Obstetric Violence in Hospital-Based Childbirth: Perspectives of Childbearing Women and Healthcare Providers

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Table of Contents

Abstract vi
Résumé vii
Acknowledgements viii
Glossary ix
List of Abbreviations x
List of Tables xi
List of Figures xii
Chapter 1: Introduction 1
The Global Response to the Mistreatment of Women in Childbirth 5
Birthing in Canada 8
Research Aim and Objectives 15
Significance of the Research 16
Situating the Researcher 16
Overview of Thesis 19
Chapter 2: Literature Review 20
Defining Mistreatment, Disrespect and Abuse, and Obstetric Violence 20
Women's Experiences of Obstetric Violence 23
Provider Perspectives of Obstetric Violence 29
Structural Dimensions of Obstetric Violence 31
Naming "Violence" in Childbirth: Conceptual Challenges 35
Chapter 3: Theoretical Framework 38
Critical Feminist Philosophical Foundations of the Research 39
Intersectionality 42
Feminist Poststructuralism 47
A Critical Exploration of Congruence and Tensions Between Intersectionality and Feminist Poststructuralism 55
The Potential of an Integrated Framework for Studying Obstetric Violence 57
Matricentric Feminism 59
Violence, Power, and their Nexus 61
Chapter 4: Methodology 67
Overview of Qualitative Research 67

Research Type and Design 67
Study Setting 70
Sampling and Recruitment 70
Data Collection 75
Data Analysis 81
Trustworthiness 86
Ethical Considerations 90
Chapter 5: Results – Childbearing Women 94
Theme 1: Living Through Obstetric Violence 95
Defining Obstetric Violence 95
Telling Obstetric Violence Through Emotion 103
Enduring Impacts of Obstetric Violence 110
Theme 2: The Sociocultural Political Landscape of Childbirth 126
Barriers and Breakdowns in Prenatal Care 127
Paradigms of Birthing Care 130
Woman, Mother, Other: Politeness, Gratitude, and Endurance 133
Racism, Sexism, Fatphobia and More: Structural Violence in the Lives of Women 137
Theme 3: Power and Control in Childbirth 142
Strategic Adaptations and Self-Protection 142
Constraint, Coercion, and Compliance 144
Precarious Resistance 146
Theme 4: Roots and Reinforcements of Obstetric Violence 149
Medical Authority and Paradigms of Care: Risk, Control, and Pathology 149
Normalization: Obstetric Violence as Routine 155
Gender and Sociocultural Norms: How Obstetric Violence is Silenced 160
Systemic Dysfunction and the Public Health Crisis 164
Theme 5: Pathways to Humanized Care 174
The Power of Validating Interactions 174
Systemic Reform 176
Epistemic Justice: Contributing to the Collective Narrative 179
Chapter 6: Results – Healthcare Providers 184
Theme 1: Not Heroic, but Human: Obstetric Violence Through the Eyes of Providers 184
Defining Obstetric Violence 185

Drivers of Obstetric Violence 193
Recognizing the Impacts of Obstetric Violence 216
Theme 2: Complicity and Care: How Providers Navigate OV 219
Advocacy: From Constrained to Subversive to Outspoken 219
The Emotional Labour of Perinatal Nursing 225
Bearing Witness to Obstetric Violence: Moral Distress, Vicarious Trauma, and Burnout 230
Theme 3: Provider-led Responses to Obstetric Violence 236
From Provider Mental Health to Trauma-Informed Care: Strategies for Promoting Humanized Care 236
The Importance of Dialogue: Awareness Raising and Speaking of 'Violence' 246
Chapter 7: Discussion, Implications, and Conclusion 252
The Epistemic Thread 254
The Promise of a Good Birth and Institutional Betrayal 264
Obstetric Violence as an Environment of Care 273
Systemic Racism in Canadian Perinatal Healthcare 278
Strengths and Limitations 283
Implications and Recommendations 287
Conclusion 299
References 301
Appendix A 355
Appendix B 357
Appendix C 359
Appendix D 363
Appendix E 368
Appendix F 372
Appendix G 377
Appendix H 378
Appendix I 379
Appendix J 381
Appendix K 386
Appendix L 391
Appendix M 396
Appendix N 401

Appendix O 404
Appendix P 405

Abstract

Obstetric violence, the disrespect and abuse experienced by birthing individuals in hospital settings, represents a significant global public health concern. It stems from normalized practices in childbirth that routinely violate autonomy while remaining obscured within standard institutional care. Although its significant and enduring impacts are widely recognized, obstetric violence remains a neglected area of inquiry in Canada. This study used a qualitative instrumental case study design, guided by Stake's approach, to explore obstetric violence in hospital-based childbirth. Thirteen childbearing women who experienced obstetric violence and six perinatal healthcare providers were recruited for qualitative interviews exploring their experiences and perspectives of obstetric violence in Montreal, Canada. A review of media and policy documents was also conducted. The study was informed by an intersectional feminist poststructuralist framework and guided by Feminist Relational Discourse Analysis. Findings from childbearing women reveal emotional, verbal, physical, and epistemic forms of violence that are produced and sustained through relational, sociocultural, and institutional conditions and discourses. These experiences disrupted meaning-making, mental health, and familial relationships, eroded trust in the healthcare system, and altered future reproductive choices. Healthcare provider accounts further illustrate how obstetric violence is normalized through professional hierarchies, systemic pressures, and racialized, gendered, and medicalized norms and biases. Witnessing obstetric violence contributed to moral injury, altered the quality of care provided, and led to career changes. By analyzing the myriad sociocultural and institutional discourses and counter-discourses present in the narratives of both women and providers, the study offers insights into how obstetric violence may be constructed, normalized, and contested. In doing so, pathways to more humanized and equitable perinatal care are put forth.

Résumé

Le manque de respect et les abus subis par les personnes en cours d'accouchement hospitaliers, désignés sous le terme de violence obstétricale, constituent un enjeu majeur de santé publique à l'échelle mondiale. La violence obstétricale découle de pratiques normalisées lors de l'accouchement hospitalier qui violent systématiquement l'autonomie tout en restant largement invisibles dans les soins standards. Bien que ses impacts significatifs et durables soient largement reconnus, la violence obstétricale demeure un domaine de recherche négligé au Canada. Cette étude a utilisé un design qualitatif de type étude de cas instrumentale. Treize participantes ayant vécu la violence obstétricale et six prestataires de soins œuvrant dans des services périnataux hospitaliers à Montréal, Québec, ont été recrutés pour des entretiens qualitatifs explorant leurs expériences et perspectives. Une revue documentaire des médias et des documents de politique a également été réalisée. L'étude s'appuyait sur un cadre théorique poststructuraliste féministe intersectionnel et a été analysée à l'aide de l'analyse discursive relationnelle féministe. Les récits des femmes révèlent des formes de violence émotionnelle, physique et épistémique, produites et maintenues à travers des interactions relationnelles et des discours socioculturels et institutionnels, perturbant la construction de sens, la santé mentale et les décisions reproductives futures. Les récits des prestataires éclairent la normalisation de la violence obstétricale dans l'accouchement institutionnel, renforcée par les hiérarchies professionnelles, les contraintes systémiques et des présupposés racialisés et genrés. Le fait de témoigner de cette violence a contribué au préjudice moral ainsi qu'à des changements dans l'emploi. En portant attention aux discours et contre-discours présents dans ces récits, l'étude met en lumière la manière dont la violence obstétricale est construite, normalisée et contestée, et propose des pistes vers des soins périnataux plus humains et équitables.

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Glossary

Birth trauma – Overwhelming psychological distress experienced during childbirth, arising from a perceived or actual threat to the birthing individual or their baby. This may be related to medical interventions, the mode of birth, or interactions with healthcare providers, and may result in long-term impacts on individuals (Beck, 2004).

Childbirth – The period beginning with the onset of labour, through to the birth of the child, and ending with the third stage of labour (expulsion of the placenta), and including vaginal, instrumental, and operative delivery.

Colonialism – Attempted or actual imposition of policies, laws, the economies, cultures or systems, and institutions put in place by settler governments to support and continue the occupation of Indigenous territories, the subjugation of Indigenous nations, and the resulting internalized and externalized thought patterns that support this occupation and subjugation (Women and Gender Equality Canada, 2025).

Gender-based violence – Violence based on gender norms and unequal power dynamics, perpetrated against someone based on their gender, gender expression, gender identity, or perceived gender. It takes many forms, including physical, economic, sexual, as well as emotional or psychological abuse (Women and Gender Equality Canada, 2025).

Obstetric violence – A form of normalized structural, gender-based violence that encompasses a range of abusive, disrespectful, and dehumanizing behaviours enacted by health care providers towards pregnant and birthing individuals, impacting their quality of life, and producing inequitable perinatal health outcomes.

Perinatal care – Care provided to a pregnant person and their baby, during pregnancy, childbirth, and into the postpartum period (Public Health Agency of Canada, 2018).

Person-centered care – An approach to health care that sees and treats persons holistically, taking into consideration many levels of needs and goals, and supporting the individual in leading a meaningful life (Registered Nurses' Association of Ontario, 2025).

Structural violence – An imperceptible violence that permeates social structures, produces unequal power relations, an unequal distribution of income, education, and health and social services and disparate health outcomes (Galtung, 1969)

List of Abbreviations

CBW……Childbearing Woman

FRDA…….Feminist Relational Discourse Analysis

GBV…….Gender-Based Violence

HCP……Healthcare Provider

2SLGBTQI+……..Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex People

OV……Obstetric Violence

PTSD……Post-Traumatic Stress Disorder

NICU……...Neonatal Intensive Care Unit

WHO……..World Health Organization

List of Tables

Table 1. Sample Characteristics: Childbearing Women

Table 2. Sample Characteristics: Healthcare Providers

Table 3. Analytic Phases of Feminist Relational Discourse Analysis

Table 4. Themes and Sub-themes from Interviews with Childbearing Women

Table 5. Themes and Sub-themes from Interviews with Healthcare Providers

List of Figures

Figure 1. Defining Disrespect and Abuse of Women in Childbirth

Figure 2. Birth Monopoly Obstetric Violence Pyramid

Figure 3. Structural Dimensions of Obstetric Violence

Figure 4. Integrated Intersectional Feminist Poststructuralist Framework

Figure 5. Sample Coding Scheme

Figure 6. The Epistemic Thread

Chapter 1: Introduction

Obstetric violence (OV) refers to the normalized mistreatment of birthing individuals by healthcare providers, embedded within the everyday practices of hospital-based childbirth, and encompassing practices that are disrespectful, abusive, and dehumanizing. The literature demonstrates that prevalence estimates of OV in childbirth vary significantly from country to country; for example, reported rates are 78.6% in Malawi (Sethi et al., 2017), 78.4% in Italy (Scandurra et al., 2021), 23.6% in Mexico (R. Castro & Frías, 2020), 20% in the United States (Mohamoud et al., 2023), and 18% in Myanmar (Bohren et al., 2019). Following a visit to Canada in 2018, the United Nations Special Rapporteur on violence against women reported that violence against women in reproductive healthcare was a global issue, transcending geographic borders and socioeconomic levels, and that significant gaps and challenges existed in Canada to address the issue (Šimonović, 2019).

Different forms of OV exist on a broad spectrum, ranging from subtle and seemingly benign acts of non-supportive care, coercion, or degrading language to overt acts of physical violence such as unconsented vaginal exams and slapping. More broadly, mistreatment in childbirth has been categorized as physical, verbal, psychological, and sexual abuse, stigma and discrimination, failure to meet professional standards of care, inappropriate use of procedures, poor rapport between women and providers, and health system conditions and constraints (Bohren et al., 2015). Support from care providers, the perceived quality of the provider-patient relationship, and involvement in decision-making are the most important predictors of the self-reported quality of childbirth experiences, far outweighing the impact of other factors, such as pain and pain relief, medical outcomes, interventions, age, socioeconomic status, and birth environment (Hodnett, 2002). Moreover, the attitudes and behaviour of care providers have been

found to be some of the most significant predictors of birth trauma (Elmir et al., 2010; Reed et al., 2017).

Experiences of OV are often marred by feelings of fear, neglect, powerlessness, dehumanization, and objectification; these experiences are inherently harmful, are a violation of human rights, and may also pose significant consequences to birthing individuals, their infants, and their families in the short and long term. These include injury from direct physical violence and the iatrogenic effects of non-indicated interventions, emotional and psychological harm, including postpartum depression (Kohan et al., 2025; Kulkarni, 2025; Madlala & Kassier, 2018; Souza et al., 2017), and feelings of failure and fear related to childbirth (Briceno Morales et al., 2018). Adverse experiences and interactions in birth may also contribute to birth trauma, overwhelming psychological distress experienced during birth that impacts women's health and well-being, and may result in post-traumatic stress disorder (PTSD) associated with childbirth (Beck, 2018; El Founti Khsim et al., 2022; Reed et al., 2017). Experiences of mistreatment in childbirth are also linked to impaired maternal-infant bonding and family dynamics (Rodríguez-Almagro et al., 2019; Shorey & Wong, 2022), decreased utilization of both maternal and infant health care in the postpartum period (Leite et al., 2021), and decreased uptake of prenatal care or declining care altogether in future pregnancies (Asefa et al., 2018; Elmir et al., 2010; Miller & Lalonde, 2015). In infants, maternal mental health and impaired bonding may have short- and long-term psychological and emotional impacts as well, by way of altered attachment between mother and infant. It has also been demonstrated that OV is linked with decreased rates of breastfeeding initiation and continuation (Ballesta-Castillejos et al., 2025; Leite et al., 2023). Perinatal maternal stress experienced during pregnancy and the postpartum period has also been shown to increase the risk of metabolic, immunologic, and neurobehavioral disorders among

infants in the long-term (Ryan et al., 2025). Thus, OV has consequences that extend well beyond the individual, impacting the health and well-being of the maternal-infant dyad by way of multiple pathways and throughout the lifespan.

Following decades of robust action and attention paid to improving maternal morbidity and mortality rates globally, international human rights bodies, global health organizations, and reproductive rights advocates have endeavoured to expose the pervasive and normalized nature of disrespectful and abusive behaviour experienced by many women during childbirth (Freedman & Kruk, 2014; Sadler et al., 2016). As such, significant advancements have been made in describing and measuring the nature and prevalence of childbirth mistreatment, though most attention has been paid to perinatal care contexts in low- and middle-income countries experiencing greater challenges to maternal and newborn morbidity and mortality (Bowser & Hill, 2010; Sadler et al., 2016; World Health Organization [WHO], 2015). Research examining the issue in high-income settings remains comparatively scarce (Garcia, 2023; Sadler et al., 2016), yet advocacy groups and mass and social media point to OV being an insidious and underreported aspect of the childbirth experience for many women (Bland et al., 2020; Choudhury, 2019; The Obstetric Justice Project, 2026; Tresierra, 2019). In high-income settings, most pregnant individuals have access to skilled birth attendants, institutional birth, and life-saving technologies; however, factors such as the medicalization of birth, risk-averse cultures of care, high medical liability costs, and human resource shortages produce unique contexts for harmful practices to occur and remain undetected (Hall et al., 2012; Shaw et al., 2016). In the United States and Canada, mistreatment has been found to disproportionately affect individuals from racialized or ethnic groups, immigrants, and those with a low-income, pointing to the fact that structural dimensions play a determining role in the quality of perinatal care (Centers for

Disease Control and Prevention, 2019; Morton et al., 2018; Vedam, Stoll, McRae, et al., 2019; Vedam, Stoll, Taiwo, et al., 2019). For example, in 2023, the Centers for Disease Control and Prevention published that approximately 20% of women in the United States experience at least one form of mistreatment during childbirth, including being ignored by health care providers, having requests for help refused or not responded to, being shouted at or scolded, having physical privacy violated, and being threatened or coerced. The rate of mistreatment jumps to 30.0%, 29.3%, and 27.3% for Black, Hispanic, and multiracial women, respectively. Further, 40.1% of Black women report at least one form of discrimination while receiving perinatal care (Mohamoud et al., 2023). Other factors found to be associated with an increase risk of OV are younger age, lower educational level (Bohren et al., 2019; Scandurra et al., 2021), not having attended prenatal childbirth courses, having a vaginal birth (Scandurra et al., 2021), being attended by a physician as opposed to midwife, lack of a birth companion, and lack of non-pharmacological pain support (Aşci & Bal, 2023).

These inequities may be further compounded for 2SLGBTQI+ individuals, who continue to experience particular vulnerability to stigma, discrimination, and exclusion in cis-heteronormative perinatal healthcare settings (Zeta & Patil, 2026). Although the empirical literature on OV has historically been grounded in cisgender women's experiences, the literature suggests that gender and sexually diverse individuals face distinct forms of harm in perinatal care, including misgendering, assumptions about family and parenting configurations, and a need to continually explain or justify themselves to care providers (Fischer, 2021). Together, these experiences are demonstrated to contribute to feelings of invisibility, marginalization, as well as compounded trauma among 2SLGBTQI+ birthing individuals (Klittmark et al., 2023; Searle et al., 2017). While the term "women" is used in many studies cited throughout this dissertation,

this reflects the language of the existing literature rather than an assumption that OV is limited to cisgender women. In the presentation of this study's findings, gendered language is used in relation to participants' self-identification, all of whom identified as cisgender women, while also acknowledging that OV is experienced across a broader range of gender identities.

The Global Response to the Mistreatment of Women in Childbirth

In 1985, the WHO addressed concerns regarding the over-medicalization of birth in the article entitled "Appropriate Technologies for Birth". The title of the article is indicative of the biomedically driven, technocentric approach to birth at the time of its publication, and though the intent was to outline the potential risks of such an approach, the perceptions and experiences of women who were having these technologies liberally used on them were overlooked (World Health Organization, 1985) – not an uncommon characteristic of women's health research at the time. During this era, international organizations had their efforts turned, reasonably so, to reducing maternal and newborn morbidity and mortality rates, increasing access to facility-based birth, and expanding coverage of interventions. Still, the quality of the care that women received within those facilities remained a secondary issue, if addressed at all.

In the early 2000's, action on maternal and newborn health continued to target morbidity and mortality ratios and child-specific outcomes (Sen, Reddy, & Iyer, 2018). However, mounting evidence pointed to the fact that despite many more women gaining access to facility-based birth and skilled birth attendants, their experiences within these same facilities were marked by abusive and disrespectful treatment (D'Oliveira et al., 2002). A 2010 landscape analysis by Bowser and Hill was the first of its kind to explore the evidence for disrespect and abuse in facility-based birth. The report found that disrespect and abuse were pervasive in facilities worldwide, and did not hinge solely on the behaviour of a few corrupt individuals; rather they

were the result of deeply ingrained systemic issues (Bowser & Hill, 2010). In 2015, the WHO released a report entitled "The Prevention and Elimination of Disrespect and Abuse During Facility-Based Birth", wherein they expressed concern at the "disturbing picture" emerging in the literature around women's childbirth experiences, and made a formal call for greater action, dialogue, research, and advocacy on the issue. The report points to a lack of international consensus on how to define and measure the issue, and a consequent lack of knowledge on its prevalence and impact on women's health, well-being, and choices (World Health Organization, 2015). More recently, the UN Special Rapporteur on violence against women released a report outlining the issue of mistreatment and violence against women in reproductive health services and its causes, consequences, and steps for future action, with a focus on childbirth and OV (Šimonović, 2019). Despite this call to action, and nearly three decades since the WHO first denounced the medicalization of birth, trends suggest that addressing OV may be an uphill battle. For example, despite convincing evidence that injudicious use of non-indicated interventions and technologies is harmful in low-risk birth, cesarean birth rates are rising in many high-income countries, and these rates have been found to be more strongly tied to economic and geographical factors than to actual medical need (Betran et al., 2021; Sadler et al., 2016).

In the decade that followed the release of the 1985 WHO report, international human rights bodies also turned their focus to the mistreatment of women in childbirth. Framing the issue as a violation of human rights mobilized advocacy movements among women's rights activists and international human rights organizations (Williams & Meier, 2019). In 1993, the UN released the Declaration on the Elimination of Violence Against Women, laying the foundations for formally addressing the human rights of women in childbirth. The White Ribbon Alliance was founded in 1999, forming a non-partisan, non-governmental, international coalition

of actors seeking to address issues of gender inequality and discrimination within policies, health systems, and in the allocation of resources. Such initiatives made way for violence towards women in pregnancy and childbirth to be addressed within legal systems, offering individuals recourse in the wake of violent and traumatic birth experiences (Williams & Meier, 2019). More recently, the application of a human rights framework to examine gaps and failures in perinatal healthcare has served to illuminate distinct subsets of mistreatment, such as forced sterilization and detainment in facilities, undeniable violations of human rights (Khosla et al., 2016). In the United States, legal scholars have critiqued the inaccessibility of legal recourse for the majority of women in the country, and the inefficacy of legal systems to address claims of OV outside of human rights violations, which often become qualified as issues of medical error or interpersonal conflict that gain little traction (Diaz-Tello, 2016).

The Latin American Movement for Humanized Birth

The emerging discourses described above were occurring in parallel with grassroots social justice movements that had taken root in Latin America in the 1980's. As international organizations were convening to improve the survival rates of women globally, activists in Latin America were concerned with a different reality: soaring cesarean-section rates, the over-medicalization of birth, and violence in obstetric care. In 2004, Argentina pioneered a legal framework for the humanization of care in facility-based childbirth, emphasizing dignified and respectful care practices by health care providers (Borges, 2018). Despite widespread colloquial adoption of the term *obstetric violence* among advocacy communities, activists refrained from using the term in political settings out of fear of being perceived as sensationalist and of being delegitimized. The term nevertheless gained traction, and formal recognition of OV came in

2007, when Venezuela became the first country to adopt it into law as a criminal act, therein defining it as:

> the appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanized treatment, an abuse of medication, and to convert the natural processes into pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women (Pérez D'Gregorio, 2010, p. 201).

In the wake of this, similar laws were adopted by a number of countries, including Argentina in 2009, Mexico in 2014 (Williams et al., 2018), and Portugal in 2025 (IPOV-Respectful Care, 2025).

Critically, the term OV and its origins within social justice movements make it distinct from other, more neutral terms such as "mistreatment" and provide a framework for understanding OV as a form of structural and gender-based violence (GBV), and a significant human rights, political, legal, and public health concern (Edward & Kibanda, 2022; Miltenburg et al., 2018; Pickles, 2024; Sadler et al., 2016).

Birthing in Canada

On a global scale, Canadian perinatal health indicators place the country well above the majority in terms of perinatal and infant health. Yet, Canada's steadily increasing maternal mortality rate, absence of a national tracking system for maternal deaths, and a deficient and incomplete national perinatal surveillance system depict a perinatal health system that is falling behind and failing childbearing individuals and their infants (Aflaki & Ray, 2023).

Though the Society of Obstetricians and Gynecologists of Canada report the primary causes of maternal morbidity and mortality to be age, medical co-morbidities, and "risks and

resiliencies" among a growing refugee and immigrant population (Society of Obstetricians and Gynecologists of Canada, n.d.-a), the literature decisively points to social determinants of health and structural racism as inextricable from existing racial disparities in perinatal health outcomes (Vedam et al., 2024). Crucially, both federal and provincial governments have continued to neglect the importance of collecting race-based health data, this despite evidence of systematic racism in Canadian healthcare and concrete evidence of a Black perinatal health crisis in other high-income countries (Hoyert, 2025; Women and Equalities Committee, 2023). Several studies have provided evidence of racial disparities in adverse perinatal health outcomes in the Canadian context (Mckinnon et al., 2015; Miao et al., 2022; Weckman & Farrugia, 2025), as well as evidence that these numbers have been trending upwards over recent years (Auger et al., 2012).

Beyond physical health indicators, even less is known about perinatal healthcare experiences of birthing individuals in the country, especially those that are negative or involve mistreatment or OV. The most recent national data on the experiences of birthing individuals within the Canadian perinatal healthcare system come from the 2006-2007 Canadian Maternity Experiences Survey, reported by the Public Health Agency of Canada (2009). While this survey provided important insights, including overall satisfaction with care and differences by type of birth attendant, its findings are now nearly two decades old and only superficially examined the quality of the patient-provider interaction. With regard to the quality of birth experiences, 53.8% of women reported having a very positive birth experience; the remainder reported somewhat positive (26.2%), neutral (11%), or negative experiences (9%). The survey reported that the vast majority of women gave birth in hospitals (97.9%), which is significant given that satisfaction varied by provider type. Notably, women attended by midwives were more likely to report positive experiences than those attended by physicians. Respondents with low-risk pregnancies

attended by an obstetrician were more likely than those attended by a midwife to experience medical acts such as induction or augmentation of labour, electronic fetal heart monitoring, spinal anesthesia, episiotomy, and cesarean delivery. Many respondents were required to travel outside of their community to obtain obstetric care: in Nunavut, as many as 64% were required to travel outside of their community, starkly contrasting with the Canadian average (25.6%). Satisfaction also varied by region, with satisfaction rates being two times higher in Ontario than in Nunavut, for example. Beyond these general trends, there is limited contemporary data in Canada on disrespect, abuse, or OV from the perspectives of birthing individuals, and even less so from the perspective of healthcare providers.

A Brief History of 20th Century Childbirth in Quebec, Canada

The last few centuries marked an important shift in the evolution of childbirth from a female-led, community-based event towards how it is perceived and managed today. Against the backdrop of white Eurocentric, imperialist, colonialist, religious projects of the 18th and 19th centuries, childbirth (read women) took on the status of being undignified, innately dangerous and pathological, and in need of saving from itself. Childbirth became increasingly confined to obstetrical wards, purportedly under the care of expert and diligent men with the strength, intelligence, and technical skill to control what had previously been wild, primitive, and uncontrolled (Bessaïh & St-Amant, 2017). In the late nineteenth and early twentieth centuries, Canada saw the steady hegemonic rise of obstetrics and hospital-based birth, alongside the growing social approval of physicians as experts in managing pregnancy and childbirth. During this era, medicalized birth became the norm, supported by broader social, political, and cultural shifts that positioned physiological birth, home birth, and midwives as unsafe, uncivilized, and incapable of managing the inherent risks and pathology that pregnancy was increasingly

presumed to hold (Born, 2003; Wood, 2018). Persistent lobbying by the medical profession in Canada led to the eventual criminalization of midwifery in 1895, placing childbirth under the sole jurisdiction of physicians, effectively eradicating midwifery practice, and laying the groundwork for the misconceptions, fears, and stigma that surround midwifery practice in Canada today (Born, 2003).

The 1960s and 1970s saw the rise of the natural childbirth movement as a response to the highly medicalized approach to childbirth that had come to dominate perinatal care. The emergence of discourses framing physiologic birth and midwifery as viable and even desirable options challenged assumptions that childbirth belonged solely under the surveillance of a trained obstetrician (Bessaïh & St-Amant, 2017; Wood, 2018). In Québec, midwifery was legalized in 1999 following years of advocacy and political struggle, reflecting a broader movement across Canada to reintroduce midwifery after decades of marginalization and stigmatization. Yet, despite legalization and growing demand, access remains limited to this day. Only approximately 5% of births in Québec involve a midwife, compared to roughly 13% nationally, 18% in neighbouring Ontario, and nearly 30% in British Columbia (Canadian Association of Midwives, 2023). Limited training capacity, workforce shortages, and insufficient birthing centre infrastructure continue to constrain access, even in regions where demands are high (Mignacca & Odura, 2025; Mouvement pour l'autonomie dans l'enfantement, 2026).

Obstetric Violence in Canada: Slow Progress Towards Recognition

In Canada today, there is a critical gap in public health initiatives aiming to describe the breadth and depth of OV, a major barrier to understanding the scope of this phenomenon on a national level. One notable exception to this gap is the work of the Birth Place Lab at the University of British Columbia, which has been a leading voice in advancing research on

respectful maternity care and OV. The Birth Place Lab has released a number of reports highlighting the prevalence of mistreatment and inequities in perinatal care in Canada (Malhotra et al., 2024; Niles et al., 2021; Vedam, Stoll, McRae, et al., 2019). Most notably, they have recently completed a large national survey of approximately 6,000 women across Canada examining experiences of perinatal care (Vedam et al., 2024). At the time of writing, findings from this survey have yet to be published in their entirety in peer-reviewed literature.

Despite existing research and political action on the issue being in its infancy, mass and social media point to it being a longstanding concern for women across the country. In 2016, the Canadian Broadcasting Corporation (CBC) exposed hundreds of complaints made to Canadian hospitals wherein women alleged experiencing discrimination, harassment, bullying, undignified care, and unconsented procedures during childbirth (Burns-Pieper, 2016). In response, policy leaders, including the CEO of the Society of Obstetricians and Gynecologists of Canada (SOGC) at the time, stated that abuse and disrespect during hospital-based birth in Canada were rare and not an issue of concern; while the Chair of the University of Toronto Department of Obstetrics and Gynecology stated that, "systems are rigorous at all levels such that Canadian women listening on CBC can be firmly reassured this is not a concern in Canada," (Burns-Pieper, 2016, para. 14). These responses highlight a concerning lack of insight among key Canadian decision-makers and leaders at the time of the publication. In 2026, the SOGC had yet to formally acknowledge mistreatment, disrespect, abuse, or OV as an issue of concern in Canada. The society's *Statement on Respectful Care* acknowledges the right of all women to have a safe and respectful birth experience, yet refrains from acknowledging the vast evidence pointing to the contrary, and emphasizes in that statement that, "obstetricians, nurses, family physicians, midwives and doulas are extraordinarily caring professionals who are mindful of the particular

vulnerability of women during and after labour, and are deeply sensitive and caring to the needs of the women in their care" (Society of Obstetricians and Gynecologists of Canada, n.d.-b, para. 2). Their notable silence on OV stands in stark contrast to reports by advocacy groups (Birth Trauma Ontario, 2026; Regroupement Naissance-Renaissance, 2019; The Obstetric Justice Project, 2026) and media outlets that have shared numerous accounts of women experiencing unconsented inductions (Fatima, 2020), being ignored, undermined, bullied, and infantilized during childbirth (Tresierra, 2019), and among Indigenous women, having coerced or unconsented sterilization procedures (Basile & Bouchard, 2022; Standing Senate Committee on Human Rights, 2022). The prevalence and harmful nature of these experiences, as evidenced in these and other testimonials, make clear the need for formal and systematized data around negative or traumatic experiences endured during perinatal care.

Obstetric Violence in Quebec: A Grassroots Effort Gaining Traction

Regroupement Naissance Respectée and Mouvement pour l'Autonomie dans l'Enfantement represent two feminist organizations leading the way in advocating for the sexual and reproductive rights of women in Québec, with both placing a strong focus on collective community-based initiatives to raise awareness of obstetric and gynecological violence. A report published in 2016, led by Dr. Sylvie Lévesque in conjunction with community health workers from the Regroupement Naissance Respectée, published a report documenting the issue of obstetric and gynecological violence from the perspective of community health workers and birth support workers. Therein, they called attention to the issue as pervasive in the Quebec healthcare system (Lévesque et al., 2016). In 2019, Regroupement Naissance Respectée launched an initiative inviting women to share testimonials of obstetric and gynecological violence through an online platform; over 240 testimonials were collected. These were later shared with the

Secretary of the College of Physicians of Quebec, who responded, “Truly, this is not something that is reported to us anywhere, nor something for which we conduct many investigations” (Gelly, 2019, para. 16, translated from French). In this same response, the secretary characterized the issues raised in the testimonials as a matter of “communication” as opposed to “violence” and referred to implicit consent as a legitimate approach to care, and a likely reason for “misunderstandings” between providers and patients (Gelly, 2019). In contrast, midwifery associations in the province have been calling attention to the issue of OV for over a decade and urging the Quebec Ministry of Health and Social Services to develop a formal action plan to address the issue (Gagné, 2015).

Despite reticence from medical bodies to formally acknowledge the systemic nature of OV, some changes have occurred in recent years that point to shifting tides. In 2022, the College of Physicians of Quebec added “Obstetric and Gynecological Violence” as a subject of service user complaints and investigations. Though a critical step towards quantifying the phenomenon, the complaint process remains a lengthy and often disappointing one for those seeking official means of redress; only 1% of complaints filed with the College of Physicians of Quebec regarding obstetric and gynecological violence result in a decision by the disciplinary council (Poiré, 2022). Several media reports have described one Montreal-based obstetrician whose license has been revoked twice since 2019, both times for making inappropriate sexual remarks in the presence of a pregnant woman. Between 1989 and 2020, this obstetrician was the subject of 11 disciplinary hearings with the College of Physicians of Quebec (Riga, 2023). This case raises important questions around the effectiveness of disciplinary measures to effectively educate, rehabilitate, and hold such individuals accountable. It also begs the question, what

culture is in place such that a practitioner with a (long) history of patient complaints has been allowed to continue acting in such a brazen way?

Against the backdrop of grassroots, community-based, and midwife-led awareness raising and calls to action, the Quebec Ministry of Health and Social Services explicitly named obstetric and gynecological violence as an issue of concern in its Action Plan for Perinatal and Early Childhood Health (2024). At the time of writing, the document is the only one of its kind in the country to do so. Within the action plan, the ministry points to the impact of obstetric and gynecological violence on maternal mental health and service utilization, specifically acknowledges the need for awareness raising among providers, and states as an objective that a respectful, safe, non-discriminatory, and non-stigmatizing culture of care be established. Additionally, a recent government-funded research project, led by Dr. Sylvie Lévesque, in partnership with organizations such as the Regroupement Naissance Respectée, has embarked on a multi-phase, province-wide project to measure and describe the quality of obstetric and gynecological care in the Quebec healthcare system, with special attention to patient-provider interactions, satisfaction with care, trust in the healthcare system, and obstetric and gynecological violence (Lévesque et al., 2026). Early findings from this research demonstrate that following recent interactions with obstetric and gynecological care in the province, only 62% of respondents reported trusting the healthcare system after the experience (Levesque et al., 2026).

Research Aim and Objectives

The overall aim of the proposed research study is to explore OV in hospital-based childbirth. The study objectives are to: (1) examine birthing individuals' experiences of OV in hospital-based childbirth; (2) examine perinatal healthcare providers' perspectives of OV in

hospital-based childbirth; (3) identify factors that contribute to the occurrence of OV in hospital-based childbirth; and (4) identify strategies to address OV in hospital-based childbirth.

Significance of the Research

This research raises awareness of OV, contributes to understanding its impacts on Canadian women and their families, identifies factors that contribute to its occurrence, and informs policies and practices that promote dignified, respectful, and safe obstetrical care. Beyond documenting harms, this study employs a critical, feminist, and discourse-analytic lens to illuminate how OV has historically been produced and normalized. Discourse analysis enables the identification of dominant narratives that shape and give meaning to experiences of childbirth, while allowing for the recognition of counter-discourses and practices of resistance within hospital-based childbirth, providing insight into sites where institutional and cultural norms can be challenged. In doing so, the research extends beyond individual-level interventions, emphasizing the potential for structural and cultural transformation within perinatal healthcare. Framing the research within a social justice lens ensures attention to intersectional inequities, including race, class, citizenship, gender, and other dimensions of marginalization. By examining OV through this perspective, the study acknowledges that experiences of childbirth are not only shaped by institutional contexts but also by broader sociocultural and political conditions, and that solutions must similarly engage with them.

Situating the Researcher

My interest in this research emerges from multiple, sometimes conflicting positions that I hold simultaneously, as a nurse trained and socialized within institutional perinatal care, as a witness to women's mistreatment within that system, and as a birthing person myself, all of which have shaped my critical engagement and investment in the issue of OV.

I began my career as a novice nurse on a tertiary-level labour and delivery unit, where I spent several months learning protocols and checklists and being pushed towards efficiency and speed above most else. There was little time or encouragement to question routine practices. Yet, early on, I experienced a persistent sense of confusion and discomfort about what I was witnessing and at times participating in. Over time, the insidious and increasingly conspicuous (to me) ways women were disrespected and abused during childbirth became hard to ignore. Sometimes this mistreatment was overt, such as a slap to the thigh. More often, it appeared in subtle and normalized forms: laughter at a birth plan in the privacy of the nursing station, planning interventions around the availability of physicians, or unconsented procedures. Particularly troubling was the extent to which such practices were ignored, justified, or sanctioned by other healthcare providers. One encounter early in my career remains etched in my memory as a critical turning point in my preoccupation with OV. I witnessed a non-indicated episiotomy be performed on a woman who had clearly and repeatedly refused the procedure. Standing at the foot of the bed, the male physician and the woman's spouse had coaxed her, emphasizing that the episiotomy would speed up the birth. The woman continued to refuse until she eventually fell silent. The physician performed the episiotomy, and immediately afterward, the woman began to cry, turning her face to the wall, and stating, "I'll never be the same again." Her baby was born moments later to smiles and congratulations, and her words went unnoticed amid the commotion. I was profoundly affected by the immediacy and depth of her response, not only to the episiotomy but, I believe, to having her refusal categorically overridden. In the years that followed, I came to understand the unequivocal violence that had occurred in that interaction. I began to grapple with the incongruity between institutional claims of high-quality

care and the mistreatment I was witnessing. I also began to question my own complicity within a system where disrespectful and abusive practices were common and often condoned.

The birth of my son in the year preceding my doctoral studies marked another defining moment, as my professional concerns became personal, deepening my emotional engagement with the issue of OV. During my pregnancy, I learned that my insider status as a perinatal nurse offered little protection from scrutiny. I concealed my decision to pursue a midwife-led homebirth and when I eventually disclosed this choice to a trusted colleague, they responded, "You're psychotic. You need a psych eval." I felt ashamed and seen as negligent. Although I persisted with my decision and had a healthy and affirming homebirth, I still felt preoccupied with the need to justify and defend my decision. In resisting institutional birth, I found myself somehow bound to it. The birth of my daughter midway into my doctoral research was a breech vaginal birth in a hospital during which I, gratefully, received respectful and humanized care. The experience was disarming and disrupted my expectations, opening more space for the ambiguity, messiness, and multiplicity of care experiences.

These experiences must be understood alongside my own social location. I come to this research as a settler scholar, white, cisgender, and able-bodied. These identities grant me a substantial degree of privilege, shaping how I am received and afforded credibility within health care and academic settings, and in everyday life. I recognize that my relational stance, my research methods, and my analysis are shaped by, and cannot be disentangled from, white Eurocentric and biomedical spheres in which I have been brought up. I also acknowledge that in my own childbirth, I was far more likely than any Black, Indigenous, or person of colour to have my rights respected, my desires and concerns attended to, and my life protected. My professional identity afforded me further advantage within the birthing system, including access to medical

knowledge, familiarity with institutional norms, and protections not equally available to many others. Situated within these intersecting identities, as a mother, nurse, and researcher, this study is oriented toward relational and reflexive knowledge production, while recognizing that many mothers' realities extend beyond my own awareness and lived experience.

Overview of Thesis

The remainder of this thesis will be organized into six subsequent chapters: Chapter Two reviews the literature on OV, including a review of empirical evidence on the experiences and perspectives of birthing individuals and healthcare providers, and a review of conceptual challenges and debates surrounding OV terminology; Chapter Three outlines the epistemological foundations and the intersectional feminist poststructuralist theoretical framework guiding the study; Chapter Four details the methodological approach, specifically the instrumental case study design and Feminist Relational Discourse Analysis; Chapters Five and Six present the results, focusing on interviews with childbearing women and healthcare providers, respectively; finally, Chapter Seven discusses the main findings, highlights broader implications and recommendations, and offers concluding thoughts.

Chapter 2: Literature Review

A review of the literature was conducted to identify literature examining OV in hospital-based childbirth, using the databases Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline, Embase, GenderWatch, Web of Science, and PsycINFO. Key search terms included but were not limited to: “obstetric violence”, “mistreatment”, “disrespect and abuse”, “birth trauma”, “patient abuse”, “medical violence”, “medicalization of birth”, “obstetric racism”, “labour and delivery”, “perinatal”, “birth”, “childbirth”, “hospital-based birth”, “facility-based birth”, “gender-based violence”, and “structural violence”. Additional sources from the grey literature and mass and social media were retrieved through an internet search. No temporal or geographic limits were applied to the literature search. Because research on OV remains limited and emerging, maintaining a broad scope ensured the inclusion of important foundational work on the concept of *obstetric violence*. It also allowed for examination of how the concept has evolved across medical, political, legal, and other contexts. The literature generated will be presented in the following sections: (1) Defining Mistreatment, Disrespect and Abuse, and Obstetric Violence, (2) Women’s Experiences of Obstetric Violence, (3) Provider Perspectives of Obstetric Violence, (4) Structural Dimensions of Obstetric Violence, and (5) Naming “Violence” in Childbirth: Conceptual Challenges.

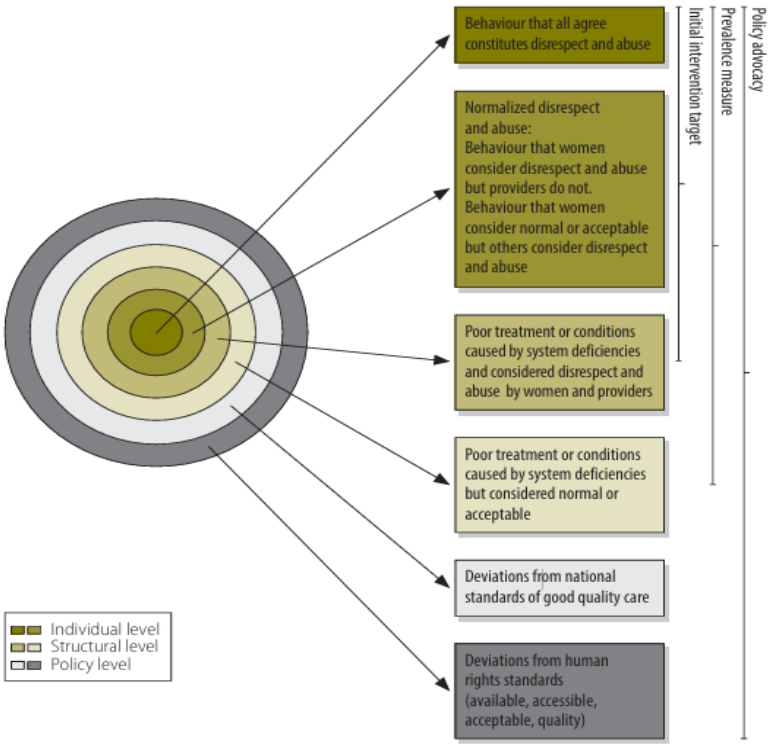
Defining Mistreatment, Disrespect and Abuse, and Obstetric Violence

In 2010, the United States Agency for International Development (USAID) released a landscape analysis of disrespect and abuse in facility-based childbirth (Bowser & Hill, 2010), catalyzing a surge of research on the issue, which had gained little attention in the decades preceding the report (Sen, Reddy, & Iyer, 2018). In the report, Bowser and Hill define seven major categories of disrespectful and abusive treatment: (1) physical abuse, (2) non-consented

care, (3) non-confidential care, (4) non-dignified care, (5) discrimination based on specific patient attributes, (6) abandonment of care, and (7) detention in facilities. These, in combination with lack of financial access, lack of geographical access, and cultural preferences, were identified as leading to the underutilization of skilled birth attendants (Bowser & Hill, 2010), which appears to be the report's primary outcome of interest. Freedman et al. (2014) elaborated on Bowser and Hill's framework to include structural and gender-based inequalities, highlighting the complex relationship between expectations, normalization, individual action, and systemic conditions that sustain disrespectful and abusive behaviours (see Figure 1).

Figure 1

Defining Disrespect and Abuse of Women in Childbirth



Note. From "Defining Disrespect and Abuse of Women in Childbirth: A Research, Policy and Rights Agenda" by Freedman et al., 2014, *Bulletin of the World Health Organization*, *92*, p. 915–916. Copyright 2014 by WHO.

In 2015, Bohren and colleagues (2015), in affiliation with the WHO, released an evidence-based typology of mistreatment in facility-based childbirth, drawing on a mixed-methods systematic review of 65 studies. To date, it is the most comprehensive attempt at operationalizing childbirth mistreatment and has contributed to the development of standardized assessment and measurement tools. The seven overarching categories of mistreatment are identified as: (1) physical abuse, (2) sexual abuse, (3) verbal abuse, (4) stigma and discrimination, (5) failure to meet professional standards of care, (6) poor rapport between women and providers, and (7) health system conditions and constraints (Bohren et al., 2015).

Obstetric Violence Frameworks

In Venezuelan law, criminalized acts of OV include the following offenses: (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 breast-feeding 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; and (5) performing delivery via cesarean section, when natural childbirth is possible, without obtaining voluntary, expressed, and informed consent from the woman (Pérez D'Gregorio, 2010, p. 202).

Birth Monopoly (2026), an advocacy-based non-governmental organization in the United States, offers a definition of OV tailored to the U.S. context. It includes elements not commonly described in other definitions, capturing a spectrum from normalized, seemingly benign behaviours to overtly coercive or violent ones. These include presenting routine practices as if no choice exists; failing to ask before touching the pregnant person; framing care in terms of

providers “allowing” or “letting” someone do something; and invoking phrases such as “all that matters is a healthy baby.” It also encompasses degrading behaviours such as bullying, intimidation, disregard for birth plans, or persistent pressure for interventions after repeated refusals. At the most extreme end are acts that constitute assault, including forced procedures and the use of physical force (see Figure 2).

Figure 2

Birth Monopoly Obstetric Violence Pyramid



Note: From *Obstetric Violence,* by Birth Monopoly, 2026 (https://birthmonopoly.com/obstetric-violence/). Copyright 2026 by BirthMonopoly.com

Women’s Experiences of Obstetric Violence

Globally, women have reported nurses, physicians, and midwives as perpetrators of OV (Bohren et al., 2015). Descriptions of OV typically include issues of consent and a perceived lack of autonomy, resulting in feelings of powerlessness, fear, and of being a passive participant in birth (Bohren et al., 2015; Bradley et al., 2016; Mihret, 2019). Women describe a lack of

communication and support, including being excluded from decision-making (Bohren et al., 2015), dismissal of concerns and anxiety (de Oliveira et al., 2017), and feeling invisible, uncared for, and neglected (Brandao et al., 2018; Westergård et al., 2025). Women describe feeling dehumanized and objectified (Byrne et al., 2017), having their bodies exposed to the gaze of large groups of strangers (Elmir et al., 2010), and forced into undesirable or humiliating positions (Bohren et al., 2015). Verbal abuse is commonly reported, including the use of language described as “humiliating”, “harsh”, “belittling”, and “bullying”(Bohren et al., 2015; Chadwick, 2017). The most common forms of physical violence reported in the literature are hitting and slapping (Bohren et al., 2015), as well as excessive and painful vaginal exams and unconsented episiotomies (Alnemari et al., 2020; Chattopadhyay et al., 2018; Meijer et al., 2020).

Not all instances of OV result in trauma, however, the literature suggests that when women do report a traumatic birth, the quality of interactions with care providers is one of the most important factors contributing to the degree of trauma, more than type of birth or medical interventions received (Reed et al., 2017). A woman’s perceived level of control, quality of communication, and level of emotional support from care providers have been identified as factors that can reduce or even prevent a traumatic childbirth experience (Hollander et al., 2017). In a meta-ethnography by Elmir et al. (2010)women described authoritative and disrespectful care during childbirth as leaving them feeling “invisible and out of control,” with some characterizing their experiences as “barbaric,” “intrusive,” “horrific,” and “degrading,” and likening their treatment to being a “lump of meat” or “slab on a table”. For some, a traumatic birth was experienced as akin to a violent crime (Elmir et al., 2010; Morris et al., 2023). In fact, parallels have been drawn between the gendered dynamics, violence, trauma, and mental health

outcomes that exist in experiences of sexual assault and rape, and those associated with traumatic childbirth (Morris et al., 2023).

Women's Experiences of Obstetric Violence in Canadian Perinatal Care

In the Canadian context, research specifically examining women's experiences of mistreatment, disrespect, abuse, or OV during childbirth is limited. In the available literature exploring perinatal care experiences, experiences of mistreatment or trauma related to provider interactions often emerge as incidental findings (Chalmers & Omer Hashi, 2002; Gagnon & Champagne-Poirier, 2021; Grewal et al., 2008; Hall et al., 2012; Reitmanova & Gustafson, 2008; Vang et al., 2018; Varcoe et al., 2013).

In a survey of British Columbian women's perceived sense of autonomy and respect in childbirth, the majority of respondents reported that providers made most decisions on their behalf. Significantly lower autonomy scores were linked to being cared for by a physician, as compared to a midwife, having a difference in opinion with a care provider, and having a perceived sense of discrimination based on race or ethnicity (Vedam, Stoll, McRae, et al., 2019). Among a sample of 892 service users in British Columbia, those who declined recommended treatments during childbirth described feeling the need to "fight" for their right to refuse certain aspects of care. Interactions with providers were described as tense and fraught, marked by coercive tactics, such as morbid threats, and a sense that compliance was highly valued by the healthcare team (Niles et al., 2021).

In line with evidence emerging in other high-income countries (Heys et al., 2021), racialized and marginalized individuals in Canada appear to be at a greater risk of experiencing discrimination and unkind and disrespectful care during childbirth (Small et al., 2014). For example, immigrant Punjabi women living in Canada reported that their childbirth experiences

were overall positive, yet interactions with providers were marked by poor communication and culturally insensitive care that led to feelings of confusion, abandonment, and dismissal (Grewal et al., 2008). Similar childbirth experiences were found among immigrant Muslim women, who described experiences of discrimination and stereotyping, insensitivity, and disrespect, for example, having requests for male providers to knock before entering the room ignored (Reitmanova & Gustafson, 2008). Immigrant women living in rural and urban settings in Alberta have also described perinatal care experiences marked by discrimination and stereotyping, culturally insensitive care, lack of choice, and inadequate consent processes (Higginbottom et al., 2016).

A study examining the birthing experiences of Somali women in Canada with a history of female genital mutilation revealed that many had experienced mistreatment in the form of harsh language, culturally insensitive care, derogatory remarks, expressions of surprise or disgust when their perineum was seen, rough and painful touch, and lack of consideration for postpartum perineal pain (Chalmers & Omer Hashi, 2000, 2002). Boakye et al. (2023), exploring the childbirth experiences of Black Canadian women, uncovered obstetric racism to be pervasive in the attitudes and behaviours of healthcare providers, contributing to feelings of dehumanization, invisibility, and trauma, and amplifying distrust in the healthcare system.

Indigenous Perinatal Health and Obstetric Violence. Indigenous people in Canada experience significant health disparities compared to the general population. The country's colonial legacy and discriminatory policies are at the root of socioeconomic inequalities, the erasure of culture and traditional Indigenous practices, and limited access to local healthcare services, compounded by pervasive and intersecting racism and sexism, contributing to greater adverse reproductive health outcomes among Indigenous women (Weckman & Farrugia, 2025).

Indigenous women are two times more likely to die during the perinatal period compared to the general population (Kolahdooz et al., 2016) and experience higher rates of perinatal depression, anxiety, thoughts of self-harm, and inadequate social support when compared to non-Indigenous women (Bacciaglia et al., 2023). Nunavut, home to one of Canada's largest Indigenous populations, has one of the highest rates of inadequate perinatal care and an infant mortality rate three times the national average (Kolahdooz et al., 2016). Structural manifestations of colonialism impact women's socioeconomic status, employment, access to healthy environments and food, as well as exposure to stress and violence (Bacciaglia et al., 2023).

The provision of reproductive healthcare to Indigenous women has been marked by troubling reports of coerced or forced sterilization, which have been ongoing since at least the 1930's, when a number of Canadian provinces enacted legislation that made forced or unwitting sterilizations lawful (Zingel, 2019). Though this legislation has long since been repealed, advocacy groups, community-based organizations, and media reports suggest that Indigenous women continue to undergo sterilization procedures without their full and informed consent (Bell, 2021; Fournier, 2021; Zingel, 2019). A recent report of First Nations and Inuit women's healthcare experiences in Quebec collected 35 testimonies of imposed sterilizations, imposed abortions, and OV, in the form of discriminatory behaviour, verbal, psychological, and physical violence, neglect, and denial of care (First Nationas of Quebec and Labrador Health and Social Services Commission, 2022). In Quebec, a recently formed coalition of Indigenous researchers, health care providers, and advocates has united in a call for greater action on the practice of forced sterilization, noting the "glaring lack of relevant data" on the issue in the province (Bell, 2021).

In an ethnographic study of rural Indigenous women's experiences of perinatal care in British Columbia, women described distressing birth experiences marked by inadequate local care services and economic challenges related to forced evacuated birth in urban centres (Varcoe et al., 2013). Stereotyping and experiences of racism are common among pregnant Indigenous women evacuated to larger Southern cities for childbirth (Vang et al., 2018; Varcoe et al., 2013). As Josepi Padlayat, then Elder and Chair of the Inuulitsivik Board of Directors in Nunavik, stated,

> I understand that some of you think that birth in remote areas is dangerous. And we have made it clear what it means for our women to give birth in our communities. And you must know that a life without meaning is much more dangerous (National Aboriginal Council of Midwives, 2013, as cited in Dawson & Suntjens, 2022, p. 233).

Dawson and Suntjens (2022) describe forced evacuation for birth as a colonial policy that has historically caused significant harm to families and communities, and continues to be reinforced by biomedical, institutional, and risk discourses that undermine Indigenous women's and midwives' self-determination in childbirth. The authors frame these evacuations, alongside high rates of birth alerts and baby apprehensions among Indigenous families, as distinct forms of OV and reproductive oppression.

Obstetric Violence in the time of COVID-19

The COVID-19 pandemic, through its socioeconomic consequences, disruptions to health systems, and rapid implementation of emergency healthcare policies, exposed the fragility of gender equality at a broad societal level, as well as the precarity of women's human rights in pregnancy and childbirth (Azcona et al., 2022; Davis-Floyd et al., 2020; Sadler et al., 2020). Globally, the pandemic reversed previously declining trends in poverty and increased rates of forced displacement among women, while maternal mortality rose in several contexts. In Canada, pregnant individuals became twice as likely to report symptoms of depression and

anxiety compared to before the pandemic, with disproportionately higher rates among those from low-income households (Azcona et al., 2022). Globally, restrictions imposed on birthing individuals included prohibition of a birth companion, limitations on breastfeeding, and separation of mother and newborn. The majority of these early restrictions were hastily applied, unmediated, and deviated from recommendations from authoritative bodies, such as the WHO (Sadler et al., 2020). These "just in case" restrictions that focused solely on minimizing the risk of viral transmission, while overlooking the well-founded value of social contact for the health and well-being of birthing individuals and families, resulted in acutely stressful and potentially harmful birthing conditions (Lalor et al., 2021). Restrictions not only posed a threat to the immediate mental well-being of women, but through restrictions limiting mother-infant contact, posed a threat to the immediate and future development and well-being of the child (Liese et al., 2021). The well-being of mothers and babies is understood as inherently relational, yet the near-universal enforcement of social isolation policies reflects a system that prioritizes the biophysiological aspects of the person at the expense of their psychosocial and emotional well-being. The urgency of the pandemic, the strain on and scarcity of resources, and narratives centering care providers as "heroes" created fertile grounds for harmful non-evidence-based policies to be enforced without question (Rice, 2022).

Provider Perspectives of Obstetric Violence

Providers report organizational factors as contributing to harmful behaviours and attitudes towards women, including exhaustion, excessive workload, and lack of time and resources (Arnold et al., 2019; Bohren et al., 2017; Cardoso et al., 2017; Sens & de Faria Stamm, 2019; Unutkan & Elem, 2024). Interprofessional and gendered power dynamics are perceived as resulting in hierarchies of authority, workplace discrimination, violence and bullying, and

feelings of powerlessness which push providers to treat women poorly (Arnold et al., 2019; Asefa et al., 2018; Mayra et al., 2022; Perera et al., 2018; M. Shaw et al., 2020). Beneficent intent commonly emerges as a reason for engaging in acts of OV; for example, providers report acting in the best interest of the mother by prioritizing medical knowledge to ensure safe outcomes, intervening precipitously without informed consent for medical reasons, and using coercive strategies when non-compliance is perceived as putting a woman or baby at risk (Bohren et al., 2017; Cardoso et al., 2017; Freedman et al., 2018; Smith-Oka, 2022a). Slapping and hitting women in the final stages of birth has also been described by providers as a form of encouragement (Maung et al., 2020; Yalley, 2023).

In a study measuring doula and nurse observations of disrespectful care in childbirth in the United States and Canada, two-thirds of the respondents reported witnessing other providers engaging in disrespectful and verbally abusive behaviours, most notably coercion, lack of consent, and threats that a baby would die if a woman did not comply with medical recommendations (Morton et al., 2018). Nurses who witness disrespectful or abusive treatment report significant emotional and psychological impacts, including emotional burnout, compassion fatigue, and secondary traumatic stress (vicarious trauma). Such experiences are linked to an increased desire to leave the field of obstetrics or nursing altogether (Beck & Gable, 2012; Morton et al., 2018). Beck and Gable (2012) emphasize that secondary traumatic stress in labour and delivery nurses is elevated by feelings of powerlessness or helplessness. In the context of mistreatment, emotional burnout among perinatal support workers, such as nurses and doulas, may contribute to a sense of depersonalization and emotional disengagement with clients. Emotional burnout among this population may also contribute to greater acceptance of or resignation to overmedicalized care, which only further reinforces emotional and psychological

strain (Naiman-Sessions et al., 2017). Care providers also report struggling with whether to address the occurrence of OV with women who deny mistreatment or who do not report mistreatment, a potential source of moral distress for care providers (Bergeron et al., 2019).

Structural Dimensions of Obstetric Violence

The literature suggests that OV is normalized by women, providers, and institutions alike (Freedman & Kruk, 2014). As Unutkan and Elem (2024) note, the ubiquity of violence towards women on a societal level is a powerful normalizing force that renders OV unremarkable and a taken-for-granted aspect of healthcare. In qualitative accounts of mistreatment in childbirth, perceived disrespect and abuse are frequently balanced with a perception of having received *technically* safe care (Bohren et al., 2015). In some cases, women have reported experiencing unnecessary interventions or unconsented care, yet perceived it as a normal part of birth and did not characterize it as OV (da Conceição Silva et al., 2019; Lansky et al., 2019). Freedman and colleagues (2018) report that measurements of disrespect and abuse during facility-based childbirth are dramatically higher in third-party observers (70%) when compared to self-reported measurements by birthing women themselves (10%). Several factors may contribute to underreporting among birthing individuals, including certain forms of OV being accepted as routine and therefore presumably necessary aspects of birth care, an inability or unwillingness to report OV (Betron et al., 2018), courtesy bias (the overreporting of satisfaction out of politeness or courtesy), and fear of reprisal if one is to complain about poor care (Freedman et al., 2018).

In addition to being normalized, several systemic factors have been identified as contributing to the existence of OV. These include a lack of consensus on terminology, a lack of context-specific measurement tools (E. C. Collins et al., 2025; Savage & Castro, 2017), a lack of accountability at the institutional level (Jewkes & Penn-Kekana, 2015), and limited attention

paid to structural drivers of OV (Sen, Reddy, & Iyer, 2018). Gender and race have been identified as significant structural dimensions of OV and will be discussed next.

Gendered Dimensions of Obstetric Violence

Gendered norms and assumptions deeply shape perinatal care encounters and represent critical drivers of OV. Gender-normative behaviours associated with femininity, such as gratitude, emotional self-management, deference, and being "easy to care for" and compliant, can support positive interactions when relationships are equitable. However, these same norms often constrain women's ability to assert their needs or express dissatisfaction. Women may withhold critique, belittle their own feelings, or rationalize inadequate support, reproducing patterns of deference that reflect broader patriarchal norms in obstetrics (Westergren et al., 2021).

A substantial body of feminist scholarship underscores that the mistreatment of women and birthing people in childbirth constitutes a form of GBV and discrimination. Harmful gender stereotypes, such as assumptions that women lack decision-making capacity or should defer to medical authority, are embedded in obstetric paternalism through coercion, inadequate or absent consent, and dismissal of the birthing person's own knowledge and desires (Khosla et al., 2016). Sadler et al. (2016) and Giacomozzi et al. (2021) argue that OV is neither accidental nor random; it is directed at women because they are women, rooted in longstanding beliefs about femininity and the behavioural expectations attached to it. When labouring bodies act in ways that fall outside "acceptable" feminine behaviour, when they are loud, messy, intense, angry, and powerful, OV serves to discipline women back into compliance with gendered norms and the social order that relies on them.

Gender-based social norms and the patriarchal values embedded in the biomedical model operate as an "invisible power" that normalizes violence as part of childbirth and of women's

social worlds more broadly (Freedman et al., 2018). Within cis-heteronormative patriarchal logics, motherhood is framed as both biological destiny and moral imperative; women are socially conditioned to adopt docile, maternal behaviours and to tolerate or excuse harm in the name of being a "good mother" (Shabot & Korem, 2018). In this context, loud labouring bodies are construed as aggressive, uncontrolled, or unfeminine. Violence, and the threat of it, then become mechanisms for dominance, discipline, and reinstating the status quo (Shabot, 2016).

Obstetric Racism and the Black Perinatal Health Crisis

The evidence strongly suggests that social categorizations beyond gender intersect to drive the disproportionate mistreatment and inequitable perinatal and newborn health outcomes among certain groups, a reality that has been readily acknowledged in the literature (Betron et al., 2018; Mannava et al., 2015; World Health Organization, 2015). In the United States, Black, Hispanic, and multiracial women are more likely to report mistreatment during a hospital-based childbirth (30%) compared to white women (20%); and approximately 40% of Black, Hispanic, and multiracial respondents report discrimination during said care (Mohamoud et al., 2023). The Centers for Disease Control reported that in 2023, Black women in the United States were over three times more likely to die from pregnancy-related causes than white women, even when socioeconomic factors were held even. The gap has steadily been widening, as maternal mortality has continued to increase among Black women, and decrease among white women (Hoyert, 2025). In the United Kingdom, where individuals have access to universal government-funded health care, and thus a perhaps more apt comparison to Canada, racial discrepancies persist; Black women are almost four times more likely to die of pregnancy-related causes than white women (Women and Equalities Committee, 2023).

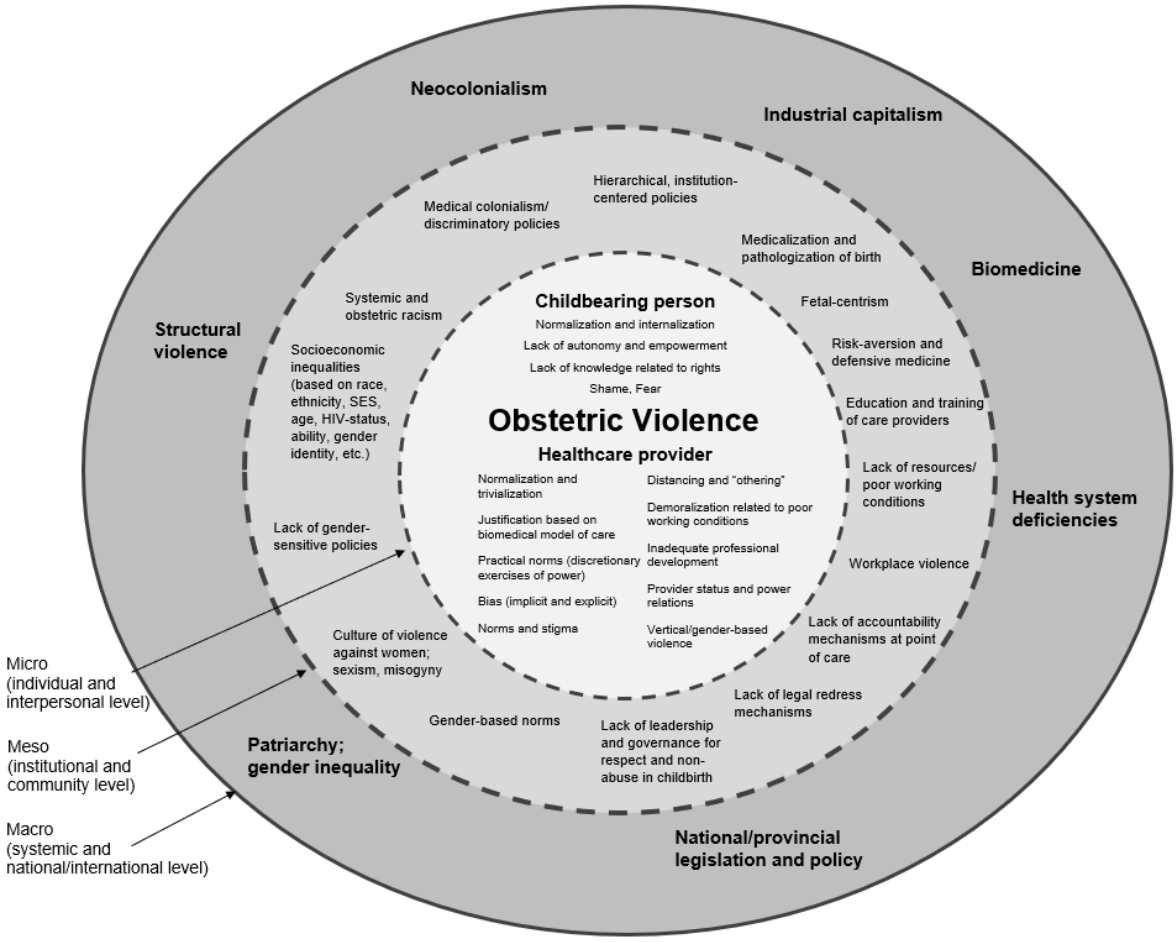
Income and education are not protective; in fact, in some cases, Black women with higher education and income than their white counterparts have been found to still be at a greater risk of dying from pregnancy-related complications (Dayo et al., 2023). Many factors have been proposed as contributing to the issue, including differing and often limited access to services throughout the lifespan (e.g. the hospitals where Black women give birth tend to be of lower quality – a remnant of segregation) (Howell et al., 2016), cumulative exposure to chronic and generational stress related to experiences of racism and discrimination (Gravlee, 2009), and racial biases among providers (Mehra et al., 2020; Sacks, 2018).

In the wake of discourses surrounding OV, attention has turned to examining the differential experiences of OV among racialized groups of women. Davis (2019) suggests that the term *obstetric racism* more adequately represents the intersection between OV and medical racism that characterizes the childbirth experiences of Black women. Exploring the birthing experiences of Black women in the United States, Davis (2019) found that mothers narrated experiences of neglect, dismissal, and disrespect through a unique historical lens of enslavement, segregation, and medical experimentation. Indeed, modern obstetrical practice still relies on techniques developed by Marion Sims, historically considered the "father" of modern obstetrics and gynecology, who, throughout the 1800's, conducted brutal, unconsented, unanesthetized experiments on enslaved Black women and girls (Washington, 2006).

The conceptual model depicted in Figure 3 synthesizes the literature addressing the structural drivers of OV, including systems of oppression such as patriarchy, racism, neocolonialism, biomedicine, and others. The structural drivers are presented within a socioecological model, situating the phenomenon of OV at the individual and interpersonal levels, where multi-level factors interact to perpetuate it.

Figure 3

Structural Dimensions of Obstetric Violence



Note. Data are drawn from the following sources: Bacciaglia et al., 2023; Betron et al. (2018); Bowser & Hill (2010); Bradley et al. (2016); Davis (2019); Dawson & Suntjens, 2022; Freedman et al. (2018); Jardim & Modena (2018); Jewkes & Penn-Kekana (2015); Kukura, 2018; Miltenburg et al. (2018); Sadler et al. (2016); Sen, Reddy, Iyer, et al. (2018); Shabot (2020); Shabot & Korem (2018); Vacaflor (2016); Weckman & Farrugia, 2025; Westergren et al., 2021.

Naming "Violence" in Childbirth: Conceptual Challenges

To equate normalized forms of mistreatment or routine obstetric practices as violent has proven contentious. As Dixon (2015) notes, "the very pairing of the terms obstetric and violence is unexpected, jarring, and provocative" (p. 450). There remains no international consensus on how disrespectful and abusive treatment of women during childbirth should be defined or

measured (E. C. Collins et al., 2025; Garcia, 2023). As a result, terms such as *disrespect and abuse*, *mistreatment*, and *obstetric violence* are often used interchangeably, despite important conceptual origins and differences.

Since its emergence into the global health arena around the turn of the 21st century, mistreatment in childbirth has largely been treated as a public health concern, approached through an apolitical, biomedical lens. Much of this literature has focused on operationalizing and measuring the phenomenon, framing it as a failure of evidence-based care and locating it primarily at the interpersonal or institutional level (Chadwick, 2018). In contrast, authors have argued that *obstetric violence* is the only term that explicitly incorporates GBV and structural violence and therefore, has greater potential to address the power relations and social structures underpinning harmful practices in perinatal care (Sadler et al., 2016; Shabot & Korem, 2018). Among those who adopt the term OV, it is understood not only as a conceptual expansion, but also as a way of communicating the seriousness and impact of these experiences on women's reproductive lives (Lévesque & Ferron-Parayre, 2021; Savage & Castro, 2017). From a legal and human rights perspective, framing reproductive injustices as OV elevates the issue to the level of GBV and opens avenues for political and legal action where they may previously have been ignored. For example, Kvinna till Kvinna (2024), a feminist advocacy organization writing on the Israeli–Palestinian conflict and genocide in Gaza, frame the violence experienced by childbearing women (including attacks on civilians, chronic stress, displacement, and lack of access to food and water) as forms of OV and GBV, which has served to advance the issue on a global scale.

At the same time, the use of the term has been widely contested. Critics argue that applying the label *violence* to normalized or structural forms of harm risks portraying women as

passive victims and may be disempowering (Lappeman & Swartz, 2019). Another frequently raised critique is that the term implies intentionality and individual blame, potentially antagonizing providers and creating resistance to change (Arnold et al., 2019; Lappeman & Swartz, 2019). Bohren et al. (2020), representing the WHO, similarly argue that OV terminology may alienate providers and policymakers, proposing *mistreatment during childbirth* as a more inclusive term that facilitates engagement across stakeholder groups. Relatedly, the WHO has increasingly promoted the language of *respectful maternity care*, positioning it as less hostile and more conducive to collaboration (Sen, Reddy, & Iyer, 2018). Cluver et al. (2023) express staunch opposition to the term OV, noting, “such inflammatory language shreds the ability for nuanced, scientific debate” (p. 818).

However, abandoning the language of *violence* out of concern for professional discomfort risks reproducing the very power hierarchies that research on OV seeks to challenge (Salter et al., 2021). Moreover, characterizing harm as *violence* serves to disrupt the ease with which these experiences are minimized, normalized, or dismissed (Shapiro, 2018). Additionally, the initial tendency to qualify the term violence as "hostile" or "inflammatory" reflects a partial definition of violence that narrowly focuses on individual acts of interpersonal violence. The structural dimension of OV is integral to understanding how harm operates within institutional childbirth, redirecting blame away from individual providers and instead targeting broader institutional, political, and cultural forces. Retaining the language of violence therefore carries political weight, while softer, more palatable terminology risks perpetuating the very hierarchies that allow experiences of harm to be overlooked and to continue occurring (Salter et al., 2021; Shapiro, 2018). Therefore, based on this literature review and for the purpose of this thesis, the term 'obstetric violence' has been retained.

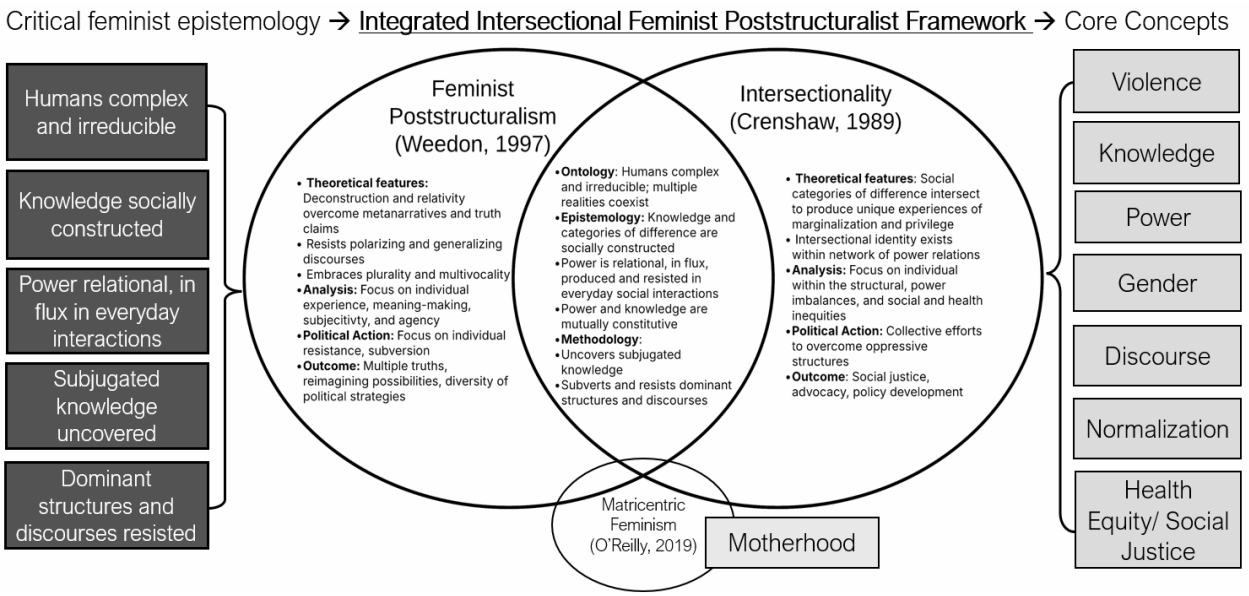
Chapter 3: Theoretical Framework

The literature demonstrates that OV is a complex and multi-level issue; it manifests at the individual and interpersonal level, is entrenched in policies and institutions, is shaped by historical, sociocultural, and political factors, and is often legitimized and normalized, resulting in highly variable perceptions of what constitutes violence. The study therefore requires a theoretical approach that attends to this complexity and aligns with the study's critical orientation and its pursuit of transforming the system within which women birth. The following section situates the study within the paradigm of critical theory, and more specifically within feminist theory. Each is discussed with regard to its ontological, epistemological, and methodological orientations. The two theories, intersectionality (Crenshaw, 1991) and feminist poststructuralism (Weedon, 1997) that form the integrated theoretical framework for the study are then outlined.

In combination, intersectionality and feminist poststructuralism engage with key theoretical concepts drawn from the literature on OV, such as violence, power, knowledge, gender, health inequity, and normalization. Independently, intersectionality provides a lens through which to observe and interpret differential experiences of OV within varying identity positions and a robust praxis-oriented framework attuned to social justice, while feminist poststructuralism offers a theoretical lens with strong explicatory power for exploring subjective experience, agency, discourse, power, and the normalization of violent systems. Matricentric feminism as defined by O'Reilly (2019) provides additional conceptual structure to the framework, emphasizing the social and political dimensions of mothering and the unique vulnerabilities and power relations surrounding motherhood (see Figure 4 for the integrated framework).

Figure 4

Integrated Intersectional Feminist Poststructuralist Framework



Note: The integrated framework depicts key theoretical features of intersectionality and feminist poststructuralism including their overlapping ontological, epistemological, and methodological domains, as well as core theoretical concepts. Matricentric feminism is depicted as providing complementary theoretical context specific to motherhood.

Critical Feminist Philosophical Foundations of the Research

Critical Theory

Researchers hold philosophical assumptions that underpin their worldview and influence the beliefs they bring to the research process. Guba and Lincoln (1994) classify these philosophical assumptions into four broad paradigms: the positivist, post-positivist, constructivist, and critical theory paradigms. Each is defined in terms of their orientation towards ontology (the nature of reality), epistemology (the nature of knowledge and of the researcher/research relationship), axiology (the role of values in research), and methodology (the process for conducting research) (Creswell & Poth, 2018). Critical theory assumes a historical realist ontology; social, cultural, economic, and political factors converge over time to form

historically situated structures that are apprehended as "real" (Guba & Lincoln, 1994). For some, these structures produce experiences of domination, alienation, and collective struggle (R. A. Morrow & Brown, 1994). From a critical perspective, knowledge is transactional and subjective, that is, knowledge is produced in the interactions between the researcher and the research subjects. Findings are value-mediated and value-dependent, and contingent on socially and historically specific contexts. Methodologically, critical theory is dialogical in that it calls for dialogue between the researcher and the subject of the research, and dialectical in that it aims to expose hidden power imbalances, reconstruct previously held constructions, and guide illumination and transformation (Lincoln & Guba, 1994). An important critique of critical theory lies in its assumption that "oppressed" subjects may be perceived as ignorant to oppressive systems and therefore require enlightenment and emancipation; a perspective that may be perceived as paternalistic (Campbell & Bunting, 1991). Feminist theory, falling within the broad scope of critical theory (Guba & Lincoln, 1994; Weaver & Olson, 2006), provides meaningful insight to address such issues and is a fundamental pillar of this research.

Feminist Theory

Feminist theory contends that patriarchal social structures dictate norms and practices that oppress, exploit, and limit the opportunities of women in society (Annandale & Clark, 1996). Patriarchal power relations permeate every aspect of society, from internalized gender norms to the androcentricity of scientific knowledge production to the sexual division of labour (Wall, 2007). Methodologically, feminist theory moves beyond the critique of ideology sought in critical theory, to include a critique of androcentrism, racism, and other oppressive structures that impact the lives of women (Campbell & Bunting, 1991). In feminist research, the research "subject" becomes a "participant" in a non-hierarchical and collaborative partnership with the

researcher (Campbell & Bunting, 1991). Feminist theory maintains that patriarchal social relations produce and uphold certain forms of knowledge as superior, while delegitimizing or excluding others (Harding, 2004). As such, feminist research seeks to reveal knowledge based in women's experiences and perceptions, as well as highlight the experiences of previously excluded or marginalized voices (Harding, 2004).

Importantly, feminist theory is not an "internally coherent body of thought" and is marked by "internal divisions" (Annandale & Clark, 1996). Branches of feminist theory, such as radical feminism, have been critiqued as essentializing women to the detriment of those who are excluded from the white-dominant construction of "women" available in contemporary feminist discourses (Carastathis, 2014). Patricia Hill Collins (2000), a preeminent Black feminist scholar, argues that this results in a racially neutral analysis that, by ignoring differences among women, serves to further entrench social inequalities between them. This is a crucial consideration in the application of feminist theory to the study of OV, which has previously been described as more prevalent among low-income women, women from racialized or ethnic groups, and immigrant women (Morton et al., 2018). Therefore, this study calls for feminist theory which attends not only to issues of gender, but also those of race, socioeconomic status, Indigeneity, and the multitude of other factors that impact individual experiences of OV. The forthcoming section will describe intersectionality, feminist poststructuralism, and matricentric feminism which theoretically inform the study, and which together provide a comprehensive means of exploring OV as a complex, discursively produced, and multi-level issue which is differentially experienced by women based on their unique social identities.

Intersectionality

In this study, intersectionality is employed as a central theoretical framework within the integrated approach, guiding the examination of how power operates and is experienced across multiple social locations. Intersectionality has been described and utilized differently across the literature as a theoretical framework, an analytic lens, and a political or heuristic tool to examine and critique how systems of power and inequality intersect (Bilge, 2013). Intersectionality asserts that individual positions of discrimination (or privilege) result from the intersection of multiple mutually constitutive social categories at the individual level (e.g., race, gender, socioeconomic status) within social, cultural, historical, and political structures. Intersectionality "highlights the need to account for multiple grounds of identity when considering how the social world is constructed" (Crenshaw, 1991, p. 1245). Intersectionality is a complex process, wherein the impact of a single identity category cannot be pre-determined, individual experiences are multi-dimensional, oppression and privilege coexist, and social positions are unfixed, changing over time and place (Hankivsky, 2014).

The term *intersectionality* was coined in the late 1980s by Kimberlé Crenshaw (1989), a Black feminist legal scholar who applied intersectionality as an analytic tool to examine the mechanisms by which Black women were persistently being excluded from feminist discourses privileging white women and antiracist discourses privileging Black men, resulting in unique experiences of marginalization. The foundational work that underlies intersectionality as it is known today can be attributed to Black feminist work taking place in the United States in the 1960's-1980's, during which time various authors and groups sought to address the "double jeopardy", "multiple jeopardy", or "interlocking oppressions" that Black women were experiencing (Carastathis, 2014). Black feminists understood their experiences to be shaped not

only by sexism and racism, but also colonialism, militarism, and capitalist exploitation (P. H. Collins & Bilge, 2016)

An ongoing point of debate among feminist scholars is that of intersectionality's theoretical and methodological ambiguity and open-endedness (Davis, 2008), or what McCall (2005) refers to as its "murkiness". The debate centres on a few key areas. First, intersectionality's theoretical moorings appear to be varied. On the one hand, intersectionality is founded in the political standpoint of Black feminists who identified themselves as a distinct group with shared experiences of marginalization and disparate life outcomes, demonstrating its affiliation with standpoint theory (Carbin & Edenheim, 2013). However, in early intersectional texts, Crenshaw (1989) appeared to suggest that no one single factor could be isolated and identified as being the most significant marker of inequality in the lives of Black women. The idea that social locations intersect and that no single source of inequality can be identified as central to individual experiences seems antithetical to feminist standpoint epistemology, a viewpoint that rests on there being a unified standpoint amongst women.

Intersectionality has also been described as emerging from a postmodern perspective. Early intersectional scholars drew upon poststructural thinking to deconstruct race and gender binaries in an attempt to theorize identity in more complex and heterogeneous ways (Nash, 2008; Tolhurst et al., 2012; Walby et al., 2012). The emergence of intersectionality is widely understood to be the result of a political impetus amongst Black feminists seeking to confront the universalizing and exclusionary tendencies of a mainstream and racist feminism that espoused an idea of 'woman' that ultimately rendered Black women invisible (Nash, 2008). In Crenshaw's (1991) seminal intersectional analysis of Black women's experiences of violence, the author describes intersectionality as a link between contemporary identity politics and postmodern

theory. Likewise, many postmodern feminist theorists in the 1990's found intersectionality of value in deconstructing dominant modernist paradigms while keeping a focus on the gendered experiences of women (Davis, 2008). Based on these accounts, intersectionality did not stand in opposition to poststructuralism but acted as a bridge between disparate feminist approaches.

Further obscuring the field is a lack of ontological engagement among those who draw upon intersectionality (Martinez Dy et al., 2015) and a lack of a clearly defined intersectional theory and methodological approach (Bowleg, 2012; Nash, 2008; Yuval-Davis, 2006). Specifically, intersectionality has been critiqued as lacking sufficient theoretical explicatory power pertaining to the formation and articulation of identity, subjectivity, and agency (Bilge, 2010a; Nash, 2008). According to Geerts and van der Tuin (2013), the focus within intersectionality "on severely marginalized subjects leads to an epistemological problem: the experiences of oppressed subjects who are also partially privileged disappear, which turns intersectional theory into a rather defeatist theory of victimization" (p. 175). In this interpretation, intersectional theory is predicated on a limited conception of power as exclusively restrictive for those falling on the lower end of the power hierarchy, effectively denying their ability to exercise agency. Despite these lacunae, intersectionality is nevertheless called upon by a diversity of researchers attempting to theorize the remarkably complex and intersecting dimensions of identity, as well as the structural processes at play in individual experiences of health inequity (Bowleg, 2012).

Core Concepts in Intersectionality

Collins and Bilge (2016) define the six core principles of intersectionality as social inequality, power, relationality, social context, complexity, and social justice. *Social inequality* is often the catalyst behind intersectional projects. Intersectional analyses seek to expose how

inequality is caused by a multitude of factors that look beyond racism and sexism alone; analyses may also look to structures such as capitalism, nationalism, and neo-liberalism as defining ideologies that shape experiences of inequality. *Power,* conceptualized within intersectionality as a relationship*,* acts within different domains, including the structural, cultural, disciplinary, and interpersonal domains, each of which can be analysed separately to gain a better understanding of the overall power dynamics in a larger social phenomenon. The domains often intersect and are non-hierarchical. Power relations are understood as acting within mutually constructing and "interlocking" systems of power, such as racism and sexism, which can be analysed across the different domains of power. *Relationality* represents intersectionality's commitment to connectedness, the building of relationships across divisions, and the creation of coalitions. A relational perspective is one that rejects binary thinking; the intent of intersectionality is not to examine groups or individuals in silos and highlight differences between them, rather, it seeks to examine their interconnections and areas of overlap. *Social context* is an intrinsic aspect of any intersectional analysis. Social inequality, power relations, and relationality are always viewed within the social context, taking into consideration the historical, political, and intellectual features that shape experience. Importantly, as users of an intersectional framework, we must acknowledge how our social context influences the perceptions, thoughts, and biases we carry into every project. *Complexity* describes the complex and challenging nature of analysing and disentangling the four core themes of intersectionality: social inequality, power, relationality, and social context. It is fundamental to intersectionality, while also acknowledged as confounding intersectional analysis. As Collins and Bilge (2016) note, intersectional analysis "is difficult, precisely because intersectionality itself is complex. This level of complexity is not easy for anyone to handle. It complicates things and can be a source of frustration for scholars,

practitioners, and activists alike" (p. 40). *Social justice*, though not a requirement of intersectional work, represents a common source of motivation for those engaging the theory. The framework is often called upon by those who question the status quo, believe that systemic change is imperative for egalitarian societies, and question and critique the legitimacy of institutions and structures claiming to be democratic.

Intersectional Contributions to the Research

Intersectionality has been described as a paradigm, framework, or theory to advance political action, advocacy, and social justice work across a variety of contemporary contexts such as professional, academic, and healthcare settings, as well as society at large. As an approach to health research, advocacy, and policy development, intersectionality is concerned primarily with historically oppressed and marginalized populations who have previously been excluded from knowledge production and who experience disparate health outcomes (Bowleg, 2012). As an analytic tool, intersectionality examines "how power relations are intertwined and mutually constructing." (Collins and Bilge, 2016, p. 20). Categories of race, class, gender, sexuality, ability, ethnicity, nation, religion, and so on serve as areas of analysis. These categories reference important social divisions that are at the root of power relations producing forms of discrimination like racism, sexism, heterosexism, and class exploitation.

Power is also central to the goal of research grounded in intersectionality: to expose and transform structures of power and domination. Intersectionality also offers a lens through which to interpret and critique how power relations influence the production and dissemination of knowledge (S. Cho et al., 2013). Drawing on a Foucauldian conception of power (see section on Feminist Poststructuralism for further discussion of the concept), intersectionality assumes that power is continually being produced, reproduced, and resisted within relationships. From this

perspective, power differentials at the individual and structural levels produce social categories and subject positions that dictate experiences of marginalization, oppression, and privilege (Hankivsky, 2014). Within intersectionality, the practice of critically examining power relations extends beyond the subject of inquiry to include the researcher-subject relationship. This practice of reflexivity enables researchers to consider their own social position, critically reflect on their own assumptions, and recognize and include a diversity of perspectives in the production of knowledge (Hankivsky, 2014).

Intersectionality supports the praxis-oriented goals of the research, which understands OV as a contemporary injustice experienced differentially across social positions. Intersectionality takes this research well beyond a single-axis analysis of OV as a matter of gender alone, to address the multitude of factors that render subjective experience and social structures so irreducibly complex (Carastathis, 2014). While intersectionality is applied in many forms inside and outside academia, and scholars continue to debate whether intersectional analysis should occur at the macro level, micro level, or both, and whether it is ontologically and epistemologically commensurate with postmodern and poststructuralist theories (Bilge, 2010b; P. H. Collins & Bilge, 2016), this flexibility serves as a strength. It allows this study to draw selectively on intersectionality's core components while combining them with the explicatory power of feminist poststructuralist theory.

Feminist Poststructuralism

Feminist poststructuralism, founded in the work of Chris Weedon (1997), brings together feminist theory and Michel Foucault’s poststructuralism to examine how gendered power relations are produced, negotiated, and resisted through discourse. Feminist poststructuralism is committed to critically examining the lived experience of women through the poststructural

concepts of subjectivity, discourse, knowledge, and power. By integrating these concepts with feminist commitments to analyzing and transforming women's lived experiences, feminist poststructuralism offers a framework for understanding how subjectivities, norms, and inequalities are constructed and how they can be challenged or deconstructed (Weedon, 1997). In nursing scholarship, Megan Aston (2016) further operationalizes feminist poststructuralism as both a theoretical and methodological approach, emphasizing its utility for examining how institutional practices, professional discourses, taken-for-granted norms, and power relations between healthcare providers and clients shape health care experiences and issues of social justice.

It follows that a core aim of feminist poststructuralism is to expose and dismantle patriarchal structures and discourses entrenched in androcentric, Eurocentric, and logocentric ideology, which act to subordinate and constrain women (Weedon, 1997). In a patriarchal system, power relations centered on gender and sex differences define women's experiences. Patriarchal norms and expectations, dispersed through discourses dictating how women are to look and behave, constitute the gendered subject positions that women inhabit and transgress to one degree or another. Such positions are reinforced by explicit and implicit forms of social approval or punishment that are registered in all social interactions. Though the patriarchal structure of society is the core of a feminist poststructural analysis, Weedon (1997) acknowledges that women's lives are diverse and shaped by a multitude of shifting power relations that drive systems of oppressions such as racism, classism, and heterosexism.

Poststructuralism, Power, and Discourse

Poststructuralism and its core concepts – power and discourse, as well as knowledge, subjectivity, and agency – inform the methodological approach of the research. Poststructuralism

emerged from a critique of structuralism's assumption that universal and totalizing truths and structures determine meaning and social life, for example, the notion that through social coherence, a "common good" can be achieved. Instead, poststructuralism argues that meanings are historically contingent, unstable, plural, and shaped by relations of power (Cheek, 2000). Ontologically, poststructuralism and feminist poststructuralism contend that there are multiple unfixed realities, which arise in individual subjective experience. Poststructuralism rejects universal truths and binaries, seeking instead to deconstruct social categories that essentialize groups as either one thing or another. For example, poststructuralism rejects the notion of one essential womanhood – women's experiences of oppression are not homogenous. Instead, our individual positions in society and the subjectivities we embody are multiple, unfixed, and constantly under construction; they are historically and socially specific, and therefore continually being (re)constructed. Our subjectivities, individual consciousness, and the meaning we ascribe to our experiences are dictated by power relations and contingent on the discourses available to us at any given point in time (Weedon, 1997).

Poststructuralism, espousing pluralism while rejecting categorization, has been critiqued as blind to the contemporary struggles of groups with shared experiences of discrimination (Weedon, 1997). Weedon, however, contends that feminist poststructuralist theory, while rejecting the notion that social categorizations represent essential truths and absolutes, still recognizes that many individuals share common experiences. Poststructuralist theorists may employ categories such as race and gender in the analytic process, while nevertheless remaining committed to the notion that categories are unfixed social constructions that hold historically and culturally specific meaning. Weedon proposes that the unfixed nature of structures gives more

freedom and choice to individuals; we are not bound by essential truths, and therefore our precarious subjectivities may serve as "sites of struggle and potential change" (p. 40).

Power and Discourse. Foucault (1977, 1978) contributed significantly to theorizing the workings of *power* and power relations in society, institutions, and the day-to-day lives of individuals. Foucault asserted that no one individual or institution *possesses* power; it is a social process that is in constant flux, dispersed, embodied, and "built consistently into the flows and practices of everyday life" (McHoul & Grace, 1993, p. 7) – a perspective that is fundamental to feminist poststructuralism as well (Weedon, 1997). Asymmetrical forces and relationships of power result in more marginalized positions and more central, normative, and authoritarian positions (Mason, 2001). While traditional feminist framings presuppose power to be a singularly oppressive force in the lives of women, through a poststructuralist lens, power is understood as productive. In this "productive hypothesis," power not only constrains individuals, but also produces knowledge, assumptions, norms, and categories that regulate the individual and their sense of self (Mason, 2001; McHoul & Grace, 1993). Thus, feminist poststructuralism shifts the examination of power away from locating blame solely in individuals or institutions. As Aston (2016) explains, institutions and individuals themselves do not act independently; rather, power operates through discourses that people take up, reproduce, negotiate, or resist. This perspective challenges notions of unidirectional flows of power and binary framings of oppressors and victims, instead directing attention to how particular ideas become normalized, legitimized, or marginalized within specific contexts and in the stories people tell about their lives.

Foucault (1978) argued that power in the modern age became increasingly organized around the administration and management of life, what he termed *biopower*. Rather than relying

on the sovereign right to "take life or let live" (p. 136), modern power works by fostering, optimizing, and regulating life. Biopower operates through two forms: one targeting the individual body through disciplinary techniques that foster productivity, docility, and efficiency, and the second, targeting populations through regulatory measures that manage biological processes, like birth and health, on a collective level. Through careful monitoring and regulation, the subjugation of bodies and the control of populations is achieved (Foucault, 1978). The concept of biopower, in the context of obstetrics, highlights how women's bodies become sites of regulation and intervention within medical care. Through the medicalization and pathologization of birth, practices are oriented toward managing risk, producing compliant subjects, and securing the desired product – a healthy infant (Bellon Sanchez, 2014). Foucault (1973) described the *medical gaze* as a technology of power that objectifies the patient through clinical scrutiny, producing a subject that can be known and defined in terms of biomedical knowledge. In childbirth, this *obstetric gaze* situates the maternal body within a distinct obstetric discourse, where examinations, measurements, and documentation classify women as normal or deviant according to parameters that enable the monitoring, control, scrutinization, and labelling of pregnant bodies (Davis & Walker, 2010).

Discourses consist of taken-for-granted or invisible rules and common assumptions which provide the basis for conscious knowledge (Cheek, 2000, p. 23). As Weedon (1997) notes, discourses "are more than ways of thinking and producing meaning. They constitute the nature of the body, unconscious and conscious mind and emotional life of the subjects which they seek to govern" (p. 105). Discursive texts, that is, the language, images, and discursive practices that represent discourses, carry linguistic or historical meaning and constitute how we perceive our experiences, our social relations, and the meanings we attribute to them (Powers, 2013).

Discourse is closely linked to the concepts of *power* and *knowledge*. Discourse provides the rules that make certain kinds of knowledge possible, shaping what can be said, who can speak, and which statements count as true. These discursive rules are upheld through power relations, thus, power determines which discourses gain authority, and which forms of knowledge gain legitimacy and dominance (Cassidy et al., 2016; Cheek, 2000). Concurrently, these same mechanisms operate to marginalize, delegitimize, or exclude other discourses. In other words, discourses represent particular political interests; they are never neutral. They emerge from and help reproduce social and institutional arrangements that benefit some groups over others. However, discourses are not fixed or impermeable. Within any given power network, cleavage points exist where alternative or counter discourses (e.g. feminist, marginal) may act to undermine, expose, and dismantle dominant systems, and offer opportunities for individuals to remake, reimagine, or reclaim meaning in their lives (Weedon, 1997). This leads to the poststructural perspective on *agency,* which challenges assumptions about individual autonomy and rational choice. Rather than assuming a wholly rational, autonomous subject freely choosing among all possible options, poststructuralism argues that what we take to be "choice" is shaped by the discourses available to us. Our sense of what is possible, in terms of action, compliance, resistance, or subversion, is shaped by what we have been told is possible, and by the norms and narratives that structure our social world (Weedon, 1997).

Discourses shape and constitute individual *subjectivity*, "the conscious and unconscious thoughts and emotions of the individual, her sense of herself and her ways of understanding her relation to the world" (Weedon, 1997, p. 32). Experience and meaning are not based in an essence at the heart of the individual, as is proffered within liberal humanist discourses. Instead, our subjectivities and our understanding of the world are constantly under construction,

contingent on the multitude of discourses available to us in any given context and always a product of society, culture, and history (Cheek, 2000).

Language is the material through which discourse is expressed. It enables us to think, speak, and make meaning of the world around us. Meaning is understood as produced within language, as opposed to language representing the inherent meaning of reality. For example, there is no essential meaning to the word *mother*; instead, the word carries a variety of different meanings based on the historical, geographical, cultural, or familial context within which it is used. The title of mother may carry varying meanings for a woman across different areas or times of her life, as the role carries different and even inconsistent understandings of the opportunities and restrictions it entails.

Feminist Poststructuralist Contributions to the Research

Feminist poststructuralism challenges the forms and sources of knowledge that have previously been legitimized and upheld in favour of alternative, marginal, or excluded discourses and sources of knowledge. This is critical in transforming the lives of women, as knowledge is perceived as constructing meaning in a patriarchal social order that alienates and delegitimizes women. Feminist poststructuralist theorists therefore seek to contribute to knowledge production that serves the interests of women. It provides a means of exploring why women adopt certain social positions and engage in social relations that might subordinate their own interests or that propagate patriarchal social norms; what mechanisms produce the conditions for individuals to willingly adopt such “discursive positions”? At the level of the individual, feminist poststructuralism theorizes the origins of experience, how meaning is produced, how and why conflicts exist, and how we might act to change our experience. At the structural level, it offers a

theory that can account for the social and political structures and discourses that constitute experience.

This theoretical approach is therefore well suited to prioritizing women's accounts of childbirth in an arena historically dominated by patriarchal and biomedical discourses. It also helps illuminate why women may perceive their experiences so differently: some adopt the rhetoric of the risk-averse, biomedical model of care, while others resist or reject it in favour of alternative discourses. In doing so, it provides a framework for understanding what may lead some to identify their experience as violent while others may not. Feminist poststructuralism attempts to account for these differing social realities and the varying social interests they serve. This lens also prompts important questions about the broader system. Who, or what structures, benefit from the current model of care? Who benefits when normalized forms of OV are ignored, or when those who speak of harm are silenced? And what is gained or lost if we actively acknowledge practices that may be experienced as violent by some women?

Feminist poststructuralism also offers a lens to explore the conscious and unconscious thoughts and emotions that contribute to women's subjective experiences of childbirth, and to question where they come from. What discourses were available to women in the formation of their subjective experiences and in the meaning attributed to them? This opens the door to considering the role of individuals, institutions, and mass and social media in the dissemination of both dominant and marginal discourses, and how these may be interrogated and integrated by women.

A Critical Exploration of Congruence and Tensions Between Intersectionality and Feminist Poststructuralism

Debates within third- and fourth-wave feminist literature have positioned intersectionality and poststructuralism as epistemologically incommensurate, framing them as theoretically opposed (Mann, 2018; Willett & Etowa, 2023). This section draws on the extant literature to examine points of tension and congruence between the two approaches to social critique. It will be shown that, despite apparent differences, intersectionality and feminist poststructuralism can be understood as complementary frameworks. The integrated framework employed in this research allows for deepened analysis of women's OV experiences, the power relations and discourses that shape them, and avenues for advocacy and political action.

Points of Congruence

Ontologically, both intersectionality and poststructuralism view humans as complex and irreducible, and realities as multiple. Intersectionality holds that identity and social location are socially constructed and that experiences of privilege and oppression are fluid and context-bound (S. Cho et al., 2013; P. H. Collins & Bilge, 2016). Similarly, poststructuralism contends that multiple unfixed realities arise from subjective experience, where individuals may inhabit contradictory subject positions depending on context (Weedon, 1997). Epistemologically, both approaches share a social constructionist view of knowledge: it emerges through social interaction and is shaped by the power-laden contexts in which it is produced (Mann, 2018). This shared understanding of knowledge production results in a further congruence: both approaches aim to uncover and validate subjugated, marginalized, and otherwise silenced forms of knowledge (Mann, 2018). They advocate a broadened, inclusive understanding of what counts as legitimate knowledge, valuing insights produced both inside and outside academic spaces (P. H.

Collins & Bilge, 2016; Mann, 2018). As with early intersectional scholars who critiqued feminist and anti-racist discourse, feminist poststructuralists similarly view knowledge production as a means of subverting and resisting dominant discourses (Arslanian-Engoren, 2002).

Points of Tension

Mann (2018) speaks to the "unhappy marriage" of intersectionality and poststructuralism, arguing that the misguided wedding of the two has resulted in an epistemologically untenable union in third and fourth feminist scholarship. Mann's main critique concerns how each approach treats "categories." Poststructuralism rejects categorical or essentialist thinking, while intersectionality treats categories of difference as sites through which power operates and which remain important for analysis (Chan et al., 2019). However, intersectional scholarship increasingly emphasizes that human experience is too complex for categories to function in anything more than a provisional way (Martinez Dy et al., 2015). Hankivsky (2014) describes categories as irreducible and shifting across time and place; Hancock (2007) similarly describes them as fluid and relational, with no single category holding primacy. Thus, intersectionality need not be read as rigidly categorical, but rather as attentive to the social constructs that shape lived experience. This is strongly aligned with Weedon's (1997) view that categories such as gender, race, and class can be used analytically so long as their meanings are understood as historically and socially specific. Annandale and Clark (1996) likewise argue that poststructuralism does not deny poverty, racism, or sexism, but merely challenges "grand theories" that claim to fully explain them. Together, these perspectives reflect a strand of poststructuralism more compatible with intersectionality than a strict anti-essentialist poststructuralist stance would tolerate.

Power and Political Praxis

Poststructuralism draws on Foucault's conceptualization of power as diffuse, dynamic, and embedded in everyday relations. Political resistance therefore often occurs through micro-level acts that disrupt power relations (Mann, 2018). Intersectionality, by contrast, has long been oriented toward macro-level political change, with collective activism and advocacy therein aimed at transforming structural oppression (Carastathis, 2014; Mann, 2018; Yuval-Davis, 2006). However, Weedon (1997) argues that feminist poststructuralism allows for political change at *both* individual and structural levels; individuals may adopt, resist, or ignore discourses, but are also constrained by material conditions, social processes, and institutional arrangements that shape subjectivity. In this framing, individual and structural transformation are not mutually exclusive but represent interconnected sites of resistance.

Mann (2018) also argues that the two theories depict "marginalized" people differently within power relations. This author claims intersectionality anchors marginalization within hierarchical, group-based inequalities, whereas poststructuralists more often conceptualize marginalized individuals as positioned outside normative structures rather than oppressed within them. However, intersectional scholars such as Hankivsky (2014) emphasize that categories operate non-hierarchically; oppression and privilege coexist, shift, and vary with social context, and categories do not always map neatly onto structures of oppression. This fluidity challenges Mann's rigid depiction of intersectionality, raising the possibility that the contrast between "hierarchies" and "planes" may be more semantic than substantive.

The Potential of an Integrated Framework for Studying Obstetric Violence

Intersectionality and poststructuralism, especially feminist poststructuralism, share significant ontological and epistemological common ground, including relativistic views of reality and socially constructed knowledge. Existing tensions stem less from fundamental

incompatibilities and more from the open-endedness and variability within both theoretical traditions. Rather than obstacles, these tensions provide opportunities to strengthen analysis by drawing on areas of convergence while mobilizing the unique contributions of each approach. In doing so, both frameworks support reflexive practice, critique, and political resistance.

A combined framework as proposed in Figure 4 enriches the study of OV by supporting the political aims of the research and deepening analytic attention to its multi-level complexity. It facilitates a creative feminist practice that opens new lines of inquiry, encourages debate, and informs future advocacy, research, and policy development. Intersectionality strengthens the praxis-oriented goals of this study by highlighting how OV differentially affects birthing women based on their social positionalities and by framing OV as an issue of social injustice. In the Canadian context, its political impetus responds to norms rooted in the values of white, heterosexual, middle-class men embedded in colonial histories, which produce damaging impacts for marginalized groups (Hankivsky & Christoffersen, 2008). Integrating poststructuralism, with its focus on plurality of meaning and experience, broadens the range of political strategies and emancipatory aims that can emerge (Aranda, 2006). Together, the two approaches support political change at multiple levels.

Intersectionality moves this analysis beyond a singular focus on gender to address the many social factors and structures that contribute to the complexity of subjective experience (Carastathis, 2014). Its ambiguity becomes a strength, allowing for postmodern iterations that align well with feminist poststructuralism. As Davis (2008) argues, intersectionality gives "political credibility" to feminist poststructural projects that might otherwise appear overly focused on heterogeneity and too far removed from collective feminist struggles. Poststructuralism, in turn, invites plurality, multivocality, and deep attention to identities and

subjectivities. Together, the two offer a comprehensive means of examining individual experiences of OV as well as the historical, social, and political systems and power relations that produce it.

Matricentric Feminism

Within the integrated critical feminist framework, matricentric feminism (O'Reilly, 2019) offers a focused conceptual lens that expands on the social and institutional regulation of motherhood. Matricentric feminism is a "mother-centred mode of feminism," which seeks to place mothers, as distinct from women, their experiences, work (performance of mothering), and challenges at the centre of feminist inquiry. It does not reduce women to their maternal roles, nor does it assume mothering is a universal or defining identity. Rather, it treats mothering as a significant *practice*, as opposed to strictly an identity, shaped by the social, cultural, and material conditions under which it is performed. Within matricentric feminism, mothering is defined as a form of labour – skilled, thoughtful, and socially vital that forms an inarguably important component of women's lives despite being historically undervalued and taken for granted. As O'Reilly (2019) surmises, "any understanding of mothers' lives is incomplete without a consideration of how becoming and being a mother shape a woman's sense of self and how she sees and lives in the world" (p. 14).

Matricentric feminism firmly distinguishes itself from "maternalism," the gender-essentializing ideological framing of mothers as possessing innate knowledge and skills or natural caregiving instincts. Instead, it resists assumptions that mothering "comes naturally" to women. This reframing aligns with the broader theoretical stance of the research. Just as feminist poststructuralism examines how discourses shape what is possible or attainable, matricentric feminism interrogates how cultural beliefs about mothering shape expectations, the meaning

placed on mothering and motherhood, and the constraints placed on women who inhabit the role. This perspective also resonates with intersectionality in its recognition that maternal experiences are structured by race, class, gender, ability, Indigeneity, and other axes of identity. In fact, O'Reilly argues that the mother identity should be understood as existing within the complex intersectional matrix, distinct from gender, and worthy of independent consideration in political, social, and intersectional inquiry.

At the core of matricentric feminism is the distinction between patriarchal motherhood and feminist mothering. Patriarchal motherhood refers to the institution, defined by male-dominated norms and systems. Feminist mothering, in contrast, is a practice grounded in agency, self-definition, and the potential for empowerment. This mirrors the broader tensions within feminist poststructuralism: the constant negation that women undertake between dominant discourses and alternative, resistant ones. In fact, a central aim of matricentric feminism is to contest and deconstruct patriarchal discourses of motherhood, namely those that dictate what a "good mother" should be and do. It seeks to imagine and support forms of mothering that are self-defined, complex, unconstrained, and grounded in women's agency rather than in externally imposed ideals. Matricentric feminism also challenges the persistent child-centredness that shapes much of the academic and public discourse on motherhood. Rather than framing motherhood exclusively through the needs or outcomes of children, it recentres mothers' perspectives, experiences, and subjectivities. It sees mothering and motherhood, informed through the voices and experiences of mothers themselves, as a site for activism and political change, where discourses that dispossess women of their own central position in motherhood can be resisted.

Violence, Power, and their Nexus

While the integrated framework establishes the philosophical and theoretical foundations of this study, violence and power function as central analytic constructs through which OV may be examined and elucidated.

Violence

The concept of violence, in its multiple iterations, is central to understanding the dynamics of power, harm, and social inequality that play out in OV. Within feminist poststructural and intersectional frameworks, violence is not limited to physical harm. It encompasses structural, symbolic, epistemic, and other subtle forms that shape people's lives, experiences, and choices. Considering violence as a core concept allows us to examine not only what constitutes harm, but who experiences it, who may perceive and name it, and how it is normalized within various systems. In the context of perinatal care, this conceptual lens is suitable for understanding the continuum of harms that birthing people may experience and the ways in which violence can be rendered invisible, yet profoundly consequential.

Gender-based violence (GBV) is violence rooted in gender inequality and gendered power dynamics, perpetrated on individuals or communities based on their gender, gender identity, or perceived gender (Women and Gender Equality Canada, 2025). It is "endemic, universal and multi-dimensional and operates as intimate, interpersonal and structural violence" (Ali & Rogers, 2023, p. 3). Though GBV may affect any individual regardless of gender, the vast majority of cases involve men perpetrating violence towards women and girls. Thus, GBV is often used interchangeably with *violence against women* (Ali & Rogers, 2023).

Johan Galtung (1969), a leading sociologist in the study and conceptualization of *structural violence*, describes the term as an imperceptible violence that permeates social

structures, producing unequal power relations and disparate health outcomes, and ultimately limiting human potential. Structural violence, according to Galtung, is essentially social injustice: the unequal distribution of income, education, and health and social services. He emphasizes that inequalities cannot be considered in isolation, as status within one system often translates to other spheres of life (Galtung, 1969). Galtung's depiction of structural violence speaks to its subtlety and insidiousness: "Structural violence is silent, it does not show – it is essentially static, it *is* the tranquil waters. In a *static* society, personal violence will be registered, whereas structural violence may be seen as about as natural as the air around" (1969, p. 173).

According to Galtung, structural violence manifests both in structures and in the outcomes produced by these same structures. For example, structural violence is both the unequal decision-making power in how resources are distributed and the unequal share of these resources. In the context of OV, this compels an examination not only of the relationship between the biomedical model of care and women's experiences of mistreatment, but also of the mechanisms that have guaranteed the hegemony of the biomedical model in obstetric care. While OV is widely accepted as a deeply structural issue, rooted in historical and systemic processes, norms, and habits, scholarly and legal approaches often rely on narrow victim–perpetrator conceptualizations of interpersonal violence in its examination (Chadwick, 2025). Structural violence, as Galtung (1969) notes, is embedded in the very systems and "tranquil waters" of society, making it largely invisible and difficult to remedy through legal, liability-focused frameworks alone. This underscores the importance of a theoretical lens that situates OV within broad structures, emphasizing the disparities in maternal outcomes by race, class, and other axes of oppression.

While structural violence highlights systemic forces that produce harm, *symbolic violence* (Bourdieu, 2002) shows how these structures are internalized and enacted at the individual level, shaping what is perceived as legitimate or acceptable. Bourdieu (2002) describes symbolic violence as a process of collective social domination and control that is embedded in the actions and cognition of individuals; a process that is at once "violent" and "gentle". It is an invisible, unconscious manipulation that brings individuals to perceive dominant forms and sources of knowledge and the asymmetrical distribution of power as legitimate. Regardless of their stake in the distribution of power, subjects are complicit in perpetuating symbolic violence by maintaining their own subjugation and behaving and thinking in ways that fit the constraints of their conferred social position and identity (O'Byrne & Woodyatt, 2016). This concept parallels Weedon's (1997) assertion that in a patriarchal social structure, women may adopt discursive positions that ultimately subordinate their interests and undermine their well-being.

Symbolic violence is closely linked to cultural and institutional practices that define what is "normal" or "legitimate" knowledge. For example, it legitimizes certain forms of expertise while devaluing others, shaping who is recognized as an authority and whose embodied or experiential knowledge is dismissed (Bourdieu, 2002). In patriarchy, symbolic violence operates through gendered norms and expectations, such as the socialization of women to be deferential, nurturing, and self-effacing, thereby perpetuating systemic inequalities without overt coercion (Weedon, 1997).

Symbolic violence offers a critical lens for examining violence in medicine, where health institutions and care providers occupy socially conferred positions of authority that render their actions legitimate, even when those actions cause harm (Shapiro, 2018). In childbirth, interventions such as episiotomies, cesarean births, or restrictive labour protocols violate the

physical integrity of the birthing person yet are often perceived as necessary to prevent greater harm. In other words, beneficent intent and a desire to protect the physical well-being of the patient become a justification for behaving in ways that may be perceived adversely by the patient or may even result in undue or unintended harm. The determination of *necessity* in medical intervention is fraught: whose needs are being prioritized and to what end? Decision-making may be shaped by overestimation of risk, desensitization to the harm associated with interventions, and defensive medicine aimed at mitigating liability (Smith-Oka, 2022a). In this way, beneficent intent can justify practices that inadvertently or unnecessarily harm patients, exemplifying obstetric iatrogenesis or the "obstetric paradox": intervening to protect while simultaneously causing harm (Liese et al., 2021).

Žižek's (2008) theorization of violence speaks to how social processes that violate, degrade, and marginalize are normalized and rendered invisible. According to Žižek, violence takes two broad forms, subjective and objective. Subjective violence is brazen and overt, and inflicted by an "identifiable agent," such as in acts of battery, crime, or terror. Objective violence, on the other hand, is diffuse and woven into people's daily lives in such a way that it is imperceptible. It is embedded in language and in social, economic, and political systems and operates through subtle mechanisms such as coercion and manipulation to sustain unequal power relations. Objective violence exists when social, economic, and political systems (e.g. capitalism, racism) are functioning in their intended way, and is the backdrop upon which subjective violence occurs (Žižek, 2008). Subjective violence is confronting, draws our attention, and detracts us from noticing the deeper, more insidious forms of objective violence. Subjective violence is perceived as an "irrational" departure from the "normal," whereas objective violence exists in and is a product of the "normal" state. It is in this way that invisible, systemic forms of

violence can be normalized, including by those who have violence enacted upon them (Žižek, 2008).

The Nexus between Violence and Power

The work of Gail Mason (2001) theorizes the nexus between power and violence, specifically how power relations may operate to produce interpersonal violence. Mason draws on feminist and Foucauldian poststructuralist theories in a qualitative exploration of lesbian women's experiences of violence, in order to provide a theory for understanding violence as an instrument of power. Therein, violence is defined in an interpersonal sense, including the exercise of physical force by one person over another, as well as the threat of violence and acts of intimidation. Mason centres women's experiences, showing how violence reveals the fluid and relational nature of power through processes of control, compliance, subversion, and resistance (Mason, 2001).

In line with both feminist and Foucauldian theories, Mason (2001) asserts that violence is an oppressive act, where oppression is understood as a form of domination or subordination that causes harm or places restrictions on another. Socially constructed hierarchies of difference, based on gender or race, for example, shape the nature and occurrence of domination (Mason, 2001). Violence is oppressive in an immediate physical sense, but also in the way that it intimidates, restricts, and produces feelings of fear, shame, and worthlessness. However, violence is also productive in that it generates knowledge that informs how women perceive themselves and others, and how they manage behaviours to mitigate risk. For example, women may come to perceive certain behaviours as likely to instigate violence and will avoid these behaviours to mitigate the threat or enactment of violence (Mason, 2001).

According to Mason, power and violence are intimately linked and can be perceived as acting hand in hand. For example, GBV is a symptom of social, cultural, historical, political, and gender inequalities, whereby the enactment of violence by men towards women (more often than not) correlates with their higher standing in the gendered power dynamic. Simultaneously, these behaviours further subordinate and constrain women, thereby perpetuating the oppressive system. According to Mason, in this case, GBV is a form of power that exerts control over women at a systematic level. Violence can also be understood as a tool to reinstate or reclaim power when it is threatened; violence thus maintains social order in the face of "disobedience" and resistance by women. In other words, power does not necessitate violence; the absence of violence may even indicate that power is effectively exerting domination and control through its more subtle and insidious forms. Thus, violence is an instrument of power, utilized when power is jeopardized by resistance (Mason, 2001).

Chapter 4: Methodology

The following chapter discusses the methodological considerations of the research study. The chapter begins with an overview of qualitative research, followed by a discussion of the selected methodology, Stake's (1995) qualitative instrumental case study design. A discussion of data collection, including a presentation of sociodemographic characteristics of the study sample, will follow. Next, data analysis will be discussed, including a review of the selected analytic method, Feminist Relational Discourse Analysis (Thompson et al., 2018). The chapter closes with a discussion of trustworthiness and ethical considerations of the study.

Overview of Qualitative Research

Qualitative approaches to research rest on the ontological assumption that reality is socially and psychologically constructed, context-dependent, and multiple. Accordingly, the qualitative researcher is viewed as part of the world of study and participates in the subjective co-construction of knowledge (Creswell & Poth, 2018). Qualitative researchers use inductive, interpretive, and naturalistic approaches in the study of social phenomena in order to more fully comprehend the experiences, worldviews, and understandings of individual participants (Gelo et al., 2008).

Research Type and Design

This study used a case study design, which is ideally suited to developing an in-depth understanding and rich description of a phenomenon through the inclusion of a wide range of perspectives and data sources (Cope, 2015). Specifically, the project was guided by Stake's (1995) approach to case study research (CSR), which is flexible and open to the researcher's epistemological and theoretical stance. A strong alignment exists between the key theoretical tenets of this study and the features of a Stakian case study; intersectionality and feminist

poststructuralism seek to uncover and understand the social context that frames and constitutes individual lived experience, uncover and include a multitude of perspectives, and seek to uncover the particularities of a social issue that might otherwise be taken for granted or perceived as unambiguous.

Case Study Research

CSR aims to explore a real-life case over time, through in-depth examination of evidence from multiple data sources (Cope, 2015). The inclusion of different participant groups allows for a holistic understanding of a phenomenon by including a variety of experiences, perspectives, and worldviews (Denzin & Lincoln, 2018). Case study methodology is well-suited to answering explanatory "how", "what", and "why" questions of a particular social issue (Crowe et al., 2011)and is also used to explore the lived experience of complex phenomena (Anthony & Jack, 2009). A hallmark of CSR is the identification of a case, defined as a bounded and integrated system, which may include a physical location, event, policy, or social phenomenon (Crowe et al., 2011).

Stake (1995) identifies three types of case studies: intrinsic, instrumental, and collective. An *intrinsic case study* seeks to explore a distinctive or singular case that is of interest in and of itself. An *instrumental case study* is an approach to case study research that examines a case to better understand a phenomenon; the case is not the focus of the study, rather, it is a means to understanding a broader issue. A *collective case study* examines multiple cases in one study, which allows for cross-case comparison, and may contribute to better understanding a phenomenon, social issue, or theory (Stake, 1995).

Philosophical and Theoretical Underpinnings of Case Study Research. Stake's (2005) approach to CSR is constructivist in nature. Ontologically, constructivism asserts that realities

are multiple, relative, and locally constructed. Though reality is individually constructed, elements may be shared between people and across groups and cultures (Guba & Lincoln, 1994). Epistemologically, constructivism holds that knowledge is subjective and transactional; knowledge is created in interactions between the researcher and participant (Guba & Lincoln, 1994). The approach is flexible in that the researcher brings their own philosophical and theoretical stance to the research and selects a methodology most suited to the aim of their study (Casey & Houghton, 2010). Broadly, case study methodology is qualitative and inductive (Creswell & Poth, 2018). Stake's approach to CSR draws from phenomenology, ethnography, and naturalistic research (Yazan, 2015). Through observation and interpretation, the researcher is attuned to and upholds the realities of all participants, and the differences and contradictions that exist between them (Stake, 1995).

Instrumental Case Study

The specific case study approach selected for this research was a single instrumental case study design (Stake, 1995), wherein OV in hospital-based childbirth was the phenomenon of interest, and the city of Montreal, Canada was the case under examination, which served to illustrate the broader phenomenon (Luck et al., 2006). The nature of instrumental case study was fitting for this research; the aim of this study was to explore the broad phenomenon of OV in hospital-based childbirth, where the illustrative case, that is the setting of Montreal, Canada, is typical as opposed to unique, of less importance than the phenomenon, and serves as a means of investigating the issue (Crowe et al., 2011). Instrumental CSR is ideally suited to the inclusion of multiple data sources to gain a holistic understanding of the phenomenon and the personal, social, historical, and political contexts underpinning it (Baxter & Jack, 2008). The features of an instrumental case study thus strongly aligned with the research objectives: exploring the

experiences and perspectives of childbearing individuals and healthcare providers on the issue of OV in hospital-based childbirth, as well as the broad contextual factors that contributed to its occurrence and normalization.

Study Setting

The Greater Montreal Area, Canada, served as the setting of this study. As a linguistically and ethnoculturally diverse urban centre and the second most populous city in Canada, Montreal provided a rich sociocultural context in which to examine OV. The Greater Montreal area has over 10 hospitals offering perinatal services, and in 2024, the Island of Montreal had an annual birth volume exceeding 19,000 (Institut de la statistique du Québec, 2026), offering access to a wide range of individuals' childbearing experiences and healthcare provider perspectives. These characteristics offered a context in which social, political, and institutional processes shaping OV could be explored across different sites within a single bounded system. Participants were eligible if they experienced OV during childbirth in a Montreal-based hospital or were perinatal HCPs working in a Montreal-based hospital. This research was not affiliated with or conducted within any healthcare institutions.

Sampling and Recruitment

The sampling methods used were purposive, including maximum variation and snowball sampling. Purposive sampling was used to recruit participants who could inform the aims of the research, while maximum variation sampling ensured diversity among participants in terms of demographics and individual experiences (Polit & Beck, 2017). Snowball sampling was done through word of mouth and distribution of study materials by participants. Participants were recruited based on their ability to provide an in-depth account of OV in hospital-based childbirth, therefore, the sample consisted of (1) individuals who had experienced OV during a hospital-

based childbirth (termed childbearing women [CBW]), and (2) perinatal healthcare providers (HCPs) with experience working on a perinatal unit. Overall, the intersectional feminist poststructuralist lens shaped decisions surrounding participant recruitment, including attention to heterogeneity within the sample. Recruitment sought to include participants occupying diverse social and professional positions in order to examine how OV experiences are differentially shaped by social location.

In a single case study design, sample size is determined by the breadth and depth of data sought. To provide opportunities for a variety of participants to share their experiences in an in-depth way, while facilitating data management and analysis, the research initially aimed to recruit approximately 25 participants, which is consistent with previous instrumental case study research (Macdonald, 2019; Ramji, 2016). The study aimed for CBWs to comprise a greater proportion of the overall sample, reflecting both their lived experiences of OV and the study's feminist orientation, which seeks to centre women's voices and experiences (Campbell & Bunting, 1991). The final sample size included 19 participants (13 CBWs and six HCPs), determined by data saturation within each participant group. Data saturation was approached as an incremental, interpretive process, wherein saturation was understood as the achievement of sufficient depth and conceptual understanding rather than the mere repetition of accounts (Saunders et al., 2018).

Childbearing Women

Inclusion criteria required that participants be over the age of 18, had experienced OV during a hospital-based childbirth in Montreal within the five years prior to participation, and spoke English and/or French. The five-year timeline was selected to ensure a contemporary representation of OV and the social, political, and healthcare context in which it occurred. At the

time of recruitment, this temporal boundary aligned with key policy developments, including the Public Health Agency of Canada's (2017) *Family-Centred Maternity and Newborn Care: National Guidelines*, which emphasize the normalization of birth and the protection of sexual and reproductive rights. It also followed the WHO's 2015 statement on the prevention and elimination of disrespect and abuse during facility-based childbirth. Together, these documents reflect a period in which respectful, rights-based maternity care has been explicitly articulated at national and international levels, allowing the study to examine OV within this contemporary policy environment. Individuals who had experienced OV during more than one childbirth were invited to discuss multiple experiences, provided they met inclusion criteria. Individuals no longer residing in Montreal at the time of participation, but whose childbirth occurred in Montreal, were also eligible to participate. Individuals were also eligible to participate regardless of prior or ongoing complaints or legal proceedings related to their childbirth experience. Relevant legal considerations were addressed during the consent process.

Recruitment of CBWs initially involved contacting community organizations with requests to disseminate recruitment flyers (Appendix A) within their communities. Organizations were selected based on their work with parents and individuals in the perinatal period, including those serving marginalized and racialized populations, immigrants and individuals with precarious immigration status, and those with precarious socioeconomic status. One community-based organization agreed to disseminate recruitment materials through its social media pages and physical spaces. This organization supports individuals in the perinatal period as well as a broader community of healthcare and community-based perinatal professionals. No participants ultimately enrolled through this recruitment pathway.

Additional recruitment occurred through dissemination of recruitment flyers to local Facebook parenting groups and one provincial Facebook page related to OV advocacy. The majority of participants were recruited through these means. Recruitment information was also shared with a perinatal physiotherapist who works extensively with postpartum women, who agreed to make the study information available to potential participants. A small number of participants were recruited through this pathway. All participants were invited to share the study information within their networks to facilitate snowball sampling, however this resulted in no additional enrolments.

Recruitment through digital platforms enabled participation from across Montreal and promoted variation in participants' sociodemographic characteristics, as well as in the hospitals where perinatal care was accessed. All recruitment materials were disseminated in French and English, and participants were invited to complete interviews in either language. Given that early participants demonstrated a diversity of experiences and characteristics, recruitment efforts ultimately remained focused on digital platforms rather than community organizations.

Initial dissemination of recruitment materials began in October 2022; however, no participants enrolled prior to a research leave by the primary investigator (January 2023–December 2023). Recruitment recommenced in January 2024 and concluded in June 2024. During this phase, recruitment flyers were posted on social media pages on two occasions and shared by two social media users within their personal networks. One individual expressed interest in participating in October 2024. Though recruitment had concluded at that time, the participant was included given the nature of their experience and its relevance to the study aims.

Several challenges arose during recruitment. Of the four community organizations initially contacted, two did not respond, and one declined to disseminate the recruitment

materials due to concerns that participation could cause psychological or emotional harm to community members. Recruitment was advertised as taking place in Montreal. While the initial focus was on participants residing on the Island of Montreal, individuals from the broader Greater Montreal Area also expressed interest. Given slower than anticipated enrolment, participants residing in the Greater Montreal Area were included, as their experiences aligned with the study aims and reflected the interconnected metropolitan context. As a result, a small number of participants who had experienced OV in hospitals outside the Island of Montreal, but within the Greater Montreal Area, were included in the final sample. Most individuals who contacted the principal investigator proceeded to participate in the study, however, five CBWs ceased communication following initial contact.

Healthcare Providers

Inclusion criteria for HCPs required that they had at least two years of experience working in a perinatal context, providing care to birthing individuals in a Montreal-based hospital, had worked in the setting in the two years prior to participating, and spoke English and/or French. Eligible HCPs included registered nurses, licensed practical nurses, advanced practice nurses, nurse managers, and physicians, including residents, family physicians, and obstetricians/gynecologists. Obstetrical anesthetists, midwives, and birth support workers (e.g., doulas) were not eligible to participate, as they interact with birthing individuals in specific and/or limited instances and settings.

HCPs were recruited through dissemination of recruitment flyers (Appendix B) to existing professional and community networks of the principal investigator. Recruitment materials were distributed via general network emails and shared within a Facebook group aimed at nurses. Individuals within these networks were invited to further disseminate the study

information to HCPs in their own professional networks. To reduce any potential pressure to participate, individuals were not contacted with direct requests to participate, and all referrals were participant-initiated. Recruitment flyers targeting HCPs were also shared on the same Facebook pages and through the community-based organization used for CBW recruitment. Recruitment followed the same timeline as that for CBWs. Though enrolment was slower than anticipated, the target sample size was achieved within the timeline and concluded in June 2025.

Recruitment of HCPs included some unique challenges. Several participants expressed concerns regarding confidentiality and anonymity, particularly in relation to the professional risks associated with sharing critical reflections on perinatal care practices and personal places of work. In light of these concerns, detailed information about specific practice sites and a breakdown of participants by profession is intentionally withheld to protect participant anonymity. Participants were not aware of one another's participation in the study. Additionally, interview excerpts were not attributed to specific individuals to reduce the risk of deductive disclosure in a small sample. One individual who had initially shown interest ultimately withdrew prior to being interviewed for reasons unrelated to the study.

Data Collection

Participants

In total, 19 participants were recruited, resulting in 22 interviews. This included 13 CBWs, who participated in a total of 15 interviews (see Table 1 for CBW sample characteristics). Among CBWs, one had experienced OV during two childbirths, while the remainder experienced OV during one childbirth. The study was open to birthing individuals of all genders, however all participants identified as cis-gender women. Approximately 62% identified as white, with 38% identifying as members of racialized or ethnically minoritized groups. English was identified as a primary language for 77% of participants. Just under half of participants were

immigrants and had emigrated to Canada between four and 27 years prior. The average age of participants was 35 years. CBWs described experiences across ten different hospitals; however, specific institutions and their distribution are not reported to protect participant anonymity.

Table 1

Sample Characteristics: Childbearing Women

CBW Characteristics		**N (%)**
Age	18-24 years old 25-34 years old 35-44 years old	1 (7.7%) 5 (38.5%) 7(53.9%)
Racial or Ethnic Identity	White (North American and/or European) South Asian Middle Eastern Arabic, North African	8 (61.5%) 3 (23.1%) 1 (7.7%) 1 (7.7 %)
Sexual Orientation	Heterosexual Bisexual Queer Prefer not to answer	9 (69.2 %) 2 (15.4%) 1 (7.7%) 1 (7.7%)
Primary Language	English French	10 (76.9%) 3 (23.1%)
Family Status	Married Common-law or living with partner Single Single parent in non-common law partnership	9 (69.2%) 2 (15.4%) 1 (7.7%) 1 (7.7%)
Highest Level of Education	Graduate studies Undergraduate studies CEGEP/College	9 (69.2%) 3 (23.1%) 1 (7.7%)
Gravida Status at Time of Event [a]	Primigravida Multigravida (2nd pregnancy)	12 (85.7%) 2 (14.3%)
Type of Birth [a]	Vaginal birth Unplanned cesarean birth Planned cesarean birth	8 (57.2%) 5 (35.7%) 1 (7.1%)
Citizenship Status	Canadian-born Immigrant	7 (53.8%) 6 (46.2)

Note. N = 13.

[a] One participant reported on two childbirths in which OV was experienced, therefore, certain reported characteristics reflect an additional pregnancy.

Six HCPs were recruited, participating in a total of seven interviews (see Table 2 for HCP sample characteristics). Their professions included nurses, family physicians, and obstetricians.

Table 2

Sample Characteristics: Healthcare Providers

HCP Characteristics		**N (%)**
Age	25-34 years old 35-44 years old 55 years and above	2 (33.3%) 3 (50%) 1 (16.7%)
Racial/ Ethnic Identity	White (North American and/or European) Black – African Prefer not to answer	4 (66.7%) 1 (16.7%) 1 (16.7%)
Gender	Woman Man	5 (83.3%) 1 (16.7%)
Years of practice	2-5 years 6-10 years 11-15 years 16-20 years 21 years +	1 (16.7%) 1 (16.7%) 2 (33.3%) 1 (16.7%) 1 (16.7%)
Employment Status	Employed, full-time Employed, part-time	3 (50%) 3 (50%)

Note. N = 6.

The specific distribution of provider professions is not reported to protect participant anonymity. Their average age was 40 years, and their average years of practice were 14 years. Five HCPs were actively working in obstetric settings at the time of participating, while one had transitioned to a different care setting but had worked in an obstetric setting in the two years prior to participating.

Data Collection Methods

Multiple data collection methods are used in CSR (Cope, 2015). This study included individual interviews, document review (e.g., regional, provincial, and national policy documents), a review of mass and social media, field notes (including participant observation during interviews), and a reflexive journal.

Individual Interviews. In-depth, one-on-one interviews were conducted with individuals from each participant group. Interviews were conducted in French or English, depending on participant preference. Interviews were semi-structured and guided by questions developed in alignment with the research objectives, literature review, and theoretical framework. Separate interview guides were used with CBWs (Appendix C, English; Appendix D, French) and HCPs (Appendix E, English; Appendix F, French), with questions tailored to reflect the participants' role in or experience of childbirth and mistreatment. Both interview guides comprised four broad sections: (1) personal experiences and perspectives of OV; (2) factors that drive and contribute to OV; (3) strategies to mitigate and prevent OV; and (4) closing reflections on the interview experience. In accordance with the intersectional feminist poststructural framework, interview questions were designed not only to elicit descriptive accounts of events, but to explore meaning-making and key constructs such as power and discourse. For instance, the interview guide for CBWs included the questions: what did the experience mean to you; do you perceive power relations or imbalances as having impacted your experience; in what ways do you think your experience was impacted by biases or discrimination from the healthcare team or from the healthcare providers? While the guides provided a framework, interviews generally progressed in a naturally open-ended, unstructured way, and in response to participants' specific experiences, knowledge, and emotional comfort level. Notes were taken during interviews, including participant observations, salient or noteworthy experiences or perspectives, and questions or topics for follow-up.

Interviews were conducted via the secure virtual meeting platform, Zoom. Interviews were conducted in the private home office of the primary investigator. Participants were asked to indicate that they were in a private location at the beginning of interviews. Participants were

given the option to be audio-recorded, video-recorded, or neither. Prior to consenting, participants were informed that upon recording, Zoom automatically generates both audio and video files, but that if they consented to being audio-recorded only, the automatically generated video files would be permanently deleted from the private laptop of the primary investigator immediately following the interview. All participants agreed to be audio and/or video recorded. Audio and video recordings, as well as interview transcripts, were saved to the password-protected personal computer of the primary investigator. Audio recordings were used to review and clean the automatic Zoom-generated interview transcripts. All transcription work was carried out by the primary investigator. Following transcription and cleaning, French interview transcripts were translated to English by the primary investigator. Video recordings were reviewed in some cases for the purpose of participant observation. Interviews lasted between 45 and 120 minutes, though the majority lasted around 90 minutes. Three participants requested a second interview in order to expand on aspects of their experiences that they felt were not fully captured in the initial interview. Two participants voluntarily sent follow-up emails in order to expand upon or share aspects of their experience that they felt were missed in the interview.

Document Review. Document review provides insight into the personal, institutional, social, historical, and political contexts of a case study (Stake, 1995). In this instance, document review contributed to a holistic understanding of OV in hospital-based childbirth and the context within which it occurs. Documents reviewed included official governmental and organizational documents (regional, provincial, federal, and international reports, statements, and policy documents), and mass and social media documents (newspaper, magazine, and online media articles, blogs, and social media pages). Documents were identified through a keyword search in Google and in the search boxes of governmental websites (e.g., Santé Montréal, Institut national

de santé publique du Québec, Health Canada), non-governmental organization websites (e.g., Regroupement Naissance Respectée, WHO, United Nations), and websites of relevant professional orders, associations, and societies (e.g., Ordre des infirmières et infirmiers du Québec, Association des obstétriciens gynécologues du Québec, Society of Obstetricians and Gynecologists of Canada). Keywords or phrases searched included "obstetric violence," "mistreatment," "abuse and disrespect," "birth trauma," "birth rape," and "obstetric racism," Search words "respectful," "dignified," and/or "humanized" and "maternal care," "perinatal care," and/or "obstetrical care" were also used to yield documents relevant to the broad organizational and political healthcare context. Keywords or phrases were searched in combination with the keywords "Canada," "Quebec," and "Montreal" where necessary to narrow the geographical scope of documents. Keywords or phrases were also searched in French. Social media sites Instagram, Twitter, Facebook, and YouTube were searched using the keywords or phrases listed above, through the platform search bars. The public pages of individual users who used relevant keywords or phrases, and who discussed OV or related topics, were also searched for other relevant content. Using this approach allowed for colloquial terms or phrases that were previously unknown to the primary investigator to be identified and then used in subsequent searches. For example, using this method led to the discovery of the campaigns *#IsMomOk* and *#PayeTonUterus* on Instagram and Twitter, which were campaigns inviting individuals to share experiences of OV online. Documents identified as relevant to the case were bookmarked in the web browser, or directly in social media platforms (e.g. relevant Instagram posts were bookmarked to a designated folder within the platform). Documents were then reviewed using a data extraction form (Appendix G). The form was used to document the following information: author and/or organization, location, document type, intended audience, date of

publication/dissemination, summary of the document, relevance of the document to OV in hospital-based childbirth, if and how OV is defined, micro-, meso-, and macro-level factors addressed within the text, and discourses present within the text.

Data Analysis

Feminist Relational Discourse Analysis

In qualitative CSR, data from multiple sources converge in the analytic process to contribute to a holistic understanding of the phenomenon under study. Overall, the analytic process in a Stakian case study is flexible and suited to the aims of the study. As Stake (1995) notes, "each researcher needs, through experience and reflection, to find the forms of analysis that work" for them (p. 77). Feminist Relational Discourse Analysis (FRDA), as described by Thompson et al. (2018), draws on feminist epistemology, Foucauldian discourse analysis, and voice-centered analysis to examine how individual experiences are shaped by, negotiated within, and resist broader social, cultural, and institutional discourses. FRDA therefore provided an epistemologically congruent and well-defined approach to data analysis that aligned with the aims of the study. This analytic method seeks to illuminate structural systems of power while foregrounding the voices of those who are often marginalized within them. Speaking to the dual orientation in FRDA, towards micro and macro levels of analysis, Thompson et al. (2018) note,

> Voice is a key site of meaning because voices are structured and mediated by discourses. Equally, discourse cannot then be taken as a site of meaning without voice because it is through voice that discourses construct and mediate identities, and discourses become situated (p. 99).

As Thompson et al. (2018) point out, tensions between phenomenological approaches that foreground personal voice and poststructural analyses that emphasize discourse and power have long shaped feminist inquiry. While phenomenological approaches risk treating experience

as transparent "truth," discursive approaches may obscure the personal by prioritizing structural critique. Rather than viewing this tension as a limitation, Thompson and colleagues argue that it expands analytic possibilities, serving to "shed light on structural systems of power and the voices of those who go unheard within these" (Thompson et al., 2018, p. 99).

FRDA includes two analytic phases (see Table 3). The first phase is a poststructuralist discourse analysis, which draws out the broad discourses shaping participants' narratives. The second phase focuses on analysing participants' voices in relation to those discourses, presented as "I" poems, which serve to highlight individual voice within the structural contexts that emerge through the discourse analysis.

Table 3

Analytic Phases of Feminist Relational Discourse Analysis

Phase 1: Poststructuralist Discourse Analysis	**Phase 2: "I" Poems – Analyzing Emergent Voices**
• Reading and listening to the talk • "Chunking" talk into sections. • Labelling chunks of talk with descriptive codes • Identifying recurring codes, or in-vivo themes • Identifying discourses • Identifying discursive patterns • Theoretical accounting: Identifying discursive realms	• Multiple listenings • Generating "I" poems • Listening for contrapuntal voices • Putting the personal in the political

Note. Adapted from "Feminist Relational Discourse Analysis: Putting the Personal in the Political in Feminist Research," by L. Thompson, B. Rickett, & K. Day, 2018, *Qualitative Research in Psychology, 15*(1), 93–115. (https://doi.org/10.1080/14780887.2017.1393586).

Analytic Process

Data collection and analysis of interview transcripts occurred concurrently to ensure that the phenomenon of interest was adequately attended to and that relevant data were collected

(Stake, 1995). The analytic process was iterative and inductive, while also being informed by the intersectional feminist poststructuralist framework and the principal investigator's conceptual understanding of OV as described in the literature. Analysis was conducted separately for each participant group. Interviews with CBWs were analysed in their entirety before analysis of HCP interviews began, allowing for focused engagement with each dataset and the development of analytic insights specific to each group.

In Phase 1 of FRDA, the discourse analysis, audio files were listened to multiple times through the process of transcription, which allowed for familiarization with the data. Following transcription, all interviews were imported into NVivo (Version 14) qualitative data analysis software. Repeated reading of transcripts provided an initial sense of the overarching stories being told, emotional tone, and what meaning participants may have attributed to their experience. Annotations were created throughout this phase to document emerging observations and patterns. Next, transcripts were divided into "chunks" or sections of text pertaining to a particular topic and labelled with codes. As the volume of codes increased steadily, codes were exported from NVivo into Excel to facilitate management and analytic decision-making. Codes were reviewed and defined, and expanded, collapsed, merged, or removed where appropriate. This process supported the development of themes, sub-themes, and sub-sub-themes. Codes were then refined within NVivo to reflect adjustments. As the themes and sub-themes were being refined, transcripts were revisited in an iterative manner to ensure coherence.

In accordance with Phase 1 of FRDA, the next analytic step was to identify discourses, or the ways that participants spoke about different themes. Through prolonged engagement with participant accounts, discourses emerged as general patterns in the way participants spoke about expectations, beliefs, what they held to be true or taken for granted, and the meanings they

attributed to particular experiences. For HCPs, discourses emerged largely in the ways they discussed their professional roles, obligations, and guiding principles. The discourse analysis was further informed by key poststructuralist assumptions articulated by Cheek (2000): that language is never transparent or value-free; that analysts are both readers and producers of discourse; and that discourse analysis does not aim to produce a singular or closed interpretation. In this approach, text is not treated as illustrative of another point, but as data in itself. Questions considered during analysis, as outlined by Powers (2013), included whose interests were served by particular discourses; who benefited and who was marginalized; who was afforded legitimacy and authority, and on what grounds; how autonomy and responsibility were enhanced or constrained; what forms of domination were established or resisted; what counter-discourses were present; whose voices were heard or silenced; and in what ways participants experienced constraints on speaking or unequal access to knowledge. Discourses functioned both as themes in their own right and as threads running across themes. For example, the theme, or discursive realm, of *motherhood* was accompanied by discourses such as *maternal sacrifice is inherent to motherhood*, which shaped how participants interpreted expectations, responsibilities, and experiences related to childbearing and care.

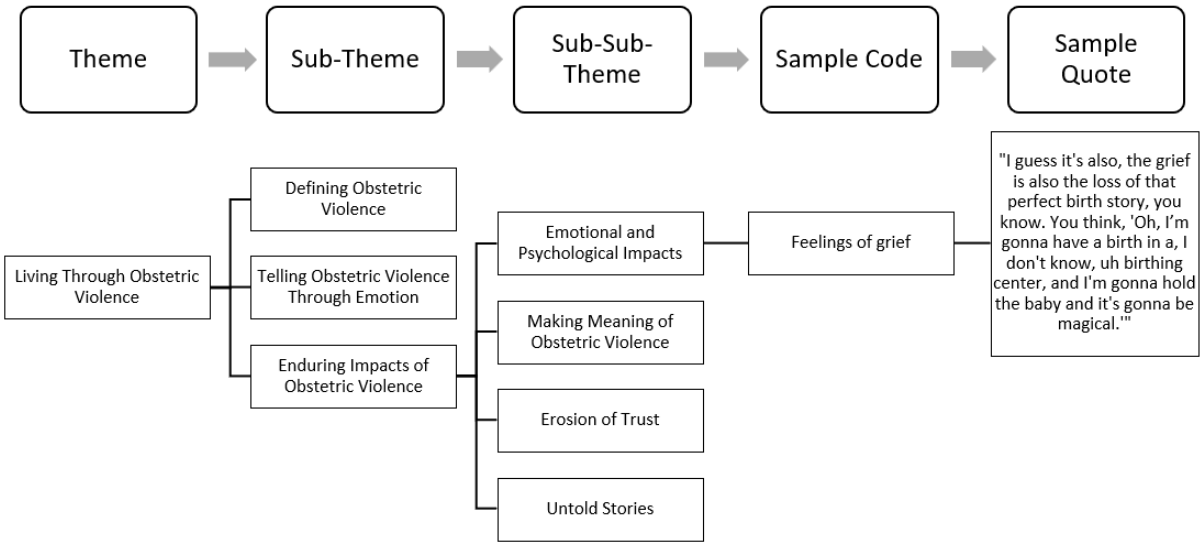
While identifying discourses formed part of the inductive FRDA process, their interpretation was simultaneously informed by the intersectional feminist poststructural framework. This guided the coding of broader feminist poststructuralist constructs beyond discourse, including knowledge, agency, subjectivity, gender, and power. For instance, the code *withholding health information from provider,* analysed through the construct of agency, was then simultaneously coded as *discursive resistance*. Additionally, remaining attentive to how gender emerged implicitly through participant perspectives, beliefs, language, and ways of

speaking allowed for instances of *self-minimization* (e.g. calling oneself "silly," apologizing for displays of emotion) to be analysed and coded as *gendered social norms*.

A further deductive analytic layer was applied with specific orientation towards intersectionality, which allowed for coding in accordance with broader theoretical constructs including intersectional positionality, sociocultural context, and social justice. For instance, the inductive code *feeling judged/scrutinized* overlapped with the broader code *racism and discrimination*; the code *sharing story to warn others* when viewed through an intersectional lens was simultaneously coded under *social justice*. Questions that were considered through an intersectional lens included how participants described their own social locations and intersecting identities; what forms of privilege or marginalization were evident in their accounts; what power imbalances were perceived; and what structures, policies, or institutional practices enabled or constrained agency. See Figure 5 for a sample coding scheme.

Figure 5

Sample Coding Scheme



Phase 2 of FRDA involved the creation of "I" poems, which are intended to privilege participants' voices that may otherwise become lost within broader political and discursive representations. In alignment with the feminist aims of this study, and the goal of foregrounding the voices of women in accounts of OV, this step was applied only to interviews with CBWs. "I" poems were constructed by extracting statements spoken in the first person within a single transcript, including "my" statements, and "we" and "you" statements when used in a collective sense. First-person statements contributing to key discursive realms within a single transcript were collated to form poems. Not all first-person statements were included; poems were crafted for clarity and narrative flow while maintaining fidelity to participants' accounts. A select number of exemplar poems were developed and included to illustrate findings from Phase 1.

In this second phase of FRDA, attention is given to *contrapuntal voice*, understood as the presence of multiple, sometimes conflicting ways of making sense of experience within a single narrative (Thompson et al., 2018). In this study, contrapuntal voice was not treated as a separate analytic category during the construction of "I" poems. Instead, it was attended to through examination of tensions, shifts, and contradictions within participants' accounts as they negotiated dominant and counter discourses (e.g. "doctor knows best" versus "why didn't healthcare providers trust me"). These tensions are visible in the main findings in Phase 1 and in the "I" poems through movements between compliance and resistance, trust and doubt, and alignment with or questioning of varying discourses.

Trustworthiness

The concept of validity in qualitative research emerged from positivist conceptualizations of scientific rigour and has traditionally served as a measure of how accurately a phenomenon or a participant's subjective account of reality has been depicted (Denzin & Lincoln, 2018).

Alternative conceptualizations of validity have emerged that align more closely with constructivist, transformative, and postmodern views of reality as socially constructed in each interaction; in these instances, a researcher does not seek to accurately represent the "truth" as it is constantly in creation and not ascertainable (Koelsch, 2013). When conducting research within these alternative paradigms, J. Cho and Trent (2006) propose that validity, or what they term *transformational validity*, is better understood as a measure of commitment to social justice, deepened understanding of social processes, and actions taken to transform systems. In this study, the concept of transformational validity guided the use of various strategies to enhance trustworthiness, both with regard to how well the study represented participants' experiences, and also with regard to maintained commitment to social change.

Whittemore et al. (2001) identify primary validity criteria in qualitative research as credibility, authenticity, criticality, and integrity. These criteria provided further structure to considerations of trustworthiness in this study. *Credibility* refers to the confidence a reader has in the trustworthiness of the researcher's interpretation of data. *Authenticity* is the degree to which the report resonates with participants and portrays their experiences in a transparent way, attending to the multitude of perspectives and meanings that may exist. *Criticality* requires a researcher to critically reflect on all aspects of the inquiry, including their own position and biases that they may bring to the research. Finally, *integrity* refers to the repeated and judicious process of critically appraising and verifying interpretations, discrepancies, and alternative understandings (Whittemore et al., 2001). Credibility and authenticity were attended to by providing a clear and consistent outline of the philosophical, theoretical, and methodological underpinnings of the study. Next, triangulation was employed by including multiple data sources and multiple participant groups to inform the phenomenon of interest. In this case, triangulation

was not an attempt to verify claims using multiple data sources, rather, it served to provide a holistic and multivocal account of OV in hospital-based childbirth. Peer debriefing with the advisor and committee members facilitated ongoing discussion, reflection, and refinement of the analysis. In the presentation of results, thick rich descriptions and substantial evidence are provided to support interpretations. Stake's (1995) "Critique Checklist for a Case Study Report" provided a final measure of trustworthiness to ensure that certain components were included in the report and to assess its overall quality (see Appendix H). J. Cho and Trent (2006) describe two primary strategies for enhancing transformational validity as *reflexive member-checking* and *critical reflexivity of self*, discussed in the following sections.

Reflexive Member-Checking

During the preliminary data analysis phase, participants were invited to a follow-up member-checking interview. Seven CBWs and one HCP agreed to a meeting. Reflexive member checking provided an opportunity to share findings with participants, to ensure that their experiences and perspectives were represented authentically, and to invite alternative interpretations (Stake, 1995). A reflexive approach to member checking, as described by J. Cho and Trent (2006), moves beyond a technical "truth seeking" form of member-checking, to one that prioritizes the co-construction of knowledge between the researcher and participant. Reflexive member checking creates an opportunity for participants to engage in self-reflection, gain new perspectives, and overcome feelings of isolation in their experience (Candela, 2019). The intent of member checking in this instance was therefore to create an open and equal space for participants to discuss their thoughts and feelings about the research process, share their insights, and participate in the analytic process. Member-checking meetings were largely conversational in style, as opposed to a unidirectional exchange of information. Participants were

invited to question the preliminary findings and propose alternative perspectives, a strengthening factor in transformational research (J. Cho & Trent, 2006).

Critical Reflexivity of the Self

Reflexivity involves recognizing one's own subjectivity, history, positionality, and politics. It is a process of critical self-reflexivity and conscious self-scrutiny, where the researcher considers both how they shape and are shaped by the research process and its participants (Pillow, 2003). Reflexivity calls upon the researcher to question and make explicit their own values and assumptions as well as acknowledge what may be taken for granted and what may be unknown (J. Cho & Trent, 2006). Reflexivity involves looking towards the self and the other, as well as questioning how and why the products of our research came to be. Pillow (2003) describes this process as an important step in validating qualitative research; raising questions about and deconstructing the research process ultimately serves to legitimize it.

Writing from a feminist perspective, Anderson (1991) refers to reflexivity as a step towards "unmasking" oppressive structures and power imbalances inherent within the research process. To be reflexive in feminist practice is to pay close attention to steps in the research process that may be exploitative or authoritarian and act to equalize the researcher-participant relationship (Pillow, 2003). Attention to power differentials is central to intersectional research where the reflexive process begins even before the research problem is determined. Reflexivity requires a researcher to consider how and why a specific research problem has been established, who it is a problem for, and who serves to benefit from the research (Hankivsky, 2014). Strategies that were used to foster reflexivity included making explicit my personal experiences, perceptions, and feelings with regard to the research, documenting my epistemic stance, and keeping a reflexive journal. I kept a reflexive journal through the research process, documenting personal thoughts, emotions, assumptions, reflections, emerging questions, and rationale behind

decisions made throughout the research process. This practice allowed me to reflect upon, record, and appraise my personal values, beliefs, preconceptions, and personal interests in order to promote a deepened understanding of how these may have been impacting the research process (Carpenter, 2011).

Ethical Considerations

Ethical considerations are central to research on sensitive topics. Sensitive research can be defined as research that addresses topics perceived as threatening, including those that involve deeply personal or sacred experiences, concern deviance or social control, potentially impinge on the interests of those in positions of power, as well as research examining experiences of violence, as it may evoke painful emotions and memories (Dickson-Swift et al., 2009). Particular caution must be paid to confidentiality, informed consent, and anonymity in the conduct of research on sensitive issues. Attending to these issues with sustained and careful attention is integral to building trust between researcher and participant and to reducing the risk of (re)traumatization (Marsh et al., 2017). Ethical approval for the study was obtained from the Research Ethics Board of the University of Ottawa (see Appendix I).

Consent forms (Appendices J, K, L, M) were shared with participants in advance of virtual interviews to allow sufficient time for review and were revisited prior to the start of each interview. During this process, several participants, both CBWs and HCPs, expressed concerns regarding confidentiality and anonymity. For CBWs, these concerns primarily related to the potential implications of sharing their experiences for future interactions with perinatal care providers. For HCPs, concerns centered on the implications of discussing colleagues and the possibility of being identified based on personal characteristics or details related to specific clinical encounters. Pre-interview discussions therefore often centered on providing detailed

measures to be taken to protect participant privacy. These included: storing identifying information separately from research data; assigning participant identification numbers to all research materials; restricting access to the participant identification list to the principal investigator only, with this information stored in a password-protected document on a password-protected personal computer of the primary investigator; and presenting findings in an aggregated form. In the reporting of findings, potentially identifying characteristics were omitted, and quotations were modified where necessary to prevent deductive identification of participants or of healthcare providers being discussed within the quote (e.g. masking the profession, gender, or place of work of the provider). Quotations were not attributed to individual participants. Participants were informed of their right to decline participation or to withdraw from the study at any time without consequence and were reminded of this throughout the research process.

A strategy of partial disclosure was used in this study to minimize potential influence on participant responses while maintaining informed consent. During recruitment, consent, and participant interviews, the term *"mistreatment"* was used in place of *"obstetric violence."* Despite the study being aligned politically and epistemologically with the term *obstetric violence*, the term *"mistreatment"* is more prevalent in the literature, media, and across a variety of health disciplines, and was therefore considered more likely to resonate with participants. The use of the term *"mistreatment"* was therefore intended to minimize potential influence on participant responses and to allow participants to describe their experiences as freely as possible, using their own language. Immediately following each interview, a debriefing script (Appendix N) was read to participants. This script disclosed the study's use of the term OV as a central analytic concept, reiterated the measures taken to ensure confidentiality and anonymity, and

confirmed participants' consent to having their interview included in the study. This approach has been previously used in similar research exploring women's experiences of OV in hospital-based childbirth (Landry, 2019).

Additional ethical considerations related to the potential emotional and psychological impacts of participation. For CBWs, recounting experiences of OV or trauma posed a potential risk of psychological or emotional distress. For HCPs, discussing perspectives on OV, personal experiences, and accounts involving colleagues also carried the potential for emotional or psychological burden. In addition, HCPs faced possible social or professional repercussions should their participation become known within their professional networks. The informed consent process prepared participants for these potential risks. All participants were reminded that they could choose what to share during interviews and could withdraw from the study at any point without providing a reason. All participants were provided with a list of relevant health and social support resources immediately following the interview (CBWs: Appendix O; HCPs: Appendix P).

In qualitative research involving sensitive topics and marginalized or vulnerable populations, researcher self-disclosure has been widely recognized as a practice that can foster trust, reciprocity, and meaningful engagement. Careful and deliberate self-disclosure can help reduce power imbalances, signal respect for participants' knowledge, and support participants in articulating deeply personal experiences (Liamputtong, 2007). During initial interviews, I intended to maintain a more formal researcher stance and to avoid disclosing my own experiences as a perinatal nurse or as a birthing person, although participants were presumably aware of my nursing background. After the first interview however, the importance and impact of reciprocity became quickly apparent. Brief, intentional sharing of my own experiences related

to childbirth and OV created space for rapport, empathy, and mutual understanding to emerge. Personal disclosures were limited to the beginning and end of interviews, ensuring that participants' accounts remained central. This approach was adopted as a reflexive and ethical strategy to foster trust and relational safety, while minimizing undue influence on participants' narratives.

Chapter 5: Results – Childbearing Women

This chapter presents the results of data from participant interviews, voice notes, and written accounts from CBWs. Data drawn from the document review provided contextual grounding to the results. Results are organized into five themes: (1) *Living Through Obstetric Violence*, (2) *The Sociocultural Political Landscape of Childbirth*, (3) *Power and Control in Childbirth*, (4) *Roots and Reinforcements of Obstetric Violence*, and (5) *Pathways to Humanized Care*, each with related sub-themes (see Table 4). Selected 'I' poems have been integrated throughout this chapter to illustrate CBW's personal experiences of navigating care encounters and how power relations and discourses were reproduced or contested through voiced accounts. Results from HCP interviews are presented in Chapter Six.

Table 4

Themes and Sub-Themes from Interviews with Childbearing Women

Results: Childbearing Women	
Themes	**Sub-themes**
Living Through Obstetric Violence	Defining Obstetric Violence
	Telling Obstetric Violence through Emotion
	Enduring Impacts of Obstetric Violence
The Sociocultural Political Landscape of Childbirth	Barriers and Breakdowns in Prenatal Care
	Paradigms of Birthing Care
	Woman, Mother, Other: Politeness, Gratitude, and Endurance
	Racism, Sexism, Fatphobia and More: Structural Violence in the Lives of Women
Power and Control in Childbirth	Strategic Adaptations and Self-Protection
	Constraint, Coercion, and Compliance
	Precarious Resistance
Roots and Reinforcements of Obstetric Violence	Medical Authority and Paradigms of Care: Risk, Control, and Pathology
	Normalization: Obstetric Violence as Routine
	Gender and Sociocultural Norms: Silencing Obstetric Violence
	Systemic Dysfunction and Public Health Crisis
Pathways to Humanized Care	The Power of Validating Interactions
	Systemic Reform
	Epistemic Justice: Contributing to the Collective Narrative

Theme 1: Living Through Obstetric Violence

This theme captures how participants described experiencing OV as it unfolded, how it was felt, and its lingering impacts over time. This theme is organized into three sub-themes: (1) *Defining Obstetric Violence* delineates the range of practices, interactions, and structural conditions through which harm was enacted in care; (2) *Telling Obstetric Violence through Emotion* attends to the immediate and embodied emotional responses that accompanied these experiences, including fear, distress, powerlessness; and (3) *Enduring Impacts of Obstetric Violence* explores the enduring consequences of these experiences, including emotional and psychological impacts, erosion of trust in health care, and impacts on meaning-making that extended far beyond the moment of birth.

Defining Obstetric Violence

The direct behaviours, omissions, and institutional conditions that participants described as mistreatment or abuse, or that were experienced as harmful, were organized into five categories: (1) epistemic violence, (2) relational fractures, (3) verbal and psychological abuse, (4) violations of bodily autonomy and physical abuse, and (5) institutional and systemic conditions.

Epistemic Violence. *Epistemic violence,* or violence that attempts to disqualify or silence the knowledge of marginalized subjects (Dotson, 2011), emerged across all participants' accounts. It was evident in experiences of dismissal and the undermining of women's embodied knowledge and interpretations of their own experiences. One participant's account of having her pain denied exemplifies this form of violence: "It was really like the condescension in my eyes, like, 'Oh come on now […] That's not possible,' or, 'Get a grip, it's not that bad, you have the epidural, there's no way you're feeling anything'" [Translated from French].

Forms of epistemic violence also included instances in which providers implicitly framed women as incompetent or unqualified to make decisions, often through infantilizing language or by framing their resistance to certain procedures as irrational or stubborn. In one example, a provider continued to pressure a participant to accept an epidural despite her repeated refusal. Her embodied knowledge that she had the capacity and desire to cope with the contractions unmedicated was undermined by the physician:

> It was often like [the doctor] seemed discouraged when I said I didn't want [the epidural]. And I was like, 'Why do you keep insisting? Why do you absolutely want me to take it?' […] He said, 'Well, you keep wanting to act so tough.'

Another participant described the response of providers when she refused repeated blood tests for her infant, for whom blood tests had already returned as normal: "When I started refusing more blood tests, they started saying, 'Oh, mommy is getting the blues.' And which I found interesting, cause you're kind of weaponizing someone's feelings, you know.'" In the following example, the provider implied poor maternal judgement in an attempt to elicit compliance to an intervention the participant strongly believed was unnecessary:

> When I said no to the blood draw, one nurse came, and she told me, 'You know, sometimes we have to do hard things for our kids. It might not be easy to see them in pain, but we have to do this for them.'

Epistemic violence also included instances where information was inadequately communicated or withheld, restricting participants from having a comprehensive understanding of their condition and available care options, and eroding their ability to fully affirm or assert their autonomy.

Epistemic violence also included failing to obtain full and informed consent, presenting procedures as routine or non-optional, and a general lack of communication. One participant described her experience of being left alone in the recovery area following a cesarean birth, with no phone and no information about her baby: “Nobody tells me if the baby is alright or not. […] You should tell me! Tell me the baby is alright.” Another participant shared, “No one told me I could take a shower! […] I stayed two days with my post-birth sweat, which wasn't very nice, and I was like, *Oh, there's a shower here? No one thought about […] telling me?*”

As the following participant expressed, in addition to being a violation of bodily autonomy, having the episiotomy forced on her was largely problematic because of the lack of information made available to her at the time, which left an enduring sense of uncertainty about the necessity of the procedure:

> It's possible that an episiotomy was truly necessary, and I'm left with this uncertainty whether it is, whether it isn't. […] But really the problem was that it wasn't posed to me like an option. It was posed to me like, ‘I'm doing this without clarification on why.’ […] And there wasn't a sense that [the doctor] cared what I wanted at that moment, even though of course she was doing it to my body.

Relational Fractures. *Relational fractures,* as they are termed here, represent violations of the relational dimension of care, including violations of one’s dignity, emotional integrity, and reciprocity that arise in interpersonal interactions. Relational fractures arose through negative or hostile provider attitudes, described by some participants as “poor bedside manner” or an “unprofessional” approach. Participants described providers who were rude, disrespectful, and angry, and who demonstrated judgmental, condescending, and belittling attitudes. Others described cold or emotionally detached approaches to care, where providers appeared rushed,

distracted, or spoke in brusque ways. In some cases, this extended into instances where single providers or large groups of providers entered the room, but failed to introduce themselves, or did not interact with the participant at all.

Some providers were described as being like “robots” or “call centre operators” that were going through the motions or following a checklist, which contributed to a perceived lack of care, and the prioritization of unit logistics over the person:

> They read from a script. […] Really, like [the doctor who discharged me] was asking questions based on a questionnaire in his mind, like going through the questions because he had to. And that was it, ‘You’re released. Because you were here for 48 hours, you gotta go.’

Several participants spoke directly to the lack of compassion and empathy that providers demonstrated, even in moments that were particularly distressing or vulnerable:

> The last person who saw me, […] he came in. I was destroyed. He was asking how I'm doing. […] I told him, ‘I'm, I feel a bit depressed. I feel like sometimes I don't feel anything.’ […] Like I'm talking, talking, talking. He's not there. And then he pulls the bandage off, and then he signs the paper to release me.

Instances of neglect and delayed or absent care contributed to a broader sense of invisibility, being forgotten, or abandoned. One participant recounted being left unattended for a long period of time during labour while under epidural anesthesia. After insisting that the oxytocin, a common labour induction medication, be stopped due to unmanageable pain, she was warned that doing so could jeopardize her baby’s well-being. She recalled that following her request, “no one comes to see me for the next hour and a half.”

Relational harm did not only emerge through direct interpersonal dynamics with HCPs. For several participants, it also surfaced in moments when support or physical closeness with a spouse or baby was restricted by care providers. For example, participants described having their spouse cast to the side while they were pushing. Participants' accounts of being separated from their newborns, such as being denied skin-to-skin contact or having their time in the neonatal intensive care unit (NICU) limited by hospital policies and logistics, were often profound and laden with grief and anguish. Though the separation of mother and baby was rarely intentional, but more so the result of hospital policy, participants did experience providers as dismissive and uncaring in response to requests to see their baby. For example, one participant recalled, "Every time I asked, [the nurses] would shut me down, say, 'Just go to sleep, relax, […] you'll be with your baby […] after this.'" The following excerpt illustrates how one participant perceived a gatekeeping of her baby, where her ability to be with her newborn in the NICU was made conditional upon meeting unattainable physical expectations after her cesarean birth:

> They put me in a [postpartum] room that there is another woman with a kid. I hear the other kid cry, I can't see my baby. It was *so* difficult. And I'm there crying and begging them to just let me see the baby [sobbing] and uh, they're like, 'Oh we can't let you go because if you fall there is nobody there to help you.' I'm like 'I'm going to be on a wheelchair.' And they're like, 'Oh if you can walk to the door, you can go see your baby.' And I can't get up, it hurts like hell.

This same participant later described a similarly distressing experience in the NICU that, while perhaps not intentionally cruel, reflected a hospital policy that was experienced as rigid and dehumanizing. Despite being in significant pain following major surgery, her ability to remain close to her baby in the NICU was made contingent on demonstrating a willingness to be present

at predetermined intervals. The implication was that unless she could show up every two hours, it would be assumed that she did not have a strong enough desire to see her baby:

> They were like, 'If you want to stay in the hospital with the baby, we can give you a room, but you have to show up every two hours for the baby's feeding.' […] They're like, 'Oh, our concern is your baby. We don't have enough room, the priority is with the parent who wants to be with their baby every two hours.'

Verbal and Psychological Abuse. Verbal and psychological forms of OV include harsh, angry, threatening, and condescending language and tone, as well as actual threats, coercion, and manipulation. This sub-type of OV represents violations that overlap with relational fractures and epistemic violence, yet are especially hostile, overt, or egregious forms of verbal abuse. "Yelling" and "screaming" were common forms of verbal abuse. In the following quote, the participant described being subjected to yelling and threats to her baby's life:

> At the very last moment, [the baby] was about to come out, and then [the doctor] rushed in, like, in a whirlwind, and she yelled at me, and I had to get on my back right away or else my 'baby was going to die' [Translated from French].

A number of participants also faced condescension, shaming, mockery, and humiliation. One participant described an encounter in which she experienced pressure and judgement around breastfeeding, paired with verbal aggression:

> A few hours [after the birth], the nurse comes in, turns on all the lights, she says, 'Did you breastfeed your baby?' 'No, I *just* gave birth.' She starts to scream at me. But it's because my baby hadn't woken up, you know? She starts screaming at me, 'She needs to be woken up, you need to feed her, she needs milk, what haven't you breastfed her already?!' [Translated from French].

Violations of Bodily Autonomy and Physical Abuse. Violations of bodily autonomy and physical abuse include rough touch, painful vaginal exams, violations of privacy, and inadequate pain management. Unconsented or forced procedures, while previously described as constituting epistemic violence, also demonstrate violations of bodily autonomy and physical abuse when violating the person's physical boundaries or integrity. The following excerpt encapsulates multiple violations of bodily autonomy and physical abuse, including the use of forceps after refusal, and an episiotomy done without the participant's knowledge:

> The vacuum popped off, […] and then [the doctors] said, 'Well, we'll just use the forceps then.' And I was like, 'No, I don't want forceps. There's no way you're doing that to me,' with terror on my face. […] And they said, 'We're doing it anyway, because that's where we're at.' […] Then once [the baby] was out, I asked, 'How badly did I tear?' And [the doctor] says, 'Oh, well you didn't tear. We did an episiotomy.' […] But no one told me. And if I hadn't asked, they wouldn't have said anything [Translated from French].

Another participant described repeated rough and painful vaginal exams, which were often unconsented, with inadequate pain management:

> They started the vaginal exams. Oh, God, they killed me! […] The fact that they would just randomly come and put their hand in […] and they would leave me so sore. […] I was *screaming,* 'Get your hands off my vagina,' you know? […] Every time two new people coming and putting, shoving their hands inside you. […] It was hell. And I was bleeding […] I was so sore that […] I couldn't even walk.

Several participants also described restricted mobility, such as being confined to the bed to facilitate fetal monitoring. Participants also described being forced to lie flat on their backs during labour and vaginal exams, despite requests to the contrary. For example, a physician was

described by one participant as implying that her being on all fours was the "wrong position" and "not okay." The participant noted that the physician repeatedly told her to return to lying on her back with little consideration for her preference or comfort: "The doctor would come in and and just be like, 'Get on your back.' […] He was lowering the bed, and I was like falling off the bed and vomiting. […] I'm half numb. I'm struggling."

Institutional and Systemic Conditions. This sub-type focuses on forms of OV that were experienced through institutional and systemic conditions. Participants described organizational cultures that prioritized protocols, efficiency, and provider-centered logistics over individualized, person-centered care. These conditions included rigid adherence to standardized care pathways, limited flexibility around women's preferences, and care decisions shaped by staffing, scheduling, and workload pressures. Experiences of racism, stigma, and discrimination also fall within this subtype of OV, often intersecting with policies and practices that contributed to feelings of judgement, scrutiny, and alienation. While racism, stigma, and discrimination are introduced here as a type of OV, and part of the systemic conditions shaping care, they are examined in greater depth in the sub-theme *Racism, Sexism, Fatphobia and More – Structural Violences in the Lives of Women*, which situates these experiences within the broader sociocultural and political landscape of childbirth.

Participants described organizational cultures that were protocol-driven and that prioritized standardized approaches to care. One described the approach as stepwise, with providers following "ABCDE," while another described it as a "path" that providers would not deviate from. One participant illustrated how such an approach reduced birthing individuals to machines that could be manipulated:

> ‘We’re used to this, here’s the protocol, the person arrives, she broke her water, we give her an IV, we give her [oxytocin], we check her cervix, we give her the epidural…’ No, you have a person in front of you. […] This isn’t a robot, […] where you press on one, two, three buttons, and then the machine works [Translated from French].

Within such protocol-driven cultures, participant preferences that deviated from the norm or standard were often disregarded or labelled as “wrong.” For example, one participant described her preference to breathe while pushing (open-glottis pushing), to which providers responded, “that’s not how you do it,” and proceeded to instruct her to hold her breath while pushing (closed-glottis pushing). Notably, open-glottis pushing is a safe approach to pushing that promotes energy conservation in the birthing person, perineal integrity, and oxygen delivery to the fetus (Prince et al., 2025).

Organizations were also described as more provider-centered than person-centered, with care decisions perceived as being dictated by unit logistics. One participant described having her induction scheduled three days before the recommended date, so that her birth would “accommodate the holiday schedule.” Interventions were described as done to “satisfy the doctor's convenience.” For example, one participant described needing to have the epidural done at a time that fit into the anesthesiologist’s schedule. “It's either now or I don't know when,” she recalled the nurse stating.

Telling Obstetric Violence Through Emotion

The emotional and affective dimension of women’s experiences formed a significant portion of their narratives and an integral way in which they processed and described mistreatment during childbirth. Women described a wide range of emotions, often conveying a sense of ambivalence, mixed emotions, and uncertainty, both during the birthing experience and

persisting into their current lives. As one participant shared, “Well, on one hand, it's um, it's a big old jumble. On one hand, of course I'm grateful that my daughter was delivered safely, and also there was a measure of me that was grateful that it was over.” Several other women described similar experiences in which brief moments of joy or gratitude for the safe delivery of their baby occurred against the backdrop of an otherwise emotionally painful experience. As one participant expressed, “I really regret having given birth at the hospital, but I still had a very beautiful birth.”

Contrarily, other women described having a generally positive childbirth experience marked by acute instances of mistreatment, as the following participant illustrated, “It really was you know, 90% positive, 90% the way I wanted it to go. And then that 10% bitter taste because of that one person.” For one participant experiencing mistreatment during labour and while undergoing an emergency cesarean birth, feelings of fear outweighed the positive feelings associated with the birth of her child:

> The feeling that I had was just scared […] this feeling was big enough, it was like overshadowing all the other feelings that I had at that moment of like, ‘Yay, my baby is coming! I finally get to see [him].’ […] Nothing but fear.

Emotional accounts of OV, especially for those who entered childbirth with a certain level of trust or deference towards the healthcare system and healthcare team, often overlapped with feelings of confusion and disorientation. As one participant expressed, “I was […] in so much pain, yeah. The pain, the soreness, and worry that *what the hell is happening*. […] I would start trembling the minute I would […] see them coming in.” Many described betrayals of trust, as in the following case of a participant who felt that a lack of expected provider support led to her inability to initiate breastfeeding: “I didn’t really go looking for the help I needed because I trusted the people who were supposed to help us, but in the end, they weren’t helping at all. In

fact, they were just making things worse" [Translated from French]. The following quote illustrates one participant's account of having her membranes artificially ruptured after previously refusing the procedure:

> [The physician] did a vaginal exam on me, and she kept asking me to 'bear down, bear down,' and it broke my water. I was like trying to push and thrust in the way that she was asking me to. […] I was just oblivious. I was not aware what she was doing, and I realized afterwards that she intended to break my water. I got quite upset, and she denied it.

Feelings of disempowerment, helplessness, and loss of control permeated each of the participants' stories, with a common sentiment being that they "had no choice." For many, the hospital environment and the process of labour and birth were experienced as overwhelming and disorienting. The physically demanding and painful nature of childbirth contributed to feeling exhausted, worn down, and emotionally destabilized. Participants described being unprepared and blindsided by clinical procedures such as induction, stimulation, and the rapid cascade of interventions in emergent situations. These experiences were often compounded by violations of privacy and bodily autonomy and exclusion from care decisions.

Several participants described feeling dismissed or invalidated by their care providers, particularly when they voiced concerns, asked questions, or expressed pain. For example, one participant recalled the experience of having her pain wholly dismissed by a physician during a vaginal exam, while being addressed in an infantilizing term: "It was like, who are you to tell me that I'm not in pain? […] Really a feeling of complete invalidation. Plus, the famous, 'my dear,' […] I found that so condescending [Translated from French]." These moments of dismissal were often accompanied by a sense of being a burden or an inconvenience to the clinical team.

Participants recounted being met with body language or curt responses that conveyed annoyance or impatience. This dynamic contributed to feelings of being a "thorn in the side," as one participant expressed, as though their presence complicated workflow.

Many participants described feelings of isolation, neglect, and alienation during their childbirth experiences. As one participant expressed, "I was under a lot of pressure. I was scared. I was alone. My husband was gone. At this point, the nurse that was familiar with me, I couldn't see her anymore." These feelings emerged in moments where labour support was lacking, when they were physically left alone, often in distressing situations, when information was withheld, and when their needs were neglected. One participant describing a particularly traumatic cesarean birth shared,

> They didn't come […] tell us that, 'This is what we're going to do.' Nothing. I woke up in a shock. My husband woke up in a shock, and they […] moved me from the […] bed to the stretcher, and in ten minutes, I'm out of the room waiting outside the operation theatre, and I have to prepare myself. And I have no family. […] There's nobody to tell me that it's going to be okay. I have to tell myself that [crying].

The participant later went on to describe waking up in the recovery room: "There's nobody there. There is *not a soul there.*"

Many described situations in which they were in the presence of a healthcare provider, yet felt emotionally neglected and uncared for, because of a cold, rushed approach that often lacked empathy or compassion. Others described feeling invisible or ignored, even in the presence of large groups of people, who presumably were invested in their care. One participant described being treated as unimportant, while her labour companions were cast to the side, depriving her of their support:

> The room suddenly filled up with like people […] my doula and my boyfriend were like sidelined, and the doctor and the [medical] student were there, just both yelling at me to push. […] We weren't […] seen the whole time as important players.

One participant described that she felt disregarded and that she was not taken into consideration despite being at the centre of a disagreement between care providers and her labour companions:

> I didn't feel like I was considered at all, at all, at all. You know, no one ever explained anything to me, no one ever asked me any questions. Uh, there was even arguing at one point, and I was like, 'Hello? I'm right here, why is no one talking to me?' I was ignored. That part was really hard [Translated from French].

All participants experienced feelings of dehumanization, devaluation, and disrespect. Participants described feeling like "just another case" or a "number." Often, there was a feeling that care providers did not see participants as humans, but instead as a task to be completed or to fit into a provider's schedule. In the following quote, the participant speaks to how she perceived the dehumanization and disrespect from care providers as being a sign of emotional distancing that facilitated workflow: "The easiest way for them to do their work is to not treat me as an equal, […] to kind of tell me what to do, or to put me in my place."

The emotional toll of OV was profound, with many participants describing intense feelings of helplessness and distress during and after their childbirth experiences. For instance, one participant discussed the emotional distress of being separated from her newborn who had been admitted to the NICU and felt unsupported by staff in her requests to see them:

> I remember crying so loud, and I *hated* my husband like. I hated him because he was able to go to the NICU. […] I'm like, 'I just wanna see my son now, he's my first child, I just wanna see him.' And my husband was able to go and leave me and go to the NICU, and I

> just remember hating him so much, like so jealous, so like, *I just wanna see my baby, too. Why can't I?* [crying].

These feelings of helplessness and distress often emerged in moments where participants were physically vulnerable, such as during invasive procedures or when experiencing severe pain, and were compounded by a lack of support or clear communication. Fear and terror were also recurring emotions, which were triggered by sudden changes in clinical plans or during emergency interventions, often with poor communication, or by aggressive or hostile behaviour from providers. Some participants expressed fearing for their own lives or those of their babies, as the following participant described in an instance of having no communication from a nurse while her baby's heart rate was dropping: "I'm like, oh my God, you know, like I'm there praying, you know, to God. Just hoping that the past nine months wasn't a waste of time." Others feared that their baby would be apprehended by child protective services. For instance, one participant expressed,

> I have certain factors that I don't always fit into the streamlined cookie-cutter mould of how they would like a birth to go, and […] as soon as you start deviating from that, it becomes a lot of conflict. […] my fear is that […] I'll get like flagged to youth protection.

Others expressed fear that they would face retaliation or punishment for not complying with provider demands, which often led them to agree to unwanted interventions. For one participant, feelings of terror emerged from having forceps inserted into her after having categorically refused the procedure:

> I didn't want the forceps at all. […] And after, my partner said to me, 'I never saw you like that, […] pure panic.' That's what was on my face. […] The worst feeling that has stuck with me […] comes from there, from the feeling of terror.

Participants described feeling judged or scrutinized by care providers, in relation to their body size, care choices, or emotional responses. Embarrassment and shame emerged in moments where participants felt they were not meeting expectations, whether clinical, cultural, or personal. Some internalized these judgments, questioning their own adequacy or worthiness as mothers. For example, one participant described being told by nurses that she was putting her baby's health in jeopardy by not breastfeeding. "[I felt I] was a bad mother because I wasn't breastfeeding through the pain," she shared.

Faced with repeated invalidation and disrespect, some participants described a sense of resignation, futility, feigning indifference, or emotionally detaching in order to survive the experience. This emotional withdrawal often came across as a protective response, a way to cope with the futility of trying to assert themselves in an environment that did not recognize their agency. For instance, one participant described "conceding" to the team's insistence that she should push on her back, after she had been asking for "20 minutes" to push on all fours: "At that point, I'm like, just get the f*****g baby out. Get him out. I don't care." Resignation was not a reflection of true acceptance, but rather a symptom of emotional exhaustion and a loss of hope that their needs would be acknowledged. As one participant expressed, "I don't argue with [the nurse], I just tell myself […] I don't care basically, it won't change anything" [Translated from French].

Anger and frustration were common responses to OV, and frequently emerged from being coerced, dismissed, and disrespected, and in response to hostile or antagonistic attitudes from providers. For instance, in the following quote, the participant described her experience attempting to initiate breastfeeding as she was being pressured to move to a different room:

> I couldn't get up and move. I asked them to like, roll the bed over […], and that was a huge conflict between me and the staff. […] I remember like just getting really angry and yelling to like insist that I was gonna do this breastfeeding. And I got my baby to latch as I was […] being carted in a wheelchair from one room to another.

Spousal presence played a significant role in participants' emotional experiences. Spouses were described as a great source of comfort, someone who knew their needs and desires intimately, and someone who could "step in" and provide some measure of protection. However, notably, participants also described distress at witnessing the impacts of poor care on their spouses. As one participant shared, "It's not just me. It was my husband too, right. He was having a hard time too, he couldn't say anything. […] Like seeing someone you love in pain, it's painful and devastating because you can't do anything about it." Others shared accounts of their spouses feeling "angry," "traumatized," and, similarly to participants, a sense of helplessness or inability to contradict medical staff.

Enduring Impacts of Obstetric Violence

Participants described the enduring impacts of OV as significant and extending well beyond the moment of childbirth. The following sub-theme speaks to these impacts, which include emotional and psychological impacts, altered meaning-making processes, erosion of trust in the healthcare system, and untold stories of harm.

Emotional and Psychological Impacts. Narratives of childbirth were filled with vivid descriptors that conveyed its residual emotional weight and impact on the self, and how individuals made meaning of the experience. Participants described their experiences as "dark," "terrifying," "scary," and "horrible." Women told stories of "suffering," emotional pain, and of

being traumatized. Negative childbirth experiences felt “hard,” “crazy,” “full of tension,” “like an ultimate crisis,” and even as something that didn’t belong “in the 21st century.”

The long-term mental health impacts of OV were wide-ranging, with participants expressing residual feelings of anger, rage, resentment, regret, shame, and grief. Often, childbirth narratives were imbued with emotion, with many participants tearful and sobbing during the interview process. One participant reported being diagnosed with PTSD, postpartum depression, and suicidality in the year following childbirth. Several participants spoke to the traumatizing nature of their experience, and the ongoing emotional pain that these experiences evoked. Avoiding memories was protective for some, as one participant noted, “I don’t want to go there.” Others described visceral memories that had endured over months and years, for example, one participant described her memory of having an episiotomy cut, which she had not consented to:

> I feel like it was in a cartoon where I'm just like going about my business and all of a sudden, I look up, and here's the doctor standing with the knife […] That's honestly the memory I have like, ‘What, what is that?! What are you doing!?’

A few participants spoke specifically to the concept of *birth trauma*. For one participant who was pregnant with her second child at the time of being interviewed, residual birth trauma came into focus as her pregnancy began to be impacted: “I'm now 32 weeks pregnant. […] I realized that I've carried a lot of […] birth trauma with me, and and it's sometimes hard to feel positive about the [forthcoming] birth.” The concept of the *anniversary of birth trauma,* which identifies the anniversary of a traumatic birth as a potential source of psychological distress (Beck, 2006)*,* emerged for two participants. One participant expressed that the date of her birth trauma was a source of distress in the days leading up to it and served as a reminder of painful memories: “A year after he was born, whenever [the date] comes, I have to force myself to try

thinking [of] something else. [Three days], then I'm fine." Another described contending with the anniversary of her traumatic birth, and its synonymity with her child's first birthday: "It feels like it happened yesterday. [...] I was taking out my […] child's photos for her first birthday, and I was seeing those photos from her first day, and I still cry when I see them."

Grief emerged in participant narratives in multiple forms: loss of respect and dignity, loss of oneself ("I lost myself"), and primarily the loss of the desired and imagined birth experience. As one participant shared, "The grief is also the loss of that perfect birth story […]. You think, 'Oh, […] I'm gonna hold the baby, and it's gonna be magical.' […] So, there's a lot of grief […] around that." Participants reflected idealized views of a first birth, which contributed to the complexity of grief. For example, as one participant expressed, "Yeah, it's hard because I feel like the birth of your first child, […] I wanted there to be joy there, and there was none of that. There was like fear, confrontation."

In the aftermath of OV, many participants grappled with complex feelings of guilt, regret, self-blame, and doubt about whether they could have done things differently to change the outcome of their birth. These emotions were often tied to a sense of having failed to advocate for themselves or protect their babies. One participant noted, "I should have been more suspicious." Another, reflecting on her first encounter with her newborn 24 hours after an emergency cesarean birth, recalled, "They don't take the baby out. They are like, 'Oh, she's sleeping,' […] If it was me now, I would have said, 'The hell that she's sleeping, wake her up, she needs to be in my arms right now.'"

Participants questioned their decisions, wondering if they had misunderstood, misjudged, or somehow contributed to the harm they experienced. This internal conflict was intensified by a lack of validation from care providers, as one woman described, "[I feel] uncertainty that I had

made the right choices for myself, since the healthcare provider in charge of my case at that point was not in agreement, and didn't value what I wanted." Some described cycles of self-blame, replaying events in their minds and searching for ways they could have acted differently. These feelings often persisted long after birth, shaping their postpartum experience:

> One thing I definitely learned is there is no perfect birth. […] I can imagine having a nicer birth, but there isn't a perfect one. […] There is still sadness definitely, and I think the sadness is, I wish I had listened to myself the most, or that I trusted what I could sense in my body [Translated from French].

For another participant, "shame and embarrassment" lingered as she reflected on her daughter's birth during which she faced dismissive and degrading comments about her body. She attributed her negative experience, at least in part, to her own perceived shortcomings:

> [My lack of self-esteem] seeps into every aspect of my life, and it steals a lot of positive moments. […] The fact that my self-esteem and my feelings about myself ruined my daughter's birth makes me so upset because […] it wasn't the time to be feeling bad about myself.

These examples suggest that for some participants, an absence of compassionate care was less a failing on the part of providers and more a reflection of their own worth or effort. This internalization underscores the emotional vulnerability of childbirth and how provider attitudes can leave a lasting imprint on an individual's sense of self during a very impactful moment of their life. For example, one participant reflected, "My overall impression at the time, and I guess, lingering to this day, is that [the doctor] was impatient, and that made me feel like her time was more valuable than mine, at this very tender moment."

Participants also described a lingering sense of uncertainty and confusion about why certain decisions were made, or how particular outcomes came to pass. This uncertainty often revolved around whether a different provider, intervention, or communication might have led to a different result. Participants questioned whether what had happened was inevitable, or a product of missed communication. As one woman reflected, “I do wonder, would it have ended in that crazy [operating room] situation with [another doctor]? Would the ending have been different?” Another questioned, “Would these impacts have happened anyway if those unwanted interventions hadn’t been done? We’ll never know” [Translated from French]. For some, uncertainty persisted for years, entangled with feelings of resentment and doubt. One participant shared,

> Even now, two years later, I feel like it would have been possible for me to have given birth to her without [an episiotomy], and that option was taken away from me. […] Maybe [I felt] doubt that I understood what was going on. Was my baby really in danger? And if so, of course I would agree. But if not, then I wouldn't. And I didn’t feel like I really got that information.

Others spoke of this uncertainty extending into early motherhood, wondering whether difficulties in soothing their infants were somehow linked to their separation at birth: “I was always wondering if I can’t calm her down right now […] is it because she didn’t see me right away?” For a few participants, these unanswered questions prompted them to seek out their medical records, in an attempt to “understand [the provider’s] perspective,” and to finally make sense of “their side.”

Anger and rage emerged in the aftermath of OV, which for some had a significant impact on personal relationships and infant bonding. Persistent anger and resentment often stemmed

from unanswered questions, feelings of betrayal and loss, and when harm was perceived as intentional. As one participant expressed,

> Today, […] I'm still angry at that OB. […] I want answers. Like, why was she so rude? Why did she try to push us towards something that she knew […] was breaking protocol? […] I don't understand, and I think I won't understand, and this decision that they made on the day […] like every little thing that she could do […] Makes me angry.

Altered family planning occurred for a number of participants, with fear and anxiety, as well as residual birth trauma, impacting their decision-making around future children. While some participants chose to delay future pregnancies, "maybe in a year," one participant felt the risk of having another child was too great:

> I told myself, I told my husband, 'No more kids. That's it, I'm done. I'm not putting my body through this again, and I'm not risking my body in the hands of doctors who have no compassion.' […] I cannot go through another two years of therapy. […] I might not make it.' […] So no, no more kids. […] it's very disappointing.

The impact on the family planning desires of spouses was profound as well, as one participant expressed, "My husband and I are so traumatized that when we think about having another child my husband is like, 'I can't go through that again.'" One participant described what she perceived as a societal impact of negative birth experiences: "We're seeing lots of women having less children, […] and I've heard a lot of moms say, 'No, that's my one and only because I'm not going through this again.'"

Making Meaning of Obstetric Violence. In the unfolding of participants' interviews, the ways in which they interpreted and made sense of their experiences over time revealed a process of meaning-making that moved participants towards understanding, coming to terms, or,

for some, healing. Through their stories, participants expressed emotional ruptures, impacts on their sense of self, and impacts on how they saw themselves in a broader, collective context.

These interpretations were mediated by dominant cultural narratives of childbirth as at once challenging and unpredictable, while also transformational, magical, and joyful. Participants described that they expected childbirth to be an affirming transition to motherhood, as one participant shared, “When a mother delivers a child, it's not just a child that she delivers. She herself has changed everything inside her.” Childbirth was a chance to “understand the power of your body,” another participant stated. One participant described that her experience led her to feel that her unmedicated childbirth was “like a fight.” She continued, “Like a ‘You're gonna prove ‘em wrong,’ or like, ‘I did it,’ instead of it just being what it is, just a part of life.” For her, childbirth went from a meaningful life event to something adversarial, framed not as an event in its own right, but as a contradiction to medicalized childbirth.

These internalized cultural narratives set the backdrop for what women expected of the experience, with OV mostly reflecting a departure from these expectations. Their emotional expressions conveyed a sense of rupture in failing to have the positive and affirming experience they expected and desired. Several participants described a deep sense of *stolen joy*, a recognition that one of the most meaningful moments of their lives had been appropriated, taken from them, or diminished. For example, one participant expressed, “It was the time to be happy and welcome my daughter, but it just, it was stolen from me.”

Cultural and institutional narratives that emphasized a healthy baby as the primary measure of a “good” or successful birth heavily impacted how women attributed meaning to their experience. Even when their own well-being had been compromised, the majority of participants leaned heavily on the idea that their child was born healthy or alive when discussing the positive

aspects of their birth. A lot of the time, participants seemed to vocalize this "good birth" discourse upon narrating the negative aspects of their experience, suggesting that it allowed them to distance themselves from the painful aspects of birth. However, for others, this same narrative was explicitly described as an invalidating one, that minimized feelings of harm, dissatisfaction, and invisibility. The following quote demonstrates how, for one participant, despite her conscious awareness of the discourse as potentially harmful, it still shaped how she came to terms with her experience: "It was an unpleasant event, it wasn't fun, but we'll make do, you know? My baby is healthy. The infamous, *my baby is healthy, it's all good"* [Translated from French].

The following "I" poem demonstrates how the discourse of a "good birth" is voiced through accounts of OV. In the poem, the participant shifts back and forth between expressions of appreciation and acceptance for the outcome of her child's birth – "it is what it is", "I just wanted my baby to be safe", "I felt safe" – and expressions of dehumanization and betrayal – "I wasn't really a person", "I was kind of robbed."

I don't think I was really quite prepared

I wasn't able to see my son for about four, five hours, whereas my husband was. Which was, it was fine

I was quite upset, though, in the moment

I wish I had had more information going in

I wish that I had done it more a natural birth. But of course, it worked out.

My [baby] is alive, there's no issues with that.

I remember crying so loud

I felt really dismissed

I felt really like I was acting crazy

I was, you know, maybe I was

I had heightened emotions. It wasn't maybe a normal reaction

I just really wanted to see my baby

I didn't really feel human. Like, it just felt very… cold

My concerns were dismissed… Anyway, it is what is

I don't want to be too hard on that

I knew that these nurses were busy

I know there's a lot of patients

I know it's the very stressful time

I didn't want to be too hard about that. But it definitely felt like I wasn't really a person

I mean, it wasn't the best experience

I realize that I let the doctors and nurses be in charge, and that's fine

I just wanna have my baby

I just want my baby to be safe. That's, that was my, my mission going in

I was kind of robbed. […] It didn't feel like a positive experience of my [baby] coming to the world

I think back, I just feel shame and embarrassment

I hate, because these issues come up in my life all the time of this, this low self-esteem

I do wish that it didn't impact that moment as much as it did

I was taken aback because I did have respect for this doctor

I felt safe with her. I felt like she knew what she was doing

I definitely didn't get anything compassionate or warm

I don't wanna place the blame on anyone in particular

I don't want to say that the entire experience was negative

You know, of course, it was still amazing to have my [baby].

The “I” poem reveals how the participant made meaning of her birth, as at once meeting her preconceived notions of a good birth, where her child was born alive, while simultaneously being a source of suffering, diminishment of self, and shame. She appears to question the validity of her feelings that arise despite the successful outcome, questioning whether they are normal, and referring to feeling “crazy.”

Rather than unfolding unambiguously, meaning-making often involved emotional contradictions. Joy represented just one of the multiple and complex emotions in the landscape of childbirth. Across stories, participants' descriptions captured the simultaneous presence of opposites: suffering and joy, vulnerability and guardedness, violation and care, and knowing and unknowing. Many resisted framing their experiences as either wholly positive or wholly traumatic. Instead, they portrayed childbirth as emotionally layered and ambiguous, as the following participant shared,

> You can look at the scar and think of everything that went wrong, or you can look at it and think of the birth of your son, who you love so much, […] We're really grateful. And even though it was such a crap experience, […] I have this feeling of gratitude that I've been able to access despite everything. […] And I think that's been like, really healing, basically.

Some reflected on the diametrical nature of their experience in a more pragmatic sense. For example, one shared, *"*It could have been worse, […] but it could have been better*,"* while another framed it, *"*It's like, *check*, ok, that was an experience, I did it, I wouldn't do it again. […] but I don't have the impression of being traumatized by it" [Translated from French]. These accounts illustrate the emotional paradox of childbirth, how people can hold disparate emotions side by side.

Many participants described active efforts to process and make sense of their experiences, seeking reassurance, information, and community as they worked toward understanding or acceptance. Several began counselling or therapy, sought assistance with childcare, and turned to friends and family for support. Some turned to online postpartum groups, podcasts, or other digital spaces for support and connection. One participant described

being a member of a forum on Reddit, a social media platform, where members shared postpartum stories; the participant expressed her realization, through exposure to the stories of other women, that her experience could be described as harmful, violent, and abusive: "It happened to me, s**t." For others, the emotional work of processing involved moving through fear and avoidance to eventual openness to future pregnancies. As one participant described,

> I didn't want to have any more kids after the first. […] It took some time […] I was like, no way am I reliving that, no way am I reliving that violence, that disrespect. […] Then, little by little, I listened to some podcasts, read up on midwives, and then I thought, okay, if I do have another kid, it'll be with a midwife [Translated from French].

For some, the quality of the childbirth experience had a profound effect on the transition to motherhood and the internalization of a mother identity. The attitudes of care providers could contribute to feeling like a "bad mother," particularly when participants struggled with breastfeeding or felt judged for their infant feeding decisions. As one recalled, "I came out of her four-month appointment, and it was like, I was sobbing in the car. […] *That's it, I'm mistreating my child*, you know?" For others, childbirth brought renewed awareness of past trauma and shifts in self-perception. One participant reflected, "[I] had a lot of childhood trauma, so everything was all bottled up inside. So, somewhere it had to come out, I think. But yeah, I feel I see myself very differently now than I did [when] I was a kid, and as I was a teenager, and as I was before, even before I became a mom."

Over time, meaning-making extended beyond the self toward a broader collective awareness. Shared stories of personal betrayal, loss, and injustice were described through the lens of collective injustice for mothers, understood as universally subjected to disrespectful and degrading care in childbirth. Several participants spoke of women they knew personally who had

lived similar experiences of mistreatment and of the "loads of stories out there." One participant shared, "I know a friend, also a new mother like me, who went through worse than I did. […] There are a lot of people who've gone through [mistreatment]. Oh, there's no value, […] no care for mothers." Some expressed worry for other women who could potentially be exposed to similar care conditions, as in the following example of a participant who was left unattended and bleeding for several hours after birth: "I didn't have any serious health complications as a result of this. […] But it, it also makes me worried like, I mean, what if there is someone that they don't check for hours, and she is, you know, hemorrhaging?"

Recognition of the widespread nature of mistreatment extended into strong moral conviction that mistreatment was categorically wrong: "It's not okay," "Nobody should have to go through this, nobody." Participants expressed a strong desire for care practices in childbirth to evolve, with one participant expressing, "I hope at some point people or doctors think beyond their medical practice and think about the mothers as human beings." Several other participants echoed this sentiment that change and action were necessary to protect women from future harm: "It could impact [others], it could have an impact on their attachment with their baby. So, that's why we should try to make sure it doesn't happen again. […] So that no one has to live through this again."

Feelings of anger and outrage also arose at the thought of other women being exposed to mistreatment; one participant described angrily confronting a resident she overheard telling another postpartum individual that it was normal for breastfeeding to hurt, while another expressed her strong intolerance at the notion that marginalized individuals would likely experience far worse treatment than she had. She stated,

> Something that I cannot tolerate is injustice and for me it felt like it was an injustice. And at the same time something at the back of my head was, *I am extremely privileged. I'm educated, I'm white,* […] I cannot even imagine how much like racism and discrimination, and […] it was angering me that like, it's terrible like, if I'm going through this, everyone else must be going through this, and some people ten times, a million times worse, and I was angry.

Familial relationships and infant bonding were also impacted, often secondary to mental health concerns, as was the case for the following participant who described herself as having postpartum rage:

> I started feeling a lot of anger. […] After I delivered and came back home, I started hating the sight of my child. […] I would tell my husband, 'Just take him and go. I don't want to see him. Just take him to the other room, just away from my sight.' […] Yeah. So, it affected our relationship also to greater extent.

The childbirth experience also placed stress on spousal relationships, as one participant expressed, "I don't think our relationship was able to handle everything that went wrong, […] the accumulation of all those things was really damning for us."

Participants also described their experiences as contributing to their aversion to breastfeeding or decision to discontinue breastfeeding. One participant who was struggling with breastfeeding in large part to her baby's tongue-tie, which would only be identified weeks later, felt immense pressure to continue breastfeeding, which ultimately led her to not only discontinue breastfeeding, but feel averse to it. As she described,

> [The nurses] told me that if I didn't breastfeed my baby, that the digestive system wouldn't develop properly, and that she would have problems. So, all those things that

> the nurses told me, it's like I developed an aversion to breastfeeding […] [My husband and I] said to ourselves, 'Breastfeeding is bad, there's too much pressure. Breastfeeding is not good. We're going with formula' [Translated from French].

Another participant noted that, despite generally positive support from the nursing staff, the painful and invasive interventions of one nurse during infant feeding led her to feel that breastfeeding had "not been a great experience," and prompted her to transition to formula feeding.

Erosion of Trust. Experiences of OV contributed to an erosion of trust in the healthcare system. Hospitals were described as "dangerous" places to be avoided, not only for future pregnancies, but for healthcare in general. Some women expressed apprehension about interacting with providers again, wondering, "Am I safe to go talk with this doctor? […] Are they going to hear me? Are they gonna listen to me or is it gonna be a similar situation, or something else." Others described a complete loss of confidence in care providers. As one woman stated, "All the nurses and doctors who were there with me, there's not one that helped me. They just hindered, from beginning to end. And, I would have been better off delivering at home with my doula and my husband" [Translated from French].

For one immigrant participant, her sense of disillusionment was compounded by the idealized image of the Canadian healthcare system she had bought into before emigrating to the country. She shared,

> It shifted my idea of […] the health system. […] I lost a little bit of my trust in, in doctors and nurses. […] I grew up in a country that's very […] hierarchical as a society. But […] a doctor's never been angry at me cause I said 'no,' or because I decide [for myself]. […] So, it was a bit weird to see that, that the hospital system is, there is a definite hierarchy.

For others, distrust shaped their decisions around future reproductive healthcare. One participant, who had felt pressured into an induction and had her membranes ruptured without consent, expressed a refusal to accept similar interventions in her next pregnancy: “This time around, I am not gonna entertain any suggestions of being induced, I'm not gonna let them do ultrasounds late in the pregnancy to try to find reasons to induce me, or to scare me into accepting being induced.”

Experiences of mistreatment also prompted several participants to shift to midwife-based care for subsequent births. Participants described the two approaches as “two completely different worlds,” and in all cases, participants expressed that their experiences with midwives were far more positive than those that occurred in hospital:

> With my first [hospital-based birth], […] I wasn’t able to have my rights respected, I wasn’t able to fight for myself, I had all the protocols done *to me*, they didn’t trust me. Versus the second [midwife-led birth], […] it couldn’t have gone better, […] everything just flowed, it was a gentle birth, it was serene, it was just *wow* [Translated from French].

The physical impacts of interventions, like incontinence and pain related to the use of episiotomy and forceps, were perceived as being the result of poor communication and decision-making on the part of providers. For example, one participant who experienced a fourth-degree tear and long-term perineal pain and dysfunction as a result of a forceps delivery, reflected,

> I just felt really disrespected by [the nurse] because she just wasn't paying attention, she wasn't coaching me at all, and she was yelling at me for not [pushing] it correctly. So yeah, […] like, how much of the lack of being coached resulted in the type of birth I had […] I don't know if that would have happened.

One participant described the impacts of having her postpartum symptoms dismissed in the hours following childbirth, and the resulting months-long delay in diagnosis and treatment for anemia and anemia-induced syncope:

> I think that a lot of my problems with not being able to care for my child could have been prevented had the medical staff been taking better note of my, my general state, and things like my inability to walk, my […] syncope, the feeling of weakness, […] being too weak to be able to hold my baby. I think had they really been looking for that, […] maybe they could have helped me get a diagnosis earlier.

Untold Stories. Despite the profound impacts of OV on women, participants described a reluctance to share their birth stories in social or public spheres, often out of fear of judgment, shame, or social invalidation. For some, the research interview was the first time they had shared their birth story in its entirety. One participant described how deeply isolating it had felt to carry her story alone:

> It's very hard. You don't know who to talk to. Initially, you think people will say that […] you're complaining. […] After my therapist, I think I've spoken about this to you. I haven't spoken to anyone, not even to my family.

Others recalled attempts to share their experiences but being met with dismissal: "I understand why women don't dare [share their stories]. I shared [my story] on Facebook. 'Oh, your baby is healthy. You shouldn't complain.' That's always what we get told." Another participant similarly expressed,

> You're the first one I'm telling about this. […] It's difficult to talk about it because I, I feel like, at the end of the day, I, I came home with two healthy babies, you know. I didn't have any serious health complications as a result of this.

One withheld her story in an attempt to preserve the joy of others who had positive experiences:

> I was happy for them. They had a positive experience. [I was] a little bit jealous that I didn't. […] And I also didn't want to change the mood of like, 'Well, you guys had a great one. But this is what happened to me.' Like I, I didn't want to take that away, so I just went with it.

Others described simply not being ready: "I was two months postpartum, and my friend wanted to hear my birth story. I just said, 'No, I'm sorry, I can't.'" For one participant, not sharing was an act of protection, both for herself and for others. Having successfully advocated for a vaginal birth after resisting pressure to consent to a cesarean birth, she chose not to tell friends who had felt similarly pressured but whose births had ended in emergency surgery. Finally, some avoided telling their stories because doing so brought up painful memories. As one put it, "I have […] aversion to talking about what happened […] now that a year has gone by, I have been more able to do so. […] I notice in myself that I […] avoid things that bring up these memories."

Theme 2: The Sociocultural Political Landscape of Childbirth

This theme captures the broader sociocultural and political conditions that frame how CBWs experienced and understood OV. The section is organized into four sub-themes: (1) *Barriers and Breakdowns in Prenatal Care* explores how early encounters with the healthcare system reflect wider systems of inequality and position women as marginalized to varying degrees even before birth; (2) *Paradigms of Birthing Care* examines the dominant models, values, and assumptions that organize contemporary birthing care models; (3) *Woman, Mother, Other: Politeness, Gratitude, and Endurance* attends to the normative expectations placed on women and that extend in care encounters; and (4) *Racism, Sexism, Fatphobia, and More:*

Structural Violence in the Lives of Women illustrates the intersecting forms of oppression shaping women's lives and experiences of care.

Barriers and Breakdowns in Prenatal Care

Negative prenatal care experiences were common among participants. The very act of finding an obstetrician was a hurdle for some, while others experienced long delays in obtaining a new physician specializing in high-risk pregnancy after a high-risk diagnosis. One participant agreed to being followed by a "rotating cast of residents," which she ultimately experienced as challenging due to having a lack of personal connection with her physician. Several participants referenced brief, minutes-long prenatal care appointments with their obstetrician where the focus was largely placed on assessing physical symptoms. During these appointments, participants felt rushed, that teaching was limited, and that there was little time to have their questions answered. Importantly, negative experiences were not confined to physicians alone. Participants described harsh, dismissive, and at times discriminatory interactions with nurses, ultrasound technicians, and administrative staff, which further compounded their sense of marginalization within the healthcare system.

High-risk pregnancies were the source of stress, anxiety, fear, and depression for many participants. High-risk pregnancies also shifted the nature of childbirth, as many participants required an induction of labour. The participants shared a variety of conditions that resulted in being labelled high-risk: fetal genetic abnormalities, fetal heart valve defects, intrauterine growth restriction, babies that were large for gestational age, placental complications, cholestasis of pregnancy, and gestational hypertension. Two of the pregnancies were conceived through artificial reproductive technologies, while three participants spoke to the experience of lengthy and challenging experiences of infertility and conception. Having a high-risk pregnancy was

described by one participant as “traumatizing,” and a source of vulnerability: “Going through a difficult pregnancy specifically made everything […] seem worse. Also, we were already like weakened when we got to the hospital.” She added, “You don’t know if the baby is gonna be healthy. […] You go dark.” Existing chronic and mental health conditions, as well as previous experiences of trauma, including gynecological violence, childhood trauma, and unspecified trauma, were reported by half of the participants.

The majority of participants, 12 out of 13, were first-time mothers at the time that OV was experienced. Being a first-time mother was expressed by many as a source of insecurity, fear, uncertainty around childbirth and obstetrical care, and lack of knowledge regarding care options. Several participants stated that they went into childbirth with limited knowledge. As one participant expressed, “As a first-time mom […] you don't know of anything about birth.” Participants expressed that as first-time mothers, they felt limited in their ability to refuse certain interventions or advocate for themselves when they disagreed with care decisions. One participant described having her request to labour on all fours denied by the doctor: “It was my first time, it was a lot. […] *I know I have the right to do it anyway, but no, you said no, so I won’t do it*” [Translated from French].

Participants described varying types of family systems, as well as varying sizes and compositions of their social support networks. Half of the participants were immigrants, with some having immigrated to Canada within the two years prior to the study. This impacted heavily on the degree of familial support they could access during pregnancy, and for two participants meant that they had no family in the country. Immigrants also spoke to the difficulty in navigating an unfamiliar healthcare system.

Two participants spoke to the experience of being a single mother, which was a conscious choice, yet still described as challenging. One participant described being the first in her social network to have a child and therefore having no other peers to provide guidance and validation. For another, though family members were present in their support networks, their support was perceived as tenuous. One participant described coming from a family of physicians who were vocal about their medical opinions, which tended to undermine her own philosophy around childbirth. Another participant described her mother as disapproving of her desire for an unmedicated birth, noting, "Even though I'm a person who's very clear on what I wanted, it does introduce doubt, and it does introduce a negative aspect, tension, where it doesn't need to be." Two participants described having lost a parent prior to birth, which contributed to complicated experiences of grief and loss of tangible support. One shared,

> Just a lot of the responsibility is falling on me, which normally I'd be fine with, but it's scary. […] And some of the promises, promised forms of support didn't work out, you know be it my mom, or a doula. […] and my dad had died, so my mom was not present, or she didn't want to be present, […] she didn't end up showing up for me in that way.

Taken together, these experiences reveal how individual struggles in prenatal care are shaped by broader sociocultural and political forces that structure the degree and quality of support that different individuals have access to. The barriers participants encountered, including difficulty accessing care, fragmented provider relationships, rushed appointments, discrimination, and personal pregnancy challenges, reflect systemic patterns. Ultimately, these conditions created a landscape in which first-time mothers, immigrants, and those with limited support entered childbirth already vulnerable, highlighting the cumulative breakdowns that set the stage for OV.

Paradigms of Birthing Care

Participants' expectations and understanding of care were largely shaped by competing paradigms of childbirth: *medicalized birth* versus *physiologic birth.* Medicalized birth describes birth that is treated as a medical pathology, and that is perceived as requiring the intervention of a physician and the use of technology to proceed successfully (Cahill, 2001). Physiologic birth is broadly defined as birth that proceeds spontaneously, with minimal or no medical intervention (Kennedy et al., 2015). In participants' accounts, these paradigms extended beyond technical aspects of childbirth alone, conveying complex personal, cultural, and moral meanings. Medicalized birth and physiologic birth were often discussed as mutually exclusive and singularly associated with hospital-based care and midwife-assisted care, respectively. This dichotomous framing shaped how childbirth itself was understood. Medicalized birth and physiologic birth were positioned in opposition as pathological versus natural, dangerous versus safe, hard versus easy, and pragmatic versus transformational. As a result, references to one's desire to accept or avoid interventions functioned as shorthand for broader ideologies about birth, rather than as simple preferences.

Participants described how these ideological markers shaped how they were perceived and treated by care providers. Women who expressed hesitancy toward interventions such as epidurals, forceps, or cesarean births were more likely to be stereotyped by providers as anti-medical, resistant, or difficult. On the other hand, openness to medical interventions generally served as a marker of deference towards medical authority, or of being an "easy" patient. However, one participant described that her tendency to show interest in and ask questions about medical interventions was poorly received by providers:

> I have been in awful lot of hospitals as a patient, and also as someone who works as a medical anthropologist. […] So, if you try to use accurate medical words… there's no right way to do things, because if you are being too medicalized […] people think you're […] being patronizing. And that's a lot what I found, like when I would try and understand, like, 'Oh, we can see the PhD.' Or I've been told several times, 'Oh, your midwife trained you well' [condescending tone].

The participant's experience that there is "no right way" to interact with providers is indicative of women being expected to concede to biomedical ideology, but not engage with biomedical knowledge, nor be seen as legitimate knowers within the system.

A number of participants who expressed an interest in physiologic birth described how this became the source of stereotyping and judgment from care providers. One participant described how nurses reacted to her as a certain "type" of mother:

> I felt like something that really triggered the nurses was, […] there is this idea of a mother who wants to give birth in a […] [midwife-led] birthing centre who doesn't want to take epidural, […] who wants to breastfeed. […] There was a stereotyping of that identity. […] So, when I was so tired, and when they said, 'Are you okay with [formula feeding]?' And I was just like, 'Okay.' That they were like, 'Wow!' You know, like, 'Whoa! We have managed to convince this, not even a person, this stereotype to do this.'

Another participant similarly described how her initial expression of wanting to delay a recommended cesarean birth resulted in the physician abruptly shutting down communication and suggesting that she had unrealistic expectations and was being irrational:

> I didn't even say no, I just said like, 'I'd rather try to get to labour, like can we keep trying?' […] And it was almost like [the doctor] just threw his hands up and like, was

> like, ‘Face reality!’ […] I feel like if someone had sat down and taken five minutes to explain […] why a C-section was a good idea, […] like I could have got there.

Several women described that their label, physiologic versus medicalized, framed all subsequent care. Changes in their desires and preferences during labour were treated as remarkable, or in some cases, treated as failures or betrayals of their original orientation. For example, one participant recounted how her request for an epidural, which she had previously expressed wanting to avoid, was met with surprise and subtle judgment from the nurse. The participant’s experience was suddenly reframed by the nurse as no longer “natural,” reflecting how deeply internalized binary thinking between medical and physiologic birth can be:

> [The nurse] does look at me a bit, in a way […] I can't tell which emotion it was, but she does say, ‘But [sigh] I thought you wanted a natural birth… But you know, like, that's okay, I'll help you move.’ I was like, okay*,* like*,* bam, you're not having a natural birth.

Despite the framing of paradigms as mutually exclusive, women’s positions were rarely so rigid. Though hospitals were often perceived as incompatible with physiologic birth, they were still understood as sites of safety where potential or actual risks could best be mitigated, as the following participant illustrates: “I had […] really wanted to avoid medical interventions, but I also wanted to be at the hospital because it was, we were like a bit concerned about the birth.”

Rather than being perceived as complementary, midwifery and medicine were often described as in opposition to one another. Participants described a perceived social and cultural divide between the two care pathways, wherein women were forced to choose between respectful woman-centered care and clinical, baby-centered care. This binary framing positions both care models as deficient in some way or another, such that a holistic, humanized, and safe approach to childbirth seemed difficult to obtain. One participant noted,

> Like, if you have a birth at home with a midwife versus a hospital, for example, and, like, the whole approach is so different. And as a mom, like a pregnant person, you feel like you have to choose, you have to be like, 'Do I want to be respected, or do I want my baby to be in the most safe environment,' you know?

Despite being a legally recognized and regulated specialty in Canada and being integrated into the public healthcare system in Quebec, midwifery and midwives were described by participants as stigmatized and regarded as illegitimate. One participant described her pediatrician as being ignorant to the role of midwives, comparing her midwife to a doula, telling her that she was "putting her baby's life in danger" by relying on a doula, and stating that she "shouldn't believe everything doulas say." One participant, who had required being transferred from a midwife to an obstetrician mid-pregnancy, described how her preference for a midwife-led birth may have been perceived as a rejection by hospital-based providers,

> It felt like the system works on a hierarchy, and the fact that I'm denying… […] I'm not thinking of a hospital as the best place to have birth, or that I'm not coming in here with like, *[…] this is where I want to do this,* that there was definitely like a clash.

The participant perceived that initially turning down hospital-based care was not only taken as a criticism but contributed to her potential alienation and dehumanization. She described the shift in provider attitudes when she did ultimately accept medical intervention: "I don't know if it's an ego clash, but it felt as though […] me saying yes to some things that they thought I wouldn't say yes to, kind of made me more of a person in their eyes."

Woman, Mother, Other: Politeness, Gratitude, and Endurance

Participants shared accounts of what it means to be a woman, a mother, and for some, a marginalized or racialized "other." These social identities are inseparable, as individuals inhabit

multiple and intersecting identities that interact in a gendered and racialized healthcare setting. Gender is diffuse and ubiquitous, and when intersecting with the dynamics of obstetrical care, where the patient is necessarily biologically feminine, and where the practitioner has historically occupied the role of authoritative expert, it creates a setting primed for normative expectations to surface. Across all interviews, participants expressed to some degree or another the expectation to be polite, deferential, to minimize disruptions, and to be uncomplaining. The following excerpt illustrates one participant's experience of pushing:

> I have back-to-back contractions, but for three, four minutes there's nothing. Everyone stares at me, and I'm like, trying not to burp my brownie again […] I have to apologize because I feel everyone is waiting. […] The tension is horrible.

This passage demonstrates the expectation this participant feels to maintain a certain level of decorum and physical restraint, despite an immensely challenging physiological process. She is cognizant of the gaze of the many HCPs in the room and feels pressure to apologize for making them wait between contractions, a process entirely out of her control.

Certain mothering/motherhood discourses were embedded in all participant narratives, shaping expectations of pregnancy, childbirth, and the postpartum period, including how mothers should feel and behave. Most prevalent was the discourse of the *selfless mother*, a mother who sacrifices herself and prioritizes her child's needs above her own, no matter the cost to herself. As one participant stated, "Once you're a mother, you don't have time for yourself." Maternal sacrifice appeared as a taken-for-granted aspect of the role, overlapping with expectations to be polite, grateful, and uncomplaining. In some instances, selflessness was described as a source of fulfillment, purpose, and strength. Rather than feeling constrained by the expectation to prioritize their baby's needs, some participants embraced it as a positive aspect of their maternal identity.

More often, however, participants did not respond to these discourses in fixed or singular ways. Instead, they demonstrated an ongoing negotiation of multiple, and at times conflicting, beliefs and expectations surrounding what it means to be a mother.

Participants' narratives also illustrated strong ideas about what it meant to be a "good" or "bad" mother. As one participant expressed, they held the belief that a "classic mom" feels an immediate maternal bond and overwhelming emotions towards her newborn; however, when she instead "didn't feel anything," she experienced self-doubt and internal conflict. Other participants expressed feeling like a "bad" mother for failing to fulfill certain expectations, like when they missed a prenatal appointment, or opted to formula feed. Participants held themselves to high standards, expressing a sense of needing to intuit their newborn's needs, and respond to them quickly. In the following "I" poem, the participant speaks to her complex emotional reaction to her first encounter with her infant, who is in an incubator in the NICU, told through the lens of mothering, and punctuated by relational fractures:

I had a C-section
I tell my husband, 'Go with her'
I don't trust anybody
I didn't see my baby. They just take the baby
I see like a tiny thing
I'm alone
I'm there crying and begging them to just let me see the baby
I saw her the day after
I go, I go see the baby, they don't take the baby out
I had a lot of problems breastfeeding
I can't calm her down anymore
I have a sad photo that my husband took of me just putting my hand inside one of those boxes to just touch my baby
My emotions are f****d up

I see the baby
I'm like, is this my baby? This is *my* baby?
I don't feel anything at that point
I was like, holy crap, this is way different than what I had in my mind
I hold her the morning after, and it's like, okay, okay, she's so tiny
I feel like, I dunno, emotional because she's so tiny
I don't feel like a mother right now
You see the movies and how they are happy to have their first child, it was nothing like the movies.

The "I" poem reveals a deep sense of helplessness, isolation, and distrust felt by the participant in the midst of an emergency cesarean birth, marked by separation from her newborn that persisted into the next day. The poem reveals the complex interplay between the profound suffering of the participant through this experience, and the prevailing notion that as a mother, she nevertheless expected herself to be happy and immediately demonstrate the ability to calm and feed her baby, whom she had been separated from for so long.

Societal discourses circulating in media impacted how women conceptualized childbirth. As the participant in the poem above noted, her experience ended up being "nothing like the movies." In another instance, a chaotic emergency cesarean birth was described like "a scene out of Grey's Anatomy." For one participant, a decades-old Monty Python comedy sketch satirizing the disrespect and neglect of women in childbirth, once "hilarious" to her and her boyfriend, now brought her to tears:

> We watched it after the birth, and we cried because it was so accurate. […] We were like, 'That's not funny anymore, because that's what our birth experience was like.' We felt like, when in that skit, she asked, 'Well, what can I do?' And they're like, 'Nothing Ma'am, you're not qualified.' That's exactly what it felt like, […] 'Madam […] you're not qualified to make any decisions here.'

Her noting that the sketch was made "in the sixties or seventies," and that "not much has changed," revealed the persistence of cultural narratives that frame birthing women as uninformed, or "unqualified" for birth.

Racism, Sexism, Fatphobia and More: Structural Violence in the Lives of Women

While racism, sexism, fatphobia, linguistic marginalization, and more can be understood as forms of OV when enacted in care, they are presented here as parts of the broader sociocultural and political landscape that shape how women enter, experience, and interpret childbirth. This section outlines the multiple forms of stigma and discrimination narrated by participants as they reflect broader, deeply embedded forms of structural violence that shape women's everyday lives. These incidents are not isolated to the healthcare encounter, but rather are manifestations of intersecting systems of oppression that form a critical part of the sociocultural and political landscape of childbirth. Several participants voiced that their experience of pregnancy and childbirth was shaped by an intersection of multiple social identity categories, beyond gender and motherhood. These included race, ethnicity, immigration status, language, religion, education, relationship status, body size, and vaccination status.

A number of the racialized or ethnically minoritized participants described experiences of being othered, alienated, and of discrimination and stereotyping. For example, one young Black Muslim participant shared that she felt stereotyped as being forced into unwanted marriage and motherhood: "I feel like maybe a lot of questions arose behind my back maybe about like, 'Does she really want to get pregnant? Does she want to get married?'" While no participants recounted instances of overt racism, many described more ambiguous forms of racial microaggressions such as being asked, "Where are you from?" despite being born or predominantly raised in Canada, or when providers would dismiss symptoms of pain or fatigue as related to lifestyle

factors, as opposed to legitimate health concerns. For one participant, the provider's gaze on her exposed breasts led to feelings of alienation: “It felt as if she was looking at me like I'm a little bit alien, and [as if she were thinking], ‘I don't know exactly how to behave in this situation.’” Racial dynamics were often experienced as nebulous and difficult to articulate. The following quote points to the challenge in identifying and articulating covert and subtle forms of racialization and discrimination:

> I don't know how to say this, but um, all the nurses were, most of the nurses were white, and I could… It's a weird thing, but it's almost like I… There was a racial element to it, and I don't know how to put a finger on that. But there was a little bit of that.

For some racialized participants, mistreatment was perceived as being unrelated to their racial or ethnic background. Nevertheless, the following passage illustrates the potential for discourses of self-responsibility around discrimination to be internalized:

> All the nurses that I had, […] they were [from] […] all sorts of countries, […] and I wasn't mistreated by them. I mean, by nature, I'm someone who's approach- very approachable, you know. I'm chatty, I'm very respectful towards other people, you know. So, […] I don't think there's anything that I had done in order to initiate this type of behaviour from [the nurse].

For some, there was an existing distrust in the healthcare system, based on their own past experiences, while others described a certain skepticism towards providers or vigilance towards stereotyping or discriminatory treatment passed down through warnings from their families or communities. One participant described her community as being particularly vulnerable to accusations of child neglect: “This is something I was told, […] like, ‘Whatever the doctor tells you, just do it. Like whatever they say, just do cause like they might bring the child services on

you'". For some, carrying the status or label of *immigrant*, or of not having public health insurance (a signifier of being an outsider), contributed to a sense of being judged and scrutinized:

> I think something there was happening in the background. […] I think they were worried, […] we said we had paid, but like they had no proof on the moment that we had paid […] So, I think there was all this tension about the fact that I come from the midwife, I'm an immigrant, maybe I'm not gonna pay them.

One participant perceived that her identity, including her ethnic background, was disregarded or went unnoticed by care providers, which contributed to a sense of depersonalization, or dehumanization: "I don't think they treated me because of me, as a specific person, or my ethnic background, or anything. I think I was just another case on their table."

Fatphobia, stereotyping, and discrimination around weight and body size surfaced for two participants. Both described how assumptions about their bodies shaped the care they received and contributed to feelings of shame, invisibility, and dehumanization. One participant, who had a healthy BMI throughout her pregnancy, described being labelled as obese due to swelling. She expressed concern that this mischaracterization influenced clinical decisions, stating that she felt "clumped in" with assumptions about having a large baby and being at higher risk. She reflected on the broader culture of "shaming or blaming," noting, "This medically incorrect assessment of my body made me concerned that their medical decisions or suggestions were based on preconceived notions rather than a proper medical assessment." Another participant, who had a history of eating disorders, recounted a deeply painful experience during her cesarean birth. As she lay exposed on the operating table, her physician and the surrounding staff made jokes about her weight, comments that were medically irrelevant. As the participant recounted,

> I was alone while they were joking about my weight, and how, 'Oh, this pregnancy, she didn't gain this much. You know, you, you gained less weight than the last one,' and stuff like that. The nurses laughing around me. […] Uh, they asked me if I was cold, and the one nurse was like, 'Oh, a big girl like you, you know, you run more warm.'

The participant described feeling humiliated and emotionally overwhelmed, adding, "I just wanted to cry cause it's such a personal thing for me to deal with. […] All I could think about while my daughter was being delivered is my weight and it felt so stolen […] from me."

Some participants shared that being in a culturally diverse care setting felt protective. They described feeling more comfortable or less scrutinized when providers reflected a range of racial or ethnic backgrounds. One participant shared feeling frustrated and angry that a nurse with her same ethnicity and mother tongue behaved in a way that the participant perceived as overly familiar and unprofessional. One white participant expressed feeling self-conscious and worried that her behaviour would be perceived as crude or offensive by a nurse wearing a hijab, which to the participant was a signal of conservatism. Another participant expressed concern that her choice to remain unvaccinated could be a source of discriminatory treatment, and one questioned whether her status as a single mother left her more vulnerable to judgment or coercion. Each of these instances reflects the complex and nuanced interactions and expectations that arose on the basis of the participants' multiple social positionalities.

The cultural, political, and legal landscape of Quebec is heavily shaped by its linguistic history. French is the province's official language, and in Montreal, most residents are fluent in both French and English. Over the years, language laws have sought to restrict the use of languages other than French in public services, including healthcare. Many study participants were bilingual, though French was the mother tongue of less than half. Limited access to English

services posed challenges for three participants. For example, one participant birthing in a Francophone hospital, herself fluent in French, asked for time to translate information for her Anglophone spouse. She perceived the team as acting "curt" in response, saying the request "rubbed nurses the wrong way." After her infant's transfer to the NICU, staff refused to communicate with her spouse in English, leaving the couple uncertain about their baby's condition. Another participant with limited French described feeling unwelcome in a Francophone hospital, sharing, "Mostly they speak French. […] They could speak English, but sometimes I feel like I'm pissing people off by not being able to speak French." These examples illustrate how language policies and cultural attitudes towards language can constrain emotional safety and communication in care. In the following case, communication barriers not only led the participant to perceive that her needs were an inconvenience, but also that they were the cause of her inadequate pain management and eventual health complications related to urinary retention:

> I think [the nurse] spoke a bit of English; that might have been, you know, a translation issue, but I kept saying, 'It hurts my urethra.' She didn't understand. Finally, she gave me some Tylenol […] and put the catheter back in. But it was such an inconvenience, it felt like.

In addition to those who experienced marginalization directly, some participants were acutely aware of their privilege within the system. A few named their whiteness, high education level, or training within the healthcare domain as placing them at an advantage. One participant recounted having her doctoral-level training weaponized against her by providers; upon asking questions or seeking clarification for care decisions, one healthcare provider replied to her, "Oh, we can tell the PhD student in the room." This is an example of the complexity that exists around advantage and disadvantage; in this setting, what might be presumed as a source of social capital,

or protection against discrimination, became a source of backlash for this participant, and a tool that the providers used to undermine her.

Theme 3: Power and Control in Childbirth

This theme captures how participants navigated power, control, agency, and authority within childbirth encounters. Across accounts, childbirth was described as an ongoing negotiation of power between women and healthcare providers, shaped by asymmetries in knowledge, institutional authority, and control over decision-making. This theme is organized into three sub-themes: (1) *Strategic Adaptations and Self-Protection* explores the ways women adjusted their expectations and behaviour prior to and within birth encounters in response to perceived risk or threat; (2) *Constraint, Coercion, and Compliance* examines how women navigated institutional authority, constraints on their autonomy and agency, coercive tactics by providers, and acts of compliance; and (3) *Precarious Resistance* attends to moments where women attempted to assert agency or challenge care, often with the need to weigh personal and relational risk.

Strategic Adaptations and Self-Protection

Participants described certain strategic adaptations or forms of self-protection that were internalized and normative habits and behaviours that had been adopted over time and in social interactions within and outside healthcare. One participant spoke to the gendered stereotypes that she was especially conscious of as she navigated different social spaces during pregnancy:

> Like at work and everywhere else, I was so conscious. Like, all the time, because […] if you do something, they're like, ‘Oh, you're emotional,’ or ‘You’re hormonal because you're pregnant.’ So, you are doubly conscious with everything, with yourself, right? Because you don't want people to say, ‘Oh, she's hormonal right now.’

Another participant recounted similar prenatal care experiences, where she resisted any outward display of emotion to minimize unhelpful conversations with providers and avoid being infantilized:

> I often had to take it on myself […] I'm not a big fan of having my blood drawn, or having needles and stuff, and I would just not say anything, I will not show anything, cause I'm like, it's just not worth being called a baby […] And I would like, just try to disengage, and you try to not focus on pain, and you try to disengage from your own body sensations.

For other participants, often those who identified as racialized or marginalized, or those who expressed a pre-existing awareness of obstetric harm, a sense of anticipatory harm and orientation towards self-protection was common. These participants shared that they had preexisting conceptions of the health care system and perinatal care as systematically disrespectful, disempowering, and harmful, generated through their own experiences or through communal and media stories. Many of these women entered childbirth already in a state of guardedness, vigilance, and embodied distrust, using phrases such as "armed with information" and "fight for what I wanted." Being well informed and prepared for adversarial encounters provided some measure of protection from harm, as the following participant describes,

> It's just a hospital being a hospital. I knew it was gonna happen. I knew I was gonna get steamrolled, and I knew that there was gonna be rhetorical talking, and I was ready for all of that, because I know it's a healthcare system, and I was like, *they're not going to be any different for me.*

Constraint, Coercion, and Compliance

The notions of constrained autonomy, agency, and assertiveness extended across all participant accounts. Most often cited as a source of constraint were provider attitudes and behaviours that participants described as authoritative, paternalistic, and infantilizing. The exercising of power by providers over women occurred on a spectrum, from obscured violations through to the overt denial of rights, such as in the case of forcing procedures on non-consenting participants. The ways in which women responded to controlling or coercive attitudes and behaviours of providers were often driven by a desire to protect themselves and their babies from harm, minimize conflict, ensure safe care, and for some, simply endure childbirth. The following quote underlines the complex "dance," as one participant put it, of navigating power relations in the delivery room:

> I had the coached labour, that I really think was not needed. And when I challenged some of these while trying to give birth, [the nurse] was like, 'Nope, that's how I've been taught. That's how you do it.' And I was just like, okay, I'm just gonna give birth. Gonna get the hell out of my bedroom. I'm just gonna get [the baby] out and just not see you again.

This scene exemplifies this back-and-forth flow of power: the conflict between divergent sources of knowledge, the attempts to challenge authority, the rigidity of task-based care, and the undermining of the participant's autonomy and embodied knowledge. Importantly, in the example, complying with the nurse's demands was not necessarily an act of submission; instead, it could be viewed as a form of constrained agency, where a calculated decision was made to ensure safety, maintain a certain degree of control, and reduce harm by bringing a difficult experience to an end as quickly as possible.

Providers often exercised authority over participants by framing procedures as "routine," "normal," "the way we do it," or as a matter of "need," words that subtly encouraged staying "in line." In these cases, participants' fundamental right to choice seemed suddenly out of grasp. As one participant shared,

> [The doctor] said, 'You need an episiotomy,' you know. And I didn't agree. And at that point my husband also stepped in and was advocating for me as well. Um, and she was ultimately very insistent and did it, and the baby *was* born right after.

Instances of coercion were recounted by several women and often included threats that non-compliance with suggested care would jeopardize the baby's health or life. One participant described that in response to asking that her intravenous oxytocin be paused to give her a reprieve from painful contractions, her physician threatened that doing so would be putting her baby's life in danger. He told her that he would allow her to "one hour maximum" with the oxytocin off. Her words offer a brief, yet incisive account of how effective such coercive tactics can be in leading individuals, in a state of heightened vulnerability, to agree to care that conflicts with their own perceived needs:

> They lead you toward what *they* want. […] Is it conscious that they're trying to scare you? I don't know. But like, I mean, you're full of hormones, full of emotions, and then they say, 'Well, if you don't do this, this is what's going to happen.' 'Uh, okay, uh…' [reluctant tone] [Translated from French].

Significantly, the participant described that shortly after being issued the threat, she asked the physician to clarify whether her baby was in danger, to which the physician stated in a laissez-faire tone that the baby would be "delivered just fine."

Compliance emerged in participants' narratives, at times as an experience of having lost one's voice, but more often compliance was described as a conscious act. For instance, women deliberately complied with care that they did not agree with, or that was not aligned with their preferences, to avoid certain harms. Conceding to unwanted, uncomfortable, or harmful interactions was understood as a means of avoiding other, seemingly more harmful outcomes. Women were frequently in the process of analyzing actual or perceived risk, including the risk of providers responding in threatening or retaliatory ways. In the following example, the participant had already asked for her potential cesarean birth to be delayed, which appeared to have inconvenienced the physician. Despite enduring repeated vaginal exams, which were a source of discomfort for her, the participant perceived that pushing back any more than she already had would anger the physician:

> He did so many exams […] unnecessarily, like an insane amount of vaginal exams [grimacing]. […] I'd already pushed back against him on the C-section thing, I didn't even feel like fighting about the exams. I was just like, 'Fine, do it.' […] Even asking questions felt like a thorn in his side. […] So, we were kind of trying to like, yeah, we didn't want to piss him off. You know, we wanted like to have a good relationship with him because we needed him. We wanted his obstetrical expertise, basically.

Precarious Resistance

Resistance took many forms, from subversive acts to overt defiance in the face of controlling providers. Resistance was often precarious, paired with a sense of apprehension, doubt, or fear related to anticipated or real consequences, both in a practical and relational sense. For example, in response to women's attempts at asserting their autonomy or agency, providers engaged in ways that were experienced as punitive, retaliatory, and passive-aggressive.

Epistemic and discursive resistance offered women an invisible, perhaps less risky way of resisting the authority and control of providers, through cognitive processes that reinforced their own sense of agency. These included acquiring knowledge during pregnancy, cognitive reframing, withholding information from providers, and strategies used in the postpartum period to gain understanding and clarity around their experiences of OV.

During pregnancy, participants described their attempts at acquiring knowledge and information about pregnancy, labour, and birth through prenatal classes, social networks, and digital spaces. For some, this meant educating themselves on the indications, risks, and benefits of medical interventions, or understanding the phases of childbirth and physiological processes that were happening as they went through labour. One participant described the process of seeking out literature that normalized childbirth as a means of surrounding herself with a certain kind of "energy" in the lead-up to childbirth:

> I wanted to surround myself with uh, *this is normal, you can do it, this is positive, you can do it.* You know, I wanted to surround myself with that kind of energy before going in. […] What I believe is that a lot of agency has been taken away from women, and a lot of fear has been built up around childbirth.

As this participant illustrates, the act of discursively resisting the dominant narrative of childbirth as something to be feared provided a means of retaining her agency. Another participant described preparing and practicing a "protocol" for clinical encounters with providers, a list of questions to ask and steps to follow as a means of advocating for herself every time an intervention was suggested to her.

A further form of epistemic resistance occurred through cognitive reframing, the act of shifting one's perspective or interpretation of a challenging situation (Mohn, 2024). Reframing

could be seen as a means of countering discriminatory or degrading narratives about themselves, or a means of framing care providers critically or unfavourably. Even in moments of coerced or forced procedures, having the ability to discredit or undermine care providers, for example through silent internal monologue or in conversation with labour companions, could be understood as an attempt to regain control over the narrative. During their interviews, several women characterized providers, especially physicians and residents, as "idiots," "incompetent," and as lacking intelligence or critical thinking. They displayed humour, sarcasm, and derision in their characterization of providers: "You are a doctor, if you don't have [compassion], why do you come to this? *Oh, I was smart. I was supposed to be a doctor*. Get out of here man, sick!" Providers were often described as unkind, cold, arrogant, and lacking compassion and empathy. One participant demonstrated disdain when describing residents that she perceived as focused on academic achievement and gaining experience: "Oh, were you the top of your class? [sarcastic tone]. You didn't show compassion. You didn't do your job. You were in a rush. You thought you have to go room by room and gain experience, I guess?"

For two of the participants, withholding information from providers served as a form of epistemic resistance that allowed them to retain personal knowledge and control how they were perceived. For one participant, this meant concealing that she was feeling depressed because she perceived that disclosing her symptoms would delay her discharge from the postpartum unit, and she "just wanted to get out." Another participant, a young, racialized woman, described withholding symptoms of fatigue in her postpartum assessment to ensure she maintained the image of a stable and competent mother, and to ensure that she would "fall under the radar." Her decision was shaped by previous experiences of being stigmatized and discriminated against, and awareness that women in her Black Muslim community had faced scrutiny and involvement

from child protective services. In both cases, the act of withholding information was protective, but also risky, as their symptoms were related to significant health conditions, underscoring the trade-offs women may make to protect themselves in healthcare environments that feel unsafe.

Epistemic forms of resistance emerged in the aftermath of OV as well, in the form of women seeking out answers and clarity to their experience, which allowed them to more wholly process and make meaning of their childbirth. For some, this meant planning to ask their physician specific questions, obtaining their health records, speaking to friends and family, and seeking out reassurance in digital spaces.

Theme 4: **Roots and Reinforcements of Obstetric Violence**

This theme examines the structural, cultural, and institutional factors that sustain and reinforce OV. These factors intersect to create conditions where OV is normalized, obscured, or accepted as part of routine care. This theme is organized into four sub-themes: (1) *Medical Authority and Paradigms of Care: Risk, Control, and Pathology* highlight the prevailing discourses of risk, control, and pathology in modern day obstetric care and how these frame what is perceived as a "successful" birth; (2) *Normalization: Obstetric Violence as Routine* speaks to how OV came to be justified, minimized, and internalized as normal; (3) *Gender and Sociocultural Norms: Silencing Obstetric Violence* explores sociocultural norms unpinning OV; and (4) *Systemic Dysfunction and Public Health Crisis* explores systemic conditions contributing to OV through the eyes of women, including ineffective complaint and redress mechanisms, and impacts of the COVID-19 pandemic.

Medical Authority and Paradigms of Care: Risk, Control, and Pathology

Participants described care environments governed by a biomedical model where routine interventions and the (over)use of technology were the norm. For most participants, labour was

spent on continuous fetal monitoring, “strapped” to the bed, undergoing frequent vaginal exams, blood tests, and palpations, often to the sound of “beeping machines.” The predominance of the biomedical paradigm extended into care that was experienced as excessively fear-based and aimed at mitigating risk, often at the expense of emotional safety and autonomy. On being diagnosed with oligohydramnios, or low amniotic fluid, one participant shared,

> They slapped the label of [oligohydramnios] on me and then wanted to induce me for that, and I wish I had been more clear-sighted, but they talked about my baby dying and it sounded like it was really imminent, that there was a risk, it was a real emergency, and so I agreed to the induction.

One participant whose membranes had ruptured prior to her labour starting, noted that despite all clinical indicators pointing to her baby being healthy, she was labelled as at-risk and the healthcare team continually pressured her to agree to a cesarean birth:

> There were no problems with the baby, she was monitored. […] They were saying that I was putting my baby’s life in danger […] because I had broken my water, so it was always, ‘Risk of infection, we can’t wait, we need to get her out’ [Translated from French].

Even in the absence of risk factors, or actual medical need, providers demonstrated a desire to expedite labour and birth. One participant described being told on multiple occasions during her labour that her chances of delivering vaginally were low given her slow progress in early labour. She added, “No one expected me to give birth that fast. […] And that's why they pushed so much for me to have a C- section, because they were just like, ‘She's not gonna get there.’” Participants described interactions where providers demonstrated a lack of confidence in women’s ability to birth physiologically, vaginally, or with minimal medical interventions. For

example, expressing a desire to delay or avoid an epidural was frequently met with pressure and messaging that there was “no need to suffer” without pharmacological pain management. Another participant described the lingering impact that came from the lack of trust in her and her capacity to make decisions:

> The feeling that has stayed with me from my first [childbirth] is really, I wasn’t able to have my rights respected, and that I wasn’t able to stand up for myself, that I had the protocols done to me, and that no one had confidence in me [Translated from French].

Biomedical norms resulted in rigid adherence to standardized averages, including those related to fetal weight and pregnancy timelines. Deviations from these standards were often treated as inherently risky or pathological, with limited consideration for individual, genetic, or ethnic variation, as the following excerpt illustrates:

> I was also not a big baby […] there was big concern around the baby's weight […] we got sent to a high-risk doctor […] the first thing he said is, ‘I'm not gonna let you go beyond 38 weeks,’ […] He kept arguing that this is a high-risk situation, and that's why we need to do an early induction to get the baby out earlier. […] I guess I, cause there wasn't any other signs, I would keep insisting that I don't think this is a high-risk situation […] I even tried to show him like these numbers vary a lot depending on which ethnicity you're considering.

Participants also expressed skepticism towards a reliance on technological measurements that they perceived as imprecise or insufficiently integrated normal variations. As one participant explained,

> The medical system can be quite dangerous for people who don’t fit within the norm, and that’s what I felt too with having a very large baby. [….] The ultrasound is corrected for

> an average-size kid, and as soon as you get into very large or very small, the accuracy decreases dramatically. And also, people aren't trained on that, they're trained on like, the normal cases.

Hierarchical dynamics between providers and birthing individuals further signalled the presence and impact of biomedical authority. Several participants described having "blind trust" in the healthcare team and the broader healthcare system in the lead-up to their births. Cultural and institutional narratives around the authority of medical practitioners, especially physicians, were deeply held, including the belief that "doctor knows best", and that the healthcare team should be left to make the best decisions, and "do what needs to be done" to keep them and their baby safe. One participant succinctly expressed how despite a conscious awareness of her rights, the dynamics of the doctor-patient relationship led her to comply with unwanted interventions without question. "When a doctor says something […] you need to respect it. […] We listened, and we followed," she expressed. Another participant reflected on the internalized and conflicting beliefs about medical authority and personal autonomy that she navigated during her hospital admission:

> They never asked me if I had a birth plan. […] Part of me felt like I was being taken care of because it was immediately like, 'Okay, your water broke, come on, we'll set you up, hook you up.' […] But then at a certain point, you say to yourself, 'No, wait a minute. Shouldn't you have asked me first?' […] It was kind of both, between, 'Oh okay, well, they're handling it, I need to trust them and let go.' And then, 'Wait a minute, why aren't you explaining anything, why aren't you telling me why?' [Translated from French].

In the following "I" poem, the authoritative knowledge of providers is highlighted, including how it was deployed by providers and navigated by one participant as she experienced the repeated denial of her experiential and embodied knowledge:

I would arrive at appointments, [the doctor] would be like, 'Do you have any questions?'
'I don't know, do I? I can't know what I don't know'
I would go look for information elsewhere
I didn't know how to manage the contractions
We were kind of left to ourselves
I wanted to keep moving, and they told me, 'No, you can't, you'll fall, you'll get tired'
'I can feel my legs'
I know I have the right to do it anyway, but no, you said no, so I won't do it
I knew [my rights], but in the moment, I wasn't able to enforce the
I don't know if it was the timing, the stress, the newness, being in the hospital
I don't know, but in that moment, we listened and we followed
I know my energy, and I'd been awake 45 hours, I was fine, truly. But it was, 'No, you'll get tired, you won't be able'
I understand that maybe for others it would've been more tiring, but they don't know me
I know myself, they could've trusted one, my feeling, and also my *knowing* of myself, you know?
I could feel the baby wanting to make its way into the pelvis
I could feel the pressure
I could feel my contractions
I held my breath and it was like a team of football coaches yelling at you to push
I didn't like it. Like, let me do my thing, I'll push, I know I have to push
I could feel it
I wasn't making it up
I asked, 'How badly did I tear?' She said, 'Oh, you didn't tear, we did an episiotomy.' If I hadn't asked, they wouldn't have told me
I talked about [my birth] to anyone who asked me how it went
I didn't hold back

> [My sister] was like, 'Yes, but your baby is healthy, so don't complain' [Translated from French].

The poem exemplifies how questions of knowing – what is asked, told, withheld, and dismissed – structure power relations across pregnancy, labour, and birth. Throughout the experience, the participant's knowledge and intuition were consistently undermined and treated as unreliable or untrustworthy, even as she remained acutely aware of her own feelings, needs, and desires. As reflected in the repeated phrase "I don't know," compliance emerged not out of trust and deference, but often self-doubt and uncertainty.

Medical expertise and authority were frequently exercised or enforced on the grounds of interventions being necessary for the baby's or mother's physical safety. Accounts of such interactions often overlapped with the notion of *beneficent intent,* the principle of acting in the best interest of the patient. This framing was often internalized by participants, who felt compelled to comply with care that was pushed as being in their "best interest," even when it conflicted with their own needs or with what they perceived as best for themselves and their baby.

Across interviews, "safety" was a recurring concept, but one almost exclusively equated with physical safety. Emotional safety seemed absent from discussions of maternal well-being. Many participants felt their emotional needs were treated as insignificant when compared to measurable biomedical indicators. As one participant described,

> Their care ends and begins with checking whether the scar has healed. 'You're okay? Fine. But baby's gained weight? Okay. Baby's getting milk? Okay? Or, if he's not getting milk, then give him formula.' That's it. This is all they think.

Social discourses framing providers as integral to successful birth outcomes were described as contributing to the notion that childbirth is risky and to be feared. Reflecting on the widely held belief that medical interventions are integral to a safe birth, one participant noted,

> That belief comes from popular culture, and from history a bit. And all the stories that get circulated, whether we like it or not, in the media. In a case where a mother gives birth on the side of the highway, the headline is always, 'Oh! The wonderful paramedic, or the wonderful firefighter, or whoever, who managed to save the baby at the last second!' But in reality, if they hadn't been there, the baby would have been totally fine, and they didn't do any manoeuvre other than catch the baby outside. […] Sometimes babies do need *something*, sure, it happens. But it gives the idea that the *majority* need help, when actually it's the opposite [Translated from French].

Normalization: Obstetric Violence as Routine

The normalization of OV is the invalidation, justification, and rationalization of women's experiences of harm. It perpetuates a culture of silence where women feel that their suffering is illegitimate or unworthy of acknowledgment. Participants' accounts revealed that mistreatment was routinely minimized or justified, both by themselves and by others, as related to routine aspects of care, personality issues, workload stress, or the result of beneficent intent on the part of providers.

The minimization of participant pain, discomfort, or distress by providers was a recurring theme. Participants described moments when their physical suffering was dismissed, invalidated, or even mocked. One participant recounted a particularly vivid and distressing moment during a manual rotation of her baby:

> At the beginning of pushing, the baby was posterior, so [the doctor] said, 'I'm going to put my arm in and turn him.' […] It scratched me from the inside, like she was using her nails. I said, 'It hurts, it's scratching!' She laughed and said, 'That's impossible, I don't have nails, hahaha!' […] I said, 'I'm telling you that it's scratching me right now.' She said, 'No, my dear, that's not possible' [Translated from French].

Pain was often treated as routine or expected, with multiple participants told that pain was "normal." One participant described the normalization of her pain during a vaginal exam: "It hurts like hell, […] and they are like, 'Oh, we know it hurts.' […] It's like freaking accepted that it should hurt." Another described witnessing a woman in her shared room being forced to breastfeed despite obvious pain, with staff insisting, "It's okay, it's normal." The minimization of emotional distress also occurred, as the following participant who had been separated from her baby recounted, "They didn't really seem to understand why [seeing my baby] was so important for me, and I felt really dismissed. I felt really like I was acting crazy."

Participants recognized that the routinization of certain procedures or practices contributed to their desires or needs being overridden. One participant expressed that the routine aspects of care that she experienced as violating could just as easily have been experienced as positive by other women who preferred a greater level of "guidance":

> I don't think that, intentionally, they said to themselves, 'Her, we don't like her, and we're going to violate her rights.' It's just the routine. They told themselves, 'Well, we know what we're doing, she'll trust us.' There are people who would have thought it was a very lovely birth, being guided like that and being taken charge of [Translated from French].

Relatedly, some participants described an "it is what it is" sentiment towards the healthcare system, and described being habituated to uncomfortable, painful, or suboptimal care through previous interactions in reproductive health settings. One participant reflected on her negative experience in fertility clinics: "It had been two years of going through this. […] That's how it was in fertility clinics. Maybe because of that, I was almost used to feeling like a number."

Mistreatment was at times framed as an interpersonal issue, a matter of personality, mood, or interpersonal incompatibility, rather than a systemic or institutional problem. One participant recalled being told by a nurse friend, "You got the worst family doctor. […] She doesn't know what she's doing" [Translated from French]. Others described feeling like they had simply encountered a provider who was having a bad day: "I strongly believe that it's not because that person was like that with me that they'll necessarily be like that with everyone […]. Not in the sense that I'm the problem, but in the sense that we all have bad days." When mistreatment is framed as an isolated event, the pervasive structural nature of the issue is obscured, and instances of harm can be ignored or written off. For the participant who described her provider as having a "bad day," she felt it would unfairly impact their reputation to make a complaint. In the following example, the participant described not wanting to overly focus on the actions of one individual, despite having a traumatic experience,

> Overall, my experience was good, and I was thankful for everybody that was there that helped me. So, you know, […] I couldn't be like, just obsessed about that one nurse, […] that one negative experience, although it clearly […] contributed to the whole traumatic experience of it.

Participants often described their providers as “good” based on technical skill, even when they lacked empathy, warmth, or attentiveness. This framing reflects how dominant definitions of “good care” are shaped by systemic norms that prioritize efficiency and expertise over relational and emotional support. Two participants qualified their physicians as “good,” but lacking compassion. One participant commented, “My doctor, who has been a good doctor, she's very competent as a doctor, but the bedside manner wasn't really there.” Another shared,

> [My doctor] did an amazing C-section […] and that's maybe something he's really good at, a surgical procedure. […] In a different situation where you had a planned C-section, and you wanted like a doctor who is really good at that procedure, you might have been really satisfied with his approach.

These accounts suggest that participants felt compelled to accept a trade-off between technical competence and emotional care, often privileging the former.

Nurses were frequently described as “nice” or “sweet,” terms that appeared repeatedly across interviews. This characterization was often paired with accounts of mistreatment, suggesting that participants’ experiences of harm were buffered by this perceived “niceness.” For example, one participant expressed, “I found the care that I was given [during labour], […] the nurses were excellent. […] They were very, very sweet. But as soon as I went into recovery, uh, I felt like it was a totally different environment.” In some cases, participants may have expressed gratitude for nurses out of a sense of obligation or a need to soften critique. In the following example, a participant who expressed intense emotional distress from being separated from her baby in the NICU, stated, “The nurses were nice and everything. But then you know, from time to time, me being in pain, not having seen my baby, I go see the baby. They don’t take the baby out.”

Participants also perceived that nurses were acting under the authority of physicians or constrained by institutional protocols. There was an undercurrent of empathy toward nurses, who were seen as having limited power to intervene or advocate on behalf of birthing individuals. One participant described having reported feeling dizzy and unable to stand after giving birth yet being pressured by a nurse to provide a urine sample. She shared, “I felt for [the nurse], like, her job’s really hard […] like she was probably ordered to go in there and get the urine sample ASAP.”

Several participants extended empathy toward providers, attributing mistreatment to systemic pressures, emotional burnout, or the overwhelming nature of their work. As one participant stated, “I really like to believe that all these professionals go in there because they are deeply empathetic people that want to help. But […] if you put anyone under too much undue stress, […] they will start mistreating people.”

This empathetic justification was especially prominent in reflections on nurses and physicians during the COVID-19 pandemic. One participant described, “I didn’t really feel human. Like, it just felt very […] cold, like my concerns were dismissed. […] They were quite busy, and it was during the pandemic as well. So, I don’t want to be too hard on that.” Others justified their experiences by referencing the systemic conditions shaping the mental well-being of providers. As one participant observed, “What I really sensed was this – these are people who are overwhelmed and overworked and […] when they come into this room […] it's a persona that helps them to do their work.” These narratives reflect a complex negotiation between acknowledging harm and empathizing with those who caused it, mediated by an interplay between multiple norms and discourses: an obligation towards gratitude, nurses as “nice” yet helpless providers, and social and media discourses around provider burnout. Yet participants

also resisted these and offered counter-narratives. As one participant stated, “I’m sorry but no, someone who is that mean is not someone doing their best. Just because you're overwhelmed, it doesn’t make it okay to tell a mother that her not breastfeeding will cause her baby to develop poorly.” As the quote illustrates, even among those who did not feel compelled to excuse provider behaviour, there was still pressure to adhere to social discourses that framed providers as well-intentioned and beyond reproach.

A recurring element across interviews was the lack of education that would enable birthing people to advocate for themselves. Participants described entering childbirth with limited knowledge of their rights, their bodies, or the procedures they were undergoing. One participant reflected, “There is a severe lack of education about the human body […] You cannot advocate for yourself if you don’t know what you’re advocating for, and not everyone starts from the same base of knowledge.” Another described how fear, paired with a lack of knowledge, was used to compel compliance:

> It’s the fear of, ‘If you don’t do this, you’ll kill your baby.’ I think we hear that often in testimonies: ‘The doctor told me if I didn’t do it, I’d kill my baby.’ […] It’s the lack of knowledge in the face of all that [Translated from French].

These accounts underscore how the routine and habitual nature of OV, fearmongering, a lack of self-perceived knowledge and advocacy skills, empathetic justifications for poor care, and feeling the need to accept a trade-off between technical aspects of care and emotional care all contribute to the normalization of OV.

Gender and Sociocultural Norms: How Obstetric Violence is Silenced

Beyond its routinization within clinical care, participant narratives illustrated how OV is embedded within broader gendered and cultural norms that regulated how women responded to

OV and silenced their attempts at voicing their experiences. CBWs described expectations to endure suffering, to prioritize the needs of their baby over their own, to be grateful and uncomplaining, and to frame their experience as ultimately positive, even when their experiences were challenging, painful, or traumatic.

Participants described how the discourse of maternal sacrifice was used to justify or minimize their own suffering. Several participants felt they had no choice but to comply with care framed as "best for the baby," even when it conflicted with their own desires or understanding of what was best. As one participant explained, "My experience and my body's well-being, and my mental well-being was totally sidelined, because the focus was having [the baby] born healthy. And that was my priority *too*. But […] it was a horrible experience for me."

The idea that a healthy baby was the only acceptable outcome served as a powerful silencing force, discouraging women from expressing distress or calling out harm. For women to advocate for their own needs was often framed as selfish or inappropriate, such as the often heard, "you're putting your baby's life in danger," being used to dissuade women from refusing certain forms of care. The following participant reflected on how this fetal-centric framing contributed to feelings of guilt and silencing of her personal experience:

> I was mangled, you know, I was a mess afterwards. […] It really felt bad in a sense, to [hear], 'But you had […] a healthy baby, right?' […] Because it made me feel like bad for complaining, essentially. Like I shouldn't complain about this experience that was really not fun, because the only thing that's important is your son being born healthy.

Participants described how interactions with family, friends, and other mothers included pressure to be uncomplaining, to accept what they had "signed up for," and reminders that they "should have thought of it before getting into it." As one participant recounted, "I had a lot of

mothers tell me, ‘Oh, welcome to motherhood! What, you thought it was so easy, is it?’” The social conditioning of women, by other women, was identified as contributing to this discourse: “It's a lot of conditioning of some women in their homes. I saw that a lot, a lot of mothers [themselves] say this to a lot of other mothers.” Maternal suffering was not only normalized but often valorized as a rite of passage into motherhood. One participant reflected on how this discourse was perpetuated by providers:

> From some of the nurses, […] especially those who are mothers, it felt like, ‘We went through it, and we adapted to it. So why can't you?’ There was a little bit of feeling of […] ‘This is how it is. And it was hard for me too, […] you just gotta get on with it.’

Another described how conversations with peers often led to comparing of suffering, where women were encouraged to see their experience as relatively positive. As one participant shared,

> Sometimes when I talk about the birth with other women, it's like, ‘Oh, well, *I* had a 4th degree tear.’ It's like this competition, a little bit of like, it's supposed to be bad. Like, ‘Birthing a child is this crazy intense experience and […] what happened to you is just […] childbirth. […] Women used to die in childbirth all the time.’ You know, like that attitude. […] ‘You didn't die, and your son didn't die so, […] count your blessings.’

In the aftermath of OV, participants recounted being told, explicitly or implicitly, that gratitude should override any negative feelings about their care. One participant shared,

> If I complain, when I tell someone that the nurses were mean to me, it’s always, ‘But your baby is healthy. Why are you complaining?’ And it’s like I have no right to be angry that they harmed me from beginning to end, because they didn’t kill my baby, who was already perfectly healthy anyway [Translated from French].

In addition to external pressure to conform to dominant norms of maternal sacrifice, enduring suffering, and gratitude, participants also demonstrated internalized norms and beliefs through the way they narrated their experiences in the interview process. Participants described experiences that were at times traumatic, as "little," "not a big deal," or as "not fun." Others deflected from painful or traumatic accounts by pairing them with statements that minimized their suffering or emphasized appreciation: "The worst feeling […] comes from the terror I felt […] So, there you go. Otherwise, the rest was fine. Baby was healthy. They let us do skin-to-skin at our request" [Translated from French]. Participants demonstrated self-minimization, often apologizing for crying or for speaking at length during interviews. Some described themselves as "silly" or "acting like a child" when recounting moments of emotional vulnerability during their childbirth.

Even when participants recognized the harm they experienced, many refrained from naming it as trauma. "I'm not traumatized, but what I went through doesn't make sense," one said. She continued, "But in a way, it is trauma. When you say, 'I don't want to go back there,' well, that's what it is" [Translated from French]. Others expressed gratitude for care that was clearly suboptimal: "I'm grateful for the hospital being the way it was. Definitely not as bad as my friends." One participant reflected on how she had come to rationalize her experience, despite feeling retraumatized in a subsequent pregnancy:

> I consider myself lucky in many aspects […] I guess I'm told not to complain too much. And I guess I don't have much to complain about. So, I think that's, that's the mix of the internal process that's happening there. Like the rationalization and the, 'Well, you know, it could have been worse. […] You have a healthy kid, and you're healthy. Just put it out of your mind.' Until you have the second one, and then all the trauma comes back.

Systemic Dysfunction and the Public Health Crisis

The following sub-theme describes characteristics of the public healthcare system that CBWs perceived as contributing to OV, including: public health care limitations and the impacts of COVID-19, cultures of workplace violence and poor working conditions, elements pertaining to experience, training, and generational tensions, and failing complaint and redress mechanisms. Overall, participants described the healthcare system as stretched to its limits, where staff shortages, high patient loads, and logistical constraints compromised the quality of care. Emotional detachment, burnout, and inflexibility were common, with providers prioritizing checklists over patients' emotional and relational needs. Experiences were negatively impacted by discontinuity of care and lack of postpartum follow-up, undermining trust and leaving many feeling unsupported or unable to advocate for themselves. Policies and hospital structures, ranging from cold rooms to underfunded facilities, added to feelings of vulnerability. Many participants linked these systemic conditions to experiences of OV, noting that the environment itself, compounded by COVID-19 restrictions, shaped interactions and constrained the ability of providers to respond with empathy, patience, or person-centered care.

Public Health Care Limitations and COVID-19. Participants expressed concern over rotating providers, which limited therapeutic relationships and capacity for self-advocacy. One participant expressed discomfort at "some random dude" performing vaginal exams on her. The absence of her physician during her labour and birth was "careless" and "irresponsible," one participant reflected. She continued, "I don't understand how you've been with one doctor for so long, and suddenly two students come out of nowhere and do your exam." The following participant described the risk in not knowing one's delivery doctor ahead of time, describing it as Russian "roulette," a game of chance with a high risk of harm:

> My mom was followed by the obstetrician who delivered her babies. […] I know it means your schedule is terrible if you work in that field, but it, it is also like the most humane way to do it. I mean, it's really, it's really hard to not know who your delivery physician will be.

Lack of postpartum follow-up and limited appointments reinforced feelings of dehumanization and silencing of OV experiences. The majority of participants described postpartum appointments as rushed and limited to an assessment of physical symptoms:

> I was surprised too, […] there was no real follow-up with my doctor's office after that. There was the six-week checkup, […] it was only about three, four minutes. Just check the incision, and that's it. […] It's the way our […] healthcare system is, too. I don't wanna place the blame on anyone in particular, […] it's difficult in the healthcare sector.

Public healthcare limitations left participants feeling at the mercy of available providers, with little incentive for respectful care. As one participant expressed, "They're like, 'Oh, I'm the only doctor here. If I'm not here, you don't get a doctor." She continued, "Knowing the health care [system], knowing that we are short on doctors and everything doesn't help. It prevents you from talking." Participants also noted that high physician remuneration attracted individuals to the field who were more interested in social and financial status than the human aspects of care:

> I think that doctors shouldn't be paid as much as they are, because the fact that they're paid this ridiculous salary makes it that those who want to become doctors are people who just want the money, and who want prestige. […] So of course, you end up with doctors who are ultra arrogant who think they are like gods, and that they know everything […] and that patients are less than, and that they know nothing, so they need to make all decisions made for them [Translated from French].

Physical space was also challenging. Participants described separation from their infants in the NICU, having to travel long distances to reach the NICU, procedural barriers to accessing the NICU and associated feelings of alienation, and post-operative mobility challenges. Participants also described hospitals as "underfunded," "bare bones," and "old."

All participants gave birth between 2021 and 2023, with many subjected to COVID-19-related restrictions and the second-hand impacts of provider stress. For four participants, policies restricted participants from having more than one person in the delivery room, which forced them to exclude doulas or family members that they had planned to include in their birth,

> It was […] in the upswings of Omicron COVID, and which is really unfortunate, […] on the day that I gave birth, my only one other support person was allowed in the room, that was going to be my partner, […] and not my doula. […] It was my first time. I had no idea how it was gonna go, but it was intense, […] that person was, you know, our advocate and that.

Others perceived constraints on nurses' ability to be present at the bedside: "For sure, [COVID-19] had an impact. There was no time for [providers] to stay in the room. [..] Nurses were no longer supposed to stay in the room and provide labour support. […] So, we didn't see her."

One participant described how not being vaccinated against COVID-19 led to her being stereotyped as an "antivaxxer." She recounted, "[The nurses] brought up the MMR vaccine and accused me of lying when I said that I got it while I was planning my pregnancy." She also described feeling shamed for not being vaccinated: "I asked [the nurse] to take precautions anyway even if she's vaccinated, and she said I was the one spreading COVID, not her."

Culture of Workplace Violence and Poor Working Conditions. A culture of workplace violence, or lateral violence, was observed through conflict and mistreatment between providers. One participant described how conflicting messaging from nurses regarding an epidural protocol led to one nurse getting into "big trouble." The same participant further described that, upon discovering a sponge had been left in her abdomen during her cesarean birth, the physician proceeded to yell at the medical resident: "During the past 30 years, this is the first time [this has happened] to me! It never happened to me [before]!" Conflict often revolved around patient care decisions, where differences in willingness to adhere to patients' desires or preferences became a source of tension. One participant described the "toxic" nature of the healthcare setting for providers, where "kind nurses" were reprimanded by "mean nurses" for making too many concessions for birthing individuals. Another participant described expressing to her nurse that she was experiencing significant discomfort with the incremental increases in the oxytocin rate, and the ensuing conflict that arose between the nurse and doctor:

> The doctor said to the nurse, 'Okay, let's go back up to this dose [of oxytocin],' […] then she didn't change the dose. […] And then he came back, and he was like, 'Didn't I tell you to…' [yelling] […] I was kind of like happy she hadn't changed it. […] She was doing her best to be very patient-centric. And you know, that didn't sit well with him.

Participants referred to long workdays, multiple patients, and limited institutional support, succinctly captured by the following participant: "I think people are less human when they tend to be more busy." Another participant shared a similar opinion:

> I think that a lot of the staff I worked with mistreated me because they were under a lot of pressure to do a lot with very little resources. They didn't have enough staff for the people they needed to treat, they didn't have enough rooms, […] they just didn't have enough.

High stress contributed to inflexibility and adherence to standard protocol, leaving little room to accommodate individual needs: “The nurses were overworked, hyper stressed, not being properly supported. So as soon as something deviated from their standard protocol, […] this was like an insurmountable challenge for them to try to accommodate me in that.” Pressure to increase patient turnover, paired with provider stress, was described as creating a “factory” environment where participants felt rushed or deprioritized:

> The nurse I was working with made it very clear that there was another mom that had to give birth, needed to use the room, so they needed me to vacate it. […] I think that they were burnt out. They were very fixated on certain protocols, like just getting me out of the room, even though […] I kept saying, like, ‘I'm too dizzy.’ I had been vomiting, I was dizzy, and I was like, ‘I can't get up.’

Mental health support for providers was perceived as lacking; participants described physicians and nurses as “burnt out,” “high strung,” and experiencing “compassion fatigue.” One participant described of her physician: “She was so not in her body,” adding that she felt unable to have an “adult to adult conversation” with her. Another participant noted that despite providers being “overwhelmed and overworked,” she believed they had “no support system in terms of their emotions.” She continued, “I don't think anyone's sitting with them and going, ‘Oh, how was that for you like when that kid died.’ […] Everyone's walking around high stress levels and…I don't think that's helping them make good decisions.”

Experience, Training, and Generational Tensions. Perspectives on the impact of experience, training, and generational characteristics were mixed, with younger providers described as at once more aware and open-minded about alternative approaches to care, as well as more insecure and inflexible, needing to “cling on” to “textbook” processes. More

experienced providers were at once described as confident, technically skilled, and expert communicators, while also set in their ways and authoritative.

For some participants, provider experience contributed to emotional attunement and a humanized approach. As one participant expressed, “The doctor was super funny, […] the ones who were experienced were really good. Like they know how to talk to you, to calm you down.” Experience was perceived as building the confidence and intuition to integrate technical and emotional care. One participant who described her doctor as “great,” noted, “I can’t imagine that someone right out of school would have these reflexes.” The idealization of the older generation of doctors emerged, with one participant describing her physician as “one of the last of his generation that was really an amazing doctor.”

However, some participants noted that older providers could also be inflexible or paternalistic and rigidly adhering to practices that were not evidence-based. The “old guard,” as one participant described, “are […] also extremely resistant, because [they] practice a certain way and deviating from that way is extremely hard. So, if you have a protocol in mind, you just [go] for it like in automatic mode.” One participant described of her physician “His whole demeanour [was] just not very caring […] Like he's older, close to retirement. Um, so like, is that an old, an old school approach that he's just kind of always like that?”

Less experienced nurses were also described as less emotionally supportive and as lacking communication skills, as the following participant described,

> Even when you go for a test, they send a nurse that is like, is in internship. They can’t […] find the heartbeat, and then their face changes, you *panic* because you’re like, *oh, the heartbeat is gone,* you know. Then I’m like, *come on*, I know they should learn, but shouldn’t they teach them, ‘Be there!’

Newer nurses were also described as lacking the training to provide adequate labour support, "I found [labour] really intense, and I didn't know how to manage the contractions. […] There was no one to guide us. It was all new nurses who didn't really know how to answer our questions."

Training systems were generally perceived as inadequate, and heavily focused on "chemistry and mathematics" versus the humanistic aspect of care. Several participants expressed a sense of unfairness and frustration that birthing individuals are used as educational "tools" in the clinical training of new practitioners. Institutions were also described as being marked by systemic racism and colonialism that translate to biases among providers:

> How do you undo centuries of colonization and racism that are pervasive into our own institutions and day-to-day life? […] People that go to like medical school or go to nursing school, they have a history of beliefs and perspective as well, that needs […] to be challenged, I reckon.

One participant reflected on systemic racism often being overlooked in training institutions and the healthcare system:

> I think that the […] Western medical system is currently based on […] a very white-centered approach, and […] at its basis, actually done on extremely racist studies. […] I believe it to be very institutional, because they don't have any classes on all of that. They barely have any training, any discussions, any any room for it.

'There's no point': Complaint and Redress Mechanisms. Despite the severity of their experiences, most participants did not file formal complaints about the OV they endured. The barriers to speaking out were numerous and deeply embedded in both personal and systemic contexts. Postpartum exhaustion, feeling emotionally overwhelmed, and the immediate demands of newborn care left many women without the time, energy, or clarity to pursue redress. As one

participant expressed, “All my energy was being used to take care of my baby, and my baby’s well-being, and I just had zero energy to file a complaint.” For others, fear of reprisal, lack of knowledge about the complaint process, and a pervasive sense of futility shaped their decision-making.

Only one participant out of 13 reported having filed a formal complaint with the hospital. Validation from the nursing staff served as a catalyst, without which the participant believed she never would have made a complaint. As she explained, “We were like, well, if the nursing staff thought it wasn't cool, then they probably know what they're talking about. They see it like multiple times every day. So, it wasn't just… normal.” Few others shared informal feedback with their care providers, such as during postpartum appointments or in the case of one participant, through a letter to her midwife that she hoped would ultimately be shared with the medical team. Yet even in these cases, follow-up from the medical team was minimal or nonexistent, reinforcing the perception that OV is tolerated, overlooked, or dismissed.

For marginalized women, the stakes of speaking out were even higher. One participant, reflecting on advice from her family, shared, “So for me, I did think about [filing a complaint]. But my parents, everyone was like, ‘No, just don't do it. What if they find out your name, […] find out who you are […]?’ And I'm like, **‘**Yeah, that's right.’” Concerns about being labelled as unstable or unfit, and of making oneself vulnerable to child protective services led some to remain silent. Others feared that drawing attention to themselves would result in further scrutiny or harm, especially when their family doctor was affiliated with the same hospital at which they delivered.

The emotional toll of the complaint process also served as a deterrent. Participants described the difficulty of revisiting traumatic experiences, or of being emotionally unprepared

to express their experience in the form of feedback. As one participant shared, “I was livid […] I was so angry […] I just didn’t know what would come through me, […] like, *will I even make sense?* […] I don't know if I'm ready yet in, in some sense.” For another participant, the refrain, “Just let it go. Move on,” provided insight into her own decision-making around filing a formal complaint; she perceived the process of filing a complaint as a potential barrier to emotionally processing, accepting, and moving on from her childbirth experience. Others shared doubt about whether their stories would be taken seriously, and the internal conflict of weighing the costs and benefits of speaking out. One participant reflected,

> It was an unpleasant event, it wasn’t fun, but we’ll deal with it, you know? My baby is healthy, the famous saying *my baby is healthy, everything’s fine.* But it was later, reading testimonies, connecting with certain people on social media, that I was like, ‘Oh, it’s not normal to have experienced it that way!’ […] But then telling myself, ‘What’s the point of filing a complaint, anyway? […] Is it really going to change anything?’ [Translated from French].

Participants noted that emotional harm and poor provider attitudes were difficult to quantify and therefore doubted that they would be accepted as legitimate grounds for complaint, when stacked against medical errors with tangible physical consequences. As one woman explained, “The fact that the nurses were mean, that’s not something you can quantify. […] But the fact that I was subjected to the gestational diabetes protocol when I didn’t have it, that I could have filed a complaint about.” The perception that medical outcomes were “positive” led some participants to dismiss the idea of pursuing a complaint, even though they had considered it, as the following participant described,

> I didn't want to follow up with the hospital because I felt, knowing how the hospital worked, all of the outcomes were positive in the end for me. […] Medically speaking, everything worked out well. So, I knew that it would just not be considered. So, I decided to not pursue, […] even writing a letter. Like, I had the name of the doctor. I could find her email address and just say, 'Hey, like that was not okay.' […] Except […] me writing it out and saying it wouldn't, it wouldn't be worth it.

Narratives justifying or sanctioning provider behaviours were also described as dissuading women from speaking up about their experience, as the following participant expressed, "They really have to do something really serious for it to be taken seriously. Otherwise, we get told, 'They're really busy, they're overworked, they're doing their best.'" Similarly, another participant described weighing her options for providing feedback about her experience, including the possibility of sharing it informally on social media. She struggled with the idea of publicly criticizing one individual she perceived as overworked and "still a person behind it all," ultimately deciding against it. She explained that she didn't "want to go online and trash someone's reputation," reflecting that the provider "might have been working a 60-hour shift." Instead, she planned to obtain her hospital records and consider filing a formal complaint later, emphasizing, "I just don't want this to happen again. But going online and bashing someone, that's just not my style" [Translated from French].

Others described how the rushed nature of postpartum follow-up appointments made it difficult to express their concerns:

> I had a call with my last OB. […] I lost everything that I wanted to ask. I was so rushed, and I was also, you know, you're not good, you're six weeks after […] giving birth, you

know? […] You're still in it, right? […] Now that I'm out of it, I'm like, I should have stopped him and said 'Hey, the residents sucked. You know it is on you to teach them.'

Ultimately, the narrative that "everything worked out in the end," often in reference to the physical outcomes, served to silence women's experiences. The lack of clear, accessible, and responsive complaint mechanisms left participants feeling that their voices would not lead to change, and that their suffering, particularly emotional harm, would not be recognized as valid and worthy of action. For many, the process of filing a complaint felt daunting, futile, or emotionally burdensome, and as a result, even when participants considered speaking up, they often concluded, "there's no point."

Theme 5: Pathways to Humanized Care

Amid narratives of harm, participants also shared moments of compassion, validation, and agency, paired with reflections on potential strategies for mitigating harm in childbirth, which comprise this final theme. Three sub-themes are presented here: (1) *The Power of Validating Interactions* explores the aspects of care that eased moments of mistreatment, contributing to feelings of being validated, humanized, and that positively impacted how women recalled certain moments in childbirth; (2) *Systemic Reform* describes strategies for change through the eyes of women, from transforming care models to raising awareness about the mistreatment of women in birth; and (3) *Epistemic Justice: Contributing to the Collective Narrative* illustrates the impact that story sharing can have on the meaning-making process around childbirth and on a broader collective understanding of OV and it's impacts.

The Power of Validating Interactions

Small but meaningful gestures from providers offered a reprieve from distressing situations. Acts such as eye contact, gentle touch, and active listening had profound impacts on

CBWs. Validation and emotional support counteracted helplessness and distress. For example, one participant recalled the positive impact that her nurse had during her emergency cesarean birth and in the moments leading up to going under general anesthesia:

> I just remember […] everyone yelling. I was like, 'No, no!' And then they put me to sleep. […] And thank God, [Nurse], the nurse came in, and I remember someone asking her like, 'Who are you?' And she's like, 'I'm the obstetrical nurse.' But she like insisted on staying. I'm so grateful because, like she, she like had been with us the whole time. And she knew, like, how afraid I was.

Participants recalled instances where providers advocated for their preferences or accommodated their requests. "The nurses were excellent," shared one participant, "They helped us into the bath, […] they made accommodations." Another recalled the recovery room staff failing to provide adequate pain relief following her cesarean birth: "I couldn't open my eyes, couldn't speak, from how much pain I was in." She described her great relief when her physician, outraged at the lack of pain management, intervened on her behalf. She described his response to the other providers: "He said to them, 'Hello? […] Have you seen her? […] She's in pain, […] she's felt everything since the operating table. You need to give her something else'" [Translated from French]. In the account, the participant experienced the provider's advocacy as protective, even though it was communicated in an unprofessional manner. This example highlights the complexity of person-centered care practices, as they intersect with institutional norms and potentially toxic workplace cultures.

Access to tools like birthing balls, showers, and intermittent monitoring allowed women to manage pain and labour in ways that felt empowering. When providers respected requests for delayed pushing or explained procedures clearly, participants felt more in control and less

traumatized. For participants with infants admitted to the NICU, opportunities to be involved in infant care contributed to a sense of fulfillment and self-efficacy. One participant recalled the importance of being able to carry out nurturing tasks like putting a blanket on her baby.

Supportive relationships with spouses, midwives, and doulas were a source of validation and empowerment. Spouses were a common source of emotional and practical support, working alongside participants through self-advocacy, or often, as a proxy for their labour spouse. Doulas were also seen as a person who could support and care for both the woman and her partner. They also were a source of information about rights and promoted self-advocacy. According to one participant, "My doula […] really made it clear that I needed to prioritize what was good for me, and that everything again, barring emergency, is a choice, and it may not be presented as a choice." Another, who described her doula as a "guardian angel," shared,

> People said, 'Oh, have a doula,' and we're like, 'It's our first birth. Let's just try.' […] It was such a blessing to have her with [us]. So, it was the best decision we made regarding [the birth]. [She] […] could reflect back what she'd seen of what happened in a very professional and level-headed way. […] And so that was just like a perspective we didn't have because we were both just completely confused and afraid. So, just amazing.

Systemic Reform

Participants emphasized the need for systemic reform to address OV and birth trauma. Suggested areas for change included improved prenatal education, trauma-informed training for providers, enhanced communication, and stronger accountability mechanisms. Addressing provider burnout and fostering a culture of empathy were viewed as essential to mitigating OV and improving birth experiences. Women called for care models that prioritize relational safety,

informed consent, and shared decision-making. Participants envisioned systems in which emotional well-being is valued alongside physical outcomes.

Participants highlighted the need for greater emphasis on person-centered approaches. Several women described how validation, reassurance, and emotional presence could have substantially altered their experience. For example, one participant noted,

> Look, I'm not saying that having a child is a bed of roses, but you can make it at least 80% comfortable for the mother. Calm her down. Tell her, you know, assure her it's okay 'It's going to be painful, you will feel the pain, but we are trying to do our best here. We are on your side.'

Another emphasized the importance of listening and validation in moments of vulnerability: "I do wish that I had just been validated in my needs, which was just to get up and get clean. But it's hard to say, but yeah…Listening, validation, empathy."

Enhancement of training programs to include cultural competence and concepts related to person-centered care was identified as a bottom-up approach that could bring about change over the long-term. For example, one participant noted that widened understandings of cultural birth practices might lead to support for the inclusion of "extended family and community" in the birth process. Another participant noted that medical school teaches students to deal with "machines" rather than "human beings," and called for the concepts of "compassion, empathy, [and] openness" to be systematically incorporated into training programs for all health care professionals.

Transforming dominant medical models of care to overlap with, include, or shift toward midwifery models was identified as a potential source of positive change. Participants emphasized the potential value of including midwives in hospital settings, expanding their scope

of practice, and incorporating elements of midwifery philosophy, particularly respect for the autonomy of birthing individuals, into medical education and training. Some participants described interdisciplinary professional development initiatives that brought midwives, physicians, and nurses together as important opportunities for knowledge exchange, collaborative practice development, and smoother transitions when care is transferred from midwives to physicians during labour.

The contrast between models of care was described as stark: “It feels like there's a very stark difference in the kind of care. But if midwives were given a touch more power. Like, I was really shocked at what midwives are and aren't allowed to do.” Others emphasized the importance of learning from midwifery approaches: “If doctors learned from midwives that things are a choice, and to put that choice back to women.” Participants also felt that greater awareness of the role and scope of midwifery practice was needed to reduce stigma and promote collaboration among healthcare professionals. One woman described the response of nurses during her labour: “A lot of them thought that I was gonna go give birth […] in a field, like when I was talking about my midwife.”

Participants identified gaps in prenatal communication as a key area for improvement. They called for more opportunities to develop therapeutic relationships with physicians and other care providers prior to labour, as well as more direct and intentional discussions about needs, values, and desires related to childbirth, including through a more standardized use of birthing plans. Improved postpartum follow-up, in terms of frequency, duration, and timing, was also identified as an avenue for feedback about the birthing experience to be shared. In the words of one participant, greater contact between the provider and patient in the postpartum period would

contribute to providers "understanding the turmoil that [obstetric violence] creates" and "create more empathy on the part of practitioners."

Improved feedback and accountability mechanisms were identified as potential avenues for raising awareness and promoting behavioural change among providers. Participants called for systematic tools for communicating their feedback and concerns, such as more robust patient advisory committees, or opportunities for women to share their birth stories directly with providers. One participant noted that strategies for raising awareness about patient mistreatment could be applied in parallel with institutional efforts already underway that targeted the mistreatment of providers by patients. She noted, "You get [to the hospital], and it's like, 'Oh, don't be violent with us,' or the notes are everywhere, 'We don't tolerate violence.' Okay, but patients shouldn't be having to deal with your attitude either, right?"

Some participants pointed to broader structural and policy-level efforts already underway. One described her involvement in Indigenous-led initiatives following the death of Joyce Echaquan and the emergence of Joyce's Principle:

> Joyce's Principle that stemmed from the death, the horrible death of Joyce, I think is making some waves. […] There's like lots of different committees, some are part of the nursing school, and are actually working to like recreate some curriculums. Some are doctors that are trying to like retrain some curriculums, […][or] teachers in colleges and high school that are thinking about adding things, and how to retrain, how to like raise awareness.

Epistemic Justice: Contributing to the Collective Narrative

For many, sharing one's birth story with loved ones, in digital spaces, and in the context of the study, served as a form of epistemic justice, a means of reclaiming their birth narratives,

and an act of contributing to the collective understanding of OV. “Seeing your experience and your words being part of something bigger, I think it can be very healing,” shared one participant. For another, sharing her own story was a way of speaking on behalf of her friends “who’ve been through a lot themselves.” Though some participants preferred to maintain some level of anonymity upon sharing their stories on public forums or avoided naming specific hospitals to avoid tarnishing their reputation, others chose to warn women against specific hospitals. Participants described that bringing their experience to light was important in raising awareness among other birthing people and HCPs and contributing to systemic change. As one participant noted,

> There’s loads of stories out there. No one is collecting them, […] that's why I joined your study when I saw it […] it's important, like, to share these stories and like, feed them back in a way that practitioners can understand.

Participants expressed hope that their testimonies would resist the normalization of OV by expanding the scope of what is understood as harmful or traumatic in the provision of care. They challenged the notion that only dramatic or life-threatening events warrant attention, asserting that emotional harm and disrespect are equally deserving of acknowledgement. One participant expressed, “Like, it's not because I didn't have a C-section, and I didn't lose my blood and almost died, that I'm also worth listening to what happened.”

Story sharing also fostered personal healing and was described as “grounding” and “a kind of processing.” One participant described that the study interview was her first time telling her story in its entirety, noting, “I do think I want to share about this, because I can't be alone in having these kinds of experiences.” Contributing to the wider collective also represented an opportunity to overcome feelings of isolation. A similar sentiment was conveyed by another

participant as she described the positive impact of sharing her story with a friend who underwent similar medical interventions in birth:

> When this happened to me, […] I just felt like I needed to talk to somebody. […] The most healing I would say I had was talking to a friend, […] who also had a forcep experience. And talking about it with her, I felt that was really, was really good.

For another participant, the importance of disclosing her experience in the research process came into sharper focus through hearing a friend's account of mistreatment during a pregnancy loss. Previously undecided about participating in the study, it was this account that appeared to transform her personal story into part of a collective. As she explained, "That's why I came, because I heard, like, a terrible gynecological story from another friend. I was like, 'No, I should [share my story].'" Her motivation emerged from a drive for justice on a collective level:

> I can't believe we still treat women like this, like that's crazy. […] I just thought like, I don't want to just go all through my life hearing these stories from other women of mistreatment, and like not… What can I do? You know? What can I do, like? Not much. But then I was like, I could speak to this researcher, and maybe like that research will have an impact.

Having negative experiences witnessed or reflected by labour companions, family members, or providers reinforced a sense of being seen and heard and helped legitimize participants' feelings of harm. One participant noted that her "midwife was shocked" upon reading her medical record, and shared "even my mother noticed," when referencing her physician's "cold" approach. For another participant, support from multiple sources helped her make sense of what happened:

> Having [our doula] reflect [the physician's poor communication] back to us and be really supportive… And then, like, a family friend was a nurse in the NICU […], and when we talked about the birth with her, she was [….] incredibly sympathetic. And and then I had a few sessions with my therapist. So, all that to say, like, I processed the birth quite a lot.

These moments of recognition were often recounted in detail, suggesting how significant such validation felt for participants. They also confirmed participants' experiences as "not normal" and diminished self-doubt, especially when echoed by people with clinical experience. One participant shared, "When I spoke about [my experience] with my doctor, he said, 'Ah, I know who you're talking about… We have problems [with that provider].' […] So, I said to myself, 'Okay*,* when your doctor says it's not normal…'" Another described the weight of a nurse's opinion in overcoming uncertainty about whether what she lived through constituted mistreatment:

> The main nurse that was there when we delivered, […] she's seen everything, right… And if she's telling us, 'Oh, like, yeah, what happened with you guys wasn't [normal].' You know, cause there's still a lot of doubt like, […] is what happened to us worthy of complaint? […] Or is this just sort of what can happen when things don't go well in labour and delivery? […] Was this mistreatment?

In summary, this chapter presented the results from interviews with CBWs, examining how OV was experienced, interpreted, and lived through from pregnancy to postpartum. Across themes, participants described a range of practices through which harm was enacted, and that were accompanied by immediate emotional impacts such as fear, distress, and powerlessness, as well as residual effects that extended well beyond birth. Accounts demonstrated that women experience childbirth and OV as unfixed, ambiguous, and at times contradictory experiences. For

many women, OV eroded trust in healthcare systems, altered their sense of self, and reshaped how they understood both childbirth and motherhood. These experiences and impacts were mediated by discourses of femininity, motherhood, birth, safety, and medical authority. Women's narratives also highlighted the ongoing negotiation of power in childbirth; participants described engaging in strategic adaptations, compliance, and precarious forms of resistance in efforts to protect themselves and their babies, minimize conflict, and ensure safe care. While deeply emotional personal accounts of harm prevailed, women also expressed wider knowledge of the systemic factors driving OV and its normalization, including risk-averse and fetal-centric care models, and strained healthcare institutions.

Chapter 6: Results – Healthcare Providers

This chapter presents results from interviews with HCPs. It is organized into three themes: (1) *Not Heroic, but Human: Obstetric Violence Through the Eyes of Providers*, (2) *Complicity Amidst Advocacy: How Providers Navigate Obstetric Violence*, and (3) *Provider-led Responses to Obstetric Violence* (see Table 5). While the results from CBWs predominate, HCP interviews were used to complement and deepen the overall analysis.

Table 5

Themes and Sub-Themes from Interviews with Healthcare Providers

Results: Healthcare Providers	
Themes	**Sub-themes**
Not Heroic, but Human: Obstetric Violence Through the Eyes of Providers	Defining Obstetric Violence
	Drivers of Obstetric Violence
	Recognizing the Impacts of Obstetric Violence
Complicity and Care: How Providers Navigate Obstetric Violence	Advocacy: From Constrained to Subversive to Outspoken
	The Emotional Labour of Perinatal Nursing
	Bearing Witness to Obstetric Violence: Moral Distress, Vicarious Trauma, and Burnout
Provider-led Responses to Obstetric Violence	From Provider Mental Health to Trauma-Informed Care: Strategies for Promoting Humanized Care
	The Importance of Dialogue: Awareness Raising and Speaking about "Violence"

Theme 1: Not Heroic, but Human: Obstetric Violence Through the Eyes of Providers

The following theme examines how HCPs define, understand, and make sense of OV within the context of everyday clinical practice. The section is organized into three sub-themes: (1) *Defining Obstetric Violence* explores how providers defined and conceptualized OV; (2) *Drivers of Obstetric Violence* examines the structural, organizational, and cultural conditions that contribute to OV, such as biomedical ideologies, racism and sexism, and systemic and

institutional dysfunction; and (3) *Recognizing the Impacts of OV* focuses on providers' reflections on the consequences of OV for childbearing people.

Defining Obstetric Violence

HCPs described the mistreatment of women in childbirth as a systemic and commonplace problem. One nurse, having taken an interest in OV in her clinical practice prior to the interview, stated, "Now that I know like a lot about obstetric violence, I can't not see it in my workplace. Like, I see it everywhere." The same provider described how she witnessed patients being excluded from care decisions "on a daily basis," and that it was "more shocking," or unusual, to involve patients in decision-making or to take their birth plan into consideration. Though some HCPs identified that specific individuals stood out as perpetrators of OV in their workplaces, describing certain colleagues as "the worst", or as having "always acted that way", they generally perceived that OV was a structural, systemic, or organizational issue that was pervasive in their workplace.

The ubiquity of mistreatment and violence towards patients across healthcare settings was noted by multiple participants. As one nurse explained, "I don't think mistreatment is unique to an obstetrical sphere, far from it. I mean, we hear it in every domain of medicine, you know, in the emergency rooms, on the wards, in clinics." Another nurse described the uniquely gendered dimension of obstetric settings, pointing to particularly stark gender-based power dynamics emerging in birth:

> I'm sure this happens everywhere where the medical staff is like *above all*, and is like, 'I know everything. And this is what you're gonna do.' I just think it's, it just looks almost worse in obstetrics, because a lot of times, it's like the male medical staff […] controlling a bit the woman, you know. […] So, I just think it looks worse in this specialty.

This account highlights that while mistreatment in healthcare may be widespread, its manifestations in obstetrics take on distinctive forms, shaped by gendered power dynamics and the intimate, vulnerable, and exposing nature of birthing care.

Several participants described OV as embedded in the culture of their workplace, a harmful and "insidious," yet normalized, approach to caring for birthing individuals. One nurse wondered, "How for years did we go ahead and think it was okay? I'm not sure, like culture, I guess," highlighting the potential for mistreatment to become invisible when entrenched as the norm over time. Efforts to change problematic practices were met with resistance from other care providers, underscoring their deep-rooted and routinized nature. For example, one physician described their effort to change procedures around preparing patients for cesarean births, primarily by reducing physical exposure on the table. Despite explicit conversations within the team, longstanding habits went unchanged:

> [The team] talked about, you know, not putting a patient spread-eagle on the table, and how we're going to [prepare a patient] […] and the same frickin' nurses do the same frickin' thing, because that's the way they've done it forever. *Nobody* listened. Nobody *heard* it. And nobody *respected* it.

As a cultural phenomenon, OV was described as transmitted generationally from trainer to trainee, and trickling down through hierarchical structures. As one nurse expressed,

> I just think it's something that we've always done, this is the culture, and it's just, it's being passed on to like the next medical team, like the next doctors, nurses. Like, you know, it's, it's starting above, high up, and it's just, […] we just keep on going.

One physician shared a similar perception of OV as historically entrenched in the biomedical notions of "hierarchy" and "authority," noting, "It's hard when that's been the penetrating culture

of medicine from the very beginning to kind of break those dynamics. So, I do still feel like that traditional sort of notion somehow remains." OV was described by another physician, not as a one-way, perpetrator-victim dynamic, but as a broader environmental condition where all individuals involved, including the providers, are exposed to harm:

> Obstetrical violence relates to the mistreatment of healthcare workers, too, that they don't talk about, right. And it's less likely because of that power dynamic. But it does happen, right? […] It's the whole thing, it's the whole environment. And it could be geared towards the woman, the partner, the baby, the practitioners, the environment, you know?

The participant added, "Sometimes there is the element of completely unrealistic expectations on the woman's side, right? Like, because you're labouring and you're in pain, you cannot *bite us*, okay?" This notion that unreasonable or hostile patients could be a source of stress was echoed by a nurse who shared,

> There are certain patients you just don't click with. And there are certain personalities that are just really difficult people, and there are unlikable people. Like we're not going to encounter everyone that's likable. And […] the way they approach you and […] what they ask of you is, is something that's unreasonable.

As these preceding statements suggest, HCPs perceived OV as a dynamic, two-way interaction that unfolds within complex relational settings, not simply as a one-way process in which a provider intentionally violates a passive patient. Furthermore, several HCPs described OV as subjective, questioning the possibility of defining certain forms of care as objectively harmful when women's perceptions and past experiences are taken into consideration. As one nurse expressed,

> You can take two individuals, and you can make them go through exactly the same experiences, where the same people spoke to them or acted the exact same way, and one will be perfectly content, and the other one will be traumatized. So, the other *huge* factor is individual perception of things, right. […] So, it's almost impossible to really have a *true* reflection of someone's experience, right?

The ways in which HCPs conceptualized OV often relied on implicit understandings of what constituted "real" violence. Participants described harmful acts as occurring on a "spectrum," from subtle to overt, emotional to physical, and ranging from merely inconvenient to seriously harmful. For one nurse, witnessing a physician slap a labouring patient constituted an unmistakable "aggressive […] violent act," whereas a "disrespectful and condescending" eyeroll was interpreted as "not violent, […] just rude." Another nurse described covert microaggressions as more commonplace in their workplace than overt acts of physical violence: "There hasn't been that many severe instances of […] violence, or stuff like that. It's been those little things, […] well, they're not little, but [violence] hasn't happened as much as like the micro mistreatment that we see." These statements illustrate how non-physical forms of violence may easily fall outside the threshold of what providers define as violence and inadvertently contribute to them being minimized. This was not a shared perspective across HCPs, however, as one nurse emphasized that emotional and psychological violence may harm women in invisible yet significant ways:

> I think we know that, you know, physical violence is wrong, but a lot of people don't see that their words and their behaviour is equally harmful, and the idea of, you know, a healthy baby and getting out of the hospital, and 'Well, at least she had a healthy baby.' It doesn't end there, and like, women go home with these huge scars.

Types Of Obstetric Violence. While a detailed typology of OV from CBW accounts has been outlined in Chapter Five, HCPs also described behaviours, omissions of care, or systemic issues that they understood as forms of OV. Their descriptions mirrored those of CBWs and fell under the same categories described in the preceding chapter: relational fractures, epistemic violence, verbal and psychological abuse, violations of bodily autonomy and physical abuse, and institutional and systemic conditions. The most commonly reported types of OV included those pertaining to lacking or absent consent processes, authoritative and paternalistic attitudes and behaviours, and dehumanizing and disrespectful attitudes and behaviours. Accounts of racism, stigma, and discrimination were notably common.

Relational Fractures. HCPs identified relational fractures such as aggressive or brusque communication, disrespectful treatment, and a focus on physical outcomes rather than the whole person. They also described care that was impatient, rushed, or overly protocol-driven. A lack of empathy, labour support, and person-centered approaches was frequently noted. The following nurse described an encounter in which the physician's abrupt, insensitive, and procedural approach demonstrated a total lack of emotional attunement, connection, and compassion in the painful moments following the delivery of a stillborn baby:

> That day, during that delivery [of a stillbirth], everything was going well […], and that's when [the resident and I] realized, 'Oh, we didn't call the staff. '[…] As soon as [the staff doctor] walked in, the whole ambience of the room was like upside down. It was like, 'Let's go, let's give her [oxytocin] right away. Let's put 40 units in the bag.' I'm like, 'Everything's going well, she's not bleeding.' She's crying, she's sobbing. She's holding her dead baby in her arms. And she's not really understanding what's happening. And you see this doctor coming in, jamming, like pushing on her belly to have this placenta come

> out […] And then after everything is done, […] [they] said, 'I don't know if you're thinking about having any more kids, but I think you should wait six weeks before you have sex.' And then [the doctor] left the room and it was like, 'Okay, I'm going back in bed.'

Epistemic Violence. Providers' accounts revealed multiple practices that constituted epistemic violence, where women's knowledge, agency, and credibility were undermined and appropriated. Childbirth was described as a process controlled and managed externally by the medical team, while the birthing person was treated as secondary to the process. In the words of one nurse,

> We're not considering the patient's wishes in her delivery. Like, it's her delivery ultimately, and we're just going in okay with, 'Do this, this, this. Baby has to be out by this time.' And we're just telling her how it should be, instead of like incorporating her as part of the process.

HCPs described patterns such as lacking communication and consent, coercive tactics such as fearmongering and threats, framing of interventions as inevitable, treating silence as agreement, and the dismissal of women's concerns, such as pain. HCPs also provided accounts of paternalistic, infantilizing, and belittling attitudes from providers. One nurse described, "You get the like, 'Ugh, she doesn't want a vaginal exam, does she even wanna deliver?' and 'Why doesn't she want induction? She's just being silly'". These attitudes were described both during patient interactions and, more commonly, in the privacy of offices and nursing stations. One nurse referred to the "mocking that is done of women when they make choices that are different than the mainstream, […] kind of behind their back […] saying […] 'You know she's just gonna end up in a C-section.'"

Verbal and Psychological Abuse. HCPs pointed to instances of verbal and psychological abuse, including blaming, shaming, and the use of yelling or mocking tones. They described disparaging comments, threatening language, and even imposing body language as tactics sometimes employed to assert authority or gain compliance. Such behaviours, while often justified in high-stress environments, were recognized as harmful. In the following quote, the nurse depicted a physician's threatening demeanour in juxtaposition to the physically vulnerable woman with a known history of trauma:

> While he's talking loud to her like this [loud booming tone], he's standing over her while she's lying in bed, no clothes on, no underwear, strapped up. It's not like she can just get up and walk away. It was just not a good situation. It was just, the visual was just a tall, big man yelling at this woman in labour who's got this crazy history of trauma.

Violations of Bodily Autonomy and Physical Abuse. HCPs also acknowledged violations of bodily autonomy and instances of physical abuse. Examples included rough or invasive touch, restricted mobility during labour, and the performance of interventions such as episiotomies or forceps deliveries without consent. "Some doctors actually, like it feels like CPR on the patient's belly," described one nurse speaking about the degree of physical force used by some physicians in the application of fundal pressure, an intervention that was described by participants as a non-evidence-based procedure used to expedite birth. One nurse also described overt physical abuse: "I have witnessed patients getting hit by some of the doctors during like a delivery. I've heard it, I've seen it." […] One nurse described a specific instance of physical abuse in which the patient, in the process of pushing, was slapped by the physician:

> Like, the patient's pushing, [..] and this doctor was like slapping her face to like, wake her up. […] Cause the patient after pushing would kind of just like close her eyes and be like relaxed. And [the doctor's] like, 'Come on, you have to get this baby out, wake up.'

Iatrogenic harm caused by unconsented, refused, or injudiciously used medical interventions, also fell under this category of OV. This form of harm was much more ambiguous and difficult to name, as it was the result of medically sanctioned procedures that in other cases would have a therapeutic benefit. Inherent physical injuries related to childbirth, such as perineal tears, and those related to the application of unnecessary medical interventions were also difficult to disentangle. As one nurse reflected,

> There's a tear, so you think to yourself, is that tear caused by the forceps, or is it caused by the vacuum, or is it caused by the traumatic birth, or is it caused by the fundal pressure that the partner was doing, or whatever. Like, you know, you're kind of, you don't know where to pinpoint, where what's like, where did it go wrong?

***Institutional and Systemic Conditions*.** Providers described institutional and systemic conditions and constraints that both constitute forms and drivers of OV. These include overburdened institutions, lacking resources, and negative workplace cultures. They further described an approach to care that was over-medicalized and pushed non-indicated or non-evidence-based practices. Racism, stigma, and discrimination were readily discussed by participants as contributing to the disparate treatment of racialized and marginalized women, in the degree of respect and dignity afforded to them, and in the quality and timeliness of care, such as pain management. While these conditions are presented here as a form of systemic OV, they also operate as drivers of OV and will be examined more fully in the forthcoming section.

Drivers of Obstetric Violence

Biomedical Model. The biomedical model of birth emerged as a primary driver of OV. Not all participants explicitly named the "biomedical model," yet their narratives reflected corresponding ideologies and discourses: biomedical knowledge as superior and the pregnant female body as risky, threatening, pathological, and needing to be contained and controlled. The institutional culture of their workplaces included descriptions of a highly medicalized and technological approach to childbirth, of rapid cascades of interventions, and of a fear-based, risk-averse approach to all birthing individuals, regardless of individual medical need. One physician spoke directly to the biomedical, risk-based lens as directly contributing to overmedicalization and the undermining of patient autonomy in childbirth:

> It's this notion of risk reduction at all moments. […] I remember a colleague once telling me, 'I look at [obstetrics] like a disaster waiting to happen, but I hope for the best.' I said, 'If you wear that lens, you will certainly overmedicalize, when the lens is that I'm just waiting for the worst.'

While CBWs pointed to over-medicalization as an issue as well, they experienced a certain level of uncertainty around whether medical decisions were truly necessary and in their best interest. HCPs, on the other hand, held the medical knowledge and insider perspective to affirm that certain medical procedures are routinely applied, without medical need, often as a means of expediting deliveries and managing unit logistics. Other times it was a matter of habit, as one physician articulated, care is often carried out "with the justification of emergencies and rapidity, and then we carry it over to the non-urgent."

The unpredictability of childbirth, even when low-risk and absent of risk factors, was described as contributing to rigidity, a tendency to be controlling, and frustrations when events deviated from the "norm." One family physician noted,

> Our experiences scar us, right? So, it's very known in medicine that if you've had a bad outcome, all of a sudden, you might be changing something. […] Other things like, decreased fetal movements at term, even if you have a beautiful [non-stress test], and normal [amniotic] fluid, 'Just induce her, just induce her!' Right? Because, of course, nobody wants the woman to come back […] with [a stillbirth] right, and we all have this anxiety and this control need, you know?

While the biomedical model shapes professional knowledge and practice, the above quote illustrates how personal exposure to adverse outcomes or traumatic events can further reinforce seeing childbirth as inherently threatening and pathological, compounding an already overly medicalized approach.

The biomedical model also emerged in accounts of care that prioritized efficiency, standardization, and hierarchical decision-making. Care was conveyed as heavily reliant on standard procedures and hospital protocols, as opposed to situational or based on the individual needs of the person. As one nurse expressed, caring for a patient with an epidural meant adhering to a strict protocol that dictated she turn the patient at a certain interval, even in instances where the patient had a different preference: "We have to turn from left to right every hour. This is what the paper says." Care was described as routinized, universally applied, and as excluding the birthing person: "We're just going in telling them how it's gonna happen […] instead of incorporating her." One physician described their workplace as perpetuating a narrow, one-size-fits-all lens of childbirth: "We're in our little silo of, 'This is how the trajectory of labouring

woman comes in, and this is how she exits.'" Protocols and standard procedures, treated as sacrosanct, contributed to institutional cultures that were experienced as disciplinary and punitive for HCPs. Rules and norms prioritizing control, perfectionism, and efficiency were enforced, while deviations from the norm or mistakes left HCPs vulnerable to scrutiny and potential discipline. As one physician noted,

> There's this fear. People hold things inside, and then their behaviour starts to change. They become harder, and they put up their walls because they don't wanna be vulnerable […] They don't wanna seem incompetent, right? They don't wanna expose flaws. Like there's so much fear about making mistakes. And we've protocolized medicine a lot, you know, and we've done all these things, so they *have to* follow.

Participants also described an approach to care that was "provider-centered" instead of "patient-centered." Certain interventions and practices were described as applied in such a way to suit physicians' schedules and to optimize their own comfort and preferences. "Just the simple thing of positioning a woman in a place where you need her to push right? Because all of a sudden, it's, it's the body that you need to control to bring down to a spot," noted one physician of the common enforcement of the lithotomy position. She continued, "These are not things where we're trying to violate someone. We're trying to make sure we have good visibility and can act if we need to."

Biomedical knowledge was described as predominating over and undermining all other forms and sources of knowledge. Providers were described as experts who hold a monopoly over medical knowledge, act as the primary decision-maker, and lead the passive, unknowing, and inexperienced patient through childbirth. One nurse described this dynamic: "I think it's the […]

position of power like, ‘It’s our job, we know what we're doing, we do this every day, […] she doesn't know what to expect, so I'm going to tell [her] how it should go.’” Another shared,

> I guess it's […] an ego thing also, maybe, for some of the medical team. Like, […] ‘We've studied this for years, we’ve practiced for years, we in our minds, we know it's better for the patients.’ And then, when [patients] go against that, or […] suggest something else, we're like, ‘Well, what do you know?’

The tendency to question the legitimacy of women’s opinions or perceptions about their own experiences was common. One nurse described a patient who declined certain interventions as in “ a total other vortex,” a subtle implication that her perception or judgement was distorted. Another spoke about the “he said, she said” dynamic when a provider and patient share differing accounts of care, suggesting some potential to question or discredit the patient’s account. In the following example, a nurse described her reaction to a patient complaining about a vaginal exam experienced as painful and aggressive: “This patient took it very aggressively, but a lot of the vaginal exams are painful for the patients. It's not something that's pain-free.” One physician expressed similar views, suggesting that what women might perceive as mistreatment is more a matter of misinterpretation, especially outside of overt cases of physical violence:

> Because, sometimes it's not mistreatment, right? It could be in the interpretation. There's, there's so many factors that come into it. Sometimes it’s, in fact, like someone being violated. […] I have seen a woman being slapped, okay? Which is an obvious […] aggressive, violent act.

Participants described the biomedical approach as heavily focused on physical indicators of success, with the psychological and emotional well-being of birthing individuals treated as incidental, or even trivial. As one physician commented,

> An experienced doctor can foresee bad outcomes, and so an experienced doctor is trying to prevent poor outcomes, […] and the mental outcome well, I mean, what does he have to do with that? His job: is the mother alive in the end? Is the baby alive? Okay, his job is done. Mental? Go see a psychologist. That's their job.

Fetal-centrism was also described as a core feature of the biomedical approach to childbirth, placing the baby at the centre of care. Therein, treatment is justified on the grounds of protecting the baby, potentially at the expense of the mother's own preferences and well-being ("all that matters is a healthy baby"). The following physician described the unique complexity of obstetric care as involving two patients simultaneously, and the tendency for providers to perceive themselves as needing to protect the fetus, even from its own mother:

> We're very unique in the sense that this second person [fetus] is not legally recognized to have rights until he or she is on the outside, right. So, I think that adds an element for the provider where they need to advocate for that vulnerable little being. So, when there is a contrast in opinions or refusal, it's, it's a lot more difficult, I think, for the provider to accept this, because they feel like they're the, the lawyer or the advocate, or the saviour of this little…

In one example, the nurse framed an induction around the baby's needs, stating, "That baby was an induction and needed to come." They continued by describing the patient as "jeopardizing her child's life, by […] having […] her membranes ruptured for so long. And not letting us do this, and […] not working with us to get the baby out." On the surface, this does not negate the possibility for offering supportive and compassionate care to the woman, however, the language used framed the mother as non-compliant, difficult, and as posing a threat or danger to her child.

Beneficent intent emerged in all participant accounts as driving care decisions, whether it was perceived as disrespectful, abusive, or otherwise. According to one nurse, “Everybody at their core is there for a reason. You don't work in the Quebec healthcare system in the public sector, if you don't have like some sense that you want to help people.” Another nurse, reflecting on her prior mistreatment of patients, revealed that intentionality weighed heavily in how providers made meaning of their own actions: “I don't feel ashamed, because […] I'm doing this job to try to help patients. […] I'm there to give them a good experience. I know at the core, I'm doing something in my mind that I think is right.” Beneficent intent was strongly intersected with perceptions of “safety.” Providers respected patients’ preferences, as long as those preferences aligned with what providers determined would protect the physical safety of the mother, and often more so, that of the baby. As one nurse commented, “Overall, I think I incorporate what the patient's wishes are very well. Unless it's unsafe or like, we don't do this here, or something like that.”

Though nurses described their workplaces as being increasingly less hierarchical, and as promoting shared decision-making and expertise across professional groups, they also pointed to the persistent and insidious belief in physician superiority. Despite noting, “I don't find as a nurse that there's that much of a hierarchy,” one nurse stated, “There's like those one or two doctors that are on, it's definitely… There is a hierarchy, and I have to do pretty much what they say. […] I'll just do whatever they want.” Participants described some physicians as displaying arrogance, a superiority complex, or a “God complex”:

> There's like this God complex of like, ‘I know every, I know everything. You guys don't know anything. And you guys need to follow what I, what I say, and what I, what I tell

> you to do without questioning it.' I don't think it works. It used to work before, I'm sure, like, you know, when nurses were doctor assistants and didn't think […] on their own.

The Intersection of Sexism, **Racism, and Stigma**. HCP accounts supported the experience conveyed by women that sexism, racism, stigma, and discrimination were pervasive in hospital-based care. Rather than operating as discrete forces, these dynamics were impossible to disentangle. As such, participant accounts are presented here through an intersectional lens, illustrating how overlapping systems of oppression function as key drivers of OV.

Gender was addressed by participants as a significant dimension of mistreatment in childbirth. For one nurse, the gendered dimension of obstetrics, overlaid with the intimate nature of care in the field, contributed to behaviours being tolerated and normalized while they would be seen as unacceptable in other contexts:

> If you went yourself and you went to a [physiotherapist], […] like someone else that does like something quite intimate. And then the person suddenly like ripped off the sheet, and then the door opens, and their colleague came to ask them when they're going for lunch, and then they were like, 'Well, I see that you have something wrong here, so can you just like flip over and I'm gonna fix it.' […] You'd be like, 'This is terrible.' But, like, suddenly in birthing, we accept this idea that this is the way it is.

Gendered dynamics between male HCPs and CBWs were described as resulting in the invalidation of women's experience and embodied knowledge. One nurse expressed needing to "fight" against a male resident, who seemed disconnected from female pain, to secure adequate pain management for a labouring patient: "He was like, […] 'She could always take Tylenol.' I was like, 'Have you gone through period pain? Tylenol is not enough, and she's going through ten times worse than period pain.'" Participants described invasive vaginal exams as shocking,

especially when conducted by males. One nurse shared, “I see them opening her legs, it's shocking to see now that I know that's part of the mistreatment.” Cultural norms about modesty and sexuality were noted as exacerbating this dynamic for some populations: “A lot of cultures are […] not open sexually and stuff like that. And they're not used to having like a vagina out to air, especially in front of a man.”

Mistreatment was not described as exclusive to male providers. Female physicians were also understood as internalizing patriarchal and misogynistic views of women in childbirth, demonstrating dominating and controlling behaviour over birthing individuals. Participants noted that these behaviours were learned through training and modelled within a patriarchal culture of medicine. As one physician framed it, female physicians were “raised in the same atmosphere” and “raised by white men.” Mistreatment, while not exclusive to men, was described as a vestige of toxic masculinity, carried forward in obstetrical settings over decades. One nurse observed that when female physicians were inappropriate, it seemed “more acceptable” and created “more of a connection” with the patient, making it appear less harmful.

Providers further described women being treated differently based on their physical appearance, body size, or the degree to which they conformed to ideals of femininity and attractiveness, described by one nurse as “skinny, like pregnant but skinny, like good skin, like makeup, hair is done, nails are done, like you know, she takes care […] of herself.” This reflects broader patriarchal norms that value women according to physical appearance. As another nurse shared,

> With the male medical team […] I definitely see how they speak to the patients that are from here, who speak English very well, versus how they treat the patients who aren't from here, or who are not attractive, let's just say […] hair everywhere […] maybe not

> washed because she's been in pain for so long. […] Maybe she has an odour. They're definitely treated differently.

Notably, Western beauty standards intersected deeply with race, ethnicity, language, and class in the biases and stereotypes carried by providers, as the above account demonstrates.

These intersections appeared evident in the assessment and management of pain among Black women. "I do see the difference in like pain management for […] patients who speak English and are pretty, versus the […] African American patient," observed one nurse. She added,

> She's in pain, but [the physicians] don't see the contractions on the monitor, so they'll be like, 'Well, she's making this up.' […] Whereas the other patient, […] 'Let's give her something for pain.' […] We'll believe more the affluent patient.

The racial biases and stereotypes underlying such dismissals of pain were sometimes explicit. As one nurse recalled,

> [The doctor] said […] 'Black women have a lot of collagen, […] when they get hurt, it doesn't hurt as much. […] It's the melatonin and the collagen. […] This Black lady is super Black […] so she's gonna be just fine.'

Several HCPs echoed this harmful stereotype: that Black women have a higher pain tolerance and are better able to heal without intervention. Other stereotypes were noted, such as certain racialized or ethnic groups being described as more likely to have "fast" births, or as being more or less vocal in birth. One physician noted, "I have had a colleague who […] turns around in front of the woman and says, 'Always remember, these women…' and then starts naming another three nationalities, 'They don't know how to push.'" Disparities were observed

not only in spoken stereotypes, but in providers' entire relational stance towards individuals. One nurse noted,

> This one doctor in particular will come and sit next to the patient, […] calmly discuss, […] make jokes. Whereas that same doctor would go to like the Indian lady […] and be more like above her, more authoritative, […] and tell the patient what we're doing.

Language barriers further compounded differences in management, as the following nurse described,

> If there's a language barrier […] [the patient] will just say, 'Pain, pain.' […] Then I'll see the staff [doctor] be like, 'I don't know what to do […] it could be a small pain, […] ligaments or something.' […] They're not going as in-depth as they would with another patient. They won't treat their pain, but they'll treat the other women's pain.

For women who were described as "not from here" and having a "big language barrier", there was also an overlapping assumption of deference to medical authority and lack of knowledge about consent: "I don't even know if they […] know what [consent even] is. They're just like, 'This is what I do. You're the doctor, do what you want.'"

The convergence of racism, sexism, classism, and stigma was described as having severe consequences for patients. One nurse recounted a case that illustrated how these dynamics resulted in the neglect of a woman of colour who was recovering from a non-pregnancy-related surgery and for whom symptoms of preterm labour were ignored:

> I had a woman one day who was post-op. […] She complained about pain all night. […] She ended up delivering the baby on the surgical floor. […] They kept saying, 'Oh, we thought she was peeing herself.' And I was like, *how?!* […] She was poor, she was of

> colour, […] and I just kept thinking to myself, 'If this was a white woman, […] this wouldn't have happened.'

Another nurse highlighted how racism has impacts beyond simple quality of care issues or inadequate pain management, also contributing to Black infant mortality:

> I feel like someone somewhere is not doing their job correctly, like someone is skipping something, and that's why we're ending up with Black women losing their babies, […] and we don't really take it seriously. And then the baby dies. And you're like, 'Well, okay, it happens.' Kind of like, normalize it.

There was a sentiment of frustration over the lack of progress and racial injustice over decades. As one nurse shared, "I see my grandma through these Black women. […] My grandma gave birth in the 1970s. So, let's say it was bad in the 70s, […] why is it still bad in 2024? […] Why did we not get better?"

Negative Workplace Cultures. Negative workplace cultures, embedded with professional hierarchies and abusive power dynamics, represented an important driver of OV in the narratives of HCPs. Lateral violence, or violent, abusive, bullying, or harmful behaviour amongst members of the healthcare team, was commonplace. Participants described instances of verbal abuse, including the use of harsh or rude tones, yelling, belittling or condescending language, as well as hostile and intimidating remarks. For example, doctors were described as calling the competence of nurses into question:

> Sometimes [doctors are] like, 'I need […] an actual nurse in the room.' What are we? Like, there's three [nurses] next to you? What they mean is like, 'Y'all are incompetent. I need someone who will know what I'm about to say ten steps ahead of when I'm gonna say it.' Which is not gonna happen, right?

Bullying among nurses was also described, often from senior nurses towards junior nurses:

> Some nurses, […] they'd been there for so long that they were also very fed up with the way things are, or like the way things are handled […] and they would just openly complain. Or if you messed up, or […] if you weren't quick enough to help them with something, or… There was some lateral violence going on […] for sure.

For one participant, nurse-on-nurse bullying was a contributing factor in her taking a leave of absence. She shared, "I was fearful to go back to work after I had been off, and I had fear because there was some bullying going on." One physician also described an instance of physical abuse between a physician and nurse. While this was the only example that emerged in participant interviews, as the witness pointed out, the seeming indifference on the part of the perpetrator was a troubling indicator that such behaviour was normalized:

> I watched a […] physician […] hit a nurse with a clipboard, […] Like, if I'm watching it, how often […] does that happen that a doctor is actually hitting a nurse? I mean, […] you could call 911! […] If we permit it and we allow it, it's gonna continue. And as long as it continues, it's gonna be a nightmare.

Physicians observed the mistreatment of nurses as well, with one noting, "We have nursing retention issues chronically, and I really do believe it has a lot to do with the way they are treated on a day-to-day basis […] by other team members. I'm convinced."

For the following physician, the reality of lateral violence in daily work life stood in stark contrast to professional discourses of teamwork and respect touted by higher-ups, a contradiction that provoked a deep sense of frustration and bitterness:

> I mean the, the bulls**t about, you know, 'We're all a team, we respect one another, we work together, we work together hard for the patient.' […] But when I'm hearing that a

> senior nurse […] goes to a physician in the middle of the night and […] the doctor turns around and does this to her [signalling middle finger].

The participant added, "That nurse knew that nothing was gonna happen," pointing to a general passivity, or acceptance of the unlikelihood of accountability or reprimand.

Instances of verbal and physical abuse were not stand-alone events; they occurred in environments that were largely adversarial and antagonistic. Participants described working in silos and conflictual interactions when viewpoints between providers diverged. One nurse shared, "I wanted to slap him," when a resident did not adequately address a patient's pain. Participants also noted that scrutiny and blame were common, which contributed to silencing and defensiveness when mistakes or poor outcomes occurred. "We have this culture of like, 'Oh, we have to be perfect and competent because someone's going to blame us, yell at us.' […] Instead of just having an openness and saying, 'Hmm, I think we went wrong here,'" shared one physician. Another nurse shared, "Sometimes […] other nurses can be hard on you […] like, 'Hey! What are you doing? […] Did you check the tracing? Look at this, […] your patient just had a huge [deceleration]! What are you doing?!"

Workplace culture and interpersonal dynamics between providers were described as also impacting the patient, both directly and indirectly. For example, one physician spoke of the team conflict that occurs at the bedside, noting, "The poor patient is often caught in this obvious tension. […] They're watching us interact amongst each other, and they're listening to everything we say, and holding on to it." They continued, "Like the physician comes in, and he's like, 'What, what's going on here!?' And the minute that is asked, […] there's a sense of, 'Oh, something's been missed. Have they mismanaged me? Do they disagree?'" Unhealthy work environments could also trickle down and have indirect impacts on patient care. One nurse

described the “mind-taxing” nature of critical care when it overlapped with lateral violence in the workplace: “It's heavy on the mind […], and then your mind is preoccupied with that. And you can't put a hundred percent towards your patient, you know?”

Negative workplace culture also contributed to and was reinforced by a sense of futility, resignation, or complacency expressed by providers in the face of problematic working conditions and behaviours. For example, “Whatever, that’s just them,” served as a common refrain when brushing off the inappropriate conduct of colleagues. One physician pointed to a generational divide, suggesting change felt unlikely to come from older practitioners: “You know, I can be woke, but it's not my generation that's gonna change it.” A deep current of resignation and exhaustion also emerged in response to more overtly harmful behaviours, such as racial stereotyping. In the following excerpt, a nurse recalled the way in which their charge nurse reacted to a physician’s racist remark:

> [The doctor] was like, ‘[…] Black people, they can power through the pain.’ […] And our charge nurse is Black. […] I'm like, ‘Are you not hearing this?’ and she goes, ‘Meh. Like, there's too many battles to fight. […] This is not part of them.’

Institutional and Systemic Pressures. A prominent driver of OV described by participants was that of institutional and health system dysfunction and the pressures this placed on providers in the provision of care. Demanding workloads, resource shortages, and the resulting stress placed on providers were evident in all participant interviews as driving mistreatment. In fact, the majority of self-reported instances of OV were attributed to time and resource constraints, and the ensuing physical and emotional toll that these working conditions placed on providers.

Nurses described their work as being highly pressured, and as needing to meet high standards of rapidity and efficiency. As one nurse shared, messaging from superiors and co-workers constantly pushed individuals to work more quickly: "'You need to deliver her faster. You need to transfer her. You need to do this. You need to get that' […] 'She can't expect to have everything go her way because we don't have time for that.'" Even for participants who described themselves as vocal advocates for respectful and humanized care, pressures related to unit management, such as bed allocation, led them to push interventions that were counter to the patient's wishes, or were not medically indicated. One nurse described that in cases where she was unable to adequately provide labour support, she would "encourage" the patient to accept an epidural despite their desire or preparedness for it. The following participant, in her role as a nurse in charge, described gently coaxing women into non-medically indicated artificial rupture of membranes to expedite labour:

> If the unit's busy, like we're less likely to let the patient kind of go on her own. […] Like, if her water is not broken, it's her first baby, she's been three centimetres for, I don't know, four hours, […] we're feeling pressure to be like, 'Okay, like you know, breaking the water will be the next step. It'll kind of accelerate the process.'

One nurse described instances in which she directed irritability and frustration at women requesting labour support or pain management, which she felt helpless to provide as she was required to juggle multiple patients. This participant was not alone in recognizing the importance of labour support and emotional presence, yet ultimately having to forego these elements of care:

> It was a busy night, and so I couldn't be there for her the way she needed. She needed a midwife there with her. She needed somebody there with her, she needed the world to

> slow down to minus five miles per hour, so she could understand everything that was going on.

The emotional toll of working in high-pressure environments was widely acknowledged as negatively impacting the quality of care as well, what several participants described as a "human" response to the conditions of the workplace. One nurse spoke about the conflicting emotions she experienced after witnessing OV: "I spent my whole life thinking of nurses and doctors as heroes, and that's why I wanted to be one, and, and, and [mistreating patients] is not heroic at all. *But*, *but* it is human. Okay?" Her reflection reveals the weight of the "hero" discourse that often surrounds providers. This narrative had initially inspired her to enter nursing, yet over time she had to reckon with the realities of practice that were counter to her idealized image of the heroic provider. Instead, she now saw providers as flawed humans capable of making mistakes.

Several participants, including the following physician, emphasized that OV often emerged from providers' emotional strain rather than intentional harm:

> I don't think anyone sets out to harm another person. Um, there's always a reason that it's there, right, and often it's individual unhappiness, or not being in a good place, being burnt out, feeling stressed, having been felt like you were mistreated. So, you're putting up barriers to protect yourself.

Participants described the use of "dark humour" and "cynicism" as coping strategies for stress and unpredictability. Some questioned their own coping responses, wondering whether "making jokes at patients' expense" or "laughing about things in their birthing plan" were ways of self-protection or attempts to "make themselves feel better." One nurse explained that mocking or

making disparaging comments often reflected frustration with “difficult” patients or their “unrealistic” demands:

> Yeah, it's dark, but maybe it's a coping mechanism. […] Do I think it's wrong, you know, for you to be frustrated with a patient? No, I think we're human. I think we will get frustrated if somebody has a birthing plan that's just out in left field, and it makes no sense for her medically. But it’s when it goes in the room, and […] it alters your treatment, that's when I think it's really dangerous.

Such reactions, whether defensive, derisive, or expressed through humour, were characterized by participants as largely automatic, “knee-jerk” reactions that protected them emotionally. However, as the previous quote points to, venting through disparaging or disrespectful comments in the privacy of the nursing station was dangerous in that it could, over time, shape the mindsets, beliefs, and biases carried into patient encounters.

An additional layer of emotional reactivity described by providers was brought on by the dual responsibility for both the mother and baby, which was heightened in response to disagreements over care between providers and patients. One nurse explained that it may be easier to respect the autonomy of an individual refusing life-saving treatment in any other setting; however, obstetric care is “very different if that woman is also carrying a life inside her […] because we're not just talking about her care, we're talking about the baby's care as well.” For participants, this fetal-centric framing complicated emotions at the bedside, increasing the potential for personal bias and judgement to get in the way of objectivity.

Systemic dysfunctions further identified by participants as driving OV included the current pay-per-client healthcare model. Physician participants identified this as incentivizing healthcare teams to maximize the number of births in order to increase government

disbursements, and as contributing to brief prenatal and postpartum appointments. As one physician commented, “Everything seems to be about money. Nothing seems to be about patient care.” The provider went on to describe that most prenatal appointments last mere minutes, noting that patients were treated as “a chip, […] not women.” They added, “If you do well, when you bring in more patients, the government pays you more. So, what we're doing […] is, we're looking at patients as pieces.”

Perinatal health care was also described as being devalued institutionally and on a broader systemic level, despite its critical importance in establishing the foundations of health for parents and families and being the first contact with the healthcare system for many first-time parents. As one physician described,

> On the whole, […] hospitals, […] they run a little bit like a business. […] So, you'll put more your efforts in oncology, and which is very significant, or perhaps cardiology. […] When we're asking for [resources], they’re gonna be like, ‘Your patients are healthy, […] they don't need much!’ […] It's deemed to be a healthier clientele. We just don't put as much importance.

Normalization. Verbal abuse and relational fractures in care were described as common occurrences that had become invisible or benign over time, with the lack of overt physical violence serving as proof of the absence of all violence. In other words, physical abuse marks “true violence” and makes emotional or psychological abuse tolerable or innocuous by comparison. As one nurse noted,

> I'm grateful, I've never seen […] sexual stuff. […] I've never seen any like physical abuse like, being aggressive physically or sexually. For me it was just more […] verbal abuse

> that I've seen. […] And so, I hate to say this, but like I'm grateful that it was verbal, not anything else.

The normalization of abusive or violent treatment also manifested itself through providers downplaying the severity of mistreatment or minimizing women's experiences of harm. In one example, a nurse described an interaction she had with a patient in the aftermath of mistreatment from a physician. The woman, having been scolded by the physician during birth for pushing "ineffectively," turned to the nurse for emotional support. The nurse shared her response: "I just said, 'Don't think about it. […] You're fine, your baby's fine. Everything's okay. […] Don't think about what he said.'"

OV was also minimized and normalized through the attribution of feelings of harm or trauma in birthing individuals as subjective interpretation, mediated by individual characteristics, such as hypersensitivity, complex personal circumstances, or a history of trauma. One nurse reflected,

> Especially in obstetrics, there's like this *huge* background to their experience. We don't know that they didn't have child trauma, we don't know that they didn't spend years of infertility, we don't know that their dynamic between the couple is super unsupportive. […] So, it's like we can do our best, and yeah… […] Can we be responsible for her reaction that she felt traumatized?

Normalization also occurred when instances of mistreatment were written off as the actions of a "particular" provider or a "bad apple," with ill intentions or individual character flaws. "The ones that perpetrate obstetrical violence are the same over and over again," noted one nurse. Individuals occupying leadership positions were seen as perpetuating an overall culture of violence and acting as a hurdle to institutional and systemic change: "I don't think

anything's gonna happen […] until [the head of department] is gone because [they're] a very dominant personality. [They have] a lot to say." Ascribing the issue of OV to specific individuals reveals something about the system itself, one in which problematic behaviour may come to be written off or treated merely as a nuisance. For example, one nurse questioned the ease with which her charge nurse brushed off an incident in which a physician verbally abused a patient: "I went to see the charge nurse, and I said, 'Did you just hear what he said,' and she said, 'Well, that's [Doctor] for you.' It's like, are we normalizing, you know?"

For some participants, the use of an authoritative, or even aggressive or harsh approach with patients was justified. Participants described behaviours such as using a stern tone of voice and "blunt" or "threatening" language when it was a matter of "safety," such as when a baby's life was determined to be in jeopardy. One nurse shared,

> It really is because it's critical care, and when lives are on the line, like life and death situations, sometimes you have to have a strong hand. Sometimes […] people react differently to fear, and emergency situations. And so, sometimes you need someone firm to say, 'Okay, I need you to push now, push really hard, push.' […] You know, these situations, where you […] can seem aggressive, you know.

Another nurse described the use of yelling in her workplace as a means of disciplining patients that were labelled as oppositional or disobedient, a behaviour that was not only justified by some, but even encouraged. In the following, the participant described a team debrief following an encounter in which a physician yelled at a patient who had declined recommended care:

> The nurse in charge was against the patient. She was like, 'Oh, well, she deserved to be yelled at, because that's her reality.' That nurse in charge was used to that environment.

> […] For the nurse in charge, she was saying, 'No, that patient was in the wrong! The doctor was in the right to go in and speak to her like that. You shouldn't feel guilty, […] she deserved that.'

The scene portrays a workplace where authoritative figures were not only sanctioning abusive behaviour but also minimizing and dismissing the feelings of guilt expressed by the nurse, effectively silencing opportunities for self-reflection and neglecting to address the mental health needs of affected staff.

Cultures of Accountability and (Lack of) Redress. Workplace accountability mechanisms, including debriefing processes around difficult or conflictual clinical encounters and formal reporting systems, were described as absent, poorly understood, or inconsistent, which contributed to OV being under-addressed or swept under the rug. One nurse shared of their workplace: "Management doesn't talk about [obstetric violence] *at all*." Instead, instances of OV were talked about in private, in "hush-hush" ways, making the rounds as "gossip." According to one nurse, employees were not explicitly encouraged to report professional misconduct or patient mistreatment, and colleagues did not habitually make formal reports; when they did, it rarely resulted in tangible change. This was echoed by another nurse who stated, "I've reported people before, and I feel like things don't necessarily […] come of it. Like, I've gone through official channels to report, maybe the person got talked to, I don't know. But there's no […] follow-up necessarily." Another nurse shared their experience of reporting OV to the nursing leadership, illustrating the ambiguity and confusion faced by providers in the process:

> I informed the charge nurse, and then she informed […] our head nurse, and then from there, I guess it went to some like, committees? I don't know which committees are

> involved with this. I don't even know if the patient even complained about it. I don't think so. I don't even think the patient was even aware of what went on.

Reporting instances of OV or workplace violence was often done reluctantly, and in fear of retaliation or other professional repercussions. Notably, fears were often less about job loss and more about relational consequences, interpersonal dynamics, and the potential for escalating tension in patient care situations. As one nurse expressed,

> I wouldn't be scared of losing my job. […] It's more like I'm scared of how they'll react to it, like they'll take it in […] a bad way, whereas I'm just trying to […] shed light on it so we could just improve on it. They'll take it personally and think I'm like attacking them and […] saying that they're violent and they're abusive and saying that they're actually mistreating women, and then from there they'll probably […] escalate it.

Participants also reflected on instances where nurses who did file complaints or spoke up publicly faced prolonged professional and personal consequences. One recalled a colleague who initially felt supported for having spoken up about OV, but endured long-term fallout, leaving others deterred from following the same path. Participants described several perceived risks of speaking up: "getting in trouble," colleagues "hating" them, or being labelled as someone who "tattles," and fears of facing stigma or of being alienated. Overall, nurses perceived the system for reporting mistreatment as not only unclear, but unsafe.

Impacts of the COVID-19 Pandemic. Several participants identified the COVID-19 pandemic as exacerbating existing systemic conditions driving mistreatment, such as provider burnout and resource shortages, while pandemic-related policies were described as directly impacting the birthing experience. The impact of COVID-19 could not be understated; one physician spoke of the severe impacts of forced overtime on nursing retention, while another

physician noted about the pandemic: “The work itself was very urgent and very intense […] The conditions were so bad we should have all quit, you know.” One nurse described the pandemic as “100%” having a “big impact” on the mistreatment of women in childbirth. The following nurse depicted the way provider attitudes were impacted by the pandemic, including fear of contagion, seeming stigmatization, ostracization, and dehumanization of those with or suspected of having COVID-19:

> When COVID especially just first started, […] the doctors were scared of everything, of going to patients’ rooms. […] They were almost scared of the patients and treating them like as if they [..] have like, Ebola. […] They were just poorly treated. If you had COVID, if you were positive, for sure, like you weren't treated well. It was as if you had this big sickness. […] Anyone who was symptomatic, they barely didn't want to go […] in the room. […] But they were just treated as if they were like these lepers in the corner.

The participant added, “There was a divide between the nurses and the doctors. […] The nurses we would go in [the patients’ rooms] no problem.” This statement draws an explicit line between how physicians and nurses adapted to the realities of the pandemic. Whether driven by fearlessness or professional scopes of practice, nurses were described as the providers bearing the brunt of direct patient care.

The limiting of non-essential providers in clinical encounters, or the use of “skeleton crews,” whether due to staff shortages or deliberate policies, was a major source of concern for one physician who discussed feeling unsupported in a particularly difficult clinical encounter:

> This was in the middle of COVID, in the middle of the night, nurse and I alone. Situation was absolutely deplorable. The nurse […] never came back to obstetrics. No support, no respect. And I think, if we're not respected, […] why would you want to work there?

For this participant, not only did the conditions of the encounter lead to feelings of disrespect but were severe enough to drive one nurse away from obstetrics altogether. The same participant added that they were preoccupied by "the lack of civility that we have developed since COVID […] towards one another," pointing to the negative impacts of the pandemic on a general culture of professionalism. The slow-down of certain administrative processes or services, deemed non-essential, was also described by another physician as delaying the processing of official complaints regarding patient mistreatment and other forms of professional misconduct. Overall, the conditions of the pandemic acted as fertile soil for the erosion of professional standards, relational cultures, and accountability measures.

Birthing individuals also experienced restrictive visitor policies and the exclusion of labour support people during the pandemic. One nurse, reflecting on such policies, shared, "I can't imagine just delivering on my own in this isolated box." The impact was described as compounding existing alienation and isolation faced by immigrants and those with language barriers: "You're taking away the support person from this patient. Some of them, again, they're by themselves here in a new country, don't speak the language, now you're by yourself." As this nurse highlights, measures banning support people not only intensified isolation, but also disproportionately harmed already marginalized groups, leaving them more vulnerable to traumatic birthing conditions.

Recognizing the Impacts of Obstetric Violence

This sub-theme explores how HCPs interpreted the impacts of OV on patients. Across accounts, providers tended to perceive patient silence, passivity, or compliance as apparent ignorance or acceptance, reflecting a belief that violence may be internalized, invisible, or acceptable to those experiencing it. One provider stated, "She's maybe just used to this," while

another shared, “Patients don't know the difference.[…] For them, it's like, ‘Well, my baby's here, my baby's healthy.’ And it's us who knows the difference.” Patient passivity was also framed as deference to provider authority, where individuals enthusiastically submitted to medical expertise. A recurring binary emerged in participant narratives, positioning providers as dominant experts and patients as compliant followers, as the following quote illustrates:

> Whatever the doctor, […] nurse, healthcare professional wants, […] they project that onto the patient. So, the patient just feels like, ‘I don't know what we're talking about, […] I've never done this before. I'm gonna follow you, you're the expert.’

At the same time, some HCPs suggested that apparent indifference masked a deeper intuitive sense of harm among birthing individuals. As one provider reflected, “You just know, deep down, like, if you put yourself as that patient, it doesn't feel right.”

Providers demonstrated awareness of the potential for birth trauma and the retraumatization or revictimization of patients through OV. Multiple participants spoke to the prevalence of GBV and sexual violence experienced by women in the general population. For one physician, this meant that the nature of obstetrical care made retraumatization likely: “If we understand that 50% of women in the world are victims of rape, […] anything that I do to a patient could be misconstrued.” One physician reflected on how his very presence could be experienced as harmful for a woman with layered trauma histories, including sexual, generational, and racial trauma: “If I take the patient who is Black from Central Africa, and I'm the white guy in the room, that can be viewed as trauma.” Similar to CBWs, HCPs evoked the belief that childbirth is supposed to be a beautiful, monumental, and transformational life event, and OV and associated trauma were described as robbing women of that moment.

Even though providers generally perceived physical violence as objectively more harmful than non-physical forms of violence, it was broadly accepted that the quality of interpersonal interactions was a primary cause of distress or birth trauma and could even be more impactful than physical or medical outcomes of birth. One physician explained: “Usually [complaints are] not because of bad outcomes. […] Most of the [Canadian Medical Protective Association] complaints come in because of not feeling listened to, given explanations, consented properly.” Another physician shared, “I would say over 95% [of birth trauma] has to do with the human interaction, or lack of.” One nurse shared her surprise at a woman being induced for having developed PTSD from a previous birth, marking a realization for her of the impact that the interpersonal aspects of care could have on individuals:

> I was like, wow, […] our actions really affect these patients. […] [The reason for induction was] previous traumatic birth. […] When you hear that normally, it's like, okay, a forcep, a vacuum, […] but this was like the whole, not only that part, but it was also how the healthcare providers were with the patient. And she's in therapy.

Along with birth trauma and retraumatization, other impacts of OV noted by participants were postpartum depression and anxiety and fear of future pregnancies. One physician expressed their understanding of how these residual mental health impacts, if left untreated and carried into future pregnancies, can contribute to negative outcomes for both the mother and future baby. Other participants noted that postpartum mental health impacts related to OV could also disrupt or lead to the discontinuation of breastfeeding, further impacting infant health. The quality of the birth experience was also described as foundational to overall maternal and familial health, and as “trickling” down and having significant impacts on societal health. One physician reflected,

> How do you change society? How? It's often way too late once someone is in adulthood and well established in their personality. Like, if you can […] foster those bonds and safer home environments and families, and support families, you'll create adults who then create their own family. The cycle can go right?

Theme 2: Complicity and Care: How Providers Navigate OV

The following theme explores the complex and often contradictory positions of HCPs as they work within systems where OV occurs. The section is divided into three sub themes: (1) *Advocacy: From Constrained to Subversive to Outspoken,* explores provider advocacy in multiple forms, and how it exists within a system that simultaneously drives them towards complicity; (2) The *Emotional Labour of Perinatal Nursing* reveals the emotional work carried out by nurses, balancing the demands of patient safety, workplace stress, and professional relationships dictated by hierarchy; and (3) *Bearing Witness to OV: Moral Distress, Vicarious Trauma, and Burnout* explores the wide range of emotional and affective responses of providers in the face of OV.

Advocacy: From Constrained to Subversive to Outspoken

For participants, advocacy was rooted in a recognition of OV as a pressing concern in their places of work. Many were vocal about the issue, confronting individual providers about specific incidents, or seeking to educate providers and raise awareness through formal and informal conversations. The act of advocating for patients was most often described by nurses, who saw themselves as needing to protect or speak up for patients in the face of physician mistreatment.

Constrained Advocacy. The emotional and affective responses of participants who witnessed OV often acted as a barrier to on-the-spot advocacy. Their accounts reinforced that

OV was not only something *done to* patients but also something *felt* as vicariously violent or traumatizing by those observing it. Feeling distressed or shocked in the face of an abusive, threatening, or disrespectful colleague was common, and made it difficult to speak up in the moment; like feeling "dead frozen in her tracks," one nurse described. Another nurse described the strong emotional response she had to watching a physician yell angrily at a patient with a known trauma history, and who had resisted many aspects of care:

> I just lost the ability to advocate for her in the moment […] because the tension and the anger, […] the power, the powerfulness of the [doctor] who was yelling, like it was just so, so… It shocked me, it was inappropriate, and so I was like, *Whoa*! I was taken aback, […] it was almost like I disassociated for a minute.

The perceived "powerfulness" of the physician played strongly into the nurse's perception of a lack of safety that led her to dissociate from the stressful encounter. Nurses also described feeling afraid and intimidated in the face of physicians' yelling or aggressive behaviour, fearing that if they intervened, they might face verbal retaliation within the clinical encounter. As one nurse explained, she questioned whether speaking up might provoke further anger or jeopardize her professional relationship with the physician:

> I was just like, 'Holy s**t. What the f**k do I do here? What do I say here? If I say something, will he respond? Will he yell at me? […] What will be the repercussion for me? And I have to continue to work with this doctor.'

Power differentials emerged in participants' reflections as a primary factor influencing whether individuals were willing or able to speak up in the face of OV. For example, newer nurses were described as more reluctant to voice concerns or officially report patient mistreatment. One participant, recalling her early career, reflected on feeling at a loss for "what

to say and how to handle it," when observing mistreatment, pointing to skill, knowledge, and confidence as facilitating advocacy. Age and power differentials between practitioners were identified as a constraint on advocacy by another nurse who shared, "It's hard when you're like 22, and the patient's 28 or 30, or whatever. And then the doctor's 50. Like, this whole power dynamic, of course, that's going to exist." Younger nurses were described as more likely to speak about incidents informally amongst close colleagues, as a means of venting and seeking support and guidance.

On a professional level, advocating for the patient during instances of mistreatment was also perceived as "undermining the […] doctor, nurse, patient relationship," or in other words, as discrediting the authority of a physician. There was a perceived futility in challenging physicians' decision-making, particularly to oppose the misuse, or non-indicated use of interventions that were otherwise legitimate interventions. One nurse reflected on the challenge of voicing disagreement in the face of irrefutable medical reasoning:

> I feel like there's always a rationale for everything that [doctors] do. […] And I could go and argue and be like 'Oh, well, I didn't feel like it was necessary,' and [the doctor] would be like, 'Well, I felt like it was necessary. And that's it.'

This example illustrates how entrenched hierarchies and centralized decision-making limit the capacity of nurses and other providers to challenge poor conduct or question non-evidence-based practices.

When advocacy was constrained, nurses found themselves inadvertently complicit in care that was non-person-centered, unconsented, disrespectful, or dehumanizing. In the following case, the nurse described a clinical encounter in which the patient, deemed "non-compliant" by the team, was being verbally abused by the physician for not pushing effectively:

> [The doctor] is yelling at the patient, […] [The other nurse and I are] up by the patient's head, holding her hand and saying, 'It's okay, sweetie, just try to push harder. It's okay.' […] The two staff doctors are arguing over the patient. And I'm like, oh my God, this can't get any worse. Anyway, so he did an episiotomy, and so I tried to cough to cover the sound of the snipping.

The nurse's words reveal the emotional distress that she too felt in the moment, feeling unable to intervene on behalf of the patient except to offer reassurance and cough over the sound of an episiotomy. In another example, the nurse consulted with the attending physician about a patient who was "resistant" to routine induction procedures, to which the physician responded by entering the patient's room and yelling at her for "not letting the nurses" do their job. Though the nurse's intention was to seek guidance for a challenging clinical situation, she inadvertently provoked the instance of mistreatment, which left her feeling "mortified."

Subversive advocacy. While some providers felt constrained or inhibited from advocating for patients, others engaged in subversive acts in support of patients' interests and preferences, even if that meant going against medical orders or unit policies. One participant described the way in which some nurses would undermine physicians' orders that they objected to, without directly confronting them: "They'll say 'Yes,' to the doctor, 'Yes, yes, I'll do that,' and they'll come back and be like, 'Oh, that pissed me off. No, I'm not gonna do that to the patient.' […] But they have a rationale behind it." Another nurse described medical residents choosing not to call staff physicians into patients' rooms if they expected them to disrupt the "calm" in the room; however, described one resident as "afraid that she'll get into trouble" for doing so. One physician shared an example of a family physician deliberately circumventing referral policies for high-risk patients by calling them directly, to ensure that a woman with a

history of sexual violence and birth trauma received care they knew would be sensitive to her needs. As the participant recounted,

> I had a family doctor call me and ask if I could take on a patient who wasn't technically in my rota. [They] said, 'I'm a little embarrassed because she's not one of your patients I'm supposed to send to you.' I told her, 'I don't really care, nobody's going to know that.'

Shirking orders and unit procedures thus entailed some degree of precarity, though, as the previous examples demonstrate, it appears that less was at stake for those in the highest position of power, obstetricians.

Nurses also described intervening in subtle, non-confrontational ways during the consent process, when they perceived that consent was incomplete, pressured, or coerced. Participants described efforts to reaffirm patients' autonomy after physicians had shared information, using phrases such as, "You do have a choice," "You can say no," or "Do you know that they are about to cut an episiotomy?" Others offered reassurance during interventions through phrases such as, "Is it okay? I'll hold your hand the whole time." For nurses, much advocacy took place in the aftermath of OV, through attempts to validate patients' experiences of harm, and providing them with information on how to contact the ombudsperson or file an official complaint.

Subversive advocacy occurred outside of direct patient care as well. One nurse recalled raising the issue of OV in casual conversation with a physician, who had a reputation for frequently engaging in harmful practices, by presenting it as a concern about the practices of "other" doctors. This approach served as a means of voicing concern without directly challenging the authority of that one "problematic" individual.

Outspoken Advocacy. Open, vocal, or formal advocacy was far less common, and more likely among those in elevated positions of power. Several participants described experience and expertise as affording them the privilege and ability to assert themselves in clinical encounters, without fear of repercussion. For some, this meant being pejoratively named the "obstetric violence person," or for one outspoken nurse being told, "you're such a feminist." For others, being an outspoken advocate against OV meant being recognized as a mentor that other providers turned to for support on issues of patient mistreatment. A common thread among vocal advocates was that it had become a central feature of their professional identity, and a topic that they felt compelled to discuss with coworkers on a regular basis. As one participant described, "I'm someone who's shy in general. But since being a nurse, and working on this unit, I have eventually come out of my bubble […] so now it's just, it's like word vomit, I can't stop it." Another physician expressed, "You want to scream it from the top of the buildings, you want to inform and educate everyone."

The ability to advocate on behalf of patients was further described as a matter of "experience" and "confidence" in "taking up this space to talk about it." One nurse shared,

> I would have zero problems, saying, 'Hey, I need to talk to you in the hallway first, and I won't take no for an answer.' […] At this point with my experience and what led me here, […] I would have no problem.

Participants also described acts of proxy advocacy, speaking up on behalf of colleagues who were unable or unwilling to confront perpetrators of OV, or report incidents to superiors. One nurse described a peer who witnessed patient mistreatment as being "afraid" and "shy" to speak up about unprofessional conduct, to which the participant offered to report the issue as her own:

> I did that once to my colleague. She was like, 'No, [the doctor will] know it's me and […] I don't want that doctor to hate me or to say something.' And I said, 'No, it's okay. I'll put my name on it, […] you don't need to send it anonymously.' […] I spoke up. […] I said it out loud so that all the nurses heard it, 'This and this and this happened to me.'

Experience not only gave individuals the confidence and skills needed to advocate on behalf of patients, but also lent them credibility and respectability in the eyes of other practitioners, as one nurse explained,

> I think it's earned like in the sense that, […] I can't imagine if I just showed up and said it that, they would be … I sometimes reflect on like, if it was a doula that did it, they might be like, 'Ugh, whatever.' […] But I think when you've been there for a while, […] they know that you do quote unquote good work in their eyes.

The Emotional Labour of Perinatal Nursing

Emotional labour emerged as a central feature of the perinatal nursing role in this study. *Emotional labour*, in the context of workplaces, is defined by Hochschild (2003) as the process of managing, suppressing, or performing emotions to protect a sense of care and safety in others. Nurse participants described emotional labour through the management of their own emotional reactions to distressing encounters, prioritizing the needs and comfort of patients and other providers, and managing conflict. Participants' narratives contained discourses of childbirth as a "pivotal" and "monumental" event. The profound meaning that participants placed on childbirth and the responsibility that providers felt to nurture and uphold it also represented a primary aspect of the emotional labour that nurses described. In the words of one nurse:

> My parents talk about us being born, and they always remember in these details, and I'm like, gosh, like, I'm part of that experience, like every day. Someone's gonna remember

> me or be like ‘That bitchy nurse that said that’ or ‘That great nurse,’ or whatever. So, […] it does weigh on me a lot in that way. So, […] I always try and keep that in my mind.

Nurses also defined childbirth as a “life or death” situation and a heavy weight to bear. One nurse, describing the challenge of collaborating with patients who “say no to everything”, explained, “You can see the writing on the wall, […] you can’t bear the burden of like that baby’s safety all day long. […] It's hard to carry that worry that that baby might not live.” Another shared the emotional labour related to the emotional impact of dealing with infant loss:

> It is a lot of emotional labour. […] You get a story from I don't know, an acquaintance who's telling you about something that really doesn't seem that important to you, […] then you realize, like, ‘It's not a big deal that your car is broken like when somebody just lost their baby.’

Emotional labour was especially prominent in accounts of OV. In these instances, nurses described managing their own distressing emotions and attempting to protect patients from OV, while simultaneously attempting to maintain the integrity of professional relationships. “I feel like I do walk that fine line between the doctors and the patients,” shared one nurse. She continued,

> I hear myself sometimes saying things where I'm like, ‘Oh, yeah, that might not have been within the patient's choice.’ […] Like one of the doctors will say, ‘How could she *not* take an epidural?’ […] And I'll be like, ‘Oh, yeah, […] might have been a good idea for her to get an epidural.’

This quote captures the fine line nurses walk; on one side is a commitment to patient autonomy and respect, and on the other, a need to play along with and show solidarity with physicians, even if that means engaging in condescending or disrespectful remarks about women’s choices.

For participants, building a therapeutic bond with the patient was a crucial aspect of the nursing role that they saw as distinct from the role that physicians could fulfill. One participant shared that this positioned her as a confidant, where she was often the recipient of patient feedback about physician mistreatment, which required her to then make the decision whether to "escalate it or not." She shared, "It just proves how much of a *rapport* that I built with the patient that she was able to, like, you know, verbalize her feelings." Some nurse participants described that once they had developed an emotional bond with patients, they experienced worry and apprehension when leaving them in the care of another nurse or a physician who they perceived as likely to mistreat the patient. For one participant, this meant all the work she had put into respecting and protecting the patient's needs and desires would be rendered useless:

> You do the best so that they have a great time with you when you're there, and then now you know, this particular doctor is coming, or this particular nurse, and you're like, 'Well, that was wasted.' […] I gave great care, but then I know the next eight hours, it's for nothing.

The role of the nurse was often described as one of emotional mediator, which required the nurse to engage in validation and attempts at reconciliation with patients in the wake of mistreatment from other providers. One nurse recounted the words of a physician towards a patient who refused an episiotomy and sustained a severe perineal tear during birth: "Next time, when the doctor tells you that I need to cut, it's not because I enjoy cutting people's perineum. […] This is a very difficult tear. You're making my night very difficult." The nurse recounted her subsequent reaction and attempt at validating and reassuring the patient: "[The patient] said, 'I'm really sorry.' […] I just said, […] 'He was very rude and unprofessional to you, whatever. Just think about your baby. […] You did so well.'

Another nurse described her attempts at deescalation and repair with a patient and her spouse after a physician had yelled at her and abruptly left the room: “I was like, ‘Okay, let's just take a deep breath, and I'm very sorry for what just happened. […] Let's just try to relax for a second and try to figure out how we can get back on track.’” For another, remaining silent in the face of a physician verbally abusing a patient was a deliberate attempt at de-escalation: “I felt like if I added my voice to that situation, it would have been even worse for the patient.” She expressed her worry that intervening risked greater confrontation and emotional harm towards the patient: “If he was angry with me, or if it started more confrontation, it would have […] just contributed to the trauma of this patient.” As emotional mediators, nurses described needing to navigate emotional terrain, manage the feelings of all parties involved, maintain calm, and minimize harm to the patient.

Participants also described the emotional work involved in discussing or raising concerns about care decisions or engaging in patient advocacy. One aspect of this work discussed by all nurse participants was what is termed here *performative deference*, the effort made to perform in a deferential or submissive manner when engaging with other providers. This included regulating one’s tone, affect, and word choice when engaging with other providers, usually with the hope of minimizing defensiveness or avoiding conflict. One nurse described the tactful approach and cheerful tone she would adopt when providing feedback to ensure providers didn’t feel attacked or criticized:

> When a doctor is coming out of the room, and I just didn't love how he approached the patient, […] I won't say like, [blunt tone] ‘This is obstetric violence.’ I'll be like, [cheerful tone] ‘Oh, by the way, you know […] I learned *this*!’ […] Like, I try to make it in a way where they don't feel like I'm attacking them, or I'm saying they're violent.

Another provider described attempting to provide feedback to a colleague about their inappropriate and culturally insensitive remarks made to a patient, in a gentle and complimentary way: “I gave feedback to a colleague once. […] I'm like, ‘I really appreciate your time! Thank you so much, for you know, taking her on. That comment was not exactly proper modelling to our learners, right?’” Another provider described softening feedback by referencing her own past mistakes, attempting to reduce the risk of the colleague taking it “personally”:

> I've had like a few [colleagues] […] that were taken aback, that took it personally. But I'm like, ‘No, no, it's okay, like, it's just something you're not aware of.’ […] And I try to say, like, ‘Oh, you know, I've done it too before, but just now I'm aware of it, so I try not to do it again.’

The effort required to be emotionally attuned to and manage the needs and potential reactions of multiple individuals was, in the words of one nurse, “stressful” and “anxiety-inducing.” She expressed a sense of frustration and lack of fairness at having to constantly moderate her speaking style, and bear the brunt of patient advocacy, in the face of inconsiderate colleagues:

> Why can't I just say it? Why can't you just, first of all, why can't you just be aware, one? Second, why can't I just tell you and like it ends there? Why do I have to make sure I'm saying it in this way, whereas you're not saying it in that way to the patient?

Patient advocacy and awareness raising was not only emotionally taxing in the moment, but also described as an endlessly repeating process needing to be carried out with rotating casts of medical students and residents:

> The problem is like, especially the residents, the [medical] students, they go to different hospitals, and they're only here like a few years. Sometimes they're gone, and then it's a new batch. It's like you have to constantly be redoing this work.

Bearing Witness to Obstetric Violence: Moral Distress, Vicarious Trauma, and Burnout

Witnessing OV was an emotionally distressing experience for participants in the moment; participants described feelings of shock, disbelief, dissociation, fear, helplessness, shame, disgust, horror, and outrage. The emotional complexity of bearing witness to OV was conveyed in the words of one nurse as she described watching a woman with a history of abuse and trauma be yelled at, belittled, and threatened by members of the medical team: "I felt ashamed, ashamed and powerless, and angry and disgusted." Participants also described embodied experiences of distress in instances of OV: feeling an urge to cry, feeling one's "heart sink" to the floor, and feeling frozen in place. One nurse vividly described her physical response to the violent actions of a physician:

> I do believe that it is violence, […] it really felt violent to me. I had the same physical response to, when I was in it, to if I was being hit…frozen. You know, I was frozen. I couldn't speak. My heart sunk to the floor. I was shocked, and everything, the same feeling I would have if I was being punched.

Participant narratives included accounts of "knowing something was wrong" and feeling conflicted in how to respond or feeling unable to respond with the "right" or "best" course of action. These accounts point to the psychological process of moral distress, feelings experienced when a person is conflicted about or constrained from acting in alignment with personal or professional ethical or moral beliefs (Reis & Lesandrini, 2025). The following excerpt, in which

a nurse described witnessing the rough application of non-medically indicated fundal pressure, exemplifies the fraught nature of morally complex clinical encounters:

> At first, you're like, […] *Oh my God, what's happening?* But you know, […] you're so shocked […] that you don't know what to do, and you know it's wrong, but […] your body goes into this like shock. […] Do you stop it, do you let it continue? You don't know what to do, so you're just in shock, and you don't […] even know how to move.

Another nurse noted, "I think it's something that's always like weighed heavily on me. […] Am I part of it, am I part of the system that is the problem?" She described feeling personally empowered to provide respectful and high-quality care, yet her words convey the internal conflict that can arise when personal values are incongruous with systemic ones:

> What's kept me going in obstetrics, I think for a long time, is that, you know, the idea that I can make change. […] Every patient that I care for, […] that is changing [the system]. […] But I am part of a system that does mistreat women, and […] women do go home with this feeling of being mistreated.

While moral distress often arose from witnessing interpersonal acts of OV, one physician spoke to the distressing nature of clinical decision-making and the potential for harm of making a "mistake" or of not doing the "right thing":

> There's always an insecurity in what we do. […] You can always question the decision you're making, […] 'Am I doing the right thing? Is this the right thing to do now? Am I making a mistake? Am I gonna hurt the patient? Am I gonna hurt the baby? What is my team gonna think of me?' Right? Because not only do I not have time to treat patients properly, I may not have […] the time to mentor a medical student or resident, and I may actually traumatize them.

As the participant points out, a lack of time, an important systemic and institutional constraint and driver of mistreatment, compounds an already tense decision-making process in which the well-being of two individuals hangs in the balance.

Participants spoke to the impact of repeated and unresolved exposure to morally distressing situations over time. One nurse wondered, “What do you do? What what do you do when, when something inappropriate happens? How do you in that moment say, ‘Hey, that's not cool.’ […] Do you just let it happen, and then go document?” She continued, “Those situations definitely stick with you.” Lingering feelings of regret, remorse, and guilt were common, even in instances where participants felt they had done their best: “I felt guilty, and I still feel guilty, in a way. I still feel guilty. […] But I was like, *I tried and tried*. I had tried everything I knew how to do.” Other times, these feelings led participants to wonder what they could have done differently, or in the words of one participant, “so many *woulda, coulda, shouldas*.” One physician reflected on the impact of formerly participating in acts that they would now define as OV:

> I had to look at my practice. […] I started to look at what I was doing, how it could be either viewed as traumatic, how it *was* traumatic, how it wasn't what the patient wanted, and how it wasn't what I wanted for the patient.

Across participant narratives, a wider set of responses were consistent with the presence of vicarious trauma, the personal consequences of being directly exposed to traumatized individuals or populations (Shapiro, 2018). These responses included the imprinting of emotions and memories related to traumatic events. For example, one nurse described in vivid detail a scene in which a physician yelled at and threatened a patient, a memory that she described as unforgettable:

> Another doctor came into the night and came to deliver her own patient. […] It was her first baby, they didn't wait an hour to start pushing. […] This particular doctor *yelled* at the patient. […] I'll never forget the tone, […] 'I'm not delivering a dead baby tonight! Push!'

Another shared, "I've seen a lot of things, and I experienced some things. […] I felt that it left such an imprint on my practice now, and also just an imprint in my heart that I wish I was better prepared for." Even several years after a particularly traumatizing event, one nurse shared her lingering feelings, "I just feel so, I feel so bad for her, *still*," and added that she and her colleagues "still talk about it."

Lingering feelings of anger, indignation, disbelief, and outrage brought about through exposure to OV frequently arose in interviews as well. As one physician expressed,

> We have colleagues that I'd like to slap from here to there. Like, really?! This is 2024, you don't talk to women this way. You just *don't*. They do! And they continue to. They degrade, they erode, they minimize, they… And it doesn't matter what kind of, you know, protective factors you've got in your life, what kind of resilience you have. Who wants to be in, who wants to be present with someone like that?

For some, these feelings had gradually hardened into cynicism, a feature of vicarious trauma that perpetuates emotional strain and disengagement, and acts as a driver of mistreatment.

Chronic feelings of helplessness and powerlessness without the ability to intervene or bring about systemic change also contributed to a sense of futility and disengagement among some providers. For example, one nurse shared, "I was frustrated because it was like, 'Okay, I'll talk about it to my colleagues at work, but it's not leading anywhere.' We're just talking about it, and that's it, like we're aware, but what else can be done," pointing to a belief that awareness

raising was futile. Another nurse expressed feeling like she lacked the influence to bring about change: “I felt like I was too much of a small fish in a big pond to try to change anything.” For one nurse, disengagement appeared as emotional detachment from the patient:

> I'm able to like to dissociate from the emotional aspect […] with my patients. But I could, I could empathize with them with how they're feeling like, I know this is how I'm supposed to be feeling by witnessing what I'm witnessing. And I want, I, I know how they're potentially feeling, but I'm able to like disconnect myself from it also.

For others, disengagement came in the form of emotional withdrawal, disillusionment, and distrust in their institutions and colleagues. For some, this meant refraining from discussing work concerns with managers, choosing not to escalate cases of patient mistreatment, or putting their “head down” to “get the job done.” One physician, describing their workplace culture, noted,

> It's very, very, very, very, very sad. And I have these conversations with [doctors], and I have these conversations with [administrative staff], and you know, we talk about this on a regular basis. And it's sad, it's *very* sad. To the point that we don't really want to be part of it anymore.

This statement reflects disengagement and disillusionment, not only on an individual basis, but on an institution-wide basis, occurring among a variety of professionals.

Emotional exhaustion, and in some cases burnout, were also described by participants as stemming from the critical nature of perinatal care and from system-wide deficiencies, including poor working conditions and the poor treatment of patients. One nurse shared,

> Sometimes when you come home, and you're like*,* ‘I’m burnt, I just spent eight hours, you know, dealing with someone, you know, [a stillbirth], or, or a difficult labour or whatever.*’* And you realize, like, you're dealing with life and death constantly, and it's

> part of your daily life. And then you come home, and it's just like, 'Okay, now, I have to switch off.'

For another participant, short staffing and heavier patient loads were contributing to heightened stress and an inability to meet the needs of patients. Having already experienced burnout early in her nursing career, she described briefly considering leaving her job out of concern that burnout would re-occur:

> I was not in a good headspace, like for a long time. I was actually thinking of switching jobs […], and I was just like, 'I'm ready to quit my job, cause I'm not giving my 100%.' […] I've gone through a burnout, a year into my nursing career. So, I knew what it was. I was like, 'I don't wanna go through that.' It was very challenging. It was like therapy after therapy every week. […] So, I was like, 'Let's just change jobs, let's just quit.' Which is not the answer.

Other participants also described career changes in the face of poor working conditions, toxic workplaces, and exposure to OV. For example, the following physician described reaching a breaking point and quitting their job altogether: "It was time for me, cause […] I literally didn't want to be there anymore. […] I f*****g hated it. […] I left, I jumped ship because it was hopeless." One nurse described taking a leave of absence and eventually leaving the field altogether:

> It affected me so much that I left the [birthing unit] […] because at that point I had been, I think I had seen enough. […] The way the system was working didn't align with my own values and morals, and so I had to walk away.

In the face of these mental health impacts, two participants spoke of seeking professional support, pointing to the gravity of workplace environments on provider well-being. As one nurse shared,

> I still have trauma about the [birthing unit]. […] I went to therapy for about two years to heal from stuff that I had seen in the [birthing unit], and how powerless I felt, and how like I just, going over my feelings about my role and responsibility in certain situations.

Theme 3: Provider-led Responses to Obstetric Violence

The following theme focuses on possibilities for responding to OV within and beyond existing systems of care. This theme is organized into two sub-themes: (1) *From Provider Mental Health to Trauma-Informed Care: Strategies for Promoting Humanized Care* examines strategies that providers enact and imagine as promoting respectful care, including addressing the mental health of providers, addressing systemic failures, and incorporating trauma-informed care; and (2) *The Importance of Dialogue: Awareness Raising and Speaking of "Violence"* focuses on awareness-raising, the challenges and possibilities of explicitly naming and speaking about "violence" within obstetric care settings.

From Provider Mental Health to Trauma-Informed Care: Strategies for Promoting Humanized Care

Despite the myriad institutional and systemic factors driving OV, and its negative impacts on HCPs, a common thread running through participant narratives was a hope for change, and a personal sense of duty to continue to work towards its achievement. Similar to the experiences of CBWs, providers described the reparative nature of individual positive interactions and their ability to improve morale and energize advocacy efforts. For example, one nurse described the positive impact of debriefing with a physician following a traumatic clinical

encounter: “I had this huge respect for him for admitting that he was wrong. And it brought me, that brought me back to my faith in the system. You know the honesty of it all.” Another provider described respectful care as a source of healing for both patients and providers: “There are other ways, respectful ways to provide care.” They went on to describe collaborating with a patient who had a history of sexual trauma and OV in order to prevent re-traumatization, reflecting, “It was a healing experience for me.”

Training. Improvements to formalized training programs to include humanized approaches to care, empathic and compassionate communication, and an explicit focus on promoting the autonomy of patients were identified by all HCPs as crucial to achieving respectful perinatal healthcare. One nurse shared her impression that “overall, no,” residents and medical students were not aware of the issue of OV and added, “It should be discussed in school, or prior to being hired on the obstetrics floor.” Another nurse shared their impression that change predominantly came from the bottom-up, not the top-down:

> By including it in curriculum, […] I always feel like, [change] comes from the students and like the newer nurses. […] I think that that's like a really big way. […] As much as I'd love to say that you're gonna change it from like the heads of department and stuff like that.

Having residents complete training and clinical rotations in a variety of settings, under the supervision of multidisciplinary teams, was expressed by one physician as a means of expanding practice styles and instilling a person-centered approach among the newer generation of physicians:

> They should go everywhere. They should work with high-risk obstetricians, general obstetricians, family doctors, the midwives, doulas, nurses, because they need to see all

> different styles, and get all the positive from every single one of them, […] and equally, what they never want to do.

HCPs identified a need for institutional training specific to OV that would sensitize providers to its existence, what it looks like in practice, its impacts, and how to mitigate it. They suggested including OV training in formal conferences, rounds, simulation programs, and as part of the orientation of new staff. Sensitization was described as occurring in informal one-on-one interactions as well. As one physician shared, "I feed a line to our learners, 'This is a privilege, not a right.' We didn't gain this medical experience and have this job so that we can say, 'We are going to do this [to you].'"

Modelling respectful care, especially with regards to the consent process, was also described by nurses and physicians as an important means of shifting the care practices of senior and junior staff alike. One nurse shared,

> I feel like modelling, […] is like the best thing we can do for junior nurses. […] I like to give the idea of, like you kind of feed them lines, […] like, what's a little script that they can say when a doctor comes to examine their patient. […] You don't have to stop anything but like, you kind of put, you've, you've put that idea in the room. And you see sometimes the doctors will be like, 'Oh, yeah, *can* I examine you?'

Participants also described modelling conflict management and de-escalation skills for learners. One physician shared,

> If we make people more conscious [of OV] and *we* model, then they become the minority, and probably they'll feel silly, right? Like, it's important that everybody is empowered to say, 'You're making us uncomfortable. You're making a scene. Do you think you can take this outside?'

Cultural competency was also described as an important feature of training that could promote inclusive, safe, person-centered care, as one physician reflected,

> We have this culture of like, 'This is just how things are. This is what the woman wants. This is how, what we're gonna provide. This is how things are.' But it's not always how things are. […] We have a very culturally diverse population that we have to try to understand more of why certain things are important to them. […] Women who are refusing, […] we have to kind of dig deeper and try to learn.

Humanized Healthcare Models. The adoption of humanized healthcare models was described as a core strategy that could shift care practices, as well as workplace cultures, towards more person-centered, holistic, and emotionally safe care. In general, HCPs envisioned care where providers spent more time at the bedside, communicated information more thoroughly, and engaged patients in more empathetic and compassionate ways. HCPs envisioned openness, curiosity, and respect towards patients' perspectives and preferences: "The patient has her own mind. She probably has a *good* reason why she didn't want to do this. Let's find out, […] go further in the conversation. […] Because most of the time, there is a reason why."

Upholding the autonomy and agency of patients represented another key feature of humanized and respectful care. For one physician, this began with promoting self-advocacy:

> When I talk to couples prenatally, I tell them over and over, […] 'I empower you to just ask your questions. If there are things in the room, and you have a curiosity about what is being said about your care or your baby, just ask the question.'

For another physician, upholding the autonomy of birthing individuals included providing them with a full understanding of their clinical state, regardless of their perceived capacity to receive it. They noted, "I sometimes give patients more information than they need, more information

than they might be able to put up with or tolerate at a moment, but I think it's important that patients be informed about the process."

Trauma-informed care, a framework for providing care that considers the widespread nature of trauma (Perinatal Services BC, 2023), was identified as a formal and systematic approach to providing safe and humanized care for all birthing individuals. Trauma-informed care starts with recognizing the high prevalence of trauma among individuals and the probability of re-traumatization in clinical encounters. As one nurse reflected, "I am so surprised and shocked at how many women have past traumas, and how it […] brings it about when they're in labour. That pain, that it's their genitals, it's their privates. […] There's just so much involved." Another participant, a physician, reaffirmed the high prevalence of trauma among birthing women, noting, "We have to anticipate that she's one of the 50% of women that's been assaulted and raped." Within a trauma-informed framework, trauma-informed care should be applied routinely, regardless of known trauma history. However, one nurse expressed that having a patient disclose her history of trauma at her admission to the hospital could encourage staff to "handle it with kid gloves."

For individuals with a history of trauma, standard procedures and approaches to care can be experienced as harmful, as one physician reflected, "It can be retriggering and retraumatizing, even worse I think, than the initial event […] in the context of the simple things that I do." Seemingly inconsequential practices were described as having the potential to protect the psychological and emotional safety of patients, including ensuring they were draped during intimate procedures, being at eye-level when speaking to patients, and introducing oneself and calling patients by their names.

Humanized models of care were also described as mechanisms for seeing "the human" in providers, and a means of encouraging "humility" among them. Participants highlighted the importance of cultures that support accountability, continuous learning, and openness to critique: "There's always new ways to learn. […] You're not void of errors or mistakes. Everyone can make mistakes. […] It's not a mistake if you learn from it, it's a lesson." Others echoed this emphasis on responsibility, noting the importance of "taking responsibility and accountability, […] cause, you're human right." For one nurse, self-reflection on past practice was central to growth: "I do see things that I have done in the past that could contribute to the mistreatment of women. So, it's just more like a learning experience for me. […] I'm just trying not to do it again."

Collaborative models of care that decentralize authority and encourage collaboration between multiple healthcare professionals were identified as essential to improving workplace culture and, ultimately, patient experiences. For some, this could mean including midwives and doulas in multidisciplinary training programs and on units to optimize care. For one physician, collaboration required the dismantling of hierarchies: "How are we going to improve the civility? How are we going to improve the […] integrity, and the respect that everyone deserves? We have to get rid of the hierarchy." Another physician emphasized that respectful teamwork was foundational to positive birth experiences: "If we don't fix teamwork first, we can't fix the birthing experience." They noted,

> It doesn't matter who you are or what your title is, you're not more important than anybody else here. […] I feel like it's so pivotal that our teams move to that mutual respect, and that you can always learn from each other. These are very important things amongst our team that lead to negative birthing experiences.

Participants also envisioned a workplace culture where it felt safe to name and call out harmful behaviour. As one physician noted, “A culture of openness where it's okay if someone points out that you weren't the best version of yourself. […] You just reflect on yourself, and that's how you grow, right?” One nurse also pointed to debriefing as an effective tool where such structured, respectful conversations could be had, while promoting conflict resolution and teamwork.

Postpartum Communication. HCPs underscored the significance of debriefing with women in the immediate postpartum period, an often overlooked, yet meaningful practice. Some described a growing culture among more junior physicians and residents to return to the patient after a difficult or traumatic delivery. As one nurse observed,

> I do find that more and more […] residents go back to the patient when something goes wrong. […] They go back […] a few hours to a day later. They revisit the whole labour […], and they ask the patient, ‘How did you feel? Was there any questions you want me to answer?’

One nurse recalled a birth involving a young, non–English-speaking woman, with severe postpartum hemorrhage: “So many people in the room, […] all the yelling, […] the high emotions.” Afterwards, as the nurse recounted, the physician suggested they debrief: “She sat next to the patient, held her hand, apologized for the chaos, and walked her through the events. […] It was nice because I don't see that a lot.” Debriefing was also seen as essential for clarifying misinterpretations. As one physician explained, “Even if a woman lives tremendous fear, if you sit down after, […] most of the time, it has to do with what they've been told, how they've been treated.” They described being “surprised at what they tell me. […] It’s so important to do that debrief.”

Validation of negative feelings was emphasized as a simple but powerful intervention. One physician noted,

> If after we can just ask, 'Was there anything you felt […] was negative, or you're traumatized by, that you'd like to discuss with the team?' […] If the answer is, 'Well, yes.' […] Just taking that extra minute or two, it usually doesn't require a lot more time right, to validate.

The provider noted getting "surprising answers." They explained, "Once a woman said, 'Well, there was, you know, that person who walked in, and he seemed angry at me.' […] That person wasn't even *pivotal* in the management, right?" The participant added, "So, […] it could be anything. But if you name it, and then you say, 'Oh, I'm sorry you felt that way,'" emphasizing the importance of simply acknowledging the patient's experience. Despite the recognized importance of debriefing, opportunities were described as lacking: "Ideally, you wanna be visiting the woman in postpartum once […] the adrenaline and all the hormone stuff, […] but we don't get that opportunity."

Participants also imagined how extended postpartum follow-up could reduce negative feelings about birth by creating opportunities for questions that often emerge only months after birth. One nurse recounted an encounter she had at her own child's daycare with a mother who had spent years believing her nurse's actions had caused her epidural to fail, when in fact they were following the standard safety protocol. The nurse reflected, "Imagine she had had the space, like, you know, maybe one year postpartum, or maybe six months to go like, 'What was that? Can you explain to me what that was, what was that treatment you did?'" She added, "I feel like we could prevent *so much* trauma by just being like […] 'Do you remember what happened? Can we answer any questions?'"

Creating opportunities for healthcare teams to hear the birth stories of past patients was also described as "impactful," as it could provide a more accurate sense of how care was actually experienced. As one nurse noted, "Hearing their stories […] is very impactful. I mean, […] you think everything was perfect, and then she comes back and says, 'Well, like this is what happened to me.'" Gaining feedback directly through women's stories and voices "is super important," she continued, "because we do kind of other them. […] These women come in, and they have their own lives, and then we put a gown on them, and they have a baby, and they're just *that* person." Patients move quickly through the system; physicians may see them briefly at six weeks, "and then never see them again," described one nurse. Hearing patient stories served as a means of humanizing women, but in the words of one nurse, also forced providers to "live the repercussions" of patient mistreatment. In other words, it would call on providers to confront the true impacts and outcomes of their (poor) care.

Systemic Reform. Systemic and institutional processes and resources to support the well-being of healthcare providers were identified as foundational to improving birthing experiences. Two participants described the positive impacts of seeking out mental health support to cope with the cumulative impact of witnessing harm, feeling powerless, or being implicated in care practices that conflicted with their values. One nurse shared, "I went to the employee assistance program, and I went to therapy […] so that, that helped me to get to where I'm at now. But I definitely needed professional help after working there." Participants noted that provider well-being was not only important on an individual level, but as a factor contributing to team cohesion: "I really think if you look at individual wellness, and you look at the team, and you strengthen the team, the care gets optimized." An HCP's individual mental well-being was also described as fostering safe and positive patient experiences. As one physician stated, "The

first and most pivotal step in giving positive birthing experiences to our, our families is for us to be well and for the team to be strong."

While some HCPs expressed that providers who caused harm "maybe should feel ashamed," this sentiment was often accompanied by a recognition that shame was not constructive. Instead, participants emphasized the need for structured supports that would allow providers to process their actions and experiences without blame or defensiveness: "How do we help [providers]. […] Maybe there's like […] an employee assistance program for people who did feel like they've done something to now be like, 'Okay, like, it happened, like move on from it.'"

Participants also highlighted the importance of creating formal spaces for healthcare providers who witness OV to process its impact. Witnessing harm was described as emotionally burdensome. One physician emphasized that providers themselves needed to be kept safe: "I just think it's something that has to be integrated in any work that we do, […] like the practitioners have to be kept safe, too."

Addressing resource shortages was described as a means of preventing OV. "More time" was a common refrain among participants, representing a need for improved staffing and provider-to-patient ratios in a transition towards more respectful and person-centered care. "We need more nurses for sure," noted a physician, who expressed concern about burnout and forced overtime. Describing a case in which she was time-constrained in providing care to a patient with a history of trauma, and who was having a difficult labour, one nurse reflected,

> What could have made it better? […] If I had had more time with her, […] if it had been real one-to-one care, then I would have been able to take the time to be more patient and […] maybe explain things more in detail, or explain things again and again and again, as

> many times as needed. […] Just being in there with her the whole time and creating that bond and that relationship, […] and getting her more involved in her care.

Doubling the presence of staff obstetricians on hospital-based birthing units at any given moment, though described as unlikely due to financial and bureaucratic barriers, was also identified as a means of providing "safer" and "better care":

> Why can't we have two obstetricians in the place at the same time? Because I think then you can […] manage patients more effectively, you can be kinder to patients, you can actually explain things to patients, you can actually have time, because you don't have to run from here to triage to do the same things that you need to do.

The Importance of Dialogue: Awareness Raising and Speaking of 'Violence'

Across accounts, dialogue emerged as one of the few consistently available tools for naming harm, disrupting normalization and complacency, and fostering change. The following sub-theme discusses three areas pertaining to dialogue: peer teaching and awareness raising, perspectives on and conceptual engagement with *obstetric violence*, and redefining what counts as a "successful" birth. Overall, participants described conversation as a primary mechanism for uncovering what is often taken-for-granted within institutional care. Though its impact remains shaped by disagreements over terminology and constrained by broader systemic forces, providers viewed dialogue as an essential starting point. Ultimately, raising awareness, even in small and informal ways, signalled a gradual shift toward more reflexive and respectful perinatal healthcare.

Peer Teaching and Raising Awareness. Some HCPs described actively educating peers or initiating conversations about OV on their units. One nurse described entering the profession already aware of the topic, "I'm kind of, quite vocal about obstetrical violence. […] We hear a lot

about it. […] I'm interested in the subject." Informal conversations between colleagues, "on the side," were seen as more effective in bringing about change than making formal complaints or escalating incidents to higher-ups. As one nurse noted, "When I've seen something that contributes to obstetric violence, […] if it's something I could just talk to the medical professional about, […] they'll be like, 'Okay, yes,' or 'I didn't know.' Then fine." Another nurse described the ripple effects of dialogue among nursing staff: "I'm talking to other nurses about it, they're also doing it as well, […] especially some of the junior ones." Another emphasized that open, ongoing dialogue is necessary for confronting health inequities: "It's not just a feeling, like the statistics show that women of colour have poorer outcomes. […] So, making those open conversations […] that's not gonna end everything but […] it needs to be talked about."

Participants described the culture on their unit as gradually shifting over time as a result of peer teaching and open dialogue. One nurse recalled the impact that in-services on patient mistreatment had on her unit, noting that they generated much conversation, and that she "definitely saw a change." She went on to describe concrete change in one physician who had historically demonstrated problematic behaviour: "That particular doctor, now […] I definitely see [they are] different with the patients, really giving her the *full* details about the procedure like, 'Do *you* want to do this? Is it okay with *you*?'" Another nurse shared that awareness-raising efforts were slowly changing practices on their unit: "People are more aware of it now, so they try to be better about […] their interventions with the patients."

Perspectives on the Term "Obstetric Violence." Participants' reflections on the term *obstetric violence* illustrate that language, and how providers choose to name women's experiences of harm, represent an important potential step toward advocacy and transformation.

While the question of how providers defined and conceptualized OV was explored in an earlier section, this section focuses on how the concept itself shapes provider engagement, opens or closes conversation, and influences potential reform.

Participants' reactions to the term *obstetric violence* varied widely, from immediate approval, to discomfort, to concern that the term can shut down dialogue. For all, use of the word *violence* was remarkable, "shocking," "a violent term," "a big word," and not to be taken "lightly." Many described the term as powerful in naming women's experiences, yet also risky in environments where provider defensiveness was already high. For one nurse, hearing the term for the first time immediately aligned with what she had observed in her work:

> You knew it was there, and you didn't know how to term it, and I guess I kinda learned it, that term started coming out, […] in like women's magazines and like blogs. […] It was probably in research and probably in academic stuff. But I hadn't heard it. But then, when I heard it and started reading about that, I was like, 'Okay, that's what I'm part of. Like, that's what women are feeling, […] this needs to be talked about more.'

Another nurse described her recognition of OV through her own embodied experience in witnessing it: "I do believe that it is *violence* […] because it really felt violent to me!"

Recognizing that OV is normalized, one provider pointed to the importance of recognizing it as legitimate *violence:* "I mean, if it was something like sexual assault, like those are […] kind of clear […] acts of violence, like hitting someone, physical violence, things like that, they're very clear." She continued, "But obstetrical violence is just so nuanced, […] which I don't think it should be." One physician emphasized that the concept sits on a spectrum of behaviours, which complicates efforts to identify one single term that fits everything:

> I have seen a woman being slapped. […] And then there's […] a look or an eye roll to something, which is disrespectful and condescending, that some might say, well, 'That's not violent. […] There's such a spectrum of behaviours that it's hard to find the right term for this.

According to one nurse, they were open to the term, which they felt served to exemplify the gravity of the harm OV could produce: "It could definitely be called different things. […] There's a bunch of ways to describe it, but I don't mind the term because it should be shocking, so we can know it's something we need to change." Others insisted that the term's validity lies in women's self-descriptions: "If a woman tells me, 'That's how I felt it, I felt violated.' Then I say, 'Well, then, it's violent,' you know. And I think it needs to be named what the woman has felt it with, right?"

For some, the term created immediate barriers. "A lot of people take it negatively," shared one nurse. While according to one physician,

> It almost sets people back. Because if you say, 'I'm talking about obstetrical violence,' some people are gonna be like, 'Oh, here we go. Now we're going to be told how […] we're horrible, and we don't do the right thing.' […] So, it already creates a wall and a barrier.

One nurse shared, "I don't tend to use [the term]. It shuts people down. Like, if you, you say, like, 'You just committed an act of obstetric violence,' like you're never gonna have a fruitful conversation beyond that." Instead, she favoured less provocative, consent- or choice-oriented language: "I think you could kind of start with consent, and like terms of like *choice*. […] You're gonna have a way more productive conversation if you say that." One physician pointed out that

OV was too emotionally charged as a concept and may close conversations, opting instead for more neutral language:

> I don't think it's an ideal term for anyone. I don't think for the women, nor for the practitioner, because […] it can dissuade, it can evoke a lot of emotions. […] And I don't even know if *mistreatment* is even the right word, right? […] Let's talk about *negative birthing experiences*, you know, and see how we can adjust.

Redefining Successful Birth. HCPs described a growing need to rethink what counts as a "successful" birth, moving beyond quantitative measures to include the patient's experience, emotional well-being, and sense of autonomy and respect. As one nurse shared, "I think we need to […] broaden our perspectives on what the end goal is. Is it just to have a healthy baby? There's so much more we could ask for, so much more that we deserve than just that."

Others highlighted how institutional priorities continue to reinforce narrow definitions of success. One physician reflected on the emphasis on audits and clinical metrics:

> People don't focus on patient satisfaction, right? They focus on measures of, 'Let me see your C-section rates.' […] And our chart audits are all about looking at […] how can we reduce our C-section rates and all that, by going through all the steps. But it's rare that we do that focus on the patient's experience, right? Because it's harder to measure, […] I don't think we're doing it *at all*.

In summary, this chapter presented the results from interviews with HCPs, examining how OV was understood and navigated within perinatal care. Providers described OV as embedded in routine practice and driven by sociocultural and biomedical discourses, professional hierarchies, and institutional conditions. Accounts revealed the emotional toll and impacts of bearing witness to OV, including moral distress, burnout, and job changes. All HCPs recognized

that they had engaged in or perpetuated OV in small to large ways yet frequently described their involvement as unintentional. They described efforts to resist dehumanizing practices through advocacy that was often accompanied by personal or professional risk. Participants emphasized the importance of dialogue, healthy workplace environments, and systemic reform as avenues for addressing and mitigating OV.

Chapter 7: Discussion, Implications, and Conclusion

The results of this research contribute to a growing body of evidence on OV by expanding our understanding of how it manifests in care, how it is experienced, its impacts on individuals and families, and the drivers that underpin and reinforce it. In this study, childbirth marked a site of intersection between deeply personal and embodied experiences, internalized expectations and meanings around birth, medical authority, gendered norms, and intersecting systems of oppression. The findings highlight that OV is inseparable from epistemic considerations, which are reflected in participants' experiences, the impacts they endured, and their acts of testimonial resistance, here referred to as the *epistemic thread*. By situating accounts from CBWs and HCPs within the existing literature, this study demonstrates that political and transformative efforts to address OV could be strengthened both by formally recognizing the concept itself and by incorporating an explicit epistemic domain within existing OV definitions. A subsequent section explores the promise of "good" birth, mediated by discourses of motherhood, safety, and related narratives. These, together with relational fractures, lay the groundwork for feelings of individual failure, contradiction, and ambiguity in the meaning attributed to birth, and, it is argued, *institutional betrayal*. Furthermore, through the examination of both CBW and HCP experiences and perspectives, this study points to a deepened understanding of OV as a relational environment of care that impacts birthing individuals, their families, and providers with varying degrees and types of harm. Findings pointing to *moral injury* among providers will be discussed as both a symptom of OV and a condition upon which OV continues to thrive in strained healthcare settings. Finally, differential experiences of OV will be considered as shaped by systemic racism in the Canadian perinatal healthcare system, which influences how women navigate pregnancy, childbirth, and motherhood. This section

includes insights from HCP accounts on racism as entrenched and normalized within their workplaces. Prior to engaging in these discussion sections, a brief review of the analytic method and an overview of key findings will be provided to situate the remainder of the chapter.

Review of Analytic Method and Findings

This study employed FRDA (Thompson et al., 2018) as its primary analytic approach in order to attend simultaneously to voice and discourse within participants' accounts of childbirth and OV. An integrated feminist framework, drawing on feminist poststructuralism and intersectionality, guided the analysis of how sociocultural norms, institutional practices, and dominant discourses shape power relations, agency, and subjectivities in childbirth. This approach enabled an examination of OV not only as a set of discrete interactions or events, but as a relational and structural phenomenon embedded within broader systems of gendered, racialized, and medicalized care.

Through this analytic lens, the study illuminated how discourse, knowledge, and power operate within hospital-based childbirth, shaping how CBWs interpret and make meaning of their experiences and their sense of self. The findings further demonstrated that CBWs constructed narratives through myriad discourses pertaining to motherhood, birth, and medicalized birthing care, while navigating power relations with strategic adaptations, constrained agency, compliance, and precarious resistance. The discourses embedded within CBW and HCP narratives of "sacrificial motherhood" and a "good" or "successful" birth demonstrate that gendered norms and patriarchal framing of motherhood, along with biomedical notions of *risk*, *safety,* and *beneficent intent,* are internalized by birthing individuals and providers alike. Together, these heavily influence the degree to which OV is justified and normalized. As a result, the analysis served to make explicit the normative and taken-for-granted

assumptions that underpinned participant narratives and that often operate tacitly in the background of clinical interactions. Though HCPs recognized the significant consequences of OV for individuals and families, the findings emerging from their accounts highlighted health system dysfunction, professional power hierarchies, and workplace stress as contributing to a sense of constraint, powerlessness, and personal harm. Providers felt compelled to advocate for patients in ways that ranged from subversive to outspoken, despite potential professional repercussions that often stemmed from the very same ideological and discursive forces that constrained CBWs.

Voice-centered methods that included the construction of "I" poems complemented discursive analysis by giving voice to the embodied knowledge, emotional responses, and evolving sense of self of CBWs throughout their perinatal trajectories. "I" poems were valuable in illuminating tensions and contradictions between women's experiential knowing and biomedical authority, as well as the ways participants articulated uncertainty, self-doubt, compliance, agency, and resistance simultaneously. For example, within a single poem, a participant may have stated, "I don't know" multiple times, while also asserting, "I know myself," and venting frustration that she "wasn't making it up." Together, these analytic strategies provided a nuanced account of the interplay between individual voices and the broader discursive and institutional conditions that sustain OV.

The Epistemic Thread

Women's narratives revealed not only experiences of emotional and physical harm and suffering, but persistent struggles to understand, name, and make sense of what had taken place in childbirth, often in the absence of clear information, recognition, or validation from care providers. Knowledge was frequently withheld, poorly communicated, or dismissed, producing

confusion, self-doubt, and a sense of unknowing that extended well beyond the birth encounter itself. A growing collection of scholars have contributed to understanding the ways women's knowledge, interpretation, and credibility are undermined during labour and birth through an epistemic analysis, though many of these remain theoretical (Begley et al., 2019; Chadwick, 2025; Ebrahim, 2025; Shabot, 2020a; Villarmea & Kelly, 2020). This study extends that work by using qualitative findings to illustrate how epistemic violence is enacted, experienced, and negotiated within concrete accounts of OV, making visible the specific interactions and discursive conditions through which epistemic and relational harm arises. Epistemic violence, according to Graves and Spencer (2022),

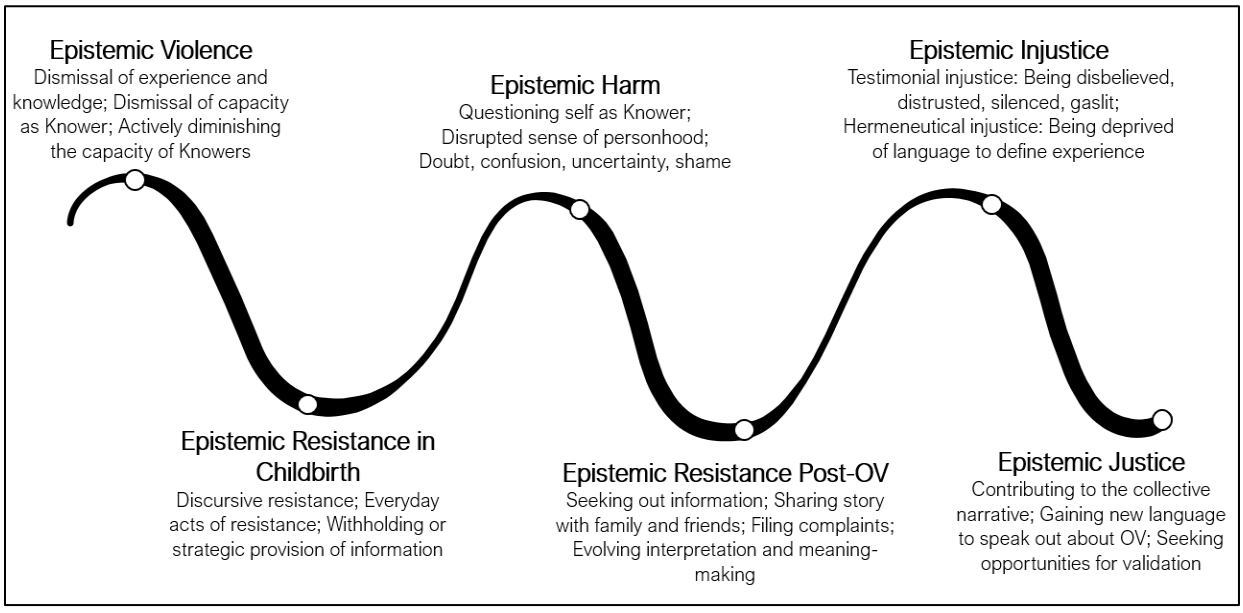
> occurs when a speaker is never given the chance to participate in the knowledge-creation process or when their epistemic contributions face power-laden denials, minimizations, or rejections based not upon the merit of their ideas expressed but rather on an alleged deficiency within a speaker's capacity to know (p. 406).

As the epistemic thread emerged and evolved in the study findings, it became impossible to ignore as a central feature of the phenomenon. Beyond the behaviours, conditions, or omissions of care that were identified as types of epistemic violence in Chapter Five, physical abuse, emotional abuse, disrespect, and neglect could also be understood as symptoms of a system that already denies the personhood and agency of women, a central component of epistemic violence (Chadwick, 2017). In fact, the study findings point to OV being fundamentally epistemic in a multitude of ways: in the ways that systems uphold medical knowledge as superior while denying women access to it, in ways that it is enacted in birth through the denial of women's embodied knowledge and experience, in the ways that deny her testimony of having experienced harm, and finally in the way that the suppression of the concept

obstetric violence itself has silenced women who lack the words to define their experience. These findings support the argument that OV operates largely through epistemic processes that regulate knowledge, and that, contrary to the perception that these forms of violence are comparatively less harmful than physical ones, are indeed profoundly painful and life-altering. As Chadwick (2025) notes, the moral and epistemic harms that result from experiences of OV, along with the silencing of these experiences, can be felt by women as devastating, and akin to having their "personhood undone and their bodies dispossessed" (p. 16). See Figure 6 for a depiction of the epistemic thread.

Figure 6

The Epistemic Thread



Understanding OV as epistemic requires examining the mechanisms through which women's knowledge is dismissed, destabilized, or overridden in clinical encounters. Shabot (2020a) provides a theoretical accounting of how certain forms of OV constitute a particular type of epistemic injustice: *gaslighting*, a process by which a person or group, intentionally or not,

causes another to distrust their own perceptions, memories, or beliefs. Shabot draws on often spoken phrases such as “you should be grateful” and “all that matters is that the baby is healthy” to highlight how women sharing accounts of violent or traumatic birth are gaslit into believing that their perception is distorted, their response irrational, or their reality not, in fact, real. Gaslighting in obstetrics has been further theorized by Fielding-Sing and Dmowska (2022) as encompassing the denial of mothers’ humanity, knowledge, judgments, and feelings as rational or legitimate. These conceptualizations closely mirror narratives that emerged in this study. Participants described experiences of being dismissed, treated as irrational or stubborn, and having negative feelings about their childbirth experiences responded to with pressure to be grateful for the good health of their baby. These reactions, originating not only from providers but also from friends and loved ones, were frequently reported. Participants’ accounts illustrated processes of self-doubt and uncertainty, including feelings that they did not fully understand their own experiences.

The concept of epistemic injustice as defined by Fricker (2007) provides further insight into the epistemic thread running through the study findings. Fricker defines two primary forms of epistemic injustice: testimonial injustice and hermeneutical injustice. Testimonial injustice involves being disbelieved or dismissed by a hearer who attributes diminished credibility to the speaker’s words, by way of both their perceived incapacity as epistemic agents and of the devaluation and abasement of the specific type of knowledge they may hold – in the case of birthing women, their embodied, experiential, traditional, and communal forms of knowledge. Hermeneutical injustice refers to the lack of available language, individually or collectively, to make sense of one’s social experience (Fricker, 2007). Accounts of OV in this study demonstrated both forms. Testimonial injustice was evident in women’s descriptions of being

undermined, judged, infantilized, or disbelieved, such as in instances where participants had their pain denied. Hermeneutical injustice emerged through constraints on the knowledge and language available to participants to interpret and articulate their experiences of harm. CBW accounts were marked by lingering feelings of uncertainty, self-doubt, and shame, as well as a tendency to minimize their experiences, such as when participants described their experiences as "not as bad as my friends," or that "it could have been worse." CBWs also avoided language such as *trauma*, *violence*, or *abuse*, despite describing experiences that easily could have been interpreted as such. Shabot (2021) argues that a lack of epistemic resources, in knowledge or language, may lead to an inability to recognize or name violence, especially in institutional settings that women have been made to trust are beneficent. Through epistemic injustice, birthing individuals are stripped of their "authorial voice", denied the ability to make meaning of their experiences, and left with insufficient language to adequately convey the harm they have endured (Chadwick, 2019).

Beyond individual interactions, epistemic violence is embedded within structural arrangements that privilege certain forms of knowledge while subordinating others and is sustained within a broader biomedical epistemology that underpins knowledge hierarchies. Within a feminist poststructural framing, epistemic violence aligns with Foucault's (1978) concept of biopower, wherein institutional and organizational power governs populations by determining whose knowledge counts, whose voice is legitimate, and the mechanisms through which knowledge can be created and acquired. Within this system, the *obstetric gaze* operates through constant observation, measurement, and monitoring, where clinical indicators overshadow women's own embodied knowledge and experiences of labour. The focus on surveillance and risk situates the clinician as the primary knower, while the labouring person

becomes an object of management rather than an active participant in their care (D. L. Davis & Walker, 2010; Foucault, 1973). In participant accounts, this appeared through the discourse of "doctor knows best," reinforced both externally by providers, family members, and society at large, as well as internally by participants themselves. For example, many participants narrated themselves as lacking knowledge – "I knew nothing" – reflecting an internalized script of being the unqualified patient in relation to providers, the legitimate experts in birth. For many, this aligned with an implicit or blind trust placed in HCPs to provide safety and support. Additionally, when certain practices and interactions were normalized and framed as routine and unremarkable, such as repeated and painful vaginal exams, women's ability to recognize harm or to trust their own interpretations of what had occurred was further limited.

The emotional intensity of participants' narratives was not merely incidental or solely in response to the challenging nature of birth; rather, it reflects the destabilizing effects of epistemic rupture on a person's sense of self. Participant narratives were marked by fear, shame, anger, grief, confusion, and lingering self-doubt. These emotional responses pointed to harms that went beyond isolated clinical interactions and reflected deeper ruptures in trust, safety, and recognition during childbirth. As Wolf (2013) notes, "women experience multiple traumas – those from the violent natures of their births and those from having no language or conceptual framework to understand what happened to them" (p.110).

Paying attention to emotion as part of the analytic process made visible forms of harm that are often minimized or ignored in social and medical discourses. Participants' accounts suggested that OV frequently involved relational injuries and violations of women's knowledge and sense-making, affecting how they understood themselves, their bodies, and their birth experiences. It was through engagement with these emotionally charged narratives that the

concept of epistemic violence emerged, not as an abstract concept, but as a way of naming the depth and lasting impact of harm described by participants. Framing OV in this way moves the literature beyond descriptive classification and toward a more relational understanding of the ways in which violence in childbirth causes suffering. The emotional harm experienced by participants is not just related to a sense of personal offence or emotional discomfort. It was also reinforced by fractures in the interpersonal relationship with providers during childbirth, a moment of heightened vulnerability that should be marked by relational safety, communal support, and affirming interactions.

Even within contexts of epistemic constraint and relational fracture, where the personhood of participants was undermined, it was not entirely erased; all participant accounts pointed to acts of epistemic resistance as a means of reclaiming some degree of agency or dignity. For example, in interviews, the internal monologue described by CBWs in instances of violation was often highly critical and condemning of care providers' behaviours and attitudes. Drawing on James C. Scott's (1985) concept of "everyday resistance", which describes subtle and non-performative micro-political acts of resistance in the face of oppressive structures, women's acts of privately rejecting judgements or labels, withholding information, narrating their experiences in counter-discursive ways, or using sarcasm or humour can be understood as forms of epistemic resistance that undermined provider authority. Participants also demonstrated *testimonial resistance*, the act of "speaking back" in the face of having one's testimony silenced, reclaiming authorial voice, and reconstructing meaning where it may have previously been appropriated (Chadwick, 2019).

In this study, the interview process itself marked the first time some participants had told their birth story in its entirety, or with the inclusion of negative details that they had withheld

from family and friends. They also demonstrated testimonial resistance through the contribution of their birth stories to the collective narrative around OV, through sharing their stories in digital spaces or among friends, and through the research process, in hopes of expanding how providers and society at large understand OV and its harms. These acts do not dismantle institutional violence, nor are they positioned here as solutions to systemic inequities; nonetheless, they do constitute meaningful sites for individuals to reassert themselves as credible knowers of their own bodies and birth experiences. As one participant shared, "Your words being part of something bigger, I think it can be very healing." Contributing to the collective narrative represented a move towards epistemic justice, in an individual and collective sense.

Conceptualizing OV as epistemic exposes the insufficiency of existing typologies that categorize specific acts and omissions without addressing their underlying causes. Frequently cited typologies of OV, mistreatment in childbirth, or disrespect and abuse in childbirth invoke the concepts of individual choice, consent, confidentiality, and non-evidence-based care (Bohren et al., 2015; Bowser & Hill, 2010; Jardim et al., 2018). While useful for surveillance and broader public health initiatives, this study argues that the language endorsed within them is provider-oriented, depersonalized, and ineffectively conveys the lived, relational, and epistemic consequences of violence as experienced by birthing people. For example, within Bohren et al.'s (2015) typology of mistreatment in childbirth, "Lack of communication" and "Dismissal of women's concerns" are categorized under the broader category "Poor rapport between provider and patient," while a "Lack of consent" is categorized under "Failure to meet professional standards of care." It could be argued that this framing dilutes the severity of harm that can arise from such interactions, like the deprivation of the fundamentally relational and intersubjective nature of childbirth, a disrupted sense of self, and feelings of personal failure, self-doubt, and

grief. Conceptualizing certain forms of OV as epistemic in nature addresses a tendency in the literature to soften or overlook the harm that occurs from epistemic power imbalances.

The study findings thus prompted a turn away from traditional typologies of mistreatment and OV, towards a revised one. Redefining OV in this way was undertaken with the intention of shedding light on the profound consequences evident in women's accounts. While some commonly adopted categories of OV were retained or only slightly adapted, including physical abuse, verbal and psychological abuse, and systemic conditions and constraints, *epistemic violence* and *relational fractures* were included to reflect provider behaviours and practices that represented acts of violence or injustice that revolved around the denial of birthing individuals as epistemic beings.

The epistemic stakes of OV become especially visible in dialogue over its naming. The introduction of the term *obstetric violence* to participants, in post-interview debriefing, did not result in immediate rejection of the term; instead, it frequently created moments of curiosity and reflection, suggesting that the term opened space for participants to reconsider the terms they had used to describe their experiences. These moments point to the generative potential of the term *violence* as an invitation to think differently about normalized or invisible forms of harm. For participants who were already familiar with the term OV prior to the interview, its availability appeared to be affirming. Several described how encountering the term in their own internet searches or readings helped them recognize that their experience had been harmful or traumatic. In these cases, naming violence did not seem to produce a sense of victimhood, but rather supported meaning-making and validation, particularly in the face of prior dismissal or silencing.

These findings align with arguments proposed in the literature that framing obstetric harm as violence may serve as an epistemic, academic, and political intervention. In the

literature, the use of the term has been described as a form of “epistemic redress” (Ebrahim, 2025), and a “conceptual apparatus [...] capable of epistemic rupture” (Chadwick, 2021, p. 108). For Lévesque and Ferron-Parayre (2021), expanding definitions of obstetric harm to include violence serves as a tool for overcoming epistemic injustice, the denial or undermining of a person's perception or experience. When women are afforded the possibility of naming their experiences as violence, it serves to empower rather than victimize them. Pickles (2023) extends this further, arguing that dominant terminology should not be determined primarily by public health institutions or care providers, but should instead emerge from the accounts of those who experience the harm. As this author proposes, the naming of violations in childbirth doesn’t expose reality; it constructs what can be known as real, thus making the invisible visible, and shaping social perceptions of the issue:

> Behind these efforts is a broader power struggle over who gets to establish a dominant discourse precisely because this provides a monopoly over how society will perceive the phenomenon, and this will influence how responses are developed and where interventions are targeted (Pickles, 2023, p. 634).

At the same time, this study supports cautions raised in the literature regarding the need for attentiveness in how the term is introduced and used. Participants’ responses suggest that engagement with the term, as opposed to its imposition, was important: allowing space for reflection, ambivalence, and dialogue mitigated the risk of further appropriation of their experiences. These findings suggest that, as a concept, OV can serve as a tool for understanding and recognition, rather than as a fixed or totalizing label.

The Promise of a Good Birth and Institutional Betrayal

Discourses of childbirth promise transformation, bonding, and fulfillment, positioning the birth of a healthy baby as a central marker of success. The notion that "all that matters is a healthy baby" has been widely discussed in the literature (Byrne et al., 2017; Perrotte et al., 2020; Westergren et al., 2021). At the same time, childbirth is frequently described as carrying great meaning and as a source of growth and self-fulfillment. It has been described as a rite of passage (Reed et al., 2016) and a symbolic, empowering life event (Gagnon & Champagne-Poirier, 2021). However, as others have noted, childbirth is also characterized by complexity: it has been described as a bittersweet paradox (Callister et al., 2001), involving a complex interplay of emotions (Etowa, 2012), and as a kaleidoscope of emotions (Pereda-Goikoetxea et al., 2024). The findings from this study are consistent with these conceptions of childbirth, as participants narrated experiences that were often emotionally paradoxical, contradictory, and ambiguous.

Findings from this study demonstrated that becoming a mother and experiencing a birth that was considered successful in a biomedical sense did not resolve or alleviate the harm produced through OV; rather, it often intensified it. When women emerged from childbirth with physically healthy outcomes and their autonomy upheld on paper, yet still felt violated, confused, or disappointed, they were also left to contend with sociocultural narratives that instruct new mothers to feel joyful, celebratory, and grateful (Westergren et al., 2021). Thus, when they lacked feelings of fulfillment or joy following birth or lacked the sense of having had a "good" birth, they often described accompanying feelings of self-doubt, regret, guilt, and shame for failing to fulfill those norms. Participants also described experiences of loss, including relational fractures, grief, "stolen joy," and feelings of betrayal, which led to further complexity in how they processed and interpreted their experiences. Elsewhere in the literature, women's accounts

of childbirth marked by OV describe similar disruptions in how they made meaning of childbirth experiences, including pregnancy and birth as a *battle*, as a *bodily sacrifice*, and a *disrupted rite of passage* (Garcia et al., 2024).

Participants' accounts further revealed that these experiences, already ambiguous and unsettled, were compounded by discourses which largely reflected biomedical definitions of safety and risk. While conceptualizations of safety have traditionally relied on provider-derived definitions centered on clinical risk, patient-derived conceptualizations of safety in perinatal settings have been described as rooted in "feeling safe" rather than simply "being safe" (Barrow et al., 2023). Feeling safe is closely linked to patients' experiences of receiving care, including whether social, emotional, and cultural needs are acknowledged and supported. As Lyndon and colleagues (2023) argue in "Emotional Safety is Patient Safety," prevailing patient safety paradigms can undermine experiential knowledge and dismiss the significance of emotional harm, particularly when traditional safety metrics centered on maternal and fetal morbidity and mortality are achieved and lauded. Thus, when speaking about the good or successful nature of their births, participants' accounts revealed a striking dissonance. Although many described profound distress and the absence of emotional safety, they continued to rely on definitions of safety centered on physical outcomes, most often emphasizing physical health, or even simply, their survival ("I'm just thankful that we are both alive").

Within HCP and CBW accounts alike, and biomedicine as a whole, discourses of fetal-centrism and maternal-fetal antagonism – the notion that the fetus's best interests are antagonistic to the mother's (Davis-Floyd, 2004) – also prevailed. When invoked as justifications for violent practices that harm the mother in so-called pursuit of a healthy infant, a mother is left with no choice but to comply and endure, lest she reveal herself as selfish or uncaring, a tension

present in CBW accounts. The discourse of the self-sacrificing mother was particularly salient in CBW accounts and was reinforced by HCP narratives that reflected similar, and at times more deeply internalized beliefs regarding the primacy of fetal health. HCPs described feelings of responsibility or protection toward infants, particularly when mothers were perceived as making decisions that conflicted with medical recommendations or routine aspects of care. These accounts pointed to a deeper layer of maternal-fetal antagonism, wherein providers not only perceived mother and baby as having opposing needs but, at times, came to perceive the mother herself as a source of danger to the fetus. This perception positioned the provider as needing to protect the baby from the mother rather than from the risks of birth, an outcome of maternal-fetal antagonism (Davis-Floyd, 2004). These dynamics shaped the emotional experiences of CBWs. Mothers contended with multiple and often conflicting feelings, particularly negative emotions that did not align with the ideal of the mother who willingly sacrifices herself and finds fulfillment in doing so. When women could not meet this ideal, some explicitly named feelings of guilt and shame, while others demonstrated the need to reaffirm gratitude for the safe delivery of their child. As Shabot and Korem (2018) argue, women who desire a humane birth, one in which they are respected as subjects rather than positioned solely as vessels for fetal well-being, and who are expected to perform "good motherhood" through total sacrifice, are easily made to feel shame for wanting or expecting to be cared for themselves.

Thus, multiple discourses and sociocultural norms were at play in how good" and "safe" births were constructed by CBWs and HCPs. However, noticeably absent from HCP accounts, when considering care choices in the supposed best interest of the infant, was the evidence which strongly suggests that trauma and stress experienced during the perinatal period affects both mother and infant through multiple pathways, including through maternal mental health,

attachment, breastfeeding, and subsequent healthcare engagement (Ballesta-Castillejos et al., 2025; Leite et al., 2021; Ryan et al., 2025; Shorey & Wong, 2022). This evidence disrupts essential pillars of violent obstetric practices: that infants and mothers are distinct and that harming the mother to protect the infant is in the best interest of the infant, neither of which takes into consideration the interdependent nature of the maternal-infant dyad.

"Good birth" and the dynamics therein must also be considered within broader neoliberal logics that structure institutional healthcare and medicine. Neoliberalism, widely recognized as a pillar of contemporary healthcare, centers ideals of autonomy, self-determination, and personal responsibility (Aires et al., 2025; Kingma, 2021; Smarandache et al., 2016; Villarmea & Kelly, 2020). Through processes of normalization and responsibilization, individuals come to internalize expectations about appropriate bodies, behaviours, and choices, ultimately adopting a constant state of self-surveillance and self-discipline (Foucault & Rabinow, 1984; Parker, 2014). Within this framework, risk can be mitigated through individual effort, while adverse experiences may be reframed as failures of preparation or self-advocacy rather than as products of institutions (themselves the arbiters of risk) (Cheek, 2008). In childbirth, these neoliberal logics are reflected in dominant discourses of choice, autonomy, and individual rights, which are often positioned as benchmarks of a successful and self-affirming birth. While these are important concepts in determining legal redress or rehabilitation measures in OV (A. Castro, 2019; Kukura, 2018; Pérez D'Gregorio, 2010; Quattrocchi, 2019; Williams et al., 2018), they also carry important limitations. As Berzon and Shabot (2023) argue, Western neoliberalism is "ill-suited to a global conversation that includes women and the voices of a broad scope of cultural, religious, and ethnic identities" (p. 54). The harm caused by OV extends beyond constrained choice or impeded self-determination, representing instead a violation of the

sociocultural, relational, communal, and intersubjective conditions necessary for safe and meaningful birth (Shabot, 2020b).

The literature largely links birth trauma to fractured relationships with caregivers, producing feelings of being ignored, uncared for, unsupported, or cut off from others at moments of profound vulnerability (Reed et al., 2017; Thomson & Downe, 2008). Women have described a resulting "loss of self" (Byrne et al., 2017), and Shabot (2020b) characterizes such experiences as "solitary birth," in which women feel isolated and detached despite being surrounded by people. OV thus produces relational fractures, disruptions to interdependence, care, and mutual recognition, leaving women "deprived of a subjectivity that is truly sustained and contained by others" (Shabot, 2020, p. 6). CBW accounts closely mirrored these descriptions, with poignant stories of isolation, abandonment, and waking after birth with no one by their side, underscoring how negative birth experiences often are a result of relational fractures rather than simply a loss of autonomy. When autonomy, individual choice, and self-determination are framed as defining features of a successful birth, responsibility for a harmful or disappointing experience may more easily be turned inward. Several CBWs believed that their experiences could have been more positive if only they had prepared more, educated themselves more, advocated more effectively, or spoken up in different ways. Feelings of regret, self-blame, and shame persisted even in accounts involving overtly demeaning or inappropriate provider behaviour. Together, these findings illustrate how neoliberal logics of self-governance may intensify feelings of individual failure. This individualization of responsibility extends beyond healthcare settings; Canadian news media representations of OV similarly frame mistreatment as a problem to be managed through individual victim empowerment, or through a list of "tips" to avoid mistreatment, as opposed to through systemic change (Hill, 2022). News media shapes how a social issue is

perceived, and within the Canadian media, OV has been reinforced as an interpersonal issue that requires individuals to increase efforts in education, self-advocacy, and in pursuing and escalating complaints.

For many CBW participants, failure to have a good birth overlapped with what had been an implicit trust in physicians and healthcare systems to take care of them and make decisions in their best interest – trust in care that should have produced the promised "good birth." When this trust was violated, it gave way to shock, disappointment, distrust, and it is argued here, *institutional betrayal*. Institutional betrayal is defined as "individual experiences of violations of trust and dependency perpetrated against any member of an institution" (Smith & Freyd, 2014, p. 577). The findings of this study address a gap in the literature exploring the link between institutional betrayal and the loss of trust that occurs in experiences of OV.

Conceptually, institutional betrayal explains how institutional failures, such as negligence, failure to prevent harm, dismissal of needs, and failure to address mistakes or incidents, can produce or compound trauma (Smith & Freyd, 2013). Thus, institutional betrayal can arise from harm endured during care, as well as in how institutions respond in the aftermath of these events. Theoretically, institutional betrayal offers a broadened understanding of trauma stemming from betrayal, as possibly occurring outside of individual acts of violence or betrayal. The concept thus also represents a turn away from individualized and biomedical conceptions of trauma as an individual pathology to be diagnosed and managed in isolation. Feminist psychological theories of institutional trauma emphasize that institutions are central to embodied experiences of harm (Thompson, 2021). In the words of Sara Ahmed (2017):

> The personal is structural. I learned that you can get hit by a structure, you can be bruised by a structure. An individual man who is given permission: that is a structure. His violence is justified as natural and inevitable: that is a structure (p. 30).

Conceptually, institutional betrayal provides a lens for understanding the betrayal and loss of trust that may occur in OV, outside of the personal patient-physician relationship.

While institutional betrayal literature has largely examined sexual assault in universities and the military (Pinciotti & Orcutt, 2021; Smith & Freyd, 2013), emerging work suggests it manifests in interactions with healthcare institutions and is a predictor of disengagement from healthcare (Rastegar et al., 2025; Smidt et al., 2021; Smith, 2017). Institutional betrayal has been found to be associated with depression, anxiety, dissociation, and PTSD (Christl et al., 2024; Smith, 2017). Institutional betrayal in childbirth has received far less attention in the literature, with only a handful of articles examining the issue. Shoemaker and Smith (2019) found that almost half of the women in their sample who had experienced an adverse event in childbirth reported experiencing institutional betrayal. Kulkarni (2025) found that women giving birth experienced institutional betrayal in the form of medical errors, adverse consequences, and unexpected or lasting pain, which were associated with increased risk of postpartum mental health challenges.

The most closely relevant conceptualization of trust in the healthcare context is fiduciary trust, which characterizes the relationship between patients and healthcare providers (Kukura et al., 2020; Smith, 2017). Fiduciary relationships are marked by significant asymmetries in knowledge, power, and authority, creating an ethical obligation for healthcare providers to act in the interests of those entrusted to their care. Through a fiduciary lens, Kukura (2020) describes perinatal healthcare as evolving toward a two-patient model, often invoking language suggestive

of maternal–fetal conflict despite the interdependent health of mother and fetus and the fetus's incapacity for consent. Within this framework, "divided loyalties" toward mother and baby, perceived as having conflicting interests, contribute to abuses of fiduciary power, including coercive practices aimed at compelling mothers to accept care framed as in the baby's best interest. From this perspective, abuse of fiduciary power constitutes a betrayal of patient trust, not only at the interpersonal level, but also in the institutions and professional structures that legitimize such practices.

Findings from this study suggest that women who held implicit trust in the healthcare system experienced shock, surprise, betrayal, disappointment, and a sense of being let down following OV. Evidence of betrayal in this study included participants' reflections that things were meant to go differently, that they regretted putting their trust in providers and hospitals, and confusion about why their "good" or "normal" experiences felt so bad. Loss of trust was also reflected in hospitals being reframed as sites of danger. This reframing often emerged in the immediate postpartum period, with hospitals described by CBWs as needing to be escaped from. Framed as sites of danger, participants described avoiding hospitals in future pregnancies or avoiding future pregnancy altogether. CBWs who entered childbirth with distrust still reported betrayal, linked to internalized ideals that childbirth and motherhood should be happy and joyful, and to the failure of that promise. From institutional theory, institutions need not be limited to physical sites such as hospitals; they may also represent ideologies, regimes of knowledge and power, disciplines, and spaces (Ahmed, 2017; Foucault, 1977; Thompson, 2021). In this sense, the institution of childbirth, mediated through sociocultural and biomedical discourses, may itself constitute a site of betrayal. The same can be said for patriarchal motherhood, which O'Reilly (2018), in her matricentric feminist framework, defines as the institution of motherhood

structured by male-dominated norms and systems that fail to account for mothers' agency and their capacity to define motherhood on their own terms.

Across accounts, relational fractures emerged as a central form of institutional betrayal. These included a lack of compassion in the face of suffering, abandonment by providers, having spouses or labour companions cast to the side, and disruptions to early bonding with infants. Several mothers described feelings of disappointment, anguish, and grief related to being separated from their babies at birth. For some, this separation was experienced as a form of "gatekeeping," in which access to their baby felt controlled or mediated by institutional policies. Participants also described a pervasive sense of being robbed of symbolic or sacred moments that are widely promoted within hospital discourses of patient-centered care, such as the first skin-to-skin contact between mother and baby, uninterrupted early breastfeeding, or even the ability to touch or hold one's baby. The absence or disruption of these moments, strongly promoted within mothering and institutional discourse as foundational to the early mother-infant bond, were a source of deep loss, longing, and suffering for some patients. The literature similarly documents the harms experienced by mothers whose infants are admitted to the NICU, including distressing interactions with providers and a sense that their maternal role had been usurped. Fenwick et al. (2008) describe mothers feeling like intruders within the NICU, experiencing misplaced ownership in which the baby appeared to "belong" to the unit rather than to them. Tolton (2022) further illustrates how separation in the NICU is accompanied by normative expectations that mothers perform the "good mother" role by being compliant, educable, and grateful, with nurses positioned as mentors and protectors and mothers expected to follow behind in order to gain access to their infant.

As trust in institutions eroded, the dominant discourse positioning hospital-based birth as inherently safe became disrupted. Participant definitions of safety evolved to emphasize the emotional and relational facets of safety, no longer perceiving safety as predominantly physical and singularly available within hospital-based birth. In this reframing, hospitals became sites of danger, where safety was not guaranteed. For many women, these emerging counter discourses around risk and safety translated into tangible changes, including, for four of the six participants who had had a second birth since their OV experience, transitions to midwifery-based care. As previously noted, institutional betrayal may also arise when institutions fail to adequately address and take accountability for the harm done to an individual. In this study, formal complaint and reporting processes were frequently described as insufficient, offering little validation, accountability, or repair, and thus may have contributed to feelings of betrayal. Participants characterized these processes as burdensome, emotionally risky, and unlikely to lead to meaningful change. For racialized and otherwise marginalized women, the complaint process was experienced as particularly fraught, carrying heightened risks of exposure and scrutiny, and in some cases deterred them from engaging in the process altogether.

Obstetric Violence as an Environment of Care

Findings from this study point to OV as an ambient environment of care that shapes the experiences of both birthing individuals and providers. Within this environment, HCPs were pressured to prioritize efficiency, adhere to protocol, and mitigate risk, while relational attunement and emotional presence and flexibility were devalued. This helps explain why moral distress appeared repeatedly in provider accounts yet was frequently normalized. While this analysis remains firmly centered on women's accounts of harm, CBWs themselves often situated their experiences within a broader system marked by resource constraints and emotional strain

among providers. Drawing on both CBW and HCP narratives, this section examines how OV emerges within conditions that negatively impact the provision of ethical, relational, responsive care, while also negatively impacting providers. Participants' accounts point to the presence of *moral distress* and, it will be argued, *moral injury* among HCPs, suggesting that OV produces harm beyond the birthing individual alone.

Providers were described by CBWs as emotionally disconnected, exhausted, and constrained by institutional policies. HCP accounts corroborated these observations, describing experiences of shock, disbelief, dissociation, fear, helplessness, shame, disgust, horror, and outrage when witnessing OV. Several providers described an incapacity to respond in the face of abusive or disrespectful colleagues, at times describing feelings of fear or violation themselves. These experiences reflect moral distress, wherein healthcare providers are aware of the harms or limitations of certain practices but feel unable to act otherwise due to time pressures, rigid protocols, hierarchical constraints, or fear of reprimand (Kendall-Tackett & Beck, 2022; Reis & Lesandrini, 2025). In perinatal contexts, the literature demonstrates that providers experience moral distress related to a perceived inability to provide the ideal care to their patients in the face of interventionist cultures of care, time constraints, and oppositional dynamics between providers and patients (Fachon et al., 2025; Rubashkin & Minckas, 2018)

This tension reflects what Chalmiers (2022) conceptualizes as cognitive dissonance within biomedical models of childbirth care, illuminating the moral distress described by HCP participants. This author describes how practitioners manage the dissonance of beneficent intent, a pattern also evident in HCP accounts, alongside causing harm through violent practices governed by biomedical ideology that objectify birthing women. According to Chalmiers (2022), justifications for such practices rest on three pillars: the belief that pregnancy and labour are

inherently risky, that physician intervention, violent and otherwise, is required to minimize this risk, and that some bodies are implicitly riskier, usually due to sociocultural biases based in racism, classism, and ableism. Providers may experience a dissonance between intuitive, empathic, human responses and the perceived necessity to override these instincts in favour of evidence-based, routinized, or violent procedures that would otherwise not be socially acceptable (e.g. unconsented or forceful touch, vaginal exams) (Chalmiers, 2022).

Over time, unresolved moral distress appeared to accumulate for the study participants, manifesting as frustration, cynicism, emotional numbing, withdrawal from relational engagement, and resignation, which has been described as *moral residue* (Reis & Lesandrini, 2025). This residue reshapes how providers relate to patients, how they understand their professional role, and how much effort they are willing or able to expend. For example, practices such as shaming patients may represent dysfunctional coping strategies within environments characterized by chronic moral constraint and emotional overload (Smith-Oka, 2022b). In fact, within this study, some providers described engaging in behaviours such as body shaming or belittling humour as a way of coping with the stress of their workplaces. Moral distress therefore represents both a potential consequence and a driver of OV. This interpretation does not justify or minimize harmful behaviour but situates it within an environment of care characterized by OV.

In its most severe form, and accumulated over time, moral distress can amount to *moral injury*, characterized by erosion of identity, loss of trust in the healthcare system, and a sense of compromised moral integrity (Thomas & McCullough, 2015). Gilligan (2014) defines moral injury as “a shattering of trust following an experience of betrayal in a situation where the stakes were high and the betrayal was culturally sanctioned” (p. 92). Providers in this study described

experiences consistent with this conceptualization, including shame, guilt, loss of trust in the healthcare system, erosion of professional identity, and a sense of having betrayed their moral and ethical commitments, while some felt the need to leave their places of work altogether. In healthcare workers, moral injury has been linked to psychological distress and burnout (Williamson et al., 2018), and has been identified as a particular risk for perinatal care providers forced to intervene in ways that contravened evidence, policy recommendations, and codes of ethics under pandemic conditions (Horsch et al., 2020). Importantly, recognizing moral injury among providers does not negate or diminish the harm experienced by CBWs, nor does it absolve providers of their responsibility in acting in the name of violent systems. Rather, it highlights how institutional conditions that normalize OV also constrain moral agency, producing an environment in which respectful, relational, and ethical care is difficult to sustain.

A key discursive insight emerging from this analysis is that the same institutional and gendered discourses that silenced and regulated CBWs also constrained the moral agency of some providers. Kendall-Tackett and Beck (2022) note that a common theme in birth trauma research from the perspective of healthcare providers is feelings of powerlessness and helplessness, raising questions about why providers feel unable to stop mistreatment, and which individuals or professions are most likely to experience feelings of powerlessness or censorship. Kendall-Tacket and Beck (2022) connect moral distress to nurses' lack of power within gendered hospital hierarchies, which they argue continue to shape professional dynamics despite changes in nursing's professional status over the past decades. In the same ways that CBWs navigated power dynamics through performative deference, compliance, and precarious resistance, so too did HCPs, particularly nurses. Nurses' accounts of using softened, friendly tones, and careful, non-confrontational communication, as well as subversive advocacy, reflect a performance of

feminine gender norms of deference and "niceness", as Sommers (2005) describes in *The Tyranny of Niceness.* CBW accounts offer an illuminating perspective from the other side of the interaction – "nice" nurses figured prominently in their accounts, appearing to simultaneously mitigate experiences of harm while also seeming to contribute to the empathic justification or normalization of harm.

Emotional labour may also be described as an adaptive response to distressing workplace encounters within gendered power hierarchies. Emotional labour among nurse participants included not only direct patient care but also behaviours aimed at de-escalating conflict, mitigating trauma, and managing their own perceived competence. Importantly, emotional labour is described as both a skill and a burden; it can be an affirming aspect of the nursing role; however, when emotional labour is performed in the face of institutional constraints, poor working conditions, and gender and professional power hierarchies, it can contribute to cognitive dissonance, stress, and burnout (Hochschild, 2003; Hogan & Drentea, 2023). Nurse participants frequently described engaging in acts of emotional labour upon witnessing OV. Within institutional contexts that devalue relational work, such interventions could be described as significant acts of resistance, while nevertheless putting much strain on already burdened providers.

While gender inequalities and a broader culture of violence against women have been widely identified as contributors to power imbalances between providers and patients in the provision of perinatal healthcare (E. C. Collins et al., 2024; Mayra et al., 2022; Unutkan & Elem, 2024), fewer studies have examined how gender or other power imbalances and lateral violence between providers shape the presence and persistence of OV. Existing research suggests that providers who attempt to advocate on behalf of patients or speak out against OV face significant

barriers, including lack of institutional support and social repercussions such as ostracization (E. C. Collins et al., 2024; Snyder, 2025). For the participants, the risks and repercussions of speaking up effectively silenced their desire or attempts to advocate on behalf of patients or confront colleagues. Moral injury among providers may therefore both result from and contribute to OV, creating a self-reinforcing cycle that sustains harm.

Systemic Racism in Canadian Perinatal Healthcare

Systemic racism emerged as a pervasive force across both CBW and HCP accounts, shaping experiences of care, vulnerability to harm, and responses to OV. Racialized participants described heightened scrutiny, diminished credibility, and feelings of alienation within clinical encounters, often expressed through nuanced, ambiguous, or subtle interactions such as racial microaggressions. In some cases, stigma and discrimination had material consequences; self-policing or withholding important health information for fear of scrutiny, of being labelled in a negative or derogatory way, or of risking the involvement of child protective services meant that some participants were unable to have legitimate health concerns attended to. In parallel, HCPs acknowledged that racial bias and stereotyping, particularly toward Black women, are widespread within their perinatal care settings and meaningfully influence care delivery. For example, multiple HCPs revealed that the denial of Black women's pain occurred frequently.

Bhupaul and Lissio (2025) document how Black women in Canada contend with persistent stereotypes of exceptional strength and resilience, which in perinatal care settings can amount to dismissal of pain, poor pain management, and neglecting to address legitimate health concerns. As Attanasio and Hardeman (2019) demonstrate, Black and Latina women are more likely to be characterized as non-compliant, aggressive, or difficult, drawing on entrenched racialized stereotypes such as the "angry Black woman." These characterizations undermine

women's credibility, constrain their agency, and shape how their needs and preferences are attended to. Thus, Black and other racialized individuals face the added task of mitigating racism through strategies such as seeking representation in healthcare providers and choosing midwifery care (Bhupaul & De Lisio, 2025). This reveals the layered psychological and relational burdens produced by racist systems for racialized women, first by the impact of enduring racism itself, and by the added burden of having to strategically navigate a system that is not only unsupportive, but potentially unsafe.

The literature further demonstrates that pandemic-related policies disproportionately impacted marginalized perinatal populations, widening rather than mitigating existing health inequities (John et al., 2021). Fang et al. (2024) further demonstrate that English-speaking Black individuals in Québec, positioned as both racialized and linguistic minorities, experienced greater discrimination, reduced access to care and information, and heightened dissatisfaction with the healthcare system during the pandemic, when compared to white or French-speaking Black individuals. These disparities underscore how intersecting forms of marginalization compound vulnerability to harm.

The experiences of racialized individuals seeking perinatal care, as mediated by multiple intersecting forms of oppression, were foregrounded in the accounts of racialized CBWs in this study. CBW narratives resonated with broader theorizations on coerced silencing and self-regulation as a form of epistemic injustice among marginalized groups (Dotson, 2011). As Crenshaw (1991) argues, people of colour are often forced to weigh the risks of voicing or reporting harm with the risks of reinforcing dominant racial stereotypes. This dynamic was evident in CBW accounts of carefully managing their needs, emotions, and requests in childbirth to avoid negative labelling. Such coerced silencing reinforces dominant images of birthing

women as compliant, passive, or uninterested in decision-making, while simultaneously contributing to the perception that OV is rare or insignificant. In this way, epistemic mechanisms within OV, like silencing and delegitimization, may also shape the public perceptions of whether a problem exists at all.

Beyond racial and ethnic identity, the study findings suggest that one's allegiance to one birthing paradigm or another functioned as an additional axis of privilege or marginalization within perinatal care encounters. As one participant who identified as South Asian and a recent immigrant illustrated, she felt the need to manage her emotional reactions and discontent with the quality of her care out of fear of being labelled difficult or confrontational. Simultaneously, as a person who identified as aligning with the philosophy of midwifery, she was acutely aware of being stereotyped as inflexible, irrational, and overly "natural," a term used pejoratively. Notably, CBWs who approached childbirth from a more medicalized perspective still described restrictive stereotypes and a tendency for providers to extrapolate their medical preferences to much broader assumptions about their personhood. For example, one CBW who was open to medical interventions felt reprimanded for demonstrating any uncertainty or skepticism towards procedures, as if being "medicalized" immediately meant she was also expected to be fully compliant and passive. Taken together, these findings point to the strength of ideological thinking surrounding medicalized versus physiologic birthing paradigms, and how philosophical alignment with either one can shape a person's perceived identity and influence how providers respond to them. In this way, birthing philosophy itself may function as a distinct axis of intersectional experience unique to perinatal care.

Systemic racism in obstetrics, often referred to as *obstetric racism*, is well documented (Boakye et al., 2023; D.-A. Davis, 2019; Lennord et al., 2025). Examining this through the lens

of *epistemic racism* highlights how racialized harms are produced, reinforced, and normalized through knowledge systems. Epistemic racism, a form of epistemic violence, is one component of systemic racism and involves the delegitimization, marginalization, and erasure of non-white-Eurocentric knowledge, its production and consumption, and those who hold it (Almeida, 2015; Kubota, 2020). By framing obstetric racism as both systemic and epistemic, this perspective underscores how inequities in perinatal care emerge not only from biased policies or actions, but also from the devaluation of certain non-dominant ways of knowing.

In the Canadian context, Dayo et al. (2023) provide a critique of the healthcare system as "race-evasive" or colour-blind, which they argue contributes to the invisibility of race in clinical encounters – evidence of epistemic racism. For pregnant Black women, this often results in poor healthcare experiences, including, for example, providers lacking knowledge of health issues more prevalent among Black communities. By default, whiteness is treated as the norm, which can lead to the interests and needs of Black women being overlooked. Beagan et al. (2024) highlight the experiences of Black women healthcare professionals in Canada, illustrating how epistemic racism operates even among providers. Their findings point to Black health care professionals not being recognized as credible professionals despite qualifications; the need for invisible labour to counter perceived deficits in credibility; devaluation of knowledge while being subjected to racialized and gendered stereotypes; and pressure to adopt professional norms aligned with whiteness in order to be seen as legitimate. These experiences demonstrate how epistemic racism constitutes both a form of systemic exclusion and a mechanism through which dominant cultural knowledge is reinforced. Such conditions also have undeniable implications for Black birthing individuals, as the knowledge of Black and other racialized health

professionals that could strengthen the quality and inclusivity of care is diminished or marginalized.

These epistemic and systemic dynamics are not merely theoretical; they are reflected in measurable inequities in maternal and neonatal outcomes. There is consistent evidence of Black–white disparities and Indigenous-white disparities in maternal and neonatal outcomes in Canada (Lennord et al., 2025; Weckman & Farrugia, 2025), and consistent findings from other high-income countries demonstrating that Black women face markedly higher risks of adverse birth outcomes (Mohamoud et al., 2023; Vedam, Stoll, Taiwo, et al., 2019; Women and Equalities Committee, 2023). Yet, Canada still lacks comprehensive race-based and Indigenous identity health data (Bhupaul & De Lisio, 2025; Canadian Institute for Health Information, 2022; Dayo et al., 2023). The absence of disaggregated data both reflects and reproduces structural inequities, limiting the capacity to identify and prevent their existence in perinatal care, and making them easier to deny.

This dynamic becomes particularly visible in Québec, where Premier François Legault has consistently rejected the characterization of provincial institutions as systemically racist, arguing that while racism exists among some individuals, it is not embedded throughout the system as a whole (Banerjee, 2020; Red Coalition, 2024). His stance is particularly egregious when examined in relation to cases in which the existence of systemic racism in healthcare has been brought to public attention. Joyce Echaquan, a 37-year-old Atikamekw woman who died in 2020 at a Québec hospital after livestreaming staff directing racist and degrading remarks toward her, is but one of countless such cases. In response to Echaquan's death, the Atikamekw Nation developed Joyce's Principle, a proposed framework to ensure Indigenous peoples' right to equitable, culturally safe, and discrimination-free access to health and social services. While the

Québec government expressed willingness to use it as guidance, it refused to formally adopt the principle because it references systemic racism. Even as it states a commitment to improving care for Indigenous communities, the government has continued to reject the notion that the province and its systems are historically and foundationally racist (Richardson, 2020). The Québec Department of Justice has also recently rejected millions in race-based funding intended for the roll-out of Impact of Race and Culture Assessments, again stating that the province does not subscribe to the concept of systemic racism underlying the initiative (Hopper, 2025). Such denial limits institutional accountability and equity-oriented reform, while simultaneously discrediting, invalidating, and ignoring the experiences of Indigenous, racialized, and marginalized individuals in the province. In this sense, the denial of systemic racism functions as a form of epistemic violence, obscuring the existence of widespread and systematized harms that these populations continue to be confronted with.

Strengths and Limitations

This study has several strengths that contribute to its methodological, theoretical, and practical contributions to the literature on OV. A key strength lies in its theoretical grounding. By integrating feminist poststructuralism, with attention to key poststructural concepts, alongside intersectionality, the study attends simultaneously to lived experience, discourse, and power (Willett & Etowa, 2023). This framework enabled OV to be examined not only as a set of discrete events or practices, but as a relational and structural phenomenon embedded in sociocultural norms, institutional conditions, and everyday interactions. This approach supported a nuanced analysis of epistemic violence, power negotiations, and the normalization of harm in childbirth.

Methodologically, the use of FRDA is a further strength. This approach foregrounded participants' meaning-making, emotions, and voices, allowing the analysis to capture both what happened and how participants understood and lived through their experiences over time. The inclusion of analytic strategies that were both voice- and discourse-centered enabled attention to emotionality, relational contexts, and subjectivity (Paliadelis & Cruickshank, 2008; Thompson et al., 2018). The reflexive and relational interview approach, with attention paid to empathy, reciprocity, and deliberate self-disclosure, also strengthened rapport and facilitated the sharing of sensitive and often painful accounts (Liamputtong, 2007; Marsh et al., 2017).

Another strength is the inclusion of HCP perspectives alongside women's accounts, as well as a document review that enabled analysis of discourses circulating in social and mass media and in written texts related to childbirth and OV. This multi-perspective approach allowed OV to be examined as an ambient feature of the environment of care, affecting both those who give birth and those who provide care. Importantly, this framing does not decentre women's experiences but aligns with their own observations that providers are often working under significant strain. Including these perspectives made it possible to explore vicarious trauma and moral injury among providers as systemic phenomena, and to identify potential pathways for change that attend to humanized approaches to perinatal care, while considering the well-being of providers.

The study also benefits from its geographical specificity. By situating findings within the sociopolitical landscape of Montreal, Québec, the analysis connects individual experiences of OV to broader structures of power without relying on an overly abstract or decontextualized structural lens that can make systemic change seem unattainable. This contextual setting

strengthens the study's relevance for policy, advocacy, and health system reform, particularly in relation to racialized inequities in perinatal health within a large urban Canadian context.

Several limitations must be considered. First, despite efforts to promote diversity on a range of sociodemographic variables, over half of the CBW participants were white and Canadian-born, which resulted in the study inadvertently privileging the experiences of care of this dominant group. In the Canadian context, attention to the perinatal healthcare experiences of Indigenous peoples is especially critical; however, no Indigenous participants could be recruited for this study. While systemic racism emerged clearly in both CBW and HCP accounts, the CBW sample size and composition limit the ability to fully explore a diversity of racialized experiences. Furthermore, the perspectives of 2SLGBTQI+ parents and families were absent from the sample. Given the documented ways dominant gender ideologies shape reproductive healthcare and parenting experiences, the elevated risk of being mistreated in childbirth among 2SLGBTQI+ individuals, and the underrepresentation of gender non-conforming groups in existing perinatal health research (Croll et al., 2022; Liu et al., 2024), this represents an important gap. The study was also limited in its exclusion of the perspectives of the partners of childbearing individuals. Though CBW participants did discuss the perspectives and experiences of their labour companions and partners to some degree, these accounts were rather limited in scope. Participants did describe their partners as experiencing similar feelings of distress, helplessness, and loss of agency in the face of OV, as well as mental health impacts in the postpartum period, which points to potential areas of inquiry when considering the experiences, roles, and impacts on family and labour companions in instances of OV. Additionally, the small sample size of HCPs limits the extent to which provider perspectives can be fully represented. This was a purposeful decision made with the intention of privileging and upholding the voices

of CBWs, while maintaining feasibility. Nonetheless, this constrains the diversity of provider perspectives represented, including variation across roles and practice contexts.

A further limitation emerged from the inclusion of both English and French interviews. French interviews were translated into English for analysis and reporting. Given the use of FRDA, which places emphasis on language and sociocultural meaning, translation presents a limitation. Certain expressions carry relational and cultural meanings that are difficult to convey fully in another language. For example, one participant described being addressed as *"ma belle,"* a term that literally translates to "my beautiful"; however, within the unique sociolinguistic context of Québec, it may be used in an infantilizing or condescending sense when directed from one adult to another. In these instances, interpretive judgment was required to convey how such expressions functioned within participants' accounts – a process that was aided by the researcher's bilingual status and embeddedness in the mixed sociolinguistic culture of the setting. Nevertheless, while care was taken to remain attentive to context and meaning, translation and interpretation are inherently subjective, and some nuance may be lost in the process (Cormier, 2018).

While the study emphasizes the importance of intersectionality, as well as feminist poststructural discourse analysis for understanding both lived experiences of OV and its perpetuation, it did not incorporate participatory or collaborative research approaches. Such approaches are widely recognized as critical for advancing the priorities and well-being of marginalized and underrepresented groups, and their absence represents a limitation in terms of addressing issues of social justice and the potential for community-driven change (M. Morrow et al., 2022).

Finally, the relational interview approach, including partial disclosure and emotional engagement, may have shaped the data produced. While this approach was undertaken intentionally and reflexively to support ethical engagement and trust, it, along with my positionality as a perinatal nurse, may have influenced how participants framed their accounts or what they chose to disclose or emphasize. Rather than viewing this entirely as a limitation, it is understood as inherent to the co-constructed nature of qualitative knowledge production; nevertheless, it remains an important consideration when interpreting the findings.

Implications and Recommendations

Several implications and recommendations emerge from this study, spanning clinical practice, education, research, and policy. The findings show that OV is normalized within institutional childbirth and reinforced by a complex interplay of discourses and entrenched systems of oppression. Strategies for addressing OV have largely relied on criminal justice approaches that define violence as discrete acts enacted by identifiable perpetrators. While criminal punishment and individual redress have an important role in addressing certain forms of abuse or violence in the delivery of care, these approaches do little to address structural violence or the subtle, normalized forms of harm that often lack a clear perpetrator (Chadwick, 2025). This limitation is problematic, given that it is often these normalized and subtle harms that create the conditions upon which more overt episodes of violence occur. These experiences play out in concert with complex, ambiguous, and paradoxical birthing experiences that are highly contingent on the presence of reflexive, compassionate, person-centered approaches. These dynamics underscore the importance of attending to OV on multiple levels. In this study, attention to relational, sociocultural, and institutional discourses was essential to understanding how structural conditions can trickle down to the interpersonal sphere. These insights support a

number of recommendations to be discussed in this chapter, including adopting trauma and violence-informed approaches to care, collaborating with and expanding towards midwifery and alternative models of care, integrating epistemic and anti-racist frameworks into professional training and education, and using decisive language such as “obstetric violence” in policy and reporting.

Clinical Practice

Trauma and violence-informed care is increasingly being adopted across healthcare organizations and represents a promising approach to addressing the relational and emotional harms that may arise in perinatal care (Perinatal Services BC, 2023). Trauma and violence-informed approaches take into consideration how trauma and violence impact individuals and shape their behaviours, adaptations, health outcomes, and interactions with healthcare providers and systems. Trauma and violence-informed approaches are oriented toward promoting care environments that are safe, respectful, inclusive, and supportive, minimizing retraumatization, and fostering empowerment, healing, coping, and resilience (Isobel, 2023; Public Health Agency of Canada, 2025). Trauma and violence-informed approaches are driven by a recognition of the high prevalence and enduring impacts of violence and trauma. Trauma may result from a single event, sustained exposure to traumatic environments, or occur at a collective level, such as the intergenerational or historical violence and trauma experienced by Indigenous peoples through colonization (Native Women’s Association of Canada, 2024). In Canada, 67% of women report exposure to at least one traumatic event in their lifetime (Statistics Canada, 2024), and 39% of women aged 15 years and older report having experienced at least one physical or sexual assault since the age of 15 (Statistics Canada, 2019). These figures underscore the reality that a

substantial proportion of individuals seeking perinatal care will have prior experiences of trauma or violence.

This reality was clearly recognized by HCPs in this study. Many spoke candidly about the high prevalence of trauma among their patients and its relevance to their daily practice, describing how trauma shapes perceptions of safety in childbirth encounters. As one male provider poignantly stated, his mere presence in the delivery room could be traumatizing. Importantly, findings from this study also reinforce that trauma in childbirth is not limited to those with pre-existing trauma histories. Birth itself may be experienced as traumatic, particularly when care is characterized by disrespect, neglect, loss of control, or betrayal, as was the case for CBWs in this study. As such, trauma-informed care should not be reserved for those who disclose trauma, nor treated as a specialized intervention, but rather adopted as a universal, everyday approach to perinatal care (Perinatal Services BC, 2023).

Trauma and violence-informed approaches are grounded in four core principles that guide both individual and organizational practice: recognizing the impacts of trauma and violence on people's lives and behaviours, creating emotional and physical safety for clients and service providers, fostering choice, collaboration, and connection, and adopting a strengths-based, capacity-building orientation. Drawing on the work of Ponic et al. (2016), recommendations based on these four principles are presented here. First, providers should understand how trauma and violence shape individuals' lives, behaviours, and engagement with healthcare. This includes ongoing self-education on the interplay between trauma, coping strategies, and health outcomes. Providers are encouraged to approach responses such as substance use, ambivalence about pregnancy, missed care, or heightened fear with curiosity and context, providing active listening, validation, and safety without requiring disclosure. At the

organizational level, trauma awareness should be embedded in policies, staff training, and attention to risks of vicarious trauma among healthcare providers. Second, trauma-informed care emphasizes emotionally and physically safe environments. Safety is actively cultivated through respectful communication, transparency, and consistency. Providers can enhance emotional safety by explaining procedures, inviting questions, supporting trusted companions, and ensuring explicit consent and neutral language. Attention to environmental factors, such as curtains and draping, is also essential. Third, these approaches prioritize choice, collaboration, and connection. Restoring agency is central, achieved by offering options for positions, pain management, or environmental preferences, engaging in shared decision-making, respecting birth plans, and privileging patient voices. Organizations support this by allowing time for relationship-building, reflecting on power dynamics, and establishing patient feedback mechanisms. Finally, trauma and violence-informed care adopts a strengths-based, capacity-building approach. Providers recognize resilience, normalize emotional responses, and support grounding or coping strategies that enhance empowerment. Systemically, this requires sufficient time and resources to foster a workplace culture valuing emotional intelligence, reflective practice, and responsiveness to diverse social contexts.

Restorative justice frameworks offer further guidance on practices that seek to repair harm, rebuild trust, and promote provider reflection through dialogue, acknowledgment, and collective accountability (Eniasivam et al., 2022). Restorative justice approaches to systemic harm are non-punitive, and in the context of OV, focus on the experiences of birthing individuals while also exploring moral and emotional impact on providers who engage in violent practices and cause harm, creating space for ethical reflection and learning (Abojer et al., 2025). In clinical practice, restorative processes invite storytelling and often painful dialogue about power and

harm. They also entail structured follow-up with those involved in incidents of violence, allowing providers to recognize harm, engage in deep reflection, and reconnect and reintegrate in a meaningful way with patients and staff (Klasson et al., 2025). Perinatal nurses in this study described the ways they navigated OV as "not heroic all, but…human," emphasizing the need for supportive environments that address moral injury while fostering a culture of compassionate, accountable care. Implementing restorative practices in perinatal settings can therefore strengthen provider well-being, improve patient–provider relationships, and contribute to reversing injustice and inequities in care delivery.

Education

Health professional education represents a foundational opportunity for permanent systemic change, particularly in perinatal care where nurses play a central role. Nurses are often at the bedside throughout childbirth, serving not only as clinical supports but, as the study suggests, as advocates, interpreters, and mediators in power relations between physicians and birthing individuals. Despite this critical position and potential to influence cultural change, nursing education in Canada, like much medical education, remains rooted in white, Eurocentric epistemologies that shape knowledge production in ways that uphold structural inequities (Paton et al., 2020). Concepts of gender, sexuality, and race, as taught in these frameworks, are narrowly defined within the material and social interests of dominant groups. In the absence of structural reform, interventions such as implicit bias training or diversity statements are insufficient to counter centuries of epistemic violence. As Paton et al. (2020) state,

> One cannot discuss equity and social justice without first having built and defined inequity and injustice. One cannot discuss anti-racism without the existence of the construct of race. If the contemporary [education system] […] is structurally unsound

> […] then no amount of implicit bias training or well-crafted diversity statements can erase the centuries of epistemic violence (p. 1110).

In perinatal settings, this insight was reflected in providers' own accounts of moral injury; many nurses described tensions between their intent to support women's autonomy and the constraints of institutional norms and hierarchies that persistently pressured them to undermine patient knowledge and agency.

The path forward therefore lies in deconstructing the epistemological frameworks that underpin professional education and centering previously marginalized and delegitimized ways of knowing. This includes integrating heterogeneous, fluid, communal, intergenerational, and socioculturally specific knowledge into curricula, an approach consistent with epistemic pluralism (Paton et al., 2020). Intersectionality offers a guiding lens towards pluralism, emphasizing the need to consider race, gender, class, and other axes of identity in both admissions and hiring practices. Efforts must go beyond superficial indicators of diversity (e.g. the presence of white women in medicine), toward meaningful structural changes in knowledge creation, recognition, and dissemination (P. H. Collins & Bilge, 2016).

The Truth and Reconciliation Commission of Canada's Call to Action #24 explicitly calls upon medical and nursing schools to require all students to complete coursework addressing Indigenous health, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. The Call further specifies the need for skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism (Truth and Reconciliation Commission of Canada, 2015). While some medical and nursing programs across Canada have introduced coursework on Indigenous health, such content is not universally

mandatory, and implementation has remained uneven, with several projects only in their proposal phase (Canadian Broadcasting Corporation, 2025). Meaningful engagement with Call to Action 24 requires all nursing and medical schools to move towards structural integration of the called-upon coursework, as well as integration of Indigenous knowledge systems and critical analysis of anti-Indigenous racism within health professional training.

In addition to Indigenous content, nursing, and other healthcare professional educational programs must also incorporate formal anti-Black racism training. The Ottawa Declaration on Black Health in Canada (2025) highlights the need for education that moves beyond cultural sensitivity toward curricula that examine how anti-Black racism shapes health experiences, outcomes, and provider practice. Such training must engage nurses not just in recognizing bias, but in understanding how systems, policies, and everyday practices reproduce inequity.

Research

The findings of this study underscore that OV stems from deeply embedded ideological systems that drive harmful yet normalized perinatal care practices. While empirical research in other high-income settings has looked specifically at OV, as is the case in the United States, Canada's sociocultural, historical, and political contexts differ substantially. As such, developing a national evidence base is critical to understanding the prevalence, mechanisms, and consequences of OV particular to the Canadian context. While literature on experiences of OV among birthing individuals remains scarce, as has been noted throughout, even less attention has been paid to the experiences and perspectives of perinatal healthcare providers (Perrotte et al., 2020). Research into the issue must continue to prioritize a holistic, multi-level approach, taking into account and including the very individuals through which OV, as a form of gender-based and structural violence, operates and continues to be perpetuated.

There is also a need for research that rigorously documents racial disparities and systemic inequities in perinatal care. As has been previously discussed, the collection and publication of race-based data on a systemic, nationwide level would be prudent. Representation in such research is critical in advancing community-based solutions and amplifying the voices of equity-deserving groups (M. Morrow et al., 2022; Weckman & Farrugia, 2025). Participatory, community-based, and community-led methodologies are particularly important in resisting epistemic violence and ensuring that knowledge production does not reproduce the very hierarchies it seeks to dismantle. In generating a context-specific and structurally grounded understanding of OV in Canada, research can illuminate the intersecting sociocultural, colonial, political, and epistemic dimensions of harm.

It is also recommended that future research centre on intersectional and anti-racist frameworks. OV does not operate along a single axis of identity; rather, it is shaped by the convergence of race, Indigeneity, migration status, language, disability, socioeconomic position, and gender identity. Intersectional methodologies are necessary to capture how these dimensions of identity compound marginalization and shape differential treatment within perinatal settings (Hankivsky et al., 2010). An anti-racist research orientation moves beyond documenting disparities to interrogating the embedded ideologies and norms that produce them. This includes critically examining how whiteness functions as the standard in knowledge production, education, funding decisions, and policy development (Almeida, 2015).

Research into systemic inequities must also address the unique needs of diverse racialized and Indigenous childbearing individuals and newborns across the country. For example, the impact of systemic barriers rooted in Indigenous racism and colonial policies that have erased traditional birth practices cannot be understated, and requires specific community-led responses

(Dawson & Suntjens, 2022; Smylie & Phillips-Beck, 2019). Research exploring and documenting specific forms of OV among Indigenous peoples such as forced sterilizations, baby apprehensions, and forced evacuation for birth requires attention.

Research should also focus on interventions, including trauma-informed and midwifery-led models of care, to evaluate their effectiveness in reducing OV and improving maternal and infant outcomes. By generating a context-specific understanding of OV in Canada, research can illuminate both the individual and specific sociocultural, historical, colonial, and political dimensions of harm, creating pathways for transformation in clinical practice, policy, and education.

Policy

Policy reform represents another critical avenue for addressing OV, yet the possibilities and limitations of reform warrant careful consideration. As discussed throughout this dissertation, OV is embedded within broader institutional, professional, and sociocultural arrangements that shape how childbirth is understood and managed. Like other systems of power and oppression, biomedicine derives authority in part through the privileging of particular forms of knowledge while marginalizing others. As Rolfe (2001) explains, a fundamental tenet of positivism and, by extension, biomedicine, is its claim to objectivity – a stance that positions other epistemologies as less legitimate. Thus, a biomedical, technocratic approach to childbirth is not merely one paradigm among others, but a hegemonic structure that shapes norms, professional hierarchies, and definitions of risk, safety, and success in alternative birthing spaces as well. Consequently, reforms implemented within biomedical systems may be constrained when they fail to address the underlying assumptions, hierarchies, and distributions of authority that sustain violent practices. Efforts to address OV therefore require ongoing critical

engagement with the conditions that render violence legitimate, necessary, or invisible in the first place. Empirical evidence further informs the challenges of reform in biomedical environments. A qualitative meta-synthesis of integrated midwifery–physician care models found that, rather than preserving midwives' philosophy of care, integration within hospital-based systems was associated with processes of "deprofessionalization" and deviations from the foundational tenets of midwifery. Midwives described a systematic erosion of their ability to provide physiologic, woman-centered, evidence-based care (Mcfarland et al., 2020). Political engagement also does not guarantee material change. For example, in 2008, the Quebec government committed to 10% of prenatal care being provided by midwives by 2018; the current number sits well below that target (Mouvement pour l'autonomie dans l'enfantement, 2026).

Likewise, participants' accounts within this study demonstrated that addressing OV requires more than reforming or reinforcing existing systems. Rather, their accounts exposed the limits of neoliberal claims that positive and affirming birth experiences can be achieved through increased autonomy, self-advocacy, and informed choice. This is particularly noteworthy when their efforts occur within institutions that continue to undermine women's knowledge and their need for relational interdependence and safety. For instance, CBW participants who arrived at the hospital armed with information, prepared to advocate for themselves, and equipped with birth plans were often met with resistance, and in some cases, intensified pressure and coercive tactics aimed at gaining their compliance or consent. Those who displayed legitimate medical knowledge, which would presumably be a protective aspect in a biomedical setting, were instead reprimanded for transgressing the bounds of who could be considered a holder of such knowledge. Provider accounts further illustrated this contradiction. While some providers described their workplaces as having made improvements to their consent processes, or having

trained staff on person-centered care approaches, these changes existed alongside persistent disparities in how these actually played out at the bedside; for example, the physician who was described as adopting a completely different tone and body language based on patients' racial identities and performance of beauty standards. As van der Waal et al. (2025) state:

> The attempted reform of the obstetric institution by the institution itself, disguises the many solutions to obstetric violence already offered and practiced by mothers, midwives, and activists, such as mutual aid and radical care outside of the obstetric institution (p. 156).

In other words, the solutions to addressing OV, founded within the very logics of neoliberal, institutional biomedical birth, are not best found within those same systems. Within this study, participants who experienced OV did not describe feeling reassured by care available within hospital settings. Instead, many came to view hospitals as sites of danger rather than safety. In response, participants identified seeking midwifery-led care in subsequent pregnancies as the only viable means of achieving a birth that felt safe, respectful, and aligned with their needs. Notably, all participants who pursued midwifery care described these experiences as profoundly different from their hospital births and consistently characterized them as positive. Midwifery care was experienced as safer precisely because it recognized women as knowledgeable participants in their own care, rather than as passive recipients. This stood in contrast to hospital-based experiences characterized by epistemic, verbal, physical, and structural forms of violence.

From an abolitionist perspective, these findings point to the importance of expanding and calling upon alternatives to hospital-based obstetrics rather than focusing exclusively on reforming existing institutions (van der Waal, 2025; van der Waal et al., 2023). Supporting midwifery-led models of care, improving access to out-of-hospital birth options, and removing

structural barriers to midwifery practice represent concrete pathways toward reducing OV. As a recommendation, health systems and policymakers should prioritize the expansion of midwifery services and recognize the potential for collaborative models of care that uphold the benefits of midwifery and its philosophical underpinnings.

Language used in policy and institutional settings shapes how harm is defined and has the potential to change how it is recognized and responded to. Research on domestic and intimate partner violence demonstrates that shifts in policy language, such as moving away from *battered woman* which emphasizes physical violence, towards explicitly naming non-physical forms of violence such as coercive control, have altered institutional responses, expanded legal protections, and increased recognition of emotional and psychological forms of harm (Burnett, 2021; Graham et al., 2025). Following a string of local news articles reporting on and using the term “obstetric violence”, the complaints commissioner of a Montreal health and social services centre saw an influx of complaints regarding experiences of mistreatment in childbirth (Lemoine et al., 2022). Similarly, incorporating the term “obstetric and gynecological violence” within complaint portals, such as that of the College of Physicians of Quebec, which allows complaints explicitly referencing OV, has led to increases in reported cases (Poiré, 2022). These examples underscore that shifting language is not symbolic alone; it can affect institutional accountability and patient safety in material ways. Finally, the collection and reporting of race-based data are essential to addressing obstetric racism and inequities in perinatal care. Without such data, systemic harms, particularly those affecting racialized or marginalized women, will remain invisible, and policy interventions will fail to adequately address inequity.

In summary, while concrete approaches such as the implementation of trauma- and violence-informed care, restorative justice practices, and the incorporation of anti-racist

frameworks in training and education do hold promise, this study suggests that reforms implemented within biomedical systems may be limited when they fail to address the underlying systems that have entrenched and normalized OV in the delivery of perinatal care. To the extent that OV is embedded within broader institutional, professional, and sociocultural systems and relations, meaningful change will also require ongoing critical engagement with the discourses, norms, and conditions that produce OV and render it acceptable in the pursuit of safety, as defined by the obstetric institution. Efforts to address OV must therefore extend beyond individual behaviour change and include accountability for the practice of obstetrics, as one that rests on subordinating the knowledge and experience of birthing individuals and violating them in the name of safety, risk management, and efficiency. Efforts must continue to engage collective forms of advocacy, dialogue, and awareness-raising that make OV not only visible, but intolerable. Naming OV is a start, but its existence must be recognized and condemned across all spheres, in practice, education, research, and policy.

Conclusion

This study offers a critical and timely contribution to understanding OV within Canadian hospital-based perinatal care. Guided by an intersectional feminist poststructuralist framework and FRDA, and drawing on qualitative accounts from both birthing individuals and providers, the research demonstrates that OV is not reducible to isolated acts of misconduct. Rather, it is produced and normalized through relational interactions, institutional routines, and sociocultural discourses that shape how risk, safety, knowledge, and motherhood are constructed in childbirth settings. Central to this study is the framing of OV as a structural issue, as well as a relational and epistemic one, sustained by intersecting systems of power.

From the very beginning, the voices of birthing women were central to this work. Listening closely to their experiences revealed that OV resulted in harm on emotional, physical, and epistemic levels that shaped how they understood their bodies, their choices, and their own personhood. These harms unfolded within professional environments characterized by hierarchies of authority, systemic pressures, and intersecting forms of discrimination, including racism and gendered expectations. Healthcare providers, in turn, described witnessing or participating in violent practices and systems in ways that contributed to moral injury, burnout, and in some cases, decisions to leave practice. Their accounts underscore that OV is sustained not only through individually driven actions, but through institutional constraints and dominant discourses that regulate and significantly impact providers themselves.

The findings highlight the urgent need for epistemic and structural reform across research, clinical practice, professional education, and policy. Addressing OV requires action at multiple levels and a sustained commitment to perinatal care that is humane, equitable, and responsive to the lived realities of birthing people. A Canadian research agenda is urgently needed that prioritizes the perinatal health of equity-deserving groups, critically examines the role of language and discourse in shaping care experiences, and evaluates interventions and alternative models of care aimed at reducing harm. Meaningful transformation will depend on centering intersectional, anti-racist, and pluralistic ways of knowing, and on challenging the discursive and institutional conditions that continue to normalize OV within hospital-based childbirth.

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Appendix A
Recruitment Flyers for Childbearing Women



Have you experienced mistreatment by members of the healthcare team during a hospital-based childbirth?

You are invited to participate in a doctoral research study exploring the mistreatment of women during hospital-based childbirth. The study aims to explore the experiences of those who have been mistreated during childbirth as well as the perspectives of perinatal healthcare providers on the issue.

Participation:

- Your participation includes the completion of a short sociodemographic questionnaire and one 60–90-minute virtual interview with the student researcher, Andrea Willett
- The interview will take place at a date and time that are convenient for you
- Your participation is voluntary and confidential

You are eligible to participate if:

- You experienced mistreatment by a member or members of the healthcare team during a childbirth in a Montreal hospital in the last five (5) years
- You are 18 years of age or older
- You speak English or French

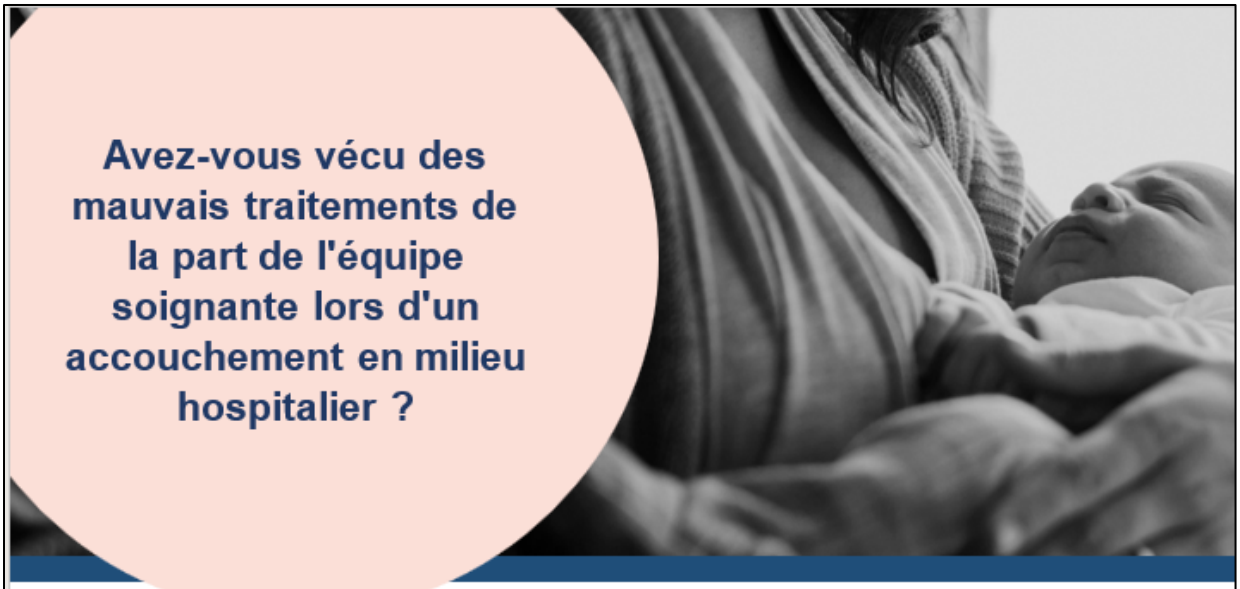
Selection of participants will occur on a first-come, first-served basis

Interested in participating or have questions about the study?

Contact Andrea Willett by email at: [redacted]

uOttawa

*This study is being conducted independently from any organization, agency, or healthcare institution



Avez-vous vécu des mauvais traitements de la part de l'équipe soignante lors d'un accouchement en milieu hospitalier ?

Nous vous invitons à participer à une étude de recherche doctorale explorant les mauvais traitements des femmes lors de l'accouchement en milieu hospitalier. L'étude vise à mieux comprendre les expériences des personnes ayant vécu des mauvais traitements lors d'un accouchement ainsi que les perspectives des professionnel·le·s de la santé en périnatalité sur ce phénomène.

Participation:

- Votre participation implique de remplir un court questionnaire sociodémographique et de participer à une entrevue d'environ 60-90 minutes avec l'étudiante chercheuse, Andrea Willett
- L'entrevue aura lieu virtuellement à un moment qui vous convient
- Votre participation est volontaire et confidentielle

Critères de participations:

- Vous avez vécu des mauvais traitements de la part de l'équipe soignante lors d'un accouchement en milieu hospitalier à Montréal dans les cinq (5) dernières années
- Vous êtes âgée de 18 ans ou plus
- Vous parlez l'anglais ou le français

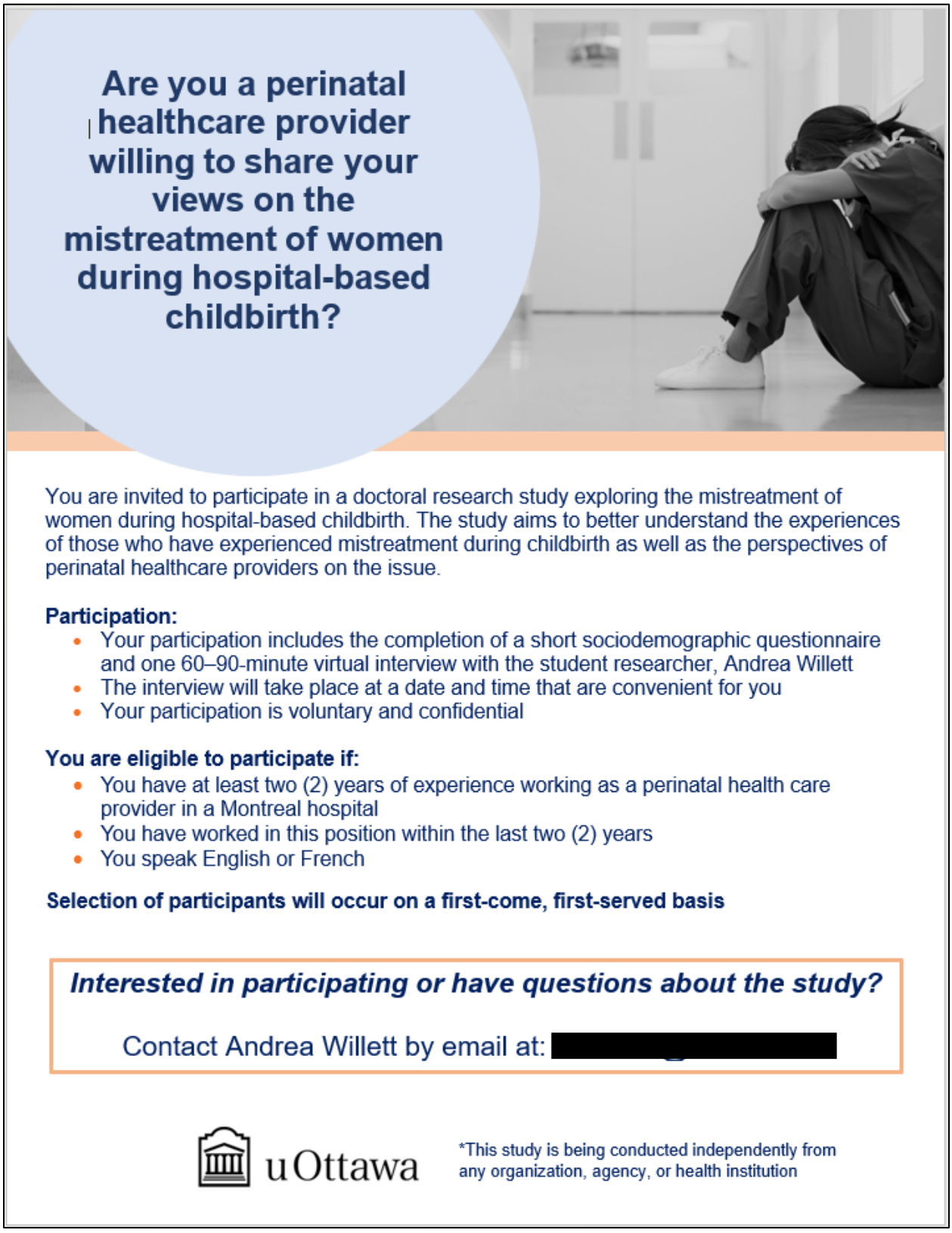
La sélection des participants se fera sur la base du premier arrivé, premier servi

Si vous aimeriez participer ou pour plus de renseignements, veuillez communiquer avec Andrea Willett par courriel : [redacted]

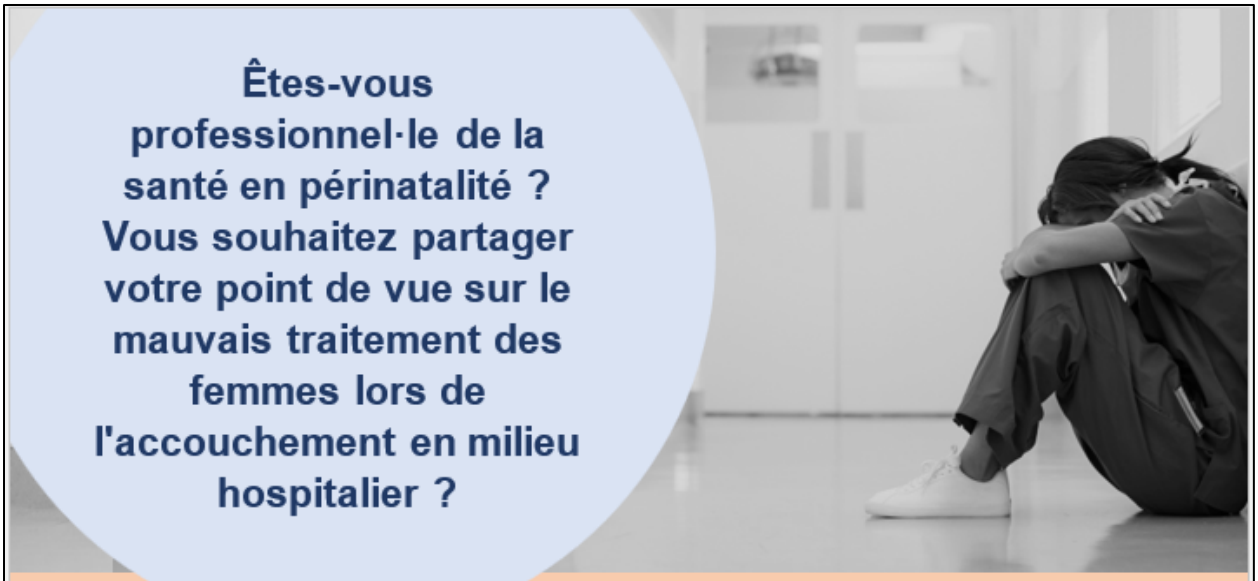
uOttawa

* Cette étude est menée indépendamment de tout établissement, organisation ou agence de soins de santé

Appendix B
Recruitment Flyers for Perinatal Healthcare Providers



Êtes-vous professionnel·le de la santé en périnatalité ? Vous souhaitez partager votre point de vue sur le mauvais traitement des femmes lors de l'accouchement en milieu hospitalier ?



Nous vous invitons à participer à une étude de recherche doctorale explorant le mauvais traitement des femmes lors de l'accouchement en milieu hospitalier. L'étude vise à mieux comprendre les expériences des personnes ayant vécu des mauvais traitements lors d'un accouchement ainsi que les perspectives des professionnel·le·s de la santé en périnatalité sur ce phénomène.

Participation:

- Votre participation implique de remplir un court questionnaire sociodémographique et de participer à une entrevue d'environ 60-90 minutes avec l'étudiante chercheuse, Andrea Willett
- L'entrevue aura lieu virtuellement à un moment qui vous convient
- Votre participation est volontaire et confidentielle

Critères de participations:

- Vous êtes professionnel·le de la santé en périnatalité ayant au moins deux (2) ans d'expérience de travail dans une unité périnatale d'un hôpital de Montréal
- Vous travaillez actuellement ou avez travaillé dans ce milieu dans les deux (2) dernières années
- Vous parlez l'anglais ou le français

La sélection des participants se fera sur la base du premier arrivé, premier servi

Si vous aimeriez participer ou pour plus de renseignements, veuillez communiquer avec Andrea Willett par courriel :

[redacted]

uOttawa

* Cette étude est menée indépendamment de tout établissement, organisation ou agence de soins de santé

Appendix C
Semi-Structured Interview Guide for Childbearing Women – English

Pre-interview Steps

Welcome and Introduction

Overview of Study

The mistreatment of women during hospital-based childbirth has become an area of increasing concern in Canada and around the world. Mistreatment during hospital-based childbirth may encompass behaviours including but not limited to disrespectful treatment, lack of control over decision-making, stigma and discrimination, and physical abuse that occur during labour, birth, and/or the immediate postpartum period occurring in a hospital. Through this research, we hope to gain a deeper understanding of the multiple dimensions of the issue, specifically women's experiences of mistreatment during hospital-based childbirth and perinatal healthcare provider perspectives on the issue. Additionally, this research seeks to contribute to a greater understanding of the interpersonal, institutional, and structural/social factors that contribute to the issue, as well as strategies to address and prevent it. Your thoughts, ideas, and perspectives related to your experience of being mistreated in childbirth are important and deserve to be heard. By sharing these, you are helping to raise awareness about the issue and contribute to a broadened understanding of its impacts on women, and how the issue can be addressed and prevented.

I would like to remind you that this interview is confidential, so please answer as freely and honestly as possible. However, I would ask that you do not name specific individuals in your answers. Do you have any questions before I begin?

Interview Questions

Objective: Examine women's experiences of OV in hospital-based childbirth.

1. Can you tell me about your childbirth experience?
    a. Share whatever aspects of your story that are important to you.
        i. How did your labour and birth unfold? Without naming specific individuals, can you describe who was present, their roles?
        ii. Was it what you envisioned it would be?
    b. Feel free to share all the aspects of your story, both positive and negative.
2. Can you tell me about your experience of being mistreated during childbirth?
    a. How do you define being mistreated during labour and birth?
    b. Can you describe a specific moment of mistreatment that stands out in your mind? Was it an overall approach of the healthcare team throughout your labour and birth?
    c. Without naming specific individuals, who was involved, what did they say and/or do?
    d. How did it make you feel? What did it mean to you?
    e. What was your reaction to being mistreated? Did you report your concerns to the healthcare provider(s) or other staff in the birthing center?
3. In what ways has your experience impacted you? What are your thoughts and feelings about it today?
    a. Did you seek out additional support to address the impacts of the experience? Sharing your experience with family and friends, attending support groups, seeking out formal mental health support?

b. Did you inform your care provider or the institution about your experience? Informally, or through an official complaint process? What was their (the) reaction to you doing this?

Objective: Identify factors that contribute to the occurrence of OV in hospital-based childbirth.

4. What do you think led the healthcare team or health care provider(s) to mistreat you? What leads you to believe that?
    a. Are there individual or interpersonal factors that you think contributed to you being mistreated? Contextual or institutional factors? Structural or societal factors?
    b. If childbirth occurred following the start of Covid-19 pandemic, in what ways do you think it impacted the care you received?
    c. Do you perceive power relations or imbalances as having impacted your experience? Between you and the healthcare team? Within the healthcare team?
5. In what ways do you think your experience was impacted by biases or discrimination from the healthcare team or from the healthcare providers?
    a. Do you think you were treated differently because of your social identity? Because of your race, ethnicity, gender, sexual orientation, socioeconomic status, health history, or other characteristics that you think are relevant?
6. Considering the mistreatment of women during hospital-based childbirth outside of your own experience, can you describe institutional or structural factors that you believe contribute to the issue?

   a. Do you perceive certain discourses in your social environment, in the media, in the healthcare system, or in society at large as contributing to the issue? How so?

Objective: Identify strategies to address OV in hospital-based childbirth.

7. What strategies do you think could help prevent the mistreatment of women during hospital-based childbirth?
   a. What could healthcare providers do? Healthcare institutions? Educational institutions? Society at large?

Closing Questions

8. Is there anything else you would like to share?
9. To close, could you please briefly describe what this interview process was like for you?

Appendix D
Semi-Structured Interview Guide for Childbearing Women – French

<u>Étapes préalables à l'entrevue</u>

Bienvenue et introduction

Aperçu de l'étude

La maltraitance des femmes pendant l'accouchement est devenue un sujet de préoccupation croissante au Canada et à l'échelle mondiale. Les mauvais traitements lors de l'accouchement en milieu hospitalier comprennent, sans s'y limiter, des comportements tels qu'un traitement irrespectueux, la négation de l'autonomie, la stigmatisation et la discrimination, ainsi que la violence physique qui se produisent pendant le travail, l'accouchement et/ou la période post-partum immédiate dans un hôpital. Cette étude vise à mieux comprendre les multiples dimensions du phénomène, notamment les expériences des femmes ayant subi des mauvais traitements lors d'un accouchement en milieu hospitalier ainsi que les perspectives des professionnels de la santé en périnatalité sur le sujet. De plus, cette recherche vise à contribuer à une meilleure compréhension des facteurs interpersonnels, institutionnels, sociaux et structurels qui contribuent à ce problème, ainsi que des stratégies pour l'aborder et le prévenir. Votre témoignage, vos réflexions et vos avis sur les mauvais traitements que vous avez subis lors de votre accouchement sont importants et méritent d'être entendus. En les partageant, vous contribuez à sensibiliser le public à ce problème et à mettre en lumière son impact sur les femmes, ainsi que les solutions possibles pour le combattre.

Je voudrais vous rappeler que cet entretien est confidentiel. Veuillez donc répondre le plus librement et le plus honnêtement possible. Je vous demande toutefois de ne pas nommer de personnes spécifiques dans vos réponses. Avez-vous des questions avant que je commence ?

Questions d'entrevue

Objectif : Examiner les expériences des femmes relatives à la VO lors de l'accouchement en milieu hospitalier.

1. Pouvez-vous me parler de votre expérience d'accouchement ?
    a. Partagez tous les aspects de votre histoire qui sont importants pour vous.
        i. Comment se sont déroulés le travail et la naissance ? Sans nommer des individus précis, pouvez-vous décrire qui était présent, leurs rôles ?
        ii. Est-ce que cela correspondait à ce que vous aviez imaginé ?
    b. N'hésitez pas à partager tous les aspects de votre histoire, qu'ils soient positifs ou négatifs.
2. Pouvez-vous me parler de votre expérience de maltraitance lors de votre accouchement ?
    a. Comment définissez-vous la maltraitance dans le contexte du travail et de l'accouchement ?
    b. Pouvez-vous décrire un moment précis où vous avez été maltraitée et qui vous a particulièrement marquée ? S'agissait-il d'une approche globale de l'équipe soignante pendant la durée de votre travail et de votre accouchement ?
    c. Sans nommer des individus spécifiques, qui était impliqué, qu'est-ce qu'ils ont dit et fait ?
    d. Comment vous êtes-vous sentie après avoir été maltraitée ? Qu'est-ce que cela a signifié pour vous ?

e. Quelle a été votre réaction après avoir été maltraité ? Avez-vous informé le(s) professionnel(s) de santé ou les autres membres du personnel du centre de naissance de vos inquiétudes ?

3. En quoi votre expérience vous a-t-elle impacté ? Quelles sont vos pensées et vos sentiments à ce sujet aujourd'hui ?
    a. Avez-vous cherché un soutien supplémentaire pour faire face aux impacts de l'expérience ? Partager votre expérience avec votre famille et vos amis, participer à des groupes de soutien, rechercher un soutien formel en santé mentale ?
    b. Avez-vous informé votre médecin ou l'établissement de votre expérience ? De manière informelle ou par le biais d'un processus de plainte officiel ? Quelle a été leur (la) réaction lorsque vous avez fait cela ?

Objectif : Identifier les facteurs qui contribuent à la présence de la VO dans le cadre de l'accouchement en milieu hospitalier.

4. Selon vous, qu'est-ce qui a amené l'équipe soignante ou le(s) professionnel(s) de la santé à vous maltraiter ? Qu'est-ce qui vous amène à croire cela ?
    a. Y a-t-il des facteurs individuels ou interpersonnels qui, selon vous, ont contribué à ce que vous soyez maltraité ? Facteurs contextuels ou institutionnels ? Facteurs structurels ou sociétaux ?
    b. Si l'accouchement a eu lieu pendant la pandémie de Covid-19, en quoi pensez-vous que cela a eu un impact sur les soins que vous avez reçus ?

   c. Avez-vous l'impression que des hiérarchies ou des inégalités de pouvoir ont eu un impact sur votre expérience ? Entre vous et l'équipe soignante ? Entre les membres de l'équipe soignante ?

5. De quelle manière pensez-vous que votre expérience a été influencée par des préjugés ou une discrimination envers vous de la part de l'équipe de soins ou de soignants individuels ?
   a. Pensez-vous que vous avez été traité différemment en raison de votre position ou identité sociale ? En raison de votre race, de votre origine ethnique, de votre sexe, de votre orientation sexuelle, de votre statut socio-économique, de vos antécédents médicaux ou d'autres caractéristiques que vous jugez pertinentes ?
6. Considérant la maltraitance des femmes pendant l'accouchement en milieu hospitalier en dehors de votre propre expérience, pouvez-vous décrire les facteurs institutionnels, structurels, ou sociétaux qui, selon vous, contribuent au problème ?
   a. Percevez-vous certains discours dans votre environnement social, dans les médias, dans le système de santé ou dans la société en général comme contribuant au problème ? Comment ?

Objectif : Identifier des stratégies pour aborder l'OV dans le cadre de l'accouchement en milieu hospitalier.

7. Selon vous, quelles stratégies pourraient aider à prévenir la maltraitance des femmes lors de l'accouchement en milieu hospitalier ?
   a. Que pourraient faire les professionnels de santé ? Les établissements de santé ? Les établissements d'enseignement ? La société en général ?

Questions de clôture

8. Y a-t-il autre chose que vous aimeriez partager ?
9. Pour conclure, pouvez-vous décrire brièvement comment vous avez trouvé ce processus d'entrevue ?

Appendix E
Semi-Structured Interview Guide for Perinatal Healthcare Providers - English

Pre-interview Steps

Welcome and Introduction

Overview of Study

The mistreatment of women during hospital-based childbirth has become an area of increasing concern in Canada and around the world. Mistreatment during hospital-based childbirth may encompass behaviours including but not limited to disrespectful treatment, lack of control over decision-making, stigma and discrimination, and physical abuse that occur during labour, birth, and/or the immediate postpartum period occurring in a hospital. Through this research, we hope to gain a deeper understanding of the multiple dimensions of the issue, specifically women's experiences of mistreatment during hospital-based childbirth and perinatal healthcare provider perspectives on the issue. Additionally, this research seeks to contribute to a greater understanding of the interpersonal, institutional, and social factors that contribute to the issue, as well as strategies to address and prevent it. As a perinatal healthcare provider, your thoughts, ideas, and perspectives on the issue are important and will contribute meaningfully to addressing the aims of the research.

I would like to remind you that this interview is confidential so please answer as freely and honestly as possible. However, I would ask that you do not name specific individuals in your answers. Do you have any questions before I begin?

Interview Questions

Objective: Examine perinatal healthcare provider perspectives on OV in hospital-based childbirth.

1. What led you to want to share your perspective on the mistreatment of women during hospital-based childbirth?
2. How would you define the mistreatment of women during childbirth?
    a. What provider behaviours would you describe as forms of mistreatment during labour? During birth?
    b. Would you describe it as an individual issue, as an issue specific to the birthing unit where you work, an institutional issue, a systemic issue, or a combination of these?
3. Can you share with me an example of a time you witnessed a woman being mistreated by a healthcare provider or the healthcare team while she was in labour and/or birthing?
    a. Why do you feel that the situation that you witnessed would be interpreted as mistreatment?
    b. Without naming the individual, can you discuss who was involved, their role? What was the context?
    c. How did this make you feel? How did you respond? Did your co-workers respond? If yes, how so?
    d. In your opinion, what factors contributed to this situation?
    e. Was this situation addressed in any way by yourself, other staff, management, or higher up? If yes, how so?
4. Have you ever found yourself in a situation where you believe that your actions may have been interpreted as mistreatment by a woman who was in labour and/or birthing? If no, go to Question #5. If yes, continue to Question #4.

a. Why do you think that your actions may have been interpreted as mistreatment by the woman who was in labour and/or birthing?
b. Without naming the individual, can you discuss who was involved, their role? What was the context?
c. How did this make you feel? How did you respond?
d. In your opinion, what factors contributed to this situation?
e. Without naming the individual, did you share this situation with anyone in your work environment? If yes, with whom? How did these person(s) respond?

Objective: Identify factors that contribute to the occurrence of OV in hospital-based childbirth.

5. What factors do you believe contribute to the mistreatment of women during hospital-based childbirth? What leads you to believe that?
    a. Are there individual or interpersonal factors that you think contribute to the issue? Contextual or institutional factors? Structural or societal factors? Or a combination of these?
    b. In what ways, if any, has the Covid-19 pandemic contributed to the issue?
    c. Do you perceive power relations or imbalances as contributing to the mistreatment of women during hospital-based childbirth? Between women and the healthcare team? Within the healthcare team? Or a combination of these?
    d. Do you perceive certain discourses in your professional or social environment, in the media, in the healthcare system, or in society at large as contributing to the issue? How so?

6. In your opinion, do biases or discrimination amongst the healthcare team contribute to the issue?
    a. Do you think certain women are treated differently because of their social identify? Because of their race, ethnicity, gender, sexual orientation, socioeconomic status, immigration status, health history, or other characteristics?

Objective: Identify strategies to address OV in hospital-based childbirth.

7. Has this issue been addressed in your workplace? If so, how? At what level? By whom?
8. What strategies do you think would help to prevent the mistreatment of women during hospital-based childbirth?
    a. What could healthcare providers do? The birthing unit in which you work? Healthcare institutions? Educational institutions? Society at large?

Closing Questions

9. Is there anything else you would like to share?
10. To close, could you please briefly describe what this interview process was like for you?

Appendix F
Semi-Structured Interview Guide for Perinatal Healthcare Providers - French

Étapes préalables à l'entrevue

Bienvenue et introduction

Aperçu de l'étude

La maltraitance des femmes pendant l'accouchement est devenue un sujet de préoccupation croissante au Canada et à l'échelle mondiale. Les mauvais traitements lors de l'accouchement en milieu hospitalier comprennent, sans s'y limiter, des comportements tels que le manque de respect, la négation de l'autonomie, la stigmatisation et la discrimination, ainsi que la violence physique qui se produisent pendant le travail, l'accouchement et/ou la période post-partum immédiate dans un hôpital. Cette étude vise à mieux comprendre les multiples dimensions du phénomène, notamment les expériences des femmes ayant subi des mauvais traitements lors d'un accouchement en milieu hospitalier ainsi que les perspectives des professionnels de la santé en périnatalité sur le sujet. De plus, cette recherche vise à contribuer à une meilleure compréhension des facteurs interpersonnels, institutionnels, sociaux et structurels qui contribuent à ce problème, ainsi que des stratégies pour l'aborder et le prévenir. En tant que professionnel de la santé périnatale, vos réflexions, idées et points de vue sur le sujet sont importants et contribueront grandement à la réalisation des objectifs de cette étude.

Je voudrais vous rappeler que cet entretien est confidentiel. Veuillez donc répondre le plus librement et le plus honnêtement possible. Je vous demande toutefois de ne pas nommer de personnes spécifiques dans vos réponses. Avez-vous des questions avant que je commence ?

Questions d'entrevue

Objectif : Examiner le point de vue des professionnels de la santé périnatale sur la VO lors de l'accouchement en milieu hospitalier.

1. Qu'est-ce qui vous a amené à vouloir partager votre point de vue sur la maltraitance des femmes lors d'un accouchement en milieu hospitalier ?
2. Comment définiriez-vous la maltraitance des femmes lors de l'accouchement ?
    a. Quels comportements des professionnels de la santé décririez-vous comme des formes de maltraitance pendant le travail ? Lors de l'accouchement ?
    b. Le décririez-vous comme un problème individuel, un problème spécifique à votre salle d'accouchement, un problème institutionnel, un problème systémique, ou une combinaison de ces facteurs ?
3. Pouvez-vous partager avec moi un exemple d'une fois où vous avez vu une femme être maltraitée par un professionnel de la santé ou par l'équipe de soins de santé pendant qu'elle était en travail et/ou en train d'accoucher ?
    a. Pourquoi pensez-vous que la situation dont vous avez été témoin serait interprétée comme de la maltraitance ?
    b. Sans nommer la personne, pouvez-vous discuter de qui était impliqué, de son rôle ? Quel était le contexte ?
    c. Comment cela t'a fait sentir? Comment avez-vous réagi ? Vos collègues de travail ont-ils réagi ? Si oui, comment ?
    d. À votre avis, quels facteurs ont contribué à cette situation?
    e. Cette situation a-t-elle été abordée de façon quelconque par vous-même, d'autres membres du personnel, la direction ou un responsable supérieur ? Si oui, comment ?

4. Vous êtes-vous déjà retrouvé dans une situation où vous pensez que vos actions ont pu être interprétées comme de la maltraitance par une femme qui était en en travail et/ou en train d'accoucher ? Si non, passez à la question #5. Si oui, passez à la question #4.
    a. Pourquoi pensez-vous que vos actions ont pu être interprétées comme de la maltraitance par la femme qui était en travail et/ou en train d'accoucher ?
    b. Sans nommer la personne, pouvez-vous discuter de qui était impliqué, de son rôle ? Quel était le contexte ?
    c. Comment cela t'a fait sentir? Comment avez-vous réagi ?
    d. À votre avis, quels facteurs ont contribué à cette situation?
    e. Sans nommer la personne, avez-vous partagé cette situation avec quelqu'un dans votre environnement de travail ? Si oui, avec qui ? Comment ces personnes ont-elles répondu ?

Objectif : Identifier les facteurs qui contribuent à la présence de la VO dans le cadre de l'accouchement en milieu hospitalier.

5. Selon vous, quels sont les facteurs qui contribuent à la maltraitance des femmes lors de l'accouchement en milieu hospitalier ? Qu'est-ce qui vous amène à cette opinion ?
    a. Y a-t-il des facteurs individuels ou interpersonnels qui, selon vous, contribuent au problème ? Facteurs contextuels ou institutionnels ? Facteurs structurels ou sociétaux ? Ou une combinaison de ceux-ci ?
    b. De quelles manières, s'il y en a, la Covid-19 a-t-elle contribué à ce problème ?
    c. Percevez-vous que des hiérarchies ou des inégalités de pouvoir contribuent à la maltraitance des femmes lors de l'accouchement en milieu hospitalier ? Entre les

femmes et l'équipe soignante ? Au sein de l'équipe soignante ? Ou une combinaison de ceux-ci ?

d. Percevez-vous certains discours dans votre environnement professionnel ou social, dans les médias, dans le système de santé ou dans la société en général comme contribuant au problème ? Comment ?

6. À votre avis, les préjugés ou la discrimination au sein de l'équipe soignante contribuent-ils au problème ?

    a. Pensez-vous que certaines femmes sont traitées différemment en raison de leur identité sociale ? En raison de leur race, de leur origine ethnique, de leur sexe, de leur orientation sexuelle, de leur statut socio-économique, de leur statut d'immigrant, de leurs antécédents médicaux ou d'autres caractéristiques ?

Objectif : Identifier des stratégies pour aborder l'OV dans le cadre de l'accouchement en milieu hospitalier.

7. Ce problème a-t-il été abordé dans votre milieu de travail ? Si oui, comment ? A quel niveau ? Par qui ?
8. Selon vous, quelles stratégies aideraient à prévenir la maltraitance des femmes lors de l'accouchement en milieu hospitalier ?

    a. Que pourraient faire les professionnels de la santé ? L'unité de naissance dans laquelle vous travaillez ? Les établissements de santé ? Les établissements d'enseignement ? La société en général ?

Questions de clôture

9. Y a-t-il autre chose que vous aimeriez partager ?

10. Pour conclure, pouvez-vous décrire brièvement comment vous avez trouvé ce processus d'entrevue ?

Appendix G
Data Extraction Form

Title:

Author/organization:

Location:

Document Type:

Intended Audience:

Date of publication/dissemination:

Summary of the document:

Relevance of the document to OV in hospital-based childbirth:

Definition/conceptualization of obstetric violence:

Micro-, meso-, and macro-level factors addressed:

Discourses present within the text:

Appendix H
Stake's (1995)[1] Critique Checklist for a Case Study Report

1. Is the report easy to read?
2. Does it fit together, each sentence contributing to the whole?
3. Does the report have a conceptual structure (for example, themes or issues)?
4. Are its issues developed in a serious and scholarly way?
5. Is the case adequately defined?
6. Is there a sense of story to the presentation?
7. Is the reader provided with some vicarious experience?
8. Have quotations been used effectively?
9. Are headings, figures, artifacts, appendixes, and indexes used effectively?
10. Was it edited well, then again with a last-minute polish?
11. Has the writer made sound assertions, neither over- or under- interpreting?
12. Has adequate attention being paid to various contexts?
13. Were sufficient raw data presented?
14. Were the data resources well chosen and in sufficient number?
15. Do observations and interpretations appear to have been triangulated?
16. Are the role and point of view of the researcher nicely apparent?
17. Is the nature of the intended audience apparent?
18. Is empathy shown for all sides?
19. Are personal intentions examined?
20. Does it appear that individuals were put at risk?

[1] Source: Stake (1995, p. 131).

Appendix I
Certificate of Ethics Approval

21/08/2025

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

CERTIFICAT D'APPROBATION ÉTHIQUE | CERTIFICATE OF ETHICS APPROVAL

Numéro du dossier / Ethics File Number	H-04-22-7756
Titre du projet / Project Title	Obstetric Violence in Hospital-Based Childbirth: An Instrumental Case Study
Type de projet / Project Type	Thèse de doctorat / Doctoral thesis
Statut du projet / Project Status	Renouvelé / Renewed
Date d'approbation (jj/mm/aaaa) / Approval Date (dd/mm/yyyy)	01/09/2022
Date d'expiration (jj/mm/aaaa) / Expiry Date (dd/mm/yyyy)	31/08/2026

Équipe de recherche / Research Team

Chercheur / Researcher	Affiliation	Role
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Conditions spéciales ou commentaires / Special conditions or comments

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21/08/2025

Université d'Ottawa

Bureau d'éthique et d'intégrité de la recherche

University of Ottawa

Office of Research Ethics and Integrity

Le Comité d'éthique de la recherche (CÉR) de l'Université d'Ottawa, opérant conformément à l'*Énoncé de politique des Trois conseils* (2014) et toutes autres lois et tous règlements applicables, a examiné et approuvé la demande d'éthique du projet de recherche ci-nommé.

L'approbation est valide pour la durée indiquée plus haut et est sujette aux conditions énumérées dans la section intitulée "Conditions Spéciales ou Commentaires". Le formulaire « Renouvellement ou Fermeture de Projet » doit être complété quatre semaines avant la date d'échéance indiquée ci-haut afin de demander un renouvellement de cette approbation éthique ou afin de fermer le dossier.

Toutes modifications apportées au projet doivent être approuvées par le CÉR avant leur mise en place, sauf si le participant doit être retiré en raison d'un danger immédiat ou s'il s'agit d'un changement ayant trait à des éléments administratifs ou logistiques du projet. Les chercheurs doivent aviser le CÉR dans les plus brefs délais de tout changement pouvant augmenter le niveau de risque aux participants ou pouvant affecter considérablement le déroulement du projet, rapporter tout évènement imprévu ou indésirable et soumettre toute nouvelle information pouvant nuire à la conduite du projet ou à la sécurité des participants.

The University of Ottawa Research Ethics Board, which operates in accordance with the *Tri-Council Policy Statement* (2014) and other applicable laws and regulations, has examined and approved the ethics application for the above-named research project.

Ethics approval is valid for the period indicated above and is subject to the conditions listed in the section entitled "Special Conditions or Comments". The "Renewal/Project Closure" form must be completedfour weeks before the above-referenced expiry date to request a renewal of this ethics approval or closure of the file.

Any changes made to the project must be approved by the REB before being implemented, except when necessary to remove participants from immediate endangerment or when the modification(s) only pertain to administrative or logistical components of the project. Investigators must also promptly alert the REB of any changes that increase the risk to participant(s), any changes that considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project or the safety of the participant(s).

Coordonateur / COORDINATOR
Coordonnateur de l'éthique / Ethics Coordinator
Pour/For **Daniel LAGAREC** Président(e) du/ Chair of the **Comité d'éthique de la recherche en sciences de la santé et sciences / Health Sciences and Sciences Research Ethics Board**

550, rue Cumberland, pièce 154
Ottawa (Ontario) K1N 6N5 Canada

550 Cumberland Street, Room 154
Ottawa, Ontario K1N 6N5 Canada

613-562-5387 • 613-562-5338 • ethique@uOttawa.ca / ethics@uOttawa.ca
www.recherche.uottawa.ca/deontologie | www.recherche.uottawa.ca/ethics

Appendix J
Informed Consent Form for Individual Interviews with Childbearing Women – English



Informed Consent Form

Title of the study: Exploring the Mistreatment of Women During Hospital-Based Childbirth: An Instrumental Case Study

Principal Investigator (Student Researcher):

Andrea Willett RN, MScN, PhD candidate

School of Nursing, Faculty of Health Sciences, University of Ottawa

Contact Information:

Telephone:

Email:

Thesis Supervisor:

Josephine Etowa PhD RM RN FWACN FAAN, FCAN Professor,

School of Nursing, Faculty of Health Sciences, University of Ottawa

Contact Information:

Telephone :

Email:

This consent form has two parts:

1. **Information Sheet (to share information about the project with you)**
2. **Verbal Consent Script (to be completed at the time of the interview)**

<u>Part 1: Information Sheet</u>

Invitation to Participate: You are invited to participate in this doctoral research study being conducted by Andrea Willett, doctoral candidate of the School of Nursing at the University of Ottawa, under the supervision of Professor Josephine Etowa, School of Nursing, University of Ottawa. This research study is being conducted independently from any health care institution, organization, or agency, including those where you may have learned about the study.

Your participation in this study is completely voluntary. Please take the time to read and understand this document carefully before deciding to participate. Also, take the time to ask any questions or voice any concerns that may arise during this process. If you accept to participate, you will be asked to verbally consent to the process prior to your participation.

Purpose of the Study: The mistreatment of women by healthcare providers during hospital-based childbirth has become an area of increasing concern in Canada and around the world. Mistreatment during hospital-based childbirth may encompass behaviours including but not limited to disrespectful treatment, lack of control over decision-making, stigma and discrimination, and physical abuse that occur during labour, birth, and/or the immediate postpartum period occurring in a hospital.

The purpose of this qualitative study is to explore the mistreatment of women during hospital-based childbirth and to broaden understanding of the multiple dimensions of the issue.

The specific objectives of the study are:

1. To examine women's experiences of mistreatment in hospital-based childbirth.
2. To examine perinatal healthcare providers' perspectives of the mistreatment of women during hospital-based childbirth.
3. To identify factors that contribute to the mistreatment of women during hospital-based childbirth.
4. To identify strategies to address and prevent the mistreatment of women during hospital-based childbirth.

Participation: You are invited to participate in the study if:

- You are a perinatal healthcare provider with at least two years of experience working in a perinatal unit of a Montreal hospital
- You currently work or have worked in the setting within the last two years
- You are fluent in English or French

Your participation in this study will consist of the completion of a short socio-demographic questionnaire and one semi-structured individual interview. The questionnaire will take 10-15 minutes to complete and will be done via an online survey platform (SurveyMonkey). The interview will take place over a virtual meeting platform (Zoom) and will last between 60-90 minutes. The interview will take place at a date and time that are convenient for you. You will have the option to be audio-recorded, video-recorded, or neither. Audio recordings will be used for transcription purposes only. Video recordings will be used for the sole purpose of noting non-verbal behaviour or other observations and will not be included in publications, presentations, or made public in any way. Videos will only be viewed by the principal investigator. During audio recording through the Zoom platform, a video recording is automatically generated. If you decline to be video recorded, the automatically generated video recording will be permanently

deleted immediately following your interview. You may inform the principal investigator of your decision to be recorded or not at the start of your interview.

During the interview you will be asked about your perspective with regards to the mistreatment of women during hospital-based childbirth, factors that you perceive as contributing to the issue, and ways in which you believe the issue can be addressed and prevented. Following the interview, you will be invited to a follow-up phone call or virtual meeting where the principal investigator will share preliminary findings with you, invite you to share your thoughts and feelings on the analysis, and debrief about the research process in general.

Risks: There are some risks associated with participation in this study. Discussing your perspectives on the mistreatment of birthing women and/or discussing personal experiences during which you have witnessed or partaken in the mistreating women may cause you to feel psychological or emotional discomfort. Disclosing information about colleagues may also lead you to feel psychological or emotional discomfort. There may also be social repercussions should your involvement in the study or information that you shared become known. If you experience discomfort, you are encouraged to express how you are feeling to the interviewer. If specific questions cause you to feel discomfort, you may refuse to answer them without giving a reason. You may also choose to end the interview at any time. Following the interview, you will be offered a list of health and social support resources that may be of help to you.

Benefits: Sharing your perspective will contribute to a broadened understanding of the multiple dimensions related to the mistreatment of women during hospital-based childbirth, the factors contributing to such mistreatment, and strategies that may contribute to addressing and preventing the issue.

Confidentiality and Privacy: The information that you share during the study will remain strictly confidential. All participant identifying information will be kept separate from the research data. Only an identification number will appear on the interview transcript; only the principal investigator and the thesis supervisor will have access to the list of study participants and identification numbers. In the event that study findings are published, measures will be taken to protect your anonymity. Study findings will be aggregated, and any specific cases, characteristics, words, or locations that have the potential to identify you will not be included. Any quotations included in published work will be reported anonymously.

If you are currently part of or have been part of a lawsuit and/or complaint related to the mistreatment of a women during childbirth, you are strongly encouraged to contact your lawyer and/or professional order prior to agreeing to participate in order to determine the implications, legal or otherwise, of your involvement in the study. If you have signed a confidentiality agreement as part of legal proceedings, you must respect the terms of the agreement at all times during the research process.

In order to minimize the risk of security breaches and to help ensure your confidentiality we recommend that you use standard safety measures such as using a secure connexion when completing the study and signing out of your account, closing your browser and locking your screen or device when you are no longer using it.

Conservation of Data: All electronic files, including audio and/or video recordings and interview transcripts will be kept on the password protected computer of the principal investigator. Paper copies of interview transcripts and hand-written notes will be kept in locked cabinets in the home office of the principal investigator and in the office of the thesis supervisor at the University of Ottawa. Electronic copies of the transcripts will be kept on a password protected computer of the thesis supervisor. Electronic files will be kept in a secure manner for a period of five years following the thesis defense and deleted thereafter. Hard copy data will be kept in a secure manner for a period of five years and shredded thereafter.

Voluntary Participation: You are under no obligation to participate in this study. If you do choose to participate, you can withdraw at any time and/or refuse to answer any questions, without suffering any negative consequences. If you choose to withdraw from the study before the results are published, you can decide whether your data will be included in the study or not. If you choose to withdraw after the results are published, the data collected from you will not be removed from existing publications, but your data will not be used in future publications if you choose.

If you have any questions about the study, you may contact the principal investigator, Andrea Willett or their supervisor, Josephine Etowa. If you have any questions regarding the ethical conduct of this study, you may contact the Office of Research Ethics and Integrity via email (ethics@uottawa.ca) or telephone (613-562-5387).

Part 2: Verbal Consent Script

Have you had the time to thoroughly review the Information Sheet?

Do you have any questions about any of the information in the Information Sheet?

If yes: Have all your questions been answered?

I would like to remind you that by agreeing to participate, you are in no way waiving your right to withdraw from the study at any point without giving a reason. Your participation in this study is strictly confidential and no information will be released that could disclose your identity.

Are you ready to decide if you want to participate in this study?

Do you want to participate in this study?

If no: *End interview.*

If yes: Please confirm that you have been provided all the information about this study and that you consent to participate.

Please state whether you consent to be audio-recorded, video-recorded, or neither.

Start interview.

Appendix K
Informed Consent Form for Individual Interviews with Childbearing Women - French



Formulaire de consentement

Titre de l'étude : Explorer la maltraitance des femmes pendant l'accouchement en milieu hospitalier : une étude de cas instrumentale

Chercheuse principale (étudiante-chercheuse) :

Andrea Willett RN, MScInf, candidate au doctorat, École des sciences infirmières, Faculté des sciences de la santé, Université d'Ottawa

Coordonnées :

Téléphone :

Courriel :

Directrice de thèse :

Josephine Etowa PhD RM RN FWACN FAAN, FCAN Professeure, École des sciences infirmières, Faculté des sciences de la santé, Université d'Ottawa

Coordonnées

Téléphone :

Courriel :

Ce formulaire de consentement comporte deux parties :

1. **Fiche d'information (pour partager des informations sur le projet avec vous)**
2. **Script de consentement verbal (à compléter au moment de l'entrevue)**

<u>Partie 1 : Fiche d'information</u>

Invitation à participer : Vous êtes invité à participer à cette étude de recherche doctorale menée par Andrea Willett, candidate au doctorat de l'École des sciences infirmières de l'Université d'Ottawa, sous la supervision de la professeure Josephine Etowa, École des sciences infirmières

de l'Université d'Ottawa. Cette étude de recherche est menée indépendamment de tout établissement, organisation ou agence de soins de santé, y compris ceux où vous avez peut-être pris connaissance de l'étude.

Votre participation à cette étude est entièrement volontaire. Veuillez prendre le temps de lire et de comprendre attentivement ce document avant de décider de participer. Prenez également le temps de poser toute question ou d'exprimer toute préoccupation qui pourrait survenir au cours de ce processus. Si vous acceptez de participer, vous serai demandé de consentir verbalement au processus avant votre participation.

Objectif de l'étude : Les mauvais traitements infligés aux femmes par les professionnels de la santé lors de l'accouchement en milieu hospitalier sont devenus un sujet de préoccupation croissante au Canada et à l'échelle mondiale. La maltraitance lors d'un accouchement peut englober des comportements incluant, sans s'y limiter, un traitement irrespectueux, la négation de l'autonomie, la stigmatisation et la discrimination, ainsi que la violence physique qui se produisent pendant le travail, l'accouchement et/ou la période post-partum immédiate.

L'objectif de cette étude est d'explorer le mauvais traitement des femmes lors de l'accouchement en milieu hospitalier et de mieux comprendre les multiples dimensions de ce phénomène.

Les objectifs spécifiques de l'étude sont :

1. Examiner les expériences des femmes relatives à la maltraitance lors de leur accouchement en milieu hospitalier.
2. Examiner le point de vue des professionnels de la santé périnatale sur la maltraitance des femmes lors de l'accouchement en milieu hospitalier.
3. Identifier les facteurs qui contribuent à la présence de la maltraitance des femmes dans le cadre de l'accouchement en milieu hospitalier.
4. Identifier des stratégies pour aborder la maltraitance des femmes dans le cadre de l'accouchement en milieu hospitalier.

Participation : Vous êtes invitée à participer à l'étude si :

- Vous avez vécu des mauvais traitements de la part d'un ou plusieurs membres de l'équipe soignante lors d'un accouchement en milieu hospitalier à Montréal dans les cinq (5) dernières années
- Vous êtes prête à partager votre expérience de maltraitance lors de votre accouchement
- Vous êtes âgée de 18 ans ou plus
- Vous parlez l'anglais ou le français

Votre participation à cette étude consistera à remplir un court questionnaire sociodémographique et assister à un entrevue individuel semi-structuré. Le questionnaire prendra 10 à 15 minutes à remplir et se fera via une plateforme de sondage en ligne (SurveyMonkey). L'entrevue se déroulera sur une plateforme de rencontre virtuelle (Zoom) et durera entre 60 et 90 minutes. Le

lieu et le moment de l’entrevue seront déterminés avec la chercheuse, selon vos disponibilités. Vous aurez le choix entre un enregistrement audio, vidéo ou aucun des deux. Les enregistrements audios seront utilisés uniquement à des fins de transcription. Les enregistrements vidéo seront utilisés pour noter le comportement non-verbal ou d'autres observations et ne seront pas inclus dans des publications, des présentations ou rendus publics de quelque manière que ce soit. Les vidéos ne seront visionnées que par la chercheuse principale. Lors de l'enregistrement audio via la plateforme Zoom, un enregistrement vidéo est automatiquement généré. Si vous refusez d'être enregistré sur vidéo, l'enregistrement vidéo généré automatiquement sera supprimé de façon permanente immédiatement après votre entrevue. Vous pouvez informer la chercheuse principale de votre décision d'être enregistré ou non au début de votre entrevue.

Au cours de l'entrevue, des questions vous seront posées sur votre expérience de maltraitance lors de votre accouchement, sur l'impact que cette expérience a eu sur vous, sur les facteurs qui, selon vous, ont contribué à votre maltraitance, sur les facteurs qui, selon vous, contribuent au problème en général, et sur les façons dont vous pensez que le problème peut être abordé et éliminé. Après l'entrevue, vous serez invitée à un appel de suivi ou à une rencontre virtuelle où la chercheuse principale vous fera part des résultats préliminaires, et où vous serai invité à partager vos réflexions et vos sentiments quant à l'analyse, et à faire un débriefing sur le processus de recherche en général.

Risques : Il y a certains risques associés à la participation à cette étude. Il est possible que le fait de raconter votre expérience suscite des réflexions ou des souvenirs émouvants ou désagréables. Dans ce cas, nous vous encourageons à exprimer ce que vous ressentez à la chercheuse. Dans le cas où des questions spécifiques vous causent un malaise ou une détresse, vous pouvez refuser d'y répondre sans donner de raison. Vous pouvez également choisir de partager votre histoire dans un format qui vous est plus confortable, par exemple une conversation non structurée, ou même de mettre fin à l'entrevue. À la suite de l'entrevue, une liste de ressources de santé et de soutien social qui pourraient vous être utiles vous sera proposée.

Avantages : En participant à cette recherche, vous pourrez contribuer à une meilleure compréhension de l’expérience des femmes qui subissent des mauvais traitements lors d''un accouchement en milieu l'hospitalier, de l’impact de ces expériences sur les femmes, des facteurs qui contribuent au problème et des stratégies qui peuvent contribuer à lutter contre ce problème.

Confidentialité : Les informations que vous partagez au cours de l'étude resteront strictement confidentielles. Toutes les informations permettant d'identifier les participants seront conservées séparément des données de recherche. Chaque participant se verra attribuer un numéro et seul la chercheuse et la directrice de thèse auront la liste des participants et des numéros correspondants. Seul le numéro d'identification apparaîtra sur la transcription de l'entrevue. Dans le cas où les résultats de l'étude seraient publiés, des mesures seront prises pour protéger votre anonymat. Les résultats seront agrégés, et les cas, caractéristiques, mots ou lieux spécifiques qui pourraient permettre de vous identifier ne seront pas inclus. Toutes citation incluse dans un travail publié sera rapporté de manière anonyme.

Si vous faites ou avez fait partie d'un processus judiciaire lié à votre maltraitance pendant votre accouchement, nous vous encourageons fortement à contacter votre avocat avant d'accepter de participer à l'étude afin de déterminer les implications juridiques de votre participation. Si vous avez signé une entente de confidentialité dans le cadre d'une procédure judiciaire, vous devez respecter les termes de l'entente à tout moment pendant le déroulement de cette étude.

Afin de minimiser le risque de brèches de sécurité et d'aider à garantir votre confidentialité, nous vous recommandons d'utiliser des mesures de sécurité standard telles que l'utilisation d'une connexion sécurisée au moment de l'étude et la déconnexion de votre compte, la fermeture de votre navigateur et le verrouillage de votre écran ou de votre appareil lorsque vous ne l'utilisez plus.

Gestion des données : Tous les fichiers électroniques, incluant les enregistrements audio et/ou vidéo et les transcriptions d'entrevues, seront conservés sur un ordinateur protégé par un mot de passe de la chercheuse principale. Les copies papier des transcriptions d'entrevues et les notes écrites à la main seront conservées sous clé dans le bureau de la chercheuse principale, à son domicile, et dans le bureau de la directrice de thèse à l'Université d'Ottawa. Des copies électroniques des transcriptions seront conservées sur un ordinateur protégé par un mot de passe de la directrice de thèse. Tous les documents de recherche seront conservés de façon sécuritaire pendant une période de cinq ans après la fin de l'étude et seront détruits par la suite.

Participation volontaire : Vous n'avez aucune obligation de participer à cette étude. Si vous choisissez de participer, vous pouvez vous retirer à tout moment et/ou refuser de répondre à toute question, sans aucune conséquence négative. Si vous choisissez de vous retirer de l'étude avant la publication des résultats, vous pouvez décider si vos données seront incluses dans l'étude ou pas. Si vous choisissez de vous retirer après la publication des résultats, les données recueillies auprès de vous ne seront pas retirées des publications existantes, mais vos données ne seront pas utilisées dans les publications ultérieures si vous le souhaitez.

Si vous avez des questions sur l'étude, vous pouvez contacter la chercheuse principale, Andrea Willett ou sa directrice de thèse, Josephine Etowa. Si vous avez des questions concernant la conduite éthique de cette étude, vous pouvez contacter le Bureau d'éthique et d'intégrité de la recherche par courriel (ethique@uottawa.ca) ou par téléphone (613-562-5387).

Partie 2 : Script de consentement verbal

Avez-vous eu le temps de lire attentivement la fiche d'information ?

Avez-vous des questions sur les informations contenues dans la fiche d'information ?

Si oui, est-ce que toutes vos questions ont été répondues ?

Je tiens à vous rappeler qu'en acceptant de participer, vous ne renoncez pas à votre droit de vous retirer de l'étude à tout moment sans donner de raison. Votre participation à cette étude est strictement confidentielle et aucune information ne sera publiée qui pourrait révéler votre identité.

Êtes-vous prêt à décider si vous voulez participer à cette étude ?

Voulez-vous participer à cette étude ?

Si non : *Terminez l'entrevue.*

Si oui : Veuillez confirmer que vous avez reçu toutes les informations sur cette étude et que vous consentez à y participer.

Veuillez indiquer si vous acceptez d'être enregistré sur support audio, vidéo ou aucun des deux.

Début de l'entrevue.

Appendix L
Informed Consent Form for Individual Interviews with Healthcare Providers – English



Informed Consent Form

Title of the study: Exploring the Mistreatment of Women During Hospital-Based Childbirth: An Instrumental Case Study

Principal Investigator (Student Researcher):

Andrea Willett RN, MScN, PhD candidate

School of Nursing, Faculty of Health Sciences, University of Ottawa

Contact Information:

Telephone:

Email:

Thesis Supervisor:

Josephine Etowa PhD RM RN FWACN FAAN, FCAN Professor,

School of Nursing, Faculty of Health Sciences, University of Ottawa

Contact Information:

Telephone :

Email:

This consent form has two parts:

3. **Information Sheet (to share information about the project with you)**
4. **Verbal Consent Script (to be completed at the time of the interview)**

<u>Part 1: Information Sheet</u>

Invitation to Participate: You are invited to participate in this doctoral research study being conducted by Andrea Willett, doctoral candidate of the School of Nursing at the University of Ottawa, under the supervision of Professor Josephine Etowa, School of Nursing, University of Ottawa. This research study is being conducted independently from any health care institution, organization, or agency, including those where you may have learned about the study.

Your participation in this study is completely voluntary. Please take the time to read and understand this document carefully before deciding to participate. Also, take the time to ask any questions or voice any concerns that may arise during this process. If you accept to participate, you will be asked to verbally consent to the process prior to your participation.

Purpose of the Study: The mistreatment of women by healthcare providers during hospital-based childbirth has become an area of increasing concern in Canada and around the world. Mistreatment during hospital-based childbirth may encompass behaviours including but not limited to disrespectful treatment, lack of control over decision-making, stigma and discrimination, and physical abuse that occur during labour, birth, and/or the immediate postpartum period occurring in a hospital.

The purpose of this qualitative study is to explore the mistreatment of women during hospital-based childbirth and to broaden understanding of the multiple dimensions of the issue.

The specific objectives of the study are:

5. To examine women's experiences of mistreatment in hospital-based childbirth.
6. To examine perinatal healthcare providers' perspectives of the mistreatment of women during hospital-based childbirth.
7. To identify factors that contribute to the mistreatment of women during hospital-based childbirth.
8. To identify strategies to address and prevent the mistreatment of women during hospital-based childbirth.

Participation: You are invited to participate in the study if:

- You are a perinatal healthcare provider with at least two years of experience working in a perinatal unit of a Montreal hospital
- You currently work or have worked in the setting within the last two years
- You are fluent in English or French

Your participation in this study will consist of the completion of a short socio-demographic questionnaire and one semi-structured individual interview. The questionnaire will take 10-15 minutes to complete and will be done via an online survey platform (SurveyMonkey). The interview will take place over a virtual meeting platform (Zoom) and will last between 60-90 minutes. The interview will take place at a date and time that are convenient for you. You will have the option to be audio-recorded, video-recorded, or neither. Audio recordings will be used for transcription purposes only. Video recordings will be used for the sole purpose of noting non-verbal behaviour or other observations and will not be included in publications, presentations, or made public in any way. Videos will only be viewed by the principal investigator. During audio recording through the Zoom platform, a video recording is automatically generated. If you decline to be video recorded, the automatically generated video recording will be permanently

deleted immediately following your interview. You may inform the principal investigator of your decision to be recorded or not at the start of your interview.

During the interview you will be asked about your perspective with regards to the mistreatment of women during hospital-based childbirth, factors that you perceive as contributing to the issue, and ways in which you believe the issue can be addressed and prevented. Following the interview, you will be invited to a follow-up phone call or virtual meeting where the principal investigator will share preliminary findings with you, invite you to share your thoughts and feelings on the analysis, and debrief about the research process in general.

Risks: There are some risks associated with participation in this study. Discussing your perspectives on the mistreatment of birthing women and/or discussing personal experiences during which you have witnessed or partaken in the mistreating women may cause you to feel psychological or emotional discomfort. Disclosing information about colleagues may also lead you to feel psychological or emotional discomfort. There may also be social repercussions should your involvement in the study or information that you shared become known. If you experience discomfort, you are encouraged to express how you are feeling to the interviewer. If specific questions cause you to feel discomfort, you may refuse to answer them without giving a reason. You may also choose to end the interview at any time. Following the interview, you will be offered a list of health and social support resources that may be of help to you.

Benefits: Sharing your perspective will contribute to a broadened understanding of the multiple dimensions related to the mistreatment of women during hospital-based childbirth, the factors contributing to such mistreatment, and strategies that may contribute to addressing and preventing the issue.

Confidentiality and Privacy: The information that you share during the study will remain strictly confidential. All participant identifying information will be kept separate from the research data. Only an identification number will appear on the interview transcript; only the principal investigator and the thesis supervisor will have access to the list of study participants and identification numbers. In the event that study findings are published, measures will be taken to protect your anonymity. Study findings will be aggregated, and any specific cases, characteristics, words, or locations that have the potential to identify you will not be included. Any quotations included in published work will be reported anonymously.

If you are currently part of or have been part of a lawsuit and/or complaint related to the mistreatment of a women during childbirth, you are strongly encouraged to contact your lawyer and/or professional order prior to agreeing to participate in order to determine the implications, legal or otherwise, of your involvement in the study. If you have signed a confidentiality agreement as part of legal proceedings, you must respect the terms of the agreement at all times during the research process.

In order to minimize the risk of security breaches and to help ensure your confidentiality we recommend that you use standard safety measures such as using a secure connexion when completing the study and signing out of your account, closing your browser and locking your screen or device when you are no longer using it.

Conservation of Data: All electronic files, including audio and/or video recordings and interview transcripts will be kept on the password protected computer of the principal investigator. Paper copies of interview transcripts and hand-written notes will be kept in locked cabinets in the home office of the principal investigator and in the office of the thesis supervisor at the University of Ottawa. Electronic copies of the transcripts will be kept on a password protected computer of the thesis supervisor. Electronic files will be kept in a secure manner for a period of five years following the thesis defense and deleted thereafter. Hard copy data will be kept in a secure manner for a period of five years and shredded thereafter.

Voluntary Participation: You are under no obligation to participate in this study. If you do choose to participate, you can withdraw at any time and/or refuse to answer any questions, without suffering any negative consequences. If you choose to withdraw from the study before the results are published, you can decide whether your data will be included in the study or not. If you choose to withdraw after the results are published, the data collected from you will not be removed from existing publications, but your data will not be used in future publications if you choose.

If you have any questions about the study, you may contact the principal investigator, Andrea Willett or their supervisor, Josephine Etowa. If you have any questions regarding the ethical conduct of this study, you may contact the Office of Research Ethics and Integrity via email (ethics@uottawa.ca) or telephone (613-562-5387).

Part 2: Verbal Consent Script

Have you had the time to thoroughly review the Information Sheet?

Do you have any questions about any of the information in the Information Sheet?

If yes: Have all your questions been answered?

I would like to remind you that by agreeing to participate, you are in no way waiving your right to withdraw from the study at any point without giving a reason. Your participation in this study is strictly confidential and no information will be released that could disclose your identity.

Are you ready to decide if you want to participate in this study?

Do you want to participate in this study?

If no: *End interview.*

If yes: Please confirm that you have been provided all the information about this study and that you consent to participate.

Please state whether you consent to be audio-recorded, video-recorded, or neither.

Start interview.

Appendix M
Informed Consent Form for Individual Interviews with Healthcare Providers – French



Formulaire de consentement

Titre de l'étude : Explorer la maltraitance des femmes pendant l'accouchement en milieu hospitalier : une étude de cas instrumentale

Chercheuse principale (étudiante-chercheuse) :

Andrea Willett RN, MScInf, candidate au doctorat, École des sciences infirmières, Faculté des sciences de la santé, Université d'Ottawa

Coordonnées :

Téléphone :

Courriel :

Directrice de thèse :

Josephine Etowa PhD RM RN FWACN FAAN, FCAN Professeure, École des sciences infirmières, Faculté des sciences de la santé, Université d'Ottawa

Coordonnées

Téléphone :

Courriel :

Ce formulaire de consentement comporte deux parties :

3. **Fiche d'information (pour partager des informations sur le projet avec vous)**
4. **Script de consentement verbal (à compléter au moment de l'entrevue)**

<u>Partie 1 : Fiche d'information</u>

Invitation à participer : Vous êtes invité à participer à cette étude de recherche doctorale menée par Andrea Willett, candidate au doctorat de l'École des sciences infirmières de l'Université d'Ottawa, sous la supervision de la professeure Josephine Etowa, École des sciences infirmières de l'Université d'Ottawa. Cette étude de recherche est menée indépendamment de tout

établissement, organisation ou agence de soins de santé, y compris ceux où vous avez peut-être pris connaissance de l'étude.

Votre participation à cette étude est entièrement volontaire. Veuillez prendre le temps de lire et de comprendre attentivement ce document avant de décider de participer. Prenez également le temps de poser toute question ou d'exprimer toute préoccupation qui pourrait survenir au cours de ce processus. Si vous acceptez de participer, vous serai demandé de consentir verbalement au processus avant votre participation.

Objectif de l'étude : Les mauvais traitements infligés aux femmes par les professionnels de la santé lors de l'accouchement en milieu hospitalier sont devenus un sujet de préoccupation croissante au Canada et à l'échelle mondiale. La maltraitance lors d'un accouchement peut englober des comportements incluant, sans s'y limiter, un traitement irrespectueux, la négation de l'autonomie, la stigmatisation et la discrimination, ainsi que la violence physique qui se produisent pendant le travail, l'accouchement et/ou la période post-partum immédiate.

L'objectif de cette étude est d'explorer le mauvais traitement des femmes lors de l'accouchement en milieu hospitalier et de mieux comprendre les multiples dimensions de ce phénomène.

Les objectifs spécifiques de l'étude sont :

5. Examiner les expériences des femmes relatives à la maltraitance lors de leur accouchement en milieu hospitalier.
6. Examiner le point de vue des professionnels de la santé périnatale sur la maltraitance des femmes lors de l'accouchement en milieu hospitalier.
7. Identifier les facteurs qui contribuent à la présence de la maltraitance des femmes dans le cadre de l'accouchement en milieu hospitalier.
8. Identifier des stratégies pour aborder la maltraitance des femmes dans le cadre de l'accouchement en milieu hospitalier.

Participation : Vous êtes invité à participer à l'étude si :

- Vous êtes un professionnel de la santé en périnatalité ayant au moins deux ans d'expérience de travail dans une unité périnatale d'un hôpital de Montréal
- Vous travaillez actuellement ou avez travaillé dans ce milieu dans les deux dernières années
- Vous parlez l'anglais ou le français

Votre participation à cette étude consistera à remplir un court questionnaire sociodémographique et assister à un entrevue individuel semi-structuré. Le questionnaire prendra 10 à 15 minutes à remplir et se fera via une plateforme de sondage en ligne (SurveyMonkey). L'entrevue se

déroulera sur une plateforme de rencontre virtuelle (Zoom) et durera entre 60 et 90 minutes. Le lieu et le moment de l'entrevue seront déterminés avec la chercheuse, selon vos disponibilités. Vous aurez le choix entre un enregistrement audio, vidéo ou aucun des deux. Les enregistrements audios seront utilisés uniquement à des fins de transcription. Les enregistrements vidéo seront utilisés pour noter le comportement non-verbal ou d'autres observations et ne seront pas inclus dans des publications, des présentations ou rendus publics de quelque manière que ce soit. Les vidéos ne seront visionnées que par la chercheuse principale. Lors de l'enregistrement audio via la plateforme Zoom, un enregistrement vidéo est automatiquement généré. Si vous refusez d'être enregistré sur vidéo, l'enregistrement vidéo généré automatiquement sera supprimé de façon permanente immédiatement après votre entrevue. Vous pouvez informer la chercheuse principale de votre décision d'être enregistré ou non au début de votre entrevue.

Au cours de l'entrevue, des questions vous seront posées sur votre point de vue concernant le mauvais traitement des femmes lors de l'accouchement en milieu hospitalier, sur les facteurs qui, selon vous, contribuent à ce phénomène et sur la manière dont vous pensez que ce phénomène peut être abordé et prévenu. Après l'entrevue, vous serez invitée à un appel de suivi ou à une rencontre virtuelle où la chercheuse principale vous fera part des résultats préliminaires, et où vous serai invité à partager vos réflexions et vos sentiments quant à l'analyse, et à faire un débriefing sur le processus de recherche en général.

Risques : Il y a certains risques associés à la participation à cette étude. Discuter de votre point de vue sur le mauvais traitement des femmes lors de l'accouchement et/ou discuter de vos expériences personnelles au cours desquelles vous avez été témoin ou participé au mauvais traitement des femmes pourrait susciter des réflexions ou des souvenirs émouvants ou désagréables. La divulgation d'informations sur vos collègues peut également vous amener à ressentir un inconfort psychologique ou émotionnel. Il peut également y avoir des répercussions sociales si votre participation à l'étude ou les informations que vous avez partagées sont révélées. Dans le cas où des questions spécifiques vous causent un malaise ou une détresse, vous pouvez refuser d'y répondre sans donner de raison. Vous pouvez également choisir de mettre fin à l'entrevue à tout moment. À la suite de l'entrevue, une liste de ressources de santé et de soutien social qui pourraient vous être utiles vous sera proposée.

Avantages : En partageant votre point de vue, vous contribuerez à une meilleure compréhension des multiples dimensions liés à la maltraitance des femmes lors de l'accouchement en milieu hospitalier, des facteurs qui contribuent à cette maltraitance et des stratégies qui peuvent permettre de répondre à ce problème et de le prévenir.

Confidentialité : Les informations que vous partagez au cours de l'étude resteront strictement confidentielles. Toutes les informations permettant d'identifier les participants seront conservées séparément des données de recherche. Chaque participant se verra attribuer un numéro et seul la chercheuse et la directrice de thèse auront la liste des participants et des numéros correspondants. Seul le numéro d'identification apparaîtra sur la transcription de l'entrevue. Dans le cas où les résultats de l'étude seraient publiés, des mesures seront prises pour protéger votre anonymat. Les résultats seront agrégés, et les cas, caractéristiques, mots ou lieux spécifiques qui pourraient

permettre de vous identifier ne seront pas inclus. Toutes citation incluse dans un travail publié sera rapporté de manière anonyme.

Si vous faites ou avez fait partie d'un processus judiciaire et/ou d'une plainte concernant le mauvais traitement d'une femme lors de son accouchement, nous vous encourageons fortement à contacter votre avocat et/ou votre ordre professionnel avant d'accepter de participer afin de déterminer les implications, légales ou autres, de votre participation à cette étude. Si vous avez signé une entente de confidentialité dans le cadre d'une procédure judiciaire, vous devez respecter les termes de l'entente à tout moment pendant le déroulement de cette étude.

Afin de minimiser le risque de brèches de sécurité et d'aider à garantir votre confidentialité, nous vous recommandons d'utiliser des mesures de sécurité standard telles que l'utilisation d'une connexion sécurisée au moment de l'étude et la déconnexion de votre compte, la fermeture de votre navigateur et le verrouillage de votre écran ou de votre appareil lorsque vous ne l'utilisez plus.

Gestion des données : Tous les fichiers électroniques, incluant les enregistrements audio et/ou vidéo et les transcriptions d'entrevues, seront conservés sur un ordinateur protégé par un mot de passe de la chercheuse principale. Les copies papier des transcriptions d'entrevues et les notes écrites à la main seront conservées sous clé dans le bureau de la chercheuse principale, à son domicile, et dans le bureau de la directrice de thèse à l'Université d'Ottawa. Des copies électroniques des transcriptions seront conservées sur un ordinateur protégé par un mot de passe de la directrice de thèse. Tous les documents de recherche seront conservés de façon sécuritaire pendant une période de cinq ans après la fin de l'étude et seront détruits par la suite.

Participation volontaire : Vous n'avez aucune obligation de participer à cette étude. Si vous choisissez de participer, vous pouvez vous retirer à tout moment et/ou refuser de répondre à toute question, sans aucune conséquence négative. Si vous choisissez de vous retirer de l'étude avant la publication des résultats, vous pouvez décider si vos données seront incluses dans l'étude ou pas. Si vous choisissez de vous retirer après la publication des résultats, les données recueillies auprès de vous ne seront pas retirées des publications existantes, mais vos données ne seront pas utilisées dans les publications ultérieures si vous le souhaitez.

Si vous avez des questions sur l'étude, vous pouvez contacter la chercheuse principale, Andrea Willett ou sa directrice de thèse, Josephine Etowa. Si vous avez des questions concernant la conduite éthique de cette étude, vous pouvez contacter le Bureau d'éthique et d'intégrité de la recherche par courriel (ethique@uottawa.ca) ou par téléphone (613-562-5387).

Partie 2 : Script de consentement verbal

Avez-vous eu le temps de lire attentivement la fiche d'information ?

Avez-vous des questions sur les informations contenues dans la fiche d'information ?

Si oui, est-ce que toutes vos questions ont été répondues ?

Je tiens à vous rappeler qu'en acceptant de participer, vous ne renoncez pas à votre droit de vous retirer de l'étude à tout moment sans donner de raison. Votre participation à cette étude est strictement confidentielle et aucune information ne sera publiée qui pourrait révéler votre identité.

Êtes-vous prêt à décider si vous voulez participer à cette étude ?

Voulez-vous participer à cette étude ?

Si non : *Terminez l'entrevue.*

Si oui : Veuillez confirmer que vous avez reçu toutes les informations sur cette étude et que vous consentez à y participer.

Veuillez indiquer si vous acceptez d'être enregistré sur support audio, vidéo ou aucun des deux.

Début de l'entrevue.

Appendix N
Post-Interview Debrief and Verbal Consent

Title of the study: Exploring the Mistreatment of Women During Hospital-Based Childbirth: An Instrumental Case Study

Principal Investigator (Student Researcher):

Andrea Willett RN, MScN, PhD candidate

School of Nursing, Faculty of Health Sciences, University of Ottawa

Contact Information:

Telephone:

Email:

Thesis Supervisor:

Josephine Etowa PhD RM RN FWACN FAAN, FCAN Professor

School of Nursing, Faculty of Health Sciences, University of Ottawa

Contact Information:

Telephone :

Email:

The form has two parts:

1. **Information Sheet (to explain and justify partial disclosure in the lead up to and during the interview)**
2. **Verbal Re-Consent Script**

Review of the Purpose of the Study: The mistreatment of women by healthcare providers during hospital-based childbirth has become an area of increasing concern in Canada and around the world. Mistreatment during hospital-based childbirth may encompass behaviours including but not limited to disrespectful treatment, lack of control over decision-making, stigma and discrimination, and physical abuse that occur during labour, birth, and/or the immediate postpartum period occurring in a hospital.

The purpose of this qualitative study is to explore the mistreatment of women during hospital-based childbirth and to broaden understanding of the multiple dimensions of the issue.

Information and Explanation for Partial Disclosure (Debriefing Script)

Thank you for taking the time to participate in this interview. Your experience and the perspectives you have shared, in combination with those of other participants will contribute greatly to better understanding the mistreatment of women during hospital-based childbirth.

Various terms have been used to describe the mistreatment of women by health care providers during hospital-based childbirth, including the terms mistreatment, disrespect and abuse, and dehumanized care. Another term that has recently emerged in a number of countries is the term "obstetric violence," which specifically frames the mistreatment of women by health care providers during childbirth as a form of structural violence and gender-based violence. Using this terminology provides a framework to understand the structural dimensions of the issue, for example structural power differentials between healthcare providers and patients, or women and men, and issues related to stigma and discrimination. The intent is to shift responsibility from individual actors to structural drivers. This terminology is also a step towards addressing the matter as a serious societal concern, and a matter of human rights. This research will use the term "obstetric violence" through the process of data analysis and in the presentation of research findings, which may be made public.

The reason that the term "obstetric violence" was not used in the recruitment, consent, or interview process was to prevent your responses from being influenced and to allow you to answer as freely as possible about your experience.

Considering the partial disclosure of this information prior to now, I ask that you affirm your consent to participate in this study. I would like to reassure you that the information that you shared during the interview will remain strictly confidential and will be treated anonymously. I would like to remind you that by affirming your participation, you are in no way waiving your right to withdraw from the study at any point without giving a reason.
If you have any questions about the study, you may contact the principal investigator, Andrea Willett or their thesis supervisor, Josephine Etowa. If you have any questions regarding the ethical conduct of this study, you may contact the Office of Research Ethics and Integrity via email (ethics@uottawa.ca) or telephone (613-562-5387).

Verbal Re-Consent Script
Do you have any questions about any of the information I have just discussed?

If yes: Have all your questions been answered?

I would like to remind you that by affirming your participation, you are in no way waiving your right to withdraw from the study at any point without giving a reason.

Considering this information, do you still consent to have your interview included as part of the research study?

If no: Thank you for your time. Any recordings and notes taken during your interview will be permanently deleted and will not be included in the study. *End interview.*

If yes: Please confirm that you still consent to participate in the study. *Verbal consent documented via recording or in researcher notes.*

You will be sent a copy of this information sheet following this interview.

End interview.

Appendix O
List of Health and Social Support Resources for Childbearing Women

Health and Social Support Resources

- **For non-urgent follow-up**
  - Contact your family physician
  - Contact your local Health and Social Services Centre (CISSS) or Integrated University Health and Social Services (CIUSSS)
    - To find your CISSS or CIUSSS:
    - https://sante.gouv.qc.ca/en/repertoire-ressources/votre-cisss-ciusss/

- **For urgent care**
  - Call 911

- **Ordre des psychologues de Québec –** Find psychological services specific to your needs and in your area
  - Website : www.ordrepsy.qc.ca
  - Phone : 514 738-1223 or 1 800 561-1223
  - English and French

- **NDG Therapy** – Psychotherapy practice specializing in perinatal and postpartum mental health, offering individual counselling and support groups for postpartum women
  - Website: www.ndgtherapy.com
  - Phone: 514 266-0531
  - English and French

- **AMI-Quebec** – Non-governmental organization offering free mental health programs, including workshops, support groups, and individual or family counselling for a variety of mental health concerns
  - Website: www.amiquebec.org
  - Phone: 514 486-1448
  - English and French

- **Les Relevailles de Montreal** – Perinatal Resource Centre offering a variety of free perinatal support groups, parenting workshops, and individual telephone support line
  - Website: www.relevailles.com
  - Phone : 514 640-6741
  - French

- **Postpartum Depression & Anxiety Support Group** – Facebook group, closed peer support group for women with prenatal or postpartum mood disorder, private and confidential, available 24/7
  - Website: https://www.facebook.com/groups/maternalmhmatterssupportgroup/
  - English

Appendix P
List of Health and Social Support Resources for Perinatal HCPs

Health and Social Support Resources

- **For non-urgent follow-up**
  - Contact your family physician
  - Contact your local Health and Social Services Centre (CISSS) or Integrated University Health and Social Services (CIUSSS)
    - To find your CISSS or CIUSSS:
    - https://sante.gouv.qc.ca/en/repertoire-ressources/votre-cisss-ciusss/
  - Contact the Employee Assistance Program affiliated with the CISSS or CIUSSS where you are employed

- **For urgent care**
  - Call 911

- **Ordre des psychologues de Québec –** Find psychological services specific to your needs and in your area
  - Website : www.ordrepsy.qc.ca
  - Phone : 514 738-1223 or 1 800 561-1223
  - English and French

- **AMI-Quebec** – Non-governmental organization offering free mental health programs, including workshops, support groups, and individual or family counselling for a variety of mental health concerns
  - Website: www.amiquebec.org
  - Phone: 514 486-1448
  - English and French