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ISBN 978-90-429-5477-9

https://www.peeters-leuven.be/detail.php?search_key=9789042954779&series_number_str=16&lang=en

Ethics of Care
Volume 16

Recommitting to Reproductive Justice: Care Ethical Perspectives

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PEETERS
Leuven – Paris – Bristol, CT
2025

Table of Contents

CHAPTER 4

A care(less) learning process: the hidden curriculum in midwifery education in Chile

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Introduction: Chile's childbirth landscape

In 2014, an article entitled 'Chile, a Good Place Where to be Born', stated that the country had some of the best maternal and child health conditions globally, a 'situation that is comparatively far superior to other aspects of national life' (González 2014, 874). In the article, the success of social and health policies such as the institutionalization and professionalization of childbirth, was evidenced by the low rates of maternal and infant mortality.[1] But, the outcome of not dying tells us little about the conditions in which birth takes place and about the lived experiences of those who are part of care interactions. The general health indicators hide large gaps in access and quality of health care between private and public health facilities, as well as disparities between territories, in a context in which the public healthcare system has important deficiencies in hospital infrastructure, low privacy in patient care, and a low level of wages for practitioners (Goic 2015). The causes of these deficits date back to the 1980s, when a neoliberal healthcare system was introduced by the Pinochet regime (1973-1990), creating a private sector that has

[1] In 2017, the maternal mortality ratio in Chile was 13 per 100,000 live births, with the average rate in Latin America and the Caribbean being 74/100,000 (WHO 2019). In the same year, the infant mortality ratio in Chile was of 6 children under one year of age per 1,000 live births, while the region had a rate of 15/1,000 (UNICEF 2018).

led to inequality of access and structural disadvantage for several segments of the population, including women (Unger et al. 2008; Sakellariou and Rotarou 2017). The country also exhibits a lack of options regarding place of birth; only facility births are covered by insurance, and home birth, although not illegal, is discouraged (being an option only for the elite). Further, there are very high rates of routine obstetric interventions and cesareans – which accounted for 59% of births in 2021 –, which are harmful and against national and international guidelines (MINSAL 2008; WHO 2018; Subsecretaría de Salud Pública 2022).

Regarding women's childbirth experiences of care, the study by Binfa et al. (2016) showed that they were not heard, did not receive information, were not considered in decision-making regarding procedures or interventions, and in some cases were mistreated. The Chilean Observatory of Obstetric Violence's (OVO Chile) survey showed that in 71% of childbirth experiences in public hospitals, and 52% in private clinics for the period 2014-2017, women were not given information about obstetric interventions; in 43% and 17% they were criticized or repressed by health professionals for expressing emotions and/or pain during labor and birth; in 18% and 5% they were physically abused in some way (such as slapping or shoving). These gaps are exacerbated if we analyse the data by educational level: 29% of women with the lowest educational level in the sample (who did not complete primary education) experienced physical abuse, versus 5% in the case of women with graduate degrees; and 59% versus 15% were criticized/repressed for expressing emotions or pain (OVO Chile 2018). All of the above constitutes obstetric violence, which has been a central topic in Latin American activism for sexual and reproductive rights.

These concerns have been in the Chilean rights and health agenda since the beginning of this millennium. The first childbirth rights social organizations were founded in the year 2000. By 2016, 16 of them gathered in the National Coordinator for the Rights in Childbirth, and have since then been working for a bill on respectful childbirth and against obstetric violence (which is currently being

discussed in Congress). Regarding health policies, a comprehensive program for the protection of children, called 'Chile Grows with You' [Chile Crece Contigo] was launched in 2007 (MIDEPLAN 2009), and in 2008, the Manual for Personalized Attention in the Reproductive Process was published by the Ministry of Health (MINSAL 2008). These policies have placed a strong emphasis on promoting personalized care for women and their families during pregnancy and birth, and reducing unnecessary obstetric interventions. Since their implementation, there has been an improvement in certain isolated practices,[2] but, until now (early 2023), there has not been a paradigm shift towards the humanization of care (Binfa et al. 2016; OVO Chile 2018; Sadler 2021). A reproductive rights approach has dominated the health agenda, with measures focusing on improving information and services, without a critical reflection on how healthcare structures are promoting social injustice and violating women's rights (Sadler 2021). Such a limited view is at odds with a framework of reproductive justice, in which the approaches of reproductive rights, human rights and social justice are intertwined (Ross and Solinger 2017).

In this scenario, what is the role played by midwives, given they are the main caregivers during pregnancy and childbirth in the country? Is midwifery education promoting the necessary skills for a paradigm shift that integrates reproductive justice?

Midwifery's curriculum

The first School for Midwives was founded in Chile in 1834, it acquired university character during the 1950s (Zárate 2018), and is currently a direct entry university career of 5 years of extension. Midwives' field of action differs between the public and private health systems. In public health, midwives are the main caregivers for low-risk pregnancies and births, supervised by on-duty obstetricians who

[2] Mainly those indicators that constitute goals for the 'Chile Grows with You' program (such as the presence of a companion during labor and birth, and skin-to-skin contact with the newborn).

manage high-risk cases, instrumental births, and cesareans. In the private sector, although midwives are present throughout labor and birth, obstetricians are the primary care providers.[3] Regarding the number of midwives in the country, in 2019 there were about 66 licensed midwives for every 1,000 live births. This figure is near the average of the Organization for Economic Cooperation and Development for the same year, which was 68 licensed midwives per 1,000 live births (OECD 2023). But, while in private health there is a ratio of 1 midwife per woman in labor, in the public sector it can account for 1:5.

We have, then, a scenario in which all women have contact with a midwife during pregnancy and childbirth. And, although their field of practice is narrowing due to the expansion of private care and the increase in cesareans, there is potential for them to work towards the implementation of the 'personalized' model of care (MINSAL 2008). But the country exhibits an over-medicalized childbirth scenario, with alarming numbers of women being disregarded and having experienced mistreatment (Binfa et al. 2016; OVO Chile 2018; Sadler 2021). Moreover, recent studies show that midwives and obstetricians are aware of the available evidence towards the need to implement a humanistic model of childbirth, which is reflected in international and national health recommendations (Binfa et al. 2016; Sadler 2021). These studies show, at the discursive level, an acknowledgment of the benefits of such a model, but without an application into practice.

One way to approach how this gap is generated is by analyzing the socialization process by which students become health professionals, that is, the process through which they acquire the norms, values, behavior and skills of the group to which they seek to belong. Within this broad topic, the study of the medical curriculum has received

[3] As private care and cesareans have been increasing in the country, the number of births attended fully by midwives has been decreasing: in 2000, midwives were in charge of 52% of all births (Leiva 2016), a number which has dropped to around 30% in 2021 (this is a rough calculation from data on births from 2021, obtained from Subsecretaría de Salud Pública 2022).

great interest. We will understand the curriculum as a process of construction, negotiation and selection of knowledge, identities, representations, and professional and disciplinary achievements, expressed in a set of intentional, meaningful, and organized qualifications administered in a training itinerary (Universidad de Chile 2021). A curriculum contains, firstly, an explicit or official dimension, which is expressed in the formal documents that establish the approach and pedagogical strategies, its objectives, contents, methodologies, resources, and evaluation criteria. At this explicit level, the graduate profiles can serve as a guiding tool to understand universities' strategic aspirations; these are formal declarations that higher education institutions make towards society and themselves, compromising the formation of a professional identity (Hawes 2010). When revising the graduate profiles of midwives from 22 public and private universities in the country, which are available online, certain key dimensions are repeated: solid ethical and moral values, sense of social responsibility, abilities to deliver biopsychosocial/integral/holistic/humanized care, with respect for social and cultural diversity, integration of a gender approach, and a base on solid scientific evidence.[4]

The ethical domain is present in all midwifery graduate profiles, being a central criterion of evaluation to accredit such programs by the National Accreditation Commission (CNAP 2007). In the different midwifery graduate profiles, this domain is presented as: (bio) ethical attitudes, training, approach, framework, behavior, or principles. In some profiles, it is phrased solely as 'ethics', in others as 'bioethics', and in others, it is accompanied by the adjective 'medical' or 'scientific', such as 'medical ethics', or 'ethical principles of medical

[4] The analysis of midwifery graduate profiles in the country was carried out thanks to funding obtained through the 'Individual Research Contest' from Universidad Adolfo Ibáñez, during 2020. The 22 midwifery programs analysed were: Universidad de Atacama, U. de Antofagasta, U. de Tarapacá, U. de Valparaíso, U. de Viña del Mar, U. de Chile, U. de Los Andes, U. del Desarrollo, U. de Santiago de Chile, U. Andrés Bello, U. Diego Portales, U. Mayor, U. Autónoma, U. San Sebastián, U. Bernardo O´Higgins, U. SEK, U. de Talca, U. de la Frontera, U. Adventista, U. de Concepción, U. Austral, U. de Aysén.

disciplines', or 'ethical-scientific approach'. They all refer to the framework of bio-medical ethics which is at the core of bio-medical training.

While ethics is such a strong pillar in the curriculum, how is it possible that women are still being systematically abused during childbirth? We could find some hints in the informal and hidden curricula of medical education.[5] According to Hafferty (1998), the informal curriculum is an interpersonal form of teaching and learning, and, as the explicit one, follows learning objectives. The hidden curriculum refers to the set of norms, attitudes, expectations, beliefs, and practices that are unconsciously installed in the structures and functioning of institutions and in the establishment and development of their hegemonic culture (Hafferty 1998). It hardly operates through the formal content that is taught, but in a subtle and unrecognized way, through ritual behaviors, assumptions, and shared beliefs of the faculty; producing true moral training (Hafferty and Franks 1994). It is this last curriculum which mostly shapes the distance between what students are taught (through direct means) and what they learn (through indirect means), given the sustainability and stability of the learning that it produces (Dixon, Smith-Oka and El Kotni 2019).

In an attempt to approach some fundamental elements of the hidden curriculum, in the following sections we will draw testimonies from interviews and discussion groups carried out with midwifery students and young midwives in the context of three research projects on topics related to sexual and reproductive health care in Chile, funded by the National Agency for Research and Development (ANID), between 2014 and 2023.[6] From all interviews and discussion

[5] In this chapter, when referring to 'medical education', 'medical students', 'medical curriculum', we are including the training of obstetricians/gynecologists and of midwives, given they are trained in the same principles of the biomedical paradigm.

[6] Projects: FONIS SA13I20259 'Perceptions and practices on cesarean section' (2013-2016); FONDECYT 11190701 'Encounters and tensions in the construction of young bodies and sexualities' (2019-2023); FONIS SA19I0091 'Barriers for the prevention and detection of HIV/AIDS in young people' (2019-2023). All projects had approval of Ethical Committees.

groups with midwives, we selected those conducted with students (since their 3rd year of studies, when they started clinical practice) and young midwives who graduated less than two years ago at the time of the encounter, which accounted for 11 in-depth interviews and 3 discussion groups.[7] These midwives were studying or had studied in 8 different universities across the country. In all projects, the interview guides included questions about their experiences as students and their perception of their career curriculum. The interviews and discussion groups were audio recorded and transcribed verbatim in Spanish, and analysed using thematic analysis, a qualitative method that enables thematic patterns to be identified from the collected data (Creswell 2014). The verbatim quotations selected for this chapter were translated by a native English-speaker translator and checked by the authors to verify the translations had captured their original meanings.

A care(less) learning process

Paradigmatic contradictions

When talking to midwifery students and recent graduates (which we will refer as students/midwives) about their programs, they all mentioned there is a paradigmatic shift in the childbirth model of care, which they learned about:

> They taught us that the paradigm had changed, the model had changed to a more holistic one. […] They emphasized that when women are admitted in hospital, in labor, they have rights and they should be the center of attention, not us; that we are at their service… everything framed in the context of a model of respected, humanized childbirth. (I1, graduated 6 months ago)[8]

[7] Some preliminary results about midwifery's curriculum based on one of these projects (FONIS SA13I20259) were part of Fernanda Cordero's professional internship report (2016) and Michelle Sadler's PhD dissertation (Sadler 2021). For this chapter, we add results from the two other projects quoted before.

[8] 'I' stands for interviews (numbered 1 to 11), and 'DG' for discussion groups (numbered 1-3).

Although they are taught about the 'new' model, they recognize great differences between teachers; with some faculty members being more 'old fashioned' or 'traditional' in their approaches, and others being aligned with the current recommendations for care. This leads to big contradictions in the training programs, which contain opposing principles and elements: 'I cannot understand how there is so much disagreement between one teacher and another' (I8, 3rd year student).

> Theoretically, the younger teachers have taught us a lot about humanized childbirth, emphasizing the importance of avoiding obstetric violence and the importance of respect. But others unfortunately do not follow that line and have more traditional practices. When it comes to clinical practice, unfortunately, there is almost no space for humanized childbirth. (I4, 3rd year student)

These divergences between more and less up-to-date approaches generates confusion, frustration, and impotence in the students:

> You must take your own positions, to get your own idea, but that is not fair, you would expect it to be more consistent, that you would be taught the 'correct' way. That is what you expect of university. (DG1, 4th year student)
>
> One questions many things […] many times they ask us to study things that we know are against available evidence… It really makes you angry, you feel sad, you feel powerless, and you feel like arriving the next day with an updated book or paper and say: 'Look, this is not the case anymore.' (I3, 5th year student)

The testimonies of students/midwives are coherent in describing that their study programs are not based on up-to-date evidence, as is declared in their graduate profiles. This is aggravated in clinical practices, where the distance between what should be done – humanistic model – and what is done is accentuated. These outdated approaches towards childbirth are also described in a sociology dissertation that analyses obstetric education in Chile (Hernández and Soto 2020). Thus, the 'new' model appears, in the words of a young graduate, as a 'theoretical fiction' (I6, graduated 4 months ago). In these lines, midwifery students feel they must find – on their own – the resources

that the university did not provide: 'Unfortunately, our undergraduate training was very incomplete in several dimensions […], we had to educate ourselves in many topics' (I10, graduated 2 years ago); 'We had serious deficiencies in training in super essential things' (I7, graduated 8 months ago).

We will extend in some of these 'super essential things'; those which were mentioned by all students/midwives interviewed, intertwining our findings with other studies and discussions.

'I must be a robot'

The dimension most frequently mentioned by the students/midwives is the process of emotional disconnection that they are asked to go through. At odds with the declared 'bio-psycho-social', 'integral', 'humanized', 'holistic' approach that is found in the graduate profiles, in course syllabi and in the discourse of many teachers, they experience a strong implicit force that requires them to leave emotions aside to become 'adequate' professionals, which is especially experienced in clinical practices: 'They bullied me a lot because I would go aside and cry, because I couldn't bear how badly they were treating women. And I was always criticized for being too emotional' (I2, graduated 2 years ago); 'As a student one gets involved with women, one offers emotional support… and they question you for that, they say you are not doing your job well' (DG1, 5th year student).

> [Connecting emotionally] Is very frowned upon, like if you almost cannot be good technically and get emotionally involved with the woman… if you hold her hand it's like: 'Why are you holding her hand if that's not your job?' […] I cannot have feelings and I must be a robot, because that is what is expected of me; to be technically good and treat her fairly well… but not to go further: not to look into her eyes, or to be more of a person with her. (I3, 5th year student)

Thus, the 'good' job is the one where women are treated well enough, but without a real empathic or compassionate connection. It is as if emotions would contaminate the technical skills of practitioners. And this principle is deeply embedded in modern medicine and has not changed much since its foundation. Modern science was founded on

masculine principles and everything metaphorically associated with the feminine – such as emotions – was looked down upon. Let us recall that The Royal Society (formally the Royal Society of London for Improving Natural Knowledge), founded in the 1660s, aimed to build a masculine philosophy. In such a paradigm, there was no chance for truth if affections and feminine principles predominated; the scientific ideal – with tools such as logic and analysis – had to be separated from the emotional realm (Sheperd 1993).

The imagery of the robot, mentioned by several students/midwives, alludes to the mechanistic principle by which natural wholes are similar to complicated machines composed of parts lacking any intrinsic relationship to each other: 'The woman is a bread recipe; the bread comes, it is toasted and it is taken out… insert the intravenous drip, put on the monitor, do a test, break the membranes, oxytocin, oxytocin, oxytocin, make it all happen quickly, quickly, quickly' (I6, graduated 4 months ago). The principles of body/mind separation, as of the body as a machine are reinforced, as components of biomedicine's principle of separation, in which things are better understood out of their context: 'We learn to control all the processes, to treat the human being as a machine… literally in this case: the woman in labor as a machine. And we are obviously dehumanizing all the processes' (I1, graduated 6 months ago). So, human existence is dissected into parts: body-as-machine lacking relation to emotional or spiritual dimensions, and individual persons-as-autonomous beings lacking relation with others.

Biomedicine's structural dominant feature is biologicism – the biological dimension being a principle of identification and professional differentiation and the core of the professional training –; thus, the core content of training is biological, leaving social, cultural, and psychological processes as anecdotal (Menéndez 2003). The weak formation in the integrality of the human and emphasis on the biological leads by default to a neglect of the emotional dimensions, to an emotional numbness (Davis-Floyd 2018). Thus, despite the declared commitment to integrality and holism, a hidden curriculum grounded in biologicism and fragmentation persists.

'Women exaggerate to catch our attention'

When analysing the category of "gender approach", there are significant contradictions and gaps between midwifery programs' declarations and the embodied learnt experience of students. In midwifery graduate profiles, a 'gender approach' is stated but almost never developed in depth. When looking at students/midwives learning processes, it comes down to the declaration of treating women/men/others with equality and without discrimination based on their sexual/gender identity. But it does not refer to a paradigmatic questioning of the prevailing gender order, with an understanding that gender inequalities are embedded in all levels of society, impacting midwifery care at different levels (Christianson, Lehn and Velandia 2022).

We will analyse a few elements that play a central role in the reproduction of gender inequalities, as experienced in students/midwives' educational processes. There is compelling scholarship that shows gender biases in the foundations of modern medicine, but such biases are rarely discussed in midwifery programs, and are reproduced and taught with almost no critical discussion. The embedded principle that women are inferior to men and pathological by nature (Martin 1987; Villarmea 2021) is reproduced in the explicit, informal, and hidden curriculum. As an example, in previous research we have analysed how certain supposed racial characteristics of the 'Chilean woman' would make them more unsuitable – than other populations – to have vaginal births, given the reduced size of their pelvises; an idea which is present in textbooks and reinforced in clinical interactions with teachers and mentors (Sadler 2016). The small pelvises are just one of many physiological and psychological traits which put women – and Chilean women in particular – at a disadvantage, as mentioned in the interviews, such as 'hormonal imbalance', 'low pain tolerance', or 'low tolerance for uncertainty'. These ideas go hand-in-hand with the prevailing symbolic opposition between men/mind/rationality/objectivity and women/body/emotionality/subjectivity (Sheperd 1993, Harding 1996), expressed in a hidden curriculum that denigrates women and leads to a lack of credibility being attributed

to what they express: 'We were told that women exaggerate to catch our attention, they will fuss over anything, they will be super demanding… so we do not have to take them much into account or they will become more demanding' (DG3, graduated 1 year ago).

In the childbirth scene, the devaluation of 'patient' and 'woman' acquires a particular depth, which is rarely seen in other health interactions. The childbirth scene is about pregnant and birthing bodies[9] living a sexual-reproductive process, where the symbolic association with the natural and untamed body (versus the rational self) is explicitly deployed. Sara Cohen-Shabot has argued that the powerful, strong, sexual laboring bodies defy 'the feminine mode of bodily comportment under patriarchy and thereby seriously threaten the hegemonic powers' (2016, 231). Thus, 'obstetric violence appears as a tool for taming a rebelling body, for putting a feminine body "in its place" if it challenges its femininity, its condition as object, through a loud and subversive embodied subjectivity' (234). This is clearly expressed in students/midwives' testimonies: 'I could count with less than one hand the births I have seen where a woman is allowed to express herself as she is feeling' (I9, graduated 8 months ago).

> At first it was so shocking to see the midwives telling women to shush when the baby was almost out! 'Shhhhh, shhhhhh, don't make noise, don't make noise!' The woman is giving birth, how would you expect she wouldn't make any noise?! (I11, 4th year student)

The 'taming' interactions operate to a greater extent on those who are subordinated among women: those who live socioeconomic vulnerability, ethnic minorities, migrants, gender diverse people, adolescent women. They are more deprived of the possibility of agency than women who occupy positions of greater privilege. As one example, the OVO Chile survey showed that 20% of women who reached the lowest educational level of the sample had vaginal examinations carried out by 5 or more different health professionals, compared to less than 1% of women with a graduate degree; and the former were

[9] Including cisgender women, transgender men, or gender diverse people who have a uterus and can experience (biological) pregnancy and give birth.

5 times more likely to experience more than 7 vaginal examinations through labor than the latter (OVO Chile 2018). This, in a context in which health students' internships can only be carried out in public hospitals, where women can be manipulated and disrespected in ways women in the private sector do not get to see. Studies in the country show how women with lower educational levels, adolescent women, and migrant women live worse abuses, who, in many cases, describe care as a favor more than a right (OVO Chile 2018; Ortiz et al. 2021; Obach, Carreño and Sadler 2022).

Here, as in the other dimensions we have discussed, despite midwives' graduate profiles having a strong emphasis in respect for differences and diversities (mentioning socio-economic, cultural, and ethnic differences, respect for sexual and gender diversity, among others), there are big shortcomings in these issues. A quote from a 4th year student illustrates this:

> I chose my university because it supposedly had a more 'biopsychosocial' approach than others, but I have found that such approach is only focused on an ideal or traditional user, who is a 'standard Chilean' woman, urban, who can read and write. It is very worrying that I am finishing my studies and I do not have any tools to approach an adolescent woman, or a drug-dependent woman, or a woman who hasn't finished school, or is in a vulnerable situation. Nor do I have the tools to approach multicultural care, either indigenous peoples or migrants. And even least with trans people, or people deprived of liberty, or in street situations, or with psycho-manic disorders, for example. We [students] are very critical of our undergraduate education and practice; the health system is not designed to consider any kind of dissent or non-conformity in any aspect of culture. (DG2, 4th year student)

In these aspects, we identified a worrying lack of approaches that allow understanding how these structural factors are involved in the discrimination and abuse experienced by women in general, and especially by women in vulnerable positions.

No voice or vote

Hierarchies within the medical staff were a topic mentioned by almost all students/midwives interviewed. On one level – related to

gender inequalities – we find the power imbalances within health professions, where medicine (ob-gyn) is considered superior to midwifery. It is a system that is based on an androcentric logic, hence it follows that the specialty that holds the most prestige and power in the system, is masculinized, regardless of the sex of the practitioners. Ob-gynecology (male) dominates midwifery (female); dyad that reproduces the binary polarizations of the attributes that are assigned to the genders.

> If the doctor indicates to break membranes, the midwife – being in agreement or not – must break membranes, because it is a medical indication… the hierarchy weighs very strongly and they are quite aggressive in the way they explain it to you: 'There doesn't need to be a reason, it's because I'm the doctor, because I'm in charge, because I say so'. (I2, graduated 2 years ago)

Another student expresses how she feels as 'scum' for doctors: 'The truth is that doctors are a world apart; I have never felt taken into account by a doctor, I feel worse than scum, like nobody' (I8, 3rd year student). These testimonies show an order of hierarchies as follows: ob-gyns (and anesthesiologists), midwives, midwifery students, and finally birthing women – who do not share the 'authoritative knowledge' (Jordan 1993) to deal with childbirth. In clinical practices, practicing midwives/teachers many times reproduce the abuse of power they themselves experience from obstetricians, towards their students.

For Roberto Castro (2014), the medical field, like the military, is rigidly organized into lines of command and different ranks. The centrality of such hierarchies is learned through a punishment dynamic, and through a set of practices and conventions that manifest themselves from the first days of study. These types of disciplining are explicit in the testimonies of students in Chile: 'There are midwives and teachers who discredit and embarrass you in front of the woman' (I4, 3rd year student); [After making a mistake in inserting the intravenous drip] 'The teacher laughed out loud in front of everybody and ridiculed me… she humiliated me in front of my classmates and of

the woman' (I7, graduated 8 months ago). Hernández and Soto's (2020) thesis on midwives' and obstetricians' education in the country, also confirms the constant humiliations to which students are subjected.

Our findings show various forms of devaluation and contempt against students in clinical practice: not greeting them, ignoring them, not taking their opinions into account, not responding to their questions or concerns, not allowing them to take breaks or to have snacks, giving them ridiculous nicknames, mocking them… making them feeling 'worthless'. In many cases, students/midwives feel compelled to follow their superior's instructions, even if they do not agree, for fear of being further scolded, humiliated, or of failing the courses. Refusing the teacher's indications may not only have negative consequences for the students but also for birthing women:

> We were a group of about eight students and they were teaching us how to do vaginal examinations. I stayed aside and the teacher scolded me because I did not come closer to look. I told her that there were already a lot of people and we were trespassing on the woman's privacy and integrity. She told me that with such an attitude I would never become a midwife, and made me do the examination myself, as a way of punishing me. (I11, 4th year student)

Several student/midwives interviewed described how they were threatened with failing their clinical courses if they did not obey and comply with executing practices or interventions they thought were harmful and disrespectful towards women, and felt impotence and then guilt.

> You can't say anything against what the superiors tell you… it's kind of funny because as a student, you can't look, you can't give your opinion… you just have to do what they tell you, nothing more is expected of you… don't even think about contradicting them… it's a major sin when one thinks of saying: 'No, I'm not going to do this', [because as a result] they attack you as a student and attack the woman as a mother. […] I think that's the biggest form of violence against students, that they have no voice or vote. (I2, graduated 2 years ago)

From a moral colonialism to an ethics of care

The disappointment: not being able to 'really' care

Medical education institutions are cultural and moral entities that build what is valued in clinical practice and what is expected of medicine (Hafferty 1998). As we have seen, it is mainly through the informal and hidden curriculum – and during the clinical practice – that students acquire their embodied ethical behavior (Hafferty and Franks 1994; Salehi 2006; Azadi et al. 2017). We revised how, despite midwifery's graduate profiles having a strong emphasis on incorporating bio-ethical principles of care, students are taught to detach from emotions, reproduce gender and other social inequalities, embody hierarchies and reproduce abuse of power, in such a way that those norms and values can become integrated in their practice as 'the way'.

Studies around the world with ob/gyn and midwifery students show similar findings. In Mexico, Roberto Castro's research (2014) has found that the three fundamental dimensions that the ob/gyns are taught through the hidden curriculum are corporal disciplining, gender discipline, and the order of hierarchies within the profession. In the USA, Robbie Davis-Floyd (2018), in addition to Castro's categories, identifies cognitive narrowing and transformation, and emotional numbing. In South Africa, Veronica Mitchell (2019) reveals a medical curriculum that focuses on individual competence, promoting distancing and separation, with students feeling powerless, helpless, and undermined by the norms of practice and hierarchy in medicine.

In our findings, many students experienced a gradual disenchantment and disappointment regarding what they thought the profession would be. The main disappointment is that they are not allowed/permitted to care as they had pictured care should be.

> I had thought that when I entered the university it would be different… Oh god! I'm sorry [crying, long pause]. I thought that I was going to be able to be more 'me', and I have hardly had that possibility. Perhaps only when I've been able to be alone with a woman and I've been able to hold

> her hand… and I've felt really useful… I feel more useful holding her hand than assisting the birth… they're ugly births… for me it is more important to attend one respected birth than millions of ugly births. (I3, 5th year student)

This quote is from a 5th year midwifery student, who lived a discrepancy between what she had thought midwifery would be and what she was exposed to. The consequences are deep: at the time of the interview, she was on a mental-health-related leave of absence from university and was not sure if she would finish her degree. She described how several other classmates were in similar situations: 'Many are seeing psychologists […] We carry the weight of being a witness and sometimes accomplice of violence against women, plus the violence towards you as a student' (I3, 5th year student). These feelings have been described by midwifery students in different settings around the world (Moyer et al. 2016 in Ghana; Coldridge and Davies 2017 in England; Van der Waal et al. 2021 in South Africa and the Netherlands; Schoene et al. 2023 in Germany).

Among the students/midwives interviewed in our projects, we find a deep awareness of the abuses and violence they are experiencing themselves, witnessing and/or being asked to exercise. Most mention 'obstetric violence', 'discrimination', and 'xenophobia', among other concepts which show the extent of their critical approaches towards their curriculum in general, and especially towards their experiences in the clinical field. When tracing the origins of these critical views, they state the influences of the feminist and sexual and reproductive rights movement in the region and country.

Eva van Reenen and Inge van Nistelrooij (2019) argue that such negative feelings towards medical education can be explained, in part, by the lack of care during medical encounters which results in harm. So, harm is done at the expense of an explicit ethical approach. Thus, as paradoxical as it might sound, could it be that the 'ethics' being taught in medical school is at odds with a 'real' possibility to care? Feminist ethicists have been claiming that the supposedly 'neutral' or 'universal' perspective of traditional ethics (like deontology

or consequentialism) is a specifically white male perspective. Margaret Walker (1989) referred to a 'moral colonialism', given that individuals disappear behind impartially applied context-free policies. For Jennifer MacLellan, in such an ethical framework, which applies universal principles of morality, decisions are thought to be made from an impartial position, 'uncorrupted by personal views, interests or networks. This arrangement is described as fair, where all stand equal before the rules governing society' (2014, 3). Monica Christianson, Sine Lehn and Marianne Velandia recapitulate the contributions of feminist authors in criticizing traditional westernized ethical principles as 'relying on individualism and agency, rationality, and independence, preferences that could mask power relations, dominance, and structural inequalities, disregard women's experiences and interests, and disrespect women's capabilities for moral reflection' (2022, 3).

A way out of the traditional bioethics' limitations, as has been proposed by feminist scholars, is an ethics of care. Since its early formulation in 1982 by Carol Gilligan, it has contributed to the proposition that people are necessarily interconnected beings. As Giovanni Maio (2018) shows, beyond some slightly different conceptions in what an ethics of care is, different authors agree in its core elements: people are oriented towards relationships to others as a fundamental feature of human existence; rather than on the sovereignty of each individual, it focuses on their fundamental dependence; rather than basing its actions on abstract rules, it takes practice itself as the foundation for the actions required; and it is primarily response-focused – responding to the needs of those who are dependent on help. The author states that 'care ethics represents a counterpoint to operational rationality because it practices a rationality of its own, in which feelings, intuition, and sensations are just as important as calculations, and in which experience is attributed an epistemological value which is overlooked in the structural logic of modern medicine' (Maio 2018, 59).

Carlo Leget, Inge van Nistelrooij and Merel Visse (2019) argue that ethics of care has advanced in complexity to develop into an interdisciplinary field of inquiry, which is driven by societal concerns.

Based on the contributions of Joan Tronto (1993), they explain how caring has come to be understood as a socially and politically mediated practice, given that it is inherently relational and co-constituted by both caregivers and care receivers, and because it is co-constitutive to the living together of people in an organized community. Therefore, the principles of an ethics of care align much more closely with the 'heart' of midwifery, as reflected both in international declarations (ICM 2014) and in the local midwifery graduate profiles we revised earlier. Could integrating care ethics into the medical curriculum, then, provide a potential solution?

Decolonizing medical education and advancing towards reproductive justice

In 2014, Jennifer MacLellan called to revisit the ethical foundations of midwifery practice to better reflect the ethic of care, with the goal of reversing the trend towards dehumanized care. Following MacLellan, Elizabeth Newnham and Mavis Kirkham (2019) questioned whether moving away from biomedical principlism as the dominant ethical framework in midwifery and towards an ethic of care could help alleviate the problems we have so far discussed. They argued that 'a focus on care ethics has the potential to remedy these problems, by making power relationships visible and by prioritizing relationships over abstract ethical principles' (2019, 2147). Similarly, Eva van Reenen and Inge van Nistelrooij suggested that integrating insights from care ethics, such as vulnerability, relationality, and contextuality, into medical education could foster a more caring practice of health professionals. They argued that 'morality would no longer emerge solely from principles based on rationality and universality but from relational practices' (2019, 1165).

Newnham and Kirkham acknowledge that this shift may not happen quickly due to the 'entrenched attitudes, vested interests, and fear of noncompliance that surround the present power structure' (2019, 9). Such power structures and the socialization into their principles are no small thing to tackle. Van der Waal and colleagues have argued that obstetric training should be understood 'as an initiation into a misogynistic, heteronormative, colonial, and racialised

institution, and thus as an initiation into practices of reproductive injustice through obstetric violence' (2021, 37). Traditional bioethical principles, embedded in these power dynamics, rarely allow for the rise of care ethics, which centers on relationships and interconnectedness – values often at odds with the biomedical paradigm's focus on autonomy and a fragmented, mechanistic, and androcentric view of humanity. A shift toward an ethic of care, embedded in reproductive justice, therefore requires the decolonization of biomedicine.

For Sarah Wong, Faye Gishen and Amali Lokugamage (2021), "decolonizing" refers to recognizing how colonialism and discrimination have shaped societal systems, offering alternative ways of thinking that re-center the perspectives of historically oppressed and marginalized populations. A decolonial approach to medical education, therefore, seeks to train health practitioners to challenge the status quo, with a deep understanding of the historical, social, cultural, and political determinants of health (Lokugamage, Ahillan and Pathberiya 2023). This entails dismantling the hidden curriculum in which colonial legacies perpetuate unconscious biases that reinforce classism, sexism, ableism, xenophobia, and gender discrimination (Wong, Gishen and Lokugamage 2021).

Decolonizing biomedicine requires recognizing it as just one of many healing systems, grounded in the belief system of Western modernity, with dominant features such as biologicism (Menendez 2003) and a devaluation of the feminine (Martin 1987; Shepherd 1993). This decolonization effort should incorporate three key concepts: epistemic pluralism, which acknowledges that all healthcare systems have evolved through interactions with other traditions within a global context; cultural safety and humility, which recognize the inherent power imbalances between clinicians and patients; and critical consciousness, which fosters reflexivity about the nature, sources, and distributions of power in healthcare (Wong, Gishen and Lokugamage 2021).

Although an ethic of care as part of a decolonizing project is promising, can it be implemented within the current paradigm? In Chile, as we have seen, although midwifery graduate profiles adhere to a

'humanistic' model of childbirth and integrate principles of an ethics of care, students often experience this as a 'theoretical fiction' since the model is neither embodied by (many) teachers nor enacted in clinical practice. Most hopes of encountering caring scenarios are shattered when students are exposed to what childbirth 'care' truly looks like in practice, shaped by intersecting systems of oppression and framed by colonialist policies designed to maintain power (Ross and Solinger 2017). A radical decolonial project would recognize that these power structures are so deeply entrenched in education that only a fundamental transformation of the system's rules can enable a shift toward care ethics and reproductive justice.

What might such a project look like? Decolonizing knowledge and integrating an ethic of care would require a comprehensive transformation of midwifery curricula. Eva van Reenen and Inge van Nistelrooij argue for a multifaceted approach that encompasses the formal, informal, and hidden curricula of medical training. This means 'changing an institution, a culture, and its underlying morality' (2019, 1168), addressing both didactical and non-didactical challenges. The didactical challenge involves creating a more caring learning environment, while the non-didactical one requires acknowledging how medical morality implicitly shapes medical ethics and professional behaviors. These challenges might be overcome by focusing more deeply on the clinical phases of training and creating awareness of implicit moral frameworks among healthcare practitioners.

The learning and training processes need to be embedded in nurturing environments where an ethics of care is actively practiced. Rather than focusing mainly on technical skills, midwifery training should embrace a holistic understanding of childbirth, valuing the emotional, cultural, and social aspects alongside clinical interventions. Rather than adhering to biomedicine's reductionist principles of biologism, fragmentation, and individualization, curricula should embrace knowledge from diverse healing systems and promote intercultural models of care (Dixon, Smith-Oka and El Kotni 2019), integrating biomedical training and practice with other paradigms. Integrating an ethic of care requires prioritizing relationships across

all care settings, extending beyond clinical and hospital environments to include access to home births and midwifery-led units (Newnham and Kirkham 2019), along with greater opportunities for students to engage with women and families in community-based contexts. These elements would foster a more holistic philosophy of care. A curriculum based on the ethics of care must also be embedded in violence-free practices that position students as active participants in the construction of knowledge and relationships that shape their future professional identity. This approach requires prioritizing collaborative learning that disrupts the verticality and authoritarianism of the traditional biomedical model, fostering shared decision-making with women and their families and cultivating relationships of care. Moreover, the ethics of care calls for a critical examination of the educational system's power structures, challenging the hierarchies that have historically subordinated midwives throughout their training and practice and colonised their professional identity.

For this shift to be sustainable, it is vital to create spaces for reflection and self-care among students and educators, fostering empathy not only for women and families but also among peers. This would build a community of care that decolonizes the educational experience from within. Such a training model would not only prepare midwives to approach childbirth with a humanistic and culturally sensitive lens but also empower them to challenge and transform the power structures that perpetuate obstetric violence and reproductive injustices in contemporary healthcare systems.

Acknowledgments

The analysis of midwifery graduate profiles was possible thanks to funding from the 'Individual Research Contest' from Universidad Adolfo Ibáñez, during 2020. The testimonies of midwifery students and recently graduated midwives were gathered within three research projects funded by the Chilean National Agency for Research and Development (ANID): FONIS SA13I20259 'Perceptions and practices on cesarean section' (2013-2016); FONDECYT 11190701 'Encounters and tensions in the construction of young bodies and

sexualities' (2019-2023); FONIS SA19I0091 'Barriers for the prevention and detection of HIV/AIDS in young people' (2019-2023).

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