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ETHICS CASE

How Should Trainees Respond in Situations of Obstetric Violence?

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Abstract

Argentina passed a law for humanized birth in 2004 and another law against obstetric violence in 2009, both of which stipulate the rights of women to achieve respectful maternity care. Clinicians and women might still be unaware of these laws, however. In this article, we discuss the case of a fourth-year medical student who, while visiting Argentina from the United States for his obstetric rotation, witnesses an act of obstetric violence. We show that the student's situation can be understood as one of moral distress and argue that, in this specific instance, it would be appropriate for the student to intervene by providing supportive care to the patient. However, we suggest that medical schools have an obligation to better prepare students for rotations conducted abroad.

Case

Paul is a fourth-year medical student doing an away rotation in high-risk obstetrics in Buenos Aires, Argentina. He is part of the third-wave of medical students from a prestigious US medical school rotating at this hospital, which is where students from the local medical school also train. Paul's medical school helped to build this Buenos Aires-based medical school five years ago.

Before traveling to Argentina, Paul met with his friend, Bethany. "Watch out when you're on the labor floor," Bethany warned him. "You might see some violence toward the patients. I certainly did."

Upon learning this, Paul looked up issues about violence in labor and delivery settings and found that the term "obstetric violence" is used to describe a broader range of health care professionals' behaviors and communications that dehumanize, pathologize, and abuse women during "reproductive processes," especially childbirth. Paul learned that instances of obstetric violence are documented in numerous countries, including the United States, even though no US law expressly prohibits obstetric violence.

Now on the labor floor at the hospital in Buenos Aires, Paul observes resident physicians and nurses interacting with women delivering babies. In one case, Paul sees a resident physician yelling at a patient who has been pushing for over four hours. Loudly and

punitively, he tells her that she will most likely need an operative vaginal delivery or a cesarean section. He points his finger crudely at her vagina, threatening to do an episiotomy. He degrades her further, "You're so weak! I need you to push! Animals can push their babies out harder than that! Get going!" The patient's nurse hits her on the arm and points to her vagina, "You need to push harder, or the doctor is going to cut you."

Paul steps back, upset and trying to collect his thoughts. "This is so obviously wrong," he thinks. "What should I do?"

Commentary

The mistreatment of parturient women in health care delivery settings is a form of violence that is embedded both in health systems and in the hierarchical power structures within hospitals [1]. In 2014, the World Health Organization published a statement to draw attention to the mistreatment of pregnant women in birth facilities [2]. In a commonly used framework in global health, Bowser and Hill detailed several categories of mistreatment including physical abuse, nonconsented care, nonconfidential care, nondignified care, discrimination, abandonment of care, and detention in facilities [3]. Somewhat distinct from this framework, several countries in Latin America have framed the mistreatment of parturient women from the perspective of dehumanizing experiences that result from the inappropriate medicalization of natural processes in childbirth [4]. Brazil pioneered the discussion on humanization of birth care in 1993, but it was not until the 2000s that the term "obstetric violence" started to be used in childbirth activism and legislation [5, 6]. Both the humanization of birth movement and laws against obstetric violence advocate for birth as a normal event in which women should be in charge and medical interventions only used when necessary [7].

In this case, Paul begins to wonder if he should intervene in the abuse he observes. However, becoming an advocate in the moment of witnessing violence or reporting a potentially illegal incident after the fact are two actions that need to be approached delicately so as not to put the woman or the medical student at risk. Because of the compromised position of the patient and the student, the hosting and home medical schools might have a greater duty to intervene in situations of obstetric violence.

The Humanized Birth Movement in Argentina

As part of the region's efforts to demedicalize birth, in 2004 Argentina passed a law for humanized birth that put forward the rights of every pregnant woman to information as well as to dignified, respectful, and high-quality maternity care [8]. In 2009, following Venezuela's first institutional recognition of obstetric violence under the Organic Law on Women's Right to a Life Free of Violence [9], Argentina enacted a law against obstetric violence [10]. This law frames obstetric violence as a gender rights issue and defines it as a type of violence executed by health personnel on the woman's body and her

reproductive processes that is frequently expressed through dehumanized treatment, as was the case with the birth Paul witnessed.

It is important to stress that regulations under the 2004 Law for Humanized Birth in Argentina were not set out in detail until 2015 [11]. Due to this law's novel nature, hospitals, physicians, clinics, and even pregnant women might not be aware of their rights and responsibilities or of prohibited behaviors in the delivery suite [12]. After the passage of a law, behavior change can be slow and might require that citizens pursue accountability in a public fashion. Since the passage of the obstetric violence law, only one woman has initiated a legal proceeding against her physician [13].

The resident physician's verbal abuse and the nurse's physical abuse in this case are expressly forbidden under Argentine law. Types of verbal abuse during childbirth identified in literature reviews include harsh or rude language, judgmental or accusatory comments, and blaming for poor outcomes. Types of physical abuse identified in literature reviews include women being beaten, slapped, kicked, or physically restrained to the bed during delivery [14]. By these criteria, Kruk et al. found in postpartum interviews with 593 women in Tanzania that 13 percent experienced shouting or scolding, 11 percent reported threatening or negative comments, and 5 percent experienced slapping or pinching [15]. Bohren et al.'s interviews with Nigerian health care practitioners and women of reproductive age revealed that they believed abusive behaviors to be acceptable measures to get women to cooperate with the care plan or to optimize outcomes for the baby [16]. These findings indicate that [mistreatment during childbirth](#) is not restricted to Latin America but is also prevalent in other regions of the world.

Medical Students and Moral Distress

Before discussing Paul's options to intervene or not in this situation, it is important first to frame his reaction to what he witnessed in the delivery room. Paul is experiencing moral distress, defined by Berger as "the cognitive-emotional dissonance that arises when one feels compelled to act against one's moral requirements" [17]. Due to the poor behavior modeled by the resident and the nurse, Paul feels unsure about whether to speak up about what is "so obviously wrong."

The experience of moral distress is common in medical training. In a cross-sectional survey of health professions students in the United Kingdom (UK), 69.9 percent of female and 59.9 percent of male medical students reported witnessing a senior clinician breaching patient dignity or safety, and 80.4 percent of female and 71.5 percent of male medical students reported being victims of abuse themselves [18]. Across all professionalism dilemmas, women reported being significantly more likely than men to classify themselves as distressed [18]. We don't know how common moral distress is for students in the cross-cultural context; focus groups conducted with faculty experts in

global health revealed that students confront ethical dilemmas concerning respect for patient autonomy and power dynamics [19].

On What Grounds Might Action Be Justified?

Paul has two routes of action: intervening in the moment of the abuse or reporting the incident to the proper authorities in a reasonable amount of time. Intervening in the moment could be grounded in the bioethical principle of justice that compels professionals to protect the rights of the patient. The Argentine law for humanized birth clearly states that verbal and physical abuse of pregnant women is a violation of their rights [6]. Given that abuse in childbirth can impact a woman's physical and psychological health including greater risk of postpartum depression or posttraumatic stress disorder (PTSD) [20], Paul could also justify intervening based on the principle of nonmaleficence. Thus, solid ethical principles support an immediate action.

On the other hand, Paul must balance potential actions against other considerations arising from his position as a medical student in an Argentine hospital where he might have incomplete information about the unit culture and hospital routines. If Paul's intervention involves [challenging the resident's management](#) of an "abusive" situation, the resident could be put on the defensive, potentially worsening an already antagonistic situation. Although the resident might have committed an illegal act, he is likely providing adequate clinical care to this patient; an antagonistic situation could compromise clinical care. Finally, becoming an advocate in the moment might open up the possibility of Paul himself being harassed and abused. Given these possibilities, notifying the resident of his abusive behavior would be difficult to justify on the grounds of beneficence or nonmaleficence.

Paul might also need to consider whether he is legally obligated to act. According to Argentina's law against obstetric violence, anyone who witnesses an incident of obstetric violence should report it to the competent administrative authority determined by the local jurisdiction [10]. In reality these mechanisms would be difficult for a foreign medical student to navigate. However, it would be relatively safe for Paul to give the patient information about her rights under the law for humanized birth. From this point forward, the patient could decide whether it was in her best interests to pursue legal recourse.

Potential Solutions

Supportive care for laboring and postpartum women. Fortunately, for a medical student like Paul who feels compelled to act in response to moral distress, there is a relatively simple way to intervene—namely, Paul could propose providing supportive care to the laboring woman. Supportive care would include emotional and physical support, listening to the pregnant woman's concerns, or helping her feel empowered. Evidence shows that women who are supported during labor—by a male partner, a health care worker, or a

doula (a trained assistant for birth and postpartum support)—report lower levels of mistreatment [21]. Continuous support also has clinical benefits. In a systematic review encompassing 15,061 women in 21 clinical trials, women who had continuous labor support were more likely to have a spontaneous vaginal birth, less likely to use epidural anesthesia, and less likely to report dissatisfaction [22]. With the patient's permission, Paul could accompany the woman through the rest of her labor, or, if the patient expressed concerns about involving Paul directly, he could facilitate involvement of her family. Finally, in contrast to the above possibility of confronting the resident and the nurse about their abusive behaviors, the medical team would be more likely to view Paul's supportive care in a favorable light.

Having established a relationship with the patient during her labor, Paul could continue supportive care into the postpartum period. Postpartum hospitalizations in Argentina normally last 2-4 days [23], and in our experience it is common for medical students to round on the patients whose births they observed. For women who have experienced potentially abusive situations, our approach is to create space for the woman to name her own experience; we believe it would be inappropriate for a medical student to name the abusive experience for her. Paul could create space for the patient by asking open-ended and nonjudgmental questions to probe the woman's perspective on her labor experience and help her arrive at her own conclusions. If the woman is already identifying her birth experience as abusive, then the medical student could inform her about the law for humanized birth and the law on obstetric violence. Either way, Paul should connect the patient to the hospital's psychosocial support services, since women who experience abuse in childbirth are at risk for poor postpartum mental health outcomes [24].

Institutional responses to obstetric violence. Most medical students will likely experience moral distress whether at home or abroad. While some experts have suggested that [emotional support interventions](#) might be helpful to students [18], others have argued that an institutional response would be more effective [17]. However, we have no information on effective institutional responses to moral distress in the global context.

Nonetheless, we believe that the sending and receiving institutions have a duty to prepare students for the contexts into which they will be inserted. Jogerst et al. have helpfully detailed the proposed knowledge, attitudes, and skills required for learners in global health, which can serve as a guide for clerkship directors [25]. It does not appear that Paul was appropriately supported to achieve competency appropriate to his level. Instead, Paul learned about the potential for abusive situations in childbirth from a returning medical student, quite apart from the official curriculum. To better prepare students, clerkship directors from home and host institutions could incorporate general material on global health competencies and moral distress and specific material on respectful maternity care.

For instance, the Argentine and American obstetric clerkship directors could create the space for medical students to do formal presentations on the global and national evidence concerning the mistreatment of pregnant women, including the different types of mistreatment, their prevalence, and their impact on women's and newborn's health. Clerkship directors need to prepare students in appropriate ways to intervene if abusive situations arise in childbirth, especially in how to provide supportive care and how to work collaboratively with the clinical team. Finally, in Paul's case, given the specific nature of the reporting mechanisms, the Argentine clerkship director should make it clear to whom students should report potentially abusive behaviors.

It can be difficult to challenge strongly held beliefs about and ingrained patterns of practice in childbirth. As trainees, medical students play an important role in learning to become respectful maternity care clinicians. A systematic review performed by Mannava et al. found widespread negative attitudes held by maternity care physicians toward pregnant women in low- and middle-income countries, suggesting that long-term investments in health system infrastructure and in health care workers' education, communication skills, and work-life balance will be key to training the next generation [26].

Conclusion

With regulations in place, achieving a national-level commitment to respectful maternity care in Argentina is possible. With the right institutional structure, rotating medical students can play an important role in advancing respectful maternity care abroad. If an institutional structure is lacking, students can provide supportive care to laboring women—a well-established intervention to improve the birth experience and prevent mistreatment. Students can also inform women of their legal rights; however, it would be challenging for an American student to report obstetric violence under Argentine law. When guidelines are lacking, students should push for clear expectations from their clerkship directors about whether and to whom they should report incidents of obstetric violence.

Efforts to improve maternity care go beyond the legal recognition of obstetric violence and the health care professional's in-the-moment reaction to an instance of mistreatment of a pregnant woman. The cooperating medical schools should assume responsibility to inform students about different norms and behaviors and prepare them to react adequately in situations that create moral distress. If Paul's friend had not informed him about this type of mistreatment of pregnant women, he would have arrived in Argentina unaware of the legal framework or without a previous consideration of his ethical role.

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