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ARTICLE

Beyond Malpractice: Gynecological Violence, a New Concept to Confront an Old Problem

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Abstract
This paper proposes the concept of gynecological violence as a necessary expansion of obstetric violence to encompass a broader range of experiences and affected groups. While obstetric violence primarily focuses on pregnancy, childbirth, and postpartum, gynecological violence includes healthcare experiences throughout the entire life cycle of individuals assigned female at birth, beyond maternity. The concept aims to highlight physical, psychological, or sexual abuses in medical settings that undermine bodily autonomy and reproductive rights. A review of evidence from feminist research and public health is conducted to provide an integrated perspective. It is argued that gynecological violence should be understood within the broader context of the hegemonic medical system, where gender biases and unequal power relations between healthcare providers and patients persist. This proposal seeks to expand the conceptual framework to enable critical analysis and inform public policies aimed at preventing such violence, ensuring respectful gynecological care that is free from discrimination and centered on human rights.

1. Introduction

The history of women's health is deeply entangled with structures of medical authority, gender norms, and the regulation of the bodies of persons assigned female at birth (Ehrenreich and English 2006; Federici 2004; Jordanova 1989). Feminist research on health and medicine has shown that medical institutions not only provide care but also exercise control over bodies and sexualities, whether by shaping the meanings of crucial concepts such as disease and normality, or by medicalizing and intervening in those bodies that, through such concepts, become pathologized (Ehrenreich and English 1978; Martin 2001). These dynamics are particularly visible in the gynecological sphere, where natural processes such as menstruation, childbirth, menopause, and sexuality have been persistently medicalized and over-intervened (Cleghorn 2021).

In contemporary societies, the bodies of persons assigned female at birth are subject to regulation, control, normalization, and conditioning by a gendered system that differentiates and discriminates against them, supported by specific institutions (including the medical institution). The body constitutes a central locus of experience,

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and any intervention upon it has profound effects on identity and life itself. Historically produced as a sexed body (Esteban 2004; Rothman 1982), it has been accompanied by health dispositifs designed to regulate the entire life cycle of persons assigned female at birth.

Medicine, as an institution, has systematically ignored persons assigned female at birth, failing to recognize them as reliable sources of knowledge about their own processes (Cleghorn 2021; Valls-Llobet 2009). Within the hegemonic medical model, the female body has been represented as pathological, unruly, or untrustworthy, and therefore as suspect, requiring constant surveillance and intervention (Ortíz Gómez 2006). At the same time, embodied knowledge has been denied and usurped, producing and reproducing a social order in which the experiences of persons assigned female at birth are subordinated to medical authority. Pain and discomfort reported by them are frequently met with suspicion (if not outright dismissal), reproductive decisions are subject to external control, and the most intimate dimensions of corporeality are regulated by professionalized knowledge.

In this article, we propose a conceptual intervention aimed at expanding the critical vocabulary on gendered violence in the field of health (Hester 2018). Building on debates around obstetric violence (a term developed to describe specific forms of institutional violence in childbirth and perinatal care) we introduce the concept of gynecological violence. While the notion of obstetric violence has made visible mistreatment, over-intervention, coercion, and disrespect experienced by women in reproductive contexts, we argue that its scope remains limited. Many forms of harm, abuse, and denial of agency occur outside obstetric care (the experiences of transgender and non-binary persons, of those undergoing menopause, of young persons who do not wish to reproduce, or of individuals diagnosed with gynecological conditions such as endometriosis). Gynecology, broadly understood as the medical specialty concerned with the reproductive and sexual health of persons assigned female at birth, constitutes a privileged site for examining how these harms are produced, legitimized, and what they reveal about the broader cultural landscape of gender relations.

The concept of gynecological violence seeks to account for practices that remain invisible under the framework of obstetric violence, as they are not limited to the regulation of reproductive processes and can therefore affect other bodies. It requires attending to violence throughout the life cycle of persons assigned female at birth, regardless of whether they identify with that sex, in the context of sexual healthcare.

By gynecological violence we designate all situations of violence rooted in gender bias that occur within the space of gynecological care. It is perpetrated by health professionals and includes practices that naturalize relations of subordination between medical personnel and patients, direct acts of psychological or physical violence, as well as any form of abuse or sexual violence. This concept draws attention to the ways in which "care" often intertwines with domination (Tronto 1993), and how the legitimacy of medical authority can normalize iatrogenic harm. By articulating this concept, we seek to make visible a set of experiences that have been insufficiently recognized.

At the conceptual level, our proposal rests on a particular notion of violence. Rather than defining violence exclusively as physical aggression, we adopt a broader interpretation that conceives of it as a social relation grounded in the denial of the other. Violence, in this sense, refers to any practice that harms or undermines the integrity of persons by negating their subjectivity, autonomy, or dignity (Bufacchi 2022; Pickles 2024). This perspective situates gynecological violence within a continuum of practices ranging from overt abuse to more subtle forms of domination. It also helps explain why

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many women describe certain gynecological encounters as experiences of humiliation, infantilization, or dispossession even when no "physical harm" is present in the strict sense of the term.

To contextualize our argument, we situate gynecological violence within the continuum of violence against women. Feminist theory has long insisted that gender-based violence must not be understood as isolated episodes but rather as interconnected practices that sustain systems of power (Kelly 1988; Russell 1986). Gynecological violence is thus not an anomaly or an exception, but part of a broader pattern in which violence against women and against persons assigned female at birth is normalized, tolerated, and often rendered invisible. The medical sphere operates as one of the key sites where this normalization takes place. Far from being a private matter, violence in medical contexts must be recognized as socially and institutionally mediated, deeply tied to the gendered organization of care and authority.

Recognizing gynecological violence also requires attending to its consequences for those who experience it. Its impact far exceeds the immediate moment of the clinical encounter. Persons assigned female at birth too often describe a loss of autonomy, an undermining of their decision-making capacity, and a sense of being annulled or infantilized (Purdy 2006; Swahnberg et al. 2007). These experiences shape self-image, self-esteem, and the relationship to one's own body, including the capacity for pleasure and sexual agency (Salinero 2021). Yet these consequences are not only destructive. Many women develop forms of resistance and coping, ranging from seeking alternative health practices to engaging in collective activism aimed at transforming medical institutions. Understanding both the harms and the resistances generated by gynecological violence is essential for a fuller picture of its significance.

Our conceptual proposal unfolds in several stages. First, we situate our argument in relation to feminist research on women's health, analyzing how medical authority has historically exercised control over persons assigned female at birth. This discussion underscores the persistent suspicion directed at women's narratives of pain, the medicalization and pathologization of natural processes, and the embedding of gynecology within the biomedical model. We then proceed to distinguish the concept of gynecological violence from obstetric and reproductive violence. We clarify the scope of the term, offer a working definition, and explain how it makes visible forms of harm that remain obscured under existing categories. We also examine the conceptual foundations of the term by elaborating the notion of violence that sustains it. We defend a relational understanding of violence as the denial of the other, which captures both the structural and everyday dimensions of gynecological practices. This allows us to situate gynecological violence within the continuum of violence experienced by persons assigned female at birth, emphasizing its interconnection with other forms of gender domination and its role in reproducing a sociocultural context that normalizes harm. Finally, we address some of the consequences of gynecological violence.

By presenting this conceptual framework, our aim is not only to name and describe a particular set of harmful practices but also to contribute to the broader feminist critique of the medical model. In doing so, we seek to expand the analytical and political tools available for confronting gendered violence in healthcare. Much of this proposal is grounded in the authors' own work, which is informed and supported by empirically based studies published in peer-reviewed journals. Naming gynecological violence constitutes an act of visibility: it transforms isolated experiences into a recognizable pattern, opening the possibility of collective recognition, the demand for accountability, and the prospect of change.

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2. Making patients, making power: medical control over those assigned female at birth

For decades, numerous scholars have emphasized the androcentric nature of medicine and its detrimental effects on the lives and health of women and individuals assigned female at birth (Ehrenreich and English 2006; García-Dauder and Pérez-Sedeño 2017; Hubbard 1995; Martin 2001; The Boston Women's Health Collective 2006; Valls-Llobet 2009). This androcentric framework has shaped a perception of these bodies as inherently flawed (Kitzinger 2006), abnormal, and thus in need of intervention, medicalization, and control. While such critiques have become foundational within health discourse, the dominant biomedical model continues to reproduce practices, narratives, and power relations that have undergone minimal transformation.

We are confronted with an authoritarian and hierarchical model that fragments and norms bodies. Wherever hierarchy and authoritarianism exist, violence soon follows. Critiques of violence within the health system are not new (Barber 2007), nor is criticism of the iatrogenesis produced by medicine as an institution (Illich 2015). Since the 1990s, a debate has emerged around the practice of vaginal examinations, giving rise to sustained critiques within the gynecological field (Bewley 1992; Cardozo 1992). More recently, Cohen (2025) has denounced the performance of unconsented educational pelvic exams on anesthetized patients, highlighting the collapse of legal and ethical safeguards for patient consent. Critical discussions of the right to health often end up narrowing this right to questions of access to medical services. Such a reduction sidelines other forms of care (frequently situated outside the clinical sphere) that could substantially limit the need for medical intervention and, in doing so, mitigate some of the forms of violence that emerge within health systems. This constrained understanding reinforces a profoundly individualized and biologicist model of care, one in which the social dimensions of health and illness are marginalized (Laurell 1982, 1989; Menéndez 2020). A grasp of the violence embedded in healthcare provision therefore requires attention to these broader social determinants, without which the phenomenon cannot be fully understood.

Generally, studies show that women experience more violence in health services than men, and this occurs across the life course (Brüggemann et al. 2012; Levinson and Shojania 2011; Schroll et al. 2013; Söderberg et al. 2011). This situation intensifies in what is commonly called "women-specific care" (d'Oliveira et al. 2002). Although this term is problematic, because it tends to reduce women's health to their reproductive functions (Esteban 1996) and denies biological and social differences in the health–disease process, it is evident that those assigned female at birth are more exposed to violence due to normative control over their bodies and sexuality (Rich 1995), and the reproduction of misogynistic medical discourses and imaginaries that present them as physically inferior and emotionally unstable. In other words, certain anatomic and physiological differences are assigned a negative value. These practices take place within the healthcare context and are often presented as the basis for authorizing medical interventions.

In this context, we can no longer consider violence in health as occasional or isolated. It has always been there; we are now simply more capable of recognizing, naming, and reporting it. To acknowledge this means accepting that violence, particularly violence against those assigned female at birth, is a structural part of the hegemonic medical model. Similarly, this violence must be understood as part of a continuum targeting individuals assigned female at birth within our culture (Cárdenas and Salinero 2023).

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The hegemonic medical model (Menéndez 2020) has been identified as one of the main arenas for producing and reproducing the subordinate position of those assigned female at birth (Cárdenas and Salinero 2024), and is characterized by a conception of health that pathologizes some natural processes, thereby authorizing their subsequent medicalization by expert doctors. This, combined with the growing conflation of health with access to medical services, has fundamentally disempowered individuals and communities from caring for their own health and addressing processes that traditionally were not medicalized (Illich 2015). In this sense, the hegemonic medical model has enabled effective social control over the population and their bodies.

When such control is exercised without consent, disproportionately or dehumanizingly, and while ignoring subjectivities, it becomes violence, whether subtle or explicit, individual or structural. This violence causes suffering, damages the relationship with the health system that is supposed to help, and undermines trust in it. These are forms of violence that are normalized, if not legitimized, and masked by discourses of care (Cárdenas and Salinero 2022) that present harm as help, placing responsibility on victims themselves. The intersectional nature of this violence is undeniable: not all bodies are treated equally, those assigned female at birth who are Indigenous, Afrodescendant, migrant, young or elderly, poor, or living with disabilities experience more severe and systematic violence (Castro et al. 2015; Cárdenas and Salinero 2022, 2023; Davis 2019; Hernández and Rangel-Flores 2023; Van der Waal et al. 2023). In these cases, gender, race, class, and other forms of subordination interweave, deepening inequality in access to and quality of medical care received. Medical control over bodies is not only exerted through gender but is further complicated by other structural dimensions that determine who is more susceptible to being medicalized, silenced, or violated.

3. From obstetric violence to gynecological violence: broadening the field and making the hidden visible

The reality of obstetric violence and its adverse effects on those who experience it is already well established. Numerous studies across the globe document normalized practices that systematically violate the sexual and reproductive rights of women during pregnancy, childbirth, and the postpartum period (Almonte 2016; Belli 2013; Bellón 2015; Camacaro 2009; Cohen Shabot and Korem 2018; Chiaroti et al. 2008; Cladem 1998; García Núñez et al. 2022; Pozzio 2016; Quintanela 2020; Sadler et al. 2016; Sena 2016; Sesia 2020; Tobasía-Hege et al. 2019), as well as their impacts on individuals assigned female at birth (Colectiva contra la violencia ginecológica y obstétrica 2020; Salinero and Cárdenas 2021; Cárdenas and Salinero 2022, 2023; Sampaio et al. 2019). Though grounded in Latin American theorizations, this reality has been recognized worldwide (Acharya et al. 2021; Chadwick 2017, 2021; Di Lello Finuoli 2024; Maciel et al. 2019; Mayra et al. 2022; McKenzie 2025; Mena-Tudela et al. 2020; Morena et al. 2024; Pickles and Herring 2020; Pickles 2023; Ruiz-Berdúm and Olza 2016; Simeneh et al. 2024; Yalley et al. 2024). While our work draws on this body of research, we have found it necessary to expand it for various reasons that we will explain later, incorporating it into the broader space that our proposed concept of gynecological violence offers. While we do not have room to revisit the concept of obstetric violence in depth, we will focus on the differences between it and our proposed concept and on what the broader perspective of gynecological violence brings to light. What we aim to do is to

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make certain routine forms of violence within the medical model, particularly in the gynecological field, visible forms that occur at different life stages beyond reproduction.

Focusing exclusively on one phase of women's life cycles risks inadvertently excluding a range of service users (transgender people, women who do not wish to reproduce, or are in non-reproductive stages), as well as practices of violence not necessarily linked to childbirth, yet commonly experienced by those assigned female at birth (non-consensual pelvic exams, coercion into routine PAP smears, pathologization and medication of natural processes such as menstruation and menopause, pressure for surgical menopause, overuse of hysterectomies, sexual abuse, normalization of pain that impedes timely recognition of endometriosis symptoms, etc.). In our research experience, all these situations are normalized, a part of daily male domination that significantly affects the lives of those who experience them. Similarly, individuals assigned female at birth who identify as transgender or non-binary and who need to undergo gynecological examinations report high levels of discomfort and mistrust when accessing services. This may be due, for example, to the hyperfeminized environment, the emphasis on reproductive medicine, or pressures to transition from one sex to another when that is not their interest (Cárdenas and Salinero 2024; Muwnguzi et al. 2025; Oppenheim 2023). Even the materials used in pelvic exam training tend to erase patient diversity and emphasize medical authority, thereby sidelining the patient's agency (Towle 2022). This mismatch between the person attending the consultation and the traits expected of them can make them feel out of place, producing feelings of shame and strangeness, and may facilitate discriminatory treatment.

Moreover, part of the social acceptance gained by the concept of obstetric violence may stem from its occurrence within practices that do not fundamentally question traditional gender roles for women (their reproductive character) and which even conservative groups can endorse, given the "sacralized" nature of motherhood in our societies, a phenomenon Adrienne Rich referred to as maternal subjectivity (1995). Childbirth is also a more "watched" process than the opaque space of the gynecological consultation, often provided by private practitioners working alone, with no institutional oversight or accountability. We do not mean to diminish the significance of what occurs during birth, but rather to expand attention to a vast range of violent and subordinating practices affecting those assigned female at birth, but not only those who identify as women and wish to reproduce.

Ultimately, we propose a necessary widening of the spectrum of settings, services, practices, and groups affected by violence, which are overlooked when we focus solely on obstetric violence. Likewise, we argue that gynecological violence, which legitimizes a violent and hierarchical relationship between medical personnel and patients, can serve as a precursor to obstetric violence. That is, it normalizes and legitimates an abusive and dehumanizing type of interaction, leading individuals to arrive at childbirth with a diminished awareness of their rights, more willing and prepared to endure and normalize violence. Violence is learned and reproduced daily within a dehumanizing and disrespectful social model that denies patients' integrity, objectifies them, and annihilates them. All of this serves to maintain social control and gender inequalities.

4. On the concept of violence underpinning gynecological violence

We understand violence as a form of social relationship characterized by the negation of the other. That is, these are acts that occur within regulated and norm-governed relationships between individuals, in which one party to the relationship actively denies

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the other, thereby inflicting psychological injury or causing harm. Defining violence as a form of social relationship highlights the active role of the individuals involved and, at the same time, prevents the act from being confined or attributed solely to a single agent within the social field. Violence, in most cases, occurs in the presence of others who act as witnesses. It is thus a triadic relationship in which the actions of one party (the perpetrator) affect the others (victims and bystanders), who in turn may respond in ways that sustain and, in some cases, reinforce these violent practices. Violence is not necessarily the act of a single agent; it can be collectively enacted, and it cannot be fully understood without linking it to the concrete interests of the agents involved, even when its usefulness extends beyond the specific relationship in which it occurs (e.g., sustaining an oppressive and unequal gender system).

From this perspective, the context is no longer a mere backdrop against which violence takes place but becomes crucial for understanding the interactions that occur in a given social setting, the norms that operate within it, and the power relations that traverse it. It constitutes a meaningful temporal and spatial situation in which social relationships are produced, interpreted, and made sense of. We will later show how these forms of violence are sustained by the existence of institutional and social contexts that do not prevent or sanction them, contexts that sometimes facilitate, promote, or even legitimize them. The presence of third parties in a violent relationship contributes, when it does not explicitly oppose it, to the legitimization and normalization of that violence.

For us, the concept of symbolic violence (Bourdieu 2021) is crucial, as it helps to make sense of deeply embedded, everyday forms of violence, through which perception and evaluation schemas are developed from the dominant side of the relationship. That is, the frameworks for accessing and interpreting reality are created by one group and imposed upon the subordinated, thereby naturalizing violence and presenting it as inevitable, justifiable, or normal. The patriarchal structure of domination constitutes the matrix within which gynecological violence emerges, either by directly legitimizing physical, psychological, or sexual assaults, or more indirectly, by legitimizing forms of moral violence (Segato 2003), in which people assigned female at birth internalize the domination system and reproduce the inequality that it entails.

From this perspective, violence is a type of social relationship that harms or destroys a person's physical or psychological integrity (Bufacchi 2022; Pickles 2024), positioning them in a state of subordination vis-à-vis the one who exercises it. Within a relational definition of violence, what is ultimately denied is the other's recognition, their voice and their full experience of subjectivity (Gilligan 2024). Hence, the effects of such violence are experienced as a relational trauma (Benjamin 2012), which becomes even harder to process when masked by rhetorics of care (Salinero and Cárdenas 2021) and presented as actions taken in the supposed interest of the person being harmed (Ehrenreich and English 2010). The rhetorics of care disguise harm as help and often go as far as to blame the victim for the violence inflicted upon them. As a result of this violation of integrity or negation of subjectivity, the person experiences harm, suffering, or injury, sometimes enduring, always significant. In this way, gynecological violence deeply damages the intersubjective bond that ties us to others; it is always a negation of the other, a rupture of boundaries through the use, or threat, of force, a denial of recognition, and a major impediment to the process of identification.

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5. Gynecological violence as part of the continuum of violence against women

Violence is a common experience among those assigned female at birth. Thus, gynecological violence is not an isolated event but part of a broader spectrum of interrelated behaviors. These behaviors occur within a sociocultural context that normalizes violence against women and people assigned female at birth, serving as a mechanism of social control over their bodies. Gynecological violence is much more frequent and widespread than generally assumed and, given its magnitude and consequences, represents a serious public health issue (Colectiva contra la Violencia Ginecológica y Obstétrica 2020; Salinero et al. 2023).

By continuum, we refer to the interconnectedness of various violent experiences across women's lifespans, all of which (domestic violence, sexual harassment, rape, etc.) share the common aim of contributing to the social control, coercion, and subordination of women (Cárdenas and Salinero 2023; Kelly 1988; Russell 1986). Many of these experiences are lived on a daily basis and are shared by those assigned female at birth. These are often rendered invisible, as they appear "normal" or "natural," as if they could not be otherwise. The normalization and naturalization of suffering are integrated into the daily rhythms and practices of life (Das 2015). These experiences are cumulative in nature, emotionally and psychologically, and can manifest in obvious ways (such as physical or sexual violence) or in more subtle forms of control, threat, or discrimination. All such expressions reinforce unequal power relations. In most cases, this everyday violence is experienced and confronted individually, in isolation, because it is presented as accidental, isolated, or unusual, leading to the internalization of pain and suffering as a more or less permanent aspect of one's life. What appears as isolated or exceptional is, in reality, systematic and routine, restricting freedom and dramatically affecting the lives of many women.

We believe it is crucial to understand that this violence is not accidental. It is grounded in gender bias that is continually reintroduced in healthcare encounters with those assigned female at birth, and it occurs within a context of contestation and resistance to male power. In our societies, female bodies are effectively regulated, controlled, normativized, and shaped by a gender system that differentiates and discriminates, a system sustained by specific institutions, including the medical establishment (Martin 2001; Federici 2004). The body is central to lived experience, and any action imposed upon it impacts identity and one's sense of self (Esteban 2004). For people assigned female at birth, the body has historically been produced as sexed, giving rise to specific health-related technologies that have no male equivalent and that accompany them throughout their lives. As Emily Martin (2001) has shown, Western medicine has constructed the female body as inherently dysfunctional or deviant from the male norm, thus justifying constant interventions into its physiology. This has led to the production of technologies aimed at controlling physiological processes related to sexuality (e.g., menstruation, childbirth, menopause) by pathologizing and medicalizing them—that is, by treating natural processes as potentially risky diseases in order to authorize medical intervention (Cárdenas and Salinero 2023; Cleghorn 2021).

The notion of gynecological violence can be situated within the broader continuum of violence against women, as it constitutes yet another expression of the structural and normalized forms of harm that shape their everyday lives. While obstetric violence can be understood as one dimension of gynecological violence (particularly related to reproductive processes) its scope is narrower. Gynecological violence encompasses obstetric practices but also reveals qualitatively distinct forms of violence that occur

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across different stages of life, extending beyond the reproductive sphere. Importantly, it brings into focus the experiences of groups that have historically remained invisible within medical and social discourses, such as persons assigned female at birth who are not heterosexual or cisgender, and who often confront neglect, marginalization, or direct harm within gynecological care.

6. Consequences of gynecological violence and forms of coping/resistance

At a broader level, gynecological violence has led many women and people assigned female at birth to distance themselves from essential health services, either by turning to alternatives outside the hegemonic medical model or by postponing fundamental exams (even when these are part of public health policies in many countries). The fear of re-experiencing violence, being abused, or losing autonomy constitutes one of the most immediate effects of this form of violence (Cárdenas and Salinero 2023, 2024). This violence undermines public trust and operates in a paradoxical manner: it harms while simultaneously calling on users of gynecological and obstetric services to be responsible and to submit to an increasing number of medical procedures. We argue that the performance of such procedures (mammograms, pelvic examinations, contraceptive implants, and other routine gynecological or obstetric procedures) becomes a new gendered demand, confronting people assigned female at birth with a tension between the responsibility to care for themselves and the need to avoid spaces where they may be systematically subjected to violence. Institutionally, the erosion of respect and empathy is one of the most far-reaching consequences, creating conditions conducive to the dehumanization of relationships within the healthcare system.

At a personal level, gynecological violence causes, whether intentionally or not, deep harm to the experience of the body and sexuality as sites of pleasure, joy, and freedom (Salinero and Cárdenas 2021; Cárdenas and Salinero 2022). It contributes to the perpetuation of male domination and the control of bodies, extending the continuum of violence against people assigned female at birth. As discussed earlier, gynecological violence denies autonomy and recognition, producing experiences of infantilization or erasure. What is excluded and negated through gynecological violence is the capacity to pursue one's own life projects and to decide how to live and manage one's health autonomously. In other words, a healthcare model is shaped that disables the possibility of self-care and autonomous decision-making by replacing individuals with the figure of the expert and reducing health to mere access to medical services. The technocratic and allegedly egalitarian utopia that underpins this model is rooted in the disqualification of people from taking responsibility for their own health (Illich 2015), legitimizing excessive medical practices and interventions upon their bodies.

As we have noted, gynecological violence, including obstetric violence, may profoundly alter the basic assumptions of individuals, affecting their self-image, self-esteem, relationships with others, and their relationships with their own bodies (Salinero 2021; Cárdenas and Salinero 2022). It can also produce severe physical consequences (such as fistulas, tearing, painful sexual activity, scarring, etc., mostly related to childbirth), which often require further surgical or medical interventions to repair the damage caused by health professionals themselves. Important psychological consequences also emerge, including depression, anxiety, or emotional pain. Many women describe this experience as traumatic, that is, a deep psychic wound caused by a violent situation that threatens their integrity.

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If we also consider the cultural expectations that impose silence and solitude on many people assigned female at birth in the face of such violence, the social denial of the harm they endure, the lack of support from close relationships, and the absence of effective formal mechanisms for complaint, justice, or redress, the severity of this reality becomes even more evident (Pickles and Herring 2020). This attempt to render invisible both the victims and the violence they experience contributes to the reproduction of existing structures, sex/gender stereotypes, and unacceptable medical practices that normalize and legitimize abuse. It is precisely here that the relational nature of this violence is revealed: it is often perpetuated through the silence of those who witness it, including health workers and medical team members, which constitutes a form of complicity and a serious breach of professional ethics.

The deep power differentials inherent in the hierarchical organization of the health system, along with the lack of explicit regulations governing doctor–patient relationships, lie at the core of this type of violence. Cultural expectations and gender roles may also facilitate its emergence or toleration, through appeals to so-called "feminine" characteristics such as the presumed tolerance to pain or the already mentioned maternal subjectivity (Rich 1995), which imply the internalization of the expectation to endure suffering for the sake of loved ones, especially children. In this sense, gynecological violence constitutes yet another way of putting women and people assigned female at birth in their place (Cárdenas and Salinero 2024; Cárdenas et al. 2024), especially those who transgress traditional gender roles, assert their rights, or challenge the authority of medical professionals.

Among the consequences experienced by users of gynecological services, beyond a broad spectrum of symptoms, is the perceived loss of autonomy and the experience of objectification, with the impossibility of choice emerging as a central theme (Cárdenas and Salinero 2024). The absence of consent for initiating procedures or treatments, as well as the disregard of patient preferences, frequently accompany this sense of disempowerment (Swahnberg et al. 2007). Similarly, depersonalized care and interactions that treat the individual as merely an organ or body part are deeply disturbing and erode agency. As a result, many individuals feel erased, and their knowledge is ignored and invalidated. Knowledge resides solely with the clinical staff. The client becomes a patient, an exposed, naked body to be examined. Such a relationship is only possible because of the excessive hierarchy embedded in the interaction, causing those seeking care to feel dismissed, infantilized, and even violated.

When the medical gaze focuses on an organ or body part rather than the person as a whole, the actions carried out may not be perceived as violent or at least not with the same intensity. Throughout their lives, many women are subjected to both minor and major rituals of humiliation that, by legitimizing violence, reinforce power asymmetries and prejudice. Knowledge is located exclusively on one side of the relationship, and punishment arises in response to transgression. Those who ask too many questions, who challenge medical decisions, or who denounce discriminatory attitudes within healthcare teams are punished (Cárdenas and Salinero 2023, 2024). In such dynamics, violence remains ever-present: a disapproving gesture or an inappropriate comment may quickly escalate into a painful procedure (Castro 2019). As if this were not enough, victims are often blamed for what happens to them, made responsible for the violence they suffer. This violence is so normalized that, even when recognized, it is often regarded as inherent to this form of "care." The existing power asymmetries within the medical staff act as a strong mechanism that prevents health personnel from filing complaints, leading to ethical lapses (Brüggeman and Swahnberg 2014; Swahnberg et al. 2010).

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Thus, the potential transgression of bodily boundaries and privacy constantly hovers over the relationship between the medical staff and the client (Cárdenas and Salinero 2023). To fully understand this issue, it is necessary to consider the specific context of gynecological consultations. People assigned female at birth are often naked and with their genitals exposed before a stranger, a situation that places them in a position of particular vulnerability. The gynecological examination has been described as inherently stressful and anxiety-inducing (O'Laughlin et al. 2021). For many women, the experience evokes fear of abuse or recalls past traumatic experiences inside or outside of the medical setting. Inappropriate touches, obscene comments about their bodies or genitals, being asked to undress without justification, or being pressured to undergo pelvic exams unrelated to the reason for their visit are not isolated incidents (Cárdenas and Salinero 2024; Cárdenas et al. 2024; Swahnberg et al. 2011). These situations trigger deep fears and memories of previous trauma in many women and people assigned female at birth (Iraola et al. 2024). In fact, a pelvic exam performed without explicit consent constitutes sexual assault in and of itself (Hendricks and Seybold 2022). Over the past years, we have collected dozens of testimonies recounting experiences of sexual abuse during gynecological consultations, as well as other severe forms of explicitly sexual violence perpetrated in contexts where patients are exposed and often overwhelmed by shame and fear. These narratives were gathered through different strategies, including in-depth interviews, focus groups, and, in some cases, open-ended responses to questionnaires. Several of these accounts have been published and analyzed in our previous work (see Cárdenas and Salinero 2021, 2024). Such abuse constitutes a direct violation of the trust placed in health professionals and is facilitated by the power they hold due to their institutional authority, social prestige, and the lack of clear guidelines regulating appropriate conduct in these interactions (in some contexts, such rules do not exist, and in others, even when they do, they are ineffective in preventing violence). Furthermore, reporting these incidents and providing evidence is often exceedingly difficult for victims, which contributes to their vulnerability and sense of helplessness.

We argue that the deep emotional and physical impact of gynecological violence remains largely underexplored. These experiences can leave lasting psychological and physical scars that, in many cases, never fully heal. The consequences of lost autonomy, violence, and sexual abuse in gynecological settings are far-reaching: they affect self-image, self-esteem, one's relationship with their body and sexuality, as well as their social relationships (Salinero 2024). They can also cause long-term physical injuries and persistent psychological effects such as sadness, fear, guilt, self-blame, insecurity, and shame (Cárdenas and Salinero 2021, 2023, 2024).

In the face of the high likelihood of experiencing this violence at least once in their lifetime, many women have adopted specific coping strategies. One of the most common involves attending medical appointments accompanied by trusted individuals who can offer emotional support and help ensure safety (particularly in contexts where violence is a real possibility). In the case of LGBTIQA+ individuals, this strategy is often complemented by the development of lists of queer-friendly professionals as well as those to be avoided under any circumstances. These strategies are frequently accompanied by cispassing techniques, attempts to be perceived as cisgender through specific appearances, behaviors, or gender expressions (to minimize the risk of discrimination or violence in healthcare settings). Cispassing, in itself, may also constitute a form of violence (Cárdenas and Salinero 2024), reflecting the structural challenges that sexual and gender minorities face in accessing safe and respectful care (Basualto et al. 2023; Cárdenas et al. 2024).

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A second coping strategy involves addressing the situation directly, expressing dissatisfaction and setting boundaries. This requires making an effort to speak up during the appointment, sometimes by interrupting or refusing treatment. However, not everyone is able to rely on this form of resistance, whether due to emotional readiness or practical constraints (such as economic limitations or urgent medical needs) that may lead individuals to overlook or tolerate violence even when they recognize it as such.

A third form of coping involves behavioral or cognitive avoidance and denial. Its function is to disconnect or distance oneself from stressful interactions. The goal is to disengage or detach from the distressing experience. In this context, it may manifest as the decision not to attend gynecological appointments, or, when doing so, to mentally dissociate from the procedure, severing the experience from one's own body.

Additionally, we have identified more collective or community-oriented coping strategies that go beyond emotional or instrumental support. These include active participation in activist groups or militant spaces where survivors are supported, their experiences collectively processed, and those who have suffered violence are defended. This kind of action provides a sense of purpose and may also include direct action practices such as public denunciations, protests, boycotts, or *escraches* of perpetrators in contexts where impunity persists. These actions aim to safeguard one's narratives from social prejudice, expose perpetrators, and raise public awareness about the events that occurred. They represent self-organized responses to the lack of adequate institutional mechanisms to address such violence, and they aim to transform future conditions using the means available.

7. Discussion: violence, everyday life, and self-reconstruction

Only when a situation of social injustice is recognized as such can new meanings emerge to challenge a particular social order. When what often occurs in gynecological settings is named for what it is, free of euphemism, violence can be made visible and confronted. The task is precisely to generate concepts that shed light on a very old phenomenon that has been so deeply normalized and naturalized that it continues to occur to this day. Thus, describing a reality that oppresses those assigned female at birth is merely the first step. Documenting violence and rendering it visible is a fundamental task for those of us engaged in feminist research. It serves as a precursor to transformative action against a reality that oppresses and denies us. Reclaiming the practical and everyday experiences of people assigned female at birth as a legitimate, embodied form of knowledge is essential to this aim, especially as it explores the nature of our own experience and enables us to collectively reflect on it and include, as a research objective, resistance to such practices.

The reproduction of gynecological violence within institutions, and the reproduction of gender biases that make it possible, means that such violence should not be understood merely as a punishable act committed by medical personnel who deviate from their duty of care. Rather, it must be recognized as a political act (Griffin 1985), insofar as it constitutes yet another form of social control that affects all women and people assigned female at birth. This underscores the need to historicize the discipline of gynecology (Cleghorn 2021; Cooper-Owens 2018; Jordanova 1989; Ortíz Gómez 2006) and understand it as another mechanism for perpetuating male dominance. It is a form of social control over sexuality from which all men benefit, directly or indirectly.

One form of rejecting domination is to challenge the definition of events. This means contesting the characterization of gynecological violence as merely interpersonal

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misconduct or isolated incidents of disrespect perpetrated by a few "deviant" individuals who differ from the "normal" majority (Kelly 1988). We must acknowledge that it is a complex, multi-level process rooted in society and crystallized in its institutions, yet exercised and reproduced daily in interpersonal relationships. It is a widespread phenomenon, legitimated by discourses of care and institutional denial, grounded in a culturally organized violence against people assigned female at birth. In this regard, the violence that occurs in gynecological settings must be considered sexual violence, not only because of the nature of the practices and the bodily zones involved, but because of their underlying objectives.

Historicizing the practice of gynecology is essential, as it reveals a discipline that from its origins has assumed heterosexuality as the norm (Rich 1995) and was built upon the torture of women of color (Oakley 1984; Cooper-Owens 2018). It is a practice aimed at controlling bodies, regulating sexuality, and normalizing behaviors. Furthermore, as shown in the classical findings of Scully and Bart (1973), it contains outdated and erroneous views of female sexuality and portrays women in stereotypical roles marked by passivity and the availability of the female body for male pleasure. There is no equivalent medical practice linked to men's bodies, none that accompanies them throughout their lives, requiring a series of mandated exams or procedures. Likewise, hostility and domination are central to the construction of masculinity, and the control of the sexuality of those assigned female at birth lies at the origin of patriarchal societies, it is a result of the colonization of their/our bodies. Gynecology has historically contributed to the social control of femininity and female bodies. Rather than being a misapplication of a specific medical practice, this control is inherent to the discipline itself. There is a foundational violence at its core.

Moreover, the threat and reality of gynecological violence give rise to self-protection strategies (such as avoiding medical checkups or returning to natural gynecology practices), specific coping mechanisms, and a rejection of newly imposed gender role expectations. These are practices inherent to the hegemonic medical model and, given their endorsement by the state, they may constitute blatant violations of the human rights of people assigned female at birth. Many such individuals organize their lives around care practices and precautionary strategies that allow them to comply with mandated gynecological exams while emerging unscathed from each visit to health services. For instance, before each appointment, they may activate a support network, go accompanied by a trusted friend or colleague, and take precautions regarding the choice of the attending clinician—preferring a female doctor recommended by someone they know—to minimize discomfort or potential mistreatment. What is undeniable is the fear, anxiety, or anger provoked by these checkups for many women and the enduring impact they have on many others.

In this regard, there are several areas we must explore in setting out an urgent and compelling agenda for those working in the field of gynecological violence. It is crucial to think about violence as intrinsically linked to social hierarchies and to examine the formation of a medical *habitus* in which violence is validated and employed as a pedagogical strategy. This line of inquiry (Castro and Erviti 2015) opens fruitful avenues for investigating the history of the medical discipline to this day, scrutinizing its practices and hidden curriculum, and challenging the arrogance of a knowledge system that imposes itself as the only legitimate one.

Furthermore, it is striking that the tools and care settings have changed little over the past decades, despite the need to adapt them to those receiving care rather than those delivering it. If such encounters inherently generate anxiety, it becomes essential to

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design more welcoming and less distressing spaces and materials, to cultivate warmer, closer relationships. The bodily position assumed during gynecological visits, the sense of helplessness it induces, the need to treat consent as an ongoing negotiation, and the imperative to respect the wishes and preferences of those seeking care are all crucial (Cárdenas and Salinero 2024).

It is equally important to actively challenge entrenched stereotypes about people who have experienced gynecological violence, especially the belief that they are passive or incapable of confronting violence. Our research has uncovered the erroneous assumption that these women are socio-economically vulnerable, less educated, or incapable of empowerment when asserting their rights. These stereotypes are not only inaccurate but also shift the burden of violence onto those who experience it, denying its structural nature and the deeply embedded gender biases in healthcare provision. Survivors are blamed for not resisting or confronting the violence in a timely manner. Far from supporting these misconceptions, we must demonstrate the multiple strategies they employ to resist and protect themselves from violence.

Unfortunately, it is not always possible to escape gynecological violence. We have collected many accounts from women who, despite being fully aware of the violence and doing everything in their power to avoid it, experienced even greater harm (Cárdenas and Salinero 2021, 2024). Avoiding violence and responding to it may seem like obvious courses of action, but reality is often more complex, especially when the violence is disguised as care or when individuals cannot risk being denied medical attention due to financial constraints. Even among those with economic resources and education, violence occurs with disturbing frequency. It may take different forms, but it serves the same purpose.

Similarly, there is a common assumption that those who have suffered violence become helpless victims who must be supported and for whom decisions must be made, as if they were incapable of determining what is best for themselves. This is a new form of violence, one that claims to be protective but in practice deprives them of their agency and decision-making power.

Lastly, it is essential to critically reexamine the various practices of resistance to the gynecological care model. Opposing the medicalization and pathologization of natural processes entails a commitment to remove them from hospitals and clinics, to empower people by teaching them to care for their own health, and to offer services that do not strip them of their agency. In this light, birthing centers, home births, comprehensive sexuality education with a gender perspective, and the recovery of ancestral knowledge about natural gynecology must be seriously considered as valid alternatives in the processes of care and self-care for people assigned female at birth.

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References

Acharya, Arun K., Rashmi Sarangi, and Sushree Subhalaxmi Behera. 2021. Experiences and impacts of obstetric violence on women in India within the public health system. *Journal of Feminist, Gender and Women Studies* 11: 37–45.

Almonte, Gabriela. 2016. Violencia ginecológica y obstétrica: La medicalización del cuerpo femenino [Gynecological and obstetric violence: The medicalization of the female body]. *Revista Décsir* 2: 1–10.

Barber, Christopher F. 2007. Abuse by care professionals. Part 1: An introduction. *British Journal of Nursing* 16 (15): 938–40.

Basualto, María José, Javiera Zúñiga, and Manuel Cárdenas. 2023. La consulta ginecológica: Un desafío para las mujeres lesbianas y bisexuales en Chile [Gynecological consultation: A challenge for lesbian and bisexual women in Chile]. *Musas* 8 (2): 44–65.

Belli, Laura. 2013. La violencia obstétrica: Otra forma de violación a los derechos humanos [Obstetric violence: Another form of human rights violation]. *Revista Redbioética UNESCO* 1 (7): 25–34.

Bellón, Silvia. 2015. La violencia obstétrica desde los aportes de la crítica feminista y la biopolítica [Obstetric violence from the contributions of feminist criticism and biopolitics]. *Dilemata* 18: 93–111.

Benjamin, Jessica. 2012. El tercero. Reconocimiento [The third. Recognition]. *Clínica e Investigación Relacional* 6 (1): 169–79.

Bewley, Susan. 1992. Teaching vaginal examination. *BMJ* 305: 369.

Bourdieu, Pierre. 2021. *La dominación masculina* [Masculine domination]. Barcelona: Anagrama.

Brüggemann, Jelmer, and Katarina Swahnberg. 2014. Staff silence about abuse in health care: An exploratory study at a Swedish women's clinic. *Clinical Ethics* 9 (2–3): 71–76.

Brüggemann, Jelmer, Barbro Wijma, and Katarina Swahnberg. 2012. Abuse in health care: A concept analysis. *Scandinavian Journal of Caring Sciences* 26 (1): 123–32.

Brunello, Silvia, Magali Gay-Berthomieu, Beth Smiles, Eneidia Bardho, Clémence Schantz, and Virginie Rozée. 2024. *Obstetric and gynaecological violence in the EU: Prevalence, legal frameworks and educational guidelines for prevention and elimination*. Brussels: European Parliamentary Research Service.

Bufacchi, Vittorio. 2022. Three questions about violence. *Washington University Review of Philosophy* 2: 209–18.

Camacaro, Marbella. 2009. Patologizando lo natural, naturalizando lo patológico: Improntas de la praxis obstétrica [Pathologizing the natural, naturalizing the pathological: Imprints of obstetric praxis]. *Revista Venezolana de Estudios de la Mujer* 14 (32): 147–62.

Cárdenas, Manuel, and Stella Salinero. 2022. Obstetric violence in Chile: women's perceptions and differences among health centers. *Revista Panamericana de Salud Pública* 46: e24.

Cárdenas, Manuel, and Stella Salinero. 2023. The continuum of violence against women: Gynecological violence within the Medical Model in Chile. *Sexual and Reproductive Healthcare* 37. https://doi.org/10.1016/j.srhc.2023.100891

Cárdenas, Manuel, and Stella Salinero. 2024. Loss of autonomy, legitimization of violence, transgression of intimacy and fear of abuse: A thematic analysis of stories of gynecological violence and its consequences. *Feminism and Psychology* 34 (3). https://doi.org/10.1177/09593535241242551

Cárdenas, Manuel, Stella Salinero, and Jimena Silva. 2024. A qualitative analysis of coping strategies among people assigned female at birth who have experienced gynecological violence in Chile. *Violence Against Women* 31 (14). https://doi.org/10.1177/10778012241283495

Cardozo, Linda. 1992. Teaching vaginal examination. *BMJ* 305: 113.

Castro, Arachu. 2019. Witnessing obstetric violence during fieldwork: Notes from Latin America. *Health and Human Rights* 21 (1): 103–11.

Castro, Arachu, Virginia Savage, and Hannah Kaufman. 2015. Assessing equitable care for Indigenous and Afrodescendant women in Latin America. *Revista Panamericana de Salud Pública* 38 (2): 96–109.

Castro, Roberto. 2014. Génesis y práctica del habitus médico autoritario en México [Genesis and practice of the authoritarian medical habitus in Mexico]. *Revista Mexicana de Sociología* 76 (2): 167–97.

Castro, Roberto, and Joaquina Erviti. 2015. *Sociología de la práctica médica autoritaria: Violencia obstétrica, anticoncepción inducida y derechos reproductivos* [Sociology of authoritarian medical practice: Obstetric violence, induced contraception, and reproductive rights]. México: UNAM.

Chadwick, Rachel. 2017. Ambiguous subjects: Obstetric violence, assemblage and South African birth narratives. *Feminism and Psychology* 27 (4): 489–509.

https://doi.org/10.1017/hyp.2026.10062 Published online by Cambridge University Press

Chadwick, Rachel. 2021. Breaking the frame: Obstetric violence and epistemic rupture. *Agenda* 35 (3): 104–15.

Chiaroti, Susana, Gloria Schuster, and Susana Arminchiardi. 2008. *Con todo al aire 2. Reporte de derechos humanos sobre atención en salud reproductiva en hospitales públicos* [With everything on air 2: Human rights report on reproductive health care in public hospitals]. Rosario: INSGENAR/CLADEM.

Cladem. 1998. *Silencio y complicidad: Violencia contra las mujeres en los servicios públicos de Perú* [*Silence and complicity: violence against women in public services in Peru*]. Lima and New York: Cladem/CRLP.

Cleghorn, Elinor. 2021. *Unwell women: Misdiagnosis and myth in a man-made world*. New York: Dutton.

Cohen, Rachel Beth. 2025. Unconsented educational pelvic exams on anesthetized patients: The collapse of legal and ethical safeguards for patient consent. *Maine Law Review* 77 (1): 27–68.

Cohen Shabot, Sara, and Keshet Korem. 2018. Domesticating bodies: The role of shame in obstetric violence. *Hypatia* 33 (3): 384–401.

Colectiva contra la Violencia Ginecológica y Obstétrica. 2020. *Primera encuesta nacional de violencia ginecológica y obstétrica: síntesis de resultados* [First national survey on gynecological and obstetric violence: summary of results]. Valparaíso, Chile: Colectiva contra la Violencia Ginecológica y Obstétrica.

Cooper-Owens, Deirdre. 2018. *Medical bondage: Race, gender, and the origins of American gynecology*. Athens, GA: University of Georgia Press.

D'Oliveira, Ana Flavia, Simone Diniz, and Lilia Schraiber. 2002. Violence against women in health-care institutions: An emerging problem. *The Lancet* 359: 1681–85.

Das, Veena. 2015. *Affliction: Health, disease, poverty*. New York: Fordham University Press.

Davis, Dána-Ain. 2019. Obstetric racism: The racial politics of pregnancy, labor, and birthing. *Medical Anthropology* 38 (7): 560–73.

Di Lello Finuoli, Mariana. 2024. Obstetric violence in Italy. *Hospitals* 1 (1): 3–15.

Ehrenreich, Barbara, and Deirdre English. 1978. *Complaints and disorders: The sexual politics of sickness*. Old Westbury, NY: Feminist Press.

Ehrenreich, Barbara, and Deirdre English. 2006. *Brujas, comadronas y enfermeras* [Witches, Midwives and Nurses]. Olmué: Metcalfe y Davenport.

Ehrenreich, Barbara, and Deirdre English. 2010. *Por tu propio bien: 150 años de consejos expertos a las mujeres* [For your own good: 150 years of expert advice for women]. Madrid: Capitán Swing.

Esteban, Mari Luz. 1996. Relaciones entre feminismo y sistema médico-científico [Relations between feminism and the medical-scientific system]. *KOBIE, Antropología Cultural* 7: 17–40.

Esteban, Mari Luz. 2004. *Antropología del cuerpo: Género, itinerarios corporales, identidad y cambio* [Anthropology of the body: Gender, corporeal itineraries, identity and change]. Barcelona: Bellaterra.

Federici, Silvia. 2004. *Calibán y la bruja: Mujeres, cuerpo y acumulación originaria* [Caliban and the witch: Women, body and primitive accumulation]. Madrid: Traficantes de Sueños.

Galtung, Johan. 1990. Cultural violence. *Journal of Peace Research* 27 (3): 291–305.

García Núñez, Carmen, Thania Guzmán Guzmán, Stella Salinero Rates, and Daniela Vargas Castillo. 2022. Colonización de nuestros cuerpos territorios y usurpación de nuestra salud sexual [Colonization of our bodies and territories and usurpation of our sexual health]. In *IV Informe sobre derechos sexuales y reproductivos en Chile* (pp. 76–87), ed. Stephanie Ott. Chile: Corporación Miles-Chile.

García-Dauder, Silvia, and Eulalia Pérez-Sedeño. 2017. *Las "mentiras" científicas sobre las mujeres* [Scientific "lies" about women]. Madrid: Catarata.

Gilligan, Carol. 2024. *En una voz humana* [In a human voice]. Madrid: Taurus.

Griffin, Susan. 1985. *Woman and nature: The roaring inside her*. New York: Harper & Row.

Hendricks, Perry, and Samantha Seybold. 2022. Unauthorized pelvic exams are sexual assault. *The New Bioethics* 28 (4): 368–76.

Hernández, Eduarda, and Yesica Rangel-Flores. 2023. Una mirada desde la interseccionalidad a la violencia obstétrica en mujeres indígenas [An intersectional view of obstetric violence against indigenous women]. *CONfines* 37: 31–48.

Hester, Helen. 2018. *Xenofeminism*. Cambridge: Polity Press.

Hubbard, Ruth. 1995. *Profitable promises: Essays on women, science and health*. Monroe, ME: Common Courage Press.

Illich, Ivan. 2015. Némesis médica [Medical nemesis]. In *Obras reunidas I*. México: Fondo de Cultura Económica.

https://doi.org/10.1017/hyp.2026.10062 Published online by Cambridge University Press

Iraola, Elizabeth, Menard Jean-Pierre, and Patrick Chariot. 2024. Experience of Pelvic Examination and Uptake of Gynecological Care Following Domestic or Sexual Violence: a Systematic Review. *Trauma Violence Abuse* 25 (5): 4030–44. https://doi.org/10.1177/15248380241270038

Janoff-Bulman, Ronnie. 1992. *Shattered assumptions: Towards a new psychology of trauma*. New York: Free Press.

Jordanova, Ludmilla. 1989. *Sexual visions: Images of gender in science and medicine between the eighteenth and twentieth centuries*. Madison, WI: University of Wisconsin Press.

Kelly, Liz. 1988. *Surviving sexual violence*. Minneapoli: University of Minnesota Press.

Kitzinger, Sheila. 2006. *La crisis del parto* [The birth crisis]. Tenerife: OB STARE.

Laurell, Asa Cristina. 1982. La salud y la enfermedad como proceso social [Health and illness as a social process]. *Revista Latinoamericana de Salud* 2: 7–25.

Laurell, Asa Cristina. 1989. Social analysis of collective health in Latin America. *Social Science and Medicine* 28: 1183–91.

Levinson, Wendy, and Kaveh Shojania. 2011. Bad experiences in the hospital: The stories keep coming. *BMJ Quality and Safety* 20 (11): 911–13.

Maciel, Monik, Beatrice Blondel, and Marie-Josèphe Saurel-Cubizolles. 2019. Physical violence during pregnancy in France: Frequency and impact on the health of expectant mothers and new-borns. *Maternal and Child Health Journal* 23 (8): 1108–16.

Martin, Emily. 2001. *The woman in the body: A cultural analysis of reproduction*. Boston: Beacon Press.

Mayra, Kaveri, Jane Sandall, Zoë Matthews, and Sabu Padmadus. 2022. Breaking the silence about obstetric violence: Body mapping women's narratives of respect, disrespect and abuse during childbirth in Bihar, India. *BMC Pregnancy and Childbirth* 22: 318.

McKenzie, Gemma. 2025. Quest narratives and heroine journeys: The road to freebirth and the joy of undisturbed physiological birth. *Frontiers in Global Women's Health* 5: 1495914. https://doi.org/10.3389/fgwh.2024.1495914.

Mena-Tudela, Desirée, et al. 2020. Obstetric violence in Spain (Part I): Women's perception and inter-territorial differences. *International Journal of Environmental Research and Public Health* 17 (21): 7726.

Menéndez, Eduardo. 2020. Modelo médico hegemónico: tendencias posibles y tendencias más o menos imaginarias [Hegemonic medical model: possible and imaginary trends]. *Salud Colectiva* 16: e2615.

Morena, Donato, et al. 2024. Obstetric violence in Italy, from theoretical premises to court judgments. *Clinical Therapeutics* 175 (11): 57–67. https://doi.org/10.7417/CT.2024.5034.

Muwanguzi, Patience A., Racheal Nabunya, and Moses Sabila. 2025. Experiences of violence and abuse among transgender women in healthcare settings in Uganda: A community-engaged qualitative study. *BMC Health Services Research* 25: 431.

O'Laughlin, Danielle J., et al. 2021. Addressing anxiety and fear during the female pelvic examination. *Journal of Primary Care and Community Health* 12.

Oakley, Ann. 1984. *The captured womb: A history of the medical care of pregnant women*. Oxford: Basil Blackwell.

Oppenheim, Hannah. 2023. Transgender gynecology: The construction of medical knowledge and health social movements as catalysts for change. Bachelor's thesis, Vassar College.

Ortiz Gómez, Teresa. 2006. *Medicina, historia y género: 130 años de investigación feminista* [Medicine, history and gender: 130 years of feminist research]. Oviedo: KRK Ediciones.

Pickles, Camila, and Jonathan Herring. 2020. *Women's birthing bodies and the law: Unauthorised intimate examinations, power, and vulnerability*. Oxford and New York: Hart Publishing.

Pickles, Camilla. 2023. "Obstetric violence," "mistreatment," and "disrespect and abuse": Reflections on the politics of naming violations during facility-based childbirth. *Hypatia* 38 (3): 628–49.

Pickles, Camilla. 2024. Everything is obstetric violence now: Identifying the violence in obstetric violence to strengthen socio-legal reform efforts. *Oxford Journal of Legal Studies* 44 (3): 616–44.

Pozzio, María Raquel. 2016. La gineco-obstetricia en México: Entre el parto humanizado y la violencia obstétrica [Gynecology and obstetrics in Mexico: Between humanized childbirth and obstetric violence]. *Revista Estudos Feministas* 24 (1): 101–17.

Purdy, Laura. 2006. Women's reproductive autonomy: Medicalisation and beyond. *Journal of Medical Ethics* 32 (5): 276–80.

Quintanela, Carmen. 2020. *Violencia ginecobstétrica. Abusos, malos tratos e incomodidad en los servicios ginecobstétricos del norte de Centroamérica* [Gynecological and obstetric violence: Abuse, mistreatment,

https://doi.org/10.1017/hyp.2026.10062 Published online by Cambridge University Press

and discomfort in obstetric and gynecological services in northern Central America]. Ciudad de Guatemala: Agencia Ocote.

Rich, Adrienne. 1995. *Of woman born: Motherhood as experience and institution*. New York: Norton.

Rothman, Barbara Katz. 1982. *In labor: Women and power in the birthplace*. New York: W. W. Norton.

Ruiz-Berdúm, Dolores, and Ibon Olza. 2016. The past and the present of obstetric violence in Spain. In *VI Jornadas Internacionais de História da Psiquiatria e Saúde Mental*, ed. Ana Leonor Perera and Joao Pita. Coimbra: Universidade de Coimbra.

Russell, Diana H. 1986. *The secret trauma: Incest in the lives of girls and women*. New York: Basic Books.

Sadler, Michelle, et al. 2016. Moving beyond disrespect and abuse: Addressing the structural dimensions of obstetric violence. *Reproductive Health Matters* 24 (47): 47–55.

Salinero, Stella. 2021. "Fue un terremoto": Violencia obstétrica y relatos de mujeres en Chile ["It was an earthquake": Obstetric violence and women's stories in Chile]. *Debate Feminista* 62: 142–68.

Salinero, Stella. 2024. Posición obligatoria: Experiencias de violencia en la consulta ginecológica en Chile [Compulsory position: Experiences of violence in gynecological care in Chile]. *Revista Interdisciplinaria de Estudios de Género* 10: e1076.

Salinero, Stella, and Manuel Cárdenas. 2021. Violencia ginecológica y silencio al interior del Modelo Médico en Chile [Gynecological violence and silence within the Medical Model in Chile]. *Revista de Obstetricia y Ginecología de Venezuela* 81 (3): 226–38.

Salinero, Stella, Daniela Vargas, and Manuel Cárdenas. 2023. *Segunda encuesta nacional sobre violencia ginecológica y obstétrica en Chile: Síntesis de resultados* [Second National Survey on Gynecological and Obstetric Violence in Chile: Summary of Findings]. Valparaíso: Colectiva Contra la Violencia Ginecológica y Obstétrica.

Sampaio, Juliana, Tatiana Tavares Lopes de Albuquerque, and Bento Thuany. 2019. Um corte na alma: Como parturientes e doulas significam a violência obstétrica que experienciam [A cut to the soul: How parturients and doulas signify the obstetric violence they experience]. *Revista Estudos Feministas* 27 (3): e56406.

Schroll, Anne-Mette, Hanne Kjærgaard, and Julie Midtgaard. 2013. Encountering abuse in health care: Lifetime experiences in postnatal women. *BMC Pregnancy and Childbirth* 13 (74). https://doi.org/10.1186/1471-2393-13-74.

Scully, Diana, and Pauline Bart. 1973. A funny thing happened on the way to the orifice: Women in gynecology textbooks. *American Journal of Sociology* 78 (4): 1045–50.

Segato, Rita. 2003. *Las estructuras elementales de la violencia* [The elementary structures of violence]. Santiago: LOM.

Sena, Ligia Moreiras. 2016. Ameaçada e sem voz, como num campo de concentração: A medicalização do parto como porta e palco para a violência obstétrica [Threatened and voiceless, like in a concentration camp: The medicalization of childbirth as a gateway to obstetric violence]. Doctoral thesis, Universidade Federal de Santa Catarina.

Sesia, Paola. 2020. Violencia obstétrica en México: La consolidación disputada de un nuevo paradigma [Obstetric violence in Mexico: The contested consolidation of a new paradigm]. In *Violencia obstétrica en América Latina*, ed. Patrizia Quattrochi and Natalia Magnone. Buenos Aires: Cuadernos del ISCo. EDUNLa.

Simeneh, Getinet Tilahun, et al. 2024. Obstetric violence and associated factors among women who gave birth at public hospitals in Addis Ababa. *Frontiers in Global Women's Health* 5.

Söderberg, Siv, Malin Olsson, and Lisa Skär. 2011. A hidden kind of suffering: Female patients' complaints to Patient's Advisory Committee. *Scandinavian Journal of Caring Sciences* 26 (1): 144–50.

Swahnberg, Katarina, Suruchi Thapar-Björkert, and Carina Berterö. 2007. Nullified: Women's perceptions of being abused in health care. *Journal of Psychosomatic Obstetrics and Gynecology* 28 (3): 161–67.

Swahnberg, Katarina, Barbro Wijma, and Karin Siwe. 2011. Strong discomfort during vaginal examination: Why consider a history of abuse? *European Journal of Obstetrics and Gynecology and Reproductive Biology* 157 (2): 200–5.

Swahnberg, Katarina, Anke Zbokowski, and Barbro Wijma. 2010. Ethical lapses: Staff's perception of abuse in health care. *Journal of Psychosomatic Obstetrics and Gynecology* 31 (3): 123–29.

The Boston Women's Health Collective. 2006. *Our bodies, ourselves: Menopause*. New York: Touchstone Books.

https://doi.org/10.1017/hyp.2026.10062 Published online by Cambridge University Press

Tobasía-Hege, Constanza, et al. 2019. Irrespeto y maltrato durante el parto y el aborto en América Latina [Disrespect and abuse during childbirth and abortion in Latin America]. *Revista Panamericana de Salud Pública* 43 (36).

Towle, Sarah. 2022. 'Poorly relaxed women': A situational analysis of pelvic examination learning materials for medical students. *Medical Education* 56 (7): 716–723.

Tronto, Joan C. 1993. *Moral boundaries: A political argument for an ethic of care*. New York: Routledge.

Valls-Llobet, Carme. 2009. *Mujeres, salud y poder* [Women, health and power]. Madrid: Cátedra.

Van der Waal, Rodante, Kaveri Mayra, Anna Horn, and Rachelle Chadwick. 2023. Obstetric violence: An intersectional refraction through abolition feminism. *Feminist Anthropology* 4 (1): 91–114.

Yalley, Abena A., Gabija Jarašiūnaitė-Fedosejeva, Burcu Kömürcü-Akik, and Liliana de Abreu 2024. Addressing obstetric violence: a scoping review of interventions in healthcare and their impact on maternal care quality. *Frontiers in Public Health* 12: 1388858.

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