Evaluating the Doctor-Patient Relationship and How it Affects Cases of Obstetric Violence

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Abstract

Pregnancy is a medically vulnerable state for the woman where trust and communication between the pregnant woman and her obstetrician is critical. Obstetric violence is the abuse against woman during pregnancy and childbirth that can occur from healthcare professionals. Though previous studies have suggested the presence of obstetric violence, it has yet to be quantified and nor assess possible causes as to why. Even in life-threatening situations, women should have the right to refuse care such as a "caesarean section, episiotomy, and vacuum-assisted delivery," and being coerced into procedures can be mentally and physically traumatizing to women. The correlation between a physician's characteristics and the occurrences of obstetric violence will be investigated and evaluated. It is expected that more empathetic obstetricians who spend more time building a rapport with their patients and with their nurses about their patients will be less likely to commit obstetric violence against their patient. In summary, it is expected that the more empathetic an obstetrician is, the better rapport he or she will establish with their patient and, thus, the less likely the obstetrician will be to commit violence against the patient. A pilot survey was conducted with parameter questions and evaluated a woman's experiences and determined if a pregnant woman or previously pregnant woman has experienced any number of specified types of violence from medical professionals. It did find that some women did experience incidences of violence from medical professionals.

Keywords: pregnancy, obstetric violence, cesarean, coerced, empathetic, rapport, communication

Introduction

Pregnancy is a transient condition unique to women. Though it is tied to the sex of an individual, it is not a defining characteristic in that, although it is necessary to be a woman in order to be pregnant, it is not necessary to be pregnant in order to be a woman. Not only is pregnancy a transient condition, but also a medically vulnerable state for the woman where trust and communication between the woman and her obstetrician is crucial.

Societally, pregnant women are considered vulnerable especially in the context of stress, domestic violence, and low-income, but clinically, pregnant women as a group should not be considered vulnerable because they have the same, "capacity for autonomous decision making as," [1] their nonpregnant counterparts. Furthermore, it is important for the patient and doctor to trust and communicate with each other in order for the doctor to not override the patient's rights and choices regarding the patient's pregnancy.

Obstetric violence is the "physical, sexual, and/or verbal abuse…" intimidation, "…coercion, humiliation, and/or assault that occurs to…" [2] pregnant women and, "…birthing people by medical staff including nurses, doctors, and midwives." The mistreatment or disrespect of a woman's rights in childbirth should not occur as it is a violation of a woman's rights [3] and it can have traumatic mental and physical consequences.

There are many forms in which obstetric violence can occur. There is the rumored "husband stitch," in which after birth, the physician gives the woman an extra stitch during the vaginal and perineal repair after it was either torn or surgically cut (episiotomy). The extra stitch is called extra for a reason and leads to discomfort during the postpartum recovery process and painful intercourse. To repair a tear or surgical cut, skin is brought together in order to facilitate the healing process. With the husband stitch, an extra stitch brings together more skin than in order to tighten the introitus (the opening of the vagina) beyond what is necessary which is what causes pain during sex as skin does not have the same elasticity as the muscles of the vaginal canal and vaginal introitus (vaginal opening).

There have been no concrete studies on the husband stitch and most medical professionals consider it a myth since there has only been anecdotal reports from women, but there has been an account of it being performed and reported by a gynecologist in a historical medical journal in 1885 [4]. There is also another account from a doctor's colleague of a patient asking her doctor before delivery if she could have a husband stitch as she heard that it tightens up the vagina to its original state [5]. The doctor barely won the lawsuit when the woman sued the doctor for malpractice because it was "too tight." An interesting, yet unmentioned implication about this case was that the doctor was essentially incompetent in that he did not understand the anatomy of a vagina in that the introitus and the vaginal canal is a muscle that can expand and contract and will eventually shrink back to its predelivery state [6] and that male sexual pleasure is derived from pelvic floor muscles and the vaginal canal and not just the introitus and yet the husband stitch only tightens the introitus. This makes the husband stitch irrelevant, frivolous, and harmful whether it is asked for by the woman, the woman's spouse, or performed without the consent of either.

There is also the issue of forced and coerced cesareans as seen in Dray's pending malpractice lawsuit where she specified, she did not consent to a C-section before delivery and refused it throughout delivery and yet the doctor still performed it. One in three babies are

delivered by C-section in the United States one average. More statistical data is needed about why the rate of C-sections is higher than the ideal rate for C-sections [7] whether it being due to some hospitals having a quota for the number of C-sections they want to perform or whether it is the financial incentive of obstetricians being paid more when they perform a C-section [8] or due to a physician practicing defensive medicine when worried about a malpractice lawsuit [9] or a combination of those three factors and more.

Determining why obstetric violence occurs and how it can be reduced is a human's rights issue as disrespect and abuse during pre-natal care and delivery are violations [10]. The objective of this study was to look at the experiences pregnant women had in order to obtain an idea about the empathy levels of an obstetrician and see what relationship empathy, or the lack thereof, had with obstetric violence. The women were of obstetric violence and which types of violence in hopes of bringing more awareness to this issue to both the medical professionals as well as the pregnant women themselves which is why the survey gathered the data it did.

Methods

This was an anonymous, survey-based study in which women who had previously been pregnant were asked questions about their experiences and quality of care during pregnancy. A survey was conducted asking a sample of women about their experiences during prenatal care, during the birthing process, and after birth. An IRB form was submitted to ensure the protection of human participants in this research study and safeguards (resources for the respondent to reach out to in the case of triggering anxiety, extreme duress, or even a PTSD episode) were put into place in the consent form and at the end of the survey.

Recruitment

Methods for recruitment involved using Amazon Mechanical Turk (mTurk), a crowdsourcing marketplace for participants. The target sample size were women respondents ages 18 years and older who have had a full-term pregnancy and who have had medical professionals attend to them in a medical facility. There are incentives raffle prize to have a chance at obtaining one of six visa gift cards that are $35, $25, or $15 in addition to being paid twenty cents for completing the survey through mTurk.

Survey Design and Scope

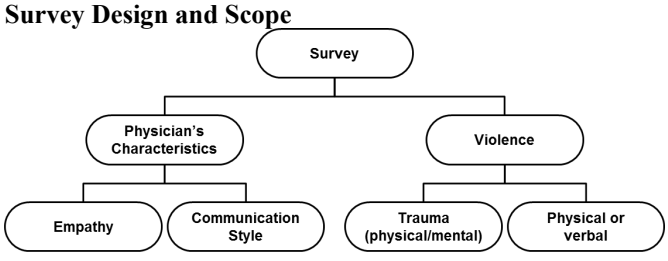

Figure 1. Summary of the elements of the survey. The survey consisted of 32 questions identifying a physician's characteristics based on the presence of empathy and types of communication. The survey also identified the incidence of violence and whether the violence experienced was physical and/or verbal and if it led to either physical and/or mental trauma during their pregnancy, whether in the past or current.

The type of information obtained from participants determined whether or not they have been pregnant, having them answer the question if they have experienced obstetric violence from a medical professional. Furthermore, the survey asked more specifically if they have experienced a vaginal exam without consent, a forced cesarean surgery, physical force to prevent birth while waiting on the doctor to arrive, physical restraint during birth, sexual comments/sexual assault during exams or procedures, bullying on a medical professionals part in order to coerce the participant into a certain procedures (e.g. episiotomy or C-section when it is not medically necessary for the patient to have one performed on the patient), the participant not being given the ability to consent, not being educated on what procedures the physician will do and not being informed of possible repercussions thus the participants was not able to give informed consent, and being mistreated in a disrespectful way without regard for the participant's autonomy.

Other information obtained from the survey will be to question the participants who were or are pregnant and whom have a primary physician at a medical hospital and who have or will give birth at a hospital. The survey questions also evaluated the interactions the participants have had will their medical care team and how they interacted with the participants. The information obtained from this will narrow down or identify what key characteristics of a physician that are present in cases of obstetric violence. The goal of this section was to categorize how the physicians communicated with their patients and would be determined to be noncommunicative, communicative and responsive, or communicative and non-responsive. The characteristics of a physician were used as a marker to indicate the presence and level of empathy a physician had with the participant, the pregnant patient.

There were several disqualifiers in the survey on Qualtrics to automatically screen out participants as seen below in Table 1. As mentioned in the footnotes, a qualifier on mTurk was having the gender of respondents being set to true so only female mTurkers will be able to view and thus take the survey on mTurk. Parenthood status was also set to true as well so only mTurkers who have had a child could only view and take the survey on mTurk.

Data Analysis

The survey was created on Qualtrics and the responses were recorded there to export to excel for data analysis.

Qualtrics recorded fifty-two respondents. Eight respondents listed themselves as male and had to be rejected from the sample size. Though setting the standard to reject males from the survey may seem arbitrary the fact that this group chose male in a survey for women who gave birth indicates that they were not paying attention and demonstrated that the male category was inherently problematic. This group among others in the sample size also had other indications of lack of participant awareness

like contradictory answers (e.g., working forty years in the medical health field yet stated his age as a twenty-eight-year-old male). There were also respondents who gave multiple contradictory answers (e.g., a respondent reported "no" to their decisions and choices that guided the maternity care and delivery process, then saying the caregiver always involved them in decisions about prenatal care, and then also said they were treated with "care and kindness," "dignity and respect," and then with "disdain and contempt."). These respondents were rejected for lack of participant awareness. There were also respondents who only answered the consent form but did not complete the survey. This left only fourteen approved respondents with reliable and quality data. One respondent out of fourteen, when analyzing the last question of the survey that asked the participant if they experienced obstetric violence said prefer not to answer. This respondent was removed from the sample for analysis in figure 3.

Results

The importance in asking those specific survey questions was that the participants may not consider what they have experienced to be obstetric violence, or they may feel too ashamed to admit that they have experienced obstetric violence. These questions under were parameter questions to determine whether or not the participants have experienced obstetric violence or not.

In order to assess the prevalence of obstetric violence, the survey section "Impression of Care" section, multiple questions were categorized into types of violence as physical violence, non-physical violence, and if it led to trauma. However, the types of experiences were analyzed, but the frequency in which the individual had those experiences were not. Therefore, the data in figure 2 represents the diversity of the types of violence experienced and not the overall individual incidences. Some questions are highlighted below in table 2.

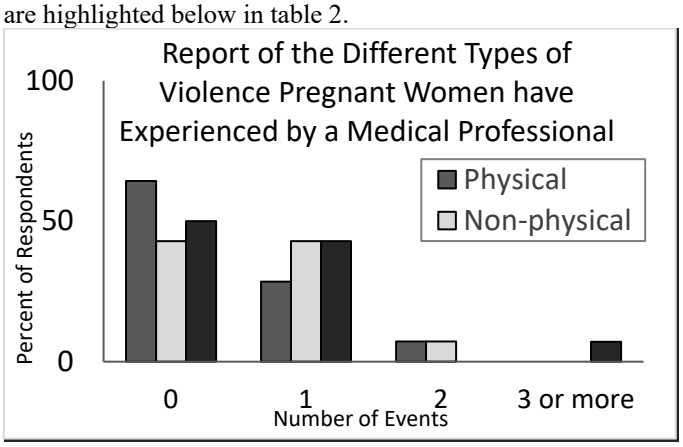

Figure 2. Summary of the different types of violence respondents reported to experiencing. Most of the respondents had experienced none of the different types of events of violence from a medical professional whereas some respondents had experienced some incidences of physical violence, non-physical violence, and trauma from medical health professionals.

Table 2. Highlight of some answers that indicate the presence of physical violence, non-physical violence, and if it led to trauma.

Incidence of Violence	Answer
Physical	A forced cesarean surgery even though you nor the baby were not experiencing medical distress
Physical	Nurses restraining legs closed to prevent the birth of the baby while waiting for the doctor to arrive
Non-physical	Inappropriate sexual comments during prenatal checkups, examinations, procedures, or birth
Non-physical	Bullying or coercion into procedures, like induction, episiotomy, cesarean, or natural birth, without medical reason
Traumatic	Less likely to trust a caregiver (medical health professional) again
Traumatic	Less likely to want to become pregnant/have another baby again

Out of the original sample size where 14 responses were analyzed, 26.6% of respondents reported experiencing obstetric violence, 6.7% of respondents reported they have experienced discomfort, but not obstetric violence, 60.0% of respondents reported not experiencing obstetric violence, and 6.7% of respondents reported prefer not to answer.

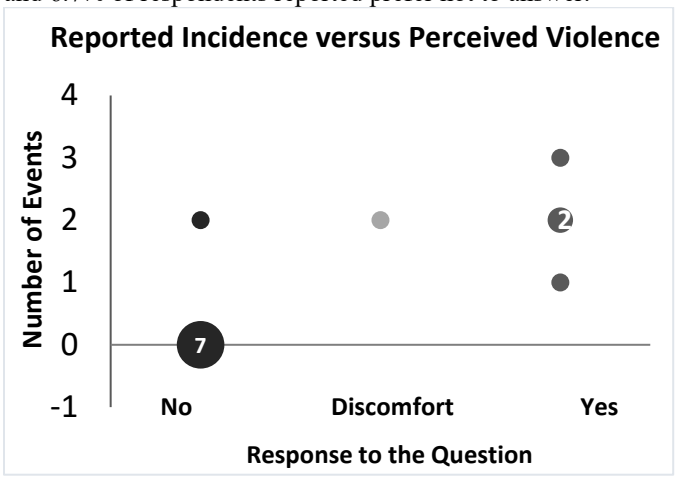

Figure 3. The sample size for this figure does not include the respondent who reported "prefer not to answer," leaving this figure with a sample size of 13. The figure contains dots proportional to the number of respondents who answered no, discomfort, or yes to experiencing obstetric violence. That data was cross-referenced to the number of types of events of violence the respondent reported to experiencing. The smallest dots labelled without a number are equal to 1 respondent. The number in the other dots represent the number of respondents who answered that way. One participant chose not to respond to this question.

Discussion

There seems to be a lack of knowledge of what obstetric violence see since women reported to experiencing different types of violence by medical professionals throughout the survey and yet still reported "no," or they experienced "discomfort, but would not call it violence." This is interesting to note because it shows a discrepancy between knowing one has experienced violence while not recognizing it as such as seen in figure 3. This could be due to shame or other feelings in not wanting to admit to the severity of the situation, it could be due to that it may be easier to cope with thinking one did not experience abuse,

or the person simply did not know that what was experienced was actually a case of violence. Whatever the reasons may be, will have to be investigated for further research.

For future research, it would be better to first have a study looking at incidence of violence alone where we ask if a participant has had a violent experience. Once that is establish, the study can then ask if that experience occurred during pregnancy and that can be expanded to asking if it was a medical health professional who was violent to the participant.

There was much learned about the process of research, creating a thesis, research experimental design in terms of creating a survey, and not only analyzing data obtained, but also whether or not the data is reliable.

Another part of the thesis mentioned how physicians also communicated with their nurses about their patients. Although the survey did not have any questions to evaluate this, I still think is critical to have this type of communication in the medical health field because it helps keeps the physicians and nurses up to date with each other about their patients and it also helps keep both accountable and responsible to their patient. This would be another element to investigate for further research.

I believe it is important to evaluate the levels of empathy a physician has for his or her patients in order to ensure the best quality care possible. We can look to see if there is a correlation could be made between the amount of empathy a physician, or any medical health professional, has. With how essential empathy is in the field of medicine, to the point where medical schools are looking into developing their curriculum to include courses on empathy, this study could be a starting point into for looking into how empathy affects the level of rapport a physician can have with his or her patient and the level of quality care provided. This could be a great starting point to make training courses to help physician with this necessary skill on how to communicate with empathy.

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I would also like to thank my peers in class for offering advice and criticisms.

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