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Nursing-Related Interventions to Obstetric Violence: A Literature Review

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NURSING-RELATED INTERVENTIONS TO OBSTETRIC VIOLENCE

by

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ABSTRACT

The aim of this literature search was to explore the prevalence of obstetric violence and identify nursing interventions that could potentially prevent the mistreatment of pregnant women in the United States healthcare system. *Background*: The topics of obstetric violence and healthcare disparities have been gaining awareness. Other countries have a larger body of research for obstetric violence compared to the U.S. *Methods:* CINAHL Plus with Full Text and MEDLINE databases were utilized. Global perspectives were considered in conjunction with the U.S. and specifically Florida. Healthcare disparities in obstetric care were identified, based on race, ethnicity, socioeconomic status, sexuality, disability, weight, and age. *Results:* There were seven studies related to obstetric violence in U.S. healthcare facilities, none in Florida. These studies found there was obstetric violence in U.S. healthcare facilities, however, it was inconclusive to the degree and rate of mistreatment as well as the effectiveness of any stated prevention strategies. The quality of the reporting limited the generalizability and rate of mistreatment. *Discussion:* Nursing interventions to obstetric violence were readiness to learn, shared decision-making, empathy, and self-reflection. Nurses can implement these interventions to improve the quality of patient care and prevent violence within the healthcare setting.

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INTRODUCTION

Injustices can be found globally and can affect anyone, however people who identify with certain demographic groups are found to be impacted disproportionally (World Health Organization, 2014). This is particularly true for women in general. Race, socioeconomic class, sexuality, state of illness or disability, weight, and age are all factors of an individual's idenitity that contribute to healthcare disparities.

The topic of obstetric violence has begun to have controversy. There has been discourse regarding how it should be named or defined, as violence is a word with a heavy connotation. Violence does not strictly infer intentionality, and there is no limit to its degree. In the context of obstetric violence, providers are capable of committing harm towards their patients, just as that harm can take many forms. Lappeman and Swartz discussed the possible harmful effects of using such a phrase instead of "obstetrical mistreatment" or "malpractice", which could be offensive to providers and their profession or lead to misinterpretation of the events that occurred (Lévesque & Ferron-Parayre, 2021).

The word violence is multidimensional and can comprehensively define the ubiquitous harm towards obstetric patients across the world and throughout time (Lévesque & Ferron-Parayre, 2021). There must be an understanding that obstetric violence is more than conspicuous and observable single harmful acts; violence is a broad term that can take on many forms (Montanez et al., 2020). Violence is one of many similarly defined words that can describe the horrific nature of mistreatment towards in patients in healthcare systems across the world. These actions do not define every practitioner, the practice, or the healthcare system entirely, but do so in that any

practitioner can unintentionally or intentionally cause harm and any patient can be affected by this violence within the practice.

Operational Definition

Obstetric violence is the mistreatment of patients in the antepartum, intrapartum, and postpartum stages of pregnancy by health professionals (van der Waal, 2022). This violence can be phsycial, verbal, and emotional, and includes but is not limited to: abuse, neglect, discrimination, denial of healthcare, mismanagement of medication administration, detainment, nonconsensual procedures (i.e., episiotomies, fundal massages, the “extra stitch”), coercion of procedures, inadequate education, and overall lack of compassion and nonadherence to caregiving standards (van der Waal, 2022; Darilek, 2018). Appendix A. (Operational Definitions) includes the definition of obstetrical violence, along with other terms used interchangeably or in conjunction.

BACKGROUND

The topics of obstetric violence and healthcare disparities have been gaining awareness. Other countries have a larger body of research for obstetric violence compared to the U.S. (Vargas et al., 2021). The United States currently has the highest increasing maternal mortality rate out of all of the developed countries in the world (Ozimek & Kilpatrick, 2018). In 2021, the total U.S. maternal mortality rate was 32.9 per 100,000 women; the maternal mortality rate for non-Hispanic Black women was 2.6 times the rate for non-Hispanic White women (Hoyert, 2023). It has not been readily available nor disclosed what the precise reason is for the increase in deaths; however, the discrepency between the trend of White and Black maternal mortality rates in the United States is evidently clear as being a healthcare disparity.

METHODS

Academic literature regarding obstetric violence in the United States were searched utilizing two databases: CINAHL Plus with Full Text and MEDLINE (EBSCOhost). The search conducted in CINAHL included the terms "'obstetric violence' or 'abuse during childbirth' or 'disrespect and abuse during childbirth' or 'obstetric mistreatment' or 'mistreatment during childbirth'" and "'united states' or 'america' or 'usa' or 'u.s.' or 'united states of america'" with the exclusion of "'substance abuse' or 'intimate partner violence' or 'domestic violence' or 'fetal alcohol syndrome'". MEDLINE was utilized with the same search criteria in a separate search.

RESULTS

The search in CINAHL Plus with Full Text yielded 7 results exclusively in the United States originating in 2016. The same search conducted with MEDLINE yielded 7 results in the U.S. starting in 2006.

One of the qualitative studies in the search result found that 66% of the participants (N = 200), who all received facility-based care for their childbirth, reported experiencing at least one form of incivility in a Labor and Delivery unit (Vargas et al., 2021). The forms of incivility the participants were asked upon ranged from lack of empathy or humane treatment to uncomfortable physcial interactions. The researchers found that while healthcare professionals' intent to harm is questionable, incivility towards obstetric patients in United States hospital systems is relevant and clearly a violation of respect (Vargas et al., 2021). The term "violence" is often thought of equating to extreme aggression. Unfortunately this leads to the misunderstanding of mistreatment, incivility, and disrespect as contributing factors of gender-based and healthcare associated violence.

As mentioned earlier, intentionality is not required for violence to take place. A concept called medical iatrogenesis is a blanket term for injuries by health professionals towards patients caused by ineffective, unsafe, and erroneous treatments (Liese et al., 2021). This term can be applied to obstetric violence as the combination term "obstetric iatrogenesis". 62 women who experienced obstetric iatrogenesis in U.S. healthcare facilities were interviewed; the types of mistreatment they endured include excessive and/or painful cervical exams, EFM (electronic fetal monitor) false positives, supine birthing positions, verbal threats, mother blame, lack of informed consent, racism, and other health disparities (Liese et al., 2021).

Structural sexism has been tied to the high rate of cesarean births in the U.S. (Nagle & Samari, 2021). There were 987,187 low risk births by women in the U.S. ages 15-49 in 2018; of these, 25.06% were cesarean births (Nagle & Samari, 2021). Cesarean births are at an increased risk for maternal and fetal complications compared to spontaneous vaginal births (Teitler et al., 2019). The statistic of at least one-fourth of low risk births in the U.S. being surgical in nature brings to question the medicalization of obstetric practice in U.S. healthcare systems. Over or under use of medical interventions compromises the health, safety, and bodily autonomy for obstetric patients.

A survey conducted in the United States and Canada analyzed the witnessed experiences of 967 Labor & Delivery (L&D) nurses and 1435 doulas (Morton et al., 2018). The researchers found that most survey results were insignificant for the types of disrespectful care listed but 2/3rds accounted for the mishandling of informed consent occassionally or frequently, 1/3rd of participants claimed witnessing healthcare providers pressure patients to undergo certain procedures, and more than 1/5th of participants collectively observed patients undergo more procedures based on racial factors (Morton et al., 2018). Overall, a "failure to meet professional standards" was the most remarkable response from the survey; there was a high correlation between increased reports of disrespect and abuse against patients and the desire for the nurses/doulas to leave the profession (Morton et al., 2018). The researchers also found that the people of color in the observer population of the survey were more likely than white observers to reports incidences of disrespect and abuse (Morton et al., 2018). These survey results are significant in understanding how nurses and doulas perceive obstetric violence in U.S. healthcare facilities.

Florida

The few studies above are the majority of the available literature of obstetric violence in the United States (Vargas et al., 2021; Liese et al., 2021; Nagle & Samari, 2021; Teitler et al., 2019; Morton et al., 2018; Ozimek & Kilpatrick, 2018; Hoyert, 2023). A search of "obstetric violence" or "abuse during childbirth" or "disrespect during childbirth" or "disrespect and abuse during childbirth" or "obstetric mistreatment" or "mistreatment during childbirth" and "Florida" in the CINAHL Plus with Full Text and MEDLINE databases were insignificant for any results relevant to the relationship between obstetric violence and the state of Florida. In these instances, there is a large gap in literature in the United States and a lack thereof specifically in Florida. This necessitates further research of the incidence of obstetric violence in the United States and specifically Florida over time and in recent years, as well as the types of mistreatment by healthcare professionals in facility-based care.

Global Perspectives

Mistreatment in the obstetric healthcare setting has known no boundaries; birthing individuals face obstetric violence regardless of where they are in the world and can be mistreated by anyone no matter their profession (Lévesque & Ferron-Parayre, 2021). Research studies of reported violence in healthcare institutions have been conducted in several countries globally (Darilek, 2018) including the United States, India, Ethiopia, Tanzania, Brazil, Ghana, Latin American countries, Nordic countries, and more (Vargas et al., 2021; Mayra et al., 2022; Mengesha et al., 2020; Freedman et al., 2018; Leite et al., 2020; Rominski et al., 2017; Alghamdi et al., 2019; Sadler et al., 2016).

Research has shown that most women in India have experienced some form of mistreatment during childbirth (Mayra et al., 2022). The researchers utilized body mapping techniques to understand the perspective of Indian women during childbirth and what their expectations are of their care. This allowed each participant to individualize their experience and explain it through storytelling. Eight women participated in the exercise and gave detailed interviews of their experiences between home and hospital facility births. There were positive and negative experiences noted, all of which contribute to the understanding of an Indian woman's experience with childbearing in a patriarchal society. The researchers reached the conclusion that birthing maps are essential tools for assisting women with telling their stories, and that there is a gap in research literature regarding women voicing their opinions concerning their healthcare (Mayra et al., 2022).

Ethiopia is one of the countries in Sub-Saharan Africa to have the highest maternal mortality ratio in the world (Mengesha et al., 2020). Ehtiopian women suffer from low-quality healthcare and a limited number of trained birth-assisting health professionals. The lack of resources and access to quality healthcare has lead to poor outcomes for childbearing women. A systematic review consisting of qualitative, quantitative, and mixed studies confirmed widespread reports of mistreatment (Mengesha et al., 2020). Every study had participants who reported at least one form of obstetric violence during their childbirths. There were some extreme accounts of abuse such that some of the women in the studies recalled they had been detained for failure of payment or prevention of home delivery (Mengesha et al., 2020). Countries differ in healthcare facility policies and law regarding maternal and fetal health, which may account for the variances in the reports of abuse from women globally. The researchers of the systematic review inferred that the

reputation of mistreatment by healthcare professionals is deterring Ethiopian women from receiving childbirth care from hospital facilities (Mengesha et al., 2020).

The Staha project explored the prevalence of Disrespect & Abuse (D&A) in Tanzania and the interdimensional perspectives of what is considered violence (Freedman et al., 2018). The study defined D&A by category of overt and covert abuse, meaning abuse that is obvious and abuse that is defined in contrast by women and healthcare professionals. The researchers studied 469 births across two hospitals in the Tanga region by requesting reports from the childbearing women and the observers in the room. There was a sizeable difference between reports of D&A by the women (7-10%) and the observers (34-70%). The observers for the most part reported the violence, and the researchers hypothesized this may be due to internalization of violence for women and the normalization of the same violence for the healthcare professionals. Although there are laws in Tanzania that prohibit maternal violence, especially such acts that are undeniable, healthcare professionals are still found to be culpable of malpractice as evidenced by the reports of the observers. The birthgiving women in the study underreported because they were treated as though the abuse was the standard of care (Freedman et al., 2018).

The prevalence of obstetric violence in Brazil was between 11.3 and 18.3 % in 2020 (Leite et al., 2020). The researchers in Leite et al. (2020) conducted a survey of 23,378 puerperal (first six weeks postpartum) women and interviewed them twice within the next year as a follow-up. The researchers asked the participants several indicators regarding their hospital stay, their treatment, and demographics. The results determined that 44.3% of the women reported at least one form of abuse and there was a strong correlation between the instances of violence and postpartum depression. The researchers determined the plan of action following these results is to

identify measures to combat obstetric violence to decrease the likelihood of complications for mothers like postpartum depression (Leite et al., 2020).

A group of midwifery students in various regions of Ghana participated in a focus group to recount their involvement in respectful and disrespectful experiences with birthing mothers (Rominski et al., 2017). They first described what they defined as respectful patient care, responses ranging from patients receiving respect to the expectation for patients to give respect to their healthcare providers. Then, the studying midwives described events of disrespect and abuse they either observed or participated in and the researchers found three common themes: rationalization of disrespect and abuse, culture of blame, and no alternative to disrespect and abuse (Rominski et al., 2017). Increasing the proportion of women who give birth in the hospital has been found to decrease maternal mortality rates (Rominski et al., 2017). Birthing individuals in both Ghana and Ethiopia are frightened of being physically, mentally, and emotionally abused by a health professional in healthcare facilities (Rominski et al., 2017; Mengesha et al., 2020).

An integrated worldview of obstetric violence is necessary to understand the cultural components that affect the forms of disrespect in various countries' health facilities. Sadler et al. (2016) analyzed the state of the world regarding disrespect and abuse during childbirth. They found that c-sections and episiotomies are two of the most widespread interventions during childbirth and neither of them are as necessary as much as they are utilized. There is evidence of the restricted use of episiotomies resulting in better outcomes for mothers as opposed to routine use, and c-sections are performed at a high rate in areas such as Latin America despire the maternal mortality rate no longer being significantly affected by c-section rates once they are higher than 10% (Sadler et al., 2016). The researchers suggest that since obstetric violence is such a complex and

overlapping issue amongst many countries, there should be changes along several levels such as legislation, economics, advocacy groups, education, and research (Sadler et al., 2016). Fundamentally improving higher education and legislation regarding protection of the rights of childbearing women are ways to prevent obstetric violence in the long run, which will ensure more permanent change.

Disparities

Mistreatment during childbirth is not limited by country. Individuals from all over the world have suffered during and/or after their pregnancy, some more than others. Research has shown there is a correlation between the social determinants of health and adverse pregnancy outcomes, like maternal mortality (Shah et al., 2021). There are health disparities for birthing individuals based on the grounds of race, ethnicity, gender, sexuality, socioeconomic status, age, diabilities, weight, and illnesses (Redshaw & Heikkila, 2011; Wells & Lang, 2016; Mengesha et al., 2020; Scala, 2022; Wudneh et al., 2022; Sethi et al., 2017). These discrepancies in healthcare and obstetric mistreatment by health professionals are not mutually exclusive concepts, but are often one in the same.

Maternal mortality rate disparities of White and Black mothers have been recorded in the United States for the past 90 years, Black women averaging to be 3.55 times more likely to die in childbirth than White women (MacDorman et al., 2021). Racism has been so pervasive in the healthcare system that maternity patients have even been discriminated against based on their partner's race (Vedam et al., 2019). The BME (black and minority ethnic) population suffers disproportionally from certain illnesses or disease states such as preeclampsia, cardiomyopathy, embolism formation, and obstetric hemorrhage (MacDorman et al., 2021). BME maternal

morbidity and mortality rates in the U.S. can be attributed to lower quality healthcare, restricted access to resources, poor contraceptive use, and pre-pregnancy factors such as the mother's preexisting conditions (Oribhabor et al., 2020). The healthcare system in the United States contributes to racial and ethnic inequalities within the population, and requires improvement through inclusion, education, and the dismantling of barriers to equitable care for the BME population (Oribhabor et al., 2020).

Disrespect and abuse towards mothers during childbirth is likely to happen in low-income countries due to a lack of resources and quality facility-based healthcare (Okafor et al., 2015; Kujawski et al., 2017). Mothers in countries such as Nigeria, Tanzania, and Ethiopia often resist childbearing in a facility to avoid mistreatment by the health professionals and detainment for not being able to afford their hospital bills (Okafor et al., 2015; Kujawski et al., 2017; Mengesha et al., 2020). In the Giving Voice to Mothers study, 2,138 women in the U.S. were surveyed based on their childbirth experience either at home or at a facility. It was found that the participants with a lower SES were twice as likely to experience verbal abuse and violation of privacy by HCPs in a facility-based setting (Vedam et al., 2019). Maternal patients with a lower socioeconomic status (SES) in any country are often unable to obtain healthcare from adequately funded facilities with highly educated and trained employees in their area. Restricted access to resources and lower quality healthcare can lead to increased maternal morbidity, mortality, and overall mistreatment.

Labor and delivery facility-based services are traditionally heteronormative, where heterosexuality is expected for most or all patients. There has been an expectation for the patient to be a woman accompanied by her male spouse. Health professionals must be inclusive in their care and education as patients vary in their gender identities, sexual preferences, and family

structure. Otherwise, patients and their partners can be subjected to discrimination. A systematic literature review of same-sex couples' perceptions of healthcare services in Nordic countries found that the mothers were overall content with their treatment, but there are institutional barriers to inclusive care (Wells & Lang, 2016). These barriers include education, resources, and interactions with health professionals that are centered around opposite sex couples. The mothers and co-mothers felt that there is still progress to be made with the inclusion of gender-neutral language and communication with both the patient and their partner (Wells & Lang, 2016). These experiences do not seem to be acts of overt violence, however there is a marked neglect towards LGBTQ+ patients in healthcare regarding their need for individualized care. People across the spectrum of gender identity and sexuality can be mistreated through bias, and/or a lack of perspective by an antiquated system.

Younger and older mothers are at an increased risk for poor maternal and fetal outcomes (Scala & Orsini, 2022; Lisonkova et al., 2017). Advanced maternal age is becoming a trend amongst industrialized countries such as Canada (Scala & Orisini, 2022). Health professionals have been encouraged to educate mothers about the risks of childbirth beyond the age of 35 to prevent the likelihood of morbities and mortality (Lisonkova et al., 2017). While health professionals may want to prevent harm to their patients in good faith, this could lead younger and older childbearing individuals to be subjected to discrimination. In Canadian policy texts regarding advanced maternal age, older mothers are considered "risky," "unnatural," and "irresponsible" (Scala & Orsini, 2022). These terms share in quality a critical attitude towards mothers and their children.

73.6% of Americans are considered overweight as of 2018 (Fryar et al., 2020). Despite this prevalence, weight bias is present in the healthcare system (Phelan et al., 2015). Minority women and individuals with a lower SES or educational background are disproportionally affected by weight discrimination (Ferrante et al., 2016). 1 out of 5 pregnant women in an online study (501 total participants, n = 92) experienced weight stigma by their healthcare providers in a prenatal or postpartum healthcare facility (Incollingo et al., 2020). Manifestations of the weight stigma they expereinced primarily by obstetricians (33.8% of reported sources) and nurses (11.3%) were negative attitudes and judgement, conclusive statements about their weight, focus on negative outcomes, and inappropriate comments (Incollingo et al., 2020). The stigma against obese and overweight individuals by health professionals creates a barrier to accessible and equitable healthcare (Alberga et al., 2019). Negative behaviors and attitudes towards obese patients can deter them from seeking healthcare and result in negative outcomes for their quality of life and mental health, such as a higher risk for depression (Phelan et al,. 2015).

Vulnerable Populations

Vulnerable populations have often been victims of the most severe forms of abuse in the healthcare setting (Dobbing & Tomkins, 2021; Zinnari, 2021; Lovell, 2015). In the past, disabled women losing their autonomy and right to reproductive healthcare was commonplace (Stern, 2016). Women with disabilities have more protections today (U.S. Department of Justice, 2023), but may still be subjected to healthcare-associated violence. 31 states, including Florida, allow forced sterilization of disabled women (National Women's Law Center, 2022). Twenty-two women with disabilities (physical, intellectual, or sensory) in Ethiopia were interviewed regarding their experiences with institutional deliveries (Wudneh et al., 2022). They recounted some positive

experiences and negative experiences, including physical and verbal abuse, discrimination, and violation of privacy from a health professional either to themselves or to another woman. The women described the acts of violence as either being due to their disability, or rather as an unintentional consequence to a highly-populated facility. In this case, the violence was caused by the prejudices of the health professionals and/or by a flawed healthcare system. Either of these reasonings are issues to be resolved by sensitivity training, education, lower patient to provider ratios, and individualized care for each patient, especially for minority populations.

DISCUSSION

Obstetric violence has been researched for the most part in recent years. It has been stated there is a need for further research (Vargas et al., 2021; Ozimek & Kilpatrick, 2018), whether in the incidence rate or the quality of the occurrences. There is a gap in the body of literature regarding the United States especially on a state-level. Although the presence of mistreatment in United States healthcare facilities has been reported, there is a lack of comprehensive research that explores the level of violence in all contexts (such as the professionals responsible or the affected regions of the country), why the violence is prevalent, and what has been or should be implemented to prevent future events.

Centers for Medicare & Medicaid Services provides an inventory for their quality metrics, which are defined by them as "tools that help us measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care" (CMS, 2022). There are 978 active measure variants; of these, only 16 are related to pregnancy. The topics of these measures are limited to contraceptive care, elective delivery, exclusive breast milk feeding, maternal morbidity, prenatal and postpartum care, and ultrasound determination of pregnancy location (CMS, 2023). The measure that addresses obstetric violence to the most extent is "Prenatal and Postpartum Care", in which the rationale mentions preventative measures to pregnancy-related deaths such as improved quality and access to care and healthier lifestyle habits (CMS, 2023).

The World Health Organization (2014) recognized the influx of research and suggested five actions to be taken to prevent obstetric violence around the world: support from governments and development partners to continue research, initiatives for respectful maternity care programs, dignified and respectful care policies, create and analyze data regarding respectful and disrespectful care systems, and encourage every possible entity to combat obstetric violence. There is a necessity for an increase in research regarding disrespectful care and the effects of respectful care in healthcare facilities globally. Governments in countries with or without existing research should provide adequate funding for research institutions to further investigate obstetric violence in healthcare facilities and the effects of respectful and disrespectful care among patients. The implementation of maternity care programs and policies across all facilities would standardize positive, respectful practice and enforce patient rights. Patients especially must be encouraged to have an active part in their childbirth and verbalize their experience in healthcare facilities.

Violence in obstetric facilities occurs for a multitude of reasons, ranging from a facility's lack of resources to a health professional's beliefs and attitudes. Adverse treatment towards patients, such as physical, verbal, or emotional abuse, neglect, and discrimination, can be combatted on a local level through accountability. Interprofessional relationships between health professionals are necessary as teamwork and communication skills fulfill patient care; health professionals must be able to be responsible for their own actions as well as the actions of their team members. =

Nursing Interventions

Pregnancy is a vulnerable state, and requires care beyond that of a nonpregnant patient. Nurses in United States healthcare facilities are at the bedside throughout the entire labor and delivery process, and care for the mother and newborn(s) for days after. These professionals are either one of or are the most present member of the patient's healthcare team in a facility-based setting. While they do not implement medical interventions, the nursing interventions are those that protect the patient's well-being as a whole. Readiness to learn, shared decision-making, empathetic practice, and self-reflection are a few of the most important qualities a nurse must have in the obstetric field.

To intervene effectively, nurses must possess readiness to learn. Traditional nursing prioritizes life-saving measures. Fundal massages, for instance, are used to prevent hemorrhage. These interventions are utilized in healthcare facilities across the world despite insignificant evidence of beneficial impact (Farrington et al., 2021). Patients deserve to be adequately educated and warned about potentially harmful and painful procedures. Fundal massages, along with other medical interventions during childbirth such as episiotomies, frequent vaginal examinations, and controlled cord traction, may cause more harm to the patient than the absence of intervention (Çalik et al., 2018). Nurses and other medical staff must be willing to adapt to the most recent available knowledge and transform their practice as healthcare changes. Consent and patient preference must be respected even in the most acute patient cases.

Excessive medical interventions and reduced shared decision-making are common factors of obstetric violence in high-income countries (Begley et al., 2019). Shared decision-making is a necessary component of health professional and patient interactions; health professionals and their patients must collaborate to reach the best possible plan of care. Providers have a duty to ensure

their patients are informed of the options in their care, and to maintain the patient's authority to make healthcare decisions for themselves. C-sections and other procedures are often encouraged by medical professionals in healthcare facilities in the United States even for low-risk individuals for the purposes of a timely birth or private insurance incentives (Begley et al., 2019). Nurses are their patients' advocates, and they must protect their right to choose their care and to be informed of their choices. Obstetric nurses should be present for provider-patient interactions and intervene in the case of discrepencies in communication or respect of the patients' decisions.

One of the most important qualities for any health professional to have is empathy. A systematic review of the measurement of empathy in midwives and other professionals was limited by the available research, but did find there was a link between health professionals lacking empathy and lasting negative birth outcomes for the patient (Charitou et al., 2019). Patients in every stage of labor and delivery require their healthcare team to be present and supportive, especially their nurses. Active listening and therapeutic communication are a few ways nurses (and other professionals in the patient's healthcare team) can practice empathy.

Doctors, midwives, nurses, and other professionals improve their care through practice. Health professionals must have the ability to reflect on their personal beliefs and attitudes and previous patient experiences to provide better care for future patients. Focusing on the negative and positive experiences can improve care while also being rewarding (Koshy et al., 2017). Providers can frame their past experiences by reflecting on the situation and focusing on the who, when, where, why, how, and what could have been done differently (Koshy et al., 2017). This is especially important to keep in mind as healthcare professionals can harbor or gain prejudices

within their practice. Nurses must be able to look inward, examine their beliefs and attitudes, and understand how they treat their patients to ensure individualized, unique care.

CONCLUSION

There is still much to be done to prevent obstetric violence in the United States and healthcare facilities across the world. Patients continue to face mistreatment by health professionals in varying degrees as healthcare disparities prevail. There are gaps in the research of obstetric violence, more or less depending on the region globally. Continued research of patient care and contributing factors could give a clearer picture to the state of obstetric care today, and provide a stronger foundation for interventions on a local, national, and global scale. Nurses are one of the key components in preventing obstetric violence. Within their scope of practice, nurses can protect their patients through evidence-based care, compassion, and respect.

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APPENDIX A. OPERATIONAL DEFINITIONS

Term	Definition
Obstetrics	"A branch of medical science that deals with pregnancy, childbirth, and the postpartum period" (Merriam-Webster, n.d.).
Structural violence	"Refers to a form of violence wherein social structures or social institutions harm people by preventing them from meeting their basic needs" (Lee, 2019).
Obstetric violence Obstetric mistreatment Disrespect and abuse during childbirth	"The disrespect and/or abuse of patients in the antepartum, intrapartum, or postpartum stages of pregnancy by healthcare professionals" (van der Waal, 2022).
Abuse	"Cruel, violent, or unfair treatment of someone" (Cambridge, n.d.)
Neglect	"The failure of a designated care giver to meet the needs of a dependent" (Lachs & Pillemer, 1995).
Medical malpractice	"Medical malpractice is defined as any act or omission by a physician during treatment of a patient that deviates from accepted norms of practice in the medical community and causes an injury to the patient" (Bal, 2009).
Health professional	Health professionals "advise on or apply preventive and curative measures, and promote health with the ultimate goal of meeting the health needs and expectations of individuals and populations, and improving population health outcomes" (World Health Organization, 2013).