	30.9
John H. Stroger Jr. Hospital of Cook County	◒	31.1