Obstetric Violence as a Civil Battery: Exploring the Limitations of Tort Law in the Context of Unauthorised Vaginal Examinations

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OBSTETRIC VIOLENCE AS A CIVIL BATTERY: EXPLORING THE LIMITATIONS OF TORT LAW IN THE CONTEXT OF UNAUTHORISED VAGINAL EXAMINATIONS

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2022

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List of abbreviations

Journals

CLJ = Cambridge Law Journal

CLP = Current Legal Problems

JTL = Journal of Tort Law

KLJ = King's Law Journal

LQR = Law Quarterly Review

OJLS = Oxford Journal of Legal Studies

RHM = Reproductive Health Matters

SACQ = South African Crime Quarterly

Publishers

CUP = Cambridge University Press

HUP = Harvard University Press

MUP = Manchester University Press

NYUP = New York University Press

OUP = Oxford University Press

ACKNOWLEDGEMENTS

I would like to thank my supervisors, Dr Camilla Pickles and Dr Elizabeth Chloe Romanis, for their exceptional support and guidance throughout the course of this research project. I am immensely grateful for their expertise and insights, their time, their commitment to both my personal development as a researcher and the development of this work, and most of all, for their unwavering faith in me.

I would also like to thank Dr Andy Hayward and Dr Andrea Mulligan, for agreeing to examine this work.

Finally, I would like to thank my family and my partner for their unconditional emotional support - with a special thank you to my Uncle Paul.

Introduction

In recent years, the position of birthing women in the law has garnered considerable academic attention. Scholarly engagement with childbirth has led to the emergence of a rich literature across the social sciences, and has been facilitative in exposing that, in all stages of maternity care[1] and across a range of geopolitical contexts,[2] women and birthing people are being subjected to various forms of mistreatment and abuse. This phenomenon has been provided lexical recognition through the term 'obstetric violence',[3] a discursive and epistemic label communicating the perturbing nature of the phenomenon and implicating its gender-based and structural dimensions.[4]

Notably, obstetric violence encompasses a broad spectrum of abusive practices, all of which constitute severe human rights violations[5] warranting legal condemnation. Examples include verbal degradation, physical abuse, and the performance of interventions and practices, such as caesarean sections, episiotomies, and vaginal examinations, without consent.[6] This dissertation, however, will concentrate on one particular manifestation - unauthorised vaginal examinations (UVEs). Vaginal examinations are widely performed throughout childbirth as a clinically endorsed means of determining labour progression.[7] However, numerous studies indicate that these examinations are being performed without the requisite consent. In such instances, women have felt violated and dehumanised, producing emotional parallels with sexual violation and leading some women to conceptualise their experiences as 'birth rape'.[8] The comparison harshly illuminates the insidious nature of violence in the maternity care context as, despite the lived experience of many women and birthing people, it is only recently that such persons have been enabled to epistemically identify UVEs as obstetric violence. It is therefore essential that the law responds and empowers women and birthing people to seek justice against this gross human rights violation.[9]

This dissertation contributes to the growing legal literature on obstetric violence, deploying an intersectional feminist legal perspective to navigate mistreatment and abuse during childbirth as a gender and law issue.[10] Application of gender sensitive perspectives to the operation of law in the context of reproduction and reproductive harm has made transparent 'the dismissal of gender-

[1] Joanna Erdman, 'Commentary: Bioethics, Human Rights and Childbirth' (2015) 17 Health and Human Rights Journal.
[2] Rachelle Chadwick, 'Ambiguous Subjects: Obstetric Violence, Assemblage and South African Birth Narratives' (2017) 27(4) Feminism and Psychology 438.
[3] Camilla Pickles, 'Eliminating Abusive ''Care'': A Criminal Law Response to Obstetric Violence in South Africa' (2015) 546 SACQ 6.
[4] Michelle Sadler et al, 'Moving Beyond Disrespect and Abuse: Addressing the Structural Dimensions of Obstetric Violence' (2016) 24 RHM 47-50.
[5] World Health Organization, 'The Prevention and Elimination of Disrespect and Abuse During Facility-based Childbirth: WHO Statement' (Geneva, World Health Organization 2014) 1.
[6] Meghan Bohren et al, 'The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review' (2015) PLoS Medicine.
[7] National Institute for Health and Care Excellence (NICE), Intrapartum Care: Care of Healthy Women and Their Babies during Childbirth: Clinical Guideline 190 (London, NICE, 2014) at www.nice.org.uk/guidance/cg190 [1.4.5].
[8] Camilla Pickles, 'When Battery is not Enough: Exposing the Gaps in Unauthorised Vaginal Examinations During Labour as a Crime of Battery' in Camilla Pickles and Jonathon Herring (eds), *Women's Birthing Bodies and the Law: Unauthorised Intimate Examinations, Power and Vulnerability* (Hart 2020) 128.
[9] John Seymour, *Childbirth and the Law* (OUP 2000) 202.
[10] Sarah Murphy, 'Labour Pains in Feminist Jurisprudence: An Examination of Birthing Rights' (2010) 8(2) Ave Maria Law Review 468.

specific suffering… [and its consequent preclusion] from the scope of legal redress'.[11] Nevertheless in legal academia, childbirth specifically had remained widely underexamined[12] until recently. Multidisciplinary engagement across the social sciences has proven invaluable in sharpening our understanding of childbirth, generating new discourses to confront and supersede alternative 'discourses of law, medicine, science and technology which are embedded in a construction of pregnancy which comes from an outside, male standpoint'.[13] Given the complexity of childbirth as an inherently personal[14] yet simultaneously social event,[15] a women and birthing people centred lens is vital. Adopting this lens enables us to challenge masculine constructs of childbirth and birthing bodies, and symbiotically problematise gender stereotypes and gender oppressive norms which ground UVEs and other violent maternity care practices.[16] My research establishes a normative foundation for such a lens, providing a theoretical underpinning for future empirical studies.

Understanding the contours of this phenomenon and of the unique harms and wrongs suffered by women and birthing people is essential to ensuring optimal sensitivity and legal receptivity. The legal framework relied upon must possess the capacity to provide redress for individual women and birthing people subjected to UVEs.[17] Naturally, 'redress will mean different things to different people',[18] complicating the task of determining the most efficacious legal mechanism. Beyond an individual focus, however, it is also vital that the legal response furthers the wider objective of preventing obstetric violence. This mandates an interrogation of the role of existing legal avenues in executing this objective, and in facilitating the materialisation of rights entitlements during labour and childbirth.[19] Here, I explore use of the civil law. This is because other avenues of law, such as criminal and human rights law, have received greater consideration in the discourse so far.

This dissertation advances my undergraduate research on addressing UVEs using the tortious action of civil battery, 'the intentional application of force against another person, without that person's consent and without lawful excuse'.[20] However, here I provide a richer understanding of the various dimensions of obstetric violence. I also explore the theory of tort law in greater depth, with especial emphasis on the critiques found within feminist jurisprudence. Further issues with battery as a litigatory device are explored, as are critiques surrounding the operation of consent in law which were constrained in my previous work. This dissertation thus critically engages with the benefits and

[11] Robin West, 'The Difference in Women's Hedonic Lives: A Phenomenological Critique of Feminist Legal Theory' in Martha Fineman and Nancy Thomadsen (eds), *At the Boundaries of Law: Feminism and Legal Theory* (Routledge 2013) 116.
[12] Jamie Abrams, 'Distorted and Diminished Tort Claims for Women' (2013) 34(5) Cardozo Law Review 1958.
[13] Alison Diduck, 'Legislating Ideologies of Motherhood' (1993) 2(4) Social and Legal Studies 471.
[14] Sarah Cohen Shabot, 'We Birth with Others: Towards a Beauvoirian Understanding of Obstetric Violence' (2021) 28(2) European Journal of Women's Studies 9.
[15] Elizabeth Kukura, 'Contested Care: The Limitations of Evidence-Based Maternity Care Reform' (2016) 31 Berkeley Journal of Gender Law and Justice 244.
[16] Debra DeBruin and Mary Faith, 'Coercive Interventions in Pregnancy: Law and Ethics' (2021) 23(2) Journal of Health Care Law and Policy 192.
[17] Andrea Mulligan, 'Redressing Unauthorised Vaginal Examinations Through Litigation' in Camilla Pickles and Jonathon Herring (eds), *Women's Birthing Bodies and the Law* (Hart 2020) 172.
[18] Ibid.
[19] Camilla Pickles, 'Reflections on Obstetric Violence and the Law: What Remains to be Done for Women's Rights in Childbirth?' (8th March 2017) < https://www.law.ox.ac.uk/research-and-subject-groups/international-womens-day/blog/2017/03/reflections-obstetric-violence-and > accessed 8th February 2022.
[20] *Collins v Wilcock* [1984] 1 WLR 1172.

limitations of applying tortious battery to this manifestation of obstetric violence, and determines the extent to which the action could address the wrongs and harms of UVEs.

Why Battery?

Notably, both the torts of negligence and battery have been identified as potential avenues for redressing UVEs under civil law.[21] However, I examine the tort of battery because it constitutes the more appropriate action in this context. In contrast to the tort of negligence, battery can be established with greater ease since there is no requirement for claimants to establish that a duty of care existed, for tangible injury to result, and the question of causation is irrelevant.[22] Battery can also be assumed preferrable to negligence in this context for reasons beyond the relative ease of the claim.

First and foremost, the negligence framework is orientated around the reasonable person, a standard amenable to the 'good mother'[23] archetype. The mirroring of the reasonable person with ideals of normative motherhood was evident in *Montgomery v Lancashire Health Board*.[24] Although the case has been commended as progressive for its recognition of the doctrine of informed consent,[25] the judiciary relied upon assumptions surrounding the 'risks which any reasonable mother would wish to take into account'.[26] This statement arguably indicates judicial fallibility to representative heuristics, encouraging reliance on gender, racial, and other stereotypes, and potentially shaping assumptions about what a reasonable woman, or as here, what a 'reasonable mother' would do or know, based off the 'extrapolation of judicial experiences of ''women''.[27] Invocation to reasonable motherhood therefore reinforces expectations surrounding maternal behaviour – specifically, maternal self-sacrifice. This obscures the harms and wrongs victim-survivors may have suffered and extends the medical control exerted over women's and birthing people's behaviour beyond the event of childbirth. Battery, on the other hand, has the capacity to avoid these tropes because it does not require the judiciary to adjudge their behaviour according to a standard of reasonableness, one clearly influenced by normative, societal constructions of reasonable motherhood.

Additionally, negligence has been heavily criticised as androcentric by feminist tort scholars.[28] Consequently, negligence could be considered inherently prejudicial against women and people of minority genders. Finally, the conceptual core of the tort of negligence is damage, which may be problematic in the context of UVEs since women and birthing people may not feel they have suffered a loss as a result of the practice.[29] This is recognised by Mulligan, who accordingly views

[21] See for examples, Mulligan (n 17) and Pickles, 'When Battery is Not Enough' (n 8).
[22] Susan Bewley, 'The Law, Medical Students, and Assault' (1992) 304 British Medical Journal 1551.
[23] Maria Borges, 'A Violent Birth: Reframing Coerced Procedures During Childbirth as Obstetric Violence' (2018) Duke Law Journal 857. I discuss this archetype further in Chapter 1.
[24] [2015] UKSC 11.
[25] Emma Cave, 'Selecting Treatment Options and Choosing Between Them: Delineating Patient and Professional Autonomy in Shared Decision-Making' (2020) 28 Health Care Analysis 4.
[26] [2015] UKSC 11 [113]. Notably, judicial comments also contained implicit assumptions surrounding birthing behaviour, such as the idealisation of vaginal delivery - see Lady Hale at [114]; 'if she is prepared to *forgo the joys of natural childbirth'.*
[27] Kylie Burns, ''In this Day and Age'': Social Facts, Common Sense and Cognition in Tort Law Judging in the United Kingdom' (2018) 45(2) Journal of Law and Society 246.
[28] Leslie Bender, 'A Lawyer's Primer on Feminist Theory and Tort' (1988) 38 Journal of Legal Education 37.
[29] Mulligan (n 17) 176.

that 'the vindicatory charge of battery is instinctively more appropriate and attractive than loss-focused negligence'[30] for redressing UVEs. Since the focus in negligence is on physical or psychological damage as the measurable loss, negligence does not accommodate for the full range of harms of UVEs which may be more intimate, complex, and personally affective. By contrast, battery is committed to protecting bodily inviolability with or without consequential loss having resulted.[31] It is also arguable that uncritically, a hyperfocus on 'loss' and 'damage' may be an inappropriate way of conceptualising the harm that occurs when a woman or birthing person is subjected to a bodily violation, such as UVEs. For example, in the context of sexual assault, High cautions against the harmful consequences of mediating the experience of sexual violation as the 'shattering' or 'destroying' of dignity,[32] since it implies that a victim-survivors' status as a dignity-bearer is indelibly lost.[33]

For these reasons, civil battery can be deemed more appropriate than the negligence action for addressing UVEs.[34] Presently, however, in England and Wales neither tort has been used by a claimant to seek redress following an UVE.[35] Furthermore, it has been noted that the judiciary 'strive to avoid subjecting [healthcare professionals] to liability under battery',[36] with negligence being the preferred vehicle for holding healthcare professionals to account for clinical misconduct. In light of the various difficulties associated with negligence claims, this could reasonably be perceived as an expedient tactic for the protection of the medical profession.[37] Nevertheless, support for reliance on battery can be drawn from the fact one of the earliest recorded actions in battery addressed an UVE performed upon a woman.[38] Further still, battery has been used in the reproductive context against other unauthorised bodily violations.[39] Consequently, battery is the most viable avenue for redressing UVEs under tort law, and this dissertation examines its potential in the obstetric violence context.

Dissertation Structure

Part 1 provides a comprehensive understanding of obstetric violence as a form of gender-based and structural violence intersecting across multiple axes of disadvantage. Current understandings and definitions of obstetric violence are elucidated, explicating the difficulties that have arisen in the process of identifying, naming, and conceptualising this form of violence. The semantic connotations of this label are explored, as well as its epistemic and discursive value, to endorse use of obstetric violence terminology within socio-legal discourse. The discussion then explores the gender-based and structural dimensions of obstetric violence. UVEs are located as a violent practice, highlighting

[30] Ibid 180.
[31] Ibid 179.
[32] Anna High, 'Sexual Dignity and Rape Law' (2022) 33(2) Yale Journal of Law and Feminism 24.
[33] Ibid 30.
[34] For further, general critiques surrounding use of the tort of negligence in the obstetric violence context, see Farah Diaz-Tello, 'Invisible Wounds: Obstetric Violence in the United States' (2016) RHM.
[35] Charles Foster, 'How Should the Performance of Periparturient Vaginal Examinations be Regulated?' in Camilla Pickles and Jonathon Herring (eds), *Women's Birthing Bodies and the Law* (Hart 2020) 98.
[36] Margaret Brazier and Emma Cave, *Medicine, Patients and the Law* (6th edn, MUP 2016) 126.
[37] See Izhak Englard, *The Philosophy of Tort Law* (Dartmouth 1993) at 162, who notes the shift towards negligence was purposed 'to restrict the scope of medical liability'.
[38] Gwen Seabourne, 'The Role of the Tort of Battery in Medical Law' (1995) 24(3) Anglo-American Law Review 728. See also *Latter v Braddell* [1881] 50 LJ QB.
[39] *Cull v Royal Surrey County Hospital* [1932] 1 BMJ 1195; the case concerned the performance of an unauthorised hysterectomy.

the deeply harmful consequences of these examinations.[40] Contextualisation as to why UVEs constitute obstetric violence will make clear the need for legal recourse, providing a conceptual thread throughout this dissertation for determining the limitations of tortious battery and the wider tort framework against the wrongs inherent in this violation.

Part 2 undertakes a theoretical and practical evaluation of tort law as a potential framework through which to address obstetric violence. A preliminary discussion of alternative avenues available, namely, human rights instruments, the criminal law, and implementation of discrete frameworks, will provide a general premise for contrast with the tort framework to illustrate why they could be deemed, comparatively, less suitable. The multifarious objectives of tort are examined to determine the utility of the tort system and the civil suit for women and birthing people subjected to UVEs. In particular, the cathartic value of the civil suit, effectuated through objectives such as vindication, compensation, accountability, and deterrence, is substantiated. However, I illustrate that the realisation of these objectives in practice remains largely equivocal. Additionally, critiques raised by feminist scholars to lament the inaptitude of tort in the context of gendered experiences and gender-based harms are considered. Nevertheless, the discussion concludes that tort law is an available, albeit imperfect, avenue for redress.

Part 3 focalises use of civil battery, assessing both the theoretical and practical implications of its application to UVEs. An examination of the requisites of battery is undertaken. The contact mandate and the torts approach to intention are scrutinised, highlighting the practical benefits of the respective approaches but also problematising how the battery action abstracts UVEs from context. Additionally, the actionable per se liability status of battery is discussed, noting its especial virtue in the context of UVEs. However, again, consideration of the benefits of per se liability status is accompanied by an acknowledgement of its hindrances. Finally, it is noted that the presence of legally valid consent to the contact will preclude a successful action in battery. Given the contingency of consent and its role in delineating the boundary between legal medical intervention and battery, the final chapter is dedicated to its operation.

Thus, part 4 explores the issues presented by the legal requirements of consent. The discussion first highlights the disjuncture between consent standards as stated in clinical guidelines and actual approaches to consent in the maternity care context. It then proceeds to interrogate the requirements of legally valid consent in the context of vaginal examination, lamenting the flaws in its legal construction. Having identified its flaws however, and subsequent implications for bringing an action in civil battery, I challenge the emphasis on 'informed consent' as a means through which to prevent obstetric violence. I also question more broadly the extent to which legal reform of consent standards will protect women and birthing people from UVEs and other manifestations of obstetric violence.

Ultimately, this dissertation renders transparent the deficiencies of applying the tort of battery in the context of UVEs during labour and childbirth. The precipitates of obstetric violence are deeply rooted, and whilst an action in battery may provide redress for, and meet the justice needs of, some women and birthing people, the action does not sufficiently address the wrongs of UVEs. Nor does it adequately address this violation as a form of gender-based and structural violence, failing to secure its prevention. Although obstetric violence is not ineradicable, current legal frameworks are not equipped to work towards this wider objective. The need for unique legal provisions will become increasingly apparent as this dissertation progresses. The law must demonstrate responsivity to

[40] Camilla Pickles and Jonathon Herring (eds), 'Introduction', *Women's Birthing Bodies and the Law* (Hart 2020) 3.

obstetric violence in a manner that speaks to the lived experiences of women and birthing people, and must account for the structural and gender-based dimensions which underly UVEs. The capacity of tortious battery to achieve this is undoubtedly bounded.

A Note on Terminology

Women and 'Birthing People': Gender Beyond the Binary

As noted by Otto, feminists and international bodies have widely adopted the language of gender and gender-based violence ('GBV') as a synonym for women and violence against women, obfuscating the emancipatory potential of gender analyses[41] and perpetuating the exclusionary consequences of cis women centring.[42] Throughout this dissertation however, in grounding obstetric violence as a subset of GBV, I embrace gender as a social category in refutation of biological essentialism.[43] I emphasise the importance of conceptualising gender beyond the binary frame[44] so that the exclusionary conflation of violence against women and GBV is disabled from performing an erasure[45] of transmasculine and genderqueer people from social and legal spaces. Thus, whilst this dissertation focuses on women's experiences primarily, given the majority of birthing persons do identify as women, it aims to carry a feminist brief 'for everyone who experiences gender-based violence [in the maternity care context], including those who do not identify as, or are not perceived to be, women'.[46] Necessarily then, I refer to birthing people throughout my analysis, acknowledging that like women, they too are vulnerable to obstetric violence. I also highlight that, considering the gendered dimensions of UVE, the practice constitutes an assault on birthing persons on a secondary level through the misgendering of such individuals.

Violence in the 'Maternity Care Context'

Throughout this dissertation, I frequently and interchangeably refer to the phenomenon as obstetric violence, as well as violence in the 'maternity care context'. This is to clarify that obstetric violence is not limited to obstetrical care only, but pervades wider care structures, such as midwifery and antenatal care.[47]

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[41] Diane Otto, 'International Human Rights Law: Towards Rethinking Sex/Gender Dualism' in Margaret Davies and Vanessa Munro (eds), *The Ashgate Research Companion to Feminist Legal Theory* (Ashgate Publishing 2016) 240.
[42] Rachelle Chadwick and Jabullile Mavusco, 'On Reproductive Violence: Framing Notes' (2021) 35(4) Agenda 4.
[43] Otto (n 41) 242.
[44] Sarah Brubaker, 'Embracing and Expanding Feminist Theory: (Re)conceptualizing Gender and Power' (2021) 27(5) Violence Against Women 724.
[45] Karen Boyle, 'What's in a Name? Theorising the Inter-relationships of Gender and Violence' (2019) Feminist Theory 32.
[46] Otto (n 41) 245.
[47] For elaboration, see contributions in Angela Castañeda, Nicole Hill and Julie Johnson Searcy (eds), *Obstetric Violence: Realities, and Resistance from Around the World* (Demeter Press 2022).

Chapter 1: Understanding Obstetric Violence

1.1 Recognition of Obstetric Violence – Adopting an Obstetric Violence Perspective

Women and Birthing Peoples Lived Experiences

Feminist activism and social science research has exposed a disturbing pattern of mistreatment and abuse manifesting in all stages of maternity care[48] and across a range of geopolitical contexts.[49] A systematic review conducted by Bohren et al revealed that women are being subjected to various forms of abuse, are being denied the right to make choices relating to their maternity care, and are being forced to undergo invasive procedures.[50] The findings were organised into seven primary typologies: namely, sexual abuse; verbal abuse; physical abuse; stigma and discrimination; failure to meet professional standards of care; poor rapport between women and health care providers; and health system conditions and constraints.[51] These findings have been substantiated by an evolving body of research measuring abuse and mistreatment during childbirth.[52] Through activist engagement with women, lived experiences have been foregrounded, with accounts confirming women and birthing people are being 'dehumanised, humiliated, subject to unnecessary interventions, shouted at, and turned into passive objects',[53] resulting in profound harm and 'birth trauma'.[54] Revealingly, some women have described their birthing experiences as akin to torture.[55] Birthing experiences have also been assimilated to sexual assault and 'birth rape',[56] capturing the extent to which 'women feel their bodies are invaded [and] violated'.[57] Generally, healthcare professional-patient interactions in which women are denied control are implicit in negative, violent and degrading birth experiences,[58] and the understanding emerging from these accounts is that 'childbirth… is all too often an experience of other people taking control of a woman's body'.[59]

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[48] Erdman (n 1) 17.
[49] Chadwick, 'Ambiguous Subjects' (n 2) 489.
[50] Bohren et al (n 6).
[51] Ibid.
[52] See for example, Megan Bohren et al, 'How Women are Treated During Facility-based Childbirth in Four Countries: A Cross-sectional Study with Labour Observations and Community-based Surveys' (2019) 394(10210) The Lancet; Rachel Reed et al, 'Women's Descriptions of Childbirth Trauma Relating to Care Provider Actions and Interactions' (2017) 17(1) BMC Pregnancy Childbirth; Saraswathi Vedam et al, 'The Giving Voice to Mothers Study: Inequity and Mistreatment During Pregnancy and Childbirth in the United States' (2019) 16(77) Reproductive Health.
[53] Sara Cohen Shabot, 'Amigas, Sisters, we're Being Gaslighted: Obstetric Violence and Epistemic Injustice' in Camilla Pickles and Jonathon Herring (eds), *Childbirth, Vulnerability and Law: Exploring Issues of Violence and Control* (Routledge 2019) 20.
[54] Reed et al (n 52) 21.
[55] Gill Thomson and Soo Downe, 'Widening the Trauma Discourse: The Link Between Childbirth and Experiences of Abuse' (2008) 29(4) Journal of Psychosomatic Obstetrics and Gynaecology.
[56] Pickles 'When 'Battery' is not Enough' (n 8) 128.
[57] Sara Cohen Shabot, 'We Birth with Others' (n 14) 5.
[58] Borges (n 23) 851.
[59] Camilla Pickles and Jonathon Herring (eds), 'Introduction' *Childbirth, Vulnerability and Law* (Routledge 2019) 9.

Whilst there is no data establishing its global prevalence, the research indicates that mistreatment and abuse during childbirth is a widespread and surreptitious phenomenon, which cannot be reduced to isolated incidents of clinical malpractice or mere misconduct by rogue healthcare professionals.[60] We are facing obstetric violence.

Validating Women's Experiences: Recognition of Obstetric Violence

Formal recognition and conceptualisation of obstetric violence first began in Latin America. Activist movements against the medicalisation and pathologisation of childbirth[61] generated widespread scrutiny,[62] and problematised violence associated with medicalisation in facility-based maternity care.[63] As a result of concerted efforts, obstetric violence was legislated against for the first time in Venezuela in 2007, as one of 19 forms of violence against women prohibited by the Organic Law on the Right of Women to a Life Free of Violence.[64] Countries such as Bolivia, Brazil, Argentina, Uruguay, Panama and Mexico have since implemented similar laws,[65] adopting obstetric violence as a legal term and creating discrete frameworks with both criminal and civil law remedies.[66]

Obstetric violence has also been recognised on the international level, with the UN Special Rapporteur on Violence Against Women producing a thematic report, drawing upon the international evidence, condemning obstetric violence and its various manifestations.[67] The report 'authoritatively links routine facility-based practices and interventions to current constructions of violence'[68] and stresses the need for states to respond to this gross violation of women's human rights accordingly.[69] Additionally, whilst failing to refer to the issue as obstetric violence, the World Health Organization (WHO) also recently released a statement demanding greater state action against this human rights issue.[70] The importance of these developments in vindicating lived experiences of violence during childbirth cannot be understated, and adoption of obstetric violence

[60] Pickles, 'When 'Battery' is not Enough' (n 8) 131.
[61] Lydia Dixon, 'Obstetrics in a Time of Violence: Mexican Midwives Critique Routine Hospital Practices' (2015) 29(4) Medical Anthropology Quarterly 442.
[62] Caitlin Williams et al, 'Obstetric Violence: A Latin American Legal Response to Mistreatment During Childbirth' (2018) 125(7) International Journal of Obstetrics and Gynaecology 1209.
[63] However, see Violette Perrotte et al, '"At Least Your Baby Is Healthy" Obstetric Violence or Disrespect and Abuse in Childbirth Occurrence Worldwide: A Literature Review' (2020) 10(11) Journal of Obstetrics and Gynaecology, noting that violence in obstetrics can be linked to both hyper and under medicalisation.
[64] Organic Law on the Right of Women to a Life Free of Violence 2007, Article 51.
[65] Patrizia Quattrocchi, 'Obstetric Violence Observatory: Contributions of Argentina to the International Debate' (2019) 38(8) Medical Anthropology 764.
[66] Borges (n 23) 830.
[67] United Nations General Assembly, 'Report of the Special Rapporteur on Violence Against Women, its Causes and Consequences on a Human Rights-Based Approach to Mistreatment and Violence Against Women in Reproductive Health Services with a Focus on Childbirth and Obstetric Violence', UN Doc A/74/137 (2019).
[68] Pickles and Herring (eds), 'Introduction' *Women's Birthing Bodies and the Law* (n 40).
[69] United Nations General Assembly (n 67) [75].
[70] World Health Organization, The Prevention and Elimination of Disrespect and Abuse During Facility-based Childbirth: WHO Statement (Geneva, World Health Organization, 2014).

framing is pivotal in 'allow[ing] a conceptual and ideological shift from conceiving these occurrences as accidental and random situations to seeing them as a structural condition'.[71]

Legal developments in the Global South, and condemnation of obstetric violence on the international level, represent powerful developments for illuminating the issue of violence during childbirth and for promoting (if not necessitating) wider global responsivity. The recent obstetric violence cases of *SFM v Spain*[72] (*SFM*) and *NAE v Spain*[73] illustrate such responsivity, and demonstrate the role of the Committee on the Elimination of Discrimination Against Women ('CEDAW') in addressing obstetric violence. For states committed to protecting women and birthing people's human rights then, redress and prevention of obstetric violence is obligatory.

1.2 Defining Obstetric Violence

Despite increasing recognition and academic engagement with obstetric violence, a lack of conceptual cohesion and understanding persists.[74] Unsurprisingly therefore, no uniform definition of obstetric violence has been formulated in law, the international arena, or global public health discourses.[75] For some academics, this presents a significant barrier to addressing the phenomenon,[76] as ambiguity complicates endeavours to identify a robust legal response.[77] However, whilst there is 'no consensus on what practices constitute obstetric violence',[78] there is a general understanding it encompasses both explicit and subtle forms of abuse[79] and importantly, that it can be committed through acts as well as omissions - since both can result in a violation of personal integrity.[80] Furthermore, as cautioned by Miltenburg et al, 'the search for universal definitions…[and] clear typologies…can result in misleading and narrow dichotomies',[81] obscuring divergence in experiences of violence and omitting others altogether. Given the 'specific forms [this] violence may take differ depending on the situation, local cultures and politics, racist inequalities

[71] Paola Sesia 'Naming, Framing and Shaming through Obstetric Violence: A Critical Approach to the Judicialisation of Maternal Health Rights Violations in Mexico' in Jennie Gamlin, Sahra Gibbon, Paola Sesia and Lina Berrio (eds), *Critical Medical Anthropology: Perspectives in and from Latin America* (UCL Press 2020) 236.
[72] Committee on the Elimination of Discrimination Against Women, 'Decision Adopted by the Committee under Article 4(2)(c) of the Optional Protocol, Concerning Communication No.138/2018' UN Doc CEDAW/C/75/D/138 [7.5].
[73] Committee on the Elimination of Discrimination Against Women, 'Views adopted by the Committee under Article 7 (3) of the Optional Protocol, Concerning Communication No. 149/2019' UN Doc CEDAW/C/82/D/149/2019.
[74] Elizabeth Kukura, 'Obstetric Violence' (2018) 106(3) Georgetown Law Journal 726.
[75] Laura Zazzaron, 'Obstetric Violence as Violence Against Women: A Focus on South America' (Thesis, Università Ca' Foscari Venezia 2017) 120.
[76] JP Vogel et al, 'Promoting Respect and Preventing Mistreatment During Childbirth' (2016) 123(5) International Journal of Obstetrics and Gynaecology 672.
[77] Maura Lappeman and Leslie Swartz, 'How Gentle Must Violence Against Women Be in Order to Not Be Violent? Rethinking the Word "Violence" in Obstetric Settings' (2021) 27(8) Violence Against Women 988.
[78] Borges (n 23) 834.
[79] Silvia Sánchez, 'Obstetric Violence: Medicalization, Authority Abuse and Sexism within Spanish Obstetric Assistance. A New Name for Old Issues?' (Master's thesis, Utrecht University 2014) 45.
[80] Camilla Pickles, 'Leaving Women Behind: The Application of Evidence-based Guidelines, Law, and Obstetric Violence by Omission' in Camilla Pickles and Jonathon Herring (eds), *Childbirth, Vulnerability and Law* (Routledge 2019) 154.
[81] Andrea Miltenburg et al, 'Maternity care and Human Rights: What do Women Think?' (2016) 16(17) BMC International Health and Human Rights 102.

and other stratified strands of discrimination',[82] conceptual malleability in our understanding of obstetric violence is to be preferred over an intractable universal definition. As such, the 'polysemic, imprecise and even ambiguous'[83] quality of the concept should be considered a strength.[84] Notwithstanding the lack of universal definition however, obstetric violence is formally defined in Venezuelan legalisation as:

''the appropriation of women's body and reproductive processes by health personnel, which is expressed by a dehumanizing treatment, an abuse of medicalisation and pathologisation of natural processes, resulting in a loss of autonomy and ability to decide freely about their bodies and sexuality, negatively impacting their quality of life."[85]

This definition indicates that obstetric violence encompasses a broad spectrum of abuse and mistreatment suffered by women and birthing people during childbirth.[86] It also locates obstetric violence as a form of GBV producing gender-based harms, and signals the violation of human rights fundamentals entailed by appropriation of the birthing body. Articulating obstetric violence as a subset of GBV also implicates its structural dimension, allowing us to 'frame the discussion of abuse and disrespect within the broader field of structural inequalities and violence against women'[87] and minority genders. Whilst this definition is not without its limitations,[88] it provides an appropriate foundation upon which a greater understanding can be developed.

1.3 'Obstetric Violence': Endorsing the Label

Across the literature obstetric violence has been conceptualised variously,[89] with placatory descriptors – referred to here as the 'softer terminologies'- [90] of 'abuse and mistreatment',[91]

[82] Rachelle Chadwick, 'Breaking the Frame: Obstetric Violence and Epistemic Rupture' (2021) Agenda 3.
[83] Paola Sesia, 'Obstetric Violence in Mexico: The Disputed Consolidation of a New Paradigm' in Patrizia Quattrocchi and Natalia Magnone (eds), *Obstetric Violence in Latin America: Conceptualisation, Experiences, Measurement and Strategies* (Buenos Aires, National University of Lanús 2020) 28.
[84] Jonathon Herring, 'Identifying the Wrong in Obstetric Violence: Lessons from Domestic Abuse' in Camilla Pickles and Jonathon Herring (eds), *Childbirth, Vulnerability and Law* (Routledge 2019) 69.
[85] Rogelio Pérez DiGregorio, 'Obstetric Violence: A New Legal Term Introduced in Venezuela' (2010) 111 International Journal of Gynaecology and Obstetrics 201.
[86] Although, see Pickles, 'Leaving Women Behind' (n 80) 152, noting that Article 51 limits the scope of this definition to primarily focus on violence stemming from the pathologisation of childbirth.
[87] Sadler et al (n 4) 50.
[88] See ibid at 52, noting that the definition does not sufficiently articulate that 'this phenomenon is inherent to the structural dimensions of maternity care provision'; Quattrocchi 'Obstetric Violence Observatory' (n 65) at 771, lamenting that 'the legal definition does not allow us to understand and explain the historical, social, political, and economic roots that produce and legitimise this kind of violence', and Chadwick, 'Ambiguous Subjects' (n 2) at 491, noting the definition problematically 'positions women and birthing people as victims', and 'assumes that obstetric violence is limited to clear acts of abuse, dehumanization and appropriation by identifiable perpetrators'.
[89] Surbhi Shrivastava, 'Evidence of Obstetric Violence in India: An Integrative Review' (2020) 52(4) Journal of Biosocial Science 611.
[90] Chadwick, 'Breaking the Frame' (n 82) 106.
[91] Bohren et al (n 6).

'obstetric aggression',[92] 'disrespect and abuse',[93] and 'dehumanised care',[94] amongst other terms, being used variably and at times interchangeably. Here, however, 'obstetric violence' is adopted in recognition of its lexical vitality, and in light of the numerous issues with softer terminologies which I identify below.

'An Unfair Distortion'?

The term obstetric violence possesses 'a disruptive and radical edge'[95] which has provoked considerable semiotic discussion.[96] In particular, the label has been refuted by members of the medical community, who consider the identification of coercive, autonomy dispensing obstetric interventions and practices as violence 'unfairly distortive'.[97] Correspondingly, discomfort with the label has been exacerbated by stigmatisation concerns - arising due to use of the term 'violence'. According to Lappeman and Swartz, 'violence' could be perceived as suggesting patients are victims of intentionally inflicted harm,[98] though in reality, 'mistreatment may stem from both intentional and unintentional actions of healthcare providers'.[99] Whilst the authors subsequent argument against use of obstetric violence terminology rests upon a superfluous nuance (since 'regardless of the individuals' intent, the outcome or the impact is still what it is—violence')[100] it could nevertheless support concerns that political collaboration with the medical profession may be compromised by the use of a 'radical' term.[101] However, whilst appreciating these concerns, the narratives minimise the gravity of mistreatment and abuse suffered by women and birthing people throughout childbirth.[102] The semantic discourse is abstracted with concern over the term's implications for the medical community, subordinating empathic concern for women and birthing people subjected to violence, and disregarding that the lexicon through which women describe their experiences[103] renders the label entirely appropriate. Furthermore, and as I elucidate in section

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[92] Anna Ozhiganova, 'Authoritative Knowledge of Childbirth and Obstetrics: Analysis of Discursive Practices of Russian Perinatal Specialist' (2020) 4(4) Population and Economics 89.
[93] Diana Bowser and Kathleen Hill, 'Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth: Report of a Landscape Analysis' (USAID-TRAction Project and Harvard School of Public Health University Research, 20th September 2010) < https://cdn2.sph.harvard.edu/wp-content/uploads/sites/32/2014/05/Exploring-Evidence-RMC_Bowser_rep_2010.pdf > accessed 13th November 2021.
[94] C Misago et al, 'Culture of Dehumanisation of Childbirth' to 'Childbirth as a Transformative Experience': Changes in Five Municipalities in North-east Brazil' (2001) 75(1) International Journal of Gynaecology and Obstetrics.
[95] Chadwick, 'Ambiguous Subjects' (n 2) 491.
[96] José Belizán et al, 'Every Woman in the World Must Have Respectful Care During Childbirth: Reflections' (2020) 17 Reproductive Health 2.
[97] Giovanni Scambia et al, ''Obstetric violence": Between Misunderstanding and Mystification' (2018) 228 European Journal of Obstetrics and Gynaecology and Reproductive Biology 332.
[98] Lappeman and Swartz (n 77) 996.
[99] Virginia Savage and Arachu Castro, 'Measuring Mistreatment of Women During Childbirth: A Review of Terminology and Methodological Approaches' (2017) Reproductive Health 5.
[100] Camilla Burnett, 'Commentary on the Article "How Gentle Must Violence Against Women Be in Order to Not Be Violent? Rethinking the Word 'Violence' in Obstetric Settings," Reframed Within a Critical Discourse Orientation' (2021) 27(8) Violence Against Women 1005.
[101] 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(2) Third World Quarterly 387.
[102] Rachel Chadwick, 'The Dangers of Minimising Obstetric Violence' (2021) Violence Against Women 1.
[103] See studies by Rachel Reed et al (n 52) at 7, where women described feeling 'mutilated', 'damaged' and 'violated'.

1.3.1, rejection of the term may be due to a misconceived understanding of violence.[104] Reconceptualising violence can ameliorate stigmatisation concerns whilst countervailing the eclipsing of GBV from recognition.

The Decontextualising and Reductive Impact of Softer Terminologies

Unlike the language of obstetric violence which has been criticised for stigmatising healthcare providers,[105] softer terminologies supposedly generate less reproval and indicate conceptual distinctions 'between egregious cases of bodily violation and less extreme – though still harmful, ways coercion and disrespect seep into clinical relationships'.[106] There are, however, considerable drawbacks to using softer terminologies.

One major problem with the softer terminologies is their decontextualising and reductive impact. Sesia problematises the language of 'dehumanised care' as bifurcating the interconnected issue of healthcare provider-patient violence from the inherent, systemic issues manifesting in modern obstetrics.[107] She notes that this division permits the misconception and 'reduction of the latter to a technical quality issue',[108] failing to question the underlying genealogy and ideology informing interventionist and coercive practices, and obscuring the patriarchal genesis of bodily appropriation.[109] Conversely, 'obstetric violence' has a contextualising quality in its explicit focalisation of violence against women and birthing people in the maternity care context.[110] Whilst terms such as mistreatment and abuse therefore penetrate the problem at the micro-level, obstetric violence addresses the systemic dimensions of this violence within the multifarious ways mistreatment and abuse transpire.[111] Additionally, since 'naming practices make more or less visible who is doing what to whom, and foreground differing sets of connections',[112] the pairing of 'obstetric' and 'violence' is valuable for making transparent not only the institutionalisation of violence in obstetrics, but also for locating this violence within the wider panorama of GBV.[113] The pairing of the terms, as with the terms 'sexual violence' and 'domestic violence', delineates the violence continuum.

Another issue is that softer terminologies imply hierarchies of harm and severity. The term 'abuse' is often used to encompass non-physical acts as discrete from physical acts of violence, 'reinforcing fixed ideas about violence and the ambiguity of abuse',[114] and dichotomising experiences to indicate their differential severity. For some, this may be valuable for reflecting the gravity of healthcare professional conduct and to minimise stigmatisation.[115] However, the harmful consequences of organising some experiences as more serious than others should be given primary consideration

[104] Quatrocchi, 'Obstetric Violence Observatory' (n 65) 770.
[105] Kukura, 'Obstetric Violence' (n 74) 765.
[106] Ibid.
[107] Sesia 'Obstetric Violence in Mexico' (n 83) 37.
[108] Ibid.
[109] Ibid.
[110] Pickles, 'Leaving Women Behind' (n 80) 152.
[111] Savage and Castro (n 99) 6.
[112] Boyle (n 45) 21.
[113] Rachel Jewkes and Loveday Penn-Kekana, 'Mistreatment of Women in Childbirth: Time for Action on this Important Dimension of Violence against Women' (2015) 12(6) PLOS Medicine 1.
[114] Heather Fraser and Kate Seymour, *Understanding Violence and Abuse: An Anti-oppressive Practice Perspective* (Fernwood Press 2017) 21.
[115] Kukura, 'Obstetric Violence' (n 74) 765.

when making terminological decisions. These consequences include trivialisation and invalidation of some experiences, and reinforcement of exclusionary, masculine understandings of violence. Further, hierarchisations may be especially harmful for particular sociodemographic groups. According to research conducted by Vedam et al, compared to white women, racialised women were more likely to report having been shouted at and scolded during childbirth,[116] which as indicated above, would fall under the 'less serious' category of abuse. They were also more likely to report having been ignored and having their requests for help refused[117] - ultimately omissions, precluded from masculine conceptions of violence altogether. These findings indicate that erroneous racial stereotypes and beliefs cultured by early obstetric and gynaecological medicine, such as 'the myth black women were impervious to pain',[118] continue to systemically influence healthcare responsivity to racialised women's voices and needs during childbirth. Damningly, a recent Birthrights inquiry into racial injustice in UK maternity care corroborates the presence of these erroneous myths and their repercussive racial biases, with many racialised women reporting that they felt their voices went unheard, and that their pain was dismissed or minimised.[119] Thus, hierarchisations may indirectly privilege and provide stronger conceptual condemnation to harms less likely to be experienced by marginalised groups of women.

Notably, even if the hierarchisations implied by softer terminologies were not harmful, efforts to create distinctions are ultimately unnecessary. Given the label obstetric violence contextualises its systemic character, thereby illuminating and interrogating power dynamics,[120] the narrow individual perpetrator-victim dyad is not being raised to stigmatise healthcare professionals.[121] This further problematises the reductive impact of softer terminologies and reinforces the value of 'obstetric violence' as an umbrella concept.

I also submit that that those labels which evade articulating the phenomenon as violence are purposed to enable 'moral release'[122] for healthcare professionals and the medical institution. Moral release, according to Romito, is a cognitive strategy allowing individuals to manipulate the meaning of events, thereby altering internal and external reception of their behaviour.[123] Means of achieving this include linguistic avoidance, a technique used 'deliberately or unconsciously to permit perpetrators of violence… [to] disappear from discourses'[124] as well as through 'euphemising, which allows a phenomenon to be labelled in an imprecise way such as to obscure the seriousness or responsibility of whoever committed it'.[125] Softer terminologies therefore provide a linguistic means for obscuring women's violent experiences, mitigating unease and preserving the status quo.[126] The

[116] Vedam et al (n 52) 8.
[117] Ibid.
[118] Deirdre Cooper-Owens, *Medical Bondage: Race, Gender, and the Origins of American Gynaecology* (University of Georgia Press 2017) 44.
[119] Birthrights 'Systemic Racism, Not Broken Bodies: An Inquiry into Racial Injustice and Human Rights in UK Maternity Care' (May 2022) available at < https://www.birthrights.org.uk/wp-content/uploads/2022/05/Birthrights-inquiry-systemic-racism_exec-summary_May-22-web.pdf > accessed 27th May 2022.
[120] Cynthia Salter et al, 'Naming Silence and Inadequate Obstetric Care as Obstetric Violence is a Necessary Step for Change' (2021) 27(8) Violence Against Women 1023.
[121] Ibid.
[122] Patrizia Romito, *A Deafening Silence: Hidden Violence Against Women and Children* (Bristol University Press 2008) 35.
[123] Ibid 45.
[124] Ibid.
[125] Ibid.
[126] Chadwick, 'The Dangers of Minimising Obstetric Violence' (n 102) 2.

softer terminologies thus represent the language of the 'deeply toxic and persistent sociosymbolic structures trivialising gender-based violence',[127] and their use undermines the enterprise of dismantling the same such structures producing this violence.

Whilst the notion of violence in obstetrics may be disconcerting, and alternative terminologies may reduce hostility, 'obstetric violence' authentically voices the severity of the issue, elucidates its systemic dimension, and signifies harms caused to women and birthing people in this context are no less deserving of legal condemnation than harms caused by GBV in other contexts.[128]

'Obstetric Violence': An Epistemic Device

The label of obstetric violence also 'constitutes an epistemic intervention'[129] equipped with substantial explanatory power.[130] As Chadwick explains, the language of obstetric violence 'disrupts the normalising edifices of medical, obstetric, legal and institutional common sense knowledge systems in which gestating persons are routinely and unthinkingly stripped of rights, embodied integrity, and epistemic agency'.[131] Naming the phenomenon as obstetric violence is therefore more than merely an isomorphic description[132] but a rupturing apparatus with subversiv impact in critiquing the sociocultural systems of obstetrics and biomedicine, and their submergence in, and reproduction of power asymmetries.[133]

The language of obstetric violence not only captures the severity of the problem, but also supplies women and birthing people with a 'linguistic tool for transforming traumatic experiences into a chance to question and change reality'.[134] It counteracts the impact of oppressive societal prescriptions of what violence is,[135] helping to suspend cognitive operations (mental negation and reconstruction of very real experiences of violence), through the provision of a vocabulary which vindicates lived experience. Whilst the violence inherent in bodily objectification and appropriation may occur during labour and childbirth, this violence is reproduced in the denial of subjectification.[136] The merit of the label for facilitating epistemic recognition also has important implications for empowering women and birthing people and for catalysing a shift in maternity care practices. Since 'broader politics and power relations are not only implicated in experiences of violence, but also who is able to authoritatively speak of [violence],'[137] by using the label as opposed to alternative terms, we 'privilege an alternative prescription of reproductive experiences of violation'[138] and provide an alternative epistemic frame to dismantle normative power systems and structures.[139]

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[127] Ibid.
[128] Family Resemblance, 'When Childbirth Feels Like Assault' (*Brightthemag,* 18th November 2016) < https://brightthemag.com/when-childbirth-feels-like-assault-779a5859185e > accessed 29th November 2021.
[129] Chadwick, 'Breaking the Frame' (n 82) 2.
[130] Sesia, 'Obstetric Violence in Mexico' (n 83) 36.
[131] Chadwick, 'Breaking the Frame' (n 82) 7.
[132] Sesia, 'Naming, Framing and Shaming' (n 71) 238.
[133] Sadler et al (n 4) 51.
[134] Sánchez (n 79) 95.
[135] Romito (n 122) 34.
[136] Shabot, 'Amigas, Sisters' (n 53) 27.
[137] Fraser and Seymour (n 114) 20.
[138] Chadwick, 'Breaking the Frame' (n 82) 6.
[139] Ibid.

'Obstetric Violence': Legitimising Potential

Obstetric violence also possesses legitimising potential and an awareness-raising capacity at the political level.[140] This is because 'use of the term implies the assumption of several critiques shared by current childbirth activism... [rendering 'obstetric violence'] a powerful concept for strengthen[ing] activist arguments'.[141] The recent 'success of obstetric violence as critical terminology'[142] in spurring global recognition of violence in facility-based childbirth as a transnational issue[143] attests its socio-political value. The legitimising potential of the term also reinforces the importance of dynamism when conceptualising obstetric violence, as formulating a definition which excludes some experiences would unintentionally suggest their invalidity.

Ultimately, language is a powerful tool[144] and the words we use 'shape the ways in which it is (not) possible to understand the issues at stake, the ways they are legislated against… and the responses… deemed most appropriate'.[145] Through naming the phenomenon as obstetric violence, we harness the political, semantic, epistemic and discursive potency of the term to vindicate obstetric violence and to convey its exigency, producing legal and material consequences.[146] Whilst there may be unintended repercussions of using the term (anyways countervailable), this does not supersede the importance of naming violence against women and birthing people to identify and condemn the discrimination, disempowerment and harms they are subjected to during childbirth.[147] To exploit the power of obstetric violence terminology fully, however, it is also necessary to reconceptualise our understanding of violence.

1.3.1 Reconceptualising Violence

Traditional Understandings of Violence

Violence itself is a polysemic phenomenon.[148] Despite the complexities of violence however, its dominant social conception largely fails to reflect this reality. For this reason, resistance to conceptualising abuse and mistreatment in the maternity care context as 'obstetric violence' may, partially, be due to subscription to the traditional (masculine and exclusionary) conception of violence. Whilst feminist theorists engaging with violence have rebuked traditional conceptions to enhance our understanding,[149] in the context of mistreatment and abuse during labour and

[140] Soo Downe and Nancy Stone, 'Midwives and Midwifery: The Need for Courage to Reclaim Vocation for Respectful Care' in Camilla Pickles and Jonathon Herring (eds), *Childbirth, Vulnerability and Law* (Routledge 2019) 89.
[141] Sánchez (n 79) 63.
[142] Chadwick, 'The Dangers of Minimising Obstetric Violence' (n 102) 6.
[143] Ibid.
[144] Romito (n 122) 44.
[145] Boyle (n 45) 20.
[146] Sesia, 'Obstetric Violence in Mexico (n 83) 47.
[147] Salter et al (n 120) 1020.
[148] Ester Espinoza-Reyes, 'Decolonizing the Womb: Agency against Obstetric Violence in Tijuana, Mexico' (2020) 21(7) Journal of International Women's Studies 192.
[149] Jinee Lokaneeta, 'Violence' in Lisa Disch and Mary Hawkesworth (eds), *The Oxford Handbook of Feminist Theory* (OUP 2016) 1025.

childbirth by healthcare professionals, the meaning of violence has been less well explored.[150] Violence must be conceptualised heretically, beyond its traditional confines and in light of gendered experiences.

As has been widely recognised, the traditional conception of violence is affixed to notions of physicality, intentionality, hostility and grave visceral harm.[151] The normative and enduring status of this understanding of violence is apparent on the international level. For example, the WHO defines violence as:

'The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood to result in injury, death, psychological harm, maldevelopment or deprivation'.[152]

Whilst this definition accounts for collective violence and for use of power, as well as force, it nevertheless demonstrates that the restrictive[153] connotative association between violence and intentionality remains central,[154] and culturally, physical force continues to be 'fetishised' as the primary way of inflicting harm.[155] However, intentionality, brutality and physicality are not exclusive components of violence,[156] and 'definitions of violence that place the accent on intent have largely been rejected of late in favour of broader conceptions… that underscore the victim's perceptions and the consequences for that victim'.[157] This shift is significant because the focus on such components within the traditional conception precludes broader recognition of divergent experiences of violence – particularly GBV. This also creates a 'curious paradox',[158] wherein GBV is most perceptible when its 'gendered dimension is denied and when it looks most like men's own experiences of extreme violence',[159] perpetuating its misrecognition. In order to capture and faithfully reflect the variegated ways that violence is experienced, particularly by women and minority genders, we must reconceptualise violence.

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[150] Although, see Camilla Pickles, 'What does 'violence' mean in obstetric violence?' (*Make Birth Better*, 24th March 2021) < https://www.makebirthbetter.org/blog/what-does-violence-mean-in-obstetric-violence > accessed 15th December 2021.

[151] Sara Cohen Shabot, 'Why ''Normal'' Feels so Bad: Violence and Vaginal Examinations During Labour – A (Feminist) Phenomenology' (2020) Feminist Theory 2.

[152] World Report on Violence and Health: Summary (WHO) < https://www.who.int/violence_injury_prevention/violence/world_report/en/summary_en.pdf > 5

[153] Jason Wyckoff, 'Is the Concept of Violence Normative' (2013) 67(3) Revue Internationale de Philosophie 338.

[154] Lappeman and Swartz (n 77) 988; Salter et al (n 120) 1020; however, for an alternative interpretation of intent within the WHO definition, see Johanna Shapiro, '"Violence" in Medicine: Necessary and Unnecessary, Intentional and Unintentional' (2018) 13(7) Philosophy, Ethics, and Humanities in Medicine 1.

[155] Oren Nimni, 'Defining Violence' (*Current Affairs*, 17th September 2017) < https://www.currentaffairs.org/2017/09/defining-violence > accessed 8th December 2021.

[156] Nigel Rapport, ''Criminals by Instinct'': On the ''Tragdey'' of Social Structure and the ''Violence'' of Individual Creativity' in Göran Aijmer and Jon Abbink (eds), *Meanings of Violence: A Cross Cultural Perspective* (Routledge 2000) 53.

[157] Sylvie Lévesque and Audrey Ferron-Parayre, 'To Use or Not to Use the Term "Obstetric Violence": Commentary on the Article by Swartz and Lappeman' (2021) 27(8) Violence Against Women 1013.

[158] Boyle (n 45) 23.

[159] Ibid.

Violence as Violation

An alternative school of thought promotes a broader understanding of violence as violation.[160] It is this conceptualisation which ought to be applied and understood in the obstetric violence context, as 'violence lies in the violation of a woman's bodily and psychological integrity during labour and childbirth'[161] and in the violation of reproductive subjectivity.[162] Violation of reproductive subjectivity refers to, in a broader sense, the violence of 'being diminished, appropriated, reduced, unseen, unheard, and incapacitated, as an embodied, relational, and epistemic subject during reproductive life events'.[163]

For some, this conceptualisation 'may stretch violence too far beyond its *ordinary* meaning',[164] resulting in the encompassing 'of a lot of things that people do not inherently recoil at as violence… [thereby] mak[ing] it difficult to convey the urgency of eliminating it'.[165] However, violence is a socially constructed and ambivalent concept.[166] As explained by Munro, the parameters of violence are 'malleable and fluctuating [and] though grounded in a very real experience of harm and wrongdoing, they are heavily socially constructed, relating in complex and mutually-affirming ways to observers' normative responses'.[167] Thus, invocation to an 'ordinary meaning' of violence and concerns that 'violence as violation' dilutes the evocative import of characterising phenomena as violence eschews the insularity of the masculine conception. It also overlooks the 'link between the ability to inflict untold damage and willed distortion'[168] permitted by mainstream discourses and conceptions in obscuring many forms of GBV.[169] As a social construct then, 'violence lies in the eye of the beholder',[170] and the shift away from perpetrator's intent is therefore rectificatory. The broader conceptualisation invaluably 'allows researchers to penetrate the personal experience and subjective meaning of violence for those involved... enable[ing] emergent ''emic'' perspectives to be integrated into the concept'[171] in reflection of embodied subjectivities and lived experiences of violence.

Furthermore, this ontological grounding better accounts for the polysemic nature of violence. Whilst the conception of violence which centralises masculine mandates of intentionality and physicality is preoccupied with the interpersonal, direct violence paradigm, violence as violation better accounts for different forms of violence, including symbolic and structural violence, as well as interpersonal violence. Whilst we may struggle to reconcile symbolic and structural violence with the narrow conceptualisation, given they can manifest non-physically and without intention, violence as violation accommodates for the various natures and forms violence can take.

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[160] Vittorio Bufacchi, 'Two Concepts of Violence' (2005) 3 Political Studies Review 193.
[161] Pickles, 'Leaving Women Behind (n 80) 153.
[162] Chadwick, 'Breaking the Frame' (n 82) 113.
[163] Ibid.
[164] Herring, 'Identifying the Wrong in Obstetric Violence' (n 84) 68.
[165] Nimni (n 155).
[166] 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) 28.
[167] Vanessa Munro, 'Violence Against Women, ''Victimhood'' and the Neoliberal State' in Margaret Davies and Vanessa Munro (eds), *The Ashgate Research Companion to Feminist Legal Theory* (Ashgate Publishing 2016) 271. See also; Burkhard Liebsch, 'What Does (Not) Count as Violence: On the State of Recent Debates About the Inner Connection Between Language and Violence' (2013) 36 Human Studies 22.
[168] Jaqueline Rose, *On Violence and Violence Against Women* (Faber & Faber 2021).
[169] Shabot, 'Why ''Normal'' Feels so Bad' (n 151) 2.
[170] Rapport (n 156) 39.
[171] De Haan (n 166) 36.

Ultimately, in the context of obstetric violence, violence lies in the violation of reproductive subjectivity and (though not exclusively) in the violation of bodily and psychological integrity.[172] This reconceptualised understanding of violence provides an optic to bring into focus the 'unnoticed acts and invisible perpetrators'.[173] Integrating gendered experiences to construct violence in light of feminine gender dimensions provides us the opportunity 'to reposition our starting points and redirect our attention when considering the relationship between gender, violence, law and discourse, as well as our sites of action'.[174]

1.4 Understanding the Contours of Obstetric Violence

The Multifaceted Nature of Obstetric Violence

Obstetric violence is a multifaceted phenomenon,[175] being imbricated at the nexus of gender and institutional violence[176] and occurring 'at both an individual and structural level'.[177] It is therefore necessary to dissect the issue of obstetric violence to fully understand its contours, as without acknowledgement of the symbiotic relationship between the individual and institutional components of obstetric violence,[178] we risk setting tort law objectives for which it is structurally unsuited to achieve.[179]

1.4.1 Obstetric Violence: Elucidating the Gender Dimension

What is Gender-based Violence?

GBV can be defined as 'violence directed against a person because of that person's gender, or violence affecting persons of a particular gender disproportionately'.[180] GBV occurs in many forms and its global pervasiveness reflects worldwide systemic gender inequality.[181] 'Gender' itself is a social construction and an organising principle for societal interaction operating at macro, interactional and individual levels,[182] such that the 'substantive effect of gender is performatively produced and compelled by the regulatory practices of gender coherence'.[183] As an organising principle then, gender provides 'hegemonic ideals for masculine and feminine discursive

[172] Pickles, 'Leaving Women Behind' (n 80) 153.
[173] Fraser and Seymour (n 114) 24.
[174] Aisha Gill, 'Violence' (2016) Feminist Review 112 7.
[175] Dixon (n 61) 348.
[176] Sesia 'Obstetric Violence in Mexico' (n 83) 28.
[177] Pickles and Herring, 'Introduction' in *Childbirth, Vulnerability and Law* (n 59) 3.
[178] Munro (n 167) 274.
[179] Peter Cane, *The Anatomy of Tort Law* (Hart 1997) 236.
[180] European Commission <https://ec.europa.eu/info/policies/justice-and-fundamental-rights/gender-equality/gender-based-violence/what-gender-based-violence_en > accessed 2nd December 2021.
[181]Meghan Ott, 'Series: What Does That Mean? Gender-based Violence', (*Women for Women International*, 4th June 2021) < https://www.womenforwomen.org/blogs/series-what-does-mean-gender-based-violence > accessed 2nd December 2021.
[182] Hilde Jakobsen, 'What's Gendered about Gender-based Violence? An Empirically Grounded Theoretical Exploration from Tanzania' (2014) 28(4) Gender and Society 542.
[183] Judith Butler, *Gender Trouble: Feminism and the Subversion of Identity* (Routledge, 2nd edn 1999) 33.

positionings',[184] integral to the maintenance of power asymmetries implicated in the perpetration of violence. Thus, violence and gender are mutually constitutive, since 'violence is both made possible by gender/power relations and gender/power relations rely on violence for their reproduction'.[185] Whilst this relationship manifests in all facets of social life, in the reproductive and maternity care context, this relationship is intensified by the patriarchal ideology pervading modern reproductive and obstetric medical care.

Patriarchal Ideology and the Role of Gender Stereotypes

At the centre of the relationship between gender and violence rests 'patriarchal ideology [which] presents the subordination of women as natural, legitimate and desirable and contributes to making the reality of domination acceptable or invisible to the dominated'.[186] GBV operates as a surreptitious tool for preserving patriarchal order because women's constant phenomenological disposition within patriarchy prevents epistemic recognition of this violence in all facets of women's lives.[187]

Applying this insight in the context of pregnancy and childbirth, a 'woman's body at its most powerful and creative, doing what a man's body cannot do, is challenging patriarchy',[188] and obstetric violence can thus be understood as a patriarchal attempt 'to gain control over the female body and restore it to male control'.[189] This objective, despite reflecting outdated historical views surrounding women's purpose as gestational carriers for men,[190] overtly suffuses obstetric practices, resulting in the dehumanisation, objectification and appropriation of the birthing body. This is substantiated by Sadler et al, who posit that 'childbirth at the hospital is frequently depicted through a chain of patriarchal forces'.[191] Vexatiously, this violence is obscured because medicine, 'as a patriarchal, normative and powerful institution [with] a long, monopolistic history of carving out territory and pathologising differences',[192] harnesses and reinforces patriarchal motifs and gender stereotypes to guise and legitimise violence during childbirth.

Gender stereotypes depicting women as reproductive vessels and incompetent decision-makers[193] are intrinsically connected to patriarchal and sexist ideologies, wherein 'the female body is defined by its utility and function within the reproductive and sexual strategies of patriarchal hegemony, [which] in patriarchal cultures… results in exploitation and appropriation of the body'.[194] Ideologically, bodily appropriation is justified by the delineation of difference and supposed defectiveness, with 'female corporeality being conceptualised… as leaky, eruptive and volatile,

[184] Jakobsen (n 182) 544.
[185] Catia Confortini, 'Galtung, Violence, and Gender: The Case for a Peace Studies/Feminism Alliance' (2006) Journal of Peace Research 355.
[186] Romito (n 122) 31.
[187] Sara Cohen Shabot, 'Afterword: Unauthorised Intimate Examinations as/and Sexual Violence: Some Epistemic and Phenomenological Considerations' in Camilla Pickles and Jonathon Herring (eds), *Women's Birthing Bodies and the Law* (Hart 2020) 196.
[188] Herring, 'Identifying the Wrong in Obstetric Violence' (n 84) 80.
[189] Ibid 80.
[190] Elizabeth Chloe Romanis et al, 'Reviewing the Womb' (2020) 47(12) Journal of Medical Ethics 827.
[191] Sadler et al (n 4) 51.
[192] Ian Goodwin-Smith, 'Bloodlust: A Postcolonial Sociology of Childbirth' (2012) 18(5) Social Identities 525.
[193] Christina Zampas, 'Human Rights and Gender Stereotypes in Childbirth' in Camilla Pickles and Jonathon Herring (eds), *Women's Birthing Bodies and the Law* (Hart 2020) 81.
[194] Jacquelyn Zita, 'The Premenstrual Syndrome "Dis-easing" the Female Cycle' (1988) 3(1) Hypatia 90.

inextricably associated with the bodily secretions of female reproduction'.[195] Permeation of this ideology within traditional systems, practices, and professional discourses accepted as authoritative[196] allows discriminatory attitudes and manifests various forms of obstetric violence founded on 'stereotypes such as privileging the reproductive function of the woman, her infantilisation or the perception she is incapable of making decisions over her health and body'.[197] The following sections illuminate the gender stereotypes operating in the maternity care context.

Gender Stereotypes in the Maternity Care Context

Vulnerability

One erroneous stereotype operating in the maternity care context is that women in labour are vulnerable and emotionally volatile.[198] Whilst conceding that 'childbirth is not risk-free',[199] stereotypical assignment of women and birthing people in labour as especially vulnerable has harmful consequences given 'perceptions of vulnerability are strongly linked to the recognition of autonomy'.[200] This is evident within a body of case law subscribing to the view that, 'in the throes of labour with all that is involved in terms of pain and emotional stress',[201] women may be unable to make valid medical decisions, supporting the peculiar notion that pregnancy and childbirth, represented as states of vulnerability, impact on individuals' capacity to consent.[202] The stereotype thereby opens the door to unwarranted paternalism,[203] and paternalistic interventions help 'colonise childbirth and reproduce the material effects of colonial subjectivity',[204] enacting epistemic oppression.[205] Notably, whilst vulnerability stereotyping may be benevolent, it nevertheless strips women and birthing people of decision-making power,[206] and reinforces their subordination as the archetyping of women as vulnerable, in turn, 'valorises the ideal liberal subject… constructing [him] as invulnerable'.[207]

Additionally, the stereotype is both integral to, and a consequence of, the redefinition of childbirth as a pathological process. As Goodwin-Smith highlights, there exists a 'rigid epistemological block to dialogue which surrounds medical discourse on pregnancy… [and as such] pregnancy is pathologised

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[195] Kirsty Keywood, 'More than a Woman? Embodiment and Sexual Difference in Medical Law' (2000) 8 Feminist Legal Studies 320.
[196] Goodwin-Smith (n 192) 524.
[197] Cristen Pascucci, 'Spain 2019: Four Case Studies of Lawsuits for Obstetric Violence' (*Birthmonopoly*, April 27th 2019) < https://birthmonopoly.com/spain-obstetric-violence-lawsuits/ > accessed 10th November 2021.
[198] Zampas (n 193) 84.
[199] *A NHS Foundation Trust v An Expectant Mother* [2021] EWCOP 33 [13].
[200] Anna Arstein-Kerslake, 'Gendered Denials: Vulnerability Created by Barriers to Legal Capacity for Women and Disabled Women' (2019) International Journal of Law and Psychiatry 66.
[201] *Rochdale Healthcare (NHS Trust) v C* [1997] 1 FCR 274. See also, *Norfolk and Norwich Healthcare NHS Trusts v W* [1997] 1 FCR 269.
[202] Anna Nelson and Elizabeth Chloe Romanis, 'The Medicalisation of Childbirth and Access to Homebirth in the UK: COVID-19 and Beyond' (2021) 29(4) Medical Law Review 674.
[203] Wendy Rogers et al, 'Why Bioethics Needs a Concept of Vulnerability' (2012) 5(2) International Journal of Feminist Approaches to Bioethics 14.
[204] Goodwin-Smith (n 192) 521.
[205] Serene Khader, 'The Feminist Case Against Relational Autonomy' (2020) 17(5) Journal of Moral Philosophy 504.
[206] Rebecca Cook and Simone Cusack, *Gender Stereotyping: Transnational Legal Perspectives* (University of Pennsylvania Press 2010) 14.
[207] Jonathon Herring, *Law and the Relational Self* (CUP 2019) 42.

and treated as an illness and, culturally, through processes of discourse, we come to view it that way too'.[208] Denoting women as especially vulnerable therefore reinforces the view of pregnancy and childbirth as pathological events, concealing the patriarchal ideology informing interventionist practice and encouraging women's docility during childbirth. Thus, *creating* vulnerability to excessive medical intervention.[209] As 'our experience of the body is very likely symbolically mediated by ideologies and socio-cognitive factors impact[ing] on how one interprets bodily states',[210] it is suggested the stereotype encourages women and birthing people to interpret the physiological processes and pain of labour and childbirth as threatening and dangerous, exhorting submission to medical professional dictates, as the equivocality of the space between physiology and pathology is, arguably, 'as much socially constructed as identifiable as an objective transition between the normal and abnormal'.[211] A social construction of childbirth in which women are victims to natural physiological processes 'can become embodied, internalised and enacted'.[212]

Drawing upon vulnerability theory however,[213] stereotyping of women and birthing persons as especially vulnerable should be challenged. Vulnerability theory postulates that 'vulnerability is an ontological condition of our humanity',[214] and that as human beings, we are all inherently vulnerable and dependant on others for our well-being and human flourishing.[215] Thus, in refutation of the stereotype, academics have emphasised 'the source of vulnerability is not the woman, but the structure of medical and societal force acting upon her during childbirth'.[216] By unveiling the patriarchal origins of the stereotype and its relationship to paternalistic intervention, we can use the theory to recognise that whilst vulnerability is intrinsic to being human, 'population groups are vulnerable to [and are made vulnerable by] the representations and interests of administrative power'.[217] It is also submitted that this inversely exposes the dependency of power structures in creating and perpetuating systemic conditions of vulnerability to maintain dispositions of control. Notably, whilst all women and birthing people are deemed vulnerable due to the states of labour and childbirth, perceptions of vulnerability are impacted by various factors. For example, the racist conception of racialised women and birthing people as impervious to pain, truncates the extent to which they are perceived as vulnerable patients in need of clinical support.[218]

Incompetent Decision-makers

Women and birthing people are frequently stereotyped as unable to make sound medical decisions.[219] As recognised by Villarmea, this stereotype gained traction within 18th century

[208] Goodwin-Smith (n 192) 527.
[209] Allison Wolf and Sonya Charles, 'Childbirth is Not an Emergency: Informed Consent in Labour and Delivery' (2018) 11(1) International Journal of Feminist Approaches to Bioethics 33.
[210] Zita (n 194) 91.
[211] Denis Walsh, 'Childbirth Embodiment: Problematic Aspects of Current Understandings' (2010) 32(3) Sociology of Health and Illness 494.
[212] Ibid 495.
[213] Martha Fineman, 'The Vulnerable Subject: Anchoring Equality in the Human Condition' (2008) 20 Yale Journal of Law and Feminism 177 2.
[214] Rogers et al (n 203) 12.
[215] Fineman (n 213) 19.
[216] Pickles and Herring, 'Introduction' *Childbirth, Vulnerability and Law* (n 59) 8.
[217] Goodwin-Smith (n 192) 521
[218] Cooper-Owens (n 118) 44. See also; Rachelle Chadwick, *Bodies that Birth: Vitalizing Birth Politics* (Routledge 2018).
[219] Cook and Cusack (n 206) 12.

medicine, and 'misogynistic theories relating female sexual configuration and procreative function to the supposedly inferior mental capacities of women'[220] became a poignant source of legitimacy for sexual inequality.[221] As such, the female body was viewed as 'inherently defective… and in need of constant manipulation by man'.[222] Whilst these misogynistic medical theories have been discredited, the stereotype continues to furtively exert influence, especially during childbirth, with social and legal consequences beyond the clinical sphere. The tenacity of the stereotype is reflected in the sustained view that refusing obstetric intervention 'is an atypical response when required to save the foetus… rais[ing] questions about the woman's decision-making capacity',[223] and the English (en)forced caesarean section case law arguably 'reveal(s) a blanket assumption of maternal incompetence'.[224] Thus, when women and birthing people make 'atypical' medical decisions, the stereotype is invoked to justify the overriding of their choices. Notably, this stereotype also interacts with the 'good mother' stereotype (explored below). The normative content of the good mother stereotype contributes in delineating atypical/typical birthing behaviours and decisions, permitting the exertion of obstetric power to control 'epistemic dimensions and physical aspects of… the pregnant person',[225] and inviting healthcare professionals to 'perform a moral evaluation of [women and birthing persons] … as a director of consciousness'.[226] These evaluations are also implicitly conducted and supported by the courts.[227]

Ultimately then, the idea of women as impaired epistemic agents is a pervasive patriarchal motif,[228] which in the birthing context, manifests stereotypical assumptions of women and birthing people as incompetent decision-makers. For marginalised women and birthing people, denial of epistemic agency and competency is even more acute due to racist, classist, and other prejudices.[229] For example, indigenous birthing women's knowledge is delegitimatised in maternity care settings as an ongoing expression of colonialist processes.[230] This enables law and medicine, as mutually

[220] Stella Villarmea, 'When a Uterus Enters the Room, Reason Goes out the Window' in Camilla Pickles and Jonathon Herring (eds), *Women's Birthing Bodies and the Law* (Hart 2020) 70.
[221] Ibid.
[222] Robbie Davis-Floyd, 'The Technocratic, Humanistic, and Holistic Paradigms of Childbirth' (2001) 75 International Journal of Gynaecology and Obstetrics 6.
[223] Ismaili M'hamdi Hafez, 'Forced Caesareans: Applying Ordinary Standards to an Extraordinary Case' (2021) 47(4) Journal of Medical Ethics 233.
[224] Sheena Meredith, *Policing Pregnancy: The Law and Ethics of Obstetric Conflict (*Ashgate 2005) 38. For an invaluable discussion of this topic, see also, Samantha Halliday, *Autonomy and Pregnancy: A Comparative Analysis of Compelled Obstetric Intervention* (Routledge 2015).
[225] Gabriela Arguedas Ramirez, 'Obstetric Power, Therapeutic Abortion, Human Rights and State Femicide: A Reflection Located in Latin America' in Patrizia Quattrocchi and Natalia Magnone (eds), *Obstetric Violence in Latin America* (Buenos Aires, National University of Lanús 2020) 93.
[226] Ibid.
[227] See for example, *Guys and St Thomas' NHS Foundation Trust v R* [2020] EWCOP 4, where Hayden LJ explicitly acknowledged that 'judges in the past may have strained to conclude women… lacked decision-making capacity in order, for the highest of motives, to protect the life or health of both the mother and her unborn child' [56] notwithstanding judicial recognition of the right of women to make 'morally repugnant' medical decisions [54] (citing *St Georges Health Care NHS Trust v S* [1998] 3 All ER 67).
[228] Shabot, 'Amigas, Sisters, we're Being Gaslighted' (n 53) 26.
[229] Ibid 26.
[230] Emily Gaffney Gleason et al, ''Parir no es un asunto de etnia, es un asunto de humanidad": experiencias frente a la violencia obstétrica durante la atención al parto en mujeres indígenas' (2021) Salud Colectiva 17(1). [Emily Gaffney Gleason et al, "Giving Birth is Not a Matter of Ethnicity, it is a Matter of Humanity": Experiences of Obstetric Violence During Childbirth Among Indigenous Women' (2021) Collective Health 17(1) 1].

reinforcing institutions[231] to collude in imposing obstetric intervention.[232] The stereotype is reinvigorated through this collaboration, creating and maintaining gender differences[233] which ground women's inferiority to men and legitimise masculine control of the birthing process.

The 'Good Mother'

The 'good mother'[234] is a multidimensional construct attuned to different geopolitical contexts and informed by different ideals about who is a 'desirable reproducer'.[235] As Halliday highlights, recent (en)forced caesarean section cases in England and Wales indicate that, prejudicially, it is women from marginalised groups (eg non-white women, or women with mental illnesses or learning difficulties), who are disproportionately distinguished from the good mother archetype.[236] Generally, however, good mothers are those who prioritise the foetus and necessarily conform with instructed birthing practices, irrespective of personal interests and preferences.[237] This stereotype undermines women's autonomy and facilitates violence on binate levels. On one level, it permits unauthorised intervention to be seen as justified on the presumption women will always act in the interest of the foetus. The stereotype therefore relegates women and birthing people to reproductive instruments[238] by prescribing their function as vessel for the birth of a healthy child, and uncritically assumes the ethical legitimacy of altruistic self-sacrifice essentialised by the normative mother birthing script.[239] A script authored by patriarchal ideology. The axial of female identity with normative motherhood, as a patriarchally colonised concept,[240] 'reinforces notions about the female body... [delimiting] the range of acceptable bodily configurations, reproductive behaviours, desires'[241] and birthing behaviours. This bleeds into the stereotype's operation on a second, more insidious level, as it promotes the expectation women will self-subscribe to the position of 'sacrificial lamb'.[242] Failure of women to act in self-sacrificial ways produces 'gendered shame',[243] an emotional response to disciplinary forces acting upon the embodied self,[244] 'transforming the lived-body into a

[231] Elizabeth Chloe Romanis, 'Legal Method and Health Law in Feminist Perspective' (forthcoming).
[232] Elizabeth Kingdom, 'Body Politics and Rights' in Jo Bridgeman and Susan Millns (eds), *Law and Body Politics: Regulating the Female Body* (Dartmouth 1995) 1.
[233] Nancy Levit, *The Gender Line: Men, Women, and the Law* (NYUP 1998) 3.
[234] DeBruin and Faith (n 16) 187.
[235] Chadwick and Mavuso, 'On Reproductive Violence' (n 42) 2. See also Ximena Briceño Morales et al, 'Neither Medicine nor Health Care Staff Members are Violent by Nature: Obstetric Violence from an Interactionist Perspective' (2018) 28(8) Qualitative Health Research at 1313, and Nada Amrouissia et al, ''Is the Doctor God to Punish Me?!'' An Intersectional Examination of Disrespectful and Abusive Care during Childbirth against Single Mothers in Tunisia' (2017) 14(1) Reproductive Health.
[236] Halliday, *Autonomy and Pregnancy* (n 224) 168-169.
[237] Anna Nelson, 'Vaginal Examinations During Childbirth: Consent, Coercion and COVID-19' (2021) 29(1) Feminist Legal Studies 123.
[238] Zampas (n 193) 85.
[239] Elselijn Kingma, 'Harming One to Benefit Another: The Paradox of Autonomy and Consent in Maternity Care' (2021) 35(5) Journal of Bioethics 459.
[240] Susan Boyd, 'Motherhood and Law: Constructing and Challenging Normativity' in Margaret Davies and Vanessa Munro (eds), *The Ashgate Research Companion to Feminist Legal Theory* (Ashgate Publishing 2016) 310.
[241] Jennifer Denbow, *Governed through Choice: Autonomy, Technology, and the Politics of Reproduction* (NYUP 2015) 12.
[242] Borges (n 23) 839.
[243] Sara Cohen Shabot and Keshet Korem, 'Domesticating Bodies: The Role of Shame in Obstetric Violence' (2018) 33(3) Hypatia 384.
[244] Ibid 385.

body-object'.[245] The role of gendered shame is particularly pervasive in the context of obstetric violence, as internalisation of the good mother construct 'prime[s] women to experience obstetric violence as a normal part of being… [an] all-giving mother'.[246] Cyclically, by standardising the expectation that women and birthing people will do everything to prioritise the foetus, violence as a means to this end is internalised as acceptable by both women and healthcare professionals.

Overall, therefore, these stereotypes fortify the fallacy of women's inferiority to men and function to homogenise pregnant women and birthing people, ignoring their individual needs and denying them their rights,[247] whilst framing violation and intrusion 'not as violence, but as an expected legitimate response to women's nature'.[248]

1.4.2 Obstetric Violence: Elucidating the Structural Dimension

As propounded by Sadler et al, obstetric violence should also be analysed as a ramification of structural violence[249] in 'transcend[ance] of the central thesis of gender-based violence'.[250] This is reinforced by the UN Special Rapporteur's recognition that obstetric violence is situated within a 'continuum of violations occur[ing] in the wider context of structural inequality, discrimination and patriarchy'.[251] Continuum thinking offers an important intervention[252] in the obstetric violence discourse, as it recognises GBV needs to be situated within the larger social milieu[253] to avoid a reductionist understanding of the issue,[254] and to permit a conceptualisation of gender, power and their relationship to violence reflective of structural, relational, as well as individual dynamics.[255] To understand the structural dimension of the phenomenon further, and the implications for relying upon an action in civil battery, it is first necessary to understand the concept of structural violence.

What is Structural Violence?

Structural violence, seminally conceptualised by Galtung, occurs when 'social structures or institutions harm people by preventing them from meeting their basic needs… [through] institutionalised elitism, ethnocentrism, classism, racism, sexism'[256] and other matrixes of discrimination. Galtung also notes that 'cultural violence', which permeates all aspects of our social life, justifies and legitimises structural (as well as personal) violence.[257] This process of institutionalisation and legitimisation 'makes reality opaque so we do not see violent act[s] - at least

[245] Ibid 388.
[246] Ibid 394.
[247] Zampas (n 193) 86.
[248] Shabot, 'Afterword' (n 187) 197.
[249] Sadler et al (n 4) 47.
[250] Morales et al (n 235) 1309.
[251] United Nations General Assembly (n 67) [9].
[252] Boyle (n 45) 19.
[253] Morales et al (n 235) 1309.
[254] Gwen Hunnicutt, 'Varieties of Patriarchy and Violence Against Women: Resurrecting "Patriarchy" as a Theoretical Tool (2009) 15(5) Violence Against Women 563.
[255] Brubaker (n 44) 724.
[256] Tanya Zakrison et al, 'Social Violence, Structural Violence, Hate, and the Trauma Surgeon' (2019) 49(4) International Journal of Health Services 666.
[257] Johan Galtung, 'Cultural Violence' (1990) 27(3) Journal of Peace Research 291.

not as violence'.[258] Whilst the concept of structural violence alone is insufficient for understanding the ubiquity of obstetric violence, insertion of the concept into a larger feminist framework[259] and anchoring engagement with GBV in a structural analysis, exposes the 'interconnections between divergent contexts and experiences of violence, enabling us to see points of continuity between what might otherwise appear as distinct incidents… [as well as] the broader symbolic consequences'[260] of violent interactions which might otherwise be dismissed.

Structural Violence in Maternity Care

Violence in maternity care must be understood as a product of systemic practices and institutionalised inequalities which uphold and reproduce normative power structures.[261] As Meredith notes, medicine has arrogated itself a role as 'arbiter of reproductive behaviour',[262] and in the maternity care context, 'obstetric hegemony… controls, disciplines and disempowers women'[263] and birthing people. The pathologisation and medicalisation of childbirth and obstetrical disciplinary control 'not over any individual but rather specifically over the female body',[264] subjugates women and birthing people 'within hierarchal and authorisation structures of medical speciality which are deeply patriarchal in historical origin, medical practice, and socio-clinical interactions'.[265] The institutionalisation of subjugating violent practices and repeated exposure to them 'normalises the abnormal'.[266] The structural dimension of obstetric violence therefore gives the phenomenon an insidious quality, as obstetric practices constituting violence against women have become socially legitimised and unquestioned, perpetuating systematic devaluation of women's active participation in the birthing process and the disregarding women and birthing people's epistemic knowledge.[267] The normalisation of violence throughout the maternity care journey thereby permits the maintenance of power asymmetries and the oppression of women and birthing people as epistemic agents during facility-based childbirth.[268]

1.4.3 Interaction with Other Structural Inequalities: Intersectional Sensitivity

As a form of structural violence, obstetric violence is exacerbated by and interacts with other structural inequalities. This is because the institution of 'medicine is a microcosm of wider society, where race, gender and class controls are routinely enacted… contribut[ing] to obstetric violence'.[269]

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[258] Ibid 301.
[259] Fernando De Maio and David Ansell, "As Natural as the Air Around Us": On the Origin and Development of the Concept of Structural Violence in Health Research' (2018) 48(4) International Journal of Health Services 755.
[260] Munro (n 167) 274.
[261] Sadler et al (n 4) 51.
[262] Meredith (n 224) 82.
[263] Sarah Baker et al, '"I Felt as Though I'd Been in Jail": Women's Experiences of Maternity Care during Labour, Delivery and the Immediate Postpartum' (2005) 15 Feminist Psychology 319.
[264] Sesia, 'Naming, Framing and Shaming' (n 71) 237.
[265] Ibid.
[266] Zakrison et al (n 256) 665.
[267] Quattrocchi, 'Obstetric Violence Observatory' (n 65) 771.
[268] Sadler et al (n 4) 51.
[269] Colleen Campbell, 'Medical Violence, Obstetric Racism, and the Limits of Informed Consent for Black Women' (2021) 26 Michigan Journal of Race and Law 68.

Thus, whilst obstetric violence is explicable by structural gender inequality and the institutionalisation of patriarchal maternity care practices, 'gender, as a structure that orders social practice, interacts with other social structures'[270] and various inequalities are inscribed into institutional maternity care.[271] In this sense, 'obstetric violence acts as a mode of discipline that is inextricably entangled with multiple axes of social marginalisation'.[272] Demonstrably, one need only look to structural inequalities manifesting against racialised persons and other marginalised groups, such as overall worse maternity outcomes,[273] to convict these experiences are not merely a 'by-product of biology, epigenetics or poverty'[274] but can be directly linked to structural racism and systemic over medicalisation and neglect.[275] This not only indicates that 'women's reproductive possibilities… are effects of macro-economic structures and global, racial-ethnic hierarchies… [but supports that] reproduction and reproductive labour is relational, implicating a whole range of positional privileges and modes of domination that play out in interpersonal interactions'.[276] Indeed, the perturbing fact that in the United Kingdom, black women are four times more likely to die during childbirth than white women,[277] attests that structural inequalities are reproduced and manifest through violent maternity care practices.

Adopting an intersectional feminist lens is vital to appreciate that interlocking identities have a material impact on women's and birthing people's lived experiences[278] of violence in the maternity care context. Application of a single-axis lens would distort these experiences,[279] eliding that violent interactions are shaped and exacerbated by other identity dimensions.[280] In recognition of this, academics such as Davies and Campbell traverse the intersect of gender and race in foregrounding 'obstetric racism' – structural racism in medicalised childbirth - within and beyond the discourse on obstetric violence,[281] 'engaging with the distinct history and the continuity of reproductive subordination'[282]particular to black women to understand their disposition and experiences. Discrete foregrounding and wider intersectional consciousness is important to forbear the silently

[270] Mara Vigoya, 'Sex/Gender' in Lisa Disch and Mary Hawkesworth (eds), *The Oxford Handbook of Feminist Theory* (OUP 2016) 856.
[271] Erdman (n 1).
[272] Chadwick, 'Ambiguous Subjects' (n 2) 493.
[273] Birthrights, 'Systemic Racism, Not Broken Bodies' (n 119). See also, Kylea Liese et al, 'Obstetric Iatrogenesis in the United States: The Spectrum of Unintentional Harm, Disrespect, Violence, and Abuse' (2021) Anthropology and Medicine 28(2).
[274] Karen Scott and Dána-Ain Davis, 'Obstetric Racism: Naming and Identifying a Way Out of Black Women's Adverse Medical Experiences' (2021) 123(3) American Anthropologist 682.
[275] Campbell (n 269) 50.
[276] Katharine McCabe, 'Stratification in Reproductive Healthcare: An Analysis of Pathways of Inclusion Among Sexual Minorities, Substance Users, and Women Who Use Midwives' in Elizabeth Mitchell Armstrong, Susan Markens, and Miranda R Waggoner (eds), *Reproduction, Health and Medicine* (Emerald Publishing Limited 2020) 174.
[277] Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK 'Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19' (MBRRACE-UK Report, November 2021).
[278] Kimberley Mutcherson (ed), *Feminist Judgments: Reproductive Justice Rewritten* (CUP 2020) 4.
[279] Kimberle Crenshsaw 'Demarginalising the Intersect of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory, and Antiracist Politics' in Katharine Bartlett and Rosanne Kennedy (eds), *Feminist Legal Theory: Readings in Law and Gender* (Westview Press 1991) 57.
[280] Kimberle Crenshaw, 'Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Colour' (1991) 43(6) Stanford Law Review 1242.
[281] Dána-Ain Davis, 'Obstetric Racism: The Racial Politics of Pregnancy, Labour, and Birthing' (2019) 38(7) Medical Anthropology 570.
[282] Campbell (n 269) 70.

homogenising tendencies[283] of legal discourses and laws designed for 'woman' embodying universal criteria,[284] and by demanding attention to the intersectional effects of obstetric violence,[285] we repudiate the notion of the birthing room as a disconnected sphere 'in which systemic prejudices are suspended'.[286] Intersectionality is therefore a necessary constituent of my methodology.

1.4.4 Multidimensionality: Conclusions

As clarified by the discussions above, obstetric violence can be viewed as a product of a 'multi-factorial framework where institutional and gender-based violence overlap'.[287] Contextualising obstetric violence as structural violence has important implications for understanding the ubiquity of this violence within the social relationships in the clinical environment, and for directing our legal responses. A structural analysis divulges the position of healthcare professionals as 'unconscious perpetrators of an existing violence structure',[288] clarifying that mistreatment and abuse, and general disregard of women's rights entitlements during childbirth, reflect institutional norms which have sown fertile ground for the production of obstetric violence.[289] Whilst this avoids directly implicating healthcare professionals as violent actors, ensuring their culpability is not misrepresented, it nevertheless 'exposes a clear logic behind the systemic nature of how violence is distributed'[290] in medical institutions along gendered lines and against other marginalised identity dimensions, resulting in a distinctive pandemic of violence in the reproductive and obstetric context.

1.5 Situating UVEs as Obstetric Violence

Unauthorised Vaginal Examinations

Gynaecological examinations are a routine practice performed by healthcare professionals throughout childbirth to monitor cervical dilation and to assess labour progression. Clinical guidelines such as those provided by the National Institute for Health and Care Excellence ('NICE')[291] recommend the performance of examinations at regular intervals. However, 'women exist beyond the realm of clinical indication and they are diverse',[292] and an overly procedural approach to maternal intervention is resulting in the performance of examinations without consent. These UVEs contravene the medio-legal tenet that 'a labouring woman is, like any other adult of sound mind, entitled to decide which, if any… treatment to undergo, and consent must be obtained before

[283] Katherine Bartlett, 'Feminist Legal Methods' (1990) 103 Harvard Law Review 836.
[284] Vigoya (n 270) 861.
[285] Louise Roth, *The Business of Birth: Malpractice and Maternity Care in the United States* (NYUP 2021) 50.
[286] Chadwick, 'Breaking the Frame' (n 82) 6.
[287] Jennifer Murray De López, 'When the Scars Begin to Heal: Narratives of Obstetric Violence in Chiapas, Mexico' (2018) 23(1) International Journal of Health Governance 3.
[288] Borges (n 23) 856.
[289] Roberto Castro and Joaquina Erviti, 'Violations of Reproductive Rights during Hospital Births in Mexico' (2003) 7 Health and Human Rights 95.
[290] Kathleen Ho, 'Structural Violence as a Human Rights Violation' (2007) Political Science 4.
[291] National Institute for Health and Care Excellence (NICE), 'Intrapartum Care' (n 7) [1.4.5].
[292] Pickles, 'Leaving Women Behind' (n 80) 145.

interfering with her bodily integrity'.[293] Indeed, numerous studies have revealed that women across the globe are not being consulted or informed about the vaginal examinations they are subjected to,[294] with the UN Special Rapporteur highlighting the perversity of UVEs in her report.[295] Alarmingly, the Association for Improvements in the Maternity Services (AIMS) deduce that 'if a healthcare professional has made up his/her mind that an examination is necessary, consent will be assumed and the examination performed'.[296] The prevalence of this routinised violation of women and birthing people is made more perturbing by the fact that, although gynaecological examinations are a convenient means of determining labour progression, they are not a clinical necessity and their utility is limited.[297] This therefore substantiates that even in modern obstetrics, procedures and practices are performed unnecessarily[298] and 'routinely… not because they make scientific sense but because they make cultural sense',[299] revealing the role of coercive practices (such as routine UVEs) in producing docile birthing bodies controlled by the institution and its gendered ideal.[300] The violent and harmful nature of UVEs is summarised below, but will be made lucid throughout this dissertation.

The Harm in UVEs

In the maternity care context, 'medical professionals routinely interact with parts of the body whose invasions raise particularly sensitive issues',[301] and the relationship between vaginal examination and bodily autonomy is particularly complex.[302] Studies also indicate that generally, choice and control are strongly correlated with positive birth experiences and outcomes.[303] In light of this relationship between involvement in decision-making processes during childbirth and positive birthing experiences and outcomes[304] (considered beyond the healthy mother, healthy baby metric)[305] consent to these invasive examinations is paramount. The especial importance of consent is more

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[293] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 [87].
[294] See Rachel Thompson and Yvette Miller, 'Birth Control: To What Extent Do Women Report Being Informed and Involved in Decisions about Pregnancy and Birth Procedures?' (2014) 14(1) BMC Pregnancy and Childbirth 7; Sahar Hassan et al, 'The Paradox of Vaginal Examination Practice During Normal Childbirth: Palestinian Women's Feelings, Opinions, Knowledge and Experiences' (2012) 9(1) Reproductive Health 16; Bohren et al (n 6) 17; Morales et al (n 235) 1312, amongst others.
[295] United Nations General Assembly (n 67) [28].
[296] AIMS 'VEs - Essential Diagnostic Tool?' (AIMS Journal 2010 22(1)) < https://www.aims.org.uk/journal/item/ves-essential-diagnostic-tool > accessed 9th December 2021.
[297] Ibid.
[298] Alexis Hoffkling et al, 'From Erasure to Opportunity: A Qualitative Study of the Experiences of Transgender Men Around Pregnancy and Recommendations for Providers' (2017) 17(2) BMC Pregnancy and Childbirth 12.
[299] Davis-Floyd (n 222) 7.
[300] Quattrocchi 'Obstetric Violence Observatory' (n 65) 772.
[301] Kingma (n 239) 457.
[302] Neda Taghinejadi and Brenda Kelly 'Female Genital Examination and Autonomy in Medicine' in Camilla Pickles and Jonathon Herring (eds), *Women's Birthing Bodies and the Law* (Hart 2020) 51.
[303] Rebecca Brione, 'Non-Consented Vaginal Examinations: The Birthrights and AIMS Perspective' in Camilla Pickles and Jonathon Herring (eds), *Women's Birthing Bodies and the Law* (Hart 2020) 33. See also Shaunette Meyer, 'Control in Childbirth: A Concept Analysis and Synthesis' (2013) 69(1) Journal of Advanced Nursing.
[304] Roxana Behruzi et al, 'Facilitators and Barriers in the Humanization of Childbirth Practice in Japan' (2010) 25 BMC Pregnancy and Childbirth 16.
[305] See Roth (n 285) at 28, who explains that this metric – which narrowly equates positive birthing experiences and outcomes with the avoidance of maternal and perinatal mortality and morbidity - has resulted in the importance of the birth experience itself being overlooked.

fully realised when we conceive the genitals as a 'cultural terrain upon which the personal meets the political, [where] social battles are fought and lost, and the boundaries of power are drawn and reclaimed'.[306] UVEs however, as 'a subjugating operation, done to… are an administration of the affairs of the other'[307] which deny women and birthing people choice and control over access to their bodies. Such a gross violation unsurprisingly produces both short-term and long-term harms.[308] Additionally, and as I elaborate upon in chapter 3, UVEs possess a 'wider social meaning tied explicitly to the deliberate and routine violation, sexualisation and dehumanisation of women',[309] and women express feeling dehumanised[310] and violated[311] as a result of the practice, resulting in traumatic birth experiences.

Furthermore, women and birthing people subjected to UVEs may be at an amplified risk of suffering from birth trauma if they have previously experienced sexual violence.[312] Whilst some may experience the practice as 'an aggravating annoyance, another woman – particularly one with a history of sexual assault – may find the same vaginal penetration to be deeply traumatic'[313] and akin to sexual violation, as reified by the 'birth rape' analogy.[314] Whilst the analogy may generate unease, it is unsurprising that some women apprehend unauthorised digital penetration during labour and childbirth as a sexual violation, given 'vaginal examinations are more specifically related to childbirths' sexual dimension and sexuality is integral'.[315] Additionally, whilst healthcare professionals 'aspire to a professional, scientific detachment, patients simply do not think of their intimate regions in a detached or neutral way'.[316] For this reason, the relevant perspective is that of the birthing person, not the healthcare professional who may regard the examination as trivial.[317] Further still, under patriarchy, women's bodies are 'sexualised terrain'.[318] Thus, it is submitted that failure to appreciate childbirth's sexual dimension and to comprehend the potential for UVEs to be experienced as a sexual violation reveals the extent to which institutionalised practices condition a medicalisation schema,[319] resulting in the birthing body to be perceived vacuously as an object of medical intervention. As a result, the parallels between sexual objectification and violation and medical objectification and violation are artificially obscured. In this sense, the birth rape analogy emphasises women and birthing people's 'subordination… to the institutional structures of ideology, power, and language that define masculinised medicine'.[320] The unsettling nature of the analogy should raise serious concerns even though UVEs – in most instances - are not sexually motivated.[321]

[306] Taghinejadi and Kelly (n 302) 62.
[307] Ian Goodwin-Smith (n 192) 533.
[308] Ibid 31.
[309] Kingma (n 239) 458.
[310] Bohren et al (n 6) 17.
[311] Reed et al (n 52) 5.
[312] Ibid 7.
[313] Kukura, 'Obstetric Violence' (n 74) 728.
[314] Pickles, 'When 'Battery' is not Enough' (n 8) 128.
[315] Shabot, 'Afterword' (n 187) 196.
[316] Lori Bruce, 'A Pot Ignored Boils On: Sustained Calls for Explicit Consent in Intimate Medical Exams' (2020) 32(2) HEC Forum.
[317] Phoebe Friesen, 'Educational Pelvic Exams on Anesthetized Women: Why Consent Matters' (2018) 32 Bioethics 298 306.
[318] Carol Smart, *Feminism and the Power of Law* (Routledge 1989) 38.
[319] Roth (n 285) 21.
[320] Carine Mardorossian*, Framing the Rape Victim: Gender and Agency Reconsidered* (New Brunswick, Rutgers University Press 2014) 69.
[321] Jonathon Herring, 'Implied Consent and Vaginal Examination in Pregnancy' in Camilla Pickles and Jonathon Herring (eds), *Women's Birthing Bodies and the Law* (Hart 2020) 143.

Additionally, UVEs breach the 'thick interpersonal trust'[322] shared between patient and healthcare professionals. Hospitalised childbirth requires women and birthing people to give healthcare professionals physical, emotional and personal access to their bodies,[323] and to invite their participation in an intimate and life-changing event. Healthcare professionals who perform UVEs grievously breach this trust, disregard women and birthing people's desires and needs, and violate their personal integrity; wrongs implicated in women's lived experiences of birth trauma.[324]

Clearly, the 'harm [of UVEs] is complex and difficult to capture along one moral axis'[325] and harms experienced will inevitably diverge. Nevertheless, a preliminary appreciation of the harms and iatrogenic consequences of UVEs is necessary to locate the practice as a form of obstetric violence, and to ensure appropriate legal responses are enforced.

1.6 The Legal Lacuna

1.6.1 Why Has the Law Failed to Address Obstetric Violence?

Despite findings revealing the ubiquity of UVEs and other forms of obstetric violence, urging legal intervention, the law has failed to respond accordingly. This can be attributed to various factors which I discuss below.

Lack of Awareness Amongst Women

A major factor hindering legal redress against obstetric violence is lack of awareness and epistemic recognition amongst women and birthing people. This is because whilst 'UVEs are indeed bodily apprehended as violent…full epistemic recognition of violence is often obstructed because the experience perfectly coincides with women's normal phenomenological situation within patriarchy'.[326] As a result of this hermeneutical disadvantage, women are 'unable to make sense of [their] ongoing mistreatment, and this, in turn, prevents [them] from protesting it, let alone securing effective measures to stop it'.[327] The violence of UVEs is particularly well concealed, owing to the status of the practice as a normal, and seemingly unquestionable part of labour management.[328] Additionally, women's embodied selves are silenced by obstetric authoritative knowledge. 'Silencing' represents 'a key epistemic mechanism [operating to] colonise women's bodily and emotional experiences of birth'.[329] Whilst silencing is of itself, a hermeneutical aspect of obstetric violence,[330] the impact of silencing in negating lived-experiences during childbirth, buttressed by the role of

[322] Herring, 'Identifying the Wrong' (n 84) 74.
[323] Ibid.
[324] Reed et al (n 52) 7.
[325] Sylvia Goldberg, Lisa Jennifer and Megan Aston, 'Vulnerability, Harm, and Compromised Ethics Revealed by the Experiences of Queer Birthing Women in Rural Healthcare Burrow' (2018) 15(4) Journal of Bioethical Inquiry 518.
[326] Shabot, 'Afterword' (n 187) 196.
[327] Miranda Fricker, *Epistemic Injustice: Power and the Ethics of Knowing* (OUP 2007) 161.
[328] Shabot, 'Why ''Normal'' Feels so Bad' (n 151) 3.
[329] Rachel Chadwick, 'Practices of Silencing Birth, Marginality and Epistemic Violence' in Camilla Pickles and Jonathon Herring (eds), *Childbirth, Vulnerability and Law* (Routledge 2019) 37.
[330] Ibid 32.

gendered shame in depoliticising experience,[331] may encourage women to restructure reality[332] in denial of their traumatic experiences. This process of silencing, shaming, depoliticising, and restructuring consequently prevents epistemic recognition of violence in maternity care.

Inability to recognise UVEs (and other violent practices) as violence is exacerbated by the image of the maternity ward as a benevolent environment. Shabot explains that 'violence is frequently conceptualised as requiring intention and as oxymoronic in spaces perceived as essentially benevolent or involving practices understood to be in the patients' best interests'.[333] The semblance of compassion provided by the ward environment obscures mistreatment and abuse and legitimises violent practices imposed upon women per their predetermined best interests. Simultaneously, obstetric violence has been 'conferr[ed] a degree of normality that has allowed it to exist spontaneously within a violent social order, as an embodiment of the naturalisation of social violence',[334] contributing to underestimation, concealment, tolerance, and assumptions of generalised indifference, and 'plac[ing this] 'violence in the category of inconsequential social phenomena'.[335]

Even for those possessing the necessary epistemic resources to recognise UVEs as violence, numerous institutional and cultural impediments may discourage women and birthing people from seeking justice through the law. Impediments include difficulties securing a lawyer willing to take on the case[336] and economic disincentives, such as financial constraints and low compensatory awards. Further, for racialised people – against whom the law has often been used as a means for systematic oppression – recourse to the law may be a daunting prospect. Litigation also requires a gruelling degree of emotional resilience, and women and birthing people may be deterred from bringing an action due to the impact of testimonial smothering, which as Dhairyawan explains, occurs when self-censorship is deemed 'preferable to the psychological trauma of being dismissed or disbelieved'.[337] Further still, for some women and birthing people in different geopolitical contexts, childbirth is a shrouded topic of conversation due to is ascription to sexual intercourse, inhibiting open discussion and reporting of [violent] birthing experiences.[338]

Lack of awareness amongst women and birthing people has therefore inhibited (and will continue to inhibit) legal responsivity. This makes the conscious-raising function of obstetric violence discourses and activist movements all the more important for enabling women 'to draw insights and perceptions from their own experiences and those of other women and to use these insights to challenge dominant versions of social reality',[339] to vindicate experiences of violence in maternity care and to provide women and birthing people with the epistemic resources needed to seek legal redress.

[331] Shabot and Korem (n 243) 394.
[332] Romito (n 122) 34.
[333] Shabot, 'Afterword' (n 187) 197.
[334] Morales et al (n 235) 1314.
[335] Ibid.
[336] Diaz-Tello (n 34) 59.
[337] Rageshiri Dhairyawan, 'The Medical Practice of Silencing' (2021) The Lancet 838.
[338] Kaveri Mayra et al, 'Breaking the Silence About Obstetric Violence: Body Mapping Women's Narratives of Respect, Disrespect and Abuse During Childbirth in Bihar, India' (2022) 22(318) BMC Pregnancy and Childbirth 16.
[339] Bartlett (n 283) 866.

Lack of Awareness Amongst Institutional Stakeholders

Similarly, a lack of awareness amongst institutional stakeholders is hindering efforts to address UVEs and obstetric violence more broadly in law. As explained by Reed et al, 'dehumanising practices are so pervasive within maternity services that healthcare providers are unable to perceive them'.[340] The systemic character of violence in the maternity care context results in its normalisation, meaning violence goes unrecognised not only by women and birthing people as the subjects of violence, but also by their immediate community and by healthcare providers themselves.[341] This obliviousness 'allows institutional reproduction of obstetrically violent practices without being questioned'.[342] Additionally, healthcare professionals capacity for retrospection is hindered by authoritarian obstetric dispositif, as in medicine, 'institutionalised power and authority create a sense of entitlement to which there is arguably still limited external challenge'.[343] External challenge, necessary for dismantling violent structures, is cyclically inhibited by the lack of awareness amongst women themselves as well as the wider public.

This is substantiated by observations made by academics in the Global South who highlight the deficit in European discourses on obstetric violence as lacking in political perspective,[344] indicating the need to gain political traction and interinstitutional collaboration. As was the case in Latin America, only with intense and widespread scrutiny[345] was the phenomenon legislated against. Overall, widespread lack of awareness has profound consequences for how the law addresses (or fails to address) this gross violation of women's rights during childbirth.[346]

Limited Research

Obstetric violence remains poorly understood,[347] and although there has been a recent influx of systemic studies measuring abuse and mistreatment in maternity care contexts,[348] the findings are geographically and demographically restricted.[349] Additionally, the lack of reporting by women of their experiences of obstetric violence due to factors considered above means the empirical data is limited, and further research is therefore necessary to gain a fuller insight into the scope of the problem. However, this does not indicate obstetric violence is not occurring on a perturbing scale. Rather, it reinforces the extent to which the issue has been obscured.[350] Nevertheless, for some

[340] Reed et al (n 52) 8.
[341] Shabot and Korem (n 243) 392.
[342] Espinoza-Reyes (n 148) 197.
[343] Liz Kelly, 'The Conducive Context of Violence Against Women and Girls' (*Discoversociety,* 1 March 2016) Available at < http://discoversociety.org/2016/03/01/theorising-violence-against-women-and-girls/ > accessed 15th November 2021.
[344] Patrizia Quattrocchi 'Obstetric Violence, From Latin America to Europe: Similarities and Differences in the Current Debate' in Patrizia Quattrocchi and Natalia Magnone (eds), *Obstetric Violence in Latin America* (Buenos Aires, National University of Lanús 2020) 179.
[345] Williams et al (n 62) 1208.
[346] Kukura, 'Obstetric Violence' (n 74) 725.
[347] Ibid 726.
[348] Carlos Vacaflor, 'Obstetric Violence in Argentina: A Study on the Legal Effects of Medical Guidelines and Statutory Obligations for Improving the Quality of Maternal Health' (LLM thesis, University of Toronto 2015) 65.
[349] Savage and Castro (n 99) 3.
[350] Kukura, 'Obstetric Violence' (n 74) 758.

commentators amongst the medical community,[351] research limitations and considerations have been raised to contest women's experiences of obstetric violence.[352] This rhetoric, though sanitised by the language of scientific empiricism, is damaging, as it indirectly impedes legal responsivity by invalidating victim-survivors experiences. It also creates a risk of re-traumatisation and exposes 'supercilious attitudes and a lack of empathic concern'[353] for women's negative birth experiences. Ultimately however, 'no research consideration can disqualify a woman's birth experience [as] both are orthogonal to each other',[354] and as a form of structural violence, it is impossible to deploy a direct method to quantify[355] obstetric violence.

The Limits of Existing Law

The legal lacuna may also be partially explained by the limits of existing law. Concerted efforts to identify appropriate legal avenues through which to address UVEs have resulted in divergence in opinions over which legal framework to utilise - though unity in general dissatisfaction with the frameworks available, with some commentators suggesting that the regulation of these examinations is outside the scope of law.[356]

This indicates overall 'uncertainty as to how UVEs should be addressed and overarching ambiguity surrounding the respective roles of different potential redress routes'.[357] A common thread across the debate however is the limitations of existing laws for responding to the specific gendered and structural dimension of this violence. This is consistent with wider feminist jurisprudence which recognises that law can be prone to a fundamental deficit; a failure 'to reflect the reality of human existence',[358] and to fully speak to women's experiences. We should therefore hesitate before uncritically applying existing law to obstetric violence, as the law 'may benevolently or malevolently confirm women [and birthing people] in discursive positionings within the context of a powerful discourse, one in which their knowledge and discrete experiences are disqualified and/or subjugated',[359] and existing frameworks may be inappropriate for addressing the specific dimensions of this violence. Whilst an expansive discussion of every potential redress route is outside the scope of this dissertation, the benefits and drawbacks of various legal avenues will be outlined in chapter 2, before comprehensively engaging with the tort law framework and use of civil battery.

[351] Scambia et al (n 97) 332.
[352] Michael Rost, "Boiling up the Problem of Violence" in Childbirth? - An Ethical Viewpoint on Medical Professional Responses to Women's Reports of Mistreatment in Childbirth' 32(2) (2020) Ethik in der Medizin 190.
[353] Ibid 192.
[354] Ibid 190.
[355] De Maio and Ansell (n 259) 755.
[356] Foster, 'How Should the Performance of Periparturient Vaginal Examinations be Regulated' (n 35) 105.
[357] Brione, 'Non-consented Vaginal Examinations' (n 303) 37.
[358] Pamela Scheininger, 'Legal Separateness, Private Connectedness: An Impediment to Gender Equality in the Family' (1998) 31 Columbia Journal of Law and Social Problems 284.
[359] Carol Smart, 'Law's Power, the Sexed Body, and Feminist Discourse' (1990) 17 Journal of Law and Society 204.

Contextualising Obstetric Violence: Concluding Remarks

Ultimately, naming, conceptualising, and understanding obstetric violence represents a cardinal step in tackling the issue. Receptivity to the contours of this complex phenomenon is vital for ensuring women's and birthing people's degrading and dehumanising birth experiences are naturalistically represented in legal discourses and for promoting collaboration in efforts to address and prevent violence during labour and childbirth. An understanding of the structural and gender-based dimensions of this violence is essential to meaningfully engage with the question as to how the law should respond. It is only with this understanding that we can perceive the deficiencies of tortious battery for addressing UVEs as a form of obstetric violence.

Chapter 2: Interrogating the Functions of Tort Law

2.1 Redressing UVEs: The Need to Identify an Appropriate Legal Avenue

Women and birthing people subjected to UVEs during labour and childbirth must be able to seek legal redress. Across the discourse, academics have begun to identify and interrogate different legal avenues through which to confront obstetric violence. So far, however, less consideration has been given to the redress needs of individuals. Given the centralising of lived experience as a frame for understanding the harms and wrongs of obstetric violence, engagement with this topic is necessary to ensure that whilst working towards a larger project of systemic eradication of this violence, women and birthing people are not made peripheral subjects of legal concern. Legal responses must therefore be able to account for, and respond to, the fact UVEs constitute an acute act of violence on an individual level, as well as a chronic and systemic manifestation of violence on a structural level.[360]

Seemingly, the redress question has not yet been posed to victim-survivors of obstetric violence, with research necessarily having been focused on documenting and understanding women's experiences. Although, indicatively, in *SFM* reparations were requested as a measure of redress, and the victim-survivor also asked that the CEDAW Committee mandate state party intervention to ensure non-repetition of discriminatory and violent maternity care practices against women.[361] Furthermore, in cases litigated in Mexico with the assistance of the Information Group on Reproductive Choice (GIRE), compensation and/or state guarantees of non-repetition have been sought.[362] In most of these cases, however, neither measure of redress has been provided.

Women's answers to the justice question in other contexts of GBV may also offer transferrable insights. Notably, the breadth of 'justice' as a theoretical lens precludes its discussion here, and the relationship between redress and justice is generally taken as a given by feminist scholars. However, drawing from scholarly engagement with justice and GBV, such as that provided by McGlynn and Westmarland through their 'kaleidoscopic justice' concept,[363] we can infer that justice for women and birthing people may entail several components. It may include: being granted a voice; experiencing validation; vindication; recognition; dignity; and connectedness.[364] It is arguable that the legal framework used to address UVEs should aspire to evince these components of justice through its processes and measures of redress. It is also essential, however, that the legal action utilised furthers overarching objectives beyond redress for the individual. Particularly, it should possess the capacity to foster systemic change, ensuring prevention of obstetric violence. Fortunately, this objective exists harmoniously with, and is seemingly salient to, justice on the

[360] Dixon (n 61) 447.
[361] CEDAW, Decision adopted by the Committee under article 4(2)(c) of the Optional Protocol, concerning communication No. 138/2018 (n 72) [3.10].
[362] Information Group on Reproductive Choice (GIRE), 'Obstetric Violence: A Human Rights Approach' (2015) available at < https://gire.org.mx/wp-content/uploads/2020/02/ObstetricViolenceReport.pdf > accessed 16th May 2022 [94-98].
[363] Clare McGlynn and Nicole Westmarland, 'Kaleidoscopic Justice: Sexual Violence and Victim-Survivors' Perceptions of Justice' (2019) 28(2) Journal of Social and Legal Studies 180; the authors explain 'kaleidoscopic justice' denotes a framework in which 'justice [is] constantly refracted through new experiences or understandings; [as] an ever-evolving, lived-experience'.
[364] Ibid.

individual level. For example, victim-survivors of sexual violence regard cultural and social transformation as a fundamental element of justice.[365]

Whilst a critical exploration of all potential redress routes remains outside the scope of this dissertation, I provide an overview of alternative avenues identified by scholars and birth right activists, namely, human rights instruments, criminal law, and discrete frameworks. This will supply a background point of contrast with the underexamined tort system, whilst underlining the general inaptitude of the current legal landscape for addressing GBV - and focally, for responding to the multifarious wrongs and harms of UVEs. Indeed, academics such as Foster have expressed doubts as to whether law can be used effectively to address UVEs,[366] and it is acknowledged that given the multidimensionality of the phenomenon, a multidimensional approach is necessitated. However, legal redress is imperative and 'women's experiences, perspectives, and voices [must be brought] into law in order to empower women, and legitimate the[ir] experiences'.[367] The complexity of obstetric violence and the nexus of issues arising when determining which legal response should be used to address UVEs (and other forms of obstetric violence) should incentivise, not deter, critical engagement with the deficiencies of our legal frameworks, allowing us to highlight their limitations and direct legal reform.

2.2 An Overview of Alternative Avenues

Human Rights Instruments

Numerous academics rely on human rights instruments to explore redress for obstetric violence, and as noted by Lokugamage and Pathberiya, 'human rights in childbirth is an emerging field within reproductive health rights'.[368] This indicates the fertility of the human rights arena for addressing UVEs and other manifestations of obstetric violence.[369] As a matter of general principle, the European Court of Human Rights ('ECHR') has affirmed that any medical intervention 'implicates the right to respect for private life'.[370] Since many instances of obstetric violence contravene this rights entitlement – UVEs being a paradigmatic example – a rights claim could be brought before the courts. This is supported by *YF v Turkey*[371] and other cases concerning UVEs conducted outside the birthing context.

The suitability of bringing an action against UVEs under human rights instruments is readily apparent, as human rights instruments possess 'universal foundations in respect for human

[365] Fjóla Hildur Antonsdóttir, 'Compensation as a Means to Justice? Sexual Violence Survivors' Views on the Tort Law Option in Iceland' (2020) 28(3) Feminist Legal Studies 280.
[366] Foster, 'How Should the Performance of Periparturient Vaginal Examinations be Regulated' (n 35) 105.
[367] Lucinda Finley, 'Breaking Women's Silence in Law: The Dilemma of the Gendered Nature of Legal Reasoning' (1989) 64 Notre Dame Law Review 907.
[368] Amali Lokugamage and Sithira Pathberiya, 'Human rights in Childbirth, Narratives and Restorative Justice: A Review' (2017) 14(1) Journal Reproductive Health 1.
[369] However, there has been inconsistency in the ECHR protection of women's rights in the maternity care context. See Chao-Yuan Chen and Marie Cheeseman, 'European Court of Human Rights Rulings in Home Birth Set to Cause Trouble for the Future: A Review of Two Cases' (2017) 25(1) Medical Law Review for commentary on the conflicting ECHR home birth cases.
[370] Rajat Khosla et al, 'International Human Rights and the Mistreatment of Women During Childbirth' (2016) 18(2) Health and Human Rights Journal 137.
[371] *YF v Turkey*, App no 24209/94 [2003] ECHR 39.

dignity'.[372] Through vindicating the need to respect the dignity of women and birthing people, 'human rights set standards for maternity care at both a systemic and individual level'[373] and communicate the impermissibility of UVEs as a human rights violation. Further, since human rights instruments constitute 'mechanisms of accountability able to scrutinise institutions and to challenge normative power hierarchies',[374] it is arguable that they may better facilitate systemic reform of maternity care practices. This suggestion is bolstered by the poignancy of human rights language and discourses, as they have political currency and engender greater public empathy and social concern.[375]

However, the potential of regional human rights instruments in the context of GBV has been undercut by the courts lack of understanding of women's experiences.[376] With regards to GBV and rights violations in the reproductive and maternity care context, this may be due to the fact that healthcare professionals' views have been granted persuasive authority in Strasbourg, whilst the perspectives of women and birthing people have been absent.[377] Furthermore, the court's inability to accommodate and understand pregnant women's and birthing people's experiences - and the vitality of reproductive self-determination[378] - is inhibited by conceptual invocation to the archetypal 'rights-bearer as a disembodied, genderless person of reason'.[379] Ignorance to gendered-experience has consequently resulted in a failure to recognise the 'discriminatory nature of gender-based violence, undermin[ing] its systemic nature'.[380] Thus, the masculinist assumptions and understandings which animate human rights result in the 'occlu[sion] of forms of oppression and violations suffered by women... [and] human rights discourse often abstracts from the structural determinations that position diverse groups of women in fundamentally inegalitarian ways'.[381]

Although, international human rights mechanisms may hold greater promise, as demonstrated by CEDAWs role in *SFM.* However, CEDAW focuses on eliminating discrimination against women exclusively,[382] and reflects a dualistic understanding of gender/sex found in most international

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[372] Elizabeth Prochaska, 'Human Rights in Maternity Care' (2015) 31(11) Journal Midwifery 138.
[373] Elizabeth Prochaska, 'Human Rights Law and Challenging Dehumanisation in Childbirth: A Practitioner's Perspective' in Camilla Pickles and Jonathon Herring (eds), *Childbirth, Vulnerability and Law* (Routledge 2019) 136.
[374] Erdman (n 1) 47.
[375] Ronagh McQuigg, 'Gender-based Violence as a Public Health Issue and the Legal Perspective: A Critical Overview' in Keerty Nakray, *Gender-based Violence and Public Health: International Perspectives on Budgets and Policies* (Routledge 2012) 48.
[376] Liiri Oja and Alicia Yamin, ''Woman" in the European Human Rights System: How Is the Reproductive Rights Jurisprudence of the European Court of Human Rights Constructing Narratives of Women's Citizenship?' (2016) 32 Columbia Journal of Gender and Law 63.
[377] Fleur van Leeuwen, 'The missing voice of pregnant women: third party interventions in the Dubska and Krejzova case' (Strasbourg Observers', November 23rd 2015) < https://strasbourgobservers.com/category/cases/dubska-and-krejzova-v-czech-republic/ > accessed 4th February 2022.
[378] Ivana Radačić, '(En)gendering Inclusiveness in the Jurisprudence of the European Court of Human Rights' (PhD thesis, University College London 2008) 220.
[379] Ibid 21.
[380] Ibid 218.
[381] Moya Lloyd, '(Women's) 'Human Rights: Paradoxes and Possibilities' (2007) 33(1) Review of International Studies 100.
[382] Otto (n 41) 236. See also; Gabrielle Simm, 'Queering CEDAW? Sexual Orientation, Gender Identity and Expression and Sex Characteristics (SOGIESC) in International Human Rights Law' (2020) 29(3) Griffith Law Review at 394, highlighting that 'CEDAW is built on certain assumptions about heteronormative women'.

human rights instruments and treaties.[383] Whilst human rights mechanisms such as CEDAW may be better equipped to address obstetric violence as a form of discrimination, the exclusionary consequences for victim-survivors of obstetric violence who do not identify as women are clear.

Additionally, although human rights instruments are strongly vindicatory, by contrast to the tort system, they are designed to reinforce the 'benefit of right[s] for society… not just the value of the right to the individual'.[384] Whilst human rights are fundamentally forward-looking in their design to ensure non-repetition of rights violations, tort law is backwards-looking,[385] as its primary focus has been said to be restoring claimants to their pre-wronged disposition.[386] As a consequence of these respective approaches to vindication, tort law, not human rights law, results in damages for rights violations.[387] Whilst the importance of damages will differ amongst persons, damages provide collateral benefits whilst operating as a means for expressing messages to society, such that their significance on the individual and wider level is overlooked in the human rights arena. Nevertheless, in the obstetric violence context, human rights principles and language have proven invaluable as forces of mobilisation, and they have been used compellingly to confirm state obligations to address it. However, it has been suggested that tort law could be enriched by human rights principles whilst simultaneously serving as a vehicle for their protection.[388]

Criminal Law

Criminal law has also been advocated as a means through which to address obstetric violence. Academics have begun to consider reliance on existing criminal offences,[389] as well as discrete criminalisation - as has occurred across Latin America. Generally, use and/or introduction of criminal law provisions against obstetric violence has been endorsed by the UN Special Rapporteur,[390] and criminal law intervention would align with recommendations provided by CEDAW for addressing GBV.[391]

Criminalisation of UVEs performed during labour and childbirth may provide an effective means of redressing and preventing the practice on the individual and structural level. Criminal law is naturally

[383] Otto (n 41) identifies exceptions however, such as the Committee Against Torture which 'disrupts gender dualism with its recognition gendered human rights abuses can be experienced by people of diverse gender identities' 244.
[384] Jenny Steele, 'Damages in Tort and Under the Human Rights Act: Remedial or Functional Separation?' (2008) 67(3) CLJ 619.
[385] Dan Priel, 'Structure, Function, and Tort Law' (2020) 13(1) Journal of Tort Law 32.
[386] Benjamin Zipursky, 'Civil Recourse, Not Corrective Justice' (2003) 91 Georgetown Law Journal 695.
[387] Steele (n 384) 608.
[388] Lord Bingham of Cornhill, 'Tort and Human Rights' in Peter Cane and Jane Stapleton (eds), *The Law of Obligations: Essays in Celebration of John Fleming* (Clarendon Press 1998) 3.
[389] See, for example, Catarina Sjölin, 'Including the Victim's Perspective: Can Vaginal Examinations Ever be Sexual Assaults?' in Camilla Pickles and Jonathon Herring (eds), *Women's Birthing Bodies and the Law* (Hart 2020); Karen Brennan, 'Reflections on Criminalising Obstetric Violence: A Feminist Perspective' in Camilla Pickles and Jonathon Herring (eds), *Childbirth, Vulnerability and Law* (Routledge 2019) at 236; and Pickles, 'When Battery is Not Enough' (n 8).
[390] United Nations General Assembly (n 67) [7].
[391] Committee on the Elimination of Discrimination Against Women, 'General Recommendation No.35 on Gender-Based Violence Against Women, Updating General Recommendation No.19', UN Doc CEDAW/C/GC/35 (2017) [24(a)].

concerned with public (as opposed to private, interpersonal) obligations,[392] and ensures their observance through punitive means. Criminal punishment would therefore powerfully express community censure of UVEs,[393] vindicating the suffering caused to individuals as a result of the practice. The expressive capacity of criminalisation may also be valuable on the social and systemic level, since upon defining violence as criminal, 'many people see it and care about it [but when] it is simply a by-product of our social and economic structure, many do not see it; and it is hard to care about something one cannot see'.[394]

However, criminal law has struggled to accommodate abuse and violence experienced by women.[395] Tuerkheimer notes that 'the criminal justice systems structurally deficient response to harms suffered largely by women percolates outside the boundaries of law, warping social understandings of gender-based violence'.[396] For this reason, non-traditional means of redressing GBV have been increasingly explored by feminist scholars.[397] Additionally, due to deficits in understanding[398] and the structure of the criminal trial, encounters with the criminal law system are adversarial, and often distressing,[399] with gender stereotypes operating to sustain a culture of scepticism towards women's experiences of violence.[400] This results in victim alienation, which is augmented by victim-survivors' peripheral standing in the process.[401] It is unsurprising, therefore, that victim-survivors of GBV have voiced a lack of trust in the system[402] and have felt as though they have been treated unsympathetically.[403] For racialised persons in particular, lack of trust in the criminal justice system is exacerbated by institutionalised racism,[404] as well as the intersectional, interactional blindness of criminal justice responses to the 'social, economic and cultural barriers which impede access of ethnic minority groups'.[405] Notably, however, this blindness afflicts other bodies of law, representing a shortcoming of the wider legal system.

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[392] Karen Yeung and Jeremy Horder, 'How Can the Criminal Law Support the Provision of Quality in Healthcare?' (2014) 23(6) BMJ Quality and Safety 520.
[393] Brennan (n 389) 245.
[394] Vittorio Bufacchi, 'Rethinking Violence' (2009) (4) 10Global Crime 293.
[395] Brennan (n 389) 226.
[396] Deborah Tuerkheimer, 'Recognising and Remedying the Harm of Battering: A Call to Criminalise Domestic Violence' (2004) 94(4) Journal of Criminal Law and Criminology 94(4) 960.
[397] Antonsdóttir (n 365) 278.
[398] Vanessa Munro, 'Domestic Violence, Trauma and Vulnerability' in John Child and Antony Duff (eds), *Criminal Law Reform Now: Proposals and Critique* (Hart 2019) 248.
[399] Nicola Godden, 'Claims in Tort for Rape: A Valuable Remedy or Damaging Strategy?' (2011) 22 KLJ 176.
[400] For examples, see; Jericho Hockett et al, 'Rape Myth Consistency and Gender Differences in Perceiving Rape Victims: A Meta-Analysis' (2016) 22(2) Violence Against Women, on the impact of gender stereotyping and rape myths in the context of sexual violence and Silke Meyer, 'Still Blaming the Victim of Intimate Partner Violence? Women's Narratives of Victim Desistance and Redemption When Seeking Support' (2016) 20(1) Theoretical Criminology, noting the persistence of stereotypical and victim-blaming attitudes towards women reporting intimate partner violence.
[401] Judith Herman, 'Justice from the Victim's Perspective' (2015) 11(5) Violence Against Women 582. See also, Nicola Lacey, 'Violence, Ethics and Law: Feminist Reflections on a Familiar Dilemma' in Susan James and Stephanie Palmer (eds), *Visible Women: Essays on Feminist Legal Theory and Political Philosophy* (Hart 2002) at 124, who notes how 'violent exclusions of the rape victims experience – her (or his) constitution as an 'unspeakable subject' [has] direct consequences for criminal laws capacity to respond to sexual violence'.
[402] McQuigg (n 375) 41.
[403] Pilar Albertín et al, 'A Feminist Law Meets an Androcentric Criminal Justice System: Gender-Based Violence in Spain' (2020) 15(1) Feminist Criminology 75.
[404] Jyoti Belur, 'Is Policing Domestic Violence Institutionally Racist? A Case Study of South Asian Women' (2008) 18(4) Policing and Society 426.
[405] McQuigg (n 375) 42.

Furthermore, criminal law is primarily concerned with punishment,[406] and in the context of obstetric violence and UVEs this may be deemed inappropriate. Manifestations of obstetric violence often result from inadvertence, and for some, use of criminal liability to punish inadvertent conduct is generally inappropriate.[407] Many healthcare professionals who perpetrate obstetric violence are, often unknowingly, instruments of an existing violent structure.[408] Criminal punishment may therefore be ineffectual in changing their behaviour and for dismantling the underlying violent structure. Furthermore, cognitive psychology also suggests that punishment and elicitation of guilt may actually be counterproductive to behaviour reformation.[409] Additionally, in the sexual violence context, studies indicate that 'victim-survivors [do not] automatically go to tropes of convictions and punishments'[410] as evincing justice. Thus, if punishment fails to reform healthcare professional conduct on a systemic level, and also does not cohere with the redress needs of individual women and birthing people, alternative legal responses may be preferrable. This is not to say criminal law is an invariably inappropriate response, but if a crime of obstetric violence was introduced, the ambit of the term would necessarily be restricted.[411] Though traditionally, 'criminal law has not been used to capture non-fatal medical harm-doing',[412] and despite general aversion to criminalising healthcare professional conduct,[413] for intentionally abusive manifestations of obstetric violence a criminal law response is firmly warranted.[414]

Implementing Discrete Frameworks

Numerous countries across the Global South have implemented novel legal frameworks through which healthcare professionals can be held accountable for obstetric violence.[415] Advantageously, these frameworks 'make visible the social dynamics insitgat[ing] obstetric violence… [and contextualise] obstetric violence as part of women's human rights struggles'.[416] Furthermore, discrete legal provisions more powerfully reinforce the fundamentality of rights to reproductive self-determination and obstetric autonomy. Especial reinforcement may be necessary given that 'current obstetric practice consistently disregards autonomy rights',[417] notwithstanding existing legal regulation. Additionally, this approach would be consistent with legal trends responding to GBV in other contexts. To condemn obstetric violence with the same voracity and to address its structural embeddedness, equally vindicatory provisions may be necessary. However, so far, the discrete

[406] Robert Sullivan, 'Wrongs and Responsibility for Wrongs' in Mathew Dyson (eds), *Unravelling Tort and Crime* (CUP 2014) 102.
[407] Yeung and Horder (n 392) 522.
[408] Borges (n 23) 856.
[409] Andrew Siegel, 'On Narcissism and Veiled Innocence: Prolegomena to a Critique of Criminal Law' (1992) 15(3) International Journal of Law and Psychiatry 345.
[410] McGlynn and Westmarland (n 363) 185.
[411] Pickles, 'Eliminating Abusive "Care"' (n 3) 11.
[412] Alexandra Mullock, 'Surgical Harm, Consent, and English Criminal Law: When Should ''Bad-Apple'' Surgeons be Prosecuted?' (2021) 21(4) Medical Law International 344.
[413] Jonathon Montgomery, 'Medicalizing Crime - Criminalizing Health? The Role of Law' in Charles Erin and Suzanne Ost (eds), *The Criminal Justice System and Health Care* (OUP 2007) 272.
[414] Pickles, 'Eliminating Abusive "Care"' (n 3) 11.
[415] Dixon (n 61) 443.
[416] Sánchez (n 79) 40.
[417] Jessica Flanigan, 'Obstetric Autonomy and Informed Consent' (2016) 19(1) Ethical Theory and Moral Practice 240.

frameworks implemented in Latin America have had minimal impact.[418] Quattrocchi, highlighting the failure of the implementation process in Argentina, contends that the public policy response and the legal measures introduced are proving 'insufficient to combat the multidimensionality of the issue'.[419] This demonstrates that, on their own, bespoke laws will not be enough. Nevertheless, discrete frameworks which provide both criminal and civil law remedies may be better equipped to respond to discrete circumstances and experiences of violence, to cater for individual justice needs, and to instigate systemic change.

Ultimately, by drawing upon the insights and learning from the experiences of Latin American countries who have introduced discrete provisions tackling obstetric violence,[420] it would be viable to create more robust frameworks to address UVEs and other manifestations of obstetric violence. Furthermore, it is arguable that by articulating this violence from the perspective of women and birthing people and crafting provisions accordingly - to account for the specific dimensions of this violence - an 'obstetric violence framework would do a lot more than the current legal system'.[421] However, introducing such a framework would not be an easy undertaking, representing a huge political and legal project. Confounded by the current political climate and the lack of public policy concern for women's health issues, it is hard to imagine such sweeping changes being introduced in the contemporary context. Reliance on existing avenues of law is, therefore, arguably necessary. Nevertheless, as this dissertation progresses, I lend increasing support to the call for a discrete obstetric violence framework.

2.3 Examining the Tort Framework

In contrast to the aforementioned avenues, tort law has received marginal consideration in the obstetric violence discourse,[422] and in general, 'childbirth is deeply under-theorised in tort'.[423] Tort is a broad system comprising a range of actions, generally categorisable in terms of negligence-based rules (which dominate tort scholarship debates and discourse), strict liability, and the intentional torts.[424] Since this dissertation explores the extent to which the tort of battery addresses the wrong of UVEs, I will focus on academic engagement with the intentional torts to identify their function within the wider tort framework. I will also provide insight into the potential utility of the tort system for addressing GBV, as the preoccupation with negligence has resulted in a general, underexamined assumption tort law is an 'improper vehicle for address[ing] instances of aggression, or abuse of power',[425] and women's experiences of violence more broadly.

Tort Law: The Theoretical Landscape

[418] Vacaflor (n 348) 3.
[419] Quatrocchi, 'Obstetric Violence Observatory' (n 65) 772.
[420] Williams et al (n 62) 1209.
[421] Borges (n 23) 862.
[422] Although, see Mulligan (n 17) and Diaz-Tello (n 34).
[423] Martha Chamallas, 'Social Justice Tort Theory' (2021) JTL 18.
[424] Mark Geitsfeld, 'Conceptualising the Intentional Torts' (2018) 10(2) JTL 160.
[425] Martha Chamallas, 'Will Tort Law Have Its #Me Too Moment?' (2018) 11(1) JTL 48.

Tort law appears to 'lack a common ambition',[426] and general ambiguity surrounding the functions of tort means that there is 'no consensus about the appropriate rationale for tort liability'.[427] I therefore provide an overview of the dominant theories: economic, corrective justice, civil recourse, compensation-deterrence and social justice theory, to discern objectives which are arguably central to tort.

On the economic view, 'tort law [is] aimed at the paramount goal of efficiency'.[428] Economic theory offers an instrumentalist account, positing that by requiring those who have committed torts to pay damages, an ex-ante incentive is generated for 'similarly situated persons to refrain from engaging in tortious conduct'.[429] Emphasis is therefore placed on the deterrence goal of tort. In complete contrast, corrective justice theory emphasises the function of the tort system as the 'correcting wrongs and restoring equilibrium between injurer and injured',[430] which is achieved by reversing wrongful transactions through compensation. Corrective justice theory can be said to embody deontological, as opposed to utilitarian values,[431] and is organised around an interpersonal bipolar justice structure.[432] Notably, both corrective justice and economic theorists rarely engage with the substantive norms or structural features specific to intentional torts such as battery.[433]

Other theories have enjoyed increased traction within torts scholarship. One such theory is civil recourse theory. Whilst civil recourse largely holds the same intuitions as corrective justice, it 'differs by suggesting tort's purpose is not to saddle wrongdoers with an obligation to repair, but instead to privilege wrong sufferers with an action'.[434] Thus, the central purpose of the civil suit is to hold wrongdoers to account – not to receive damages.[435] The account conceptualises 'wrongs' as 'violation[s] of legal norm[s] that enjoin certain conduct',[436] and therefore frames torts as a unique hybridisation of private and public law.[437] Briefly, compensation-deterrence theory contends that tort law aims to achieve and balance the objectives centralised within the theories above, identifying a mutuality between them, and suggesting that tort law aims to achieve 'collective justice'.[438] An alternative analysis of tort law is provided by social justice tort theorists. According to Chamallas, a vital objective of tort law 'must be to identify, address, and ameliorate the effects of systemic inequalities and disparities'.[439] Notably, the insights of social justice tort theorists are particularly useful for perceiving systemic biases within tort rules and remedies,[440] and therefore for highlighting material limitations of the tort system.

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[426] Kirsty Horsey and Erika Rackley, *Tort Law* (6th edn, OUP 2019) 3.
[427] Mark Geitsfeld, 'The Coherence of Compensation-deterrence Theory in Tort Law' (2012) 61(2) The De Paul Law Review 385.
[428] Martha Chamallas and Jennifer Wriggins, *The Measure of Injury: Race, Gender and Tort Law* (NYUP 2010) 14.
[429] Zipursky (n 386) 702
[430] Jennifer Robbennolt and Valerie Hans, *The Psychology of Tort Law* (NYUP 2016) 4.
[431] Zipursky (n 386) 700.
[432] Allan Beever, 'Corrective Justice and Personal Responsibility in Tort Law' (2008) 28(3) OJLS 77.
[433] Chamallas and Wriggins (n 428) 15.
[434] Carmody Tiller, 'Tort Law Inside Out' (2017) Yale Law Journal 1330.
[435] R Duff, 'Torts, Crimes and Vindication: Whose Wrong is it?' in Mathew Dyson (eds), *Unravelling Tort and Crime* (CUP 2014) 148.
[436] Zipursky (n 386) 742.
[437] Ibid 755.
[438] Geitsfeld, 'The Coherence of Compensation-deterrence Theory' (n 427) 409.
[439] Chamallas, 'Social Justice Tort Theory' (n 423) 7.
[440] Ibid 10.

Whilst these theories attempt to provide (mostly) complete rationales for tort liability, its objectives and its functions, I submit that exclusive reliance on any one of these theories belies that tort has 'developed haphazardly'[441] in response to dynamic circumstances, and as a 'complex human and social institution, shaped by many hands over many years… it cannot be explained adequately by reference to one idea, functional or otherwise'.[442] I therefore opt for a pluralist approach, identifying and examining various objectives of the tort system from across the theoretical landscape.

2.3.1 The Various Objectives of Tort Law

Having overviewed the theoretical landscape, a number of objectives of the tort system can be identified, including deterrence, accountability, compensation, vindication of wrongs, and claimant empowerment. However, there exists a disjuncture between the theoretical functions and objectives of tort law, and their materiality within the tort system. Nevertheless, these objectives are examined below to determine the suitability of tort law for the purposes of individual redress, and wider systemic prevention of UVEs. The conclusions drawn here are conjectural, due to the fact 'little is known about what litigants really want from the civil justice system and what they aim to achieve',[443] and even less is known about what redress means to victim-survivors of obstetric violence.[444] Additionally, the tort law framework has not customarily been relied upon to address instances of GBV. Notwithstanding this, given the importance of ensuring legal responses are attentive to lived experiences of obstetric violence and that resulting remedies are meaningful, an evaluation of whether the various objectives of tort provide redress on the individual, as well as systemic level, is a necessary preface to critical engagement with the tort of battery. As will become apparent, although the objectives and supposed functions of tort law present this framework as an attractive means through which to address UVEs, and potentially other forms of obstetric violence, there are numerous drawbacks to relying on tort law in this context.

Deterrence

Tort law is often said to serve a deterrent function. Deterrence theory - critical to the economic account - suggests that the prospect of tortious liability influences people's behaviour.[445] In the healthcare context specifically, the tort framework allegedly deters tortious conduct as healthcare professionals aim to avoid the costs associated with breaching the civil norms and expectations which arise within clinical relationships. Additionally, deterrence is also achieved through the

[441] Gary Schwartz, 'Mixed Theories of Tort Law: Affirming both Deterrence and Corrective Justice' (1996) 75 Texas Law Review 1826.
[442] Jason Varuhas, 'The Concept of ''Vindication'' in the Law of Torts: Rights, Interests and Damages' (2014) OJLS 259.
[443] Tamara Relis, *Perceptions in Litigation and Mediation: Lawyers, Defendants, Plaintiffs, and Gendered Parties* (CUP 2009) 33.
[444] This further underlines the importance of future empirical research.
[445] Shaun Pattinson, *Medical Law and Ethics* (6th edn, Sweet & Maxwell 2020) 99.

imperative to avoid reputational harm.[446] In regards to battery, the torts' ability to operate as a powerful deterrent[447] is arguably enhanced by its criminal law connotations.[448]

However, in practice, it has been disputed whether the tort system has a systemic deterrent capacity - and indeed, deterrence theory lacks an evidential premise.[449] Academics have also criticised tort for failing to deter even the most flagrant forms of abuse,[450] such that tortious liability is unlikely to deter more subtle forms of obstetric violence. Furthermore, though healthcare professionals are aware of the threat of civil or even criminal liability, the likelihood of legal proceedings being initiated is remote.[451] According to social science studies, this produces 'egocentric and [heuristic] availability biases [which] drive the deterrent effect of tort liability to a subsignificant level'.[452] Furthermore, Robbenholt and Hans note that 'for tort to effectively deter tortious conduct, the targets of the law must be aware and understand the rules, [and be] willing to follow [them]'.[453] Whilst healthcare professionals understand that the performance of any intervention on a capacious person without authorisation constitutes a trespass to the person, in the maternity care context, this rule has been circumvented by the finding of incapacity where the decisions of women in labour go against authoritative obstetrical advice.[454] As (en)forced caesarean section case law demonstrates,[455] failure to comply with medical professional dictates immediately raises questions surrounding the woman's capacity. Capacity considerations have arguably been used to guise healthcare practitioner unwillingness to respect the autonomy of birthing women, in the event that doing so could compromise the safety of the foetus.[456]

It is also arguable that the existence of liability insurance dilutes the preventative function,[457] as healthcare professionals will not themselves be responsible for the payment of any damages awarded to the claimant.[458] Nevertheless, some scholars uphold that tort serves a deterrent function, albeit a suboptimal one.[459] Thus, whilst recourse to battery in instances of UVEs may not assuredly secure their prevention on the systemic level, the deterrent function of the action may, to limited degree, operate as an appreciable side effect of tort liability.[460]

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[446] Russel Gold, 'Compensation's Role in Deterrence' (2016) Notre Dame Law Review 1999.
[447] Ian Kennedy and Andrew Grubb, *Medical Law* (3rd edn, Butterworths 2000) 672.
[448] See Seabourne (n 38) at 269 however, who notes the criminal law connotations of battery may conversely diminish the suitability of civil battery for regulating medical practice.
[449] Oliver Quick, *Regulating Patient Safety: The End of Professional Dominance?* (CUP 2017) 98.
[450] Chamallas and Wriggins (n 428) 4.
[451] Foster, 'How Should the Performance of Periparturient Vaginal Examinations be Regulated' (n 35) 104.
[452] Jonathon Cardi, Randall Penfield and Albert Yoon, 'Does Tort Law Deter Individuals? A Behavioural Science Study' (2012) Journal of Empirical Legal Studies 9(3) 592-593.
[453] Robbennolt and Hans (n 430) 2.
[454] Nelson and Romanis (n 202) 674.
[455] See; *Re MB* [1997] 2 FLR 426 (CA); *Rochdale Healthcare (NHS) Trust v C* [1997] 1 FCR 274; *Re AA* [2012] EWHC 4378 (COP).
[456] Samantha Halliday, 'Court-Authorised Obstetric Intervention: Insight and Capacity, a Tale of Loss' in Camilla Pickles and Jonathon Herring (eds), *Childbirth, Vulnerability and Law* (Routledge 2019) 177.
[457] Gert Bruggemeier, *Common Principles of Tort Law: A Pre-Statement of Law* (British Institute of International and Comparative Law 2004) 4.
[458] See also; Daniel Shuman, 'The Psychology of Compensation in Tort Law' (1994) University of Kansas Law Review at 53, who suggests that insurance not only dilutes the preventative function, but that it could diminish the cathartic value of compensation since the 'psychological primacy of compensation may not be adequately addressed by sterile payments to an injured person from a third-party lacking responsibility for causing the harm to the plaintiff'.
[459] Schwartz (n 441) 1818.
[460] Hans Stoll, 'Penal Purposes in the Law of Tort' (1970) 18(1) American Journal of Comparative Law 21.

Accountability

Another objective of the tort system is to hold individuals to account for committing civil wrongs,[461] as though 'tort liability does not communicate condemnation… [it nevertheless enters] … a judgement against the defendant'.[462] Accountability under civil law is therefore not narrowly assimilated with punishment and blame of individual healthcare professionals[463] but is more broadly conceived. Accountability is achieved through public judgement, orders to pay damages, and is effectuated symbolically, by requiring the defendant to face the claimant in court. The benefits of the civil litigation structure in empowering claimants are explored discretely below, but for present purposes, it is noted the litigation structure allows claimants to elicit answers directly from those who have harmed them,[464] enabling them to hold defendants personally accountable. Civil liability therefore assigns individual responsibility for tortious conduct without vilifying healthcare professionals,[465] such that accountability for the performance of UVEs may be more appropriately achieved under civil, as opposed to criminal, law. However, studies have indicated that healthcare professionals 'have a poor understanding of their legal accountability',[466] and the fact UVEs continue to be perpetrated notwithstanding the threat of tortious liability arguably lends support to these findings. This may be partially explained by the fact generally, claims are brought for harms caused to the foetus, with maternal harm being a non, if not secondary, concern. Furthermore, although obstetric negligence claims gross huge compensation sums,[467] the cost will not be borne by the healthcare professional. Just as this dilutes the deterrent function, it also diminishes the accountability enforcing function of tort law.

Compensation

Compensation is often centralised under the corrective justice account as the primary function of tort law.[468] Notably, compensation is often used restoratively, as a means for reversing wrongful transactions. In the context of obstetric violence and UVEs however, compensation is unlikely to be able to restore a wronged woman or birthing person to their pre-wrong disposition.[469] However, compensation may be remedial for some women and birthing people at an individual level, particularly in conjunction with tort's powerful vindicatory function (explored below). Beyond the individual however, compensation can serve a valuable expressive function on a wider systemic level, as 'a signal of the social worth of plaintiffs and [as] a societal measure of their suffering'.[470] As a 'medium for sending messages'[471] then, compensation can communicate the severity of the wrong

[461] Gold (n 446) 43.
[462] Scott Herschovitz, 'Treating Wrongs as Wrongs: An Expressive Argument for Tort Law' (2018) 10(2) JTL 435.
[463] Godden, 'Claims in Tort for Rape' (n 399) 161.
[464] Mathew Shapiro, 'Civil Wrongs and Civil Procedure' in Paul Miller and John Oberdiek (eds), *Civil Wrongs and Justice in Private Law* (OUP 2020) 94.
[465] Godden, 'Claims in Tort for Rape' (n 399) 141.
[466] Jane Lymer and Fiona Utley, 'Hospitality and Maternal Consent' (2013) Law Text Culture 256.
[467] See Clare Dyer, 'New Settlement Procedures: Changing the Way the NHS Resolves Negligence Claims' (2017) 358 BMJ 1; 'Obstetrics accounts for only 10% of the claims made against trusts, but 50% of the overall value of claims'.
[468] Patrick Atiyah, *The Damages Lottery* (Hart 1997) 3.
[469] Mulligan (n 17) 177.
[470] Chamallas and Wriggins (n 428) 5.
[471] Herschovitz (n 462) 431.

committed whilst symbolising public respect for the rights in question -[472] in this instance, respect for the inviolability of women and birthing people's bodies.

However, the use of compensation as a means for redress may raise concerns surrounding the commodification of human suffering, as it could be perceived degrading to valuate certain types of injuries and human relationships using commercial measures.[473] Fiske and Tetlock refer to such exchanges as 'taboo trade offs'.[474] Furthermore, the incommensurability between the wrongs and harms of UVEs and monetary compensation[475] exacerbates the difficulties with a monetised response as a means to redress, and creates quantification issues when attempting to 'construct equivalences between any two ontologically different phenomena'.[476] For this reason, compensation for gender-based harms (particularly intangible harms) 'may be more susceptible to heuristics and biases'.[477]

However, it can be argued that 'monetisation is different than commodification, particularly when plaintiffs are allowed to narrate their individual harm and place them in a social context'.[478] Thus, the mere fact that an interest is intangible should not, in and of itself, prevent valuation of the interest for compensatory purposes,[479] particularly in light of the expressive capacity of compensation and its role in enhancing the cathartic value of the suit.[480] Although, it is important that other objectives important to the individual bringing the claim are not neglected due to lawyers myopic focus on monetary outcomes,[481] as this would undermine efforts to nurture a richer vision of justice responsive to women's and birthing person's individualised needs.[482] Thus, 'our ability to offset minor discomfort and self-denials with small rewards should not mislead us to extrapolate that psychodynamic to all pain and loss'.[483] However, in respect of litigation under the intentional torts, it seems compensation plays a micro-functional role.[484]

Undervaluation of Gender-based Harm

[472] Margaret Radin, 'Compensation and Commensurability' (1993) Duke Law Journal 62.
[473] Martha Chamallas, 'The Architecture of Bias: Deep Structures in Tort Law' (1998) 146(2) University of Pennsylvania Law Review 497.
[474] Alan Fiske and Philip Tetlock, 'Taboo Trade-offs: Reactions to Transactions That Transgress the Spheres of Justice' (1997) 18(2) Political Psychology 256.
[475] Antonsdóttir (n 365) 279.
[476] Richard Abel, 'General Damages are Incoherent, Incalculable, Incommensurable, and Inegalitarian (But Otherwise a Great Idea)' (2006) De Paul Law Review 282.
[477] Yoed Halbersberg and Ehud Guttel, `Behavioral Economics and Tort Law' in Eyal Zamir and Doron Teichman (eds), *The Oxford Handbook of Behavioural Economics and the Law* (OUP 2014) 406.
[478] Chamallas, 'Social Justice Tort Theory' (n 423) 14.
[479] Richard Delgado, 'Words That Wound: A Tort Action for Racial Insults, Epithets and Name Calling' (1982) 17 Harvard Civil Rights–Civil Liberties Law Review 166.
[480] See Bruce Feldhusten, 'The Civil Action for Sexual Battery: Therapeutic Jurisprudence' (1993) 25 Ottawa Law Review, who notes that civil battery litigation may provide therapeutic benefit to claimants.
[481] Robyn Holder and Kathleen Daly, 'Recognition, Reconnection, and Renewal: The Meaning of Money to Sexual Assault Survivors' (2018) 24(1) International Review of Victimology 27.
[482] Leslie Bender, 'Feminist (Re) Torts: Thoughts on the Liability Crisis, Mass Torts, Power and Responsibilities' (1990) 4 Duke Law Journal 861.
[483] Abel (n 476) 271.
[484] Varuhas (n 442) 259.

Scholars have long recognised the gendered limitations of the tort system.[485] This manifests in the undervaluation of gender-based harms and injuries. Concerningly, in light of the expressive capacity of compensation, this may result in the trivialisation of UVEs and their subsequent harms.

As recognised by Abrams, tort law 'does not just recognise and compensate injuries; it does the political and social work of determining what will count as an injury'.[486] The political and social role of tort in validating and engendering social concern for harms is therefore of vital importance. However, tort has been widely criticised for systemically undervaluating and trivialising gender-based harms.[487] This may be explicable by the fact 'tort law has been developed largely without women and the particular harms they suffer in mind',[488] and (as in law generally) male conceptions of problems and harms inform its language and process of reasoning.[489] Consequently, gender-based harms are often obscured from recognition and/or distorted when brought under laws' lens. As the social construction of harm adopted across the legal system is based on male experience, 'particular victimisations may be recognised as legal harms only to the extent permitted by the law, and [they] are often divorced from the survivors subjective' experiences'.[490] In the obstetric violence context specifically, we are dealing with wrongs and harms for which there is no obvious male correlate,[491] such that attempting to redress the harms and wrongs of UVEs under tort may prove difficult and fundamentally inappropriate. This is especially so given the importance of accounting for this violence through a frame faithful to women and birthing people's personal lived experiences. The gendered limitations of tort law are difficult to amend 'because women lack parity in the dramatis personae opportunities of private law… [such that] judicial decisions in turn lack parity in their representations of individuals life experiences'.[492] As a result, tort law fails to accommodate gender-based harms and wrongs, and tort litigation may send harmful messages through compensatory undervaluation that these harms are de minis in nature.

Further still, masculine social constructions of harm have resulted in the marginalisation of certain types of harm (naturally, those harms which have been 'gendered female').[493] Notoriously, tort law applies its remedial zeal much more to physical harm than it does to psychological injury.[494] Tangible harms, being objectively verifiable and therefore associated with 'reason' (masculinised), are granted preferential treatment over intangible harms, which tend to be subjectively experienced and thus associated with 'emotion' (feminised).[495] The relegation of psychological harm and noneconomic injury as less serious than physical injury and economic harm has systematically

[485] Nikki Godden, 'Tort Claims for Rape: More Trials, Fewer Tribulations?' in Janice Richardson and Erika Rackley (eds), *Feminist Perspectives on Tort Law* (Routledge 2012) 174.
[486] Jamie Abrams, 'The Illusion of Autonomy in Women's Medical Decision-Making' (2014) Florida State University Law Review 41.
[487] Elizabeth Adjin-Tettey, 'Sexual Wrongdoing: Do the Remedies Reflect the Wrong?' in Janice Richardson and Erika Rackley (eds), *Feminist Perspectives on Tort Law* (Routledge 2012) 184.
[488] Godden, 'Tort Claims for Rape' (n 485) 263.
[489] Finley, 'Breaking Women's Silence in Law' (n 367) 886.
[490] Adjin-Tettey (n 487) 190.
[491] Chamallas and Wriggins (n 428) 6.
[492] Anita Bernstein, *The Common Law Inside the Female Body* (CUP 2018) 209.
[493] Martha Chamallas and Linda Kerber, 'Women, Mothers and the Law of Fright: A History' (1989) Michigan Law Review 864. See also Chamallas, 'The Architecture of Bias' (n 473) 523, noting that 'the very fact that at some level we "know" emotions, relations, and noneconomic damages are gendered female is highly significant [as] this conceptual linkage affects the way we see the world, including how we categorize injury and harm'.
[494] Anita Bernstein, 'Fellow-Feeling and Gender in the Law of Personal Injury' (2009) 18 Journal of Law and Policy 297.
[495] Adjin-Tettey (n 487) 191.

disadvantaged women and marginalised claimants,[496] and sustained emphasis on physical harm has inhibited full judicial recognition and understanding of the non-tangible aspects of claimants suffering.[497] Furthermore, whilst psychological harm is now compensable under civil law, understandings of psychic trauma are informed by public and male experiences,[498] such that 'real trauma is often only that form of trauma in which the dominant group can participate as a victim rather than as the perpetrator or etiology of the trauma'.[499] For normalised forms of obstetric violence such as UVEs perpetrated by healthcare professionals, 'to admit that these assaults on integrity… are sources of psychic trauma, admits to what is deeply wrong in many sacred social institutions, and challenges the benign mask behind which everyday oppression operates'.[500] Therefore, despite torts encompassing of psychological injury, there may remain a resistance to acknowledging, and vindicating via compensation, the psychological harms and birth trauma resulting from obstetric violence.

Compensation awards for gender-based harms in the maternity care context are also impeded by the dominant foetal focus. As has been widely recognised, the 'focus on foetal harm in modern childbirth overshadows the birthing woman in tort and distorts the normative dualities of childbirth,'[501] such that harms to women and birthing people are rendered peripheral in the civil law. Conversely, in the absence of harm to the child, the foetal focus continues to inhibit recognition of the harms suffered by women and birthing people during labour and childbirth.[502] Ultimately, this reflects and reinforces societal expectations of maternal self-sacrifice, and leads to judicial failures to recognise the 'harms and injuries associated with forcing medical intervention on an unwilling woman in labour'.[503]

Thus, tort's undervaluation of gender-based harms problematically risks trivialising women's and birthing people's experiences. The current lack of monetary value ascribed to the harms suffered by women and birthing people during labour and childbirth[504] is a disturbing declaration of the value attached to their bodies, which ultimately compromises the capacity of the tort system to meet individual redress needs, or to prevent the practice on the systemic level.

Over the years, however, tort law has developed to create space for a broader range of injuries.[505] The expansion of tort to encompass psychological injury in particular indicates the flexibility of the tort system, and arguably, suggests its capacity to respond to the aforementioned feminist critiques.[506] This may open up the possibility of transcribing into tort a 'gender infused theory of harm [which] allows women to reconceptualise when and how they experience harm on their own

[496] Chamallas and Wriggins (n 428) 2. However, see Anne Bloom and Paul Miller, 'Blindsight: How we See Disabilities in Tort Litigation' (2011) 86(4) Washington Law Review which highlights the harmful implications of the tortious focus on physical and bodily injury for disabled persons in 'encouraging [claimants] with disabling injuries to see themselves in harmful ways' 713.
[497] Anne Bloom, 'Zen and the Art of Tort Litigation' (2010) 44(1) Loylola of Los Angeles Law Review 22.
[498] Laura Brown, 'Not Outside the Range: One Feminist Perspective on Psychic Trauma' (1991) 48(1) Psychoanalysis, Culture and Trauma 122.
[499] Ibid.
[500] Ibid 126.
[501] Abrams, 'Distorted and Diminished Tort Claims for Women' (n 12) 1955.
[502] Ibid 1960.
[503] Kukura, 'Obstetric Violence' (n 74) 777.
[504] Diaz-Tello (n 34) 60.
[505] Atiyah (n 468) 56.
[506] Leslie Bender, 'An Overview of Feminist Torts Scholarship' (1993) Cornell Law Review 575.

terms'.[507] However, this is a monumental aspiration, given that ultimately, 'understanding(s) of injuries cannot be disentangled from the economic, political, and social forces [operating] in the cultural context… [and] these factors, attach[ing] a sense of harm to certain events and not to others, play a crucial role in determining social and individual perceptions of injuries …[and] subjective response to it'.[508]

For some women and birthing persons, the compensatory function of tort may not be as important as, for example, its vindicatory function,[509] and suggestively, studies in the sexual violence context indicate monetary compensation is not generally equated with justice.[510] However, awarding compensation for the harms of UVEs would send a powerful message to society about the severity of the violation. Though the expression of this message depends (precariously) on the sums awarded being substantial. Furthermore, these functions are to a degree, inextricable, particularly in an action under civil battery as 'damages give effect to the overarching vindicatory function of intentional torts, which is ingrained in their internal structure'.[511] Thus, if compensation is deemed salient as factor for redress, tort may be favourable as a framework through which to address UVEs.

Vindication

One of the most valuable but often side-lined objectives of tort law is to vindicate wrongs, as the tort system provides individuals with a 'unique opportunity to obtain legal recognition and sanction patently objectionable conduct'.[512] As Herschovitz affirms, 'sometimes we need to say, quite clearly and loudly, this defendant wronged the plaintiff, and our saying can be quite significant quite apart from any material consequences that follow'.[513] Through vindicating the wrongs suffered by claimants, tort, as an expressive institution,[514] 'attests, affirms and reinforce(s) the importance and inherent value of particular interests'[515] to the wronged individual, and by affirming their social standing, communicates this message to wider society. In respect of UVEs performed upon women and birthing people, this may be especially valuable. As explored in chapter 1, gender stereotypes subjugating women and birthing people within the patriarchal order are designed to invite, and simultaneously, legitimate bodily appropriation and violation. This process of violation and legitimation diminishes the social standing of women and undermines their status as rights bearers, notwithstanding the fact that 'women are entitled to deny others bodily access, 'especially [access] to the vagina'.[516] Bernstein highlights the especial inviolability of this locus in order to emphasise that, whilst any unauthorised contact constitutes a trespass to the person 'some invasions matter more than others… [and] the full personhood of women, unlike that of men, has been controversial

[507] Fionnuala Aoláian, 'On Being the Subject of Law: Feminist Reflections on Gender, Harm and Violence in Northern Ireland' delivered at the Stephen Livingstone Lecture (2018) available at < www.youtube.com/watch?v=yb92m12_hus > accessed 10th January 2022.
[508] Mauro Bussani and Marta Infantino, 'Tort Law and Legal Cultures' (2015) 63(1) The American Journal of Comparative law 191.
[509] F Trindade, 'Intentional Torts: Some Thoughts on Assault and Battery' (1982) 2(2) OJLS 237.
[510] Antonsdóttir (n 365) 292.
[511] Varuhas (n 442) 175.
[512] Feldhusten (n 480) 216.
[513] Herschovitz (n 462) 408.
[514] Ibid 405.
[515] Varuhas (n 442) 258.
[516] Anita Bernstein, 'Rape is Trespass' (2018) 10(2) JTL 319.

in the law [such that] it needs advocacy'.[517] Tort law, through vindicating the wrong inherent in bodily violation, could provide an avenue for such advocacy.

Additionally, having a right of action and receiving damages for the wrong suffered not only reinforces the fundamental importance of bodily inviolability, but also vitally, provides an 'acknowledge[ment of] the truth of someone else's perspective'.[518] In the context of UVEs – a routinised practice which may be viewed trivial by healthcare providers – the vindicatory function of the civil suit validates the harms and wrongs as experienced and epistemically apprehended by women and birthing people subjected to the violation.

Intentional torts evince a primary function of vindication.[519] This is especially pronounced in civil battery,[520] as its central design is 'to allow victims who have been degraded or dehumanised to repair personal and moral indignities'.[521] Thereby cohering with the understanding the harms and wrongs addressed by the tort, fitting in the context of UVEs, 'is more than something physically hurtful… [but] the failure to respect the will and personhood of another'.[522] Simultaneously, whilst vindicating the wrong inherent in UVEs, battery also operates as rights-enforcing tool,[523] vindicating women and birthing people's right to autonomy and generally, their right to reproductive self-determination. However, it has been highlighted that courts appear to disfavour vindicatory litigation for dignitary injuries, especially when no, or seemingly minimal, harm has occurred.[524] This may partially explain the relative dearth of cases brought under civil battery.[525] As I will explore in chapter 3, judicial disfavour of such litigation, and tort law's apparent failure to conceive violation as inherently harmful, detriments the vindicatory potential of the action and has various implications for compensation. Thus, diminishing the cathartic value of the suit for women and birthing people on the individual level, but also compromising its expressive vindicatory function on the wider level.

Empowerment

As a by-product of its vindicatory purposes as well as a corollary of the tortious litigation structure, tort empowers individuals in ways that other areas of law cannot.[526] From the offset, by requiring women and birthing people to initiate the claim, they are enabled to 'assume a position of control over the legal claim addressing abuse, [and to] experience agency [against the individual with who they are] in an otherwise subordinating relationship'.[527] However, as will be elaborated below, placing this burden upon women and birthing people, who may not have the resources to bring a claim, could inversely exacerbate feelings of disempowerment.

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[517] Ibid.
[518] McGlynn and Westmarland (n 363) 188.
[519] Varuhas (n 442) 259. See also; *Ashley v Chief Constable of Sussex Police* [2008] AC 962 [22] and [60].
[520] Mulligan (n 17) 180.
[521] Alan Calnan, *Justice and Tort Law* (Carolina Academic Press 1997) 175.
[522] Ibid 38.
[523] Seabourne (n 38) 278.
[524] Stephen Sugarman and Caitlin Boucher, 'Re-imagining the Dignitary Torts' (2021) 14 JTL 136.
[525] Brazier and Cave (n 36) 126.
[526] María Guadalupe Martínez Alles, 'Tort Remedies as Meaningful Responses to Wrongdoing' in Miller and Oberdiek (eds), *Civil Wrongs and Justice in Private Law* (OUP 2020) 252.
[527] Camille Carey, 'Domestic Violence Torts: Righting a Civil Wrong' (2014) 62(3) University Kansas Law Review 696.

Use of tort law, in contrast to criminal law, 'offers [claimants] the opportunity to be the courts central concern, rather than merely a peripheral subject of the defendants criminal conduct'.[528] With evidence supporting that generally, active participation in litigation and perceptions of control over the suit are linked to claimant satisfaction,[529] the ability of the tort system to empower individuals subjected to obstetric violence can be also be conceived as a component of therapeutic justice.[530] The cathartic value of civil litigation may better respond to claimant's emotional needs.[531] As a result of the civil litigation structure then, women and birthing people are granted a greater voice and the opportunity to be heard, centralising lived experiences and ensuring their recognition. Given that 'voice, in varying forms, has also been suggested as a possible means of taking ownership of the justice process',[532] empowering individuals to take ownership of the narrative of their experiences of violence may be symbolically restorative of the lack of control and voice granted to women and birthing persons subjected to UVEs. In this way, women and birthing persons can challenge the dominant medical discourses and narratives which purport to invalidate their experiences. Further, the function of tort law in empowering individuals can be buttressed by the compensatory objective, as the rewarding of compensation signifies a 'reversal of the disempowering event',[533] albeit symbolically.

Notably, the empowerment function of tort is magnified in actions under intentional torts such as battery, as they 'implicate power, and are thus an ideal forum for rectifying relative imbalances of power'.[534] Thus, the civil suit could serve as a 'female weapon of self-defence, targeting the roots of the problem; imbalances of power'.[535] However, the ability to bring a claim is largely dependent on economic disposition, as civil litigation is privately funded. Consequently, the civil suit cannot be utilised by all women and birthing people.

Impediments to Torts Empowerment Function: The Burdensome Nature of Civil Litigation

In reality, the capacity of the civil suit to empower claimants is delimited due to the burdensome nature of civil litigation. The claimant bears responsibility to initiate the suit, and consequently, to shoulder the emotional and financial costs of civil litigation. The costs involved in particular, may preclude or disincentivise initiation of an action against UVEs.[536] The quality of legal representation securable - or the ability to secure legal representation at all – is contingent on how much the individual is able to pay, as well as the potential for recovery. As such, justice under the civil law is purchasable.[537] This profit-orientation inimically 'undermines the enterprise of tort'[538] as it is unlikely that a lawsuit will materialise unless it is probable to result in a considerable award in damages.[539] If

[528] Bender, 'An Overview of Feminist Torts Scholarship' (n 506) 584.
[529] Carey (n 527) 746.
[530] Feldhusten (n 480) 216.
[531] Shuman (n 458) 44.
[532] McGlynn and Westmarland (n 363) 191
[533] Ronen Perry, 'Empowerment and Tort Law' (2009) 76 Tennessee Law Review 988.
[534] Bender, 'An Overview of Feminist Tort Scholarship' (n 506) 590.
[535] Nora West, 'Rape in the Criminal Law and the Victim's Tort Alternative: A Feminist Analysis' (1992) 50(1) University of Toronto Faculty of Law Review 117.
[536] Diaz-Tello (n 34) 59.
[537] Bender, 'Feminist (Re) Torts' (n 482) 876.
[538] Nathaniel Donahue and John Fabian Witt, 'Tort as Private Administration' (2020) 105(4) Cornell Law Review 1162.
[539] Kenneth Abraham and Edward White, 'Torts without Names, New Torts, and the Future of Liability for Intangible Harm' (2019) 68(6) American University Law Review 2106.

the civil suit empowers claimants at all then, it is a source of empowerment only for those with ample financial resources.

As well as being financially burdensome, civil litigation is emotionally taxing. Studies have indicated that the 'litigation process itself can halt or delay the plaintiffs process of healing and restoration'.[540] Whilst less adversarial than the criminal trial, civil litigation also possesses 'an aggressive masculinity about it',[541] such that women's and birthing people's voices must compete against the oppositional account of medical actors, and the 'concerning judicial narrative of heroic medicine and reckless motherhood [which] distorts and diminishes the birthing women'.[542] Similarly, gender tropes may also be marshalled to question the reliability of women and birthing person's accounts and experiences.[543] This also contributes to testimonial smothering (see section 1.6) which is partially produced through the diminishment of women - especially racialised women - as credible narrators.[544] Testimonial smothering is thus a form of epistemic injustice, and the risk of psychological trauma associated with having one's experiences of violence dismissed, may deter women and birthing people from initiating a suit. And for women and birthing people who do initiate a claim, this risk is very real.

Furthermore, just as in the criminal trial, the paradigm of 'ideal victim'[545] is similarly constructed in civil litigation, with Aoláian noting that 'the didactic of maternal identity is often actively negotiated between the poles of victimhood and agency'.[546] Whilst civil litigation is said to be emotionally empowering, the design of the civil suit in situating claimants in a uniquely agentic position creates discord with the victim paradigm. Women and birthing persons who do not present themselves as disempowered victims are less likely to receive judicial sympathy. In light of this, lawyers often create a narrative of victimhood in order to invite larger compensation sums, creating a risk of revictimisation.[547] Requiring women and birthing people to categorially identify as victims is 'stifling, and does little to advance a more complex understanding of the injuries and suffering involved'.[548] Civil litigation is therefore emotionally burdensome in multifarious ways, limiting the extent to which tort can be claimed to empower or meet the emotional needs of claimants.[549] This is especially troublesome in the obstetric violence context, where women and birthing people may be suffering from birth trauma. We need to utilise a legal framework which recognises and redresses this trauma and the harms of obstetric violence both substantively and structurally – not one which exacerbates, rather than ameliorates, their emotional turmoil.

Ultimately, 'the ability and choice to speak out [and initiate a suit] is not solely an individual one: social, structural, cultural [and economic] factors play a key part in ''who can be heard''',[550] delimiting accessibility to justice under the tort system. For marginalised people, access to civil justice may be especially difficult, and evidence suggests minority persons are largely not engaging

[540] Carey (n 527) 744.
[541] David Parltett, 'The Spirit of the Common Law and the Rights of Women: A Review of Bernstein, the Common Law Inside the Female Body' (2019) 12(1) JTL 146.
[542] Abrams, 'Distorted and Diminished Tort Claims for Women' (n 12) 1993.
[543] Aoláian (n 507).
[544] Dhairyawan (n 337) 382.
[545] Nicola Roberts, Catherine Donovan and Mathew Durey, 'Agency, Resistance and the Non-'ideal' Victim: How Women Deal with Sexual Violence' (2019) 3(3) Journal of Gender-Based Violence 327.
[546] Aoláian (n 507).
[547] Perry (n 533) 970.
[548] Bloom (n 496) 26.
[549] Shuman (n 458) 44.
[550] Roberts, Donovan and Durey (n 545) 324.

with the civil justice system.[551] Revealingly, the fact the overwhelming majority of obstetric civil negligence cases are brought by white women – despite evidence showing that systemically, black women are disproportionately experiencing abuse and mistreatment and suffer from higher rates of maternal morbidity and mortality,[552] speaks volumes about the inaccessibility of the civil justice system for minority persons. Tort litigation, therefore, does not provide a means to empowerment for all women and birthing people. The civil justice system is particularly exclusionary to those who, being statistically more vulnerable to obstetric violence, may be most in need of access.

2.4 Bipolarity and the Privatisation of Injury

The objectives and functions of tort law, whilst theoretically efficacious for meeting redress needs on the individual and potentially systemic level, are often not executed in practice. Moreover, the gendered limitations of tort law, the resulting undervaluation of gender-based harms, and the burdensome nature of civil litigation, all raise serious questions as to the suitability of relying on tort in the obstetric violence context. However, there is another glaring drawback to using the tort system to redress UVEs, discernible when the practice is considered within its wider institutional context. Tort law obstructs the systemic dimension of this manifestation of obstetric violence, as liability under civil law is deemed an atomistic, private matter between individuals. Tortious centring on a particular perpetrator and victim therefore belies the sense in which appropriation and violation of women's and birthing person's bodies during childbirth is embedded in an overall culture,[553] whilst obfuscating the social, political and economic origins of this violence.[554] Judicial analysis in civil ligation thus isolates the wrong in question as an individual act, creating a 'spatial and temporal dispersion of individual events [which] prevents recognition of its culmination as a social catastrophe'.[555] As recognised in other contexts of GBV and as should be appreciated in the obstetric violence context, the gender-based harms caused by violent maternity care practices represent social wrongs and injuries which occur on the personal level.[556] Furthermore, as 'the civil justice system… treats the matter as either a medical error or an interpersonal conflict',[557] adjudicating the issue under tort seemingly suggests obstetric violence stems from some moral failure on the part of healthcare professionals, rather than a structural problem and a facet of a wider social phenomenon of GBV which mandates collective action.[558] This is especially concerning if states feel able to exploit the 'perpetrator/victim narrative to disguise their own failures and avoid accountability for structural injustices that sustain conditions for obstetric violence'.[559] Thus, utilising tort to address

[551] 'Access to Justice: A Review of Existing Evidence of the Experiences of Minority Groups Based on Ethnicity, Identity and Sexuality' - Ministry of Justice Research Series 7/09 May 2009 < https://lemosandcrane.co.uk/resources/MoJ%20-%20Access%20to%20justice.pdf > accessed 16th May 2022.
[552] 'Mothers and Babies' MBRRACE-UK Report (n 277).
[553] Joanne Conaghan, 'Gendered Harm and the Law of Tort: Remedying (Sexual) Harassment' (1996) 16(3) OJLS 430.
[554] Erdman (n 1) 46.
[555] Kate Ramsey, 'Systems on the Edge: Developing Organizational Theory for the Persistence of Mistreatment in Childbirth' (2021) Health Policy and Planning 11.
[556] Catharine MacKinnon, *Sexual Harassment of Working Women: A Case of Sex Discrimination* (Yale University Press 1979) 173.
[557] Diaz-Tello (n 34) 60.
[558] Adjin-Tettey (n 487) 129.
[559] Reflections on Obstetric Violence and the Law: What Remains to be Done for Women's Rights in Childbirth? (Oxford Faculty of Law Research, 8th Mar 2017) < https://www.law.ox.ac.uk/research-and-subject-groups/international-womens-day/blog/2017/03/reflections-obstetric-violence-and > accessed 8th February 2022.

UVEs may inhibit acknowledgement and redressal of the practice on the systemic level, and may encourage states to [continue to] neglect their obligations to protect women and birthing people from this human rights violation.

Simultaneously, the bipolarity of tort may also result in a failure to meet the redress and justice needs of women and birthing people on the individual level. This is because the communality that renders GBV a gendered experience, 'its social impact; the social dynamic of [gendered] suffering [is] not reflected in law, especially tort law',[560] such that tort may fail to secure the social justice needs of women and birthing people. Further, by omitting to reflect the social dimension, the capacity of tort to foster a sense of connectedness amongst women and birthing people as victims of a pervasive phenomenon of violence is delimited. This is regrettable because connectedness, support, and a shared understanding of experiences can be an important source of empowerment for women, as 'fram[ing] a person's suffering as a social wrong ends some of the isolation of individual suffering'.[561] Notwithstanding this, there is a fine balance to be struck when addressing individual but simultaneously social injuries, particularly when grounding these injuries within wider frames of GBV, inequality and discrimination, as 'characterising a problem as a widespread form of discrimination may not acknowledge the unique ways in which the individual might experience the injury and need redress'.[562] Thus, it is important that a space is maintained for personal lived experiences and the individualised element of harm.

However, whilst tort undoubtedly adopts a predominantly individualist framing, 'tort is a system which is part of, is shaped by, and has influence on societal problems that transcend their effects on each individual victim'.[563] Increasingly, academics have faulted the 'contemporary conception of tort as pure ''private law''… [for] underrat(ing) the extent to which modern tort law is an aspect of background justice that governs interactions'.[564] Notably, the legal norms and rights for which tort law offers protection possess an inextricable public dimension, as 'tort establishes a sociological dialectic communities depend upon to retain their consensus about interpersonal behaviour norms'.[565] Additionally, Bernstein advances that torts constitute 'categorical hurts'; 'hurts' referring to the personal suffering individuals experience due to other's tortious conduct[566] and 'categorial', capturing the content of tortious claims as 'of general rather than exclusively personal interest',[567] such that the harm experienced must be capable of being experienced by others. On this understanding then, the civil law and decisions made under it possess an inextricable communalist dimension[568] with communalist implications, notwithstanding tortious centring on the individual.

In a similar vein, academics such as Perry argue 'tort liability for harmful abuses of power has an empowering effect at the societal level'.[569] This suggests civil litigation may, albeit indirectly, contribute to exposure and scrutiny of the hierarchies and institutional structures that facilitate

[560] Adrian Howe, 'The Problem of Privitised Injuries: Feminist Strategies for Litigation' in Martha Fineman and Nancy Thomadsen (eds), *At the Boundaries of Law: Feminism and Legal Theory* (Routledge 2013) 159.
[561] Honni van Rijswijk, 'Neighbourly Injuries: Proximity in Tort Law and Virginia Woolf's Theory of Suffering' (2012) 20(1) Feminist Legal Studies 44.
[562] Lucinda Finley, 'A Break in the Silence: Including Women's Issues in a Torts Course' (1989) 41 Yale Journal of Law and Feminism 57.
[563] Ibid.
[564] Gregory Keating, 'Form and Substance in the "Private Law" of Torts' (2021) 14(1) JTL 87.
[565] Tiller (n 434) 1356.
[566] Anita Bernstein, 'Q: What is Tort? A: Categorical Hurt' (2021) JTL 2.
[567] Ibid 1.
[568] Englard (n 37) 62.
[569] Perry (n 533) 966.

obstetric violence and as focalised here, UVEs. However, this is dependent on there being a 'growing number of successful claims [to] motivate others to take legal action and hence have a public impact'.[570] Additionally, 'tort can operate as an instrument of social pressure on government institutions by exposing poor practices and abuses of power and provoking change to policies and practices'.[571] Whilst this may be true, the extent to which tort indirectly exerts social pressure on the state is naturally limited.

Overall, it is tenable that tort law 'does not just provide a forum for private litigation… [but that] in subtle, sometimes subterranean ways, tort law shapes our expectations of one another'.[572] Arguably, tort law's public policy dimension is 'broad enough to include the goal of advancement of gender and race justice',[573] suggesting tort could be used to advance the prevention of UVEs and other instances of obstetric violence. However, it remains the case that tort law possesses an innately 'individualist philosophy'.[574] The capacity of tort law to effectively address the multifaceted dimensions of this manifestation of obstetric violence in its institutionalised context is therefore questionable.

Recourse to Tort Law: Conclusions

Pre-existing legal frameworks which scholars have identified as avenues for redressing obstetric violence can be criticised in various ways. This is not to say that human rights frameworks or the criminal law do not have a role to play. Given that actions available under these frameworks have not been designed to accommodate for the complexity of obstetric violence, my finding that they are generally inadequate should not be surprising. I do not exempt tort law from this criticism. The tort framework is also fraught with conceptual and structural deficiencies, and is limited in its capacity to respond adequately to UVEs. As feminist scholars have highlighted, this is because tort law, in spite of its facial gender-neutrality,[575] has been constructed 'using only part of human experiences… [such that the system] only partially responds to human needs'.[576] Further, by treating UVEs as torts, the structural dimension of obstetric violence and the status of the violation as a social, as well an individual injury, is problematically eclipsed.

Notwithstanding its flaws however, tort law has been, and remains 'a site for progressive reform [in its capacity] to express and reinforce universal norms and principles'.[577] It is arguable that the progressive capacity of tort should be exploited 'as one mechanism in the ongoing struggle to achieve a more egalitarian society'.[578] To a limited degree, the tort framework could be efficacious for addressing UVEs performed during labour and childbirth, as despite tort's limitations, its central objectives and the cathartic benefit of the civil suit provide a cogent argument for reliance on civil battery. In the next chapter, I comprehensively evaluate the requisites of the tort, attesting its potential application against UVEs performed during labour and a childbirth. However, 'having a

[570] Antonsdóttir (n 365) 283.
[571] Andrew Robertson and Hang Wu Tang, *The Goals of Private Law* (Hart 2009) 10.
[572] Ahson Azmat, 'Tort's Indifference: Conformity, Compliance, and Civil Recourse' (2021) 13(1) JTL 1-2.
[573] Chamallas, 'The Architecture of Bias' (n 473) 467.
[574] Cane (n 179) 236.
[575] Martha Chamallas and Lucinda Finley (eds), *Feminist Judgements: Rewritten Tort Opinions* (CUP 2020) 11.
[576] Leslie Bender, 'Changing the Values in Tort Law (Symposium on Feminist Jurisprudence)' (1990) 25(4) Tulsa Law Journal 771.
[577] Chamallas and Wriggins (n 428) 8.
[578] Tsachi Keren-Paz, *Torts, Egalitarianism and Distributive Justice* (Ashgate 2007) 4.

theoretical cause of action is not justice'.[579] Whilst bringing a successful action under the civil law could empower individual women and birthing people, the ability of the tort system to address and prevent the multifaceted dimensions of UVEs as a manifestation of obstetric violence, and to satisfactorily address the wrong inherent in this violation, is highly contestable.

[579] Diaz-Tello (n 34) 59.

Chapter 3: Addressing UVEs Under Civil Battery

3.1 Bringing a Claim in Battery

The definition of battery (for the purposes of both criminal and civil law) is provided by *Collins v Wilcock* as 'the intentional application of force against another person, without that person's consent and without lawful excuse'.[580] In the remainder of this dissertation, I will scrutinise the legal requisites of battery to determine its applicability to UVEs and to assess whether battery constitutes a suitable avenue of redress.

Before examining the requisites of the tort to reveal the benefits and, overwhelmingly, the deficiencies of the action, however, I will explore some conceptual issues with using battery to address UVEs. A preliminary concern, and a fundamental flaw of the action in this context, is its supposed gender-neutrality. The gendered limitations of battery will be a recurring theme throughout my analysis. Another issue demanding immediate attention surrounds the implications of labelling an UVE as a battery. Language is communicative, and 'law and its language can be a critical frontier for feminist change'.[581] Indeed, the importance of language has been observed through the ascendancy of obstetric violence terminology. However, conceptualising UVEs under the label of battery may sever this violation from the obstetric violence frame, obviating the powerful ability of legal labelling and terminology to influence understanding of the phenomenon.[582] Whilst these conceptual issues will not prevent a claim in battery being successful here, they delimit the extent to which the tort can be said to address this violation sufficiently, and they indicate the incapacity of battery to foster the understanding required to ensure redress needs are met on the individual and systemic level.

My analysis focuses on battery's contact and intent requirements. For completeness (and recognising its importance), I will also examine the tort's actionable per se liability status. I return to address consent separately in chapter 4. This is because consent represents the contingency upon which an action in battery rests and the topic demands exhaustive analysis. Notably, I will not consider whether a 'lawful excuse' could be raised to justify the performance of an UVE. This is because the only defence to battery which could be relied upon is necessity.[583] Given that the circumstances in which necessity can be invoked are very limited,[584] and since the defence cannot be raised to justify unauthorised medical intervention where the life of the foetus is at risk, it surely cannot be raised as a defence to UVEs.[585]

3.2 Conceptual Issues

[580] [1984] 1 WLR 1172.
[581] Stephanie Palmer, 'Feminism and the Promise of Human Rights: Possibilities and Paradoxes' in Susan James and Stephanie Palmer (eds), *Visible Women* (Hart 2002) 115.
[582] Finley, 'Breaking Women's Silence in Law' (n 367) 888.
[583] Mulligan (n 17) 179.
[584] Luke Kallberg, 'The Ethics of Separating Conjoined Twins: Two Arguments Against' (2018) 39 Theoretical Medicine and Bioethics 49.
[585] Mulligan (n 17) 179. See also *St. Georges Healthcare NHS Trust v S* [1998] 3 WLR 936.

A Gender-Neutral Tort(?)

Battery is designed to protect against unauthorised invasions of bodily integrity. This protection is universal in its reach, such that the tort is [theoretically] gender-neutral. Problematically, using battery to address UVEs eclipses that this violation is experienced by women and birthing people specifically, and fails to locate the practice as a form of obstetric violence.[586] Whilst this may not hinder the success of the action, concealment of the gendered (as well as structural) dimension of the practice fails to convey that UVEs grossly violate women's and birthing people's human rights entitlements, and obscures the personal but simultaneously social nature of the resulting harms. Additionally, by eclipsing the gendered dimension of UVEs, battery fails to reflect the specific power dynamic between the healthcare professional who has performed the UVE, and the woman/birthing person who has been violated. Generally, a rich body of research has identified the 'medical management of childbirth as a reflex of asymmetric gender powers'.[587] Power asymmetries therefore structure interactions between healthcare professionals and their patients, and in the obstetric and reproductive context especially, these interactions are socially and institutionally embedded.[588] This is elemental in creating an environment ripe for obstetric violence. In regard to vaginal examinations in particular, researchers have highlighted that the practice is 'one in which the woman can be seen at her most vulnerable, and the doctor, particularly the male doctor, at his most powerful'.[589] Battery, which addresses the perpetration of unauthorised contact in a vacuum, fails to account for this power dynamic and is blind to the power asymmetries structuring this relationship. Use of the tort therefore inimically decontextualises UVEs. For this reason, and as recognised in other areas of GBV,[590] treating obstetric violence as gender-neutral can be criticised as inappropriate.

Furthermore, this decontextualisation may have detrimental consequences on both the individual and macro level, as the lived-reality of violence during labour and childbirth is effaced by the torts gender-neutral framing.[591] This is problematic considering the critical importance of empowering women and birthing people 'to give voice to their experience, in order to shape discourse from their point of view'.[592] Indeed, the creation of new legal causes of action designed to address other forms of GBV 'has brought a new awareness of the ''social reality'', which urges the priority of defining women's injuries as women perceive them'.[593] Relatedly, a second major flaw of using battery in this context is that torts are inherently androcentric. As highlighted previously, the subject of tort is deemed male, and in practice, primarily concerned with harms and wrongs as comprehended by the male subject. As Lacey identifies, 'conceptualisation of the legal subject [as markedly male] is itself a contextualisation, a construction: law is not ''innocently acting as a mirror of nature''.[594] Masculine

[586] Pickles, 'When Battery is Not Enough' (n 8) 130.
[587] Sadler et al (n 4) 51.
[588] Anne-Marie Farrell and Sarah Devaney, 'When Things go Wrong: Patient Harm, Responsibility and (Dis)empowerment' in Catherine Stanton, Sarah Devaney, Anne-Maree Farrell and Alexandra Mullock (eds), *Pioneering Healthcare Law: Essays in Honour of Margaret Brazier* (Routledge 2015) 103.
[589] Dariusz Galasiński and Justyna Ziółkowska, 'Identity Ambivalence and Embodiment in Women's Accounts of the Gynaecological Examination' (2007) 11(4) Health 457.
[590] See for example, Catherine Mackinnon, 'Reflections on Sex Equality under Law' (1991) 100(5) Yale Law Journal at 1306, who avers that 'sexual assault cannot be treated as gender-neutral because sexual assault is not gender-neutral'.
[591] Pickles, 'When Battery is Not Enough' (n 8) 133.
[592] Cynthia Daniels, *At Women's Expense: State Power and the Politics of Foetal Rights* (HUP 2021) 146.
[593] Howe (n 560) 159.
[594] Lacey (n 401) 126.

contextualisation of the legal subject thus enacts an exclusionary violence by frustrating the accommodation of women's concerns in law.[595] Further still, feminist scholars have increasingly drawn attention to the systemic biases which plague facially neutral tort doctrines to the detriment of marginalised groups.[596] Therefore, bringing an action against UVEs experienced by women and birthing people using battery may seem incongruent and counterproductive.[597] Although, since the intentional torts 'play an insignificant role in the field of torts generally',[598] it may be possible to exploit battery's largely redundant status to feminist ends.

Whilst I have expressed concern surrounding the use of battery to address UVEs because of its acontextuality, some may contrastingly view this acontextuality as beneficial in avoiding the 'constraining [gender] dichotomisation that imbues gendered law'.[599] Gender-neutrality could insulate the action from gendered societal constructions of women and birthing people in context of labour and childbirth (see section 1.4.1). However, as recognised by Conaghan and Russel, both law and gender are enmeshed in the social order, such that a failure to ensure that gender is 'visible in law as part of the social ordering seems very strange'.[600] Reliance on battery to address UVEs during labour and childbirth therefore belies the social dimension of this form of gender-based as a mechanism for preserving an imbalance in power relations, and problematically impedes recognition of the birthing room as one of many sites of violence against women and gender minorities. Such a vacuous legal approach to the phenomenon fails to reflect the gendered reality, and to account for its entanglement in issues of power. Battery is therefore not equipped to problematise or dismantle the power dynamic identified to be a root cause of obstetric violence.[601]

Labelling UVEs as 'Battery': Linguistic Connotations and Implications

'Battery', as a legal term of art, captures a range of contact (addressed in section 3.3.1). Abraham and White note the names given to civil torts operate as 'descriptors for the core content of [the] action'.[602] In regards to battery, this is accurate insofar as the label communicates the requisite element of direct or indirect physical contact.[603] However, the etymology of the term (derivative from Latin 'battuere', meaning 'to beat/strike')[604] and its associated linguistic connotations, arguably misconstrue the conceptual core of the tort. Linguistically, battery insinuates hostile and aggressive application of force. These factors however, are not necessary elements of the tort. Even the slightest of unauthorised touches will constitute a violation of bodily integrity against which battery offers protection.[605] There thus exists a dissonance between the nature of contact and the circumstances in which a battery can occur (consistent with the conceptual core of the action as bodily violation), and popular [mis]understanding surrounding the kind and nature of contact which

[595] Ibid 128.
[596] Chamallas and Kerber (n 493) 864.
[597] Joanne Conaghan, 'Tort Law and Feminist Critique' (2003) 56 CLP 207.
[598] Carey (n 527) 731.
[599] Godden, 'Claims in Tort for Rape' (n 399) 162.
[600] Joanne Conaghan and Yvette Russell, 'Talking Law and Gender' (2015) 2 Feminist Legal Studies 203.
[601] United Nations General Assembly (n 67) [45].
[602] Abraham and White (n 539) 2091.
[603] *DPP v K (A minor)* [1990] 1 WLR 1067.
[604] Online Etymology Dictionary < https://www.etymonline.com/word/battery > accessed 21st April 2022.
[605] [1984] 1 WLR 1172 [1117].

will constitute a battery. Framing UVEs under the label of battery could consequently promote misunderstanding as to the nature of this violation and the circumstances in which it occurs.

Importantly, as explored in chapter 1, labelling matters, not least because 'an injury uniquely sustained, [or a violence uniquely experienced], by a disempowered group will lack a name, a history, and a general linguistic reality'.[606] By recognising manifestations of abuse and mistreatment under the obstetric violence label, we locate their specific context, identify the structural and gender-based dimensions of violent maternity care practices, and promote a terminological framework with semantic as well as epistemic utility.[607] However, through labelling UVEs as a battery the violation is subsumed under an alternative frame. This arguably results in the experience of UVEs as an act of obstetric violence being lost in translation. In light of the widespread lack of awareness of the phenomenon and the normalisation of UVEs, this communicative failure is concerning. At the same time, by failing to use the obstetric violence label categorically, we reduce the power of obstetric violence terminology and fail to exploit its conscious-raising potential.

The language and labelling of obstetric violence can be transformative, shaping understandings of the phenomenon and vindicating lived experiences. As noted by Fricker, 'when you find yourself in a situation in which you seem to be the only one to feel the dissonance between received understanding and your own intimated sense of a given experience, it tends to knock your faith in your own ability to make sense of the world'.[608] In light of the various forces of epistemic oppression exerted upon women and birthing people which 'disappear acts of violence [or] render them unnameable and unrecognisable within their conceptual architectures',[609] explicit identification of the experience of violence *as violence* is vital for individual women and birthing people, and for promoting fellow-feeling and wider social awareness. As noted above, the label of battery refracts the experience of UVE, as the lived-reality of violence is fundamentally altered when conceived under the conceptual frame of battery. Conversely, obstetric violence framing explicitly reflects the lived experience of women and birthing people as one of violence, foregrounding women's voices within the linguistic characterisation of this violence in law. Labelling UVEs as a battery, instead of as a manifestation of obstetric violence then, displaces the voices and experiences of women and birthing people.

Despite the limitations of battery at the conceptual level, it is conceivable that an individual seeking redress may seek to utilise this avenue, given the relative ease of establishing battery compared to other tortious remedies. Examining battery on the practical litigatory level will, however, shed further light on their broader implications for a case brought against UVEs. It is therefore necessary, in order to properly determine whether battery constitutes a suitable avenue of redress, to comprehensively evaluate battery's legal requirements.

3.3 Examining the Requisites of the Tort

A victim-survivor bringing a claim against an UVE will be able to establish that intentional contact occurred with little difficulty. However, I will identify various issues with battery's requisites, and I

[606] West, 'The Difference in Women's Hedonic Lives' (n 11) 117.
[607] Sesia, 'Naming, Framing and Shaming' (n 71) 237.
[608] Fricker (n 327) 163.
[609] Nora Berenstain et al, 'Epistemic Oppression, Resistance and Resurgence' (2021) Contemporary Political Theory 283.

demonstrate how bringing a claim against this violation abstracts UVEs from their context in numerous ways. The gendered limitations of battery will be highlighted throughout my discussion, as will the implications of applying battery in a context for which it has not been designed to accommodate.

3.3.1 Contact

Battery encompasses all forms of unauthorised contact,[610] meaning that even the slightest of touches will suffice.[611] For this reason, 'tortious batteries [may technically] range from the slightest and most innocuous touching to brutal beatings, rape and murder'.[612] Additionally, battery can be utilised against unauthorised contact arising in any context.[613] Clearly then, in respect of UVEs, the contact mandate will be satisfied.[614] However, I argue that UVEs constitute more than merely a battery, demanding scrutiny as to the torts suitability.[615]

The Nature of the Contact

Framing the contact involved in UVEs as a battery erroneously eclipses the specific wrongs and harms of the practice, as well as the context in which this bodily violation occurs. We are confronting the 'touch and penetration of an intimate part of a woman's body during a vulnerable time by those who are in a position of trust',[616] and the differences between UVEs and other forms of unauthorised contact which may constitute battery are extensive. This is recognised by Sjölin, who notes that labelling UVEs as a battery 'ignores the difference between this this violation [and, for example] a push in a pub',[617] with unauthorised vaginal touching representing an especially intrusive form of contact with discrete harmful consequences.

The practice of vaginal examination 'represent[s] a structured interaction in which ''private areas'' no longer remain private… rais[ing] problematic issues of the body and of being touched'.[618] This demands healthcare professional sensitivity when conducting examinations, and amplifies the importance of dynamic consent processes.[619] Further still, penetration of the vagina constitutes 'a particularly intrusive form of bodily interference in a world where interference with women's bodies has been common and controlling'.[620] Indeed, it has been suggested that healthcare professionals perform vaginal examinations, 'at least in part, as a ritual procedure by which [they] demonstrate

[610] Horsey and Rackley (n 426) 406.
[611] [1984] 1 WLR 1172 [1117].
[612] James Goudkamp, 'Defences in Tort and Crime' in Mathew Dyson (ed), *Unravelling Tort and Crime* (CUP 2014) 236.
[613] Pickles, 'When Battery is Not Enough' (n 8) 130.
[614] [1881] 50 LJ QB.
[615] Diaz-Tello (n 34) 59.
[616] Pickles, 'When Battery is Not Enough' (n 8) 136.
[617] Sjölin (n 389) 123.
[618] Rhoda Muliira, Vidya Seshan, and Shanthi Ramasubramaniam, 'Improving Vaginal Examinations Performed by Midwives' (2013) 13(3) Sultan Quaboos University Medical Journal.
[619] Rashmi Ashish Kadam, 'Informed Consent Process: A Step Further Towards Making It Meaningful!' (2017) 8(3) Perspectives in Clinical Research.
[620] Sjölin (n 389) 122.

they are in control of the labouring woman and the process of labour itself'.[621] The vagina is therefore an especially complex social locus,[622] and as will be elaborated upon below, UVEs are imbued with wider social meaning.[623]

Whilst all unauthorised touching establishes the basis for an action in battery, and though all forms of unauthorised bodily violation constitute fundamental wrongs (infringing rights to autonomy and bodily integrity),[624] UVEs possess social, political and sexual dimensions which do not necessarily underlie more general instances of unauthorised contact. The wrongs women and birthing people may suffer are therefore vastly more expansive, and, recognising that we are embodied beings, they may be more differentially affective amongst persons. In the following, I explore the social, political, and sexual wrongs that may be experienced as a result of UVEs. However, having identified that there does not yet appear to be a substantive discourse on the social and political wrongs of UVEs, I grant them especial attention here.

Social and Political Dimensions: Social and Political Wrongs and Harms

Scholars have recognised that childbirth produces a 'potentially threatening form of embodiment that is consequently subject to social control and policing',[625] generally in the form of medicalised and coercive childbirth rituals and practices[626] with often cultural, rather than medical, determinants.[627] In regard to vaginal examinations performed in clinical settings, the social dimension of the practice is fully appreciable by tracing its origins in early gynaecological medicine. As Taghinejadi and Kelly highlight, 'the history of the Sims speculum serves as an explicit example of the nature in which the practice of vaginal examination is inextricably entangled within its social context'.[628] The Sims speculum and the practice of vaginal examination thus possess socio-symbolic significance, emblematising the expropriation of women's bodies by the medical institution and the denial of autonomy in healthcare settings. It is also important to note that Sims conducted his experimental gynaecological procedures on enslaved African American women who were theorised to possess 'medical superbodies' fitting for experimentation.[629] As lamented by Cooper-Owens, 'for these women as representative black bodies, the meaning assigned to them held as much meaning as humiliation, brutality and violence inflicted on them, as the white doctors sought knowledge about their bodies'.[630] The Sims speculum exemplifies the historical intersection of racism and medicine, an intersection which, in light of contemporary structural racism in maternity care and the

[621] Mary Stewart, ''I'm Just Going to Wash You Down'': Sanitizing the Vaginal Examination' (2005) 51(6) Journal of Advanced Nursing 588.
[622] Taghinejadi and Kelly (n 302) 51.
[623] Kingma (n 239) 458.
[624] Jonathon Herring and Jesse Wall, 'The Nature and Significance of the Right to Bodily Integrity' (2017) CLJ 568.
[625] Rachelle Chadwick and Don Foster, 'Negotiating Risky Bodies: Childbirth and Constructions of Risk' (2014) 16(1) Health, Risk and Society 76.
[626] Davis-Floyd (n 222) 6.
[627] Marsden Wagner, 'Confessions of a Dissident' in Robbie Davis-Floyd and Carolyn Fishel Sargent (eds), *Childbirth and Authoritative Knowledge* (University of California Press 1997) 378.
[628] Taghinejadi and Kelly (n 302) 53.
[629] Talita Oseguera Wells, 'Black Women's Experiences of Stereotype-related Gendered Racism in Health Care Delivery During Pregnancy, Birth and Postpartum' (Masters thesis, University of Chicago 2019) 5.
[630] Cooper-Owens (n 118) 114.

especial vulnerability of racialised persons to obstetric violence, remains rooted within maternity care practices today.

Social control and policing during childbirth is implicit in the practice of UVE, especially when attention is drawn to the wider social significance of the vagina as a biopolitical location.[631] As recognised by Rodrigues, in cultural construction, the vagina conceived 'as a point of entry/exit… [with] the cultural emphasis on [its] receptive role in penetrative heterosexual intercourse signif[ing] its erotic quality, whilst its position as the threshold in which new life emerges associates it with the reproduction of the population'.[632] Whilst women have exclusive control over access to their bodies (an entitlement protected by various laws), cultural construction of the vagina instrumentalises her body as 'body for others'.[633] Vaginal examinations performed during labour and childbirth therefore possess inextricable, and overlapping, political and social dimensions. As such, the contact involved in UVEs manifests discrete social and political wrongs.

Social Dimension

As recognised by Kitzinger, 'one important element in the interaction of human bodies is touch. Touch conveys messages, whether conscious and purposeful or unconscious'.[634] Touches and exchanges are imbued with different meanings depending on whether they have been authorised.[635] It is for this reason that consent can be transformative,[636] and vaginal examinations performed without authorisation may subsequently be experienced as violent by some individuals. The social dimension of this violation however, ought to be appreciated to comprehend the multifaceted harms and wrongs of the practice.

The performance of vaginal examinations without consent augments the disciplinary function of the practice. Researchers have speculated that vaginal examinations are performed as a disciplinary mechanism and as part of a 'ritual of medical interaction… bear[ing] symbolic significance'[637] in illustrating the healthcare professional is in control of the woman's or birthing person's body throughout the birthing process. This is arguably substantiated by the fact that examinations are ritually performed to confirm labour (and thereby, to permit women and birthing people access to the labour ward), despite less invasive methods existing. UVEs, as a disciplinary mechanism, may therefore convey multiple negative social messages to women and birthing people.

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[631] Sara Rodrigues, 'From Vaginal Exception to Exceptional Vagina: The Biopolitics of Female Genital Cosmetic Surgery' (2012) 15(7) Sexualities 782.
[632] Ibid 781.
[633] Michelle Sadler, 'Así me nacieron a mi hija': Aportes antropológicos para el análisis de la atención biomédica del parto' en Michelle Sadler, María Elena Acuña, and Alexandra (eds) *Obach nacer, educar, sanar: Miradas desde la antropología del género* (Catalonia: Centro Interdisciplinario de Estudios de Género 2004) 13. [Michelle Sadler, ''This is How my daughter was Born'': Anthropological Contributions to the Analysis of the Biomedical Care of the Hospital Delivery' in Michelle Sadler, Maria Elena Acuna, and Alexandra (eds), Born, Educate, Heal: Perspectives from the Anthropology of Gender (Catalonia: Interdisciplinary Centre for Gender Studies 2014)].
[634] Sheila Kitzinger, 'Authoritative Touch in Childbirth: A Cross-Cultural Approach' in Robbie Davis-Floyd and Carolyn Fishel Sargent (eds), *Childbirth and Authoritative Knowledge* (University of California Press 1997) 203.
[635] Herring and Wall (n 624) 581.
[636] Alan Wertheimer, *Consent to Sexual Relations* (CUP 2003) 120.
[637] Arezou Ghane and Kate Sweeny, 'Embodied Health: A Guiding Perspective for Research in Health Psychology' (2017) 7(1) Health Psychology Review 160.

Firstly, UVEs reinforce the erroneous cultural message that childbirth is a pathological event and that birthing bodies are threatening, mandating their regulation. Here, I draw upon Lyerly's engagement with gender, shame and technological intervention during pathologised childbirth, extending her analysis to the practice of UVE. UVEs are a regulatory tool[638] laden with signalling surrounding the deficiency of women's and birthing people's bodies, rendering transparent how 'the experience of birth, suffused as it is with issues of embodiment, sexuality and power, may… impart or reinforce a painful sense of inadequacy'.[639] Consequently, UVEs may inflame gendered shame experienced by women and birthing people, as the practice communicates to them that they inhabit dysfunctional, othered, reproductive bodies requiring regulation. This can be substantiated by the fact that 'at the interface of women's subjectivity and the institutions and practices of maternity care is a pervasive affective attunement, shame, which can either burgeon or be diminished as a result of the way in which care is provided and interpreted'.[640] The performance of vaginal examinations without authorisation thus 'burgeons' the shame which may be experienced by women and birthing people, and this may be deeply affective, since shame not only impacts the 'ways in which women negotiate their gendered experiences of living in a patriarchal society',[641] but 'becomes embodied in the way we behave'.[642] The gendered shame produced by UVEs and other forms of disciplinary violence in the maternity care context also result in the silencing of women and birthing people[643] – both in terms of preventing them from voicing their needs and wants during labour and childbirth, but also by silencing women from speaking out about their violent experiences. This underlines why an embodied phenomenological approach to the practice and the experience of UVE is necessary to appreciate the harms and wrongs[644] implicated in this treatment of women's bodies in the obstetric violence context.

Interrelatedly, UVEs convey to women they are less capacious relative to men, an affront to women's and birthing people's social (and political) status and a catalyst for testimonial injustice. As indicated above, UVEs and other violent maternity care practices help to construct pregnancy and childbirth as states of 'disembodiment, pathology and fragmentation'.[645] This engenders a lack of faith in women's own embodied knowledge, contributing to the delegitimatisastion of embodied knowledge whilst accrediting the authoritative knowledge of the healthcare professional – deepening the power asymmetry within the clinical relationship. In regards to vaginal examinations in particular, this is implicit in the fact they are used by the healthcare professional to determine whether the woman or birthing person will be permitted to start pushing.[646] However, as revealed by Shabot, the practice often signifies a denial and dismissal of women's own embodied

[638] Mandie Scamell and Mary Stewart, 'Time, Risk and Midwife Practice: The Vaginal Examination' (2014) 16(1) Health, Risk & Society 84.
[639] Anne Lyerly, 'Shame, Gender, Birth' (2006) Hypatia 21(1) 103.
[640] Ibid 117.
[641] Jessica Murray, ''And They Never Spoke to Each Other of It'': Contemporary Southern African Representations of Silence, Shame and Gender Violence' (2017) 34(1) Journal of English Studies 27.
[642] Heather Savigney, *Cultural Sexism: The Politics of Feminist Rage in the #MeToo Era* (Bristol University Press 2020) 86.
[643] Dhairyawan (n 337) 838.
[644] Talia Welsh, 'The Order of Life. How Phenomenologies of Pregnancy Revise and Reject Theories of the Subject' in Sarah LaChance Adams and Caroline Lundquist (eds), *Coming to Life: Philosophies of Pregnancy, Childbirth and Mothering* (Fordham University Press 2013) 298.
[645] Meredith Nash, *Making 'Postmodern' Mothers: Pregnant Embodiment, Baby Bumps and Body Image* (Palgrave Macmillan 2012) 24.
[646] Brigitte Jordan, 'Authoritative Knowledge and its Construction' in Robbie Davis-Floyd and Carolyn Fishel Sargent (eds), *Childbirth and Authoritative Knowledge* (University of California Press 1997) 64.

knowledge.[647] Thus, women as a disenfranchised group 'suffer from systemic testimonial injustice, [as] their knowledge [is] generally considered problematic or less authoritative, rendering them vulnerable to many other, additional kinds of injustices'.[648] Notably, for racialised women and birthing people, the testimonial injustice experienced is likely to be even more acute.[649]

UVEs also wrongfully objectify women and birthing people. Objectification itself is a multi-layered concept 'in which the ideas of autonomy denial and instrumentality are at the core; but [it] also includes related notions of inertness, fungibility, violability, ownership, and denial of subjectivity'.[650] UVEs represent an incredibly intrusive form of contact, bypassing the subjectivity of individuals and reducing the body to mere object.[651] Being treated like an object through the performance of unauthorised interventions signals to women and birthing people that they do not matter as human beings.[652] 'Mattering', as a social-psychological concept, is 'positively related to self-esteem and perceived social support [and] it is negatively associated with all forms of self-consciousness and alienation'.[653] Additionally, the experience of being reduced to object to be acted upon may result in identity loss or disorientation, since 'reproductive control and ''bodily integrity'' are implicated in the formation of women's identity as well as being critical to counting as persons… rather than as merely reproductive bodies'.[654] Subsequently, denial of women's and birthing people's ability to make choices during childbirth forces them to renounce their identity,[655] signifying their instrumentalisation as the 'maternal environment'.[656] Indeed, studies have substantiated that vaginal examinations are apprehended by some women as a threat to their identity.[657] UVEs thus represent a 'violence to a women's sense of self through [the] invasion of bodily integrity'.[658] Ultimately, 'touch, is never neutral… authoritative touch by caregivers in pregnancy and childbirth conveys strong messages to the woman concerning her status vis-à-vis her attendants, the reproductive efficiency of her body, the normality or abnormality of this birth, and about her value as a woman'.[659] The contact involved in UVEs is charged in various ways as both a source of, and a means of furthering, women's and birthing people's disempowerment during labour and childbirth.

Political Dimension

UVEs also possess a political dimension and may subsequently be experienced as a political wrong. Generally, 'the body is politically significant, and it reflects the power dynamics of different cultural

[647] Sara Cohen Shabot, "You are Not Qualified—Leave it to Us": Obstetric Violence as Testimonial Injustice' (2021) 44 Human Studies 635.
[648] Ibid 639.
[649] Ibid 640.
[650] Rae Langton, 'Feminism in Philosophy' in Frank Jackson and Michael Smith (eds), *The Oxford Handbook of Contemporary Philosophy* (OUP 2007) 244.
[651] Ibid 582.
[652] Gregory Elliott, Suzanne Kao and Ann-Marie Grant, 'Mattering: Empirical Validation of a Social-Psychological Concept' (2004) 3(4) Self and Identity 342.
[653] Ibid 349.
[654] Nicolette Priaulx, 'Re-thinking Progenitive Conflict: Why Reproductive Autonomy Matters' (2008) 16(2) Medical Law Review 184.
[655] Chloe Elizabeth Romanis, 'Why the Elective Caesarean Lottery is Ethically Impermissible (2019) 27 Health Care Analysis 255.
[656] Daniels (n 592) 40.
[657] James Heslin and Mae Biggs (1971) 'Dramaturgical Desexualisation: The Sociology of the Vaginal Examination' in James Henslin (ed), *Studies in the Sociology of Sex* (Meredith Corporation 1971) 129.
[658] Priaulx, 'Re-thinking Progenitive Conflict' (n 654) 188.
[659] Kitzinger (n 634) 229.

and socioeconomic contexts'.[660] Scholars have interrogated 'the female body as a locus of direct social control and a text and medium of culture'.[661] The medical institution has complicity endorsed social and cultural expectations surrounding who women are, their behaviours, and principally, what they are permitted to do with their bodies.[662] This is why 'the coding of experiences [in the maternity care] space is inherently political… it is both constitutive and demonstrative of power dynamics [with] pregnancy and childbirth as sites for the construction of identity'.[663] This reinforces that violent maternity care practices are deployed coercively, disciplining the body and projecting an idealised maternal identity. Thus, UVEs are politically loaded, as 'an attempt of the patriarchy to gain control over the female body,'[664] and the contact involved in the practice of UVE is therefore saturated with pernicious messages surrounding women's autonomy and political status.[665] For birthing persons, the practice also represents a denial of gender identity and a mechanism of gender policing.

Whilst failure to respect women's voices during childbirth and labour reflects a general cultural phenomenon, and a 'pattern visible in so many other elements of their citizenship… in the particular scenario of childbirth, it seems even more difficult for women to say no, to exercise their autonomy and to claim their citizenship'.[666] Simultaneously, as Daniels recognises, women's and birthing people's 'right to self-sovereignty remains tied to an ethic of selfless motherhood which legitimates their secondary standing throughout the rest of the social order'.[667] Thus, women's and birthing people's ability to claim their citizenship through the exercise of agency during labour and childbirth appears to turn on whether or not the choice being made is sanctioned by medical professional. The denial of choice and the silencing of women and birthing people in this space is thus a form of disenfranchisement.

Sexual Dimension

Labour and childbirth are sometimes conceived as a sexual process.[668] Vaginal examinations in particular, may be intimately connected to sex and sexuality. Sociologists have highlighted how attempts to desexualise and depersonalise vaginal examinations (through theatrical representations and use of definite articles of speech)[669] reveals their sexual connection, and indicates the extent to which the performance of the practice constitutes a gendered interaction. Vaginal examinations performed without the requisite consent arguably represent 'a synthesis of sexual and social power – a medical professional penetrating the woman's body as disempowered body for others'.[670] It is

[660] Priaulx, 'Re-thinking Progenitive Conflict' (n 654) 199.
[661] Nash (n 645) 24.
[662] Elinor Cleghorn, *Unwell Women: Misdiagnosis and Myth in a Man-Made World* (Dutton 2021) 7.
[663] Candance Johnson, 'The ''Political'' Nature of Labour and Childbirth' in Sarah LaChance Adams and Caroline Lundquist (eds), *Coming to Life* (Fordham University Press 2013) 197.
[664] Herring, 'Identifying the Wrong' (n 84) 80.
[665] Diaz-Tello (n 34) 60.
[666] Villarmea (n 220) 68.
[667] Daniels (n 592) 136.
[668] Jane Szurek, 'Resistance to Technology-Enhanced Childbirth in Tuscany: The Political Economy of Italian Birth' in Robbie Davis-Floyd and Carolyn Fishel Sargent (eds), *Childbirth and Authoritative Knowledge: Cross-cultural Perspectives* (University of California Press 1997) 303.
[669] Catherine Cook and Margaret Brunton, 'Pastoral Power and Gynaecological Examinations: A Foucauldian Critique of Clinician Accounts of Patient-Centred Consent' (2015) 37(4) Sociology of Health and Illness 554.
[670] Sadler (n 633) 13.

unsurprising therefore that many experience UVEs during labour and childbirth as a sexual wrong,[671] with some women and birthing people using the language of rape (for example, descriptions of being 'skewered' and 'abused')[672] to describe their lived experiences. As highlighted in chapter 1, analogisation of the experience of UVE to rape - 'the most extreme form of spatial and bodily violation'[673] – conveys how profoundly harmful the practice is. Indeed, 'from a psychological [and] physical perspective, the penetration of the body…particular[ly] the penetration of one's sexual organs, may be more destructive than any that stops at the surface of the body'.[674] Notwithstanding the clinical context in which these examinations occur, penetration of the vagina without consent can have devastating consequences for women and birthing people, especially when experienced as a sexual violation. Notably, and though outside the scope of this dissertation, the experience of UVEs as a sexual wrong in some instances has urged academics such as Sjölin to examine use of sexual assault provisions under criminal law.[675]

Whilst some women and birthing people may not experience UVEs as a sexual wrong, as the preceding discussion has indicated, wrongs experienced may not only be 'sexual [but also] depersonalising and dignity-sapping'.[676] It is clear then that UVEs constitute more than mere instances of unauthorised touch, and the ramifications for women and birthing people subjected to this violation are immense. The tort of battery collapses the various social, political and sexual dimensions of the contact involved in UVEs, minimising the gravity of the wrongs and harms arising and rendering the tort a blunt tool for reflecting the nature and severity of this violation.

Relationship Between the Perpetrator and Victim-Survivor

Another significant issue with battery is that it omits to reflect the relationship between the perpetrator of the contact and the individual violated by the contact. UVEs should however, be contextualised as occurring within a specific *clinical relationship* – a relationship in which trust is cardinal. In the maternity care context, women and birthing people are required to share a physical intimacy with healthcare professionals, 'allow[ing] them to "work with their bodies" during processes - pregnancy and childbirth - that have a high emotional and psychological impact, as well as a cultural dimension',[677] essentialising trust. As such, appropriation of the woman's or birthing person's body by the healthcare professional with whom they have entrusted this intimate experience renders the contact involved in UVEs not only a violation, but also a poignant breach of trust.[678] Furthermore, it has been suggested that 'obstetric violence occurs in a specific state of embodied vulnerability, and that might be destructive for subjectivity since it fails to recognise that state and instead disallows support and demolishes relationships (among women and their lived-

[671] As Sjölin (n 389) notes at 122, 'it is too dogmatic to say that it is always sexual'.
[672] Kitzinger (n 634) 219.
[673] Iris Marion Young, 'Throwing Like a Girl: A Phenomenology of Feminine Body Comportment, Motility, and Spatiality' in Iris Marion Young*, On Female Body Experience: "Throwing Like a Girl" and Other Essays* (OUP 2005) 45.
[674] Wertheimer (n 636) 106.
[675] Sjölin (n 389).
[676] Ibid 124.
[677] Júlia Martín-Badia, Noemí Obregón-Gutiérrez, and Josefina Goberna-Tricas, 'Obstetric Violence as an Infringement of Basic Bioethical Principles. Reflections Inspired by Focus Groups with Midwives' (2021) 18(23) International Journal of Environmental Research and Public Health.
[678] Herring, 'Identifying the Wrong' (n 84) 74.

bodies; among women and their others) and interdependence'.[679] The breach of trust involved in UVEs not only ruptures the relationship between the individual subjected to the violation and the entrusted healthcare professional, but also fractures the relationship between the individual and their others. Indicatively, the harmful consequences of trust breaches in this setting have been made apparent in the finding that birth trauma, in many instances, is related 'to fractured interpersonal relationships with caregivers'.[680] The relational harms that result from obstetric violence also require acknowledgement.

Overall, battery's failure to identify that the contact involved in UVEs occurs within a specific clinical relationship, and its inability reflect the various wrongs and harms of the practice, is unsurprising in light of its acontextuality. The actionable wrong in battery is simply (and in this context, reductively) the unauthorised contact, inhibiting recognition and communication of the nature of the wrongs associated with this UVEs.[681] Nevertheless, the requirement for contact to have occurred will clearly be satisfied in a claim against an UVE. I now turn to examine the intent requirement.

3.4 Intention

Intention in battery requires only that the contact itself was intentional or at least reckless. Following *Letang v Cooper*, carelessness will no longer suffice.[682] There is no need to establish any intention as to the consequences of the intentional/reckless contact.[683] After some period of uncertainty,[684] it has been clarified the contact does not need to be maliciously motivated.[685]

In the context of UVEs performed during labour and childbirth, the requirement for intention or recklessness as to the contact alone is vital in allowing victim-survivors to bring an action, as it is generally assumed that healthcare professionals do not perform UVEs with ulterior motives. Rather, when it comes to the performance of unauthorised interventions and practices, it has been posited that 'the vast majority of doctors have good intentions… but work in a system that does not prioritise consent'.[686] The systemic nature of obstetric violence cultivates a proceduralist and insensitive approach towards maternity care practices such as UVEs, and thus arguably promotes obliviousness as to the lived experiences of women and birthing people subjected to them.[687] As emphasised in chapter 1, this is why obstetric violence must be recognised as a structural violence, contextualising that although healthcare professionals are individually, albeit often unknowingly, perpetrators of violence, this violence is ultimately embedded within the maternity care structures in which they work.[688] Another, interrelated benefit of the intent requirement of battery in this

[679] Shabot, 'We Birth with Others' (n 14) 1.
[680] Thomson and Downe (n 55) 272.
[681] Sjölin (n 389) 124.
[682] *Letang v Cooper* [1965] 1 QB 232.
[683] Trindade (n 509) 220.
[684] *Cole v Turner* [1704] 6 Mod Rep 149; *Wilson v Pringle* [1987] QB 237
[685] [1984] 1 WLR 1172; *Re F (Mental Patient Sterilisation)* [1990] 2 AC 1.
[686] Restore Midwifery Blog, Obstetric Violence and the #MeToo Movement (7th August 2018) < https://www.restoremidwifery.com/birthblog/obstetric-violence-and-the-metoo-movement> accessed 19/04/22.
[687] Flanigan (n 417) 228.
[688] This does not absolve healthcare professionals of responsibility for the violence they perpetrate against women and birthing people. Further, the assumption that most healthcare professionals do not perform UVEs

context is that it arguably minimises the risk of healthcare professional stigmatisation - on the understanding the intention required is as to the contact only. This is desirable since punishment of healthcare professionals is unlikely to correspond with the redress needs of individual victim-survivors, and because as a structural violence, stigmatisation and remote reputational harm would not be conducive to preventing UVEs.

Beyond the importance of the intent requirement on the practical litigatory level, battery's concern with intention as to the contact and not to the harm, may have more subtle, unappreciated utility in aiding to dismantle traditional, masculine understandings of violence. Academics have increasingly criticised the traditional understanding of violence as narrowly predicated on notions of physical force and physical harm, perpetrated with intent.[689] Accordingly, broader conceptualisations of violence are gaining traction, though the development of gender-based understandings and recognition of the full spectrum of violence against women and minority genders is ongoing.[690] Since battery does not require intention as to the resulting harm, using battery to redress UVEs and other instances of obstetric violence may contribute in 'directly challenging conventional conceptualisations of violence',[691] and it could also engender healthcare professional awareness of the ways in which they unconsciously facilitate, and perpetrate, violence against women and birthing people.[692] Whilst the ability of the tort to perform this reconstructive function is unattested, I speculate that litigation under battery could help to reshape understandings of violence. Though this does not compensate for the torts decontextualisation of UVEs as a manifestation of obstetric violence with specific gender-based and structural dimensions.

3.4.1 Potential Issues with the Intent Requirement

Judicial Discomfort with Battery in the Absence of Malice

The intent requirement of battery may create issues for women and birthing people notwithstanding it being crucial for bringing a claim against an UVE. The first issue can be linked to general judicial disfavour of battery in the absence of malice. Brazier and Cave note that judicial policy favours treating the tort restrictively,[693] as supported by the relative dearth of battery cases. There seems to be concerted judicial effort to avoid direct reference to the tort in battery case law.[694] In reality, the majority of civil cases against obstetrical medical misconduct are brought under negligence. This may be explicable by the fact that in the absence of hostility, 'courts and commentators… [deem that] the negligence theory better accords with the nature of the physician-patient relationship and avoids the apparent harshness of liability for battery'.[695] Whilst liability under battery may indeed

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and other violent maternity care practises with an ulterior motive should not be uncritically raised to justify the actions or omissions of all healthcare professionals in all instances of obstetric violence.

[689] De Haan (n 166) 29.

[690] Committee on the Elimination of Discrimination Against Women, 'General Recommendation No.35 on Gender-based Violence Against Women, Updating General Recommendation No.19', UN Doc CEDAW/C/GC/35 (2017) [14-20].

[691] Pickles and Herring, 'Introduction' *Childbirth, Vulnerability and Law* (n 59) 6.

[692] Sonya Charles, 'Obstetricians and Violence against Women' (2011) 11 American Journal of Bioethics 5.

[693] Brazier and Cave (n 36) 126 and Pattinson, *Medical Law and Ethics* (n 445) 104.

[694] Marc Stauch and Kay Wheat, *Text, Cases and Materials on Medical Law and Ethics* (6th edn, Routledge 2018) 2.

[695] Geitsfeld, 'Conceptualising the Intentional Torts' (n 424) 188.

seem harsh in the absence of malice, 'a physicians intentional violation of a patient's right to informed consent necessarily harms the patients interests that are protected by the tort of battery, justifying liability'.[696] Furthermore, as Dempsey and Herring note, 'the social meaning of conduct does not require any intention or purpose'.[697] UVEs have harmful social meanings for both individuals and society as a whole (see section 3.3.1). Additionally, whilst some degree of stigmatisation may be unavoidable by virtue of battery's criminal law affiliation,[698] as indicated above, the understanding battery does not require malice should ensure healthcare professionals are not vilified if they are found to be liable.[699]

Nevertheless, judicial disfavour of the action and discomfort holding healthcare professionals liable in the absence of intention to harm, whilst immaterial for the purposes of actionability, may make the litigation process more onerous. It could also generate enmity towards women and birthing people bringing the claim. Resistance to the tort also indicates that the courts continue to subscribe to the traditional construction of violence with its centring on intent - specifically hostile intent - stifling the potential for litigation under battery to advance broader and gender sensitive conceptualisations of violence. This substantiates that civil litigation is not the arena in which this important socio-political work can be carried out.

Default Assumptions of Benevolent Intent

Additionally, in the absence of scrutiny as to the motive underlying the performance of UVEs, default assumptions of healthcare professional benevolence[700] may dominate the defendant's narrative and/or could be ascribed by the judiciary. It is not my intention to suggest that 'doctors are bad individuals, but [rather to acknowledge that] they are human and members of their community and have all the biases and motivations that entails'.[701] This may well include benevolent motivation, but this should not be automatically assumed, nor should it erroneously influence judicial considerations to the detriment of claimants violated by UVEs.

Englard notes that the retreat from using battery 'has been explained by the discomfort of treating doctors, who genuinely care for the well-being of patient[s], under a doctrine sanctioned at anti-social conduct'.[702] Whilst case law clearly stipulates that affectionately motivated contact suffices for battery[703] and cannot preclude an action being brought, the mitigatory impact of the blanket assumption of healthcare professional benevolence should not be underestimated. The (en)forced caesarean section case law reveals conscious judicial efforts to characterise healthcare professionals as benign and well-intentioned. See, for example, *St. Georges Healthcare NHS Trust v S*,[704] where the judges referred to the obstetricians and social workers involved in the case as 'genuine',[705] 'well-

[696] Ibid 191.
[697] Michelle Dempsey and Jonathon Herring, 'Why Sexual Penetration Requires Justification' (2007) 27(3) OJLS 485.
[698] Girard Robertson, 'Informed Consent to Medical Treatment' (1981) LQR 104.
[699] Charles (n 692) 5.
[700] Roger Crisp, 'Medical Negligence, Assault, Informed Consent, and Autonomy' (1990) 17 Journal of Law and Society 78.
[701] Wagner, 'Confessions' (n 627) 378.
[702] Englard (n 37) 162.
[703] *R v Chief Constable of Devon and Cornwall, ex parte Central Electricity Generating Board* [1982] QB 458.
[704] [1998] 3 WLR 936.
[705] Ibid [51].

intentioned'[706] and motivated by the benevolent design to do what was best for S. Or rather, through a synthesisation of interests, what was best for the foetus.[707] The heroic and benign characterisation of the healthcare professionals and social workers in this case, who were 'admired [for their] courage',[708] shrouded the fact that they had exploited the Mental Health Act[709] and had used coercive and threatening remarks to belittle and ultimately override the wishes of S.[710] If similar characterisations are invoked in civil litigation against obstetric violence, this will detract from the fact a grave wrong has been suffered, weakening the accountability function of battery.

The tendency to characterise healthcare professionals as invariably well-intentioned is residual of 'purportedly benevolent paternalism [which] has informed medical ethics for centuries,'[711] has permitted excessive deference to the medical profession, and inevitably, has undermined judicial protection of patients.[712] Whilst paternalistic interventions may not result in immediately palpable harm, paternalism does systemically harm women and hinders the pursuit for gender equality socially and politically.[713] Unsurprisingly, the foundations of medical paternalism are grounded in patriarchal ideology,[714] and instrumentally, 'paternalism can directly increase the subjection of oppressed wills to the dominant'.[715] Despite the contemporary shift in favour of patient autonomy, courts hark back to paternalistic practices and attitudes by uncritically deferring to the judgements of medical professionals.[716] This reversion occurs in reproductive and obstetric matters chronically, and the issue was specifically raised in *SFM*. In the case, CEDAW recognised that the Spanish courts had subscribed to the 'stereotypical and discriminatory notion… that it [was] for the doctor to decide whether or not to perform [an intervention]'.[717] By endorsing such notions, the judiciary help to sustain the social conception of childbirth as a 'highly risky event that necessitates rescuing by medical authorities',[718] which 'further entrenches the power of the medical professional as the medical knower'.[719] In doing so, courts collude in maintaining the asymmetry in the doctor-patient relationship in terms of both formal and informal social power.[720] This also exposes the extent to which basic tenets of medicalised, 'technocratic childbirth have become encoded as the standards of practice regarded authoritative in courts of law'.[721] Further still, the construction of the medical professional as authoritative medical knower is polarised against the construction of the birthing

[706] Ibid [52].
[707] Ibid [50-53]
[708] Ibid [55].
[709] Mental Health Act 2003.
[710] Dara Purvis, 'The Rules of Maternity' (2017) 84 Tennessee Law Review 401.
[711] José Miola, *Medical Ethics and Medical Law: A Symbiotic Relationship* (Hart 2007) 33.
[712] Charles Foster and José Miola, 'Who's in Charge? The Relationship Between Medical Law, Medical Ethics and Medical Morality' (2015) 24(3) Medical Law Review 512.
[713] Meghan Boone, 'Considering the Risks of Medical Paternalism and Tort Liability for Reproductive Harms: A Conversation with Jill Wieber Lens' (2021) 106 Iowa Law Review 40.
[714] Camilla Pickles, 'Sounding the Alarm: Government of the Republic of Namibia v LM and Women's Rights During Childbirth in South Africa' (2018) 21 Potchefstroom Electronic Law Journal 4.
[715] Khader (n 205) 504.
[716] Sarah Devaney and Søren Holm, 'The Transmutation of Deference in Medicine: An Ethico-Legal Perspective' (2018) 26(2) Medical Law Review 204.
[717] CEDAW, 'Decision Adopted by the Committee Under Article 4(2)(c) of the Optional Protocol, Concerning Communication No.138/2018' UN Doc CEDAW/C/75/D/138 (n 72) [7.5]
[718] Shabot, 'Afterword' (n 187) 197.
[719] Romanis, 'Legal Method and Health Law in Feminist Perspective' (n 231).
[720] Devaney and Holm (n 716) 204.
[721] Robbie Davis-Floyd and Elizabeth Davis, 'Intuition as Authoritative Knowledge in Midwifery and Home Birth' in Robbie Davis-Floyd and Carolyn Fishel Sargent (eds), *Childbirth and Authoritative Knowledge* (University of California Press 1997) 316.

woman within the judicial discourse. In civil litigation in this context, when women refuse the interventions advised by healthcare professionals, a problematic judicial narrative of heroic medicine versus impetuous motherhood 'distorts and diminishes the birthing woman'.[722] This narrative dominates *St Georges*, with S explicitly referred to as the 'unusual and unreasonable mother-to-be'.[723] This narrative reflects outdated, but resilient gender tropes which dichotomise men as rational, and women as irrational, subjects.[724] Implicit reliance on these tropes by the judiciary, (who already habitually construct doctors as skilled and patients as difficult and emotional) is purposed to legitimise law and medicine's paternalising responsibility over women and birthing people during labour and childbirth.

Notwithstanding the increasing diminution of medical paternalism and traction of patient autonomy, the default assumption that healthcare professionals are benevolently motivated is likely to continue to exert normative influence on judicial responses in cases of medical misconduct. In a claim brought against an UVE, the influence of this assumption may be particularly affective since violence in the maternity care context continues to be perceived as paradoxical.[725] Furthermore, unauthorised interventions are deemed less grievous and are not immediately identified as violations because they are (illegitimately) sanctioned by the medical model,[726] and performed in the medically predetermined interests of labouring women and birthing people.[727]

Presumptions of benevolent intent which battery could inadvertently permit, preserve a covert bias in favour of protecting the integrity of medical professionals, immunising the medical institution from answerability to law and affecting judicial responses to civil claims. However, as a matter of legal principle, 'misguided intentions do not salvage what is a profound violation of the bodily integrity of the patient'.[728] As the UN Special Rapporteur has voiced, whilst 'healthcare providers do not intend to treat their patient's badly…medical authority can foster a culture of impunity, where human rights violations not only go unremedied, but unnoticed'.[729] Judicial invocation to the image of healthcare professional as benevolent medical all-knower minimises the severity of the violation, undercuts the vindicatory function of tort, and fortifies the culture of impunity identified by the UN Special Rapporteur.

One final concern I raise here draws upon psychological studies into harm perception and intentionality, which have revealed the operation and impact of motivated reasoning.[730] This research has indicated that 'harm is evaluated as more serious when the actor acted intentionally'.[731] The absence of intention to harm is, therefore, likely to influence third-party perceptions of the severity of UVEs and other manifestations of obstetric violence. This exacerbates potential for the harms of UVEs being trivialised (a risk addressed further in the following section)

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[722] Abrams, 'Distorted and Diminished Tort Claims' (n 12) 1993.
[723] [1989] 3 WLR 936 [57]. The judge not only polarised S against the heroic and well-intentioned healthcare professionals, but impliedly, against the good mother archetype; 'faced with the serious consequent risk to the health of their babies very many mothers would be prepared to compromise with their beliefs'.
[724] Villarmea (n 220) 71.
[725] Shabot, 'Afterword' (n 187) 197. This observation also has detrimental implications for a claimant bringing an action under the tort of negligence.
[726] Marsden Wagner, *Born in the USA: How a Broken Maternity System Must Be Fixed to Put Women and Children First* (University of California Press 2006) 11.
[727] Shabot 'Afterword' (n 187) 197.
[728] Chamallas and Finley (n 575) 139.
[729] United Nations General Assembly (n 67) [15-16].
[730] Robbennolt and Hans (n 430) 34.
[731] Ibid 32-33.

and consequently, undercompensated.[732] Though this risk may arise in litigation under any existing legal framework used to address obstetric violence, given it is generally unintentionally perpetrated, it is important that this risk is mitigated with an appreciation and understanding of the specific nature and gender-based harms of UVEs. The civil battery action fails to ensure this.

Nevertheless, the requirement for intention or recklessness as to the contact, and not to the harm, is essential. It would be enormously difficult for a woman bringing a claim to prove that a healthcare professional intended to cause harm by performing an UVE in light of the assumptions explored above, and in the majority of instances, intention to harm will have been absent. In the next section, I explore a feature of battery with similar vitality in this context – actionable per se liability status.

3.5 Actionable per se Liability Status

The tort of battery is actionable without requiring the claimant to establish evidential harm resulted from the intentional contact. Indeed, harm is essentially irrelevant to the tort[733] as the 'actionable injury is the invasion of the body',[734] with the legal wrong being the unauthorised contact.[735] Notwithstanding this, batteries, and especially UVEs, involve a severe violation even in the absence of evidential harm.[736] Indeed, some commentators have noted that since 'intentional rights-violations implicate normatively distinct concerns for rightsholders interest in autonomy, dignity'[737] the violation of these fundamentally causes intangible harm to the individual.[738]

The actionable per se liability status of the tort is advantageous in multifarious ways. Powerfully, battery enforces the fundamental principle that 'every person's body is inviolate'.[739] This applies with equal force to women's and birthing people's bodies, though seemingly requires advocacy in and outside the maternity care context. Battery may provide an avenue for such advocacy, especially since affirmation of the principle of bodily inviolability is not contingent on evidence of harm. Despite the spectrum of wrongs and harms that may be suffered by individual women and birthing people, not all persons will experience physical or psychological injury as a result of the practice. However, since the tort is committed to protecting bodily inviolability with, or without consequential loss being suffered,[740] battery may be vital for providing victim-survivors of obstetric violence an avenue for redress. Additionally, the fact a woman or birthing person is able to initiate a claim without having necessarily suffered evidential harm indicates the practicability of bringing an action in civil battery as opposed to criminal battery. This is because, as stated in the Crown Prosecution

[732] Ibid 34.
[733] Robert Stevens, 'Private Rights and Public Wrongs' in Mathew Dyson (ed), *Unravelling Tort and Crime* (CUP 2014) 131.
[734] Brazier and Cave (n 36) 125.
[735] Ibid.
[736] Wertheimer (n 636) 102.
[737] Geitsfeld, 'Conceptualising the Intentional Torts' (n 424) 176.
[738] Crisp (n 700) 78.
[739] *Re F (Mental patient sterilisation)* [1990] 2 AC 1 [71].
[740] Mulligan (n 17) 179.

Service guidelines, criminal proceedings are unlikely to be commenced unless evidential harm has resulted.[741]

This feature of battery also stands in contrast to the tort of negligence, which contains a threshold for actionability by requiring clinically recognised physical or psychological injury to have been suffered.[742] A claim cannot be brought in negligence for distress falling short of psychiatric illness, for example.[743] Whilst this further indicates the practical utility of battery over negligence, it also substantiates the vindicatory potential of battery in validating the multifaceted and divergent lived experiences of women and birthing people. Indeed, battery does not mandate the compartment of women's and birthing people's experiences under 'validated' categories of injury.[744] Such an open-textured approach is invaluable in creating a space for lived experience, and for accommodating for the reality that the harms and wrongs of UVEs will diverge amongst victim-survivors.

I also argue that a categorical approach to understanding and conceptualising harm is obtuse since 'traumatic events refract outwards to produce all kinds of affective responses, not just clinical symptoms'.[745] The negligence claim, whilst accommodating for feminised harm (ie, psychological harm) remains exclusionary. Battery, in providing redress for, and vindicating the wrong inherent in this violation on a standalone basis,[746] uniquely accommodates for UVEs and the harms which may or may not be suffered as a result. This substantiates that battery represents the more appropriate avenue for redressing UVEs,[747] as it 'more fundamentally vindicates the underlying autonomy and self-determination interests at stake',[748] and does not preclude an embodied approach to the harms of the practice.

The actionable per se liability status of battery and subsequent centralising of bodily violation as the actionable injury also has unattested symbolic potential. Battery could help transform regard of women's and birthing people's bodies across discourses of medicine, law, and beyond. As Grosz notes, 'the female body has been constructed… as a leaking, uncontrollable, seeping liquid; as formless flow; as viscosity, entrapping, secreting; as lacking not so much or simply a phallus but self-containment – not a cracked or porous vessel, like a leaking ship, but a formlessness that engulfs all form, a disorder that threatens all order'.[749] This patriarchal metaphorisation of woman's body as a site of disorder[750] is magnified in the reproductive and obstetric context due to the misconception that childbirth is inherently dangerous, and requires intervention.[751] As a result, violations of women's bodies are 'framed not as violence, but as an expected legitimate response to women's

[741] The Code for Crown Prosecutors (CPS, October 2018) available at < https://www.cps.gov.uk/sites/default/files/documents/publications/Code-for-Crown-Prosecutors-October-2018.pdf > accessed 14th June 2022.
[742] [1965] 1 QB 232.
[743] *Alcock v Chief Constable of South Yorkshire Police* [1992] 1 AC 310 [318].
[744] Nicky Priaulx, 'Endgame: On Negligence and Reparation for Harm' in Janice Richardson and Erika Rackley (eds), *Feminist Perspectives on Tort Law* (Routledge 2012) 40.
[745] Ann Cvetkovich, *An Archive of Feelings: Trauma, Sexuality and Lesbian Public Lives* (Duke University Press 2002) 19.
[746] Varuhas (n 442) 269.
[747] Mulligan (n 17) 180.
[748] Chamallas and Finley (n 575) 126.
[749] Elizabeth Grosz, *Volatile Bodies: Toward a Corporeal Feminism (Theories of Representation and Difference)* (Indiana University Press 1994) 203.
[750] Conaghan, 'Tort Law and Feminist Critique' (n 597) 196.
[751] Halliday, 'Court-Authorised Obstetric Intervention' (n 456) 179.

nature'.[752] Demonstrably, in the sexual violence context, the pervasiveness of rape myths[753] within the criminal justice system exemplifies the way in which blame is attributed to women's physicality, justifying sexual intrusion and violation whilst sustaining rape culture. Comparably, in the maternity care context, constructions of women's and birthing people's bodies as warranting invasion are present in (en)forced caesarean section case law. For example, in *NHS Acute Trust & The NHS Mental Health Trust v C*,[754] though C lacked capacity, the narratives in this case starkly illuminate the view that processes of labour and childbirth entitle healthcare professionals to invade women's bodies, and that women and birthing people ought to grant them bodily access unequivocally. In the case, the obstetrician implored the court to order the declaration on the basis:

'C would not be able to tolerate labour and comply with the necessary directions required to keep her and her baby safe… [she] will not tolerate examinations and treatments that may be necessary throughout birth [and] without clinical interventions, risk to mother and baby are high'[755]

This statement reflects the view that childbirth requires regulation and intervention.[756] The semantic field of risk ('comply', 'necessary' 'required', 'safety' and 'risk' explicitly) and direct reference to the requirement for C to tolerate examinations (and other interventions) throughout childbirth, further demonstrates regulatory control and elucidates the relationship between risk, bodily surveillance and medical intervention[757] during pathologised childbirth.

Alarmingly, the judiciary echoed the rhetoric of the medical professional in constructing C as passive, implicitly objectifying her as a vessel for the delivery of the foetus whilst justifying the medical intervention sought.[758] Contrastingly, in numerous cases the courts have affirmed that a pregnant woman 'is entitled not to be forced to submit to an invasion of her body,'[759] and powerfully, that 'the inviolability of a woman's body is a facet of her fundamental freedom'.[760] However, these affirmations continue to be rendered hollow by the courts inability to conceive childbirth as anything other than a pathological process, and their reluctancy to value women and birthing people as epistemic agents.[761] Bryan and Carpi also highlight how the subtexts of the very same cases proclaiming to protect the autonomy of pregnant women are constructed to 'expose the pregnant woman to covert non-legal mechanisms of disciplinary control'.[762] The language used and the judicial framing of the facts in these cases, determine how the issues are perceived, as well as the ultimate outcome, under a guise of legal neutrality.[763] Against this context, battery may possess prophylactic value. The tort is fundamentally designed to vindicate the wrong inherent in unauthorised bodily violation, thereby upholding and protecting individuals' bodily integrity. Applying the tort to UVEs

[752] Shabot, 'Afterword' (n 187) 197.
[753] Nicola Godden, 'Rape and the Civil Law: An Alternative Route to Justice' (Durham University E-Theses 2009) 32.
[754] [2016] EWCOP 17.
[755] Ibid [26-27]
[756] Halliday, 'Court-Authorised Obstetric Intervention' (n 456) 191.
[757] Scamell and Stewart (n 638) 84.
[758] Halliday, 'Court-Authorised Obstetric Intervention' (n 456) 194.
[759] [1998] 3 WLR 936 [50].
[760] *An NHS Foundation Trust and Another v R* [2020] EWCOP 4 [67].
[761] Lucinda Finley, 'Female Trouble: The Implications of Tort Reform for Women' (1997) Tennessee Law Review 858.
[762] Jane Bryan and Daniela Carpi, 'Reading Beyond the Ratio: Searching for the Subtext in the "Enforced Caesarean" Cases' in Daniela Carpi (ed), *Bioethics and Biolaw through Literature* (De Gruyter 2011) 116.
[763] Ibid 120.

and vindicating the bodily inviolability of women and birthing people subjected to them, challenges the patriarchal construction of their bodies as inviting intrusion and violation.

3.5.1 Potential Implications of the Torts Per Se Liability Status

There are a number of issues associable with per se liability status which negate its aforementioned benefits and detract from the otherwise valuable focus on bodily violation.

Trivialisation of UVEs

Undoubtedly, battery's design to protect against unauthorised bodily violations whether consequential harm has materialised or not is invaluable for reasons considered above. However, the actionable per se liability status of battery may lead to a failure to articulate the severity and scope of harm that may be suffered due to UVEs. In practice, battery is limited in its capacity to generate understanding as to the actual harms of UVEs, or to promote recognition of this violation as an act of [obstetric] violence. This is partially because tort law - and law in general – has an embedded, insular understanding of what harm is, of the values underpinning protected rights and ultimately, of human nature.[764] This legal understanding of harm is overwhelmingly informed by male experience. Consequently, the 'gender-specific suffering that women endure is routinely ignored or trivialised in the larger (male) legal culture'.[765] This is reflective of the deeply social and gendered nature of harm as a concept, as 'gender shapes the distribution of particular harms and gender hierarchies produce an ordering in which some harms are privileged over others'.[766] Accordingly, harms which are not physical or do not meet the threshold of psychological injury are obscured within tort law. Additionally, the threshold for establishing that a psychological injury has occurred is high, and only those individuals whose psychological suffering manifests in a way that can be filtered and categorised through the medical frame will be granted a clinical diagnosis. Thus, whilst evidence of the gender-based harms resulting from UVEs is not legally required to claim in battery, its use in this context will perpetuate tort laws exclusion of such harms from recognition, trivialising, if not denying their reality. As a consequence, there will be an ongoing failure on the part of healthcare professionals and the judiciary to grasp the connection between unauthorised *bodily violation as violent*, and harmful to women and birthing people.

Ignorance to gendered harm is evident both in the Spanish obstetric violence cases, as well as in domestic (en)forced caesarean section case law. In *SFM,* CEDAW acknowledged that the Spanish courts had failed to recognise the claimant had 'also suffered a moral injury from being deprived of her right to make informed decisions about her own health and body'.[767] Seemingly, intangible aspects and consequences of interference with individuals' interests in autonomy, bodily integrity and so forth, have not been granted the same acknowledgment as legitimate losses and harms by contrast to tangible harm.[768] *Shaw v Kovak and University Hospitals of Leicester NHS Trust*[769] - which determined that a violation of autonomy, alone, is not a head of actionable damage - arguably

[764] Pickles and Herring, 'Introduction' *Womens Birthing Bodies and the Law* (n 40).
[765] West, 'The Difference in Women's Hedonic Lives' (n 11) 116.
[766] Conaghan, 'Tort Law and Feminist Critique' (n 597) 192.
[767] Pascucci, 'Spain 2019: Four Case Studies of Lawsuits for Obstetric Violence' (n 197).
[768] Adjin-Tettey (n 487) 192.
[769] [2017] EWCA Civ 1028.

exemplifies disavowal of this interference as in and of itself, injurious. Judicial failure to comprehend the relationship between UVEs and other unauthorised bodily violations as harmful can be detected in *Re AA (Mental Capacity: Enforced Caesarean).*[770] In determining what course of action would be in the best interests of *AA* (who lacked capacity),[771] the judiciary did not consider the harm inherent in unauthorised bodily violation. Permission was therefore granted to proceed with the deeply intrusive surgery, without even informing *AA* prior.[772] Although the courts routinely recognise there is a serious bodily violation implicated in the performance of invasive procedures,[773] there is a disconcerting absence of recognition on the part of the judiciary of the harms inherent in unauthorised violation in the obstetric violence context. This is despite clear evidence that women's and birthing people's sense of control over medical interventions during childbirth is a vital component for positive birthing experiences. Notwithstanding this evidence, judicial failure to recognise the personal and emotional harm of being violated result in its dismissal as a 'matter of mere perception'.[774]

Problematically, judicial responsivity to the gendered harm inherent in the violation of women's and birthing people's bodies is curtailed by the focus on physical harm. Referring again to *AA,* in making the best interest's determination, the court emphasised the 1% chance of uterine rupture occurring during vaginal delivery.[775] Contextualised against the multifarious harms and wrong which may be experienced due to unauthorised violations, this centralising of (a very small *risk* of) physical harm seems cursory compared to the other factors the birthing person themselves may have thought more material. Again, the preoccupation with physical injury and impact is embedded in the tort system. However, revealingly, and in contrast to the (en)forced caesarean cases, there does appear to be a judicial willingness to acknowledge the trauma and harm associated with the performance of unauthorised caesarean sections in the English sterilisation cases.[776] This observation calls into question the extent to which the failure to account for the harm inherent in unauthorised violation in the context of labour and childbirth is the result of an obliviousness as to the reality of this harm.

Notably, failure to vindicate the gendered harms of obstetric violence is an issue which transcends tort law. It can be implied that a failure to appreciate the severity of the harms which flow from being violated through unauthorised maternity care practices (and other manifestations of obstetric violence) may explain the limited application of, and treatment of cases under, the obstetric violence frameworks. As highlighted by Sánchez, despite discrete laws having been implemented in Venezuela since 2007, the law is only being applied where obstetric violence has resulted in the death of the woman, foetus, or child.[777] Seemingly then, even with the advent of discrete legislation designed to redress and provide a route to acknowledgement of the various harms of obstetric violence, such harms have not been granted concordant recognition by the bringing of cases by victim-survivors. However, the obstetric violence frameworks, nevertheless, hold the potential to engender understanding of the severity of this violence and its subsequent harms. The same cannot

[770] [2014] 2 FLR 237.
[771] MCA 2005.
[772] Halliday, *Autonomy and Pregnancy* (n 224) 67.
[773] [2016] EWCOP 17 [12].
[774] CEDAW, Decision adopted by the Committee under article 4(2)(c) of the Optional Protocol, concerning communication No.138/2018 (n 72) [3.5].
[775] Halliday, 'Autonomy and Pregnancy' (n 224) 65.
[776] Kristin Savell, 'Sex and the Sacred: Sterilization and Bodily Integrity in English and Canadian Law' (2004) 49(4) McGill Law Journal 1136. For case law, see *Re L (Patient: Non-consensual Treatment)* (1996), [1997] 1 FLR 837.
[777] Sánchez (n 79) 58.

be said for battery. Whilst battery is founded on the violation of bodily integrity itself, such that harm is immaterial to actionability, battery falls short of conveying that UVEs are not just a wrong, but a manifestation of a wider phenomenon of violence, producing a spectrum of gendered harm. This challenges the suggestion the tort could help deconstruct traditional understandings of violence, as speculated in section 3.4.

Implications for Compensation

As a result of this failure to convey the gravity of the wrongs and harms inherent in this violation, compensations sums from a successful tort act for UVEs are likely to be meagre. In general, the awarding of paltry compensation sums in litigation under the intentional torts has not gone unrecognised,[778] and the case of *Lumba v Secretary of State for the Home Department,*[779] (concerning a claim brought under the per se liability tort of false imprisonment) seemingly indicates this is a conscious judicial decision. In *Lumba*, the court viewed that 'given no substantial loss [had been] prove[n]'[780] the claimant was entitled to only nominal compensatory damages, having explicitly rejected the claimants' request for separate vindicatory damages purposed to 'reflect the special nature of the wrong'[781] – the infringement of liberty. Revealingly, Lord Dyson regarded the proposal for a separate category of 'vindicatory' damages inappropriate, given this would open the door for their application in other cases brought under the per se liability torts, including battery.[782] Whilst previous judicial statements[783] and the dicta of dissentient Lord Justice Walker in *Lumba*[784] acknowledge that awards can (and should) be granted to vindicate wrongs suffered, the delimiting of compensation in *Lumba* is concerning on numerous levels. Not only does it increase the difficulties a victim-survivor may face securing a lawyer willing to take the case, especially in the absence of tangible harm, it also undermines the ability of tort to empower victim-survivors and provide catharsis – important factors for redress.

As addressed in chapter 2, compensation can – and does – play an elemental role in the restorative process.[785] The rewarding of compensation against UVEs, symbolically at least, represents a 'reversal of the disempowering event'[786] and signifies a reallocation of power within the asymmetrical patient-doctor relationship.[787] However, compensation should not be overcentralised if in doing so, lawyers re-victimise women and birthing people[788] and inadvertently recapitulate the patriarchal constructions of birthing women and people found in medicolegal discourses.

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[778] Varuhas (n 442) 259.
[779] [2011] UKSC 12.
[780] Ibid [101].
[781] Ibid [100].
[782] Ibid [102].
[783] *Watkins v Home Office* [2006] UKHL 17. LJ Walker at 68 'even the most trifling and transient physical assault would undoubtedly have given the respondent a cause of action in private law for trespass to the person, sounding in damages (and if appropriate aggravated or exemplary damages)'.
[784] [2011] UKSC 12, LJ Walker at 194; 'the common law has always recognised that that an award of more than nominal damages should be made to vindicate an assault on an individual's person or reputation, even if the claimant can prove no special damage'.
[785] Shuman (n 458) 52.
[786] Perry (n 533) 988.
[787] Shuman (n 458) 59.
[788] Perry (n 533) 970.

Furthermore, given the functional interrelation of compensation and vindication in tort law, the granting of compensation can serve to validate (or invalidate), the severity of obstetric violence and the harms of UVEs, reinforcing the principle of bodily inviolability not only to the individual woman or birthing person subjected to the violation, but also communicating this affirmation on a wider social scale. However, tort law tends to reflect societal understandings of what behaviour constitutes a wrong[789] and of what suffering is recognisable as compensable harm. Since damages are supposedly deliberated on a proportional basis to the scale of the interference,[790] the lack of monetary compensation ascribed to gendered harms[791] is an unsettling declaration of the value attached to women's and birthing people's bodies. Whilst this is in part, a consequence of tort laws privileging of men's interests[792] (impacting the categorisation and level of compensation),[793] 'denying legal recognition of the harm by failing to award money or devise alternative ''compensation'' sends negative messages about the importance or value of [the claimant's] lives, and the range of their suffering'.[794] Battery's failure to articulate the harms of UVEs, and the restrictive judicial approach applied to compensation for per se liability torts, is likely to result in meagre awards being granted and a subsequent failure to vindicate the wrongs inherent in violating a woman's body during labour and childbirth. As such, the harms of UVEs are 'of a kind which would be very difficult to quantify in a manner which would allow for redress under tort law'.[795] Though undoubtedly, only substantial awards could adequately reflect the gravity of the wrongs and harms suffered when a woman or birthing person is subjected to an UVE.

This issue is exacerbated by the [in]significance of battery relative to the dominant tort of negligence action, with the latter infamous for reaping considerable compensatory awards. From this perspective, battery is side-lined by the negligence action, diminishing the vindicatory potential of battery and marginalising vindication as an objective of tort law. This may deter individuals initiating litigation for vindicatory purposes whilst maintaining the tortious centring on compensating losses as opposed to compensating harms. Further still, the dominance of negligence sustains judicial preoccupation with harms as understood by the male subject. This raises the concern that reliance on battery to address the various wrongs and harms of UVEs (though a fanciful endeavour from the offset), may result in them being peripheralised and viewed as less grievous, fortifying a gendered hierarchy of harm within tort.

Judicial failure to recognise – and compensate for – the range of maternal harms flowing form a healthcare professionals' violation of a woman's body ultimately reflect obstinate values of maternal self-sacrifice and medicalised childbirth.[796] As such, 'tort law simultaneously diminishes both the physical nature of what has happened to a woman's body and the devastating emotional and relational impact',[797] discounting women's experience and precluding a gender sensitive understanding of harm. Clearly, maternal injury remains a site of inequality.[798] It is highly unlikely that litigation under battery will correct the general tortious obscuring of maternal harm. Instead,

[789] Cane (n 179) 71.
[790] Varuhas (n 442) 283.
[791] Diaz-Tello (n 34) 60.
[792] Though undoubtedly, it is socially privileged men who reap the benefits of tort laws' androcentricity.
[793] Godden, 'Tort Claims for Rape' (n 485) 171.
[794] Bender, 'Feminist (Re) Torts' (n 482) 875.
[795] Nelson (n 237) 217.
[796] Chamallas and Finley (n 575) 125.
[797] Ibid 123.
[798] Chamallas, 'Social Justice Tort Theory' (n 423) 17.

reliance on battery, and tort law moreover, may actually invisibilise this form of GBV and its subsequent harms.

Contact, Intention, and Actionable per se Liability Status: Concluding Remarks

As I have substantiated, it seems 'battery is too loosely defined to have any meaningful sway when confronted with the formidable social powers of medical authority and harmful gender norms'.[799] There are numerous issues associable with the torts requisites, and overall, it appears that battery obscures the specific nature and harms of UVEs in various ways. This finding clearly has negative implications for determining whether the tort is able to secure redress needs on the individual and systemic level. In various ways and to a degree that cannot be ignored, the requirements of battery obscure the gendered harms and wrongs of the practice. Though the requirements I have examined thus far do not preclude a woman or birthing person from being able to bring an action, for liability in battery to be established, it needs to be proven that the contact was perpetrated without legally valid consent. In this examination, I discuss the legal construction of consent and wider issues relating to the conceptual foundations underpinning it, to identify the difficulties that a victim-survivor of obstetric violence may face in establishing that they did not consent to the vaginal examination(s) they were subjected to.

[799] Pickles, 'When Battery is Not Enough' (n 8) 141.

Chapter 4: The Issue of Consent

4.1 UVEs: The Issue of Consent

To be successful in a claim of battery, the victim-survivor must establish that the healthcare professional performed the vaginal examination without first having obtained legally valid consent. In this chapter, I will therefore examine the legal requirements of valid consent. I will also consider the different forms of signalling consent that may be relied upon (express and implied consent), to question the ethicality of the latter in the context of vaginal examination.

For a patient to have provided legally valid consent to a vaginal examination, they must have had mental capacity, their consent must have been informed, and it must also have been submitted voluntarily. Under the Mental Capacity Act 2005[800] (MCA), patients will be deemed mentally capacious, and therefore able to provide or withhold their consent to medical intervention, if they can understand, retain, and use/weigh information relevant to the decision, and if they are able to communicate their decision.[801] The MCA codified the former common law capacity test provided by the judgement in *Re C*.[802] Cases such as *Chester v Afshar*[803] and *Montgomery*[804] have provided that, for consent to be considered informed, healthcare professionals are required to engage with the patient to the extent that risks and benefits of, and alternatives to, interventions are disclosed. However, as I clarify in section 4.3.2, for a healthcare professional to avoid liability in battery, the patient need only be given 'sufficient information'. This requires that the patient is informed merely in 'broad terms'[805] as to the substance of the procedure. Finally, the consent must also have been voluntarily provided, meaning that the patient was not unduly influenced into agreeing to the vaginal examination. I analyse these requirements throughout this chapter, illustrating the difficulties a victim-survivor may face establishing that they did not consent to the UVE.

The difficulties I explore will also indicate on a broader level, that there are serious flaws in the law's understanding of consent and its conceptual foundations in traditional autonomy theory. Whilst a comprehensive exploration of the relationship between consent and autonomy is outside the scope of this dissertation, it is broadly understood that consent operates as a mechanism for the protection of patient autonomy.[806] However, feminist scholars recognise that the conception of autonomy underpinning consent in law abstracts persons from their bodily, social and affective contexts[807] whilst gendering autonomy male.[808] Unsurprisingly then, an individualistic understanding of agency and decision-making permeates the doctrine of informed consent, which 'invariably

[800] Mental Capacity Act 2005.
[801] Ibid, s3.
[802] *Re C (Adult: refusal of medical treatment)* [1994] 1 All ER 819 (QBD).
[803] [2004] UKHL 41.
[804] [2015] UKSC 11
[805] *Chatterton v Gerson* [1981] QB 432.
[806] Farrell and Devaney (n 588) 105. See also *Glass v UK* [2004] 1 FLR 1019.
[807] Lacey (n 401) 126. See also; Jennifer Nedelsky, 'Law, Boundaries and the Bounded Self' (1990) Representations 1670; Angela Thachuk, 'Midwifery, Informed Choice, and Reproductive Autonomy: A Relational Approach' (2007) 17(1) Feminism and Psychology 43; Laura Davy, 'Between an Ethic of Care and an Ethic of Autonomy: Negotiating Relational Autonomy, Disability, and Dependency' (2019) 24(3) Journal of Theoretical Humanities.
[808] Purvis (n 710) 372.

obscures medical violence against vulnerable communities [and] presumes medical decision-making occurs within a vacuum, unencumbered by systems of power and inequality'.[809] The flaws in the conceptual underpinning of consent, and the general deficiencies of the current legal formulation and treatment of consent, raise troublesome implications for victim-survivors seeking redress for the UVE(s) they experienced using the tort of battery. Not only does this indicate the incapacity of battery to provide redress on the individual level, but also the incapacity of battery to secure prevention of the practice on the systemic level. Seemingly then, whilst healthcare professionals have obligations to engage women and birthing people in the process of obtaining an informed consent, the law does not appear to have much influence in practice.[810] Despite a judicial rhetoric promoting patient autonomy and patient-centred care, the law is 'often not commensurate with the spirit or letter of the law'[811] when the patient concerned is a labouring woman or birthing person.

4.2 Consent in the Maternity Care Context

As affirmed in *Montgomery,* a labouring woman is, like any other 'adult of sound mind, entitled to decide which, if any… treatment to undergo, and consent must be obtained before interfering with her bodily integrity'.[812] Healthcare professionals are therefore required to ensure that *informed* consent is obtained before providing any medical treatment, or performing any medical intervention.[813] As Richard notes, 'when discussing ''informed consent'' at law, we are not discussing the mere agreement (or not) to undergo medical treatment… [but rather, we are] concerned with the quality of advice and information given to a patient prior to treatment'.[814] The importance of informed consent is also emphasised in various clinical guidelines designed to guide healthcare professional conduct, and to regulate medical encounters in line with both ethical standards and the law.[815] For example, the Royal College of Obstetricians and Gynaecologists (RCOG) conceptualise the process of obtaining informed consent as one of 'shared understanding and decision-making between patient and clinician [which] must be approached diligently and robustly'.[816] This guidance reflects the understanding that a dynamic approach to the consent process is salient for advancing greater maternal autonomy during pregnancy, labour and childbirth.[817] However, as voiced by Joffe and Truog, 'physicians often do not live up to their obligation to facilitate autonomous authorisation'.[818] Despite the emphasis in guidelines and the role of best practice standards in

[809] Campbell (n 269) 50.
[810] Villarmea (n 220) 66.
[811] Campbell (n 269) 67.
[812] [2015] UKSC 11 [87].
[813] [2004] UKHL 41.
[814] Bernadette Richards, 'Autonomy and the Law: Widely Used, Poorly Defined' in David G Kirchhoffer and Bernadette J Richards, (eds), *Beyond Autonomy: Limits and Alternatives to Informed Consent in Research Ethics and Law* (CUP 2019) 19.
[815] Although, see Maria Sheppard, 'Fallacy or Functionality: Law and Policy of Patient Treatment Choice in the NHS' (2014) 24(4) Health Care Analysis at 289, noting that 'the guidance and the requirement to engage with the patient generally goes beyond what English law demands of doctors'.
[816] RCOG, Clinical Governance Advice No. 6 January 2015, 'Obtaining Valid Consent' < https://www.rcog.org.uk/media/pndfv5qf/cga6.pdf > accessed 7th July 2022.
[817] Benjamin Chojnacki, 'Pushing Back: Protecting Maternal Autonomy from the Living Room to the Delivery Room' (2010) 23(1) Journal of Law and Health 81.
[818] Steven Joffe and Robert Truog, 'Consent to Medical Care: The Importance of the Fiduciary Context' in Franklin Miller and Alan Wertheimer (eds), *The Ethics of Consent: Theory and Practice* (OUP 2010) 348.

shaping healthcare professionals' behaviour, it remains the case that chronically, shared-decision making regresses into 'consenting the patient'.[819] In the maternity care context, studies evidence a systemic failure on the part of healthcare professionals to secure women's and birthing people's informed consent to a range of interventions during labour and childbirth.[820] This corroborates Romanis's conviction that, 'despite autonomy's central place in health law, in practical terms it remains that maximally autonomous choices remain inaccessible to women.'[821] Indeed, in the lived-context of the birthing room, autonomy is treated as a dispensable principle.[822] This is also mirrored in the court room, with judges struggling to respect and uphold women's autonomy rights, especially in the later stages of pregnancy.[823]

In regards to vaginal examinations specifically, guidelines provided by the NICE stipulate that women and birthing people should be informed as to why an examination is being advised, what the examination entails, and vitally, that they should only be carried out with the agreement of the patient.[824] However, 'many women are coerced into giving uninformed consent by staff leading them to believe that vaginal examinations are necessary for the safety of themselves or their baby… [and] even when women are well informed and have decided against vaginal examination, they often find their decision is not respected'.[825] As this finding suggests, women's and birthing people's autonomy rights are being compromised by the practice of UVE through 'abusive, opportunistic, or misguided practices that variously undervalue or overvalue consent, that fictionalise it or that are fixated by it, and that treat it too casually or too cautiously'.[826]

In an instance where a woman or birthing person has explicitly refused consent to a vaginal examination and a healthcare professional has proceeded forcibly, or if a healthcare professional has taken absolutely no steps to obtain consent before performing an examination, it will be relatively easy for the claimant to establish that the contact was unlawful. However, this discussion encompasses a broader range of circumstances which produce greater legal complexities - for example, where explicit refusal has not occurred or where some steps have been taken to gain consent, but where there has nevertheless been some failure in the authorisation process. This therefore includes those instances where a victim-survivor was deemed to have consented (impliedly, or expressly), but where this consent was not a reflection of their true state of mind. In this broader range of circumstances, the success of a claim in battery is less well assured. Ultimately, 'consent may be undermined in a variety of subtle and hidden ways… [and] although from an ethical perspective we may consider consent obtained in such circumstances is not a true consent, the law is more circumspect in its approach'.[827] This may preclude the battery claim as an avenue of redress for many women and birthing people subjected to UVEs.

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[819] Stella Villarmea and Brenda Kelly, 'Barriers to Establishing Shared Decision-Making in Childbirth: Unveiling Epistemic Stereotypes About Women in Labour' (2020) 26(2) Journal of Evaluation in Clinical Practice 516.
[820] Bohren et al (n 6).
[821] Romanis, 'Legal Method and Health Law in Feminist Perspective' (forthcoming) (n 231).
[822] Villarmea (n 220) 67.
[823] Emma Walmsley, 'Mamma Mia! Serious Shortcomings with Another ''(En)forced'' Caesarean Section Case Re AA [2012] EWHC 4378' (2015) 23 Medical Law Review 136.
[824] NICE Guidelines, Intrapartum Care for Healthy Women and Babies Clinical Guideline [CG190] 3 December 2014 < https://www.nice.org.uk/guidance/cg190/resources/care-of-women-and-their-babies-during-labour-and-birth-pdf-322358575813 > accessed 26th July 2022.
[825] AIMS, 'VE's – Essential Diagnostic Tool?' (n 296). See also; Ashley Shepherd and Helen Cheyne, 'The Frequency and Reasons for Vaginal Examination in Labour' (2013) 26(1) Women and Birth 53.
[826] Deryck Beyleveld and Roger Brownsword, *Consent in the Law* (Hart 2007) 333.
[827] Brennan (n 389) 238.

4.3 Valid Consent: The Legal Requirements

To successfully claim in battery, the burden of proof rests with the claimant to establish that legally valid consent was not obtained[828] for the vaginal examination(s) they were subjected to. Notably, this position has been recognised as somewhat harsh[829] and criticised as 'inconsistent with a person's right of bodily integrity'.[830] It is, however, congruent with the understanding in English civil law that consent (specifically, absence of consent) constitutes a component of the tort of battery, rather than operating as a defence to battery - as is the case in Canada and Australia.[831] It could also be argued that if a reasonable belief in consent were permitted to operate as a defence to tortious battery, biases in favour of the medical profession would likely result in the defence being successfully raised overwhelmingly in litigated cases.

For consent to be invalid in the eyes of the law, it must be established that the patient had been insufficiently informed, and/or that the consent was involuntarily given. In a claim brought against an UVE in battery, the determination as to whether the contact was or was not consensual will likely generate an evidentiary dispute and interpretative complexities.[832] However, even in those instances where consent has clearly not been obtained or where there has been a failure in the authorisation process, the law struggles to conceive 'that a woman would not want every examination possible during labour to protect the well-being of the child… [and therefore also] struggles to see [UVEs] as a wrong [but instead] something which enables a woman to perform her ''natural role'''.[833] As judges mediate the account and experience of the victim-survivor subjected to the UVE and the healthcare professional who violated them, this may have detrimental implications for the capacity of the action to meet the redress needs of victim-survivors, if not more damningly, for the success of the claim.

4.3.1 A Note on Capacity

Under the MCA, persons over the age of 18 with the requisite capacity have an absolute right to submit or refuse their consent to medical intervention.[834] For persons who lack capacity in accordance with the legislative definition,[835] medical treatment may be performed without their consent, provided the treatment is deemed to be in the patients' best interests.[836]

A patient will be found to lack capacity for the purposes of s.2 if they are unable; to understand the information relevant to the decision; to retain the information; to use or weigh the information in order to make a decision, and to communication their decision. Notably, a healthcare professional

[828] *Freeman v Home Office* [1984] QB 524.
[829] Pattinson, *Medical Law and Ethics* (n 445) 106.
[830] Department of Health and Community Services v JWB (1992) 175 CLR 218 [310-311].
[831] Alex Geisinger, 'Does Saying ''Yes'' Always Make It Right? The Role of Consent in Civil Battery' (2021) 54 University of California Davis Law Review 1857.
[832] Conaghan, 'Gendered Harm' (n 553) 415.
[833] Pickles and Herring, 'Introduction' *Womens Birthing Bodies and the Law* (n 40).
[834] MCA 2005.
[835] MCA 2005, s2.
[836] Hazel Biggs, ''Taking Account of the Views of the Patient'', but only if the Clinician (and the Court) Agrees - R (Burke) v General Medical Council' (2008) 19(2) Child and Family Law Quarterly 4.

who has performed an UVE could potentially argue that – at the time – the birthing person lacked capacity and that the vaginal examination was performed in their best interests, such that their lack of consent is irrelevant. Cases such as *St Georges*[837] demonstrate that healthcare professionals can retrospectively claim that the labouring woman upon whom they performed an unauthorised intervention (without having first obtained a court order), lacked capacity under the MCA. Further, recent cases have now enabled the courts to pre-authorise the performance of certain interventions in the event the birthing person becomes incapacitated at a future point.[838] Additionally, it is conceivable that an UVE could be found to have been performed in the best interests of a birthing person per s.4 MCA, as the courts demonstrate extreme deference to the opinions of healthcare professionals[839] even when there is only a marginal clinical benefit gained, or a marginal clinical risk avoided, by performing the intervention. This is illustrated in *AA,* where a caesarean section was deemed in the patient's best interests in order to avoid the approximated 1% risk of uterine rupture occurring during vaginal delivery.[840]

Notwithstanding the above, for present purposes, it is assumed a victim-survivor bringing the claim had capacity at the time the UVE was performed. However, I nevertheless provide an overview of the literature critiquing the capacity framework, with especial emphasis on criticisms raised against its application in the labour and childbirth context.

As Foster identifies, there exists in law 'a dramatic and draconian apartheid between the capacitous and the incapacitous'.[841] Despite the consequences of being found to lack capacity, however, 'capacity' has been criticised for lacking nuance and philosophical sophistication.[842] Further, the MCA does not cater specifically to the particular exigencies of labour and childbirth.[843] Labour and childbirth produce complex states of power and vulnerability, and in 'occupy[ing] a space like no other',[844] pregnant women and birthing people may not always fit squarely within the capacitous/incapacitous binary which underpins consent in law.[845] As a consequence, they are often assumed to lack capacity.[846] Furthermore, and as explored in chapter 1, the resilience of the stereotype of women and birthing people as incompetent, irrational decision-makers indicates that incapacity is assumed consequential to the states of pregnancy, labour and childbirth. Whilst judges have dismissed the notion that upon becoming pregnant, women lose mental capacity (and with it, their right to autonomy),[847] capacity considerations continue to be raised in order to undermine women's and birthing people's status as autonomous beings.

The medical institution portrays pregnant women and birthing people who do not defer to medical expertise as irrational.[848] Given that the ability to reflect and make rational decisions has often been

[837] [1998] 3 All ER 67.
[838] [2020] EWCOP 4.
[839] Halliday, *Autonomy and Pregnancy* (n 224) 214.
[840] [2014] 2 FLR 237. For an insightful discussion of this case, see; Halliday, *Autonomy and Pregnancy* (n 224).
[841] Charles Foster, 'Autonomy in the Medico-Legal Courtroom: A Principle Fit for Purpose?' (2013) 22(1) Medical Law Review 58.
[842] Ibid.
[843] John Mason and Graeme Laurie, *Mason and McCall Smith's Law and Medical Ethics* (9th edn, OUP 2013) 92.
[844] Claire Murray, 'Troubling Consent: Pain and Pressure in Labour and Childbirth' in Camilla Pickles and Jonathon Herring (eds), *Women's Birthing Bodies and the Law* (Hart 2020) 161.
[845] Ibid.
[846] See; Nelson and Romanis (n 202) at 674, and Halliday, 'Court-Authorised Obstetric Intervention' (n 456).
[847] [2015] UKSC 11 [116].
[848] Purvis (n 710) 401.

understood as a testament to whether or not an individual has the capacity for autonomy,[849] their portrayal as such has troubling implications which often unfold through the application of mental capacity law. Whilst persons with capacity are entitled to make 'irrational' medical decisions,[850] and though irrationality is not a component of the legislative capacity test, in the birthing context irrationality is treated and accepted as evidence of mental incapacity. Conversely, rationality (and thus capacity) is equated with and demonstrated 'by a willingness to deny self-interest and relinquish moral decision-making power'.[851] Further still, definitions of rationality are entangled in gender and racial inequality, since women and birthing people 'who differ from their medical or legal practitioners in race, ethnicity, religion, or class are less likely to be seen as rational actors in the health care and legal systems'.[852] Whilst the determination as to whether an individual lacks capacity is ultimately reserved to the judiciary, medical professional opinion is strongly influential,[853] and in cases such as *Norfolk and Norwich Healthcare (NHS) Trust v W*[854] amongst others, we continue to encounter judicial use of the capacity test as a 'mechanism through which to establish, silently and implicitly, desired norms of patient behaviour and identity against which the real pregnant women whose cases come before the courts'.[855] Concerningly, the courts have also recently created an avenue through which the choices of capacitious women and birthing people can be challenged,[856] with 'risk' now being used as a gateway for authorising contingent or anticipatory relief within the ambit of the MCA.[857] This development takes application of capacity law in the context of labour and childbirth to another paternalistic extreme. Again, whilst it is assumed here the victim-survivor bringing a claim had capacity at the time of the UVE, this discussion makes clear how the 'assumption that labouring women lack capacity during labour and childbirth has clearly shaped how consent is obtained in obstetric practice',[858] with healthcare professionals failing to listen, or to grant women and birthing people a voice in their birthing experiences.[859] Whilst we can acknowledge that decision-making may be impacted by the pain and pressure of labour and childbirth, 'without also challenging the binary framework of consent, we may reify the stereotype that pregnant women and birthing people are not fully autonomous subjects,[860] such that 'the physical fact of pregnancy will always remain an impediment to ensuring women are treated as full, equal people in healthcare contexts and beyond'.[861]

Manipulative application of capacity law in the context of labour and childbirth - purposed to furtively preserve foetal life[862] and exempt healthcare professionals from liability - arguably reveals a judicial prejudice in favour of protecting the medical institution, and a tendency towards regulating women's and birthing people's behaviour. This corroborates Baker's contention that the legal system 'is used as leverage to extort consent from unwilling women, rather than protecting them

[849] Denbow (n 241) 796.
[850] *Re T (Adult: Refusal of Medical Treatment)* [1992] 4 All ER 649.
[851] Daniels (n 592) 49.
[852] Kenneth Veitch, *The Jurisdiction of Medical Law* (Taylor and Francis 2007) 94
[853] Ibid 94.
[854] [1997] 1 FCR 269.
[855] Veitch (n 852) 98.
[856] Sara Fovargue, 'In Whose Best Interests? Childbirth Choices and Other Health Decisions' (2021) 137 Law Quarterly Review 617.
[857] Aimee Hulme, 'An Emerging Pattern? A Further Case of Anticipated Capacity Loss in Pregnancy: North Middlesex University Hospital NHS Trust V SR [2021] EWCOP 58' (2022) Medical Law Review 7.
[858] Pickles, 'Sounding the Alarm' (n 714) 14.
[859] Villarmea and Kelly (n 819) 517.
[860] Murray, 'Troubling Consent' (n 844) 170.
[861] Boone (n 713) 41.
[862] Halliday, *Autonomy and Pregnancy* (n 224) 169.

and their right to determine medical care'.[863] Drawing from this, the success of a claim against an UVE in battery may be compromised by a legal approach to consent designed to provide greater defensive benefit to healthcare professionals than it does protective benefit to women and birthing people.[864]

4.3.2 The Requirement for 'Sufficient Information'

In order to provide legally valid consent to medical treatment patients must have received 'sufficient information'.[865] However, as identified by Cave, 'descriptions [in clinical guidelines] of what constitutes sufficient information is not an accurate description of what is required for consent to be [legally] valid.[866] As this discussion will substantiate, the disparity between the informational threshold for valid consent relevant to battery and the clinical guidance is glaring.

In the maternity care context, research suggests that women and birthing people are frequently provided biased and/or insufficient information by their healthcare professionals.[867] However, for a healthcare professional to avoid liability under battery, the patient need only be informed in 'broad terms'[868] as to the substance of the procedure, ie, what the practice entails. This standard sets a relatively low level of information disclosure[869] and confers significant discretion to the judiciary.[870] Additionally, this broader awareness does not have to be provided directly by the healthcare professional.[871] Notably, the level of information disclosure required to avoid liability in battery is considerably lower than that required to avoid liability for the tort of negligence. Negligence is arguably more patient-centric in this respect, since more extensive information disclosure is required.[872] It follows that, a patient may be sufficiently informed to meet the threshold for valid consent necessary to avoid liability for battery, but they may not have been provided enough information to provide 'informed consent', necessary to avoid liability in negligence.[873] This indicates that, when establishing whether or not consent to a UVE was legally valid in a battery claim, we are not concerned with 'informed consent' (denoting a certain quality and comprehensiveness of information having been provided prior to the medical intervention),[874] but rather, the issue is whether or not the claimant knew what the vaginal examination entailed. Risks of and alternatives to vaginal examinations need not to have been disclosed. As a result, battery has been marginalised as a litigatory vehicle for patients,[875] and the 'broad terms' standard of information disclosure is

[863] Heather Joy Baker, "We Don't Want to Scare the Ladies:" An Investigation of Maternal Rights and Informed Consent Throughout the Birth Process' (2010) 31 Women's Rights Law Reporter 539.
[864] Elsa Montgomery, 'Silence, Acquiescence or Consent: Interpreting Women's Responses to Intimate Examinations' in Camilla Pickles and Jonathon Herring (eds), *Women's Birthing Bodies and the Law* (Hart 200) 48.
[865] *Chatterton v Gerson* [1981] QB 432.
[866] Emma Cave, 'Valid Consent to Medical Treatment' (2020) Medical Ethics 3.
[867] Susan Huschke, 'The System is Not Set up for the Benefit of Women': Women's Experiences of Decision-Making During Pregnancy and Birth in Ireland' (2022) 32(2) Qualitative Health Research 330.
[868] [1981] QB 432 [433].
[869] Stauch and Wheat (n 694) 124.
[870] Ibid 122.
[871] Pattinson, *Medical Law and Ethics* (n 445) 110.
[872] Sheppard (n 815) 287.
[873] Peter Skegg, 'English Medical Law and ''Informed Consent'': An Antipodean Assessment and Alternative' (1999) 7(2) Medical Law Review 138.
[874] Richards (n 814) 19.
[875] José Miola, 'On the Materiality of Risk: Paper Tigers and Panaceas' (2008) 17 Medical Law Review 79.

therefore arguably too low.[876] This leads Forsberg to conclude that in the context of UVEs, a claim in battery is unlikely to be successful.[877]

The broad terms threshold not only threatens the success of an individual claim in battery, however. Concerningly, this threshold fails to deter healthcare professionals from performing vaginal examinations on assumptions of women's and birthing people's understanding. This dismisses the personal dignitary importance of ensuring that an understanding of the interventions and practices they are undergoing is present, and undermines the utility of the informed consent process for engaging with women and birthing people as active participants in their maternity care experiences.[878] The 'broad terms' informational standard thus disregards the vitality of the decision-making process to women and birthing people, instead, nurturing the 'dominant male, ''rational'' medical model'[879] which preserves medical knowledge – and thus a claim to superior decision-making authority – to the medical institution and its professionals.[880] Whilst it is possible that a more patient-centric information standard could be adopted in battery, the courts have proven hesitant to advance such a development,[881] and as is stands, an action resting on insufficiently informed consent would be hard to establish and unlikely to succeed. In light of the UN Special Rapporteurs identification of the role of informed consent in preventing obstetric violence, this is particularly disappointing.[882]

However, informed consent is not a panacea for obstetric violence, and in regard to the informational requirement, it is speculative whether raising the standard will protect women and birthing people from UVEs and other forms of obstetric violence. Whilst an increase in knowledge could improve the potential for shared-decision making,[883] the idea that providing information results in a reallocation of decision-making authority fails to sufficiently apprehend and understand the role of power dynamics within the patient-healthcare professional relationship in undermining patient autonomy. It may even elevate the privileging of authoritative medical knowledge, undermining, rather than promoting an 'alternative birth ecology… [in which] knowledge [is] horizontally rather than hierarchically distributed'.[884] Thus, rather than narrowly emphasising informed consent as a way to respect the autonomy of patients (an idea accordant with traditional autonomy theory), it may be more conducive to secure broader acknowledgement of the 'social contexts and power relationships [which] inform and influence patients' autonomy and healthcare decision-making processes'.[885] In the following discussion, I examine the requirement for consent to the vaginal examination(s) to be voluntary, the 'most neglected dimension of consent in contexts of

[876] Cave, 'Valid Consent' (n 866) 2.
[877] Lisa Forsberg, 'Childbirth, Consent, and Information about Options and Risks' in Camilla Pickles and Jonathon Herring (eds), *Childbirth Vulnerability and the Law* (Routledge 2019) 167.
[878] Stephanie Tillman, 'Consent in Pelvic Care' (2020) 65(6) Journal of Midwifery and Women's Health 754.
[879] Les Haberfield, 'Pregnant Women: Judicial Intervention and the Right of Pregnant Women to Refuse Medical Treatment' (1995) James Cook University Law Review 40.
[880] Devaney and Holm (n 716) 204.
[881] Emma Cave and Nina Reinach, 'Patient Rights to Participate in Treatment Decisions: Choice, Consultation and Knowledge' (2019) 7(2) Journal of Medical Law and Ethics 160.
[882] United Nations General Assembly (n 67) [84].
[883] Cara Delay and Beth Sundstrom, 'The Legacy of Symphysiotomy in Ireland: A Reproductive Justice Approach to Obstetric Violence' in Elizabeth Mitchell Armstrong, Susan Markens, and Miranda R Waggoner (eds), *Reproduction, Health and Medicine* (Emerald Publishing Limited 2020).
[884] Jordan (n 646) 74.
[885] Jennifer Bell, 'Relational Autonomy as a Theoretical Lens for Qualitative Health Research' (2020) 13(1) International Journal of Feminist Approaches to Bioethics 71.

medical practice and research'.[886] I will consider power dynamics and other affective contexts further.

4.3.3 The Requirement for Consent to be Voluntarily Given

To be legally valid, consent must also be submitted voluntarily. Clearly, if a woman's or birthing persons explicit wishes not to be subject to a vaginal examination are overridden, absence of consent will be easily established. Consent will also be involuntary – and therefore invalid – if the patient had been 'unduly influenced'.[887] However, the doctrine of undue influence requires the claimant to prove that their will had had been 'overborne'.[888] This is a difficult undertaking, as indicated by *The Centre for Reproductive Medicine v U*.[889] Pattinson has criticised the law as it stands for failing to protect patients.[890] In *U*, even though a healthcare professional had exerted 'considerable pressure'[891] on a patient who was recognised to be especially emotionally vulnerable,[892] the courts declined to find the patient had been unduly influenced. Similarly, in *Freeman v Home Office (No.2),*[893] whilst the court acknowledged that it was necessary to take into account the hierarchal context against which the claimant allegedly consented to the medical treatment, this was not enough for the courts to deem the consent invalid.[894] This reflects 'a tendency in the practice of the courts to rely on more limited conventional understandings'.[895] For a woman or birthing person who had consented to a vaginal examination on an involuntary basis, judicial reluctancy to fully acknowledge the ways in which power imbalances and other impediments 'can influence, limit and shape individuals' choices when this may render appeals to ''free'' choice meaningless',[896] could mean that legally valid consent will be found to have been present.

Increasing attention has been directed to healthcare professional-patient power dynamics. Many scholars have recognised and drawn attention to the inherent risk that healthcare professionals may exploit the power asymmetry within the verticalised and depersonalised clinical relationship[897] by engaging in coercive behaviour.[898] This risk is arguably magnified in the maternity care context, not least because women (and other marginalised groups)[899] are more vulnerable than other patients to

[886] Thomas Beauchamp, 'Autonomy and Consent' in Franklin Miller and Alan Wertheimer (eds), *The Ethics of Consent* (OUP 2010) 55.
[887] Pattinson, *Medical Law and Ethics* (n 445) 128.
[888] [1992] 4 All ER 649 [662].
[889] [2002] EWCA Civ 565 [22].
[890] Shaun Pattinson, 'Undue Influence in the Context of Medical Treatment' (2002) 5(4) Medical Law International 305.
[891] [2002] EWCA Civ 565 [21].
[892] Ibid [22].
[893] [1984] 1 All ER 1036 CA.
[894] Godden, 'Tort Claims for Rape' (n 485) 167.
[895] Ibid.
[896] Ibid 168.
[897] Nathalia Klering et al, 'Obstetric Violence and Medical Education: Answering "Who Is Afraid of Obstetric Violence?" (2020) 21(1) Brazilian Journal of Mother and Child Health 345.
[898] Stauch and Wheat (n 694) 119.
[899] See for examples, Goldberg, Jennifer and Aston (n 325) at 512 highlighting that 'queer birthing women routinely experience vulnerability as part of their embodied queerness as lived within heteronormative and homophobic structures' and Rachel West and John Bartkowski, 'Negotiating Patient-Provider Power Dynamics in Distinct Childbirth Settings: Insights from Black American Mothers' (2019) 9(45) Societies, for an insight into black women's experiences of powerlessness and vulnerability in childbirth settings.

coercion.[900] And as posited by Kennedy et al, 'the lack of literature surrounding women's refusals of obstetric interventions may infer that [they] do not feel they can refuse professional recommendations'.[901] Indeed, power imbalances have been identified as a root cause of obstetric violence.[902] The ability of women and birthing people to refuse their consent to interventions may be compromised by various structural and interactional factors.

Coercive practices and interactions are institutionally embedded and sanctioned in the maternity care context, such that their coercive quality is muted as a result of their routinisation and normalisation. The performance of vaginal examinations to determine established labour, (established labour being required by all maternity care institutions in order to grant women and birthing people admission to the labour ward), is a prime example of an institutionally embedded, coercive practice which restricts patient choice.[903] The standardisation of examinations as the door to accessing care produces an implicit requirement for submission,[904] since 'most women will not make choices that they perceive might alienate those providing them with care'.[905]

The way in which healthcare professionals conduct examinations on an interactional level further impedes women's and birthing people's agency and ability to refuse consent to the practice. In one study conducted by Hassan et al, around 77% of women reported being given instructions before the vaginal examination was performed,[906] and its seems that overwhelmingly, women are told what to do, or what will happen to them, rather than being granted a voice in the decision-making process.[907] In some instances, healthcare professionals exert pressure on women and birthing people to behave in expected ways, cementing norms for others to follow.[908] For example, in one encounter, a woman recalled being informed that if she did not cooperate, the healthcare professionals attending to her 'would start to get frustrated.'[909] In other cases, however, 'coercion can be psychological or implicit, ie, related to the authoritativeness of biomedical knowledge and power issues in the doctor-patient relationship'.[910] Whilst some healthcare professionals may not be aware that their behaviour or words are being perceived as pressure,[911] studies indicate that some healthcare professionals actively 'try to persuade patients to agree to their recommendations… which [may] involve ''being emotive''[912] and sending in other healthcare professionals to ''sort of

[900] Flanigan (n 417) 240.
[901] Sophie Kennedy et al, 'Consent on the Labour Ward: A Qualitative Study of the Views and Experiences of Healthcare Professionals' (2021) 264 European Journal of Obstetrics and Gynaecology and Reproductive Biology 153.
[902] United Nations General Assembly (n 67) [49].
[903] Rebecca Brione, 'Person-Centered Maternity Care: COVID Exposes the Illusion' (2022) 15(1) International Journal of Feminist Approaches to Bioethics 131; Andrew Kotsaka, 'Informed Consent and Refusal in Obstetrics: A Practical Ethical Guide' (2017) 44(3) Birth 197.
[904] Brione, 'Non-Consented Vaginal Examinations' (n 303) 29.
[905] Julie Jomeen, Choice, *Control and Contemporary Childbirth: Understanding Through Women's Stories* (Taylor and Francis 2010) 18.
[906] Hassan et al (n 294) 16.
[907] Huschke (n 867) 339.
[908] Baker et al (n 263) 318.
[909] Lisa De Maria et al, 'Non-physician Providers of Obstetric Care in Mexico: Perspectives of Physicians, Obstetric Nurses and Professional Midwives' (2001) Human Resources for Health 5.
[910] Quatrocchi, 'Obstetric Violence Observatory' (n 65) 763.
[911] Judy Jou et al, 'Patient-Perceived Pressure from Clinicians for Labour Induction and Caesarean Delivery: A Population-Based Survey of US Women' (2015) 50(4) Health Services Research 973.
[912] See also, Joana Vilela da Silva, 'Physicians Experiencing Intense Emotions While Seeing Their Patients: What Happens?' (2016) 20(3) The Permanente Journal, who highlights the significant role of emotions in human interactions (specifically healthcare professional-patient interactions) in 'yielding communicative intentions,

sway someone''.[913] Women and birthing people respond to their situation as patients in submitting to healthcare professional dictates as they 'become enmeshed in the hospital structure of tacit, socially imposed rules of conduct'.[914] This is also underlines why the concept of coercive control is useful for understanding violence in the maternity care context,[915] with 'obstetric violence operat[ing] as a dynamic relational process that produces docile bodies and complex intersectional subjectivities during birth'.[916]

Dixon Woods et al conclude that women's and birthing people's choices are 'circumscribed, if not pre-determined, by the rules of the game in this particular field and the power relations contained therein.'[917] Concerningly then, the consent process 'does not safeguard against the functioning of power within a relationship; it simply becomes incorporated within that relationship and is part of the game within which the relationship is located'.[918] This is all the more insidious as patients internalise hegemonic obstetric norms to collaborate in their own subordination.[919]

Birthing experiences are also regulated by other social forces, specifically, gendered identities[920] which further compromise women's ability to refuse interventions. As explained by Jomeen, the institution of motherhood, as a cultural construction, carries powerful influence within women's birthing experiences and also generates 'a climate of opinion against which others perceive [her] behaviours and actions'.[921] Demonstrably, during labour and childbirth the gendering of women and birthing people means that choice, and specifically, the ability to consent or refuse consent to interventions, is situated in the maternity care context, with the result being that they are likely to make choices 'perceived to facilitate ''niceness'' and approved [birthing] behaviour'.[922] Women's choices are thus enacted within a restrictive range of disciplining - and at times, conflicting - framings of 'ideal femininity, sexuality and sacrifice'.[923]

In response to the above, feminist scholars have expressed scepticism as to whether decision-making in the reproductive context is ever truly autonomous[924] (at least on the traditional understanding), as although choices may appear freely made, in actuality they are socially structured and coerced.[925] In the maternity care context then, '''choice'' is potentially coercive, as it ignores the asymmetrical relations and cultural impediments enforced through the obstetric hegemony'[926] and

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modelling behaviour, promoting attachment, influencing information processing, *and even determining choices'* (emphasis added).

[913] Kennedy et al (n 901) 151.

[914] Mary Dixon-Woods et al, 'Why do Women Consent to Surgery, Even When They do not Want to? An Interactionist and Bourdieusian Analysis' (2006) 62(1) Social Science & Medicine 2747.

[915] Herring, 'Identifying the Wrong' (n 84) 72.

[916] Chadwick, 'Ambiguous Subjects' (n 2) 490.

[917] Dixon-Woods et al (n 914) 2749.

[918] Ibid 2751.

[919] Sadler (n 633) 18.

[920] Karin Martin, 'Giving Birth Like a Girl' (2003) 17 Gender and Society 69-70.

[921] Jomeen (n 905) 55.

[922] Judith McAra-Couper, Marion Jones and Liz Smythe, 'Caesarean-section, My Body, My Choice: The Construction of ''Informed Choice'' in Relation to Intervention in Childbirth' (2012) 22(1) Feminism and Psychology 90.

[923] Claudia Malacrida and Tiffany Boulton, 'Women's Perceptions of Childbirth "Choices": Competing Discourses of Motherhood, Sexuality, and Selflessness' (2012) 26(5) Gender and Society 769.

[924] Catriona Mackenzie and Natalie Stoljar, *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self* (OUP 2000) 220.

[925] Zairu Nisha, 'Technicisation of "Birth" and "Mothering": Bioethical Debates from Feminist Perspectives' (2021) 13(133) Asian Bioethics Review 142.

[926] Baker et al (n 263) 355.

thus repudiates the oppressive nature of the medical institution as a patriarchal construction.[927] When confronted with omnipresent medical authority, 'enforced in those countless situations where women are told what to do… and a technocratic maternity system that favours standardised procedures over subjective needs and desires, it is, arguably, not easy for women to ''simply say no'''.[928] Further still, socio-cultural differences and axes of disadvantage 'place an additional layer of complexity over the socially constructed context of choice, power and relationships within maternity care encounters'.[929] Clearly then, choice and consent cannot be considered in a vacuum.[930]

Despite the fact that many women and birthing people feel unable to refuse examinations, the law appears inoperative in practice.[931] In a case brought against an UVE in battery, it is likely that the courts will fail to recognise the role of healthcare professional-power dynamics and other facets of oppression in compromising notions of choice.[932] This may be due to the laws androcentric and atomistic understanding of how autonomy is exercised and expressed in the consent process, but also due to judicial incredulity that a woman or birthing person would refuse their consent to procedures and practices advised by their medical professionals.[933] This limits the protection offered by battery, and highlights the inaptitude of this avenue for redressing UVEs and other instances of obstetric violence.

4.4 Express and Implied Consent

There will not always be harmony between objective perceptions and subjective conceptions of consent. Consent is ultimately 'a state of mind personal to the victim of the battery'.[934] Law's conceptualisation of valid consent does not sufficiently address this reality – a critique and concern germane to the wider ethical debate surrounding the [in]appropriateness of relying on implied consent in the context of obstetric intervention.

Two forms of signalling consent are generally deemed acceptable and widely relied upon in medical contexts; express and implied consent. Express consent usually entails the patient's explicit verbal agreement. By contrast, implied consent is drawn 'implicit[ly] in the relationship between parties and [is derived from patient's] behaviours and understandings'.[935] As such, implied consent is socially constructed.[936] In regards to the practice of vaginal examination, as a matter of best practice, the General Medical Council guidance recommends that express consent should be secured.[937] This reflects an understanding of express consent as a more reliable indication of the patient's state of mind.[938] However, this is not invariably the case for many reasons (some of which I have explored

[927] Mackenzie and Stoljar (n 924) 220.
[928] Huschke (n 867) 340.
[929] Lyn Ebert et al, 'Socially Disadvantaged Women's Views of Barriers to Feeling Safe to Engage in Decision-making in Maternity Care (2014) 27(2) Women and Birth 136.
[930] Rosemary Hunter and Sharon Cowan (eds), *Choice and Consent: Feminist Engagements with the Law and Subjectivity* (Routledge 2007) 1.
[931] Villarmea (n 220) 67.
[932] Herring, 'Identifying the Wrong' (n 84) 83.
[933] Pickles and Herring, 'Introduction' *Women's Birthing Bodies and the Law* (n 40).
[934] *Sidaway v Bethlem Royal Hospital* [1985] AC 871 [894].
[935] Baker (n 863) 551.
[936] Parltett (n 541) 145.
[937] General Medical Council, 'Decision Making and Consent' (GMC Guidelines 2020) [5].
[938] Herring, 'Implied Consent' (n 321) 149.

above).[939] It is for this reason that consent forms cannot be relied upon as a substitute for meaningful, ongoing dialogue designed to secure the individual's needs.[940] Indeed, informed consent is a dynamic process of continual communication and interaction,[941] and without that process, any signed consent form is just a piece of paper.[942] It follows that consent is specific and requires reiteration for each treatment.[943] Securing an express consent to one examination then, does not secure consent to all further examinations.

Despite the consensus that ethically, express consent should be sought for the performance of vaginal examinations, research has revealed that implied consent is nevertheless being relied upon.[944] I problematise this state of affairs on numerous grounds, not least because implied consent 'fails to provide the moral or legal justification for vaginal examinations'[945] since this form of contact is prima facie wrongful.[946] First of all, implied consent is ineluctably ambiguous,[947] being constructed by the healthcare professional from an individual's behaviours. As Tierney notes, in the process of obtaining this socially constructed consent, 'the subjective dimension of the interaction may be sacrificed or lost due to the routinised objectification that occurs through the highly ritualised language of the medical case'.[948] Indeed, the modern maternity care environment is a 'context in which the authoritative knowledge of biomedically trained professionals' reigns… [and] in such an environment… a doctor conveniently need not take notice of the mental/emotional expressions of the woman in labour'.[949] This ultimately leads to a failure to acknowledge that 'conformity may masquerade as consent'.[950] As indicated in the preceding discussion, many women and birthing people feel unable to question the authoritative control of the healthcare professional.[951] Performing vaginal examinations on the basis of implied consent may therefore cause significant harm to some women and birthing people, as implied consent is not a reliable indication of the individuals true state of mind. Further still, the 'way that healthcare professionals approach consent indicates their attitude towards their patients'.[952] Permitting healthcare professionals to perform UVEs on a medical conceptualisation of consent demonstrates negligent concern for patient well-being, and dismisses that these examinations constitute 'a serious invasion of sexual and bodily privacy'.[953]

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[939] Pattinson, *Medical Law and Ethics* (n 445) 108.
[940] General Medical Council (n 937) [55].
[941] United Nations General Assembly (n 67) [38].
[942] Jessica Berg, Paul Appelbaum, Charles Lidz, and Lisa Parker (eds), *Informed Consent: Legal Theory and Clinical Practice* (OUP 2001) 188.
[943] Sylvie Lévesque et al, 'Obstetric Violence in Health Care: A Conceptual Analysis' (2018) 31(1) Feminist Research Journal 230.
[944] Montgomery (n 864) 46.
[945] Herring, 'Implied Consent' (n 321) 143.
[946] Ibid.
[947] John Kleinig, 'The Nature of Consent' in Franklin Miller and Alan Wertheimer (eds), *The Ethics of Consent* (OUP 2010) 12.
[948] Thomas Tierney, 'Foucault on the Case: The Pastoral and Juridical Foundation of Medical Power' (2004) 25(4) Journal of Medical Humanities 278.
[949] Szurek (n 668) 298.
[950] Cook and Brunton (n 669) 556.
[951] Ellen Lazarus, 'What Do Women Want? Issues of Choice, Control, and Class in American Pregnancy and Childbirth' (1994) 8(1) Medical Anthropology Quarterly 37.
[952] Alasdair Maclean, *Autonomy, Informed Consent and Medical Law: A Relational Challenge* (CUP 2009) 72.
[953] Herring, 'Implied Consent' (n 321) 148.

Ultimately, only full, rich, and express consent should be relied upon in the maternity care context,[954] and the law should require that an individual's subjective intention 'is signalled distinctly and definitely, personally, and unequivocally'.[955] Implied consent fails to abridge an understanding between patients and doctors. Notwithstanding its ethical failings, where a vaginal examination has been performed on an assumption of implied consent, the fact that privately, the woman or birthing person did not consent is irrelevant, since legally valid consent will likely be found to exist. Whether their consent was not truly informed or even voluntary, is inconsequential if the healthcare professional can establish that they believed that consent existed. In allowing healthcare professionals to rely on implied consent, the law allows healthcare professionals to fictionalise consent, precluding a vast majority of women and birthing people from claiming in battery.[956]

Consent: Concluding Remarks

In the maternity care context, consent requires an especial ethical sensitivity, without which women's and birthing people's human rights will be compromised.[957] In this sense, healthcare professionals are pivotal agents in restraining or liberating women's autonomy.[958] However, as noted by Cahill, 'maternity care is a key area in which women's ability to exercise real choice and make informed decisions is limited and where doctor/patient interactions are themselves constructions of existing gender orders; women's autonomy continues to be violated through both quite subtle and overt discourse and practice'.[959] Despite the importance of the consent process for protecting women and birthing people and recognising their status as autonomous human beings, in many instances, vaginal examinations are being performed without legally valid consent. However, the various shortcomings of the laws approach to consent means that women and birthing people will continue to be harmed by the performance of unauthorised interventions during labour and childbirth.[960] The low standard of information required for the 'sufficient information' threshold to be met, and the onerous task of establishing that consent was involuntarily provided using the doctrine of undue influence, indicate that a claim brought in battery against a UVE will likely be unsuccessful.

However, although medical informed consent and the subsequent litigation rarely benefits those patients directly involved, it has, and continues to stimulate debate surrounding the nature of the healthcare professional-patient relationship[961] as 'the precedential dimensions of common law adjudication… also shape the backdrop of the general rules that regulate social interaction'.[962] Law constantly clarifies and revises informal rules at the boundaries, creating alignments to minimise opportunities for conflict.[963] In light of the failures of the current rules of consent as they pertain to action in battery following an UVE, applying a more patient-centric conceptualisation of valid consent may be necessary to ensure that women and birthing people are actually protected against

[954] Villarmea (n 220) 77.
[955] Beyleveld and Brownsword (n 826) 344.
[956] Herring, 'Implied Consent' (n 321) 148.
[957] Murray, 'Troubling Consent' (n 844) 168.
[958] Sánchez (n 79) 23.
[959] Heather Cahill, 'Male Appropriation and Medicalization of Childbirth: An Historical Analysis' (2001) 33(3) Journal of Advanced Nursing 334.
[960] Murray, 'Troubling Consent' (n 844) 168.
[961] Sheppard (n 815) 290.
[962] Ibid 288.
[963] Richard McAdams, *The Expressive Powers of the Law: Theories and Limits* (HUP 2017) 260.

bodily violations in the maternity care context. A reappraisal of the requirements of legally valid consent as they relate to the tort of battery, is therefore, arguably necessary. Under the present standard of consent there is a real risk that, despite the lived experiences of women and birthing people subjected to UVE(s), an action in battery against this violation will be unsuccessful.

Ultimately, there is potential for a richer, more receptive conceptualisation of consent across the legal system; one in which the various forces of oppression which impede and negate individuals' ability to grant and refuse their consent are meaningfully acknowledged and applied by the courts. This must continue to be interrogated within future work. However, reform of the legal requirements for valid consent as they apply to battery will not be enough to protect women and birthing people from UVEs, and other forms of obstetric violence. For a woman or birthing person bringing a claim against an UVE in battery, however, redress and justice may remain elusive.

Conclusion

This dissertation has sought to comprehensively evaluate use of civil battery as a mechanism through which to redress UVEs performed during labour and childbirth. Overall, I have illustrated that battery is, theoretically, a viable avenue for redress.[964] The tort could provide a reasonable avenue of redress for some women and birthing people subjected to UVEs,[965] and by inference, other unauthorised interventions. However, it is important to recognise that 'having a theoretical cause of action is not justice'.[966] Whilst in some instances recourse to civil battery may be viable, it does not follow that reliance on the tort is appropriate or efficacious in the context of UVE.

Ultimately, redress needs will differ amongst victim-survivors of obstetric violence, and though tort law has been theorised to provide redress for wrongs suffered by claimants via a multitude of objectives, the extent to which the tort system secures its purposes is dubious in reality. Having recognised the especial potential of tortious compensation, vindication, and empowerment on the individual (and indirectly, the wider level), torts undervaluation of gender-based injuries, lack of regard for gender specific suffering (a consequence of its androcentricity), and the burdensome nature of civil litigation, seriously undermine the extent to which the tort system can be argued equipped to deal with obstetric violence as a form of GBV and its consequences for victim-survivors. Prospectively, future empirical work would be invaluable to validate or challenge the ideas I have raised throughout this work, as well as the conclusions I have ultimately reached, as they relate to women's and birthing people's lived experiences and redress needs.

However, the requisite elements of civil battery are, on the practical litigatory level, uniquely accommodating. To reiterate, the requisite of intention to touch and not an intention as to the resulting harm is invaluable in allowing women and birthing people to bring a claim. This is because in most instances, it will be assumed that a healthcare professional did not perform the UVE with any ulterior motive. Similarly, the actionable per se liability status of battery is another important feature, permitting victim-survivors to seek redress irrespective of whether or not they have suffered physical or psychological injury as result of the UVE(s). This enables the tort to vindicate the wrong experienced through bodily violation, and in turn, defends the inviolability of women's and birthing people's bodies in a context where bodily appropriation and violation are otherwise legitimised by the hegemonic norms of maternity care and its culture. It is arguable that this also aids the promotion of a conception of harm, and of violence, in which gendered subjectivities are grounded, where the accent on intention is muted, and one in which violation represents the substratum of our understanding.

Nevertheless, the capacity of the tort to meet the redress needs of women and birthing people on the individual level, and to prevent the practice of UVEs on the systemic level, is highly questionable. Problematically, the tort of battery obscures the gender-based and systemic dimensions of UVEs. UVEs – and unauthorised obstetric interventions generally - are fundamentally different from other types of medical battery.[967] Bringing a claim against UVEs under civil battery subsequently fails to engender an understanding of the practice in its institutional context. This therefore risks the minimisation and trivialisation of women's experiences and manifests consequences for the

[964] Mulligan (n 17) 193.
[965] Ibid 190.
[966] Diaz-Tello (n 34) 77.
[967] Borges (n 23) 853.

outcome of the action, such as meagre compensation awards. Furthermore, encompassing UVEs under the conceptual parameters of battery does nothing to specifically define the practice as one of obstetric violence. This failure diminishes the gravity of this violation and fails to demand attention to the particularities of the phenomenon – including the power imbalances which enable the perpetration of violence in the maternity care context. Not only are asymmetrical power relations a primary cause of obstetric violence,[968] they may also preclude legal protection of women and birthing people if the impact of these dynamics in governing interactions in the maternity care context are overlooked. This is particularly apparent when looking at the requirements of informed consent.

In conclusion, the deprivation of maternal rights and experiences of violence within maternity care structures is a pervasive and multidimensional problem. Whilst tort law may constitute one tool for advancing women's and birthing people's interests during labour and childbirth,[969] 'individual tort litigation is necessary, but not sufficient for the task of ending obstetric violence'.[970] The capacity of civil battery to play a meaningful role in addressing and preventing UVEs is limited. Whilst it may be possible to refine judicial engagement with the tort, 'to bring the irreducible other under the remit of [existing] law is to effect a certain reductive violence against their difference',[971] and it is more appropriate to explicitly recognise UVEs as obstetric violence and develop legal responses accordingly.[972] Ultimately, tort law, and law in general, fails to speak to women's and birthing peoples lived experiences.[973] Legal solutions, however, need to address issues as experienced by women and birthing people,[974] and by 'ensuring embodied experiences receive attention in legal analysis, we may be able to cut across the biases towards the male norm that exist in medicine'[975] law, and other structures through which we mediate and make sense of our experience of the world.

Further still, responses to UVEs must recognise the structural inequalities and systemic biases that create and foster the conditions making violence against women and birthing people possible.[976] It follows that, to address UVEs and other manifestations of obstetric violence in a way that accounts for the complex exigences of this particular phenomenon, the development and implementation of a discrete law is urgently mandated. The introduction of a legal provision against obstetric violence in England and Wales would help to instigate a shift in power relations and to sustain accountability on both the individual and collective level.[977] Although, obstetric violence requires broader, global legal responses – which may be adapted to the local contexts – to protect women and birthing people across the world.[978] The experiences of countries across Latin America (who have implemented obstetric violence provisions from as early as 2007) could prove instructive in this regard. However, there is also a need to reform healthcare professional education,[979] amongst other initiatives. Without a comprehensive shift in maternity care structures, maternity care practices and processes, the overall culture and crucially, in power dynamics, efforts to secure respectful maternity care and

[968] United Nations General Assembly (n 67) [49].
[969] Conaghan, 'Tort Law and Feminist Critique' (n 597) 184.
[970] Diaz-Tello (n 34) 62.
[971] Lymer and Utley (n 466) 243.
[972] Sjölin (n 389) 125.
[973] Pickles, 'When Battery is Not Enough' (n 8) 141.
[974] Brione, 'Non-Consented Vaginal Examinations' (n 303) 39.
[975] Romanis, 'Legal Method and Health Law in Feminist Perspective' (n 231).
[976] Miltenburg et al (n 81) 108.
[977] Pickles, 'Eliminating Abusive ''Care''' (n 3) 12.
[978] Sadler et al (n 4) 52.
[979] Klering et al (n 897) 345.

to prevent violence against women and birthing people during labour and childbirth, will fall short.[980] The law does however, have an important role to play.

[980] Ramsey (n 555) 13.

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