REFLECTIONS ON CRIMINALISING OBSTETRIC VIOLENCE – A FEMINIST PERSPECTIVE

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INTRODUCTION

Obstetric Violence (OV) – mistreatment, abusive, or disrespectful treatment of women in childbirth - has gained increasing attention in recent years. However, there is little research on its legal aspects,[1] including the question of whether it is or should be a target of the criminal law, though there are at least three jurisdictions in Latin America where specific statutes protecting women against OV have been enacted.[2] And, in the South African context, Pickles has argued that OV should be criminalised there.[3] This chapter provides the first exploration of the question of criminalisation of OV in England and Wales.

OV is identified in the literature as a form of gender-based violence: it is directed against women and stems from patriarchal gender norms.[4] Recognition that an act of violence is a form of violence against women, reveals not only the harm done to the individual victim, but also the role such violence plays in reinforcing gender norms and oppression of women in general. Traditionally, however, violence against women has been unacknowledged and minimized (for example domestic violence, marital rape), not only in society but in law, and the criminal law has struggled to accommodate women's experiences of abuse and violence.[5]

Feminist analyses show that the law is patriarchal[6] and that criminal law doctrine is based on the male, not the female, subject.[7] Historically, the male character of the criminal law is most evident in, for example, the common law defence of provocation which in its classic formulation facilitated lenient treatment for killings done in 'righteous male anger' – the murder of an unfaithful wife and/or her lover, being the quintessential example[8] – and the way the offence of rape was originally conceived of as a crime against the property interests

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[1] For some exceptions, see Michelle Oberman, 'Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts' (2000) 94 *Northwestern University Law Review* 451; Camilla Pickles, 'Eliminating Abusive 'Care': A Criminal Law Response to Obstetric Violence in South Africa' (2015) 54 *SA Crime Quarterly* 5; Farah Diaz-Tello, 'Invisible Wounds: Obstetric Violence in the United States' (2016) 24 *Reproductive Health Matters* 56.

[2] See Lydia Z Dixon, "Obstetrics in a Time of Violence: Mexican Midwives Critique Routine Hospital Practices" (2015) 29(4) *Medical Anthropology Quarterly* 437, 443 (referring to Venezuela and the Mexican state of Veracruz); Carlos H Vacaflor, 'Obstetric Violence: A New Framework for Identifying Challenges to Maternal Healthcare in Argentina' (2016) 24 *Reproductive Health Matters* 65 (discussing the legal framework in Argentina).

[3] Pickles (n 1).

[4] See discussion in section 1 below.

[5] For example, marital rape was only recognised as a crime in the 1990s: see *R v R* [1991] 4 All ER 481 (HL)

[6] Carol Smart, 'Legal Regulation or Male Control', in *Law, Crime and Sexuality: Essays in Feminism* (Sage Publications, 1995); Janet Rifkin, 'Toward a Theory of law and Patriarchy' (1980) 3 *Harvard Women's Law Journal* 83.

[7] Generally, Nicola Lacey, 'Unspeakable Subjects, Impossible Rights: Sexuality, Integrity and Criminal Law', in *Unspeakable Subjects: Feminist Essays in Legal and Social Theory* (Hart Publishing, 1998).

[8] J Radford 'Marriage Licence or Licence to Kill? Womenslaughter and the Criminal Law' (1982) 11 *Feminist Review* 88; S Edwards, 'Male Violence Against Women: Excusatory and Explanatory Ideologies in Law and Society', in S Edwards (ed) *Gender, Sex and the Law* (Croom Helm, 1985).

of the victim's husband or father.[9] As Nicolson has observed: 'The criminal legal subject is male… [I]t is [male] behaviour which informs the norms of criminal law and the response of actors of the criminal justice system'.[10]

In recent decades, there has been increasing feminist focus on criminal law reform to address the law's gender bias against women. This has met with some success, such as through replacing provocation with a new defence of loss of control,[11] reforming rape laws,[12] and the introduction of new offences to target gender-based violence such as domestic abuse[13] and 'revenge porn'.[14] The government has also recently announced plans to criminalise 'upskirting'.[15] Recently, feminist scholars have also highlighted the need to create specific offences to capture the gendered harms that women experience in the context of image-based sexual abuse.[16]

It is against this context – the gendered nature of OV, and the law's inherent maleness and consequent historical failing to address the concerns of women - that the issue of enacting a specific offence of OV is considered. It will be argued that the criminalisation of OV requires a specific statutory crime. From the outset, it is important to highlight, that my suggestion is not that all instances of mistreatment identified in the literature be subject to the criminal law, and more will be said on that as the argument develops. However, what is important is that the law takes an approach focused on women's experiences of violence and which seeks to challenge the gender norms on which OV is based. While the discussion will focus on the legal position in England and Wales, much of what is said will be applicable to other jurisdictions, at least those with a similar social, cultural and legal context.

Section 1 outlines the concept of OV and explains its conception as a form of gender-based violence. Section 2, focusing on non-fatal offences against the person (NFOAP) and the new wilful neglect and ill-treatment offences found in the Criminal Justice and Courts Act 2015 (CJCA), explores limitations of the current criminal law with regard to targeting abusive treatment of women in childbirth. Following on from this discussion, it is argued in section 3 that a specific offence of OV which takes a woman-centred approach would: first, identify abuse of women in childbirth as a matter that demands a specific criminal response, draw attention to this issue and properly label the wrong/harm involved; and, second, enable the law to be formulated to take account of the particular experiences of women in childbirth. Section 4 will conclude the chapter.

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[9] Lacey, (n 7) 106.
[10] Donald Nicolson, 'Criminal Law and Feminism', in Donald Nicholson & Lois Bibbings (eds.), *Feminist Perspectives on Criminal Law* (Cavendish Publishing, 2000) 25.
[11] Coroners and Justice Act 2009, s 54-56.
[12] Sexual Offences Act 2003, s 1(rape), 74-76 (consent).
[13] Serious Crimes Act 2015, s 76 (Controlling or Coercive Behaviour in an Intimate of Family Relationship).
[14] Criminal Justice and Courts Act 2015, s 33 (Disclosing Private Sexual Photos and Films with Intent to Cause Distress).
[15] https://www.gov.uk/government/news/government-acts-to-make-upskirting-a-specific-offence
[16] Clare McGlynn, Erica Rackley & Ruth Houghton, 'Beyond "Revenge Porn": The Continuum of Image-Based Sexual Abuse' (2017) 25 *Feminist Legal Studies* 25.

1. OV – MEANING, SCOPE, AND ITS GENDERED ROOTS

'OV' is a broad concept used by activists and writers to draw attention to and address mistreatment of women in childbirth.[17] Other terminology describing the phenomenon include 'disrespect and abuse' of women in childbirth, 'dehumanised care', 'birth rape', 'mistreatment of women' and 'childbirth abuse'.[18] There is no consensus on the terminology. Some writers use the terms interchangeably, while others seek to distinguish 'mistreatment' from 'violence' on the ground that the former is a more inclusive term that captures the broader range of experiences described in the research.[19] In this chapter, I will mainly rely on the term OV, but I will also use other terminology, such as 'abuse' and 'mistreatment'. Although I recognise that these terms could hold different meanings, and that there is a wider debate about appropriate terminology, I will use them interchangeably.

Although there is no settled definition, Chadwick summarises the consensus: 'OV includes both direct violence (physical, verbal and sexual abuse), subtler forms of emotional violence (dehumanization, disrespect, and undignified care) and structural violence (stigma, discrimination, and systematic deficiencies).'[20] It covers a wide range of conduct, perpetrated with different degrees of culpability, and includes (but is not limited to) the following examples: forced/non-consented to medical procedures (e.g. caesarean sections, episiotomies, inductions, forceps delivery, vaginal examinations); unnecessary, but apparently consented to, medical treatments; withholding medical treatment/pain relief; slapping, pinching, restraining of women during labour; verbal and emotional abuse (e.g. shouting, threats, coercion, being lied to obtain compliance/consent); neglect; and disrespectful treatment (e.g. putting the needs of the care-provider ahead of those of the woman; ignoring the woman's embodied experience).[21] A key aspect of OV is that it undermines, indeed strips women of their, autonomy and dignity. [22] Understanding these examples of abuse/mistreatment as 'violence', takes the concept of violence beyond traditional accounts which view violence as involving a physical attack. Indeed, as a concept, OV intentionally 'confront[s] problematic practices, which have often been hidden, invisible, unacknowledged, as forms of violence',[23] and 'seek[s] to name phenomena which are not easily or normatively recognised as forms of violence … as *violence*'.[24] Thus, OV serves to reveal and identify what is otherwise hidden and to challenge minimization of women's experiences of abuse in childbirth.

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[17] For example, see Dixon (n 2); Rachelle Chadwick, 'Obstetric Violence in South Africa' (2016) 106(5) *South African Medical Journal* 423.

[18] JP Vogel et al, 'Promoting Respect and Preventing Mistreatment During Childbirth' (2015) *An International Journal of Obstetrics and Gynaecology* 671, 672; Rachelle Chadwick, 'Ambiguous Subjects: Obstetric Violence, Assemblage and South African Birth Narratives' (2017) 27(4) *Feminism & Psychology* 489, 491; Meghan A Bohren et al, 'The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review' (2015) 12(6) *PloS Med.*

[19] Bohren et al (n 18).

[20] Chadwick (n 18) 492.

[21] For examples see: Vogel (n 18) 672; Chadwick (n 18) 491-92; Ana Flávia Pires Lucas d'Oliveira, Simone Grilo Diniz & Lilia Blima Schraiber, 'Violence Against Women in Health-Care Institutions: An Emerging Problem' (2002) 359 *The Lancet* 1681, 1681-83; Bohren (n 18).

[22] Joanna N Erdman, 'Bioethics, Human Rights, and Childbirth' (2015) 17(1) *Health and Human Rights* 43, 45; Bohren et al (n 18)

[23] Chadwick (n 17) 423.

[24] Chadwick (n 18) 492.

The concept of OV emerged in the fight for a humanised approach to childbirth, and sought to highlight the damage perpetrated on women by medicalised childbirth.[25] As such, it embraces routine obstetric practices in a technological age within medical settings, identifying the unnecessary/improper use of routine bio-medical interventions as 'violence'.[26] Consequently, OV may be perpetrated by individual care providers (e.g. midwives, obstetricians), and at a systematic level by health institutions and services through their policies, protocols, working environments and resources. Indeed, as Freedman and Kruk have summarised, research shows that 'this is not the phenomenon of a few bad apples. Rather, it runs wide and deep in the maternity services of many countries.'[27]

Mistreatment and abuse of women in childbirth is a global phenomenon. Although much of the literature has focused on Latin American and African countries,[28] there is also evidence of women's experiences of mistreatment in childbirth in high income settings.[29] For example, Reed et al in their study of women who experienced post-birth trauma across a number of countries, including Australia, North America and Europe, highlighted that many women reported being lied to and threatened to get their agreement to medical interventions. These threats often focused on the welfare of the baby ('the dead baby threat'); that a caesarean would be performed without consent; or that the woman would be reported to social services, and her baby taken from her, if she did not comply with medical authority. [30] Women's experiences of trauma included violence and physical abuse, and they used language associated with sexual assault to describe these experiences.[31] An English study by Baker et al highlighted a number of examples of mistreatment of women in childbirth, including problems in relation to decision-making with regard to obstetric interventions such as episiotomies and inductions.[32] Women in this study indicated that they had little choice over decisions about such procedures in that they were given inadequate information by staff and/or that their preferences and embodied experiences were ignored. Some women reported that they were 'talked into' or 'bullied' to obtain their consent.[33]

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[25] ibid 491.
[26] Dixon (n 2) 437-38, 441-42.
[27] Lynn P Freedman & Margaret E Kruk, 'Disrespect and Abuse of Women in Childbirth: Challenging the Global Quality and Accountability Agendas' (2014) 384 *The Lancet* 42. See also Rachel Jewkes, Naeemah Abrahams & Zodumo Mvo,'Why Do Nurses Abuse Patients? Reflections from South African Obstetric Services' 47(11) (1998) *Soc. Sci. Med.* 1781, 1791-92; d'Oliveira et al (n 21) 1683.
[28] See Bohren et al (n 18) for overview.
[29] See Sarah R Baker et al, ' "I Felt as Though I'd Been in Jail": Women's Experiences of Maternity Care During Labour, Delivery and the Immediate Postpartum' (2005) 15(3) *Feminism & Psychology* 315 (England and Wales study); Bohren et al (n 18) (systematic review of 65 studies across 34 countries, including high-income settings); Rachel Reed, Rachael Sharman & Christian Inglis, 'Women's Descriptions of Childbirth Trauma Relating to Care Provider Actions and Interactions' (2017) 17 *BMC Pregnancy and Childbirth* 21 (world-wide study, mainly comprised of participants from Australia, Oceania, North America and Europe); Diaz-Tello (n 1) (discussing forced caesarean sections in the USA).
[30] Reed et al (n 29) 25.
[31] ibid 25-26.
[32] Baker et al (n 29) 324-25
[33] ibid. 324.

OV is identified as a form of gender-based violence.[34] In other words, it stems from and reflects oppressive cultural attitudes to women and wider structural gender inequality.[35] As highlighted by Dixon, 'how women are treated in labour and birth … mirrors how they are treated in society….'[36] A number of researchers have identified parallels between OV and intimate-partner violence because similar coercive tactics are employed to those used by abusive men (e.g. manipulation, intimidation, violence) and because it is based on gender norms.[37]

Although all patients are susceptible to paternalistic medical practices and infringements of their autonomy in medical decision-making, as Dodds has highlighted, women are especially vulnerable in this respect, particularly in the context of reproductive health decisions: patriarchy, the choices women have to make, and normative ideas that women are 'irrational' mean that their autonomy is undermined.[38] Specifically in relation to childbirth, it is understood that the relationship between birthing women and their midwives/obstetricians is affected by oppressive patriarchal gender norms about the value of women and how 'good' women/mothers should behave. In her South African study into why midwives abuse their patients, Chadwick found that '… class, racialized and gendered imperatives about "good mothers" and "good women" intertwine[] with medical norms surrounding the ideal of the 'good patient', to create relational networks of discipline, punishment, normalizing judgment and coercion.'[39] The role of patriarchal gender norms that devalue women are also found in high-resource settings and 'Western' cultures where prominent ideals of 'maternal sacrifice', which expect that women put their babies first, even where this is against their own interests, make them more susceptible to medical authority, pressure and abuse.[40]

Related to this is the cultural value of the foetus, and the impact of advances in technology on medical perceptions of the foetus as a 'second-patient'.[41] This can create a maternal-foetal conflict, in medical eyes, with, in more extreme cases, medical personnel viewing their role as being to protect the foetus/baby *against* its' mother.[42] Fear of civil liability if the child is injured through negligent medical treatment during childbirth, may also make medical

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[34] For example, see Rachel Jewkes & Loveday Penn-Kekana, 'Mistreatment of Women in Childbirth: Time for Action on This Important Dimension of Violence Against Women' (2015) *PLoS Med* e1001849; Dixon (n 2)
[35] Jewkes & Penn-Kekana (n 34).
[36] Dixon (n 2) 447.
[37] For further discussion, see Jonathan Herring in this collection. See also Dixon (n 2) 447-50; Sonya Charles, 'Obstetricians and Violence Against Women' (2011) 11(12) *The American Journal of Bioethics* 51; Meghan A Bohren et al, '"By slapping their laps the patient will know that you truly care for her": A Qualitative Study of Social Norms and Acceptability of the Mistreatment of Women During Childbirth in Abuja, Nigeria' (2016) 2 *Population Health* 640, 642.
[38] Susan Dodds, 'Choice and Control in Feminist Bioethics', in Catriona Mackenzie & Natalie Stoljar, *Relational Autonomy: Feminist Perspectives on Autonomy, Agency and the Social Self* (OUP, 2000) 217.
[39] Chadwick (n 18) 501.
[40] See generally, Pam Lowe, *Reproductive Health and Maternal Sacrifice: Women, Choice and Responsibility* (Palgrave-Macmillan; 2016), esp chs 2, 5 & 6.
[41] Samantha Halliday, *Autonomy and Pregnancy: A Comparative Analysis of Compelled Obstetric Intervention* (Routledge, 2016) 1-4; Sheena Meredith, *Policing Pregnancy: the Law and Ethics of Obstetric Conflict* (Ashgate, 2005), 1-2, 5-6.
[42] Oberman (n 1) 451-52.

professionals/institutions push for certain kinds of treatment or intervention against the wishes of the birthing woman. As Baker et al argue, in relation to their English study:

> 'The pursuit of the "birth machine" with its ever-increasing use and reliance on technologies and interventions … enacted within a fetocentric environment in which the life of the foetus … and fear of litigation dominate, mean that the rhetoric of informed choice … is just that – rhetoric…. In the context of childbirth, "choice" is potentially coercive as it ignores the asymmetrical relations and the cultural impediments enforced through the obstetric hegemony, which operates within a patriarchal culture.'[43]

Thus, ideals of maternal sacrifice and 'good' motherhood, alongside an increased focus on foetal safety and welfare, can make women in childbirth more vulnerable to abuse, and, in particular, to treatment that undermines autonomy.

The question I seek to address in this chapter is the role of the criminal law in responding to this. In the following section, I explore the limits of the criminal law in responding to OV, before examining the potential of existing offences to capture some examples of OV.

2. Criminalising Obstetric Violence

My argument proceeds on the basis that at least some of the harms perpetrated on women by abusive obstetric practices merit criminalisation, and, indeed, as explored in this section, are already potentially captured by existing offences. Taking this as my starting point, I will argue that if we seek to criminalise OV, what is needed is a specific statutory offence. As I demonstrate, while existing offences might be used to target obstetric abuse, they may not be particularly effective at capturing the gendered violence involved. A specific offence would not only label the crime correctly, it would also enable the law to take account of and respond to the role of gender norms in the perpetration of abusive obstetric practices, and the gender-based harms perpetrated on childbearing women, notably, but not exclusively, those involving autonomy-infringements. A specific offence may also serve to challenge oppression of women in this context, and resist minimization of their experiences of abuse.

As explained, OV is a broad and somewhat ill-defined spectrum ranging from relatively minor (e.g. being rude or disrespectful in attitude) to very serious harms/wrongs (e.g. forced medical procedures). From a legal perspective, the issue is what role the criminal law can play in relation to some, but not all, instances of OV. There are complex issues that arise when considering questions of whether conduct could be criminalised, including practical considerations such as what we might seek to achieve by criminalisation; and whether this would be best realised through the criminal law, or whether other forms of legal regulation would provide a more effective response.[44] We also must be cognisant of the limits of the

[43] Baker et al (n 29) 334.

[44] Other legal responses to OV could include tort and human rights litigation, and regulatory frameworks. See Karen Yeung & Jeremy Horder, 'How Can the Criminal Law Support the Provision of Quality in Healthcare?' (2014) *BMJ Qual Saf* Published Online First: [March 5, 2014], 1, 2.

criminal law. Indeed, whilst criminalisation may be appealing, it should never be taken lightly because, unlike with other forms of legal regulation, it involves the coercive power of the state, allowing for state punishment and condemnation of wrong-doing.[45] The criminal law, therefore, should be used with restraint. For example, Mill's 'harm principle',[46] which is often considered central to the question of the limits of the criminal law, argues that the only rationale for criminalisation is the prevention of harm to others, which means that criminalisation is justified if it will prevent harm.[47] This approach does not mandate criminalisation in such circumstances, however; it merely permits it, and there will be other factors to take into account.[48]

One of the restrictions generally accepted by theorists on the scope of the criminal law is that, due to the significant consequences of criminalisation for individuals, we should only criminalise *serious* blameworthy harms.[49] This would suggest that only serious incidents of OV would lend themselves to criminalisation. However, although I do not wish to suggest that mistreatment of women in childbirth always warrants criminalisation, we should, following what was said in the previous section,[50] guard against trivialisation of birthing women's experiences of violence. In particular, in determining what merits a criminal response it is necessary to challenge the criminal law's traditional male approach to violence and harm. The question of what conduct would cross the threshold to become the concern of the criminal law should be informed by women's experiences and cognisant of and responsive to the gendered roots of the harm involved. What might appear to be 'trivial' on an objective assessment, may take on a different level of gravity when considered from the perspective of women in labour and when account is taken of the gendered nature of the violence involved. First, as noted above, in the OV literature, the term 'violence' is used to describe phenomena not normally viewed as violent[51] and it would be important that the law took a broad approach to conceptualising violence. Indeed, the Supreme Court in *Yemshaw* recognised that for the purposes of the Housing Act 1996, domestic violence included emotional, psychological and financial abuse.[52] Traditionally the criminal law's offences of violence (NFOAP, discussed below) have focused on requirements of physical touching and/or injury of a particular nature (either physical or psychiatric) and degree.[53] As Herring argues, referring to this issue in the context of domestic violence, the law ignores the impact of the context of the relationship in which the violence occurred as well as the broader social

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[45] Andrew Ashworth, 'Conceptions of Overcriminalization' (2008) 5 *Ohio State Journal of Criminal Law* 407, 408, 410; Douglas Husak, 'The Criminal Law as Last Resort' (2004) 24(2) *Oxford Journal of Legal Studies* 207; AP Simester, et al, *Simester and Sullivan's Criminal Law: Theory and Doctrine* (6th ed, Hart Publishing, 2016) 659-60.
[46] John S Mill, *On Liberty* (1859), ch 1.
[47] For example, see generally, Jonathan Herring, *Great Debates in Criminal Law* (3rd ed, Palgrave, 2015), ch 1; Simester (n 45) 660-667.
[48] ibid.
[49] For example, see Ashworth (n 45).
[50] See discussion above at nn 23-24.
[51] ibid.
[52] J Herring, 'The Meaning of Domestic Violence: *Yemshaw v London Borough of Hounslow* [2001] UKSC 3' (2001) 33(3) *Journal of Social Welfare and Family Law* 297.
[53] In the offences of battery/assault; Actual Bodily Harm; Wounding or Grievous Bodily Harm, discussed below section 2.b.

context when considering the severity of the attack; this can mean that women's experiences of violence are trivialised within the traditional criminal law framework.[54] Second, recognising that OV is form of gender-based violence also increases its seriousness because not only is the injury to the individual victim identified, but so too is the wider public harm in terms of the role this violence plays in oppression of women in general.

Notwithstanding this, it seems there will be examples of OV that would not be serious enough to warrant criminal sanction. An example might be where a midwife/obstetrician spoke to a woman in a harsh or demeaning way (though there may be situations where verbal abuse would cross the threshold). Further, even if serious harm was caused, there would be no criminalisation in the absence of fault (e.g. if it was caused accidentally). However, there are other instances of abuse/mistreatment that should attract the attention of the criminal law, such as, for example: deliberately withholding pain relief, where this was not warranted on medical grounds; and blameworthy autonomy-infringements, such as that which occurs where medical procedures are performed without consent, or where women submit to medical procedures/examinations due to improper pressure, lies, lack of information, or threats. Indeed, as in explored in the following section, some of these examples are already captured by the criminal law.

2.a Obstetric Violence under Current Offences

Historically the criminal law has had little to do with medical practice, and, except in cases where death was caused through gross negligence, medical professionals had not faced criminalisation for harms perpetrated on their patients.[55] The Francis Report into serious mistreatment and neglect of patients at Mid-Staffordshire NHS Trust highlighted the inadequacies of the existing criminal law framework, namely that, unless it could be shown that death had resulted, it was impossible to criminalise medical professionals who mistreated, neglected or abused patients in their care.[56] Consequently, two new offences were created, which are largely concerned with criminalising poor, abusive or unsafe (medical) care. Sections 20 and 21 of the CJCA 2015 specifically target 'care workers' (including medical professionals) and 'care providers' (for example NHS Trusts). The section 20 offence criminalises individuals who ill-treat or wilfully neglect those in their care.[57] The section 21 crime criminalises 'care providers', and would enable criminalisation of, for example, an NHS Trust, where a medical professional ill-treated/wilfully neglected a patient; the Trust's activities were organised or managed in a way which amounted to a gross breach of a relevant duty of care to the patient; and in the absence of such breach, the ill-treatment/neglect would not have occurred or would have been less likely to occur.

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[54] Herring (n 52) 300-301.
[55] Hannah Quirk, 'Sentencing White Coat Crime: the Need for Guidance in Medical Manslaughter Cases' [2013] 11 Crim. L.R. 871-72; Amel Alghrani et al, 'Healthcare Scandals in the NHS: Crime and Punishment' (2011) 37 *J Med Ethics* 230.
[56] Robert Francis QC, *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* (2013, London: The Stationery Office). For discussion see Alghrani et al (n 55); Yeung & Horder (n 44).
[57] For a brief outline, see Zia Akhar, 'Vulnerable Patients, Wilful Neglect and Proof of Sufficient Certainty: Part 1' (2017) 181 JNP 385.

Crucial to these offences is the fact that the conduct in question did not meet accepted standards of care and that the professional had knowledge, recklessness or a 'couldn't-care-less' attitude in this regard.[58] The wilful neglect offence, for example, is committed where the professional deliberately refrained from acting or refrained from acting because of not caring whether action was required or not.[59] The ill-treatment offence requires deliberate conduct which could properly be described as ill-treatment, where the perpetrator either appreciated that he was inexcusably ill-treating the patient, or was reckless in this regard.[60] Proof of harm, such as physical or psychological injury or suffering, or actual or threatened damage to health is not required.[61]

Clearly these offences which capture substandard medical practice could be used in cases involving abuse/mistreatment/neglect of women in labour. For example, if a woman was denied pain relief where this denial breached accepted medical standards of care, and where the midwife or obstetrician had the requisite degree of fault (i.e. knowledge, recklessness, or couldn't care less attitude with regard to their failure to provide pain relief), the wilful neglect offence would arguably be committed. It is unclear the extent to which these offences will be effective at capturing autonomy-infringements. Arguably, however, carrying out a medical procedure that was either unnecessary or not consented to could constitute ill-treatment.

A question may arise as to whether it will it be more difficult to prove the legal requirements for these crimes in situations where the patient is under the care of medical professionals for a relatively short period of time, as may be the case for a woman in labour, and where the incident in question involved a one-off failure in care that had no long term or serious consequences for the patient? Arguably not: these offences do not require persistent neglect or ill-treatment, and, as noted, proof of harm is not required. However, the decision on whether to prosecute may be influenced by whether the woman experienced physical, mental or emotional suffering or harm. Indeed, consideration of sufficiency of evidence of the offence requirements is only one aspect of the decision, with prosecutors also having to consider the likelihood of conviction, based on that evidence, and whether prosecution is in the public interest.[62]

In this regard, it is plausible that prosecutions will be reserved for particularly egregious instances of neglect and ill-treatment, such as those involving vulnerable patients with pressing medical needs where the failure in care caused or risked serious suffering or harm. In OV cases, will prosecutions be taken against medical staff where ultimately no harm was caused/risked to the woman or her baby, notwithstanding the significant distress and

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[58] See guidance from following cases: *R v Newington* (1990) 91 Cr App R 247; *R v Sheppard* [1981] AC 394; *R v Turbill and Broadway* [2014] 1 Cr App R 7; *R v Patel* [2013] EWCA Crim 965; and Crown Prosecution Service (Legal Guidance), *Ill-Treatment or Wilful Neglect – Sections 20 to 25 of the Criminal Justice and Courts Act 2015* (17 Oct 2017), available at https://www.cps.gov.uk/legal-guidance/ill-treatment-or-wilful-neglect-sections-20-25-criminal-justice-and-courts-act-2015, accessed 19 Nov 2018.
[59] *R v Turbill and Broadway* [2014] 1 Cr App R 7
[60] *R v Newington* (1990) 91 Cr App R 247.
[61] *R v Newington* (1990) 91 Cr App R 247; *R v Patel* [2013] EWCA Crim 965.
[62] Crown Prosecution Service, *The Code for Crown Prosecutors* (October, 2018), available at: https://www.cps.gov.uk/sites/default/files/documents/publications/Code-for-Crown-Prosecutors-October-2018.pdf, accessed 23 Feb 2019.

indignity she may have suffered due to neglect/ill-treatment during labour, and the longer-term impact this may have on her? Given what has been said about the impact of gender norms and the importance of foetal welfare, will women who report instances of ill-treatment/neglect encounter disbelief or dismissive attitudes from the police and prosecutors and ultimately be less protected than other patients?

It may also be possible to criminalise some instances of OV, particularly non-consented to medical interventions, through NFOAP. These crimes cover non-consented to touching (battery), and also situations where harm (physical or psychological) was unlawfully caused, either through a battery or other means, through the actual bodily harm (s47), grievous bodily harm and wounding offences (s20/18) found in the Offences Against the Person Act 1861. A key rationale of these crimes is the protection of bodily integrity and autonomy: "[t]he fundamental principle, plain and uncontestable, is that every person's body is inviolate. It has long been established that any touching of another person, however slight, may amount to a battery."[63] Although these crimes are not specifically targeted at medical professionals, they have, in theory, the potential to capture non-consented to medical treatment.

Consent plays a vital role in delineating what conduct the criminal law will criminalise in the context of NFOAP. In summary, any unconsented to touching outside of what is acceptable as part of everyday life constitutes a battery.[64] This includes non-consensual medical treatment. If surgery was involved, it could constitute the more serious unlawful wounding offence (s18/20),[65] or, if an unconsented to intervention resulted in some other legally recognised harm to the patient (including diagnosed psychiatric harms, such as depression and PTSD, but not emotional harms such as fear, anxiety and distress),[66] it could amount to actual bodily harm[67] or grievous bodily harm.[68] Mentally competent patients can, therefore, refuse medical treatment, even if this refusal would result in serious harm to them or another person, including death: no matter how foolish or irrational their decision may appear to be, the choices of a mentally competent patient must be respected; non-consensual medical treatment is a criminal offence.[69]

In legal doctrine, birthing women are not treated differently to other patients. Providing she has mental capacity,[70] a woman can refuse medical interventions, such as vaginal examinations, inductions, episiotomies and caesarean sections, even if this puts, not only her own life/health at risk, but also that of the foetus/baby.[71] In particular, normative

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[63] *Collins v Wilcock* [1984] 3 ALL ER 374 (QBD), per Ld Justice Goff.

[64] ibid.

[65] A 'wound' requires that both layers of the skin was cut (*Moriarty v Brookes* (1834) 6 C & P 684, 172 ER 1419; *M'Loughlin* (1838) 8 C & P 635, 173 ER 651), as would be the case with surgery interventions.

[66] *Chan-Fook* [1994] 2 All ER 552; *Burstow* [1998] AC 147.

[67] Actual bodily harm is "any hurt or injury calculated to interfere with the health of comfort" of the victim, but it must be more than "slight and trifling": *Donovan* [1934] KB 498; *Miller* [1954] 2 QB 282.

[68] Grievous bodily harm means "really serious harm": *DPP v Smith* [1961] AC 290

[69] For example, see *Airedale NHS Trust v Bland* [1993] AC 789; *Re T* [1992] EWCA Civ 18; *Re MB (An Adult: Medical Treatment*) [1997] 2 FLR 426; *St Georges NHS Trust v S; Regina v Collins & Ors, Ex Parte S* [1999] Fam 26.

[70] The issue of capacity is discussed further below at nn 98-112.

[71] *St Georges NHS Trust v S; Regina v Collins & Ors, Ex Parte S* [1999] Fam 26.

expectations about 'good motherhood' and medical imperatives to preserve the life/health of mother/foetus/child have no bearing on legal doctrine. As emphasised by the Court of Appeal in *S v St George's NHS Trust*, the foetus' 'need for medical assistance does not prevail over [the pregnant woman's] right. She is entitled not to be forced to submit to an invasion of her body against her will, whether her own life or that of her unborn child depends on it'.[72]

However, in medical and legal practice it is not so straight-forward. As Farrell and Devaney argue, the right to not be compelled to undergo medical treatment does not necessarily mean that patients are empowered to make choices about their care: medical hegemony creates a 'power asymmetry' which makes patients vulnerable to paternalistic medical practices.[73] As noted, women in labour may be particularly vulnerable to having their choices with regard to treatment challenged due to gender norms surrounding 'good motherhood', the position of the foetus as second-patient, and fears of litigation if harm results.[74] Because a woman's decisions carry implications not only for her own health but that of the foetus/baby, medical professionals may struggle to act in accordance with her wishes if they believe her choices endanger the foetus. As Baker et al state: '… the power and influence of obstetric hegemony, with its philosophy of pathology and a paternalistic model of care enacted within a fetocentric environment, acts to control, discipline and disempower women and their bodies during childbirth'.[75] Normative expectations of 'good motherhood' may also affect how women make decisions; for example, they may submit to medical treatment they do not want due to pressure in the delivery room and/or because they have internalised social norms about their obligations as 'mothers'.[76]

The literature on OV shows that consent may be undermined in a variety of subtle and hidden ways in the privacy of the delivery room, such as through threats, pressure, exploitation, manipulation, deception, inadequate information, or lack of consultation. Although from an ethical perspective we may consider that consent obtained in such circumstances is not a true consent, the law is more circumspect in its approach. Indeed, although the courts have become more willing to find no consent due to deceptions/pressure in the context of sexual offences,[77] there is little evidence of a similar approach being taken for NFOAP, particularly in medical settings. One problem is that there is limited guidance on the meaning of consent in the context of NFOAP;[78] another is that, even if we did have a coherent doctrine of

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[72] ibid [50].
[73] Anne-Maree Farrell & Sarah Devaney, 'When Things Go Wrong: Patient Harm, responsibility and (Dis)empowerment', in Catherine Stanton et al (eds) *Pioneering Healthcare Law: Essays in Honour of Margaret Brazier* (Routledge, 2016) 106-107.
[74] See text above at n 34-43.
[75] Baker et al, (n 29) 319.
[76] Catriona MacKenzie and Natalie Stoljar, 'Introduction: Autonomy Reconfigured', in *Relational Autonomy: Feminist Perspectives on Autonomy, Agency and the Social Self* (2000), New York: Oxford University Press) 20.
[77] This is based on an interpretation of the meaning of consent for the purposes of sexual offences only, found in section 78 of the Sexual Offences Act 2003. For examples of cases taking broader approaches, see *Assange v Swedish Judicial Authority* [2011] EWHC 2849 (Admin); *McNally* [2013] EWCA Crim 1051; *R(F)* [2013] EWHC 945 (Admin), where deceptions as to wearing a condom, gender, and withdrawal prior to ejaculation, were held to vitiate consent on the ground that there was no freedom to choose.
[78] Simester et al (n 45) 786.

consent, it may not, in its generic form, cater well for the particular issues that arise in obstetric situations.

Consent does not require an express oral or written agreement; agreement may be implied from the circumstances (e.g. if a patient moved position to allow an examination to be conducted). Further, failure to communicate a lack of consent, for example through resistance or protest, does not mean that the patient has consented.[79] There is the potential for misunderstanding, but where this occurs – i.e. where a medical professional mistakenly believes a patient was consenting when in fact they were not – they cannot be liable for a criminal offence, something which reflects the requirement for blameworthiness in the criminal law.[80]

In criminal law, the basic consent principles are: consent must be expressly or impliedly given; the patient must have mental capacity; and, consent will be vitiated by frauds as to the nature or quality of the act or the identity of the perpetrator, and by certain threats.[81] There are difficulties, however, in determining the precise meaning and scope of these common law rules. There is limited case law, particularly regarding medical contexts, and none which address unwanted medical interventions on birthing women.

The general position on frauds is that a deception (which can include a failure to disclose information) as to the nature or quality of the conduct[82] or the identity of the perpetrator negates consent.[83] However, there is little guidance on the meaning of 'nature' and 'quality'. The only case law from the criminal courts in medical contexts does not offer much insight, dealing with situations involving deceptions as to medical qualifications[84] or professional registration,[85] or where the medical procedure was carried out for a wholly non-medical (and sexual) purpose.[86]

One issue that arises is whether failure to disclose the risks of a procedure would invalidate consent. The criminal courts have interpreted 'nature' to mean the central features of the conduct in question, but to not extend to collateral matters.[87] It was held, in the context of criminalising HIV transmission through consensual sexual intercourse under NFOAP (as section 20/18 offences), that the 'nature' of an act includes the risk of harm attached,[88] which would suggest that failure to disclose to a patient the risks involved in a procedure would vitiate consent to that procedure, leaving open the possibility of conviction for a NFOAP. However, the approach taken by the courts to consent in the context of civil battery (which is

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[79] *Malone* [1998] 2 Cr App R 447.
[80] *Morgan* [1976] AC 182; *Jones* (1986) 83 Cr App R 375.
[81] See generally, David Ormerod, *Smith and Hogan Criminal Law* (12th ed, OUP, 2008) 591-96
[82] See *Tabassum* [2000] Cr App R 328.
[83] Ormerod (n 81) 592-96.
[84] *Tabassum* [2000] Cr App R 328, where women were deceived as to the defendant being medically qualified to carry out breast examinations for research purposes, it was held that there was no consent because the women had been deceived as to the quality of the act (i.e. that it was for a medical purpose).
[85] *Richardson* [1998] Cr App R 200, where it was held there was a valid consent from dental patients notwithstanding that the defendant, who was a qualified dentist, was suspended from practice.
[86] *Green* [2002] EWCA Crim 1501.
[87] Ormerod (n 81) 594-95.
[88] *Dica* [2004] EWCA Crim 1103; *Konzani* [2005] EWCA Crim 706.

defined in the same way as a criminal battery) suggests that a narrower approach would be taken in medical contexts. Although failure to inform a patient about a risk involved in a procedure may give rise to a negligence claim, providing inadequate disclosure caused harm to the patient,[89] the civil courts have refused to find a battery in such situations, in one case holding that it would be 'deplorable' and 'insupportable' to do so, and this is due to the implication that a crime had also been committed.[90] In civil law battery cases providing the patient was 'informed in broad terms about the nature of the procedure' there is a true consent.[91]

To take another example, if a woman is deceived, not about the risks of the treatment but about the risks to her/baby of not undergoing that procedure, would this constitute a fraud which vitiates consent? Possibly, the deception could be construed as relating to the purpose of the act - for example, where the risk to the baby is over-stated and it is said that the procedure is necessary to save the baby's life, arguably this involves a deception as to purpose. However, it is unclear whether deceptions as to purpose fall within the scope of legally recognised negations of consent.[92] One factor that might be relevant in such cases is the professional's reason for the treatment. For example, if they acted out of genuine, albeit misguided, concern for the woman and her baby, would the courts be less likely to find vitiated consented (i.e. that there was a relevant deception), than in a case where the doctor acted for an objectively 'bad' motive, such as, for example, to meet targets or for financial gain?[93] Although the conventional view is that motive is irrelevant on the question of whether particular criminal offences have been committed (unless it is a specific offence requirement), there is jurisprudence indicating that motive is not always ignored in criminal cases. Interestingly, two such cases have involved medical contexts where the doctor's motive appears to have been influential in persuading the court that they had not committed an offence.[94]

It might be possible to argue that such a deception constituted a threat (e.g. 'if you don't comply, your baby will die'), but, again, we have limited clarity on when threats suffice to negate consent for the purposes of NFOAP.[95] To take another example, if a woman agreed to treatment she did not want because she was threatened with having her child taken into care or with court-authorised medical treatment (e.g. she was told that if she did not consent her mental capacity would be challenged and that a court would likely order that the procedure be carried out against her will in her best interests), would this vitiate consent? Most likely such examples would be dealt with on a case-by-case basis, it being for the jury to decide whether the nature of the threat/pressure and its impact on the victim meant that her will was

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[89] Informed consent in the context of negligence requires disclosure of material risks: *Montgomery v Lanarkshire Health Board* [2015] AC 1430.
[90] *The Creutzfeldt-Jacob Disease Litigation* [1995] 54 BMLR 1.
[91] *Chatterton v Gerson* [1981] QB 432.
[92] Unless as in *Tabassum* (n 82) this was then construed as being a lie as to the quality of the act.
[93] For example, in one case of civil battery where the courts did find that consent was vitiated, despite the fact that the patients were aware of the nature of the procedure performed, the professional, a dentist, had carried out extensive but unnecessary dental work on patients for financial gain: *Appleton v Garrett* 34 BMLR 23.
[94] Bodkin Adams [1957] Crim LR 365; Gillick v West Norfolk and Wisbech AHA [1985] 3 All ER 402 (HL).
[95] Ormerod (n 81) 596; Simester (n 42) 788-90.

overborne so that she submitted, rather than consented to the act in question.[96] Medical contexts will present particular difficulties. First, it seems likely that 'threats' are likely to take the more subtle form of pressure, manipulation, persuasion, or exploitation.[97] Second, some level of persuasion and indeed pressure ought to be acceptable, and medical professionals should not be deterred by fear of legal action, and in particular criminalisation, from persuading their patients to accept a particular treatment, particularly in situations where the treatment is necessary, or highly desirable, to prevent harm to the patient (including harm to her baby).

Finally, there is the issue of mental capacity. On this matter the law is well developed and clear, but its application indicates that in practice birthing women's autonomy is not well protected.[98] Although there can be no legally valid consent where mental capacity is lacking, this does not mean that medical procedures cannot be performed in such cases. Indeed, the law facilitates non-consented to medical treatment where a patient lacks capacity, providing this is in the patient's best interests.[99] What this means is that if a woman refuses consent to, for example, a caesarean section, challenging her mental capacity provides a route to facilitating that procedure without risking criminal liability.

First, section 5 of the Mental Capacity Act 2005 allows for clinical judgments about a patient's capacity and best interests to enable lawful medical treatment without the patient's consent. Provided reasonable steps were taken to ascertain mental capacity, and there was a reasonable belief that the patient lacked capacity and that the treatment was in her best interests, no offence is committed. In essence, this provision enables clinicians to make their own determinations about mental capacity, and thus exercise their medical authority to determine the patient's best interests.[100] However, Jackson highlights that medical professionals do not always understand this test or how to apply it.[101]

Medical teams may also avoid criminal liability by seeking a declaration of incapacity and court-authorised treatment.[102] Indeed, in obstetric cases this is the recommended course of action where women who refuse to agree to a proposed procedure (usually a caesarean section) are suspected to lack capacity, rather than relying solely on clinical judgments about capacity/best interests.[103] Whether this happens in practice is another matter. Further, it seems the courts only pay lip service to autonomy rights in this context: there have been numerous cases of court-authorised caesareans based on incapacity/best interests.[104] This is despite the fact that in *St George's Healthcare NHS Trust v S* a competent pregnant woman's right to refuse medical treatment was upheld, even where this put her own and/or the foetus' life at

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[96] Simester et al (n 45) 789-90.
[97] Emily Jackson, Medical Law: Text, Cases and Materials, 4th ed (Oxford University Press, 2016), 314-15.
[98] Halliday (n 41), ch II; Sabine Michalowski, 'Court-Authorised Caesarean Sections – The End of a Trend? (1999) 62(1) *Modern Law Review* 115.
[99] Mental Capacity Act 2005, s 2-5.
[100] See generally, Emily Jackson, 'From "Doctor knows Best" to Dignity: Placing Adults who Lack Capacity at the Centre of Decisions about Their Medical Treatment' 81(2) (2018) *Modern Law Review* 247-281
[101] ibid 249.
[102] Mental Capacity Act, 2005, s 2, 3, 4, 15.
[103] *NHS Trust and Ors v FG* [2014] EWCOP 30; see Jackson (n 81) 258.
[104] See Halliday (n 41) ch II, for an overview

risk, and the Court of Appeal clearly recognised the importance of a woman's autonomy rights, which were not diminished by her state of pregnancy.[105]

However, despite legal principles which clearly uphold a competent pregnant woman's right to refuse treatment, in practice there has yet to be a case where the issue of whether a caesarean could be performed was still live and the courts upheld the woman's capacity and her allowed her refusal of treatment to stand.[106] Although the Court of Appeal in *St George's* did find in the woman's favour, the procedure had already been carried out. In other words, the life/health of the baby was no longer at stake. As Halliday argues, the decision might have been different had it been an emergency situation where the life of the mother/foetus was at risk.[107]

The court-authorised caesarean case law highlights that the practice of the law may not necessarily reflect the legal principles. Although gender norms play no role in the legal rules, as Halliday's analysis of the case law both before and after the *St George's* decision indicates, there remains significant scope for paternalistic and gendered attitudes to infuse the law's application.[108] Indeed, Halliday argues that where medical professionals are of the view that a woman's refusal to consent to a caesarean endangers the foetus, the law on incapacity is used as a 'device' to order that the procedure be carried out in her best interests.[109] Further, as Michalowski highlights, although the same legal principles apply, in practice it seems women in childbirth are treated differently to other patients in that there are few cases involving other patients where the courts have been so willing to authorise medical intervention on the grounds of incapacity/best interest.[110] Where a woman's decision to refuse treatment threatens foetal safety, the courts seem willing to protect the foetus, despite the fact that the law does not support such an approach.[111] In fact, Halliday suggests, rather than protecting women, the law on capacity ensures they meet the 'socially constructed view of motherhood which requires women to act altruistically, doing whatever is necessary for the foetus'.[112]

The approach taken in these cases suggests that women who claim that a criminal offence was committed against them are likely to meet many obstacles, not least the challenge of overcoming normative expectations and how these may affect the interpretation and application of the law. In other words, the idea that everyone's body is inviolate, and that everyone has the right to refuse medical treatment may not provide much protection for women in obstetric cases, and this is not only due to potential shortcomings in current legal doctrine, but also to how gender norms affect the application of legal rules, something that is very apparent in how the law has been applied in capacity cases. Indeed, as experiences with other gender-based crimes, such as sexual offences, has shown, where crime is embedded in

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[105] (n 69) [43-50].
[106] Halliday (n 41) ch II, esp at 40, 85.
[107] ibid 58.
[108] ibid ch II for an overview.
[109] ibid 86—87, 91.
[110] Michalowski (n 98) 126.
[111] Michalowski (n 98) 126-27; Halliday (n 41) 85.
[112] Halliday (n 41) 89.

gender norms those same norms also affect how criminal justice actors involved in processing the case, from the police through to jurors, interpret and implement the law.[113]

Linked to this is the fact that women in such situations may not realise they have been the victim of a crime. Ultimately, the violence of the act is invisible to both victims and the criminal justice system. As Bibbings has observed in relation to NFOAP in the context of domestic violence, victims internalise gender norms and may not interpret what has happened to them as 'violence':[114] 'the gender of the perpetrator and victims, combined with the context in which the violence occurs, has an effect upon whether incidents which potentially constitute offences will actually be perceived as such and, if so, reported, charged, prosecuted and found to attract criminal liability'.[115]

Following the analysis in this section, it is evident that overall the current criminal law provides an inadequate response to OV. Of course, the argument could be made that many patients may experience similar harms, and that given that specific crimes to target abuse in the medical context were created in 2015, surely OV should be dealt with under these offences, and, if there are any gaps, these could be closed by the creation of additional offences (or amendment to existing offences) to ensure that all patients are equally protected. In other words, why should birthing women be treated differently to other patients?

My suggestion for a specific OV offence is not based on the notion that women in childbirth need additional protection compared to other patients, rather that because their experiences are different, they require different protection which can take account of and respond to the particular circumstances of these cases, notably the following features: unlike with other patients whose vulnerability to abuse/mistreatment/violence stems from their physical and/or mental weakness and disempowerment due to illness, women in childbirth are not 'sick'; the additional moral and social pressure on women to make decisions, not only for themselves but for their unborn children, and in particular that normative expectations of 'good motherhood' make them vulnerable to unwanted medical interference and abusive care; finally, the perception of the foetus as 'second-patient', the ethical dilemma faced by medical staff where the woman's decision could lead to death or injury to the foetus, and the perceived maternal-foetal conflict that therefore arises, which may make medical professionals more willing to cross the line into seriously unprofessional standards of care that are properly the concern of the criminal law. The above analysis argues that existing legal doctrine would likely struggle to incorporate these experiences of violence and normative understandings would likely affect the interpretation and implementation of the law. There is therefore a need for a separate offence that is tailored to address the particular factors involved and which can counteract rather than reinforce gender norms in how the law is applied.

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[113] See generally Nicolson (n 10); Nicola Lacey, 'General Principles of Criminal Law? A Feminist View', in Donald Nicholson & Lois Bibbings (eds.), *Feminist Perspectives on Criminal Law* (Cavendish Publishing, 2000) 97-98.

[114] Lois Bibbings, 'Boys will be Boys: Masculinity and Offences Against the Person', in Donald Nicholson & Lois Bibbings (eds.), *Feminist Perspectives on Criminal Law* (Cavendish Publishing, 2000) 246.

[115] ibid 231.

3. The Argument for a Woman-Centred Offence

Following the analysis in the previous section, there are two arguments in favour of establishing a specific offence to target violent obstetric practices: first, to identify and properly label the wrong/harm done and in so doing to draw attention to this issue and express the community's intolerance of abuse of women in childbirth; second, to allow for a woman-centred approach to the definition and scope of the offence, which acknowledges women's experiences of violence and appreciates the gendered nature of the harm/wrong involved.

First, even if some aspects of OV are captured by existing criminal offences, it may be important to explicitly recognise this as a separate crime which properly identifies and labels the harms involved. The concept of OV acknowledges as violence incidents that traditionally do not attract that label and, in so doing, challenge the minimisation of women's experience of maternity abuse. However, if violence against women in childbirth is subsumed within standard criminal law offences, it is hidden, and the public, women themselves, and criminal justice officials may not perceive that a crime has been committed; the harm in question is not identified and indeed is rendered invisible. The expressive potential of the criminal law is also diminished. As McGlynn et al argue with regard to 'image-based sexual abuse', 'shoe-horning practices into conventional privacy-related offences risks obscuring the nature of the abuse and reducing any potential expressive effect of the criminal law'.[116] Further, drawing on Vera-Gray's work on street-harrassment, they also highlight the problem of normalisation of women's experiences of abuse – on the street and on-line – and the importance of the criminal law, and proper labelling of crimes, to 'name' the conduct in question as abuse, thus 'reflect[ing] women's experiences and … resist[ing] minimisation of these forms of harm'.[117] Thus, a statutory crime of 'OV', or some other suitably labelled offence, would not only draw attention to this issue, it would also allow for identification of the specific harms done to women who are victims of serious and blameworthy abusive maternity care, and to resist minimization of their experiences.

Related to this, it is suggested that the state should recognise OV as a *crime.* As Duff argues, certain wrongs[118] *should be* criminalised 'to mark them out as public wrongs, which must be condemned as such, and for which their perpetrators must be called to answer'.[119] He sees crimes as wrongs that 'properly concern[] the public'[120] because they involve an attack on our core community values, and therefore warrant a collective community response.[121] In this regard, unlike with other forms of regulation, the criminal law can demonstrate societal intolerance of violence against birthing women and perform an important expressive function. As Yeung and Horder observe in relation to the creation of the 2015 offences, the

[116] McGlynn et al (n 16) 31.
[117] ibid 40
[118] Taking a legally moralist approach, he views crimes as 'wrongs' rather than 'harms'
[119] R A Duff, *Answering for Crime: Responsibility and Liability in the Criminal Law* (Hart Publishing, 2009) 89.
[120] ibid 141.
[121] ibid 140-46.

criminal law is the 'most powerful and important social institution through which we hold to account, and express public censure of, those who mistreat others in a wholly unacceptable and highly culpable way.'[122]

Second, the law, as it stands, fails to recognise and address the specifically gendered aspects of OV. I have focused on the law's approach to consent, which links in with infringements of autonomy and bodily integrity, in the previous section. Arguably there are also other facets of the existing law that would fail to accommodate women's experiences of abuse in childbirth, such as for example the law's limited understanding of violence and harm (as physical or psychological but not emotional harm). The laws discussed in the previous section, particularly NFOAP, are 'male' laws which were not created to capture the sort of harms perpetrated on women by OV. As Bibbings has argued, despite being ostensibly gender neutral, these offences are ultimately masculinist in nature.[123] Feminist scholarship has revealed that the meaning and scope of the criminal law is affected by sex and gender.[124] Thus, for the criminal law to play any role in responding to these situations it needs to take a more woman-centred approach to issues such as consent (and autonomy), violence and harm. In particular, it should be recognised that the harm involved is one involving autonomy and dignity infringements that have gendered roots.

Further, the concepts of autonomy and choice, so central to the issue of consent for the purposes of NFOAP, are *male.* The traditional conception of autonomy as individualist and rationalistic is 'inextricably bound up with masculine character ideals'.[125] This fails to capture the position of birthing women. Indeed, it could be said that the whole idea of 'choice' in the context of use of medical interventions in childbirth is suspect.[126] As discussed above, she is, or least is perceived to be, in a relational rather than an individualistic position by virtue of her role in bringing forward human life, something which may affect not only her own self-perception with regard to the choices she makes, but also how others, particularly medical professionals and those close to her, view her choices and the extent to which she should be free to choose when her decision is thought to endanger the foetus. These are issues that need to be considered in the criminal law's understanding of consent. In this regard, feminist theories of relational autonomy, allow us to take account of the impact of socialization and social relationships on autonomy.[127] For instance, in this context it would facilitate a better understanding of the impact of oppressive gender norms on the woman's decision making. These feminist critiques of traditional masculinist autonomy and their understandings of relational autonomy could help to inform criminal law in any law reform agenda.

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[122] (n 44) 5.
[123] Bibbings (n 114).
[124] Lacey (n 113) 88, 96-98.
[125] Mackenzie and Stoljar (n 70) 3, & 5-12.
[126] Katherine Beckett, 'Choosing Cesarean: Feminism and the Politics of Childbirth in the United States' (2005) 6(3) *Feminist Theory* 251-75 at 262-69.
[127] Mackenzie and Stoljar (n 76) 4, 13, 20. Carolyn McLeod and Susan Sherwin, 'Relational Autonomy, Self-Trust, and Healthcare for Patients Who are Oppressed', in Catriona Mackenzie & Natalie Stoljar, *Relational Autonomy: Feminist Perspectives on Autonomy, Agency and the Social Self* (OUP, 2000) 259-60.

Conclusion

In approaching the creation of a specific OV offence, we must be cognisant of what criminalisation entails – coercive state censure and punishment – and understand that the decision to criminalise is not something that should be taken lightly. The fact that the criminal law already targets non-consensual medical treatment, albeit not particularly effectively in this instance, as well as abusive/negligent treatment of patients by doctors/nurses, suggests that criminalisation of this specific aspect of medical care would not necessarily be inappropriate. However, it will not always be desirable to criminalise medical professionals who mistreat women in childbirth. There is a need to ensure that medical professionals are not inhibited from doing their jobs effectively through fear of criminalisation, and that there is a clear line between legal and illegal conduct, not forgetting that improper or unethical medical treatment does not always merit criminalisation: we are only concerned with serious and blameworthy incidents.

What is crucial to ensure is that the construction of an OV offence is based on the understanding that this is a form of gender-based violence. It is beyond the scope of this article to suggest a possible framework as a number of issues would need to be explored in detail. For now, I suggest that in considering an offence of OV, the approach to harm, consent, seriousness, fault, and defences (and other matters), must be informed by the experiences of women and must understand the gendered context and the imbalance in power in the relationship in which OV occurs. The vulnerable position the woman is in due to the role of patriarchal norms and her relationship with the foetus, should be taken account of so that the law protects women against normative expectations, rather than drawing on these norms to undermine the protection offered by the law.

Finally, questions may arise about whether criminalisation would be the best outcome for women. Women as victims of gendered crimes, such as rape and domestic violence, are often revictimized by the criminal justice system; they are disempowered, when the state takes over their grievance; and let down when conviction and punishment do not follow. Indeed, as Lacey has argued, focusing solely on criminal law doctrine is an inadequate response because this does nothing to change cultural attitudes that affect how the criminal law is then interpreted and utilised by the police, prosecutors, judges and juries. As the experience with rape has shown, irrespective of changes to legal definitions, problematic gender norms – rape myths – still play a crucial role in the outcome of these cases.[128] This does not mean we should not strive to improve the law, but to remind us that legal reform is only part of the answer.

[128] Lacey (n 113) 99.