

Obstetric Violence in Italy: From Theoretical Premises to Court Judgments

D. Morena¹, L. De Paola¹, M. Ottaviani¹, F. Spadazzi¹, M.V. Zamponi¹, G. Delogu¹, N. Di Fazio¹

¹Department of Anatomical, Histological, Forensic and Orthopaedic Science, Sapienza University of Rome, Rome, Italy

Abstract

Introduction. Historical mistreatment and violence directed toward women's bodies extend to the field of medicine, and obstetric and gynecological practices are not immune to such misconduct. Obstetric violence (OV) refers to actions involving disrespectful, abusive, or coercive treatment directed at pregnant and birthing women. This includes institutional and personal attitudes that lead to the violation of women's autonomy, human rights, and sexual and reproductive health. Despite various international legislative initiatives and recommendations from the World Health Organization (WHO) addressing disrespectful and abusive treatment, OV is still poorly known to Italian public opinion. This study aims to investigate whether the concept of OV has been conversely assimilated in judicial decisions.

Materials and methods. A retrospective analysis was conducted to scrutinize judgments in Italy until June 2023 related to OV. The Italian legal database 'De Jure Giuffrè', which collects sentences by various Courts, and the terms 'obstetric' and 'violence' as keywords were used for the research.

Results. The full-text revision of the results (n. 41 sentences) allowed the selection of 5 eligible contributions covering the following issues: Informed Consent, Kristeller maneuver, Vaginal Birth After Cesarean (VBAC), Acceleration of childbirth without indication, and Episiotomy. The analysis of individual judgments was complemented by an examination of the key issues involved.

Conclusions. The reviewed judgments frequently seemed to be grounded in technical aspects and inclined towards a predominant evaluation of childbirth outcomes. However, some encouraging aspects emerged, particularly in terms of attention to the female body, acknowledgment of consequences within the intimate-relational dimension, and a commitment to the principle of self-determination through the provision of free and informed consent. Ensuring the psychophysical well-being of women and unborn children, fostering positive interactions between pregnant women and medical staff, and actively working to reduce the grounds for litigation are among actual emerging priorities in healthcare.

In this sense, fundamental elements include the implementation of continuous staff training and education as well as a focus on promoting the self-determination of women, leveraging new technologies for this purpose, and ensuring legal protection of their rights. *Clin Ter* 2024; 175 (1):57-67 doi: 10.7417/CT.2024.5034

Keywords: *Obstetric Violence, Female Body, Informed Consent, Kristeller Maneuver, Vaginal Birth After Cesarean (VBAC), Acceleration of Childbirth, Episiotomy*

Correspondence: D. Morena, email: donato.morena@uniroma1.it

Introduction

The history of women is marked by a red thread of violence that has crossed all the ages of humanity (1). Despite advancements in recent decades, various forms of violence against women persist, albeit in very different ways. A specific area that is garnering increased attention is obstetric-gynecological care, where violence against women is manifested in the form of 'obstetrical violence' (OV). In recent years, OV has become a prevalent topic in public debate, attracting growing interest from governments, international associations, and social activism movements (2). This concept was first elaborated in Latin American countries, propelled by protest movements advocating for the autonomy of women during pregnancy and childbirth (3). In 2007, Venezuela became the pioneering country to legally recognize the term 'obstetric violence', providing an official definition for the concept, defined in the 'Ley Orgánica sobre el derecho de las mujeres a una vida libre de violencia', at art. No. 15, as "the appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanized treatment, an abuse of drugs, and to convert natural processes into pathological ones, bringing with it the loss of autonomy and the ability to freely decide about one's body and one's sexuality, with a negative impact on the quality of life of women" (4). Per art. No. 51 of the same Law, OV is defined by the provision of inappropriate and ineffective assistance in obstetric emergencies as: i) compelling the woman to lie on her back with her legs raised when a vertical birth is feasible; ii) impeding early mother-child union and/or early breastfeeding without medical justification; iii) obstructing the presence of a companion, and, in general, disrupting the natural process of a low-risk birth without medical indication and/or without the woman's consent.

In 2014, the World Health Organization (WHO) released a statement titled 'The Prevention and Elimination of Abuse and Disrespect during Assisted Delivery in Hospital Facilities' (5), although it did not explicitly use the term 'obstetrical violence'.

The statement contains a list of "disrespectful and abusive treatments", such as "outright physical abuse, profound humiliation and verbal abuse, coercive or unconsented medical procedures (including sterilization), lack of confi-

dentiality, failure to get fully informed consent, refusal to give pain medication, gross violations of privacy, refusal of admission to health facilities, neglecting women during childbirth to suffer life-threatening, avoidable complications, and detention of women and their newborns in facilities after childbirth due to an inability to pay" (6).

One of the significant challenges in monitoring and addressing the phenomenon of OV stems from the lack of clear defining boundaries. There is no international unanimity on how to define abusive practices and assess them. Consequently, obtaining reliable epidemiological data on OV and its consequences becomes challenging, impacting the ability to implement effective measures to counteract it (7).

Generally, the definition of OV includes acts related to women's reproductive and sexual health. This includes the excessive use of medical procedures, the administration of treatments and medication without consent, and a lack of respect for the female body and the freedom of choice regarding interventions on it. The process of progressive medicalization, especially the integration of complex physiological events such as pregnancy, childbirth, puerperium, and lactation, into a medical framework historically focused on disease treatment, inevitably poses a critical issue (8).

Recently some studies have attempted a systematic classification of practices that can be characterized as 'abusive', identifying several types of behavior, summarized in 7 categories: (1) physical abuse; (2) non-consenting care; (3) non-confidential care; (4) undignified care; (5) discrimination based on specific attributes of the woman; (6) neglect, denial, or negligence of care; and (7) detention in health facilities (6).

Some scholars have expressed reservations about the use of the term 'violence' in reference to procedures performed or omitted by healthcare professionals who often find themselves acting in conditions where the 'best interest' of the woman and the fetus may be in conflict, with implications for malpractice liability (9). Therefore, it has been suggested to replace the term OV with 'obstetric mistreatment' (10).

However, this proposal does not capture the broader dimension of the term 'violence', which encompasses cultural, social, and institutional aspects, including the disempowerment of women from decisions about maternity and structural healthcare deficiencies, as well as the subjective perception of women's experiences (11).

As mentioned, a crucial aspect is a woman's personal perception of feeling subjected to violence, which is more decisive than the individual act itself. Effectively, OV has ontologically different aspects compared to other forms of violence, even within the healthcare field.

As gender-based violence is directed against healthy women, and even more marginalized gender groups such as pregnant transgender individuals, OV effectively represents a feminist issue as part of the broader patriarchal oppression of women (12).

In recent years, cultural changes have drawn attention to OV due to increased awareness among women about their rights and a greater propensity to report abuses. Several international studies also indicate that this phenomenon is reported by both women and health professionals, not only in low-income countries but also in high-income ones (13,14),

with a prevalence of up to 30% of women admitting having suffered a subtype of OV during childbirth (15).

OV represents a critical problem also from a prognostic standpoint, leading to serious and multifaceted consequences. Beyond physical implications, there are psychological repercussions, including persistent nightmares, panic, fear of childbirth, severe stress, and disorders such as acute postpartum stress disorder, post-traumatic stress disorder (PTSD), postpartum depression, and even conditions burdened by suicidal ideation (16,17). Reactivation of a previous PTSD can also occur because OV can be experienced as re-victimization (18).

The consequences, distinct from directly affecting women who have experienced violence during childbirth, can also indirectly involve their partners and the newborns (17,19). Furthermore, recent studies suggest that staff who witness this type of violence may also experience secondary traumatic stress in response to their involvement in traumatic births (20).

In this regard, a recent Italian study has indicated that more than half of health professionals in the obstetrics-gynecological field express concerns about the quality of communication with women and family members, and less than a third are satisfied with training and supervision related to the consent request process (21).

Similar findings have emerged from international studies conducted with birth workers, including doulas, childbirth and labor educators, and delivery nurses (22). More than half of the interviewees reported having witnessed procedures against a woman's will, and almost two-thirds witnessed procedures performed without giving the woman the choice or time to consent.

These analyses also mark a turning point in the objection that OV is not a genuine form of violence, as it is unavoidable and unintentional because health professionals care for the health of women and children according to the principle of beneficiary.

Irrespective of the legal implications of the psychological aspects of 'guilt' for violent acts, it becomes evident how cultural and institutional conditions can play a decisive role in perpetuating violence against women. Attention should be directed towards these aspects.

On the other hand, the traumatic consequences of OV can compromise trust in the healthcare systems, discouraging the use of maternity assistance services and women's healthcare, and exercising a deterrent role to further pregnancies (23,24).

In Italy, since the middle of the last century, the swift transition that led to the transfer of an intimate event like childbirth from the domestic family environment to hospitals was driven by the necessity to implement specialized medical and technological measures to mitigate the risk of complications for both the mother and the unborn children (25).

This process of medical care for pregnancy, childbirth, and the postpartum period, defined in Italy as the 'birth path', is ongoing in most countries worldwide (13) and has demonstrated its ability to ensure a substantial improvement and significant reduction both in maternal and infant morbidity and/or mortality.

However, insufficient attention has been given to the consequences of these changes. While it is universally reco-

gnized that the course of treatments must be fully and freely agreed upon by doctors and patients, this decision-making process is intuitively simpler when there are clear indications for a specific pathology and when people are solely responsible for their bodies. Pregnancy and childbirth represent unique events in a hospital setting, where healthcare professionals are tasked with sharing the diagnostic-therapeutic path with a woman burdened with the dual responsibility of safeguarding her health and that of the unborn child.

For instance, certain treatments (e.g., Kristeller maneuver or episiotomy) may not have been pre-agreed upon by professionals and pregnant women; alternatively, pregnant women may need to provide consent for a treatment considered urgent by the healthcare staff, often in situations of intense psychological and physical stress.

In such cases, the full validity of the consent is also of questionable legitimacy. It is precisely in this context that OV can manifest, stemming from the more or less conscious abuse of autonomy and the right to self-determination of pregnant women (8).

Finally, OV extends beyond individual acts and encompasses the broader issue of the quality of healthcare facilities. The ability of healthcare professionals to provide and promote best practices could be impacted by the precarious conditions of healthcare systems and working conditions (26). In this perspective, OV also represents a crucial matter of public health and institutional interest, including the legal dimension.

The present study aimed to focus on the data from Italian legal databases in search of the term 'obstetric violence' to assess the extent to which this concept has entered jurisprudential considerations and what impact it can have on the obstetrics-gynecological clinical field. Finally, we have sought to highlight the main repercussions in the context of gender and individual violence and what feasible proposals for change exist.

Materials and methods

A retrospective analysis was conducted to examine judgments issued in Italy until June 2023 related to OV. The research utilized the Italian legal database 'De Jure Giuffrè', which includes sentences pronounced by various Italian Courts such as the Constitutional Court, the Civil Cassation and the Criminal Cassation, along with 64 other authorities, both of legitimacy and merit. The terms 'obstetric' and 'violence' were used as keywords for the search. As this is an observational retrospective study, the involvement of our hospital ethics committee was not required, and obtaining informed consent was deemed unnecessary. Similar methodologies have been employed in previous studies conducting retrospective analyses on medico-legal issues within Italian healthcare settings (27).

Results

The application of the search strategies reported above enabled the finding of 41 sentences: 1 sentence of Civil Cassation, 14 sentences of Criminal Cassation, 16 sentences

of the first instance Court, and 10 sentences of the second instance Court (Court of Appeal). The full-text review allowed for the selection of 5 eligible contributions that addressed the following points: Informed Consent (1 case); Kristeller maneuver (2 cases); Vaginal Birth After Caesarean (VBAC, 1 case); Incongruous acceleration of delivery (1 case), and Episiotomy (1 case). Therefore, we have, proceeded to examine the individual issues, including the jurisprudential cases that emerged from the research.

Informed consent

The protection and guarantee of women's right to self-determination and free and informed consent during pregnancy, childbirth, and postpartum assume a primary role (28).

The issue becomes even more relevant when one considers that in recent decades, in Italy and other Western countries, there has been an increasing use of unnecessary medical practices in the so-called 'birth path' (29). In maternal care, there is now an acknowledged gap between evidence and clinical practice, reaching rates far higher than they should be based on the recommendations published by the WHO (30).

Such rates can be seen as indications of the misuse of unnecessary medical interventions. Similarly, Evidence-Based Medicine highlights the inappropriate use of certain medical practices as unnecessary and associated with poor perinatal outcomes for both women and infants in terms of physical and psychological-emotional well-being (31,32).

To reduce the inappropriate use of some practices, it would be helpful to provide communication in advance about the possibility that some of these practices may be necessary in certain circumstances, including urgency (33).

Similarly, it should be explained promptly what these practices consist of, to permit an independent and free choice by pregnant women. Indeed, it's worth noting the *vulnus* in the therapeutic alliance with healthcare providers when the procedures implemented are not agreed upon, leading women to feel deprived of their self-determination during a particular moment of their life.

Therefore, there appears to be a clear need for women to reappropriate an active, central, and competent role. However, in this view, special emphasis should be placed on informed consent, which, even from a medico-legal perspective, plays a central role in understanding and choosing the best possible treatment during all stages of pregnancy (34).

Information is a precise right of citizens in their capacity as patients and is based on the Convention for the Protection of Human Rights and Dignity of Human Beings (35).

Despite such recognitions, literature reports cases of evident violations against women's self-determination. Diaz-Tello (36), for instance, recounts several instances of American women who were forced by medical staff, even with threats of legal consequences, into undergoing a Caesarean section (C-section), avoiding proceeding with the VBAC, in the 'best interests' of the woman, her family, and her unborn child.

It should be emphasized that during pregnancy, urgent situations may arise that cannot be prevented despite being foreseeable. These situations require timely medical inter-

vention and do not always allow for the implementation of adequate information about the procedure to be performed. Therefore, although the formation and signing of informed consent are fundamental moments in the doctor-patient relationship, especially in gynecological-obstetric situations, there may be peculiar problems that make appropriate consensual acquisition difficult, if not impossible (37).

VBAC

The maxim “once a Caesarean, always a Caesarean” (38) remained a prevailing belief until more recent times, when the option of having a vaginal birth was gradually embraced even after a previous cesarean section. This change was advocated by the WHO to decrease the global rate of C-sections (39).

In the UK, the rate of cesareans increased from 9% in 1980 to 23% in 2006 (40). In the United States, it rose from 19.7% in 1994 to 29.1% in 2004. In Italy, currently, the average national percentage is 31.12%, with a high tendency to use cesareans in accredited nursing homes, where this procedure is recorded in about 45.3% of births (41).

Italy is one of the countries with the highest rates of cesareans globally. Cesarean births are more frequent in women with Italian citizenship than in foreign women, at 32.4% compared to 27.2%. There is also significant variability by geographical area and between regions, ranging from 19.6% in the Autonomous Province of Trento to 50% in the Campania Region (41). Across all regions, the annual rates of cesareans and VBAC appear to be inversely related (42).

The balance between the two procedures has been dynamic over time, and both have their pros and cons. On the one hand, the perception of the risk that cesarean birth would negatively impact future fertility has diminished, influencing women’s choices towards elective cesareans. On the other hand, the concern among health professionals about facing accusations of malpractice has grown over time, leading to a preference for choosing C-sections over VBAC (43).

Moreover, it should be noted that hospital gynecological services are provided to healthcare facilities in very different ways. For a vaginal birth, the amount paid by the Italian National Health Services varies between 1,300 and 1,600 euros, whereas for a cesarean birth, it varies between 2,000 and 2,800 euros. This financial aspect could have a considerable influence on the propensity of health professionals to choose the surgical cesarean section (44).

These data become even more critical in light of the success rate of VBAC, which is generally greater than 60% (45). This procedure also presents several additional advantages: children born through vaginal birth will have a lower incidence of asthma (46), type 1 diabetes mellitus (47), neoplasms (48), obesity up to 5 years of life, allergies (49), ulcerative colitis (50), gastroenteritis (51), arthritis, and metabolic syndromes (52). There are also numerous advantages for women (53), including a reduction in intra-operative death rates, composite maternal morbidity, post-partum hysterectomy, amniotic fluid embolism, and a decrease in the long-term consequences on maternal health, such as abnormal placentation, a risk that tends to increase with the number of cesarean sections (54-59).

Case 1. A case concerning Informed Consent and VBAC

The case pertains to judgment No. 95 issued by the Court of Pavia in the year 2020 (60). A claim for compensation for non-patrimonial damage, which refers to harm not directly tied to financial or economic losses but encompasses physical damages, emotional distress, pain, suffering, and violations of personal rights, was filed by a pregnant woman at 40 weeks and 3 days gestation. This was her second pregnancy, following a previous C-section.

The claim originated from alleged OV, wherein the woman, who had expressed her desire to give birth vaginally, underwent a situation that resulted in emotional distress and perceived violations of her rights during the childbirth process.

She was hospitalized for checkups and informed that the possibility of proceeding with vaginal childbirth would be evaluated. However, she was asked to sign the surgery consent form for “mere safety, to avoid, in an emergency circumstance, a waste of time”. After signing the informed consent, she was reminded that the operating room “was ready”, and that the C-section would be performed immediately. The woman also complained of emotional distress, the ineffectiveness of anesthesia, and a lack of empathy from healthcare providers. Finally, she complained that consent to surgery had been obtained with a misleading proposal and that the promise to wait was false since she had been transported directly to surgery after signing.

The judges noted that a distinction needed to be made between non-patrimonial damage stemming from subjective suffering and the damage resulting from the violation of the right to self-determination. However, in the present case, the plaintiff had specifically sought compensation for non-patrimonial damage resulting from OV.

Regarding OV, the judges based their assessment on the premise that the woman had been informed days before the procedure about the potential complications of vaginal childbirth. According to the judges, the claimant herself was aware of the medical opinion expressed by the staff who would assist her during the delivery. She could not have been unaware that the responsibility for the delivery would lie with that healthcare staff. In other words, the patient should have reasonably explored other options if she was genuinely convinced that vaginal childbirth had no contraindications, considering the apparent “disappointment” expressed by the medical staff regarding her choice.

In conclusion, according to the judges, the timing of the surgery was deemed appropriate. The frustration resulting from the expectation that it would only be performed after the failure of the attempted vaginal birth cannot be considered OV, such as to justify compensation for non-patrimonial damages.

Kristeller maneuver

Kristeller maneuver is one of the most controversial obstetric practices due to the increased risk of peripartum complications and the physical and psychological trauma to which the pregnant woman is subjected (61,62).

It is a technique first described in 1867 by the German obstetrician Samuel Kristeller, who proposed a new proce-

ture for the 'expressio foetus' (expulsion of the fetus) (63). This technique involves massaging the uterus during labor and applying multiple compressions in a short timeframe along the long axis of the birth canal to assist in the expulsion of the fetus.

However, over the decades, however, this procedure has undergone many changes (64). Currently, the maneuver is performed by applying, theoretically, gentle pressure with one hand on the fundus, oriented at about 30° and 45° to the maternal spine, in the direction of the pelvis (65). In recent decades, this maneuver has been at the center of numerous scientific disputes (66,67) due to potential maternal-fetal injuries, as it's a kind of procedure often performed with considerable physical force.

Studies that have investigated the perspective of women have highlighted its negative impact on the birth experience (68). Among the main injuries that can occur following the Kristeller maneuver, there are uterine rupture, injuries to the anal sphincters, fractures of the ribs, or damage to the liver and spleen. For the unborn, cases of brain damage, including intracranial hemorrhage, cerebral palsy, as well as damage to the liver and spleen, or fractures of the humerus, have been reported (69).

Unfortunately, the exact prevalence of the use of this maneuver is unknown. Despite the potential consequences for both the mother and the newborn, it appears to be used frequently in clinical practice, particularly in low-income countries (69-72). In Italy, even though it is no longer recommended, this maneuver is still commonly used. However, a real estimate of its use is not always possible due to the medical-legal risk, and it is not consistently documented in medical records (73).

Cases 2 and 3. Two cases involving the Kristeller maneuver

Two Court sentences were identified in which the Kristeller maneuver was mentioned in connection to OV. In judgment No. 26997 of 2015 from the Criminal Cassation (74), the consideration was whether the signs observed during labor should have prompted the medical staff to perform a C-section instead of persisting with a vaginal birth. This persistence resulted in the death of the unborn due to severe acute hypoxia.

It was also a matter of ascertaining whether the Kristeller maneuver and the application of the vacuum extractor had been carried out correctly. The expert evaluation during the first degree of judgment established that the execution of the Kristeller maneuver had exacerbated the hypoxia and increased the pressure on the fundus of the uterus, leading to a subdural hemorrhage in the fetus.

The judge of the first instance adopted this evaluation, asserting that the Kristeller maneuver was deemed improper, performed with violence and that the use of a vacuum extractor had undoubtedly caused traumatic damage. In the second instance, the experts raised doubts about the necessity of a cesarean birth. The Court of Appeal accepted these conclusions, which, however, were not adequately justified, as determined by the judges of Cassation.

Another case, No. 788 of 2021 from the Court of Appeal of Potenza (75), involved a claim for damages suffered by the newborn due to paralysis of the right upper limb re-

sulting from shoulder dystocia during childbirth. The case also sought compensation for both patrimonial loss and non-patrimonial damages by the parents.

The judges acknowledged two distinct liability profiles for the physicians: i) choosing to let the midwife handle the assistance despite the critical conditions, and ii) assisting the midwife in performing the Kristeller maneuver.

Experts also regretted the absence of detailed medical records, particularly regarding the facilitation/disengagement maneuvers, as the techniques were poorly described. It is noteworthy that the incompleteness of the medical records serves as evidence of a causal relationship between medical assistance and the damage claimed by patients, particularly when it obstructs the determination of the causal chain (76,77).

Episiotomy

In spontaneous births, tissue tears can occur and, to prevent these injuries, episiotomy, an incision of the external genitalia and perineum, can be performed during labor. Risks associated with this practice include its application without indication and/or without consent. According to the WHO, it should not be routinely recommended for women experiencing spontaneous vaginal delivery (78,79).

Although still common, the use of episiotomy has significantly decreased in recent years, and its percentage varies substantially both between and within countries (80).

Generally, during vaginal delivery, pelvic floor traumas can occur, with the potential for spontaneous or iatrogenic damage to the anterior or posterior perineum (80).

Thus, in both cases of spontaneous lacerations and following the use of an episiotomy, potential complications to consider include dyspareunia, perineal pain, fecal and urinary incontinence, and bleeding, with heavy consequences on the women's quality of life (81). Moreover, severe perineal trauma includes third- and fourth-degree lacerations and poses a higher risk of residual defects (82). It is precisely to avoid these serious injuries that episiotomy has been historically used (83).

Episiotomy became widely used after the publication of a study conducted in 1920 by DeLee (84), advocating for its routine performance. However, this practice was later questioned (85). In 2009 (86), a research demonstrated the selective use of episiotomy was preferable to its systematic use, as the latter resulted in a higher incidence of third- and fourth-degree perineal tears. It was also demonstrated that both episiotomy and spontaneous perineal tears may increase the incidence of dysfunctions such as stress urinary incontinence, overactive bladder, anal incontinence, and pelvic organ prolapse (85,87). For these reasons, both the WHO and the American College of Obstetricians and Gynecologists recommend only the selective use of episiotomy (28,87).

Some authors have even characterized episiotomy as a form of 'female genital mutilation' if performed without the right clinical indications and in the absence of informed consent (88-91). Exposing a woman to a procedure with potentially serious consequences, when unnecessary and/or without informed consent, is considered equivalent to undermining her human and sexual rights. This includes her right to self-determination and maintaining integrity in reproductive health (92).

In Italy, there has been a decrease in the use of episiotomy, from 69% of vaginal deliveries in 2002 to 42% in 2010-2011 (93). However, there are regional disparities, as in 2020 the use of this practice ranged from 1.4% in Valle d'Aosta to over 30% in Sicilia. There are no clinical reasons for this variability; however, it can be interpreted as an alarm for inappropriateness.

Case 4. Injuries resulting from episiotomy

The case concerns a forty-year-old patient for whom an episiotomy was performed during the expulsive phase of vaginal delivery. Following this, the patient experienced a third-degree laceration. Despite interventions, this laceration led to irreversible anal incontinence, also causing difficulties with sexual intercourse (94). The Court of Cassation deemed the appeal of the injured parties valid, addressing (i) errors by the Judges of the Court of Appeal in assessing damages, considered already present in the form of past sphincter hypotonia; and (ii) inadequate compensation for the spouses' non-patrimonial damage, despite the repercussions of the physical damages on intimacy.

Oxytocin for labor induction

Another aspect to consider when discussing OV, certainly in correlation with the concept of episiotomy, is the timing of childbirth. Pregnancy and delivery should be respected within their physiological timeframes, allowing the mother's body to adapt to the passage of the baby through the birth canal. However, medicine has considered it necessary and possible to reduce pain and labor time by expediting delivery through the exogenous administration of oxytocin (95,96). Nevertheless, this practice can result in physical damage to the mother and the unborn child and is rightfully included in the assessment of actions related to OV.

Physiologically, oxytocin is released into the maternal circulation in a pulsatile manner, while synthetic oxytocin is administered via a continuous intravenous infusion. This implies the possibility of administering a higher dose than necessary, leading to increased risks of side effects (97,98).

The unnatural acceleration of labor increases the risk of both fetal and woman distress and damages. To avoid these kinds of complications, clear protocols and procedures for the use of oxytocin have been established (99,100).

According to the American College of Obstetricians and Gynecologists (ACOG) (101), labor induction is a therapeutic option when the benefits of a rapid delivery outweigh the risks of continuing the pregnancy or undergoing a natural delivery later. The ACOG has also developed clear indications and contraindications for the induction and acceleration of labor (102).

Before using exogenous oxytocin, a careful evaluation of the clinical history of the pregnant woman and the condition of the unborn child is necessary. This evaluation is essential to enhance the application and safety of the use of this medication. A discussion with the woman should take place before the procedure and should include an explanation of potential risks and benefits, an estimated length of labor, and what might happen if the induction is unsuccessful. Ade-

quate education on the potential risks of elective induction would appear to be useful in encouraging women to wait for spontaneous labor (103).

Among the side effects of the use of exogenous oxytocin, the most common and the most fearsome is represented by excessive uterine activity, known as tachysystole, defined as more than 5 contractions in 10 minutes on average over 30 minutes (104). Tachysystole can have a progressively negative effect on fetal oxygenation and the infant's acid-base balance at birth, and therefore should be avoided (105,106). It is recommended to follow a standard protocol for the administration of oxytocin to reduce this risk of tachysystole, but also of other complications such as fetal hypoxemia, fetal acidemia, maternal lacerations, and pain, placental abruption, uterine rupture, unnecessary cesarean delivery, hemorrhage, and postpartum infection (101,107-110).

The management of the administration of oxytocin risks should include: i) the selection of appropriate candidates; ii) an accurate assessment of the useful dosages; iii) information to the woman regarding the potential risks and benefits to obtain informed consent; iv) identification and timely resolution of side effects and possible complications (100,110).

Adherence to the ACOG and American Academy of Pediatrics (AAP) recommendations could minimize the risk of iatrogenic prematurity, with possible neonatal complications, and maternal damage, leading to lower treatment costs (111) and less risk of professional liability (112,113).

Case 5. A case of vagino-perineal laceration due to improper acceleration of delivery and inadequate assistance

The present case (114) concerned damages caused by vagino-perineal laceration during childbirth, due to improper acceleration of delivery and inadequate assistance in a full-term pregnancy. The judges of the first instance had concluded that an inadequate administration of oxytocin had caused an incautious acceleration of the expulsion phase and vagino-perineal lacerations.

The woman, experiencing her first pregnancy, urgently arrived in the morning at the Obstetric Gynecological Emergency Room for full-term labor, which had progressed regularly until that point. Upon admission, it was recorded that the membranes were intact, and the contraction activity was 2-3 acts every 10 minutes. Around 4:30 PM, a pre-labor check was performed, noting a flattened, soft, 2 cm dilated cervix, cephalic presentation, intact membranes, absent amniotic fluid, and uncoordinated uterine contractions. At 10 PM, amniorrhexis was performed. The assessment revealed a centralized, flattened, soft cervix, 3 cm dilation, cephalic presentation, ruptured membranes, tinted amniotic fluid, and regular fetal pelvic proportion. Subsequently, at 11 PM, oxytocin administration began at an initial rate of 10 drops per minute, increased to 20 drops per minute around 11:45 PM, and then further increased to 30 drops per minute at midnight.

The cardiotocographic tracings were normal until 00:30 – 00:40 AM. However, from that point onward, they began to show an indeterminable baseline, reduced variability, the presence of multiple atypical variable decelerations, and uterine contractile activity indicative of pathological

tachysystole during the expulsion phase. Subsequent recordings also appeared pathological, with a baseline of 100 bpm, reduced variability, the presence of multiple atypical variable decelerations, and uterine contractile activity during the expulsion phase.

At 11:20 PM, the labor program recording commenced and concluded at 1:12 AM, while a few minutes before the medical record reported: “head wedged in the perineal plane...she is moved from the stool to the labor-bed because she is unable to walk to the delivery room”. At the expulsion of the head and the fetal body, an “extensive perineal tear involving the anal sphincter and exposing the anterior wall of the rectum” was noted. The newborn was healthy while the mother was transferred to the operating room to perform a colporrhaphy and reconstruct the muscular plane of the levator ani.

In conclusion, the administration of oxytocin, both inadequately indicated and in terms of administration modality, resulted in tachysystole, causing significant disruption to fetal oxygenation and abnormal cardiotocographic tracing. Fortunately, the rapidity of the expulsion phase did not lead to fetal harm but increased the likelihood of perineal lacerations.

Discussions

The present study, starting from a general theoretical framework, aimed primarily to analyze how the issue of OV is currently addressed in Italian jurisprudence.

The examination of sentences from Italian courts has underscored how OV is currently an aspect that faces challenges in being fully understood in terms of its qualitative significance.

The judgments at the trial level largely mirror the assessments of expert consultants, who are tasked with analyzing the operational procedures performed by the parties involved in the specific case. The outcome of healthcare practices and the subsistence of non-patrimonial damages seem to be predominant factors in the judgments. It becomes evident that the distress experienced by women, resulting from the denial of the right to self-determination and shared decision-making in the care process, is deemed secondary to medical outcomes, with a particular emphasis on the health of newborns.

For instance, in Case No.1, the right to self-determination and the resulting sufferance from the denial of this right were deemed secondary to the technical efficacy of childbirth procedures. Moreover, it was emphasized that the responsibility for upholding this right to be respected should rest with the same individual.

Similar evaluative principles appear to have been applied in the judgment of procedures involving women's bodies, such as the Kristeller maneuver. In Cases No. 2 and 3, the assessment of the indication and adequacy of this practice has been deduced solely from the successful outcome of childbirth. Hence, a maneuver that can potentially be very painful and traumatizing is considered implicitly admissible without explicit consent.

However, some critical elements of its application are starting to be addressed in judgments. A reassuring factor

is the increasing attention to the implemented procedures, with censures in case of deficiencies in medical records. The traceability of maneuvers is crucial to having accurate data on the type and quality of care provided to women during pregnancy and labor (Case No.3).

Regarding practices that may result in anatomical complications, such as episiotomy and oxytocin administration, there is a growing focus on the impact on the female body, irrespective of the success of childbirth (Case No.4), with consideration also given to the consequences on the intimate-relational dimension (Case No.5).

It is desirable that these changes could be accompanied by a greater emphasis on women's rights, allowing for free and informed choices regarding medical activities directed at their bodies. Additionally, providing information about possible alternatives and consequences is crucial.

Concerning information and education, a shortage has been lamented in surveys involving healthcare personnel (21), and there is also a need for legal recognition, as indicated by findings from the judgments. In the current evolution of both medical science and legislation, it is primarily recognized as a specific right of the citizen. This characterization is also a direct derivation of the provision in the Convention for the Protection of Human Rights and Dignity of the Human Being (35). Article 5 of the Convention states that an intervention in the field of healthcare can only be performed with the free and informed consent of the patient, after receiving adequate information about the purpose and nature of the intervention, as well as its consequences and risks.

Increasing attention to these issues could be addressed through enhanced training and information for women and healthcare staff. In the childbirth process, a central role should be assumed by informed consent, given its fundamental importance for self-determination (115,116).

Consent should be obtained not only at a single time before labor but preferably at several stages throughout pregnancy.

In this regard, it is appreciable that the Italian Society of Gynecology and Obstetrics (SIGO) has formulated specific documents for informed consent as well as dissent and refusal of proposed treatments (37).

In these models, the opposition of healthcare professionals can be expressly stated; nevertheless, they will act with full respect for professionalism and the appropriate care due to the case. Additionally, the ethical and legal responsibility for potential damages related to the choice made by the signatory is emphasized.

In case of dissent, procedural alternatives are explicitly proposed to pregnant women, even though they may be considered suboptimal and not shared by healthcare providers, and these alternatives can also be rejected.

Precisely because Italian jurisprudence distinguishes between the absence of consent and the presence of explicit dissent, these models allow the healthcare professional to demonstrate the patient's explicit refusal, freely expressed, to a proposed treatment. This helps prevent the occurrence of confrontational situations and/or litigations as it permits the women in labor to choose which medical intervention to accept and which to refuse, in light of the adequate information received and her own ethical and moral convictions (117).

It can be argued that, in an effort to prevent a highly complex and debilitating phenomenon like OV, the groundwork has been laid for valuing women's self-determination during gestation. An additional step forward could be represented by the use of new technologies and artificial intelligence. A digital learning environment, such as virtual simulation, could be utilized for potential choice scenarios. The use of simulation-based learning is now routinely applied in the training of healthcare professionals, utilizing both low and high-fidelity methods (118). Simulation helps in acquiring and refining both cognitive and technical skills essential for performing both simpler (though not without risk) and more complex patient care tasks, as well as for decision-making processes. Similar programs could also be expanded to include women's childbirth preparation courses.

This approach could more easily and intuitively provide women with the opportunity to comprehend any issues they may encounter during childbirth and delivery, enabling an advanced evaluation of consent. It could also have a positive impact on the interaction between pregnant women and the healthcare staff, thereby preventing distress for both parties and potential grounds for medical-legal litigation.

Limits

The limitations of the present study primarily stem from the possibility that not all instances of judgments on OV were comprehensively documented in the utilized database. While this latter serves as the primary source for the collection of Italian Courts' judgments, there is a notable absence of precise information regarding its thoroughness. Moreover, a limited number of cases has been found, which has prevented the analysis and comparison of variables that could serve as predictors of judicial decisions and as aids to provide clear medico-legal guidance. Finally, it should be emphasized that the national debate on OV is quite limited, and there are no institutional guidelines to enable the assessment of clinicians' adherence to recommendations on the subject.

Conclusions

The lack of education on OV has been reported in surveys involving health professionals, and, as evidenced by the judgments, the legal context is also lacking. Information and education are crucial elements for enhancing women's self-determination during childbirth and the delivery process. The significance of obtaining informed consent or dissent should be emphasized at every stage of pregnancy. Even in emergencies, women's consent to medical procedures should be well-understood and respected. In this regard, new technologies could prove useful in facilitating early communication between medical staff and patients.

Finally, adherence to the ethical and medico-legal methodological steps for acquiring consent or dissent to procedures and interventions, as well as the implementation of information and education through innovative interventions, could have a beneficial impact in reducing defensive medicine behaviors adopted by doctors in obstetric gynecology,

which are often critically burdened by malpractice claims and compensation demands (119).

Conflicts of Interest

The authors declare no conflict of interest.

Funding details

This research received no external funding.

Data Availability Statement

All information was extracted from Court sentences in the public domain. The Court materials, once the case is decided by a Judge's ruling, are subject to consultation, and the data can be extracted.

References

- O'Brien E, Rich M. Obstetric violence in historical perspective. *Lancet*, 2022 Jun 11;399(10342):2183-2185.
- Santos MJDS, Neves DM. A Manifest against the Homogenisation of Childbirth Experiences: Preserving Subjectiveness in a Large Dataset of the «Babies Born Better» Survey. *Soc. Sci.* 2021, 10, 388.
- Gobernas-Tricas J, Boladeras M. El Concepto "VIOLÊNCIA OBSTÉTRICA" y el Debate Actual sobre la Atención al Nacimiento; Tecnos Editora: Madrid, Spain, 2018; 13p.
- Gaceta Oficial De La República Bolivariana De Venezuela. Ley Orgánica sobre el derecho de las mujeres a una vida libre de violencia. 2007. (Accessed on December 09, 2023, at: <https://www.acnur.org/fileadmin/Documentos/BDL/2008/6604.pdf>).
- WHO. The prevention and elimination of disrespect and abuse during facility-based childbirth. 2015. (Accessed on December 09, 2023, at: https://apps.who.int/iris/bitstream/handle/10665/134588/WHO_RHR_14.23_eng.pdf?sequence=1&isAllowed=y).
- Bowser D, Hill K. Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth Report of a Landscape Analysis; Harvard School of Public Health & University Research Co., LLC: Cambridge, MA, USA, 2010.
- Diniz SG, Salgado HO, Andrezzo HFA, et al. Violência obstétrica como questão para a saúde pública no Brasil: Origens, definições, tipologia, impactos sobre a saúde materna, e propostas para sua prevenção. *J. Hum. Growth Dev.* 2015, 25, 377-376.
- Ferrão AC, Sim-Sim M, Almeida VS, et al. Analysis of the concept of obstetric violence: scoping review protocol. *Journal of personalized medicine.* 2022 Jun 30;12(7):1090.
- Abrams J. Distorted and diminished tort claims for women. *Cardozo Law Review* 1955 (2013);34.
- Chervenak FA, McLeod-Sordjan R, Pollet SL, et al. Obstetric violence is a misnomer. *American journal of obstetrics and gynecology*, 2023 (Clinical Opinion).
- Sadler M, Santos MJ, Ruiz-Berdún D, et al. Moving beyond disrespect and abuse: addressing the structural dimensions of obstetric violence. *Reprod health matters*, 2016; 24:47-55.
- Cohen Shabot, S. Making loud bodies "feminine": a feminist-phenomenological analysis of obstetric violence. *Human Studies.* 2016;39, 231-247.
- Faheem A. The nature of obstetric violence and the organizational context of its manifestation in India: a systematic review. *Sex Reprod Health Matters.* 2021;29(2):2004634.

14. Tricas JG. Violência obstétrica: Aproximación al concepto y debate en relación a la terminología empleada. *Musas*, 2019; 4, 26–36.
15. Goaz Melet S, Feldman N, Padoa A. [OBSTETRIC VIOLENCE - SINCE WHEN AND WHERE TO: IMPLICATIONS AND PREVENTIVE STRATEGIES]. *Harefuah*. 2022 Sep;161(9):556-561. Hebrew.
16. Silveira MF, Mesenburg MA, Bertoldi AD, et al. The association between disrespect and abuse of women during childbirth and postpartum depression: Findings from the 2015 Pelotas birth cohort study. *J Affect Disord*. 2019 Sep 1; 256:441-447.
17. Beck, C. T. (2004). Birth trauma: in the eye of the beholder. *Nursing research*, 53(1), 28-35
18. Olza Fernández I. PTSD and obstetric violence. *Midwifery Today Int Midwife*. 2013 Spring;(105):48-9, 68.
19. Taghizadeh Z, Ebadi A, Jaafarpour M. Childbirth violence-based negative health consequences: A qualitative study in Iranian women. *BMC Pregnancy Childbirth* 2021;21,572.
20. Sadler M, Santos MJ, Ruiz-Berdún D, et al. Moving beyond disrespect and abuse: addressing the structural dimensions of obstetric violence. *Reprod Health Matters* 2016;24:47-55.
21. Valente EP, Mariani I, Covi B, et al. Quality of Informed Consent Practices around the Time of Childbirth: A Cross-Sectional Study in Italy. *Int J Environ Res Public Health* 2022; 19:7166.
22. Roth L, Heidbreder N, Henley M, et al. Maternity support survey: a report on the cross-national survey of doulas, childbirth educators and labor and delivery nurses in the United States and Canada. 2014. (Accessed on December 09, 2023, at: <https://maternitysurvey.files.wordpress.com/2014/07/mss-report-5-1-14-final.pdf>).
23. Bohren MA, Hunter EC, Munthe-Kaas H, et al. Facilitators and barriers to facility-based delivery in low- and middle-income countries: a qualitative evidence synthesis. *Reprod health* 2014;11:71. <https://doi.org/10.1186/1742-4755-11-71>.
24. Kujawski S, Mbaruku G, Freedman LP, et al. Association between Disrespect and Abuse During Childbirth and Women's Confidence in Health Facilities in Tanzania. *Matern. Child Health J* 2015;19:2243–2250.
25. Falagario M, Greco F, De Padova M, et al. The Role of Episiotomy in Emergency Delivery. In: Cinnella, G., Beck, R., Malvasi, A. (eds) *Practical Guide to Simulation in Delivery Room Emergencies*. Springer, Cham, 2023: 893-914.
26. Bohren MA, Vogel JP, Hunter EC, et al. The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review. *PLoS Med* 2015;12, e1001847.
27. Mele F, Leonardelli M, Duma S, et al. Requests for Compensation in Cases Involving Patients' Falls in Healthcare Settings: A Retrospective Analysis. *Healthcare (Basel, Switzerland)* 2023;11:1290. <https://doi.org/10.3390/healthcare11091290>
28. The Ottawa Charter for Health Promotion, International Conference on Health Promotion. World Health Organization (WHO), 1986 (Accessed on December 09, 2023, at: <https://www.who.int/teams/health-promotion/enhanced-well-being/first-global-conference>).
29. Basevi V, Morciano C. Evidence-based recommendations for physiological pregnancy care: the Istituto Superiore di Sanità (ISS) model, 2010: 79-83.
30. Chalmers B. WHO appropriate technology for birth revisited. *Br J Obstet Gynaecol* 1992;99:709-10.
31. Sackett D L, Rosenberg W M C, Gray M J A, Haynes B R, Richardson S W. *Evidence-Based Medicine: How to Practice and Teach EBM; Evidence-Based Medicine: New York, NY, USA, 2000.*
32. Care in normal Birth. A practical Guide. Technical Working Group, World Health Organization. *Birth*. 1997 Jun;24(2):121-3.
33. Grandolfo M, Lauria L, Lamberti A, et al. Pre- and post-natal assistance: promotion and assessment of operational models quality. The 2008-2009 and 2010-2011 surveys. 2012, "Istituto Superiore di Sanità, Rapporti ISTISAN 12/39".
34. Bettocchi S, Murgia F, Greco F, Morena MG, Palieri T, Pisante A, Fascilla FD, Nappi L. Laboratory and Instrumental Diagnostics. In *Practical Clinical Andrology*. Springer, Cham, 2022: 227-236.
35. Convention for the protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (ETS No. 164). Oviedo 04/04/1997. Made executive in Italy with the L.28 marzo 2001 n. 145.
36. Diaz-Tello, F. Invisible wounds: obstetric violence in the United States. *Reprod health matters* 2016;24:56-64.
37. Scambia G, Scollo P, Vizza E, Ghezzi F. *Treatise on Obstetric and Gynecologic Surgery, SIGO*. Ed. Edra, 2019.
38. Cragin EB. Conservatism in Obstetrics. *NY Med J* 1916;104: 1–3.
39. WHO recommendations: non-clinical interventions to reduce unnecessary caesarean sections. Guidelines Review Committee, Maternal, Newborn, Child & Adolescent Health & Ageing, Sexual and Reproductive Health and Research. 11 October 2018: 79.
40. Hamilton BE, Martin JA, Ventura SJ. Births: preliminary data for 2005. *Health estat*. Hyattsville, MD. National Center for Health Statistics, November 21, 2006.
41. Boldrini R, Di Cesare M, Basili F, Campo G, Moroni R, Romanelli M, Rizzuto E. Birthplace: Birth certificate at birth (CedAP) – Analysis data 2020. Ministry of Health 2021. (Accessed on December 09, 2023, at: <http://www.salute.gov.it/statistiche>).
42. Biswass A. Management of previous cesarean section. *Curr. Opin. Obstet. Gynecol* 2003, 15:123-9. ACOG II- 2 ISS I.
43. Ecker JL, Frigoletto FD, Frigoletto FD Jr. Cesarean delivery and the risk-benefit calculus. *N Engl J Med* 2007;356: 885-9. ACOG III ISS IV.
44. Italian positions on selected issues on remuneration of care services. Ministry of Health D.L. 18 October 2012. "Gazzetta Ufficiale n. 23 del 28 gennaio 2013". (Accessed on December 09, 2023, at: <https://www.gazzettaufficiale.it/eli/id/2013/01/28/13A00528/sg>)
45. Gardner K, Henry A, Thou S, et al. Improving VBAC rates: the combined impact of two management strategies. *Aust N Z J Obstet Gynaecol* 2014;54:327-332. <https://doi.org/10.1111/ajo.12229>.
46. Huang L, Chen Q, Zhao Y, et al. Is elective cesarean section associated with a higher risk of asthma? A meta-analysis. *J Asthma* 2015;5:16-25
47. Vehik K, Dabelea D. Why are C-section deliveries linked to childhood type 1 diabetes? *Diabetes* 2012;61:36-7.
48. Wang R, Wiemels JL, Metayer C, et al. Cesarean section and risk of childhood acute lymphoblastic leukemia in a population-based, record-linkage study in California. *Am J Epidemiol* 2017;185:96-105.
49. Mitselou N, Hallberg J, Stephansson O, et al. Cesarean delivery, preterm birth, and risk of food allergy: Nationwide

- Swedish cohort study of more than 1 million children. *J Allergy Clin Immunol* 2018;142:1510-1514.
50. Sevelsted A, Stokholm J, Bønnelykke K, et al. Cesarean section and chronic immune disorders. *Pediatrics* 2015;135:e92-e8.
 51. Francino MP. Birth mode-related differences in gut microbiota colonization and immune system development. *Ann Nutr Metab* 2018;73:12-6.
 52. Neu J, Rushing J. Cesarean versus vaginal delivery: long-term infant outcomes and the hygiene hypothesis. *Clin Perinatol* 2011;38:321-31.
 53. Macones GA, Peipert J, Nelson DB, et al. Maternal complications with vaginal birth after cesarean delivery: a multicenter study. *Am J Obstet Gynecol* 2005;193:1656-62.
 54. Barger MK, Weiss J, Nannini A, et al. Risk factors for uterine rupture among women who attempt a vaginal birth after a previous cesarean: a case-control study. *J Reprod Med* 2011;56:313-20.
 55. Grobman WA, Lai Y, Landon MB, et al. National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Prediction of uterine rupture associated with attempted vaginal birth after cesarean delivery. *Am J Obstet Gynecol* 2008;199:30. e1-5.
 56. Smith GC, Pell JP, Pasupathy D, et al. Factors predisposing to perinatal death related to uterine rupture during attempted vaginal birth after caesarean section: retrospective cohort study. *BMJ* 2004;329:375.
 57. Paladini, D, Franzè V, Morena, M, et al. INDIAMAN 20 (INstant DIAgnosis of 20 Major ANomalies) protocol: application of IOTA diagnostic strategy to fetal anomalies. *Ultrasound Obstet Gynecol*, 2023;62:61-68.
 58. Grivell RM, Barreto MP, Dodd JM. The influence of intrapartum factors on risk of uterine rupture and successful vaginal birth after cesarean delivery. *Clin Perinatol*. 2011;38(2):265-75.
 59. Landon MB, Hauth JC, Leveno KJ, et al. Maternal and perinatal outcomes associated with a trial of labor after prior cesarean delivery. National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. *N Engl J Med*. 2004;351(25):2581-9.
 60. Tribunale di Pavia Sez. III, 21 gennaio 2020, (ud. 18/01/2020, dep. 21/01/2020), n.95.
 61. Matsubara S. Uterine fundal pressure: is it really a culprit of poor maternal and neonatal outcome? *J Obstet Gynaecol Res*. 2014 Jul;40(7):1956.
 62. Merhi ZO, Awonuga AO. The role of uterine fundal pressure in the management of the second stage of labor: a reappraisal. *Obstet Gynecol Surv*. 2005 Sep;60(9):599-603.
 63. Kristeller, S. Die Expressio foetus. *Monatsschrift für Geburtskunde und Frauenkrankheiten. Gesellschaft für Geburtshilfe in Berlin*, 1867, 29.1867: 337-87.
 64. Waszyński E, Zabieg K. Kristeller's procedure--Expressio fetus, its genesis and contemporary application. *Ginekol Pol* 2008;79:297-300.
 65. Simpson KR., Knox GE. Fundal pressure during the second stage of labour: clinical perspectives and risk management issues. *The American journal of maternal child nursing* 2001; 26 (2):64-71.
 66. Sagi-Dain L, Maymon R. The condemned fundal pressure maneuver: time to reconsider? *Arch Gynecol Obstet* 2022;306:1953-1957.
 67. Sartore A, De Seta F, Maso G, et al. The effects of uterine fundal pressure (Kristeller maneuver) on pelvic floor function after vaginal delivery. *Arch Gynecol Obstet* 2012;286:1135-9.
 68. Çalik KY, Karabulutlu Ö, Yavuz C. First do no harm - interventions during labor and maternal satisfaction: a descriptive cross-sectional study. *BMC Pregnancy Childbirth* 2018; 8:415.
 69. Habek D, Cerovac A, Mikuš M. Kristeller's fundal expression: clinical, forensic and deontological controversies. *Arch Gynecol Obstet*. 2022 Dec 13. doi: 10.1007/s00404-022-06881-x. Epub ahead of print. PMID: 36512110
 70. Farrington E, Connolly M, Phung L, et al. The prevalence of uterine fundal pressure during the second stage of labour for women giving birth in health facilities: a systematic review and meta-analysis. *Reprod Health* 2021; 18:98. doi: 10.1186/s12978-021-01148-1. PMID: 34006288; PMCID: PMC8132352.
 71. Sentilhes L, Sénat MV, Boulogne AI, et al. Shoulder dystocia: guidelines for clinical practice from the French College of Gynecologists and Obstetricians (CNGOF). *Eur J Obstet Gynecol Reprod Biol* 2016;203:156-61. doi: 10.1016/j.ejogrb.2016.05.047. Epub 2016 May 30. PMID: 27318182
 72. RCOG. Shoulder dystocia (Green-Top Guideline no. 42); 2012. (Accessed on December 09, 2023, at: www.rcog.org.uk)
 73. Frati P, Fineschi V, Di Sanzo M, et al. (2017). Preimplantation and prenatal diagnosis, wrongful birth and wrongful life: a global view of bioethical and legal controversies. *Hum Reprod Update* 2017; 23:338-357.
 74. Italian Criminal Court of Cassation, section IV, April 2015, n.26997.
 75. Italian Appeal Court of Potenza, section I, December 2021, n.788.
 76. Italian Civil Court of Cassation, section III, November 2017, n. 27561-
 77. Italian Civil Court of Cassation, section III, June 2015, n. 12218.
 78. WHO Recommendations: Intrapartum Care for a Positive Childbirth Experience; World Health Organization: Geneva, Switzerland, 2018.
 79. World Health Organization Division of Family Health Maternal Health and Safe Motherhood: Care in Normal Birth: A Practical Guide. Report of a Technical Working Group; World Health Organization: Geneva, Switzerland, 1996.
 80. Graham ID, Carroli G, Davies C, et al. Episiotomy rates around the world: an update. *Birth* 2005;32:219-23.
 81. Mous M, Muller SA, de Leeuw JW. Long-term effects of anal sphincter rupture during vaginal delivery: faecal incontinence and sexual complaints. *BJOG* 2008;115:234-8.
 82. Sundquist JC. Long-term outcome after obstetric injury: A retrospective study. *Acta Obstet Gynecol Scand* 2012;91:715-8.
 83. Kalis V, Laine K, De Leeuw JW, et al. Classification of episiotomy: Towards a standardisation of terminology. *BJOG* 2012;119:522-6.
 84. DeLee, JB, Gabbe, SG. The prophylactic forceps operation. *Am J Obstet. Gynecol* 2002;187:254-255.
 85. Banta D, Thacker SB. The Risks and Benefits of Episiotomy: A Review *Birth* 1982; 9:25-30.
 86. Carroli G, Mignini L. Episiotomy for vaginal birth. *Cochrane Database Syst Rev*, 2009: 1-53.
 87. Committee on Practice Bulletins-Obstetrics. ACOG Practice Bulletin No. 198: Prevention and Management of Obstetric Lacerations at Vaginal Delivery. *Obstet Gynecol* 2018;132:e87-e102.

88. Wagner M. Episiotomy: a form of genital mutilation. *Lancet* 1999 5;353:1977-8.
89. Belizán JM, Miller S, Salaria N. We need to stop female genital mutilation!. *Reprod Health* 2016;18;13:43.
90. Sagi-Dain L, Kreinin-Bleicher I, Bahous R, et al. Is it time to abandon episiotomy use? A randomized controlled trial (EPITRIAL). *Int Urogynecol J* 2020;31:2377-2385.
91. Jiang H, Qian X, Carroli G, et al. Selective versus routine use of episiotomy for vaginal birth. *Cochrane Database Syst Rev* 2017;2:CD000081.
92. Albolino S, Bellandi T, Cappelletti S, et al. New Rules on Patient's Safety and Professional Liability for the Italian Health Service. *Curr Pharm Biotechnol* 2019;20, 615–624.
93. Lauria L, Lamberti A, Buoncristiano M, et al. Percorso nascita: promozione e valutazione della qualità di modelli operativi. Le indagini del 2008-2009 e del 2010-2011. Roma: Istituto Superiore di Sanità 2012. (Rapporti ISTISAN 12/39).
94. Italian Civil Court of Cassation, section III, December 2010, n.11958.
95. Viero C, Shibuya I, Kitamura N, et al. Oxytocin: crossing the bridge between basic science and pharmacotherapy. *CNS Neuroscience Ther* 2010;16:e138-56.
96. Kernberg A, Caughey AB. Augmentation of Labor: A Review of Oxytocin Augmentation and Active Management of Labor. *Obstet Gynecol Clin North Am* 2017;44:593-600.
97. Zeeman GG, Khan-Dawood FS, Dawood MY. Oxytocin and its receptor in pregnancy and parturition: current concepts and clinical implications. *Obstet Gynecol* 1997;89:873-883.
98. Rooks JP. Oxytocin as a "high alert medication": A multilayered challenge to the status quo. *Birth* 2009;36:345-348.
99. California Maternal Quality Care Collaborative. Improving Healthcare Response to Obstetric Hemorrhage. Palo Alto, CA: California Maternal Quality Care Collaborative, 2010. (Accessed on December 09, 2023, at: http://www.cmqcc.org/ob_hemorrhage)
100. Simpson KR. Clinicians' guide to the use of oxytocin for labor induction and augmentation. *J Midwifery Womens Health* 2011;56:214-21.
101. American College of Obstetricians and Gynecologists. ACOG Practice Bulletin No. 107: Induction of Labor. Washington, DC: Obstet Gynecol 2009;114:386-397.
102. American College of Obstetricians and Gynecologists. ACOG Practice Bulletin Number 49, December 2003: Dystocia and Augmentation of Labor. Washington, DC: Obstet Gynecol. 2003;102:1445-54.
103. Simpson KR, Newman G, Chirino OR. Patient education to reduce elective inductions. *MCN Am J Matern Child Nurs* 2010;35:188-94.
104. Macones GA, Hankins GDV, Spong CY, et al. The 2008 National Institute of Child Health and Human Development workshop report on electronic fetal monitoring: update on definitions, interpretation, and research guidelines. *Obstet Gynecol* 2008;112:661-6.
105. Bakker PC, Kurver PH, Kuik DJ, et al. Elevated uterine activity increases the risk of fetal acidosis at birth. *Am J Obstet Gynecol* 2007;196:313.e1-6.
106. Bakker PC, van Geijn HP. Uterine activity: implications for the condition of the fetus. *J Perinat Med* 2008;36:30-7.
107. Clark SL, Simpson KR, Knox GE, et al. Oxytocin: new perspectives on an old drug. *Am J Obstet Gynecol* 2009;200:35.e1-6.
108. Crane JM, Young DC. Meta-analysis of low-dose versus high-dose oxytocin for labour induction. *J Soc Obstet Gynaecol Canada* 1998;20:1215-1223.
109. Simpson KR. Cervical Ripening, Induction and Augmentation of Labor. AWHONN Practice Monograph. 3rd ed. Washington DC: Association of Women's Health, Obstetric, and Neonatal Nurses, 2009.
110. American Academy of Pediatrics, American College of Obstetricians and Gynecologists. Guidelines for Perinatal Care. 6th ed. Elk Grove Village, IL: American Academy of Pediatrics & American College of Obstetricians and Gynecologists, 2007.
111. Kaimal AJ, Little SE, Odibo AO, et al. Cost-effectiveness of elective induction of labor at 41 weeks in nulliparous women. *Am J Obstet Gynecol* 2010; 204, 137.e1–137.e1379.
112. Clark SL, Belfort MA, Byrum SL, et al. Improved outcomes, fewer cesarean deliveries, and reduced litigation: results of a new paradigm in patient safety. *Am J Obstet Gynecol* 2008;199:105. e1-e17.
113. Clark SL, Belfort MA, Dildy GA, et al. Reducing obstetric litigation through alterations in practice patterns. *Obstet Gynecol* 2008;112:1270-1283.
114. Italian Court of Appeal of Florence, May 2022, n.1010.
115. Di Fazio N, Fineschi B, Caporale M, et al. Recent Judgement of the Italian Judiciary about medical assisted procreation (MAP): is informed consent valid after parents separation? *Clin Ter* 2021;172:253-255.
116. Di Fazio N, Delogu G, La Russa R, et al. Voluntary interruption of pregnancy (VIP) in Italy: interpretation of the current situation according to the report 2019-2020 of the Italian Ministry of Health. *Clin Ter*. 2022 May 25;173(3):235-242.
117. Mandarelli G, Tarsitani L, Parmigiani G, et al. Mental capacity in patients involuntarily or voluntarily receiving psychiatric treatment for an acute mental disorder. *J Forensic Sci* 2014;59:1002–1007.
118. Achiron R, Adamo L, Weissbach T. Simulation in Obstetric: From the History to the Modern Applications Reuven Achiron, Laura Adamo, and Tal Weissbach. In: Cinnella, G., Beck, R., Malvasi, A. (eds) *Practical Guide to Simulation in Delivery Room Emergencies*. Springer, Cham, 2023: 3-18.
119. Fineschi V, Arcangeli M, Di Fazio N, et al. Defensive Medicine in the Management of Cesarean Delivery: A Survey among Italian Physicians. *Healthcare (Basel)* 2021;9:1097.