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Midwives' lived experiences of obstetric violence: a hermeneutic phenomenological study

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ABSTRACT

Background: Obstetric violence encompasses harmful practices and care dynamics during pregnancy, childbirth, and postpartum that undermine women's dignity, autonomy, and rights, and is associated with structural, gender, and organisational factors in maternity care.
Objectives: To explore how midwives understand, experience, and interpret obstetric violence in delivery room settings, including its perceived causes and contextual conditions.
Methods: A qualitative study based on Gadamerian hermeneutic phenomenology was conducted with ten hospital midwives from two public hospitals in Andalusia and Catalonia. Semi-structured interviews (November 2024–April 2025) were audio-recorded, transcribed verbatim, and analysed iteratively using ATLAS.ti, with researcher triangulation and participant validation.
Results: Midwives described obstetric violence as a multifactorial phenomenon influenced by women's vulnerability, communication, professional practices, and healthcare system conditions. Woman-centred care, communication, and professional autonomy were identified as protective factors, while workload and institutional constraints hindered individualised care. This study contributes an underexplored midwifery perspective to a field mainly focused on women's experiences.
Conclusions: Preventing obstetric violence requires strengthening communication, informed consent, women's participation, professional education, and organisational conditions that support respectful, woman-centred maternity care. Obstetric violence should be interpreted not only in relation to individual intent, but also in relation to its relational, structural, and experiential dimensions.

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Obstetric violence; midwives; woman-centred care; informed consent; professional autonomy; structural factors; qualitative research; hermeneutic phenomenology

Introduction

Obstetric violence refers to practices, omissions, and care dynamics during pregnancy, childbirth, and the postpartum period that may violate women's dignity, autonomy, and rights (Rodríguez Mir & Martínez Gandolfi, 2021). It includes not only overtly disrespectful or degrading practices, but also relational and organisational conditions that can leave women feeling silenced, disempowered, or excluded from decisions about their own bodies and reproductive processes (Chaib, 2019; Rodríguez Mir & Martínez Gandolfi, 2021). Recent scholarship has increasingly emphasised that obstetric violence cannot be understood solely as an individual or interpersonal issue, but must also be examined in relation to structural conditions,

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institutional culture, gendered power relations, and the medicalisation of childbirth (Nagle & Samari, 2021; Sadler et al., 2016; Wallace, 2020).

The concept remains contested (Ferrão et al., 2022). Some authors explicitly frame obstetric violence as a form of gender-based violence because it reflects historically rooted inequalities in the treatment of women's bodies and reproductive experiences (García, 2018; Mena-Tudela et al., 2022). By contrast, some professional organisations and healthcare practitioners challenge the term, arguing that it may imply intentional harm in situations where professionals perceive themselves as acting in accordance with clinical standards and with the aim of protecting maternal and foetal wellbeing (Lappeman & Swartz, 2021). This conceptual tension is particularly relevant in maternity care, where interventions may be clinically justified yet still be experienced by women as dehumanising, coercive, or non-consensual (Ferrão et al., 2022; Lappeman & Swartz, 2021).

Evidence from Europe and beyond suggests that the phenomenon is neither isolated nor marginal (Parliament, 2024). Women report experiences related to lack of information, absent or insufficient consent, restriction of movement, repeated and unwanted examinations, lack of privacy, disregard for birth preferences, and exclusion from decision-making (Asociación El Parto Es Nuestro, 2016; Martínez-Galiano et al., 2021; Mena-Tudela et al., 2020; Van der Pijl et al., 2024). Such experiences have been associated with long-term physical, psychological, and relational consequences, including traumatic childbirth, postpartum distress, avoidance of future healthcare, and deterioration in trust toward health services (Cook et al., 2018; Declercq et al., 2007; Dikmen Yildiz et al., 2017; Fraser et al., 2025; Martínez-Vázquez et al., 2021). Obstetric violence is therefore increasingly recognised as a matter of public health, quality of care, and human rights (Ortega, 2019; Tunçalp et al., 2015).

At the same time, the occurrence and perception of obstetric violence are not shaped by professional behaviour alone (Mena-Tudela et al., 2020). Research highlights the influence of structural and contextual factors such as workload, staff shortages, institutional protocols, defensive medicine, inequalities in access to information, and women's social and cultural position (Bohren et al., 2015; Martínez-Galiano et al., 2021; Reddy et al., 2022; Sadler et al., 2016). These factors interact with communication processes and care relationships to shape childbirth experiences. In this sense, obstetric violence emerges at the intersection of individual encounters and broader institutional arrangements (Bohren et al., 2015; Sadler et al., 2016).

Despite growing literature on women's experiences of obstetric violence, comparatively little is known about how midwives understand and experience this phenomenon in practice (Lunda et al., 2024). This is an important gap, as midwives occupy a central position in childbirth care and are directly involved in communication, decision-making, advocacy, and the everyday implementation of woman-centred care (Afulani et al., 2019). Exploring their perspectives is essential to illuminate how obstetric violence is interpreted, negotiated, and potentially prevented within maternity services (Lunda et al., 2024).

Therefore, this study aimed to explore how midwives understand, experience, and interpret obstetric violence in delivery room settings, including its perceived causes and contextual conditions.

Method

Design

This study adopted a qualitative design grounded in Gadamerian hermeneutic phenomenology. This approach was considered appropriate because the purpose of the study was not only to describe midwives' experiences, but also to interpret the meanings they attributed to obstetric violence within the broader organisational, relational, and institutional contexts in which childbirth care takes place. In Gadamerian hermeneutics, understanding is dialogical and situated, and meaning emerges through interpretation rather than through description alone (Fleming et al., 2003; Gadamer, 2013).

From this perspective, obstetric violence was approached as a historically and contextually situated phenomenon. The analysis therefore extended beyond individual narratives to examine how midwives' experiences were shaped by healthcare structures, professional hierarchies, institutional protocols, and gendered assumptions embedded in obstetric care (Gadamer, 2013; Sadler et al., 2016).

In line with Gadamerian hermeneutics, the researchers' prior understandings were not treated as bias to be eliminated, but as part of the interpretive process requiring critical reflection (Fleming et al., 2003). The research

team included professionals and academics with backgrounds in midwifery, nursing, and health sciences, and an established interest in respectful maternity care and obstetric violence. Throughout the study, pre-understandings were critically examined through reflexive notes, analytic discussions, and repeated movement between the parts and the whole of the text. The study was conducted in accordance with the COREQ guidelines and reported following SRQR recommendations (O'Brien et al., 2014; Tong et al., 2007).

Participants and context

The study included midwives working in two public hospitals located in Andalusia and Catalonia: Punta de Europa University Hospital in Algeciras and Germans Trias i Pujol University Hospital in Badalona. Access to participants was facilitated pragmatically through these institutions; however, inclusion followed purposive criteria, since all participants had to be qualified midwives with direct experience in childbirth care within the Spanish public health system.

Eligible participants were required to hold a nursing degree with specialist training in obstetrics and gynaecology and to be actively affiliated with the Spanish National Health System in Andalusia or Catalonia. Ten midwives agreed to participate and completed the interviews.

The inclusion of participants from two autonomous communities was intended to broaden the contextual range of experiences rather than to establish a formal comparative regional analysis. Accordingly, regional differences were considered part of the diversity of context, but the primary analytic focus was on shared meanings and interpretations related to obstetric violence in public hospital maternity care.

Data collection

Ten semi-structured interviews were conducted between November 2024 and April 2025. The average interview duration was 35 minutes. Before each interview, the principal investigator explained the purpose of the study, addressed participants' questions, and obtained informed consent (Table I).

The interview guide explored four main areas: participants' understanding of obstetric violence; examples encountered in practice; perceived causes and contributing conditions; and the role of communication, decision-making, and institutional context. The guide was pilot tested before data collection.

Although the interviews were semi-structured, they were conducted flexibly and in a conversational manner, allowing participants to elaborate their experiences in their own terms while ensuring that all key topics were covered. Each participant was interviewed once.

In keeping with a hermeneutic phenomenological approach, sample adequacy was assessed in terms of interpretive sufficiency rather than numerical saturation alone. Data collection concluded when the final interviews no longer contributed substantially new experiential meanings or thematic insights relevant to the study aim. Participants were invited to review their transcripts and suggest clarifications or amendments if needed.

Table I. Semi-structured interview.

Section	Type of question	Interview questions
Opening	General introductory question	To start, could you share your views on obstetric violence, a term that has gained increasing attention in recent years? Please explain what obstetric violence means to you.
Development		How do you think obstetric care has changed over time? How do you feel about these new trends? Could you describe your professional experience
		Could you tell me about the importance of prioritising women's decision-making during childbirth? What is your view on this?
		What are your views on humanised childbirth? Do you think this right is currently being offered to women?
		How do you understand the concept of obstetric violence?
		Do you think obstetric violence exists in the current healthcare context?
		What do you see as the main causes of obstetric violence? Are there specific factors that may contribute to its occurrence?
		How would you describe the relationship between the healthcare professional assisting during labour and the woman giving birth?
		What changes could help reduce the likelihood that women experience childbirth care as violent?
Closing	Final question	Is there anything else you would like to add on this topic?
	Acknowledgements	Thank you very much for taking the time to participate in this interview.

Data analysis

All interviews were audio-recorded, transcribed verbatim, and analysed following a Gadamerian hermeneutic approach (Fleming et al., 2003; Tong et al., 2007). Analysis began with repeated reading of the transcripts to gain an overall sense of the material, while reflexive and analytic notes were recorded. Meaning units were then identified and coded line by line.

Coding was supported by ATLAS.ti version 8, which was used to organise and retrieve data, manage codes, and explore links between coded segments. However, the software did not perform the analysis; interpretation remained the responsibility of the research team.

Interpretation proceeded through the hermeneutic circle, involving continuous movement between individual quotations, coded segments, emerging themes, the full interview texts, and the overall phenomenon under study. This iterative process allowed meanings to be refined in dialogue with both participants' narratives and the relevant theoretical and qualitative literature (Fleming et al., 2003; Tong et al., 2007).

Codes with shared conceptual meaning were grouped into provisional categories and then developed into themes and subthemes through team-based analysis. Differences in coding or thematic interpretation were discussed in analytic meetings and resolved through reflexive dialogue and consensus. Throughout the process, particular attention was paid to preserving the link between higher-order conceptual categories and the original narratives from which they emerged (Fleming et al., 2003; O'Brien et al., 2014; Tong et al., 2007).

Ethical aspects

This study was conducted in accordance with the ethical principles of the Declaration of Helsinki (World Medical Association, 2013). Ethical approval was granted by the relevant research ethics committee under study code OMOSVO-2024. The management teams of the participating centres were informed and provided written authorisation for the study.

Participants received detailed information about the objectives and procedures of the study and provided informed consent before participation. They were informed that they could pause or discontinue the interview at any time, omit any question, or withdraw without consequences.

Given the potentially sensitive nature of the topic, interviews were conducted in a respectful and supportive manner. Although no participant required additional assistance, referral to appropriate institutional support resources would have been facilitated if emotional distress had arisen.

Data were processed confidentially in accordance with the relevant Spanish and European data protection legislation.

Scientific rigour

Methodological rigour was addressed in line with the criteria proposed by Guba and Lincoln (Guba & Lincoln, 1994). Credibility was strengthened through triangulation of data sources, including interviews, field notes, and reflective memos, as well as through participant checking of transcripts and interpretive summaries. The research team also held meetings with two external experts, who reviewed the conceptual and methodological coherence of the study and provided critical feedback.

Confirmability was enhanced through reflexive documentation and team-based analytic discussions designed to examine how interpretations were produced. Dependability was supported through researcher triangulation and by an independent review of coding decisions and thematic development conducted by two external evaluators. Transferability was addressed by providing a rich description of the participants, research settings, and methodological procedures employed.

Results

The main demographic characteristics of the ten study participants are summarised in Table II. All participants were specialist nurses in obstetrics and gynaecology currently working either exclusively in the public healthcare sector ($n = 7$) or in both the public and private sectors ($n = 3$), within the Andalusian

Table II. Sociodemographic characteristics of the participants.

Participant	Age	Sex	Work experience	Job position	Place of work
1	32	Female	7 years	Both	ICS*
2	50	Male	18 years	Public health system	SAS**
3	32	Female	5 years	Public health system	ICS
4	35	Female	6 years	Public health system	ICS
5	38	Female	9 years	Both	SAS
6	54	Female	18 years	Public health system	ICS
7	33	Female	10 years	Public health system	ICS
8	30	Female	4 years	Public health system	ICS
9	30	Female	5 years	Public health system	ICS
10	31	Female	9 years	Both	SAS

*Catalan Health Institute.
**Andalusian Health Service.

(n = 3) and Catalan (n = 7) health services. The mean age of the participants was 36.5 years (SD = 8.57; range: 36–54 years).

Data analysis yielded three overarching themes (Table III) (Figure 1): (1) Circumstances and conditions of pregnant women in the obstetric care process; (2) Professional practices and care relationships during pregnancy, childbirth, and the postpartum period; and (3) Obstetric violence in context, between care practices and healthcare system conditions.

We propose a summary table (Table IV) that maps the main dimensions of obstetric violence identified in the study across structural, relational, professional, and contextual domains.

Taken together, these themes do not only describe factors associated with obstetric violence, but also illuminate how midwives make sense of it through their lived and professional experience in delivery room settings. From this interpretive perspective, obstetric violence emerged as something midwives continuously recognise, negotiate, and respond to within the relational and structural conditions of maternity care.

Theme 1. Circumstances and conditions of pregnant women within the obstetric care process

Theme 1 captures how midwives linked women's experiences of obstetric violence to personal, emotional, social, and clinical circumstances. Across the interviews, participants described how communication, cultural context, vulnerability, and access to information shaped women's participation in care and the meanings attributed to obstetric practices. These accounts reflect not only what midwives perceive women to experience, but also how midwives themselves interpret and make sense of those experiences within their professional role in childbirth care.

Subtheme 1.1. Circumstances of pregnancy, childbirth, and the postpartum period

From midwives' perspectives, the circumstances surrounding pregnancy, childbirth, and the postpartum period shape how women may experience these stages through the interaction of biological, emotional, relational, and sociocultural factors. In the interviews, midwives described maternal experience not merely as a physical process, but as one constructed through the convergence of emotional, social, and cultural dimensions that influence how pregnant women navigate each phase of the reproductive process.

Midwives' perspectives highlight effective communication and intercultural understanding as fundamental elements in building a relationship of trust with pregnant women. However, in everyday clinical practice, these conditions may be challenged by linguistic and cultural differences or by mismatched expectations regarding the birth process. Such situations can limit empathy and emotional connection between healthcare professionals and women, thereby shaping the quality of support provided and the overall care experience.

> *"We always try to create a calm and relaxed environment so that we can connect with the woman. However, there are many situations in which that connection simply does not happen. This may be due to language barriers, cultural or religious factors, or because the woman has a very different idea of how childbirth should be. For one reason or another, the connection cannot be established, and in those cases the woman may also become more closed off and less willing to engage." (D1)*

Table III. Themes, subthemes, and analytical units.

THEMES	SUBTHEMES	ANALYTICAL UNITS
Circumstances and conditions of pregnant women in the obstetric care process	Circumstances of pregnancy, childbirth, and the postpartum period	• Communication and cultural factors • Maternal and foetal well-being and emotional experience • Clinical conditions and obstetric complications • Medical practices and interventions • Clinical relationship and maternal autonomy in decision-making
	Conditions of pregnant women	• Access to and right to information • Autonomy, empowerment, and participation • Attitudes and disposition of pregnant women • Vulnerability and power relations • Socioeconomic conditions and structural inequalities • Impact on mental health and lived experience
Professional practices and care relationships during pregnancy, childbirth, and the postpartum period	Communication, social skills, and the therapeutic relationship	• Communication and relational skills • Therapeutic bond and trust • Professional attitudes and interpersonal treatment
	Power relations in healthcare and participation in decision-making	• Paternalistic practices in care • Active participation and shared decision-making
	Professional role and autonomy	• Professional role and autonomy within the healthcare system • Professional responsibility and ethical practice
Obstetric violence in context: between care practices and healthcare system conditions	Healthcare system conditions	• Human resources, workload, and institutional responsibility • Material resources and healthcare modernisation • Organisational models and access to healthcare • Regulatory frameworks and legal context
	Characteristics of obstetric violence	• Conceptual ambiguity and terminological controversies • Professional perceptions and awareness of the issue • Cultural and gender dimensions • Institutional violence • Typologies of obstetric violence

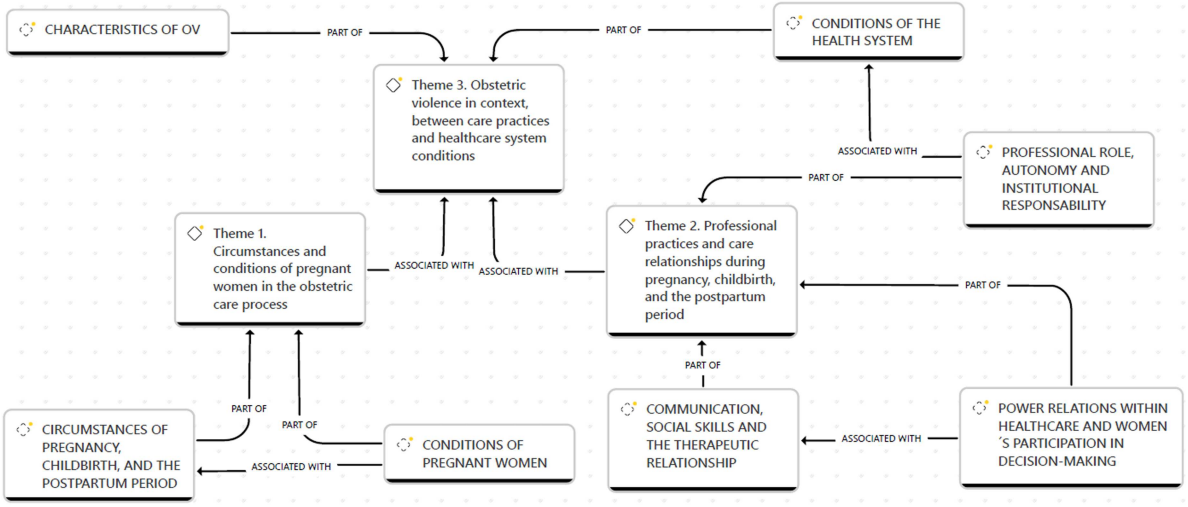

Figure 1. List of topics and subtopics.

Table IV. Dimensions of obstetric violence identified from midwives' accounts.

Dimension	Main elements described by participants	Potential implications for practice
Relational	Communication, informed consent, therapeutic relationship, women's participation in decisions.	Strengthen respectful communication and shared decision-making.
Professional	Professional autonomy, role boundaries, defensive practice, variable awareness of violence.	Support reflective practice and preserve midwives' scope of action.
Structural	Workload, staff shortages, rigid protocols, material constraints, inequalities between hospitals.	Improve staffing, flexibility, and continuity of care.
Social and contextual	Language barriers, socioeconomic inequalities, access to information, previous trauma.	Tailor care to vulnerability, culture, and informational needs.
Conceptual	Tension between women's lived experience and professionals' discomfort with the term "obstetric violence".	Promote nuanced terminology and critical dialogue in maternity care.

Women's emotional experiences and overall maternal and foetal well-being during pregnancy, childbirth, and the postpartum period depend to a large extent on the care dynamics established by midwives. These professionals are able to identify emotions and perceptions of safety, confidence, or fear that emerge at each stage, as well as to recognise how environmental conditions, the nature of professional interactions, and the support provided shape women's subjective experiences of childbirth. In this regard, the care context may function either as a space that fosters physical and emotional well-being or, conversely, as a setting marked by tension, anxiety, and psychological distress.

Maternal and foetal well-being are closely intertwined with women's emotional experiences in obstetric care. Midwives emphasise the importance of balancing clinical safety with respect for women's decisions and expectations, acknowledging that childbirth extends beyond a strictly biomedical event to become a deeply emotional, relational, and meaningful experience. This underscores the need for an empathetic and flexible professional approach in response to the inherent unpredictability of the process, alongside the promotion of transparent communication, continuous support, and a respectful, humanised care environment.

> *"I believe that women's wishes during childbirth should be prioritised and respected, provided that this does not place their own health or their baby's health at risk." (D8)*
> *"We always need to keep an open mind. Ideally, we would like every birth to be straightforward and positive, but we also have to recognise that things do not always unfold as expected. In those situations, it is essential to respect the woman's decisions as far as possible, to keep her fully informed, and to act in her best interests, with the aim that her overall birth experience is as positive as it can be and, of course, free from obstetric violence." (D3)*

It is also important to acknowledge that medical factors influence the course of pregnancy and childbirth, including diagnoses, underlying conditions, risk factors, and obstetric complications. In such contexts, midwives play a central role, as their actions shape the type of care provided, the degree of medicalisation of the process, and, consequently, women's perceptions of control or vulnerability.

Midwives reflect not only on clinical decision-making, but also on the emotional implications that arise when complications occur, as well as on the coping strategies adopted by both women and the healthcare team. When labour does not progress as anticipated, communication and respect for women's wishes become essential pillars of care.

> *"As long as an intervention is genuinely necessary, I would not consider it obstetric violence. That said, it is also true that at times we may do more than is actually required." (D7)*
> *"When complications arise, women are informed and we act in the best interests of both the woman and her baby. In that respect, I do feel that women are now much more respected. They are given greater decision-making power during labour and are provided with far more information about their options." (D9)*

Midwives also acknowledge that medical practices and obstetric interventions may be interpreted differently depending on each woman's experience. While some women perceive these interventions as supportive or beneficial, others associate them with a loss of control or experiences of obstetric violence.

> *"There are women who, when we talk about obstetric violence, are actually happy, in the sense of, 'I gave birth really fast', 'they broke my waters', 'they gave me oxytocin', you know, 'everything went so quickly'. Yes, there are women who agree with that, and that's fine. But women who do not agree with that, who have a different idea of what childbirth should be like, well… in those cases, obstetric violence does exist." (D5)*

Midwives emphasise the importance of maintaining a balance between clinical safety and respect for women's autonomy, particularly in situations where the course of labour requires immediate intervention.

Drawing on their professional experience, they recognise that appropriate obstetric management involves not only the exercise of technical judgement, but also ensuring that women understand the rationale and objectives behind each clinical decision.

At the same time, midwives acknowledge that perceptions of obstetric interventions may differ between professionals and women, leading to divergent interpretations of what constitutes appropriate, high-quality obstetric care. These situations underscore the complexity of care relationships and highlight the need to strengthen communication, informed consent, and sensitivity to women's individual expectations. Promoting women's active participation and guaranteeing their right to information are therefore key strategies for reducing perceptions of obstetric violence and fostering care grounded in trust, respect, and the humanisation of childbirth.

> *"When we are faced with an urgent situation, an emergency that takes priority, then the well-being of the mother and the baby comes first. But I still believe it is essential that she has all the information."* (D10)
> *"There are times when women consider as violence what we, from a professional point of view, see as good practice and appropriate care."* (D6)

Overall, the circumstances surrounding pregnancy, childbirth, and the postpartum period underscore the need for clear, respectful, and ongoing communication between healthcare professionals and pregnant women. Despite potential cultural barriers, priority must be given to safeguarding the well-being of both the mother and the baby, while ensuring that women receive clear and sufficient information to enable their active participation in decisions about their care.

Subtheme 1.2. Conditions of pregnant women

Midwives described women's personal and social circumstances as factors that shape how women may experience pregnancy and relate to the healthcare system. From midwives' perspectives, factors such as access to information, autonomy, social inequalities, and emotional well-being give rise to varying degrees of vulnerability or empowerment, resulting in diverse experiences and levels of engagement throughout obstetric care.

In their professional practice, midwives emphasise that women's attitudes and dispositions play a significant role in the development of the care process and in the quality of the therapeutic relationship. Some professionals note that certain women may adopt a defensive, distrustful, or seemingly disengaged stance, which can hinder dialogue and active participation in care. These attitudes are often linked to language barriers, previous negative experiences, or insufficient or unreliable information, which may generate reluctance towards medical interventions. Midwives therefore highlight the importance of empathetic and educational support aimed at building a relationship of shared responsibility and mutual trust. In this context, open communication and a receptive attitude on both sides are considered essential to fostering a positive and respectful childbirth experience.

> *"It really depends on the circumstances. Sometimes it is more difficult, especially with women who do not seem to be very engaged in the process they are going through."* (D4)
> *"Excessive information, or information that is sometimes confusing or misleading, can make women more reticent, distrustful, and reluctant to accept interventions."* (D10)
> *"It is a shared responsibility. As a professional, it is my responsibility to sit down with you, explain things, and support you, for example when you have difficulties with breastfeeding. But it is also your responsibility to make at least a basic effort to be informed."* (D1)

Midwives likewise recognise that women's empowerment and active participation in the obstetric process are fundamental pillars for ensuring respectful, violence-free care. They emphasise the importance of women being adequately informed and able to express their preferences, as this underpins informed consent and personal autonomy. However, they also caution that childbirth unfolds within a context of heightened physical and emotional vulnerability, in which power imbalances between healthcare professionals and women may constrain genuine participation. Within this context, even routine procedures can be perceived as violent when communication is insufficient or consent is absent.

> *"That woman needs to come in with a fairly clear idea of where she wants her care to go, or how she wants to be treated. That's why having a birth plan is important."* (D1)

"She needs to be informed so that she can give informed consent, as long as the decision she is making is beneficial for both her and her baby." (D9)
"We are talking about a setting in which women feel very vulnerable… and I think that has to be addressed by asking for permission and by involving her in every intervention that is carried out. It might be a routine obstetric procedure, such as a pelvic examination, but if it is done without the woman's consent or by forcing her, it can be considered obstetric violence." (D9)

Women's autonomy and empowerment depend largely on genuine access to information. Midwives note that, although active participation is actively promoted, it is not always achieved in practice. Some women show limited interest in being informed, while in other situations healthcare professionals themselves may restrict information, particularly when complications arise. As labour progresses, circumstances may change rapidly, along with the interventions required, which can affect communication and trust between women and the healthcare team. In this regard, midwives caution that withholding necessary information may also be considered a form of obstetric violence.

"I think it is extremely important for women to be informed, but in practice things are different. After all, this is not completely rigid. Decisions change, the interventions that need to be carried out also change, and that can greatly affect the woman's reaction and her relationship with the professional." (D10)
"A form of violence is also exercised against pregnant women and women in the postpartum period when they are not provided with all the information they need in order to give informed consent." (D1)

Socioeconomic conditions and structural inequalities also play a decisive role in shaping women's obstetric experiences and their ability to recognise situations that may constitute violence. According to midwives, women with higher levels of education and greater economic resources tend to be better informed and more alert to practices they perceive as inappropriate, often adopting a more vigilant stance and placing greater demands on healthcare professionals. By contrast, women in vulnerable situations, particularly those with limited resources or facing linguistic and cultural barriers, may be less likely to identify certain behaviours or interventions as violent. This places them in a position of increased dependence and passivity within the care relationship. Such gaps in information and health education can reinforce asymmetrical power relations, thereby limiting women's capacity to participate actively and to exercise control over their own bodies and the birthing process.

"There is a group of women who attend our birth centre who, in my view, are economically well off. They are well positioned financially and very well informed. As a result, they are much more alert to anything that could be experienced as obstetric violence. They are much more alert, really. (…) By contrast, women in unfavourable socioeconomic situations, immigrant women, these kinds of groups, are often not aware of obstetric violence. I would even say that the cases in which I have witnessed the most obstetric violence involve women who may have a language barrier." (D9)

The impact of obstetric care on women's mental health represents one of the most significant and enduring consequences of the reproductive process. Midwives recognise that negative experiences during pregnancy, childbirth, or the postpartum can have profound emotional consequences and, in some cases, evolve into lasting psychological trauma. Many women approach subsequent pregnancies with fear or anxiety rooted in previous unsatisfactory experiences, which in turn affects their confidence and their relationship with healthcare professionals. These perceptions underscore the need to integrate the emotional dimension into obstetric care by promoting support that prioritises empathy and the development of a strong therapeutic relationship.

"There are many degrees of obstetric violence, but clearly some of them can have a lasting impact on a woman's life in the years that follow, and in some cases, they may even remain as trauma for the rest of her life." (D1)
"There are women who arrive feeling afraid, especially those who, based on their own personal experience, have had a previous birth that they experienced as negative." (D2)

From midwives' perspectives, pregnant women's personal, social, and emotional circumstances play a decisive role in shaping their experiences of pregnancy and childbirth. Obstetric care, therefore, cannot be confined to clinical considerations alone, but must also account for the diversity of women's contexts in order to promote their overall well-being. Importantly, these findings do not represent women's direct accounts, but rather midwives' lived and professional interpretations of how women's circumstances shape care experiences and the possibility of obstetric violence.

From a hermeneutic perspective, these accounts suggest that midwives do not encounter obstetric violence as an isolated clinical event, but as something interpreted through women's vulnerability, social position, prior experiences, and capacity to participate in care. Their lived professional experience is therefore shaped by the need to constantly interpret whether care is being received as support, control, or violence, depending on the relational and contextual conditions surrounding each woman.

Theme 2. Professional practices and care relationships during pregnancy, childbirth, and the postpartum period

Theme 2 focuses on professional practices and care relationships. Midwives described communication, power relations, and professional autonomy as central factors shaping whether care was experienced as respectful, participatory, and safe, or as distancing and potentially violent. In this theme, the focus shifts more explicitly to midwives' own lived and professional experience of providing care, negotiating relationships, and interpreting when routine practice may become ethically troubling or potentially violent.

Subtheme 2.1. Communication, social skills, and the therapeutic relationship

Midwives emphasise that the way they communicate with women and manage the therapeutic relationship has a profound impact on how the reproductive process is experienced. Clear communication, respectful treatment, and the development of a relationship based on trust not only facilitate decision-making, but also help to prevent misunderstandings and negative experiences. These everyday interactions can make the difference between care that is experienced as humanised support and care that, conversely, may be perceived as violent.

Midwives described women's feelings of safety and trust in obstetric care as depending to a large extent on how professionals communicate with them. When the relationship is constrained by emergencies, high workloads, or limited time, women may feel insecure and perceive that they are not being adequately involved in decisions related to their care. By contrast, when communication is ongoing, clear, and participatory, women feel involved and valued, are better able to understand what is happening, and take on a more active role in their care. This, in turn, contributes to a closer, more respectful care experience.

> *"When there is no communication, which is often limited because of urgent cases, emergencies, or workload, then the woman may become a little… well, a little distrustful."* (D10)
> *"Humanisation goes a step further, because in that sense… it means counting on the woman, keeping her informed at all times, involving her, not taking anything for granted and… making her feel that her opinion matters, that the information belongs to her, always."* (D6)

Communication practices and the way information is conveyed to women influence not only how they understand the obstetric process, but also the relationships they form with healthcare professionals. This initial interaction lays the foundation for a bond that can either foster a sense of security or, conversely, generate uncertainty and resistance. This dynamic is particularly evident in midwives' accounts of the therapeutic relationship. When a human connection is established, even in situations where language barriers limit verbal communication, an atmosphere of closeness and support can still be fostered. By contrast, when the information available to women is incomplete or inaccurate, they may adopt a stance of doubt or opposition towards proposed interventions, which complicates care and weakens the therapeutic relationship.

> *"I always try to maintain a connection. If there is no shared language, then even through gestures, through eye contact… a therapeutic relationship can still be established."* (D9)
> *"Excessive information, or information that is slightly misleading, can make women reticent, distrustful, and reluctant towards any kind of intervention, procedure, or explanation…"* (D10)

Trust within the therapeutic relationship highlights that care is shaped not only by the information provided, but also by who conveys it and how it is communicated. From this perspective, professionals' sensitivity, training, and ways of working play a decisive role. Midwives acknowledge that their attitude and the quality of the care they provide can fundamentally transform the childbirth experience, influencing both obstetric outcomes and women's emotional experiences.

"It depends a great deal on the team and, of course, on the individual. I no longer think it is so much about the work setting itself, but rather about how each professional has lived through it, or how each one has been trained." (D10)

Communication and the therapeutic relationship are central to the provision of respectful obstetric care. When interactions are clear, consistent, and characterised by closeness, trust is strengthened and women are more likely to engage with confidence in their care. By contrast, when communication falters or distance is perceived in the professional relationship, mistrust may emerge and women may interpret the care they receive as violent.

Subtheme 2.2. Power relations in healthcare and participation in decision-making

Midwives point out that, in many cases, limited access to information places women in a position of strong dependence on professional judgement, thereby fostering paternalistic dynamics within obstetric care. When women accept recommendations without question, they relinquish involvement in decisions about their own care, reinforcing an unequal relationship in which professional authority prevails and women are expected to comply. These dynamics, which are particularly evident in settings where gynaecologists hold positions of authority, restrict women's ability to express themselves, make choices, and exercise control over their reproductive process, ultimately undermining their autonomy.

"It is a very authoritarian and hierarchical relationship between the gynaecologist and the pregnant woman, where the woman essentially complies with decisions that are being made on her behalf." (D1)
"There are people who trust completely, one hundred per cent, and do not even consider anything other than what the professional tells them. (…) I think this reflects a lack of information and education, because in my view no one should hand over their body and their process to someone else. Everyone should be the protagonist of their own process." (D4)

Against this backdrop of paternalistic dynamics, in which the gynaecologist's voice often prevails over women's preferences, midwives highlight the need to examine how women's genuine participation in their own care is constrained. In contrast to models where professional authority results in unilateral decision-making, some midwives describe practices aimed at fostering dialogue, attending to women's expectations, and adapting care plans to their wishes, even when clinical circumstances require alternative courses of action to be considered.

"As a doctor, there's often this idea that the final decision about procedures is made by the doctor, and that the patient basically has to go along with whatever decisions are being made." (D1)
"That's the very first thing I ask them when they walk through the door: how they would like the birth to be, what they have imagined… I also tell them that, within what they have imagined, reality can sometimes change, but that within those changes, we will try to make it as close as possible to what they had envisioned." (D5)

Midwives described power relations as continuing to shape women's actual participation in obstetric care, while also influencing how they themselves navigate their professional role within hierarchical care structures. Although efforts are being made to promote more shared decision-making, hierarchical dynamics, particularly within medical settings, still constrain pregnant women's autonomy.

Subtheme 2.3. Professional role and autonomy

Midwives' professional role and their degree of autonomy within the healthcare system emerge as key factors in both the prevention and the occurrence of obstetric violence. The ability to make decisions grounded in clinical and ethical judgement, together with the capacity to act independently within their scope of practice, enables midwives to provide care that is safe, respectful, and centred on the pregnant woman. By contrast, defensive medical practice, often driven by fear of complications or legal liability, may restrict professional autonomy and encourage unnecessary or routine interventions, thereby increasing the likelihood that women perceive the care they receive as violent.

Within the institutional context, midwives describe professional autonomy as a central condition for ensuring respectful, high-quality care. They emphasise that, in multidisciplinary settings, it is essential for each professional to act within the limits of their competencies and to retain the ability to intervene—or at least to raise concerns—when practices perceived as obstetric violence occur, whether these are enacted by gynaecologists or by other midwives. This capacity to express disagreement and negotiate care

decisions is viewed as crucial for safeguarding women's safety and upholding a humanised model of childbirth. Likewise, midwives stress the importance of preserving their own decision-making space within the care process, noting that others should not intervene prematurely or authoritatively in areas that fall within their professional responsibility.

> *"If at any point I feel that any of my colleagues, whether gynaecologists or fellow midwives, are engaging in some form of obstetric violence, I can speak up and try to talk to my colleague so that the care being provided is changed."* (D1)
> *"And it's also about respecting… well, everyone's professional boundaries. I'm a midwife, and I know how far I can go before I need to call you. Don't step in before that, don't put pressure on me before then (…) I know how I need to work."* (D6)

Midwives also draw attention to the pressure to avoid errors or legal claims, which often translates into defensive medical practices. Driven by concerns about potential complications or legal consequences related to professional conduct, this approach can restrict flexibility in practice and reduce the focus on women's individual needs. As a result, care may become more conservative and strictly protocol-driven, even in situations where labour is progressing within normal physiological parameters. In this way, fears of potential malpractice directly shape the style of care provided and influence how the experience is perceived by pregnant women.

> *"So I think that part of obstetric violence has to do with defensive medicine and with the fear professionals have that something might go wrong during the physiological course of a normal labour." (D2)*
> *"Maybe what one woman experiences as obstetric violence is not experienced in the same way by another (…) in the end, it is about anything that is done against the woman, of course, especially when techniques are used that are not recommended, or are even actively discouraged."* (D3)

Midwives emphasise that, within their professional role, autonomy and ethical responsibility are essential to ensuring respectful care centred on the pregnant woman. System constraints and fears of complaints or legal repercussions influence how professionals act, shaping both the quality of care they provide and the ways in which women may experience that care. Safeguarding clear professional boundaries and fostering collaborative, respectful working relationships that recognise the specific competencies of each team member are therefore key to promoting safe, woman-centred obstetric care. These findings show that midwives' lived experience of obstetric violence is deeply relational. They do not describe violence only as something women may suffer, but as something they themselves must interpret, negotiate, and sometimes resist within everyday care relationships. In this sense, their professional experience is marked by a continuous ethical tension between supporting women's autonomy and working within institutional and hierarchical constraints.

Theme 3. Obstetric violence in context: between care practices and healthcare system conditions

Theme 3 situates obstetric violence within broader healthcare system conditions. Midwives associated women's experiences not only with interpersonal practices, but also with workload, institutional rigidity, inequalities between centres, and regulatory pressures that shaped everyday obstetric care.

Subtheme 3.1. Healthcare system conditions

Midwives emphasise that healthcare system conditions have a direct impact on both the quality of care and women's experiences during pregnancy, childbirth, and the postpartum period. Patient safety and quality of care depend not only on professional competence, but also on institutional support, access to up-to-date technology, and adherence to the regulatory frameworks that govern obstetric practice.

Workload and stress levels strongly shape how midwives are able to provide care, with direct consequences for the quality and safety of obstetric services. When care demands are high and staffing levels are insufficient, the time available to inform women, provide continuous support, and promote their active participation is reduced. This often leads to more standardised or less individualised decision-making. Such overload does not rest solely on professionals, but also reflects institutional responsibility, as healthcare organisations are required to ensure adequate working conditions and sufficient resources. When these

structural limitations are not addressed, they may give rise to practices that women perceive as forms of obstetric violence, even in the absence of any explicit intention to cause harm.

"And then there are other factors, like stress and workload in hospitals. Because sometimes you're working under a lot of pressure, and that means you don't really have the time to explain things properly to the woman or give her the time she needs to decide about things that, in the end… you end up doing more automatically." (D9)
"Workload, of course. There are times when we're overwhelmed, and we may not provide the level of care we should. And sometimes women perceive this as obstetric violence, which in some cases may even be happening, perhaps even unconsciously." (D3)

Midwives acknowledge that the availability of material resources and the level of modernisation of obstetric services vary widely across healthcare centres and regions. While some hospitals have adopted more humanised and respectful approaches to childbirth care, progress remains slow in others, where rigid protocols continue to limit women's autonomy and restrict professionals' ability to adapt care to individual circumstances. This lack of institutional flexibility can hinder the implementation of a woman-centred model of care, generating tensions between individual needs and established standards of practice.

"In terms of overall development… when it comes to improving things and introducing new approaches in hospitals, like humanised childbirth, this is happening much more slowly in some regions." (D9)
"Many women assume that if a certain technique is being used, it must be the best option for them. But often it's simply because we don't have enough staff, or because we don't have other methods available." (D1)
"There are healthcare centres where protocols are already in place, and these protocols are very rigid, so the couple's decisions are not respected." (D2)

Midwives also note that hospital organisational models and access to obstetric care are far from uniform, as they are shaped by institutional, territorial, and sociocultural factors. They highlight substantial differences between hospitals and autonomous communities in terms of the range of birthing options available and the extent to which humanised models of care have been implemented. In addition, they warn that women with lower socioeconomic status, limited access to information, or who belong to certain cultural contexts tend to have fewer opportunities to make choices or actively participate in their care. These structural inequalities restrict equity in obstetric care and perpetuate disparities in the quality of care provided.

"If you have a certain level of education, or the ability to access certain services or information, then yes, those options are offered to you. But if you don't have that level of access, or because of your cultural background (…) you may simply not be given those options. You are no longer seen as someone who should be informed about all the possibilities available." (D8)
"It's not possible in all hospitals, and it's not possible in all autonomous communities either. As I said, there are big differences between hospitals. Some are still trying to change, and I want to believe that, in the long run, things will improve." (D9)

Midwives express ambivalent views regarding regulations and the legal framework surrounding obstetric care. While they acknowledge the importance of regulatory measures to protect women's rights and ensure respectful care, they also report that the increasing institutional and media focus on obstetric violence can generate professional insecurity. Some describe how regulatory pressure and the fear of being publicly questioned or blamed shape their everyday practice, leading to more defensive and less spontaneous forms of care. According to the midwives, this climate may undermine the natural flow of the care relationship and shift the focus away from women's needs towards legal self-protection, ultimately weakening trust and communication between professionals and pregnant women.

"Sometimes, for real change to happen, for people to actually become aware of it, I think stronger words are needed so that… especially women understand what this really involves. (…) But at the same time, now there are moments when everything gets labelled as obstetric violence without much justification, and we need to be careful with how we use that terminology." (D9)
"It makes us work in self-protection mode. No… I don't think it's helping our profession. We don't have that freedom anymore to just… I don't know, before, you always thought: we're going to take good care of this woman, she'll feel well cared for, she'll trust us. But now, with this whole… trend around obstetric violence, you start thinking: how is she going to take this? And you end up protecting yourself all the time, protecting yourself a lot with paperwork and with how you phrase things. And I think you lose some of that naturalness, that connection." (D6)

Taken together, midwives' accounts indicate that structural features of the healthcare system, including resource availability, institutional organisation, and the regulatory environment, play a decisive role in shaping both the quality of care and its capacity to be delivered in a humanised manner. High workloads, material constraints, inequalities between healthcare centres, and increasing legal pressure create a context that can significantly constrain midwives' professional practice.

Hermeneutically, these accounts suggest that midwives understand obstetric violence not only through individual care encounters, but also through the structural conditions that shape what kinds of relationships and decisions are possible in practice. Their interpretations reveal that obstetric violence is negotiated within a field of tension between institutional constraints, professional responsibility, and women's lived experiences of care.

Sub-theme 3.2. Characteristics of obstetric violence

Obstetric violence emerges as a complex phenomenon encompassing individual, cultural, institutional, and professional dimensions. Its definition remains contested, both because of the wide range of practices it includes and because of the debates surrounding the term itself, particularly its political and gendered connotations. From the midwives' perspective, obstetric violence cannot be separated from the cultural and structural factors that sustain it; at the same time, they reflect on the ethical responsibility of those involved in maternity care and on the different forms of violence that may arise in everyday clinical practice.

Midwives express ambivalent views regarding the concept of obstetric violence. On the one hand, they acknowledge that certain practices can cause genuine harm to women and consider the term useful for drawing attention to situations involving violations of women's rights. On the other hand, they report discomfort with a label they perceive as accusatory, as it may imply intentional harm on the part of healthcare professionals, an interpretation they firmly reject as inconsistent with their professional ethos. This tension makes it more difficult to distinguish between practices that are inherently harmful and situations arising from adverse obstetric outcomes or negative subjective experiences that are not linked to a deliberate intent to cause harm.

> *"Maybe another word would be more appropriate, but the truth is… what is being done really is violence."* (D4)
> *"It's quite aggressive, honestly. Because it gives the impression that the professional wants to cause harm, and I really believe that never… I mean, even if you have carried out acts of obstetric violence, you have never thought that you were going to harm that woman."* (D8)
> *"I think it's too much, and I think that any disagreement with the woman, or when the woman has not achieved that ideal birth, is called violence."* (D6)

From the midwives' perspective, obstetric violence is viewed as an infrequent and exceptional occurrence rather than a routine feature of everyday care. They describe it as arising mainly in specific situations characterised by urgency, high care pressure, or inadequate communication, rather than as a systematic or widespread practice. At the same time, they acknowledge varying levels of professional awareness, noting that certain behaviours are not always recognised as problematic by those who enact them. As a result, perceptions of obstetric violence are not uniform: situations may arise in which professionals do not consider their actions inappropriate, while women experience them negatively because they do not align with their expectations or wishes, even when care is provided according to professional standards.

> *"It obviously still exists, and I believe it will never be completely eradicated, because there will always be situations in which you, as a professional, will not perceive obstetric violence, but the patient will perceive it as such, because it is not what she would have wanted, even when there is no other option."* (D8)
> *"I don't think it happens every day or everywhere. I think it's more of an exception to… sometimes, actions that are taken that are not communicated well, or that we are forced to take because of nerves and the emergency, but very occasionally, very occasionally."* (D6)

Midwives understand obstetric violence as closely connected to gender-based violence. They argue that these practices cannot be examined in isolation, but rather as the outcome of a historical transformation in childbirth care. What was once a domestic, physiology-centred process supported by midwives gradually shifted into the hospital setting, where it became largely controlled by medical professionals. This transition led to the progressive medicalisation of childbirth and to the displacement of women from a central role in their own reproductive process.

Within this context, midwives highlight that the gradual empowerment of women and increased access to information have played a key role in rendering visible practices that were previously normalised or silenced. Growing social awareness and the articulation of reproductive rights have enabled women to reclaim a voice and greater decision-making power, bringing into question forms of care that are now increasingly recognised as manifestations of obstetric violence.

> *"Obstetric violence is a type of gender-based violence, it is a form of violence against women."* (D4)
> *"There is a culture of machismo and paternalism where women have never had a say in matters concerning their health, and little by little, we are taking control of our decisions and, of course, now is when these situations are coming to light."* (D3)

Building on this understanding of obstetric violence as a violation of women's consent and autonomy, midwives extend their analysis to a broader structural dimension of the problem. They argue that many of these situations cannot be attributed solely to individual professional decisions, but are embedded within forms of institutional violence shaped by excessive workloads, shortages of human and material resources, and barriers to accessing healthcare services. Within this context, non-consensual interventions may become normalised and, in some cases, practices lacking scientific justification persist. Midwives identify these practices as particularly harmful and clearly situated within the scope of obstetric violence.

> *"For me, obstetric violence is any act committed against women of sexual and reproductive age that is not consensual, authorised, or validated by the woman herself."* (D4)
> *"Techniques that I consider to be directly violent, and even more so when there is no evidence to support them, because then I consider this to be even more obstetric violence."* (D9)

From this perspective, midwives stress that obstetric violence cannot be reduced to a single form of expression, but instead encompasses multiple, interconnected dimensions that mutually reinforce one another. In their accounts, they describe how such practices may appear in both subtle and overt ways, ranging from symbolic forms that are often normalised or even internalised by women themselves, to manifestations of a psychological or sexual nature. This multiplicity broadens the scope of obstetric violence and underscores the complexity of the phenomenon.

> *"It's because it's not just obstetrics; it's also sexual, gynaecological, it affects partners, children too. I mean, it encompasses… I think obstetrics almost falls short."* (D4)
> *"They attack a bit, well, they affect her health, her well-being, not so much physically, but also psychologically."* (D10)
> *"Obstetric violence exists on a continuum, from a low level to a serious and significant level that has an impact on that woman's mental health."* (D1)

Overall, midwives conceptualise obstetric violence as a complex and multifactorial phenomenon that is not always intentional and is shaped by cultural, gendered, and institutional factors. They acknowledge both the conceptual debates surrounding the term itself and the persistence of normalised practices that are clinically contraindicated and may lead to negative experiences for women. From their perspective, making these realities visible and strengthening professional awareness are essential steps towards more respectful and ethical obstetric care, focused on safeguarding both the physical and emotional well-being of pregnant women.

Discussion

The aim of this study was to explore how midwives understand, experience, and interpret obstetric violence in delivery room settings, including its perceived causes and contextual conditions. The findings show that, from midwives' perspectives, obstetric violence is a complex and multifactorial phenomenon shaped by the interaction of women's vulnerability, communication practices, professional roles, institutional organisation, and wider structural conditions.

A central finding was the tension between professional intent and women's lived experience. Participants repeatedly expressed discomfort with the term obstetric violence because they associated it with an accusation of deliberate harm, which they considered inconsistent with the ethos of maternity care. At the same time, their accounts acknowledged that women may experience care as invasive, disempowering, or dehumanising even

when professionals believe they are acting appropriately or in accordance with clinical standards. This tension suggests that obstetric violence should not be analysed solely in terms of intent, but also in relation to its relational, emotional, and experiential consequences (Freedman & Kruk, 2014; Lappeman & Swartz, 2021).

This interpretation is consistent with literature that frames obstetric violence and mistreatment in childbirth as phenomena embedded in broader systems of care, power, and accountability rather than as isolated acts of individual wrongdoing (Bohren et al., 2015; Freedman & Kruk, 2014; Sadler et al., 2016). In this sense, the present findings support a more integrative understanding that connects rights-based and gender-sensitive perspectives with analyses of structural violence, institutional culture, and everyday professional practice (Bohren et al., 2015; García, 2018; Lappeman & Swartz, 2021; Nagle & Samari, 2021; Sadler et al., 2016).

Communication emerged as one of the most important dimensions across the interviews. Midwives consistently associated respectful care with clear information, involvement in decision-making, and a therapeutic relationship based on trust. Conversely, insufficient explanation, poor timing of information, or lack of meaningful consent could transform even clinically indicated procedures into experiences perceived as violent (Martínez-Vázquez et al., 2021; Moncrieff et al., 2022; Van der Pijl et al., 2024). This finding aligns with previous studies showing that consent processes, communication style, and women's sense of agency strongly influence how childbirth care is experienced (Alrida et al., 2025).

The findings also highlight the role of women's social and emotional circumstances. Midwives described how language barriers, limited access to reliable information, socioeconomic inequalities, previous traumatic experiences, and variable levels of empowerment shaped women's vulnerability within obstetric care. These accounts suggest that obstetric violence cannot be detached from the unequal distribution of informational, cultural, and relational resources that enable women to participate actively in childbirth decisions (Cook et al., 2018; Dikmen Yildiz et al., 2017; Fraser et al., 2025; Martínez-Vázquez et al., 2021).

Importantly, the interviews placed strong emphasis on structural and organisational factors. High workload, staff shortages, institutional rigidity, lack of material resources, and regional inequalities were described as conditions that constrained communication, reduced the possibility of individualised support, and encouraged routinised or defensive practice (Wallace, 2020). These findings indicate that obstetric violence should not be understood as a problem located only at the level of individual professionals. Rather, the healthcare system itself may generate conditions under which respectful, woman-centred care becomes more difficult to sustain (Bohren et al., 2015; Martínez-Galiano et al., 2021; Reddy et al., 2022; Sadler et al., 2016).

This structural dimension is especially relevant in relation to professional autonomy. Midwives described autonomy as protective because it enabled them to advocate for women, adapt care to individual circumstances, and challenge practices they considered inappropriate (Simmelink et al., 2023). However, they also reported that fear of complaints, medico-legal exposure, and hierarchical professional cultures could encourage defensive practice and reduce the flexibility needed for woman-centred care. This finding resonates with work suggesting that organisational culture and provider working conditions directly shape respectful maternity care (Bohren et al., 2015; Pérez-Castejón et al., 2025; Reddy et al., 2022).

The study also contributes to ongoing conceptual debates around the term obstetric violence. Participants' narratives suggest that conceptual resistance to the term is not simply rhetorical; it reflects deeper tensions between professional identity, accountability, and women's interpretation of care. Rather than resolving this tension by choosing either a purely accusatory or purely exculpatory position, the findings support a more nuanced approach that recognises both the reality of women's harmful experiences and the fact that these experiences are often produced within structural and relational conditions rather than through explicit malicious intent (Lappeman & Swartz, 2021).

Taken together, the findings reinforce the need to address obstetric violence at multiple levels simultaneously: communication and informed consent; women's participation and empowerment; professional education and reflexive practice; and organisational conditions such as staffing, continuity of care, and institutional support for woman-centred models (Afulani et al., 2019; Tunçalp et al., 2015). Focusing only on individual behaviour would risk obscuring the structural conditions that shape how care is delivered and experienced.

Rather than pointing to a single source of harm, the analysis shows that midwives interpret obstetric violence as something produced and negotiated within tensions between women's autonomy, professional responsibility, and the structural realities of maternity care.

Limitations of the study

This study has several limitations that should be considered when interpreting its findings. First, it focuses exclusively on midwives' perspectives and does not incorporate the views of women, obstetricians, nurses, or other maternity care professionals. As a result, the findings illuminate one important perspective on obstetric violence, but not the full dialogical complexity of the phenomenon.

Second, participants were recruited from only two public hospitals in Andalusia and Catalonia. Although this allowed in-depth exploration of experiences across two contexts, the study was not designed as a regional comparison, and the findings cannot be readily transferred to other autonomous communities, private healthcare settings, or other national contexts.

Third, as in all qualitative research based on personal narratives, the findings are shaped by participants' perceptions, recollections, and professional self-understandings, and may be influenced by social desirability or retrospective interpretation.

Future studies should therefore integrate the perspectives of women and other professionals and explore how obstetric violence is negotiated across multiple voices and care settings.

Practical and organisational implications

From an applied perspective, the findings suggest that reducing experiences of obstetric violence requires interventions at both relational and structural levels. Communication, informed consent, and shared decision-making should be strengthened through continuing education for midwives and other maternity care professionals, with specific training modules focused on respectful maternity care, relational ethics, and women-centred communication (Afulani et al., 2019).

At the organisational level, workload management, adequate staffing, and continuity of care should be prioritised so that professionals have sufficient time to explain procedures, support women's preferences, and adapt care to individual circumstances. Institutional protocols should explicitly prioritise women's autonomy, informed consent, and participation, while remaining flexible enough to accommodate person-centred practice.

The findings also point to the importance of creating working environments that support midwives' professional autonomy and reduce the defensive pressures associated with medico-legal fear. Service-level review of staffing models, documentation requirements, and escalation pathways may help create conditions under which respectful, safe, and humanised care is more feasible in everyday practice.

Addressing obstetric violence through a comprehensive approach that simultaneously considers communication, professional practice, service organisation, and the wider institutional context therefore emerges as a key strategy for improving childbirth experiences and maternity care quality.

Conclusions

The findings of this study indicate that obstetric violence is a complex and multifactorial phenomenon shaped by women's vulnerability, professional practices, care relationships, and healthcare system conditions. From the perspective of midwives, effective communication, informed consent, a trust-based therapeutic relationship, and women's active participation are essential to preventing situations experienced as violent and to promoting respectful, humanised care.

At the same time, structural factors such as work overload, shortages of human and material resources, institutional rigidity, and professional hierarchies directly influence the care environment and may limit the capacity to provide individualised support. Midwives recognised that consciously violent practices were uncommon, yet they also acknowledged that interventions performed in accordance with clinical routines could still be experienced negatively by women, especially when information was insufficient or autonomy was compromised.

These findings suggest that obstetric violence should not be interpreted only in relation to individual intent, but also in relation to its relational, structural, and experiential dimensions. Midwives' experiential knowledge therefore represents a valuable resource for advancing maternity care models grounded in respect, safety, and women's empowerment.

By making visible how obstetric violence is interpreted and negotiated by midwives in everyday care, this study contributes to a more nuanced understanding of the phenomenon as relational, contextual, and institutionally mediated.

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Data availability statement

Data available under reasonable request to the corresponding author.

Ethical statement

Ethical approval was granted by the relevant research ethics committee under study code OMOSVO-2024. The management teams of the centres where the research was conducted were duly informed and they provided written authorisation for its implementation. The project was carried out in accordance with the provisions of Spanish Law 14/2007 on Biomedical Research.

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