Quaderni del Dipartimento di Giurisprudenza
dell'Università di Torino

THE SUBTLETIES OF GYNAECOLOGICAL AND OBSTETRIC VIOLENCE

A MULTIDISCIPLINARY PERSPECTIVE

edited by

BARBARA GAGLIARDI

UNIVERSITÀ
DI TORINO

Edizioni
Scientifiche
Italiane

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Opera finanziata con il contributo del Dipartimento di Giurisprudenza dell'Università di Torino.

La presente opera è stata sottoposta a revisione da parte di una Commissione di Lettura di docenti del Dipartimento nominata dal Comitato Scientifico della Collana in conformità al Regolamento delle pubblicazioni del Dipartimento di Giurisprudenza dell'Università di Torino.

Gagliardi, Barbara (*edited by*)
The Subtleties of Gynaecological and Obstetric Violence.
A Multidisciplinary Perspective
Quaderni del Dipartimento di Giurisprudenza dell'Università di Torino - 8/2026
Napoli-Torino: Edizioni Scientifiche Italiane - Università degli Studi di Torino

80121 Napoli, via Chiatamone 7
www.edizioniesi.it
info@edizioniesi.it

10124 Torino, Via Verdi 8
www.collane.unito.it/oa/
openaccess@unito.it

pp. XIV+202; 22,5 cm
ISBN: 978-88-495-6175-3

ISBN: 9788875904104

Prima edizione: maggio 2026
un volume in lingua inglese

Gli autori dichiarano che l'eventuale utilizzo di sistemi di intelligenza artificiale per la redazione dei lavori è avvenuto soltanto a fini strumentali e di supporto dell'attività intellettuale.

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ISBN 978-88-495-6175-3

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Introduction

This volume collects the proceedings of a conference held on 8 October 2024 at the Department of Law of the University of Turin, with the support of the 'Research Center for Women's and Gender Studies' (Centro Interdipartimentale di Ricerche e Studi delle Donne e di Genere - C.I.R.S.De.).

The conference convened scholars from diverse disciplinary fields and geographical contexts to examine a topic that has gained increasing prominence in both academic debate and public discourse: obstetric and gynaecological violence. Long underreported and insufficiently addressed, this phenomenon has in recent years become more visible thanks to the efforts of associations, activists, and survivors. Their engagement has taken shape through awareness-raising campaigns,[1] artistic and literary works,[2] podcasts,[3] popular publications,[4] public reports,[5] research projects,[6] and, in several countries, legislative initiatives.[7]

[1] Roses Revolution in Spain and other countries, #PayeTonUtérus and #balancetongyneco [Expose Your Gynecologist] in France, #AncheAme [Me Too] or #bastatacere [Stop Staying Silent] in Italy; Observatory on Obstetrical Violence OVO-Italia: <https://ovoitalia.wordpress.com/indagine-doxa-ovoitalia> accessed 16 December 2025; the Belgian *Plateforme citoyenne pour une naissance respectée* [Citizen Platform for a Respectful Birth]: <https://www.naissancerespectee.be/> accessed 16 December 2025.

[2] Joyce Carol Oates, *Butcher: A Novel* (Alfred A. Knopf 2024).

[3] Domitilla Pirro, Benedetta Petroni, Sara Bertazzini, *A gambe larghe, Un podcast contro la violenza ginecologica* [Legs Wide Open: a Podcast against Gynecological Violence] (Mondadori Studios 2024), <https://open.spotify.com/> accessed 16 December 2025; Maëlle Sigonneau and Mounia el Kotni *Im/patiente* [Im/Patient] (Nouvelles Écoutes 2019), <https://open.spotify.com/> accessed 16 December 2025.

[4] Mounia El Kotni and Maëlle Sigonneau, *Im/Patiente - Une exploration féministe du cancer du sein* [Im/Patient - A Feminist Exploration of Breast Cancer] (First 2021).

[5] Haut Conseil à l'Egalité entre les femmes et les hommes, *Les actes sexistes*

 ISBN 978-88-495-6175-3

Various definitions and classifications of obstetric and gynaecological violence have been proposed. The concept encompasses not only physical violence and sexual abuse, but also verbal and psychological forms of violence. These may include neglect, inadequate communication between healthcare professionals and patients, emotional abuse, lack of information, insults, denigratory comments, dismissal of patients' accounts, disregard for their expressed preferences (for example, concerning the position adopted during childbirth), and similar behaviours. In many cases, the behaviours of healthcare professionals are *perceived* as violent because they fail to adapt medical communication to patients' cognitive and linguistic characteristics. The perception of having suffered abuse may often arise from the absence of due consideration for – or even the denial of – the cultural traditions of ethnic minorities. At the same time, the notion covers behaviours resulting from structural and organisational deficiencies within healthcare systems, such as lack of privacy during hospitalisation and treatment, inadequate facilities (due to overcrowding, noise, poor hygiene, or disorganisation), or insufficient or inadequately trained healthcare staff.

The notion first emerged in public debate and activist discourse

durant le suivi gynécologique et obstétrical [Sexist Acts During Gynecological and Obstetric Care] (2018); House of Commons - Women and Equalities Committee, *Women's reproductive health conditions* (2024); Virginie Rozée and a., *Case studies on obstetric violence: experience, analysis, and responses* (European Union 2023).

[6] See the Obstetric Violence project funded by H2020 (MSCA, PI Dr. Patrizia Quattrocchi); the report on *Obstetric violence in the European Union: Situational analysis and policy recommendations* elaborated within Scientific Analysis and Advice on Gender Equality in the EU (SAAGE) project (funded by EU-DG JUST, PI Dr. Patrizia Quattrocchi)

[7] The first legislative measures explicitly addressing obstetric and gynaecological violence were enacted in Central and South America, marking a pioneering moment in the recognition of such practices as forms of institutional and gender-based violence within the legal domain (see ch. 4, n. 1). In Europe a law addressing obstetric violence has recently been adopted in Portugal: Lei n. 33/2025, *Promove os direitos na gravidez e no parto* [Promotes rights during pregnancy and childbirth]; see also the Belgian *Rapport d'information concernant le droit à l'autodétermination corporelle et la lutte contre les violences obstétricales* [Information Report on the Right to Bodily Self-Determination and the Fight Against Obstetric Violence], adopted by the Senate on the 15.01.2024; in France, the proposition de loi n° 238 *visant à renforcer un suivi gynécologique et obstétrical bientraitant*, enregistrée à la Présidence du Sénat le 12.01.2023 [Draft bill No. 238 aiming to strengthen respectful gynecological and obstetric care, registered with the Presidency of the Senate on 12/01/2023].

ISBN 978-88-495-6175-3

in the form of obstetric violence within South American feminist movements. In that context, activists criticised the hyper-medicalisation of pregnancy and childbirth, viewing it as a form of institutional control over women's bodies. They promoted active childbirth and advanced a model of care grounded in the empowerment of pregnant women.

Over time, additional forms of conduct have been subsumed under the broader concept of obstetric and gynaecological violence. Of particular significance is the field of reproductive medicine. The recognition of reproductive rights and the development of the concept of 'reproductive justice'[8] initially gained prominence in relation to equitable access to abortion and were later extended to services connected with medically assisted reproduction. More recently, the entire field of gynaecology has come to be seen as warranting careful scrutiny. Its close connection to sexuality and to the most intimate dimensions of personal identity makes gynaecological examinations an especially sensitive context. During pelvic examinations and in the provision of reproductive services, individual vulnerabilities are particularly pronounced and risk being further exacerbated.

The very notion of 'violence' in this context is contested. While the term is increasingly present in national and international legal texts[9] and is widely used by social movements, its appropriateness is questioned. Alternative formulations such as 'substandard and disrespectful care',[10] or 'mistreatment'[11] have been proposed not only by health professionals, but also by researchers. According to this perspective, the term 'violence' suggests intentional and extreme acts of harm and may therefore unfairly stigmatise professionals operating within overstretched healthcare

[8] Loretta J. Ross and Rickie Solinger, *Reproductive Justice: An Introduction* (University of California Press 2017).

[9] See Parliamentary Assembly of the Council of Europe, Resolution 2306 (2019) on *Obstetrical and gynecological violence;* Dubravka Šimonović, Report on *violence against women, its causes and consequences*, submitted on 11.07.2019 to the UN General Assembly.

[10] European Association of Perinatal Medicine (EAPM), European Board and College of Obstetricians and Gynaecologists (EBCOG) and European Midwives Association (EMA), 'Joint position statement: Substandard and disrespectful care in labour - because words matter' (2024) 296 European Journal of Obstetrics & Gynecology and Reproductive Biology 205.

[11] Meghan Bohren *et al.*, 'The mistreatment of women during childbirth in health facilities globally: a mixed-methods systematic review' (2015) 12(6) PLoS Medicine e1001847; Frank A. Chervenak *et al.*, 'Obstetric violence is a misnomer' (2024) American Journal of Obstetrics & Gynecology 1138.

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systems. Such terminology is considered counterproductive, as it risks hindering constructive dialogue and fostering a climate of distrust between patients and healthcare providers.[12]

From a legal perspective, however, such a narrow understanding of violence is open to question. Legal definitions of violence vary considerably depending on the relevant branch of law – whether civil, criminal, or international – as well as on the interpretative context in which the concept is applied[13] and its application cannot be confined to deliberate physical aggression alone. Rather, it must be understood within the broader human rights framework and in light of the fundamental principles of autonomy, dignity, and informed consent.

At the same time, the use of such a strong and evocative term – as professional bodies often lament – plays a crucial role in bringing to light practices that might otherwise remain invisible.[14] As feminist scholarship has emphasised, naming the phenomenon is a necessary precondition for recognising its impact and affording protection to those affected. Indeed, naming 'performs a critical function', helping to 'make sense of experiences, develop consciousness-raising initiatives, improve measures for solidarity, and develop practical ways to bring about social change'.[15] Some have also observed that acknowledging the violence suffered has a specific psychological effect. Indeed, it helps individuals overcome negative experiences and 'can become a tool for transforming a traumatic experience into a chance to question and change reality'.[16]

Ensuring access to respectful and person-centred care is not merely an ethical imperative but a matter of legal and constitutional significance. It directly engages the individual's right to therapeutic self-determination, understood as a fundamental expression of personality and human dignity.[17] As the Hippocratic tradition

[12] The use of the term 'violence' may elicit a 'negative emotional reaction (…) together with a more defensive and less collaborative mind-set': EAPM *et al.* (n. 10); Carlo Botrugno, 'Obstetric Violence from the Perspective of Everyday Bioethics' in Lucia Re, Carla Strazzeri and Sara Fariello (eds), *Obstetric Violence as Gender Based Violence* (De Gruyter 2026) 9.

[13] Giulio De Simone, 'Violenza (diritto penale) [Violence (criminal law)]' in *Enciclopedia del diritto*, vol XLVI (Giuffrè 1993) 884.

[14] Camilla Pickles, 'Obstetric Violence, 'Mistreatment', and 'Disrespect and Abuse': Reflections on the Politics of Naming Violations During Facility-Based Childbirth' (2023) 38 Hypatia 628, 634.

[15] Pickles (n. 14).

[16] Maria T.R. Borges, 'A Violent Birth: Reframing Coerced Procedures during Childbirth as Obstetric Violence' (2018) 67 Duke Law Journal 827, 852.

[17] Cons. St, sez. III, 2 settembre 2014, n. 4460.

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reminds us, medicine exists to serve the person;[18] every therapeutic act must begin with respect for the individual – not as an external constraint, but as its very foundation.

The use of the term 'violence' situates abuses perpetrated in clinical settings within the broader framework of gender-based violence and highlights their structural dimension. Individual instances of gyneacological and obstetric abuse are part of the broader problem of gender-based violence because they 'bring with [them] loss of autonomy and the ability to decide freely about their bodies and sexuality'.[19] Medicine, for its part, has historically contributed to laying the philosophical foundations of Western misogyny.[20] In the provision of care, women have long been relegated to ancillary roles. The traditional knowledge of female healers – the so-called 'wise women' – was disparaged as superstition or witchcraft and gradually supplanted by scientific knowledge monopolised by men.[21] The growing presence of women in obstetric and gynecological care roles does not seem, in itself, to have changed the dominant culture.[22] The study and description of the female body as imperfect or 'mutilated', beginning with the Hippocratic writings, served to confine women to socio-cultural roles centred on caregiving.[23]

However, this reflection must not result in the erosion of the therapeutic alliance, which remains the cornerstone of medical care. Denunciation must not turn into hostility towards healthcare professionals – an outcome that, regrettably, is not uncommon.[24]

[18] Lodovico Balducci, 'Personhood: an inconvenient truth', (2012) 10 Journal of Medicine and the Person 93.

[19] Borges (n. 16) 827.

[20] Christia Mercer, 'The philosophical roots of Western misogyny' (2018) 46(2) Philosophical Topics 183; Valentina Gazzaniga *et al.*, 'Storia e medicina di genere' [History and Gender Medicine] (2018) 78 Medicina e Chirurgia 3503.

[21] Barbara Ehrenreich & Deirdre English, *Witches Midwives & Nurses* (Feminist Press 2010).

[22] In Italy, for instance, over 60% of gynecologists are women: see Ministero della Salute, *Le donne nel Servizio Sanitario Nazionale - anno 2021* [Ministry of Health, Women in the National Health Service - 2021] (2023) 25.

[23] Zoe Adams, '(Dis)ease: The Rhetoric of Illness in Depictions of the Healthy Female Body from Hippocrates to the Present' (2015) Senior Capstone Projects Paper 413.

[24] In Italy see the recent d.l. 1 October 2024, n. 137, *Misure urgenti per contrastare i fenomeni di violenza nei confronti dei professionisti sanitari, socio-sanitari, ausiliari e di assistenza e cura nell'esercizio delle loro funzioni nonchè di danneggiamento dei beni destinati all'assistenza sanitaria* [Urgent Measures to Combat Violence against Health, Social and Health Care Professionals,

 ISBN 978-88-495-6175-3

Rather, the focus should shift to institutional responsibility: to the organisational contexts in which care is delivered and to the implementation of effective preventive measures. Only through systemic reform can we ensure both the protection of patients and adequate working conditions for professionals, thereby enabling the full exercise of their competence and vocation.

The present volume is situated within this framework. It brings together contributions from a range of disciplinary perspectives – legal, psychological, medical, sociological, and anthropological – in an effort to examine the phenomenon in all its complexity. Legal scholars specialising in administrative, criminal, and international law engage in dialogue with criminologists, psychologists, sociologists, anthropologists, and physicians, fostering an exchange that is both rigorous and multidimensional. As the World Health Organization has consistently emphasised, 'violence prevention activities typically involve partnerships across sectors of society, scientific disciplines and organisations', as well as the active involvement of communities.[25] In this context, law cannot operate in isolation: to be truly transformative, it must engage with other fields of knowledge and practice.

The volume opens with a contribution by Georgia Zara, which conceptualises obstetric violence as a form of epistemic injustice with profound psychological consequences. It then turns to legal analysis, with particular attention to the protection of the individual right to self-determination, in the chapters authored by Joana Falxa, and by Raluca Bercea and Cristina Nicorici.

The subsequent contributions, by Barbara Gagliardi and Silvia Carabelli, trace the conceptual evolution that has led to the recognition of not only abuses perpetrated during labour and childbirth, but more broadly all forms of misconduct occurring within gynaecological healthcare services.

Finally, the last three chapters address specific manifestations of gynaecological violence. Sarah Gino and Elena Rubini examine the clinical management of gender-based violence, highlighting the good practices necessary to ensure that medical examinations following sexual assault do not inflict further harm. Raffaella Ferrero Camoletto and Federica Manfredi situate within the

Auxiliaries and Assistance and Caregivers in the Exercise of their Functions, as well as Damage to Assets Assigned to Health Care], converted into l. 18 November 2024, n. 171.

[25] Etienne G. Krug *et al.*, 'The world report on violence and health' (2002) 360 Lancet 1083.

ISBN 978-88-495-6175-3

concept of gynaecological violence the phenomenon of medical gaslighting in cases of contested illness, where healthcare professionals dismiss or invalidate patients' symptoms and lived experiences. Roxana Andreea Toma focuses on the violence and structural barriers to accessing quality gynaecological care experienced by incarcerated women.

The comparative dimension of the conference – particularly the discussion of Italy, France, and Romania – proved especially fruitful. Each national context presents distinct legal and demographic challenges; yet all confront similar tensions in their efforts to regulate and reform the most intimate domains of medical care.

Obstetric and gynaecological violence is a widespread global phenomenon, although its manifestations do not always coincide across different settings. In low- and middle-income countries, reports more frequently document incidents linked to resource constraints within healthcare systems, such as shortages of qualified staff or inadequate infrastructure and facilities.[26] This does not suggest that gynaecological and obstetric violence is exclusive to, or necessarily more prevalent in, these contexts.

Particularly in these settings, obstetric violence is very often recognised as an indirect contributor to maternal mortality. Abusive or degrading experiences during childbirth may discourage women from seeking institutional care in subsequent pregnancies or from accessing healthcare services altogether, thereby increasing the risks associated with pregnancy and delivery.[27]

Across all settings – whether in high-income or in low- and middle-income countries – instances of abuse, violence, discrimination, and neglect have been documented.

Among the contexts examined in this volume, France stands out for the particular degree of institutional attention devoted to the phenomenon, as Silvia Carabelli's contribution demonstrates. Although Portugal was the first European country to enact legislation specifically addressing obstetric violence,[28] the French experience remains especially noteworthy. Awareness of its significance grew

[26] Bohren *et al.* (n. 11).

[27] Even in high-income countries, previous experiences of obstetric violence frequently influence women's decisions in subsequent pregnancies, leading them to choose home birth. In many instances, however, these remain institutionalised and planned care pathways, organised within the framework of the national health system rather than outside it. See Nadine Pilley Edwards, *Birthing Autonomy. Women's Experiences of Planning Home Births* (Routledge 2005).

[28] See n. 7.

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markedly following the *touchers vaginaux* scandal, which exposed the practice of conducting pelvic examinations on anaesthetised patients without first obtaining their informed consent.[29]

By contrast, as highlighted in the chapter by Raluca Bercea and Cristina Nicorici, the Romanian context is characterised by 'high levels of institutional tolerance towards domestic violence'. A 'systemic lack of sensitivity towards women's bodies' contributes to an institutional and cultural climate that is likewise unfavourable to the recognition and reporting of obstetric and gynaecological violence. This situation is further complicated by the significant presence of the Roma ethnic minority, historically subjected to discrimination, which renders the analysis particularly compelling.

The reference to the treatment of ethnic minorities brings into focus a defining feature of the contributions collected in this volume: their intersectional approach. The analysis demonstrates how the cumulative effect of multiple vulnerability factors exacerbates obstetric and gynaecological violence. This is evident in the case of women who are survivors of sexual violence – as discussed by Sarah Gino and Elena Rubini – incarcerated women – the focus of Roxana Andreea Toma's chapter – and, as previously noted, Roma women.

What emerged clearly from the conference – and is reflected in the chapters gathered here – is the urgent need for continued legal, empirical, and theoretical engagement with this issue. The concept of violence is not static: it assumes different contours depending on whether it is experienced by pregnant women, adolescent girls, survivors of abuse, incarcerated persons, migrants, Roma women, older persons, LGBTQIA+ individuals, or those living with poorly understood medical conditions. Likewise, the specific medical context – whether abortion services, childbirth, medically assisted reproduction, first gynaecological examinations, or cancer screening – shapes both the forms that violence may take and the types of intervention required.

Such awareness of complexity does not hinder legal reflection; rather, it constitutes its necessary starting point. The task ahead – analytical, normative, and institutional – is demanding but indispensable. It is our hope that this volume makes a meaningful contribution to that endeavour.

[29] F Béguin, 'Le gouvernement veut empêcher les touchers pelviens sans consentement' [The government wants to prevent pelvic examinations without consent] Le Monde (2015) <www.lemonde.fr> accessed February 2026.

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Section I
Obstetric violence

Georgia Zara

Psychological Implications and Consequences of 'Gynaecological and Obstetric Malpractice'. When the Intention to Harm Becomes 'Secondary' to the Harm and Trauma Suffered

1. *Introduction*

The principle that people and their needs should be at the centre of the healthcare system is not new. It was Hippocrates (460 B.C.E. - 377 B.C.E.) who said: '[i]t is more important to know what kind of person has a disease than to know what kind of disease a person has'. The idea of treating patients in a personalised, respectful and enabling way is linked to the idea that patients are *equal partners* in healing (Coulter & Oldham, 2016). This concept is central to psychology, as it has been empirically proven that a good relationship contributes significantly to the client connecting with the therapy, adhering with its protocol, and deriving the greatest benefit from it.

The concept of 'equal partners' refers to the recognition of equal dignity and self-determination, while renouncing to any form of expectation that patients should have the same competence as healthcare professionals but to recognise them as an active part of decisions related to their health and well-being.

Wolf *et al.* (2017) conducted a qualitative study exploring the impact of a person-centred care model by engaging patients and professionals in hospital settings in thematic semi-structured

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interviews. Patients appeared to value the human connection beyond both the formal aspects of participation and the sense of empowerment. Indeed, patients were satisfied with being able to ask questions and receive information; for them, participation was perceived as informed discussion and consent, and they were more inclined to rely on professional knowledge and expertise, when trust was developed, and did not necessarily look for opportunities for empowerment and activation. These findings also suggest that professionals need to recognise the importance of *human connectedness* and emotionally supportive relationships in the process of helping patients to participate.

1.1. *Doctors and patients: Do they really have different attitudes and expectations of their roles?*

The climate of human connectedness promotes trust and better patient engagement in decision-making about their health: compliance should be recognised in the service of self-determination and not as an obstacle of its exercise. It facilitates the work of the professional staff, making it possible to proceed in respect of both patients' needs and guidelines.

Some interesting clinical findings show, for example, that:

- Women expect the gynaecologist to communicate with them, inform them about their health and decide (together) with them on the next steps.
- Insufficient or unclear information promotes anxiety, which can lead to extreme reactions: women may visit the clinic unnecessarily or possibly not return at all (Larsen *et al.*, 1997; Mete, 1998; Şirin & Nar, 1999; Wendt *et al.*, 2004; Wijma *et al.*, 1998; Yanikkerem *et al.*, 2009).[1]

This is why knowledge is considered one of the biggest barriers to accessing treatment and diagnosis.[2] As the report of the UK Committee on Women's Rights and Equal Opportunities (2024) vividly illustrates, women are more likely to suffer from poor health and other conditions due to a lack of knowledge about important aspects of their anatomy, leaving them dependent on others to make decisions on their behalf.

Similarly, research shows that according to physicians:

- Patients want their doctor to 'take responsibility'.

[1] For further specific details see also American College of Obstetricians and Gynecologists (ACOG), 'News Release' <http://www.acog.org>.

[2] Bloody Good Period, FRSH (WRH0048).

ISBN 978-88-495-6175-3

• Authority, paternalism and objectivity are seen as essential characteristics of a *reassuring* doctor and practitioner (Kessel, 1979), especially because any consultant visit to the hospital makes people emotionally regress to a status of dependency on the one who should know more and better: the doctor (for further details see Fantry, 2016; Hajek and König, 2020), so that an important requisite of reassurance is information (Kessel, 1979, p. 1130).

Zeldow and Braun (1985) developed a scale to measure regressive behaviour and regressive attitudes in patients admitted to hospital for various medical conditions. Their BUMP scale consists of 32 items, which are divided into the following areas: *behavioural regression* (Factor 1); *poor patient-staff relations* (Factor 2); *depression and anxiety* (Factor 3); *passivity and withdrawal* (Factor 4). Although BUMP was developed to monitor and assess the general regressive behaviour of hospitalised patients, it seems to summarise, *mutatis mutandis*, some of the psychological stages that hospitalised women experienced because of impaired care, making them not only distressed but also insecure.

However, the risk of specialised (e.g., gynaecological) consultation rooms becoming the site of misconduct, abuse, or violence can potentially be high because gynaecological examinations involve the exposure of intimate body parts with loss of control (Yanikkerem *et al.*, 2009). For these reasons, it is not unusual for women to postpone gynaecological examinations as long as possible, with potentially detrimental consequences for health (Hilden *et al.*, 2003).

Research on patients' accounts of their experiences in the consulting room describes the enduring sense of disorientation many women felt and remembered by using near-traumatic expressions of which some examples are listed below:

• It was an intrusion into the most intimate dimension of the self: sexuality (Golding *et al.*, 1998).

• It was exacerbated by physical discomfort (Hilden *et al.*, 2003).

• It was unpleasant and humiliating (Wijma *et al.*, 1998).

• It triggered negative feelings: fear of illness, pain, shame (Wendt *et al.*, 2004).

Studies looking at mistreatment, including physical, verbal, emotional and psychological abuse in health and social care settings have increased since 2010, when Bowser and Hill published an analysis reporting on disrespect and abuse of

 ISBN 978-88-495-6175-3

women during childbirth. Unfortunately, the incidence of these types of abusive experiences within the maternity care has not decreased and many more areas of the health care system in high-, middle- and low-income countries worldwide are affected (d'Oliveira *et al.*, 2002).

This landscape of disrespect (Bowser and Hill, 2010) is rooted at the individual level (e.g., patient characteristics, staff burnout and stress, staff workload, lack of specialised training), at the institution level (e.g., disorganisation, low staff turnover, institutional culture), at the policy level (e.g., resource scarcity, minimum funding, risk-averse policies, mismanagement of behavioural emergencies), and at the societal level (e.g., gender inequality, normalisation of violence, marginalisation, stigmatisation, stereotyping and prejudice). Moreover, many of the studies reviewed found that misconceptions about ethnic minorities, people of low economic status, and immigrants are widespread, influential and pervasive.

Indeed, disrespect and abuse are more likely to be triggered in contexts where violence is normalised at all levels (individual, relational, social, political) of the socio-ecological system. The belief that injustice and mistreatment are part of life leads to the false conviction that one must expect it sooner or later because no one is exempt. This creates a climate that condones violence to such an extent that patients, in Bowser and Hill's (2010) research, reported that they deserved it or that it was necessary for them to be abused to ensure that they were safe (as in mental health or elderly care) (Al-Maraira and Hayajneh, 2019; Baker *et al.*, 2016; Bower *et al.*, 2003) or that their baby was born safely (Bohren *et al.*, 2019; Schaaf *et al.*, 2023). Examples of this will be found in other studies too (see later in this chapter for details).

The belief that physical or verbal mistreatment is necessary to minimise clinical harm is one of the greatest instruments of power that can be used to control and subjugate people in today's healthcare system. Violence and mistreatment cannot be equated with assertiveness, urgency of intervention or mastery of techniques, because a responsible and competent professional is, above all, both respectful and ethical, as well as able to act quickly. This does not mean that a professional does not make mistakes; it means that the mistakes that occur are not the result of a disregard for the patient's needs and rights. When mistreatment occurs, both responsibility and ethics are absent, and professional care collapses, leading to severe consequences for the patient and for medical staff as a whole.

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Indeed, research shows that the use of force and threats can be associated with iatrogenic harm, i.e. harm caused by medical and psychological treatments or interventions. In addition, many people's emotional and behavioural distress is a by-product of poor clinical care and/or negative interpersonal encounters due to stigma and at the clinic level (Parker *et al.*, 2020) or what is named 'medical misogyny' in the report of Women and Equality Committee commissioned by the House of Commons in the UK (2024). This can manifest as psychological trauma, compounded by behavioural dysregulation, and even lead to physical harm.

Based on this assumption, the focus of this chapter is on the psychological implications and consequences of gynaecologic and obstetric malpractice compared to good practise and on the exploration of what is often – not uncontroversially – referred to as gynaecologic and obstetric violence (GOV). This paper begins with an examination of the available literature on this topic and then explores how the issue is currently treated as malpractice or violence in order to explore possible ways to prevent such cases from recurring.

1.2. *Can we really talk about violence? or Are we in front of a misnomer?*

Much attention is given to the question of whether it is better to talk about violence rather than malpractice, as if the term malpractice trivialises what certain patients experience and downplays professional responsibility. For some researchers this malpractice is is in fact no different from a form of interpersonal violence, structurally and organisationally embedded in the fabric of society, reproducing social inequalities between groups (Sadler *et al.*, 2016), rooted in gender biases (Cárdenas-Castro & Salinero-Rates, 2024) and coercive heteronormativity (Fonquerne, 2021), and facilitating the perpetuation of patterns of abusive and disrespectful behaviour in healthcare settings (Lévesque *et al.*, 2018, 2021).

Other researchers are of the opinion that this malpractice cannot be equated with violence *per s*e, since the intent of harm is missing (Di Lello Finuoli, 2022; Lappeman and Swartz, 2019, 2021). Rather, it can be assumed that in a system where resources are scarce and healthcare professionals are exploited and overburdened with a large sense of responsibility (Briceño Morales *et al.*, 2018; Gray *et al.*, 2019; Policy Department for Citizens' Rights and Constitutional Affairs, 2024), there is a

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risk of providing compromised and distorted clinical care, that certainly leads to mistreatment (Bohren *et al.*, 2015) and ends up in malpractice.

Both perspectives have their advantages and disadvantages. The inclusion of intent entails the risk of criminalising healthcare professionals. If intent is excluded, there is a risk that the problem will be downplayed.

Undoubtedly, it is important to gather evidence of how these realities that are told, experienced, caused, remembered and witnessed can indeed become a source of discomfort, misunderstanding and mistreatment, to the point when they become malpractice and abuse and violence.

We can see if the nominal differences affect the outcomes.

If one wants to focus on gynaecological and obstetric 'malpractice', the implication may be more on:

- The appropriation of women's bodies and reproductive processes by healthcare professionals, which manifests itself in dehumanised treatment, the misuse of medication and the transformation of natural processes into pathological ones.
- The result for women is a loss of autonomy and the ability to make free decisions about their own bodies and sexuality, which has a negative impact on their quality of life.

There is no doubt that the way something is named helps to create its identity and the narrative with which it is perceived and evaluated (Pickles, 2023). Addressing the controversies surrounding these views is relevant in that it highlights the convergence of interpersonal, institutional, cultural and social factors that perpetuate this problem and the debate over whether this problem is 'violence'.

Despite this increased awareness, research is sparse. Making matters even more complex is the fact that there are undoubtedly major barriers to prevention, namely the lack of globally accepted definitions of what constitutes respectful maternity care and abuse during childbirth, for example (Vogel *et al.*, 2016).

The following section of this chapter deals with the view that we are dealing with multiple forms of harmful practices perpetrated within gynaecological and obstetric care.

2. *The harmful practices in gynaecological and obstetric care*

Even if gynaecological and obstetric care cannot be reduced in its harmful practices, what comes to light cannot be ignored,

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as more and more cases of malpractice seem to call into question the integrity of the entire healthcare system. As a report requested by the EU Committed for the FEMM committee (Brunello *et al.*, 2024) emphasises, 'while obstetric violence may be suffered during pregnancy, childbirth and post-partum, women might experience gynaecological violence during gynaecological consultations throughout their lives' (p. 14). Indeed, it is relevant to emphasise that these forms of 'malpractice' should not only focus on childbirth, because an exclusive focus on this area supports reductionism, as women should not only be seen as reproductive beings.

A currently available definition of obstetric and gynaecological violence is that of Resolution No. 2306 of the Parliamentary Assembly of the Council of Europe, adopted on October 3, 2019, which defines violence as follows (Article 3):

> a form of violence that has long been hidden and is still too often ignored. In the privacy of a medical consultation or childbirth, women are victims of practices that are violent or that can be perceived as such. These include inappropriate or non-consensual acts such as episiotomies and vaginal palpation carried out without consent, fundal pressure on the cervix or painful interventions without anaesthetic. Sexist behaviour in the course of medical consultations has also been reported.

This resolution (Article 4) points out that Argentina and Venezuela are the two countries where obstetric violence is recognised and punished by law. However, it also underlines that although Article 39 of the Istanbul Convention explicitly condemns forced abortions and forced sterilisations, it does not address obstetric and gynaecological violence in general.[3]

In the report commissioned by the European Union (Brunello *et al.*, 2024), the prevalence of obstetric and gynaecological violence in the EU is divided into three main areas:

- *Forced or unconsented medical interventions* include forced contraception, forced sterilisation, forced abortion and any medical examination or intervention performed without consent (IPPF European Network, 2022).
- *Refusing or delaying treatment* includes delaying or

[3] See Article 13 of the Venezuelan Law; 'Profili penali della c.d. violenza ostetrica' [Criminal Law Aspects of So-Called Obstetric Violence] (2022) Sistema Penale 1; Rogelio Pérez D'Gregorio, 'Obstetric violence: a new legal term introduced in Venezuela', *International Journal of Gynecology and Obstetrics* (2010) 111 201-202.

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refusing to provide medication for pain management during procedures (RODA, 2021), delaying or refusing abortion treatment, withholding information and contact (SPAVO, 2023), restricting movements (i.e. no choice of birthing position), and refusing obstetric care (RODA, 2021).

• *Non-medically necessary (harmful) procedures* include routine inductions of labour, routine C-sections, routine episiotomies, and medical practices such as the Hamilton manoeuvre[4] and the Kristeller manoeuvre.[5]

Most studies examined in the above report dealt with obstetric violence, while very few explored the prevalence rates of gynaecological violence, which contributes to its invisibility. Notwithstanding this critical point, the findings clearly show that these practices go beyond gynaecological and obstetric violence to include psychological and emotional abuse when experiences of discrimination, lack of privacy, neglect (including denial of dignified treatment), denial of care, verbal abuse and inadequate pain relief are denounced.

2.1. *Between misunderstanding and mystification: An open debate…*

Clinical study shows that going to the doctor is universally a psychological experience (Leibowitz *et al.*, 2018), and this is the starting point for understanding whether the formulation of abuse and violence in gynaecological and obstetric practice can be better communicated than mistreatment and malpractice. One should ask whether the absence of intent downplays the seriousness of the behaviour. An answer to such a complex question is not easy to give and cannot capture all the sensitivities and responsibilities involved.

Claire Simon enters a gynaecology department of the Tenon hospital in the XX arrondissement in Paris; it is a journey into

[4] The *Hamilton manoeuvre* is a method of inducing labour in which the midwife or doctor peels the lower pole of the amniotic sac with their fingers to release prostaglandins and induce labour. It is performed by vaginal examination and is usually a little uncomfortable as the vagina is sore afterwards. Sometimes there is a small loss of blood or cervical mucus (see Brunello *et al.*, 2024).

[5] The *Kristeller manoeuvre*, also known as fundal pressure during the second stage of labour, involves applying manual pressure to the uppermost part of the uterus in the direction of the birth canal to support a spontaneous vaginal birth and avoid a prolonged second stage or the need for an operative birth (Hofmeyr *et al.*, 2017).

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a hospital that she defines as a place where everyone arrives with their own story and leaves with a different biography. She concludes her journey with a documentary entitled *Notre Corps* (2023), which is a testimony to the realities narrated through gynaecological and obstetric experiences, leading Simon to state that the measure of freedom and democracy of an entire society is rooted in women's bodies.

When it comes to exploring how 'gentle' violence must be to be considered 'non-violent' or 'non-offensive', the 'soft factor' of harmful outcomes must be considered an oxymoron of the health practice (Chadwick, 2018; Lappeman and Swartz, 2021; Nixon, 2011), as the inappropriateness of the term 'violence' or 'soft violence' inhibits professionals or disempowers women.

Hand and Nelson (2025) examined the systematic harms reported in maternity care by focusing their attention on the processes for minimising violence in gynaecological and obstetric practice. Their work summarises two different perspectives.

Those who reject the term violence come from the medical field and argue that the use of the term 'obstetric violence' is inflammatory (Cluver *et al.*, 2023) because it implies an intent to harm with the physical force used to save lives (Chervenak *et al.*, 2023). The phenomenon of gynaecology or obstetrics being associated with 'violence' therefore causes serious social concerns and damages the image and reputation of professionals working in this medical field.

On the other hand, those who endorse the term 'obstetric violence' recognise that violence can be experienced regardless of the perpetrator's intent, and since language matters, refusing to name it means refusing to acknowledge it. It means covering it up, ignoring it and dismissing it. According to Boudreaux (2019), if the problem is not named, it remains invisible and is therefore almost impossible to address and, consequently, to solve.

However, to believe that this forceful and disrespectful practice can be called 'violence' in order to resolve the debate is rather naïve. The term 'violence' may sound stronger, but it runs the risk of reducing everything to one behaviour, however criminal it may be. Research has shown that what happens in the healthcare system goes far beyond behaviour: it is malpractice in its fullest sense, challenging the principles and ethics of care, violating the core of trust in a professional relationship, disregarding the patient's self-determination and agency. Malpractice can be even more troubling than violence because it is a long-term process that escalates in nature and in its consequences.

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Healthcare providers who behave disrespectfully or abusively may do so in part because they hold a powerful position and represent a powerful system (d'Oliveira *et al.*, 2002), but also because *authoritative knowledge* (Jordan, 1997) seems to convince them to deprioritise everything at the expense of people's self-determination, which in turn requires time that is usually lacking in the healthcare system. This form of malpractice describes an important form of epistemic rupture (Chadwick 2021, p. 109) experienced by women in gynaecology departments, and specifically points to the institutional and gendered nature of this practice, highlighting the systems of oppression that enable and underpin it (Sadler *et al.*, 2016).

If the interest is focused on the consequences for patients, it does not matter whether it is 'gynaecological and obstetric' violence or malpractice, as the effects are likely to overlap. Research findings (Langevin, 2020; Lévesque and Ferron-Parayre, 2021; Roman, 2017; Williams *et al.*, 2018) suggest that:

- Systemic violence and epistemic injustice can provide the breeding ground in which violence and malpractice can emerge and, unfortunately, remain hidden.
- Looking only at symptoms creates *invisible beings* who are expected to play an accepting role.
- Power inequality and asymmetry in the doctor-patient relationship can lead to misunderstandings, so that the decision is imposed and then simply accepted because it is made for the benefit of the patient, while the patient's rights, if any, are disregarded.
- The definition of violence based on intentionality is outdated and does not encompass all harmful situations that can arise due to malpractice.
- The elimination of intent does not make things less serious.

Since 'gynaecological and obstetric violence' or malpractice is a relatively new concept, women who have experienced it have difficulty in seeing, naming and understanding it as such. When women do recognise it, they are unsure what to do and are reluctant to report it.

3. *Disrespectful care versus respectful care in the health system*

Scientific and clinical literature is homogeneous in recognising that the health system around the world is facing a serious crisis (WHO, 2025), and that the gynaecological and child-birth areas are not immune from it (WHO, 2023).

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Respectful care is a fundamental right of all people: '[t]he right to the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction as to race, religion, political opinion, economic or social condition' (WHO, 2008).

The right to health is a comprehensive right; it includes freedoms and entitlements; it entails dignity, care and continuous support. Health services should be provided to all without discrimination, and services, goods and facilities must be available, accessible, acceptable and of good quality (WHO, 2008). A general description of what respectful care is does not guarantee an equally understanding of what disrespectful care implies. People can react differently to situations and their sensitivity can either increase their vulnerability or their resilience.

Disrespectful care in the context of healthcare can refer to attitudes and behaviours that violate a person's dignity, privacy, confidentiality, and dismiss informed choice, self-determination and autonomy. It encompasses a range of practices from physical and verbal abuse to disregard for patient preferences and needs, and can have a significant impact on physical and psychological well-being.

With these definitions in mind, the remainder of the chapter will focus on healthcare, where women's right to sexuality and motherhood play an important role.

4. *Letting scientific evidence speak*

Recent studies have further contributed to our understanding of what constitutes disrespectful and abusive healthcare practice, and the extent to which to gynaecological and obstetric malpractice is widespread worldwide. Studies show that this is not limited to low-and middle-income countries (Amathullah *et al.*, 2023; Negero *et al.*, 2021) but also reported in high-income countries too (Fraser *et al.*, 2025; Martínez-Galiano *et al.*, 2021). Two pieces of evidence explore gynaecological and obstetric 'violence' separately.

According to the Haut Conseil à l'Égalité (2008, cited in Toupin and Lévesque, 2025), gynaecological violence encompasses a wide range of practices, acts, gestures, statements or behaviours, both committed and omitted, that occur in healthcare settings. It includes the lack of free and informed consent, the lack of justification for medical interventions or interventions that go

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against scientific evidence and best practices (CEND, 2019; Quéré, 2019).

For the meta-analysis, 1,821 records were screened, comprising 65,343 women; 25 studies between 2016 and 2023 covered 15 high-income countries, including ten European countries (France, Germany, Ireland, Italy, Poland, Portugal, Spain, Sweden, Switzerland, the Netherlands) and two Middle Eastern countries (Israel, Saudi Arabia) as well as Australia, Chile and the USA.

As already mentioned before in this chapter, the specific forms of maltreatment examined were (a) lack of access to analgesics with a pooled prevalence of 17.3% (95% CI, 6.9-27.7); (b) ignoring requests for help with a pooled prevalence of 19.2% (95% CI: 11.7-26.6); (c) yelling and scolding by medical staff with a pooled prevalence of 19.7% (95% CI: 13.0-26.4); (d) Kristeller manoeuvres with a pooled prevalence of 30.3% (95% CI: 22.1-38.5).

A meta-analysis examined specifically 'obstetric violence' in high-income countries (Fraser *et al.*, 2025). Given the lack of an internationally recognised definition of obstetric violence, Fraser and colleagues (2025) have identified some definitions of that could form the conceptual basis of their meta-analysis. Obstetric violence is not only considered a violation of women's rights (WHO, 2014) but is also defined as a form of dehumanising care, disrespect and abuse, and mistreatment of women (Bohren *et al.*, 2015; Martínez-Galiano *et al.*, 2021). Considering the nature and impact of its consequences, and in line with the definition included in the previously cited report (Brunello *et al.*, 2024), obstetric violence can be psychological, such as humiliation or invasion of privacy; verbal, such as staff shouting at, yelling, insulting or threatening the pregnant woman; and physical, such as interfering with the woman without her informed consent or using coercive language to obtain consent. Obstetric violence may also consist of denying access to pain medication when it is required or denying the presence of the partner during childbirth, creating a climate of painful isolation and insecurity.

In another study carried out in Spain in 2019, which involved 899 women, the prevalence of obstetric violence was significantly high (Martínez-Galiano *et al.*, 2021). The violence mostly consisted of physical (e.g., repeated vaginal touching, the Kristeller manoeuvre or pressure on the uterine fund, the acceleration of labour by exogenous administration of oxytocin) and psycho-affective violence (e.g., not allowing early skin-to-

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skin contact between the mother and the newborn, early start of breastfeeding performed by health professionals in childbirth care, not respecting a birth plan which was agreed to be followed). In line with these findings, it seems relevant to point out that many of the procedures or medications were given without consent making them acts of insensitiveness within a context in which self-determination of patients should be not only respected but also encouraged.

Bohren and colleagues (2015) conducted a systematic review involving 65 studies in 34 countries. These findings were in line with the other study and illustrate that women's experiences of childbirth in health facilities worldwide are indeed associated with mistreatment and denial of autonomy. This leads to what Greenfield and colleagues (2016, p. 265) define as 'traumatic birth', which encompasses those events or treatment that cause profound distress or psychological disturbance. Self-blame, a sense of helplessness and Post-Traumatic Stress Disorder (PTSD) symptoms such as anxiety, fear, depression, dissociation, traumatic flashbacks and impaired social functioning are probably the most common consequences of experiencing obstetric malpractice (Martínez-Galiano *et al.*, 2021).

In another study conducted by Toupin and Lévesque (2025), nine participants were interviewed about their experiences of various harmful acts in the context of gynaecological health services. The negative experiences shared by the participants were grouped into six categories that echoed what was already found in other studies: having no choice, not being listened to, being treated insensitively, being dehumanised, being abandoned, and having their sense of reality questioned (gaslighted).

An interesting review by Downe *et al.* (2023) looks at theories of interventions to reduce physical and verbal abuse in the maternal and neonatal environment. 188 studies with explicit or implicit underlying theories to address mistreatment, including physical and/or verbal abuse, in health and social care were examined. The theories identified were those that relate not only to the health or social care system *per se*, but also to wider societal and cultural norms, as well as to the behaviours, norms and attitudes of health care professionals. Two themes emerge as important in understanding what appears to leave room for mistreatment leading to what patients experience as violence. The first is that violence is normalised in society, particularly towards what Downe *et al.* (2023) refer to as 'othered' groups who are more likely to experience intersectional marginalisation (e.g., in

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mental health care, certain disciplinary or abusive practices are justified because it is believed that patients "deserve' it or that it is necessary for them to be abused, to ensure that they are 'safe' […] or that their baby is born 'safely" (p. 30). The second reason is the belief that mistreating women is necessary to reduce clinical harm. These findings clearly confirmed what was found in the study by Bowser and Hill (2010) previously described. According to Downe *et al.* (2023), these are contexts in which physical and verbal abuse are justified as being in the best interests of the service user (or, in maternity care, the mother and/or baby) because they are believed to reduce certain physical harms, even if there is no evidence of such benefits and even if the abuse could lead to emotional and/or psychological harm.

A project based on the Doxa-OVOItalia Survey (*Observatory on Obstetric Violence Italy* - OVOItalia, 2017), which involved a sample of 5 million Italian women, between 18 and 54 years old, provides some interesting information on the traumatisation that some women claim to have experienced during their pregnancy and the birth of their child:

- 41% of mothers (4 out of 10 women) reported experiencing acts that violated their personal dignity.
- 11% of mothers stated that they had been traumatised by the inadequate care in hospital and therefore preferred to postpone the decision to have another pregnancy for many years. For 6% of these mothers, the trauma was so severe that they decided not to have any more children, with an estimated 20,000 unborn children per year.

The crucial aspect of neglecting informed consent emerged as what numerous women who participated in the survey experienced as one of the most offensive underestimations, namely not being recognised as an active part of the decision about their pregnancy:

- 30% of women who have undergone an episiotomy in the last 14 years, i.e. 1.6 million women (61% of women who have undergone an episiotomy), stated that they did not give informed consent to authorise the procedure.
- 15% of women who underwent this practice, which corresponds to around 400,000 mothers, had their genitals affected.
- 13% of women felt deceived.

These results deserve critical consideration because they are relevant not only as an expression of malpractice in its full form, but also in terms of their traumatic consequences they entail.

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These findings make it clear that the concept of gynaecological and obstetric violence may not be comprehensive enough to encompass all the specific forms of mistreatment that women may experience, which include a transvestite lack of human consideration, accompanied by neglect, disrespect, and psychological humiliation in one of their most important areas of identity – sexuality – and during one of life's most significant moments: childbirth.

> 'Do as much as possible for the patient, and as little as possible to the patient'
> *Sigmund Freud*

5. *The psychological effects of gynaecological and obstetric abuse, violence, mistreatment and malpractice*

The psychological impact of gynaecological and obstetric abuse, violence or mistreatment and malpractice may be overlooked or dismissed as a myth or something that does not occur in high-income countries. However, as research shows, they can occur anywhere in the healthcare system and, unfortunately, a country's high scientific and clinical standards are not necessarily a guarantee against them. Therefore, they deserve attention because they can have a significant impact on the life of a person and their family.

Avoidable physical pain, professional negligence, disrespectful behaviour, medical errors and breach of trust can have psychologically traumatic consequences. The consequences can manifest in various forms, including excessive fear that leads to regressive behaviour and dependency, stress, humiliation, loss of dignity which involves loss of self-esteem and self-agency, anxiety, depression and even post-traumatic stress disorder (PTSD), as illustrated in Figure 1.

It is not uncommon for psychological violence to arise when personal beliefs clash with those of patients. For example, issues such as female virginity before marriage, sexual activity outside marriage, abortion, surrogate pregnancy, gender orientation and gender reassignment are still controversial in some contexts and, even if they should not be, they can create tension between patient and doctor, with serious consequences for the psychological well-being of patients.

 ISBN 978-88-495-6175-3

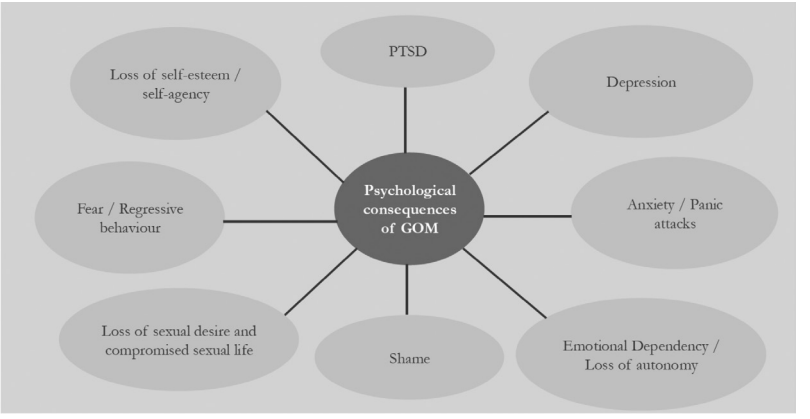

Figure 1 - A map of the major psychological of gynaecological and obstetric malpractice (GOM)

Experiences of an overwhelming sense of solitude and a loss of sexual desire are likely to affect the stability of the couple, often leading to separation.

Solid clinical evidence suggests that PTSD can result from experiences such as abuse, both physical and sexual and can be at the basis of symptoms such as anxiety, depression, and externalising behaviours (for a specialised description see Rezapour, 2024) as it is seen in women who 'survived' experiences of gynaecological and obstetric malpractice (GOM). These variables can increase the likelihood of relationship dissolution and divorce.

Evidence shows that negative birth experiences can have serious adverse effects on maternal mental health and was found to be the most significant predictor for postpartum posttraumatic stress disorder (PP-PTSD) (Dekel *et al.*, 2017).

In a study carried out to document manifestations of disrespect and abuse during childbirth in German maternity care (Limmer *et al.*, 2023), non-consented care was the most commonly reported form of mistreatment, along with being coerced into accepting interventions instead of being engaged in a process of informed decision-making during childbirth.

Both conducts that involved *hands on actions*, such as the use of fundal pressure by maternity care providers in the second stage of labour, and *hands off actions* such as being uncovered and having unknown people involved, e.g., medical students, watching the birth without the woman's consent, and felt ignored or neglected were some other most frequently cited mistreatment experiences that were linked to women's

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perceptions of traumatic childbirth (Vedam *et al.*, 2019; Beck, 2018; Harris and Ayers, 2012). These practices undermined women's autonomy and were felt as disrespectful and abusive (Limmer *et al.*, 2023).

5.1. *Why do the consequences sometimes and in certain contexts count more than the intentions?*

These findings show how important it would be to promote a patient-centred care in which patients are actively listened to, their concerns are addressed, and they feel supported. To prevent experiences of malpractice in gynaecology, it would be crucial to implement strategies that enhance care, patient autonomy and informed decision making and promote professional development for reflective practice, as also suggested by Spinnewijn *et al.* (2024) in a qualitative Dutch study in which 20 clinicians were interviewed to investigate the implementation of shared decision making.

Despite health professionals looking for the best health outcomes of the mother and the newborn, the clinical evidence seems to suggest that health professionals by seeking to adhere to protocols and good practice (Martínez-Galiano *et al.*, 2021; Morris *et al.*, 2023) may forget to offer sufficient information, explanation and reassurance to women, which makes them feel mistreated during childbirth or feel 'in the dark' about their care (Bohren *et al.*, 2015).

In a healthcare system that aims to put patient care and welfare at the centre, professionals have an ethical obligation to always apply evidence-based and best practices, even more so when dealing with emergencies or critical cases, so that the patient never feels unheard.

Tronto (2010, p. 160), in her analysis of the elements of disrespectful (bad) and respectful (god) care, described the four phases of care that are also applicable to what is necessary for a gynaecology and obstetrics department that works clinically and ethically in meeting the health needs of patients: *caring about* involves recognising a need for care; *caring for* requires taking responsibility and feeling accountable in order to meet that need; *care giving* consists of the actual physical work of providing care; *care receiving* involves evaluating how well the care provided met the caring needs.

All these ways of caring are important to avoid the danger of limiting care to just care giving, rather than understanding the whole process of care, which includes attention to the person

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and their needs, the distribution of responsibilities and the allocation of resources. Indeed, care is not a commodity, like the purchase of services, but a process (Tronto, 2010).

Downe *et al.* (2023) point out that sustainable solutions to prevent these forms of mistreatment and malpractice (i.e. poor care) must not only focus on the failure of health professionals through guidelines, trainings or audit procedures but must look beyond this to longer-term solutions that can promote sustainable and responsible changes in attitudes and beliefs that then lead to significant behaviour change and a provision of good care. Fisher (1990) argued that caring often seems to consist of 'something extra' (Fisher 1990). To paraphrase her words and apply them to the gynecological and obstetric setting, that 'something extra' should be equated with the status of 'continuous and daily' adequate care for all, always and in all circumstances, *without any ifs* or *buts*.

This would entail encourage behaviour change across the entire health system: from frontline health workers to senior executives and managers, from organisational funders and auditors to local community leaders, politicians and all other key stakeholders.

Furthermore, working on strategies to reduce stigma and discrimination could be another significant part of addressing the mistreatment experienced by women (Bohren *et al.*, 2022). It follows that improving communication strategies, interpersonal skills and professional awareness of the role that health professionals play in the lives and agency of their patients can also make an important contribution to reducing the mistreatment of women in the healthcare sector (Olde Loohuis *et al.*, 2023).

> '[…] even the most brilliant results were liable to be suddenly wiped away if my personal relation with the patient was disturbed […]'. (Freud, 1927/1961, p. 27).

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Joana Falxa

Refusing Care in the Delivery Room - A Review of the French Legal Background

Introduction

Maternity, childbirth, and perinatal care represent relatively recent domains within the broader historical framework of medical practice. The institutionalization of childbirth is, in fact, a modern phenomenon: the first widespread hospital births in Western societies only began to occur in the mid-20th century. This transition has been described by some scholars as the 'big move' (*grand déménagement*),[1] a term that captures the profound societal and cultural shift from home-based to hospital-based deliveries that began in earnest during the 1950s. Today, the vast majority of births occur in hospitals. In France, for instance, official statistics show that approximately 98% of births take place in hospitals,[2] underscoring the scale and permanence of this transformation.

[1] Elsa Boulet and Ronald Guilloux, *Enfanter, entre normes médicales et représentations sociales* [Giving Birth: Between Medical Norms and Social Representations] (érès 2024) 10.

[2] INSEE, 'Les 784 000 naissances de 2016 ont eu lieu dans 2800 communes' [The 784,000 births in 2016 took place in 2,800 municipalities] (2017) 92 *Insee*

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With this transition, the monitoring of pregnancy has become a structured process of medical care. It typically involves a series of consultations, diagnostic tests, and follow-up examinations, all aimed at ensuring both maternal and fetal health. In contemporary society, pregnancy and childbirth are no longer viewed solely as natural processes but have increasingly come to be seen through the lens of risk management and medical oversight.

Childbirth itself remains an especially delicate and emotionally charged moment. In the collective imagination, it continues to be perceived – rightly or wrongly – as a situation fraught with risk. This perception persists despite the marked decline in both maternal and fetal mortality rates since the mid-20th century,[3] a decline largely attributable to advances in medical science, hygiene, and obstetric techniques. Nevertheless, the enduring association between childbirth and danger reflects deep-rooted cultural beliefs and a residual anxiety that often surrounds this pivotal event.

As a direct consequence of this medicalization, there has been a significant increase in the number and variety of medical procedures associated with pregnancy and childbirth. These include routine ultrasounds, medically assisted reproduction techniques, manual vaginal examinations, invasive diagnostic procedures such as amniocentesis, and various forms of anesthesia such as epidurals. Other interventions commonly used include the administration or application of hormones – such as oxytocin or prostaglandins – to induce or accelerate labor, mechanical actions like membrane stripping, and surgical procedures such as episiotomies or cesarean sections. In certain cases, interventions may also involve the manual removal of the placenta under anesthesia, as well as blood transfusions if complications arise. Taken together, these procedures exemplify the extent to which childbirth today is framed as a highly medicalized, highly managed episode – essentially, a moment of intense clinical care.

Focus <https://www.insee.fr/fr/statistiques/3047024#consulter> accessed 16 March 2025.

[3] INSEE, 'La mortalité infantile est stable depuis dix ans après des décennies de baisse' [Infant mortality has been stable for ten years after decades of decline] (2018) 117 *Insee Focus* <https://www.insee.fr/fr/statistiques/3560308> accessed 16 March 2025; Marie-Hélène Bouvier-Colle and Emmanuelle Szego, 'La mortalité maternelle en France depuis 1945' [Maternal Mortality in France since 1945] in Christophe Bergougnian *et al.* (eds.), *La population en France* [Population in France] vol II (Cudep 2005) 373.

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Against this backdrop, a growing desire to 'demedicalize' childbirth has emerged and settled among certain groups of patients and healthcare professionals alike. This desire has been expressed through calls to reduce the number of interventions, respect physiological processes, and reintroduce a sense of autonomy and personal experience into the birthing process. Many expectant mothers, alongside some midwives and doctors, have expressed a preference for giving birth outside of the traditional hospital setting, whether at home or in birthing centers designed to support more natural deliveries.[4] Others wish to remain within the hospital system but seek to give birth under clearly defined conditions that prioritize minimal intervention and physiological labor.

A key instrument in this movement is the increasingly widespread use of the '*birth plan*' or '*birth project*'.[5] This document provides a structured way for expectant mothers – and, by extension, couples – to articulate their preferences, expectations, and desires regarding labor and delivery. Birth plans often include preferences about pain management, preferred birthing positions, who may be present during labor, and which procedures should be avoided unless medically necessary. The birth plan thus serves as both a communication tool and a declaration of autonomy.

However, tensions can and do arise in clinical settings when medical professionals are confronted with birth plans that contradict standard practice or clinical judgment. When proposed or expected actions are viewed by some as ethically questionable or experienced by patients as physically invasive or distressing, the issue of refusing care, whether by the caregiver or the patient, takes on particular significance.

Refusal of care, broadly speaking, encompasses two distinct but interconnected realities, depending on the perspective from

[4] Nicole Thualagant, 'Vers une pratique du care ? Témoignages de sages-femmes en transition vers une nouvelle pratique' [Towards a Practice of Care? Testimonies from Midwives Transitioning to a New Practice] (2024) 37(2) Recherches féministes 16

[5] Haute Autorité de la Santé [HAS, French National Authority for Health], *Suivi et orientation des femmes enceintes en fonction des situations à risques identifiées* [Follow-up and Care Guidance for Pregnant Women Based on Identified Risk Situations] Recommendation for Best Practice (2016) 9 <https://www.has-sante.fr/jcms/c_547976/fr/suivi-et-orientation-des-femmes-enceintes-en-fonction-des-situations-a-risque-identifieesv> accessed 16 March 2025.

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which it is considered. From the standpoint of the patient, it may refer to a situation in which a healthcare provider refuses to offer care. From the opposite viewpoint – that of the healthcare provider – it pertains to the patient's refusal to accept treatment or medical intervention.

In obstetrics, the latter scenario is more complex in its implications. This involves the pregnant individual or the woman in labor refusing a proposed medical intervention or treatment. Such refusals are generally regarded as expressions of personal autonomy. However, in obstetric contexts, the implications of a patient's refusal may extend beyond the individual herself, affecting the fetus as well. This dual stake complicates the ethical landscape, given that under French law, the fetus is not recognized as a separate legal person with rights of its own.

Adding to this complexity is the possibility that the refusal of care may not originate from the patient herself but from a third party, most often, a spouse or partner, who may exert influence or attempt to make decisions on the patient's behalf. This can raise further legal and ethical concerns, especially in situations where the autonomy of the pregnant individual is called into question.

After this quick overview of the key issues surrounding the refusal of obstetric care, highlighting the significant legal, ethical, and professional considerations at play, in the subsequent sections, we will delve deeper into these complexities, exploring the relevant legal frameworks, professional guidelines, and ethical dilemmas that arise within the patient-caregiver relationship during pregnancy and childbirth. Through this analysis, we aim to better understand the nuanced dynamics of care refusal, from both the caregiver's (1) and the patient's perspectives (2).

1. *Refusal of Care by the Caregiver*

The first scenario analyzed is the refusal of care by the healthcare provider. In this context, the term *caregiver* will be used to refer broadly to all medical professionals involved in obstetric care, including but not limited to physicians, midwives, and other authorized practitioners.

1.1. *Legal framework for refusal of care*

The central function of the caregiver, as the very term implies, is to provide care. Consequently, the refusal to deliver

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care constitutes an exception to the general rule and must be justified by specific, legitimate circumstances. To regulate this sensitive area of practice, French law establishes a detailed legal framework that defines the conditions under which care may be lawfully withheld.

According to Article L.1110-3 of the French Public Health Code, a caregiver may legally refuse to provide treatment when the refusal is '*based on an essential personal or professional requirement affecting the quality, safety, or effectiveness of care*,' except in cases of emergency and without breach of humane duties (art. L.1110-3 CSP, para. 7). French case law has validated such refusals in instances where the healthcare provider experienced a serious breakdown in the therapeutic relationship,[6] faced violent or abusive behavior from the patient,[7] or recognized a lack of professional competence to safely perform a requested procedure.

In some situations, the law allows for refusal of care based on conscientious objection. Healthcare professionals may invoke a *clause de conscience* – a conscience clause – to refuse participation in procedures that conflict with their personal, ethical, or religious convictions.[8] Several (if not the most) of the medical acts covered by these *conscience clauses* (mostly considered 'non-therapeutic'[9]) are directly related to procreation or reproductive capacity, and therefore to gynecology and obstetrics: abortion (art. L. 2212-8 and R. 4127-18 CSP) and sterilization for contraceptive purposes (L. 2123-1 CSP) in particular. Although a similar clause was discussed in the context of the reform to medically assisted reproduction laws, the proposed amendment was ultimately not adopted. It is important to underscore that, even when invoking such clauses, caregivers are required to ensure continuity of care by referring the patient to another qualified professional or service capable of delivering the requested care.

[6] Chambre Disciplinaire Nationale de l'Ordre des Médecins [CDNOM, National Disciplinary Board of the French Medical Association], decision 17 Septembre 2010, no. 10525.

[7] Conseil d'État, 29 juin 2020, no. 429766.

[8] Dominique Laszlo-Fenouillet, *La conscience* [The Conscience] (LGDJ 1993) 215; David Hiez, 'La clause de conscience ou la conscience source du droit' [The Conscience Clause or Conscience as a Source of Law?] in *Mélanges en l'honneur de Philippe Jestaz* [Collected Essays in Honor of Philippe Jestaz] (Dalloz 2006) 209; Xavier Bioy, 'Les clauses de conscience des soignants' [Care Giver's Conscience Clause] (2025) 190 *Médecine et Droit* 1.

[9] Bioy, (n. 41) 2.

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1.2. *Unlawful refusal of care*

It should be emphasized that refusal of care, while possible, can under no circumstances be based on discriminatory grounds. Article L.1110-3 of the Public Health Code refers explicitly to Articles 225-1 and 225-1-1 of the French Penal Code, which enumerate a wide array of protected characteristics. These include origin, sex, family status, pregnancy, physical appearance, particular vulnerability resulting from economic situation, surname, place of residence, state of health, loss of autonomy, disability, genetic characteristics, moral beliefs, sexual orientation, gender identity, age, political opinions and affiliations, union activities and affiliation, whistle-blowing status, ability to express oneself in a language other than French, membership or non-membership, real or assumed, of a specific ethnic group, nation, alleged race or religion, or and status as a victim or witness of sexual harassment.

A patient who believes she has been subjected to an unjustified refusal of care on any of these prohibited grounds may file a formal complaint with either the director of the local health insurance organization or the president of the relevant professional body (e.g., the Order of Physicians or the Order of Midwives). Once filed, the caregiver is notified and may be summoned within a one-month period. A conciliation process, managed by a joint commission comprising representatives from the professional order and the health insurance body, must begin within three months. Should conciliation fail or if a repeat offense occurs, the case may be referred to a disciplinary court. The president of the professional council (*Président du Conseil de l'Ordre*) may attach their own formal opinion to the complaint. If the professional council fails to act, the health insurance director may impose financial penalties within three months on the healthcare professional.

1.3. *Refusal of care and liability*

In most other cases, refusal of care – particularly in obstetrics – rarely leads to civil, criminal or disciplinary liability. The decision to choose one medical intervention over another, based on clinical judgment or therapeutic necessity, generally cannot be held against a caregiver, unless it leads to direct or indirect harm to the patient or the fetus. In such cases, liability arises only if the caregiver is found guilty of ordinary negligence

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(in cases of direct harm) or gross negligence[10] (in cases of indirect harm). Depending on the outcome, this could give rise to charges of involuntary injury or manslaughter in the criminal field, as well as potential civil liability[11] and/or disciplinary liability.[12]

Some legal scholars have proposed that disciplinary sanctions could be applied not only in cases of technical error and personal injury, but also in cases of what has been termed a 'humanist fault'.[13] This is defined as '*a failure by the healthcare professional to comply with the duty inherent in his or her profession, to respect the human person and his or her dignity, and more generally, to violate the duty of conscience*'.[14] The failure to respect the patient's wishes, for instance, by performing a procedure specifically rejected in a patient's birth plan, such as an episiotomy, without compelling medical justification, could be punished as a 'humanist fault'. While rare, this form of fault has begun to appear in professional disciplinary or ordinal decisions since 2015 (Order of Physicians rarely, a few decisions for the order of Midwives), primarily in cases involving unprofessional conduct, such as rudeness, insensitivity, or lack of empathy, rather than strictly procedural violations. Notably, such behavior can also have repercussions under employment law.[15]

[10] Gross negligence ('*faute caractérisée*') is defined by courts in this case as a 'particularly intense negligence which exposes the victim to a very serious risk of which the perpetrator was not unaware'. See 'La faute caractérisée en droit pénal' [Gross Negligence in Criminal Law] (2003) 1 Revue de science criminelle et de droit comparé 79.

[11] Physicians' civil liability may fall within the jurisdiction of the administrative courts (under public law) or the judicial courts (under private law), depending on the place of practice and the links between the practitioner and the practice structure: public hospital in the first case, independent practice or private salaried practice in the second.

[12] Jean Penneau, *La responsabilité du médecin* [Medical Liability] (Dalloz 2004) 24; Sylvie Welsch, *Responsabilité du médecin: risques et réalités judiciaires* [Medical Liability: Risks and Legal Realities] (Litec 2005) 11; Christine Maugüe, 'La responsabilité juridique du médecin' [Physician's Legal Liability] (1999) 89 Pouvoirs 31. See, for instance, on civil liability under private law: Cour de cassation, 1ère section civile, 23 janvier 2019, no 18-10.706

[13] Anne Simon and Elsa Supiot (dir.), *Les violences gynécologiques et obstétricales saisies par le droit* [Gynecological and Obstetric Violence Addressed by the Law] (Institut des Études et de la Recherche sur le Droit et la Justice 2023) 127 <https://ierdj.fra1.digitaloceanspaces.com/media_library/2023/12/19.18_VIOLENCES_OBSTRETICALES_rapport.pdf>.

[14] Anne Laude, Bertrand Mathieu, Didier Tabuteau, *Droit de la santé* [Health Law] (PUF 2009) 476.

[15] Cour de Cassation, 1ère section civile, 5 avril 2018, n. 17-11.897,

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Finally, there are situations where the law actually imposes a duty on caregivers to refuse certain treatments. Article R.4127-40 of the Public Health Code (formerly Article 18 of the Code of Medical Ethics) prohibits subjecting patients to unjustified risk. In such instances, failing to refuse a request that poses significant danger without therapeutic benefit could result in disciplinary action or civil liability. A striking example is provided by a 1998 case-law decision,[16] in which a physician complied with a high-risk treatment request from a 44-year-old patient with a history of obstetric complications. The patient died following induced labor and severe hemorrhaging. The court ruled that the physician should have refused the requested intervention due to the clear and unjustified risks involved.

Thus, while refusal of care by an obstetrician is a multifaceted issue that may involve legal and ethical ramifications, it remains relatively rare and is generally addressed within the established framework of medical liability. The far more complex and ethically charged scenario arises when the patient herself refuses care.

2. *Refusal of care by the patient*

The obstetric patient, much like any other patient, is first and foremost an individual with the right to make autonomous decisions regarding her health. Informed consent is a cornerstone of medical ethics and law, and it applies equally to obstetric care. The introduction of the Kouchner Law of March 4, 2002,[17]

concerning the dismissal for gross misconduct of an anaesthetist, on the grounds that his aggressive and discourteous conduct toward several patients – including parturients – had damaged the clinic's reputation.

[16] Cour de Cassation, 1ère section civile, 27 mai 1998, n. 96-19.161. A 44-year-old woman, mother of four children, who had suffered two abortive accidents, presenting dysovulation, consulted a gynecologist with the aim of having a fifth child. They proceed to an ovarian induction and programmed the birth with 'artificial' induction a few days before term. The physician having agreed, the delivery took place, but complications arose, such as uterine rupture, immediate heavy hemorrhage, haemostasis hysterectomy followed by surgical haemostasis to deal with the hemorrhage, concluding with the death of the patient.

[17] Loi n. 2002-303 du 4 mars 2002, relative aux droits des malades et à la qualité du système de santé [concerning patients' rights and the quality of the healthcare system]. Stéphane Prieur, 'Les droits des patients dans la loi du 4 mars 2002' [Patients' rights under the Law of 4 March 2002] (2002) 8 Revue générale de droit médical 119; Aa.Vv., Dossier 'La loi du 4 mars 2002: vingt ans

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in France marked a significant turning point in patient rights, enshrining the fundamental principle that every patient has the right to refuse care. This right complements the principle of respect for the integrity of the human body, which is enshrined in Article 16-3 of the French Civil Code. Understanding the dynamics between patient autonomy, informed consent, and medical necessity is essential in the context of obstetrics, particularly in cases of refusal of care.

2.1. *Legal framework: informed consent and patient autonomy*

Article L. 1111-4 of the French Public Health Code states that a patient has the right to make decisions about their health in collaboration with healthcare professionals. This decision-making process is based on the information provided by the healthcare provider, who must ensure that the patient fully understands the proposed treatment options, their urgency, risks, and potential alternatives. A crucial element of this framework is the right to refuse care, which is absolute. No medical intervention can take place without the free and informed consent of the patient, who retains the right to withdraw that consent at any point during the process.[18]

The law also acknowledges that when a patient is unable to express their wishes – due to unconsciousness, for example – medical intervention may proceed in emergency situations, but only in accordance with strict legal criteria. In such cases, the patient's right to refuse care is temporarily overridden by the need for immediate action to preserve life. However, this right remains intact once the patient regains consciousness and can communicate their preferences. Scenarios arise in which caregivers must balance respect for patient autonomy with their ethical duty to protect life. These scenarios can be categorized into three main types, each with two possible variations.

après' [The Law of 4 March 2002: Twenty Years On] (2022) Revue de droit sanitaire et social 195.

[18] Antoine Leca and Caroline Berland-Benhaim, 'Le consentement au soin replacé dans une perspective historique' [Consent to medical treatment reconsidered from a historical perspective] in Anne Laude (dir), *Consentement et santé* [Consent and Health] (Dalloz 2014) 19-34; Caroline Lantero, 'Réflexions sur la fondamentalisation des droits des patients. L'exemple de la violation du consentement' [Reflections on the Fundamentalisation of Patients' Rights. The Example of the Violation of Consent] (2022) Revue de droit sanitaire et social 216.

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Firstly, in clinical scenarios involving absolute emergencies, particularly when an unconscious patient is brought to a medical facility in a condition that necessitates immediate and potentially life-saving intervention, the principle of medical necessity governs the response. Under such circumstances, healthcare professionals are permitted (indeed, obligated) to administer treatment without prior consent, as the patient's inability to express a current, informed decision nullifies the relevance of any previously stated refusals. Even when a written document indicating a refusal of care is discovered, such as an advance directive or a living will, it does not carry binding legal force unless it is clear, informed, and recently reiterated. The lack of the patient's present capacity to consent overrides prior declarations, especially in cases where delay in treatment could result in irreversible harm or death.

In contrast, when the patient is conscious and facing an unforeseen, life-threatening condition, both medical ethics and legal standards affirm the obligation to provide urgent care.[19] In such instances, however, the patient retains the right to refuse a proposed medical procedure. If a refusal is expressed, it must be meticulously documented by the healthcare team, including the time, nature of the refusal, and the information provided to the patient. Furthermore, given the evolving nature of emergencies, such refusals must be reassessed within a reasonable timeframe, particularly if the situation is subject to rapid change or deterioration.

Secondly, in the context of relative or deferred emergencies, where the urgency is less immediate but intervention remains necessary, the approach is more nuanced. When the patient is unconscious, and therefore incapable of providing informed consent, the healthcare team must seek guidance from the patient's trusted support person, legal proxy, family members, or close relatives. This process of consultation serves to honor the patient's presumed wishes and facilitates a degree of shared decision-making. Nevertheless, it is important to underscore that such input is advisory in nature; healthcare professionals are not legally bound by the opinions expressed by these parties, even the 'trusted person' ('proche de confiance') designated by the patient to this purpose.[20] Healthcare professionals retain

[19] Gérald Kierzek and Jean-Louis Pourriat, 'Refus de soins en situation d'urgence' [Refusal of Care in Emergency Situations] in *Urgences 2009* (SFMU 2009) 467.

[20] Art. L. 111-4 of the French Public Health Code.

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the authority and responsibility to proceed with the treatment they deem medically appropriate, especially if a refusal from relatives would compromise the patient's health or conflict with established standards of care.

When the patient is conscious in such situations, the obligation to provide complete and comprehensible information becomes critical. The healthcare team must ensure that the patient is fully informed about their condition, the risks involved, and the available therapeutic options. If the patient chooses to refuse care, this decision must be informed, voluntary, and made with full awareness of the consequences. As such, thorough documentation with a precise oral explanation becomes a protective measure both for the patient's autonomy and for the legal security of the healthcare professionals involved. The patient must confirm his or her decision after a reasonable period of time.

Thirdly, in cases of foreseeable emergencies, where the clinical situation has been anticipated – such as in patients with chronic illness or previously expressed treatment preferences – the physician's duties are again shaped by the specific context. When a patient has reiterated a clear and specific refusal of a particular treatment, such as intubation, transfusion, or resuscitation, this decision must generally be respected, even in life-threatening situations. This reflects a strong commitment to respecting patient autonomy.[21] However, exceptions may arise when the refusal appears unclear, insufficiently informed, or potentially coerced. In such instances, the physician may be ethically and legally justified in providing life-saving care, invoking the principle of beneficence in the face of ambiguity or risk.

French legal doctrine has evolved significantly to clarify the obligations of physicians when confronted with refusals of care.[22] Central to this framework is the notion that the physician bears the responsibility of ensuring that such refusal is not only clearly expressed, but also informed and voluntary. In situations where there is reasonable doubt – whether concerning the clarity, recency, or voluntariness of the refusal – the law allows a degree of professional discretion to intervene in the patient's best interest.[23]

[21] Conseil Constitutionnel, 2 juin 2017, décision n. 2017-632 QPC.

[22] Sidonie Gidienne, 'Refus de soins aux urgences : quel cadre légal?' [Refusal of Care in Emergency Settings] in *Urgences 2015* (SFMU 2015) 1.

[23] Ministère de la Santé et des Solidarités, 'Charte de la personne hospitalisée' [Patient's Charter] (2006) 7.

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In summary, whether the situation involves absolute, relative, or foreseeable emergencies, the interplay between patient autonomy and medical necessity remains a defining feature of emergency care. The ability to differentiate among these categories and to act appropriately within each legal and clinical framework is essential for medical practitioners. Furthermore, rigorous documentation and a thorough understanding of evolving jurisprudence are indispensable tools for balancing ethical integrity with legal responsibility. French courts have consistently emphasized a patient-centered approach, while also acknowledging the complexity and urgency that characterize real-world medical decision-making under emergency conditions.

2.2. *Medical decision-making in the context of obstetrics*

The fundamental principles outlined above apply universally across all branches of medicine, including obstetrics. However, there are unique considerations when it comes to obstetric care, as pregnant individuals may face situations where their decisions not only affect their own health but also the health of the fetus. Therefore, medical providers in obstetrics must navigate a delicate balance between respecting the patient's autonomy and ensuring the health and safety of both the person giving birth and the fetus.

The application of informed consent in obstetrics is particularly pertinent in scenarios where a pregnant individual refuses a procedure, such as a vaginal examination, a screening test, or even more invasive interventions like an episiotomy or cesarean section.

2.2.1. *Non-emergency situations and refusal of treatment in obstetrics*

In non-emergency situations, such as a routine consultation or a planned act, a patient may refuse specific medical treatments or procedures. This may include declining diagnostic tests or examination such as the vaginal swab for group B streptococcus, screening for trisomy 21, or even a vaginal examination. In such circumstances, the patient's autonomy must be upheld, provided that their decision is informed and made with full understanding of the potential clinical consequences.

To ensure the validity of such a refusal, healthcare professionals

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must provide the patient with comprehensive, accurate, and balanced information about the proposed procedure, its benefits, the potential risks, and any available alternatives. Moreover, healthcare professionals should make every reasonable effort to ensure that the patient understands what is at stake, engaging in a genuine dialogue with the patient, verifying their understanding and addressing any concerns or misconceptions. This could involve offering alternatives, such as a different healthcare professional, or making adjustments to the birth plan in a way that respects the patient's wishes and values,[24] while maintaining the overall safety and well-being of both the mother and fetus. It is important to point out that the jurisprudence of both professional and administrative tribunals does not consider the duty to inform incumbent on healthcare providers to be absolute in the context of childbirth. In fact, as vaginal delivery is considered to be a natural and unavoidable event at the end of pregnancy, and not a medical procedure, the information requirements placed on healthcare professionals have traditionally been less stringent than for conventional medical procedures.[25] However, case law has evolved to impose a duty to inform when childbirth requires medical intervention or when there is a 'frequent or serious risk that can normally be foreseen'.[26]

Thorough documentation of the patient's decision to decline care is fundamental. In many cases, healthcare providers use signed forms to demonstrate that the patient has received the necessary information and is aware of the consequences of their decision. However, it is important to note that simply obtaining a signed form does not absolve the healthcare provider from ensuring that the patient has been fully informed.[27] In those

[24] Anne Gestalder, *Le projet de naissance et son impact sur le ressenti des violences obstétricales des accouchées* [The Birth Plan and Its Impact on Women's Perception of Obstetric Violence] (dissertation, School of Midwifery of Metz 2021) 15; Aurore Johannot and Jeanne Stocker, *L'utilisation du projet de naissance permet-il d'améliorer l'expérience des femmes de l'accouchement?* [Does the Use of a Birth Plan Improve Women's Childbirth Experience?] (dissertation, School of Midwifery of Vaud 2016) 12.

[25] Caroline Lantero and Diane Roman, 'L'obstétrique et le juge administratif, au-delà de l'accident' [Obstetrics and the Administrative Judge: Beyond the Accident] (2022) Revue française de droit administratif 749.

[26] Conseil d'État, 27 juin 2016, n. 386165.

[27] Emmanuel Terrier, 'Médecine : réparation des conséquences des risques sanitaires' [Medicine: Compensation for the Consequences of Health Risks] in *Répertoire de droit civil* (Dalloz 2020) 88.

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situations, drawing up a birth plan would appear to be an effective way of facilitating the acceptance of certain medical procedures that were not initially planned.[28] As the courts have clearly stated, a signature is not a substitute for a clear and transparent explanation of the risks and benefits involved.

Failure to respect a patient's refusal of care, particularly when expressed clearly and informed by appropriate explanation, can have significant legal implications. Such failure may be interpreted as a violation of the patient's right to bodily integrity and could be construed, under certain circumstances, as an unlawful medical intervention. Exceeding the patient's wishes may lead to liability on the part of the healthcare provider. This may involve civil liability, which may translate in compensation for damages caused, as in the situations above described.[29] The healthcare provider may also incur disciplinary liability – whether for technical negligence, failure to provide information or humanist faut. In the most serious cases, criminal liability could be contemplated, on the grounds of unintentional violence, or even sexual assault in certain circumstances, although case law rules out this possibility.[30] It is interesting to note that the concept of obstetric violence does not yet exist in these terms in French legal framework and case law,[31] although the courts (both administrative and judicial) have in some decisions condemned practices that fall within this concept.[32]

[28] Gestalder (n. 57) 39-41.

[29] See n 12 above.

[30] Sophie Paricard, 'Le défaut de consentement à l'examen gynécologique constitue-t-il un viol?' [Does Lack of Consent to a Gynecological Examination Constitute Rape?] (2023) Journal de droit de la santé et de l'assurance maladie 37. When the reported facts are related to an invasive medical act that is perceived as uncomfortable, or even non-consensual, but is consistent with standard procedures and practised in accordance with the state of the art, such act can't be construed as sexual assault: Disciplinary Chamber of First Instance of the Order of Midwives [Chambre disciplinaire de première instance (CDPI), ordre des sages-femmes], 11 juillet 2010, n. 1003; CDNOM, 22 mars 2011, n. 10744; CDNOM, 21 janvier 2016, n. 11582-2; CDPI Ordre des sages-femmes, 23 juin 2017, ID 102, n. 20160308; CDN Ordre des sages-femmes, 4 juin 2019, ID 195, affaire 39; National Disciplinary Chamber (CDN) Ordre des sages-femmes, 6 novembre 2020, n. 35.

[31] Adélie Cuneo, Laurence Warin, 'Le juge face aux violences obstétricales : une prise en compte en demi-teinte' [The Judge Confronting Obstetric Violence: A Mixed Response] (2023) 37 Journal de Droit de la Santé et de l'Assurance Maladie 28.

[32] For a detailed review, see Lantero and Roman (n 58) 743.

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2.2.2. *Emergency situations and overriding a refusal in obstetrics*

In certain emergency situations, the healthcare team may face a scenario where a patient refuses medical treatment that is deemed necessary to save their life or the life of their fetus. Under normal circumstances, an individual's right to refuse medical care is protected by law. However, when the context shifts to an acute emergency – particularly one involving an immediate threat of serious harm or death –, the law provides exceptions to this rule.

For example, during labor, a pregnant individual may refuse interventions such as a cesarean section, episiotomy, or blood transfusion. In situations where the refusal of these treatments endangers the life of the mother or fetus, the medical team may, under certain conditions, override the patient's refusal, especially if they believe that the interventions are essential for survival. However, this remains a controversial issue, and medical providers must proceed with caution, ensuring that any intervention is proportionate to the situation and that every effort has been made to communicate with the patient about the potential consequences of their decision. The goal must be to inform the patient of the likely consequences of their decision, while making every possible effort to obtain voluntary compliance.

These challenges are even more pronounced when refusals are grounded in religious beliefs or personal convictions, such as in the case of members of the Jehovah's Witness community, refusing blood transfusions. French jurisprudence,[33] as well as part of the international legal doctrine, acknowledges that in life-threatening situations, medical providers may override a patient's refusal if it is essential to preserve life. Nonetheless, this authority must be exercised with extreme prudence, taking into account not only the clinical condition but also the broader ethical and legal ramifications.

One illustrative case is the French Council of State's ruling in 2022,[34] which upheld a medical decision to transfuse a patient despite their explicit refusal. The court upheld the physician's decision to administer the transfusion, affirming the legal principle that intervention is permitted where there is uncertainty regarding the informed nature of the refusal. Although this

[33] E.g., Conseil d'État, 26 octobre 2001, n. 198546.
[34] Conseil d'État, 20 mai 2022, n. 43713.

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ruling did not concern obstetric care, it carries important implications for the broader medical field, including obstetrics. The ruling confirms that doctors are not legally liable if they override a patient's refusal in an effort to preserve life, provided the intervention is deemed proportionate and necessary.

2.2.3. *Refusal in obstetric emergencies: maternal versus fetal health*

When a pregnant person refuses medical care that that could be essential to preserving their life, the situation becomes even more complex. In obstetrics, there is an added layer of complexity when the refusal of care may put the fetus at risk. A refusal of a potentially life-saving procedure, such as a cesarean section or episiotomy,[35] creates a particularly sensitive dilemma. In such cases, the law prioritizes the autonomy and bodily integrity of the pregnant person. Medical professionals are not typically permitted to override a patient's refusal, even if the intervention is believed to be necessary to safeguard the fetus,[36] unless there is a direct and immediate threat to the mother's life.

For instance, if a mother declines an intervention that could save the life of the fetus, such as a cesarean section to prevent fetal distress, the medical team cannot simply proceed with the procedure without the mother's consent. Although the healthcare team can make every effort to persuade the patient and involve third parties (such as family members or spiritual advisors) in the decision-making process, the legal framework upholds the mother's autonomy in making decisions that affect her body.[37]

This principle is rooted in the respect for maternal personal autonomy and the right of the patient to make decisions about their body, even when those decisions may negatively impact the fetus. Healthcare providers must tread carefully, ensuring that all efforts to inform and involve the patient are documented, and that all solutions are explored to resolve the conflict.

[35] Episiotomy is a procedure now reserved for instrumental extractions, according to the latest clinical practice recommendations.

[36] A Defline *et al.*, 'Refus maternel de césarienne d'indication fœtale, mort-né' [Maternal Refusal of Medically Indicated Cesarean Section, Stillbirth] (2014) 43 Journal de gynécologie obstétrique et biologie de la reproduction 71.

[37] Defline *et al.* (n 69) 71; Jacques Lepercq *et al.*, 'Quelle réponse apporter à un refus obstiné de soin lors d'un accouchement ?' [How Should One Respond to a Persistent Refusal of Care During Childbirth?] (2024) 52 Gynécologie Obstétrique Fertilité et Sénologie 109.

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2.2.4. *The role of third parties: family and religious beliefs*

The involvement of third parties, such as family members or religious figures, can significantly complicate the decision-making process in obstetric care. While the presence of trusted individuals can be beneficial in supporting the pregnant patient, their influence may sometimes become coercive or obstructive, particularly when cultural, religious, or familial expectations conflict with recommended medical care. For instance, there have been reports of situations where a husband or a family member has actively pressured a pregnant woman to refuse treatment, including denying consent for specific procedures or objecting to the presence of male healthcare provider.[38] While the wishes of the family may influence the decision-making process, it is the patient's wishes that must ultimately take precedence, as long as the patient is competent to make those decisions.

In more challenging situations, family involvement may escalate into direct safety concerns. For example, if a family member's insistence on a certain course of action (or refusal of care) results in hostility, confrontation, or even physical aggression, the healthcare team must respond swiftly and may need to involve security personnel or law enforcement to ensure that the safety of both the patient and the healthcare team is not compromised.

To manage these sensitive dynamics effectively, healthcare providers must prioritize dialogue and communication to mediate the situation and ensure that the patient's autonomy is respected while maintaining a safe and supportive environment.[39] Institutional protocols typically include steps for involving security in cases of physical or verbal altercations, as well as procedures for documenting these incidents to protect all parties involved. This documentation is essential for legal accountability, clinical transparency, and the protection of all parties involved, especially when navigating high-conflict or ethically charged interactions in obstetric care.

[38] Eva Louis-Sidney, *Refus de soin en obstétrique : Approche juridique* [Refusal of Care in Obstetrics: A Legal Approach] (dissertation, School of Midwifery of Aix-Marseille 2019) 1, 29; Observatoire national des violences en milieu de santé (ONVS), *Rapport 2022* (2022) 13 and 100.

[39] Lepercq *et al.* (n 70) 113.

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2.3. *Jurisprudence and International Legal Precedents*

As previously discussed, jurisprudence in France and international legal rulings continue to shape the practice of obstetric in the context of refusal of care. A European Court of Human Rights (ECHR) ruling in 2024[40] concerning a patient's refusal to receive a blood transfusion in a non-obstetric context is a notable example of how international law continues to influence domestic legal practices. The ECHR ruled that the failure to respect the patient's wishes in this case amounted to a violation of Article 8 of the European Convention on Human Rights, which guarantees the right to respect for private and family life, including the right to make informed decisions regarding one's own body.

While this ruling did not involve obstetrics, it provides valuable insight into the broader implications of patient autonomy in medical decision-making, particularly when the refusal of care can lead to significant risks. Recognizing the far-reaching impact of this decision, the French government intervened as a third party in the case, emphasizing the importance of upholding patient autonomy while considering the potential legal and ethical challenges for healthcare providers.

3. *Conclusion*

The right to refuse medical treatment is a fundamental principle that underpins patient autonomy in French law, as well as in international legal frameworks. In the specific context of obstetric care, this right takes on heightened complexity, as clinicians must address not only the rights and well-being of the pregnant individual but also the potential implications for the fetus. Respecting a patient's wishes in these cases, particularly during critical or time-sensitive situations, requires nuanced, case-specific judgment informed by both ethical considerations and legal obligations. While healthcare providers must always prioritize patient autonomy and informed consent, they must also navigate the ethical and legal challenges that arise in emergency situations. The balance between respecting patient decisions and ensuring that medical interventions are made

[40] ECHR, Grand Chamber, 17 September 2024, *Pindo Mulla v. Spain* (no. 15541/20).

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to preserve life is delicate and requires continuous dialogue, interdisciplinary education, and the development of clear legal guidance to support clinical decision-making. Obstetric care often places professionals at the intersection of law, ethics, and medicine, where even small missteps can carry profound consequences.

The legal landscape surrounding informed consent in obstetrics will continue to evolve as case law develops and as healthcare providers adapt to new ethical challenges. Nevertheless, the fundamental guiding principle remains unchanged: the obligation to respect the autonomy, dignity, and self-determination of every patient. Ensuring that the patient's voice is heard – and legally recognized – even in moments of acute medical urgency is what ultimately will define ethical and lawful care in modern obstetric practice.

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 ISBN 978-88-495-6175-3

Raluca Bercea, Cristina Nicorici

Mapping the Romanian Legal Context of Violence at birth against (Roma) Women

1. *Introduction*

Violence against women is the most common violation of women's human rights in Europe and, as 'progress with policy and legal reform to tackle this phenomenon is slow', it 'remains widespread in all member States of the Council of Europe, with devastating consequences for women, societies and economies'.[1]

For Romania, The Gender Equality Index of 2024[2] reports that 42 out of 100 women have experienced physical and/or sexual violence by any perpetrator since age 15 (as compared to only 32 women at the European Union level), also that the percentage of women having experienced physical and/or sexual violence by any perpetrator in the past 12 months is of 9 as compared to 3 in the EU. Psychological violence is also higher in Romania (46%) than in the European Union (30%), as attested by national cases presented before the international courts.[3] Finally, the number of women and girls registered as victims of human trafficking by

[1] Council of Europe, 'Preventing and combating violence against women' <https://www.coe.int/en/web/genderequality/violence-against-women> accessed 5 June 2025.

[2] European Institute for Gender Equality, 'Gender Equality Index 2024: Violence (Romania)' <https://eige.europa.eu/gender-equality-index/2024/domain/violence/RO> accessed 5 June 2025.

[3] See the landmark Romanian cases *Bălşan v. Romania*, ECtHR, Application No. 48645/09, 23 May 2017 and *Buturugă v. Romania*, ECtHR, Application No 56867/15, 11 February 2020.

 ISBN 978-88-495-6175-3

EU Member State rate per 100 000 female population is of 4.1 in Romania, as compared to 2.7 at the general level. One explanation may stem from cultural factors: many societies – including the Romanian one – continue to maintain high levels of institutional tolerance for domestic violence and complacency in cases of systematic rights violations that undisputedly affect women more than men.[4] For instance, in a case where it does not hesitate to qualify cyber violence as domestic violence, the European Court of Human Rights also noted that 'the (Romanian) authorities were overly formalistic in dismissing any connection with the incidents of domestic violence already brought to their attention by the applicant, and thus failed to take into consideration the many forms that domestic violence may take'.[5]

Provisorily defined as a gender-based form of violence against women referring to psychological, physical and sexual abuse during obstetric and gynecological consultations,[6] gynecological

[4] For an extensive argument supporting this idea, see Raluca Bercea, 'Choosing form over content: An assessment of domestic violence cases before national courts and the European Court of Human Rights' in Elena Brodeală, Ivana Jelić and Silvia Şuteu (eds.), *Violence Against Women under European Human Rights Law: From Supranational Standards to National Realities* (Edward Elgar 2024) 137. To give only one example, in *A.E. v. Bulgaria*, the ECtHR, Application No. 53891/20, 23 May 2023, para. 122, the European Court of Human rights notes that the national authorities demonstrate a 'general institutional passivity in matters related to domestic violence'; 'for a sustained period of time women have continued to suffer disproportionately from domestic violence and the authorities have not shown that they engaged adequately with the problem'. Also, the CEDAW notes for the same country 'increases in cases of anti-gender discourse in the public domain, public backlash in the perception of gender equality and misogynistic statements in the media, including by high-ranking politicians; also by the promotion of a concept of traditional family values that confines women solely to the role of mothers with domestic responsibilities and the lack of a comprehensive strategy for the elimination of discriminatory stereotypes regarding the roles and responsibilities of women and men in the family and in society'.

[5] *Buturugă v. Romania* (n. 3), para. 78.

[6] Silvia Brunello *et al.*, *Obstetric and Gynaecological Violence in the EU: Prevalence, Legal Frameworks and Educational Guidelines for Prevention and Elimination* (European Union 2024) <https://www.europarl.europa.eu/RegData/etudes/STUD/2024/761478/IPOL_STU(2024)761478_EN.pdf> accessed 5 June 2025. See also the definition provided by World Health Organisation (in *Statement on the Prevention and Elimination of Disrespect and Abuse during Facility-Based Childbirth* (WHO 2015): any abuse, disrespect, and mistreatment in childbirth caused by healthcare professionals that results in violations of women's dignity. This can consist of outright physical abuse, humiliation caused by verbal abuse, lack of confidentiality, and neglect that results in unnecessary pain and avoidable complications.

ISBN 978-88-495-6175-3

and obstetric violence affects women in an even more vulnerable situation, so that the introductory considerations above and in particular the cultural stereotype-based dimension of the phenomenon will be confirmed.[7]

Through a case study (the 'Urziceni' case), the present paper will illustrate recent reactions of the Romanian health care personnel, hospital managers and judicial authorities (National Council for Combatting Discrimination) in an instance of discrimination against Roma women at birth (2). The national criminal legal framework will be further on investigated, as it provides rules that clarify possible responsibilities in the various situations that may arise in the context of refusing medical care and in discriminatory instances (3). Moreover, the adequacy between the legal framework and the situation in the field will be assessed within the explanatory context of a quantitative cross-sectional descriptive research issued by The Romanian Independent Midwives Association Report on obstetric violence in September 2024 (4). Concluding, the paper will confirm the argument already advanced in the relevant literature according to which, irrespective of the national particularities, obstetric and gynecological violence is situated at the convergence of two structural crises: discrimination based on gender and deficiencies of healthcare systems.[8]

2. *A case study: The 'Urziceni' case*

2.1. *The facts and the actors*

On the 31st of July 2023 the Romanian media brought to the attention of the public the situation of a 24-year-old woman, deaf and mute, of Roma origin, who ended up giving birth on the sidewalk in front of the hospital in Urziceni (a small Romanian

[7] As a proof, for example, the practices of forced sterilization that occurred across the former communist bloc, both during and after the socialist period. While in the Czech Republic at least 50 women were subject to this medical procedure, long-standing discrimination against Roma people and public lack of interest in the issue are considered to be the causes for the ineffectiveness of the reparatory measures provided by the state. For a study that analyses this phenomenon, see Lukáš Novotný, 'Illegal Sterilisation in the Czech Republic' (2024) 76(8) Europe-Asia Studies 1185 <https://www.tandfonline.com/doi/full/10.1080/09668136.2024.236273> accessed 5 June 2025.

[8] Brunello *et al.* (n.6) 11.

 ISBN 978-88-495-6175-3

town with approximately 18.000 people), instead of being taken care of inside the hospital. The woman was assisted by two paramedics from the ambulance that was called to transport her to another hospital. The images and videos that showed her while giving birth circulated all over the country, spiking a large debate regarding the management of small town hospitals, the problem of lack of medical personnel in small areas and, at the same time, the issue of lack of liability for what appeared to be an act of refusing to give aid to a woman for discriminatory reasons.

The pregnant woman arrived at the hospital with her mother-in-law and her husband around 5 a.m. and requested emergency assistance. Because the hospital did not have a gynecologist on call, the nurse decided to call an ambulance and to transfer the patient to another hospital, 60 kilometers away, where a gynecologist would have been on duty. As for the reasons why the patient had to wait outside the hospital for the ambulance and eventually to give birth there, the stories of the actors involved in the situation are very different. On the one hand, the mother-in-law of the pregnant woman noted that 'the nurse didn't look at the girl' and that she 'told us to go out to the gate, wait for the ambulance'. She also said that 'when I walked into the corridors of the ER, there was no one. All the gates and doors were open, but there was no medical staff. I started yelling down the hall: is no one here? A woman gives birth! A lady came out of a room where she was sleeping and yelled at us: why are you screaming like that lady, you woke us up?! '. On the other hand, the manager of the hospital in Urziceni denied that the nurse on call refused to give the patient medical support and accused the pregnant woman of not waiting for the ambulance in the emergency room.

From the investigative report drafted by the county Public Health Department on the 2nd of August 2023,[9] it resulted, among other problems of the hospital (such as shortage in medical staff), that the only doctor that was on call at the time of the incident was a doctor of surgical specialization. He did not consult the patient during the short time when she was into the hospital because, as the report states, he was not announced

[9] The Report of Ialomita Public Health Department of 2nd of August 2023 is available at this link: <https://hotnews.ro/document-raportul-controlului-la-spitalul-urziceni-unde-o-femeie-a-nascut-pe-trotuar-gravida-nu-a-fost-consultata-medicul-de-garda-nu-a-fost-anuntat-de-asistenta-51443> accessed 5 June 2025.

ISBN 978-88-495-6175-3

by the nurse on call of the presence of the patient and of her condition. The same report states that supposedly 'from the images recorded by the surveillance cameras, it appears that the on-call nurse tries to prevent the patient from leaving the CPU premises, but to no avail, as she heads towards the hospital gate accompanied by family members'.

The mayor of Urziceni regretted the situation but mentioned in a largely broadcast tv intervention that the patient was a 'disabled' woman of Roma origin who 'doesn't know her head', a declaration for which he was eventually fined by the National Council for Combatting Discrimination. Not long after the event, on the 3rd of August 2023, the Mayor was also excluded from the National Liberal Party. The reasons for the exclusion were both his declaration regarding the patient and his refuse to take action or to impose sanctions against the manager of Urziceni Hospital.

2.2. *The Mayor's Declaration in light of the Government's Ordinance no. 137/2000*[10]

Regarding the situation described above, the mayor stated as follows: 'It is a matter, God forbid, regrettable, that such a thing has happened. It remains to be seen what the internal investigation by the minister's people will discover, and then we will see what we have. I am waiting for the result of the investigation, after which I will gladly tell you what it is about. What if the Ministry itself is to blame? The hospital in Urziceni has a Gynecology Department without doctors. As far as I know, until I find out and see the investigation, I know the woman has a disability, God forbid. She's deaf and dumb or something, but that, or that she's Roma, matters less. My question is why the family doctors, who take money with the shovel, do not register all the people and all the sick people in all the localities of this country so that we can have an overview. Especially, a mother who also has to give birth. Family doctors have registered thousands of people for whom they collect money, and these people are prone, because they are not educated, as the present case, a deaf mute. The poor thing, she does not know her head, she's from this commune here, from Bărbulești'.[11] Later on, the Mayor tried to

[10] Published in the Official Journal of Romania no. 166/07.03.2014.

[11] Barbulesti is a small, poor community in Romania, counting approximately 7.800 people.

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argue that his initial declaration was misinterpreted. However, the National Council for Combatting Discrimination opened an investigation *ex officio* regarding his declaration as a potentially discriminatory one. The investigation was concluded almost eight months later when by its Decision of 20th of March 2024 the National Council for Combatting Discrimination found that 'the statements of the Mayor of the Municipality of Urziceni, concerning the woman who gave birth in front of the Urziceni Municipal Hospital on July 31, 2023, constitute an act of discrimination committed according to Article 2 paragraph (6) and article 15 of the Government's Ordinance nr. 137/2000. The decision was adopted by the unanimous vote of those present. The sanction established by the Council is a contravention fine in the amount of 10.000 RON[12] adopted with 6 votes for and 3 against'.[13]

Article 2 paragraph (6) of the Ordinance states that any difference, exclusion, restriction or preference based on two or more criteria provided in article 2 paragraph (1) constitutes an aggravating circumstance when establishing contravention liability if one or more of its components do not fall under the scope of criminal law. According to Article 2 paragraph (1), discrimination refers to any difference, exclusion, restriction or preference based on race, nationality, ethnicity, language, religion, social category, beliefs, sex, sexual orientation, age, disability, non-contagious chronic disease, HIV infection, belonging to a disadvantaged category, as well as any other criterion that has the purpose or effect of restricting, removing the recognition, use or exercise, under equal conditions, of human rights and fundamental freedoms or rights recognized by law, in the political, economic, social and cultural field or in any other fields of public life. According to Article 15, represents a contravention, if the act does not fall under the scope of the criminal law, any behavior manifested in public, having the character of nationalist-chauvinist propaganda, of inciting racial or national hatred, or that behavior that has as its purpose or aims to achieve dignity or the creation of an intimidating, hostile, degrading, humiliating or offensive atmosphere, directed against a person, a group of persons or a community and related to their belonging to a certain race, nationality, ethnicity, religion, social

[12] 10.000 RON is approximately 2.000 EUROS.

[13] The official press release is available at this link: <https://www.cncd.ro/comunicat-de-presa-01-februarie-2024/> accessed 5 June 2025.

ISBN 978-88-495-6175-3

category or a disadvantaged category or his beliefs, gender or sexual orientation. As for the range of fines, according to Article 26, the fine is between 1.000 to 30.000 RON (about 250 to 6000 EURO) if the discriminatory act triggers an individual, and it goes up to 100.000 RON (approximately 20.000 EURO) if the discriminatory act triggers a group of individuals.

Was the response of the national authorities effective and in line with the European minimum standards of human rights protection? For potential violations of Articles 2, 3 and 8 in conjunction with Article 14 ECHR, occurring while the victim, vulnerable according to multiple criteria (deaf and mute, about to give birth, of Roma origin, of an extremely poor and uneducated community) was in the hands of public authorities and in a public hospital, only the mayor was fined with the equivalent of about 2.000 EURO for a declaration commenting *a posteriori* the event. This may be charitably interpreted as a sign of awareness that in cases of obstetric violence the potential of stereotyping and discrimination is extremely high and relevant, hence the need for a prompt response even when it is only an element of the general context. However, it should not be forgotten that the ECtHR has established clear positive procedural obligations incumbent on the state authorities, among which to investigate whether the acts of those actively involved in the situation while it was unfolding (e.g. the doctor and the nurse on call) were not motivated by discriminatory purposes. From the perspective of the protection against discrimination, the case illustrates therefore a missed opportunity. The arrow was shot, but it missed the relevant target. While it hit the mayor, it failed however to strike the medical personnel.

3. *The Romanian criminal law framework*

As it will become obvious, the systemic lack of sensitiveness to women's bodies and needs when giving birth is compensated by a correlatively higher interest in the lack of risks for the babies and medical staff.

In respect with the protection of the fetus through criminal law means, Romania has a sensitive tradition as abortion was considered a very serious crime during a large period of the communist regime (from 1966 until the end of 1989), which, combined with the lack of means of contraception, had as a goal to stimulate the increase of population. The repeal of the

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1966 law was one of the first decisions taken by the new power installed after the fall of the communist regime. Today, abortion is criminalized by Article 201 of the Romanian Criminal code, and it is sanctioned when the interruption of the course of pregnancy is carried out in any of the following circumstances: outside medical institutions or medical offices authorized for this purpose, by a person who does not possess the qualification as a doctor specializing in obstetrics-gynecology and lacks the right of free medical practice in this specialty, and/or if the pregnancy has exceeded fourteen weeks, being punished with prison time up until three years. The punishment goes up to seven years, if the crime is committed without the consent of the pregnant woman, regardless of the conditions. The attempt to commit the crime is also punished by the law, and a pregnant woman who interrupts her pregnancy is not punished.

Moreover, Article 202 of the Romanian Criminal code sanctions several conducts that could create injury to the fetus, making a distinction considering the moment when the injury was committed: during the birth or during the pregnancy. Creating an injury to the fetus, during birth, which prevented the establishment of extra-uterine life is punishable by imprisonment from 3 to 7 years. So is the act of creating injury to the fetus, during birth, which later resulted in the death of the child. If the injury was created during the birth, but later caused only bodily injury to the child, it is punished with imprisonment from one to 5 years. Creating an injury to the fetus during pregnancy, which subsequently caused bodily injury to the child, is also punished with imprisonment from 3 months to 2 years, and, if it resulted in the death of the child, the penalty is the imprisonment from 6 months to 3 years. Injury to the fetus committed during birth by the mother in a state of mental disorder is still a crime but only sanctioned with lower limits in punishments. Criminal liability for all the acts described above exists even if they are committed with negligence. However, injury to the fetus during pregnancy by the pregnant woman is not punishable.

Apart from the two crimes mentioned above (which could be qualified as 'specific crimes'), other provisions could apply in case of obstetrical or gynecological violence, such as rape (Article 218 of the Romanian Criminal code, if a gynecological instrument is inserted in the vagina of the patient without there being a medical requirement), Article 193 (which punishes any act of violence or any act which creates physical suffering) or Article 194 (which punishes acts similar to 193 but which

ISBN 978-88-495-6175-3

result in more severe consequences). Regarding Article 194, an interesting debate is worth mentioning as it also sanctions any act of injury that result in an abortion (obviously without the consent of the pregnant woman). One author argues[14] that abortion refers to the interruption of the pregnancy evolution during its first 24 weeks. After this term, the expulsion of the product of conception, for any reason, represents a premature birth and, therefore, this consequence of abortion (Article 194 letter d) cannot exist. The same author argues that the crime of injury to the fetus could be applicable in such a case.

What is then the distinction between the crime regulated by Article 201 and respectively by Article 194? The literature cannot agree: on the one hand, there is the option that the crime regulated in Article 194 could never be committed by intent, because the intent to interrupt the course of the pregnancy exists only in the case of the crime mentioned by Article 201.[15] The proponent of this theory argues that if the author of the crime wants to interrupt the fetus' development, he must act against the body of the mother and thus affecting intrinsically the mothers' physical integrity.[16] Another well-known author argues that the crime mentioned by Article 194 can be committed also with indirect intent,[17] if the author acts with the intention to create physical injury to the mother, which triggers the abortion as a consequence.

Noteworthily, the Romanian Criminal Code foresees, in Article 77 e), an aggravating circumstance applicable to (almost) any crime: committing the crime for reasons related to race, nationality, ethnicity, language, religion, gender, sexual orientation, age, disability, illness, chronic non-contagious or HIV/AIDS infection or for other circumstances of the same

[14] Valerian Cioclei, *Drept penal. Partea specială I* [Criminal Law. Special Part I] (C.H. Beck 2024) 78. This opinion is not unanimous, other authors arguing that whenever the course of pregnancy is interrupted, article 194 could be applicable, no matter the age of pregnancy. See Sergiu Bogdan and Doris Alina Șerban, *Infracțiuni contra persoanei și contra înfăptuirii justiției* [Criminal Offences against the Person and the Administration of Justice] (Universul Juridic 2024) 193.

[15] Bogdan and Șerban (n.14) 195.

[16] Bogdan and Șerban (n.14) 195.

[17] Indirect intent exists, according to Article 16 paragraph (3) letter b) of the Romanian Criminal code when the author of the crime foresees the result of his act and, although he does not follow it, he accepts the possibility of its production.

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kind, considered by the perpetrator as causes of a person's inferiority in relation to others. This aggravating circumstance can have as an effect the increase of imprisonment by up to two years, and by 1/3rd the limits of punishment of criminal law fine.

Moreover, in Romania, both the action and the inaction can form the basis for criminal responsibility, without this being considered a breach of the principle of legality. Criminal responsibility for an inaction is possible if the inaction is expressly sanctioned by the Criminal Code (the case of the proper omissive crimes), or, based on Article 17 of the Romanian Criminal Code that states the following: 'The commissive crime that requires the production of a result is also considered committed by omission, when: a) there is a legal or contractual obligation to act; b) the author of the omission, through a previous action or inaction, created a state of danger for the protected social value that facilitated the production of the result'. Therefore, the crimes analyzed above, being crimes that require the production of a result, can be committed by action or by omission of the agent.

In the 'Urziceni' case the child was born healthy, and the mother did not face any complications at birth. This happy outcome excludes criminal liability of the medical personnel (and especially the nurse who consulted the patient) for the crimes regulated by the Articles 201, 202 and 194, who suppose that a dangerous result that affected the health of the baby and or the mother was produced. Perhaps an attempt to interrupt the course of pregnancy could be argued, if it can be proven that the inaction of the nurse who did not help the patient (although she has this legal duty, being a nurse on call at the CPU) and did not let the on call doctor know about the patient (although she had this contractual duty) triggered state of danger for the course of the pregnancy. The physical suffering of the patient cannot be denied either, as of course it would have been more appropriate to give birth on a bed, with proper medical support. It may therefore be at stake criminal responsibility for the crime foreseen in Article 193.

In our particular case study, the medical staff that was in the hospital had at least a contractual duty to help the patient. Of course, the medical staff was not of obstetrical-gynecological specialty (this being the reason why, according to the staff, the patient should have been moved to another hospital), but the lack of specialization does not qualify as an excuse for not assisting a person in danger; it could be analyzed however as a

ISBN 978-88-495-6175-3

limitation of the intent to commit a crime, being therefore an argument for a negligent crime.

At the time of the facts the press noted[18] that a criminal investigation had been open by the police for the crime of abuse of office. Up until the moment of this article no further news regarding this investigation were provided by either the police, the prosecutor or the press. Abuse of office is regulated in Article 297 of the Romanian Criminal code, stating that: 'The act of the civil servant who, in the exercise of his duties, does not fulfill an act provided by a law, a Government ordinance, an emergency Government ordinance or another normative act which, on the date of its adoption, had the force of law or fulfills it in violation of one provisions contained in such a normative act, thus causing damage or injury to rights or legitimate interests of a natural person or a legal person, se punishes with imprisonment from 2 to 7 years and the prohibition of exercising the right to hold a position public. With the same punishment is sanctioned the deed of the civil servant who, in the exercise duties, restricts the exercise of a right of a person or creates for him a situation of inferiority based on race, nationality, ethnic origin, language, religion, sex, orientation sex, political affiliation, wealth, age, disability, non-contagious chronic disease or infection HIV/AIDS'. The punishment appears to be pretty harsh, going up until 7 years.

The Romanian literature[19] argues that this crime is one of the more extensive and general incriminations in the Romanian Criminal code, with the consequence that almost any violation of the duties by a civil servant qualifies as a crime. Time will tell whether the investigation reported by the press has been a purely formal or on the contrary an effective one, protecting real and not illusory rights.

[18] <https://ziare.com/dosar-penal/dosar-penal-cazul-femeii-nascut-fata-spitalului-urziceni-1818218> accessed 5 June 2025.

[19] Sergiu Bogdan and Doris Alina Șerban, *Infracțiuni contra patrimoniului, contra autorității, de corupție, de serviciu, de fals, și contra ordinii și liniștii publice* [Offences against Property, Authority, Corruption, Public Office and Public Order] (Universul Juridic 2023) 421; Viorel Pașca, 'Cum a devenit abuzul în serviciu cea mai frecventă infracțiune de corupție' [How Abuse of Office Became the Most Common Corruption Offence] <https://www.universuljuridic.ro/cum-devenit-abuzul-serviciu-cea-mai-frecventa-infractiune-de-coruptie/> accessed 5 June 2025.

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4. *The background of quantitative cross-sectional descriptive research*

A tool allowing to better place the actors' and the authorities' reactions in the 'Urziceni' case in the Romanian societal context, is provided to us by the 'Independent Midwives' Association,[20] a highly reliable non-governmental Romanian organization, who issued in September 2024 a Report on obstetrical violence,[21] stemming from quantitative cross-sectional descriptive research and starting from the assumption that obstetric violence is a manifestation of gender-based violence, a phenomena still not sufficiently studied in Romania.[22] The research question, namely how Romanian women perceive their experience of the care they received during pregnancy, childbirth and postpartum in Romanian clinics and hospitals over a laps of 5 years (2018-2023), got 5623 valid responses. When further interpreting them, the drafters of the report, experts in gender equality studies or sociology, started from a definition of obstetric violence as 'physical or verbal abuse, disrespect and mistreatment, lack of confidentiality and neglect during childbirth perpetrated by health professionals that results in unnecessary pain'.[23]

While assessing the values embedded in such vulnerable situations as pregnancy, childbirth or postpartum, it became obvious that women's needs, experiences and bodies were virtually absent from medical discourses and practices, or, even more, often downplayed, marginalised, and stigmatised. Women and their bodies were in fact valued only insofar as they must deliver healthy babies, with a focus on minimizing risks for doctors. Rather than being respectful to the women's needs and to their bodies, the system focuses on and is built around the doctors and the babies, in view to minimize the risks for both these categories. Based on their questionnaire, the drafters of the report could also emphasize the presence at the national level of recurrent practices such as defensive medicine, high rate

[20] <https://asociatiamoaselor.ro/en/> accessed 5 June 2025.

[21] <https://moasele.ro/wp-content/uploads/2024/09/Raport-privind-violenta-obstetrica_AMI_septembrie_2024.pdf> accessed 5 June 2025.

[22] Despite obvious and notorious facts such as, for instance, that Romania is one of the countries where the number of caesarean sections far exceeds the number of natural births.

[23] Report on obstetrical violence (n. 21) 6.

ISBN 978-88-495-6175-3

of caesarean sections, restrictive birthing positions, absence of support persons or immediate separation of the mother from the baby after birth.

Noteworthily, many of the problems identified are seen by the authors of the report to be determined by a mixture of cultural and systemic factors. Among the systemic ones, extremely relevant in the Romanian context seems to be the difficulty or lack of access to paid consultations during pregnancy, which particularly affects low-income women. More generally, the report concludes on a low level of information, knowledge or awareness among women (even with higher education) in respect with obstetric violence and the different forms that it can take. Confirming this argument, it is notorious that issues related to women's bodies, rights, and autonomy are not subjects of interest to be included in the national school curricula, which raises questions about the effectivness of women's rights. Anecdoticallly, in 2020, the Romanian Senate approved an amendment to the Education Law that would have banned any reference to the concept of gender identity in schools and universities. It was for the Romanian Constitutional Court to intervene and, in the Decision no. 907/2020,[24] it ruled that a legislative provision prohibiting any educational or extracurricular activity related to gender identity – understood as the idea that gender can differ from biological sex – was unconstitutional.

If things have improved since 2020, the progress has been rather slow and non-systematic. For instance, a campaign on women's rights to health and safety was conducted between 2021 and 2023, consisting of 24 events, including 12 informative sessions on violence against women and maternal and reproductive health. While some of the events mapped women's issues, others focused on informing the participants about the tools they can use to exercise their rights (e.g. hearing with the mayor, petition, protest, etc.). 510 women were reported to have taken part in this campaign.[25] Moreover, in 2023, the association 'Mothers to Mothers'[26] requested the Romanian Government to

[24] Decision no. 907/2020, published in the Official Journal of Romania no. 68/21.01.2021.

[25] Brunello *et al.* (n. 6) 42.

[26] <https://mamepentrumame.ro/mothers-for-mothers-association/> accessed 5 June 2025.

 ISBN 978-88-495-6175-3

introduce and implement legal, policy, and support measures to tackle obstetric violence.[27]

The educational process is not without its drawbacks, mainly consisting in the risk of desinformation. In a country facing an extremely high rate of defensive medicine at birth, malveillant campaigns take advantage of this vulnerability increasing the risks. Thus, the "anti-C-section" billboards that appeared in Bucharest in April 2026 in the week of Orthodox Easter sparked a major public controversy, with experts labeling the campaign as a medical disinformation one. Placed all over the capital of the country, huge billboards claim that C-sections destroy the vital functions of childbirth and, moreover, that the absence of dilation and contractions will be genetically passed down from mother to daughter, affecting future generations. Initially, the campaign was anonymous, but media investigations identified its source in an organization reported to promote conspiracy theories. While the Romanian College of Physicians issued an official warning stating that the information thus exhibited had no scientific basis and would endanger public health, equally concerning can be considered the legislative deficient framework that allowed such medical messages to be displayed in public placed without the approval of professionals.[28]

All in all, some forms of obstetric violence occur due to a lack of communication between patients and health professionals, who may exhibit a paternalistic attitude, which raises questions of professional ethics and deontology. Also in respect with the medical staff, a contradiction was noted between the duties and responsibilities of midwives and hospital practice. Finally, anti-Roma racism persists and manifests itself both among medical professionals and the majority of women patients.[29]

[27] Brunello *et al.* (n. 6) 121.

[28] https://www.euronews.ro/articole/cine-raspunde-pentru-mesajele-alarmiste-anti-cezariana-de-pe-strazile-din-bucures, accessed 17 April 2026.

[29] The Report on obstetrical violence (n. 21) includes testimonies such as: 'I ended up in the ER, with bleeding, where I was considered to be of a different ethnicity (Roma), because it was summer and I was tanned, so the gynecologist behaved unacceptably to me and to the next patient, who was indeed Roma'; 'When I gave birth, there were several other women in the labour room, including a 16-year-old Roma girl. They scolded her like a child because she was screaming in pain and people were calling her from home, then they took her phone and hung up'; 'I was in a ward with Roma people. I had to change 2 wards in 3 days to have peace of mind and hygiene'. For a comparative perspective, see the practices concerning the Roma women

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5. *Conclusion*

Like in other European countries, obstetric violence must be understood in Romania as a form of violence manifested at the intersection between (1) the weak points of the medical system, (2) the societal stereotypes, prejudices and the traditional assignation of gender roles and (3) the prevalent ethos concerning women's bodies when confronted with the imperative of protecting a new life and the cautiousness towards the risks the medical staff is eager to assume.[30] If the purely legal national framework seems *in abstracto* appropriate both to protect women from obstetric violence and to prohibit discrimination, its effectiveness ultimately depends on the actions to be taken by the public authorities and on the overall level of compliance and awareness within society.

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Silvia Brunello *et al.*, *Obstetric and Gynaecological Violence in the EU: Prevalence, Legal Frameworks and Educational Guidelines for Prevention and Elimination* (European Union 2024) <https://

in maternities from Bulgaria, Czechia and Slovakia or Hungary (but also in France of Ireland) reported in Brunello *et al.* (n. 6) 40.

[30] See also the 'Report on obstetrical violence' (n. 21) 9.

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www.europarl.europa.eu/RegData/etudes/STUD/2024/761478/IPOL_STU(2024)761478_EN.pdf> accessed 5 June 2025.

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ISBN 978-88-495-6175-3

Section II

From obstetric to gynaecological violence

Barbara Gagliardi

The Legal Dimension of Obstetric and Gynaecological Violence

1. *Obstetric and Gynaecological Violence between Gender-Based Violence and Medical Abuse*

The concept of *obstetric and gynaecological violence* was first formally recognised in legislation in Central and South America, largely as a result of advocacy efforts of organisations committed to promoting respectful and humanised childbirth. Notably, Venezuela's *Law on the Right of Women to a Life Free of Violence*[1] explicitly addresses obstetric violence within a broader framework aimed at establishing 'conditions to prevent, treat, punish and eradicate violence against women in all its forms and spheres, by transforming sociocultural patterns that sustain gender inequality and power relations affecting women, to promote the construction of a just, democratic, participatory, egalitarian and self-reliant society' (art. 1).[2]

[1] *Ley orgánica sobre el derecho de las mujeres a una vida libre de violencia*, 23 de abril de 2007, no. 38.668. See Rogelio Pérez D'Gregorio, 'Obstetric violence: a new legal term introduced in Venezuela' (2010) 111 International Journal of Gynecology and Obstetrics 201.

[2] 'La presente Ley tiene por objeto garantizar y promover el derecho de las mujeres a una vida libre de violencia, creando condiciones para prevenir, atender, sancionar y erradicar la violencia contra las mujeres en cualquiera de sus manifestaciones y ámbitos, impulsando cambios en los patrones

 ISBN 978-88-495-6175-3

Within this legislative framework, obstetric violence is defined as '…the appropriation of women's bodies and reproductive processes by health personnel, which is expressed in a dehumanized treatment, in an abuse of medication and pathologisation of natural processes, bringing with it a loss of autonomy and the capacity to decide freely about their bodies and sexuality, negatively impacting women's quality of life' (art. 15.13).[3]

Following the Venezuelan example, further legislation addressing obstetric violence was enacted in Argentina (2009), in several Mexican states (between 2014 and 2017), in the state of Santa Catarina in Brazil (2017), and in Uruguay (2017).[4]

Attention to this phenomenon has largely been driven by feminist movements and advocacy groups,[5] which have revived the demand for bodily autonomy – a core claim of the women's movements of the 1960s and 1970s.[6] Obstetric violence is understood as a specific form of *gender-based violence against women*, in that it not only affects women disproportionately, but is also 'directed against a woman because she is a woman'.[7]

socioculturales que sostienen la desigualdad de género y las relaciones de poder sobre las mujeres, para favorecer la construcción de una sociedad justa democrática, participativa, paritaria y protagónica'.

[3] 'La apropiación del cuerpo y procesos reproductivos de las mujeres por personal de salud, que se expresa en un trato deshumanizador, en un abuso de medicalización y patologización de los procesos naturales, trayendo consigo pérdida de autonomía y capacidad de decidir libremente sobre sus cuerpos y sexualidad, impactando negativamente en la calidad de vida de las mujeres'.

[4] Patrizia Quattrocchi, 'Obstetric Violence Observatory: Contributions of Argentina to the International Debate' (2019) 38(8) Medical Anthropology 762. On the limited implementation of legislation concerning obstetric violence in South America: Farah Diaz-Tello, 'Invisible wounds: obstetric violence in the United States' (2016) 24(37) Reproductive Health Matters 56.

[5] See Rodante van der Waal, Inge van Nistelrooij and Carlo Leget, 'The undercommons of childbirth and their abolitionist ethic of care: a study into obstetric violence among mothers, midwives (in training), and doulas' (2025) 31(1) Violence Against Women 155: 'Obstetric violence is an activist term, a 'struggle concept"'.

[6] See Boston Women's Health Collective, *Our Bodies, Ourselves* (New England Free Press 1970); Teresa Bertilotti and Anna Scattigno (eds.), *Il femminismo degli anni Settanta* [1970s Feminism] (Viella 2005).

[7] Council of Europe, *Convention on preventing and combating violence against women and domestic violence*, Istanbul, 11.V.2011 (Istanbul Convention), art. 3, lett. d. On pregnancy as a gendered state: Gemma Donofrio, 'Gender during pregnancy, and abortion as gender-affirming care' (2025) 111 Virginia Law Review Online 38; Maria Vittoria Izzi, 'Identità di genere e genitorialità: un binomio da (ri)costruire' [Gender Identity and Parenthood: A Pair to (Re)Build] (2025) BioLaw Journal - Rivista di Biodiritto 349.

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Feminist legal and theoretical perspectives intersect with the critical re-evaluation of the doctor–patient relationship, as advanced by approaches such as narrative medicine and the movement for the humanisation of healthcare. These frameworks challenge technocratic models of care and advocate for relational, patient-centred practices.[8]

Recently, the Parliamentary Assembly of the Council of Europe has addressed this issue, affirming that 'in the privacy of a medical consultation or childbirth, women are victims of practices that are violent or that can be perceived as such'. These violent practices 'include inappropriate or non-consensual acts, such as episiotomies and vaginal palpation carried out without consent, fundal pressure or painful interventions without anaesthetic', but also any 'sexist behaviour in the course of medical consultations'.[9]

It is primarily women's experiences during pregnancy and childbirth that have come to the forefront of scientific inquiry and of political and institutional debate under the label of *obstetric violence*. Within this discourse, women's rights to health and self-determination are often framed as being in tension with the 'public health dimension' of pregnancy. In this context, limitations on those rights are justified by reference to a presumed public interest in protecting motherhood and the rights of the unborn child.[10]

The condemnation of obstetric violence is grounded in the assertion of the natural and physiological character of childbirth. Efforts to promote more natural, less interventionist clinical practices conflict with the increasing medicalisation – and even hyper-medicalisation – of pregnancy in contemporary Western contexts.[11] Within the dominant critical narrative, such

[8] Jean-Frédéric Levesque, Mark F. Harris and Grant Russell, 'Patient-centred access to health care: conceptualising access at the interface of health systems and populations' (2013) 12(18) International Journal for Equity in Health.

[9] Council of Europe, Parliamentary Assembly, Res. 2306(2019).

[10] Elizabeth Kukura, 'Birth conflicts: leveraging state power to coerce health care decision-making' (2018) 47(2) University of Baltimore Law Review art 4.

[11] Adrienne Rich, *Of Woman Born: Motherhood as Experience and Institution* (Virago Press 1976); Monica H. Greene, *Making Women's Medicine Masculine: The Rise of Male Authority in Pre-Modern Gynaecology* (Oxford University Press 2008) 246; William F. McCool and Sara A. Simeone, 'Birth in the United States: an overview of trends past and present' (2002) 37(4) Nursing Clinics of North America 735; Anne Simon and Elsa Supiot (dir), *Les violences*

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medicalisation is interpreted as resulting from the *infantilisation* of the birthing woman.[12] This, in turn, leads to infringements of her rights to health and self-determination, commonly referred to as *reproductive rights*, or more recently, within a broader intersectional framework, as *reproductive justice.*[13]

Accounts of obstetric violence typically describe the use of procedures or interventions that are unnecessarily painful or outdated according to current scientific standards – such as episiotomy, the *Kristeller manoeuvre*, routine urinary catheterisation, or the so-called *'husband stitch'*[14] – or which are performed without the patient's informed consent. In addition, reports frequently include instances of verbally abusive, derisive, or sexist conduct during labour, violations of patient privacy, and the provision of incomplete or misleading information regarding medical procedures and their potential consequences. These manifestations are classified and analysed in varied and detailed ways across the academic literature.[15]

gynécologiques et obstétricales saisies par le droit [Gynecological and Obstetric Violence Addressed by the Law] (Institut des Études et de la Recherche sur le Droit et la Justice 2023) 2.

[12] The medicalisation of childbirth is not invariably perceived as indicative of a negative experience. On the contrary, it may at times enhance the parturient's sense of safety, which – alongside a feeling of being supported and treated with respect – lies at the heart of what many women describe as a positive birth experience: Rachelle J. Chadwick, 'Good birth narratives: diverse South African women's perspectives' (2019) 77 Midwifery 6.

[13] Loretta J. Ross and Rickie Solinger, *Reproductive Justice: An Introduction* (University of California Press 2017).

[14] For a list of substandard care (frequently) observed in labour: European Association of Perinatal Medicine (EAPM) *et al.*, 'Joint position statement: substandard and disrespectful care in labour – because words matter' (2024) 296 European Journal of Obstetrics & Gynecology and Reproductive Biology 205.

[15] For different examples of taxonomies of obstetric violence, see Elizabeth Kukura, 'Obstetric violence' (2018) 106 Georgetown Law Journal 721, which distinguishes between abuse, coercion and disrespect; Meghan A. Bohren *et al.*, 'The mistreatment of women during childbirth in health facilities globally: a mixed-methods systematic review' (2015) 12(6) PLoS Medicine 1, which identifies forms of physical abuse (use of force, physical restraint), verbal abuse (harsh or rude language, judgmental or accusatory comments, threats and blaming), stigma and discrimination, failure to meet professional standards of care (frequent and painful vaginal exams, refusal to provide pain relief, lack of informed consent process, breaches of confidentiality, neglect, abandonment, or long delays, etc.), poor rapport between women and providers (poor communication, language and interpretation barriers, restricting birth positions, denial of companionship during labour, etc.), health

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Equally relevant are *omissive* forms of obstetric violence, including acts of neglect – whether deliberate or inadvertent – as well as the unjustified refusal to administer pain relief. Such passive behaviours, though less visible, may have equally detrimental effects on the dignity, autonomy, and physical integrity of the patient.

The aim of advocacy movements is to lift the veil of tacit tolerance that obscures these practices within the majority of legal systems. The hashtags employed in awareness campaigns – such as *#bastatacere*, *#ancheame*, and *#BreakingtheSilence* – underscore, either explicitly or implicitly, the widespread lack of awareness and the systematic underestimation of practices that are, nonetheless, alarmingly prevalent.

In contrast, scholarly and institutional engagement with the phenomenon of gynaecological violence remains relatively underdeveloped. There is no comprehensive framework for identifying disrespectful or abusive behaviours that may occur during gynaecological consultations or in the administration of treatments – regardless of whether they are connected to reproductive health services.

Numerous situations may fall within the scope of such abuse, including routine gynaecological check-ups and pelvic examinations (for instance, those carried out within cancer screening campaigns), the prescription of treatments for menopausal symptoms, and procedures related to voluntary termination of pregnancy, among others.

In such contexts, gynaecological violence may likewise involve episodes of physical abuse or, more frequently, psychological harm, including what has been described as *epistemic violence*. This may manifest in the form of sexist or moralistic remarks, clinical examinations conducted in inappropriate or non-private settings, failure to obtain informed consent, refusal to provide adequate and comprehensive information, or the dismissal – occasionally even with derision – of patients' reported symptoms (gaslighting).[16]

According to prevailing analyses, these episodes result

system conditions and constraints (physical conditions, staffing shortages, supply constraints, lack of privacy, etc.).

[16] Ingrid Ruud Knutsen, Anita Guldahl Hansen and Veslemøy Egede-Nissen, '"The sofa is my base in daily life": the experience of long-term pelvic girdle pain after giving birth' (2022) 43(1-3) Health Care for Women International 263. See also the chapter by Georgia Zara in this volume.

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from the combination of two overlapping dynamics: first, the power asymmetry inherent in the paternalistic model of the doctor–patient relationship; and second, a gendered dimension that renders obstetric and gynaecological violence a clear instance of *gender-based violence*. Not only are women disproportionately – and almost exclusively – affected by such practices, but the violence in question also reflects entrenched structural inequalities between the sexes, rooted in a long-standing history of discrimination and patriarchal norms.[17]

The aforementioned considerations remain unchanged even when the perpetrator of violent acts against a woman is herself a woman. This is because it is the discipline of medicine, together with the medical culture that underpins it, which is generally regarded as *androcentric* and patriarchal.[18] It is deemed androcentric insofar as it is predominantly based on the study of male bodies and the conditions that affect them.[19] Indeed, in the final decades of the twentieth century, a new branch of medical knowledge emerged – *gender medicine* – explicitly aimed at recognising the significance of the 'gender' variable and the biological, psychological, social, and cultural dimensions that are typically associated with it. Gender medicine highlights the need to systematically consider gender as a determinant across all branches of medicine, not only within obstetrics and gynaecology.[20]

[17] Sara Cohen Shabot and Keshet Korem, 'Domesticating bodies: the role of shame in obstetric violence' (2018) 33(3) Hypatia 384: obstetric violence is distinguished from other forms of medical violence by its close association with feelings of shame. During labour, such feelings often arise from the perceived loss of femininity associated with birthing bodies, or from their being regarded as 'too sexual or messy'. Women may also experience shame for 'being bad mothers-to-be and for acting against the myth of altruistic, self-sacrificing motherhood'.

[18] Sara Cohen Shabot, 'Making loud bodies "feminine": a feminist phenomenological analysis of obstetric violence' (2016) 39 Human Studies 231. See also Sandra Morano, *Donne che curano le donne. Ginecologhe e sala parto tra passato e futuro* [Women Caring for Women: Female Gynecologists and the Delivery Room Between Past and Future] (Carocci 2024); Lucia Re, Carla Strazzeri and Sara Fariello (eds), *Obstetric Violence as Gender Based Violence* (De Gruyter 2026).

[19] Obstetrics and gynaecology are often regarded as encompassing the scientific scope of gender medicine.

[20] Vanessa Manzetti, 'Il diritto alla salute di genere e la sindrome di Yentl: una fragile "effettività"' [The Right to Gender Health and the Yentl Syndrome: A Fragile 'Effectiveness'] (2022) 1 Nuove autonomie 133; Silvia De Francia, *La medicina delle differenze. Storie di donne, uomini e discriminazioni* [The

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At the same time, medical practice is frequently described as patriarchal, reflecting a process of 'appropriation of the female body' by healthcare professionals and a persistent failure to recognise women's capacity for autonomous decision-making. Accordingly, in obstetric care, the labouring woman is perceived as 'a collectively owned and governed instrument'.[21]

The conflict between women's right to self-determination and gender-based discrimination is particularly visible in cases of obstetric violence. As previously noted, in the prevailing culture the 'social value' attached to motherhood is often seen as taking precedence over individual interests. The 'state interest in protecting potential life'[22] correspondingly increases as pregnancy progresses and, with it, the possibility of extrauterine fetal survival, ultimately resulting in the curtailment of women's bodily autonomy.[23] Some interpretations point to the existence of a *presumption of maternal self-sacrifice*,[24] which contributes

Medicine of Differences: Stories of Women, Men, and Discrimination] (Neos Edizioni 2020); Alyson McGregor, *Sex Matters: How Male-Centric Medicine Endangers Women's Health and What We Can Do About It* (Quercus Publishing 2020); Marta Fasan and Carla M. Reale, 'Genere e sperimentazioni cliniche: il Regolamento (UE) n 536/2014, un'occasione mancata?' [Gender and Clinical Trials: Regulation (EU) No 536/2014, a Missed Opportunity?] (2002) 4 BioLaw Journal - Rivista di Biodiritto 251; Aa.Vv., *Il genere come determinante di salute. Lo sviluppo della medicina di genere per garantire equità e appropriatezza della cura* [Gender as a Determinant of Health: The Development of Gender Medicine to Ensure Equity and Appropriateness of Care] (Quaderni del Ministero della Salute 2016).

[21] Alexa Richardson, 'The case for affirmative consent in childbirth' (2022) 37(1) Berkeley Journal of Gender, Law & Justice 5. See also Salvatore Politi, 'Il monitoraggio del benessere fetale in travaglio di parto: gli attuali risvolti bioetici e medico-legali' [Monitoring Fetal Well-Being During Labor: Current Bioethical and Medico-Legal Implications] (2025) BioLaw Journal - Rivista di Biodiritto 377, concerning the uncertain scope of the physician's duty to inform and its implications for defensive medicine.

[22] *Roe v Wade*, 410 US 113 (1973). The balance tips far more strongly in favour of the state in cases where the mother seeks to avoid a particular procedure (caesarean section) during childbirth and her choice could result in fetal death. Due to this substantial risk, requiring the mother to undergo an unconsented caesarean section does not constitute a violation of her constitutional rights: *Pemberton v Tallahassee Memorial Regional Medical Center* 66 F Supp 2d 1247 (ND Fla 1999).

[23] In Italy, for example, Law no 194 of 22 May 1978 is entitled 'Rules for the social protection of maternity and on the voluntary termination of pregnancy' [Norme per la tutela sociale della maternità e sull'interruzione volontaria della gravidanza].

[24] Richardson (n. 21) 18; Kukura (n. 15) 775-778.

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to the normalisation or justification of violent or disrespectful practices. Concern for the foetus frequently serves to legitimise the infringement of the birthing woman's rights, particularly in litigation concerning medical liability and in related practices of defensive medicine. In certain contexts, it functions as a 'distorted incentive': in order to avoid liability, healthcare professionals choose to give priority to the health of the fetus over the choices of the mother.[25]

A similar interpretative framework may be applied to gynaecological violence. A collective interest may also be discerned in this context, insofar as such interventions likewise involve treatment of the reproductive system. From another perspective, however, abusive practices in gynaecological sphere may be attributed to their association with the sexual sphere – an area that, regardless of reproductive capacity, is often a locus of gender-based violence.

Even when limited to a sense of discomfort or perceived inadequacy during medical examinations, gynaecological violence warrants careful consideration for a number of reasons. First and foremost, it entails violations of the patient's dignity and right to self-determination, as it arises at the intersection between medical paternalism and the asymmetry of power inherent in the doctor-patient relationship, on the one hand, and gender-based violence and patriarchal cultural structures, on the other.

In the most serious cases, gynaecological violence may amount to sexual violence, as defined by Article 609-*bis* of the Italian Criminal Code. This offence does not require that the perpetrator act with sexual intent. Indeed, the behaviour of a healthcare professional who fails to provide full information or obtain valid consent may constitute an infringement of the patient's sexual freedom; thus, criminal liability may arise even where the professional acted solely with the intent to provide care.[26]

Traumatic birth experiences may have short-, medium-, and long-term consequences. These may include an impaired

[25] Maria T.R. Borges, 'A violent birth: reframing coerced procedures during childbirth as obstetric violence' (2018) 67 Duke Law Journal 827.

[26] Cass pen, sez III, 22 febbraio 2019, no. 18864; see also Cass pen, sez III, 30 settembre 2024, no. 35342; Cass pen, sez III, 13 dicembre 2019, no. 15219. See Bartolomeo Romano, 'La violenza sessuale in ambito sanitario: tra consenso informato e consenso tout court' [Sexual Violence in Healthcare: The Role of Informed Consent versus Consent Per Se] (2024) 3-4 Rivista italiana di medicina legale 513.

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relationship with the newborn, difficulties in breastfeeding, and negative effects on the mother's physical or mental health.[27] Research on the impact of obstetric violence has revealed that, in many cases, the trauma endured is a determining factor in the decision not to pursue a future pregnancy, or to delay it.[28] In other instances, women opt for alternative and less medicalised forms of childbirth, such as home births or so-called 'freebirth', or give birth in community-based birthing centres.

Beyond its individual implications, the phenomenon of violence in gynaecological and obstetric care has clear societal relevance – particularly within the context of healthcare policy. This dual relevance finds support in the Italian Constitution, which, in Article 32(1), defines health protection both as a fundamental right of the individual and as a collective interest.

Survivors of gynaecological violence often develop avoidant behaviours that can undermine the efficacy of both treatment and preventive health measures. This is evident in practices such as 'doctor hopping' (frequent changes of healthcare providers) and in the avoidance of routine check-ups.[29] Such behaviours stem from prior traumatic experiences and, ultimately, reflect the inadequacy of health services in promoting a culture of care that fully respects and supports the patient. Moreover, they affect the collective dimension of healthcare effectiveness and sustainability: by undermining preventive policies, gynaecological violence contributes to the deterioration of individual health outcomes, thereby generating increased costs for the healthcare system.

2. *Gynaecological Violence and the Personalisation of Medicine*

Epidemiological research has long emphasised the necessity of taking into account cultural, economic, and social determinants alongside biological and genetic factors when shaping public health policies, defining prevention and treatment strategies, and allocating healthcare resources.[30]

[27] For a description of the possible consequences of obstetric violence, see Kukura (n. 15) 754-757.

[28] See the chapter by Georgia Zara in this volume.

[29] Haut Conseil à l'Égalité entre les femmes et les hommes, *Les actes sexistes durant le suivi gynécologique et obstétrical* [Sexist Acts During Gynecological and Obstetric Care] (2018) 44.

[30] See Giuseppe Costa and Michele Marra, 'I divari nel sostegno alla salute'

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The interaction between individual characteristics and diverse contextual conditions significantly influences both patients' health outcomes and the aetiology of diseases. This interplay necessitates a move beyond standardised diagnostic frameworks.[31] The personalisation of medicine enhances the effectiveness of medical interventions, as it enables a more accurate diagnostic assessment and fosters greater adherence by patients to prescribed treatments.

The development of a therapeutic model centred on the person rather than solely on the pathology does not entail the rejection of the technical-scientific paradigm. On the contrary, the 'narrative' approach to medicine may enable more individualised therapeutic solutions,[32] especially when combined with artificial intelligence and data analysis.[33]

[Disparities in Health Support] (2022) 4 il Mulino 149; Enrico Bovo and Giovanna Boccuzzo, 'Misure di fragilità sulla base di indagini di popolazione' [Measures of Frailty Based on Population Surveys] in Giovanna Boccuzzo and Annalisa Donno (eds.), *Misurare la fragilità negli anziani* [Assessing Frailty in the Elderly] (FrancoAngeli 2025) 35-86.

[31] See Antonio del Puente, Vinicio Lombardi and Antonella Esposito, 'Personalized medicine is the evidence-based medicine saved in the right horizon' (2015) 13 Journal of Medicine and the Person 91: 'Making the person the center of medical care is mandatory to obtain adequate diagnostic clues, treatment adherence, better outcomes, in other words: an effective medical approach'.

[32] Giorgio Bert, 'Evidence-based medicine e narrative-based medicine: fronti opposti o facce di un poliedro?' [Evidence-Based Medicine and Narrative-Based Medicine: Opposing Fronts or Facets of a Polyhedron?] (2010) 1 Salute e società 38.

[33] On the diagnostic use of AI, see World Health Organization, *Regulatory Considerations on Artificial Intelligence for Health* (2023) 4. See also Ugo Pagallo, *Il dovere alla salute. Sul rischio di sottoutilizzo dell'intelligenza artificiale in ambito sanitario* [The Duty to Health: On the Risk of Underutilizing Artificial Intelligence in Healthcare] (Mimesis 2022) 33; Ginevra Cerrina Feroni, 'Sanità digitale e assetti istituzionali. Una lettura costituzionalistica' [Digital Health and Institutional Frameworks: A Constitutional Law Perspective] in Ginevra Cerrina Feroni (ed.), *Le nuove frontiere della medicina* [The New Frontiers of Medicine] (il Mulino 2024) 15; Elisabetta Catelani, 'La digitalizzazione in sanità: dal fascicolo sanitario elettronico alla blockchain' [Digitalization in Healthcare: From the Electronic Health Record to Blockchain] in the same volume 35; Elisabetta Catelani, 'La digitalizzazione dei dati sanitari: un percorso ad ostacoli' [Digitalization of Health Data: An Obstacle-Laden Path] (2023) 2 Corti supreme e salute 423; Fabio Mattei, 'Il punto di equilibrio tra sanità digitale e diritto alla protezione dei dati personali: la persona al centro delle nuove tecnologie' [The Balance Between Digital Health and the Right to Personal Data Protection: The Person at the Center of Emerging Technologies] *Le nuove frontiere…* 125; Claudio Filippi, 'L'impatto della digitalizzazione del SSN sulla protezione dei dati personali' [The Impact of Digitalization of the National Health Service on the Protection of Personal Data] in the same volume 139;

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Personalising care entails taking into account a wider range of factors, including cultural, socio-economic, spiritual, and ideological dimensions. These elements should be integrated not only into the diagnostic process but also in the formulation of strategies for engaging and communicating with patients, and in selecting the most appropriate therapeutic pathways.[34]

This approach reflects the duty of healthcare facilities to ensure full respect for all patients' rights: not only the right to physical integrity, but also the rights to self-determination, dignity, and respect for their beliefs, identities, and values.[35] As observed by the Italian administrative judge, 'the static and "medical" notion

Maurizio Rizzetto, 'Wearables e IoT per il monitoraggio costante del paziente a distanza: opportunità e limiti' [Wearables and IoT for Continuous Remote Patient Monitoring: Opportunities and Limitations] in the same volume 183**;** Graziano de' Petris, 'Dalla diagnostica in clinica all'esame a distanza' [From Clinical Diagnostics to Remote Examination] in the same volume 193**;** Andrea Laghi and Marta Zerunian, 'Considerazioni sull'implementazione dei sistemi di intelligenza artificiale in sanità' [Considerations on the Implementation of Artificial Intelligence Systems in Healthcare] in the same volume 283; Fabiola Cimbali, *La governance della sanità digitale* [The Governance of Digital Health] (Cedam–Wolters Kluwer 2023) 43; Paola Aurucci, *Il trattamento dei dati personali nella ricerca biomedica. Problematiche etico-giuridiche* [Personal Data Processing in Biomedical Research: Ethico-Legal Challenges] (Università degli Studi di Torino - ESI 2022) 69; Francesca Lagioia, *L'intelligenza artificiale in sanità: un'analisi giuridica* [Artificial Intelligence in Healthcare: A Legal Analysis] (Giappichelli 2020) 7.

[34] Caterina Iagnemma, '"Il tempo della comunicazione costituisce tempo di cura": l'approccio narrativo nella Legge n 219 del 2017' ["Time Spent Communicating Is Time Spent Caring": The Narrative Approach in Law No 219 of 2017] (2019) Giurisprudenza penale Web 1; Alessandro Lupo, 'Capire è un po' guarire: il rapporto paziente-terapeuta fra dialogo e azione' [To Understand Is to Heal: The Patient–Therapist Relationship Between Dialogue and Action] (1999) AM Rivista della Società italiana di antropologia medica 53; Christina M. Puchalski, 'Integrating spirituality into patient care: an essential element of person-centered care' (2013) 123(9) Polskie Archiwum Medycyny Wewnętrznej 491; Christina M. Puchalski *et al.*, 'Improving the spiritual dimension of whole person care: reaching national and international consensus' (2014) 17(6) Journal of Palliative Medicine 642.

[35] Alessandra Pioggia, 'Diritti umani e organizzazione sanitaria' [Human Rights and Health Organisation] (2011) Rivista di diritto della sicurezza sociale 22; Alessandra Pioggia, 'Consenso informato ai trattamenti sanitari e amministrazione della salute' [Informed Consent to Medical Treatments and Health Administration] (2011) Rivista trimestrale di diritto pubblico 127; Alessandra Pioggia, 'Dopo quaranta anni la riforma dei servizi psichiatrici contiene ancora una importante lezione sul servizio pubblico e sul suo ruolo' [After Forty Years the Reform of Psychiatric Services Still Holds an Important Lesson on Public Service and Its Role] (2018) Istituzioni del Federalismo 823.

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of health – linked to an objective and fixed understanding of an individual's psycho-physical well-being – must give way to a subjective and dynamic conception of the concrete content of the right to health'. This means promoting care that reflects the individual's own understanding 'of themselves and their dignity, through the pursuit of their personal well-being', thereby enabling the full realisation of their personality.[36]

One example of such an approach can be found in the Italian legal framework on informed consent, which establishes a duty to personalise the information provided to the patient, recognising the right of each individual to be informed 'in a complete, up-to-date and comprehensible to him/her manner'. Furthermore, the law requires that consent be obtained 'in the manner and with the tools most suited to the patient's condition' (Law No. 219 of 22 December 2017, art. 1, paras. 3 and 4). With specific reference to minors and persons with disabilities, the same legislation expressly affirms the 'right to the enhancement of their own capacity to understand and decide' (art. 3, para. 1).

In this manner, the significance of personalised dialogue is acknowledged, together with the obligation to adapt the content and method of information provision to the patient's linguistic and cognitive capacities, as well as to their personal sensitivities and identity. This approach marks a decisive shift from the 'physician-based model of informed consent' – under which a physician is required to disclose 'whatever information a reasonable medical practitioner of the same school, in the same or similar circumstances, would have disclosed' – to a 'patient-based model of informed consent'.[37] Under the latter, healthcare organisations are required to ensure that patients receive all relevant and comprehensible information, thereby enabling them to exercise their right to self-determination in making decisions about their medical care.

Simultaneously, the 'patient-centred' model requires the valorisation of the patient's personal narrative of *illness*, in contrast to the physician's focus on the *disease* as a mere clinical pathology – an approach referred to as 'narrative medicine'.[38] The time allocated

[36] Cons St, sez III, 2 settembre 2014, no 4460.

[37] Kukura (n. 15) 780.

[38] Vincenzo Masini, *Medicina narrativa. Comunicazione empatica ed interazione dinamica nella relazione medico-paziente* [Narrative Medicine: Empathic Communication and Dynamic Interaction in the Doctor–Patient Relationship] (FrancoAngeli 2016); Massimo Foglia, *Consenso e cura: la solidarietà nel rapporto terapeutico* [Consent and Care: Solidarity in the Therapeutic Relationship] (Giappichelli 2018) 26.

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for communication between physician and patient is expressly recognised as time dedicated to care (Law No. 219/2017, Art. 3, para. 8); indeed, patient involvement in medical decision-making promotes several positive outcomes, including improved physical and social functioning, enhanced adherence to treatment plans, and better clinical results.[39]

During this communicative exchange, the dialogue must engage with the patient's individual needs, expectations, values, and conception of life and care. As has been observed in legal and ethical scholarship, this model establishes an 'essential continuity between health, beneficiality and the identity of the person'.[40]

The violent – or perceived violent – nature of certain behaviours is not immune to social determinants, regardless of whether such conduct is intentional or unconscious. Socio-economic conditions, in particular, may facilitate the emergence of violent dynamics by exacerbating the power imbalance inherent in the therapeutic relationship.[41] It has thus been observed that victims of obstetric violence are more frequently young, economically disadvantaged, unmarried, HIV-positive, or members of racial, ethnic, or religious minorities.[42] These same socio-economic vulnerabilities may also underpin the adoption of more invasive or medicalised therapeutic interventions. Anthropological research highlights how therapeutic protocols often conflate genetic traits associated with specific population groups with

[39] Holly Goldberg, 'Informed decision making in maternity care' (2009) 18(1) The Journal of Perinatal Education 36, describing the benefits of patient involvement and empowerment in maternity care and newborn health. See also Rachel E. Silverman, 'Teaching those who teach to have a voice: the history and current practices of gynecological teaching associates' (2014) 12 Journal of Medicine and the Person 60, which analyses the experience of Gynaecological Teaching Associates (GTAs) on some US university campuses as a way of teaching doctor-patient communication with a goal of greater patient involvement in gynaecological examinations.

[40] Paolo Zatti, 'Consistenza e fragilità dello *Ius quo utimur* in materia di relazione di cura' [Consistency and Fragility of the Ius Quo Utimur in the Context of the Care Relationship] (2015) La nuova giurisprudenza civile commentata 22; Goldberg (n. 39) 34-35.

[41] Richardson (n. 21) 11.

[42] Kukura (n. 15) 762; Françoise Baylis, Sandra Rodgers and David Young, 'Ethical dilemmas in the care of pregnant women: rethinking "maternal–fetal conflicts"' in Peter A. Singer and A.M. Viens (eds.), *The Cambridge Textbook of Bioethics* (Cambridge University Press 2008) 101: 'state intervention is disproportionately oppressive of poor women, Aboriginal women, and women who are members of other racial and ethnic minorities'.

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lifestyle factors or general health conditions, resulting in practices that are, at least potentially, discriminatory.[43]

More broadly, in order to prevent the emergence of violence in healthcare, therapeutic interventions must respect the patient's values, beliefs, and religious, ideological, or philosophical orientations. These elements shape how individuals understand their identity and dignity and may underpin normative frameworks whose violation can render otherwise neutral medical practices violent.

As a direct corollary of the obligation to provide individualised information, the law establishes a duty to ensure appropriate medical education, including training in communication and relational competencies with patients (see Law No. 219/2017, Article 1, paragraph 10).

This reflects a broader shift toward the promotion of the therapeutic alliance and the humanisation of medicine – namely, a doctor–patient relationship grounded in values such as empathy, encounter, trust, and mutual respect.[44] Such individualisation and humanisation of care imply recognising the gender-specific character of healthcare, understood as the capacity to respond to the specific needs that stem from the patient's gender.

3. *The Intersectional Approach towards Gynaecological Violence*

The specific consideration of economic and social factors in defining violence aligns with the intersectional approach especially promoted by gender studies.

The notion of intersectionality has been developed primarily

[43] See Priscille Sauvegrain, 'La santé maternelle des "Africaines" en Île-de-France: racisation des patientes et trajectoire de soins' [Maternal health of "African" women in Île-de-France: racialisation of patients and care trajectory] (2012) 28(2) Revue européenne des migrations internationales 81: the rate of cesarean sections for African migrant women is particularly high and apparently not confirmed as a best practice by scientific data; Dorothée Prud'homme, 'Du "soin global" au traitement discriminatoire. La prise en charge des patientes identifiées comme roms dans un service de gynéco-obstétrique parisien' [From "holistic care" to discriminatory treatment: the management of patients identified as Roma in a Parisian gynecology–obstetrics department] (2016) 29 Terrains & travaux 85.

[44] Jesús Millán Núñez-Cortés, 'Humanización de la medicina, medicina humanizada, medicina humanista: ¿de qué estamos hablando?' [Humanisation of medicine, humanised medicine, humanistic medicine: what are we talking about?] (2018) 19(3) Educación Médica 131.

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by scholars in North America – particularly African American feminist theorists[45] – as an innovative framework for analysing inequalities. The intersectional approach rests on the premise that social positions and identities are multiple and not mutually exclusive. On this basis, it proposes moving beyond the prioritisation of a single axis of inequality – such as race, class, gender, sexuality, migrant status, age, or ability – in favour of an analysis that considers the simultaneous and interrelated effects of various dimensions of social identity.

In recent decades, the intersectional approach has been widely adopted to investigate both health inequalities and violence against women. In the latter context, research has shown that violence against women cannot be reduced solely to gendered power dynamics; rather, it is 'co-constructed with racial and class stratification, heterosexism, ageism, and other systems of oppression, some of which may be more salient within such interactions'.[46]

When applied to the study of health disparities, intersectionality offers a framework for analysing the role of social context in shaping gendered health outcomes. Health inequities are understood to emerge from multi-level, interdependent processes and systems that intersect and mutually reinforce one another.

Within the Italian legal system, targeted measures have recently been adopted to enhance the protection of women's health (gender medicine[47]) and the health of older persons.[48] Yet it

[45] Kimberle Crenshaw, 'Demarginalizing the intersection of race and sex: a black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics' (1989) 1 University of Chicago Legal Forum 139.

[46] Olena Hankivsky, 'Women's health, men's health, and gender and health: implications of intersectionality' (2012) 74 Social Science & Medicine 1713.

[47] Legge 11 gennaio 2018, n. 3, art 1, art 3; Ministero della Salute, 'Piano per l'applicazione e la diffusione della medicina di genere' [Health Ministry, Plan for the Implementation and Dissemination of Gender Medicine] (6 May 2019).

[48] Legge 23 marzo 2023, n. 33, 'Deleghe al Governo in materia di politiche in favore delle persone anziane' [Delegation of Powers to the Government in the Field of Policies in Support of Older People]; decreto legislativo 15 marzo 2024, n. 29, 'Disposizioni in materia di politiche in favore delle persone anziane' [Provisions Concerning Policies in Support of Older People], art 21, arts 25-32. See Teresa Andreani, 'L'assistenza continuativa e integrata alle persone anziane non autosufficienti: prime considerazioni d'insieme intorno alla legge delega 33 del 2023' [Continuous and Integrated Care for Non-Self-Sufficient Older People: Initial Overall Considerations on Law No 33 of 2023] (2024) Corti supreme e salute 207; Fabio Cembrani *et al.*, 'Le politiche a favore degli anziani non autosufficienti' [Policies in Support of Non-Self-Sufficient Older People] in the same journal 535.

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is striking that these two groups are treated as mutually exclusive categories. Although both women and older individuals are recognised as meriting special legal protection, the legislature appears to neglect the possibility of intersecting identities – such as being both elderly *and* female. Still less consideration is given to individuals affected by multiple layers of vulnerability or discrimination, such as elderly migrant women, or women who are both disabled *and* migrants.

The absence of an approach that accounts for the cumulative and intersecting nature of disadvantage fosters conditions in which violent behaviours in the provision of healthcare may arise. It deepens the inherent power asymmetry within the clinical relationship and undermines the personalisation of care.

Conversely, an adequate legal and policy framework for identifying and addressing obstetric and gynaecological violence must take into account the compounding effect of various social and structural factors. Indeed, the interplay of these elements may ultimately render a particular act or omission violent in nature.

4. *Beyond Criminal Liability: The Role of Law in the Eradication of Obstetric and Gynaecological Violence*

Although legal frameworks provide a fundamental lens for identifying and addressing obstetric and gynaecological violence, there remains a 'lack of existing legal tools to address it' in a comprehensive and systemic manner.[49]

In the Italian legal context, case law in this domain is notably scarce and limited to isolated incidents in which the absence of the patient's consent to specific acts or procedures has led to the criminal liability of healthcare professionals under Article 609-*bis* of the Penal Code (sexual violence).[50]

Though limited in number, these cases are particularly

[49] Richardson (n. 21) 5; Kukura (n. 15) 778.

[50] In many cases, victims of obstetric violence report having been 'raped': Richardson (n. 21) 42-43; Kukura (n. 15) 735. On the centrality of consent in matters of sexual freedom and in determining criminal liability: Francesco Macrì, *Verso un nuovo diritto penale sessuale* [Towards a New Sexual Criminal Law] (Firenze University Press 2010) 39; Bartolomeo Romano, *Delitti contro la sfera sessuale* [Crimes against the Sexual Sphere](Giuffrè 2022) 57.

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relevant in affirming the primacy of a patient's sexual autonomy over the professional discretion of medical practitioners. They mark a significant recalibration of the power dynamics inherent in the clinical relationship, with a shift towards female empowerment. Notably, criminal liability has been affirmed even in cases where the act in question constituted a routine component of a gynaecological examination, and the physician erroneously presumed the patient's implied consent based solely on her initial acceptance of the examination itself.[51]

As previously noted, informed consent holds particular legal and ethical weight in the context of gynaecological care, owing to the intimate nature of the interventions involved. The direct impact of such procedures on a person's sexual and bodily autonomy renders the provision of thorough information and the explicit collection of consent indispensable – not only for major interventions, but also for preparatory (e.g., pubic hair removal) or ancillary acts (e.g., catheter insertion).[52] Each component must be subject to separate, informed, and voluntary agreement.

In the field of obstetrics, the issue of consent raises even more complex ethical and legal questions. These typically revolve around the so-called maternal–foetal conflict, in which the well-being of the foetus may be pitted against the mother's sexual freedom and right to self-determination.[53] A paradigmatic example of this conflict – and its legal resolution – can be found in abortion legislation. Here, the pregnant individual's right to make autonomous decisions regarding her body is progressively constrained as the pregnancy advances, in line with the increasing

[51] Cass pen., sez III, n. 18864/2019: a lack of awareness regarding the obligation to obtain the patient's explicit consent is regarded as a lack of knowledge of criminal law, which does not exclude culpability except in cases where the error is deemed unavoidable.

[52] Shelby Harriel-Hidlebaugh, 'Not just non-consensual pelvic exams: the need for expressed consent for all intimate tasks for elective procedures' (2023) 9 Voices in Bioethics 1.

[53] Rodante van der Waal and Inge van Nistelrooij, 'Reimagining relationality for reproductive care: understanding obstetric violence as "separation"' (2022) 29(5) Nursing Ethics 1186; Françoise Baylis, Sandra Rodgers, David Young (n. 42) 97, suggesting the use of 'the more accurate, descriptive phrase, "ethical dilemmas in the care of pregnant women"'; Susan Bewley, 'Restricting the freedom of pregnant women' in Donna L. Dickenson (ed.), *Ethical Issues in Maternal-Fetal Medicine* (Cambridge University Press 2002) 131-146; Michelle Oberman, 'Mothers and doctors' orders: unmasking the doctor's fiduciary role in maternal-fetal conflicts' (2000) 94 Northwestern University Law Review 451.

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protection afforded to the developing foetus.[54]

In certain legal systems, the balancing of the mother's right to bodily autonomy with the interest in safeguarding the welfare of the unborn child can result in the direct or indirect restriction of specific choices concerning the method and setting of childbirth.[55] As a consequence, options such as home

[54] See Mary Ziegler, *Research Handbook on International Abortion Law* (Edward Elgar 2023).

[55] A different case arises where the individual's freedom of self-determination is restricted as a result of its balancing with healthcare professionals' freedom of religion. See, for instance, the Italian debate on abortion rights and healthcare providers' conscientious objection: Alessandra Pioggia, 'L'obiezione di coscienza nei consultori pubblici' [Conscientious Objection in Public Family Planning Clinics] (2015) Istituzioni del Federalismo 138; Alessandra Pioggia, 'Diritto all'aborto e organizzazione sanitaria, ovvero del diavolo nei dettagli' [The Right to Abortion and Healthcare Organisation, or the Devil in the Details] (2016) 28(1) Medicina nei Secoli 165; Maria Cristina Cavallaro, 'Autodeterminazione del paziente, obiezione di coscienza e obblighi di servizio pubblico' [Patient Self-Determination, Conscientious Objection and Public Service Obligations] (2020) PA Persona e Amministrazione 206; Lucia Busatta, 'Insolubili aporie e responsabilità del SSN. Obiezione di coscienza e garanzia dei servizi per le interruzioni volontarie di gravidanza' [Insoluble Aporias and Responsibility of the National Health Service. Conscientious Objection and the Guarantee of Services for Voluntary Termination of Pregnancy] (2017) Rivista AIC 16; Maria Pia Iadicicco, 'La lunga marcia verso l'effettività e l'equità nell'accesso alla fecondazione eterologa e all'interruzione volontaria di gravidanza' [The Long March towards Effectiveness and Equity in Access to Heterologous Fertilization and Voluntary Termination of Pregnancy] 2018) Rivista AIC 56; Bruna Mura and Lorenza Perini, 'Libere davvero? L'effettività della legge n. 194/1978 alla prova: un caso studio nel veronese' [Truly Free? The Effectiveness of Law No. 194/1978 Put to the Test: a Case Study in the Verona Area] (2023) 1S BioLaw Journal - Rivista di Biodiritto 253; Corrado Melega, 'La legge 194: un dibattito riacceso' [Law 194: A Renewed Debate] (2023) 1S BioLaw Journal - Rivista di Biodiritto 27; Giacomo Viggiani, 'Bandi per medici non obiettori. Spunti per una riflessione su aborto e libertà di scelta' [Calls for Non-Objecting doctors: Insights for Reflection on Abortion and Freedom of Choice], (2019) 2 BioLaw Journal - Rivista di Biodiritto 315; Andrea Buratti, 'Sui bandi di concorso per medici non obiettori: problemi applicativi e ricadute sul rapporto di lavoro' [On Competitive Exams for Non-Objecting Doctors: Practical Issues and Impacts on the Employment Relationship] (2017) Quaderni costituzionali 359; Marilisa D'Amico, 'Sui bandi di concorso per medici non obiettori: l'obiezione di coscienza è regola o eccezione in uno stato laico?' [On Competitive Exams for Non-Objecting Doctors: Is Conscientious Objection the Rule or the Exception in a secular state?] (2017) Quaderni costituzionali 350; Valentina Abu Awwad and Nicoletta Vettori, Servizi di interruzione volontaria della gravidanza e obiezione di coscienza: obblighi dell'amministrazione sanitaria e possibili profili di responsabilità penale' [Voluntary Termination of Pregnancy Services and Conscientious

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births or vaginal birth after caesarean section (VBAC) may be discouraged or rendered inaccessible.[56] In some jurisdictions, legislative measures explicitly or implicitly prohibit practices otherwise available to patients – for example, by forbidding obstetric professionals from assisting in home births.[57]

In other cases, restrictive effects on women autonomy arise from clinical guidelines issued by professional associations or healthcare institutions, which discourage particular practices by deeming them inappropriate. However, such recommendations are not always grounded in robust scientific consensus or uncontested evidence; at times, they reflect economic considerations or are shaped by concerns related to defensive medicine. In some legal systems, medical interventions – such as caesarean sections – can be imposed purportedly for the protection of the foetus, even in the absence of clinical emergencies.[58]

Objection: Obligations of the Health Administration and Potential Criminal Liability Issues] (2018) Rivista italiana di medicina legale 9; Nicoletta Vettori, 'Laicità e servizi pubblici. Il caso della sanità' [Secularism and Public Services: The Case of Healthcare] (2020) 3 BioLaw Journal - Rivista di Biodiritto 252; Davide Paris, *L'obiezione di coscienza: studio sull'ammissibilità di un'eccezione dal servizio militare alla bioetica* [Conscientious Objection: A Study on the Admissibility of an Exemption from Military Service to Bioethics] (Passigli 2011) 101; Rinaldo Bertolino, 'Assistenza religiosa, obiezione di coscienza e problemi morali e psicologici nel prisma della struttura ospedaliera' [Religious Assistance, Conscientious Objection and Moral and Psychological Issues in the Hospital Context] (1988) Iustitia 3, republished in Roberto Mazzola, Ilaria Zuanazzi and Maria Chiara Ruscazio (eds.), *Lo spirito del diritto ecclesiale. Scritti scelti di Rinaldo Bertolino* [The Spirit of Canon Law. Selected Writings of Rinaldo Bertolino] (Università degli Studi di Torino – Edizioni Scientifiche Italiane 2022) 344. The US legal system permits the denial of insurance coverage for contraceptive treatments to protect employers' religious freedom: Tamara Roma, 'Erasing care: banning and shadowbanning preventative sexual health in the US' (2025) 2 BioLaw Journal - Rivista di Biodiritto 83.

[56] Elizabeth Kukura, 'Contested care: the limitations of evidence-based maternity care reform' (2016) 31(1) Berkeley Journal of Gender, Law & Justice 241.

[57] ECHR, Second Section, 4 June 2019, *Kosaitė-Čypienė and others v Lithuania*; ECHR, Grand Chamber, 15 November 2016, *Dubská and others v République Tchèque*; ECHR, Second Section, 14 December 2010, *Ternovsky v Hungary*. See Caitlin Mc Cartney, 'Childbirth rights: legal uncertainties under the European Convention after Ternovszky v Hungary' (2014) 40 North Carolina Journal of International Law 543.

[58] Richardson (n. 21) 32-35; Rebecca A. Spence, 'Abandoning women to their rights: what happens when feminist jurisprudence ignores birthing rights' (2012) 19(1) Cardozo Journal of Law and Gender 101; Krista Stone-Manista, 'In the manner prescribed by the state: potential challenges to state-enforced

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In any event, judicial protection does not appear to provide an adequate remedy for the protection and restoration of infringed rights. The same uncertainties surrounding informed consent and women self-determination are mirrored in the cautious recognition of liability for damages. Where no harm to health has occurred – either because the outcome of the treatment was favourable, or because an unfavourable outcome is not attributable to professional negligence – the absence of comprehensive information seldom acquires autonomous legal significance. According to the prevailing case law, liability in damages is acknowledged only where the patient is able to demonstrate that, had they been fully informed, they would have refused the treatment administered. Alternatively, compensation may be awarded where the failure to provide information – whether omitted, incomplete, or inadequate – has resulted in a distinct and additional pecuniary or non-pecuniary loss, 'in terms of subjective suffering and the curtailment of one's psychic and physical autonomy'.[59]

Proving the harmful consequences of obstetric or gynaecological violence may be particularly challenging, especially where the trauma suffered is exclusively psychological in nature. In the field of obstetrics, the dominant cultural approach often subordinates the mother's well-being to that of the foetus, giving legal significance to the former only where demonstrable harm has occurred to the latter. Conversely, the birth of a healthy child tends to obscure the independent relevance of the mother's well-being. This results in a blurring of the distinction – however conceptually possible – between the 'normal' burdens associated with childbirth and the unjust harms arising from unlawful conduct.[60]

The most frequent manifestations of gynaecological violence correspond to forms of psychological abuse, inflicted through demeaning, intimidating, discriminatory, or sexist conduct, through so-called *gaslighting*, or by administering care within settings and circumstances that fail to safeguard the patient's privacy and dignity. Such conduct is inherently difficult to prove

hospital limitations on childbirth options' (2010) 21(5) Cardozo Journal of Law and Gender 469; Lisa Pratt, 'Access to vaginal birth after cesarean: restrictive policies and the chilling of women's medical rights during childbirth' (2013) 20 William & Mary Journal of Women and the Law 105.

[59] Cass Civ, sez III, 11 novembre 2019, n. 28985.

[60] Kukura (n. 15) 786-790.

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and to quantify in terms of harm, rendering criminal proceedings neither an effective nor a proportionate response. Criminal trials risk reproducing or exacerbating the trauma experienced, while also entailing considerable financial and temporal costs. Moreover, in many instances, criminal sanctions may appear disproportionate, particularly where the conduct in question is tolerated – or even implicitly endorsed – by prevailing cultural norms.

Similarly, civil proceedings do not offer an optimal means of redress for victims of such conduct, owing primarily to the evidentiary challenges involved in demonstrating and quantifying the damage suffered.

Conversely, the pervasive fear of incurring civil or criminal liability contributes to the widespread adoption of defensive medicine practices, which are particularly common in the field of obstetrics.[61] Notably, such practices – often implemented without the patient's explicit consent and with the potential to negatively affect the birthing experience – do not appear to produce meaningful improvements in clinical outcomes. A salient example is the routine use of continuous electronic foetal monitoring during labour, which has not been conclusively shown to reduce adverse events.[62] Gynaecologists are among the medical professionals most frequently subjected to allegations of malpractice and litigation, both in Europe and in the United States.[63] This heightened exposure results in the demand for particularly high insurance premiums, thereby imposing a significant financial burden on both individual practitioners and healthcare institutions.[64]

[61] The widespread use of caesarean sections is often attributed to defensive medicine, although the procedure itself carries greater risks than natural childbirth: Kukura (n. 15) 743-747. Restrictions on access to vaginal birth after caesarean (VBAC) are linked to 'concerns about malpractice exposure, high insurance premiums for obstetricians, distortion of the risks associated with VBAC': Judith A. Lothian, 'Risk, safety, and choice in childbirth' (2012) 21(1) The Journal of Perinatal Education 45; Elizabeth Swire Falker, 'The medical malpractice crisis in obstetrics: a gestalt approach to reform' (1997) 4(1) Cardozo Women's Law Journal 15.

[62] Politi (n. 21) 386; Y Tony Yang, David M. Studdert, S.V. Subramanian and Michelle M. Mello, 'Does tort law improve the health of newborns, or miscarry? A longitudinal analysis of the effect of liability pressure on birth outcomes' (2021) 9(2) Journal of Empirical Legal Studies 217.

[63] Data on the US situation is available in Kukura (n. 15).

[64] See Gloria Sdanganelli, 'Verso una funzione assicurativa pubblica nella sanità digitale' [Towards a Public Insurance Role in Digital Healthcare] (2024) Diritto amministrativo 891.

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Of particular interest is the potential invocation of disciplinary liability, which may be interpreted through the lens of restorative justice. This liability may result in disciplinary sanctions imposed either by professional regulatory bodies or by employers, whether public or private.

In the context of the national health service, the obligations underpinning the employment relationship are rooted in the constitutional notion of the 'duties of discipline and honour' incumbent upon those who serve the Nation (Articles 54(2) and 98(1) of the Italian Constitution). The distinctiveness of this relationship arises from the legal relevance of third parties affected by administrative action: although patients are formally extraneous to the employment relationship established with the healthcare institution, the services provided to them represents the fundamental raison d'être of that relationship.[65]

The same concept of 'duty' employed in Article 54(2) supports this construction. Traditionally, the term is associated with situations of 'general' or 'non-correlative' obligation.[66] More precisely, a 'public' or 'fundamental' duty denotes a legal position vis-à-vis the community at large, or more specifically, towards the beneficiaries of administrative activity.[67] In light of the provisions of the Italian Constitution, such duties are embedded within the employment relationship, forming the basis of the exercise of administrative functions.

[65] See Roberto Cavallo Perin and Barbara Gagliardi, 'La dirigenza pubblica al servizio degli amministrati' [Civil Service Leadership in the Service of Citizens] (2014) Rivista trimestrale di diritto pubblico 309, 312; Roberto Cavallo Perin, 'Codice di comportamento e sistema disciplinare' [Code of Conduct and Disciplinary System] in Alfredo Corpaci, Riccardo Del Punta and Maria Paola Monaco (eds.), *La riforma del lavoro pubblico. Riflessioni a due anni dalla legge Madia* [Public Sector Labour Reform. Reflections Two Years after the Madia Law] (FrancoAngeli 2018) 149; Barbara Gagliardi, *Il concorso pubblico come funzione amministrativa* [The Public Competitive Examination as an Administrative Function] (Università di Torino - ESI 2024) 123.

[66] Santi Romano, 'Doveri. Obblighi' [Duties. Obligations] in *Frammenti di un dizionario giuridico* [Fragments of a Legal Dictionary] (Giuffrè 1983) 104-105; Alberto Romano, 'I soggetti e le situazioni giuridiche soggettive del diritto amministrativo' [Subjects and Subjective Legal Situations in Administrative Law] in Leopoldo Mazzarolli *et al.* (eds.), *Diritto amministrativo* [Administrative Law], vol I (Monduzzi 2005) 162.

[67] Giorgio Lombardi, 'Doveri pubblici (dir cost)' [Public Duties (Constitutional Law)] in Enciclopedia del diritto, agg VI (Giuffrè 2002) 358; Gregorio Peces Barba Martínez, 'Diritti e doveri fondamentali' [Fundamental Rights and Duties] in Digesto delle discipline pubblicistiche, vol V (Utet 1990) 139.

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If the duties of discipline and honour are framed as serving the interests of third parties, it becomes difficult to deny the legitimacy of the patient to challenge their breach – potentially even through direct participation in disciplinary proceedings.[68]

In this respect, disciplinary proceedings may be construed as a potential forum for the application of restorative justice, reflecting a broader evolution which, until now, has largely confined the relevance of such practices to the sphere of criminal law.[69]

The integration of restorative justice programs into disputes concerning healthcare liability is by no means unprecedented. In other contexts, scholars have already observed the methodological affinities between narrative medicine and restorative justice: both are informed by a 'morality of attention' and a commitment to active listening. Both reject the standardisation of interactions between stakeholders in favour of a heightened focus on the individual and their lived experience.[70] Restorative justice is traditionally associated with characteristics that align closely with the concept of the therapeutic alliance, particularly the emphasis on dialogue and empathy between the parties involved.

It has been said that restorative justice 'promotes healing'; it represents a relational form of justice, strongly oriented towards the victim and the restoration of social harmony. In addition to the victim and the perpetrator, the model also engages the wider community. Such involvement in the conflict-resolution process ensures that the outcome is not only responsive to the needs of the immediate parties but also reflective of broader communal interests.

Even though its application in cases of sexual violence remains contentious,[71] restorative justice may hold particular significance

[68] Roberto Cavallo Perin and Barbara Gagliardi, 'Status dell'impiegato pubblico, responsabilità disciplinare e interesse degli amministrati' [Status of the Public Employee, Disciplinary Responsibility and the Interest of Citizens] (2009) Diritto amministrativo 53.

[69] See Francesco Parisi, *Giustizia riparativa e sistema penale* [Restorative Justice and Criminal Law] (Giappichelli 2025); Lindsey Pointer, *The Restorative Justice Ritual* (Routledge 2022).

[70] Claudia Mazzucato and Arianna Visconti, 'Dalla medicina narrativa alla giustizia riparativa in ambito sanitario: un progetto "integrato" di prevenzione delle pratiche difensive e di risposta alla colpa medica' [From Narrative Medicine to Restorative Justice in Healthcare: An 'Integrated' Project for Preventing Defensive Practices and Addressing Medical Negligence] (2014) 3 Rivista italiana di medicina legale 847.

[71] See Alice Ollino and Marco Pertile, 'Restorative justice as a tool to address violence against women? An assessment of the Italian case in light of

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for victims of obstetric and gynaecological violence. Indeed, it offers pathways to *reparation* that trascend the conventional compensatory logic grounded in the equivalence between harm suffered and financial compensation.

From the perspective of healthcare institutions, it is the involvement of the community that proves most valuable. Restorative justice facilitates the identification of errors, the analysis of their root causes, and the development of systemic responses capable of preventing recurrence. It thereby supports both the empowerment of victims and the transformation of prevailing cultural norms within professional communities.

4. *Better safe than sorry. The organisational approach towards obstetric and gynaecological violence*

As already noted earlier in this article, professional associations in the obstetric and gynaecological field have expressed their opposition to the use of the term 'violence' to designate the wide spectrum of episodes mainly related to obstetric and gynaecological violence.[72] It is argued that characterising predominantly unintentional conduct as *violence* risks undermining the trust that underpins the therapeutic alliance. Such terminology, critics contend, may encourage prejudice and hostile attitudes towards healthcare professionals, without yielding commensurate benefits.[73]

Admittedly, many forms of violent conduct in these contexts stem from adverse working conditions and dysfunctional organisational structures: excessive workloads and fatigue; insufficient support in administrative or instrumental tasks; inadequate bed availability; lack of appropriate clinical protocols;

the practice of international monitoring bodies' (2024) 33 Italian Yearbook of International Law 349; Paul Gavin *et al.*, 'Restorative justice in cases of sexual violence: current and future directions in the UK' (2023) 26(4) Contemporary Justice Review 393; Alexa Sardina and Alissa R. Ackerman, 'Restorative justice in cases of sexual harm' (2022) 25(1) CUNY Law Review.

[72] On the defensive reaction to the term obstetric violence by healthcare workers within the obstetric institution, see van der Waal, van Nistelrooij and Leget (n. 3) 157; Priscille Sauvegrain *et al.*, 'Avenues for measuring and characterising violence in perinatal care to improve its prevention: a position paper with a proposal by the National College of French Midwives' (2023) 116 Midwifery 103520.

[73] See n. 14.

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deficient training; understaffing; the *culture of silence* embedded in the hierarchical structure of healthcare teams; inadequate or obsolete medical equipment; and architectural environments that fail to safeguard patient privacy and dignity.

It is therefore at the organisational level – and in its regulatory discipline – that legal scholarship should principally focus its contribution to the mitigation of obstetric and gynaecological violence. As the Italian Constitutional Court has affirmed in a seminal decision, there exists a close interdependence between organisation and rights: no organisation is without the function of protecting a right, and no right can be guaranteed without an enabling organisation. The structure and design of the organisation, no less than its mere existence, determine the system's ability to safeguard individual rights.[74]

Healthcare institutions can play a pivotal role in making such episodes visible, thereby enabling critical reflection on the systemic factors that perpetuate them. To that end, institutions ought to establish accessible reporting mechanisms through which patients can communicate experiences of violent or perceived violent conduct. At the same time, it is necessary to ensure greater transparency in disciplinary proceedings, enabling patients to be informed of the outcomes of their complaints. This, in turn, may reinforce public trust in healthcare services and in institutional commitment to accountability and prevention.

Current legislation on informed consent explicitly defines the act of listening as a component of *care time*. It has rightly been observed that this entails the implementation of 'organisational measures that ensure the availability of personnel dedicated to listening to patients and addressing their needs, concerns and

[74] Corte cost., 27 novembre 1998, n. 383. See Vittorio Bachelet, *Legge, attività amministrativa e programmazione economica* [Law, Administrative Activity, and Economic Planning] (Giuffrè 1961) 912; Mario Nigro, *Studi sulla funzione organizzatrice della pubblica amministrazione* [Studies on the Organising Function of Public Administration] (Giuffrè 1966) 109, 117; Roberto Cavallo Perin, 'L'organizzazione delle pubbliche amministrazioni e l'integrazione europea' [Public Administration Organisation and European Integration] in Leonardo Ferrara and Domenico Sorace (eds.), *A 150 anni dall'unificazione amministrativa italiana* [150 Years after Italian Administrative Unification] vol I (Firenze University Press 2016) 13; Alessandra Pioggia, *La competenza amministrativa. L'organizzazione tra specialità pubblicistica e diritto privato* [Administrative Competence: Organisation between Public Law Specialisation and Private Law] (Giappichelli 2001) 179.

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anxieties', also as a means of preventing aggression against healthcare workers.[75]

Organisational standards contribute not only to ex post remediation but, more importantly, to the prevention of harm. By analysing the organisational roots of violent practices, it becomes possible to identify even minor reforms capable of transforming the contexts in which care is delivered.

Addressing organisational conditions enables the redefinition – through regulation or clinical guidelines – of the temporal, spatial, procedural and professional parameters conducive to non-violent care. New norms and standards could promote practices that are more welcoming, more attentive to patient voice, and better aligned with evolving scientific knowledge.[76] They could, for instance, specify the training required to engage effectively with migrant women, elderly patients with cognitive decline, and persons with disabilities. They might also prescribe the physical standards for examination rooms and equipment and distinguish between genuinely necessary interventions and those that are unduly invasive or coercive.

Finally, ensuring sufficient time for communication necessitates adequate staffing and work conditions. In the Italian context, at the very least, this requires a structural overcoming of the chronic underfunding of the national health service.

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Maria T.R. Borges, 'A violent birth: reframing coerced procedures

[75] Marina Di Lello Finuoli, 'Introduzione al focus "La prevenzione delle aggressioni al personale sanitario: il ruolo del diritto penale" - WHO CARES FOR THOSE WHO CARE?' [Introduction to the Focus 'Preventing Assaults on Healthcare Personnel: The Role of Criminal Law'] (2023) 4 Rivista italiana di medicina legale 815.

[76] See the chapter by Sarah. Gino and Elena Rubini in this volume.

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ISBN 978-88-495-6175-3

Silvia Carabelli

Giving Pain a Name: the Emergence of Obstetric and Gynaecological Violence in Italy

1. *Introduction*

Obstetric and gynaecological violence emerged in Italian public debate only recently, but it represents the contemporary manifestation of a structural tension that traversed for decades the relationship between women, bodies non-conforming to the sex-gender binary, and healthcare institutions. Although both fall within the same constellation of power relations that traverse the clinician-patient relationship, in Italy the two terms 'obstetric violence' and 'gynaecological violence' emerged at different times and in different ways.

Obstetric violence was first named in Latin America in the early 2000s, thanks to feminist groups and associations that built a lexicon capable of making visible the harmful practices experienced in delivery rooms.[1] This trajectory directly

[1] Patrizia Quattrocchi, 'Violenza ostetrica. Le potenzialità politico-formative di un concetto innovativo' [Obstetric Violence: The Political and Educational Potential of an Innovative Concept] (2019) 7(1) EtnoAntropologia 125 <https://doi.org/10.1473/ea.v7i1.307>.

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influenced the Italian context as well, where in 2016 the social media campaign *'Basta tacere: le madri hanno voce'* ('No More Silence: Mothers Have a Voice') collected, anonymously, hundreds of women's testimonies about the violence suffered during pregnancy, childbirth, and the puerperium.

Gynaecological violence, by contrast, is a term still little used in Italian public discourse, but it began to circulate particularly after the 2021 *'Sensibile-Invisibile'* ('Sensitive-Invisible') campaign, dedicated to chronic illnesses that predominantly affect people with a vulva and a uterus, such as vulvodynia, pudendal neuropathy, endometriosis, and fibromyalgia. The testimonies that emerged brought back to the fore the issue of sexism in biomedical research and clinical practice, showing how the problem is not confined to the moment of birth, but runs through the entire span of sexual and reproductive health pathways.

In both trajectories – obstetric and gynaecological – the impetus for change has come from women: from lives marked by pain, from dissatisfaction with the care received, and from the capacity to transform this experience into collective action, into shared languages and into political claims. The chapter reconstructs this historical-philosophical-political genealogy, interweaving written and oral sources and focusing on three interconnected levels: feminist and transfeminist mobilization practices; the institutional and regulatory process; the epistemic tension between medical knowledge and situated counter-knowledge.

2. *From viral testimonies to data collection: the birth of the Observatory on Obstetric Violence*

The *'Basta tacere'* campaign, launched on 4 April 2016 via a dedicated Facebook page, represents the turning point for the public emergence of obstetric violence in Italy. For fifteen days, women were invited to share anonymously their experiences of birth care in the form of 'photo-signs', using the hashtag #*bastatacere*. In a short time, the campaign went viral, gathering thousands of testimonies and hundreds of thousands of daily views.[2]

[2] Elena Skoko and Alessandra Battisti (eds.), #*bastatacere Report. Campagna mediatica sulla violenza ostetrica 4-19 aprile 2016* [#bastatacere Report. Media campaign on obstetric violence] (OVOItalia 2016) 22.

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Obstetric violence is understood by the promoters as a set of physical, verbal, or psychological abuses that women may suffer during pregnancy, childbirth, or the puerperium, perpetrated intentionally or unintentionally by healthcare personnel. The consequences are not limited to the single event but affect the perception of expropriation of one's own body, the loss of decision-making autonomy, and the rupture of the relationship of trust with the health system.[3]

The campaign, conceived and coordinated by Elena Skoko and Alessandra Battisti, was able to rely on the collaboration of numerous mothers' associations already active across the country.[4] The media success, with coverage in the main Italian newspapers and leading magazines was also amplified by the concurrent legislative process: the campaign was directly connected to a law proposal on obstetric violence, which gave it institutional visibility and helped it resonate among women, journalists, politicians, and health professionals alike. This convergence shows how individual experiences find resonance only when they are inscribed within a collective framework and endowed with a name capable of interpellating personal experiences, the media, and institutions.

At the close of the campaign, the promoters and the associations involved founded *OVOItalia* (Observatory on Obstetric Violence in Italy), a civil-society initiative that networked with observatories in other countries (Argentina,

[3] Meghan A. Bohren *et al.*, 'The mistreatment of women during childbirth in health facilities globally: a mixed-methods systematic review' (2015) 12(6) PLoS Medicine e1001847 <https://doi.org/10.1371/journal.pmed.1001847>; Council of Europe, Resolution 2306 (2019) 'Obstetrical and gynaecological violence' <https://pace.coe.int/en/files/28236#trace-4>; Patrizia Quattrocchi, *Obstetric Violence in the European Union: Situational Analysis and Policy Recommendations* (European Commission 2024) <https://data.europa.eu/doi/10.2838/440301>.

[4] Associations that collaborated with or supported the social media campaign: La Goccia Magica, Nanay, Ass. Centro Alma Mater, Forum PartoNaturale, Ciao Lapo Onlus, Rinascere al Naturale, Comitato per la Buona Nascita, Innecesareo Onlus, Città delle Mamme Frascati, Cerchidarcobaleno. Associations that supported the campaign. MAMI - Movimento Allattamento Materno Italiano, Associazione Crescere Insieme, Pariedipiù, Il Cerchio Rosa, Ostetrica Amica, Mammadoula, Terra Prena, Il Cerchio Rosa, Genitori Channel, Ass. Parto Naturale, Casa maternità Prima Luce, Associazione Palaver, Ass. Nascere Insieme, Pachamamma, Midwife in UK, Mama Kreis, Comitato CoRDiN, Zoè Centro Salute e Nascita, Progetto Aisha del CAIM (Coordinamento delle Associazioni Islamiche di Milano e Monza e Brianza), AIED Pisa.

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Chile, Colombia, Spain, France).[5] In 2017 *OVOItalia* commissioned from DOXA the first national survey, *'Le donne e il parto'* ('Women and Childbirth'), on a representative sample of mothers with children aged 0-14. The results outline a critical picture: 21% of women giving birth for the first time report having suffered some form of obstetric violence; more than half experienced episiotomy, and among these 61% stated that they had not given their informed consent; 27% reported inadequate or insufficient care; a significant proportion highlighted shortcomings in information, pain management, and privacy. Six per cent of respondents stated that they had given up further pregnancies because of a traumatic first birth.[6]

Although it later attracted criticism and legal challenges from healthcare professionals, the survey provides the first structured statistical analysis on a nationally representative sample in Italy of practices and perceptions attributable to obstetric violence, showing how excessive medicalization and hospital routines can be experienced as intrusive and injurious to personal autonomy.

3. *Biographies, networks, and global campaigns: the birth of the public discourse on obstetric violence*

The recent genealogy of obstetric violence in Italy intersects with two key figures: Elena Skoko and Alessandra Battisti, founders of *OVOItalia*. Since, to date, the existing documentation is patchy and insufficient for a historical reconstruction of events, I chose to interview them and then interwove oral and written sources to provide the most faithful picture possible.

Elena Skoko, Croatian, trained in Italy and now a lecturer and researcher in public health in Australia, before arriving in academia was a multidisciplinary artist and turned her own childbirth – experienced as a positive experience, in water, in Bali, with her partner and a trusted midwife – into narrative and political project.[7] The book presentation tour in Italy, starting in

[5] InterOvo, *InterOvo Statement 8th March 2016* <www.elpartoesnuestro.es/sites/default/files/recursos/documents/interovo_statement_8th_march_2016.pdf>.

[6] *Indagine Doxa-OVOItalia* (2017) <ovoitalia.wordpress.com/indagine-doxa-ovoitalia>.

[7] Elena Skoko, *Memorie di un parto cantato: una nascita gentile con Ibu Robin Lim* [Memories of a Sung Birth: A Gentle Birth with Ibu Robin Lim] (Phasar Edizioni 2013).

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2013, coincidentally enabled her to collect stories of traumatic birth and to meet numerous mothers' associations.[8]

A decisive step is the encounter with Alessandra Battisti, a lawyer who personally experienced obstetric violence and oriented her commitment towards the promotion of human rights during childbirth. The two met in Rome in 2012 during the screening of the documentary *'Freedom for Birth'*,[9] which recounts the case of the Hungarian midwife Ágnes Geréb and the judgment *'Ternovszky v. Hungary'* (2010), in which the European Court of Human Rights recognizes women's right to choose the conditions of their childbirth as part of the right to respect for private life (Art. 8 ECHR).[10]

Skoko and Battisti, consolidating their alliance on the basis of their shared social and political commitment, became advocates for Italy within the international initiative *Human Rights in Childbirth*; they translated into Italian the World Health Organization (WHO) document *'The prevention and elimination of disrespect and abuse during facility-based childbirth'*[11] and the report by UN Special Rapporteur Dubravka Šimonović[12] on violence against women in reproductive health services, with particular reference to obstetric violence.[13]

In addition to creating the network of Italian associations, the weaving of international relationships with Latin America, the United States, and other European countries – Spain in

[8] Elena Skoko, 'Interview (video call)', 11 August 2025.

[9] *Freedom for Birth*, documentary directed by T. Harman and A. Wakeford (2012) 60 minutes <https://vimeo.com/ondemand/freedomforbirth>.

[10] European Convention on Human Rights (1950), <www.coe.int/en/web/conventions/full-list?module=treaty-detail&treatynum=005>.

[11] World Health Organization, *The Prevention and Elimination of Disrespect and Abuse during Facility-Based Childbirth* (WHO/RHR/14.23, 14 September 2014) <https://www.who.int/publications/i/item/WHO-RHR-14.23>.

[12] Skoko and Battisti also contributed to the Special Rapporteur's inquiry, submitting a report on obstetric violence in Italy and being audited in that capacity.

[13] Sanità Informazione, 'Presentato a Roma il Rapporto dell'ONU sulla violenza ostetrica' (29 November 2019) Sanità Informazione, (29 November 2019) <www.sanitainformazione.it/presentato-a-roma-il-rapporto-dellonu-sulla-violenza-ostetrica>; Dubravka Šimonović, *A Human Rights-Based Approach to Mistreatment and Violence against Women in Reproductive Health Services with a Focus on Childbirth and Obstetric Violence* (Report of the Special Rapporteur on Violence against Women and Girls, its Causes and Consequences, A/74/137, UN, 11 July 2019) <digitallibrary.un.org/record/3823698>.

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particular[14] – was crucial, situating the Italian experience within the broader global movement to repoliticise childbirth, in continuity with Latin American struggles for the humanization of care along the birth pathway.[15] The countries of Latin America, in fact, were the first in the world to legislate on obstetric violence, starting in the 2000s, but above all the first, since the 1980s, to put pressure on the WHO for a demedicalisation of childbirth.[16]

Only ten years later, in 2014, the internationally coordinated campaign *#breakthesilence* on abuses and traumas suffered in maternity wards spread across several countries, including the United States.[17] Elena Skoko was herself part of this initiative, which directly informed the conception of the *#bastatacere* campaign. The second source of inspiration, as we shall see in the next paragraph, came directly from the Italian feminist movement of the 1970s.[18]

The online campaigns carried out in various countries around the world since the 2000s, the birth of numerous national observatories on obstetric violence, the shared practices of awareness-raising, dissemination, and monitoring, and above all the shared theoretical elaboration around the concept of obstetric violence, are all manifestations of the coordination and collaboration among the many groups of activist mothers engaged on an international scale.

4. *Historical genealogies: the feminisms of the 1970s and childbirth as a political issue*

The denunciation of obstetric violence is not an absolute novelty in the Italian landscape. As early as 1973 the *Movimento di lotta femminista di Ferrara* published the pamphlet: '*Basta tacere! Testimonianze di donne su parto, aborto, gravidanza e maternità*' ('No more silence! Women's Testimonies on

[14] El Parto es Nuestro (2003) <www.elpartoesnuestro.es>.

[15] Alessandra Battisti, 'Interview (telephone)', 27 August 2025.

[16] Patrizia Quattrocchi, 'Obstetric violence observatory: contributions of Argentina to the international debate' (2019) 38(8) Medical Anthropology 762 <doi.org/10.1080/01459740.2019.1609471>; World Health Organization, 'Appropriate technology for birth' (1985) 8452 Lancet 436.

[17] *#breakthesilence*, <www.facebook.com/ImprovingBirth> (2014).

[18] Elena Skoko, 'Interview (video call)' (n. 8).

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Childbirth, Abortion, Pregnancy, and Motherhood'), which gathers accounts of verbal, physical, and sexual violence suffered in the delivery room and during gynaecological examinations.[19] Starting from these testimonies, the Ferrara group, rooted firstly in the national network *Lotta femminista* (1971-1974), and then in the international network *Wages for Housework* (*Salario al Lavoro Domestico*, 1974-1979), mainly focused on wages for domestic labour,[20] engaged in a protracted dispute against the maternity ward of the Sant'Anna hospital, documented in the book: '*Lotta all'ospedale di Ferrara. Dietro la normalità del parto*' ('Struggle at the Ferrara Hospital: Behind the Normality of Childbirth').[21]

The practices implemented between 1972 and 1978 – collecting and publishing testimonies, demonstrations in front of the hospital, collective complaints to the public prosecutor's office, public contestation of hospital doctors, building alliances with nurses, midwives, female medical students, and women doctors – anticipate many elements that we find in the *OVOItalia* episode: the critique of the naturalisation of women's suffering, the dignity of the woman giving birth, respect for autonomy, transparency and sharing in clinical decisions, the politicisation of the care relationship, and open conflict with the medical profession and institutions.[22]

The testimonies collected by the group revealed a paternalistic

[19] Movimento di lotta femminista di Ferrara, *Basta tacere! Testimonianze di donne su parto, aborto, gravidanza e maternità* [Stop Keeping Silent! Women's Testimonies on Childbirth, Abortion, Pregnancy, and Motherhood] (1973) <https://www.ais-sociologia.it/wp-content/uploads/2024/06/basta_tacere.pdf>.

[20] Mariarosa Dalla Costa, *Potere femminile e sovversione sociale* [Female Power and Social Subversion] (Marsilio 1972) <www.bibliotechecivichepadova.it/it/collezioni-biblioteca/dalla-costa/mariarosa-dalla-costa-potere-femminile-sovversione-sociale-il-posto-della-donna-selma-james-venezia-marsilio-marzo>; Fiamma Lussana, *Il movimento femminista in Italia: esperienze, storie, memorie (1965-1980)* [The Feminist Movement in Italy: Experiences, Histories, Memories (1965-1980)] (Carocci 2012); Antonella Picchio and Giuliana Pincelli, *Una lotta femminista globale: l'esperienza dei gruppi per il Salario al lavoro domestico di Ferrara e Modena* (FrancoAngeli 2019).

[21] Gruppo Femminista per il Salario al Lavoro Domestico di Ferrara (ed.), *Lotta all'ospedale di Ferrara. Dietro la normalità del parto* [Struggle at the Ferrara Hospital. Behind the Normality of Childbirth] (Marsilio 1978) <www.bibliotechecivichepadova.it/it/collezioni-biblioteca/dalla-costa/dietro-normalita-parto-cura-gruppo-femminista-il-sld-ferrara-venezia-marsilio-1978>.

[22] Gruppo Femminista per il Salario al Lavoro Domestico di Ferrara (n. 21).

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and coercive care system marked by physical and symbolic violence: episiotomies without anaesthesia, verbal humiliations, lack of consent, painful treatments carried out without explanations. The activists of *Lotta Femminista*[23] read these practices as part of a broader apparatus of social control over women's bodies, rooted in the sexual division of labour, the devaluation of domestic work, and the delegitimization of women's suffering. Their analyses linked the physical and psychological distress of women giving birth to material living conditions, the care burden, and the absence of reproductive rights.[24]

The Ferrara episode, however, is situated in a historical context different from the present, marked at the time by the clandestine nature of abortion and by the centrality of the struggle for the legalization of voluntary termination of pregnancy, subsequently achieved with Law n. 194/1978.[25] It is plausible that the urgency of the problem of clandestine abortions and the institutional debate of those years obscured, in

[23] *Lotta Femminista* is not the only Italian feminist formation dealing with health in the 1970s: there are also, for example, the *Gruppi di Salute per la Donna*, which draw on other traditions of feminist thought (Luciana Percovich, *La coscienza nel corpo: donne, salute e medicina negli anni Settanta* [Consciousness in the Body: Women, Health, and Medicine in the 1970s] (Fondazione Badaracco 2005). The *Lotta femminista* groups, active in many Italian cities, including Padua, Ferrara's principal point of reference, are distinguished by the way they intertwine feminism and Marxism, have a strong internal organisational structure, are networked nationally and internationally and, finally, are strongly oriented towards political and social action rather than consciousness-raising (Lussana (n. 20) 170-177). *Lotta femminista* recognised and problematised the social care role reserved for women towards children, husbands, the elderly, the sick and the disabled, pinning them to the role of mothers in every sphere of social life, work included (Dalla Costa (n. 20); Picchio and Pincelli (n. 20)). On the basis of these analyses, the proposal to recognise the invisible, taken-for-granted work carried out daily by women within the domestic sphere as work in its own right, and therefore to be remunerated (Dalla Costa (n. 20); Picchio and Pincelli (n. 20)). Unlike the *Gruppi per la Salute della Donna*, inspired by self-help practices imported from the United States (Luciana Percovich (n. 23); Boston Women's Health Book Collective (eds.), *Noi e il nostro corpo* [Ourselves and Our Bodies] (Feltrinelli 1977), *Lotta Femminista* places the issue of health within the broader "political perspective of total refusal" of the exploitation of women, inside and outside the domestic sphere (Gruppo Femminista per il Salario al Lavoro Domestico di Ferrara (n. 21) 8).

[24] Gruppo Femminista per il Salario al Lavoro Domestico di Ferrara (n. 21).

[25] L. n. 194/1978, "Norme per la tutela sociale della maternità e sull'interruzione volontaria della gravidanza" [Provisions for the Social Protection of Motherhood and on the Voluntary Termination of Pregnancy].

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the long term, the struggle against the maternity ward conducted by the Ferrara group. Moreover, the fact that this story unfolded in a city of the 'periphery' with respect to the major centres of Italian feminism (such as Rome, Milan, Turin, Padua, etc.) probably contributed to its remaining largely unacknowledged even in feminist historiographical reconstructions of the Italian movement.[26] As Antonella Picchio has argued with specific

[26] Although the pamphlet "*Basta tacere*" published by the Ferrara group in 1973 is cited in three historical works - Luciana Percovich, *La coscienza nel corpo. Donne, salute e medicina negli anni Settanta* (82-90); Fiamma Lussana, *Il movimento femminista in Italia. Esperienze, storie, memorie* (p. 176); and Nadia Maria Filippini, *Generare, partorire, nascere: una storia dall'antichità alla provetta* (p. 292) – the history of the subsequent struggle by the basta group against the city hospital named after Sant'Anna has, to date, not yet been brought to light by any historian. Brief references can be found in Percovich, (pp. 201, 266) Lussana (p. 176), and Picchio and Pincelli (n. 20). By contrast, no reference is found in the following texts: Françoise Thébaud (ed.), *Storia delle donne in occidente. Il Novecento* [History of Women in the West: The Twentieth Century] (Laterza 1992); Perry R. Willson, *Italiane: biografia del Novecento* [Italian Women: A Biography of the Twentieth Century] (Laterza 2011); Maud Anne Bracke, *La nuova politica delle donne. Il femminismo in Italia, 1968-1983* [The New Politics of Women: Feminism in Italy, 1968-1983] (Edizioni di Storia e Letteratura 2019); Silvia Salvatici (ed.), *Storia delle donne nell'Italia contemporanea* [History of Women in Contemporary Italy] (Carocci 2022); and Paola Stelliferi and Stefania Voli (eds.), *Anni di rivolta: nuovi sguardi sui femminismi degli anni Settanta e Ottanta* [Years of Revolt: New Perspectives on the Feminisms of the 1970s and 1980s] (Viella 2023).

I owe the discovery of the path undertaken by the Ferrara group to the "*Mariarosa Dalla Costa*" archive (for a brief reconstruction of Mariarosa Dalla Costa's biographical profile, see: Irene Pessot, 'Dalla Costa Mariarosa', (2025) <www.enciclopediadelledonne.it>), donated in 2011 by the intellectual and activist of the *Lotta Femminista* group to the *Biblioteche Civiche di Padova*, where it is preserved, digitised, and today largely available online (<www.bibliotechecivichepadova.it/it/collezioni-biblioteca/dalla-costa>). In particular, the archive contains the book *Lotta all'ospedale di Ferrara. Dietro la normalità del parto*, published in 1978 by the group itself shortly before its dissolution. The book, cited in this paragraph, is, to date, the only one I have been able to locate that makes it possible to reconstruct the historical facts of those years, thanks also to the collection of various direct sources, such as documents and leaflets produced by the Ferrara group, letters and documents from other groups with which they were in contact – also on an international scale – and newspaper headlines of the time. The aforementioned volume by Antonella Picchio and Giuliana Pincelli likewise reproduces part of the primary sources gathered in the 1978 book (Picchio and Pincelli (n. 20) 119-157). Finally, I wish to thank Carolina Peverati, long-standing activist of the Ferrara group, whose oral testimony has been essential in corroborating the reconstruction proposed here (Carolina Peverati, 'Interview (video call)', 20 April 2026).

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reference to the Wages for Housework groups, Italian feminist historiography has tended to filter the political experiences of the 1970s through the subsequent hegemony of the so-called pensiero della differenza ('thought of sexual difference'), producing a partial and selective reconstruction in which the most materially grounded struggles – those centred on bodies, reproductive labour and the institutional apparatuses that govern them – have been particularly liable to erasure.[27] The fate of the Ferrara mobilization against the Sant'Anna maternity ward can be read, in this sense, as one more instance of that broader pattern of historiographical forgetting.

It is precisely this historiographical gap that OVOItalia's explicit invocation of the 1973 pamphlet works to counter: the choice of the slogan *'Basta tacere'* for the 2016 campaign aims to recognize the continuity of denunciations and the persistence of forms of obstetric violence over time.[28] The contemporary emergence of obstetric and gynaecological violence in Italy cannot be understood without returning to the feminist movements of the 1970s, which were the first to thematize the material and symbolic conditions of care in childbirth and abortion and, more generally, of gynaecological experience, denouncing the model of androcentric and patriarchal medicine.[29]

5. *The transfeminist vision of Non Una Di Meno and OVOItalia's position between continuity and divergences*

2016 is also the year of a new emergence of Italian feminism on the public scene, with the birth of the network *Non Una Di Meno.*[30] The large demonstration of 26 November in Rome – around 250,000 people in the streets against male violence against

[27] Picchio and Pincelli (n. 21) 42-49.

[28] Skoko and Battisti (n. 2). The continuity was also sustained by Elena Skoko's personal connection with Mariarosa Dalla Costa, one of the leading figures and theorists of that movement Lotta femminista – a reminder of the irreplaceable role of oral transmission in the recovery of feminist counter-histories.

[29] Percovich (n. 23).

[30] The political movement *Non Una Di Meno* is not representative of all contemporary feminisms currently present in Italy, but, if we are speaking of mass visibility in the squares, it is the only movement currently active. From the very outset it was born with an international scope: the very name was borrowed from *Ni Una Menos* Argentina, a feminist movement that subsequently spread to many countries in Latin America.

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women and gender-based violence – and the subsequent national assemblies led to the drafting of the '*Abbiamo un piano. Piano femminista contro la violenza maschile sulle donne e la violenza di genere'* ('Feminist Plan Against Male Violence Against Women and Gender-Based Violence', from here on, *'Feminist Plan'*).[31] In this document, obstetric violence is thematized as a specific form of expropriation of the body and reproductive processes, due to over-medicalization, disrespectful treatment, non-consensual practices, and moral judgement during childbirth and abortion.

Non Una Di Meno adopted from the outset a transfeminist framework, rejecting gender binarism and inscribing obstetric and gynaecological violence within a broader framework of structural violences that affect women and all subjectivities dissenting from the heterosexual and cisgender norm.[32] From the movement's perspective, the experiences of childbirth and abortion are two sides of the same problem: control over the reproductive capacity of women and people with a uterus. The issue of obstetric violence is thus anchored within the broader discourse on sexual and reproductive health and on the right to self-determination of all bodies, including LGBTQI+ bodies.

The relationship with *OVOItalia* is marked by mutual acquaintance but also by divergences in strategy and theoretical approach. On the one hand, *OVOItalia* chooses to focus on childbirth and not to link its action directly to the issue of abortion, fearing that motherhood would become an 'appendix' to other discourses.[33] On the other hand, *Non Una Di Meno*'s transfeminist perspective is not shared by *OVOItalia*.

The lack of political convergence does not, however, cancel out the resonances: many midwives active in the movement

[31] Degender Communia (eds.), *Ni una menos. Dichiariamo guerra alla violenza di genere* [Ni una menos. We Declare War on Gender-Based Violence] (Alegre 2016); Non Una Di Meno, *Abbiamo un piano. Piano femminista contro la violenza maschile sulle donne e la violenza di genere* [We Have a Plan. A Feminist Plan Against Male Violence Against Women and Gender-Based Violence] (2017) <https://nonunadimeno.wordpress.com/wp-content/uploads/2017/11/abbiamo_un_piano.pdf>.

[32] Transfeminism is a philosophical and political positioning that arose in the 2000s from the liberation struggles of trans people; it rejects gender binarism, viewing the latter as a social construct arbitrarily assigned at birth and as a tool of domination and control exercised over all subjectivities, but above all over those deemed deviant because non-binary, so as to enforce the norm that divides the world into males and females.

[33] Skoko (n. 8).

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bring the issue of obstetric violence into the streets.[34] At the same time, the transfeminist network helps to shift the gaze from the individual experience to the institutional power regime that runs through the entire healthcare system, marked by sexism, racism, and heterocisnormativity.[35] Conversely, what Skoko has stated remains true, namely that *Non Una Di Meno* has over the years concentrated its political action predominantly on the defence of voluntary termination of pregnancy, also calling for moving beyond Law n. 194/1978 because it is insufficient to protect people who choose to have an abortion.

6. *The institutional pathway of obstetric violence in Italy*

If one were to consider exclusively the official documents available on parliamentary and government portals, the reconstruction of the institutional pathway relating to obstetric violence would be extremely reductive and fragmentary. Understanding the process that led to its temporary emergence in political debate, by contrast, requires a reconstruction that goes beyond formal documentation, including an account of what occurred in informal settings and behind the scenes of parliamentary and ministerial dynamics.

The entry of obstetric violence into the institutional debate formally took place in 2016 with the Zaccagnini bill, drafted in collaboration with Alessandra Battisti and Elena Skoko of *OVOItalia.*[36] The text attempts to translate into law the aforementioned WHO statement on the prevention and elimination of abuse and disrespect during childbirth in healthcare facilities,[37] proposing clinical obligations and prohibitions based on human rights and introducing the specific criminal offence of obstetric violence, with the corresponding framework for compensation.[38]

[34] *Il terribile inganno*, documentary directed by Maria Arena (2021), <www.cinemaitaliano.info/ilterribilenganno>.

[35] Non Una Di Meno (n. 31).

[36] Battisti (n. 16).

[37] World Health Organization (n. 11).

[38] Proposta di legge ordinaria n. 3670, presentata alla Camera l'11 marzo 2016 da A. Zaccagnini, 'Norme per la tutela dei diritti della partoriente e del neonato e per la promozione del parto fisiologico' [Bill No. 3670, submitted to the Chamber of Deputies on 11 March 11 2016, 'Provisions for the Protection of the Rights of the Woman in Childbirth and the Newborn, and

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This proposal, by explicitly naming violence, differed markedly from the other nine legislative initiatives on physiological childbirth presented during the XVII legislature, which remained anchored to the theoretical framework of the humanization and demedicalisation of childbirth, with particular attention to reducing caesarean sections.[39,40] The context, in fact,

for the Promotion of Physiological (Natural) Childbirth'] <www.camera.it/leg17/126?tab=1&leg=17&idDocumento=3670&sede=&tipo=>.

[39] Proposta di legge ordinaria n. 93, presentata alla Camera il 15 marzo 2013 da P. Binetti *et al.*, 'Norme per la promozione del parto fisiologico e la salvaguardia della salute della partoriente e del neonato' [Bill No. 93, submitted to the Chamber of Deputies on 15 March 2013, 'Provisions for the Promotion of Physiological (Natural) Childbirth and the Safeguarding of the Health of the Woman in Childbirth and the Newborn'] <www.camera.it/leg17/126?tab=1&leg=17&idDocumento=93&sede=&tipo=>; Proposta di legge ordinaria n. 2818, presentata alla Camera il 14 gennaio 2015 da P. Binetti, 'Norme per l'incremento del livello di sicurezza del parto naturale' [Bill No. 2818, submitted to the Chamber of Deputies on 14 January 2015 'Provisions for Increasing the Safety Level of Natural Childbirth'] <www.camera.it/leg17/126?tab=1&leg=17&idDocumento=2818&sede=&tipo=>; Proposta di legge ordinaria n. 3614, presentata alla Camera il 17 febbraio 2016 da E. Carnevali, 'Norme per la promozione del parto naturale e per la tutela della salute e del benessere della donna e del neonato' [Bill No. 3614, submitted to the Chamber of Deputies on 17 February 2016, 'Provisions for the Promotion of Natural Childbirth and the Protection of Maternal and Newborn Health and Well-being'] <www.camera.it/leg17/126?tab=1&leg=17&idDocumento=3614&sede=&tipo=>; Proposta di legge ordinaria n. 3121, presentata alla Camera il 15 maggio 2015 da V. Colonnese, 'Disposizioni per la promozione del parto naturale e la riduzione del ricorso al parto cesareo mediante iniziative di informazione e la formazione del personale medico e sanitario' [Bill No. 3121, submitted to the Chamber of Deputies on 15 May 2015, 'Provisions for the Promotion of Natural Childbirth and the Reduction of Recourse to Caesarean Section through Information Initiatives and the Training of Medical and Healthcare Personnel'] <www.camera.it/leg17/126?tab=1&leg=17&idDocumento=3121&sede=&tipo=>; Proposta di legge ordinaria n. 3573, presentata alla Camera il 2 febbraio 2016 da V. D'Incecco, 'Norme per la tutela della salute durante la gravidanza e per la promozione del parto fisiologico' [Bill No. 3573, submitted to the Chamber of Deputies on 2 February 2016, 'Provisions for the Protection of Health during Pregnancy and for the Promotion of Physiological Childbirth'] <www.camera.it/leg17/126?tab=1&leg=17&idDocumento=3573&sede=&tipo=>; Proposta di legge ordinaria n. 3095, presentata alla Camera il 4 maggio 2015 da B. F. Fucci, 'Norme per la promozione del parto fisiologico' [Bill submitted to the Chamber of Deputies on 4 May 2015, 'Provisions for the Promotion of Physiological Childbirth'] <www.camera.it/leg17/126?tab=1&leg=17&idDocumento=3095&sede=&tipo=>; Proposta di legge ordinaria n. 3839, presentata alla Camera il 18 maggio 2016 da M. Nicchi, 'Disposizioni per la tutela delle scelte procreative delle donne e per la

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had been marked by the scandal of the Balduzzi inquiry into the inappropriateness of caesarean sections,[41] which created a climate of strong tension between the medical profession and institutions, culminating in the first, and to date only, national strike by gynaecologists and midwives.[42]

promozione del parto fisiologico' [Bill No. 3095, submitted to the Chamber of Deputies on 18 May 2016, 'Provisions for the Protection of Women's Reproductive Choices and the Promotion of Physiological Childbirth'] <www.camera.it/leg17/126?tab=1&leg=17&idDocumento=3839&sede=&tipo=>; Proposta di legge ordinaria n. 3932, presentata alla Camera il 27 giugno 2016 da G. Rostellato, 'Norme per la tutela della salute della partoriente e del neonato e per la promozione del parto fisiologico a domicilio' [Bill No. 3932, submitted to the Chamber of Deputies on 27 June 2016, 'Provisions for the Protection of Maternal and Newborn Health and the Promotion of Home Physiological Childbirth'] <www.camera.it/leg17/126?tab=1&leg=17&idDocumento=3932&sede=&tipo=>; Proposta di legge ordinaria n. 755, presentata alla Camera il 16 aprile 2013 da D. Sbrollini, 'Norme per la tutela dei diritti della partoriente, la promozione del parto fisiologico e la salvaguardia della salute del neonato' [Bill No. 3932, submitted to the Chamber of Deputies on 16 April 2013, 'Provisions for the Protection of the Rights of the Woman in Childbirth, the Promotion of Physiological Childbirth, and the Safeguarding of Newborn Health'] <www.camera.it/leg17/126?tab=1&leg=17&idDocumento=755&sede=&tipo=>.

[40] In Italy, the debate on the humanisation of childbirth care had been ongoing for over forty years; nevertheless, women's demands and testimonies had remained unheard. As we have seen, as early as the 1970s women had identified and denounced the forms of violence and mistreatment experienced in maternity wards, and in the 1980s the first bill on care during childbirth and for the hospitalised child was filed with the Chamber of Deputies, thanks to the Honourable Angela Giovagnoli Sposetti of the Italian Communist Party (Proposta di legge n. 3206, presentata alla Camera il 25 febbraio 1982 da A. Giovagnoli Sposetti, 'Norme-quadro in materia di assistenza al parto ed al bambino ospedalizzato' [Bill No. 3206, submitted to the Chamber of Deputies on 25 February 1982, 'Framework Provisions on Childbirth Care and the Hospitalized Child'] <legislature.camera.it/chiosco.asp?source=/altre_sezionism/9988/10010/10011/documentotesto.asp&content=/_dati/leg08/lavori/schedela/trovaschedacamera.asp?pdl=3206>). The leitmotif of the humanisation of childbirth, promoted by Latin American feminisms, took hold thanks to the WHO and remained in vogue until the emergence of the new term "obstetric violence".

[41] Ministero della Salute, 'Conferenza stampa. Problemi di validità delle informazioni contenute nelle SDO con procedura di parto cesareo - controllo cartelle cliniche' [Press Conference. Issues Concerning the Validity of the Information Contained in Hospital Discharge Records (SDO) for Caesarean Section Procedures - Review of Medical Records] (18 January 2013) <https://www.quotidianosanita.it/allegati/allegato2615801.pdf>.

[42] On 18 January 2013, at the end of the Monti government and one month before the national elections of February 2023, the Minister of Health Balduzzi

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The parliamentary process on the Zaccagnini proposal, interpreted by the medical profession as a reputational and

released the preliminary data of an inquiry he had promoted following the 12 January 2012 AGENAS (Agenzia Nazionale per i Servizi Sanitari Regionali [National Agency for Regional Health Services]) report on anomalies in the Hospital Discharge Forms (SDO) relating to caesarean sections. The inquiry had been launched because in some regions, particularly in the South, the diagnosis of "abnormal fetal position/presentation" was over-represented compared with the national average (around 8%), reaching, in certain facilities, values above 20% with peaks of 50%. The suspicion arose of an opportunistic use of coding to justify the surgical intervention. To verify the AGENAS report, the Ministry ordered a sample check of the medical records of first caesarean sections coded with that diagnosis: the NAS (Carabinieri Health Protection Unit) acquired 3,273 records in 78 facilities and, at the time of the press conference of 18 January 2013, 1,117 records from 32 facilities in 19 regions and autonomous provinces had been reviewed. The documentary analysis found a mismatch between what was reported in the SDO and what was documented in the record in 43% of cases, due to diagnostic discrepancies or the absence of adequate clinical documentation. Some northern regions (Veneto, Liguria, Friuli-Venezia Giulia, Valle d'Aosta, P.A. Trento) stood out for non-correspondence rates below 5% and were proposed by the Ministry as possible benchmarks of good practice. Considering the preliminary data, the Ministry recommended that the regions carry out systematic audits of the records of all first caesarean sections with a diagnosis of abnormal presentation, since the frequency of that diagnosis had been confirmed as an indicator of risk of improper completion of SDOs. On the clinical and economic plane, the inquiry highlighted the need for appropriateness: caesarean section, to be reserved for necessary cases only, exposes patients to greater risks than vaginal birth (for example, anaesthesiological complications, vesico-ureteral injuries, the need for post-partum laparotomy and, in subsequent pregnancies, uterine rupture) and entails significantly higher costs for the National Health Service.

The inquiry provoked an unprecedented scandal in the world of obstetrics and gynaecology. Trade unions and scientific societies in the field were already threatening a national strike, denouncing three problems: cuts to public healthcare; the failure to make birth centres safe, as per the 2010 State-Regions Agreement (Conferenza Stato-Regioni, 'Accordo Stato-Regioni del 16 dicembre 2010 sulle Linee di indirizzo per il percorso nascita' [State–Regions Conference, 'State–Regions Agreement of 16 December 2010 on the Guidelines for the Birth Pathway'] (18 gennaio 2011) Gazzetta Ufficiale <www.trovanorme.salute.gov.it/norme/dettaglioAtto?id=36591&completo=true>), which remained largely unimplemented, with staffing shortfalls and lack of structural equipment; and, finally, the need to "cool down" the increase in medico-legal litigation, which had become unsustainable for healthcare staff due to high insurance costs and the drift towards defensive medicine, with effects on the quality of care and on professional peace of mind (Aa.Vv., 'L'ultimatum dei ginecologi. Impegni precisi sulla responsabilità professionale o sarà sciopero' [The Gynecologists' Ultimatum. Clear Commitments on Professional Liability or There Will Be a Strike] (2012) 9/10 Gyneco AOGOI <www.aogoi.it/pubblicazioni/gyneco-aogoi/archivio/2012/>.

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legal threat, was soon obstructed. The ten proposed bills were combined in the Social Affairs Committee; informal hearings were held with the main scientific societies in the field (SIGO, AOGOI, AIO, SIMLA, and SARNEPI),[43] but not with *OVOItalia* or other mothers' associations.[44] The decision to

The Balduzzi inquiry was the last straw. On 12 February 2013, in the middle of the election campaign, a national strike was called by the FESMED union (Federazione Sindacale Medici Dirigenti) with the support of all the scientific societies in the field: AOGOI (Associazione degli Ostetrici e Ginecologi Ospedalieri Italiani), SIGO (Società Italiana di Ginecologia e Ostetricia), AGUI (Associazione Ginecologi Universitari Italiani), AGITE (Associazione Ginecologi Territoriali), SIEOG (Società Italiana di Ecografia Ostetrica e Ginecologica e Metodologie Biofisiche) and AIO (Associazione Italiana Ostetriche). The mobilisation recorded 90% participation, excluding personnel requisitioned to handle emergencies, and, to date, remains the first and only strike in the history of Italian obstetric and gynaecological personnel, who called on the political class to commit to funding the SSN and to regulating professional liability, even going so far as to float a "vote strike" in the absence of responses (Aa.Vv., '12 febbraio sciopero nazionale dei ginecologi e delle ostetriche' [12 February: National Strike of Gynecologists and Midwives] (2013) 1/2 Gyneco AOGOI <www.aogoi.it/pubblicazioni/gyneco-aogoi/archivio/2013/>). The strike was also an opportunity to contest the "Balduzzi inquiry" in strong terms. While acknowledging the legitimacy of checks on appropriateness, AOGOI condemned the dissemination of results deemed "unreliable" and "misleading" because produced "without the application of a validated and scientific method", based on a small sample selected from facilities with a high frequency of "abnormal fetal presentation", a choice considered functional to emphasising SDO-record discrepancies and to unduly generalising to more than 500 birth centres, in addition to the fact that the data had been collected without adversarial proceedings, with potential harmful repercussions for reputation and possible criminal relevance (from ideological falsehood to fraud). For AOGOI, the critical issues relating to the high number of caesareans had to be traced back to structural organisational factors in the system. At the same time, the ministerial report summarised the preliminary data as evidence of insufficient information quality, proposing systematic audits of the records of first caesareans with a diagnosis of abnormal presentation – an approach that the strike's promoters considered reductive if not accompanied by structural interventions on safety, staffing, and professional liability (Aa.Vv. (2013) 11). After the elections of February 2013, the Ministry of Health passed to Beatrice Lorenzin, and no one ever spoke again of the Balduzzi inquiry.

[43] Società Italiana di Medicina Legale e delle Assicurazioni (SIMLA), Società Italiana di Ginecologia e Ostetricia (SIGO), Società di Anestesia e Rianimazione NEonatale e Pediatrica Italiana (SARNEPI), Associazione Italiana di Ostetricia (AIO) and Associazione Ostetrici e Ginecologi Ospedalieri Italiani (AOGOI).

[44] Camera dei Deputati - XII Commissione (Affari sociali), 'Norme per la promozione del parto fisiologico', 27 luglio 2016 [Chamber

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establish a subcommittee ('Comitato ristretto') to draft a unified text would have no visible outcome: no further developments appear in the official records.[45] The absence of documentation still makes it impossible today to reconstruct clearly the entire institutional pathway. Informal parliamentary hearings, moreover, have already been criticized because, lacking a regulatory framework and full reporting, they amount to spaces devoid of transparency regarding institutional mediation with interested social parties, in which the weight of groups with greater political and economic power prevails due to the discretion exercised over who is invited.[46] With the end of the XVII legislature, the parliamentary process on the promotion of physiological childbirth was filed away with no result.

In parallel, relations between *OVOItalia* and the Ministry of Health followed an up-and-down trajectory. After the first informal meetings and a formal audition with the *Comitato Percorso Nascita* ('Birth Pathway Committee'),[47] the Ministry first proposed the legislative initiative, which brought to the writing of the aforementioned Zaccagnini bill. Then it requested nationwide data collection on obstetric violence – which *OVOItalia* provided through the DOXA survey – and finally halted all dialogue once the opinion poll results were made public.[48] Obstetric violence was considered by the Ministry to

of Deputies - XII Commission (Social Affairs), 'Provisions for the Promotion of Physiological Childbirth'] <https://www.camera.it/leg17/126?tab=4&leg=17&idDocumento=3670&sede=&tipo=>; Camera dei Deputati - XII Commissione (Affari sociali), 'Norme per la promozione del parto fisiologico', 22 settembre 2016 [Chamber of Deputies - XII Commission (Social Affairs), 'Provisions for the Promotion of Physiological Childbirth'] <https://www.camera.it/leg17/126?tab=4&leg=17&idDocumento=3670&sede=&tipo=>.

[45] Camera dei Deputati - XII Commissione - Affari sociali, 'Norme per la promozione del parto fisiologico', 18 gennaio 2017 [Chamber of Deputies - XII Commission (Social Affairs), 'Provisions for the Promotion of Physiological Childbirth'].

[46] Roberto Salvatore *et al.*, *Le audizioni informali nelle Commissioni permanenti della Camera dei Deputati. Mappatura e analisi della XVIII legislatura* [Informal Hearings in the Standing Committees of the Chamber of Deputies: Mapping and Analysis of the 18th Legislature] (The Good Lobby Italia 2021) <https://www.thegoodlobby.it/le-audizioni-parlamentari-sono-da-migliorare-e-potenziare>.

[47] Ministero della Salute, 'Comitato percorso nascita' [Birth Pathway Committee] <www.salute.gov.it, 2011, www.salute.gov.it/new/it/tema/salute-della-donna/comitato-percorso-nascita/>.

[48] Skoko (n. 8).

 ISBN 978-88-495-6175-3

be a non-existent problem in Italy, supposedly confined to the so-called 'underdeveloped' or 'developing' countries.[49] Even in the scientific literature, until 2019 there were only analyses and studies on obstetric violence in the so-called 'Global South', and just four studies on obstetric violence perpetrated against minorities living in Western countries.[50] However, following pressure from the UN and the Council of Europe,[51] it was no longer possible to deny that the problem also concerned the West, and the field of research on the phenomenon was broadened.[52]

In Italy, thanks to the scandal of the Balduzzi inquiry, to bottom-up pressure from mothers' groups, including *OVOItalia*, and to the changed international context, a small but significant change occurred with the progressive updating, from 2014 onwards, of the guidelines on caesarean section and on physiological pregnancy, to bring them into line with WHO recommendations and the most advanced scientific evidence.[53]

Overall, the reconstruction of the institutional pathway relating to obstetric violence highlights the persistence of a structural asymmetry in the relationship between women, institutions, and healthcare professions. More than forty years after the first feminist denunciations, advocacy strategies and

[49] Battisti (n. 16).

[50] Bohren *et al.* (n. 3); Meghan A. 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) Lancet 1750 <https://doi.org/10.1016/S0140-6736(19)31992-0>.

[51] Council of Europe, Resolution 2306 (2019) 'Obstetrical and gynaecological violence'.

[52] Laura K. Fraser *et al.*, 'Prevalence of obstetric violence in high-income countries: a systematic review of mixed studies and meta-analysis of quantitative studies' (2025) 104(1) Acta Obstetricia et Gynecologica Scandinavica 13 <https://doi.org/10.1111/aogs.14962>; Quattrocchi (n. 3).

[53] Istituto Superiore di Sanità, *Linee guida. Taglio cesareo: una scelta appropriata e consapevole* [Guidelines. Caesarean Section: An Appropriate and Informed Choice] (2014) <https://www.epicentro.iss.it/materno/pdf/LG_cesareo_comunicazione.pdf>; Istituto Superiore di Sanità, *Linee guida. Taglio cesareo: una scelta appropriata e consapevole. Seconda parte* [Guidelines. Caesarean Section: An Appropriate and Informed Choice. Part Two] (2016) <https://www.epicentro.iss.it/materno/pdf/LG_Cesareo_finaleL.pdf>; Istituto Superiore di Sanità, *Linee guida. Gravidanza fisiologica. Prima parte* [Guidelines. Physiological Pregnancy. Part One] (2023) <https://www.iss.it/documents/20126/9184367/SNLG+1_2023+Gravidanza-fisiologica+Parte-1.pdf>; Istituto Superiore di Sanità, *Linea guida. Gravidanza fisiologica. Seconda parte* [Guidelines. Physiological Pregnancy. Part Two] (2025) <https://www.iss.it/documents/20126/9184367/SNLG+1_2025+Gravidanza-fisiologica+Parte-2.pdf>.

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attempts to translate the problem into legislation have continued to clash with systemic resistances of a cultural and political nature. The poor transparency of informal hearings, the marginalization of women's associations in decision-making processes, corporate resistances, and ministerial inertia in addressing the problem represent elements of continuity with the dynamics already observed in the 1970s. Likewise, one can identify a parallel with the practices of self-organization and struggle undertaken by women to try to improve their condition. The distance between bottom-up activism and the institutional response thus shows the persistence of a model of healthcare governance that continues to reproduce the same hierarchies of power and the same forms of exclusion of female and LGBTQI+ subjectivities from the decision-making processes that concern them. The analogies with the 1970s will also be found in the more recent dispute with the medical profession at the epistemic level.

7. *The clinician-patient dialectic as a field of epistemic tension: 'obstetric violence' or 'sub-standard and disrespectful care'?*

In November 2017, two months after the dissemination of the DOXA data on obstetric violence collected through the opinion poll, AOGOI sent a formal cease-and-desist to *OVOItalia*. The legal document, particularly harsh and disproportionate in tone, focused on the serious reputational damage suffered by the medical profession working in the sector:

> 'It is evident that already the manner of presenting the survey, by juxtaposing the word 'violence' with the attribute 'obstetric', produces a serious denigratory effect for professionals in the field. Indeed, the words 'obstetric violence', at the moment of communication, already on their own and immediately, become a tool for offending the reputation of healthcare professionals, amounting to an overt attack and aggression against another's moral sphere, which certainly does not constitute a generic and lawful evaluative content or an expression of judgement respectful of correct language and permitted by our legal system. […] The document disseminated contains extremely serious offensive expressions that evoke deplorable behaviours attributable to the obstetric professional profile (midwives, doctors and healthcare staff), never performed and never proven, inducing in the reader's mind an unjust and intolerable complete distortion of Italian healthcare reality and in particular of obstetric and childbirth

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> care, thereby achieving a gravely defamatory result that harms the reputation of professionals'.[54]

The letter goes on in even stronger terms, asserting that, through the DOXA survey, a 'false reconstruction' of Italian healthcare is given, 'consisting of midwives and obstetric-gynaecologist doctors who are sadistic or indifferent to the person, who reap victims out of sheer cruelty', in a 'childbirth care context that is grim, inhuman, barbaric and tyrannical'.[55]

AOGOI's letter concludes by maintaining that the DOXA survey is unfounded and devoid of scientific value, and that the media campaign *'Basta tacere'*, with the anonymous collection of testimonies, is 'denigratory', 'reprehensible and disgusting'.[56] It therefore demands, by means of a formal warning, that dissemination of the collected data be halted and that all statements harmful to the medical profession's reputation be corrected, in an explicit attempt to silence the mothers' organizations and suppress the public circulation of their findings.[57]

No one in Italy had ever contested the validity of DOXA opinion polls. *OVOItalia* proposed a clarifying meeting to AOGOI, but the scientific society refused any form of dialogue.[58]

In May 2018, the DOXA data were published in one of the most authoritative international journals of Obstetrics and Gynecology, the *European Journal of Obstetrics & Gynecology and Reproductive Biology.*[59] The study constitutes the first data collection on obstetric violence in a high-income country[60] (Ravaldi *et al.*, 2018, p. 1). Since then, the conflict between healthcare professionals and patients has taken on a transnational dimension: the same journal has, in subsequent years, hosted a series of editorials in the form of reply and counter-reply. This exchange also marks a significant novelty: mothers'

[54] Vania Cirese, Antonio Chiàntera, e Elsa Viora, 'Diffida OVOItalia e DOXA' [Formal Notice (Cease and Desist Letter) addressed to OVOItalia and DOXA] (2 novembre 2017) AOGOI <www.aogoi.it/media/4408/diffida-doxa-26-10-2017-rivev.pdf> 1-2.

[55] Cirese *et al.* (n. 54) 2.

[56] Cirese *et al.* (n. 54) 3.

[57] Cirese *et al.* (n. 54) 3.

[58] Battisti (n. 16).

[59] Claudia Ravaldi *et al.*, 'Abuse and disrespect in childbirth assistance in Italy: a community-based survey' (2018) 224 European Journal of Obstetrics and Gynecology 208 <https://doi.org/10.1016/j.ejogrb.2018.03.055>.

[60] Ravaldi (n. 59) 1.

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organizations and obstetric violence observatories brought the conflict onto a new terrain, entering the space of peer-reviewed academic writing to directly challenge the medical establishment by its own rules. The dialectic that emerges between scientific societies and groups of mothers reveals a friction that cannot be reduced to simple terminological divergences, but points to a structural tension.

The first field of tension concerns the meaning attributed to the word 'violence'. The main European professional societies (EAPM - European Association of Perinatal Medicine, EBCOG - European Board and College of Obstetricians and Gynecologists, EMA - European Midwives Association) have explicitly argued that the term 'violence' evokes, in its common-sense definition, an intentional physical assault, thus amounting to an 'unjust and offensive' accusation against professionals; hence the proposal to replace it with 'sub-standard and disrespectful care', which, in their view, would allow problems to be named without ascribing malevolent intent to practitioners.[61] From this perspective, the examples adduced as sub-standard correspond to practices that violate WHO recommendations and range, for example, from the non-indicated use of procedures to deficits in informed consent, especially in non-emergency contexts.[62] By disrespectful care they mean, rather, 'forms of verbal and non-verbal communication that women, or the people accompanying them, perceive as harmful to their dignity, individuality, privacy or intimacy, or that contradict their ethnic, cultural or religious beliefs. It also includes physical abuse'.[63] The proposed terminological change insists that the lemma 'violence' risks triggering corporate defensiveness and undermining clinician-patient trust.

On the opposite side, the network of Observatories on Obstetric Violence defends the use of the term precisely because it makes visible a transversal and systemic problem, namely a set of routine practices, unreflective attitudes, and organizational structures that are not designed with the woman giving birth at the centre and that, regardless of the intention of individuals,

[61] European Association of Perinatal Medicine (EAPM) *et al.*, 'Joint position statement: substandard and disrespectful care in labour - because words matter' (2024) 296 European Journal of Obstetrics and Gynecology 205, 207 https://doi.org/10.1016/j.ejogrb.2024.02.048.

[62] European Association of Perinatal Medicine (EAPM) *et al.* (n. 61) 206.

[63] European Association of Perinatal Medicine (EAPM) *et al.* (n. 61) 206.

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can cause physical, psychological, and moral harm, infringing women's human rights.[64] In their 2024 joint response, European and Latin American Observatories recall the legal and political recognition of obstetric violence as a violation of human rights and as a specific form of gender-based violence, citing the Latin American regulatory trajectory,[65] the Council of Europe resolution[66] and WHO guidance on disrespectful and abusive treatment in delivery rooms.[67] Above all, they denounce as a strategy of 'institutional and epistemic violence' the attempt to replace the lexicon of violence with that of 'sub-standard' alone, since only the former accounts for the violation of human rights and the power asymmetries that sustain it.[68] This framework, clearly anchored in the field of human rights, interprets the facts as the products of systemic arrangements (routine procedures, organizational cultures, economic constraints, communicative and informational deficits, sexist or paternalistic practices), as well as of individual conduct (lack of knowledge of guidelines, relational and empathic deficits), thereby asserting the link between subjective experience, clinical outcomes, and medical and institutional responsibility.

The second axis of conflict derives from the social and epistemic positioning of the parties. Documents produced by the scientific societies insist on the legitimacy of their own technical-scientific authority: 'The very claims made by the OV Observatory as reported by the interviewers – such as 'forcing a woman to have an unnecessary caesarean section' or 'performing an episiotomy without warning' – fail to take account of professionals' power-duty to co-decide, to guide women's choices and to intervene urgently, even in the absence

[64] Serena Brigidi *et al.*, 'Joint response from Latin American, European obstetric violence observatories and other organizations across Europe to the joint position statement on substandard and disrespectful care in labour - because words matter' (2024) 299 European Journal of Obstetrics and Gynecology 329 <https://doi.org/10.1016/j.ejogrb.2024.05.008>.

[65] ONU Mujeres, *Panorama legal para la eliminación de la violencia contra las mujeres en los países de América Latina y el Caribe* [Legal Framework for the Elimination of Violence against Women in the Countries of Latin America and the Caribbean] (2024) <https://lac.unwomen.org/es/digital-library/publications/2024/12/panorama-legal-para-la-eliminacion-de-la-violencia-contra-las-mujeres-en-los-paises-de-america-latina-y-el-caribe>.

[66] Council of Europe, Resolution 2306 (2019) 'Obstetrical and gynaecological violence'.

[67] World Health Organization (n. 11).

[68] Brigidi *et al.* (n. 64) 329.

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of consent, to avoid a serious danger to a person's life or integrity. The fundamental misunderstanding lies in failing to consider that professionals who merely followed a woman's wishes, even when at odds with the scientific evidence, would end up endangering people's health'.[69] They also insist on the need to safeguard the reputation of the professional category and of the Italian National Health Service.[70] Here, symbolic harm to the profession becomes a central theme, confirming that the dispute concerns not only data, but also the category's public reputation and the autonomy and power of a professional group.

On the users' side, by contrast, the appeal is to the value of situated counter-knowledge: the DOXA questionnaire, though controversial, was conceived as an extension of the *'Basta tacere'* campaign and seeks to legitimize women's experience as a source of knowledge about their own bodies and the system of care they received – an explicitly 'bottom-up' epistemology that demands listening and accountability.[71] In the international publication, they conclude by stating that: 'Women who are actively involved in the decision-making process seem to trust professionals and less frequently report disrespectful or abusive behaviours; conversely, women who are not openly involved in the decision-making process are more likely to report being victims of obstetric violence'.[72]

From this follows the third factor of conflict, namely the educational, cultural, and professional background. In 2018, the presidents of SIGO, AOGOI, AGUI, and FNOPO, replying to the DOXA study, questioned the validity of the instrument and the sample, arguing that definitions and questions were 'designed to elicit answers useful to fuelling the campaign' and that the use of the term 'violence' generates 'social alarm' rather than improvement: the proposed solution is a 'methodologically correct survey' conducted by the societies themselves.[73] In this positivist epistemological framework, an objective and universal knowledge exists, and healthcare staff are its custodians. Statistical representativeness, validation of instruments, and neutrality

[69] Giovanni Scambia *et al.*, '"Obstetric violence": between misunderstanding and mystification' (2018) 228 European Journal of Obstetrics and Gynecology 331 <https://doi.org/10.1016/j.ejogrb.2018.06.012>.

[70] Scambia *et al.* (n. 69).

[71] Skoko and Battisti (n. 2).

[72] Ravaldi *et al.* (n. 59) 209.

[73] Scambia *et al.* (n. 69).

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of language become the only conditions of truth, while the experience reported by those who receive care is downgraded due to subjective biases or non-generalizable perceptions.

The counter-argument put forward by groups of mothers, in line with feminist epistemologies that criticize positivism, is that there is no knowledge produced 'from nowhere': the way in which one speaks, acts, and interprets events (including adverse ones, such as lack of consent, non-indicated separations, verbal humiliations) is always intrinsically situated and politically relevant.[74] It is in this logic that the article published by *OVOItalia* itself acquires value: not as definitive proof of the phenomenon, but as a pioneering attempt to bring mothers' voices into an international scientific journal, showing robust associations between the undermining of a woman's autonomy and capacity for self-determination and the perception of having suffered violence, irrespective of conditions and clinical outcomes.[75]

For its part, the Istituto Superiore di Sanità (Italian National Institute of Health) highlighted methodological criticalities in the DOXA study, such as, for example, selection bias in web-surveys, poor representativeness for low educational attainment and foreign citizenship, the use of overly broad definitions, and it cited, as counter-evidence, the national sample surveys on birth experiences.[76] These objections, however, are not limited to 'method', but rather imply an idea of objectivity that draws a sharp separation between clinical practice and lived experience,

[74] Linda Linda Alcoff and Elizabeth Potter (eds.), *Feminist Epistemologies. Thinking Gender* (Routledge 2015); Donna Jeanne Haraway, *Modest_Witness@Second_Millennium.FemaleMan©Meets_OncoMouse: Feminism and Technoscience* (Routledge 1997); Nancy C.M. Hartsock, 'The feminist standpoint: developing the ground for a specifically feminist historical materialism' in Sandra Harding and Merrill B. Hintikka (eds.), *Discovering Reality* (Kluwer Academic Publishers 2004) 283 <https://doi.org/10.1007/0-306-48017-4_15>; Nina Lykke, *Feminist Studies. A Guide to Intersectional Theory, Methodology and Writing* (Routledge 2010) <https://doi.org/10.4324/9780203852774>; Adrienne Rich, 'Notes toward a politics of location' in Myriam Díaz-Diocaretz and Iris M. Zavala (eds.), *Women, Feminist Identity and Society in the 1980s* (John Benjamins 1985) 7 <https://doi.org/10.1075/ct.1.03ric>.

[75] Ravaldi *et al.* (n. 59).

[76] Laura Lauria *et al.*, 'Methodological flaws in web surveys: commentary to "Abuse and disrespect in childbirth assistance in Italy: a community-based survey"' (2018) 226 European Journal of Obstetrics and Gynecology 73 <https://doi.org/10.1016/j.ejogrb.2018.05.023>.

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and that deems professional decision-making admissible even when the woman has not expressed formal consent in emergency.[77] Moreover, the critique appears to overlook a fundamental distinction: the DOXA survey was a demoscopic instrument designed to capture women's subjective experiences, not a clinical study subject to epidemiological standards of representativeness – a distinction that shapes what kind of knowledge it can and cannot claim to produce.

The fourth and final factor of tension is the divergence in the political objectives of the two constellations of actors. In the wake of methodological criticism, the Italian scientific societies promoted their own large opinion survey (over 13,000 questionnaires in 117 centres), with far more positive results, recording low percentages of dissatisfaction about information, pain control, and overall care, and a strong propensity to recommend the place of one's own birth.[78] This result is presented as 'realistic' and useful for identifying circumscribed areas of organizational improvement (for example, in the case of operative births), confirming a strategy aimed at reassuring public opinion, containing medico-legal litigation, and preserving the profession's reputational capital. In parallel, at European level, the aforementioned joint stance by EAPM, EBCOG, and EMA confirms the commitment to reducing practices not based on scientific evidence and disrespectful communication but rejects the term 'obstetric violence' as counterproductive.[79] This amounts to a policy of defending the professional category which, to defuse conflict, redefines the problem in terms of quality and safety rather than in terms of respect and wellbeing of those receiving care, rejecting the interpretative framework of human-rights violations and gender-based violence perpetrated in healthcare settings.[80]

Conversely, the joint response of European and Latin American Observatories asserts the goal of a legal and explicit recognition of obstetric violence as a violation of human rights, calling for training for all healthcare personnel with a view to real prevention, and for reparative instruments for victims: the

[77] Lauria *et al.* (n. 76).

[78] Giovanni Scambia *et al.*, 'Patient-reported experience of delivery: a national survey in Italy' (2020) 244 European Journal of Obstetrics and Gynecology 197 <https://doi.org/10.1016/j.ejogrb.2019.06.031>.

[79] EAPM *et al.* (n. 61).

[80] EAPM *et al.* (n. 61).

 ISBN 978-88-495-6175-3

horizon is thus transformative and redistributive, both at the political and epistemic level.[81]

Considering these structural tensions, the total incommunicability between clinicians and patients no longer appears as a contingent defect in dialogue, but rather as the effect of different positionings and forms of knowledge. In the medical-institutional field there prevails a semantics of prudential responsibility (avoiding the intentionality inherent in the word 'violence', protecting trust in the system, improving processes and standards) and a regime of proof dominated by metrics of representativeness and validation; the focus thus falls on the integrity and image of the profession and on the statistical appropriateness of studies. In the field of activist mothers, by contrast, the semantics are those of rights and gender-based violence, in which individual intention recedes before systemic responsibility and structures of power: to call 'violence' the practices enacted in healthcare (considered morally harmful or objectively harmful on a physical level) is to place them on a continuum with other forms of institutional violence, demanding real change, listening and respect, not merely an update of guidelines.

This semantic-epistemic gap explains why the same empirical objects (a high rate of episiotomies, a lack of consent, a humiliating word in labour) can be read now as indicators of a quality deficit, now as signals of a structure of domination and injustice. Any convergence, when it occurs, arises where the lexicon of quality meets that of rights: where informed consent, communicative transparency, and the revision of non-indicated practices are recognized as factors that reduce both the 'perception of violence' and exposure to clinical and reputational risk. This was also suggested by the DOXA analysis: explicit consent showed a strong negative association with reports of violence, indicating that it is not the clinical act as such that generates the harmful experience, but its positioning within a non-negotiated hierarchical relationship. Ultimately, the dispute over which words to use is not a terminological problem; rather, it underlies a conflict between two visions of care grounded in distinct and partially incommensurable disciplinary frameworks. The medical framework is concerned with preserving the authority of medical knowledge and correcting deviations from established

[81] Brigidi *et al.* (n. 64).

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standard of practice; the legal and human rights framework, by contrast, aims at redefining those standards in the light of lived experience and rights, demanding a rebalancing of power in the care relationship and a form of knowledge co-constructed precisely and only within the clinician-patient relationship. If power relations are not brought to light and treated as structural issues, rather than as 'noise' around the data, communication between these two frameworks will tend to remain conflictual and, paradoxically, produce further mutual distrust.

8. *The emergence of gynaecological violence through invisible illnesses*

In Italy, unlike in France, gynaecological violence has not yet been the subject of media campaigns or specific civil society initiatives and is not a consolidated term in public discourse. However, in 2021, mobilization around 'invisible illnesses' through the campaign 'sensibile-invisibile',[82] which helped to call into question medical authority with respect to chronic illnesses that predominantly affect people with a vulva and a uterus, such as vulvodynia, pudendal neuropathy, endometriosis, and fibromyalgia, which are not yet institutionally recognized, opened up a discursive space that enabled the first testimonies of gynaecological violence to emerge.

France represents a peculiar case in the global landscape: here, obstetric and gynaecological violence[83] emerges from the outset as a unitary phenomenon, fundamentally attributable to sexism that is also present in the medical sphere, which bears down upon the power asymmetry already intrinsic to the clinician-patient relationship. Between 2014 and 2017, various social campaigns spread, marked by the hashtags #*PayeTonUtérus*, #*BalanceTonPorc*, and #*BalanceTonGynéco*, denouncing non-consensual practices, humiliating communications, and sexual violence in gynaecological settings.[84] The government

[82] DINAMOpress, 'Giornata di mobilitazione nazionale Non Una di Meno in 20 città' [National Day of Mobilization of Non Una di Meno in 20 Cities] (25 October 2021) <https://www.dinamopress.it/news/giornata-di-mobilitazione-nazionale-non-una-di-meno-in-20-citta>.

[83] In France, gynaecology also includes breast care, whereas in Italy senology is a subspecialty of general surgery, not of gynaecology.

[84] Danielle Bousquet *et al.*, *Les actes sexistes durant le suivi gynécologique*

 ISBN 978-88-495-6175-3

then tasked the *Haut Conseil à l'égalité entre les femmes et les hommes* (HCE) with drafting a report to objectify the phenomenon and identify possible levers for prevention and counteraction. The HCE defines gynaecological and obstetric violence as serious sexist acts, inscribed in the history of control over women's bodies and perpetrated even without an intention to mistreat, along a spectrum ranging from micro-humiliations to sexual violence. The report identifies six types of sexist acts: failure to take account of the patient's embarrassment linked to the intimate nature of the examination; judgmental statements about sexuality, clothing, weight, or the wish or otherwise to have children; sexist insults; medical acts carried out without obtaining consent or without respecting the patient's choice; acts or refusals to act that are not medically justified; sexual violence (from harassment to assault to rape).[85] In France, then, the institutional response was immediate and took on board the feminist analyses that had emerged through the social campaigns.

In the Italian context, the discursive trigger on gynaecological violence passes largely through the emergence of vulvodynia as a problem-figure: a long-invisible illness that became a catalyst for the 'sensibile-invisibile' mobilizations and, more generally, for the thematization of chronic pelvic-perineal pain.[86] Defined

et obstétrical. Des remarques aux violences, la nécessité de reconnaître, prévenir et condamner le sexisme [Sexist Acts during Gynecological and Obstetric Care. From Remarks to Violence: The Need to Recognize, Prevent, and Condemn Sexism] (Haut Conseil à l'Égalité entre les femmes et les hommes 2018) <https://www.haut-conseil-egalite.gouv.fr/sante-droits-sexuels-et-reproductifs/actualites/article/actes-sexistes-durant-le-suivi-gynecologique-et-obstetrical-reconnaitre-et>; Silvia Brunello *et al.*, *Obstetric and Gynaecological Violence in the EU: Prevalence, Legal Frameworks and Educational Guidelines for Prevention and Elimination*, Document requested by the European Parliament's Committee on Women's Rights and Gender Equality (FEMM) (European Union 2024) <https://data.europa.eu/doi/10.2861/32832>.

[85] Bousquet *et al.* (n. 84).

[86] Silvia Carabelli, 'Vulvodinia: sana come un pesce' [Vulvodynia: Healthy as a Fish] (2022) Codici Ricerche <https://www.codiciricerche.it/it/codici404/vulvodinia-sana-come-un-pesce>; Martina Carpani, 'La vulva in fiamme' [The Vulva on Fire] (2022) Jacobin Italia <https://jacobinitalia.it/la-vulva-in-fiamme/>; Valentina Ferritti, 'Vulvodinia tra invisibilità e invisibilizzazione' [Vulvodynia between Invisibility and Invisibilization] (2023) 12(23) AG About Gender - International Journal of Gender Studies 397 <https://doi.org/10.15167/2279-5057/AG2023.12.23.2203>; *Our Body Burns*, documentary directed by Angela Tullio Cataldo (Internazionale 2022) <https://www.internazionale.it/video/2022/07/20/sofferenza-donne-

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by the WHO in ICD-11 as persistent vulval pain for more than three months without a single organic cause,[87] it is still the object of scientific debate, often unrecognized or psychologized, and still not recognized by the Italian National Health Service (SSN) as a chronic and disabling illness. Those who suffer from it experience diagnostic delays, repeated and inconclusive visits, minimization, devaluation, or normalization of pain, and the absence of structured pathways of care that take account of the constellation of comorbidities, with disabling effects on daily life, sexuality, work, and mental health.[88]

Although vulvodynia has appeared in Italian public debate only in recent years, it is not a newly discovered illness. Its first appearance in the literature, albeit not under this name, dates to the late nineteenth century. In 1976 the Society for the Study of Vulvovaginal Disease (ISSVD) significantly defined it as 'the burning vulva syndrome', and in 2003 gave it the name by which we know it today and a definition very similar to that adopted in ICD-11.[89] Vulvodynia still struggles today to be known and recognized in the medical field essentially for two reasons. The first is that a single biological cause that would make diagnosis incontrovertible has not yet been identified, a variable that puts the organicist biomedical paradigm in crisis. The second is that various female genito-pelvic and sexual disorders still fall within the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), recalling the long tradition which, starting in the nineteenth century, led to interpreting women's sexual disorders as symptoms of psychiatric illnesses.

The 'sensibile-invisibile' campaign was launched on the

vulvodinia>; Alessandra Vescio, *La salute è un diritto di genere* [Health Is a Gendered Right] (People 2023).

[87] World Health Organization, *ICD-11 for Mortality and Morbidity Statistics* (1 January 2022) <https://icd.who.int/browse/2025-01/mms/en#1539507119>; Sophie Bergeron *et al.*, 'Vulvodynia' (2020) **6(1)** Nature Reviews Disease Primers 36 <https://doi.org/10.1038/s41572-020-0164-2>.

[88] Alessandra Graziottin *et al.*, 'Vulvar pain: the revealing scenario of leading comorbidities in 1183 cases' (2020) 252 European Journal of Obstetrics and Gynecology 50 <https://doi.org/10.1016/j.ejogrb.2020.05.052>; Rebekah Shallcross *et al.*, 'Women's subjective experiences of living with vulvodynia: a systematic review and meta-ethnography' (2018) 47(3) Archives of Sexual Behavior 577 <https://doi.org/10.1007/s10508-017-1026-1>; Rebekah Shallcross *et al.*, 'Women's experiences of vulvodynia: an interpretative phenomenological analysis' (2019) 48(3) Archives of Sexual Behavior 961 <https://doi.org/10.1007/s10508-018-1246-z>.

[89] Micheline Moyal-Barracco and Peter J. Lynch, '2003 ISSVD terminology

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initiative of people living with these illnesses, in collaboration with the first Italian self-help group GAV (*Gruppo Ascolto Vulvodinia*) and several national associations (*Cistite.info* APS, AINPU ONLUS - *Associazione Italiana Nazionale Neuropatia del Pudendo*, *Vulvodiniapuntoinfo* ONLUS, AIV - *Associazione Italiana Vulvodinia*, VIVA - *Vincere Insieme la Vulvodinia*, and CFU Italia - *Comitato Fibromialgici Uniti*), with the support of the local assemblies of *Non Una Di Meno.*[90] The rallies organized in over twenty cities on 23 October 2021, often in front of healthcare institutions, centered a simple message linked to the invisibility of pain. The title 'sensibile-invisibile', in fact, evokes precisely this meaning: 'the fact that you don't see it doesn't mean I don't feel it', asserting the concrete reality of those illnesses that leave no obvious external signs. The demonstrations, amplified by the public intervention of media figures such as Giorgia Soleri, turned invisible pain into a political issue and a matter of social justice.[91,92]

At the institutional level, the mobilization led to the creation of the *Comitato Vulvodinia e Neuropatia del Pudendo*,[93] which drew up a 'bottom-up' bill, cross-signed by several political forces, for the recognition of vulvodynia and pudendal neuropathy as chronic and disabling illnesses, the establishment of dedicated public centres, a national register, funding for research and for the training of healthcare personnel, and

and classification of vulvodynia: a historical perspective' (2004) 49(10) Journal of Reproductive Medicine 772.

[90] DINAMOpress (n. 82).

[91] Sarah Barberis, 'Il dolore che la medicina non ascolta' (12 February 2022) L'Essenziale <https://www.internazionale.it/essenziale/notizie/sarah-barberis/2022/02/12/vulvodinia-medicina-donne>; Carpani (n. 86); Chiara Daina, 'Vulvodinia, il calvario delle donne in attesa di diagnosi: "Liquidate per ipocondria o stress, ma è patologia cronica. Ecco perché serve la legge"' (6 June 2021) Il Fatto Quotidiano <www.ilfattoquotidiano.it/2021/06/06/vulvodinia-il-calvario-delle-donne-in-attesa-di-diagnosi-liquidate-per-ipocondria-o-stress-ma-e-patologia-cronica-ecco-perche-serve-la-legge/6217904/?fbclid=IwAR2rhoRoC8qtBjcAZMsdZy48ObBL-lg5yZnTG5TbvPyoaioRy3jo86TUrtQ>; Valentina Ferritti (n. 86); Giulia Siviero, 'Dobbiamo parlare di vulvodinia' (5 September 2021) Il Post <https://www.ilpost.it/2021/09/05/vulvodinia/>.

[92] Ferritti's article is, to date, the only publication in an academic journal. It represents a good historical reconstruction, with only one date to correct: the first public speech on vulvodynia dates to the *Non Una Di Meno* Milan strike of 8 March 2021, not 2019 (Ferritti (n. 86) 398).

[93] <www.vulvodinianeuropatiapudendo.it>.

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employment protections for people affected.[94] Here too, the legislative process was interrupted by the end of the legislature, but the issue had by then entered the national political and healthcare agenda.

From the birth of the first Italian associations in the 2000s, and throughout the trajectory set out here, social media have been a decisive tool: they make pain narratable and shareable, have facilitated the aggregation of mutual-aid networks, and have acted as a sounding board useful for creating critical mass, especially considering the chronicity and disability of those involved, who struggle to frequent traditional social and political spaces.[95] Testimonies of gynaecological visits marked by invalidation of symptoms, attribution of pain to psychological causes, and sexist attitudes paved the way for thematizing 'gynaecological violence', taken up also by the podcast '*A gambe larghe*' ('In the spread-legged position'),[96] the first Italian editorial project on the topic, produced in collaboration with the 'Consultoria FAM' in Turin, the transfeminist heir to the experience of the

[94] Proposta di legge ordinaria n. 3540, presentata alla Camera il 28 marzo 2022 da G. Pini, 'Riconoscimento della vulvodinia e della neuropatia del pudendo come malattie croniche e invalidanti nonché disposizioni per la loro diagnosi e cura e per la tutela delle persone che ne sono affette' [Bill No. 3540, submitted to the Chamber of Deputies on 28 March 2022, 'Recognition of Vulvodynia and Pudendal Neuropathy as Chronic and Disabling Diseases, as well as Provisions for Their Diagnosis and Treatment and for the Protection of Persons Affected by Them'] <www.camera.it/leg18/126?tab=2&leg=18&idDocumento=3540&sede=&tipo=>; Disegno di legge ordinaria n. 2591, presentato al Senato il 13 aprile 2022 da G. Pisani, 'Disposizioni per il riconoscimento, la diagnosi e la cura della vulvodinia e della neuropatia del nervo pudendo, nonché misure in favore delle persone che ne sono affette' [Bill No. 2591, submitted to the Senate on 13 April 2022, 'Provisions for the Recognition, Diagnosis, and Treatment of Vulvodynia and Pudendal Nerve Neuropathy, as well as Measures in Support of Persons Affected by Them'] <www.senato.it/legislature/18/leggi-e-documenti/disegni-di-legge/scheda-ddl?did=54921>; Vulvodinia e Neuropatia del Pudendo, 'Risorse politica' (2023) <www.vulvodinianeuropatiapudendo.it/risorse/risorse-politica/>.

[95] Alice Buonaguidi Alice Buonaguidi and Chiara Perin, 'Resisting but embracing fragility. Exploring prominent themes emerging from online feminist activists' and advocates' posts addressing conditions characterized by chronic pelvic pain on Instagram' (2023) 12(23) AG About Gender - International Journal of Gender Studies 140 <https://doi.org/10.15167/2279-5057/AG2023.12.23.2110>.

[96] Domitilla Pirro *et al.*, *A gambe larghe* (2024) <https://open.spotify.com/show/7sTJnBCqq253X32wgXFEkw>.

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self-managed feminist counselling centres ('Consultori') of the 1970s.

In the trajectory of *Non Una Di Meno* as well, reflection on violence in healthcare progressively expands, especially following the Covid-19 syndemic, a critical juncture that brought health back to the centre of public discourse and highlighted the crisis in sexual and reproductive health services, from counselling centres to pathways for abortion.[97] From the initial focus on obstetric violence present in the *'Feminist plan'*,[98] the movement moves to a notion of 'structural medical violence', deriving from factors such as patriarchy, androcentrism, and gender binarism which, in the medical field, contribute to the pathologization of feminized bodies or those not conforming to gender and sexual norms, and to the consolidation of barriers to access to reproductive health, especially for those most vulnerable by virtue of gender, class, race, or disability.[99] In this framework, 'unrecognized' chronic illnesses, such as vulvodynia, pudendal neuropathy, endometriosis, and fibromyalgia, become paradigmatic examples of institutional violence that is also exercised through diagnostic omissions, the absence of care pathways, and the delegation to individual economic and relational resources.

Although the 2017 *'Feminist plan'* had already thematized the power asymmetry between healthcare personnel and patients, albeit without using the word 'violence', the 2023 *'Manifesto for the Sexual and Reproductive Health We Want'* makes explicit the concept of 'structural medical violence', which has its origin

[97] Brunello *et al.* (n. 84); European Parliament, Resolution 24 June 2021 (2020/2215(INI)) 'Sexual and reproductive health and rights in the EU' <https://www.europarl.europa.eu/doceo/document/TA-9-2021-0314_IT.html>.

[98] Non Una Di Meno (n. 31).

[99] Non Una Di Meno, 'Report Tavolo Salute - 30.01.2021' [Report Health Workgroup] (4 febbraio 2021) <nonunadimeno.wordpress.com/2021/02/04/report-tavolo-salute-30-01-2021>; Non Una Di Meno, 'Report Tavolo Salute (Bologna, Assemblea nazionale 9-10 ottobre 2021)' [Report Health Workgroup (Bologna, National Assembly, 9-10 October 2021)] (11 novembre 2021) <nonunadimeno.wordpress.com/2021/11/11/assemblea-nazionale-bologna-2021-report-tavolo-salute>; Non Una Di Meno, 'Tavolo Salute e Aborto (Torino, Assemblea nazionale 4-5 febbraio 2023)' [Report Health and Abortion Workgroup (Bologna, National Assembly, 4-5 February 2023] (31 gennaio 2023) <nonunadimeno.wordpress.com/2023/01/31/traccia-salute-e-aborto/>; Non Una Di Meno, 'Manifesto per la salute sessuale e riproduttiva che vogliamo' [Manifesto for the Sexual and Reproductive Health We Want] (2 marzo 2023) <nonunadimeno.wordpress.com/2023/03/02/interruzione-volontaria-di-patriarcato>.

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in the abuse of power that also traverses healthcare settings and which can be prevented only through respect for the principle of self-determination, the repoliticisation of the care relationship, and the redistribution of power and knowledge between caregiver and care recipient.[100] Thus, while not dwelling on the concept of 'gynaecological violence', between 2017 and 2023 *Non Una Di Meno* makes the shift from obstetric violence to a structural conception of medical violence, organically including chronic and invisible illnesses as part of the same field of power.

Even though the term 'gynaecological violence' is not yet widespread in Italy, the trajectory described here shows how it is taking shape at the intersection of the emergence of invisible illnesses, the activism of patient groups, testimonies and sharing on social networks, and transfeminist analyses and practices, taking shape as a new terrain in which the clinician-patient dialectic again becomes explicit and in which the critique of obstetric violence extends to gynaecological pathways as a whole.

9. *Conclusions*

The genealogy reconstructed in this chapter shows that the emergence of obstetric and gynaecological violence in Italy is not a sudden event, but rather the result of at least half a century of feminist and transfeminist struggles. From the *'Basta tacere'* pamphlet by the Ferrara group in the 1970s, to the 2016 social campaign *'Basta tacere: le madri hanno voce'*; from the disputes against the Sant'Anna hospital, to attempts to insert obstetric violence into the penal code; from the self-organization practices of *Lotta femminista* and the self-help of the *Gruppi per la Salute della Donna*, to the recent mobilizations for the recognition of 'invisible illnesses' as chronic and disabling, a line of continuity emerges whose focus is women's bodies, health, and the capacity of women and LGBTQI+ subjectivities to self-determine their own care pathways.

At the institutional level, this history highlights the persistence of a form of Italian health governance that tends to reproduce hierarchies of power between healthcare professions, policymakers, and users. Legislative initiatives that arise from

[100] Non Una Di Meno (n. 99).

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below are easily neutralized; institutional forms of consultation favour interlocutors endowed with greater economic and political capital; the demand for 'objective' data is mobilized selectively to delegitimize counter-knowledges produced from below. In this sense, the events connected with the institutional pathway on obstetric violence are not anomalies, but symptoms of a systemic configuration.

At the epistemic level, the dispute between 'obstetric violence' and 'sub-standard and disrespectful care' brings to light two different regimes of truth: on the one hand, a medical knowledge that claims neutrality, objectivity, the centrality of evidence, and the protection of the professional image; on the other, a situated knowledge that takes people's experience as a legitimate source of knowledge, inscribing clinical practices in a continuum of institutional gender-based violence. The conflict is played out not only over words, but over the very definition of what counts as a health problem and who has the power to name it.

The emergence of gynaecological violence through 'invisible illnesses' shows, finally, how feminist and transfeminist critique has shifted from the moment of childbirth to the entire span of sexual and reproductive health pathways. In this process, the clinician-patient relationship is rethought not only as a space of care, but as a field of epistemic and political tension in which the redistribution of power, the redefinition of quality standards, and the possibility of constructing forms of care that are genuinely shared are at stake.

From the standpoint of governance, this implies shifting attention from 'humanization' policies alone, often generic and conciliatory, to concrete devices of accountability and participation: transparency of decision-making processes; the systematic inclusion of users' associations in the definition of health policies; mandatory training of healthcare personnel on human rights, on the intersectionality of gender, race, and class issues, and on feminist epistemologies.

Only by making power relations explicit as a structural issue does it become possible to envisage a real transformation of the clinician-patient relationship and of the health system. From this perspective, the principal challenge does not consist solely in updating guidelines or improving quality indicators, but in recognizing and transforming the power relations that traverse places of care. Any intervention that aspires to prevent forms of disrespectful or harmful treatment must address this systemic dimension, promoting a redistribution of power and knowledge

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between those who provide care and those who are cared for. Until these dynamics are addressed openly, communication between clinicians and patients will continue to be marked by misunderstandings, corporate defensiveness, and mutual mistrust, limiting the possibilities of building care pathways that truly respect people's rights and lived experience.

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ISBN 978-88-495-6175-3

Section III
Gynaecological violence

Sarah Gino, Elena Rubini

The shadow of gynecological violence in the health management of gender-based violence

1. *Gender-based violence: a comprehensive view*

Gender-based violence has been recognized in recent years as a global and public health issue and a violation of human rights, including breaches of body integrity, dignity, and self-determination.[1,2,3,4]

The Explanatory Report of the Council of Europe Convention on preventing and combating violence against women and domestic violence (e.g., Istanbul Convention) defines GBV as 'any type of harm that is perpetrated against a person or group of people because of their factual or perceived sex, gender, sexual orientation and/or gender identity'.[5]

[1] World Health Organization, *Guidelines for Medico-Legal Care for Victims of Sexual Violence* (2003) <https://apps.who.int/iris/handle/10665/42788>.

[2] Seshananda Sanjel, 'Gender-Based Violence: A Crucial Challenge for Public Health' (2015) 11(2) Kathmandu University Medical Journal 179 <https://doi.org/10.3126/kumj.v11i2.12499>.

[3] Ann Öhman *et al.*, '"The Public Health Turn on Violence against Women": Analysing Swedish Healthcare Law, Public Health and Gender-Equality Policies' (2020) 20(1) BMC Public Health 753 <https://doi.org/10.1186/s12889-020-08766-7>.

[4] World Health Organization, *World Report on Violence and Health* (2002) <https://apps.who.int/iris/bitstream/handle/10665/42495/9241545615_eng.pdf>.

[5] Council of Europe, *Convention on Preventing and Combating*

 ISBN 978-88-495-6175-3

Violence against women, in the majority of cases enacted by men, is the most prevalent type of GBV, and was defined by WHO as 'any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life'.[6,7,8,9]

Different forms of GBV have been described, the most common being physical, psychological or emotional, sexual, and economic violence.[10] However, other types of abuse are worth mentioning, in particular those connected to harmful traditional practices (e.g., belief in witchcraft, breast ironing, dowry violence, early and forced marriage, female genital mutilation or cutting, honor killing), as well as limited access to education, which impacts the life of many women and girls globally.[11,12]

Of particular importance to the reflection on gynecological violence and the health management of GBV is sexual violence, which has been defined as 'any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting'.[13]

Rape, violence targeting the genital-anal region and other erogenous sites, unwanted sexual touching, forced nudity, sexual

Violence against Women and Domestic Violence (2011) <https://rm.coe.int/168008482e>.

[6] World Health Organization, 'Violence against Women' (2024) Newsroom (blog) <https://www.who.int/en/news-room/fact-sheets/detail/violence-against-women>.

[7] Council of Europe, *Gender Identity, Gender-Based Violence and Human Rights* <https://rm.coe.int/chapter-1-gender-identity-gender-based-violence-and-human-rights-gende/16809e1595> accessed 6 December 2024.

[8] UN Women, *Facts and Figures: Ending Violence against Women* (2024) <https://www.unwomen.org/en/articles/facts-and-figures/facts-and-figures-ending-violence-against-women>.

[9] ReliefWeb, *Engaging Men to End Gender-Based Violence Against Women* (2022) <https://reliefweb.int/report/world/engaging-men-end-gender-based-violence-against-women>.

[10] Council of Europe (n. 7).

[11] Coram International, *Harmful Traditional Practices* <https://coraminternational.org/themes/harmful-traditional-practices/> accessed 6 December 2024.

[12] Martina Romanisio *et al.*, 'Taking Care of Women Living with Female Genital Mutilation or Cutting: Characteristics of the Pool of Users of Two Healthcare Facilities in Turin, Northern Italy' (2025) 367 Forensic Science International 112344 <https://doi.org/10.1016/j.forsciint.2024.112344>.

[13] WHO (n. 6).

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trafficking, forced prostitution as well as coercive practices involving forced sterilization, sex selective abortion and female virginity testing are among the diverse manifestations of sexual abuse.[14,15] Interestingly, in recent years the notion of sexual violence has been expanded in some legislations to encompass not only non-penetrative acts, but also unwanted sexual touching in non-erogenous areas.[16]

Sexual abuse constitutes a violation of the sexual and reproductive health and rights of individuals, including the right to choose one's own sexual partner, to engage in consensual sexual relations, and to make free and informed decisions concerning reproduction.[17,18]

For this reason, it is of paramount importance that the health management of survivors provides them with notions of empowerment, recognizing this violation and offering through the respect of the informed consent, conceptualized following a survivor-centered approach lens, a first step in the recovery phase.

While women and girls are the population most affected by GBV, other individuals who belong to one or more vulnerable groups (e.g., due to notions of race, age, ethnicity, migration, disability, or those who have a non-conforming gender identity, whose sexual orientation is different from heterosexual, as well as those who engage in sex work or are victims of trafficking) can also be affected by it.[19,20,21,22]

[14] Preventing Sexual Violence in Conflict Initiative, *Principles for Global Action: Preventing and Addressing Stigma Associated with Conflict-Related Sexual Violence* (2017) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/645636/PSVI_Principles_for_Global_Action.pdf>.

[15] WHO (n. 4).

[16] Giulia Faillaci, 'Violenza sessuale: il "mero contatto fisico" idoneo a integrare il reato e l'attenuante della particolare tenuità' [Sexual Violence: When "Mere Physical Contact" Is Sufficient to Establish the Offence] NJUS (blog) <https://www.njus.it/news/2399/violenza-sessuale-il-mero-contatto-fisico-idoneo-a-integrare-il-reato-e-l-attenuante-della-particolare-tenuita/> accessed 10 January 2025.

[17] Ann M. Starrs *et al.*, 'Accelerate Progress - Sexual and Reproductive Health and Rights for All: Report of the Guttmacher-Lancet Commission' (2018) 391(10140) Lancet 2642 <https://doi.org/10.1016/S0140-6736(18)30293-9>.

[18] Elena Rubini *et al.*, 'Negative Consequences of Conflict-Related Sexual Violence on Survivors: A Systematic Review of Qualitative Evidence' (2023) 22(1) International Journal for Equity in Health 227 <https://doi.org/10.1186/s12939-023-02038-7>.

[19] European Union, 'Gender-Based Violence' Capacity4dev (blog) <https://capacity4dev.europa.eu/resources/results-indicators/gender-based-violence_en>.

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For this reason, it is important to understand the risk factors for GBV and the needs of everyone in an intersectional lens, recognizing how multiple identities can amplify the risk for and the impact of abuse. At the same time, while men are preponderantly the perpetrators of abuse, women have also been identified as aggressors.[23,24] Perpetrators of violence can have varying degrees of relationship with the victim, ranging from intimate partners and former partners to family members, friends, acquaintances, and even strangers. Nevertheless, intimate partner violence (IPV) is the most frequent type of GBV.[25,26]

The setting can also exacerbate the risk for violence to occur, for example in the case of conflicts and migration, which have been identified as particularly threatening, and often interconnected, for affected populations to become victims of abuse.[27] A continuum of violence has been recognized in the literature more generally on GBV but especially on migrant women.[28,29,30] This continuum not only encompasses the life

[20] World Health Organization, *Violence against Women 60 Years of Age and Older* (2024) <https://iris.who.int/bitstream/handle/10665/376338/9789240090996-eng.pdf>.

[21] Lindsay Stark *et al.*, 'Measuring Violence against Women amidst War and Displacement in Northern Uganda Using the Neighborhood Method' (2010) 64(12) Journal of Epidemiology & Community Health 1056 <https://doi.org/10.1136/jech.2009.09379>.

[22] Niloofar Dabaghi, Mostafa Amini-Rarani and Mehdi Nosratabadi, 'Investigating the Relationship between Socioeconomic Status and Domestic Violence against Women in Isfahan, Iran in 2021: A Cross-Sectional Study' (2023) 6(5) Health Science Reports e1277 <https://doi.org/10.1002/hsr2.1277>.

[23] Sverker Sikström and Mats Dahl, 'How Bad Is Bad? Perceptual Differences in the Communication of Severity in Intimate Partner Violence' (2023) 10(1) Humanities and Social Sciences Communications 89 <https://doi.org/10.1057/s41599-023-01578-1>.

[24] ReliefWeb (n. 9).

[25] EIGE, *Intimate Partner Violence* <https://eige.europa.eu/publications-resources/thesaurus/terms/1198?language_content_entity=en> accessed 8 January 2025.

[26] World Health Organization, *Global and Regional Estimates of Violence against Women* (2013) <https://www.who.int/publications/i/item/9789241564625>.

[27] Elisabeth Jean Wood, 'Variation in Sexual Violence during War' (2006) 34(3) Politics & Society 307 <https://doi.org/10.1177/0032329206290426>.

[28] Elena Rubini *et al.*, 'Migrant Survivors of Conflict-Related Sexual Violence Accessing a Specialist Health Service in Turin, Italy: A Qualitative Analysis of Clinical Forensic Interview Transcripts' (2024) 9 Frontiers in Sociology 1454700 <https://doi.org/10.3389/fsoc.2024.1454700>.

[29] Ulrike Krause, 'A Continuum of Violence? Linking Sexual and Gender-

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cycle of victims, but also the different phases of their migratory path (from their country of origin, to transit or destination countries), with victims describing suffering from a variety of forms of abuse, not limited to GBV but also intertwined with acts of violence against migrants (e.g., labor or sexual trafficking, denial of care, unlawful detainment).[31] Conflict-related sexual violence (CRSV) can be used as a weapon of war by members of armed forces but can also be enacted for opportunistic reasons by them or by civilians, who exploit the disruption of society provoked by the hostilities.[32,33,34,35,36,37] Moreover, in the context of the continuum of violence, some scholars have highlighted the necessity to incorporate IPV among the different types of CRSV.[38,39]

In the context of conflict and during migration, issues connected with notions of power, which constitute one of the

Based Violence during Conflict, Flight, and Encampment' (2015) 34(4) Refugee Survey Quarterly 1 <https://doi.org/10.1093/rsq/hdv014>.

[30] Jelke Boesten, 'Of Exceptions and Continuities: Theory and Methodology in Research on Conflict-Related Sexual Violence' (2017) 19(4) International Feminist Journal of Politics 506 <https://doi.org/10.1080/14616742.2017.1367950>.

[31] L Reques *et al.*, 'Episodes of Violence Suffered by Migrants Transiting through Libya: A Cross-Sectional Study in "Médecins du Monde's" Reception and Healthcare Centre in Seine-Saint-Denis, France' (2020) 14(1) Conflict and Health 12 <https://doi.org/10.1186/s13031-020-0256-3>.

[32] Elisabeth Jean Wood, 'Armed Groups and Sexual Violence: When Is Wartime Rape Rare?' (2009) 37(1) Politics & Society 131 <https://doi.org/10.1177/0032329208329755>.

[33] Elisabeth Jean Wood (n. 27).

[34] Laura Heaton, 'The Risks of Instrumentalizing the Narrative on Sexual Violence in the DRC: Neglected Needs and Unintended Consequences' (2014) 96(894) International Review of the Red Cross 625 <https://doi.org/10.1017/S1816383115000132>.

[35] Alicia Elaine Luedke and Hannah Faye Logan, '"That Thing of Human Rights": Discourse, Emergency Assistance, and Sexual Violence in South Sudan's Current Civil War' (2018) 42 Disasters S99 <https://doi.org/10.1111/disa.1227>.

[36] Sara Meger, 'The Fetishization of Sexual Violence in International Security' (2016) 60(1) International Studies Quarterly 149 <https://doi.org/10.1093/isq/sqw003>.

[37] Boesten (n. 30).

[38] Lindsay Stark and Mike Wessells, 'Sexual Violence as a Weapon of War' (2012) 308(7) JAMA 677 <https://doi.org/10.1001/jama.2012.9733>.

[39] Preventing Sexual Violence in Conflict Initiative, *A Theory of Change for Addressing Conflict-Related Sexual Violence* (28 November 2022) <https://www.gov.uk/government/publications/preventing-sexual-violence-in-conflict-initiative-strategy/a-theory-of-change-for-addressing-conflict-related-sexual-violence#fn:51>.

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root causes of GBV, are exacerbated. One the one hand, power equally acts as a triggering force for the start of a conflict, while on the other disproportionate power distribution is amplified during migration, which can lead to context-specific forms of abuse, such as transactional sex, namely migrants being sexually abused in order to have access to food, shelter, or to cross a border.[40]

2. *Health consequences of gender-based violence*

GBV hinders the health of individuals affected by it, and, as a global public health issue, its consequences are also reflected at institutional level.

GBV carries negative outcomes on the different dimensions of health of survivors that can affect them in the short, medium, and long-term.[41]

Violence can lead to acute physical lesions (e.g., at soft tissue and musculoskeletal level), injuries that can possibly lead to disabilities, chronic pain, and overall long-term poor health status.[42] Studies have identified contusions, abrasions, lacerations, and musculoskeletal injuries as some of the most common injury patterns observed in patients seeking emergency care for IPV cases.[43] Additionally, head, neck, and facial injuries are widely recognized in the literature as IPV-specific and are among the most documented physical sequelae, alongside injuries to the limbs and extremities, which are likely caused, in many cases, by victims attempting to defend themselves.[44,45,46,47,48]

[40] Rea A. Belanteri *et al.*, 'Sexual Violence against Migrants and Asylum Seekers. The Experience of the MSF Clinic on Lesvos Island, Greece' (2020) 15(9) PLoS ONE e0239187 https://doi.org/10.1371/journal.pone.0239187>.

[41] World Health Organization, *Understanding and Addressing Violence against Women: Intimate Partner Violence* (2012) <https://iris.who.int/bitstream/handle/10665/77432/WHO_RHR_12.36_eng.pdf>.

[42] WHO (n. 41).

[43] Randall T. Loder and Luke Momper, 'Demographics and Fracture Patterns of Patients Presenting to US Emergency Departments for Intimate Partner Violence' (2020) 4(2) JAAOS: Global Research and Reviews e20.00009 <https://doi.org/10.5435/JAAOSGlobal-D-20-00009>.

[44] Victor Wu, Harold Huff and Mohit Bhandari, 'Pattern of Physical Injury Associated with Intimate Partner Violence in Women Presenting to the Emergency Department: A Systematic Review and Meta-Analysis' (2010) 11(2) Trauma, Violence, & Abuse 71 <https://doi.org/10.1177/1524838010367503>.

[45] Rahul Gujrathi *et al.*, 'Facial Injury Patterns in Victims of Intimate Partner Violence' (2022) 29(4) Emergency Radiology 697 <https://doi.org/10.1007/s10140-022-02052-2>.

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Notably, the head and limbs are also the anatomical regions most frequently affected in femicide cases.[49,50]

From a mental health perspective, survivors can experience depression, sleeping and eating disorders, stress and anxiety disorders, self-harm, and substance abuse.[51]

Also the sexual and reproductive dimension can be directly or indirectly affected by abuse due to sexually transmitted infections, unwanted pregnancy, which can lead to termination or unsafe abortion, gynecological or urological issues, and painful sexual intercourse.[52]

Being victims of GBV can also lead to unsafe sexual or relational behaviors.[53,54,55,56,57]

Pregnancy is a condition that heightens the risk for GBV,

[46] Janet Yuen-Ha Wong *et al.*, 'Patterns, Aetiology and Risk Factors of Intimate Partner Violence-Related Injuries to Head, Neck and Face in Chinese Women' (2014) 14 BMC Women's Health 6 <https://doi.org/10.1186/1472-6874-14-6>.

[47] Bach T. Le *et al.*, 'Maxillofacial Injuries Associated with Domestic Violence' (2001) 59(11) Journal of Oral and Maxillofacial Surgery 1277 <https://doi.org/10.1053/joms.2001.27490>.

[48] Richard Thomas *et al.*, 'Upper Extremity Injuries in the Victims of Intimate Partner Violence' (2021) 31(8) European Radiology 5713 <https://doi.org/10.1007/s00330-020-07672-1>.

[49] Georgia Zara and Sarah Gino, 'Intimate Partner Violence and Its Escalation into Femicide. Frailty Thy Name Is "Violence Against Women"' (2018) 9 Frontiers in Psychology 1777 <https://doi.org/10.3389/fpsyg.2018.01777>.

[50] Georgia Zara *et al.*, 'The Medicolegal, Psycho-Criminological, and Epidemiological Reality of Intimate Partner and Non-Intimate Partner Femicide in North-West Italy: Looking Backwards to See Forwards' (2019) 133(4) International Journal of Legal Medicine 1295 <https://doi.org/10.1007/s00414-019-02061-w>.

[51] WHO (n. 41).

[52] WHO (n. 41).

[53] WHO (n. 41).

[54] Susan Rees *et al.*, 'Lifetime Prevalence of Gender-Based Violence in Women and the Relationship with Mental Disorders and Psychosocial Function' (2011) 306(5) JAMA 513 <https://doi.org/10.1001/jama.2011.1098>.

[55] Delia L. Lang *et al.*, 'Associations Between Recent Gender-Based Violence and Pregnancy, Sexually Transmitted Infections, Condom Use Practices, and Negotiation of Sexual Practices Among HIV-Positive Women' (2007) 46(2) Journal of Acquired Immune Deficiency Syndromes 216 <https://doi.org/10.1097/QAI.0b013e31814d4dad>.

[56] Michelle R. Kaufman *et al.*, 'The Intersection of Gender-Based Violence and Risky Sexual Behaviour among University Students in Ethiopia: A Qualitative Study' (2020) 11(3) Culture, Health & Sexuality 198 <https://doi.org/10.1080/19419899.2019.1667418>.

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with abuse during this life stage being more common compared to traditionally acknowledged health issues during pregnancy such as pre-eclampsia and gestational diabetes.[58,59]

GBV can also lead to fatal consequences, which can be related in the long term to chronic conditions developed after abuse, connected with self-harm, or to interpersonal violence in cases of femicide or partner homicide.[60] These are mostly perpetrated by intimate partners and are usually connected to the phenomenon of overkilling, namely when the number or the severity of the wounds provoked by the aggressor exceeds what is necessary to cause death.[61,62,63]

GBV can lead to adverse health outcomes also to individuals other than the direct victim, for example in the case of children witnessing violence, which constitutes a form of mistreatment against minors.[64,65]

Many justifications for conceptualizing GBV as a public health issue exist, and extend over the magnitude of the problem, revolving around the large number of individuals affected

[57] Zakir Gaffoor *et al.*, 'High Risk Sexual Behaviors Are Associated with Sexual Violence among a Cohort of Women in Durban, South Africa' (2013) 6(1) BMC Research Notes 532 <https://doi.org/10.1186/1756-0500-6-532>.

[58] Marco Bo *et al.*, 'Violence against Pregnant Women in the Experience of the Rape Centre of Turin: Clinical and Forensic Evaluation' (2020) 76 Journal of Forensic and Legal Medicine 102071 <https://doi.org/10.1016/j.jflm.2020.102071>.

[59] Beth A. Bailey and Ruth Ann Daugherty, 'Intimate Partner Violence During Pregnancy: Incidence and Associated Health Behaviors in a Rural Population' (2007) 11(5) Maternal and Child Health Journal 495 <https://doi.org/10.1007/s10995-007-0191-6>.

[60] WHO (n. 41).

[61] Rossana Cecchi *et al.*, 'Femicide and Forensic Pathology: Proposal for a Shared Medico-Legal Methodology' (2023) 60 Legal Medicine 102170 <https://doi.org/10.1016/j.legalmed.2022.102170>.

[62] Georgia Zara *et al.*, 'Sexual Femicide, Non-Sexual Femicide and Rape: Where Do the Differences Lie? A Continuum in a Pattern of Violence against Women' (2022) 13 Frontiers in Psychology 957327 <https://doi.org/10.3389/fpsyg.2022.957327>.

[63] Zara and Gino (n. 49).

[64] European Commission, *Witnessing Violence: Definition and Consequences* <https://ec.europa.eu/programmes/erasmus-plus/project-result-content/39822fe2-6e81-4c12-9385-c86c65de53fb/WIDE_REPORT_01_REV.pdf> accessed 8 January 2025.

[65] Carme Montserrat *et al.*, 'Children's Understandings of Gender-Based Violence at Home: The Role School Can Play in Child Disclosure' (2022) 136 Children and Youth Services Review 106431 <https://doi.org/10.1016/j.childyouth.2022.106431>.

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by it, the long-lasting damage to the health and well-being of survivors, the urgency of the response of health systems to it, and the unequal distribution of GBV. GBV is both conceptualized as a pandemic and as a health factor that can be the focus of preventive and screening campaigns. The healthcare sector has been recognized as an important stakeholder in developing training programs, policies and guidelines, as well as protocols for the management of the sequelae of GBV.[66] From a more individual perspective, the health staff is often the first point of contact for victims of GBV, a situation that poses particular challenges to providers.

The burden of morbidity and mortality of GBV related to both acute and chronic conditions suffered in the aftermath of abuse is high. A study on the Global Burden of Disease has identified IPV as accounting for more overall disability-adjusted life-years in women compared to other risk factors such as smoking, including a substantial increase in the risk for developing depression or of becoming infected with HIV.[67,68]

This burden also carries a financial cost, which for GBV in the European Union has been estimated to €366 billion a year, with violence against women amounting to 79% of this expense. These included lost economic output caused by diminished productivity by the victim, the cost of public services the survivor accessed (e.g., health, justice, housing aid, child protection), and physical and emotional impact.[69,70]

Although evidence on the cost-effectiveness of various

[66] Isabel Goicolea, 'What a Critical Public Health Perspective Can Add to the Analysis of Healthcare Responses to Gender-Based Violence That Focus on Asking' (2023) 23(1) BMC Public Health 1738 <https://doi.org/10.1186/s12889-023-16641-4>.

[67] Cory N. Spencer *et al.*, 'Estimating the Global Health Impact of Gender-Based Violence and Violence against Children: A Systematic Review and Meta-Analysis Protocol' (2022) 12(6) BMJ Open e061248 <https://doi.org/10.1136/bmjopen-2022-061248>.

[68] Ali H. Mokdad *et al.*, 'Global Burden of Diseases, Injuries, and Risk Factors for Young People's Health during 1990-2013: A Systematic Analysis for the Global Burden of Disease Study 2013' (2016) 387(10036) Lancet 2383 <https://doi.org/10.1016/S0140-6736(16)00648-6>.

[69] EIGE, *Costs of Gender-Based Violence in the European Union* (European Union 2021) <https://eige.europa.eu/gender-based-violence/costs-of-gender-based-violence> accessed 7 February 2025.

[70] EIGE, *Estimating the Costs of Gender-Based Violence in the European Union: Report* (2014) <https://eige.europa.eu/publications-resources/publications/estimating-costs-gender-based-violence-european-union-report>.

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intervention strategies seems scattered in the literature, prevention campaigns are undoubtedly key to reducing the direct impact of violence on survivors' health by reducing the prevalence of GBV itself.[71,72]

One of the many strategies that can be used to involve in the prevention of GBV in the general population, in particular the younger generations, is to ensure the delivery of comprehensive sexuality education, namely 'a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. It aims to equip children and young people with knowledge, skills, attitudes and values that will empower them to: realize their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and, understand and ensure the protection of their rights throughout their lives'. The knowledge delivered needs to be scientifically accurate, incremental, age- and developmentally- appropriate, curriculum based, and comprehensive (e.g., not limited to specific biomedical aspects).[73] This encompasses modules on relationships, human rights in relation to culture and sexuality, and violence to be provided at all levels of education. Concepts such as consent, privacy, and bodily integrity, as well as respect, communication, refusal, and negotiation skills are of fundamental importance in order to promote a climate that abhors the use of coercion and force in interpersonal relationships, including intimate partner ones.[74] This aims to equip individuals from a young age with the skills needed to understand their human rights and recognize when those rights are being violated, as well as empowering them to identify where to seek help and support.

[71] Lauren Sheppard *et al.*, 'What Interventions Are Cost Effective in Reducing Violence Against Women? A Scoping Review' (2024) 22(3) Applied Health Economics and Health Policy 283 <https://doi.org/10.1007/s40258-023-00870-0>.

[72] UNFPA, *Cost of Ending Gender-Based Violence* <https://www.unfpa.org/sites/default/files/resource-pdf/Costing_of_Transformative_Results_Chapter_5_-_Cost_of_Ending_Gender-Based_Violence.pdf> accessed 7 February 2025.

[73] UNAIDS *et al.*, *International Technical Guidance on Sexuality Education* (2018) <https://www.unfpa.org/sites/default/files/pub-pdf/ITGSE.pdf>.

[74] UNFPA, *Comprehensive Sexuality Education as a Strategy for Gender-Based Violence* (2021) <https://asiapacific.unfpa.org/en/publications/comprehensive-sexuality-education-strategy-gender-based-violence-prevention-1>.

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3. *Management of GBV at health facility level: an overview*

According to the Istanbul Convention, cases of GBV are to be managed by general services (e.g., Emergency Department, ED) or specialist ones. While the former tend to focus more on the clinical management of survivors of violence, the latter includes also sexual violence relief centers, where dedicated personnel are trained to ensure high quality clinical and forensic management. Specialist services usually coordinate their activities with anti-violence centers and other third sector organizations working at local and community level. Most commonly, in Italy victims access care through the ED, due to the very limited number of specialized centers at national level, which in addition are situated solely in North-West Italy.[75,76,77,78,79,80] Given that the personnel in the ED does not solely manage GBV cases, it is necessary for them to be fully educated and trained, to perform all the clinical procedures connected to GBV management and to fulfill their medico-legal duties. This is particularly important considering that some studies have highlighted the difficulties ED personnel have in correctly documenting the sequelae of abuse in cases of GBV and other interpersonal violence.[81] This carries important consequences spanning from the lack of appropriate measures for the clinical management of such patients hindered by the limited information available, as well as a loss of data that could

[75] Rubini (n. 28).

[76] Council of Europe, *Convention on Preventing and Combating Violence against Women and Domestic Violence*.

[77] Council of Europe, *Explanatory Report to the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence* (2011) <https://www.istat.it/it/files/2017/11/ExplanatoryreporttoIstanbulConvention.pdf>.

[78] Cristina Cattaneo *et al.*, 'Consequences of the Lack of Clinical Forensic Medicine in Emergency Departments' (2024) 138(1) International Journal of Legal Medicine 139 <https://doi.org/10.1007/s00414-023-02973-8>.

[79] Bavo Hendriks *et al.*, 'Towards a More Integrated and Gender-Sensitive Care Delivery for Victims of Sexual Assault: Key Findings and Recommendations from the Belgian Sexual Assault Care Centre Feasibility Study' (2018) 17(1) International Journal for Equity in Health 152 <https://doi.org/10.1186/s12939-018-0864-3>.

[80] Ministero della Salute, *Violenza e accessi delle donne in pronto soccorso nel triennio 2017-2019* [Violence and Women's Presentations to Accident and Emergency Departments, 2017-2019] (2022) <https://www.salute.gov.it/imgs/C_17_notizie_5187_0_file.pdf>.

[81] Cattaneo *et al.* (n. 78).

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be crucial for understanding the dimensions of the phenomenon of GBV and to correctly implement preventive measures.[82] For this reason, two initiatives have been implemented, on the one hand involving healthcare providers, and on the other by collecting and disseminating disaggregated data on GBV following the Istanbul Convention.

Educational and training activities have been provided for healthcare professionals in recent years at national and at regional level and covering different areas of interest to them. At national level, in Italy the *Istituto Superiore di Sanità* [Italian National Institute of Health], namely the leading technical-scientific body of the Italian National Health System, organized a series of online educational and training activities on the issue of GBV and violence against women. In the years 2015-2016, these involved health professionals working in ED and focused on the prevention and contrast to GBV within territorial networks, while in 2020 another course dealing with the interconnection between violence targeting women and child abuse and specifically on witnessed violence was administered, involving health and social staff working with these populations.[83,84]

Other initiatives have been organized at regional and local level, for example in Piedmont through the activities coordinated since 2009 by the regional network for the prevention and management of victims of sexual and domestic violence (*Coordinamento della rete sanitaria per l'accoglienza e presa in carico delle vittime di violenza sessuale e domestica della Regione Piemonte*), which included among others educational, awareness-raising, and training activities, as well as the development of standards of care for the management of GBV survivors in health facilities.[85]

[82] Cattaneo *et al.* (n. 78).

[83] Ministero della Salute, 'Violenza sulle Donne - La Formazione degli Operatori Sociosanitari' [Violence against Women - Training of Health and Social Care Professionals] (2023) Salute Della Donna (blog) <https://www.salute.gov.it/portale/donna/dettaglioContenutiDonna.jsp?lingua=italiano&id=4498&area=indennizzo&menu=vuoto&tab=4>.

[84] EDUISS, *Prevenzione e contrasto della violenza di genere attraverso le reti territoriali* [Prevention and Tackling of Gender-Based Violence through Local Networks] (2015) <https://www.eduiss.it/theme/tcontinuum/infocourse.php?course=179&popup=1>.

[85] IRES Piemonte/Regione Piemonte, *Il Centro di Coordinamento Regionale contro la Violenza alle Donne* [The Regional Coordination Centre for Combating Violence against Women] <http://centroantiviolenza.comune.torino.it/wp-content/uploads/MAPPATURA_-REGIONE.pdf> accessed 10 January 2025.

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From an institutional and statistical perspective at national level the Italian Institute of Statistics (ISTAT) together with the Ministry of Health collects data from the different Emergency Departments regarding cases of GBV, given that law n. 53/2022 mandates them to document data on this form of abuse, and also taking into consideration that most survivors who decide to access care do so through these general services.[86,87,88,89]

Moreover, normative changes have been implemented in the healthcare sector as well, encompassing policies and protocols regulating triage, including the mandatory assignment of a yellow or equivalent code (e.g., urgent care needed) for patients presenting for cases of GBV.[90]

Usually, the management of GBV cases follows a common pattern, namely after obtaining informed consent from the patient, the health staff conducts an interview with survivors where they describe the details of the abuse, then a top-to-toe examination is performed, and – in case it is necessary – a genital-anal examination is conducted. The findings of the medical examination are then documented in written forms and ideally through photographs.[91] More details on the clinical-forensic medical examination will be provided in the next sections.

The response to GBV, including the management of patients who experienced abuse, needs to follow a 'survivor-centered approach'.[92] This includes the right to autonomy, including deciding whether to report the violence they suffered, the

[86] ISTAT, 'Violenza e accesso delle donne al pronto soccorso' [Violence and Women's Access to Accident and Emergency Departments] https://www.istat.it/it/violenza-sulle-donne/il-fenomeno/violenza-e-accesso-delle-donne-alle-strutture-ospedaliere/accesso-delle-donne-al-pronto-soccorso accessed 10 January 2025.

[87] Ministero della Salute (n. 80).

[88] Camera dei deputati, 'Violenza contro le donne' [Violence against Women] (2024) <https://temi.camera.it/leg19/temi/violenza-contro-le-donne.html>.

[89] Council of Europe, *Convention on Preventing and Combating Violence against Women and Domestic Violence*.

[90] D.P.C.M. 24 novembre 2017, *Linee guida nazionali per le aziende sanitarie e le aziende ospedaliere in tema di soccorso e assistenza socio-sanitaria alle donne vittime di violenza* [National Guidelines for Health Authorities on the Emergency Response and Health and Social Care Support for Women Victims of Violence] (2017) <https://www.trovanorme.salute.gov.it/norme/dettaglioAtto?id=62811&completo=true>.

[91] WHO (n. 1)

[92] WHO (n. 1).

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fulfillment of the right to privacy of victims, and the assurance of access to services free from discrimination. It also includes the provision of clear information to patients on navigating the healthcare pathway and of support to overcome any barriers they may encounter.[93]

The element of informed consent gains particular value in the management of survivors of sexual violence. In this situation, consent needs to be informed in a strict sense, meaning that patients should be fully aware of the procedures to be performed and understand their right to withdraw consent at any point during the process. Beyond being a professional obligation for healthcare providers, informed consent in the case of patients who are survivors of GBV also serves as a means of restoring autonomy and decision-making over their body, thereby empowering them. This also means that the patient has the right to decide whether to undergo all phases of the clinical-forensic medical examination. If they feel uncomfortable, they can also choose to skip certain steps, such as evidence collection, genital-anal examination, photography, or reporting to authorities.

The element of informed consent also carries particular relevance in cases of obstetric-gynecological violence, namely any act by which patients are treated with injustice, abuse or discrimination during their obstetric and gynecological experiences, including abuse and not obtaining informed consent from patients. These elements translate in a loss of autonomy over patients' bodies and consequently in an infringement of their integrity as persons, resulting in dehumanization.[94,95] Once again, these forms of violence derive from an imbalance of power occurring between patients and health providers, more evident for members of specific marginalized groups (e.g., Black, Latinx, from low socioeconomic status) and encompass also routine episiotomies and frequent unjustified vaginal examinations as well as coercion, for example being pressured to induce labor. While generally being applied to abuse occurring during

[93] UNODC, Stop Rape Now and World Health Organization, *Strengthening the Medico-Legal Response to Sexual Violence* (2024) <https://www.unodc.org/documents/publications/WHO_RHR_15.24_eng.pdf>.

[94] 'Autonomy, Violence, and Consent in the Obstetric Field' (2025) 40 Hypatia 498 <https://doi.org/10.1017/hyp.2024.84>.

[95] Camilla Pickles, '"Everything Is Obstetric Violence Now": Identifying the Violence in "Obstetric Violence" to Strengthen Socio-Legal Reform Efforts' (2024) 44(3) Oxford Journal of Legal Studies 616 <https://doi.org/10.1093/ojls/gqae016>.

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childbirth, the definition of obstetric-gynecological violence can cover a variety of forms of abuse taking place in reproductive healthcare.[96,97] It is important for health staff to be aware of these forms of GBV violence in the context of healthcare, to educate and train them to prevent such behavior from happening, and to implement whistleblowing procedures so that abusive health staff can be reported and sanctioned.

Health staff members can also become victims of GBV in their workplaces, both perpetrated by patients or their relatives as well as by colleagues and supervisors. Abuses can include physical, verbal, sexual, and psychological violence. Female staff are usually the most affected group, in particular nurses. This, as any other form of GBV seriously affects victims' health and occupational capacities.[98,99,100] Therefore, health facilities should foster a culture of respect and consent that goes beyond managing cases of GBV presenting in the ED but expands over prevention activities also for GBV forms that are context-specific, including obstetrical-gynecological violence and GBV against health staff.

Survivors of GBV may face several barriers in accessing healthcare services, which encompass different domains of the patient-centered access to care model proposed by Levesque *et al.* These among others revolve around the ability of survivors to understand their need to access health services, and to seek and reach them, however, these barriers develop also at health system level, which need to be approachable, accepted, available, affordable, and appropriate to encourage access to care.[101]

GBV is a form of abuse that is particularly drenched in

[96] Restrepo-Sánchez (n. 94).

[97] Mounika Polavarapu *et al.*, 'Role of Obstetric Violence and Patient Choice: Factors Associated with Episiotomy' (2024) 69(5) Journal of Midwifery & Women's Health 718 <https://doi.org/10.1111/jmwh.13655>.

[98] Gianpietro Volonnino *et al.*, Healthcare Workers: Heroes or Victims? Context of the Western World and Proposals to Prevent Violence' (2024) 12(7) Healthcare 708 <https://doi.org/10.3390/healthcare12070708>.

[99] Sioban Nelson *et al.*, 'A Gender-Based Review of Workplace Violence amongst the Global Health Workforce: A Scoping Review of the Literature' (n.d.).

[100] May-Elizabeth E. Ajuwa *et al.*, 'Workplace Violence against Female Healthcare Workers: A Systematic Review and Meta-Analysis' (2024) 14(8) BMJ Open e079396 <https://doi.org/10.1136/bmjopen-2023-079396>.

[101] Jean-Frédéric Levesque, Mark F. Harris and Grant Russell, 'Patient-Centred Access to Health Care: Conceptualising Access at the Interface of Health Systems and Populations' (2013) 12(1) International Journal for Equity in Health 18 <https://doi.org/10.1186/1475-9276-12-18>.

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social taboos surrounding relationships and sexuality, and the same taboos may affect the decision of survivors to access care or conversely the behavior and beliefs of the health providers taking charge of victims, which may be stigmatizing and victim-blaming in nature, and characterized by a general disbelief or by adherence to stereotypes. Survivors may be aware of possible negative reactions from health staff and avoid seeking care, exacerbating the adverse consequences on their health.[102]

Providers' beliefs may also hinder access to emergency contraception or pregnancy termination for survivors of sexual violence seeking them in countries where this barrier is not present at institutional level for survivors of rape.[103,104,105] This constitutes once again a breach in their sexual and reproductive rights, that can further exacerbate the negative consequences of abuse by depriving them of their empowerment.

In specific contexts, such as during conflict and migration, victims of GBV may be unable to access care due to the disruption of health facilities provoked by the hostilities or to local legislation limiting their possibility to access those services.[106,107] This could imply that they are able to access care only after a long-time gap after the abuse occurred, with important consequences on their health status as well as with possible issues connected to the documentation of the sequelae of violence for medico-legal and protection purposes.[108,109,110,111]

[102] Rubini (n. 18).

[103] Mabel Felix, Laurie Sobel and Alina Salganicoff, 'A Closer Look at Rape and Incest Exceptions in States with Abortion Bans and Early Gestational Restrictions' (2024) <https://www.kff.org/policy-watch/rape-incest-exceptions-abortion-bans-restrictions/>.

[104] 'The Limits of Conscientious Refusal in Reproductive Medicine' no. 385 (n.d.).

[105] Shadab Shahali *et al.*, 'Barriers to Healthcare Provision for Victims of Sexual Assault: A Grounded Theory Study' (2016) 18(3) Iranian Red Crescent Medical Journal <https://doi.org/10.5812/ircmj.21938>.

[106] Rubini *et al.* (n. 28).

[107] Rubini *et al.* (n. 18).

[108] Rubini *et al.* (n. 18).

[109] Rubini *et al.* (n. 18).

[110] Elena Rubini *et al.*, 'Forensic Medical Examination after CRSV: A Scoping Review of the Literature' (2024) Journal of Forensic and Legal Medicine <https://doi.org/10.1016/j.jflm.2024.102736>.

[111] Paola Castagna *et al.*, 'Violence against African Migrant Women Living in Turin: Clinical and Forensic Evaluation' (2018) 132(4) International Journal of Legal Medicine 1197 <https://doi.org/10.1007/s00414-017-1769-1>.

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4. *Management of GBV at health facility level: the perspective of WHO*

Many of the documents dedicated to the issue of violence against women emphasize that the health care management of a patient who has experienced violence must be 'woman-centered' and guided by two fundamental principles: respect for her human rights and the promotion of gender equality. When engaging with survivors of GBV, it is therefore necessary to use a human rights based approach, in particular aiming at the fulfillment of the right to a life free from the fear or threat of violence; to self-determination, namely to make one's own decisions, including those connected to the sexual and reproductive health and more generally the right to refuse medical procedures; the right to the highest attainable standard of health; to non-discrimination; to privacy and confidentiality; and last but not least, the right to be informed.

In 2013, WHO published a series of guidelines on 'Responding to intimate partner violence and sexual violence against women', because although violence against women had already been conceptualized as a critical public health problem, it was still not covered in the health policies of many countries.

Health professionals have an important role in caring for women victims of violence through the identification, assessment, treatment, and documentation of its consequences and follow-up, also for forensic purposes.[112]

Women who have experienced violence often seek access to health care services, including for the treatment of injuries, even though they may not disclose the associated abuse or violence, and a health professional is usually the first professional point of contact for survivors of intimate partner violence or sexual assault.[113] Health workers can provide aid to survivors of GBV by facilitating disclosure, collecting forensic evidence – particularly in cases of sexual violence – or providing appropriate medical services and follow-up care. Therefore, health professionals must be able

[112] World Health Organization, *Responding to Intimate Partner Violence and Sexual Violence against Women* (2013) <https://iris.who.int/bitstream/handle/10665/85240/9789241548595_eng.pdf>.

[113] Gene S. Feder, 'Women Exposed to Intimate Partner Violence: Expectations and Experiences When They Encounter Health Care Professionals: A Meta-Analysis of Qualitative Studies' (2006) 166(1) Archives of Internal Medicine 22 <https://doi.org/10.1001/archinte.166.1.22>.

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to recognize the signs of violence and respond appropriately, also ensuring the safety of the victim. Individuals exposed to violence need comprehensive and gender-sensitive care.

The recommendations described by WHO contain evidence-based suggestions for the introduction of policies targeting health services and programs to improve the health sector response to violence against women. Each recommendation is classified as 'strong' or 'conditional', based on the generalizability of the benefits in different communities and cultures, the needs and preferences of women in accessing these services, and considering the level of human and other resources that would be required to implement them. The suggestions target health professionals, who are in a unique position to address the health and psychosocial needs of women who have experienced any form of violence.

The WHO identifies several moments in the pathway for the health management of women victims of violence, highlighting the need to provide women-centered frontline care. Any intervention should be guided by the principle of 'do no harm', ensuring a balance between benefits and harms by prioritizing the safety of women and their children. It is important to preserve the right to privacy and confidentiality throughout the pathway of care. The woman's right to self-determination must be the driving force behind the entire process, both at clinical and forensic level. The relationship between health professionals and the woman must be based on support and cooperation, as health staff must not be judgmental towards patients, should understand the gendered dimension of GBV, and recognize it as a violation of human rights.

The WHO suggests screening for sexual violence or IPV only when there are anamnestic, physical, and psychological indicators of violence (e.g., repeated visits to the ED or health care facilities, medical history inconsistent with injuries, unexplained chronic pain, alcohol/drug abuse, suicide attempts, self-harm, sexually transmitted diseases, frequent unexplained trauma, intrusive partner in consultations).[114]

In the same WHO recommendations, it is emphasized that training of healthcare professionals is crucial for providing women with adequate clinical and forensic support.

A document published by the WHO in 2020 and focusing

[114] Michele C. Black, 'Intimate Partner Violence and Adverse Health Consequences: Implications for Clinicians' (2011) 5(5) American Journal of Lifestyle Medicine 428 <https://doi.org/10.1177/1559827611410265>.

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on the management of sexual violence victims, emphasizes the role of healthcare providers in documenting the evidence found during the examination. This duty confines health staff to clinical and forensic responsibilities, as their role does not include determining whether the abuse occurred. Additionally, as the document states, the absence of evidence found during a clinical-forensic medical examination does not imply that violence did not occur.[115]

Another issue the WHO guidelines focus on is the need for obtaining informed consent from the survivor. Patients must be informed about all relevant aspects of clinical and forensic management to help them decide on what is best for them at that time. It is important to ensure that survivors understand that their consent or lack of consent to any aspect of the forensic examination will not affect their access to treatment and care. The health care staff should provide information in a language and form easily understood by the survivor. During the medico-legal examination, the woman may ask questions, interrupt the procedure at any time, and refuse any part of it. It is necessary to explain and ask for consent for each phase of the clinical-forensic management to be performed, approaching the patient gently, especially when a gynecological examination is required.

It is crucial to maintain the dignity of survivors by ensuring they are not fully undressed during examinations, recognizing that sexual violence is a deeply traumatic experience. Given the nature of the trauma, survivors may be particularly sensitive to being examined or touched, especially by a male healthcare provider. This heightened sensitivity should be acknowledged and approached with care and empathy. Additionally, as advised by the WHO, healthcare providers must be mindful of societal norms, as certain cultures may have specific prohibitions against internal vaginal examinations, even with instruments such as a speculum or swabs. Understanding these cultural contexts is essential in providing respectful and appropriate care while ensuring that medical procedures are conducted with the survivor's comfort and consent in mind.[116]

If it is relevant based on the history of violence as reported by the victim and if they have given consent, forensic evidence must also

[115] World Health Organization, *Clinical Management of Rape and Intimate Partner Violence Survivors* (2020) <https://iris.who.int/bitstream/handle/10665/331535/9789240001411-eng.pdf>.

[116] WHO (n. 115).

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be collected. This must be done during the medical examination, so that the patient does not have to undergo multiple examinations that are invasive and may be experienced as traumatic.

Before starting the examination or evidence collection, trained personnel must clearly explain the process to the survivor to prevent re-victimization. The collection of evidence does not only refer to the collection of biological material for investigations such as forensic genetics or forensic toxicology, but also the description of the injuries produced by the violent event. It is therefore necessary to examine the patient from head to toe (e.g., general and/or genital examination based on the narrative) and report the findings on the medical report. After obtaining informed consent, it is always good practice to take photographs of the injuries, as this can aid in documenting and describing them, particularly when there are multiple ones. Photos also 'freeze' the situation, providing an accurate visual record that may constitute valuable evidence in case legal action is pursued later.

When healthcare personnel take in charge women who have suffered any form of violence, they must recognize that their health needs may be significantly different from those of patients who access care for reasons other than abuse. Specifically, they may have emotional needs that require additional attention at the hand of health staff, require psychological support, and fear for their own safety or that of their children. Additionally, they might require resources beyond those the healthcare system can provide and may need assistance in navigating external referred services.

5. *Management of GBV at health facility level: the Italian point of view*

In Italy the application of the general principles outlined by the WHO are reflected in the Decree of the President of the Council of Ministers (DPCM) 24 November 2017 'National guidelines for health authorities and hospital companies regarding the rescue and socio-healthcare assistance of women victims of violence'.[117]

[117] D.P.C.M. 24 novembre 2017, *Linee guida nazionali per le Aziende sanitarie e le Aziende ospedaliere in tema di soccorso e assistenza socio-sanitaria alle donne vittime di violenza* [National Guidelines for Health Authorities on the Emergency Response and Health and Social Care Support for Women Victims of Violence].

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These originate from the work of the 'protection pathway' working group, composed of representatives of central, regional, and local administrations and the relevant non-governmental associations and other third sector organizations engaging with victims of violence.

The National Guidelines conceptualize the provision of adequate and integrated interventions in the treatment of the physical and psychological consequences that male violence produces on women's health, guaranteeing a timely and adequate care of women starting from triage, passing through clinical and forensic assistance, up to referral to public and private services offering support to survivors, to collaboratively develop a personalized support plan to help them escape a situation of violence.

The guidelines are addressed to public and private actors working in the prevention and combat of male violence against women (e.g., National Health Service, hospitals and territorial health services; territorial social services; anti-violence centers; law enforcement agencies; courts; territorial authorities…). Each member of the territorial anti-violence network operates within their respective competencies while adopting a shared and integrated approach, ensuring the woman's best interest and upholding her right to self-determination.

Thus, the aim of these guidelines is to provide an adequate and integrated intervention in the treatment of the consequences, both physical and psychological, that any form of violence produces on women's health. In particular, the National guidelines emphasize the importance of:

- Reception in the ED

Triage nurses should be professionally trained to promptly recognize any sign of violence, even when abuse is undeclared. Apart from cases where it is necessary to assign an emergency code (red or equivalent), patients accessing the ED for episodes of violence must be assigned a relative urgency code (e.g., yellow or equivalent, with a maximum 20-minute waiting time) in order to minimize the risk of second thoughts or voluntary departure from the ED.

One of the innovations proposed by decree DPCM is the obligation for health facilities to establish a 'safe' area, a dedicated space for initial reception ensuring the full respect for the privacy for patients seeking care following episodes of abuse.

It is important to keep in mind that some individual vulnerabilities may require further actions to be put in place to

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avoid additional barriers to access to care. As an example, for foreign women it may be necessary to ensure the availability of cultural and linguistic mediators or women living with disabilities may need the presence of caregivers.

- Presence of dedicated personnel

In Italy, only the Centro Soccorso Violenza Sessuale (SVS) in Sant'Anna Hospital Turin and the Centro Soccorso Violenza Sessuale e Domestica (Sexual and Domestic Violence Relief Centre) at Clinica Mangiagalli in Milan have dedicated staff specifically for managing GBV cases. In other hospitals, the presence of dedicated staff is not always guaranteed due to shortages of personnel and sometimes a lack of sufficient attention to GBV.

- Presence of trained health personnel

It is crucial to avoid subjecting the woman to multiple medical and forensic examinations whose primary goals are to describe her state of health, detect injuries and their consequences, and collect biological material. The medical personnel must perform both the medical and the forensic aspects of the examination simultaneously, which must be guided by the history of abuse disclosed by the victim.

- Risk assessment of revictimization after discharge from the ED

At the end of the diagnostic-therapeutic treatment, the health worker who took charge of the woman uses the survey tool 'Brief Risk Assessment for the Emergency Department - DA5', a five-item questionnaire to assess the risk of re-victimization.[118]

6. *Suggestions from the WHO recommendations and the Italian guidelines to prevent gynecological violence in the care of women who have experienced sexual violence*

Sexual violence has important negative consequences on the victim's health, both in the short and long term, representing one of the main causes of morbidity, disability and mortality among women. It represents a complex traumatic event that requires a multidisciplinary approach, as the needs of survivors extend beyond the clinical and psychological sphere, requiring careful

[118] Jill Theresa Messing, Jacquelyn C. Campbell and Carolyn Snider, 'Validation and Adaptation of the Danger Assessment-5: A Brief Intimate Partner Violence Risk Assessment' (2017) 73 Journal of Advanced Nursing 3220 <https://doi.org/10.1111/jan.13459>.

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consideration of forensic aspects to support the administration of justice and safeguard women's rights effectively. Given the acute nature of the phenomenon, ED personnel are the first to care for the victim and have a twofold responsibility in the management of these patients, namely to provide the victim with the necessary care, both physical and psychological, as well as to assist the victim in the management of medico-legal proceedings, by recording the event, conducting a clinical-forensic examination, documenting injuries, and collecting biological evidence.

In this medical process, the patient may risk becoming the victim of another type of violence, the so-called obstetrical-gynecological violence, broadly defined as 'violence that women may experience during gynecological examinations', including any act perceived as sexist or disrespectful of human dignity. This encompasses violations of patients' intimacy, denigrating behavior, derisive remarks, misogynistic attitudes and insults, but also to the provision of inadequate information to patients about healthcare treatments and organizational models of healthcare facilities (e.g., how to navigate the care pathway). It is important to highlight that informed consent is needed for every gynecological visit and that the information provided beforehand must be personalized and understandable by the patient.

Every health facility must develop a clear gynecological examination pathway and establish ad hoc protocols when dealing with patients in vulnerable conditions (e.g., victims of GBV). Despite the challenges that may arise due to poor working conditions and difficult organizational contexts, it is necessary to foster a relationship between health personnel and the survivor based on empathy and trust. In this light, a standardized or improvised examination setting may violate the dignity and privacy of the patient. It is necessary to minimize the movement of health personnel who are not directly involved in caring for the survivor of violence to respect her intimacy and provide an environment allowing her to express herself without fear of being judged by a variety of actors.

As suggested by the Italian guidelines issued in 2017, it is necessary to improve some key aspects of patient care starting from the reception in the ED. This initial interaction must be conducted in an environment that fully respects the patient's privacy and handled by healthcare personnel able to interpret even nonverbal cues. Health staff should refrain from making any judgement (e.g. avoid commenting on the woman's attire;

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avoid making the woman feel guilty because she is in a state of confusion because she has taken alcohol or drugs).

Healthcare facilities should have dedicated staff with the time and capacity to fully support survivors, respecting their pace and needs, as it may take up to four to five hours to provide an appropriate and tailored response. For this reason, the guidelines suggest the presence of dedicated personnel, but in Italy there are only two centers that have health personnel dedicated to taking care of women who have suffered sexual violence and GBV in general. One of the two centers is located in Turin and is open 24 hours a day, 7 days a week and has chosen to have only female staff to prevent women from feeling uncomfortable in front of male health care personnel.

Another key point in the Guidelines is the training of healthcare personnel in the management of sexually abused patients to avoid subjecting the woman to multiple medical and forensic examinations. The objective of the examination is to describe the woman's state of health and to document the injuries and their consequences. At once, the medical personnel must perform both the clinical and the forensic part, which must be guided by the history of violence as reported by the patient. For instance, it is not necessary to perform a vaginal swab if there was no vaginal intercourse, but only non-penetrative acts were performed by the aggressor. This is an additional way to avoid violating that body again.

Medical personnel should conduct a thorough head-to-toe examination while, in line with WHO recommendations, ensuring that the patient is never completely undressed. This approach helps minimize discomfort and protects the dignity of a body that has already experienced trauma.

The acquisition of consent to the proposed clinical-forensic acts interventions gains particular value in the management of women who have suffered any form of abuse, and in particular of survivors of sexual violence. It is well known that health treatments, whether diagnostic or therapeutic, require the informed consent of the person concerned to be lawful. In the healthcare management of a person who has suffered any form of violence, consent to clinical and forensic examination can be understood not only as a duty, but also as a therapeutic and ethical choice to restore integrity, dignity and respect to the violated body. The term 'violence' inherently encompasses the concept of non-consent to an act inflicted on one's own person.

In summary, to avoid the occurrence of gynecological violence

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during the health management of sexually abused women it is necessary to:

- identify a 'safe' area for the reception and care of patients in order to respect their privacy;
- have dedicated and trained healthcare personnel, possibly female;
- avoid multiple clinical and forensic examinations, which must be guided by the narration of the event as reported by the survivor;
- examine the woman from head to toe, avoiding undressing her fully;
- consider consent not only as a duty but also as a therapeutic and ethical choice to restore integrity, dignity, and respect to the violated body.

In conclusion, for sexually abused women, the lack of a dedicated path in health facilities, the lack of decision-making power in defining which clinical and forensic path to accept, not having the possibility to choose the gender of the health personnel managing their case, and the possible judgment expressed through verbal or non-verbal language (for example, not believing the sexual violence suffered by an elderly woman or by a woman in a state of confusion due to the voluntary or forced intake of alcohol or drugs), can constitute a further form of gynecological violence.

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Raffaella Ferrero Camoletto, Federica Manfredi

Exploring Gynecological Violence through a Socio-Anthropological Approach. Italian Data on the Invisibility of Female Genital Suffering

1. *Introduction*

In recent years, sociological and anthropological research has increasingly highlighted the role of power dynamics in shaping healthcare access. According to the cultural view of the world shaped by the historical moment and social context, individuals differently approach the body and the elements characterizing health and sickness, both from the perspective of potential patients and referring to how health professionals are educated. A key phenomenon within this discourse is 'medical gaslighting,' where healthcare professionals dismiss or invalidate patients' symptoms because not linkable with signs of illness (Martinez-Hernaez 2000). As a consequence, inexplicable pain is often attributed to psychological causes such as stress or anxiety. This practice disproportionately affects marginalized groups, particularly women, people of color, children, and individuals with chronic or contested illnesses (Sweet 2019). Among the causes of medical gaslighting there is the scientific gap concerning rare disease, and illness variables connected with the gender-based medicine and the perception of genital pain as a normal condition rather than a health issue deserving investigation (Seear 2009; Shallcross *et al.* 2019; Vescio 2023).

Medical gaslighting exemplifies how institutional and symbolic power reinforce gender inequalities, perpetuating epistemic and structural violence (Farmer 2003). Women's

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pain, often dismissed due to entrenched androcentric medical paradigms, becomes invisible within healthcare systems that, according to the biological paradigm, prioritize biological markers over patient narratives (Hamberg 2008; Werner & Malterud 2003). Conditions categorized as 'contested illnesses' – which lack clear biomedical evidence – are especially susceptible to this form of dismissal (Moss & Teghtsoonian 2008; Dumit 2006; Whelan 2007; Grogan *et al.* 2018).

Vulvodynia, a chronic pain condition affecting the vulvar region, exemplifies the challenges of contested illnesses. Despite its estimated prevalence of 10-16% among individuals assigned female at birth (AFAB) globally, it remains widely misunderstood and misdiagnosed, particularly in Italy (Ferritti 2023; Bonaguidi & Perin 2023). Without clear diagnostic markers, many patients experience lengthy delays in receiving medical validation, reinforcing societal biases that trivialize women's suffering. On average, Italian patients report a 4.5-year delay in diagnosis, often navigating multiple healthcare professionals before finding one who acknowledges their condition (Carpani 2023).

The absence of vulvodynia education in Italian medical curricula further exacerbates this issue, limiting clinicians' ability to recognize and treat the condition effectively. Socioeconomic and geographic factors deepen disparities in healthcare access, with northern, middle-class, white cisgender women more likely to receive timely treatment than their counterparts in southern Italy or from marginalized communities (Carpani 2022; for a comparison with endometriosis, see Braida 2024). Additionally, the privatization of healthcare increases financial barriers, restricting access to specialized care for those unable to afford out-of-pocket expenses (*www.vulvodinianeuropatiapudendo.it*).

The medical and political gap in the assistance of vulvar pain is mirrored by a broader cultural deficiency in recognizing female genitals as anatomical body parts deserving proper healthcare (Manfredi 2024). In Italian discourse, particularly within medical settings, the term vulva is often linguistically unpronounced or deliberately avoided, frequently replaced by euphemisms. A common example is the phrase 'It hurts down there,' which exemplifies this tendency to obscure direct anatomical references.

Notably, this very expression was used by Christine Labuski as the title of her report following a medical anthropological study conducted while working as a nurse at a specialized center for vulvar diseases in the United States (Labuski 2015). The widespread discomfort – or outright inability – to accurately

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name the genital area, or even specific parts of it, can be seen as a reflection of a broader cultural limitation in conceptualizing and addressing vulvar health. This linguistic gap contributes to the exclusion of vulvar anatomy from key domains such as childhood education, public discourse, medical consultations, and self-monitoring health programs. As a result, this silence not only reinforces societal taboos but also perpetuates a lack of awareness and access to appropriate medical care for vulvar conditions.

Activism has played a crucial role in challenging the systemic medical neglect. Figures such as Giorgia Soleri, an activist and social media influencer, have used digital platforms to raise awareness and combat stigma surrounding vulvodynia (Ferritti 2023). Grassroots organizations like the *Comitato Vulvodinia e Neuropatia del Pudendo* have mobilized for legislative change, advocating for the inclusion of vulvodynia in Italy's Essential Levels of Care (LEA) in 2022 to ensure access to public health and multidisciplinary care.

Social media, particularly Instagram, has emerged as a space for feminist digital activism, where patients validate each other's experiences and counter androcentric medical narratives. By documenting their pain and treatment struggles, activists reframe patient vulnerability as a source of collective resistance and push for systemic reforms in healthcare policy (Bonaguidi & Perin 2023). Inspired by movements such as *Our Bodies, Ourselves*, these activists challenge medical authority, emphasizing the legitimacy of lived experience in shaping medical discourse.

In our opinion, addressing vulvodynia requires a shift towards participatory healthcare that integrates patient perspectives and dismantles epistemic injustice. By asserting the validity of their suffering, vulvodynia patients are actively reshaping medical narratives, advocating for recognition, and demanding healthcare structures that acknowledge and address their needs (Bonaguidi & Perin 2023). Because of this, in summer 2023 we proposed a participatory action-research project involving healthcare professionals, patient associations and contacts from previous research experiences in the research design.

2. *Giving voice to embodied experiences: an action-research project*

In this article, we present and discuss the preliminary outcomes of *Giving Voice to Pain*, an action-research project co-funded by the Fondazione Cassa di Risparmio di Torino for the years 2024-2025.

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Designed as a socio-anthropological study, the project examines experiences of vulvar and pelvic pain through a dialogical and multidisciplinary approach. Its overarching objective is to explore illness narratives and investigate the structural and sociocultural factors that contribute to inequalities in access to healthcare, patient experiences, and the negotiation of therapeutic plans.

Currently underway at the University of Torino, the project is led by Professor Raffaella Ferrero Camoletto as Principal Investigator. The research team includes anthropologist Federica Manfredi and sociologist Nicole Braida as postdoctoral research fellows, alongside Nicole Bonfanti, who serves as a post-master research fellow.

By analyzing both critical issues and best practices within the Piedmont[1] – disseminating data collection across multiple provinces – the project's second general objective is to identify strengths that can be replicated in other territories, establishing the Piedmont case as a comparative model for future analyses at the national and international levels. The Piedmont region, in the national landscape, represents a case study that exhibits excellence both in the healthcare services provided (as evidenced by preliminary explorations of patient association social networks, where certain hospital departments and clinics are recognized and recommended, leading to therapeutic migration from other regions) and in patient activism and social networks (including Turin-based initiatives that contributed to the formation of a national committee on vulvodynia and pudendal neuropathy in the 2010s).

More specifically, the two general objectives are articulated through a series of sub-objectives pursued via a participatory research approach that engages patients, their associations, healthcare professionals, and members of family and social networks:

a) Document the experiences of pain/relief, exclusion/access, and discrimination/inclusion of individuals suffering from vulvar and pelvic pain.

b) Raise awareness about the risks of chronicization.

c) Create a regional network connecting patients, associations, healthcare professionals, and caregivers.

d) Identify biases responsible for critical issues such as medical nomadism, diagnostic delays, and social isolation.

[1] A North-West Italian region characterised by a strong industrial heritage (the car company FIAT), but also by a socio-economic landscape with a long tradition of agricultural production, with some food specialties (wine, cheese, meat).

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e) Understand and enhance best practices and behaviors that facilitate inclusive access to care and pain relief.

The project adopts a scientific approach that examines pain experiences at the intersection of cultural constructions and subjective interpretations. It draws on a phenomenological (Csordas 1990; Bourke 2014), multisensory (Pink 2015), and situated perspective (Ingold 2000) to provide a comprehensive understanding of vulvar and pelvic pain. The research explores the meanings patients associate with pain, the ways in which pain is negotiated, treated, and observed by healthcare professionals, and the impact of pain on partners and family members in everyday life.

Moving away from the notion of patients as passive bodies merely enduring pain with limited agency, we advocate for recognizing the active, engaging dimension of pain experiences – one that elicits agency not only in those who suffer but also in those who interact with them (Manfredi & Nardini 2022).

More specifically, the project investigates the key elements that shape these illness experiences from multiple perspectives, examining how they interact and influence one another. It also seeks to identify which factors contribute to best practices in care and which, by contrast, perpetuate the silencing of pain.

Moreover, focusing on vulvar-pelvic pain provides an opportunity to examine the cultural dynamics surrounding sexuality, particularly its impact on penetrative sexual relationships (Tolman 2005; Ayling & Ussher 2008; Bertone *et al.* 2011). To what extent are experiences of pain and illness shaped by cultural scripts related to gender – such as notions of what constitutes a healthy and appropriate femininity – or sexuality, including ideas of what defines normal sexual functionality? This focus enables an exploration of the intersections between pain, illness, gender, and sexuality, shedding light on how affectivity, partner relationships, and work-family configurations either facilitate or hinder access to care and coping with chronic pain.

Although the research explicitly examines the implications of penetrative sexual relationships, it also seeks to move beyond heteronormative frameworks. By queering the standard norm of heterosexuality (Sörensdotter 2017; Barker 2016), the study aims to investigate pain experiences across diverse sexual orientations from a comparative perspective. This approach is expected to highlight how sexual orientation influences the experience of pain in intimate relationships beyond the coital imperative (McPhillips *et al.* 2001; Hawkey *et al.* 2022; Hinchliff *et al.* 2012).

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3. *Methodology: a two-cases study*

To refine the scientific perspective and maximize research impact, the project selects two primary conditions associated with vulvar and pelvic pain: vulvodynia and endometriosis.

This selection is based on both social and biomedical reasons. From a social standpoint, these conditions warrant particular attention due to:

i) Recent media coverage highlighting issues in their management;

ii) The emergence of grassroots activism and advocacy, both digital and offline, within the Piedmontese territory, influencing care-seeking behaviors (Bonaguidi & Perin 2023);

iii) The tendency toward diagnostic and therapeutic nomadism (Cosavalente 2022);

iv) Frequent comorbidity, with both conditions often co-occurring in the same individual;

v) The relationship between cultural scripts and a bodily geography that delegitimizes and renders invisible certain pain experiences when they involve the genitals;

vi) The emphasis on genital functionality (particularly vaginal penetrability), which overshadows other genital experiences, including pain (Labuski 2015).

From a biomedical perspective, recent advancements in knowledge about these two conditions make comparative analysis accessible. Endometriosis presents more identifiable organic symptoms, facilitating diagnosis and treatment (Young *et al.*2017), while vulvodynia still poses significant diagnostic challenges (Calella *et al.* 2020). Both conditions affect a significant percentage of AFAB (assigned female at birth) individuals, with estimated prevalence rates of 10% for endometriosis and 12-16% for vulvodynia, primarily between the ages of 20 and 40. Despite endometriosis being classified as secondary pain due to its identifiable organic markers, both conditions are characterized by highly subjective pain experiences, often leading to conflicts between medical knowledge and patients' embodied knowledge. The proposed comparative approach also aims to examine other conditions studied in social research to highlight healthcare discrimination, such as fibromyalgia and other rare diseases (Brown 2019; Rossero 2022).

Rather than treating patients as a homogeneous category in opposition to healthcare professionals, the project adopts an intersectional perspective (Crenshaw 1991) to investigate

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how individual characteristics – such as gender identity, economic and cultural resources, and racialization – intersect with relational dynamics, including household configurations, affective models, and political activism, in shaping illness experiences. The study also examines how these factors influence engagement with medical knowledge and institutions, as well as access to healthcare services. A key focus of the research is on identifying communication barriers, the invisibilization of pain experiences, and the structural obstacles that hinder access to care and effective chronic pain management. By approaching pelvic and vulvar suffering as a multifaceted phenomenon (Mol 2003), understood and signified differently by the various actors involved, the project embraces a participatory approach.

The initiative collaborates with a diverse network of partners, including healthcare specialists from both public and private sectors – specifically the *Centro Multidisciplinare per la Salute Sessuale* (CeMuSS) in Turin and the private *Nuovo Centro Clinico* – as well as members of two patient advocacy groups: *Comitato Vulvodinia e Neuropatia del Pudendo* and *La Voce di Una è la Voce di Tutte*.[2] These partnerships ensure that multiple perspectives are incorporated into the research, fostering a more inclusive and impactful approach to understanding and addressing vulvar and pelvic pain. The project adopts a participatory research approach, engaging both individual and collective actors as epistemic allies and subjects rather than objects of research. By recognizing participants as knowledge producers, the study highlights the plural ways in which these individuals navigate and manage the studied conditions. This method emphasizes co-learning, aiming to challenge traditional hierarchies and forms of authority within the scientific knowledge production process. By engaging participants as equal epistemic partners (Estalella & Sánchez Criado 2018), we aim to enhance the relevance and applicability of the findings, ultimately fostering sustainable change. This approach aligns with an action-research framework, where the knowledge generated is meant to be directly applicable and useful to the various epistemic partners involved.

The multi-method approach employed in this project includes qualitative interviews, creative workshops, and the

[2] To see more: <https://www.vulvodinianeuropatiapudendo.it>; <https://www.lavocedellendometriosi.it> (accessed 18 january 2025).

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reconstruction of life and pain narratives through yoga therapy (Bussing *et al.* 2012; Astin 2004). These methods allow for a holistic exploration of the participants' experiences, bridging the gap between scientific inquiry and practical application. The research team has already established connections with Piedmontese organizations addressing vulvar and pelvic pain and is actively involved in the working group on neglected diseases within the Observatory on Women's Health. A key goal of the project is to expand this network to include a wider range of perspectives on illness, gender, and sexuality. This includes engagement with transfeminist groups that challenge biologically deterministic views of gender and advocate for a non-gendered approach to understanding these conditions.

In addition, ongoing collaborations with the Regional Equal Opportunities Commission, which began with support for the 'Vulvas on Display' project, will continue to amplify the social impact of our efforts. Vulvas on Display was the original title of a public engagement initiative consisting of an artistic exhibition curated by Federica Manfredi, which was inaugurated in February 2024 at the University Campus Luigi Einaudi in Turin. However, a healthcare partner expressed concerns about the title, fearing that it might convey a pornographic connotation due to the phrase 'Vulvas on Display.' As a result, the title was changed to 'Vulvar Pain: Art, Science, Resistance' (Manfredi 2024a).

In the summer of 2024, the exhibition was restructured into a traveling initiative to disseminate research findings, supported by a new Public Engagement grant provided by the Department of Culture, Politics, and Society at the University of Torino. The exhibition features six panels showcasing handcrafted pieces created by pain sufferers during ethnographic research, as well as two ethnography-based art pieces by Sofia Rampanelli and Lucia Bessone. It is currently being displayed in hospitals and medical schools to facilitate the co-construction of new knowledge between healthcare professionals and patients.

During preliminary discussions regarding the exhibition's transfer to new locations, some members of the local committee raised concerns about the content of the art pieces, fearing they might upset gynecology students. This reaction, coupled with the earlier concerns over the original exhibition title, highlights the sensitivity and controversy surrounding the term vulva in the Italian language – even among healthcare professionals. These episodes underscore the importance of involving healthcare specialists in the research process to better understand the

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taboos and biases connected to vulvar care, and to co-design a new cultural framework for approaching and supporting vulvar and pelvic pain sufferers.

Consistent with its participatory approach, the project envisioned diverse and heterogeneous forms of territorial impact, including:

a) Facilitating co-produced and participatory communication and understanding through multimedia platforms, a living library of patient narratives, and an online downloadable glossary-guide with a graphic-communicative approach.

b) Expanding impact reach by engaging international patient networks, healthcare professionals, and activists through podcasts and videos, subtitled in Italian and English, for widespread dissemination via social media.

c) Promoting inclusive communication strategies, integrating multisensory approaches such as artistic exhibitions alongside educational events.

d) Strengthening regional presence by establishing local representatives as information hubs on the studied conditions.

e) Raising awareness among key stakeholders (healthcare policymakers, medical professionals, patient association representatives, and healthcare students) through research reports discussed in collaboration with epistemic partners.

f) Co-designing, with participants, graphic-communicative materials to initiate body-sexuality education modules targeting young people (ages 20-30) for preventive awareness.

The action-research project is in course of development and researchers of the team address it in a continuum with other previous research dedicated to vulvar pain. For the purpose of this article, we will refer to ethnographic data from *La Stoffa del Dolore* (*The Cloth of Pain*), a qualitative research project conducted at the University of Turin (March 2023–February 2024) by medical anthropologist Federica Manfredi and supervised by sociologist Raffaella Ferrero Camoletto within the more general project framework described above. This interdisciplinary approach combined medical anthropology and sociology to examine vulvar pain as a culturally constructed phenomenon shaped by gendered meanings and sexual norms.

The research focused on the lived experiences of cisgender Italian women diagnosed with several diseases, such as vulvodynia, endometriosis, lichen sclerosus, and pelvic floor dysfunctions. Despite their clinical differences, these conditions share a common symptom: vulvar pain, which disrupts daily life,

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professional obligations, and personal relationships. Participants recounted frequent painful episodes that necessitated significant adjustments in their routines, highlighting the social burden of chronic pain, especially a pain affecting genitals.

The study employed a mixed-methods approach, including qualitative interviews with 28 white cisgender heterosexual women, consultations with healthcare professionals, participant observations at medical conferences, and a five-month online ethnography (Kozinets 2010) of patient associations and Facebook support groups. These digital spaces were selected based on interviewee recommendations and member engagement. The analysis focused on patient-doctor interactions and key moments in the Italian political landscape that have influenced public recognition of vulvar pain and patient advocacy.

To explore alternative modes of self-expression, participants engaged in a creative workshop where they used textiles to articulate their pain experiences. This approach was designed to overcome linguistic barriers in discussing pain, particularly given the stigma surrounding female pelvic pain conditions (Manfredi 2024b, 2022). The project's title, *The Cloth of Pain*, plays on the Italian phrase *'di che stoffa sei fatto'* ('what fabric are you made of'), metaphorically linking pain to identity and resilience. Through tactile engagement with fabric, participants were able to express embodied suffering in a non-verbal manner, addressing the challenges of articulating conditions that often lack social recognition. The handcrafts created during this process were later displayed in the artistic and scientific exhibition mentioned earlier.

Textile work was chosen as a research tool due to its historical associations with traditionally gendered activities, such as sewing and caregiving. However, engagement with this method varied among participants. Some were initially hesitant, concerned about their perceived lack of artistic skill. This highlighted the importance of the ethnographer's role in ensuring participants that the process of creation itself was more valuable than the aesthetic outcome – particularly when using creative, arts-based methods. On the other hand, some participants found the textile work cathartic and therapeutic, linking it to childhood memories and family emotional legacies. For example, two participants, whose grandmothers were seamstresses, found the activity deeply personal and healing.

This variation in responses underscores a key insight: research methodologies are never neutral, whether they involve standard interviews or creative methods like textile work. They actively

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shape data collection, participant engagement, and the overall relationship between the researcher and the participants (Giorgi *et al.* 2021). The different levels of engagement with the textile process reflect the diverse ways in which individuals relate to their experiences and to the research process itself.

Qualitative data were recorded, transcribed, and analyzed thematically. Ethical considerations were central to the study, allowing participants to choose between anonymity and the use of their names, professional identity and age in scientific publications and other public products. This decision sought to challenge the automatic anonymization of subjects, recognizing that erasure can contribute to the broader invisibility of vulvar pain. By centering patient voices and fostering collaborative research methodologies, this study contributes to a deeper understanding of the sociocultural dimensions of vulvar pain and the necessity of integrating patient perspectives into healthcare discourse.

4. *The Cloth of Pain: experiencing and resisting medical gaslighting*

A 2020 study by the patient association Comitato Vulvodinia e Neuropatia del Pudendo found that 32% of 439 surveyed patients had consulted more than five specialists before receiving a diagnosis. Many reported feelings dismissed by healthcare professionals, particularly gynecologists, who often attributed symptoms like burning sensations and electric shocks to psychological factors rather than organic causes. This experience of medical gaslighting (Sweet 2019) reflects a broader epistemic imbalance in which biomedical authority defines legitimate illness, sidelining patient narratives and embodied knowledge.

Valentina, a participant in this study, described how repeated medical dismissal led to self-doubt:

> There were many specialists who kept telling me that everything was fine, that there was nothing wrong with me, and that I basically needed to disconnect my mind from my vulva. At one point, I even started to think that maybe I was the one creating the problem.. Once they found out I was seeing a psychotherapist for anxiety, they immediately jumped to conclusions: 'There it is, you're anxious,' so it's the anxiety that is causing this. (*Interview with Valentina I., 14.5.2023*)

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This pattern aligns with Conrad and Stults' (2008) framework on contested illnesses, where conditions without clear biomedical markers struggle for recognition. The psychological framing of vulvar pain can also extend beyond clinical settings, influencing familial and social responses. Luisa recounted how her mother, following a doctor's suggestion, discouraged further medical consultations:

> My mother reached the point where she said, 'In my opinion, you need psychological help.. I don't think you need any more specialists. The problem is in your head. The doctor said so. Let's stop wasting money.' (*Interview with Luisa, 27.4.2023*)

This illustrates how medical gaslighting can extend far beyond the confines of a doctor's office, influencing not only the way sufferers perceive their own conditions but also how their experiences are validated – or dismissed – within their social networks. As analyzed elsewhere (Manfredi 2024b), psychology often serves as a convenient explanatory framework for so-called 'deviant' health-seeking behaviors. This reinforces a cycle in which the legitimacy of a patient's condition is not explicitly denied but instead redirected toward mental health professionals. In doing so, gynecologists and other specialists effectively absolve themselves of the responsibility to conduct further medical investigations. The assumption that stress or psychological fragility underlies 'inappropriate' behaviors – such as pain overestimation, pain catastrophizing, or the avoidance of penetrative intercourse – functions as a cognitive shortcut that enables the dismissal of both the issue and the patient. By framing the problem within psychological or cultural settings rather than biomedical ones, the burden is subtly shifted away from clinical responsibility.

As many participants in this study have emphasized, stress and depression are not uncommon after years of experiencing unexplained pain symptoms – symptoms that, despite repeated medical consultations, remain unrecognized and untreated by healthcare professionals. However, interviewees reported that stress, anxiety, and even more severe psychological distress often emerged only after a prolonged series of ineffective medical encounters. In many cases, these conditions developed following years of diagnostic and therapeutic nomadism, rather than coinciding with the initial onset of vulvar pain. Ultimately, this pattern not only compounds patients' suffering

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but also perpetuates a cycle in which their physical symptoms are continually reframed through a psychological lens, further delaying accurate diagnosis and appropriate treatment.

In response to medical dismissal and lack of institutional recognition, patient-led advocacy has become a key driver of change. In May 2022, the Comitato Vulvodinia e Neuropatia del Pudendo proposed legislation to include vulvodynia and pudendal neuralgia in Italy's Essential Levels of Care (LEA), aiming to secure healthcare access and economic support for affected individuals. Prior to this, a public demonstration in Turin, documented in *Our Body Burns* (2022) by the filmmaker Angela Tullio Cataldo, highlighted the economic burden of treatment and the impact of medical gaslighting on patients' lives. The documentary is in open access online and it supports the advocacy mission of the Comitato in visibilizing chronic pain.[3]

Regional policy initiatives also reflect resistance to the exclusive authority of biomedicine. A notable example occurred in 2023 when the Piedmont region approved a diagnostic and therapeutic protocol for vulvodynia, developed through a collaborative effort between healthcare professionals and patient representatives. This initiative exemplifies a form of definitional negotiation in which patients' lived experiences actively contribute to reshaping medical frameworks. By integrating patient expertise with biomedical knowledge, the protocol stands as a model of participatory healthcare reform that challenges traditional hierarchies of medical authority.

Despite this progress, as of early 2025, only three Italian regions – Piedmont, Trentino, and Tuscany – have established a therapeutic protocol for vulvodynia treatment. This limited implementation underscores the fact that the path toward full recognition of the condition remains in its early stages. Furthermore, the scarcity of scientific research capable of elucidating the causes and complexities of vulvodynia has created a gap that opportunists have exploited. In the absence of clear medical consensus, self-proclaimed experts have proliferated online, marketing quick-fix solutions and so-called 'restorative treatments' in exchange for direct payments. Some individuals have even positioned themselves as gurus of the disease, offering remote consultations and unverified therapeutic approaches.

[3] <https://www.internazionale.it/video/2022/07/20/sofferenza-donne-vulvodinia>.

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To support patients in navigating this challenging landscape, advocacy groups and patient associations have stepped in, compiling and distributing lists of officially recognized healthcare professionals. These lists categorize providers based on their medical specialization and the city or region where they practice, offering patients a more reliable means of selecting qualified therapists. Additionally, data from online ethnographic research on patient-centered Facebook groups reveal the emergence of informal strategies for vetting healthcare professionals. Patients frequently share experiences and evaluations of doctors, using criteria such as attentiveness, willingness to listen, and the flexibility to negotiate treatment plans according to individual needs. These grassroots efforts highlight the role of patient communities in counteracting misinformation and advocating for more patient-centered care.

5. *Discussion on preliminary results and conclusions*

This study has highlighted how vulvar pain, particularly in cases of vulvodynia, is shaped by broader socio-political and institutional dynamics that contribute to its medical marginalization. Through an analysis of medical gaslighting, contested illnesses, and patient activism, we have demonstrated that the invisibilization of vulvar pain is not merely a clinical issue but a reflection of gendered power structures embedded within healthcare systems, often leading to forms of gynecological violence that can extend beyond clinical cabinets toward family settings and in the relationship with partners.

Our findings emphasize the need for a shift toward participatory healthcare models that integrate patient narratives into medical discourse. The invalidation of pain by healthcare professionals, as reported by many interviewees, underscores the urgency of reforming biomedical paradigms that prioritize objective markers over subjective experiences. This shift is particularly relevant given the emergence of patient advocacy groups and digital activism, which have played a pivotal role in challenging medical authority and advocating for legislative recognition of vulvodynia.

Furthermore, the Piedmont regional diagnostic and therapeutic protocol represents a crucial example of definitional negotiation, demonstrating that medical and patient perspectives can coalesce to construct more inclusive healthcare frameworks.

ISBN 978-88-495-6175-3

The collaborative efforts between healthcare professionals and patients underline the potential of integrating embodied knowledge into medical decision-making, fostering a more holistic approach to treatment and care.

Future research should further explore the intersections of pain, gender, and medical legitimacy, with an emphasis on how social determinants influence healthcare access and treatment outcomes. Additionally, an intersectional approach would allow for a more nuanced understanding of how race, class, and gender identity shape patient experiences of chronic pain and their possibility to resist to gynaecological violence. In conclusion, addressing vulvar pain necessitates systemic change: from medical training that includes contested illnesses in curricula to policy reforms that recognize the socio-cultural dimensions of pain. Only through these structural shifts can we move towards a healthcare model that validates and adequately supports individuals suffering from vulvar pain.

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ISBN 978-88-495-6175-3

Roxana Andreea Toma

Gynecological Violence Incidents: The Case of Incarcerated Women

1. *Introduction*

Gynaecological and obstetric care has long constituted a silent and under-addressed issue, traditionally approached primarily in the context of pregnancy. Despite significant advances in medical science and technology, complications during childbirth continue to be reported, even when medical assistance is provided. Moreover, numerous cases involve women experiencing severe complications from gynaecological conditions that are diagnosed only at advanced stages, often resulting in infertility or the development of various forms of cancer.

Over an extended period, multiple public health campaigns have sought to raise awareness about the importance of regular medical check-ups, highlighting the broad spectrum of women's gynaecological health issues that require medical attention. These range from conditions necessitating immediate intervention – such as HPV infections and cervical cancer – to those requiring ongoing management, such as routine prenatal care.

Nevertheless, it has been observed that many women tend to neglect regular gynaecological check-ups, which are essential for early detection and prevention of disease. Instead, medical consultations are often sought only in cases of pregnancy or when urgent intervention for acute gynaecological conditions becomes necessary.

Gynecological and obstetric medical examinations, even when regular and preventive, are often perceived by women as

 ISBN 978-88-495-6175-3

experiences that evoke vulnerability and a sense of victimization. Despite advancements in medical technologies and diagnostic tools, numerous procedures continue to be perceived as harmful or violent. This perception stems not only from the inherently invasive nature of such practices but also from instances of medical negligence or insufficient care.

Violence against women remains a critical social issue, addressed across individual, societal, political, and legal dimensions. According to the *Declaration on the Elimination of Violence against Women*[1], gender-based violence encompasses 'any act.. that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life'. In most instances, physical and sexual violence against women is associated with intimate partner violence and domestic abuse.

Recently, attention has increasingly turned to another form of gender-based violence: psychological, emotional, physical, and sexual abuse occurring in gynecological and obstetric contexts. This form of violence may result from invasive procedures performed without consent, the denial or delay of necessary medical interventions, or the use of unnecessary or harmful medical practices. Such experiences have been reported to lead to severe health complications for women.

Although there is not yet a universally accepted definition, gynecological and obstetric violence is increasingly recognized as a gender-based form of abuse involving psychological, physical, or sexual harm within the context of reproductive healthcare. A comprehensive study examining prevalence, legal frameworks, and institutional responses across the 27 EU member states identified several manifestations of this violence (Brunello *et al.*, 2024): these include coerced or non-consensual medical interventions, the application of non-essential or harmful procedures, and the refusal or postponement of necessary care. The study concluded that such forms of violence can have serious repercussions on women's physical, mental, and social well-being.

Given that gynecological and obstetric examinations or procedures are inherently disempowering and can leave women feeling helpless, instances of violence – whether intentional

[1] <https://www.refworld.org/legal/resolution/unga/1993/en/10685>.

ISBN 978-88-495-6175-3

or unintentional – must be understood within a broader and more nuanced context. The quality of care and the degree of attentiveness shown by medical personnel toward women's well-being can also be shaped by broader social determinants.

Typically, the primary focus within gynecological and obstetric healthcare is pregnancy. This is followed by attention to women's heightened vulnerability to life-threatening gynecological conditions such as cervical and ovarian cancers, as well as sexually transmitted infections, including HIV.

The experience of care within these contexts may be significantly affected by intersecting social factors that heighten vulnerability to gynecological and obstetric violence. Among the most significant social determinants associated with increased victimization are low socio-economic status, young age, substance dependency (Sabbagh Steinberg, 2018), lack of education, disability, ethnicity, marital status, and incarceration (Harner & Riley, 2013; Fair & Walmsley, 2022). These factors not only increase women's exposure to violence but also intensify their susceptibility to mistreatment in clinical settings. Each of these conditions can act as a trigger for stereotype threat – a psychological phenomenon in which individuals fear confirming negative stereotypes about their social group. For example, a woman who is economically disadvantaged, unmarried, and incarcerated simultaneously faces three overlapping stereotype threats. Such intersectionality compounds her vulnerability, rendering her disadvantaged across multiple dimensions and increasing her risk of experiencing discriminatory or neglectful treatment within gynecological and obstetric care.

The concept of stereotype threat ((Steele & Aronson, 1995) refers to the psychological experience wherein individuals, particularly in highly evaluative contexts such as medical examinations, may feel anxiety due to the fear of being judged through the lens of negative societal stereotypes (Dee, 2015). Research has shown that stereotype threat is ego-depleting; the effort required to manage this stress impairs self-regulatory capacity even in areas unrelated to the specific stigmatized domain (Inzlicht, McKay, & Aronson, 2006).

Incarcerated women represent a particularly vulnerable group in this regard. Their limited autonomy in selecting healthcare providers – due to both institutional restrictions and economic barriers – often coincides with a background of social and structural disadvantage. Many incarcerated women come from marginalized socio-economic conditions, lack access

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to education, and have histories of physical or sexual abuse, frequently originating from families or communities marked by systemic violence and discrimination. Additionally, a significant proportion belong to ethnic minority groups. These intersecting forms of disadvantage subject them to multiple, simultaneous stereotype threats. As a result, incarcerated women face heightened risk of unwanted pregnancies, sexually transmitted infections (e.g., HIV, HPV), non-consensual or medically unnecessary procedures, and delayed or denied access to care (Harner & Riley, 2013).

Some forms of gynecological and obstetric violence – particularly psychological or emotional abuse – are difficult to objectively classify. In many cases, the harm is not a result of deliberate intent by medical personnel, but rather stems from the patient's subjective experience of neglect, disrespect, or coercion. Because such experiences are shaped by the patient's perception rather than overt physical harm, they pose challenges in terms of clinical recognition and legal classification. Furthermore, cultural differences significantly influence how women interpret and respond to reproductive healthcare experiences. In certain cultural contexts, women are socialized to endure pain, even when severe, as a normal part of medical procedures, whereas in other cultures, vocal expression of pain and resistance to discomfort are more culturally accepted (Campbell *et al.*, 2000). These divergent frameworks complicate the assessment and definition of what constitutes obstetric and gynecological violence across different populations.

2. *Framing the Issue and Objective of the Present study*

In recent decades, the global population of incarcerated women has grown significantly. Over 740,000 women and girls are currently held in penal institutions worldwide, either as pre-trial detainees or sentenced prisoners. Since 2000, the number of women in prison has increased by nearly 60% globally (Fair & Walmsley, 2022). In the United States, this trend is particularly striking, with the female prison population growing by 834% over the past four decades – from 26,000 in 1980 to 214,000 in 2016. The majority of incarcerated women are of reproductive age, presenting distinct healthcare needs and often bearing histories of trauma and profound social disadvantage (Sabbagh Steinberg, 2018).

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Despite their increasing numbers, incarcerated women remain largely invisible – both within the prison system and in broader society. Prisons have historically been designed for male populations, and institutional frameworks have often failed to consider the specific health and psychosocial needs of women. Reproductive healthcare, including routine gynecological screenings, pregnancy monitoring, labor and delivery support, and preventive care for life-threatening conditions such as cervical or ovarian cancer, is frequently inadequate. Although access to medical care is legally guaranteed in many prison systems, services are often delayed, inconsistently provided, or entirely neglected due to institutional bureaucracy, underfunding, or a lack of awareness regarding the health rights of incarcerated women. In addition to physical healthcare needs, incarcerated women often require emotional and psychological support – particularly during sensitive periods such as the postpartum stage or following diagnoses of serious illnesses like cervical cancer. In some prison systems, mothers are permitted to keep their infants with them until the child's first year of life, adding further emotional and developmental complexities to their experience of incarceration.

The objective of the present study is to examine the risk factors affecting the sexual and reproductive health of incarcerated women, with a particular focus on the prison population in Romania. Specifically, the study will consider cases involving (a) pregnancy and reproductive health risks (e.g., cervical cancer), (b) women belonging to marginalized groups (e.g., ethnic minorities, individuals with low socio-economic status), and (c) the absence of supportive social networks. In addition to identifying risk categories, the study aims to explore potential protective factors that may empower incarcerated women and promote their health and well-being within correctional environments.

In Romania, as of 2024, the total prison population numbered 23,741 individuals, of whom 1,085 (4.57%) were women. This proportion aligns with trends in other Eastern European countries, where, over the past decade, women have consistently represented approximately 5% of the incarcerated population, with absolute numbers ranging between 1,000 and 1,500 (Fair & Walmsley, 2022). Within the Romanian prison system, nine facilities contain specialized wings for women, and one institution is exclusively designated for female inmates. As of the latest report, this population included 10 pregnant women,

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19 women with disabilities, and 2 women living in prison with their children (Women in Prison: Global Insights from National Preventive Mechanisms | Romania, 2024). In all mixed-gender facilities, female inmates are housed in separate wings, in accordance with custodial segregation requirements.

A positive development within the Romanian correctional system is the establishment of a legal and institutional framework for the provision of obstetric and gynecological care. The National Prison Administration (Administrația Națională a Penitenciarelor, ANP) ensures that the general right to health, including access to reproductive healthcare for women, is safeguarded under the law. Medical services for female inmates are governed by Order no. 4.858/C/3.363/2022, which ensures alignment with national therapeutic standards established by relevant medical guidelines. According to these legal provisions, all incarcerated individuals undergo a comprehensive medical examination upon entry, aimed at detecting communicable diseases, chronic conditions, signs of physical abuse, addiction, mental health disorders, and suicide risk (Women in Prison: Global Insights from National Preventive Mechanisms | Romania, 2024).

In terms of reproductive health, institutional attention in Romania has primarily focused on pregnant inmates and women with children. Pregnant women are entitled to prenatal care, regular medical monitoring, appropriate assistance during childbirth, and the right to care for their child within the prison facility until the child reaches the age of one. This focus is particularly important given that a notable number of women are already pregnant at the time of incarceration or give birth during their sentence. These individuals typically present multiple vulnerability factors, including poverty, limited healthcare access, substance use, and poor physical or mental health. For example, a retrospective study by Zielinski *et al.* (2024) on pregnant inmates in Arkansas, USA, found that a substantial proportion of incarcerated women had complex health needs, with more than half reporting histories of illicit drug use and/or mental illness. Similar patterns can be assumed for pregnant incarcerated women in Romania, although systematic data remains limited.

A key protective factor for imprisoned mothers in Romania is the facilitation of social support. The prison system enables contact with family members through designated mother-child visitation areas. In 2023 alone, a total of 261 family visits

ISBN 978-88-495-6175-3

were recorded in these specialized spaces across penitentiary institutions in the country (Women in Prison: Global Insights from National Preventive Mechanisms | Romania, 2024).

While it is a notable advancement that the Romanian prison system has established a legal framework for the provision of gynecological and obstetric care, it is essential to recognize that most incarcerated women face a constellation of vulnerability factors. These include substance use disorders, histories of physical and sexual abuse, mental illness, infectious diseases, chronic conditions, and socio-economic deprivation. In her doctoral research, Sabbagh Steinberg (2018) emphasized that such factors, compounded by stigma, shame, and limited awareness, contribute to a higher risk of medical neglect or delayed care among incarcerated women – especially as many are of reproductive age. The internalization of stigma and stereotype threat, often associated with their criminal status, further deters women from seeking or insisting on necessary medical attention.

A particularly underrecognized dimension of vulnerability relates to the length of incarceration. In a qualitative study, Harner and Riley (2013) found that both women serving long or life sentences and those with short-term sentences experienced delayed or denied access to gynecological care. Women reported that their symptoms were frequently dismissed, medical consultations were rushed or inadequately explained, and test results were not communicated. Those serving longer sentences often faced postponed treatment, while women with shorter terms were advised to delay procedures until after release. These findings illustrate how systemic attitudes and institutional priorities devalue women's reproductive health in custodial settings.

Even outside prison, delays and neglect in preventive gynecological care are well-documented among free women, particularly those from disadvantaged backgrounds. Among incarcerated populations – who are disproportionately affected by histories of trauma and sexual violence – the risks are even more pronounced. For example, infections caused by HPV (Human Papillomavirus) and HIV are more prevalent among women with such backgrounds, significantly increasing the risk of cervical cancer. HPV remains the leading cause of cervical cancer, which was the fourth most common cancer among women globally in 2022, with approximately 660,000 new cases and 350,000 deaths (World Health Organization, 2022). Cervical cancer rates are disproportionately high in middle- and

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low-income countries, reflecting stark inequalities in access to HPV vaccination, cervical screening, and treatment services. While public health campaigns promoting HPV vaccination for girls exist in many countries, access remains difficult for those in vulnerable conditions, including incarcerated women, individuals without family support, and those of low socio-economic status or with limited education. For these women, improving access to preventive gynecological care requires not only medical services but also economic and social support structures that address the broader determinants of health.

Globally, the issue of gynecological and obstetric violence has gained increased recognition. Across the 27 EU member states, there are initiatives to strengthen legal frameworks and develop community-based programs aimed at increasing awareness, documenting women's experiences, creating safe spaces for reporting violence, and promoting professional accountability within healthcare (Brunello *et al.*, 2024). Despite these efforts, ongoing debate persists regarding the legal and social definitions of such violence, indicating the need for greater professional consensus and institutional commitment at legal, social, political, and psychological levels.

At the individual level, even women from privileged backgrounds often report feeling disempowered and invisible during gynecological procedures. This disempowerment is exacerbated in the case of incarcerated women, particularly those from ethnic minorities, low socio-economic groups, or with little education (Braithwaite *et al.*, 2005). Additionally, studies have shown that women with physical or intellectual disabilities (DeMaria *et al.*, 2023), members of ethnic minority groups (Mathis *et al.*, 2024), and those undergoing invasive procedures such as pelvic examinations (Bates *et al.*, 2011) frequently experience emotional discomfort and psychological distress. Emerson *et al.* (2024), through semi-structured interviews with women involved in the criminal-legal system who also had histories of substance use, emphasized the need for interpersonal connection, effective communication, and practical logistical support to facilitate access to care. These findings underscore the importance of psychological interventions aimed at empowering women to assert agency over their healthcare experiences. Supporting women in reclaiming their voice and decision-making capacity is critical for fostering trust, encouraging medical help-seeking behaviors, and ensuring dignity during gynecological and obstetric care.

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3. *Conclusions and Future Directions*

Obstetric and gynecological violence lies at the intersection of two structural crises: gender-based discrimination and the underfunding of healthcare systems and institutions (Brunello *et al.*, 2024). This form of violence encompasses psychological, physical, and sexual abuse, often manifesting through invasive or inadequately explained medical procedures, neglect of symptoms, or delays in care – some of which may be unintentional. Regardless of intent, such experiences can severely affect women's physical and psychological health and their overall well-being.

The global nature of this issue has led to growing efforts to develop legal, social, political, and psychological frameworks to address it. A wide range of vulnerability factors increases the risk of experiencing obstetric and gynecological violence. These include low socio-economic status, young age, substance use, limited education, disability, ethnic minority status, marital status, and incarceration. Each of these factors can be a source of stereotype threat, which leads to ego depletion, heightened anxiety, and a reduced ability to advocate for oneself. Women who face multiple intersecting vulnerabilities are more likely to experience cumulative stereotype threats, making them particularly susceptible to mistreatment and neglect within healthcare settings.

Stereotype threat and violence contribute to anxiety, disempowerment, and silence among affected women. This underlines the importance of psychological support that includes interventions targeting emotional regulation, anxiety reduction, and personal empowerment. Furthermore, the need for human connection, informed consent, and comprehensive communication from healthcare providers has been consistently emphasized. Women must be provided not only with medical care but also with empathy, clarity, and respect in their interactions with healthcare professionals.

Incarcerated women represent a particularly vulnerable group, facing compounded barriers to gynecological and obstetric care – both in relation to pregnancy and the treatment or prevention of reproductive health conditions. Cultural factors further influence how women perceive and respond to such violence. In some cultural contexts, women are socialized to accept pain in silence, leading to underreporting and normalization of harmful experiences. In these cases, raising awareness about the meaning

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and manifestations of obstetric and gynecological violence is essential.

The ongoing debate surrounding obstetric and gynecological violence reflects the complexity of the phenomenon, which demands further clarification, conceptual agreement, and action. Comprehensive responses must address this issue at multiple levels: legal, social, political, and psychological. Only through a multidimensional and intersectional approach can effective, compassionate, and equitable reproductive healthcare be ensured for all women.

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 ISBN 978-88-495-6175-3

List of Authors

Raluca Bercea is Professor in European Union Law at the West University of Timişoara, Romania.

Silvia Carabelli is PhD Candidate in Institutions and Politics at the Catholic University of Milan, Italy.

Joana Falxa is Associate Professor in Private Law and Criminal Sciences at the University of Pau and the Adour Countries, France.

Raffaella Ferrero Camoletto is Associate Professor in Sociology of Culture at the University of Turin, Italy.

Barbara Gagliardi is Professor in Administrative Law at the University of Turin, Italy.

Sarah Gino is Associate Professor in Forensic and Legal Medicine at the University of Eastern Piedmont, Italy.

Federica Manfredi is Post-Doctoral Research Fellow in Medical Anthropology at the University of Bergamo, Italy.

Cristina Nicorici is Assistant Professor in Criminal Law at the West University of Timişoara, Romania.

Elena Rubini is Post-Doctoral Research Fellow in Global Health, Humanitarian Aid and Disaster Medicine at the University of Eastern Piedmont, Italy.

Roxana Andreea Toma is Associate Professor in Forensic Psychology at the West University of Timişoara, Romania.

Georgia Zara is Associate Professor in Criminal Psychology and Risk Assessment at the University of Turin, Italy.

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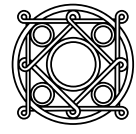

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7526063260

This volume collects the proceedings of an interdisciplinary conference on obstetric and gynaecological violence held at the University of Turin in October 2024. Scholars from the fields of law, criminology, anthropology, sociology, medicine, and psychology examine a phenomenon that is widespread, multifaceted, and controversial. Obstetric and gynaecological violence lie at the intersection of gender-based and institutional violence. Understanding these phenomena requires attention to the underlying power dynamics embedded both in the patient-doctor relationship and in broader structures of gender discrimination. Obstetric violence was first identified and denounced in the context of childbirth and pregnancy. More recent analysis have highlighted specific forms of violence within gynaecological care, ranging from the gaslighting of contested illnesses to broader practises of disrespect and abuse, particularly affecting racialised, incarcerated, LGBTQIA+, and disabled patients.

Barbara Gagliardi is Full Professor of Administrative Law at the Department of Law of the University of Turin and member of the "Centro Interdipartimentale di Ricerche e Studi delle Donne e di Genere" (CIRSDe). Her research focuses primarily on administrative organisation, with particular attention to healthcare law, higher education law, and public employment law.

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ISBN 978-88-495-6175-3

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