Received: 14 February 2018 | Revised: 13 June 2018 | Accepted: 13 June 2018

DOI: 10.1111/birt.12373

ORIGINAL ARTICLE

WILEY BIRTH ISSUES IN PERINATAL CARE

Bearing witness: United States and Canadian maternity support workers' observations of disrespectful care in childbirth

Christine H. Morton PhD[1] | **Megan M. Henley PhD**[2] | **Marla Seacrist PhD, MSN, RNC**[3] | **Louise Marie Roth PhD**[4]

[1]ReproNetwork Consulting, Redwood City, CA, USA

[2]Colorado Mesa University, Grand Junction, CO, USA

[3]California State University, Stanislaus, CA, USA

[4]University of Arizona, Tucson, AZ, USA

Correspondence
Christine H. Morton, ReproNetwork Consulting, Redwood City, CA, USA.
Email: Christine@christinemorton.com

Funding information
Indiegogo campaign individual donors; California State University, Stanislaus Nursing Faculty Grant

Abstract

Background: Disrespectful care and abuse during childbirth are acknowledged global indicators of poor quality care. This study aimed to compare birth doulas' and labor and delivery nurses' reports of witnessing disrespectful care in the United States and Canada.

Methods: Maternity Support Survey data (2781 respondents) were used to investigate doulas' and nurses' reports of witnessing six types of disrespectful care. Multivariate analysis was conducted to examine the effects of demographics, practice characteristics, region, and hospital policies on witnessing disrespectful care.

Results: Nearly two-thirds of respondents reported witnessing providers occasionally or often engaging in procedures without giving a woman time or option to consider them. One-fifth reported witnessing providers occasionally or often engaging in procedures explicitly *against* the patient's wishes, and nurses were more likely to report witnessing this than doulas. Doulas and nurses who expected to leave their job within three years were significantly more likely to report that they witness most types of disrespectful care occasionally or often (OR 1.78-2.43).

Conclusions: Doulas and nurses frequently said that they witnessed verbal abuse in the form of threats to the baby's life unless the woman agreed to a procedure, and failure to provide informed consent. Reports of witnessing some types of disrespectful care in childbirth were relatively uncommon among respondents, but witnessing disrespectful care was associated with an increased likelihood to leave maternity support work within three years, raising implications for the sustainability of doula practice, nursing work force shortages, and quality of maternity care overall.

KEYWORDS

childbirth, disrespectful care, doulas, informed consent, labor nurses, maternal quality

1 | INTRODUCTION

Disrespectful treatment during childbirth is an issue receiving global attention,[1,2] particularly in low and middle resource countries.[3,4] There is increasing recognition that disrespect and abuse in birth also occur in high resource countries, differentially affecting low-income women and women from racial/ethnic minorities and immigrant groups.[5-7] Three lawsuits filed in the United States between 2011 and 2013 focused on violations of consent and a patient's right to refuse treatment in childbirth.[8–10] In 2014, a North American–based grassroots movement, Improving Birth, emerged as a visible social media presence through its #BreakTheSilence campaign, which highlighted stories of individual women (and

their partners) who felt traumatized or victimized by disrespectful care in childbirth.[11] A 2015 article in the *Annals of Internal Medicine* described two incidents of disrespectful obstetric care with "heavy overtones of sexual assault and racism" from the perspective of United States physician trainees.[12,13] The Canadian Broadcasting Corporation exposed hundreds of complaints about disrespectful maternity care in Canadian hospitals in 2016.[14] Even if most clinicians are caring and compassionate, these examples show that disrespectful care occurs in facility-based childbirth settings in high resource countries yet the extent of disrespectful care is unknown.[15,16] This study aimed to examine and compare the frequency with which birth doulas and labor and delivery nurses (here referred to as maternity support workers) report witnessing disrespectful care in the United States and Canada.

Qualitative studies have illuminated women's experiences of disrespectful care during childbirth.[1,3,4,17,18] Verbal abuse during childbirth can have a lasting negative influence on women; decades later, elderly women describe verbal abuse during childbirth and recall being blamed for negative outcomes and scolded for being loud.[19] Women from racial and ethnic minorities have reported derogatory comments or judgmental remarks about their race or culture in maternity care settings.[6,20–22]

There is increasing specificity in the measurement of disrespectful care. In a systematic review of qualitative, quantitative, and mixed-methods studies on disrespectful care of women during childbirth cross-nationally and across income levels, Bohren and colleagues constructed a seven-item typology of disrespectful care during childbirth, shown in Table 1.[1] This study, fielded prior to Bohren et al's publication, examines six types of disrespectful care, among three typologies: *Verbal abuse*, including threats of poor outcomes, racially demeaning comments, and sexually degrading remarks; *Stigma and discrimination* in the form of extra procedures because of race/ethnicity; and *Failure to meet professional standards of care* by failing to secure fully informed consent or by performing procedures explicitly against a woman's wishes.[1] Clinicians, health organizations, and childbirth advocates recognize the growing problem of disrespectful care in childbirth; and recent efforts to develop patient-reported metrics on these phenomena show promise to better measure this critical quality issue.[2,23]

Verbal abuse can include "threatening, scolding, ridiculing, shaming, coercing, yelling, belittling, lying, manipulating, mocking, dismissing, and refusing to acknowledge—behaviors that undermine the recipient's self-esteem while enhancing the abuser's sense of power."[24] Verbal abuse can arise based on power imbalances in the clinician-patient relationship and/or race, class, and gender inequalities in society.[4,25] For example, maternity clinicians in the labor and delivery (L&D) setting (nurses, midwives, and physicians) may exaggerate fetal risks to coerce a woman to consent to clinical intervention.[26] Many women experience trauma after childbirth interventions that they subsequently come to know were coercive and unnecessary.[27]

Racial/ethnic health disparities in infant and maternal mortality are long-standing, persistent outcomes in the United States and Canada and, like disrespectful care in childbirth, represent a human rights crisis.[5] Obstetric procedures, such as cesareans, are overused among racial/ethnic minorities, and may partially account for their higher rates of morbidity.[25,28–31] Black women are more likely to report pressure to have an induction, and to have epidural analgesia, than white women in hospitals in the United States.[32,33] Hispanic women are more likely than non-Hispanic women to report pressure to have a cesarean, especially when they give birth in United States hospitals in the United States-Mexico border region.[32,34,35]

Informed consent is a key professional standard in health care, which requires that patients understand benefits and

TABLE 1 Typology of mistreatment of women during childbirth

Type of mistreatment	Definition
Physical abuse	Use of force or physical restraint during delivery
Sexual abuse	Sexual abuse or rape
Verbal abuse	Harsh language, including judgmental or accusatory comments, threats of withholding treatment or of poor outcomes, and/or blaming for poor outcomes
Stigma and discrimination	Discrimination based on ethnicity, race, religion, age, socioeconomic status, or HIV status
Failure to meet professional standards of care	Lack of informed consent and confidentiality, refusal to provide pain relief, performance of unconsented surgical operations, and/or neglect and abandonment
Poor rapport between women and providers	Ineffective communication, lack of supportive care, and loss of autonomy
Health system conditions and constraints	Lack of resources, including staffing constraints and shortages, supply constraints, and lack of privacy, lack of redress, and problems with facility culture

Source: Bohren et al. (2015).[1]

risks of proposed procedures and provide voluntary consent. Clinicians who view medical technology or procedures as routine may not give women opportunities to consider treatment options and make informed decisions. Lack of consent can violate patients' rights and may contribute to birth trauma.[20,36] More egregiously, clinicians sometimes perform invasive procedures against the explicit wishes of a maternity patient, a form of "obstetric violence" and a violation of her bodily integrity and human rights.[37]

Beyond its effects on birthing women and their families, disrespectful care witnessed by doulas and nurses may contribute to their experiencing moral distress, itself a contributor to burnout, turnover, and poor quality of care.[38] Doulas and nurses both attend to women during labor, yet differ in their philosophies, relationships to hospitals, and orientation to the emotional experience of birth.[39] A key component of the doula role is providing emotional support and helping women achieve the most satisfying birth experience possible. Doula trainings place a strong focus on how women are treated during labor and birth, including how clinicians respond to birth plans, and how clinicians speak to and about pregnant women.[40] Nurses are trained to clinically care for women and monitor fetal status, as well as provide information and physical and emotional support. Nursing schools prioritize curricula to prepare students for their clinical roles, provide little direct instruction on labor support, and place less emphasis on emotional or experiential aspects of childbirth. Most L&D nurses learn on the job and receive locally specific enculturation to a particular unit.[41,42] Unlike doulas whose clients hire them for a perceived "cultural fit", nurses are assigned to patients based on staffing needs, and may be responsible for more than one laboring woman at a time.[43] Most women in the United States and Canada give birth in a hospital with nurses, while only about 6% have the support of a doula.[44] As a result, doulas tend to support women with birth plans and some prior childbirth preparation, while nurses see the full range of women giving birth in hospitals. Little is known about the frequency with which Maternity Support Workers (MSWs) report observing disrespectful care during childbirth. Comparisons between these two maternity support roles provide insights into patterns of their perceptions of disrespectful care in childbirth.

2 | METHODS

This paper uses data from the Maternity Support Survey, a 2012-2013 cross-sectional online survey of maternity support workers (doulas and L&D nurses) in the United States and Canada, two developed countries with rising maternal mortality and recent reports of disrespectful care in childbirth.[18] The survey asked how often respondents witnessed disrespectful care, including verbal abuse, discrimination, and violations of informed consent. In this analysis, we examined the relationship between MSWs' characteristics and the frequency with which they reported observing six types of disrespectful care. The survey recruited participants through nine professional organizations representing doulas, childbirth educators, and labor and delivery nurses, and the research team publicized the survey to other MSWs via email networks and social media.[45] The Institutional Review Board at the University of Arizona determined the study to be exempt. This analysis includes only doula and nurse respondents.

The survey included questions about demographic characteristics, training and credentials, sources of knowledge about birth, financial rewards of and intention to leave maternity support work, childbirth and breastfeeding experiences, attitudes toward common labor practices, feelings of work-family conflict, work experiences including witnessing disrespectful care, work satisfaction and burnout, hospital characteristics, and understandings of informed consent and quality improvement initiatives.[45] A total of 2781 respondents completed the survey. Because the sampling method was nonrandom and the size of the sampling frame is unknown, we were unable to calculate a response rate.

We report descriptive statistics for doulas' and nurses' characteristics (Table 2). We also report the percentage of doulas and nurses in the survey who reported that they had witnessed care providers engage in disrespectful behavior (Table 3). We calculated statistical differences between the proportion of doulas and nurses who witnessed treatment they perceived as disrespectful using *z*-tests. A variety of factors may influence whether one *perceives* particular events as disrespectful, so these frequencies are not objective estimates of the incidence of disrespectful care. They likely reflect some combination of the actual frequency of disrespectful care and MSWs' sensitivity to particular interactions.

We then used logistic regression with robust standard errors to analyze the association between individual characteristics and perceptions about the frequency of six types of disrespectful care (1 = occasionally or often). The number of cases varies across models, due to missing values on the dependent variables. The logistic regression models include age, education, race/ethnicity, household income, marital status, parental status, intentions to leave maternity support work within three years, work-family conflict, emotional regulation, region, and an indicator for a nurse respondent (doula only = reference; Table 4). Because over 99.5% of respondents identified as female, models do not include gender. We used indicators for race/ethnicity (white, non-Hispanic = 1), marital status (married = 1), and whether the respondent or their partner had given birth (birth parent = 1). We measured intention to leave maternity support work with the question "Do you plan to be providing doula services three years from now?" for doulas or "Do you plan to be a

L&D nurse three years from now?" for nurses (1 = no). We defined respondents who "agreed" or "strongly agreed" with the statement, "I have trouble balancing the time demands of my maternity work with my family responsibilities and other obligations" as experiencing work-family conflict. We created a subscale for emotional regulation using the emotional intelligence scale from the measurement tool developed by Schutte and colleagues.[46] The internal consistency reliability of the emotional regulation subscale was strong for the whole sample ($\alpha = 0.84$) and within roles (nurses $\alpha = 0.82$, doulas $\alpha = 0.85$).[39] Geographic regions included Canada and the Northeastern, Midwestern, Southern, and Western Census regions in the United States (West = reference).

Since hospital policies and culture can influence the probability and frequency with which ethical violations occur and the likelihood of identifying behavior as disrespectful care, we conducted separate analyses for nurses who worked primarily in one hospital. These models included hours worked per week, years of nursing experience, Baby-Friendly Hospital status (0 = no, 1 = working toward Baby-Friendly status, and 2 = has Baby-Friendly status), and policies on vaginal birth after cesarean (VBAC; 1 = permits VBAC; Table 5). Since most doulas worked at more than one facility, we excluded doulas from these models. We used Stata to perform all statistical analyses and report odds ratios with the corresponding 95% confidence interval.

3 | RESULTS

The analytical sample comprised 1435 doulas and 967 nurses, including 58 MSWs who occupied both roles. Nurses in the sample were slightly older and more educated than doulas, and had higher household incomes (Table 2). The Canadian subsample oversampled doulas compared with nurses. Among nurses who worked primarily at one hospital, 26.3% worked at hospitals with Baby-Friendly designations and 40.9% worked at hospitals that were working toward Baby-Friendly statuses. Women with prior cesareans could attempt VBACs in hospitals where 79.2% of nurses worked.

Most doulas and nurses reported witnessing three of the six types of disrespectful care rarely or never (Table 3), but almost two-thirds (65.4%) reported witnessing a failure to provide informed consent as an occasional or frequent occurrence. One-third of MSWs reported occasionally or often witnessing a care provider threatening a woman that her baby might die if she did not agree to a proposed procedure, and doulas reported seeing this more often than nurses. Although most MSWs said that they rarely witnessed racially or sexually demeaning language, 11.3% and 8.5% of respondents reported seeing this behavior occasionally or often. Doulas were 3.4% less likely to report witnessing racially demeaning language than nurses, but were 4.7% more likely to say that they witnessed sexually degrading language. Over one-fifth of respondents (21.7%) reported witnessing women receiving more procedures because of their race/ethnicity, with 13.3% more doulas than nurses saying that this occurred occasionally or often.

A failure to meet professional standards of care was the most common type of disrespectful care reported in our survey. Overall, 65.4% of MSWs said that they had witnessed providers occasionally or often engaging in procedures without giving a woman the time or option to consider them, with no significant differences between nurses and doulas. Eighteen percent of all respondents reported witnessing providers occasionally or often engaging in procedures explicitly *against* the patient's wishes, and doulas were more likely to report witnessing this (8.5% more doulas reported this type of disrespectful care than nurses).

From multivariate logistic regression models, we find that the small minority of respondents of color (<6%) had 3.3 times higher odds of reporting that they occasionally or often heard care providers make racially demeaning remarks (OR 0.30 [0.20-0.45] for white, non-Hispanic) and 2.4 times higher odds of reporting seeing providers perform extra procedures based on a woman's race/ethnicity (OR 0.42 [0.29-0.61] for white, non-Hispanic; Table 4). Married respondents had consistently lower odds of perceiving most types of disrespectful care (OR 0.52-0.67, except for extra procedures as a result of race/ethnicity). MSWs who had given birth were more likely to report witnessing threats that the baby might die (OR 1.42 [1.09-1.71]), lack of informed consent (OR 1.36 [1.06-1.75]), and care providers acting explicitly against a woman's wishes (OR 1.40 [1.02-1.92]) than those who had not given birth (Table 4).

Doulas and nurses who expected to leave their maternity support job within three years were significantly more likely to report that they witnessed most types of disrespectful care either occasionally or often (OR 1.78-2.43). Nurses and doulas who struggled with work-family conflict also had higher odds of reporting that providers occasionally or often threatened that a baby would die if a woman refused a procedure (OR 1.23 [1.02-1.49]), used extra procedures on some women based on their race/ethnicity (OR 1.31 [1.06-1.63]), and failed to offer fully informed consent (OR 1.24 [1.03-1.50]). MSWs with higher scores on the emotional regulation scale more often reported that providers occasionally or often threatened a woman that her baby might die if she did not agree with certain procedures (OR 1.04 [1.01-1.06]), used sexually degrading language (OR 1.06 [1.02-1.10]), or engaged in procedures explicitly against a woman's wishes (OR 1.06 [1.03-1.09]). There were some regional effects, with more respondents in the Southern United States reporting some types of disrespectful care (threats that the baby would die, lack of informed consent, and violations of informed consent) more often than those in the West (OR

TABLE 2 Participant characteristics of doulas and nurses in the Maternity Support Survey, United States and Canada, 2013

Characteristics	Doulas N = 1435 M ± SD or n (%)	L&D nurses N = 967 M ± SD or n (%)
Age (in years)	40.44 ± 11.76	47.08 ± 10.98
% Births with a doula	–	6.26 ± 8.14
Nursing experience (in years)	–	21.47 ± 11.58
Nursing hours per week	–	31.20 ± 14.54
Emotional regulation (10-50 scale)[a]	42.26 ± 4.08	40.84 ± 3.98
Worker's marital status		
Married	994 (69.3)	690 (71.4)
Unmarried	441 (30.7)	276 (28.6)
Worker's parental status		
Parent (of a child by birth)	1111 (77.4)	773 (80.0)
Nonparent (of a child by birth)	324 (22.6)	193 (20.0)
Education		
High school or less	58 (4.0)	0 (0)
Some college/Associate's degree	516 (36.0)	233 (24.1)
Bachelor's degree	598 (41.7)	492 (50.9)
Master's degree	230 (16.0)	225 (23.3)
Doctorate	33 (2.3)	16 (1.7)
Race-ethnicity		
White, non-Hispanic	1338 (93.2)	915 (94.7)
Nonwhite, non-Hispanic	97 (6.8)	51 (5.3)
Household income		
<$20 000	101 (7.0)	6 (0.6)
$20 000-$34 999	173 (12.1)	13 (1.4)
$35 000-$49 999	242 (16.9)	41 (4.2)
$50 000-$74 999	330 (23.0)	172 (17.8)
$75 000-$99 999	270 (18.8)	234 (24.2)
$100 000-$149 999	206 (14.4)	311 (32.2)
$150 000+	113 (7.9)	189 (19.6)
Future work plans		
Plans to leave nurse or doula job within 3 y	116 (8.1)	193 (20.0)
Plans to continue nurse or doula job	1319 (91.9)	773 (80.0)
Experience with work-family conflict		
Work and family conflict	514 (35.8)	274 (28.4)
Work and family do not conflict	921 (64.2)	692 (71.6)
Region		
Northeastern United States	243 (17.7)	174 (18.7)
Midwestern United States	272 (19.8)	210 (22.6)
Southern United States	270 (19.6)	237 (25.5)
Western United States	375 (27.3)	219 (23.5)
Canada	216 (15.7)	91 (9.8)

(Continues)

TABLE 2 (Continued)

Characteristics	Doulas N = 1435 M ± SD or n (%)	L&D nurses N = 967 M ± SD or n (%)
Hospital policy characteristics		
Baby-Friendly Hospital status		
Not Baby-Friendly	–	276 (32.8)
Working toward Baby-Friendly status	–	344 (40.9)
Designated Baby-Friendly	–	221 (26.3)
VBAC permitted	–	666 (79.2)

[a]The emotional regulation subscale comes from the emotional intelligence measurement tool developed by Schutte and colleagues (1988).
Source: Maternity Support Survey (2013).

1.54-1.68). Compared with doulas, nurses reported less often that providers threatened that a baby would die, used sexually degrading language, engaged in extra procedures based on race/ethnicity, and engaged in procedures explicitly against a woman's wishes (OR 0.37-0.59; Table 4).

Among nurses who worked primarily in one hospital (Table 5), the effects of race/ethnicity and marital status were similar to models that included doulas and nurses without hospital variables. Nurses with higher household incomes more often reported witnessing threats that a baby might die (OR 1.26 [1.07-1.49]) and racially demeaning remarks (OR 1.36 [1.07-1.72]). Nurses who worked for a hospital that had, or was taking steps toward, Baby-Friendly Hospital status (OR 0.70 [0.52-0.92]) or at a hospital that permitted VBAC for women who were good candidates (OR 0.58 [0.34-0.97]) reported less often that they witnessed providers performing procedures explicitly against a woman's wishes.

4 | DISCUSSION

This study provides new insights into the types and frequencies of disrespectful care in the United States and Canadian birth facilities as reported by doulas and L&D nurses, and identifies systematic differences between those who report seeing different types of disrespectful care. About two-thirds of nurses and doulas reported occasionally or often witnessing providers' failure to meet professional standards of care by engaging in procedures without obtaining informed consent or, less often, acting despite a woman's explicit refusal. The informed consent process is complex in a dynamic clinical situation such as childbirth, especially when women are in labor and have not clearly articulated their preferences in advance. Some obstetric clinicians believe that maternity patients provide implied consent to all procedures when they sign hospital admissions forms, despite clear guidance from the American Congress of Obstetricians and Gynecologists which states, "Often, informed consent is confused with the consent form. In fact, informed consent is 'the willing acceptance of a medical intervention by a patient after adequate disclosure by the physician of the nature of the intervention with its risks and benefits, and of the alternatives with their risks and benefits.'[47] When asked about this distinction, the majority of respondents believed that signed forms upon admission did not constitute informed consent (74% of nurses and 80% of doulas). Indeed, nearly all (over 95%) MSWs in our survey strongly agreed that informed consent requires an ongoing decision-making process between patient and provider.

This study found a strong association between observing disrespectful care in childbirth and intention to leave the field, raising important considerations for strategies to improve maternity care quality and outcomes. MSWs who support women during labor and birth can also experience secondary trauma after witnessing disrespectful care, especially if they feel powerless to intervene.[39,48] Doulas have long struggled with ways to sustain their practice in an occupation characterized by the stresses of being on-call, and allegiance to a woman-centered model of care that is often at odds with the care they observe in hospital-based births.[40] Our study shows that L&D nurses who witness disrespectful care may also be at risk of leaving the work force, possibly because of emotional burnout and moral distress.[39] The concept of moral distress is variously defined in the research, but in general it refers to the stress engendered when health care workers have difficulties navigating practice while upholding professional values, responsibilities, and duties.[49] Research has demonstrated that moral distress has significant implications for satisfaction, recruitment, and retention of health care providers and for the delivery of safe and competent quality care.[38]

Verbal abuse in the form of threats to the baby's life was reported by one-third of respondents, with doulas significantly more likely than nurses to report this behavior occurring occasionally or often. Although concern about fetal well-being can be justified in many situations, childbirth professionals refer to the use of unwarranted threats as "playing the dead baby card."[26] Since both doulas and nurses reported

TABLE 3 Frequency (%) of doulas and nurses who reported witnessing disrespectful care by maternity support role, Maternity Support Survey, United States and Canada, 2013[a]

	Total sample N = 2344 N (%)	Doula N = 1435 N (%)	Nurse N = 967 N (%)
Verbal abuse			
Have you ever witnessed a care provider tell a woman that her baby might die if she does not agree to a proposed procedure?			
Never/rarely	1564 (66.7)	1564 (66.7)	708*** (73.2)
Occasionally/often	780 (33.3)	780 (33.3)	259 (26.8)
Have you ever heard a care provider mention a laboring woman's racial or ethnic background in a way that was demeaning?			
Never/rarely	2079 (88.7)	1289 (89.8)	836** (86.5)
Occasionally/often	265 (11.3)	146 (10.2)	131 (13.6)
Have you witnessed a care provider use sexually degrading language with a laboring woman?			
Never/rarely	2145 (91.5)	1283 (89.4)	910*** (94.1)
Occasionally/often	199 (8.5)	152 (10.6)	57 (5.9)
Stigma and Discrimination			
Have you observed a laboring woman receive more procedures because of her racial or ethnic background?			
Never/rarely	1836 (78.3)	1042 (72.6)	831*** (85.9)
Occasionally/often	508 (21.7)	393 (27.4)	136 (14.1)
Failure to Meet Professional Standards of Care			
Have you witnessed a care provider engage in procedures without giving the woman a choice or time to consider the procedure?			
Never/rarely	812 (34.6)	488 (34.0)	338 (35.0)
Occasionally/often	1532 (65.4)	947 (66.0)	629 (65.1)
Have you witnessed a care provider engage in procedures explicitly against the wishes of the woman?			
Never/rarely	1922 (82.0)	1123 (78.3)	839*** (86.8)
Occasionally/often	422 (18.0)	312 (21.7)	128 (13.2)

[a]The z-test for difference of proportions between doulas and nurses is denoted by: *$P < .05$, **$P < .01$, ***$P < .001$.

witnessing this threat, we assume that respondents in both roles are able to distinguish between a truly emergent situation where concerns about fetal status are valid compared with when the threat is empty and used as a coercive mechanism to obtain compliance. This assumption appears to be validated by our finding that two-thirds of respondents report occasionally or often witnessing failures to obtain informed consent.

We observed striking effects of MSWs' race and education on frequency of reporting disrespectful care in childbirth. MSWs of color, despite their very small numbers in the sample, had significantly greater odds of reporting that they occasionally or often observed racially degrading remarks. The effects of formal education suggest that more education may increase awareness of racial/ethnic biases in maternity care. Formal education around implicit and explicit bias could play a critical role in sensitizing MSWs to disrespectful care and empowering them to interact with patients more effectively, similar to patient safety efforts to encourage clinicians to speak up when they observe behaviors that are likely to cause harm to patients.[50] Increasing the racial/ethnic diversity of maternity support occupations can be another important strategy for reducing racial/ethnic disparities.[51]

A hospital's Baby-Friendly Initiative status had significant effects on nurses' reports of occasionally or often witnessing women receive extra procedures based on race/ethnicity and procedures performed explicitly against the woman's wishes. While the Baby-Friendly Hospital Initiative focuses on facilitating breastfeeding and has no specific prescriptions for childbirth, the initiative requires a focus on evidence-based practices, and its implementation involves conscious culture change, in addition to other organizational and system changes.[52]

Nurses who worked primarily in one hospital in the Southern United States region were significantly more likely than nurses who worked in other regions to report observing

TABLE 4 Adjusted odds ratios for associations between doula and nurse characteristics and reports of disrespectful care of women in childbirth, Maternity Support Survey, United States and Canada, 2013 (N = 2344)[a]

	Threats that a baby might die	Racist remarks	Sexist remarks	Extra procedures because of race-ethnicity	Lack of informed consent	Acted explicitly against a woman's wishes
	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)
White, non-Hispanic	0.77 (0.54-1.10)	**0.30 (0.20-0.45)**	1.12 (0.61-2.06)	**0.42 (0.29-0.61)**	0.94 (0.66-1.35)	1.24 (0.78-1.97)
Nonwhite, non-Hispanic	Reference	Reference	Reference	Reference	Reference	Reference
Married	**0.66 (0.52-0.84)**	**0.52 (0.37-0.73)**	**0.53 (0.36-0.77)**	0.81 (0.62-1.06)	**0.67 (0.53-0.85)**	**0.65 (0.48-0.86)**
Unmarried	Reference	Reference	Reference	Reference	Reference	Reference
Parent by birth	**1.42 (1.09-1.83)**	1.06 (0.74-1.51)	1.27 (0.83-1.93)	0.78 (0.58-1.03)	**1.36 (1.06-1.75)**	**1.40 (1.02-1.92)**
Nonparent by birth	Reference	Reference	Reference	Reference	Reference	Reference
Plans to leave nurse or doula job within 3 y	1.28 (0.97-1.71)	**2.07 (1.46-2.92)**	**2.43 (1.61-3.65)**	2.12 (1.55-2.90)	**1.97 (1.45-2.69)**	**1.78 (1.28-2.48)**
Plans to continue nurse or doula job	Reference	Reference	Reference	Reference	Reference	Reference
Work-family conflict[b]	**1.23 (1.02-1.49)**	1.08 (0.81-1.43)	1.32 (0.96-1.81)	**1.31 (1.06-1.63)**	**1.24 (1.03-1.50)**	1.14 (0.90-1.44)
No work-family conflict	Reference	Reference	Reference	Reference	Reference	Reference
Emotional regulation scale (10-50)[c]	**1.04 (1.01-1.06)**	1.01 (0.97-1.05)	**1.06 (1.02-1.10)**	1.02 (0.99-1.05)	1.01 (0.99-1.03)	**1.06 (1.03-1.09)**
Northeast United States	0.98 (0.75-1.29)	1.01 (0.68-1.51)	0.99 (0.64-1.55)	**1.36 (1.01-1.84)**	1.23 (0.95-1.60)	1.34 (0.96-1.87)
Southern United States	**1.54 (1.20-1.96)**	1.34 (0.92-1.93)	0.95 (0.62-1.44)	1.18 (0.88-1.58)	**1.55 (1.21-2.01)**	**1.68 (1.24-2.28)**
Canada	**0.69 (0.48-0.98)**	0.82 (0.49-1.36)	0.77 (0.43-1.37)	0.68 (0.45-1.03)	0.96 (0.69-1.34)	1.00 (0.65-1.54)
Western United States[d]	Reference	Reference	Reference	Reference	Reference	Reference
Nurse	**0.59 (0.48-0.73)**	1.29 (0.95-1.75)	**0.56 (0.39-0.81)**	**0.37 (0.28-0.48)**	0.91 (0.74-1.12)	**0.52 (0.40-0.68)**
Doula	Reference	Reference	Reference	Reference	Reference	Reference

[a]Models are adjusted for nurse/doula age, educational level, and household income. These variables had no significant effects. We include variables for all models that were significant in any of the six models. Values in bold are significant at the 0.05 level.

[b]Work-family conflict is defined as agreeing with the statement: "I have trouble balancing the time demands of my maternity work with my family responsibilities and other obligations."

[c]The emotional regulation subscale comes from the emotional intelligence measurement tool developed by Schutte and colleagues (1988).

[d]The Midwestern United States Census region was not significantly different from the Western region in any models and was excluded.

TABLE 5 Adjusted odds ratios for associations between nurse and hospital characteristics and reports of disrespectful care of women in childbirth among nurses who work primarily at one hospital, Maternity Support Survey, United States and Canada, 2013 (N = 838)[a]

	Threats that a baby might die	Racist remarks	Sexist remarks	Extra procedures because of race-ethnicity	Lack of informed consent	Acted explicitly against a woman's wishes
	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)
Age in years	0.99 (0.96-1.02)	0.96 (0.92-1.00)	0.93 (0.87-1.00)	1.00 (0.97-1.04)	**0.97 (0.95-0.99)**	0.98 (0.94-1.03)
Educational level	1.03 (0.81-1.30)	1.14 (0.80-1.61)	**2.47 (1.39-4.40)**	1.19 (0.87-1.64)	1.11 (0.90-1.36)	**1.40 (1.00-1.98)**
White, non-Hispanic	0.54 (0.26-1.13)	**0.16 (0.08-0.35)**	0.72 (0.20-2.56)	**0.33 (0.15-0.74)**	1.19 (0.61-2.32)	0.88 (0.31-2.52)
Nonwhite, non-Hispanic	Reference	Reference	Reference	Reference	Reference	Reference
Household income[b]	**1.26 (1.07-1.49)**	**1.36 (1.07-1.72)**	1.09 (0.82-1.43)	1.06 (0.86-1.32)	1.11 (0.97-1.27)	1.17 (0.96-1.44)
Married	**0.60 (0.39-0.95)**	**0.43 (0.25-0.73)**	**0.25 (0.13-0.48)**	0.95 (0.56-1.63)	**0.62 (0.43-0.91)**	0.60 (0.34-1.07)
Unmarried	Reference	Reference	Reference	Reference	Reference	Reference
Plans to leave nursing within 3 y	**1.55 (1.02-2.35)**	**3.45 (2.05-5.79)**	**4.25 (2.00-9.02)**	**2.11 (1.25-3.56)**	**1.84 (1.20-2.81)**	1.44 (0.82-2.53)
Plans to continue in nursing	Reference	Reference	Reference	Reference	Reference	Reference
Northeastern United States	1.20 (0.73-1.98)	1.27 (0.63-2.59)	0.72 (0.25-2.12)	1.61 (0.85-3.05)	1.32 (0.85-2.05)	**2.17 (1.13-4.18)**
Southern United States	**1.92 (1.22-3.02)**	1.82 (0.93-3.55)	0.77 (0.32-1.86)	1.55 (0.85-2.83)	1.46 (0.96-2.23)	1.53 (0.82-2.87)
Canada	**0.34 (0.14-0.82)**	1.31 (0.52-3.30)	0.21 (0.03-1.44)	1.30 (0.45-3.71)	0.70 (0.37-1.32)	0.63 (0.21-1.92)
Western United States	Reference	Reference	Reference	Reference	Reference	Reference
Baby-Friendly Hospital Status	1.02 (0.82-1.27)	0.87 (0.64-1.18)	0.82 (0.53-1.26)	0.78 (0.58-1.03)	0.97 (0.79-1.17)	**0.70 (0.52-0.92)**
VBAC permitted	0.83 (0.55-1.26)	0.85 (0.47-1.51)	0.70 (0.30-1.64)	0.68 (0.39-1.16)	0.88 (0.60-1.28)	**0.58 (0.34-0.97)**
VBAC not permitted	Reference	Reference	Reference	Reference	Reference	Reference

[a]These models include only nurses who work primarily at one hospital. Models are adjusted for parental status, work-family conflict, emotional regulation, years of nursing experience and the number of hours per week that nurses work at their main nursing job. These variables were not statistically significant. The Midwestern United States Census region was not significantly different from the Western region in any models. We include variables for all models that were significant in any of the six models. Values in bold are significant at the 0.05 level.

[b]Household income is an ordinal variable with the following seven categories: less than $20 000; $20 000-34 999; $35 000-49 999; $50 000-74 999; $75 000-99 999; $100 000-149 999; and $150 000 or more.

threats that babies might die. They were also more likely to report occasionally or often observing lack of informed consent and procedures performed despite women's explicit wishes against them. These types of disrespectful care are the most coercive among our six types, and may be among the many factors responsible for poor maternal and neonatal outcomes observed in the Southern United States.[53]

Occupational and family positions also have important effects on respondents' likelihood of reporting disrespectful care during labor and birth. Disrespect in the form of verbal abuse was the least likely to be reported by nurses and doulas in our sample, with 8.5% and 11.3% reporting witnessing sexually degrading or racially demeaning language, respectively. Nurses reported hearing sexually degrading comments more often and racially demeaning remarks less often, than doulas. Nurses and doulas who were birth parents were more likely to report witnessing threats, sexist remarks, and violations of informed consent than nonbirth parents, suggesting that those who have the experience of giving birth may be more sensitive to, or more likely to label, certain behaviors as disrespectful. One puzzling finding was that married MSWs were much less likely to report witnessing all types of disrespectful care than single MSWs, suggesting that single workers may be more sensitive to abuse and pay greater attention to potentially threatening situations.

A strength of our study is its large, diverse sample of doulas and nurses, and the ability to stratify analyses by several factors that affect the provision of maternity care, including hospital culture, emotional regulation, and future career plans. While our data do not identify the actual frequency of disrespectful behavior or who engaged in it, our findings provide insights into MSWs' experiences and contribute unique information about the characteristics that influence reports of disrespectful care by doulas and L&D nurses. A limitation of these data is that survey respondents chose whether to participate, making the sample nonrandom. Another limitation is that we measured the frequencies of doulas and nurses who reported ever witnessing types of disrespectful care, rather than its objective prevalence. Finally, this study does not describe the number of women who experienced disrespectful care or experienced their births as traumatic, or how the MSWs responded to disrespectful care.[54,55] Future research that examines disrespectful care needs to observe and analyze the context in which it occurs and measure the short- and long-term influence on clinicians, women, and their families.[56]

ACKNOWLEDGMENTS

We thank the leaders of participating member organizations for their assistance in the Maternity Support Survey, and all the respondents who gave their time and filled out our survey. We gratefully acknowledge the generous support of individual donors to the Indiegogo campaign. Additional financial support was provided through a faculty research grant awarded to Marla Seacrist, PhD from CSU Stanislaus. Finally, we thank our MSS colleagues, Nicole Heidbreder, MA, BSN, RN, LCCE, CLC, Birth Doula Trainer (DONA), Miriam Naiman-Sessions, PhD, and Jennifer Torres, PhD for persevering with dedication and collaborative collegiality throughout the many years of this project.

ORCID

Christine H. Morton http://orcid.org/0000-0001-8505-9877
Louise Marie Roth http://orcid.org/0000-0002-6279-9714

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How to cite this article: Morton CH, Henley MM, Seacrist M, Roth LM. Bearing witness: United States and Canadian maternity support workers' observations of disrespectful care in childbirth. *Birth*. 2018;45:263-274. https://doi.org/10.1111/birt.12373