

Abuse in Hospital-Based Birth Settings?

Susan Hodges, MS

ABSTRACT

Are laboring and birthing women treated abusively in the hospital? Although seldom recognized as abuse or violence against women, bullying and medical treatments under false pretenses, even in a hospital, constitute abuse and a basic human rights issue that needs attention. Naming the problem is a first step. The power of medical authority, the lack of accountability in the hospital hierarchical system, policies and protocols, and expectations of compliancy all make an environment ripe for abuse and present obstacles for both women and staff to recognize or stop abuse. Learning to recognize abuse and take effective action, and understanding the legal requirements for “informed consent” can help, but ending abuse will require systemic change.

The Journal of Perinatal Education, 18(4), 8–11, doi: 10.1624/105812409X474663

Keywords: abuse of childbearing women, hospital abuse, informed consent, bullying, rights of childbearing women

Regardless of our various opinions, national focus on health-care reform in the United States has brought at least some long-needed media attention to maternity care problems, such as overuse of cesarean surgery and other interventions, high costs, and poor outcomes.

A less noticed maternity care problem is how pregnant and laboring women are treated in the hospital setting. Despite the presence of many caring and supportive physicians and hospital staff, anyone involved with birthing women has heard of or witnessed many examples of verbal and physical abuse directed at women giving birth in hospitals.* Although often not recognized as abuse, this behavior toward women, especially in childbirth, is unacceptable and harmful; some forms of abuse,

such as lack of informed consent, misrepresentation of medical situations, and threats, likely contribute to the high rates of unnecessary interventions and to traumatic birth experiences.

In considering abuse in the hospital-based birth setting, I believe we are in about the same position we were in the 1950s and 1960s regarding domestic abuse and violence against women. Abuse and violence were happening, but we did not have a name for it. If your husband or boyfriend was verbally or physically abusive, well, that was just the way he was. It probably was your fault, and in any case, there was not much you could do about it.

Many years of work by courageous, determined women brought awareness that verbal and physical abuse of women is harmful and unacceptable, and more work created legal precedents, initiated education of judges, police, and hospital workers, and developed support groups and safe houses. Such

* Author's note: The focus of this editorial is on abuse in the hospital setting, where approximately 99% of U.S. births take place. However, abuse can also occur in out-of-hospital birth settings; therefore, at least some of the information and suggestions presented in this editorial may also apply to out-of-hospital birth settings.



To learn more about the effects of a traumatic birth experience partly due to the lack of respectful and protective treatment, visit the “Solace for Mothers” Web site and read “What is Birth Trauma?” (http://www.solaceformothers.org/what_birth_trauma.html).

abuse still goes on today, but at least it is recognized by the law for what it is, the public is much more aware, and women can get help on many levels.

Abuse in the hospital-based birth setting may not seem the same as domestic abuse and violence, but it is no less harmful. Verbal abuse includes behaviors such as threatening, scolding, ridiculing, shaming, coercing, yelling, belittling, lying, manipulating, mocking, dismissing, and refusing to acknowledge—behaviors that undermine the recipient’s self-esteem while enhancing the abuser’s sense of power, typical of bullying. Most of us would recognize these as abusive behaviors in just about any other setting. However, because we are socialized to both expect trustworthy and professional behavior in the hospital setting and to be “compliant” with medical directives, these behaviors are seldom recognized and interpreted as abuse. Furthermore, staff and doctors are the authorities in the hospital, while the pregnant and laboring woman is merely a “patient.” Such a huge power imbalance allows, even encourages, bullying and abuse. We tend to feel helpless, so we rationalize and accept these behaviors while denying our experience of them.

Abuse also includes actions such as medical treatment without informed consent, omission of information, overriding one’s refusal of a treatment, and misrepresentation of medical situations and the need for interventions. Because the physician is the expert, a woman may not be able to tell if the physician omits information or misrepresents the medical situation. Some women have been treated with extreme hostility, including the withholding of appropriate pain relief and obvious sexual abuse. Inappropriate medical treatments, such as the practice of administering Pitocin until the baby goes into distress (and cesarean surgery is called for), are also clearly abusive, although few women are aware that this is deliberate mistreatment. Physicians who otherwise do not seem the least bit abusive may engage in these behaviors, and nurses may feel powerless to intervene.

Rates for various birth practices—from internal exams during labor to use of drugs, inductions, and cesarean surgery—have been increasing, and episiotomies are still being performed. That each of these invasive procedures are medically unnecessary at least half the time is a clear indication that women giving birth in hospitals are being abused and harmed, both physically and emotionally.

Physicians frequently are able to get laboring women to “agree” to interventions due to the power

Abuse in the hospital-based birth setting may not seem the same as domestic abuse and violence, but it is no less harmful.


imbalance between the physician and the woman, the lack of accountability in the hospital system, and the social expectations that the doctor will only make recommendations that are necessary for our health and safety and that “patients” should be compliant. So, this kind of violence does not usually look “violent.” However, drugging or cutting a pregnant woman with no medical indication is an act of violence, even when performed by a medical professional in a hospital. Yet, I have heard many women and health workers completely excuse doctors for performing unnecessary cesarean surgeries as “defensive medicine.” In what other area of life in the United States is it apparently acceptable or legal for a professional to perform major abdominal surgery to reduce vulnerability to a lawsuit? Is this not even more violent than a black eye? And more insidious?

The problem of abuse in hospital-based maternity care is neither women’s fault nor a problem of a few individuals who are abusive. It is a systemic problem, enabled by a lack of accountability and a culture of impunity in the hospital hierarchy, where abuse and harassment come from the top down, affecting hospital staff as well as patients. In addition, when authority is rooted in what is best for the bottom line (in all of its permutations), there is no common ground with what is best for mother and baby; this disconnect also drives the abusive overuse of interventions.

Is there anything we can do? Ultimately, improving the situation will require systemic change. However, identifying that there *is* a problem is an essential first step and can help at least some women avoid or prevent abuse.

For pregnant women, knowing what to be aware of increases the likelihood of recognizing signs of disrespect or bullying from physicians or other medical staff so that they may be able to see the problem coming and take action before labor begins. For physicians and staff, we might be able to help increase understanding of the impact of harmful behaviors and teach helpful words and behaviors, even while we realize that not everyone will be open to this information.

We can increase awareness among women by identifying abuse for what it is and including infor-

 To download *Childbirth Connection’s* brochure, *The Rights of Childbearing Women*, go to <http://www.childbirthconnection.org/article.asp?ck=10084&ClickedLink=0&area=27>

 To download *The Joint Commission’s* pamphlet, *Speak Up: Know Your Rights*, go to http://www.jointcommission.org/NR/rdonlyres/58A5230D-3E58-48D8-8114-C95AF53ECA27/0/Speakup_Rights.pdf

Childbirth educators and doulas can make sure women know their basic rights.

mation about it—the forms it takes and ways to deal with it—in childbirth education classes and doula training. Excellent literature and experience about bullying and verbal abuse is available (e.g., Coloroso, 2009; Evans, 1996, 2002; Farrell, 2006, 2007a, 2007b, 2007c; Forward, 1997). Input from psychologists and counselors who specialize in this aspect of human behavior could help us come up with effective techniques for the unique circumstances of the hospital setting.

Childbirth educators and doulas can make sure women know their basic rights. *The Rights of Childbearing Women* is an excellent brochure available on the Childbirth Connection Web site (www.childbirthconnection.org). The Joint Commission (www.jointcommission.org), which accredits hospitals, has a helpful pamphlet, *Speak Up: Know Your Rights*, that specifically addresses the right to be listened to and to be treated with courtesy and respect.

Women who are well-informed and ready to ask questions about procedures, treatments, and interventions during labor can address some deficiencies of “informed consent” and not be hoodwinked into unnecessary interventions. An excellent resource is Penny Simkin’s “Key Questions About Your Care,” available on business-sized cards in Simkin’s *Doula’s Handout Packet*, which is available on her Web site (www.pennysimkin.com).

We can encourage women who have experienced abusive behavior during their pregnancy or birth to file complaints. For how-to instructions and information, read “Unhappy With Your Maternity Care? File a Complaint!” on the Web site of Citizens for Midwifery (www.cfmidwifery.org). Filing complaints alone will not solve the problem. However, women I’ve spoken with who did so felt empowered, and it helped them acknowledge to themselves that they had been mistreated and were not at fault. Filing a complaint does not require an attorney, and it makes an official record that the abuse happened. If enough women file complaints, the problem of abusive maternity care might get some attention.

To order Penny Simkin’s wallet-sized “Key Questions” cards to serve as reminders of questions to ask health-care providers, click on Doula’s Handout Packet at <http://www.pennysimkin.com/products.htm>

To view “Unhappy With Your Maternity Care? File a Complaint!” by Susan Hodges at Citizens for Midwifery, go to <http://cfmidwifery.org/Resources/item.aspx?ID=1>

Holly Goldberg’s article, “Informed Decision Making in Maternity Care,” is available at The Journal of Perinatal Education’s (JPE’s) online site (<http://www.ingentaconnect.com/content/lamaze/jpe>). Lamaze members can download a free copy of Goldberg’s article (and all other JPE articles) from the journal’s IngentaConnect site by logging in to the “Member Center” link on the Lamaze Web site (www.lamaze.org). Also, Lamaze Certified Childbirth Educators can earn continuing education credits by completing the continuing education module based on Goldberg’s article. Check out the “Continuing Education & Homestudies” link on the Lamaze Web site (www.lamaze.org).

We can encourage women who have experienced abusive behavior during their pregnancy or birth to file complaints.

Abuse continues when no one confronts the behavior. It may be that many hospital staff, overworked and stressed, are unaware of behaving abusively toward patients. Hospital policies and physician protocols may overlook informed consent and refusal issues, and the hierarchical structure of hospital systems may encourage attitudes that lead to abusive behavior and, at the same time, present obstacles to confronting abuse, especially by staff. It is likely that at least some physicians don’t realize that their actions (or omissions) may violate their legal obligations regarding informed consent and may violate “fiduciary trust”—the legal relationship and responsibilities between experts and their clients. It is possible that education modules and continuing education units on bullying and abusive behavior, as well as on legal requirements, might help. The Coalition for Improving Maternity Services (www.motherfriendly.org) is already developing pamphlets and continuing education units on informed consent and refusal. Also, Lamaze International provides continuing education units on informed consent (see Goldberg, 2009).

Although increasing awareness of both abuse and rights may not alter characteristics inherent in hospital system hierarchies, no change is possible without awareness of the problem. Abusive treatment of women in childbirth, including many forms of verbal abuse, overuse of drugs and interventions, and lack of informed consent, is a basic women’s rights and human rights issue. Attention and action are long overdue.

REFERENCES

- Coloroso, B. (2009). *The bully, the bullied, and the bystander: From preschool to high school – How parents and teachers can help break the cycle* (updated ed.). New York: Harper Paperbacks.
- Evans, P. (1996). *The verbally abusive relationship: How to recognize it and how to respond* (2nd ed.). Avon, MA: Adams Media Corporation.
- Evans, P. (2002). *Controlling people: How to recognize, understand and deal with people who try to control you*. Avon, MA: Adams Media Corporation.
- Farrell, M.V. (2006). Bullying. *Midwifery Today*, 80. Retrieved September 10, 2009, from http://www.midwiferytoday.com/articles/bullying_1.asp
- Farrell, M.V. (2007a). Finding better solutions to end bullying – What a midwife can do. *Midwifery Today*, 83. Retrieved September 10, 2009, from http://www.midwiferytoday.com/articles/bullying_4.asp
- Farrell, M.V. (2007b). The target of the bully and effects of PTSD. *Midwifery Today*, 82. Retrieved September 10,

2009, from http://www.midwiferytoday.com/articles/bullying_3.asp

Farrell, M.V. (2007c). Who is the bully? *Midwifery Today*, 81. Retrieved September 10, 2009, from http://www.midwiferytoday.com/articles/bullying_2.asp

Forward, S. (1997). *Emotional blackmail: When the people in your life use fear, obligation, and guilt to manipulate you*. New York: Harper Collins Publishers.

Goldberg, H. (2009). Informed decision making in maternity care. *The Journal of Perinatal Education*, 18(1), 32–40.

SUSAN HODGES, a birth activist for more than 15 years, is President of Citizens for Midwifery, a consumer-based organization promoting the Midwives Model of Care and representing consumer interests regarding midwifery and maternity care.



Childbirth Educators:
Help advance normal birth
by teaching mothers
about midwifery.

www.MyMidwife.org

Certified Nurse-Midwives & Certified Midwives:

- Attend almost 10% of the births in the U.S.
- 98% of the births are in hospitals, with the remainder in birth centers or at home
- Hold a master's degree
- Work collaboratively with physicians
- Practice and write prescriptions in every state
- There are over 11,000 nurse-midwives in the U.S.

