
Cruelty in Maternity Wards: Fifty Years Later

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ABSTRACT

Fifty years have passed since a scandal broke over inhumane treatment of laboring women in U.S. hospitals, yet first-person and eyewitness reports document that medical care providers continue to subject childbearing women to verbal and physical abuse and even to what would constitute sexual assault in any other context. Women frequently are denied their right to make informed decisions about care and may be punished for attempting to assert their right to refusal. Mistreatment is not uncommon and persists because of factors inherent to hospital social culture. Concerted action on the part of all stakeholders will be required to bring about systemic reform.

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“Cruelty in Maternity Wards” was the title of a shocking article published just over 50 years ago in *Ladies’ Home Journal* in which nurses and women told stories of inhumane treatment in labor and delivery wards during childbirth (Schultz, 1958). Stories included women being strapped down for hours in the lithotomy position, a woman having her legs tied together to prevent birth while her obstetrician had dinner, women being struck and threatened with the possibility of giving birth to a dead or brain damaged baby for crying out in pain, and a doctor cutting and suturing episiotomies without anesthetic (he had once nearly lost a patient to an overdose) while having the nurse stifle the woman’s cries with a mask.

The article shook the country and triggered a tsunami of childbirth reform that included the founding of the American Society for Psychoprophylaxis in Obstetrics, now known as Lamaze International. Nonetheless, as Susan Hodges (2009) recently noted in her guest editorial published in *The Journal of Perinatal Education*, despite enormous differences

in labor and delivery management, decades later, inhumane treatment remains distressingly common. American childbearing women still suffer mistreatment at the hands of care providers, ranging from failure to provide supportive care to disrespect and insensitivity to denial of women’s right to make informed decisions to common use of harmful medical interventions to outright verbal, physical, and even sexual assault. Furthermore, the more extreme examples are not aberrations but merely the far end of the spectrum. Abuse, moreover, results from factors inherent to the system, which increases the difficulties of implementing reforms.

ABUSE IN CHILDBIRTH: PARALLELS WITH DOMESTIC ABUSE

According to domesticviolence.org (an online resource devoted to helping individuals recognize, address, and prevent domestic violence), domestic violence and emotional abuse encompass “name-calling or putdowns,” “keeping a partner from

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contacting their family or friends,” “actual or threatened physical harm,” “intimidation,” and “sexual assault” (“Domestic Violence Definition,” 2009, para. 2). In all cases, the intent is to gain power over and control the victim. One could add that perpetrators, obstetric staff or otherwise, feel entitled to exert this control on grounds of the victim’s inferior position vis-à-vis the perpetrator as the following illustrate:

[The doctor claimed there] is no supporting evidence that says tearing is better, the articles weren’t written by doctors who deliver babies, and I’m in no mood to sit around wasting my time because I have to sew you up. (Doula V, personal communication, May 24, 2007)

When I [pregnant woman] attempted to discuss the birth plan with you [obstetrician], you became defensive. . . , saying, “If I want to do something to you I will do it and you will not interfere. I have delivered hundreds of babies and you have not delivered any.” (Zeller, 2004, p. 5)

Perpetrators also justify controlling the woman on the basis that it is for her or her baby’s own good, as illustrated in these excerpts from a Texas obstetrician’s birth plan reported on the *TheUnnecesarean.com* blog (Jill, 2009e):

Continuous monitoring of your baby’s heart rate. . . is mandatory. . . . This is the only way I can be sure that your baby is tolerating every contraction. Labor positions that hinder my ability to continuously monitor your baby’s heart rate are not allowed. (para. 11)

Depending on the size of the baby’s head and the degree of flexibility of the vaginal tissue, an episiotomy may become necessary at my discretion to minimize the risk of trauma to you and your baby. (para. 15)

The rate of maternal and fetal complications increases rapidly after 39 weeks. For this reason, I recommend delivering your baby at around 39–40 weeks of pregnancy. (para. 17)

A c-section may become necessary at any time during labor. . . . The decision as to whether and when to perform this procedure is made at my discretion and it is not negotiable, especially when done for fetal concerns. (para. 18)

The same Texas obstetrician also isolates women from views other than his (see above: “keeping

a partner from contacting their family or friends”), stating, “Doula and labor coaches. . . may be asked to leave if their presence or recommendations hinder my ability to monitor your labor or your baby’s well-being” (Jill, 2009e, para. 9), and a Colorado obstetrician group does the same, as illustrated in this sign posted at the group’s clinic:

Because the Physicians at [name of women’s center deleted] care about the quality of their patient’s deliveries and are very concerned about the welfare and health of your unborn child, we will not participate in: a “Birth Contract”, a Doula [sic] Assisted, or a Bradley Method delivery. (Jill, 2009e, para. 23)

Likewise, a nurse at a Virginia hospital that bans doulas states, “From a nursing standpoint, too many [doulas] crossed the line and interfered with my job” (Paul, 2008, para. 11).

TYPES OF ABUSE

Perpetrators of abuse also feel justified in using whatever means necessary to overcome resistance or to punish perceived infringements of the perpetrator’s prerogatives or real or imagined challenges to the abuser’s dominance or worldview. Coercion may take the form of verbal abuse, as in these examples:

He [doctor] stormed in aghast that I was a VBAC [vaginal birth after cesarean] and had been laboring twelve hours. He lectured me on the dangers I was incurring. . . . He informed me that IF I got an epidural and IF I made progress over the next two hours, he would let me continue. If not, he would [cesarean] section me stat. (Bax, 2007, “The Short and Long of It,” para. 8)

After a long and painful induction, . . . he [doctor] sat on the couch and complained that watching her [laboring woman] push her dead baby out [ante-partum demise at 36 weeks] was “like watching paint dry,” and left to see patients in the office. (Nurse K, personal communication, October 16, 2009)

In some cases, verbal abuse may be combined with physical abuse, as can be seen in this labor and delivery nurse’s account:

The doctor. . . stood over the patient’s bed and yelled into her face, “You can kill your baby, you can lose your uterus, but if you want to do something stupid, I guess I can’t stop you. So let’s get on with it.” He then jerked back the covers,

pulled the patient's legs apart and proceeded to perform a rough vaginal exam. (Nurse K, personal communication, October 16, 2009)

Sometimes, verbal abuse has blatant sexual overtones, as these accounts illustrate:

I have witnessed many physicians say degrading things to women in natural labor, as if punishing them for not getting pain control in order to be more passive patients, including "I don't want to hear any noise from you," "Come on, you need to open your legs, obviously you didn't mind that nine months ago." (Nurse K, personal communication, October 16, 2009)

She was crying out of fear of the [vaginal] exam, [because it] was being done by a male (very difficult for most Muslim women). . . . Dr. tells her that if she is that scared and tense already, she'll never get the baby out naturally. . . . With each subsequent exam he would then. . .condescendingly comment on how much "better" she was doing with her vaginal tension. (Doula S, personal communication, October 16, 2005)

*He told her to adjust her bottom so she was straight, he says "We want this smile to match that smile, heh heh. . .if you had an episiotomy, I'd only have to sew up a straight line." What the F**K, are you kidding me. . . ? She is naked, on her back, in a submissive position, at this doctor's mercy. I wanted to cry!* (Doula V, personal communication, May 24, 2007)

Abuse of laboring women may take the classic form of physical harm and pain, as in these examples:

"You're the one who didn't want an epidural, this is the price you pay"—this is often when they refuse to give the patient adequate local anesthetic for laceration repair, despite the fact that the patient is crying out for it and I am standing there holding it out to them. I have seen this too many times to count. The physician's answer is often "I only have a few more stitches left." (Nurse K, personal communication, October 16, 2009)

I saw one of my prenatal patients whose [cesarean-section] incision opened when her staples were removed Monday. We called the [doctor], and he pulled on the tissue until it opened down to the fascia. He then scrubbed the wound with gauze and H2O2, and packed it. The patient received no pain

medication. (Midwife D, personal communication, August 27, 2003)

Physical harm and pain inflicted on childbearing women also includes cesarean surgery without anesthesia. For example, in a publication titled *Cesarean Voices* by the International Cesarean Awareness Network, one woman recounts:

My epidural wore off during surgery and the anesthesiologist didn't believe me. . . . I could feel the stitching and then the stapling. Finally, to stop my screaming, the anesthesiologist pretty much put me completely out, but only because the surgeon told him to. (Scott, Hudson, MacCorkle, & Udy, 2007, p. 4)

According to a study by Paech, Godkin, and Webster (1998), 1 in 200 cesareans are converted to general anesthesia because of a failed epidural. However, as "Nurse K" attests, not all inadequate epidurals are addressed before surgery begins:

I have seen. . .Cesareans when a patient's epidural becomes inadequate during surgery. Despite her crying out "Ouch, I can feel that, that feels sharp! That hurts!" she is ignored, told "No, it's just pressure," "I'm not even doing anything that should hurt" . . . or "I'm almost done." I have seen this probably 8–10 times in four years at two different hospitals. (Nurse K, personal communication, October 16, 2009)

Physical abuse may not be obvious to laboring women because it happens behind the scenes or is concealed, as revealed in reports by labor and delivery nurses:

Many of the obstetricians that I work with are eager to "get her delivered" as quickly as possible. There is also "pit to distress" . . . —in other words, keep cranking that pitocin up until the baby crumps into fetal distress and the obstetrician does a stat c-section—all so the doctor can be done, and get out of the hospital. (Jill, 2009a, para. 19)

The. . .physician. . .was not satisfied with how quickly the patient was delivering (though she had been pushing less than an hour and the baby was in no distress) and so she inserted two fingers into the patient's rectum and attempted to hook the baby's chin so that the head would deliver more rapidly (without mentioning any of this to the

patient, who had an epidural). Her fingers tore right through the sphincter and the patient sustained a 4th-degree laceration. The only thing the OB told the patient about it was that because she had such a “big baby” (7lbs), she would recommend inducing at 37 weeks next time so she didn’t “tear so badly.” (Nurse K, personal communication, October 16, 2009)

Abuse in the labor and delivery unit also includes actions that, had they occurred outside of the unit, would be considered sexual assault, as in the following example:

First the doc does an exam—says there’s a [cervical] lip. . . . Next thing I know, the nurse has her hand in there, holding the cervix while mom is screaming, “get out, OUCH, get out, THAT HURTS”—I look the nurse in the eye, tell her AT LEAST 10 times, “she ASKED you to stop—she does NOT consent to this.” So now, she’s pushing. . . , but this DAMN doctor, kept trying to stretch [the vaginal opening] with his flipping fingers—and she kept screaming how bad it hurt. I kept saying to him OVER AND OVER, “can you PLEASE stop?!?! The only time she screams is when YOU DO THAT.” (Doula M, personal communication, April 2, 2003)

An Illinois woman’s story contains all of the types of abuse described above—verbal, physical, sexual, and threats of physical harm—that women may encounter in labor and delivery units. As reported on the *TheUnnecesarean.com* blog, the woman’s doctor:

- refused to let her have pain medication, telling the nurse that the woman deserved to feel pain because she had not called before coming in and that “pain is the best teacher” (Jill, 2008, “Pain is the Best Teacher,” para. 1; Jill, 2009b, para. 28);
- placed her in stirrups with toes turned in so that her buttocks were not on the table, and forced her to remain in that position until after the birth, which took over an hour (Jill, 2008, 2009b);
- repeatedly told her, “Shut up, close your mouth, and push. . .” and “there is only one voice in this room and it is mine” (Jill, 2008, para. 18 and 29; Jill, 2009b, para. 9 and 18);
- performed a rough vaginal exam during a contraction, causing extreme pain, while she said, “No. Stop!” (Jill, 2008, para. 20; Jill, 2009b, para. 10);

- inserted a catheter during a contraction, causing extreme pain, despite her asking to wait (Jill, 2008, 2009b);
- repeatedly told the woman she was going to hemorrhage and that that she and the baby might die, which was especially terrifying because she had experienced a prior stillbirth (Jill, 2008, 2009b);
- took a cell phone call from a resident and spoke at length about an abortion that he was going to perform that day (Jill, 2008, 2009b);
- told a nurse not to help her (Jill, 2008, 2009b);
- sutured her without adequate anesthesia and had her husband hold her down when she squirmed in pain (Jill, 2008, 2009b); and
- refused to let her or her husband hold the baby (Jill, 2008).

The cases described above are readily recognizable as abuse, but because of the intimacy and sexuality of childbirth, treatment that an observer would think no worse than brusque or insensitive—what Elizabeth Smythe called “the violence of the everyday in healthcare” (Thomson & Downe, 2008, p. 270)—can inflict severe psychological trauma, in this case by triggering memories of past traumatic events:

Because of the epidural, . . . when it was time to push, the nurse and the midwife kept yelling at me to keep my feet in the stirrups, but my legs were numb, so they just kept falling down to the floor. . . . They grabbed my hips and forcefully moved me around into the position they wanted me in, without asking. They just did it. And they kept yelling at me to keep my legs up, but I couldn’t. So they moved me around like a rag doll and my feet just kept falling off the table onto the floor. I was so scared, and I felt like I was doing everything wrong. They did not try to calm me, or even ask how I was doing. They just kept yelling, “This is what you have to do if you want to get your baby out! Keep your legs up!”

This forceful manipulation of my body triggered a memory in me of being gang-raped at 15 years old. During the rape, one of the boys held me down, with my hips at the edge of the bed, while the other boy raped me. He kept grabbing my hips and yanking me closer to him and my legs just felt like 50 lb weights. They just kept falling to the floor. He kept yelling, “Keep your legs up, bitch!” and I couldn’t. I couldn’t move. It was as if I was numb. During my son’s birth, the words that the nurse and midwife

yelled at me, and the ways they manipulated my body were so similar, it was as if the rape was happening all over again. I was terrified. (Rose, personal communication, September 22, 2007)

In a second example, we see the harm of staff insensitivity to the “violence of the everyday” in a doctor’s story of events after her birth told from her viewpoint and juxtaposed with her medical chart notes (Pil, 2010):

Patient: *Seven hours [after birth], I suddenly feel weak, dizzy, and nauseated. . . . The next minute, I’m hemorrhaging. There is blood spurting everywhere, clots the size of frying pans. I think I am going to die. Panicky nurses and residents crowd the room. . . . I am being stuck everywhere for an IV. . . . My underwear is cut off, injections slammed into my buttocks, my legs are forced open and somebody shoves an entire forearm into my uterus and pulls out clots. Three times. I scream and scream and scream. The pain is unbearable, and I feel brutally violated.* (para. 14)

Chart: *7:30 am: Called to see patient passing clots. . . . Blood pressure 110/67. . . . 100/60. . . . 90/58. . . . Bimanual evacuation lower uterine segment with 3 large clots. Orders: IV, Pitocin IV, [etc.]. Discussed with Doctor B.—Intern* (para. 15)

Patient: *Everyone flees the room. I am curled in a fetal position, crying and shaking. No one comes to explain why, how or what has just happened. . . . [No staff members] ever ask if I am all right.* (para. 17)

Chart: *7:40 am: BP 90/58. Will continue to observe.—Night Nurse B 8:00 am: IV running. Patient medicated with Zofran for nausea. Resting comfortably. Will monitor.—Day Nurse C* (para. 18)

Patient: *Doctor B makes rounds. “You doctors make the worst patients.”* (para. 20)

Pil’s resultant PTSD rendered her unable to return to clinical practice. Health care environments were too much of a trigger.

ABUSES UNIQUE TO CHILDBIRTH

The treatment of pregnant and laboring women opens up new categories of abuse not falling under conventional definitions. One category of abuse is denial of the right to informed choice through giving childbearing women insufficient information,

no information, or misinformation about their options. In the *Listening to Mothers II* survey, women were asked to agree or disagree with four statements on cesarean surgery’s adverse effects (Declercq, Sakala, Corry, & Applebaum, 2006). Three-quarters of the respondents on every question were either not sure how to respond or responded incorrectly. Women who had cesareans were no more likely to know the right answer than women who did not have cesareans.

A second category of abuse among childbearing women is elective primary cesarean initiated by the physician. A survey at one hospital revealed that 13% of intrapartum cesareans were at “physician request” according to the obstetrician’s self-report (Kalish, McCullough, Gupta, Thaler, & Chervenak, 2004). An additional 3% were, according to the obstetrician, a joint decision with the woman, but considering the power imbalance in the relationship, it is not unreasonable to include these in the “physician request” category. That makes 1 in 6 intrapartum cesareans at this hospital. Subjecting women to unnecessary surgery is, of course, a form of physical abuse.

A third category of abuse is denial of the right to refuse invasive medical procedures and especially to refuse surgery. Results from the *Listening to Mothers II* survey found that over half (56%) the women who wanted VBAC were denied that option (Declercq et al., 2006), and a 2009 survey of 2,850 U.S. hospitals revealed that half of the hospitals had an outright or de facto ban against VBAC, the latter meaning the hospital had no official policy against VBAC, but no obstetrician would allow one (International Cesarean Awareness Network, 2009). Vaginal breech birth and vaginal twin birth are almost impossible to obtain. Refusing vaginal birth forces women to agree to surgery or forgo medical care.

A fourth category is abuse of childbearing women by the legal system. Legal system abuses arise from medical staff and societal perception that the fetus’s rights supersede the rights of the woman. In this respect, women are worse off than they were with domestic violence before the women’s rights movement. Before, women could expect no relief from legal authorities or social services; now, they are called in on the side of the abuser. Cases include

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a California woman whose doctor threatened to report her to Child Protective Services for resisting induction for postdates (Doula E, personal communication, September 11, 2003); an Arizona woman with a prior cesarean told if she showed up in labor and refused automatic surgery, the hospital would get a court order and perform cesarean surgery anyway (Jill, 2009d); a Florida woman confined by the court to hospital bedrest for preterm contractions at 25 weeks, denied access to a second opinion, and ordered to submit to any treatment her doctor deemed necessary, including cesarean surgery (Appel, 2010); and a New Jersey woman previously diagnosed with post-traumatic stress disorder (PTSD) and depression deprived of custody of her child at birth because she refused to sign a blanket consent at hospital admission for cesarean surgery, an act cited as evidence she was too mentally ill to be a fit mother (Jill, 2009c).

ABUSE AND THE TOLL ON VICTIMS

Predictors of psychological trauma resulting from childbirth include a history of sexual assault, feelings of powerlessness, negative interactions with medical staff, failure to meet expectations, medical interventions, and unplanned cesarean surgery (Soet, Brack, & Dilorio, 2003), although trauma can also occur in spontaneous vaginal births (Soderquist, Wijma, & Wijma, 2002). Given the ubiquity of these experiences, it should not be surprising that sizeable percentages of women experience psychological trauma following childbirth. An Australian survey of women 4 to 6 weeks postpartum found that one third of respondents reported a traumatic birth event in conjunction with three or more symptoms of emotional trauma (Creedy, Shochet, & Horsfall, 2000). *Listening to Mothers II* survey investigators conducted a follow-up survey that included questions diagnostic of childbirth-related PTSD (Declercq, Sakala, Corry, & Applebaum, 2008). Nearly 1 in 5 (18%) women were experiencing some symptoms, and 1 in 10 (9%) met the full PTSD diagnostic criteria. Worse yet, symptoms are long-lived: Women were surveyed 6 to 18 months postpartum and asked about symptoms *in the past month*.

Women also specifically report experiencing their childbirth treatment as an assault: “It was like being tortured because I was...screaming,

...begging, really, really begging for [the Syntocin] drip to be turned off”; “Don’t feel I gave birth and had a baby on that day. I just felt I went into a room and was just assaulted”; and “It was violent and brutal” (Thomson & Downe, 2008, p. 270). The consequences can be severe and long-lasting, as conveyed in the following comments from women:

I was left feeling like a total failure. I left the hospital thinking that I was a horrible mom. . . . I didn’t even want to hold my baby and I was terrified of being alone with him. (Rose, personal communication, September 22, 2007)

I don’t remember my baby’s first 6 months, I was so mired in depression and post-traumatic stress—flashbacks, nightmares, sweating panics. . . . You didn’t only take my birth, though. I lost more than my son’s infancy. For a long time, I lost myself. (Bax, 2007, “The Short and Long of It,” para. 17 and 18)

I still have nightmares—six years later. (Scott et al., 2007, p. 4)

It is important to note that the vast majority of maternity care providers are not abusers. Nonetheless, abuse continues to flourish. Why isn’t it stopped? To answer this question, we must look at factors inherent to the system.

OBSTACLES TO REFORM

Most hospital social systems are rigid hierarchies. Because authoritarian social systems allow some individuals unrestrained dominance over others, mistreatment and abuse are likely to follow. For example, as a labor and delivery nurse recounts:

He asked me for an Amnihook to rupture the patient’s membranes, and when I pointed out that according to my exam, the cervix was still closed and the baby was still high. . . , he yelled at me to get out of the room and that he wanted another nurse and I was no longer “allowed” to take care of his patients. (Nurse K, personal communication, October 16, 2009)

Consider the authoritarian family and its organizing principles, as described by Virginia Satir (1988): “There is one right way, and the person with most power has it,” “There is always someone who knows what is best for you,” “Self-worth is secondary to power and performance,” “Actions are

subject to the whims of the boss,” and “Change is resisted” (p. 132). As a result, self-esteem is low; communication is indirect and incongruent; styles of interaction are blaming, placating, distracting; rules are unspoken, outdated, and when inhumane, people adapt rather than change them. As authoritarian families provide fertile ground for violence and abuse at the micro level, so authoritarian institutions do the same on the macro level. They enable what has been called a “culture of impunity” in which there is no accountability for abuses and in which its members are at risk to become—sometimes unwilling, sometimes unwitting, and sometimes neither—participants in, if not perpetrators of, abuse. For example, nurses may enforce abusive policies and practices:

If [her partner] has been asked to leave the room during a procedure or something, I try to let them know that it's not because we don't want them there. There are certain policies to be followed and it's the doctor's decision. (Gale, Fothergill-Bourbonnais, & Chamberlain, 2001, p. 268)

Nurses may also collude in abuse:

Woman during prolonged vaginal exam: That hurts my gut.

Dr.: That hurts to do that? [surprised]

Woman: Yes! Just don't do it no more. . . . No more. Please! [to husband] It hurts, it hurts. I—no more, please no more. [Vaginal exam continues]

Nurse: Just squeeze his hand. There you go. [Doesn't help]. (Bergstrom, Roberts, Skillman, & Seidel, 1992, p. 15)

Nurses may feel compelled to conceal abuse:

I do everything I can so she'll hurry up and deliver, even though ethically I feel horrible about it. I can't tell her, "Your doctor's got a golf game . . . and that's why I'm doing this to you." (Sleutel, 2000, p. 40)

And because nurses rank higher in the hierarchy than laboring women, they may engage in abusive behaviors themselves:

Frequently nurses don't want to take the time to work with difficult patients and. . . go along with

the decision to section early in the labor process. (Sleutel, Schultz, & Wyble, 2007, p. 206)

From the very beginning the nurse was very overpowering and just. . . took away everything that we wanted to do. (Mozingo, Davis, Thomas, & Droppleman, 2002, p. 346)

Even so, many individuals working in institutions with authoritarian cultures are concerned about patient well-being, yet abuse continues unchecked. How does this happen?

One theory is that nurses are usually women, and women are socialized to defer to authority. Traditional nursing training and hospital culture may reinforce this blanket deference without regard to potential conflicts with the woman's rights or her best interest.

A second theory is that authoritarian systems often lack effective mechanisms for calling abusers to account, as illustrated in this labor and delivery nurse's account:

This patient's family subsequently filed a complaint with the hospital (to match the literally 100s of complaints filed by nurses in the past 25 years) and he was suspended for one day before his privileges were returned and he was given the option to "retire" six months later. The next day he returned to the unit and sat at the nurses' station leading a discussion with 4 other OBs (including the chief of staff) saying how "dangerous" the nurses were and that "someday one of them is going to kill somebody because they don't get it that their job is just to follow orders." (Nurse K, personal communication, October 16, 2009)

As the nurse's experience also illustrates, individuals who attempt calling abusers to account may expose themselves to intimidation and retaliation, up to and including losing their job.

A third reason why abuse continues unchecked is that the lack of accountability often enables abusive doctors to use their power to trap nurses into no-win positions. For example, as this labor and delivery nurse reports:

A female obstetrician on our unit is notorious for "punishing" the nurse for failing to push Pitocin hard enough to get patients delivered by the end of the work day, by taking the patient back for a Cesarean. She then tells the nurse "Have it your way, but it's your fault she ended up with a section."

(Nurse K, personal communication, October 16, 2009)

A fourth reason for continued abuse may be because individuals who are high enough in the hierarchy to make change are unlikely to do so. During residency, doctors trained in authoritarian systems are likely to internalize as normative a model of interaction with underlings and patients that desensitizes them to problem behaviors if not converts them into outright abusers themselves. Once in practice, doctors would rarely witness their colleagues' abuses firsthand. Confronted with the more egregious nurse or patient complaints, the instinct would be to close ranks against a perceived attack from individuals below them in the hierarchy and to discount or dismiss them.

Moreover, closed systems create a conspiracy of silence. As Marsden Wagner (2006) notes, "We may talk to one another about the terrible way a certain . . . member practices obstetrics, but only in private" (pp. 22–23). He goes on to relate an anecdote of speaking at a meeting attended by doctors from a number of local hospitals at which he presented data on their hospitals' cesarean rates. Rates were as high as 60%. The next day, the obstetric community was in an uproar not about the shamefully high cesarean rates, but over who had given Wagner the data—who had broken the hospital "omertá"? Whistle-blowers in authoritarian systems run the risk of social ostracism, a powerful disincentive to taking action against peers.

What about the other side of the equation? Why do women tamely submit and do nothing even after the fact? For one thing, women in general, not just nurses, are socialized not to challenge authority. For another, women traumatized in birth display the same prisoner/victim mentality for the same reasons as victims of violent crime or abuse:

There were similarities in relation to the belief that death was imminent because of the severity of pain, suffering, and trauma; in sensations of disconnection, alienation, and isolation from social relationships; in the imbalance of power between the victim and the abusing authoritative others; and in the inducement of passivity, helplessness and depen-

gency through rituals and procedures. (Thomson & Downe, 2008, p. 270)

Female physiology may be at work as well. Taylor and colleagues (2000) dispute that "fight or flight" is the predominant response to stress in women and that belief in its being so originates in almost all studies having been done in males. They argue that "fight or flight" will be evolutionarily counterproductive in females in mammalian species who bear young with limited or no mobility. They propose an alternative: "tend and befriend." In support of their hypothesis, they cite numerous studies in animals, primates, and humans showing that stressful events trigger nurturing behavior in females. When directed toward offspring, tending calms and soothes, promoting health and well-being. Tending behaviors also reduce stress in the ones doing the tending, not just the recipients, and tending behaviors are not solely directed toward young. Tending facilitates formation of social networks among females, which ensures mutual assistance when a member is threatened. Unlike "fight or flight," which is mediated by the sympathetic nervous system, "tend and befriend" appears to be mediated by the parasympathetic nervous system, primarily by oxytocin. "Tend and befriend" could explain why laboring women submit without protest to treatment that would provoke outrage under other circumstances.

Women, of course, could complain afterwards—and some do—but most abuse victims are likely to be recovering from surgery, and all have a newborn to care for. Traumatized women will have all they can do to cope with their symptoms and function as new mothers. Few will have the physical or emotional energy to do other than try to put events behind them and carry on. For those who do complain, the system that predisposed to abuse in the first place ensures that complaints will fall on deaf ears.

What, then, is to be done? Meaningful, long-lasting change requires transforming the system. We need a system that rewards those who practice mother-friendly care. We need to introduce accountability for those who don't. Above all, we need to convert authoritarian models to collaborative social structures within which maternity care providers—doulas and educators included—are respected for their spheres of expertise, and the mother-baby dyad's physical and mental health and well-being come first.

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Systemic change will require long-term, concerted effort by like-minded groups and organizations from both within and without its institutions. As we begin our next 50 years, it is time for birth professional and advocacy organizations to “get radical,” a word whose original meaning is “fundamental,” and to take the forefront in the campaign begun by the 1958 *Ladies’ Home Journal* article, “Cruelty in Maternity Wards.” Unless and until educators, nurses, doulas, midwives, physicians, reproductive-rights activists, and childbirth reformers join hands and rise up together, childbearing women will go on having no other recourse than the kindness of strangers to protect them during a supremely vulnerable time in their lives.

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