Women's reproductive health and “failure speak”

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There are gaps between what health care providers say or intend to say and what patients hear, and certain words carry negative connotations and the baggage of past experience. For women who have miscarriages or challenges with conception, the clinical encounter is often rife with language that frames their bodies as failures, seemingly inept. “Fertility failure,” “failure to progress” and “failure to conceive” are important examples, as are descriptions of women's pelvises as “inadequate,” cervixes “incompetent” or “insufficient” and cervical mucus as “hostile.” Jargon that describes women's bodies as inherently and necessarily reproductive perpetuates the blame, stigma and sense of failure associated with infertility and works to disempower women.^{1,2}

Appeals have long been made to change the language of obstetric care.³ Analyses in a wide range of disciplines have interrogated how the language of medicine exerts power and called for the use of terms that are neutral and patient centred.

Yet “failure speak” in clinical practice, medical literature and training materials persists.⁴ Because we are researchers primarily concerned with reproduction, our friends, family and colleagues whisper their experiences with these words to us. What we hear is that failure speak results in confusion, disempowerment and the feeling of being betrayed by one's body. They cannot understand why they have failed. This language is not the sole domain of obstetrics, as many other areas of medicine describe how patients and their bodies, their organs, may “fail.” As the average age of first birth continues to rise in Canada, however, and as people increasingly seek out assisted reproduction to conceive, there is an ongoing and particularly pressing need to address failure speak in obstetric and fertility care.

Labour and birth.

The problem(s) with failure speak

Failure speak reduces a woman's pelvis, uterus and other body parts and fluids to a reproductive function, describing them in relation to others and creating a distinction between women from their embodied experiences. A pelvis may be “inadequate” for childbearing, but it is not necessarily inadequate for the woman's life otherwise. Mucus may be thick or acidic, but it is only “hostile” from the perspective of the semen in question.^{3,5} A body fails only insofar as it does not comply with what have come to be thought of as conventional reproductive norms.

Failure speak can also exacerbate the stigma and alienation experienced by those who are having difficulty with conception or with carrying a pregnancy. The pressures many women feel to become mothers are

part of persistent social narratives that depict childbearing as a natural, moral and expected process, with motherhood integral for women's psychological and psychosocial well-being.⁶ Being a mother has long been associated with being a good woman, and framing women's bodies as failing at what they may perceive as a critical task serves only to reinforce the idea that all bodies should be reproductive.⁷ Although these pressures similarly exist for men, it is important to note that the terms used to describe male body parts, fluids and functions in a clinical setting usually come without normative descriptors. The language used is that of “male-factor infertility” and an “antibody reaction,”⁸ rather than “hostile sperm” or “incompetent testicles.” Instead, stereotypically gendered metaphors — related to cars, sports, war and so on — are used to describe men's bodies and their functions in fertility care.^{8,9}

Difficulty conceiving for men might be described in terms of challenges with a “blocked exhaust” or malfunctioning “engine.” Sperm are similarly described as racing toward a finish line, or as soldiers marching forward. Another problem with failure speak is that it reaffirms power imbalances between patient and provider.

Women who seek out care to help them conceive are likely to already be frustrated by not being or staying pregnant. Normative language may be perceived as a subtle means of at once removing agency from women in what is often an already frustrating and disempowering process, and attributing them with just enough agency to be responsible for their physiologic failures. To this end, “obstetric jargon exemplifies the traditional premise that physicians control birth while women are passive agents who can fail the challenges of reproduction in countless ways.”²

Language works as a means of gatekeeping, ensuring that the reproductive experience is owned by the domain of medicine, rehearsing long-standing culture wars about reproduction in the home and the hospital. If women are to be understood as the protagonists of their bodies, the language used in the provision of care should instead centre on their experiences.

Suggestions for change

Many working in the medical humanities and in other relevant disciplines have been analyzing discursive power in medicine, but work must continue. Those who have previously called for an end to the use of normative language in obstetrics have enumerated the wide range of alternatives that might be used.^{2,3,5} Mucus is “thick,” not “hostile”; cervixes are “weakened,” not “incompetent”; and pelvises are “small,” not “inadequate.” A pregnant woman might have “toxemia of pregnancy”; however, she cannot “become toxic.”² Similarly, a woman’s “failure to progress” might be described as a “nonprogressive pregnancy,” shifting the language away from a woman’s seeming failure. A “failure to conceive” and

“fertility failure” are simply the continued state of not being pregnant.

Knowing the words is not enough. The attitudes and biases that allow such language to become accepted in the first place must be reformed. Perhaps change can be most effectively made with a new generation of physicians, starting with educational materials that discuss the role of language in medical care so that doctors can become aware of and address the assumptions inherent in authoritative knowledge. Critical pedagogical practices drawing attention to issues of identity, power and authority that condition professional discourses may go far to enable shifts in both attitudes and rhetoric.¹⁰ Practising doctors can help by remembering that each person brings their own interpretation of reproductive language to the clinical encounter, and it is this personal understanding that needs to be unpacked rather than for their experience to be repackaged into failure speak.

Conclusion

Language, simply put, is not innocuous. This is not to say that the language of failure has no place in medicine. However, the difference between nonfunctional lungs or kidneys and nonfunctional ovaries is arguably substantial. This language is particularly meaningful in reproductive health care insofar that reproduction is interlaced with social expectations for women’s bodies and lives.⁵ It carries with it the implication that women not only fail to reproduce, but also fail as women. Addressing the continued use of failure speak and its problematic associations ultimately means that providers must come to recognize women as authorities and autonomous actors in their experiences of reproductive health.

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