

Respectful care in labour

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Abstract

Provision of respectful care in labour requires awareness of the special circumstances of childbirth as a natural process. The need for woman centred humanistic care runs alongside the duty to provide access to clinical interventions as required, recognising the limitations of risk assessment. Avoidance of over medicalisation and inappropriate interventions contributes to respectful care, as does leadership to develop and sustain good working relationships among staff, so that women experience care provided by staff who are functioning at their best. Institutionalising respectful care provision alongside evidence based clinical practice represents the goal of 'mother-baby friendly birthing facilities' as advocated by FIGO.

Keywords: Maternity care, labour and delivery, clinical standards, reproductive rights

Why should it be necessary to present a review on 'respectful care in labour' to a readership of health care professionals? Clearly none of us would intend to provide or indeed admit to providing 'disrespectful care' in the labour ward. Sadly, even in well resourced settings women often report dissatisfaction with their care and as medical directors and heads of department around the world can testify, such experiences are often topics for difficult meetings with mothers and their relatives following a complaint. On such occasions the distress expressed can be just as intense following an experience of disrespect, such as a violation of privacy, of inadequate information provision or inappropriate choice of words, as it can be following some major medical mishap. This review aims to provide some reflections on the topic of respectful care and will consider the contexts both of well resourced health services but also those in low income countries where provision of high quality care can be very challenging. The review concentrates especially on the roles and responsibilities of obstetricians in the promotion of respectful care in labour.

The special circumstances of care in labour

In maternity care, clinicians have a different relationship with women than they do in most medical encounters. The notion of the privileged doctor-patient relationship is historically founded on possession of technical knowledge and therapeutic skills leading to a natural imbalance in authority, with language reflecting that relationship as in "doctor's orders" or indeed "prescription". The social, cultural and regulatory trend across modern healthcare education and practice is to place increasing emphasis on patient autonomy and a partnership between practitioner and patient as a means to achieve optimal outcomes. The UK General Medical Council specifies that for good medical practice we should "*respect patients' right to reach decisions with you about their treatment and care*" and provides a detailed listing of requirements for practitioners on the elements that must be demonstrated for them to "*establish and maintain partnerships with patients*". In parallel with these trends we have also been challenged by midwives and by women's advocates as to whether our professional attitudes and model of care are actually fit for purpose. Most fundamentally the basic point is made that childbirth is a normal bodily process and not a disease. Doctors (or

indeed any health care professional) do not have the same privileged position of a doctor-patient relationship as very often there is actually no patient, rather a woman experiencing a normal event in her life. Midwives reflect this in their use of the term 'client' rather than 'patient'. At the same time, as we know the normal can very rapidly transform into an abnormal clinical state and the client becomes a patient in an instant, requiring timely and competent clinical intervention.

The history of maternity care includes many efforts to pre select those at risk of complications during labour but, as we know, our predictive abilities are strictly limited: most 'high risk' mothers do not actually suffer complications and as a result of sheer numbers, most complications occur among those supposedly at 'low risk'. This was reflected in the World Health Organization's slogan from the April 1998 World Health Day on Safe Motherhood, "*Every pregnancy faces risk*", and underpins the international maternal health policy and programming emphasis on assuring ready access to life saving interventions for all mothers-to-be irrespective of risk status. For clinicians there is therefore a need to provide care in labour that both responds to the public health and statistical reality of ever present and unpredictable risk, while at the same time remembering that for most people most of the time childbirth is a normal process, thus requiring a service model that avoids inappropriate medicalisation and contains strong elements of humanistic and respectful care. These two requirements are not separate: if we fail to offer services in a manner that women find acceptable they will not use them and seek alternatives outside the formal health care system, potentially putting themselves and their babies at risk. This has been a major challenge in many low resource countries where very high maternal mortality rates coincide with low utilisation of health centre or hospital maternity facilities.

Disrespectful care in labour: Over medicalisation

The UK GMC states that practitioners must "*provide effective treatments based on the best available evidence*" but in order to achieve this, a combination of a supportive managerial and service context and optimal individual clinician behaviour is needed. Engagement with advocates, users and clinicians is needed to design and roll out service models that

encourage practitioners to use best evidence and avoid inappropriate interventions. In Eastern European countries the 'medical model' is still favoured and there have been recent instances of legal proceedings taken against midwives offering home birth and women seeking this option, with the latter case reaching the European Court of Human Rights. With regard to specific procedures that are used excessively in medicalised childbirth, perhaps the best example is the persistence of "routine" episiotomy on the sub-continent and in China despite exhaustive systematic review evidence against this approach.

Respectful care in labour: Fostering good practitioner behaviour

In settings where disrespect and abuse of women in labour has been identified, interventions to improve standards of behaviour by providers have been shown to be effective, even in the absence of major changes in staffing levels or resources at health facilities. In Kenya, the "*Heshima*" ('dignity') project used a multi faceted approach working with policymakers to encourage greater focus on disrespect and abuse, training providers on respectful maternity care, and strengthening linkages between the health facility and the surrounding community for accountability and governance. The findings following the intervention were a reduction in the prevalence of mothers' feelings of humiliation or disrespect from 20% to 13 % and there were statistically significant reductions in instances of physical abuse, verbal abuse and violations of confidentiality.

In addition to the technical role, specialists have a responsibility for creating and supporting good practitioner behaviour in their unit by role modelling and providing leadership to trainees and colleagues. This function is inseparable from practitioners' attitudes and behaviour towards colleagues: while undermining and bullying can be found in any health care setting or workplace in other sectors, these have been identified as especially prevalent problems in obstetric units. In the UK, recognition of this as a systemic problem led to work by the RCOG and the Royal College of Midwives on the 'clinical learning environment' and an authoritative Joint Statement in 2015 with supporting materials for training. It can be anticipated that practitioners working effectively together across disciplines

and levels of seniority and demonstrating respect for each other will not only improve the working environment for staff but translate this into respectful care for women in labour.

Shared reflection and learning between practitioners caring for women has a useful part to play in enhancing awareness of women's reproductive rights and enabling practitioners to carry this awareness into the clinical environment. FIGO has developed tools using case studies as a basis for reflection and discussion: most importantly, such activities undertaken in the clinical environment will enable specific issues in the local setting to be explored while engaging with universally applicable principles of ethics and reproductive rights.

Towards the 'mother-baby friendly birthing facility'

In partnership with other international health care professional associations and other stakeholders FIGO has set out the characteristics of a maternity unit that would meet the dual requirements of adherence to evidence based practice with avoidance of inappropriate medical interventions, and assurance of respect for women's rights and dignity during labour and delivery. Inspired by the long-established UNICEF 'Baby friendly hospital' model, the FIGO standards address aspects of care that are all too frequently absent globally, for which there is no justification for continued poor practice, but are easily remedied through intentional leadership. A good example is allowing and indeed encouraging companions to be present within delivery rooms. They also address structural issues that may be more challenging but are equally important for respectful care such as avoidance of financial exploitation in maternity care. Applicable equally to practice in wealthy and low resource countries there is now a need to develop and document prototype 'mother-baby friendly' hospitals and birthing centres that can demonstrate how respectful care can be institutionalised and made the 'new normal' for the benefit of all.

Further reading

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Test Questions related to Respectful Care in Labour

Consider the following case and answer the questions below.

You are the obstetrician serving as clinical director of a busy hospital maternity unit. A patient, Ms X has complained to the Chief Executive about her care during labour and delivery and you are asked to investigate and respond to the complaint. The complaint letter outlines several adverse experiences as follows:

- Cleaning staff entered the labour room without permission while Ms X was exposed, causing her embarrassment.
- During the staff handover at 9 pm the outgoing midwife referred to the labour progress as 'inadequate' and made Ms X feel humiliated by the implication that she was not capable of giving birth normally.
- Ms X's partner is considerably older than her. She was embarrassed when a doctor asked if he was her grandfather and laughed when told he was the partner.
- While she was pushing during the second stage, the midwife called a doctor as she was concerned about the fetal heart rate. The doctor thought it was normal and the two argued about whether intervention was needed. She felt this behaviour was unprofessional. In the end she delivered normally without complications for her or the baby but the birth experience was unpleasant because of the arguing going on.
- Ms X is a member of a Facebook group of local mothers. On sharing her experiences several mothers in the group reported similar experiences in your unit so she is concerned that the hospital has underlying problems.

Questions:

1. What would be the appropriate steps in your investigation of the complaint?

Answer: Review the case notes to identify any clinical issues; confer with your midwifery management counterpart and the manager responsible for housekeeping; obtain reports from the midwifery and medical staff attending the patient; check Unit records in case there are any other complaints involving these staff members; convene a review meeting with the clinical staff involved. Liaise with the housekeeping manager.

2. How will you respond to the complainant?

Answer: once you have all the relevant information to hand, invite Ms X and her partner to meet with you and the midwifery manager. Offer apology on behalf of the hospital.

Describe the steps taken to avoid a recurrence such as feedback to the staff involved.

Note her concern about a wider adverse pattern of experiences of mothers and reassure her you are investigating this by inviting a team of a senior midwife and obstetrician from another unit to assess the way care is provided and working relationships using the RCOG/ RCM tools. Suggest a user forum to which the local mothers will be invited.