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Workplace Aggression in the Perinatal Setting

The healthcare environment is not immune to acts of aggression. In fact, the stressful nature of the work involved, anxiety-producing conditions faced by patients and families, and certain characteristics inherent to institutional settings may even breed incivility, aggression, bullying, and violence.[1] These types of workplace aggression may, unfortunately, be promoted through apathy, acceptance, or overt encouragement within the system.[2] This editorial highlights how acts of workplace aggression by obstetric providers can occur within a hierarchical professional framework that can itself be enforced through abusive behaviors. It will conclude with suggestions for those who work within the healthcare setting to prevent and manage workplace aggression.

Recent headlines read: "Mom Who Sued Hospital for Traumatic Birth Wins $16 Million."[3] For this case of workplace aggression, several perinatal nurses were present, 2 of whom were directly implicated in the incident, although the couple chose not to sue them directly.[4] In 2014, Caroline and J. T. Malatesta filed a lawsuit for negligence and fraud against Brookwood Medical Center (Brookwood) in Birmingham, Alabama, following the birth of their fourth child. The Malatestas alleged that they chose Brookwood on the basis of its advertising targeted at women planning natural births, promising to support mobility in labor and personalized birth plans, and offering "specifically trained" nurses and wireless monitoring. However, none of these services were available to the Malatestas at the time of admission, setting up a "bait and switch" scenario. Bait and switch is a dishonest business practice of false advertising to entice customers without making the advertised goods available to them. This practice is illegal in Alabama, and customers are protected under consumer protection laws and may file a personal lawsuit when damages are claimed.[5,6]

The perinatal nurses ordered Caroline into a supine position for continuous monitoring, where she was restricted for the duration of a short unmedicated (nonepiduralized) labor. Until crowning, Caroline was able to comply with these restrictions on mobility. However, a contraction late in transition prompted an instinctive position change to hands and knees in an effort to manage the pain.

In court testimony, this couple consistently described a physical altercation that then took place between Caroline and the nurses, with the patient having a strong urge to bear down and push as the infant was crowning.[4] They stated that one nurse grabbed Caroline's wrist and pulled it overhead to rotate positions from hands and knees to supine, while another nurse held the fetal vertex in at the perineum for 6 minutes in anticipation of the provider's arrival. The healthcare record reads: "Patient instructed to lie on her back . . . . Patient encouraged not to push."[7] There was no documentation of any emergency at any time, and the nurses claimed not to remember any details of the birth.

Physician experts identified that some combination of the external force exerted by the nurse during second stage and the awkward, asymmetrical position Caroline was forced into while pushing resulted in pudendal neuralgia, a rare nerve injury that is incurable and requires constant medical management. The Malatestas alleged that pudendal neuralgia prevents Caroline from having more children, prevents the ability to be intimate sexually, and causes chronic pain.

One of the Malatestas' nurses stated under oath that they believed if Caroline were to push, the infant would deliver prior to the doctor's arrival.[5] It is possible that 1 or more of the nurses, like many perinatal nurses who find themselves pressured to enforce policies or practices that conflict with the well-being or choices of patients feared professional consequences for

Disclosure: Ms Pascucci attended the trial, read pretrial documentation and depositions, and has had extensive conversations with the Malatestas and their legal team throughout litigation. She is the Founder of Birth Monopoly and cocreator of Exposing the Silence Project. Dr Adams has disclosed that she has no significant relationships with, or financial interest in, any commercial companies pertaining to this article.

"allowing" a mother to give birth without the physician present.

OBSTETRIC VIOLENCE

Obstetric violence is, in its simplest form, a form of violence against women that occurs in the childbirth setting. It is an attempt to control a woman's body and decisions and may involve coercion, bullying, threats, and withdrawal of support, as well as other violations of informed consent and physical force. Obstetric violence might manifest as forcing a woman supine because that is the doctor's preferred position for birth, or coercing a woman who has planned a vaginal birth after cesarean to consent to surgery under threat of invoking Child Protective Services. A lawyer with National Advocates for Pregnant Women has elucidated a number of such cases involving coerced or forced cesarean births.[8] In 2016, the American Congress of Obstetricians and Gynecologists, meanwhile, expressly restated its opposition to coerced and forced medical interventions for pregnant women, "including the use of the courts to mandate medical interventions," in a Committee on Ethics Opinion. The committee reaffirmed that "pregnancy is not an exception to the principle that a decisionally capable patient has the right to refuse treatment."[9]

In 2014, the World Health Organization released a statement aimed at preventing and eliminating disrespect and abuse during hospital childbirth, based on a "growing body of research on women's experiences during pregnancy, and particularly childbirth," of "disrespectful, abusive, or neglectful treatment."[10] The statement emphasizes the rights of women throughout pregnancy and birth and calls for government and industry support of research to define the phenomenon and develop effective interventions. The statement also suggests that efforts to address workplace aggression include all stakeholders: women, communities, healthcare providers, and educators, as well as professional associations and organizations.

An infographic distributed internationally by the Women's Global Network for Reproductive Rights describes obstetric violence as the intersection of violence against women and institutional, or workplace, violence. The infographic identifies obstetric violence as verbal or physical. Obstetric violence may manifest through restriction of necessary care, disregard of basic needs, unnecessary provision of or forced medical interventions, and dehumanizing treatment.[11]

Theoretically, obstetric violence is a concept that falls under the torts of negligence (eg, violations of informed consent) or battery (eg, use of force) in the United States, but redress through the courts here is exceedingly rare, absent death or permanent injury. In other countries, for example, Venezuela, obstetric violence has been enshrined in law and is defined as "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 of the capacity to freely make her own decisions about her body and her sexuality . . . ."[12]

ADDITIONAL FORMS OF WORKPLACE AGGRESSION

The issue of choice was pivotal in the Malatesta case. The hospital had advertised support for women's autonomy and choices but, in litigation, offered abundant evidence of views to the contrary. The patient's own physician stated on record: "The doctor is the one who ultimately has the choice of how things are going to happen," even when there is no emergency or medical risk present. The nurse who forcefully changed Caroline's position testified that women planning unmedicated births "typically don't follow instructions as well" and are "not as cooperative" as patients with epidurals.[13]

To understand why this type of aggression against birthing women is so normalized, it can be helpful to look at the hierarchical framework within which it occurs. Healthcare personnel themselves can be the victims of aggression and violence within the workplace. Quine[14] identified nurses as the most bullied profession among healthcare workers. Horizontal or lateral violence in the healthcare setting can be defined as abuse, hostility, aggression, and unwanted behaviors that occur between healthcare professionals of a similar lower status within the hierarchy. Usually, these behaviors, whether physical or emotional, occur in a repeated fashion but may be covert and hard to detect.[15] Bullying is a form of horizontal violence that may be inflicted by 1 or more individuals and leaves the victim feeling abused, intimidated, and stressed.[16] Another term used for this type of behavior is "incivility": rude or discourteous behavior toward a coworker.[17] In the United States, bullying among nurses has been reported by 23% to 27% of those surveyed.[16]

Vertical violence is another type of aggression that occurs within a hierarchical system and can include any of the behaviors already mentioned but occurs from the top-down rather than within the same group. The most frequently identified aggressor is the one in a position of power within the healthcare setting,[16] such as doctor to nurse or manager to subordinate.

Workplace aggression can also have negative effects on the healthcare organization as a whole. It affects job performance, especially when workers are distracted

and increasingly absent. The quality of patient care in the healthcare environment suffers when the victim feels incompetent, unsupported in resolving the conflict, or powerless. There is evidence to show that when workplace aggression occurs, nurses are more likely to have medication errors and assigned patients have increased injuries from falls.[17,18]

ADVOCACY FOR WOMEN EXPERIENCING OBSTETRIC VIOLENCE

In recent years, consumer efforts have emerged in response to violence against birthing women. Birth Monopoly, Improving Birth, and Human Rights in Childbirth (HRIC) are just a few of the consumer advocacy organizations working to eliminate violence against women in maternity care. See Box 1. These efforts include education of the public through various awareness campaigns about evidence-based birth practices and the legal rights of childbearing women; one of the primary functions of these organizations, however, is to amplify the voices of women about experiences in maternity care. An example is Improving Birth's 2014 social media campaign #BreaktheSilence, where women photographed themselves with short handwritten accounts of their own stories of disrespect and abuse in maternity care to be posted on Facebook, Twitter, and Instagram. The campaign continues around the world organized by HRIC, an international organization that advocates for the fundamental human rights of birthing women via legislative and legal efforts, support of grassroots organizations, and coordination of media attention. The US-based Exposing the Silence Project, an offshoot of the #BreaktheSilence campaign, is an online collection of professional photographs of and interviews with women who have experienced trauma and violence in childbirth that was reported widely in US and global media.

Box 1. Resources for addressing obstetric violence

- Birth Monopoly, http://birthmonopoly.com/
- Exposing the Silence, http://www.exposingthesilenceproject.com/
- Human Rights in Childbirth, http://www.humanrightsinchildbirth.org/
- Improving Birth, https://improvingbirth.org/
- The Rights of Childbearing Women, http://www.childbirthconnection.org/rights
- The Women's Global Network for Reproductive Right's infographic, Obstetric Violence. http://www.may28.org/obstetric-violence/
- World Health Organization, The Prevention and Elimination of Disrespect and Abuse during Facility-Based Childbirth, http://www.who.int/reproductivehealth/topics/maternal_perinatal/statement-childbirth/en/

Consumer advocacy organizations such as HRIC, Improving Birth, and Birth Monopoly have been vital to organizing and supporting legal efforts like the Malatesta case. Another case bolstered by consumer organizations is that of Kimberly Turbin, a rape survivor and first-time mother in California, whose doctor was filmed bullying and being demeaning before cutting an episiotomy she explicitly refused. Consumers around the country—many of whom reported having been abused themselves in maternity care—contributed financially to Ms Turbin's cause to enable a suit to be filed against the doctor. The case is still in the courts, although the doctor has already surrendered his state medical license.[19]

INTERVENTIONS TO ADDRESS WORKPLACE AGGRESSION

Targeted healthcare education is necessary to address issues of workplace violence. Awareness among healthcare workers begins with knowledge of the problems associated with workplace aggression and the incidence that occurs, including being made aware of the signs and symptoms of those who are experiencing it. When they are promoted and enforced at all levels, respect, effective communication, and transparency in the workplace can assist in eliminating this phenomenon.

New research is needed to help raise awareness and help us better understand the prevalence of aggression—both horizontal and vertical—in the obstetric setting. Research can inform perinatal workers and administration about interventions to prevent and address aggression within the perinatal setting. One such study was performed by Beckman and Cannella[1] to identify factors of intimidation related to oxytocin administration. The researchers identified that intimidation may affect communication, patient safety, and ultimately patient outcomes. Sound qualitative studies would provide the lived experience of both healthcare workers and patients related to dealing with acts of aggression.

More research and workplace support are needed for the secondary trauma suffered by nurses and other perinatal professionals, which differs from burnout in that it may have a sudden onset and is a result of witnessing trauma rather than from long-term emotional exhaustion.[20] One study of 464 labor &

delivery nurses found that 35% reported moderate to severe levels of secondary trauma on the Secondary Traumatic Stress Scale,[21] with 26% meeting diagnostic criteria for posttraumatic stress disorder.[22] Interventions include mindfulness training[23] and compassion fatigue programs to encourage self-care[24] among traumatized healthcare professionals.

When a plan of care or administrative policy conflicts with patient preferences or patient rights, any healthcare worker, including nurses, must have a mechanism to advocate for the patient without fear of retribution. Thus, one critical solution for addressing aggression in the workplace is an anonymous, transparent reporting mechanism. Consumers, nurses, and other professionals must be able to report incidents of bullying, coercion, and other abuses without fear of recrimination and with the assurance that reports will be taken seriously.

Most importantly, for nurses to act as true patient advocates, the human and legal rights of the childbearing woman must be clarified and valued within the hospital system, not only among its users. The nonprofit Childbirth Connection, for example, published *The Rights of Childbearing Women*, outlining 20 rights that are fundamental to women during pregnancy and childbirth—rights that, when upheld, promote not only respectful care to women but also positive maternal and newborn outcomes. In partnership with an international law firm, HRIC has launched a global "Know Your Rights" campaign to educate women about rights so that they can exercise them. Even as many of the organizations that have brought the issue of obstetric violence into the view of the public work hard to educate their constituencies, hospitals must ensure that internal policies, protocols, and other institutional priorities are fully informed by patient rights.

Ideally, consumer organizations, users of healthcare systems, healthcare personnel, and healthcare organizations will develop strategies to comprehensively address violence in the perinatal workplace setting. That process will foster an environment of trust and respect that is so needed for dedicated healthcare workers and the clients they serve.

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