Obstetric and gynecological violence: Empowering patients to recognize and prevent it

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In recent years, media and social networks have brought to light growing denunciations of obstetric and gynecological care that is considered violent, disrespectful, abusive or neglectful. These behaviors, words, acts and omissions are known as obstetric and gynecological violence (OGV).

Beyond the medical domain, OGV stems from gender-based violence as well as biases and stereotypes about women (biological or gendered) and mothers. More particularly, OGV can encompass the expression of medical racism and colonialism that places racialized and Indigenous individuals at greater risk to experience it.

Obstetric and gynecological violence

Canadian studies have identified several characteristics that help us define OGV:

- treatment conducted without the patient's free and informed consent,
- professional and organizational practices that deprive individuals of their reproductive autonomy, and
- the patient's subjective appreciation of her health-care experience.

Systemic factors are also central to the occurrence of OGV, combined with interpersonal factors between women and health-care professionals. In other words, it is not just about incompetent or ill-intentioned staff. It is also about common professional and organizational practices, like economic factors, professional cultures, and hierarchical and authority relationships between health-care providers and patients. Another factor is stereotypes, prejudices and gender biases about female reproduction that are still common.

The use of the term *violence* has been criticized, mainly because it suggests the behavior contains an intent to harm. Some also argue that the use of the term may be considered as a form of violence against health-care professionals.

Nevertheless, it is increasingly acknowledged that this term is necessary to name a reality that would otherwise be ignored due to the epistemic injustices that often impair women's experiences. Epistemic injustices mean that women's testimonies are disbelieved or belittled, and that their experiences of violence are seen as normal, ignored or dismissed out of hand.

From what we know, OGV happens quite often. A study conducted in the United States shows that 17.3 percent of women respondents reported obstetric mistreatment. A survey of women who gave birth in Australia reveals that 11.6 percent of 8,546 respondents experienced obstetric violence. They reported that it left them feeling dehumanized, violated and/or powerless. Examples included vaginal exams without consent and being coerced into interventions ranging from use of stirrups to labor induction and C-sections.

Gynecological violence is less documented in the current research, although some studies in France indicate that medical acts as commonplace as prescribing contraceptive pills may give rise to behaviors and statements that violate women's dignity, such as denial of suffering, blame, judgment, imposed treatment, withheld information, misinformation, coercive heteronormativity and medical paternalism.

We do not yet have sufficient quantitative Canadian data to accurately determine how often and in which circumstances OGV happens in Canada. However, in the coming years, ongoing large-scale studies will answer these questions with respect to the realities of women in Québec and across Canada.

Leveraging women's rights to improve health care

At the heart of many OGV situations is the absence of consent, or a consent given without having received the appropriate information. This underscores the importance of respecting women's rights throughout the entire health-care pathway. Consent to receive treatment falls under the basic rights of women to their autonomy, integrity and dignity.

Many rights can empower women to understand their prerogatives in reproductive health-care situations:

- the right to consent (and also the right to refuse or to change one's mind),
- to be informed of one's status and to participate in decisions that affect the treatment plan,
- to be accompanied,
- to ask for a second professional opinion,
- to choose one's health-care professional and institution, and
- to receive adequate care from scientific, human and social standpoints.

In Québec, these rights are mainly set out in the Charter of Human Rights and Freedoms, the Civil Code of Québec and the Act respecting health services and social services. Similar rights exist in all Canadian provinces and territories.

However, awareness of these rights is not sufficient to make them effective tools to prevent OGV. More is required: first, women must be able to express their rights and exercise them at the appropriate time.

Second, health-care providers must be aware of these rights and receptive to women's claims of them. Unfortunately, patients too often fear that expressing their rights, asking questions or voicing their

disagreement with medical professionals will harm the therapeutic relationship and result in poorer care and outcomes. Afraid of being labeled as "difficult" patients, they often decide to opt out, reluctantly, of the collaborative health-care decision-making process.

Furthermore, respect for women's rights should be included in all health-care guides, protocols and directives that directly affect their reproductive health. In practice, an unnuanced implementation of practice standards and guides could lead to OGV, as it does not always allow for an accurate appreciation of individual needs and preferences.

Beyond the scientific and clinical aspects that govern the decision made when drafting clinical guidelines and protocols, the essential consideration should be the perspectives and rights of the individuals concerned. Accordingly, women should participate in the process of adopting clinical guidelines to ensure the cultural, social and interpersonal factors that can affect their needs, values and preferences are taken into account.

Although it is unclear to what extent women are actually included in such decision-making processes in Canada, studies are underway to better understand the effective implementation of women's rights in obstetric and gynecological care.

Access to justice

Finally, when OGV occurs, measures for remediation and access to justice should enable victims to regain their confidence in the health-care system, and control over their reproductive autonomy. Accountability and liability mechanisms should provide opportunities for improving professional practices and systems for health-care professionals, managers and administrators.

In Canada, taking legal action against physicians or institutions for civil, ethical or criminal liability are possible avenues. However, this type of justice is difficult to access, and victims will find the path strewn with obstacles. These barriers include prohibitive costs for civil liability, and more generally, lengthy delays and the risk of revictimization during the judicial process.

It is therefore important that we study the existing justice mechanisms and improve them in order to correct the wrong done to the victims, define institutional and individual responsibilities, and bring about significant changes in health-care organization and delivery.

Ultimately, individuals who receive obstetric and gynecological care must be heard when they say that they have received inadequate, violent treatment. They have the right to participate in meaningful definitions of good-quality health care that respects their rights and choices.

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