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Maternal Mistreatment in Healthcare: The Way Forward

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Authors' contributions

This work was carried out in collaboration between both authors. Both authors read and approved the final manuscript.

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Policy Article

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ABSTRACT

Despite the ethical principles that guide medical practice, patient abuse and mistreatment still occur. Certain populations, including pregnant women, experience mistreatment by healthcare professionals more than others. The concept of maternal mistreatment has received increased attention in recent years. However, there have been limited attempts to measure its prevalence or health consequences. This paper explores the currently available data related to maternal mistreatment and makes recommendations to collect valuable information about this emerging public health issue in Texas. This paper presents information from one of the first large-scale national studies that collected data on maternal mistreatment in the United States. In addition, the core and standard questions of the Pregnancy Risk Assessment Monitoring System (PRAMS) survey for Texas were analyzed, and questions and measures assessing maternal mistreatment and its association with social risk factors were proposed to be added to the Texas PRAMS questionnaire. Two survey questions were proposed. The first question is built on the definition of maternal mistreatment by the "Giving Voice to Mothers Study," while the social risk assessment question is an adaptation of the "Core 5 assessment questions" created by the Ohio Action Coalition. Four measures were proposed to describe the prevalence of maternal mistreatment and the relationship between mistreatment and the social determinants of health. Collecting data on maternal mistreatment and its associated factors is the first step to preventing negative outcomes from this public health menace. The support of governmental agencies and other stakeholders is required to make this issue a priority and ensure that maternal satisfaction is considered an important maternal and child health indicator.

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1. INTRODUCTION

Medicine is governed by certain ethical principles that prevent the abuse or mistreatment of patients by healthcare professionals. These moral values ensure the sharing of power, leading to respectful relationships between patients and providers. However, despite the fact that the concept of power in patient-provider relationships has received increased attention in contemporary health systems, this power is still being misused [1]. Patient mistreatment includes any form of abuse, neglect, infringement of rights, or exploitation [2].

2. DESCRIPTION OF THE HEALTH ISSUE

There are certain populations that experience mistreatment by healthcare professionals more than others; these include pregnant women and transgender people [3,4]. Abuse of women during pregnancy and delivery is an emerging public health concern [3]. As a consequence of increasing global public health conversations about maternal mistreatment in the 21st century, the term “obstetric violence” was coined in South America in 2005 [3]. Obstetric violence refers to “the appropriation of a woman’s body and reproductive processes by health personnel, in the form of dehumanizing treatment, abusive medicalization, and pathologization of natural processes, involving a woman’s loss of autonomy and the capacity to freely make her own decisions about her body and her sexuality, which has negative consequences for a woman’s quality of life” [3]. The World Health Organization (WHO) also recognizes the seriousness and potential implications of this concern [5]. In 2015, the WHO released a statement on abuse and disrespect during facility-based childbirth, publishing a five-step action plan to prevent this menace [5].

According to Bohren et al., maternal mistreatment can be organized into seven groups namely: physical abuse, sexual abuse, verbal abuse, discrimination, poor professional standards, poor rapport between providers and clients, and health system constraints [6]. Physical abuse involves causing discomfort or injury to a woman by way of physical contact [6]. It includes physical restraints, hitting, slapping, and the use of extreme force [7]. Sexual abuse is defined as comments and behavior of a sexual nature or any form of sexual contact between a patient and healthcare provider [8]. Verbal abuse involves using statements that cause emotional pain, humiliation, or fear [7]. These can include threatening or insulting language or excessive yelling. Discrimination is treating women differently on account of their race, ethnicity, gender identity, socioeconomic status and so on [7]. Poor professional standards are when healthcare workers fail to meet the preset standard of care [7]. This can be due to failure to maintain confidentiality, failure to obtain informed consent, failure to respect patient privacy, patient neglect, or poorly performed medical examinations and procedures [7]. Poor rapport is a lack of communication, understanding, and trust between providers and patients [6]. This can make women feel unsupported and like passive participants in their care. Lastly, lack of health facility resources, poorly defined hospital policies, and hospital culture can contribute to maternal mistreatment [6].

Racial and ethnic minorities are more likely to report maternal mistreatment due to the relationship between obstetric racism and medical violence [7,9]. Younger women and first-time mothers are particularly vulnerable [7]. This suggests that the experience of older women or women with previous deliveries might be a protective factor. However, it can also mean that these women have accepted these experiences as normal and are less likely to report them. On the other hand, women who deliver in birth centers and women who are attended to by midwives report less mistreatment [7]. Demographic factors like education level and socioeconomic status are inversely proportional to the prevalence of maternal mistreatment [7]. Also, women with a history of substance abuse, imprisonment, or interpersonal violence appear to be more susceptible to maternal mistreatment compared to women without these social risk factors [7]. Studies have also shown that women who opt out of certain procedures like cesarean sections are more likely to be treated poorly by healthcare workers [10].

The United States healthcare system is very outcome-driven [11]. In maternal health, avoiding maternal morbidity and mortality is considered the desired outcome [11]. Hospitals and health systems do not typically consider maternal satisfaction to be an important indicator [3].

Furthermore, the US healthcare system is hierarchical, causing maternity care providers to have an authoritative relationship with women [12]. This offsets the power balance and further relegates women to the background in their care. This culture is one of the drivers of maternal mistreatment [3,11]. Secondly, maternal care reflects the patriarchal structure of society where women are often under the authority of men, who generally have the power [3]. The patriarchal system undervalues women's rights; this inequality is seen in the health system and can propagate maternal mistreatment [3]. Currently, around 55% of obstetricians are female, with this proportion expected to continue to rise. However, the internalization of patriarchy by women might mean that the patriarchal culture in maternal care will continue to be an issue [13]. Some of the more tangible facilitators of maternal mistreatment identified by healthcare workers and women include lack of cultural competence by health workers and stressful work environments caused by understaffed departments and long work hours [6].

Sadly, despite current evidence showing that maternal mistreatment is widespread, there are very limited studies attempting to measure its prevalence or health consequences [5]. Mistreatment of women in the peripartum period can have a significant impact on the health of the woman, infant, and family. Traumatic experiences during pregnancy and delivery can cause short-term consequences that include increased postpartum pain [14]. Furthermore, these women are at risk for post-traumatic stress disorder and self-esteem loss [14]. This can affect infant care in the critical post-partum period, which can predispose the infant to long-term consequences [14]. Also, maternal disrespect and abuse can reduce trust in the health system, and this can affect the uptake of health services by the woman, her family, and the community in the future, with varying ramifications [6,7]. Additionally, medically unnecessary procedures like episiotomies and cesarean sections can be direct outcomes of mistreatment [14]. These procedures carry additional risks like bleeding, infections, and prolonged hospital stays [14]. They can also predispose to long-term complications like chronic pelvic pain and subfertility [14].

There is hardly any public health consensus regarding maternal mistreatment [5]. There is currently no standard for measuring maternal satisfaction or maternal mistreatment. Furthermore, the maternal health objectives outlined by Healthy People 2030 are focused on quantitative indicators like maternal morbidity, mortality and proportion of cesarean births [5,15]. Conversely, on the global stage, health care systems are focusing more on quality indicators [3]. This is something that the United States needs to adopt as, despite spending almost twice as much as other developed nations on maternal care, the US still reports poorer maternal and infant outcomes [3].

3. EPIDEMIOLOGY

The "Listening to Mothers" survey was one of the first population-based national surveys in the United States that attempted to measure women's experiences during pregnancy and delivery [16]. However, it did not collect data on maternal mistreatment [16]. In "The Giving Voice to Mothers Study", a large national survey conducted in 2019, maternal mistreatment was explored using the seven groups outlined by Bohren et al. [6]. The study showed that 17% of all women and close to 30% of women who received maternal care in hospitals experienced at least one form of mistreatment by care providers [7]. Verbal abuse and neglect were the most commonly reported forms of mistreatment, reported by 8.5% and 7.8% of all respondents, respectively [7]. On the other hand, physical abuse and breaking confidentiality were the least reported forms of maternal mistreatment [7]. In another survey of nurses, doulas, and childbirth educators, over 80% of these birth workers claimed to have seen other care providers perform a procedure without obtaining consent [17]. Furthermore, over 50% of respondents reported having seen a procedure performed despite the birthing person's refusal [17].

Certain populations experience disproportionately higher rates of mistreatment [7]. 32.8% of Indigenous women, 25% of Hispanic women, and 22.5% of Black women reported having experienced at least one form of maternal mistreatment compared to 14% of White women [7]. Furthermore, a quarter of women 24 years old or younger reported mistreatment compared to 14% of women over 30 years old [7]. Also, women with low family incomes were twice as likely to experience verbal abuse compared to women with moderate or high family incomes [7]. Of all the studied subpopulations in this survey, women with a history of substance abuse, imprisonment, or interpersonal violence had the highest

prevalence of maternal mistreatment, with one in three women reporting mistreatment by care providers [7].

There has been increased reporting of maternal mistreatment over the last decade [18,19]. However, due to a paucity of data, the exact trend of this health issue is not clear [18,19]. On the other hand, cesarean section rates in the United States have increased steadily, from 23% in 2000 to 31.7% in 2019 [20,21]. The rise in the rate of this potential outcome of maternal mistreatment is not due to maternal or infant factors, but to provider and organizational imperatives, with women's rights and autonomy often challenged [22]. Furthermore, even among those with the lowest clinical risks, these rates are higher in racial and ethnic minorities and low-income women [23,24]. These populations represent the same population at risk for medical mistreatment [7].

4. MEASURES

Exploring maternal mistreatment with the Pregnancy Risk Assessment Monitoring System (PRAMS), a survey that collects population-level data will provide valuable information about an emerging public health issue. Furthermore, as a result of the relationship between maternal mistreatment and the social determinants of health and the increased recognition of the influence of these social risk factors on various aspects of maternal health, this paper also advocates for the addition of a social risk screening question (the Core 5 assessment question) to the Texas PRAMS survey [25]. These are the two proposed questions:

1. During your most recent pregnancy, did you experience any of the following issues/behavior from any health care provider? For each one, check no if you did not or yes if you did.

    a. Physical abuse (aggressive physical contact, use of force, or physical restraint)
    b. Verbal abuse (harsh language, threats, or blaming)
    c. Sexual abuse
    d. Discrimination (unfair treatment due to race, ethnicity, gender identity etc.)
    e. Violation of privacy (being uncovered, having people in your delivery room, or having your personal information shared, without your consent)
    f. Poor professional standards (not offered all options before procedures, denied medications/procedures, or forced to accept treatment you did not want)
    g. Poor rapport (ignored, ineffective communication, or lack of supportive care) [7]

2. Think about the 12 months before your baby was born. For each one of the following options, check no if they did not apply to you or yes if they did.

    a. Were you worried about losing your housing or were you homeless?
    b. Did a lack of transportation keep you from work, attending medical appointments, or from getting things you need for your daily living?
    c. Did you or your family worry that your food will run out and you won't be able to get more?
    d. Did you worry that someone in your neighborhood may hurt you or your family?
    e. Did you have concerns at home with your utilities such as heat, electricity, or water? [25]

The positioning of these two sensitive questions in the PRAMS questionnaire should be thought through. This paper proposes that the screening question for maternal mistreatment should be inserted after question 29 in the core PRAMS questionnaire. The first reason for this is that the questions in that section address interpersonal violence, and this question will be consistent with that theme. Furthermore, that section already has an appropriate transition sentence before the questions. Lastly, that section is the last one that focuses on pregnancy, as the subsequent sections are about the post-partum period and the infant. The social risk screening question should be inserted after question 51 on the core survey. The questions in this section are related to income during the 12-month period before delivery, and the social risk screening question fits this theme.

The following measures are proposed to describe the prevalence of social risk and maternal mistreatment. Furthermore, the last two measures show the relationship between social risk factors and maternal mistreatment.

$$\frac{\text{Number of women that reported at least one form of mistreatment}}{\text{Total number of women that took the survey}}$$

$$\frac{\text{Number of women that reported at least one of the social risk factors}}{\text{Total number of women that took the survey}}$$

$$\frac{\text{Women who reported at least one form of mistreatment \& at least one of the social risk factors}}{\text{Number of women that reported at least one of the social risk factors}}$$

$$\frac{\text{Women who reported at least one form of mistreatment \& no social risk factors}}{\text{Number of women that reported no social risk factors}}$$

5. BIAS

As with most studies, the PRAMS survey has its limitations. The participants of this survey are not fully representative of all pregnant women. This is because respondents are women who have had recent live births; these women are randomly selected using birth certificate records [26]. As a result, there is a data gap related to women with pregnancy losses and stillbirths. This exclusion can impact the interpretation of maternal mistreatment data. It can lead to underestimation of maternal mistreatment prevalence if this issue is associated with pregnancy loss or stillbirths. Similarly, the prevalence of women experiencing social risk factors can be underestimated for this same reason. Furthermore, in 2019, Texas reported a PRAMS response rate of 41%, one of only 7 states that did not meet the CDC's minimum response rate threshold of 50% [27]. This high non-response rate can disproportionately exclude certain groups, leading to erroneous conclusions from PRAMS data.

Bias can also be introduced during data collection. Since PRAMS data is self-reported by participants, the sensitive nature of some of the survey questions, including the questions proposed in this paper, can be a source of response bias. Social desirability bias and extreme response are examples of measurement issues that can impact the collected data. Respondents may be reluctant to report very poor social risks and may not report mistreatment objectively. Also, respondents may not accurately recall some of their experiences, especially during early pregnancy. As a result, they may omit information or provide inaccurate information. This inaccurate or omitted information may lead to the misclassification of respondents.

6. NEXT STEPS

According to the CDC, after defining a health problem and collecting data on its prevalence and associated factors, developing and testing prevention strategies is the next step to preventing negative outcomes [28]. Fortunately, the World Health Organization has published a public health framework for addressing maternal mistreatment, which can be adapted [5]. Firstly, support from the government and relevant stakeholders will be required to continue to measure maternal mistreatment and also the effectiveness of any implementations. This continuous stream of data will help inform further interventions. In the United States, it is necessary for maternal mistreatment to be a priority nationally and at the state level. Secondly, health policy has an important role to play. Maternal satisfaction needs to be considered an important maternal and child health indicator. Collection and reporting of maternal satisfaction survey results should be mandated for hospitals and health centers. This will ensure that women experience high ethical standards and professional care. Furthermore, cross-tabulating the maternal mistreatment screening question with the social risk question and other socio-demographic questions will reveal some important associated factors. These upstream factors can be targeted with specific interventions. Also, healthcare providers need to be supported with manageable schedules; they also need to be trained on stress-management and effective communication strategies.

The collection and analysis of maternal mistreatment data using the World Health Organization framework will provide a direction for the implementation of practical strategies to address this public health concern. One strategy that has been shown to reduce maternal mistreatment is the increased involvement of the partners and families in the different aspects of

maternal care [29]. This is because women are less likely to suffer abuse or disrespect from healthcare providers in the presence of their family or friends. Secondly, the increased utilization of doula and peer support services during pregnancy and delivery has been linked to reduced maternal mistreatment [7,30]. Furthermore, women need to be educated on their rights to receive dignified healthcare and be provided with a judgment-free means of making complaints if they feel like their rights have been infringed upon. Lastly, hospitals and maternal care centers need to be properly staffed to prevent excessive provider workload and fatigue, which are known contributors to maternal mistreatment [6]. Also, providers should be educated on the importance of value and attitude in maternal care.

7. CONCLUSION

Public health advocates need to raise awareness about reproductive justice and the right of women to receive dignified health care. Stakeholders and the general community need to be engaged and involved in this effort to end maternal mistreatment. Also, while studies have shown that imposing penalties to address obstetric violence without addressing underlying causes produces limited changes, tort litigation for maternal mistreatment can be impactful when combined with other intervention strategies [18]. Lastly, it is important to note that the collection of data is only the first step in addressing maternal mistreatment. Effective strategies to prevent maternal mistreatment need to be implemented. The specific strategies will depend on the data analysis, which will provide some insight into some of the upstream causes of maternal mistreatment.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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