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Obstetric Violence in Italy

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Abstract: This essay focuses on so-called obstetric violence, i.e., the medical malpractice consisting of disrespect and/or abuses to the detriment of women during their labor or when they give birth, as well as during health care services concerning the sexual and reproductive sphere. The main goal is to start a debate on a topic already considered by foreign lawmakers, also for punishment purposes. After an empirical-criminological survey of the cases and the misconduct to be labelled as "obstetric violence", this essay analyses the legal tools available in Italy. From a law reform perspective, the author reflects on the (non-criminal) strategies to prevent distortions of the doctor–patient relationship as well as on the harm to women's self-determination and dignity, particularly in respect of the rules on informed consent.

Keywords: obstetric violence; informed consent; violence against women

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1. Introduction

In recent years, the issue of the violation of women's rights during childbirth, by the health care professionals, has been gaining increasing media attention. The phenomenon does not 'only' concern arbitrary medical acts that are detrimental to the freedom of self-determination of women in labor to decide when and how to provide care, but also includes *any other disrespectful and/or abusive attitude of* medical, obstetrical, nursing and socio-medical staff towards women during labor and the provision of health services related to the sexual and reproductive sphere: gynecological examinations, abortions, medically assisted procreation procedures, breastfeeding advice, contraceptive prescriptions, etc. For this reason, it is also referred to in the literature as 'obstetric violence'.

The expression—undoubtedly provocative—is not entirely inappropriate (Bohren, M. A. et al. [1], instead of the term 'obstetric violence', they propose «'mistreatment of women' as a broader, more inclusive term that better captures the full range of experiences women and health care providers have described in the literature. These experiences can be active (such as intentional or deliberate physical abuse), passive (such as unintentional neglect due to staffing constraints or overcrowding), related to the behavior of individuals (verbal abuse by health care providers against women), or related to health system conditions (such as a lack of beds compromising basic privacy and confidentiality). However, they can all impact on a woman's health, her childbirth experiences, and her rights to respectful, dignified, and humane care during childbirth»). The complaints of women in labor, conveyed above all by social networks and the media that repropose their contents, tell of physical and verbal abuse, violations of consent and privacy, the imposition of painful maneuvers, surgical incisions, and the administration of drugs; sometimes, on the other hand, they complain of labor in abandoned conditions, the refusal of pain therapy or caesarean section, the lack of adequate assistance or, at least, of the presence of a trusted person. Hence the evocation of the (criminal) notion of 'violence' and the 'criminal' relevance of the problem.

The purpose of this essay is to initiate a reflection on a topic that 'threatens' to engage the intervention of the criminal lawmaker. Downstream of the empirical-criminological framing of the case history, there will follow a description of the conducts that can be ascribed to the notion of 'obstetric violence'. It will then proceed to the verification of the

instruments of protection offered by the Italian legal system and, therefore, in a *de lege ferenda* perspective, to the reflection on the prevention strategies of the most obvious distortions of the doctor/parturient relationship and of the offences to women's self-determination and dignity in matters of sexual and reproductive health.

2. Obstetric Violence in the International Panorama

The concept of obstetrical violence was born at the end of the 1990s in Latin America, thanks mainly to the activism of associations committed to promoting greater 'humanization' of childbirth (Network for the Humanization of Labour and Birth—ReHuNa in Brazil; The Latin American and Caribbean Network for the Humanization of Childbirth—RELACAHUPAN; Grupo de Información en Reproducción Asistida in Mexico; Mujeres y niñas sin justicia in Mexico; Derechos Reproductivos en México). Awareness-raising campaigns on the prevalence and systematic nature of abuse in obstetrics and gynecology departments convinced public opinion of the need to establish a discipline to combat the mistreatment perpetrated by health personnel.

Starting in the 2000s, several Central American states decided to legally define obstetrical violence, also providing for sanctions for the most serious attacks on the freedom and dignity of patients (the first countries to have enacted ad hoc regulations against obstetric violence were Venezuela, Argentina, Mexico, and Uruguay).

The issue has now assumed international prominence, finally coming to the attention of the countries of the European Union and its institutions. Among the many references to women's rights in relation to maternity-related health services, the following initiatives are particularly noteworthy:

(i). The World Health Organization (WHO) Declaration for 'The Prevention and Elimination of Abuse and Disrespect during Childbirth in Hospital Facilities' adopted in 2014 (Available online: https://apps.who.int/iris/bitstream/handle/10665/134588/WHO_RHR_14.23_ita.pdf (accessed on 28 March 2023)).

(ii). The Resolution of the Parliamentary Assembly of the Council of Europe on Obstetrical and Gynecological Violence adopted in 2019, which defines obstetrical violence as «a violation of human rights and a manifestation of gender discrimination»; «a form of violence that has long been hidden and is still too often ignored»; and adds: «This violence reflects a patriarchal culture that is still dominant in society, including in the medical field» (Resolution No. 2306 of the Parliamentary Assembly of the Council of Europe, adopted on 3 October 2019).

(iii). The Report of Dubravka Šimonović, Special Rapporteur of the Human Rights Council, «on violence against women, its causes and consequences in relation to the human rights-based approach to ill-treatment and violence against women in reproductive health services with special reference to childbirth and obstetrical violence», adopted in 2019 (The Human Rights Council Special Rapporteur's Report is available online: https://www.ohchr.org/sites/default/files/Documents/Issues/Women/SR/A_74_137_ITALIAN.pdf (accessed on 28 March 2023)).

(iv). The European Parliament Resolution about sexual and reproductive health and rights in the EU in the context of women's health (adopted in 2021), which includes gynecological and obstetrical violence among the forms of sexual and reproductive health abuse and discrimination and human rights violations motivated by gender hatred. In the list of violence perpetrated against women, the Resolution includes «various forced and coercive medical interventions during childbirth, including physical and verbal abuse, the suturing of birth lacerations without the administration of painkillers, and disregard for their decisions and informed consent, which may be considered cruel and inhuman violence and treatment».

(v). The thematic report by UN Special Rapporteur Tlaleng Mofokeng, «Sexual and reproductive health rights: challenges and opportunities during the COVID-19 pandemic» (2021), which explicitly links the pandemic to the increase in manifestations of gender-based violence in health facilities (see No. 32: «Mistreatment, violence and obstetric

violence directed against women in reproductive health services have been documented by human rights mechanisms. Reports from Europe and Latin America indicate that the pandemic has only exacerbated this»).

A reading of the documents cited suggests that obstetrical violence should be taken seriously and, above all, that a dialogue should be initiated with health professionals on the emergence or causes of the increased perception of this form of deviance, not least in order to appease the punitive impulses that have matured in certain associations and have already been picked up by representatives of our Parliament.

The debate is, moreover, propitiated by the attention that the protection of women from gender-based violence enjoys today [2,3], as well as the issue of the intangibility of choices relating to the sexual and reproductive sphere [4,5], also with respect to family and institutional conditioning; issues that, on the medico-legal front, are part of the reflections on the enhancement of gender medicine and respect for the self-determination of the patient/participant, even in dialogue with the professional.

3. Obstetric Violence between Gender-Based Violence and Health Care Violence (and Malpractice)

Early studies on obstetrical violence, almost exclusively of a sociological or anthropological bent, set the physical and verbal aggression of health workers towards women in childbirth in the context of *gender-based violence*. Even within the framework of the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), adopted in 1979 by the UN General Assembly, General Recommendation No. 35, updating Recommendation No. 19, mentions motherhood and health status among the factors that may give rise to manifestations of gender-based violence. In literature, on the topic of gender-based violence, Forti [6] and Magaraggia [7]). Gender-based violence is «a violence that women suffer because they are women» [8]. The definition of 'gender-based violence' is found in the Istanbul Convention (see Art. 3, lett. *d*: any violence directed against a woman as such, or which disproportionately affects women), alongside 'violence against women' (art. 3, lett. *a:* a violation of human rights and a form of discrimination against women, including all acts of violence based on gender which cause or are likely to cause harm or suffering of a physical, sexual, psychological, or economic nature, including threats to commit such acts, coercion, or arbitrary deprivation of liberty, whether in public or private life) and 'domestic violence'. See also Directive 2012/29/EU, which lays down minimum standards on the rights to assistance, information, interpretation and translation as well as protection for all victims of crime, without distinction related to the type of crime and the status of the victim (see *Considerando* no. 17: violence directed against a person on account of his or her gender, gender identity or gender expression, or which disproportionately affects persons of a particular gender).

Investigations have shown how, not infrequently, the 'normal' assistance deficits 'typical' of delivery rooms (e.g., failure to call the anesthetist or gynecologist by obstetrical staff, violation of the privacy of the mother, omission of information on the health of the unborn child) are compounded by derisory comments, misogynistic attitudes, insults and other expressions of contempt, even with explicit references to sexual activity and/or the mother's inability to manage the delivery and its inability to give birth and bear the pain. On verbal abuse, with reference to comments on the sexual activity of the parturient (especially adolescent or unmarried), her ability to cope with labor and breastfeeding, her socio-economic status, or her origins, read Bohren, M. A. et al. [1]. For this reason, there is more attention to the vulnerability of the female patient in relation to all therapeutic services involving the identity or expression of the female gender.

The framing in gender-based violence, certainly correct, risks, however, overshadowing certain specificities of the phenomenon, which are useful for the criminological definition of the events.

Consider, first of all, the context in which the offences are perpetrated and the professional qualification of the active subjects: (1) obstetric violence occurs during childbirth

assistance or other therapeutic services related to sexual and reproductive health provided by health facilities (it is no coincidence that associations committed to the prevention of abuse promote home birth, which should 'save' the woman from the abuse of hospital staff); (2) it is committed by the health and socio-health professions: doctors specialized (or doctors in training) in obstetrics and gynecology, anesthesia and emergency medicine, nurses, child care workers, volunteers in public and private health care facilities, abortions consultants, etc.

These elements have suggested to scholars to also take into consideration the area of so-called health care violence. Part of the abuses would originate, that is, from the pathological distortion of the doctor/patient relationship, from the degeneration—in an authoritarian, 'violent' sense—of medical paternalism [9]. In obstetrics and gynecology wards, the parturient would be treated as a patient 'incapable' of self-determination, emotionally unreliable, undeserving of information and involvement in the choices on childbirth [10,11] and labor, together with pregnancy, would no longer represent a natural process, but a 'pathology' in need of surveillance, hospitalization and control [12]. See Sadler Spencer, et al. [13], who define it as «un modelo de nacimiento basado en la tecnología: una visión de la mujer como máquina defectuosa que debe ser constantemente controlada y monitoreada mediante el uso intensivo de tecnología para garantizar la calidad del producto-bebé». The subject is also at the center of important studies on the social and cultural changes related to pregnancy and childbirth, which have led to the medicalization (and surveillance) of reproduction, entrusted to the woman's responsibility. On the subject, Duden [4] and Cipolla [9]. It must be said, indeed, that 'health surveillance' of gestation (ultrasound scans, monitoring, certification of pregnancy at risk) is sometimes requested/demanded by women themselves, who indeed complain about the paucity of compulsory checks provided by the National Health Service. On the conception of women as instruments for satisfying the needs of others, especially 'family' needs (caring for children, the elderly and the disabled), Nussbaum [14]. The philosophical bibliography on the subject is endless. It suffices here to refer to Foucault's critique of biopolitics and biopower [15]. Consider, in this regard, that childbirth assistance is based, more than other services, on the alliance (and trust) doctor/patient, since the active collaboration of the parturient is required for the 'good outcome' of labor and the expulsive phase. Hence the re-emergence of authoritarian practices, sometimes punitive/disciplinary, through which the medical staff would like to restore the violated hierarchy by imposing itself on the parturient [13,16].

As a demonstration of the transversality of the obstetric violence problem, consider also the violations/coercion of the consent of the parturient to undergo unnecessary surgical operations (*in primis*: CS) for reasons completely unrelated to discrimination against women or gender hatred, but linked to profit motive (typical case: to obtain higher reimbursements from the public health system) or to cover up dysfunctions of the health facility (lack of specialized doctors, need to quickly clear delivery rooms, shortage of anesthetic drugs, etc.). On closer inspection, these events can be traced back to economic crime and organizational malpractice respectively, which in practice have little or nothing in common with the phenomenon we are dealing with.

Consider, again, obstetric and gynecological abuses committed in contexts of systematic violation of human rights against women, who may belong to ethnic or religious minorities, prisoners, disabled, enslaved, politically persecuted, when the health care service is the occasion for the perpetration of torture and physical violence against part of the population (sexual violence, forced sterilization, genital mutilation, procured abortion). Such episodes, which have been extensively documented, do not form the subject of our research, which is instead limited to abusive attitudes held by health professionals in lawful and free contexts.

The above overview nevertheless serves to highlight the need for an interdisciplinary approach to the phenomenon of obstetrical violence, which is able to identify its multiple links with discrimination against women and machismo, but also with the persistent spread of authoritarianism/paternalism in health care structures, the organizational shortcomings

of the public health system, the 'hierarchical' conflict between the relevant specialists, defensive medicine, the abuse of medicalization, the cultural prejudice about the pregnant woman's inability to make decisions, the unpreparedness of medical staff with regard to the discipline of informed consent and on the subject of medical humanities. On the appropriateness of favoring the dialogic and narrative approach in medicine, also in order to counter defensive practices and doctor/patient conflict, see Mazzucato and Visconti [17].

The preponderance of men among health care professionals, the observation of the typical dynamics of female victimization (with some notes of 'domestic violence' [16]), has finally led scholars to agree on the location of obstetrical and gynecological abuse *at the intersection of gender-based violence and health care/institutional violence*, from which a particular form of criminal deviance originates, with its own characteristics [13,17,18].

Following the expulsion of the cases *ictu oculi* far from the reference 'category'—inevitably heterogeneous—the definition of the events depends, therefore, on the condition of subordination/exposure of the parturient to the therapeutic and administrative/authorization decisions of the health personnel, where indifferent to the right to self-determination and possibly inspired by theories of reducing patients to the (only) generative function. In other words: a violence that women suffer as women-mothers (actual or potential), no longer people with rights but 'machine-bodies' destined for procreation, at the disposal of the practitioners.

4. Legal Definitions of Obstetric Violence

The first country to legally define Obstetric violence was Venezuela. The *Ley Orgánica sobre el Derecho de las Mujeres a una Vida Libre de Violencia* provides the following description (see Art. 15, «*Formas de violencia*», *Ley Orgánica* No 38.668, approved on 23 April 2007:

> *Se entiende por violencia obstétrica la apropiación del cuerpo y procesos reproductivos de las mujeres por personal de salud, que se expresa en un trato deshumanizador, en un abuso de medicalización y pathologización de los procesos naturales, trayendo consigo pérdida de autonomía y capacidad de decidir libremente sobre sus cuerpos y sexualidad, impactando negativamente en la calidad de vida de las mujeres.*

An *ad hoc* criminal offence is dedicated to «Violencia obstétrica» (Capitulo VI: De los delitos):

> *Art. 51. Violencia obstétrica.*
>
> *Se considerarán actos constitutivos de violencia obstétrica los ejecutados por el personal de salud, consistentes en:*
>
> 1. *No atender oportuna y eficazmente las emergencias obstétricas.*
> 2. *Obligar a la mujer a parir en posición supina y con las piernas levantadas, existiendo los medios necesarios para la realización del parto vertical.*
> 3. *Obstaculizar el apego precoz del niño o niña con su madre, sin causa médica justificada, negándole la posibilidad de cargarlo o cargarla y amamantarlo o amamantarla inmediatamente al nacer.*
> 4. *Alterar el proceso natural del parto de bajo riesgo, mediante el uso de técnicas de aceleración, sin obtener el consentimiento voluntario, expreso e informado de la mujer.*
> 5. *Practicar el parto por vía de cesárea, existiendo condiciones para el parto natural, sin obtener el consentimiento voluntario, expreso e informado de la mujer.*
>
> *En tales supuestos, el tribunal impondrá al responsable o la responsable, una multa de doscientas cincuenta (250 U.T.) a quinientas unidades tributarias (500 U.T.), debiendo remitir copia certificada de la sentencia condenatoria definitivamente firme al respectivo colegio profesional o institución gremial, a los fines del procedimiento disciplinario que corresponda.*

The definition adopted by Venezuelan law officially entered the medical-scientific debate with the publication in 2010 of an essay in the *International Journal of Gynaecology and Obstetrics*, entitled: «*Obstetric violence: A new legal term introduced in Venezuela*» [10].

In the early 2000s, other Latin American countries also worked to introduce instruments to combat medical abuse against women in childbirth. In Argentina, *Ley Orgánica* no. 25.929 of 2004 on '*Parto Humanizado*' promotes the therapeutic self-determination of women during childbirth and, in general, aims to strengthen the rights of the parents and the newborn child vis-à-vis the hospital (access of the father or another person trusted by the woman, prohibition of removal of the newborn child from the mother to favor the start of breast-feeding, the practice of rooming-in, etc.). The protection offered by the law on "*Parto Humanizado*", without express reference to obstetrical violence, was supplemented by *Ley* no. 26.485 of 2009, on «*de Protección Integral para prevenir, sancionar y erradicar la violencia contra las mujeres en los ámbitos en que desarrollen sus relaciones interpersonales*». Art. 6, lett. e) brings obstetric violence back to the modalidades of gender violence, of a physical, psychological, and symbolic kind; and it is defined as follows: «*aquella que ejerce el personal de salud sobre el cuerpo y los procesos reproductivos de las mujeres, expresada en un trato deshumanizado, un abuso de medicalización i patologización de los procesos naturales, de conformidad con la Ley 25.929*».

In similar terms are expressed by: the Mexican federal law «*de Acceso de las Mujeres a una Vida libre de Violencia*», approved in 2007 and reformed in 2022, which emphasises patriarchal prevarication in the context of health institutions [1]; and the «*Ley de Violencia basada en Género y hacia las Mujeres*» approved by Uruguay in 2017, which classifies obstetric violence among the 18 possible forms of manifestation of gender-based violence: «*Toda acción, omisión y patrón de conducta del personal de la salud en los procesos reproductivos de una mujer, que afecte su autonomía para decidir libremente sobre su cuerpo o abuso de técnicas y procedimientos invasivos*» (Art. 6, lett. h).

5. Classification

Regardless of the provision of specific incriminations of obstetric violence in the laws, the dissemination of documents proclaiming the inviolability of the rights of women accessing sexual and reproductive health services has allowed the scope of abusive conduct to be enlarged, also by specification.

Conduct is indeed very diverse. Without claiming to be exhaustive, we will try to break them down into the following categories.

(1) *Verbal violence*: mocking, sarcastic comments, scolding, humiliation, swearing, shouting, insults, intimidation, threats, insults.
(2) *Physical violence*: unnecessary surgical incisions (episiotomy, CS), Kristeller's maneuver, detachment and rupture of the membranes, pressure and thrusts on the abdomen of the parturient, beatings, injuries. Omissive conduct that causes pain and/or injury to the woman, such as failure to administer anesthetics and painkillers, failure to perform an episiotomy that causes lacerations, refusal to perform a CS at the parturient request, delays in the assistance or intervention of specialized medical personnel (anesthetists and gynecologists), is included in this category.
(3) *Violations of consent/abuse of authority*: pharmacological induction of labor in the absence of full information on the subsequent course of the birth, coercion to assume a certain position during the expulsive phase, coercion to endure continuous tracking of the fetus' vital parameters, restriction of the birthing mother's freedom of movement and/or ability to drink and eat during labor, removal of the newborn at birth that hinders the initiation of breastfeeding, violations of privacy, restriction of entry and assistance by the father of the unborn child or other person trusted by the woman.

The list of abuses reveals a mixture of criminal and non-criminal conducts, in any case offensive to the woman's self-determination and the right to consent/refusal of health services; with reference to the practices of speeding up childbirth and surgeries performed in the absence of specific medical indications (so-called non-evidence-based intervention) [13]. Net, therefore, of the impairment of the physical integrity of the parturient/patient or, more generally, of her health, the problem of obstetrical violence concerns, indeed, the relation-

ship between the woman's decision-making autonomy and the professional freedom of health personnel.

6. Obstetric Violence in Italy: An Overestimated Problem?

The attention to the phenomenon, at least at an international level, has been fostered by the cognitive contribution of the professional categories most exposed to the 'risk' of the reversal of hostile/violent/threatening attitudes towards women in labor (obstetricians, gynecologists, anesthetists). When, on the other hand, the reports concerned the conduct of practitioners in our National Health Service, the problem was greatly reduced.

We refer specifically to the survey promoted by the Observatory on Obstetrical Violence OVO-Italia together with other associations, entitled: *Women and Childbirth*. The research was conducted by Doxa using the interview mechanism, and involved about 400 women with at least one child aged between 0 and 14. From the results, as presented on the institutional website of OVO-Italia, a disturbing picture emerges: 41% of the interviewees would have declared to have received childbirth assistance detrimental to their dignity and psychophysical integrity; 21% would have declared to have suffered physical or verbal abuse during childbirth, as well as other inappropriate treatment or treatment offensive to dignity. Among the most frequently reported behaviors: failure to provide pain relief (13%); denial of support from a trusted person during labor (12%); failure to assist with the initiation of breastfeeding (27%); breaches of confidentiality at various stages of the hospital stay (19%); and serious neglect of care, leading to complications and life-threatening exposure (4%). Because of the trauma experienced during labor and delivery, 11% of mothers reported that they preferred to postpone the decision to experience another pregnancy for many years, with significant consequences on the national birth rate. According to 6% of the total number of women interviewed, the trauma was so severe that they decided not to have any more children.

The seriousness of the reported conduct required the clarifying intervention of the professional associations. In particular, SIGO (Italian Society of Gynecology and Obstetrics), AOGOI (Association of Italian Hospital Gynecologists and Obstetricians), AGUI (Association of Italian University Gynecologists), FNOPO (National Federation of Obstetricians' Professions), in the pages of the *European Journal of Obstetrics & Gynecology and Reproductive Biology*, contested: (i) the methods of the survey (also in terms of the representativeness of the sample, which is indeed small, and of the potential distortions arising from the formulation of 'suggestive' questions); (ii) the use of the term 'violence' («*The objective of the survey already emerges from the name identified to describe the phenomenon that combines the attribute "obstetric" to the word "violence", determining a serious effect of social alarm as well as damaging the image of the NHS and the reputation of the professionals working in this medical area*». The full text of the public announcement is available online: https://www.ejog.org/action/showPdf?pii=S0301-2115%2818%2930291-4 (accessed on 28 March 2023). AOGOI has also requested clarification on the sources of the survey and the methodology adopted, through a letter/questionnaire available at https://www.aogoi.it/media/4408/diffida-doxa-26-10-2017-rivev.pdf, accessed on 28 March 2023), as well as—and this is perhaps the most relevant aspect for our purposes—the basic misunderstanding of the research, i.e., to consider the will of the mother always decisive and inviolable, even when it is in conflict with the dictates of science and dangerous for her health and that of the unborn child.

Despite attempts to minimize the events, the mobilization of the 'victims' has brought to the attention of the institutions the evidently anomalous figure concerning the number of surgical deliveries. In fact, the Italian Minister of Health Renato Balduzzi, on the initiative of AGENAS (the Italian Agency for Regional Health Services), had launched an enquiry in 2013 into the validity of the information contained in hospital discharge forms (SDOs) with the cesarean delivery procedure with the diagnosis of 'abnormal position and presentation of the fetus'; a condition associated with delivery by CS, strongly represented in the health facilities of some Italian Regions, with a percentage frequency much higher than the national average, according to values incompatible with the normal distribution in

the population (on the excessive use of caesarean sections, see also ISTAT, *The reproductive health of women*, 2017, available online: https://www4.istat.it/it/archivio/209905 (accessed on 28 March 2023). Hence the suspicion of opportunistic tampering with the diagnosis, unrelated to clinical data and preordained to defrauding the Italian Healthcare System). A sample check of the medical records showed that in 43% of the cases there was no correspondence with the information in the relevant SDOs, with corresponding exposure of the parturient and the unborn child/infant to the greatest risks associated with CS delivery. These included: a threefold increased risk of death due to anesthesiologic complications; an up to 37-fold increased risk of bladder and/or ureteral injuries; an approximately 18-fold increased likelihood of undergoing a *post-partum* exploratory laparotomy; and a 42-fold increased likelihood of uterine rupture in a subsequent pregnancy compared to after a vaginal delivery. «It is clear», according to the note sent by the Italian Ministry of Health, «therefore, that caesarean section is a surgical procedure that is not without risk and should only be performed if the medical conditions that make it necessary are met. If there are no contraindications, natural childbirth is preferable to caesarean section, for the protection of the health of the mother and baby». However, that is not all. Further, in terms of costs, natural childbirth has a lower impact on the fee payable to accredited facilities. The waste has been estimated at around 80–85 million euros. Hence, on a judicial level, the transmission of the examined medical records to the competent Prosecutor's Offices, «because crimes ranging from serious personal injury to fraud against the National Health Service, to forgery in a public act could be hypothesised» (statement by NAS Carabinieri General Commander Mr. Piccinno during the press conference called to conclude the investigation).

The excessive/abusive use of surgical delivery is beyond the scope of our research, which concerns, instead, a particular form of gender-based violence in the health care context, which manifests itself in the physical and verbal aggression of medical, obstetrical, nursing and socio-medical staff towards women in labor. The problem of patient satisfaction should not concern criminal law. Consider, however, the survey anomalies and the risk of over-representation of criminality, typical of victimization surveys [19]. In the Doxa research, the different moments 'experienced' by mothers during labor and delivery were analyzed, relating not only to treatment, but also to the relationship with health workers and the communication used by medical staff, aspects that are strongly influenced by perception.

The research showed, for example, that the main negative experience during childbirth was episiotomy, which was performed on 54% of the women surveyed (and of these, 61% claimed not to have given consent). Episiotomy is, to all intents and purposes, a surgical intervention to widen the birth canal during the expulsive phase, a practice that the WHO has described as 'harmful, except in rare cases'; on the other hand, it prevents traumatic lacerations of the perineum during childbirth, and accelerates birth in the event of fetal distress. The discourse on the benefits and drawbacks of each practice related to childbirth is beyond our competence. The example of the episiotomy—but the same could be said of the CS—is in any case valid to demonstrate the influence of subjective components on the judgement of the *ex post* preference of an intervention (surgical incision vs. 'natural' laceration) by patients lacking the necessary knowledge to assess the appropriateness of the medical act in the given situation, which also concerned them. To give just one example: even natural childbirth entails several inconveniences (e.g., incontinence), so that, with 'hindsight', the woman would have preferred to resort to surgical delivery. The problem of the definitional uncertainty of 'obstetric violence' and the difficulties in detecting it is discussed seriously in international bodies. The 2014 WHO statement ('The prevention and elimination of abuse and disrespect during childbirth in hospital settings') states: «Although existing evidence suggests that women's experiences of disrespect and abuse during childbirth are widespread, there is currently no international unanimity on how to define these practices and how to measure them scientifically. Consequently, their prevalence and impact on women's health, well-being and choices remain unknown».

7. The So-Called "Zaccagnini" Bill

In 2016, a bill entitled «Regulations for the protection of the rights of the mother and newborn child and for the promotion of physiological childbirth» was presented to the Italian Parliament.

Leaving aside a detailed analysis of the entire bill, let us turn our attention to the provisions on criminal sanctions.

Art. 3 identifies the «birthing assistance practices detrimental to the dignity and psycho-physical integrity of the mother and the newborn», which are «expressly prohibited, except in cases of absolute and documented medical necessity»: (a) episiotomy: surgical cutting of the perineum and vagina; (b) use of suction cups or forceps: forced extraction of the newborn from the vaginal canal, usually associated with episiotomy; (c) artificial rupture of membranes rupture of the amniotic sac by the doctor or obstetrician; (d) manual or instrumental Kristeller maneuver: strong thrust on the woman's abdomen to exert pressure on the uterine fundus and accelerate the exit of the baby from the birth canal; (e) Valsalva maneuver: giving orders to the woman on how and when to push during labor and delivery; (f) pharmacological induction of labor: the administration of drugs to trigger or increase uterine contractions; (g) any other practice detrimental to the psycho-physical integrity of the woman. Ad hoc rules are dictated for delivery by CS and for induction of labor.

For the purposes of the present case, the provision of a new criminal offence should be noted:

Art. 14. Acts of obstetrical violence.

1. Acts of obstetrical violence constitute actions or omissions by the doctor, midwife or paramedical staff aimed at dispossessing the woman of her autonomy and dignity during childbirth.
2. In particular, they are acts of obstetrical violence:
   - (a) denying appropriate care in obstetric emergencies;
   - (b) obliging the woman to give birth in a supine position with her legs raised;
   - (c) obstructing or preventing early contact of the newborn with its mother without medical justification;
   - (d) hinder or prevent the physiological process of childbirth through the use of techniques to accelerate childbirth without the express, free, informed and conscious consent of the woman;
   - (e) performing a caesarean section in the absence of medical indications and without the express, free, informed and conscious consent of the woman;
   - (f) exposing a woman's body by violating her personal dignity.
3. Perpetrators of obstetrical violence shall be punished by imprisonment of two to four years, unless the act constitutes a more serious offence.

The bill does not seem destined to advance in the parliamentary process. Nevertheless, from a critical examination of its provisions it is possible to draw useful indications for the debate on the criminalization of obstetric violence.

It can be observed the repetition of rights already widely acknowledged to patients (the right to information on the state of health and to consent/disagreement: art. 1, (a) and (d), or the affirmation of 'rights' whose respect may not depend—and often does not depend at all, especially in the hospital context—on the actions of health and social-health care personnel (the 'right to a positive childbirth experience': art. 6, paragraph 1). The bill is also composed of statements of rights that deny the therapeutic freedom of practitioners, depriving them of the possibility (or rather: the duty) to dialogue with the parturient for the purposes of informed consent (the right to "draw up a birth plan that is binding on the chosen hospital facility": art. 1, letter c, which does not provide for the advice/assistance of a health professional for the purposes of drawing it up). The bill, then, prohibits conduct that is obviously already not permitted (Art. 6, paragraphs 2 and 3: "addressing humiliating or degrading expressions to the woman during labour, insofar as they are detrimental to her

personal dignity and dangerous for childbirth [; and] expressing unbecoming comments or appreciations about the woman's body"), or insists on promoting physiological childbirth without considering that the omission of certain practices (precisely those indicated as "detrimental to the dignity and psychophysical integrity" of the woman, e.g., induction, episiotomy, CS) does not necessarily lead to 'better' or less 'dangerous' scenarios than others, with regard to both the health status of the birthing woman and her emotional experience in relation to childbirth.

Quite apart from the critical issues that plague the regulatory drafting, the basic problem of the bill concerns the appropriateness of criminalizing obstetric violence, i.e., of selecting and describing the offending behavior (deserving and in need of punishment) in accordance with the Italian constitutional principles of criminal law.

It should be noted, moreover, that the punishment of obstetric violence would mark the debut, in the Italian legal system, of the criminal offence of violating the patient's consent, in relation, however, to a limited number of conducts (arbitrarily) selected by the drafters of the proposal, in the context of obstetrics and gynecology wards only; a choice that is unreasonable, insofar as it imposes a virtuous childbirth 'model' ('natural', physiological, slow, painful), which repudiates recourse to surgery and the acceleration of labor (and not, also, the failure to provide certain services, for example pain therapy, omissions that can force the woman into a state of agony).

In addition, it describes conducts that are imprecise or, in any event, do not necessarily depend on the determinations of the medical practitioner, with respect to a service (childbirth) whose development cannot be predetermined and respect to which the expectations and wishes of the women are changeable, even contradictory; with the effect of entrusting to the perception of the 'victim' the definition of the arbitrary, inadequate ('violent') medical act (or, indistinctly, of the omission of the due medical act), even according to an *ex post* assessment, on the basis of the progress of the physical and mental recovery of the parturient.

8. Conclusion: The Role of the Informed Consent

This essay, at this point, necessarily lands on the topic of informed consent. As is well known, Law no. 219/2017, in order to protect the «right to life, health, dignity and self-determination of the person», has exalted informed consent as an essential term of the «relationship of care and trust between patient and doctor». On the role of the informed consent read Canestrari [20–22]; Cupelli [23]; Eusebi [24]; Cacace [25]; Casonato [26]. The Law assigned to the self-determination of the sick person the widest possible scope, with particular reference to the right to refuse health treatments, renounce treatment and, therefore, 'let oneself die'.

The vehemence of media campaigns concerning obstetrical violence would suggest that medical staff systematically and widely omit information and requests for consent with respect to a series of medical acts (including surgical ones) relating to childbirth or violate the expressed dissent of women in labor to certain services. The problem is more complex.

In Italy there is no general model of informed consent to physiological childbirth. Almost all NHS facilities ask for the patient's written consent (in accordance with the indications of Law no. 219/2017) only for delivery by CS, for natural childbirth after a previous CS or for other particular interventions (e.g., fetal turning), as they are riskier for the health of the woman or the unborn child. In other terms: the acts performed by the health personnel engaged in caring for the parturient who complain, *ex post facto*, of dissent from the activities carried out by the team, cannot be described as actually 'arbitrary'.

Pregnancy and childbirth are processes with a somewhat 'unpredictable' evolution, exposed as they are to the intervention of (physiological) variables or the onset of (pathological) complications. Hence: the impossibility—or, at any rate, the great difficulty—of providing *ex ante* the parturient with truly complete information (Art. 1, par. 3, Law no. 219/2017), relating to every possible course of labor, birth, the *post-partum* phase,

etc.; unless, of course, doctor is content to provide the patient with an extremely vague informed consent form or, on the contrary, a form containing a meticulous description of all the abstractly relevant medical acts; but this would clearly be a *modus operandi* contrary to the spirit of the Italian Law.

From Law No. 219/2017, in any case, important indications are derived.

(1) The informed consent of the mother must always be sought.

Before carrying out any act or maneuver on the woman's body, initiating induction or administering drugs, it is necessary for medical personnel to seek and obtain the valid consent of the woman giving birth (which cannot be given either by her family or the father of the unborn child). The woman has the right to know about her own health condition and that of the fetus, and to be informed in a complete, up-to-date and comprehensible manner about the diagnosis, prognosis, benefits and risks of the diagnostic tests and health treatments indicated, as well as about the possible alternatives and the consequences of any refusal of the proposed treatments/surgeries (Art. 1, paragraph 3). In urgent situations, where it is not possible to inform the mother fully, the doctor is required to act in accordance with the so-called principle of beneficence. Birth attendants, on the other hand, *voluntarily* turn to the hospital to receive *assistance*, thus enabling the necessary treatment for the birth. In certain circumstances, however, the postponement of the medical act for information purposes, or to obtain the written consent of the patient, could represent a dangerous and cruel (or rather: violent . . .) practice towards a woman in labor, in a condition of unbearable suffering [27].

(2) The express dissent of the mother to certain acts is inviolable.

In the event of express dissent to undergo certain acts or treatments, e.g., surgical cuts (CS and episiotomy), these may not be performed (Art. 1, paragraph 5). In such circumstances, the woman's self-determination is insuperable, even in the event of danger to her life.

(3) The prohibition of refusing doctor/patient communication.

Law No. 219/2017 intended to promote the sharing of therapeutic choices, expressly providing that the 'time of communication between doctor and patient constitutes time of care' (Art. 1, paragraph 8) that is to say, dialogue is the privileged way for the implementation of adequate care, which is able to enhance the right to self-determination of the person assisted and, at the same time, the professionalism and experience of the doctor.

The theme of the doctor/patient relationship intercepts a much-debated issue in the field of obstetric violence. We refer to the drawing up of the so-called delivery plan, a document strongly sponsored by associations that seek to overcome the 'supremacy' of doctors and the 're-appropriation', by the part of the parturient, of the choices regarding hospital care.

These are, in fact, 'advance obstetrical treatment provisions' to which practitioners would have to slavishly adhere, so that labor and delivery would take place without 'interference'. When entering the hospital, the woman would thus have the right to present her 'plan' of birth assistance to the attendants, to prohibit the performance of the acts previously 'refused' or to 'demand' the specific treatments required.

Conceived in this way, however, the so-called birth plan irretrievably compromises the (collaborative) doctor/patient alliance, entrusting the management of childbirth to the (dis)informed choices of the parturient; a problematic scenario, as well as incompatible with the discipline of informed consent and, even before that, the civil and criminal liability of the doctor [28].

On the contrary, where the so-called plan is discussed and compiled by the pregnant woman with the help of professionals, with a view to a dialogue on the most 'feared' practices, it would serve as an instrument of communication and the maturing of conscious and shared decisions, thus reinforcing the woman's reliance on the professionals who will assist her during delivery and hospitalization; provided, of course, that they abide by it.

9. Future Directions: The Cultural Reaction to Obstetric Violence

The demands of the associations engaged in the fight against obstetrical violence—which in other jurisdictions have obtained the approval of public institutions—are aimed at promoting a therapeutic approach that is more attentive to the *vulnerability* of women who turn to sexual and reproductive health services. However, the mobilization, in principle meritorious, has gone as far as calling for the intervention of the criminal legislator, in the sense of incriminating attitudes that disrespect the dignity of users and certain arbitrary medical acts.

There is no doubt that some manifestations of obstetrical violence originate, in fact, from the resurgence of paternalism towards patients who are in a condition of physical and emotional fragility, from the opposition, even in the health care environment, to women's emancipation, with particular reference to choices concerning sexuality and parenthood, or from the 'reaction' of the medical class to the strengthening of the right to self-determination of users.

It seems, however, that criminalizing the violation of consent and attitudes vaguely offensive to women's dignity or privacy does not provide an adequate solution to preventing the phenomenon and risks, on the contrary, accentuating the doctor/patient conflict, in a context—that of maternity wards—where the therapeutic alliance is of the utmost importance, indeed all for the purposes of the woman's active collaboration in childbirth and the management of maternal and child care (i.e., safety of care).

Without prejudice to the need to activate penal intervention in the most serious cases, for conduct that integrates the existing incriminating cases (e.g., the crime of threatening, or the culpable cases related to the causation of damaging events due to inadequate care), the principle of *extrema ratio* precludes the extension of the punishable area without having tested the effectiveness of other remedies, indeed all on the level of cultural promotion, in the health context, of respect for women, the inviolability of their bodies and their choices, the value of women's dignity and the mission of caring for, listening to and protecting vulnerable patients.

It is up to the health care facilities, therefore, to undertake the most arduous task, *first and foremost* on the organizational front [1]: to intervene on the training of staff working in obstetrics and gynecology departments, to set up reporting mechanisms (by patients and professionals, in this case on the inappropriate behavior of colleagues), to invest more economic resources in the facilities concerned, for birth preparation courses, meetings with professionals and advice on drawing up the so-called birth plan [16]. Without prejudice to the compulsory requirement of consent to the surgical interventions or services, the advance and shared planning of care would allow the professional to act promptly, but respecting the needs of the birthing woman, as long as the circumstances permit.

In the event of offences against a woman's dignity and self-determination, in relation to any service related to the sexual and reproductive sphere, the structure will have to take action to reconstruct the affair and recover the failed communication; and possibly intervene at the level of disciplinary sanctions, without neglecting recourse to forms of apology, financial compensation and psychological support in favor of the victims.

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References

1. Bohren, M.A.; Vogel, J.P.; Hunter, E.C.; Lutsiv, O.; Makh, S.K.; Souza, J.P.; Aguiar, C.; Coneglian, F.S.; Javadi, D.; Oladapo, O.T.; et al. The mistreatment of women during childbirth in health facilities globally: A mixed-methods systematic review. *PLoS Med.* **2015**, *12*, e1001847. [CrossRef]
2. Bertolino, M. La violenza di genere e su minori tra vittimologia e vittimismo: Notazioni brevi. *Riv. Ital. Dirit. Proced. Penale* **2021**, *1*, 65–82.
3. Pecorella, C. Violenza di genere e sistema penale. *Dirit. Penale Process.* **2019**, *9*, 1181–1187.
4. Duden, B. *Il Corpo della Donna come Luogo Pubblico. Sull'Abuso del Concetto di Vita*; Bollati Boringhieri: Torino, Italia, 1994.
5. Trasforini, M.A. Corpi di genere, corpi relazionali. Retoriche de pericolo, violenza di genere e spazi dell'arte. In *I Modelli Sociali della Violenza contro le Donne. Rileggere la Violenza nella Modernità*; Corradi, C., Ed.; FrancoAngeli: Milan, Italy, 2008; pp. 49–65.
6. Forti, G. La tutela della donna dalla cd. violenza di genere. L'intervento sulla relazione affettiva in una prospettiva criminologica "integrata". In *Famiglia e Matrimonio di Fronte al Sinodo. Il Punto di Vista dei Giuristi*; Fumagalli Carulli, O., Sammassimo, A., Eds.; Vita e Pensiero: Milan, Italia, 2015; pp. 25–47.
7. Magaraggia, S.; Cherubini, D. *Uomini contro le Donne? Le Radici della Violenza Maschile*; Utet: Torino, Italia, 2013.
8. Quattrocchi, P. Violenza ostetrica. Le potenzialità politico-formative di un concetto innovativo. *EtnoAntropologia* **2019**, *7*, 125–147.
9. Pérez D'Gregorio, R. Obstetric violence: A new legal term introduced in Venezuela. *Int. J. Gynecol. Obstet.* **2010**, *111*, 201–202. [CrossRef] [PubMed]
10. Corn, E. Non parlarmi, non ti sento. Il perdurante disallineamento tra i bisogni delle donne maltrattate e le tutele offerte dalle norme penali. *Riv. Ital. Med. Leg.* **2018**, 599–613.
11. Cannone, C. La violenza in sala parto. Osservazioni a margine di una questione controversa. *Studi Quest. Crim.* **2019**, *1–2*, 151–164.
12. Cipolla, S.Z.M. La posizione della partoriente come misura del grado di medicalizzazione del parto. *BioLaw J.* **2022**, *2*, 457–472.
13. Nussbaum, M.C. *Giustizia Sociale e Dignità Umana. Da Individui a Persone*; Il Mulino: Bologna, Italia, 2002.
14. Foucault, M. *La Volontà di Sapere. Storia della Sessualità*; Feltrinelli: Milan, Italia, 2013.
15. Pires Lucas d'Oliveira, A.F.; Grilo Diniz, S.; Blima Schraiber, L. Violence against women in health-care institutions: An emerging problem. *Lancet* **2002**, *359*, 1681–1685.
16. Sadler Spencer, M.; Santos, M.J.; Ruiz-Berdún, D.; Leiva Rojas, G.; Skoko, E.; Gillen, P.; Clausen, J. Moving beyond disrespect and abuse: Addressing the structural dimensions of obstetric violence. *Reprod. Health Matters* **2016**, *24*, 47–55. [CrossRef] [PubMed]
17. Mazzucato, C.; Visconti, A. Dalla medicina narrativa alla giustizia riparativa in ambito sanitario: Un progetto "integrato" di prevenzione delle pratiche difensive e di risposta alla colpa medica. *Riv. Ital. Med. Leg.* **2014**, *2014*, 847–867.
18. Galimberti, D. Violencia Obstétrica. Available online: http://www.fasgo.org.ar/images/Violencia_obstetrica.pdf (accessed on 28 March 2023).
19. Forti, G. *L'Immane Concretezza. Metamorfosi del Crimine e Controllo Penale*; Raffaello Cortina: Milan, Italia, 2000.
20. Canestrari, S. I fondamenti del biodiritto penale e la legge 22 dicembre 2017 n. 219. *Riv. Ital. Dirit. Proced. Penale* **2018**, *1*, 55–85.
21. Canestrari, S. La legge n. 219 del 2017 in materia di consenso informato e disposizioni anticipate di trattamento. *Legis. Penale* **2018**. Available online: https://www.lalegislazionepenale.eu/wp-content/uploads/2018/12/Canestrari-approfondimenti-LP.pdf (accessed on 28 March 2023).
22. Canestrari, S. Una buona legge buona (ddl recante "norme in materia di consenso informato e di disposizioni anticipate di trattamento"). *Riv. Ital. Med. Leg.* **2017**, 975–980.
23. Cupelli, C. Consenso informato, autodeterminazione terapeutica e disposizioni anticipate di trattamento: Profili penali. *disCrimen* **2018**. Available online: https://discrimen.it/wp-content/uploads/Cupelli-Consenso-informato.pdf (accessed on 28 March 2023).
24. Eusebi, L. Il consenso informato e le disposizioni anticipate di trattamento. In *Itinerari di Medicina Legale e delle Responsabilità in Campo Sanitario*; Oliva, A., Caputo, M., Eds.; Giappichelli: Torino, Italia, 2021; pp. 418–430.
25. Cacace, S. La nuova legge in materia di consenso informato e DAT: A proposito di volontà e di cura, di fiducia e di comunicazione. *Riv. Ital. Med. Leg.* **2018**, *3*, 935–946.
26. Casonato, C. Taking sick rights seriously: La pianificazione delle cure come paradigma di tutela delle persone malate. *Riv. Ital. Med. Leg.* **2018**, *3*, 949–963.
27. Giunta, F. Il consenso informato all'atto medico tra principi costituzionali e implicazioni penalistiche. *Riv. Ital. Dirit. Proced. Penale* **2001**, *2*, 377–410.
28. Caputo, M. *Colpa Penale del Medico e Sicurezza delle Cure*; Giappichelli: Torino, Italy, 2017.