Violence against women VI

Violence against women in health-care institutions: an emerging problem

Ana Flávia Pires Lucas d'Oliveira, Simone Grilo Diniz, Lilia Blima Schraiber

Maternal morbidity and mortality in childbirth is a matter of utmost importance in public health. In this article, we argue that part of the problem lies in violence committed by health workers in childbearing or abortion services, which affects health-service access, compliance, quality, and effectiveness. We analysed rigorous research from the past decade and discuss four forms of violent abuse by doctors and nurses: neglect and verbal, physical, and sexual abuse. These forms of violence recur, are often deliberate, are a serious violation of human rights, and are related to poor quality and effectiveness of health-care services. This abuse is a means of controlling patients that is learnt during training and reinforced in health facilities. Abuse occurs mainly in situations in which the legitimacy of health services is questionable or can be the result of prejudice against certain population groups. We discuss ways to prevent violent abuse.

"At the medical school . . . we went to attend a delivery, a woman resident was doing it. She was sitting there in front and yelling at the mother: "Shut your mouth! Stop yelling and push! You knew what you were doing when you had sex, and now you see the result you're going to cry? Try to push and yell quietly." And we students stared and said to ourselves: "Wow, she's really totally in control of the situation. She's my idol!" (Brazilian doctor).[1]

Maternal death rates are on average 18-times higher in less-developed than more-developed countries, and 300 million women have short-term or longterm illness related to pregnancy or childbearing.[2] The problem does not lie only in access to hospital delivery or resources since avoidable deaths and serious complaints about quality of treatment occur in cities—where most births take place in hospital and in relatively well resourced facilities.[1,3–6] We suggest that part of the problem lies in violence committed by health workers, which affects health-service access, compliance, quality, and effectiveness.[2,5–8] This subject is as important as it is disturbing. Most health workers around the world make considerable efforts to provide proper care, even in adverse working conditions, and we do not intend to detract from the work of these professionals. However, addressing the problem of violence by health workers is necessary to support the efforts of dedicated staff who are committed to improving clinical practice.

In this article, we discuss research from the past decade done by universities, government agencies, and non-governmental organisations in which they have documented frequent and repeated disrespect and abuse of women by health-service staff. Most of these studies are qualitative analyses of users and providers in developing countries, are scientifically rigorous, and support assertions about dehumanisation of care made by the activists worldwide during the past two decades.[9–13] Some of these studies were designed specifically to assess this type of violence, such as those from Peru[14] and Brazil.[1,5,15] Other studies were designed to analyse views of women, health-service staff, or both on services and quality of care in Tanzania,[7] South Africa,[6,16,17] Brazil,[18–20] and Nigeria,[8] and in so doing revealed perceptions of abuse by health workers. We also used reviews that address reproductive health and violence,[4,21–23] studies on domestic and sexual violence,[24,25] and articles on sexual violence committed by health workers.[26–33]

When discussing violence against women perpetrated by health workers there is no agreed definition of violence. We focus on four types of violence: neglect; verbal violence, including rough treatment, threats, scolding, shouting, and intentional humiliation; physical violence, including denial of pain-relief when technically indicated; and sexual violence. These categories are similar to the forms of violence that occur in personal relationships—ie, emotional, physical, and sexual abuse. Other important forms of violence against women occur in reproductive health services and deserve more discussion than is possible in a short article. These forms include excessive or inappropriate medical treatments in childbirth, such as doctors doing caesarian sections for reasons related to their social or work schedules or financial incentives;[4,34,35] or adhering to obstetric practices that are known to be unpleasant, sometimes harmful, and not evidence based, including shaving pubic hair, giving enemas, routine episiotomy, routine induction of labour, and preventing women having companions in labour (figure 1).[1,2,20,21] Medical involvement in clitoridectomy,[36] forced or coerced sterilisation,[37] and virginity inspections for societal reasons[38] are other examples of inappropriate health care. Financial, geographical, and cultural inaccessibility and the poor resources and quality of many reproductive health-services worldwide are further forms of structural violence, and furthermore, show that different forms of violence are interconnected.

Neglect

A common sign of neglect in reproductive health-services is women giving birth unattended within health facilities. Many women describe neglect as the most distressing part of their experiences because they fear it will harm their

Lancet 2002; **359:** 1681–85

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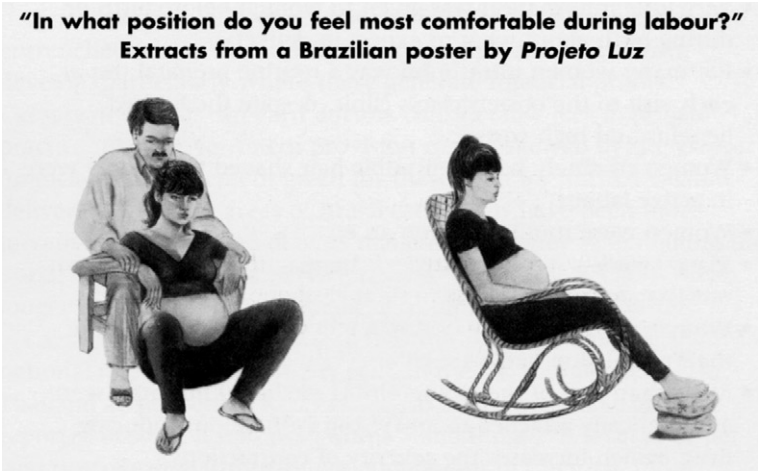

Figure 1: **Poster from a campaign to change childbirth practices, particularly routine forced immobilisation of women during labour and delivery**

babies as well as themselves, and interpret it as a sign that staff do not care or are acting unprofessionally. In a South African study in which expectant mothers were interviewed,[6] most women expressed perceptions of neglect by midwives. The study[6] used ethnographic methods to analyse obstetric public health-services in a relatively well resourced part of South Africa. The women described nurses who told them that they did not want to be bothered by women who felt the urge to push because they were sleeping, watching television, or talking among themselves and as a result, several of the women gave birth with no professional care. A similar problem was reported in Kingston, Jamaica: 65% of births at a large Kingston hospital were not attended by a physician or midwife and women complained about staff indifference.[3] In Nigeria,[8] women asserted that they were rarely physically examined during labour and were not attended by staff qualified for that purpose.

Neglect was also used as a systematic punishment and deterrent for non-compliance with the obstetric system. In many South African health facilities, women who arrived in labour without having booked a place were routinely expected to wait until all other women had been attended to before receiving care, regardless of their medical needs. Midwives explained that this behaviour was to teach women to attend antenatal care the next time they became pregnant.[6]

Even in towns where most hospital births are attended by obstetricians, for example, São Paulo, Brazil, complaints of neglect are frequently heard.[1,5,15,20,24] Sometimes, even though care is provided within the bounds of good practice, neglect is perceived because women are not given the information, support, and compassion needed for them to feel that they are being properly cared for.[1,6,15] This experience is reflected in the words of one of the women in a group in São Paulo, Brazil:

"At times, you are left for hours waiting for a 'normal' birth, while the child is not going to be born normally, and if you scream with pain the nurses say we're making a fuss about nothing."[15] [Author's emphasis]

Verbal violence

"There was a senior female obstetrician, a little ill-tempered, of whom I was afraid, and because of that I avoided screaming because of the pain as much as possible. I chose to suffer in silence in order to avoid being shouted at. It is worse if we scream when it hurt."[14]

In several studies from different continents, many women described health-care providers as unkind, rude, brusque, unsympathetic, and uncaring[1,2,14,15] and were often shouted at or scolded.[17] Relations in maternity units were often so tense that women were afraid to call for help, yell, or express their pain for fear of reprisals.[1,14–16] The Peruvian study,[14] *Silence and complicity—violence against women in public health services in Peru*, noted many well documented examples of this tension. Research in Nigeria[8] showed women forced to clean the room after childbirth if they had failed to comply with the instructions of staff. Another form of humiliation noted quite widely in South Africa,[6] Brazil,[1,15,21,] and Peru[14] consisted of crude and aggressive attacks on female sexuality via variations of the phrase: "You liked it all right when it was time to give, so don't shout now".

In abortion services, women can be verbally abused, stigmatised, their morals questioned,[14,15] and castigated as liars and habitual users of abortion services.[23] In countries in which abortion is illegal, induced abortions often end in complications that require hospital care. In such cases, health workers often report the case to the police as a crime. In Chile, 80% of women in prison for abortion were reported by the public health-system;[13] in Bolivia, health workers repeatedly threaten to report women for abortion and Catholic hospitals refuse to provide medical care.[23] In these situations, health workers can be seen as people capable of, or actually causing, deliberate harm instead of care, and any routine physical contact may be perceived as an opportunity for inflicting physical punishment.[39]

Quantitative data are scarcer than qualitative accounts, but some studies show considerable dissatisfaction with health care.[25] In Tanzania,[7] in an assessment of community satisfaction with primary care (including around 1000 people) some of the most severe community criticisms of dispensaries concerned the poor attitudes of health staff. Although "good attitude" (12%) and "good welcome" (22%) were mentioned as pleasant features of dispensary services, 50% of respondents agreed that—at least sometimes—staff showed no kindness to patients.

Physical violence

"A nurse was attending to me, she told me I had to help, to push. At that moment I couldn't. I was yelling. The nurse gave me a slap. That made me very ashamed, she treated me as a bad girl."[14]

Aggressive relationships between health-care workers and patients can include physical violence. The Peruvian,[14] and South African[6] study reported patients receiving slaps on the face and thighs while in labour. A senior midwife in South Africa told the researchers that she did not believe there was a midwife in the country who had never hit a patient and explained that they were taught how to do so during training.

"My neighbour lost a baby. She went to the hospital. There the doctors and nurses hurt her a lot. The doctor pulled the child out just like that, with no injection or anything, so she would suffer."[15]

Deliberate refusal to give anaesthetics or analgesics when indicated is also a form of physical violence. Women who have illegally induced an abortion very often do not receive necessary pain relief when they seek care at a health facility, as shown in Kenya,[22] Brazil,[15] and Peru[14,23] and do not receive adequate analgesia after abortion.[22]

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Health workers have described the use of this punishment as a way of educating women not to illegally induce abortion.[14,15,22,23] Pain relief is reserved for women who are thought to have had spontaneous miscarriages—although even these women may be subject to the same punishment if health workers do not believe them.[14,15,23] Similar findings have been noted for women undergoing episiotomies and suture during childbirth without effective analgesia, or any pain relief.[1,20]

Taken as a whole, these studies show routine negligence and verbal and physical violence. In informants' complaints, abuse and negligence seem intentional and commonplace events, an integral part of service routine, and not accidental episodes or perpetrated by a few bad staff. This perception generates a culture of mistrust between staff and patients and precludes a relationship providing cure and care.

Sexual violence

"I felt his finger reaching inside of me, which was very painful, and I soon realised that his hands were on my waist, and that he was pushing me, and that it hurt. He was only abusing me . . ."[14]

Sexual violence by health workers is much rarer than other forms of violence, but nonetheless occurs worldwide.[26–33] In a Canadian study in which 618 obstetricians and gynaecologists were interviewed, 17% of female and 8% of male participants knew a colleague who had had sexual involvement with a patient or former patient.[29] Dehlendorf[27] studied physicians who had been disciplined for sex-related offences between 1981 and 1996 in the USA and found that cases increased from 42 in 1989, to 147 in 1996. The proportion of all disciplinary action that was sex-related rose from 2·1% in 1989, to 4·4% in 1996. This rise might reflect a greater readiness to place complaints as well as a true rise in frequency.

Rapes have increasingly been reported in hospitals in Pakistan,[31] but women are usually too afraid to take action because of the stigma and shame it would bring to their families. A gang rape of an anaesthetised woman by hospital staff and their friends[31] caused considerable community protest. Sexual harassment of female nurses by male doctors has also been reported, for instance, in Pakistan[32] and Turkey.[33]

Professional context

How can so much aggression exist in an environment in which caring and respect are to be expected? The explanation lies in the socialisation of health-care professionals and broader problems in society. By virtue of their scientific training and laws regulating medical practice, doctors and, to a substantial extent particularly in developing countries, nurses, are placed in a privileged and powerful situation in relation to their patients. To be effective, health-care professionals need the cooperation of patients, and ideally this is obtained through information, participation, and trust. However, in some situations the use of disciplinary measures against patients has been legitimised. These measures are often developed within a system as being the correct way to deal with various problems, and generations of professionals learn these techniques during training or when they work in a particular environment. In South Africa, nursing training for more than a century has been explicitly linked to ideas of civilisation and moral superiority. Moral instruction, which is often perceived by patients as abuse, is seen as part of being a good nurse.[6] Some groups of women who are regularly singled out for punishment are those who might be seen to have violated social moral codes, for example, teenagers who are sexually active[16,17] or women who have had abortions.[14,15,22,23]

Violence against health-care users can occur when medical or nursing authority is threatened, or perceived as being threatened. In this situation, violence is used in an attempt to restore hierarchy and ensure obedience. In these circumstances, some staff use forms of violence and rituals of subordination to demonstrate their professional power, create distance between themselves and their patients, and gain obedience that is otherwise denied.[6,24]

Although patients hope when they seek health care to receive care as well as a cure, a caring ethic is often not strongly emphasised in health professionals' training and practice. For example, an extremely low priority is given to teaching communication skills in curricula and medical ethics classes. In many countries, people are attracted to medicine because of the attendant wealth and status, and enter nursing because there are few career opportunities for able women, especially those who lack the resources to go to university. In countries that have rigid social class or caste systems, menial activities, which are often part of good care, are seen as low class activities and thus, are not valued by health professionals who may not want to be involved in them.

Forms of structural violence experienced by staff can affect their behaviour towards patients. Heavy workload, long hours, inadequate equipment or facilities, and personal danger can demoralise and traumatise staff and lead them to take their frustration out on patients.

Violence within health-care settings often reflects dynamics that are broadly prevalent in society. In societies in which violence is highly prevalent at home, in the streets, in schools, &c, the use of violence in health-care services may be seen as an extension of generally high levels of violence in society. In some of these settings, patients and their relatives not infrequently hit health-care workers.[6,15] In many societies, women have a low status and are seen as needing discipline and control for their own good. These ideas can be interpreted in health-care settings as legitimising use of violence by staff to control female patients' behaviour.

Interventions for prevention

Eradication of violence perpetrated by health-care workers against patients requires interventions in recruitment, training, socialisation processes in professions and working environments, and improvements in working conditions. To ensure that these processes are given the priority they deserve, violence in health-care settings must be recognised and international organisations such as WHO, International Council of Nursing, and World Medical Association should lead investigation and eradication of the problem. Recognition and action are also needed at a national level from governments and professional regulatory bodies, and at a local level through improving health practice and organising community action.

Eradication of abuse of patients should start in medical and nurse training. Prominence should be given to the disciplines of ethics, anthropology, communication, and human rights including reproductive and sexual rights. Health workers need training in genuine communication with patients that includes mutual agreement and decisions on treatments, and a recognition that patients are ultimately responsible for their own lives and moral decisions. Training institutions should also take responsibility for ensuring that staff in health-care facilities used for practical training are respectful to patients (figure 2).

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Renato Curry

Figure 2: **Mothers receive their babies for early skin contact and breastfeeding immediately after delivery in a humanised public maternity ward in São Paulo, Brazil.**[1]

But training is not enough; working conditions need to be improved so that staff have the time and privacy necessary to attend to patients properly, and have service training, access to laboratory services, treatment, and drugs. Managers should be active in identifying abusive staff, complaints should be investigated, and action taken immediately. Systems need to be created and well publicised, perhaps through an ombudswoman, that actively encourage patients to complain—especially patients who are poor, illiterate, or disempowered. The partnership with organised social movements to improve maternity care locally and globally should be an important step. Effective disciplinary action needs to be taken against staff who abuse patients, and colleagues who act as whistle blowers in this respect need to be protected. Societal interventions designed to reduce overall levels of violence and improve the status of women could also contribute towards more respectful relationships within health-care facilities.

Abuse of patients in health-care settings must be ended and health workers, both doctors and nurses, should lead this process. Health-care workers should ensure that environments are created in health facilities that are conducive to individual and collective dialogue, so that patients can be heard and effective health-care achieved.

We thank Rachel Jewkes for her help in revising this paper.

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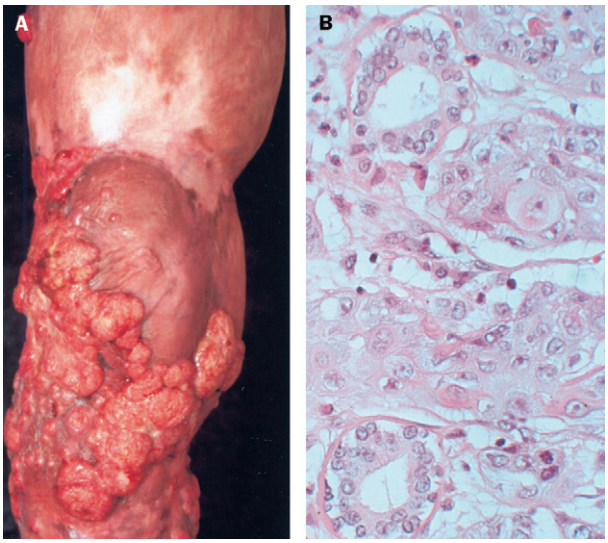
Clinical picture

Metastasising porocarcinoma following exposure to poison gas

Bettina Helmke, Hans Starz, Dieter Bachter, Bernd-Rüdiger Balda

During the Gulf war of 1991, the right leg of a 16-year-old Iraqi soldier was injured by a poison gas explosion in Kurdistan. The composition of the poison is unknown. But mustard gas, an alkylating agent used by Iraq in the last decade, is best compatible with the further course of disease. Initially, the wounds seemed negligible, but they did not heal and increased in size, accompanied by severe pain. When the patient came to our department in March, 1999, his right lower leg and knee were covered by numerous confluent red-yellowish ulcerated skin tumours of soft consistency (A). We biopsied the lesion and diagnosed porocarcinoma with mainly squamous, partially ductal differentiation (B). Metastases were found in several regional lymph nodes and the vertebral body of T12. Despite amputation of the right leg and a combined surgico-radio-chemotherapy of the metastases the patient died in December, 1999. Porocarcinoma appears to be an additional variant in the spectrum of skin malignancies documented to be potential late implications of contact with poison gas.



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