Hypatia (2024), 1–27
doi:10.1017/hyp.2024.84

CAMBRIDGE UNIVERSITY PRESS

ARTICLE

Autonomy, Violence, and Consent in the Obstetric Field

Andrés Restrepo-Sánchez

Department of Anthropology, University of Iowa, US
Email: andres-restreposanchez@uiowa.edu

(Received 16 May 2023; revised 1 September 2024; accepted 3 September 2024)

Abstract

Obstetric violence is a structural form of gender, medical, and sexual violence perpetrated by health providers and institutions during pregnancy, birth, and postpartum. It can produce physical, psychological, and symbolic harm to pregnant/birthing people and their families. Obstetric violence results from structural conditions in the technocratic model of birth and the acceptance of biomedicine as the authoritative knowledge in health care. This phenomenon produces patients' loss of autonomy and capacity to provide informed consent, which increases their vulnerability to unjustified medical procedures, resulting in negative birth experiences. In this paper, I argue that individual autonomy is necessary but not sufficient for legitimately consenting to obstetric care and preventing violence. The liberal framework of individual autonomy often ignores that childbirth is a social event where multiple individuals and cultural factors influence the consent process. Consequently, I discuss the role of relational autonomy in obstetric decision-making and describe some structural barriers that negatively intervene in this process. Finally, I propose that doulas and midwives can help nurture autonomy and caregiving skills in obstetric patients and health providers. This strategy protects the informed consent process, prevents obstetric violence, and can be effective in recentering childbirth in pregnant people and their families.

1. Obstetric violence and autonomy loss

Obstetric violence refers to pregnant and birthing people's[1] perceived experiences of loss of autonomy, consent, and abuse perpetrated by health providers and institutions in the context of pregnancy, birth, and postpartum. This phenomenon can produce physical, psychological, or symbolic harm. It has been classified as a type of gender, medical, sexual, epistemic, and reproductive violence, a violation of human rights, and a clear case of reproductive injustice. Obstetric violence results from structural health inequalities (Sadler et al. 2016; Abadía Barrero 2022), the unequal knowledge/power relations between patients and providers in clinical settings (Foucault 1976), and the

hegemony of biomedical discourses in modern obstetrics that reduce pregnant and birthing people to passive subjects during their care (Gopal 2017; O'Brien 2023). Sometimes studied along gynecological violence, which "encompasses a range of [violent] practices carried out by healthcare providers within the framework of gynecological care" (Cárdenas-Castro and Salinero-Rates 2023, para. 2), obstetric violence scholarship and activism have vastly grown in the past two decades (Kitzinger 2006; Díaz-Tello 2016; Cohen Shabot 2016, 2020, 2021a–b; Quattrocchi 2019; Castro and Savage 2019; Nalepa 2020; Paula et al. 2020; Williamson 2021; Campbell 2021; Berzon and Cohen Shabot 2023; Cantor 2023; Davis-Floyd and Premkumar 2023; Sargent and Davis-Floyd 2023).

Obstetric violence encompasses multiple forms of dehumanizing treatment and medical abuse.[2] Some of these practices include unnecessary interventions, movement restrictions, prolonged fasting, routine episiotomies, frequent unjustified vaginal examinations, verbal threatening, shaming, scolding, and other actions experienced as violent by the pregnant/birthing person during their care (Castañeda et al. 2022; Cohen Shabot and Sadler 2023). In 2014, the World Health Organization recognized that abuse, disrespect, and mistreatment during childbirth were present in health facilities, affecting women's dignity and rights (WHO 2014). Their statement responded to extensive efforts of scholars, activists, and policymakers denouncing longstanding abusive practices experienced by obstetric patients worldwide (Davis 2018; Mejía Merino et al. 2018; Jojoa-Tobar et al. 2019; Vallana-Sala 2019). Importantly, Indigenous, Black, Latinx, impoverished, queer, undocumented, young, and disabled people disproportionally experience this type of violence (Levine 2008; Berry 2010; Davis 2019; Rogerson 2019; Strong 2020; Grotti and Brightman 2021; Gleason et al. 2021).

Like other forms of medical and gender violence, obstetric violence is a multi-layered phenomenon connected to broader sociopolitical and economic inequalities, a manifestation of structural violence (Farmer 2004). It is another link in "the continuum of violence" (Kelly 1987; Cockburn 2004) and "the violence of everyday life" (Das 2007) that entrap feminized bodies worldwide. Latin American countries have led the initiative to define and criminalize obstetric violence in the legal sphere (Quattrocchi and Magnone 2020). In 2007 Venezuela was the first country to describe obstetric violence in the "Organic Law on Women's Right to a Life Free from Violence."[3] México, Chile, Argentina, and Colombia also addressed the problem and have provided recommendations for a humanized and respectful childbirth experience. Unfortunately, there is no updated information in these countries about the reported number of cases of obstetric violence or the people persecuted for it. This suggests an important gap between legislative provisions and their effective application. For instance, in the last report from 2010, only seven cases of obstetric violence had entered the Venezuelan specialized courts, and none had been resolved (CEM-UCV et al. 2011).

In addition to the physical and emotional harm—the main focus of most studies—obstetric violence produces a loss of autonomy and decision-making capacity (Cohen Shabot 2020). According to Rössler (2002, 144), "The normatively guiding idea forming the basis of the concept of autonomy is that we, each of us independently, are free and able both to choose and to live the life that will be good for us." Autonomy loss is clearly stated in the 2007 Venezuelan legislation when defining obstetric violence:

> [Obstetric violence is] The appropriation of women's bodies and reproductive processes by healthcare providers, which is expressed in a hierarchic dehumanizing treatment, an abuse of medicalization, and the pathologization of natural

https://doi.org/10.1017/hyp.2024.84 Published online by Cambridge University Press

> processes, *producing a loss of autonomy and free decision-making capacity in women regarding their bodies and sexuality*, all of which has a negative impact in their quality of life. (Art. 15.13; emphasis added)

Pregnant people's loss of autonomy over their bodies hinders their capacity to consent to or deny medical interventions. It contributes to traumatic birth experiences, feelings of disempowerment,[4] loneliness, lack of recognition, and detachment from those attending their labor (Urrea-Mora 2014; Cohen Shabot 2016; Cohen Shabot and Sadler 2023). Additionally, it fuels an extremely paternalistic model of care, characterized by accepting Western biomedicine as the authoritative knowledge during childbirth (Jordan 1983). Authoritative knowledge "helps to explain how the disempowerment and objectification of pregnant people creates a culture of silence, which ultimately dissuades individuals and their partners from engaging in active decision-making during childbirth" (Cantor 2023, 164). Medical authoritative knowledge directly targets the informed consent process and patients' autonomy about their care.

In response to the structural conditions of a health system that re/produces unequal power relationships and coercive decision-making, Western bioethicists proposed a patient-centered model of care emphasizing individual autonomy as the primary—sometimes even exclusive—ethical principle to guide medical decisions (Rybak 2009; Mapes et al. 2020). Beauchamp and Childress (1994) initially proposed individual autonomy as one of four principles of common morality in biomedical ethics, along with beneficence, nonmaleficence, and justice. For these authors, individual autonomy in healthcare is a universal, reflexive "autonomous choice" process that allows people to make informed, intentional, and rational decisions. Beauchamp and Childress (1994) defined autonomy as a capacity and liberty that health providers should consider along with the other three principles in their praxis and research (Cudney 2014; Flanigan 2016). Despite the relevance of individual autonomy in healthcare, the traditional bioethical approach has been highly criticized for its pretended universality. This model often ignores structural hierarchies, sociocultural differences, and relationships mediating decision-making (Turner 2009; Banerjee 2022).

In this article, I critique the liberal bioethical framework of individual autonomy applied to obstetric settings because it ignores the relational nature of childbirth—and healthcare in general. I argue that individual autonomy is necessary but not sufficient for legitimately consenting to obstetric care and preventing violence. This does not mean that relationality should just be introduced into the concept of autonomy as an inherent aspect of it. Instead, I stress that autonomy, even during relational contexts, is reached only when someone "is able to decide about the relational context of action itself—to decide with whom and in what relationships she wants to live, which obligations she is willing to accept, and which personal projects she wishes to pursue" (Rössler 2002, 148). Childbirth is one of those relational contexts. It is a biosocial event that includes interactions between the pregnant person, their baby, and a group of health professionals, birth attendants, partners, and family members (Osamor and Grady 2016). I argue that, in addition to individual autonomy, we must address autonomy in relation to the cultural context and its multiple actors during obstetric decision-making and care.

Unfortunately, the exercise of both individual and relational autonomy have multiple structural barriers in common. Some of these problems include racism, sexism, poverty, incarceration, lower education, and power differentials that constrain obstetric patients and their families from providing free, informed consent about their care. To tackle

https://doi.org/10.1017/hyp.2024.84 Published online by Cambridge University Press

these barriers, I highlight the role of birth advocates like midwives and doulas, who often serve as bridges between biomedical-oriented health professionals and pregnant/birthing people needing care. In addition to other structural changes required for a "deeply humanistic" model of birth (Davis-Floyd 1992, 2008), doulas and midwives can help nurture autonomy and caregiving skills (Bhandary 2020) in obstetric patients and health providers. This strategy protects the informed consent process, prevents obstetric violence, and can be an effective way to recenter childbirth experiences in pregnant people and their families.

To develop my argument, I analyze the definition of informed consent proposed by the American College of Obstetricians and Gynecologists (ACOG) and review some causes of mistrust felt by pregnant and birthing people. I explain how testimonial injustice (Fricker 2007) leads to an extremely paternalistic model of care and reinforces medical authoritative knowledge. Then, I expand on the definition of individual autonomy proposed by medical bioethics, highlight its limitations, and criticize the expected archetype of the "Reasonable Mother" resulting from it. I call for advancing upon a definition and inclusion of relational autonomy in obstetric settings following the work of philosophers, anthropologists, and bioethicists applying relational autonomy to similar health contexts. Aligned with an intersectional feminist approach (Crenshaw 1991), I expose some structural conditions affecting the informed consent process. These barriers manipulate individual and relational autonomy and open the door for obstetric violence (i.e., obstetric racism, socioeconomic disparities, and legal coercion). Finally, I address the need for a structural reform of the model of birth and the inclusion of doulas and midwives in the healthcare team. I propose that these birth workers can help nurture the autonomy and caregiving skills presented by Bhandary (2016, 2020) in her Theory of Liberal Dependency Care. Autonomy and caregiving skills are fundamental to ensuring just obstetric care and protecting the informed consent process of pregnant/birthing people and their families.

2. Informed consent and "unreliable" obstetric patients

According to ACOG (2021), "the goal of the informed consent process is to provide patients with information that is necessary and relevant to their decision making … and to assist patients in identifying the best course of action for their medical care" (e34). Usually, informed consent takes the form of a physical document signed before the patient undergoes any treatment. However, a signed document "does not guarantee that the patient's values and priorities have been taken into consideration in a meaningful way and that the ethical requirements of informed consent have been met" (ACOG 2021, e34). Informed consent requires a conversation between health providers and patients to develop trust and respect, which ultimately aims to provide good care (Flanigan 2016). Obtaining the patient's signature on a document, often difficult to understand due to medical and legal terminology, should not be considered proper informed consent (Martín-Badia et al. 2021). These documents might work as legal evidence to protect the institution during lawsuits. However, they rarely demonstrate that health providers followed the ethical procedures required for obtaining patients' *informed* consent about their care.

Informed consent is supposed to be a patient-centered, individualized, and continued process[5] that includes all risks and benefits of the available treatment options and respects the patient's values and priorities (ACOG 2021). Ultimately, the consent process should look at patients' self-determination, ideally reaching a consensus between

https://doi.org/10.1017/hyp.2024.84 Published online by Cambridge University Press

the patient and provider about the most reasonable treatment plan. In other words, it is a "mutual sharing of information between the clinician and patient to facilitate the patient's active engagement in their treatment" (Campbell 2021, 66). If a health provider fails to obtain informed consent before a medical procedure, the patient may have a valid malpractice claim for any harm related to the procedure (Mann 2004). Malpractice—failing to provide a proper standard of care resulting in patient harm—is one of the most common legal claims confronting the medical field. Notably, the doula community has popularized the BRAIN acronym for making informed decisions during childbirth. BRAIN stands for benefits, risks, alternatives, intuition, + nothing (Doula to Others 2018). With this tool, doulas teach patients and their families to explore the benefits, risks, and alternatives of each procedure with their providers. It encourages people to listen to their intuition and ultimately make the best choice for their situation, which can be doing nothing, waiting, or moving forward (Doula to Others 2018).

The doctrine of informed consent, as presented above, shifted throughout the twentieth century (Campbell 2021). First, it relied on a physician-based standard, which focused on the decision-making process from the perspective of the "reasonable medical practitioner" and their scientific standards. Under this model, patients presumed physicians knew what was best for them. Doctors were assumed to be unbiased and objective, with the expertise to make healthcare decisions for their patients. Later, bioethicists criticized this approach for its "excessive paternalism," the lack of patient agency, and the immunity it granted to physicians during legal trials despite their malpractice. Eventually, lawmakers in the United States changed their perspective on consent by demanding health professionals provide their patients with all the information needed to make informed choices. Instead of passive receptors of care, patients were now considered "reasonable subjects" with the capacity to decide for themselves (Campbell 2021). In specific life-altering procedures, such as sterilization and end-of-life treatment, the informed consent process became more rigorous, in some cases requiring a mandatory waiting period before the consent is valid.[6]

For legal purposes, most adult patients are presumed to have autonomous decision-making, which gives them the right to accept or refuse medical treatment (ACOG 2021). The exception to this rule is when a health professional determines "mental incompetence" in their patient, a strongly ableist category that scholars on neuro-divergence and disability have criticized. Under "mental incompetence"—sometimes referred to in the past as feeblemindedness—people have been confined, devaluated, and excluded from moral and political theories, denying their capacity for individual autonomy, a chief marker of moral personhood (Davy 2015; Lira 2022; Di Giulio 2024). Despite these critiques, the doctrine of informed consent in healthcare still relies on the assessment of "mentally competent reasonable patients," a category that does not apply to children, unconscious or intoxicated patients, or people with some mental disabilities, all assumed incapable of providing meaningful consent (Flanigan 2016).

Surprisingly, health personnel often count birthing people as another group incapable of providing rational consent, and there are historical explanations for this mistrust. Villarmea (2021) says that physicians have fallaciously assumed that women are irrational, extremely sensitive, and emotional since the notion of the migratory uterus appeared in texts of ancient Egyptians. The misconception of a "wandering womb" that moves freely through the body, generating disease and unpredictable behavior, connects to the idea of wombs as animals present in Plato's *Timaeus*: "The womb is an animal which longs to generate children" (cited in Villarmea 2021, 38). The myth of the migratory uterus persisted for centuries in European academic

https://doi.org/10.1017/hyp.2024.84 Published online by Cambridge University Press

medicine, serving as an etiology (the cause of a disease) for emotional volubility and imagined disorders like "hysteria." We may think that modern medicine is far from such bizarre myths. However, "the pervasive construction of the uterus as an element that renders women wild, uncontrollable, and irrational continues to influence contemporary obstetrics" (Villarmea 2021, 22).[7]

The persistent notion that wombs govern people's behavior has led healthcare workers to assume that women, and especially pregnant/birthing people, are not responsible for their actions, have no discernment capacities, and their emotional fluctuations make them incapable of making rational decisions. There is a persistent erroneous perception that people with a uterus cannot fulfill the requirements of "reasonable patients" and, therefore, cannot provide informed consent about their care. Living proof of this misconception is when health personnel infantilize obstetric patients and treat them as victims of pathological conditions requiring intervention (Vallana-Sala 2019). Instead of physiological processes, pregnancy and childbirth are seen as moments in patients' lives where the uterus "takes control of the entire body," and people's actions become irrational (Villarmea 2021). This sustained mental deficiency fallacy has not only produced medical violence but has also been used to deny women access to citizenship, their right to vote, and their autonomy for deciding about their bodies (Villarmea 2021).

Additionally, some health providers working in maternity care erroneously believe that their patients are incompetent to provide informed consent because of the physiological and psychological changes occurring during pregnancy. "For decades, the concept of 'mommy brain' (also referred to as baby brain, mom brain, momnesia, and pregnancy brain) has permeated what it is to be a mother" (McCormack et al. 2023, 335). "Mommy brain" refers to a supposed memory deficit and impaired mental capacity that manifests during pregnancy and postpartum. This idea is not only scientifically inaccurate but hides the positive adaptations that emerge in parental brains, including caregiving expertise and better emotional regulation (McCormack et al. 2023, 335). Parents experience a neurologic developmental period known as "matrescence," which is similar to the morphological brain modifications that occur in adolescence. While "mommy brain" denotes brain dysfunction, "matrescence" speaks of neuroplasticity and adaptation to new life demands. "The term matrescence, the process of becoming a mother, was first coined by the anthropologist Dana Raphael [1973], and later expanded by Aurélie Athan [2016] to include 'a developmental passage where a woman transitions, through pre-conception, pregnancy and birth, surrogacy, or adoption to the postnatal period and beyond'" (Orchard et al. 2023, 303). Davis-Floyd (1992) attributes the term to the midwife and professor Denis Walsh (2006). Importantly, "matrescence" (later known as "external gestation") is not only a hormonal change but a social and cultural adaptation to parenting.

Some health providers have also used the pain and emotional distress experienced during childbirth as excuses for ignoring informed consent. "Health workers may interpret suffering as a barrier to voluntarism if a patient is seen as making her decision out of desperation rather than her previously held values" (Roberts 2003, cited in Flanigan 2016, 229). However, empirical research into the effect of pain on deliberative competence shows that, while pain may change a person's decisions during childbirth, it does not undermine their potential to give informed consent or to know what is better for their overall well-being (Flanigan 2016). Moreover, ACOG (2016, 2021) has repeatedly stated that neither pregnancy nor childbirth pain are exceptions to consider

https://doi.org/10.1017/hyp.2024.84 Published online by Cambridge University Press

obstetric patients as rational, capable subjects with the right to accept or refuse treatment for themselves and their fetuses.

Other scholars situate the medical professionals' belief that birthing people are incapable of giving consent in the high-risk or emergency situation they face during labor, a time when making decisions can be challenging (Hawkins et al. 2011; Flanigan 2016). The language of risk in obstetric contexts is highly relevant. Obstetricians classify all pregnancies on a risk scale according to their expected outcome, where the safest pregnancy can be is "low risk," meaning only one baby in cephalic presentation[8] without additional factors requiring medical intervention. It is true that childbirth always implies some risk and that the active phase of labor (when the cervix dilates from 6 to 10 cm and contractions become stronger and more regular) is not the most optimal scenario for decision-making.[9] However, the potential or actual risks during any stage of childbirth should not be a reason for health personnel to forcibly perform or deny any procedures on their patients. According to ACOG (2016), obstetricians should follow the informed consent process even during emergencies; otherwise, the pregnant person can experience those procedures as violent or intrusive.

According to Cohen Shabot (2016), "childbirth also has a deeply sexual dimension that the medicalized model has almost completely erased: childbirth is a product of pregnancy, itself a product (almost always) of sexual intercourse. Moreover, childbirth (except in Caesarean sections) involves our genitals" (241). The sexual dimension of pregnancy and childbirth is often permeated by health professionals' patriarchal constructs of feminine sexuality. While female bodies (and those assumed to be female) are interpreted as submissive, passive, non-assertive, and at the service of others, pregnant bodies will continue to be portrayed as available objects open to manipulation and control (Kingma 2021). It is not coincidental that some birthing people describe events of obstetric violence as rape, equating medical abuse to various forms of physical and verbal sexual assault (Kitzinger 2006; Cohen Shabot 2016; Mardorossian 2019; Restrepo-Sánchez 2024). Sexist stereotypes of birthing people may explain, in part, why "the appropriation of women's bodies" is a crucial part of the definition of obstetric violence (in the Venezuela law of 2007).

Structural sexism, historical and cultural misconceptions of pregnancy, birth pain, or emergency situations are not valid reasons to invalidate a pregnant/birthing person's consent. Most pregnant/birthing people meet the "reasonable patient" capacity to "understand information that is relevant to [their] choice, communicate a choice, appreciate the consequences of [their] choice, and compare [their] choice to alternatives" (Appelbaum 2007, cited in Flanigan 2016, 227). When health providers do not acknowledge that pregnant and birthing people are "reasonable patients," they are exercising epistemic violence in the form of preemptive testimonial injustice. "Testimonial injustice occurs when prejudice causes a hearer to give a deflated level of credibility to a speaker's word" (Fricker 2007, 1). Testimonial injustice is a form of patient objectification and constitutes a common form of obstetric violence (De Barros Gabriel and Guimarães Santos 2020; Massó Guijarro 2023), often led by identity prejudice—"a label for prejudices against people *qua* social type" (Fricker 2007, 4). Other forms of epistemic obstetric violence occur when medical authoritative knowledge excludes pregnant/birthing people from the production of knowledge in medicine, including their participation in clinical research (Bellón Sánchez 2014).

https://doi.org/10.1017/hyp.2024.84 Published online by Cambridge University Press

3. Individual and relational autonomy during childbirth

Individual autonomy, understood as a person's sense of self-determination and ability to act on their own values and interests, has been the crucial pillar of the informed consent process in healthcare. However, in addition to "mental incompetence" (explained in the previous section), this principle has other restrictions. Children, for example, have special protections from the moment they are born. Despite being considered incapable of consent, "Courts are generally authorized to make medical decisions in the interest of a child even when the child's parents disagree" (Dare 2009, cited in Flanigan 2016, 225). During public health emergencies, governments may impose obligatory quarantines and vaccinations to prevent a contagious person from threatening the lives of others. In both cases, the individual autonomy of some subjects is limited for the perceived benefit of others. In the case of maternal care, should this rationale of protecting someone's well-being over another's autonomy apply to unborn infants? According to the US Constitutional Court, fetuses are not covered under the definition of "constitutional personhood" protected by the Fourteenth Amendment (1868). Therefore, pregnant and birthing people in the US should have the right to make individual choices about their health, even if those decisions represent danger for themselves or their fetuses.[10]

In line with this idea, Flanigan (2016) argues that obstetricians should only consider the mother's and not the baby's autonomy: "Though there are strong moral reasons for women in labor to mitigate the risks to unborn infants, they would not violate anyone's rights by failing to do so, whereas forced interventions during childbirth would violate the mother's medical rights" (226) and constitute a form of obstetric violence.[11] Pregnant people are allowed to make medically inadvisable choices during childbirth, like refusing a C-section that may compromise the fetus' well-being. Even when these decisions are "morally risky," they should not justify medical coercion or forced treatments (Flanigan 2016, 234). The ownership of medical rights by the pregnant/birthing person, and not by the unborn infant, protects patients' autonomy and rests on the existential and relational constructs of personhood as a state of value (White 2013).

Some paradigms in maternity care rely on the assumption that parents are willing to make sacrifices for their children, so not prioritizing the fetus represents a violation of pregnant people's autonomy. About this argument, Kingma (2021) explains that "these presumptions hold true only because, and only insofar as, women, as autonomous agents, take on the value of altruistic maternal sacrifice (to at least some extent), as well as the value of love and care to the degree that another's pain is one's own (again at least to some extent)" (461). Parental sacrifice is not a violation of individual autonomy but a reaffirmation of it. Not all parents are willing to risk their health for their unborn children's well-being. However, for those who prioritize their fetus's health over their own, their decision is grounded in and is ultimately an expression of individual autonomy.

Other authors have explored the role of individual autonomy in risky situations of reproductive care where morbidity and mortality are higher. Some examples include a patient's request for vaginal birth in a second pregnancy after a cesarean (Rybak 2009) or the use of assisted reproductive technologies after a renal transplant (Lockwood 1999). In these situations, it is important to ensure a more thoughtful informed consent process, emphasizing evidence-based recommendations and additional advice from medical academic committees. However, despite the increased risk, medical personnel should not violate patients' individual autonomy over their bodies. This would result in

https://doi.org/10.1017/hyp.2024.84 Published online by Cambridge University Press

malpractice and reproductive violence. "The experience of non-consensual medical intervention is often extremely traumatic for patients" (Flanigan 2016, 233). Moreover, it has been widely documented that people who experience traumatic births and other forms of medical violence have a higher risk of post-traumatic stress disorder and postpartum depression symptoms (Olza 2013; Junqueira et al. 2017; Martinez et al. 2021).

Western cultures often equate individual autonomy with independence, self-sufficiency, and self-directedness, characteristics of the Cartesian ideal of a rational man (Osamor and Grady 2016). The current emphasis on individual autonomy in healthcare exalts self-determination and self-government, core principles of Western democracies, and "neoliberal philosophies and policies that emphasize individual responsibility and 'choice'" (Rajtar 2018, 185). Individual autonomy operates under the paradigm of patients being autonomous, reasonable individuals, detached from cultural factors that could potentially bias their decisions. Applied to maternal care, the "Reasonable Mother" emerges as the archetypical subject in the neoliberal obstetric establishment. The Reasonable Mother complies with the expectation of obstetric patients exercising their individual autonomy in isolation, making rational decisions about themselves and their babies without the influence of their context and culture. A Reasonable Mother accepts medical authoritative knowledge (Jordan 2023), engrains herself in the technocratic model of birth (Davis-Floyd 1992), and, consequently, becomes the perfect victim for symbolic, epistemic, and obstetric violence (Bourdieu and Wacquant 1992; Fricker 2007; Cohen Shabot 2021b; Castro and Frías 2022).

The Reasonable Mother is only one phase of the "modern woman" expected from liberal societies (Van Hollen 2003). This relentless subject exculpates the institutions of patriarchal capitalism, blames other women for their disadvantaged positions, exercises intense surveillance over other bodies, and constantly calls for endless work on the self, centering the notions of empowerment and choice (Rottenberg et al. 2020, cited in Darling 2022). For a Reasonable Mother, womanhood and motherhood are often inseparable; thus, she engages in "body projects" of intensive self-regulation, self-transformation, and the disavowal of any aspects of embodiment that are non-compliant with the values of containment and optimization (Darling 2022). Sometimes, the structural demands for performing "good motherhood" translate into violence in the delivery room, with "gendered shame" playing a crucial role in reifying laboring women mainly as mothers-to-be (Cohen Shabot and Korem 2018).

Individual autonomy also plays a central role in the discourse of white liberal feminists fighting for reproductive rights, with the "pro-choice" movement as a remarkable example. Generally, people who identify as "pro-choice" believe in their right to control their own bodies, including their capacity to decide when and whether to have children. In contrast, people who want abortion to be illegal and inaccessible—often using conservative Christian rhetoric to support their views—self-identify as "pro-life." In many scenarios, these are considered outdated terms: "'Pro-choice' and 'pro-life' labels don't reflect the complexity of how most people actually think and feel about abortion. Some people and organizations, including Planned Parenthood, don't use these terms anymore" (Planned Parenthood 2024, para. 5). The Reproductive Justice Movement, as described by Loretta Ross and Rickie Solinger, "refuses the logic of individual choice. It clarifies how one's health, sovereignty, and capacity for family formation are intimately entwined with the broader social, political, and cultural landscape" (Murillo and Fixmer-Oraiz 2021, 762). The problem with individual autonomy, as reproductive justice scholars have constantly argued, is that it ignores that

https://doi.org/10.1017/hyp.2024.84 Published online by Cambridge University Press

people make reproductive choices in contexts influenced by power dynamics and shaped by cultural values, beliefs, norms, and traditions.

Autonomy is instrumentally essential for decision-making about care seeking, utilization of services, and choosing or declining treatment options. However, while individual autonomy is crucial, more is needed to understand the consent process in obstetric settings. Giving birth is a communal experience that includes (at least) the pregnant person and their baby and (often) a group of health professionals, family members, and birth workers. The social dimension of childbirth influences decision-making, inviting us to problematize the autonomous, Reasonable Mother archetype. Critiques of the liberal individual autonomy model propose that autonomy is a multidimensional process connected to different aspects of social life. People rarely make their healthcare decisions in isolation. Cultural models of health and disease, community rules, and care providers' advice influence our decisions (Shih et al. 2018). Furthermore, relationships of interdependence, such as friendship, kinship, love, care, and obligation, play a preponderant role in health choices, including the ones taken during childbirth (Gammeltoft 2008; Osamor and Grady 2016).

Under the framework of relational autonomy, people make decisions with and supported by others, and their goals are usually mixed up with the decisions of others (Cohen Shabot 2020). The relational here is not limited to intimate relationships among people but to interconnected relationships with institutional structures, law, civil society, and multiple religious and secular discursive traditions (Nedelsky 2011, Dokumacl 2020). The idea of relational autonomy has roots in early feminist accounts of womanhood, as we can read in the description of de Beauvoir's carnal subject, a being never isolated nor purely mental: "De Beauvoir's subject [in contrast to the Cartesian subject] is ambiguous in that it is always situated, particularly embodied, located in a concrete time and place, and thus singularly itself—but also always carnally open and reaching out, and thus more than (only) itself" (Cohen Shabot 2020, 7). Herring (2014) offers us a rich and compelling feminist study of the relational self—versus the individual self—and states that relational autonomy challenges the traditional conception of individual autonomy, which is built on a patriarchal liberal conception of the subject (Cohen Shabot 2020).

Mackenzie and Stoljar (2000) developed a rich anthology of contemporary feminist theories of agency. These authors critique the notions of individualism and retheorize autonomy as compatible with social interdependency. To explain their theoretical move, Mackenzie and Stoljar (2000) distinguish between procedural and substantive accounts of autonomy. The procedural accounts relate to individual autonomy, which relies upon rational reflection and the agent's independence of their beliefs, attitudes, desires, and values. Procedural autonomy is "content-neutral," disconnected from interdependent relations and cultural contexts. In contrast, substantive accounts of autonomy are connected to our desires, beliefs, and values, which cannot be separated from internalized oppressive structures and societal norms (Mackenzie and Stoljar 2000). Therefore, substantive—and not merely procedural—accounts of autonomy matter for understanding how people's autonomy works under oppression.

Oshana (2006) provides another essential contribution to theorizing social-relational autonomy. According to this author, we must consider the overall autonomy of a subject instead of their episodically autonomous actions; autonomy requires power and authority, making it impossible for subalternized subjects to be truly autonomous. Being autonomous is to be free from oppressive structures (Oshana 2006). In contrast, Mackenzie and Stoljar (2000) and Bhandary (2016) defend the possibility of achieving

https://doi.org/10.1017/hyp.2024.84 Published online by Cambridge University Press

autonomy, at least to a certain degree, even under oppressive structures. Their perspective highlights agency and the pursuit of freedom as essential aspects of the subaltern's independence mission. According to MacDonald (2010), relational autonomy should conceive external forces to the agent not simply as threats or barricades; it must address dependence as constitutive of autonomy and transform it to allow for interdependent relationships to be balanced with power and agency. When people negotiate between different social features, including their desires, values, available options, and oppressive structures, they exercise "an account of *socially embedded agency* that is fundamentally and essentially social" (Webster 2021, 117). This type of agency is different from *shared* agency—"which explores what it takes for two or more individuals to act together" (Webster 2021, 118)—and it can exist even under circumstances of oppression.

From the ethics of care, Held (2018) states that "human beings [are] vulnerable, dependent, above all interconnected, rather than [resembling] the rational, self-sufficient, autonomous individuals of the liberal traditions on which our reigning models of law and politics, and the moralities that expand them, are built" (231). A relational conception of the self closely connects care ethics with relational autonomy (Keller 1997). Interestingly, Bhandary (2016), a liberal care ethicist, rejects the concept of "bare autonomy" present in the liberal theory of Hume and Rawls, pointing out that "people's current choices arise from a cultural context with forms of prescriptive socialization that make choices within these cultures autonomous in only a very minimal sense" (54). For Bhandary (2016), "choices are made in specific contexts that are personal, familial, social, political, cultural, and temporal, and they are shaped by the availability of options and by our conceptualizations of those options" (55), which aligns with the principles of relational autonomy.

Researchers have analyzed relational autonomy and its limitations in the decision-making process of multiple health situations. Some of the cases include refusing blood transfusions by Jehovah's Witnesses (Rajtar 2018), chemotherapy options for breast cancer patients (Shih et al. 2018), and palliative care guidelines in critically ill patients in the intensive care unit (Mapes et al. 2020). One of the studies that examined relational autonomy in gynecological and obstetric settings was developed by Kaplan et al. (2017). The authors associated the limited autonomy of rural Malawi women with their increased risk of developing obstetric fistula after birth. During interviews, Kaplan et al. found that the "last word" on labor and delivery resided in the husband's authority. Men often sought the advice of the elderly women in the village and prioritized their opinions over those of their wives and the doctors providing antenatal care. This study illustrates the multiple actors involved in reproductive decision-making and how relational autonomy could harm individual autonomy and birth outcomes. However, Kaplan et al. (2017) also found that young women in Malawi were not passive victims; they had subversive ways of expressing their reproductive autonomy, for example, secretly using contraception without informing their husbands.

Relational autonomy is particularly relevant during obstetric care, and its violation can be considered a form of obstetric violence. According to Cohen Shabot (2020), "cutting the original links to our bodies and the world that constitute our phenomenological condition" (1) is a form of obstetric violence. Women and birthing people not only suffer in their physical bodies. In addition, health personnel often exclude partners, birth advocates, and support networks from the birthing rooms (Cohen Shabot 2020). This practice damages "the social, communal character of childbirth . . . [increasing] vulnerability, banning support and demolishing

https://doi.org/10.1017/hyp.2024.84 Published online by Cambridge University Press

relationships and interdependence between laboring women and their significant others during childbirth" (Cohen Shabot 2020, 2). Feelings of isolation and abandonment are common among birthing people in institutionalized environments with strict protocols for patient visits. Unsurprisingly, the protocols and restrictions established during the COVID-19 pandemic, some of which are still in place, have dramatically increased the number of situations involving giving birth in isolation (Hussein 2020; Sadler et al. 2020).

With the normalization of authoritative knowledge and the medicalization of birth in Western societies (Davis-Floyd and Cheyney 2019; Sargent and Davis-Floyd 2023), some health professionals may be afraid to cede ground to family members or other birth attendants because this could affect their autonomy. Decreased professional autonomy is defined as a lowered decision-making level, decreased job status, or inability to voice their professional opinion in the workplace. As de Jonge (1998) explains, "Job autonomy is of high importance as it protects healthcare professionals against somatic complaints, psychological distress in their work, and burnout" (cited in Perdok et al. 2017, 68). However, literature shows that good collaboration in maternity care between professionals, patients, and family members enhances the value of relational consent and improves the quality of care, job-related well-being, and satisfaction for health personnel (Perdok et al. 2017). A support network during childbirth enhances pregnant people's capacity to be autonomous, evaluate options, and make better decisions while promoting better working conditions for health providers (Hunt and Ells 2011; Shih et al. 2018).

Structural conditions can affect both individual and relational autonomy. Multiple situations distort the informed consent process, constraining a pregnant/birthing person's autonomy and increasing adverse health outcomes. These circumstances constitute what Campbell (2021) calls an "informed consent gap," a disjuncture between patient-centered care, the law in practice, and the healthcare delivery system. Many structural barriers increase the informed consent gap and reproduce structural violence in the health system (Galtung 1969; Farmer 2004). Despite not being exclusive to gynecological and obstetric care, I review three of these barriers (i.e., racism, socioeconomic disparities, and legal coercion) to understand better the structural challenges that pregnant/birthing people and their families navigate in the health system. These barriers should be understood as "interlocking systems of oppression," as proposed by the Combahee River Collective (in Moraga and Anzaldúa 2015), or as intersectional dynamics of inequality with multiplicative effects (Crenshaw 1991).

In *Reproductive injustice*, Davis (2019) exposed the precarious situation of Black mothers in the US health system. She attributed this fact to "obstetric racism," explaining that Black women had far worse outcomes in maternal mortality and morbidity than their white counterparts, even in similar socioeconomic statuses. For Davis (2019), racism works when health personnel dehumanize Black bodies by denying their pain or believing they have a higher pain threshold, a misconception with roots in the American history of chattel slavery. The relationship between Black bodies and pain resistance is an arbitrary assessment that often justifies medical and pharmacological treatment delays (Davis 2018). Health providers can influence patients' decisions with their racial prejudices about what some bodies need (like a higher/lower dose of analgesics during childbirth), even without making explicit recommendations about it (Campbell 2021). Obstetric racism is part of a medical continuum of violence that historically has used the pseudoscience of eugenics and social Darwinism to exploit Black bodies for medical experimentation, unauthorized autopsies, and even grave

https://doi.org/10.1017/hyp.2024.84 Published online by Cambridge University Press

robbing (Washington 2008). Importantly, the experiences of pregnancy and birth of Black and other Women of Color "are shaped not simply by violence and coercion by patriarchal institutions but also by the multifaceted ways in which gender interacts with interlocking systems of race, class, age, ability, sexuality, and nation" (Chinyere Oparah and Bonaparte 2016).

Socioeconomic conditions also affect pregnant and birthing people's autonomy and consent. In a literature review about women's autonomy in "low-income countries," Osamor and Grady (2016, 191) found that "many such societies still have strong social structures that rigidly define the roles of men and women, usually encoded in religious, tribal, and social traditions." It is crucial to acknowledge that "low income" indicates a country's location in the global economy, often due to legacies of colonialism. Socioeconomic conditions are highly influenced by structures of oppression such as racism, ageism, colonialism, ableism, and cis-heterosexism, all of which are correlated and directly influence women's autonomy (Kaplan et al. 2017). Low income does not have a causal relationship with patriarchy or conservative cultural traditions. Still, one cannot freely opt for the "best maternal care" within a health system facing precarious economic conditions, including a lack of resources and personnel. More qualitative studies should be developed to improve the instruments that assess autonomy in precarious contexts, especially being careful not to reproduce the narrative of the "trapped/poor women without agency" in the Global South.[12]

The surveillance of the legal system over healthcare creates additional problems for people's autonomy. In rare cases when a pregnant person's medical choices threaten to endanger her unborn child's life or health, courts have demanded the performance of C-sections, forced hospital detentions, and other intrauterine procedures against the person's will (Flanigan 2016). This legal practice violates the patient's individual autonomy, personhood, medical rights, and even the autonomy of the health professional forced to perform the procedure. Some studies in the US have also documented that lawsuits for negligence and malpractice are typical strategies patients use to gain large amounts of money in different health situations (Mann 2004). As a response, some obstetricians have opted for "defensive medicine," which often implies manipulating their patients' decisions to choose what they consider the less risky situation. Defensive obstetric care is one of the explanations for the high rate of C-sections worldwide (Mann 2004) and the perpetuation of unnecessary procedures, such as routine episiotomies, prolonged fasting, and limitation of movement without medical justification.

Among many other structural barriers, racism, economic inequality, and defensive medicine due to legal surveillance negatively impact people's individual and relational autonomy, manipulate the decision-making process, and increase the informed consent gap. In the last section, I propose a strategy to counter some of the problems present during obstetric informed consent. I follow Bhandary's (2020) suggestion to cultivate autonomy and caregiving skills and apply them to the informed consent process of pregnant and birthing people. The proposal highlights the role of doulas and midwives in transforming the technocratic model of birth into a humanistic one (Davis-Floyd 1992). Implemented with other structural changes, autonomy and caregiving skills are crucial to achieving more satisfactory and just care.

https://doi.org/10.1017/hyp.2024.84 Published online by Cambridge University Press

4. Autonomy and caregiving skills: towards a humanistic model of birth and informed consent

Foundational feminist and anthropological work on birth and reproduction has demonstrated that birth is shaped by its geographical and historical contexts. The birth model reflects systems of knowing, beliefs, and practices of the community, often reproducing existing power relations (Kay 1982; Jordan 1983; Ginsburg and Rapp 1991; Van Hollen 1994). With the emergence of modern obstetrics, the knowledge and control over childbirth moved from midwives to specialized doctors, confining obstetric care to the hospital walls (Wertz and Wertz 1977; Ehrenreich and English 1973; Gopal 2017; Basile 2019). The resulting model of birth was based on vigilance and interventionism over patients' bodies, normalizing routinary painful technologies like forceps and vacuum extractions (Davis-Floyd 1992; Martin 1987; Van Hollen 2003; Inhorn 2009).

In *Birth as an American rite of passage,* Davis-Floyd (1992) describes the different Western birth models that became popular in the transition of childbirth from home to hospital: "The industrial model of birth and its successor, the technocratic model, metaphorize and conceptualize the human body as a machine and treat it as such" (60). In these models, "the female body has long been viewed as an abnormal, unpredictable, and inherently defective machine" (Davis-Floyd 1992, 61), and the woman's reproductive tract is treated like a birthing apparatus that doctors can control and manipulate. According to Davis-Floyd (1992), the technocratic model of birth and healthcare has 12 tenets, including mind-body separation, objectification of the patient, alienation of practitioners from their patients, and standardization and hierarchical organization of care. Of special interest for this paper is the seventh tenet: the authority and responsibility are inherent in the practitioner, not the patient (Davis-Floyd 1992, 73). In the technocratic model of birth, physicians and institutions hold the power, and when this happens, the patient lacks agency.

Davis-Floyd (1992) also explains that, since the emergence of humanism as an ideology in the 1970s, some nurses and physicians have made efforts to humanize technomedicine, leading the way to a new model of birth. The humanistic model follows evidence-based medicine—"the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients" (Sackett et al. in Davis-Floyd 1992, 78). Some of the tenets of this model include the mind-body connection, the patient as a relational subject, a focus on disease prevention, and the information, decision-making, and responsibility shared between patient and practitioner (Davis-Floyd 1992). In a deeply humanistic model of birth, the doctrine of informed choice is a fundamental pillar for any medical intervention. Midwives, community health workers, and doulas have been crucial in transforming the technocratic model of birth into a humanistic one, but there is still much to be done.

As many pregnant people still give birth in a technocratic model of healthcare, finding others who can advocate for their rights, provide emotional and physical support, and ensure their individual and relational autonomy is vital. This is where midwives and doulas become key allies for pregnant/birthing people and their families (Doenmez et al. 2022; Salinas et al. 2022). According to Ford (2021), doulas are "supplementary providers who play a key role in improving maternity care" (114). They are people trained to provide nonmedical physical, emotional, and informational support during pregnancy, childbirth, and postpartum. In contrast to midwives, physicians, or nurses, a doula's presence during labor and birth is continuous and uninterrupted (Basile 2019). One of the main objectives of doulas is to rehumanize the

https://doi.org/10.1017/hyp.2024.84 Published online by Cambridge University Press

birth experience, acting as kind and compassionate caregivers (Mahoney and Mitchell 2017). Both doulas and midwives recenter the knowledge of birthing people and help them to advocate for their bodily autonomy in institutional settings. These workers disrupt the biomedical authoritative knowledge, privilege connection, and place value and priority on the everyday nonmedical bodily knowledge, intuition, and experiences of birthing people (Davis-Floyd and Davis 1996; Basile 2019).

Radical doulas and radical midwives are a subgroup within the birth movement that draws on several perspectives of reproductive justice and third-wave feminism: intersectional theory, postmodernist, and postcolonial feminism, celebrating the multiplicity and contradiction of youth culture activism (Basile 2019). Radical doulas "serve as a bridge between the political act of care and the legal practice of consent. In many ways, they 'translate' between these, helping clients discover their capabilities and desires and then acting as clients' 'voice,' advocating for their interests, and mediating consent" (Ford 2021, 118). The bridging role of doulas and midwives is similar to that of HIV/AIDS educators and rehabilitation counselors in health systems across the world (Chiu et al. 2019) or the mediation that rape advocates perform during forensic nursing investigations (Mulla 2014). All these supporting figures ultimately defend patients' rights and interests in healthcare settings, fighting against institutional barriers, medical violence, and other forms of mistreatment and abuse.

Importantly, not only midwives and doulas work towards a humanized model of birth. Rodrigues Duarte et al. (2020) explored the role of obstetric nurses working under a woman-centered care approach, protecting the relational autonomy of patients during childbirth. Their study showed that nurses' performance was "based on practices that respected the physiology of childbirth, such as welcoming, physical and emotional support to the parturient woman,[13] stimulating non-invasive and non-pharmacological pain relief practices . . . and encouraging the companion of the woman's choice" (907). Their actions resulted in a better quality of care, a reduction in episiotomies, and fewer instrumental deliveries. Davis-Floyd and Premkumar (2023) also showed that some obstetricians globally have shifted from technocratic to humanistic practices, opening the path for "deeply humanistic" models in countries like Brazil, India, Hungary, Canada, and Turkey. However, none of these figures should be seen as inherently good caregivers. Fraser (1998) showed that midwives—and I would add, other "superficial humanist" birth workers (Davis-Floyd and Premkumar (2023)—could also reproduce medical power structures, perpetuate white racial purity ideas, and suffer from the oppressive actions of state agents that dismiss their authority.

Despite the coercive nature of birth workers' regulation by the medical establishment, doulas, midwives, and other humanistic health workers can make an important difference in pivoting towards a humanistic model of birth. One plausible strategy consists of deeply humanistic workers nurturing autonomy skills in pregnant/birthing people and caregiving skills in health providers who still work under technocracy. According to Bhandary (2020), "liberal dependency care requires that existing societies support the cultivation of autonomy capacities, or skills" (97). Society must intend to achieve a high level of autonomy and caregiving skills throughout the population as a matter of justice "because they are a precondition for the veracity of judgments about justice" (98). These skills are also fundamental to function as a society, safeguard us against oppressive structures, and provide dependency care, which is "direct care that must be provided by a care-giver to the person needing care (the charge) for the continued survival of the charge" (Bhandary 2016, 43). All human beings require dependency care to survive during the first years of life, and many people benefit from it

https://doi.org/10.1017/hyp.2024.84 Published online by Cambridge University Press

when they experience any disease, temporary injury, or permanent physical or mental disability (Bhandary 2016). I consider that people during pregnancy, labor, and postpartum benefit from dependency care.

Bhandary adapted her set of autonomy skills from the feminist autonomy theory of Diana Tietjens Meyers (1989, 2002) and the thought of John Stuart Mill (1989a–b). From Meyers, Bhandary (2020) takes "the skills of communication, introspection, memory, analytical reasoning, imagination, and self-nurturing" (108), and from Mill, the "critical capacities of observation, perceptual parsing, and discriminating among possibilities" (107).[14] Autonomy skills allow individuals to identify when a policy or practice affects their individuality and decision-making, in addition to "articulate in their own ways who they are and what they value" (Bhandary 2020, 101). Bhandary's (2020) autonomy skills are "compatible with a wide range of ways of life and personal choices" (104). They do not require that people live in any particular way in their private lives but remain critical enough to protect people against being manipulated by dominant discourses and norms (Bhandary 2020). Autonomy skills are valuable on many levels and help people make rational decisions about relationships, work, economy, religion, group affiliations, study, and others.

The Meyersian autonomy skills of imagination and self-nurturing are particularly valuable (Bhandary 2020) for the case presented in this article. Pregnant people can use imaginative skills to envision other possibilities—like a more humanized and respectful model of care during labor—which is crucial for inspiring and developing new laws and clinical protocols. Additionally, self-nurturing enables patients denigrated by the medical establishment to maintain their sense of self-worth, which is generally lost under violent obstetric scenarios, and to regain their physical and psychological equilibrium after facing traumatic birth experiences.

Recognizing and fighting against structural oppressions like the ones mentioned in this article is essential for providing free, informed consent and safeguarding pregnant/birthing people from unconsented, violent medical practices. Structural change is difficult, but autonomy skills can make a positive impact, especially when considering autonomy as *choice* and *action* rather than a universal feature and ideal for all people (Westlund 2009). For example, through her autonomy skills, an Indigenous pregnant woman belonging to a community that performs rituals with the placenta could identify that a hospital protocol that discards placentas as biological waste violates her individuality and cultural traditions. She may identify that these protocols are not culturally sensitive and may have a racial bias that coerces people's decision-making about the final disposition of what was once part of their bodies. Furthermore, she might act by filing a complaint against the hospital, which ultimately can trigger the implementation of a more humanized birth protocol.

Through nurturing autonomy skills in their patients, doulas and midwives can shorten the gap between the objectified passive subject of the technocratic model of birth and the autonomous, relational subject of the humanistic model. Following the example above, the birthing Indigenous woman would probably not manage the language of medical protocols and would require the assistance of someone trained in culturally sensitive care. A doula or midwife in the health team can be the opportunity to advocate for this woman's communication, capacity of observation, and discrimination among possibilities. Nurturing autonomy does not mean that the humanistic health worker will *speak for* the pregnant/birthing person, a situation that can easily fall into violent silencing. Instead, they make the patient and their family the center of the care process,

https://doi.org/10.1017/hyp.2024.84 Published online by Cambridge University Press

reinforcing their individual and relational autonomy to evaluate, consent, or deny any intervention. Ideally, patients and family members should receive reinforcement of autonomy skills during the preconception visit (suggested for planned pregnancies), prenatal controls, and postpartum. The language of this training should be accessible to patients, avoid medical jargon or confusing physiological explanations, and ideally, it should include everyone expected in the delivery room.

Regarding caregiving skills, Bhandary (2020) states that "Most people have a natural ability to care, but this ability is differentially cultivated through social expectations, formal training, experience, and apprenticeships" (142). Based on the work of care ethicists like Tronto, Ruddick, Noddings, and Kittay, Bhandary (2020) proposes two basic and generalizable caregiving skills necessary for any form of dependency care: attentiveness and responsiveness. "Attentiveness is noticing the needs of the person cared for, which includes a grasp of life from the charge's point of view, including the charge's abilities, physical location, and feelings. Varying degrees of empathy are included within the skill of attentiveness" (Bhandary 2020, 143). Attentiveness requires paying attention to the other person, being receptive, and putting one's arrogance aside. "Responsiveness is a skill of acting in response to the needs of the dependent person, and it includes a volitional component: the person has to muster the will to act. This skill is functionally secondary to attentiveness, because if a caregiver responds to needs that have been incorrectly grasped, then they will not provide good care" (Bhandary 2020, 143–44). Under responsiveness, any intervention that the patient has not properly consented, even if coming from the "good intention" of the health team, will not be good care.

As Bhandary (2020) recognizes, "Caregiving requires additional skills and knowledge that vary based on the specified activity. Consequently, the skills of responsiveness and attentiveness have to be supplemented by relevant knowledge for the task at hand and corresponding practice-specific skills" (144). Nurses and doctors, for example, require medical knowledge and technical competence to perform procedures, which constitute the base of Western medical/nursing schools. However, to provide humanistic care during childbirth, I argue that health professionals must learn—at least—the caregiving skills of attentiveness and responsiveness. Doulas and midwives are often trained under a different, more holistic/humanistic model of care that already recognizes the relevance of these skills (Davis-Floyd 1992). Thus, they are essential to teach other health team members the need to develop these additional skills for providing good care.

In her Theory of Liberal Dependency Care, Bhandary (2020) proposes that public education must design a curriculum that teaches children basic autonomy and caregiving skills. Developing autonomy and caregiving skills takes time, so this should be a combined effort between school, family, and other institutions. For obstetric settings, I propose that doulas, midwives, and other humanistic birth workers assume the responsibility of reinforcing these skills to pregnant/birthing people, their families, and the rest of the healthcare team. Nurturing autonomy and caregiving skills is a crucial strategy to respect individual and relational autonomy, counter the elevated incidence of obstetric violence, and return the agency of childbirth to pregnant/birthing people and their families. It is a way of moving from the technocratic to a humanistic model of birth.

Following the approach of restorative justice, health professionals working under technocracy have a moral duty to learn caregiving skills and respect their patients' autonomy. This is a way to repair the harm that the medical establishment has caused to pregnant/birthing people over time. "When put into practice, the restorative process

https://doi.org/10.1017/hyp.2024.84 Published online by Cambridge University Press

itself can vary considerably, but typically requires bilateral dialog between offender and victim (and sometimes representatives of the affected community) who attempt to find a shared understanding of the harm done and how to recover from it" (Okimoto et al. 2022, 63). Doulas and midwives can be the bridges between health professionals and patients in this restorative justice process of birth model transformation.

Even though autonomy and caregiving skills are valuable resources to battle obstetric violence and protect patients' autonomy and consent, there are many other strategies that health systems must implement to stop violence and transform the birth model. For example, scholars have proposed a restructuration of the healthcare professions' curriculum, a revision of the bureaucratic institutional procedures limiting access to health services, and the implementation of birthing teams with decolonial, intersectional, and feminist caregiving approaches (Urrea-Mora 2014; Diaz-Tello 2016; Davis 2018). I believe that a joint effort of all these strategies can help reduce the cases of traumatic births and increase favorable healthcare experiences for pregnant and birthing people.

In this article, I presented the relationship between autonomy, consent, and violence in obstetric care settings. I explained the relevance of individual and relational autonomy to provide informed consent in healthcare and described some of the structural barriers that manipulate this process, including obstetric racism, socioeconomic disparities, and legal coercion. Finally, I presented the nurturing of autonomy and caregiving skills as a strategy to face obstetric violence and ensure the free exercise of people's autonomy in the decision-making processes regarding their obstetric health. It is important to address that autonomy, relational or not, has been a powerful ideal in the Western context since the Enlightenment. However, autonomy is not "a universal ideal of human agency that provides the standard by which to judge a person's status as a full agent and a fortiori his or her deservingness of our respect as an equal" (Herr 2018, 208). For non-Western societies that do not embrace autonomy as a hyper-good or that function under alternative models of care, other categories might be more useful (Herr 2018).

It is also essential to acknowledge that historical misinterpretation of women's bodies and their capacity for reasoning continues to influence how health professionals interact with their patients and doubt their judgment. Even though some health personnel interpret the critical moment of birth as an emergency, influenced by pain and cognitive changes during pregnancy, we must remember that ACOG states that pregnancy and labor are not exceptions to the principle of decision in capable patients. Furthermore, "forced compliance [to any medical intervention] raises profoundly important issues about patient rights, respect for autonomy, violations of bodily integrity, power differentials, and gender equality" (ACOG 2016, 1). In other words, any medical intervention performed on a patient without informed consent violates their rights and can be experienced as violent.

Other scholars have explored the causes and consequences of obstetric violence but have paid less attention to the ontological dimensions of autonomy, decision-making, and relationality in healthcare. Through this paper, I have engaged with philosophical and anthropological perspectives on autonomy, theories of care, and bioethics to contribute to the literature on gender and medical violence. Further studies, especially those that explore the meaning of autonomy in different populations and cultures, more accurate ways of measuring it, and good ways of teaching autonomy and caregiving skills are necessary to expand our understanding of this phenomenon. Health personnel working in obstetric care must recenter patient autonomy as a core principle of ethical practice, including the relational, cultural, and contextual aspects of the decision-making

https://doi.org/10.1017/hyp.2024.84 Published online by Cambridge University Press

process. Recentering autonomy in the informed consent process can be an effective way of preventing obstetric violence.

Acknowledgments. I thank Dr Asha Bhandary for her teaching in the Ethics seminar that originated the first version of this paper, Dr Elana Buch for her revisions and advice, and the anonymous reviewers and editorial team of *Hypatia* for their insightful suggestions. I acknowledge the economic support of Fulbright Colombia.

Notes

1 I use "pregnant and birthing people" or "person with a uterus" instead of "women" to recognize that other sex/gender subjectivities (i.e., trans men, non-binary, agender, and gender-fluid people) have the capacity to get pregnant but not necessarily self-identify as "women." In medical literature, it is common to find the use of "women" and "mother" instead of other more inclusive terms. When referring to other author's work, I maintain their use of categories.

2 Recently, health professionals have contested the use of obstetric violence as a "misnomer" that "can be seen as quite strong and emotionally charged," suggesting instead the use of "obstetric mistreatment" (Chervenak et al. 2024, S1139). However, scholars in Latin America and elsewhere recognize the theoretical and political relevance of naming this problem as a form of gender and sexual violence (Cohen Shabot 2016; Cohen Shabot and Korem 2018). According to Pickles (2023), the dominant discourse "should not be one formulated by the healthcare sector (as is the case with 'mistreatment') given their leading role in abuse and violence during childbirth" (628); instead, we should promote and embrace pregnant/birthing people's conceptualizations of the phenomenon. Despite its multiple usages, stakes, and contestations, obstetric violence has a niche in the academic and legal literature (Lappeman and Swartz 2021; Lévesque and Ferron-Parayre 2021). Like other categories describing particular forms of violence, its transitive nature "needs to be recontextualized to meet the demands of today" (Burnett 2021, 1007), which requires further anthropological, sociological, and phenomenological studies.

3 Events that the 2007 Venezuelan legislation describes as obstetric violence are: "(1) Untimely and ineffective attention of obstetric emergencies; (2) Forcing the woman to give birth in a supine position, with legs raised, when the necessary means to perform a vertical delivery are available; (3) Impeding the early attachment of the child with his/her mother without a medical cause thus preventing the early attachment and blocking the possibility of holding, nursing or breastfeeding immediately after birth; (4) Altering the natural process of low-risk delivery by using acceleration techniques, without obtaining voluntary, expressed and informed consent of the woman; (5) Performing delivery via cesarean section, when natural childbirth is possible, without obtaining voluntary, expressed, and informed consent from the woman" (Art. 51).

4 Other authors have engaged more closely with women dis/empowerment and community resistance in multiple scenarios, which distances from this paper's emphasis on individual and relational autonomy. For further exploration, I recommend readings on women's empowerment in contexts of war (Albayrak et al. 2022), domestic violence (Diallo and Voia 2016), and disability (Mason 2015).

5 Obtaining continuous consent has been emphasized in cases of sexual violence. "Consenting to one activity, one time, does not mean someone gives consent for other activities or for the same activity on other occasions. For example, agreeing to kiss someone doesn't give that person permission to remove your clothes. Having sex with someone in the past doesn't give that person permission to have sex with you again in the future." (RAINN 2024, para. 4). For more on the use of language in cases of sexual assault, see Ehrlich (1998, 2001) and Lockwood Harris (2018).

6 Some reproductive justice scholars and feminist activists have criticized this compulsory waiting period as a barrier to obtaining basic healthcare services like sterilization or abortion, especially among communities with limited resources and access to health providers. For more on this critique, see Rowlands and Thomas (2020).

7 Historically, the womb represented a threat not only to people's rationality but also to the well-being of others, especially the fetus. In *Policing pregnant bodies,* Crowther (2023) explains that from the time of Aristotle and Hippocrates, medical and philosophical writers accepted that fetuses were nourished in the womb by their mother's blood, which was often equated to menstrual blood, believed toxic by the Greeks. Thus, the pregnant body both nourished and poisoned the fetus. Menstruating women were sometimes

https://doi.org/10.1017/hyp.2024.84 Published online by Cambridge University Press

compared to basilisks (as stated in the text *On the nature of things* attributed to Paracelsus), and "the notions that menstruating women could cause wine to sour, milk to curdle, and mirrors to become cloudy were integral to both popular and scientific understandings of women's bodies" (Crowther 2023, 93).

8 This fetal presentation is considered ideal for labor. It consists of the baby positioned head-down, facing the parent's back, and the head ready to enter the pelvis into the vaginal canal.

9 In an ideal scenario, obstetricians should discuss all the possible outcomes, interventions, benefits, and risks with their patients during prenatal visits. Patients should be encouraged to present a birth plan—a document containing their preferences during labor and delivery. A birth plan has no contractual characteristics with the health provider and may vary according to the patient's health status. Still, it is a valuable tool for exercising the patient's autonomy. Midwives, doulas, and other humanistic birth workers strongly advocate for developing birth plans for all pregnant people (Amram et al. 2014, Davis-Floyd and Premkumar 2023).

10 The definition of "personhood" is not universal and depends on each country's legal system. I use the US legal definition of constitutional personhood for this article, which may change after the Supreme Court's *Dobbs v. Jackson Women's Health Organization* decision.

11 To support her position, Flanigan (2016) revisits Thomson's (1971) famous thought experiment about the moral status of fetuses in abortion cases. Thompson explains that when the fetus is connected to the mother and depends on her to survive, the decision to separate it from her, even if it dies, can be "indecent" but permissible. For Thompson, the mother maintains the right that her body should not be used as a machine against her will to sustain another's life.

12 Measuring autonomy is crucial to understanding how women and pregnant/birthing people achieve the health outcomes they want for themselves and how autonomy depends on cultural contexts. It is clear that "the standard questions used in measuring autonomy may not be equally valid across different cultural contexts" (Osamor and Grady 2016 199). However, some variables that researchers can consider are: social support structures, communication skills, decision-making power in specific contexts, and the personal dimensions of adequacy, self-assurance, and achievement orientation (Lifton 1983).

13 A woman who is in labor.

14 Bhandary (2020) provides a detailed explanation of each autonomy skill in her Theory of Liberal Dependency Care and discusses the concept of "political autonomy" in Rawls and Nussbaum.

References

Abadía Barrero, César Ernesto. 2022. *Salud en ruinas: La destrucción capitalista del cuidado médico en el Instituto Materno Infantil de Bogotá*. Bogota: Universidad del Rosario. https://doi.org/10.12804/urosario9789585000186.

American College of Obstetricians and Gynecologists (ACOG). 2016. Committe Opinion Number 664: Refusal of medically recommended treatment during pregnancy. *Obstetrics & Gynecology* 127 (6): e175–e182. https://doi.org/10.1097/AOG.0000000000001485.

American College of Obstetricians and Gynecologists (ACOG). 2021. Committee Opinion Number 819: Informed consent and shared decision making in obstetrics and gynecology. *Obstetrics & Gynecology* 137 (2): e34–e41. https://doi.org/10.1097/AOG.0000000000004247.

Albayrak, Hande, Özlem Cankurtaran, Şevkat Bahar-Özvarış and Türküler Erdost. 2022 "They taught us not only our rights as women, but also how to live": Gender-based violence and empowerment experiences of Syrian women in Turkey and the role of women and girls safe spaces: A qualitative study." *Health Care for Women International* 43 (7–8): 946–963. https://doi.org/10.1080/07399332.2021.1975120.

Amram, Natalie Lea, Michael C. Klein, Heidi Mok, Penny Simkin, Kathie Lindstrom, and Jalana Grant. 2014. How birth doulas help clients adapt to changes in circumstances, clinical care, and client preferences during labor. *Journal of Perinatal Education* 23 (2): 96–103. https://doi.org/10.1891/1058-1243.23.2.96.

Banerjee, Dwaipayan. 2022. Provincializing bioethics: Dilemmas of end-of-life care in an Indian ICU. *American Ethnologist* 49 (3): 318–31. https://doi.org/10.1111/amet.13092.

Basile, Monica. 2019. Radical doulas, childbirth activism, and the politics of embodiment. In *Body battlegrounds*, ed. Chris Bobel and Samantha Kwan. Nashville, TN: Vanderbilt University Press. https://doi.org/10.2307/j.ctv16759ws.6.

https://doi.org/10.1017/hyp.2024.84 Published online by Cambridge University Press

Beauchamp, Tom L., and James F. Childress, eds. 1994. *Principles of biomedical ethics*. 4th ed. New York: Oxford University Press.

Bellón Sánchez, Silvia. 2014. Obstetric violence: Medicalization, authority abuse and sexism within Spanish obstetric assistance. A new name for old issues? Master's Degree in Women's and Gender Studies, Utrecht University. https://studenttheses.uu.nl/handle/20.500.12932/18094.

Berry, Nicole S. 2010. *Unsafe motherhood: Mayan maternal mortality and subjectivity in post-war Guatemala*. Fertility, Reproduction, and Sexuality 21. New York: Berghahn Books.

Berzon, Corinne, and Sara Cohen Shabot. 2023. Obstetric violence and vulnerability: A bioethical approach. *International Journal of Feminist Approaches to Bioethics* 16 (1): 52–76. https://doi.org/10.3138/IJFAB-16.2.02.

Bhandary, Asha. 2016. Liberal dependency care. *Journal of Philosophical Research* 41: 43–68. https://doi.org/10.5840/jpr201662767.

Bhandary, Asha. 2020. *Freedom to care: Liberalism, dependency care, and culture*. New York: Routledge.

Bourdieu, Pierre, and Loïc J. D. Wacquant. 1992. *An invitation to reflexive sociology*. Chicago: University of Chicago Press.

Burnett, Camille. 2021. Commentary on the article "How gentle must violence against women be in order to not be violent? Rethinking the word 'violence' in obstetric settings," Reframed within a critical discourse orientation. *Violence against Women* 27 (8): 1001–08. https://doi.org/10.1177/1077801221996474.

Campbell, Colleen. 2021. Medical violence, obstetric racism, and the limits of informed consent for black women. *Michigan Journal of Race and Law* 26 (2): 47–75. https://doi.org/10.36643/mjrl.26.sp.medical.

Cantor, Allison R. 2023. "Yo trato de no llorar": Rethinking obstetric violence in Costa Rica. *Medical Anthropology* 42 (2): 163–76. https://doi.org/10.1080/01459740.2023.2166410.

Cárdenas-Castro, Manuel, and Stella Salinero-Rates. 2023. The continuum of violence against women: Gynecological violence within the medical model in Chile. *Sexual and Reproductive Healthcare* 37: 100891. https://doi.org/10.1016/j.srhc.2023.100891.

Castañeda, Angela N., Nicole Hill, and Julie Johnson Searcy, eds. 2022. *Obstetric violence: Realities, and resistance from around the world*. 1st ed. Toronto: Demeter Press.

Castro, Arachu, and Virginia Savage. 2019. Obstetric violence as reproductive governance in the Dominican Republic. *Medical Anthropology* 38 (2): 123–36. https://doi.org/10.1080/01459740.2018.1512984.

Castro, Roberto, and Sonia M. Frías, eds. 2022. *Violencia obstétrica y ciencias sociales: Estudios críticos en América Latina*. Cuernavaca: UNAM, Centro Regional de Investigaciones Multidisciplinarias.

Centro de Estudios de la Mujer de la Universidad Central de Venezuela, Araña Feminista Red de Colectivos de Mujeres, and Iniciativa por los Derechos Sexuales. 2011. Informe sobre la República Bolivariana de Venezuela 12° Ronda del Examen Periódico Universal. https://www.ohchr.org/sites/default/files/lib-docs/HRBodies/UPR/Documents/session12/VE/CEM-UVC-CentroEstudiosMujerUniversidadCentral-spa.pdf.

Chervenak, Frank A., Renee McLeod-Sordjan, Susan L. Pollet, Monique De Four Jones, Mollie R. Gordon, Adriann Combs, Eran Bornstein, Dawnette Lewis, Adi Katz, Ashley Warman, and Amos Grünebaum. 2024. Obstetric violence is a misnomer. *American Journal of Obstetrics and Gynecology* 230 (3): S1138–45. https://doi.org/10.1016/j.ajog.2023.10.003.

Chinyere Oparah, Julia, and Alicia D. Bonaparte, eds. 2016. *Birthing justice: Black women, pregnancy, and childbirth*. London: Routledge.

Chiu, Yung-Chen Jen, K. B. Boomer, and Liza M. Conyers. 2019. The impact of psychosocial factors on health and retention outcomes for people living with HIV: Implications for rehabilitation counselors and educators. *Rehabilitation Counseling Bulletin* 62 (2): 94–107. https://doi.org/10.1177/0034355218755304

Cockburn, Cynthia. 2004. The continuum of violence: A gender perspective on war and peace." In *Sites of Violence*, ed. Wenona Giles and Jennifer Hyndman. University of California Press.

Cohen Shabot, Sara. 2016. Making loud bodies "feminine": A feminist-phenomenological analysis of obstetric violence. *Human Studies* 39: 231–47. https://doi.org/10.1007/s10746-015-9369-x.

Cohen Shabot, Sara. 2020. We birth with others: Towards a Beauvoirian understanding of obstetric violence. *European Journal of Women's Studies* 28 (2): 213–28. https://doi.org/10.1177/1350506820919474.

Cohen Shabot, Sara. 2021a. Why "normal" feels so bad: Violence and vaginal examinations during labour – a (feminist) phenomenology. *Feminist Theory* 22 (3): 443–63. https://doi.org/10.1177/1464700120920764.

Cohen Shabot, Sara. 2021b. "You are not qualified—leave it to us": Obstetric violence as testimonial injustice. *Human Studies* 44 (4): 635–53. https://doi.org/10.1007/s10746-021-09596-1.

https://doi.org/10.1017/hyp.2024.84 Published online by Cambridge University Press

Cohen Shabot, Sara, and Keshet Korem. 2018. Domesticating bodies: The role of shame in obstetric violence. *Hypatia* 33 (3): 384–401. https://doi.org/10.1111/hypa.12428.
Cohen Shabot, Sara, and Michelle Sadler. 2023. "My soul hurt, and I felt as if I was going to die": Obstetric violence as torture. *Hypatia* 38 (3): 607–27. https://doi.org/10.1017/hyp.2023.72.
Crenshaw, Kimberle. 1991. Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review* 43 (6): 1241–99. https://doi.org/10.2307/1229039.
Crowther, Kathleen M. 2023. *Policing pregnant bodies: From Ancient Greece to post-Roe America*. Baltimore, MD: Johns Hopkins University Press.
Cudney, Paul. 2014. What really separates casuistry from principlism in biomedical ethics. *Theoretical Medicine and Bioethics* 35 (3): 205–29. https://doi.org/10.1007/s11017-014-9295-3.
Darling, Orlaith. 2022. "The moment you realise someone wants your body": Neoliberalism, mindfulness and female embodiment in Fleabag. *Feminist Media Studies* 22 (1): 132–47. https://doi.org/10.1080/14680777.2020.1797848
Das, Veena. 2007. *Life and words: Violence and the descent into the ordinary*. Berkeley: University of California Press.
Davis, Dána-Ain. 2018. Obstetric racism: The racial politics of pregnancy, labor, and birthing. *Medical Anthropology* 38 (7): 560–73. https://doi.org/10.1080/01459740.2018.1549389
Davis, Dána-Ain. 2019. *Reproductive injustice: Racism, pregnancy, and premature birth*, ed. Michele Rivkin-Fish, Paul Brodwin, and Susan Shaw. New York: New York University Press.
Davis-Floyd, Robbie E. 1992. *Birth as an American rite of passage*. 3rd ed. London: Routledge.
Davis-Floyd, Robbie E 2008. The technocratic model of birth. In *Medical anthropology*, ed. Cecil G. Helman. Abingdon, UK: Routledge. https://doi.org/10.4324/9781315249360-22.
Davis-Floyd, Robbie, and Melissa Cheyney. 2019. *Birth in eight cultures: Brazil, Greece, Japan, Mexico, the Netherlands, New Zealand, Tanzania, United States*. Long Grove, IL: Waveland Press, Inc.
Davis-Floyd, Robbie, and Elizabeth Davis. 1996. Intuition as authoritative knowledge in midwifery and homebirth. *Medical Anthropology Quarterly* 10 (2): 237–69. https://doi.org/10.1525/maq.1996.10.2.02a00080.
Davis-Floyd, Robbie, and Ashish Premkumar, eds. 2023. *Obstetricians speak: On training, practice, fear, and transformation*. 1st ed. Anthropology of Obstetrics and Obstetricians, vol. 1. New York, NY: Berghahn Books.
Davy, Laura. 2015. Philosophical inclusive design: Intellectual disability and the limits of individual autonomy in moral and political theory. *Hypatia* 30 (1): 132–48. https://doi.org/10.1111/hypa.12119.
De Barros Gabriel, Alice, and Breno Ricardo Guimarães Santos. 2020. The epistemic injustice of obstetric violence. *Estudos Feministas* 28 (2): e60012. https://doi.org/10.1590/1806-9584-2020V28N260012.
Diallo, S. A., and Voia, M. 2016. The threat of domestic violence and women empowerment: The case of West Africa. *African Development Review* 28 (1): 92–103. https://doi.org/10.1111/1467-8268.12169
Diaz-Tello, Farah. 2016. Invisible wounds: Obstetric violence in the United States. *Reproductive Health Matters* 24 (47): 56–64. https://doi.org/10.1016/j.rhm.2016.04.004.
Di Giulio, Marco. 2024. Motherhood, mental incompetence, and the denial of reproductive autonomy in the early years of Israeli statehood. *Journal of Social History* 57 (4): 550–77. https://doi.org/10.1093/jsh/shad087.
Dokumacl, Plnar. 2020. Toward a relational approach? Common models of pious women's agency and pious feminist autonomy in Turkey. *Hypatia* 35 (2): 243–61. https://doi.org/10.1017/hyp.2020.4.
Doenmez, Caroline Fidan Tyler, Jaime Cidro, Stephanie Sinclair, Ashley Hayward, Larissa Wodtke, and Alexandra Nychuk. 2022. Heart work: Indigenous doulas responding to challenges of Western systems and revitalizing Indigenous birthing care in Canada. *BMC Pregnancy and Childbirth* 22 (1): 41. https://doi.org/10.1186/s12884-021-04333-z.
Doula to Others. 2018. Using BRAIN acronym for informed choices. *Doula to Others* (blog). Accessed May 17, 2024. https://doulatoothers.com/using-brain-acronym-informed-choices/.
Ehrenreich, Barbara, and Deirdre English. [1973] 2010. *Witches, midwives, and nurses: A history of women healers*. 2nd ed. New York: Feminist Press at CUNY.
Ehrlich, Susan. 1998. The discursive reconstruction of sexual consent. *Discourse and Society* 9 (2): 149–71. https://doi.org/10.1177/0957926598009002002.
Ehrlich, Susan. 2001. *Representing rape: Language and sexual consent*. London: Routledge. https://doi.org/10.4324/9780203459034.

https://doi.org/10.1017/hyp.2024.84 Published online by Cambridge University Press

Farmer, Paul. 2004. An anthropology of structural violence. *Current Anthropology* 45 (3): 305–25. https://doi.org/10.1086/382250.

Flanigan, Jessica. 2016. Obstetric autonomy and informed consent. *Ethical Theory and Moral Practice* 19 (1): 225–44. https://doi.org/10.1007/s10677-015-9610-8.

Ford, Andrea. 2021. Attuned consent: Birth doulas, care, and the politics of consent. *Frontiers: A Journal of Women Studies* 42 (2): 111–32. https://doi.org/10.1353/fro.2021.0018.

Foucault, Michel. 1976. *Discipline and punish: The birth of the prison*. 2nd ed. New York: Knopf Doubleday.

Fraser, Gertrude Jacinta. 1998. *African American midwifery in the South: Dialogues of birth, race, and memory*. Cambridge, MA: Harvard University Press.

Fricker, Miranda. 2007. *Epistemic injustice: Power and the ethics of knowing*. Oxford: Oxford University Press.

Galtung, Johan. 1969. Violence, peace, and peace research. *Journal of Peace Research* 6 (3): 167–91. https://doi.org/10.1177/002234336900600301.

Gammeltoft, Tine M. 2008. Figures of transversality: State power and prenatal screening in contemporary Vietnam. *American Ethnologist* 35(4): 570–87. https://doi.org/10.1111/j.1548-1425.2008.00099.x

Ginsburg, Faye, and Rayna Rapp. 1991. The politics of reproduction. *Annual Review of Anthropology* 20 (1): 311–43. https://doi.org/10.1146/annurev.an.20.100191.001523.

Gleason, Emily Gaffney, Diana Patricia Molina Berrío, Jennifer Marcela Lopez Ríos, and Cristina María Mejìa Merino. 2021. "Parir no es un asunto de etnia, es un asunto de humanidad': Experiencias frente a la violencia obstétrica durante la atención al parto en mujeres indígenas. *Salud Colectiva* 17: e3727. https://doi.org/10.18294/sc.2021.3727.

Gopal, Meena. 2017. Traditional knowledge and feminist dilemmas. Experience of the midwives of the Barber caste in South Tamil Nadu. In *Feminists and Science*, ed. Sumi Krishna and Gita Chadha, vol. 2. New Delhi: SAGE Publications India Pvt, Ltd.

Grotti, Vanessa, and Marc Brightman. 2021. *Migrant hospitalities in the Mediterranean: Encounters with alterity in birth and death*. Cham: Springer International Publishing. https://doi.org/10.1007/978-3-030-56585-5.

Hawkins, R., M. Redley, and A. J. Holland. 2011. Duty of care and autonomy: How support workers managed the tension between protecting service users from risk and promoting their independence in a specialist group home. *Journal of Intellectual Disability Research* 55 (9): 873–84. https://doi.org/10.1111/j.1365-2788.2011.01445.x.

Held, Virginia. 2018. The ethics of care. In *The Oxford handbook of distributive justice*, ed. Serena Olsaretti. Oxford: Oxford University Press.

Herr, Ranjoo Seodu. 2018. Islamist women's agency and relational autonomy. *Hypatia* 33 (2): 195–215. https://doi.org/10.1111/hypa.12402.

Herring, Jonathan. 2014. *Relational autonomy and family law*. Cham: Springer International Publishing AG. https://doi.org/10.1007/978-3-319-04987-8.

Hunt, Matthew R., and Carolyn Ells. 2011. Partners towards autonomy: Risky choices and relational autonomy in rehabilitation care. *Disability and Rehabilitation* 33 (11): 961–67. https://doi.org/10.3109/09638288.2010.515703.

Hussein, Julia. 2020. COVID-19: What implications for sexual and reproductive health and rights globally? *Sexual and Reproductive Health Matters* 28 (1): 1746065. https://doi.org/10.1080/26410397.2020.1746065.

Inhorn, Marcia Claire, ed. 2009. *Reproductive disruptions: Gender, technology, and biopolitics in the new millennium*. 1st pbk ed. New York: Berghahn Books. https://doi.org/10.1515/9780857455635.

Jojoa-Tobar, Elisa, Yuler Darío Cuchumbe-Sánchez, Jennifer Briyith Ledesma-Rengifo, María Cristina Muñoz-Mosquera, Adriana María Paja Campo, and Juan Pablo Suarez-Bravo. 2019. Violencia obstétrica: Haciendo visible lo invisible. *Salud UIS* 51 (2): 135–46. https://doi.org/10.18273/revsal.v51n2-2019006.

Jordan, Brigitte. 1983. *Birth in four cultures*. 3rd ed. Montreal: Eden Press.

Jordan, Brigitte. 2023. Authoritative knowledge and its construction. In *Childbirth and authoritative knowledge,* ed. Robbie E. Davis-Floyd and Carolyn F. Sargent. Berkeley: University of California Press. https://doi.org/10.2307/jj.2711580.5.

Junqueira, Karina, Daphne Rattner, and Muriel Bauermann. 2017. Institutional violence and quality of service in obstetrics are associated with postpartum depression. *Revista de Saúde Pública* 51 (69): 1–11. https://doi.org/10.1590/S1518-8787.2017051006549.

Kaplan, Julika Ayla, Jonathan Kandodo, Joseph Sclafani, Susan Raine, Jennifer Blumenthal-Barby, Alison Norris, Abigail Norris-Turner, Elly Chemey, John Michael Beckham, Zara Khan, and Reginald Chunda. 2017. An investigation of the relationship between autonomy, childbirth practices, and obstetric fistula among women in rural Lilongwe District, Malawi. *BMC International Health and Human Rights* 17 (17): 1–10. https://doi.org/10.1186/s12914-017-0125-3.

Kay, Margarita Artschwager, ed. 1982. *Anthropology of human birth*. Philadelphia: F. A. Davis.

Keller, Jean. 1997. Autonomy, relationality, and feminist ethics. *Hypatia* 12 (2): 152–64. https://doi.org/10.1111/j.1527-2001.1997.tb00024.x.

Kelly, Liz. 1987. The continuum of sexual violence. In *Women, violence and social control*, ed. Jalna Hanmer and Mary Maynard. London: Palgrave Macmillan UK. https://doi.org/10.1007/978-1-349-18592-4_4.

Kingma, Elselijn. 2021. Harming one to benefit another: The paradox of autonomy and consent in maternity care. *Bioethics* 35: 456–64. https://doi.org/10.1111/bioe.12852.

Kitzinger, Sheila. 2006. Birth as rape: There must be an end to "just in case" obstetrics. *British Journal of Midwifery* 14 (9): 544–45. https://doi.org/10.12968/bjom.2006.14.9.21799.

Lappeman, Maura, and Leslie Swartz. 2021. How gentle must violence against women be in order to not be violent? Rethinking the word "violence" in obstetric settings. *Violence Against Women* 27 (8): 987–1000. https://doi.org/10.1177/1077801221996444.

Lévesque, Sylvie, and Audrey Ferron-Parayre. 2021. To use or not to use the term "obstetric violence": Commentary on the article by Swartz and Lappeman. *Violence Against Women* 27 (8): 1009–18. https://doi.org/10.1177/1077801221996456.

Levine, Nancy E. 2008. Alternative kinship, marriage, and reproduction. *Annual Review of Anthropology* 37 (1): 375–89. https://doi.org/10.1146/annurev.anthro.37.081407.085120.

Lifton, P. D. 1983. Measures of autonomy. *Journal of Personality Assessment* 47 (5): 514–23. https://doi.org/10.1207/s15327752jpa4705_12.

Lira, Natalie. 2022. *Laboratory of Deficiency: Sterilization and Confinement in California, 1900–1950s*. Oakland, CA: University of California Press.

Lockwood, Gillian M. 1999. At the coalface: Medical ethics in practice. Pregnancy, autonomy, and paternalism. *Journal of Medical Ethics* 25: 537–40. https://doi.org/10.1136/jme.25.6.537.

Lockwood Harris, Kate. 2018. Yes means yes and no means no, but both these mantras need to go: Communication myths in consent education and anti-rape activism. *Journal of Applied Communication Research* 46 (2): 155–78. https://doi.org/10.1080/00909882.2018.1435900.

MacDonald, Fiona. 2010. Relational group autonomy: Ethics of care and the multiculturalism paradigm. *Hypatia* 25 (1): 196–212. https://doi:10.1111/j.1527-2001.2010.01091.x.

Mackenzie, Catriona, and Natalie Stoljar, eds. 2000. *Relational autonomy: Feminist perspectives on autonomy, agency, and the social self*. New York and Oxford: Oxford University Press.

Mahoney, Mary, and Lauren Mitchell. 2017. Who cares? How doulas engage in radical acts of kindness. *Women's Health Activist* 42 (4): 9.

Mann, Rosemary J. 2004. The interface between legal and ethical issues in reproductive health. *Journal of Midwifery and Women's Health* 49 (3): 182–87. https://doi.org/10.1016/j.jmwh.2004.01.004.

Mapes, Marianna V., Peter A. DePergola, and William T. McGee. 2020. Patient-centered care and autonomy: Shared decision-making in practice and a suggestion for practical application in the critically ill. *Journal of Intensive Care Medicine* 35 (11): 1352–55. https://doi.org/10.1177/0885066619870458.

Mardorossian, Carine M. 2019. "Birth rape": Laboring women, coaching men, and natural childbirth in the hospital setting. In *Framing the rape victim*. Ithaca, NY: Rutgers University Press. https://doi.org/10.36019/9780813566047-005.

Martin, Emily. [1987] 2001. *The woman in the body: A cultural analysis of reproduction*. Boston: Beacon Press.

Martín-Badia, Júlia, Noemí Obregón-Gutiérrez, and Josefina Goberna-Tricas. 2021. Obstetric violence as an infringement on basic bioethical principles: Reflections inspired by focus groups with midwives. *International Journal of Environmental Research and Public Health* 18 (12553): 1–15. https://doi.org/10.3390/ijerph182312553.

Martinez, Sergio, Julian Rodríguez, Antonio Hernández, and Juan Miguel Martínez. 2021. Factors associated with postpartum post-traumatic stress disorder (PTSD) following obstetric violence: A cross-sectional study. *Journal of Personalized Medicine* 11 (338): 1–11. https://doi.org/10.3390/jpm11050338.

Massó Guijarro, Ester. 2023. Obstetric violence as epistemic injustice: Childbirth trouble. *Salud colectiva* 19: e4464. https://doi.org/10.18294/sc.2023.4464.

Mason, C. L. 2015. "Cripping" the World Bank. *International Feminist Journal of Politics* 17 (3): 435–53. https://doi.org/10.1080/14616742.2014.941252.

McCormack, Clare, Bridget L. Callaghan, and Jodi L. Pawluski. 2023. It's time to rebrand "mommy brain." *JAMA Neurology* 80 (4): 335–36. https://doi.org/10.1001/jamaneurol.2022.5180.

Mejía Merino, Cristina María, Lida Faneyra Zapata, Diana Patricia Molina Berrio, and Juan David Arango Urrea. 2018. Dehumanization during delivery: Meanings and experiences of women cared for in the Medellín public network. *Investigación y Educación en Enfermería* 36 (1): e03. https://doi.org/10.17533/udea.iee.v36n1e03.

Meyers, Diana T. 1989. *Self, society, and personal choice*. New York: Columbia University Press.

Meyers, Diana T. 2002. *Gender in the mirror: Cultural imagery and women's agency*. Oxford: Oxford University Press.

Mill, John Stuart. 1989a. On liberty. In *On liberty, and other writings*, ed. Stefan Collini. Cambridge: Cambridge University Press.

Mill, John Stuart. 1989b. The subjection of women. In *On liberty, and other writings*, ed. Stefan Collini. Cambridge: Cambridge University Press.

Moraga, Cherríe, and Gloria Anzaldúa, eds. 2015. *This bridge called my back: Writings by radical women of color*. 4th ed. Albany, NY: SUNY Press.

Mulla, Sameena. 2014. *The violence of care: Rape victims, forensic nurses, and sexual assault intervention*. New York: New York University Press.

Murillo, Lina-Maria, and Natalie Fixmer-Oraiz. 2021. Reproductive justice in the heartland: Mothering, maternal care, and race in twenty-first-century Iowa. In *Maternal theory: Essential readings*, ed. Andrea O'Reilly. Bradford, Ontario: Demeter Press.

Nalepa, Elizabeth. 2020. Naming obstetric violence as a social problem. *Practicing Anthropology* 42 (2): 42–44. https://doi.org/10.17730/0888-4552.42.2.42.

Nedelsky, Jennifer. 2011. *Law's relations: A relational theory of self, autonomy, and law*. Oxford and New York: Oxford University Press.

O'Brien, Elizabeth. 2023. *Surgery and salvation: The roots of reproductive injustice in Mexico, 1770-1940*. Durham, NC: University of North Carolina Press. https://doi.org/10.5149/9781469675893_obrien.

Okimoto, Tyler G., Udo Konradt, Sabrina Krys, and Niamh Dawson. 2022. A person-centered approach to understanding endorsement of restorative justice in response to workplace mistreatment. *Social Justice Research* 35 (1): 62–87. https://doi.org/10.1007/s11211-021-00377-w.

Olza, Ibone. 2013. PTSD and obstetric violence. *Midwifery Today* 105: 48–49. https://doi.org/10.1186/1471-2393-12-88.

Orchard, Edwina R., Helena J. V. Rutherford, Avram J. Holmes, and Sharna D. Jamadar. 2023. Matrescence: Lifetime impact of motherhood on cognition and the brain. *Trends in Cognitive Sciences* 27 (10): 974. https://doi:10.1016/j.tics.2023.06.002.

Osamor, Pauline E., and Christine Grady. 2016. Women's autonomy in health care decision-making in developing countries: A synthesis of the literature. *International Journal of Women's Health* 8: 191–202. https://doi.org/10.2147/IJWH.S105483.

Oshana, Marina. 2006. *Personal autonomy in society*. Aldershot: Ashgate.

Paula, Enimar de, Valdecyr Herdy Alves, Diego Pereira Rodrigues, Felipe de Castro Felicio, Renata Corrêa Bezerra de Araújo, Rosilda Alves da Silva Isla Chamilco, and Vivian Linhares Maciel Almeida. 2020. Obstetric violence and the current obstetric model, in the perception of health managers. *Texto & Contexto—Enfermagem* 29 (January): e20190248. https://doi.org/10.1590/1980-265X-TCE-2019-0248.

Perdok, Hilde, Doug Cronie, Cecile van der Speld, Jeroen van Dillen, Ank de Jonge, Marlies Rijnders, Irene de Graaf, François G. Schellevis, and Corine J. Verhoeven. 2017. Experienced job autonomy among maternity care professionals in the Netherlands. *Midwifery* 54: 67–72. https://doi.org/10.1016/j.midw.2017.07.015.

Pickles, Camilla. 2023. "Obstetric violence," "mistreatment," and "disrespect and abuse": Reflections on the politics of naming violations during facility-based childbirth. *Hypatia* 38 (3): 628–49. https://doi.org/10.1017/hyp.2023.73.

Planned Parenthood. 2024. Can you explain what "pro-choice" and "pro-life" means? Accessed May 17, 2024. https://www.plannedparenthood.org/blog/can-you-explain-what-pro-choice-means-and-pro-life-means.

Quattrocchi, Patrizia. 2019. Obstetric violence observatory: Contributions of Argentina to the international debate. *Medical Anthropology* 38 (8): 762–76. https://doi.org/10.1080/01459740.2019.1609471.

Quattrocchi, Patrizia, and Natalia Magnone. 2020. *Violencia obstétrica en América Latina: Conceptualización, experiencias, medición y estrategias*. Remedios de Escalada, Buenos Aires, Argentina: EDUNLa. Colección Cuadernos del ISCo. https://doi.org/10.18294/9789874937506

Rajtar, Małgorzata. 2018. Relational autonomy, care, and Jehovah's Witnesses in Germany. *Bioethics* 32: 184–92. https://doi.org/10.1111/bioe.12424.

Rape, Abuse & Incest National Network (RAINN). 2024. What consent looks like? Accessed May 17, 2024. https://www.rainn.org/articles/what-is-consent#:~:text=How%20does%20consent%20work%3F,same%20activity%20on%20other%20occasions.

Restrepo-Sánchez, Andrés. 2024. "Birth rape"? A linguistic analysis of obstetric violence as sexual violence *Women and Language* 47 (1): 5–36. https://doi.org/10.34036/WL.2024.003.

Rodrigues Duarte, Micheliana, Valdecyr Herdy Alves, Diego Pereira Rodrigues, Giovanna Rosário Soanno Marchiori, Juliana Vidal Vieira Guerra, and Mariana Machado Pimentel. 2020. Perception of obstetric nurses on the assistance to childbirth: Reestablishing women's autonomy and empowerment. *Revista Online de Pesquisa Cuidado É Fundamental* 12: 903–08. https://doi.org/10.9789/2175-5361.rpcfo.v12.7927.

Rogerson, Jennifer J. M. 2019. *Privileges of birth: Constellations of care, myth, and race in South Africa*. New York: Berghahn Books. https://doi.org/10.2307/j.ctv1dwq1j2.

Rössler, Beate. 2002. Problems with autonomy. *Hypatia* 17 (4): 143–62. https://doi.org/10.1111/j.1527-2001.2002.tb01077.x.

Rowlands, Sam, and Kevin Thomas. 2020. Mandatory waiting periods before abortion and sterilization: Theory and practice. *International Journal of Women's Health* 12: 577–86. https://doi.org/10.2147/IJWH.S257178.

Rybak, EA. 2009. Hippocratic ideal, Faustian bargain, and Damocles' sword: Erosion of patient autonomy in obstetrics. *Journal of Perinatology* 29: 721–25. https://doi.org/10.1038/jp.2009.123.

Sadler, Michelle, Gonzalo Leiva, and Ibone Olza. 2020. COVID-19 as a risk factor for obstetric violence. *Sexual and Reproductive Health Matters* 28 (1): 1–4. https://doi.org/10.1080/26410397.2020.1785379.

Sadler, Michelle, Mário J. D. S. Santos, Dolores Ruiz-Berdún, Gonzalo Leiva Rojas, Elena Skoko, Patricia Gillen, and Jette A. Clausen. 2016. Moving beyond disrespect and abuse: Addressing the structural dimensions of obstetric violence. *Reproductive Health Matters* 24 (47): 47–55. https://doi.org/10.1016/j.rhm.2016.04.002.

Salinas, Juan L., Manisha Salinas, and Megan Kahn. 2022. Doulas, racism, and whiteness: How birth support workers process advocacy towards women of color. *Societies* 12 (19): 1–15. https://doi.org/10.3390/soc12010019

Sargent, Carolyn F., and Robbie Davis-Floyd. 2023. *Childbirth and authoritative knowledge: Cross-cultural perspectives*. Berkeley: University of California Press. https://doi.org/10.2307/jj.2711580.

Shih, Patti, Frances Rapport, Anne Hogden, Mia Bierbaum, Jeremy Hsu, John Boyages, and Jeffrey Braithwaite. 2018. Relational autonomy in breast diseases care: A qualitative study of contextual and social conditions of patients' capacity for decision-making. *BMC Health Services Research* 18 (818): 1–10. https://doi.org/10.1186/s12913-018-3622-8.

Strong, Adrienne. 2020. *Documenting death: Maternal mortality and the ethics of care in Tanzania*. Oakland, CA: University of California Press. https://doi.org/10.1525/luminos.93.

Thomson, Judith Jarvis. 1971. A defense of abortion. *Philosophy and Public Affairs* 1 (1): 47–66.

Turner, Leigh. 2009. Anthropological and sociological critiques of bioethics. *Journal of Bioethical Inquiry* 6 (1): 83–98. https://doi.org/10.1007/s11673-008-9130-5.

Urrea-Mora, Fanny Consuelo. 2014. Respeto a la autonomía de mujeres gestantes en salud: Diálogo bioética-género. *Revista Colombiana de Bioética* 9: 193–236. https://doi.org/10.18270/rcb.v9i3.747

Vallana-Sala, Viviana Valeria. 2019. "It's nice to make them but not have them": Analysis of obstetric violence during delivery care in Colombia. *Revista Ciencias de La Salud* 17: 128–44. https://doi.org/10.12804/revistas.urosario.edu.co/revsalud/a.8125.

https://doi.org/10.1017/hyp.2024.84 Published online by Cambridge University Press

Van Hollen, Cecilia. 1994. Perspectives on the anthropology of birth. *Culture, Medicine and Psychiatry* 18 (4): 501–12. https://doi.org/10.1007/BF01565852.
Van Hollen, Cecilia. 2003. *Birth on the threshold: Childbirth and modernity in South India*. Berkeley: University of California Press. https://doi.org/10.1525/9780520935396.
Venezuela, República Bolivariana de. 2007. Ley Orgánica Sobre el Derecho de las Mujeres a una Vida Libre de Violencia. Gaceta Oficial de la República Bolivariana de Venezuela.
Villarmea, Stella. 2021. Reasoning from the uterus: Casanova, women's agency, and the philosophy of birth. *Hypatia* 36: 22–41. https://doi.org/10.1017/hyp.2020.45.
Walsh, Denis J. 2006. "Nesting" and "matrescence" as distinctive features of a free-standing birth centre in the UK. *Midwifery* 22 (3): 228–39. http://doi:10.1016/j.midw.2005.09.005.
Washington, Harriet A. 2008. *Medical apartheid: The dark history of medical experimentation on Black Americans from colonial times to the present*. New York: Anchor Books.
Webster, Aness Kim. 2021. Socially embedded agency: Lessons from marginalized identities. In *Oxford studies in agency and responsibility,* vol. 7, ed. David Shoemaker. Oxford: Oxford University Press. https://doi.org/10.1093/oso/9780192844644.003.0006.
Wertz, Richard W., and Dorothy C. Wertz. 1977. *Lying-in: A history of childbirth in America*. New York: Free.
Westlund, Andrea C. 2009. Rethinking relational autonomy. *Hypatia* 24 (4): 26–49. https://doi.org/10.1111/j.1527-2001.2009.01056.x.
White, Frederick J. 2013. Personhood: An essential characteristic of the human species. *Linacre Quarterly* 80 (1): 74–97. https://doi.org/10.1179/0024363912Z.00000000010.
Williamson, K. Eliza. 2021. The iatrogenesis of obstetric racism in Brazil: Beyond the body, beyond the clinic. *Anthropology and Medicine* 28 (2): 172–87. https://doi.org/10.1080/13648470.2021.1932416.
World Health Organization. 2014. *The prevention and elimination of disrespect and abuse during facility-based childbirth: WHO statement*. Geneva: World Health Organization.

Andrés Restrepo-Sánchez is a PhD candidate in Anthropology and teaching assistant at the University of Iowa, USA. He has a BS in Nursing, an MA in Cultural Studies, and an MA in Anthropology. His research interests include feminist approaches to care, violence, reproductive justice, and Colombian history. His dissertation project examines the experiences of obstetric violence and birth reform in Medellín, Antioquia, and their relation to other forms of structural violence in the country and region.

Cite this article: Restrepo-Sánchez, Andrés. 2024. Autonomy, Violence, and Consent in the Obstetric Field, *Hypatia*. doi:10.1017/hyp.2024.84