

Speech and harm: silencing refusal in the birth room

References & more:



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Central question: why does refusal of medical intimate touch fail? In particular, why does it fail in positive relational contexts, and where permissible touch requires positive consent?

Case study: routine vaginal examination (VE) during labour

Routine VEs are regular penetrative examinations performed at regular intervals during labour by clinicians (predominantly midwives) to assess the progress of labour. They are used to determine whether a birthing person is in 'established labour' and then to assess dilatation & thinning of the cervix, and descent of the foetus. NICE Guidelines suggest they are performed 4-hourly in the first stage of labour (2-hourly if delay is suspected), and hourly in the second stage. Multiple juxtapositions: intimate and invasive, yet routine and ordinary. Ubiquitous yet overlooked in consent dialogue (cf. instrumentally-mediated interventions).

1a. What is refusal?

Refusal is an action that a speaker performs with their words (Austin 1975). Refusal is a negative response to a permission request (another speech act).

e.g. (simplified!):

Midwife: "Do I have your permission to carry out a vaginal examination?" ← *This act opens up the possibility of permission being given.*

Birthing person: "No." ← *This act asserts that permission is not forthcoming: that the examination remains out of moral bounds.*

[Notice that consent is a different type of act: one that changes the moral (and legal) boundaries.]

1b. What is silencing?

Silencing is a type of speech act failure.

Speech acts can fail for lots of reasons. E.g. I can only grant or refuse permission for things that are within my jurisdiction. If I try to refuse permission for something outside my authority, my refusal 'misfires'.

Speech acts can fail even when the speaker has 'done everything right'. Lots of philosophers think that speech acts only succeed if the hearer recognises (gives 'uptake' to) what the speaker intended to do with her word.

Ideal contexts have "reciprocity", meaning speakers and hearers are able to recognise each other's speech acts as they are "meant to be taken" (Hornsby 1994).

1c. What causes silencing?

Silencing occurs when non-ideal contexts, and/or "something about" the speaker or her social role means the hearer cannot recognise her refusal (Langton 1993).

Silencing has been most actively studied in relation to sexual refusal. Langton (2012) suggests that silencing occurs when other **authoritative speech** in the social domain shapes and legitimates certain beliefs, norms and behaviours such that hearers cannot recognise refusal. This renders refusal "unspeakable" (1993).

A failed refusal does not succeed in making a claim about what is and is not permissible.

2. Silencing in the birth room

The birth room is replete with forms of authoritative speech.

Clinical guidelines are authoritative for clinicians, providers and birthing people. They "create expectations about what clinical behaviour is appropriate" (Brione 2024).

Low risk labour guidelines present VEs as "the means of creating the routine of labour care" (Brione 2024). No alternative is offered, or advice if VE is refused.

Refusing recommended care is non-normative and challenging for birthing people & clinicians (Feeley et al 2020, 2022).



Social scripts are also authoritative and normative. Scripts exist across clinical care.

Scripts "tell[] you how to behave, and what to say" (Hesni 2025). They are "blueprint[s] for a specific interaction" (Dougherty 2025), reducing participants' cognitive load.

There is "widespread social expectation that individuals act in accordance" with the relevant script (Hesni 2025). Failing to comply can attract social sanction.

Scripts can also act as **legitimising devices**, giving authority to people & behaviours that would otherwise be illegitimate. They do this by presenting certain actions as being "normal around here" (Simpson 2021) and some speakers as having authority in a particular domain.

3. Scripts in the birth room

A script exists for decision-making about routine VE. The script reflects and instantiates clinical guidance.

It was discerned from Annandale et al's study of video- and audio-recorded labours in a midwife-led unit. They call the script an "overarching interactional structure" for "scheduled" – i.e. routine – VE (2022).

Appendix 13 Overall architecture of vaginal examination decisions

Interactional activity	Example (simplified transcription)	
On admission, general informing that VEs will be conducted 4-hourly	So we examine you every 4 hours, see what's happening	VIP22
Forewarning of upcoming VE	And I examined you about 10.30, and I would normally look at doing another one 4 hours from there ... So 10, 11, 12, 1, 2. So in an hour	VIP31
Check agreement to conduct VE immediately	So would that be OK to examine you like we planned?	VIP14
Ensure/check comfort (other activities are also conducted here, including monitoring and feeling abdomen for position of the baby)	You think you can try and have a wee for me? You'll be more comfortable for the vaginal examination having had a wee	VIP37
	So it's just going to be a bit of cold gel at first. If you want me to stop, or if you're getting a contraction, just say and we'll stop	VIP22
Check consent/readiness before starting VE	Are you ready for me to (D.5) for me to go ahead	VIP30
Online commentary ⁴⁵	So baby's head is very low, I can feel that. The waters are still there ... Cervix is really thin	VIP14
Announcement of cervical dilatation	So it's about 3 to 4 centimetres, it's really stretchy, it's at the front	VIP28
Decision-making/reassurance	(Following the VE) Alright, go with it, push if you need to	VIP37
	Three to four's good, it's stretchy, waters are still there. Don't be disheartened. Try not to be sad, it's just like this one's taking a bit longer, but you'll still get a baby at the end of it, you'll just have to be a bit more patient	VIP28

Annandale et al (2022)

This script demonstrates distinct stages relevant to permission: **informing/forewarning**, **checking agreement**, and a **"consent/readiness"** check at the point of VE (each noted by ★).

The script:

- **poses VEs in terms which "expect agreement"** (Annandale et al 2022). It fails to include a **full-blooded permission request**, which opens up the possibility of refusal,
- **legitimises clinicians as authoritative speakers** in this domain (note nuance: clinicians may be authoritative about what interventions to offer but not about what will happen), and
- generates a **pseudo-legitimate expectation that VEs "will happen"** (Brione 2024), albeit with "a level of resignation" on the part of birthing people (Annandale et al 2022). It
- **presents VE as part of a recurring routine** through labour, foreseen from admission, with each VE pre-warned hours before formal 'consent' is sought,
- **tells midwives how to behave and what to say** to move birthing people through the routine of care, and
- thereby acts as a teaching tool for less experienced clinicians to learn by mimesis (Dalton and Hooker 2019).

The script **pre-emptively silences refusal**.

It **disrupts the reciprocity** needed for clinicians to recognise the authority and intended force of a refusal. Even the consent check presupposes permission will be given.

Attempted refusal may be **"unintelligible"** (Garcia 2026); met with **bafflement and insistence on compliance** (Madeley 2024).

4. Implications

Work to improve permission-related processes normally focus on consent, either as a punctate event or as part of an ongoing relational practice.

This overlooks other key aspects: *requesting* and *refusing* permission.

My analysis highlights two novel facets:

- a **widespread lack of full-blooded permission requests**, which open up the possibility of refusal of routine VE. This is not isolated to VE: GMC consent guidance (2020) omits any reference to permission-seeking as central to consent practices.
- **everyday language practices which presuppose clinician authority** over what will happen & who decides. This authority claim may not be intended by the clinician.

Refusal requires birthing people to do **doubly deviant work**: first to **open up the question of permissibility**, second to **close it down by asserting (against expectations) that permission is not given**. Script-deviation is sanctionable, exacerbating sanctions for refusing normative care.

Studying VE illuminates other aspects of birth care. VE is **fleshy, highly intimate, penetrative touch**. It routinely occurs in the absence of clinical risk factors (or mistaken questions about capacity) which can be taken to complicate questions of permission. Routine VE is poorly evidenced (Moncrieff et al 2022). It should be easy to refuse.

Linguistic practices can silence refusal and fail to recognise birthing people as moral agents. We need to **refocus attention on language use and authority relations** across care interactions and generate new blueprints to **reinforce birthing people the arbiters of their bodily permissions**.