European Journal of Obstetrics and Gynecology 296 (2024) 205–207

Contents lists available at ScienceDirect

European Journal of Obstetrics & Gynecology and Reproductive Biology

journal homepage: www.journals.elsevier.com/european-journal-of-obstetrics-and-gynecology-and-reproductive-biology

European Association of Perinatal Medicine (EAPM), European Board and College of Obstetricians and Gynaecologists (EBCOG), European Midwives Association (EMA). Joint position statement: Substandard and disrespectful care in labour – because words matter

Diogo Ayres-de-Campos [a,*], Frank Louwen [b], Victoria Vivilaki [c], Chiara Benedetto [d], Neena Modi [e], Miroslaw Wielgos [f], Melania-Elena Pop Tudose [g], Susanna Timonen [h], Marlene Reyns [i], Branka Yli [j], Pernilla Stenback [k], Inês Nunes [l], Burcu Yurtsal [m], Christophe Vayssière [n], Georges-Emmanuel Roth [o], Maria Jonsson [p], Petra Bakker [q], Enrico Lopriore [r], Stefan Verlohren [s], Bo Jacobsson [t]

[a] *Medical School, Santa Maria University Hospital, University of Lisbon, Portugal*
[b] *Department of Obstetrics and Gynecology and Obstetrics, Goethe University Frankfurt/Main and University Hospital, Germany*
[c] *Department of Midwifery, University of West Attica, Greece*
[d] *Department of Gynecology and Obstetrics, University Division at St. Anna Hospital, Torino, Italy*
[e] *Section of Neonatal Medicine, School of Public Health, Imperial College London, London, UK*
[f] *Department of Obstetrics and Perinatology, National Medical Institute of the Ministry of Interior and Administration, Medical Faculty, Lazarski University, Warsaw, Poland*
[g] *Obstetrics Department, Emergency Hospital, Buzau, Carol Davila University of Medicine and Pharmacy, Faculty of Midwifery and Nursing, Bucharest, Romania*
[h] *Turku University Hospital, Turku, Finland*
[i] *Independent Midwife, Ghent, Belgium*
[j] *Delivery Department, Oslo University Hospital, Oslo, Norway*
[k] *Arcada University of Applied Sciences, Helsinki, Finland*
[l] *Department of Obstetrics and Gynecology, Unidade Local de Saúde de Gaia/Espinho, Faculty of Medicine, University of Porto, Portugal*
[m] *Department of Midwifery, Sivas Cumhuriyet University, Turkey*
[n] *Department of Obstetrics-Gynecology-Reproduction, Paule de Viguier Hospital, CHU Toulouse, Toulouse III University, France*
[o] *Department of Obstetrics and Gynecology, CHU Strasbourg, France, University of Strasbourg, France*
[p] *Department of Women's and Children's Health, Uppsala University, Sweden*
[q] *Department of Obstetrics and Gynecology, Amsterdam UMC, Location VU Medical Center, Amsterdam, the Netherlands*
[r] *Department of Neonatology, Leiden University Medical Center, Netherlands*
[s] *Department of Obstetrics, Charité - Universitätsmedizin Berlin, Germany*
[t] *Department of Obstetrics and Gynecology, Sahlgrenska Academy, Gothenburg University, Sahlgrenska University Hospital, Gothenburg, Sweden*

ARTICLE INFO

Keywords:
Intrapartum care
Substandard care
Disrespect
Obstetric violence
Multiprofessional teams

ABSTRACT

Substandard or disrespectful care during labour should be of serious concern for healthcare professionals, as it can affect one of the most important events in a woman's life. Substandard care refers to the use of interventions that are not considered best-practice, to the inadequate execution of interventions, to situations where best-practice interventions are withheld from patients, or there is lack of adequate informed consent. Disrespectful care refers to forms of verbal and non-verbal communication that affect patients' dignity, individuality, privacy, intimacy, or personal beliefs. There are many possible underlying causes for substandard and disrespectful care in labour, including difficulties in modifying behaviours, judgmental or paternalistic attitudes, personal interests and individualism, and a human tendency to make less arduous, less difficult, or less stressful clinical decisions. The term "obstetric violence" is used in some parts of the world to describe various forms of substandard and disrespectful care in labour, but suggests that it is mainly carried out by obstetricians and is a serious form of aggression, carried out with the intent to cause harm. We believe that this term should not be used, as it does not

* Corresponding author.
E-mail address: dayresdecampos@gmail.com (D. Ayres-de-Campos).

https://doi.org/10.1016/j.ejogrb.2024.02.048

Available online 29 February 2024
0301-2115/© 2024 The Author(s). Published by Elsevier B.V. This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/).

help to identify the underlying problem, its causes, or its correction. In addition, it is generally seen by obstetricians and other healthcare professionals as an unjust and offensive term, generating a defensive and less collaborative mindset. We reach out to all individuals and institutions sharing the common goal of improving women's experience during labour, to work together to address the underlying causes of substandard and disrespectful care, and to develop common strategies to deal with this problem, based on mutual comprehension, trust and respect

Introduction

Reports of substandard or disrespectful care occurring during labour need to be a cause of serious concern for professionals working in maternity hospitals. Such reports should stimulate collective reflection by all staff members, aiming to identify causes and correcting behaviours. These situations have the potential to upset one of the most significant events in a woman's life, leaving her with negative feelings, when the general expectation is usually for a safe, positive, and life-changing experience. They may have similar negative effects on the woman's family and friends.

While some expectations of labouring women may appear unreasonable to healthcare professionals, or impossible to satisfy, such situations are rare when previous information on the labour process and on Labour Ward conditions are adequately conveyed and discussed during pregnancy. This information allows women to make informed choices on their place of birth, on shared decisions that may be required during labour, and encourages them to adapt expectations to the available conditions.

It is natural that women who have been subjected to substandard or disrespectful care during labour feel mistreated, humiliated, and sometimes even abused. It is natural that they may lose trust in healthcare professionals and healthcare institutions, especially when left without clarification, and some may feel the need to exteriorize their anger, expose the situation, or report the behaviour of individuals.

What is substandard and disrespectful care?

Substandard care generally refers to the use of healthcare interventions that are not considered best practices by the scientific and professional community. The term is also applied to the inadequate execution of interventions, and to situations where best-practice interventions are not offered or are withheld from patients. The concept of substandard care also includes the performance of healthcare interventions without adequate informed consent from patients, either due to deficiencies in the information provided or to the non-solicitation of this consent. It must be noted that in emergency situations, informed consent may need to be very brief, so as not to compromise outcome, and written informed consent for more invasive or hazardous procedures is usually dispensed.

Table 1 gives examples of common intrapartum situations where different types of substandard care are observed.

Disrespectful care generally refers to forms of verbal and non-verbal communication which are perceived by women or their companions as affecting their dignity, individuality, privacy, or intimacy; or that upset their ethnical, cultural or religious beliefs. It also includes physical abuse. Table 2 displays common types of disrespectful care that are observed in labour and childbirth.

Causes of substandard and disrespectful care in labour

There are many possible underlying causes for the occurrence of substandard and disrespectful care in labour, and these may occur isolated or in combination. Some professionals may have difficulty changing their habits, or tend to repeat actions without questioning them. They may feel a sense of security with pre-established routines, or may be insufficiently motivated to change them. Professionals may have difficulties in self-evaluation. It is easier to identify the mistakes of others than to recognize your own. It is even more difficult to question your deeply ingrained behaviours and to modify them. A professional environment focused on pointing out individual mistakes, rather than identifying system errors may also promote a defensive posture from individuals, making them less prone to accept changes.

Some professionals may still have difficulty in accepting that human beings can be profoundly different in their ways of thinking, speaking, dressing, behaving, reacting to pain, ensuring their personal hygiene, etc. They may have a judgmental or paternalistic way of evaluating these differences, and allow this to reflect on their behaviour, particularly in situations where they hold the power of knowledge and decision, while others are in less comfortable and more fragile positions.

Personal interests and individualism may also be a part of the problem, as better time-management and higher financial gain can result from certain clinical decisions. Some healthcare professionals have difficulty in defending the collective interests of the profession, and in valuing the problems of others, including patients. They may consciously or unconsciously make less arduous, less difficult, or less stressful clinical decisions. Fear of litigation may also contribute to these attitudes. More time and effort are required to provide adequate counselling to women, so that they can give a truly informed consent. Establishing a positive and empathetic environment usually also requires higher engagement and dedication.

Finally, group culture may also play a part, and the belief that "this is the way we do things" can affect individual professional groups or sometimes even the entire Labour Ward team. Scarce multiprofessional or inter-institutional interactions and different approaches to selecting and interpretating scientific evidence may contribute to the problem.

Table 1
Different types of substandard care observed in labour.

1. **Use of healthcare interventions or measures that are not considered best-practice**
   Examples: unindicated healthcare interventions such as caesarean deliveries, oxytocin augmentation of labour, amniotomy, perineal shaving, urinary catheterization, Kristeller's maneuver, or episiotomy. Exaggerated number of vaginal examinations. Unindicated measures such as limitation of accompaniment, limitation of mobility, limitation of birth position, separation of mother and newborn, or the prohibition of breastfeeding.
2. **Withholding or not offering best-practice measures and healthcare interventions**
   Examples: analgesia on request, procedures and interventions to optimise the safety of labour and childbirth, skin-to-skin contact after childbirth, early breastfeeding.
3. **Inadequately performed healthcare interventions**
   Examples: interventions carried out carelessly, resulting in unnecessary anxiety, pain or discomfort: vaginal examination, vein catheterization, urinary catheterization, epidural catheter placement, instrumental vaginal delivery, external uterine massage.
4. **Lack of adequate informed consent for healthcare interventions**
   Examples: not providing sufficient information, providing incorrect or biased information, providing information that is incomprehensible, lack of request for consent or unclear request for consent, lack of request for written informed consent for more invasive or hazardous procedures.

Table 2
Different types of disrespectful care observed in labour.

Little or no effort to establish an empathic relationship with women and their companions
Little or no effort to transmit a feeling of safety and tranquility to women and their companions
Disrespect of privacy
Disrespectful or unnecessary physical exposure
Discriminatory or judgmental comments
Disrespect for ethnic, cultural, religious, gender or other beliefs
Aggressive attitude
Verbal abuse
Emotional abuse
Physical abuse
Financial abuse

Use of the term "obstetric violence"

The term "obstetric violence" was coined in South America over a decade ago, to describe various situations of substandard and disrespectful care in labour, and has expanded to other parts of the world [1–8]. According to the Cambridge online dictionary (accessed 2 Dec 2023), violence is defined as "extremely forceful actions that are intended to hurt people or are likely to cause damage: racial/ethnic/domestic violence". The Merriam Webster online dictionary (accessed 2 Dec 2023) defines violence as "the use of physical force so as to injure, abuse, damage, or destroy".

It can therefore be concluded that, although the term "violence" has been used in academic circles to describe more psychological and less intentional ways of aggression, this has not been taken up by the general population, who still sees it as an extreme form of aggression, carried out with the intent to cause harm. However, it is well known that these intentions do not exist in the vast majority of intrapartum situations.

The inclusion of the word "obstetric" in this expression also leads the general population to believe that it is mainly carried out by obstetricians, thus excluding anesthesiologists, neonatologists, midwives, nurses and auxiliary staff from the problem, although they can also provide substandard and disrespectful care.

For all these reasons, we believe that the term "obstetric violence" should not be used to describe situations of substandard and disrespectful care, as it does not help in the identification of the underlying problem, its causes, or its correction. It is generally seen as an unjust and offensive term by obstetricians and other healthcare professionals, including those who aim to provide safe and positive experiences in labour and childbirth. It can generate negative emotional reactions from healthcare professionals, together with a more defensive and less collaborative mind-set. The term does not help to build confidence between the different players involved in the purpose of improving women's positive experiences in labour. It may prevent honest engagement between them to tackle the important issues of substandard and disrespectful care, and finding effective strategies to correct them. It has even been unjustly used in the past to denigrate the role of obstetricians in intrapartum care, and to promote the cooperative interests of other individuals and professions.

Scientific and professional societies need to be involved in efforts to eliminate, or at least to minimize, substandard and disrespectful care in labour, as they participate in the elaboration of guidelines and clinical standards, ultimately defining what is the best-practice. Patient associations also need to be involved, as they provide important feedback from women on practices that contribute to negative childbirth experiences, and that can be overlooked by the healthcare team.

Amidst present challenges, it is important to ensure that labouring women are not exposed to compromised safety or to barriers in making informed decisions. Emphasizing the dissemination of evidence-based practice, adherence to clinical guidelines and recommendations, continuous education and skills training for healthcare providers across all levels is paramount [9].

Efforts are needed to increase awareness of substandard and disrespectful care in labour, to promote further research on this topic, to foster open discussions between all stakeholders, and to develop sustainable strategies to deal with the problem. We reach out to all individuals and institutions sharing the common goal of improving women's experience during labour, to work together to address the underlying causes of this situation, and to develop common strategies to ameliorate it, based on mutual comprehension, trust and respect.

CRediT authorship contribution statement

Diogo Ayres-de-Campos: Conceptualization, Writing - original draft. All others: Writing – review and editing.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

References

[1] Perrotte V, Chaudhary A, Goodman A. "At least your baby is healthy" obstetric violence or disrespect and abuse in childbirth occurrence worldwide: a literature review. Open J Obstet Gynecol 2020;10:1544–62.
[2] Vacaflor CH. Obstetric violence: a new framework for identifying challenges to maternal healthcare in Argentina. Reprod Health Matters 2016;24:65–73.
[3] Ghanbari-Homayi S, Fardiazar Z, Meedya S, et al. Predictors of traumatic birth experience among a group of Iranian primipara women: a cross sectional study. BMC Pregnancy Childbirth 2019;19:182.
[4] Perera D, Lund R, Swahnberg K, et al. 'When helpers hurt': women's and midwives' stories of obstetric violence in state health institutions, Colombo district. Sri Lanka BMC Pregnancy Childbirth 2018;18:211.
[5] Diaz-Tello F. Invisible wounds: obstetric violence in the United States. Reprod Health Matters 2016;24:56–64.
[6] Bohren MA, Mehrtash H, Fawole B, Maung TM, Balde MD, Maya E, et al. How women are treated during facility-based childbirth in four countries: a cross-sectional study with labour observations and community-based surveys. Lancet 2019;394:1750–63.
[7] UN Human Rights press release. Spain needs to combat obstetric violence - UN experts. 9 Mar 2020. https://www.ohchr.org/en/press-releases/2020/03/spain-needs-combat-obstetric-violence-un-expert.
[8] UN General Assembly: A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence. 11 July 2019 https://eipmh.com/wp-content/uploads/2019/09/UN_Res.71170.pdf.
[9] Vivilaki VG, Asimaki E. Respectful midwifery care during the COVID-19 pandemic. Eur J Midwifery 2020;4:8.