Leaving women behind: The application of evidence-based guidelines, law, and obstetric violence by omission

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Introduction

The World Health Organization's (WHO) statement on disrespect and abuse during childbirth helped to bring much needed global attention to the fact that healthcare professionals are subjecting pregnant and birthing women to various forms of disrespect and abuse.[1] Disrespectful and abusive treatment includes physical and verbal abuse, profound humiliation, coercive or unconsented medical procedures, lack of confidentiality, failure to get fully informed consent, refusal to give pain medication, gross violations of privacy, refusal of admission to health facilities, and neglecting women during childbirth.[2] The WHO, together with other leading maternal health organisations,[3] and obstetric violence activists and researchers actively support and encourage the provision of evidence-based care to tackle abuse and obstetric violence.[4]

Evidence-based guidelines use 'the best available research on the safety and effectiveness of specific practices to help guide maternity care decisions and facilitate optimal outcomes for mothers and their newborns.'[5] These provide the necessary framework to prevent the extreme situations of doing 'too little, too late' or 'too much, too soon' which both lead to harmful

[1] World Health Organization, 'The Prevention and Elimination of Disrespect and Abuse During Facility-based Childbirth' (2014) <http://apps.who.int/iris/bitstream/handle/10665/134588/WHO_RHR_14.23_eng.pdf?sequence=1> accessed 6 June 2018.

[2] ibid.

[3] These organisations are listed on the World Heath Organization's website, <www.who.int/reproductivehealth/topics/maternal_perinatal/endorsers.pdf> accessed 6 June 2018.

[4] Simone Grilo Diniz and others, 'Abuse and Disrespect in Childbirth Care as a Public Health Issue in Brazil: Origins, Definitions, Impacts on Maternal Health, and Proposals for its Prevention' (2015) 25 J Hum Growth Dev 377; Michelle Sadler and others, 'Moving Beyond Disrespect and Abuse: Addressing the Structural Dimensions of Obstetric Violence' (2016) 24(47) Reprod Health Matters 47.

[5] Carol Sakala and Maureen P Corry, 'Evidence-based Maternity Care: What it is and What it can Achieve' (2008) <www.nationalpartnership.org/research-library/maternal-health/evidence-based-maternity-care.pdf> 21 accessed 6 June 2018.

outcomes for women.[6] In essence, evidence-based guidelines help determine when a procedure is clinically indicated and clinical indication helps to distinguish between those procedures which should be promoted or avoided.[7] Evidence-based care offers several benefits, including improved quality of care, improved clinical decision-making, and improved support for patients' informed decision-making processes.[8] Guidelines ensure consistency of care, improve efficiency of healthcare services, facilitate standardisation of good practice, and help to contain costs.[9]

Activists rely on evidence-based guidelines to counter established practices that render childbirth a pathological event. Guidelines issued by the WHO and the International Federation of Gynecology and Obstetrics played a leading role in shaping some of the obstetric violence laws found in Latin America.[10] According to Bellón Sánchez the WHO's guidelines 'are a source of authoritative knowledge in the field of childbirth assistance that activists groups in different parts of the world use as a tool to claim more respectful healthcare assistance for women'.[11] Thus, they help to dismantle abusive maternity care in jurisdictions where there are no obstetric violence laws proscribing violence against women during childbirth.

While I accept that evidence-based guidelines help to improve maternity care services, I question whether their application will always support the fight against abuse during pregnancy and childbirth. I take the position that pregnancy and childbirth should never be the reason for any woman to experience humiliation, degradation, or any form of human rights violation. This

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[6] Suellen Miller and others, 'Beyond too Little, too Late and too Much, too Soon: A Pathway Towards Evidence-Based, Respectful Maternity Care Worldwide' (2016) 388.10056 The Lancet 2176.

[7] ibid.

[8] Steven H Woolf and others, 'Potential Benefits, Limitations, and Harms of Clinical Guidelines' (1999) 318(7182) BMJ 527.

[9] ibid.

[10] Silvia Bellón Sánchez, 'Obstetric Violence: Medicalization, Authority Abuse and Sexism within Spanish Obstetric Assistance: A New Name for Old Issues' (Masters Dissertation, Utrecht University 2014) 49; Carlos Alejandro Herrera Vacaflor, 'Obstetric Violence in Argentina: A Study on the Legal Effects of Medical Guidelines and Statutory Obligations for Improving the Quality of Maternal Health' (Masters Dissertation, University of Toronto 2015) 32.

[11] Sánchez (n 10) 49.

premise demands from us that responses to abuse during childbirth should be such that no woman is left behind or side-lined during the implementation of interventions which are aimed at improving maternity care services. Further, interventions should be such that women can use them to advance their interests. We are therefore required to review critically whether interventions are adequately inclusive and accessible, bearing in mind that women are diverse, their needs are diverse, and their voices in relation to pregnancy and birth are many.

I draw from women's lived experiences of obstetric-related care to show how scientifically sound[12] evidence-based guidelines are applied in a way that silences and excludes some women from care. This process can be harmful to their psychological integrity but guidelines invisiblise these violations because there is an assumption that evidence-based care does not harm. Thereafter, I will expose the anomaly that while evidence-based guidelines are said to be developed for women's benefit, a woman cannot use the law to compel a healthcare provider to comply with guidelines when she wants access to those benefits, or to compel a healthcare provider to disregard guidelines when she does not want access to benefits. Finally, I demonstrate that, in these instances, evidence-based guidelines facilitate obstetric violence by omission. This underscores an overlooked concern that even the most well developed evidence-based guidelines may leave some women behind. I argue that an obstetric violence perspective helps to clarify this harm, it declares this harm an unacceptable consequence of evidence-based care, and it supports demands for more respectful application of guidelines.

Evidence-based guidelines silence and exclude some women

On 24 May 2017, Birthrights launched its 'Maternal Request Caesarean Campaign'.[13] The Campaign recognises that there is a small group of women who feel that having a planned caesarean section is the right option for them given their circumstances but that they are experiencing barriers regarding access to care. It identified Oxford University Hospitals NHS

[12] I assume that the guidelines are methodologically sound, and the purpose of this chapter is not to argue that the guidelines referred to herein are incorrect.

[13] Maria Booker, 'Do I Have a Right to a C-Section? Update on Oxford University Hospitals' (21 July 2017) <www.birthrights.org.uk/2017/07/do-i-have-a-right-to-a-c-section-update-on-oxford-university-hospitals/> accessed 6 June 2018.

as one of the Trusts enforcing a policy of not providing caesarean sections on request.[14] I draw from existing guidelines and recommendations, and communications between Birthrighs and the Trust to illustrate how healthcare professionals use highly regarded guidelines to silence some women and justify their exclusion from care. This discussion will not consider women's decision-making process in relation to elective caesarean sections and the complexity of autonomy and 'true choice' in the context of broader social and cultural experiences.[15] Instead, I focus on how healthcare professionals apply guidelines to women's requests for access to care that is not clinically indicated.

Childbirth by way of caesarean section is the subject of evidence-based guidelines or recommendations at international and national levels. At an international level, the most influential caesarean-section recommendation originates from the WHO. In 2015, the WHO confirmed its position that the ideal rate for caesarean sections is between ten per cent and 15 per cent.[16] Drawing from the latest available evidence-based data it reiterated that caesarean sections are effective in saving lives but only when 'they are required for medically indicated reasons' or when 'medically necessary'. This seems to establish a presumption in favour of vaginal childbirth that requires of women to make a positive case for access to caesarean sections. While the WHO emphasises the need for caesarean section decision-making to revolve around what is medically indicated, national guidelines take a more nuanced approach.

The National Institute for Health and Care Excellence (NICE) has issued clinical guidelines for the provision of caesarean sections that also draws from available evidence to guide when caesarean sections are clinically indicated, but it supports a women-centred approach.[17] A women-centred approach concerns care that is directed by a woman's needs and preferences,

[14] More Trusts are implicated, see Birthrights, 'Maternal Request Caesarean' (2018) <http://www.birthrights.org.uk/wordpress/wp-content/uploads/2018/08/Final-Birthrights-MRCS-Report-2108.pdf> accessed 30 April 2019.

[15] For a discussion of the complexity of 'choosing' caesarean sections, see Katherine Beckett, 'Choosing Cesarean: Feminism and the Politics of Childbirth in the United States' (2005) 6 Fem T 251.

[16] World Heath Organization, 'Statement on Caesarean Section Rates' (2015) <www.who.int/reproductivehealth/publications/maternal_perinatal_health/cs-statement/en/> accessed 6 June 2018.

[17] NICE, 'Caesarean Section: Clinical Guideline' (2011) <www.nice.org.uk/guidance/cg132> accessed 6 June 2018.

and it requires healthcare providers to offer evidence-based information and support to enable informed decision-making. The guideline requires healthcare providers to engage meaningfully with women who elect to give birth by way of a caesarean section. They are required to discuss reasons for the election, and the risks and benefits of the procedure. The healthcare provider should offer perinatal mental health support if a woman requests a caesarean section on the grounds of anxiety. The guideline directs healthcare providers to offer a planned caesarean section if a vaginal birth is still not an option after discussion and additional support. However, it recognises that a woman cannot compel an obstetrician to provide an elective caesarean where clinical indication is absent. The attending obstetrician is required to refer the woman to another obstetrician who will carry out the caesarean section.

The Oxford University Hospitals Trust's patient information leaflet on access to elective caesarean sections explains that the Trust does not make provision for maternal requests for caesarean sections because it only provides caesarean sections in cases where there are clinical indications supporting their use.[18] Healthcare professionals will refer women to another hospital in cases where they choose to go ahead with a caesarean section after being offered or receiving support regarding mode of birth.[19] The leaflet offers a rather inflexible approach and it is not clear if all women requesting caesarean sections will always be referred to another hospital. According to Birthrights[20] this approach to maternal requests for caesarean sections is not in line with the NICE guidelines and blanket policies of this nature are 'a violation of a Trust's legal duty to give personalised care' as confirmed in *Montgomery v Lanarkshire Health Board*.[21] According to Lady Hale:

[18] Oxford University Hospitals NHS Trust, 'I am Anxious about Giving Birth and Want to Know More about Caesarean Section' (2014) <www.ouh.nhs.uk/patient-guide/leaflets/files/10405Pcaesarean.pdf> accessed 6 June 2018.

[19] ibid.

[20] Birthrights, 'Campaigns: Our Maternal Request Campaign' (2017) <www.birthrights.org.uk/campaigns/> accessed 6 June 2018.

[21] [2016] CSOH 133.

> [A] patient is entitled to take into account her own values, her own assessment of the comparative merits of giving birth the 'natural' way and of giving birth by caesarean section, whatever medical opinion may say, alongside the medical evaluation of the risks to herself and her baby.[22]

Putting aside the issue that the Trust may be applying a blanket approach in relation to women's requests,[23] the Trust's approach is aligned with the WHO's recommendations and with the NICE guidelines in so far as access to caesarean sections is being denied because there is no clinical indication justifying this mode of childbirth. This scenario exposes some concerning consequences of the application of evidence-based guidelines: The Campaign reveals that women's voices are directly and indirectly silenced because of the application of guidelines and guidelines being applied in this way legitimise women's exclusion from care. This process can cause serious harm to women's psychological integrity, but these are rendered invisible and ignored because the harms occur while providing evidence-based care.

According to Mainz, clinical indicators are based on standards of care that are evidence-based as derived from scientific evidence or are derived from academic literature and expert panels of healthcare providers when scientific evidence is lacking.[24] Thus, 'clinical indicators' are narrowly defined and do not include factors that some women may consider to be important for their well-being during pregnancy and birth. Evidence-based guidelines can work to silence women when they are applied in contexts where there is a history of devaluing women in maternity care[25] because their adoption may merely support a shift in deference from one type of expert knowledge to another.[26] This process excludes and devalues women's knowledge

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[22] ibid [115].

[23] This is disputed. Birthrights have reports from women that they are denied access to caesarean sections without meaningful engagement while the Trust alleges that it does offer the support required by the NICE guidelines.

[24] Jan Mainz, 'Defining and Classifying Clinical Indicators for Quality Improvement' (2003) 15 IJQHC 523, 524.

[25] Sheila Kitzinger, *Birth and Sex: The Power and The Passion* (Pinter and Martin 2012) 84-100; Henci Goer, 'Cruelty in Maternity Wards: Fifty Years Later' (2010) 19 J Perinat Educ 33; Beverley Chalmers, 'Changing Childbirth in Eastern Europe: Which Systems of Authoritative Knowledge Should Prevail?' in Robbie E Davis-Floyd and Carolyn F Sargent (eds), *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives* (University of California Press 1997) 226-273; Norman Morris, 'Human Relations in Obstetric Practice' (1960) 275 The Lancet 913.

[26] Elizabeth Kukura, 'Contested Care: The Limitations of Evidence-Based Maternity Care Reform' (2016) 31 Berkeley J Gend Law Just 241, 286.

rooted in their lived experiences and can overlook them as important sources of knowledge. The Trust's inflexible reverence for professional and scientific knowledge undermines women as autonomous decision-makers.[27]

Some evidence based-guidelines may indirectly silence women because they tend to speak to general populations and are not primarily concerned with individuality. This is the WHO's approach to caesarean sections and the Trust seems to support this. A generalised view has the effect of framing all women as one type of woman. This leaves little room for the consideration of other aspects relevant to care such as a woman's individual life experiences, preferences, fears, expectations, and personal perceptions of control and life circumstances.[28] Women exist beyond realms of 'clinical indication' and they are diverse. Beckett reminds us that 'women can and do find obstetric technology to be an empowering experience'[29] but some women view technological interventions as something to actively avoid too. Thus, the NICE guidelines and the WHO recommendations speak to, and facilitate, only one of many ways a woman may need to birth, and their application needs to be individualised by the Trust.

The unimportant role of women's voices in relation to determining what care is necessary for their self-determined needs creates the situation where healthcare professionals use evidence-based guidelines to justifiably exclude women from care. The Oxford University Hospitals Trust adopts this approach. It presents elective caesarean sections as placing patients at risk that violates patient trust and frustrates the Trust's ability to fulfil their duties as doctors.[30] In

[27] Kukura (n 26) 289. Stereotyping of this nature is ever-present in reproductive care. See, Rebecca J Cook and Simone Cusack, *Gender Stereotyping: Transnational Legal Perspectives* (University of Pennsylvania Press 2010); Rebecca J Cook, Simone Cusack, and Bernard M Dickens, 'Unethical Female Stereotyping in Reproductive Health' (2010) 109 Int J Gynaecol Obstet 255; C Pickles, 'Sounding the Alarm: *Government of the Republic of Namibia v LM* and Women's Rights during Childbirth in South Africa' (2018) PER (in press).

[28] For instance, see Ellen Lazarus, 'What do Women Want? Issues of Choice, Control, and Class in American Pregnancy and Childbirth' in Robbie E Davis-Floyd and Carolyn F Sargent (eds), *Childbirth and Authoritative Knowledge: Cross Cultural Perspectives* (University of California Press 1997) 132; Soo Downe and others, 'What Matters to Women during Childbirth: A Systematic Qualitative Review' (2018) 13(4) PLoS ONE e0194906.

[29] Beckett (n 15) 259.

[30] Oxford University Hospitals NHS Trust (n 18) 4.

its correspondence with Birthrights,[31] the Trust explained that its approach is not driven by the need to meet targets, but that caesarean sections are being denied on the basis that there is no clinical indication for their use and that the Trust's decision is related to good practice and to reducing short and long-term harm to women. It recognised that some women express a fear of birth or have had a poor birth experience but that these factors do not mean that a caesarean section is 'the best option'.[32] The Trust asserted that it complies with all the relevant guidelines because it offers support to those women who request caesarean sections procedures but that 'if no clinical indication is found despite a thorough assessment, then the woman is referred to an Obstetrician in a neighbouring Trust who may support her request.'[33] It is noteworthy that the Trust did not include rationing of maternity care service as part of its decision to deny access to caesarean sections on request. While the Trust has not specifically referenced the WHO recommendations, it quite clearly reflects the WHO's position because it justifies its position on the grounds that caesarean sections come with risks and obstetricians should not subject women and their babies to any unnecessary risk.[34]

Exclusion from care leaves women with very little options and it introduces unique concerns for women because pregnancy is time sensitive. According to Birthrights, women's referrals to other Trusts are being refused because of caseload implications and other Trusts are not offering maternal request caesareans 'in order not to become targets for women refused this choice by Oxford'.[35] Further, securing care elsewhere may require women to travel long distances, bear burdensome cost implications for accommodation for relatives, or may result in a very isolated birth when accommodation for others cannot be secured. At times women are left with very little time to make necessary arrangements because some Trusts reject

[31] Oxford University Hospitals Trust replying letter to Birthrights, <www.birthrights.org.uk/wordpress/wp-content/uploads/2017/07/Letter-to-R-Schiller-Birthrights-from-OUH.pdf> accessed 6 June 2018.

[32] ibid.

[33] ibid.

[34] Oxford University Hospitals NHS Trust (n 18) 4.

[35] Birthrights replying letter to Oxford University Hospitals Trust, <www.birthrights.org.uk/wordpress/wp-content/uploads/2017/07/Second-letter-to-OUH-with-case-studies.docx> accessed 6 June 2018.

requests for caesarean sections late in gestation.[36] Rejection is also very disrespectful. One woman recounts how she felt as though healthcare providers treated her like a 'child being told off for doing something wrong' and how her attending healthcare provider refused to listen to her concerns and reasons for the request.[37] Another woman expressed frustration about the fact that healthcare providers are not prepared to 'credit women with the capacity to make informed decisions regarding risks which are acceptable to her.'[38]

One can argue that the Oxford University Hospitals Trust is compelling or forcing women to experience the physiological process of vaginal birth because the Trust is actively denying women access to an alternative mode of childbirth that is available at the facility. Women who were denied access to caesarean sections reported experiencing nightmares and sleeplessness, and feeling lonely, frightened, anxious, stressed, and being filled with dread while trying to secure access to a caesarean section during their pregnancies.[39] Furthermore, evidence reveals that women experience traumatic births in cases where they feel that they lacked autonomy and control, where they were denied access to a particular intervention, and when healthcare providers did not provide the necessary support.[40] These harms point to the fact that Trusts are compromising women's psychological integrity in rather fundamental ways. Their harms are invisiblised because evidence-based care is presented by the Trust as being the mechanism to prevent harms during childbirth. The process of invisiblising these harms allows the Trust to authoritatively assert that it is well-positioned to determine 'the best option' and the privileging of medical authority allows the Trust to assert that it is best placed to reduce short and long-term harms.

[36] ibid.

[37] ibid.

[38] ibid.

[39] ibid.

[40] Cheryl Tatano Beck, 'Birth Trauma: In the Eye of the Beholder' (2004) 53 Nurs Res 28; Rachel Harris and Susan Ayers, 'What Makes Labour and Birth Traumatic? A Survey of Intrapartum "Hotspots"' (2012) 27 Psychol Health 1166; M H Hollander and others, 'Preventing Traumatic Childbirth Experiences: 2192 Women's Perceptions and Views' (2017) 20 Arch Womens Ment Health 515.

Limited value of guidelines in law

The discussion to follow will show that a woman cannot compel a provider to comply with evidence-based guidelines to gain access to its benefits and a woman cannot compel a healthcare provider to disregard the guidelines when she does not want the benefits it has on offer. This is the situation taking place in relation to the Oxford University Hospitals Trust. For women to gain access to caesarean sections they need to be able to compel an obstetrician to comply with a portion of the NICE guidelines and to compel the obstetrician to ignore the WHO recommendations.

Courts have accepted the authoritative nature of clinical guidelines as far as they are 'evidence of good medical practice'.[41] Various healthcare providers have been found negligent for failing to comply with clinical guidelines,[42] but this is not a given. In *KR v Lanarkshire Health Board*,[43] Lord Brailsford explains that guidelines 'are the result of deliberation by panels of experts who will have regard in formulating them to available scientific information and their own collective experience. The result of that process are documents which are intended to provide clinical guidance, not set down mandatory rules.'[44] Courts accept that slavish adherence to guidelines should be avoided[45] and their application should be determined by a healthcare provider's appreciation of her or his own level of knowledge and experience.[46] This means that a more experienced provider may deviate from guidelines when her or his extensive clinical experience and knowledge indicate this may be necessary.[47] A less experienced healthcare provider, who lacks the necessary knowledge and experience, is required to follow the guidelines since these represent distilled experience of other healthcare providers that this

[41] *Smith v National Health Service Litigation* [2001] Lloyd's Rep Med 90.

[42] For instance see, *CP v Lanarkshire Acute Hospitals NHS Trust* [2015] SCOH 142; *DF v Healthcare NHS Trust* [2005] EWHC 1327.

[43] [2016] CSOH 133 [129].

[44] ibid.

[45] *Montgomery* (n 21) [203].

[46] *KR* (n 43) [129].

[47] ibid.

healthcare provider lacks.[48] This does not mean that they are compelled to comply with the guidelines, it means that the inexperienced healthcare providers should consult their more experience colleagues in cases where the application of guidelines is deemed inappropriate.[49]

Patients cannot enforce guidelines. Instead, courts adopt a flexible approach that tends to draw from and favour medical knowledge and experience as the guide to determine the justifiability of their application or deviation therefrom. Essentially, in this narrow context, the courts maintain the privileged position of medical knowledge. Medical knowledge and experience establish guidelines and medical knowledge and experience are leading points of reference when courts seek to establish when deviation or compliance is justified. It is not overtly clear how much room is available to accommodate considerations deemed important to women that are not orientated around medical considerations, strictly construed. The current approach will do little to support women who seek to enforce one set of guidelines over another, particularly when one set of guidelines promote the consideration of what women may deem necessary (NICE guidelines) over what the medical profession deems necessary (WHO recommendations). The patient-centred approach supported in *Montgomery* may help to dismantle the privileged position of medical knowledge in the context of care during pregnancy and childbirth.

The Supreme Court recognised that a number of fundamental developments have taken place in society, medical practice and the law, and these developments demand a change in the way that patients are cared for.[50] These developments include the fact that the patient/doctor relationship has evolved into one where patients are recognised as rights bearers; that access to information debunks the flawed assumptions that patients are medically uninformed and incapable of understanding medical-related matters; and that professional guidance encourages patient's informed involvement when making decisions about treatment.[51] Developments in law include the recognition of important common law values and rights such as self-

[48] ibid.

[49] ibid.

[50] *Montgomery* (n 21) [75].

[51] ibid [75]-[79].

determination and respect for private life.[52] These important values and rights support the recognition of a duty to involve patients in decision-making relating to their care and treatment.[53]

Collectively, these developments counter the legitimacy of medical paternalism and support a patient/doctor relationship where patients are treated as 'adults who are capable of understanding that medical treatment is uncertain of success and may involve risk, accepting responsibility for the taking of risks affecting their own lives, and living with the consequences of their choices.'[54] This translates into two important consequences. First, a healthcare provider is under a duty to ensure that a patient is aware of material risks inherent in treatment.[55] Second, a patient is entitled to decide whether not to incur that risk and the court recognises that the decision to incur risk may be informed by non-medical considerations.[56] The Supreme Court supports an understanding of risk that is patient-sensitive and the materiality of risk is not merely determined with reference to percentages. A patient-sensitive approach requires the healthcare provider to consider how the risk will affect the life of that individual patient if it were to materialise and 'the importance to the patient of the benefits to be achieved by the treatment'.[57]

Montgomery certainly helps to challenge medical paternalism.[58] Lady Hale proclaims, 'Gone are the days when it was thought that, on becoming pregnant, a woman lost, not only her

[52] ibid [80].

[53] ibid [80]. See also Jonathan Herring and others, 'Elbow Room for Best Practice? Montgomery, Patients' Values, and Balanced Decision Making in Person-Centred Clinical Care' (2017) 25 Med Law Rev 582.

[54] *Montgomery* (n 21) [81].

[55] ibid [82].

[56] ibid [82].

[57] ibid [89].

[58] cf, Jonathan Montgomery and Elsa Montgomery, 'Montgomery on Informed Consent: An Expert Decision' (2016) 42 J Med Ethics 89.

capacity, but also her right to act as a genuinely autonomous human being.'[59] It establishes that clinical considerations are not the only factors relevant to decision-making about care options. It effectively gives legal weight to patient's personal perceptions of risk and the types of risk they would be willing to carry. From this perspective, women may be able to challenge the Trust's position that its approach is driven by the need to avoid long and short-term harms, since risk of harms is seemingly being determined without the consideration of individual women's needs and what they perceive as risks worth taking in relation to their childbirth. It also helps to dispel the Oxford University Hospital's Trust's notion that there is only one 'best option' and that this option should be followed because the Trust declares it the best one available. *Montgomery* allows us to recognise that the 'best option' approach may come with risks that some women are not prepared to face, and they are entitled to avoid that risk.

It is noteworthy that *Montgomery* secures the right to information to make informed decisions that are patient specific, and it establishes a duty on healthcare providers to facilitate that process. However, it does not obligate healthcare providers to ensure the realisation of those decisions. Lady Hale recognises this limitation; she states a woman cannot 'force her doctor to offer treatment which he or she considers futile or inappropriate. But she is at least entitled to the information which will enable her to take a proper part in that decision.'[60] *Aintree* confirms that a patient cannot demand treatment from a healthcare provider if that treatment is not clinically indicated.[61] Clinical indication reappears, and it works to limit severely women's ability to secure an experience of childbirth shaped by the autonomous and informed decisions that *Montgomery* secures. What good is it to be part of the decision-making process when the decision reached is one that does not need to be respected?

This discussion reveals that evidence-based guidelines, which are developed for the benefit of women, do not necessarily benefit all women in practice. Some women experience harms because of their application, and this needs deeper interrogation and analysis. I argue that this

[59] *Montgomery* (n 21) [116].

[60] ibid [115].

[61] *Aintree University Hospitals NHS Trust Foundation v James* [2013] UKSC 67 [18].

scenario is not merely an issue of compliance with guidelines; it is a form of violence against women.

Obstetric violence by omission

Jewkes and Penn-Kekana argue that abuse during childbirth is in fact a *subset* of violence against women.[62] They explain:

> The essential feature of violence against women is that it stems from structural gender inequality, i.e., women's subordinate position in society as compared to men. This systematically devalues the lives of women and girls and thus enables the inappropriately low allocation of resources to maternity care that is found in many countries. It also disempowers women and enables the use of violence against them.[63]

According to Jewkes and Penn-Kekana, there are many lessons that can be learned from research on violence against women, especially when developing and evaluating policies and interventions.[64] They are on point. Obstetric violence activists established the importance of a violence perspective many years before Jewkes and Penn-Kekana published their comment, and I will draw from their contributions here.

I adopt a violence perceptive to argue that healthcare providers or Trusts commit acts of obstetric violence by omission when they employ evidence-based guidelines to deny women access to non-clinically indicated care, knowing that this denial of care will cause an infringement of women's psychological integrity. I support this argument by considering how obstetric violence is currently conceptualised in law and broader activism, and I build on this concept by drawing from Bufacchi's definition of violence.[65]

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[62] Rachel Jewkes and Loveday Penn-Kekana, 'Mistreatment of Women in Childbirth: Time for Action on the Important Dimension of Violence against Women' (2015) 12(6) PLOS Med e1001849.

[63] ibid, (footnote omitted).

[64] ibid.

[65] Vittorio Bufacchi, *Violence and Social Justice* (Palgrave Macmillan 2007) 13.

'Obstetric violence' originates from Latin America.[66] The concept has grown in popularity among many activists and researchers who demand reform of the overly medicalised and violent nature of some maternity care services. It is a term employed to name the 'malaise that many women feel after childbirth, even though society tells them that everything is alright and all that is important is that the baby is alive.'[67] 'Obstetric violence' calls out unnecessary and improper use of medicine against women and their bodies, and it locates these practices within a broader framework of historical and ingoing social inequality related to gender, race and class: 'How women are treated in labour and birth, mirrors how they are treated in society in general.'[68] An obstetric violence perspective demonstrates that disrespect and abuse during childbirth are indicators of embedded harmful attitudes towards women and their bodies.[69] These attitudes privilege medical knowledge and allow healthcare providers to enforce women's silence and compliance, and they support the imposition of routine interventions on women without consultation, informed consent, and clinical need.[70]

It is notable that 'obstetric violence' is not defined with reference to existing definitions of violence more generally. Those researchers or activists who position themselves in relation to a definition tend to draw from the art 15 of the Venezuelan Organic Law on the Right of

[66] Sánchez (n 10) 39, 50-51; Hanna Laako, 'Understanding Contested Women's Rights in Development: The Latin American Campaign for the Humanisation of Birth and the Challenge of Midwifery in Mexico' (2017) 38 Third World Q 379, 387.

[67] Sánchez (n 10) 95.

[68] Lydia Zacher Dixon, 'Obstetrics in a Time of Violence: Mexican Midwives Critique Routine Hospital Practices' (2015) 29 MAQ 437, 447.

[69] ibid 441, 444.

[70] Rachel Jewkes, Naeemah Abrahams, and Zodumo Mvo, 'Why do Nurses Abuse Patients? Reflections from South African Obstetric Services' (1998) 47 Soc Sci Med 1781; Roberto Castro and Joaquina Erviti, 'Violations of Reproductive Rights during Hospital Births in Mexico' (2003) 7 Health Hum Rights 90; Meghan A Bohren and others, '"By Slapping their Laps, the Patient Will Know that you Truly Care for Her": A Qualitative Study on Social Norms and Acceptability of the Mistreatment of Women during Childbirth in Abuja, Nigeria' (2016) 2 SSM Popul Health 640.

Women to a Life Free from Violence (2007).[71] It defines obstetric violence as the appropriation of women's bodies and reproductive processes by health personnel which brings with it a loss of autonomy and the ability to decide freely about their bodies and sexuality, and which has a negative impact on the quality of women's lives.[72] It recognises that obstetric violence is expressed as 'dehumanised treatment', 'abuse of medication', and it includes within its scope the process of converting the physiological process of childbirth into a pathological event.[73]

The Organic Law appears to promote a wide conceptualisation of obstetric violence. Arguably, any obstetric-related conduct that takes place in relation to a woman and her body during childbirth without her informed consent *could* constitute obstetric violence provided that it amounts to an appropriation of her body or that it denies her the ability to make decisions during this time. However, art 51 narrows this broad definition because it primarily focuses on preventing acts that pathologise childbirth. Article 51 of the Organic Law recognises that the following closed list of conduct constitutes obstetric violence: A failure to give effective attention to obstetric emergencies; forcing women to give birth in the supine position when the necessary means to give birth in a vertical position are available; preventing mother/child bonding and breastfeeding; altering the natural childbirth process by using acceleration techniques without voluntary and informed consent; performing a caesarean section without informed consent and when vaginal childbirth is possible.

D'Gregorio, an obstetrician from Venezuela, confirms that 'obstetric violence' is a narrowly construed concept in Venezuelan Law. He explains that the Organic Law emphasises that 'medication should only be used when it is indicated, the natural processes should be respected, and instrumental or surgical procedures should be performed only when the indication follows

[71] Argentina and some states in Mexico have also introduced obstetric violence laws but relevant provisions are not readily available to English speaking researchers, academics and activists. For more on those jurisdictions see Caitlin R Williams and others, 'Obstetric Violence: A Latin American Legal Response to Mistreatment during Childbirth' (2018) BJOG (in press). The Venezuelan obstetric violence provision was translated by Rogelio D'Gregorio in 2010 and his translation was made widely available through a prominent journal, see Rogelio Pérez D'Gregorio, 'Obstetric Violence: A New Legal Term Introduced in Venezuela' (2010) 111 BJOG 201.

[72] D'Gregorio (n 71) 201.

[73] ibid.

evidence-based medicine.'[74] Thus, while the need for informed consent features (promoting women's autonomy), the focal point of the obstetric violence articles relate to preventing the use of medical interventions that are not clinically indicated and to ensure a more humanised approach to childbirth which supports childbirth as a physiological process. Similarly, Sánchez, who studied obstetric violence activism in Spain, interprets obstetric violence laws as promoting the notion that 'pregnancy does not have to be considered a pathology, but a "natural" process'.[75] She recognises that obstetric violence laws demand that healthcare providers recognise that women are not ill and are capable of making informed decisions regarding their care during labour and childbirth but it seems that these considerations are relevant in contexts where woman are looking to avoid medicalised childbirths.

'Obstetric violence' is a helpful concept despite its narrow construction in law. It contextualises violence against women within the obstetric care environment, it demystifies how and why this violence occurs, it helps women articulate the harm they experience during labour and childbirth, and it works to challenge medical privilege by obligating healthcare providers to justify normalised and routinised conduct. However, the above application of the concept of obstetric violence creates the perception that this form of violence only concerns healthcare provider conduct that is disrespectful of the physiological process of childbirth or conduct (in the form of medical interventions) which is not clinically indicated and evidence-based. I argue that this conceptualisation of obstetric violence is far too narrow, and it overlooks many acts of violence that can occur in the obstetric care context.[76] Further, it does not reveal how healthcare professional subject women to violence while undergoing necessitated medicalised childbirths. This approach has the consequence of narrowing the potential for critical review and response.

Support for such a narrow construction of obstetric violence may lie in the fact that the concept of violence is not fully understood, or it may simply be a consequence of the fact that there is

[74] ibid.

[75] Sánchez (n 10) 60.

[76] Researchers and activists recognise a wide range of conduct as constituting violence against women during childbirth. For example, see Diniz and others (n 4) and Elizabeth Kukura, 'Obstetric Violence' (2018) 106 Georget Law J 721, 726-54.

no accepted definition of violence, and that it is an ambiguous concept that tends to be moulded by different people who adopt different perspectives.[77] Bufacchi tackles this issue. He argues that the definition of violence should be fix and not fluid and he offers a definition that may help to develop a universally applicable conceptualisation of violence.[78]

In the main, violence is defined either very narrowly or too comprehensively.[79] A narrow definition of violence defines it as an intentional act of excessive physical force used to cause suffering or injury.[80] This approach fails to recognise the fact that violence can cause emotional and psychological suffering;[81] that it can take place indirectly through institution structures and agencies;[82] and it not aligned with definitions of violence found in international and regional laws.[83] This demonstrates that there is a need for a more inclusive construction of violence and there is broader support for this approach. A comprehensive definition of violence frames violence as a 'violation of rights'.[84] While this offers a more inclusive approach, it is criticised as being too comprehensive because 'almost any act can be said to violate someone's rights, making violence ubiquitous and therefore meaningless.'[85]

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[77] Willem de Haan, 'Violence as an Essentially Contested Concept' in Sophie Body-Gendrot and Pieter Spierenburg (eds), *Violence in Europe: Historical and Contemporary Perspectives* (Springer 2007) 27; Elizabeth A Stanko (ed), *The Meanings of Violence* (Routledge 2003) 2.

[78] For his arguments on how to develop an objective dimension to the definition of violence, see Bufacchi (n 65) 30-40. He frames violence as involving the perpetrator, the victim and the spectator. The spectator helps to establish the necessary objectivity.

[79] Vittorio Bufacchi, 'Two Concepts of Violence' (2005) 3 Polit Stud Rev 193, 197.

[80] ibid.

[81] Haan (n 77) 31.

[82] Johan Galtung, 'Violence, Peace, and Peace Research' (1969) 6 *J Peace Res* 167; Bufacchi (n 79) 198.

[83] See art 1 of the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (1995); paragraph 6 of General Recommendation 19 of the United Nations Committee on the Elimination of Discrimination against Women; art 3(a) of the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (2014); art 1(j) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2005). All of these definitions adopt a much broader approach to violence against women.

[84] Bufacchi (n 79) 196.

[85] ibid 197.

Bufacchi attempts to overcome the above issue. According to Bufacchi:

> [A]n act of violence occurs when the right to integrity or unity of a subject (person or animal) or object (property) is being intentionally or unintentionally violated as a result of an action or an omission. The violation may occur at a physical or psychological level, through physical or psychological means. A violation of integrity will usually result in the subject being harmed or injured, or the object being destroyed or damaged.[86]

Bufacchi's definition locates violence in the violation of the right to integrity and not *all* human rights. Violence concerns the process of being reduced to a lesser being in physical and/or psychological terms.[87] He focuses on the consequence of conduct (violation of integrity) and looks at an incident from the perspective of the victim. This approach supports the argument that both acts and omissions can constitute violence since both hold the potential to cause a violation of integrity as a consequence thereof. However, Bufacchi explains that an omission can only legitimately amount to violence if two elements are present: Foreseeability and alternativity.[88] These elements require that the person must be able to predict the harmful consequence and it must be possible to act in a different way, and this different act must be viable.[89] 'Viability' means that the different options must be comparable in terms of the facility of access.[90]

On the subject of intentional and unintentional causing of a violation of integrity, Bufacchi recognises that intention to cause harm is what many accept as the moral line which differentiates benevolent actions from malevolent actions, and which helps to clearly

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[86] Bufacchi (n 65) 43-44.

[87] ibid 41.

[88] ibid 55.

[89] ibid 45-56.

[90] ibid 56.

distinguish between an act of violence and a mere accident.[91] However, he recognises that there are 'hard cases' where a person's integrity is violated as a result of conduct which is not merely accidental but the harmful consequence was not intended either.[92] This will be the case when harm is a foreseeable and/or avoidable. Given that the person still experiences a violation, these hard cases make it necessary to relax the intention requirement of violence and replace it with the requirement of foreseeability of inevitable consequences of one's actions.[93] Bufacchi explains that 'an act of violence occurs when injury or suffering is inflicted upon a person or persons by an agent, and the suffering is either foreseeable and/or avoidable.'[94] Following this approach helps to broaden the definition of violence to capture unintentional but foreseeable harm, it renders visible those harms that remain invisible under the narrow definition of violence, and visibility supports demands for justification and claims for accountability.[95]

Drawing from Bufacchi's general definition of violence it is clear that the 'violence' in 'obstetric violence' concerns the violation of integrity of women within the context of obstetric care context. A woman's physical and psychological integrity can be violated in many ways during obstetric 'care' and this means that the appropriation of women's bodies and reproductive process is essentially only one act of many that constitute obstetric violence. Thus, medicalisation of childbirth without justification and consent is a type of obstetric violence rather than its definition. This approach exposes the fact that the current legal definition of obstetric violence, which seems to be widely supported by activists and researchers, is too narrow and this has caused certain acts of violence to be overlooked or remain undetected.

I argue that one of the acts of obstetric violence being overlooked concerns the use of evidence-based guidelines or recommendations to deny women access to non-clinically indicated care

[91] ibid 67, 69.

[92] ibid 73.

[93] ibid 66.

[94] ibid 85.

[95] ibid 82.

and this denial causes them foreseeable harms. This is best illustrated by referring to the Maternal Request Caesarean Campaign.[96]

In maternal request cases, women are requesting access to caesarean sections for reasons considered important to them. Access is being denied because evidence-based guidelines and recommendations reveal that there are no clinical indications supporting this mode of childbirth. The denial of access to caesarean sections runs the serious risk of long-term psychological harms related to the trauma experienced as a result of being compelled into a particular mode of childbirth. I characterise this as a form of obstetric violence because this scenario causes a violation of women's psychological integrity. The violation occurs because of an omission on the part of attending healthcare providers. It constitutes violence because healthcare providers can predict this harmful consequence given that they consult with women antenatally and during this time women make their position in relation to vaginal birth clear. Healthcare professionals or Trusts can avoid violating women's psychological integrity because the reason for the denial of care is grounded in clinical indication and not limited resources. This scenario falls within the 'hard case' category: The violation of integrity is not an intended consequence of compliance with guidelines, but it is not an accident either. Healthcare providers do not intend the consequence of childbirth-related psychological trauma, but this consequence is foreseeable and avoidable. Therefore, it constitutes an act of obstetric violence by omission.

Embedding obstetric violence within broader debates about violence more generally reveals that pathologisation of childbirth without women's consent and the Trust's application of evidence-based guidelines to deny clinically non-indicated care are two sides of the same coin. In both instances women are infantilised, humiliated and subjected to the power of others.

Leaving no woman behind: Making evidence-based guidelines more effective

This chapter shows that scientifically sound evidence-based guidelines and the law can work together in particularly harmful ways for some pregnant or birthing women. For evidence-based guidelines be an effective tool to tackle abuse, as presented by the WHO and others, they need to address or challenge the underlying causes of abuse. Obstetric violence research and

[96] Booker (n 13).

activism explains that the privileged position of medical knowledge and the unequal and undervalued position of women in society are the underlying causes of abuse during obstetric care. However, evidence-based guidelines do not address these causes on their own because they work with the privileged position of medical knowledge rather than challenge it. Thus, the effectiveness of guidelines is determined by those who apply the guidelines and their perceptions of women. The law allows this to occur and it will continue to occur until mechanisms of empowerment are developed for women to use when confronted with harmful application of evidence-based guidelines.

Status quo needs to be challenged because some women are being left behind and their rights are being violated. An obstetric violence perspective is particularly helpful in this context because it disrupts medical privilege. It adopts a women's perspective by bringing into focus their experiences and this facilitates the inclusion of women's voices into spaces where they were silenced. It exposes harms that were once invisible or accepted as normal. Framing women's experiences as a form of violence against women ignites international human rights law obligations on states to 'take appropriate and effective measures to overcome all forms of gender-based violence'.[97]

The United Nations Committee on the Elimination of Discrimination against Women explains that appropriate and effective measures include legal measures such as penal sanctions, civil remedies and compensatory provisions to protect women against all kinds of violence.[98] These should be employed *together with* other measures adopted to protect and prevent violence, such as public information and education programmes to change harmful attitudes, and to offer counselling and other support services to women who have experienced violence.[99] Importantly, the Committee confirms that a state may be responsible for private acts of violence if it fails to act with due diligence to prevent and investigate violence against women.[100] The

[97] General Recommendation 19 of the United Nations Committee on the Elimination of Discrimination against Women para 24(a).

[98] ibid para 24(t)(i).

[99] ibid para 24(t)(ii)-(iii).

[100] ibid para 9.

Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence supports this position; it adopts a similar approach to state obligations in the context of violence against women.[101]

The above demonstrates that if evidence-based guidelines are to secure their spot as effective tools in the fight against abuse during pregnancy and childbirth, they will have to be subject to women's individual needs, as self-determined. The privileged position of medical knowledge should be used *for* women rather than *against* them. Further, international human rights law emphasises that violence against women needs to be tackled from multiple perspectives. This means two things: A health systems approach to abuse is not enough and women should have effective recourse in law. Consequently, when evidence-based guidelines leave some women behind and their integrity is violated as a result thereof, there must be a remedy in law available to them. The current position that courts have adopted towards evidence-based guidelines cannot be legitimately sustained.

Conclusion

Evidence-based guidelines play an important role in maternity care. They are promoted as being developed and implemented for the benefit of women, to overcome disrespect and abuse during pregnancy and childbirth. However, this chapter tells the story of women who are silenced, excluded from care, and experience violations to their psychological integrity because of the application of evidence-based guidelines and recommendations. Further, it showed that the law has little to offer by way of leverage over those making medical decisions that have such a negative impact on them. I argue that women's experiences are not mere accidents or unfortunate but acceptable outcomes of 'good medical practice' or evidenced-based care. This is obstetric violence and this form of violence is facilitated by evidence-based guidelines because the guidelines allow the application of medical knowledge in harmful ways and they are used to justify violence against women. I suspect the reason why some of the flaws of evidence-based guidelines cannot be fully appreciated is because those promoting them do not consider abuse as a form of violence or they have a restrictively narrow understanding of the

[101] See arts 5 and 7.

concept.[102] The recognition of these circumstances as a form of violence against women ignites important state obligations. A state must consider all possible avenues to prevent and protect women from violence. Violence can be prevented by supporting the use of evidence-based guidelines to facilitate meaningful informed decision-making rather than allowing healthcare providers to use them make decisions for women. Further, the state should think creatively of legal ways to accommodate women's diverse needs for care, particularly when healthcare providers attempt to override and silence them because evidence-based guidelines justify this approach.

[102] For instance, the World Heath Orgnization's researchers argue that 'violence' should be avoided because it is too narrow. They argue that 'violence' does not include unintentional harms or omissions. See Meghan A Bohren and others, 'The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review' (2015) 12(6) PLOS Med e10011847; J P Vogel and others, 'Promoting Respect and Preventing Mistreatment during Childbirth' (2016) 123 BJOG 671, 672.

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