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“You feel like you come up short over and over again”: a qualitative study of provider perspectives of barriers to respectful maternity care in Boston

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Abstract

Background Respectful maternity care is a human right. Disrespect in childbirth has been implicated in adverse maternal and child outcomes globally, including in the United States. Up to 30% of U.S. birthing people report being disrespected when giving birth, with reported rates being higher amongst racial/ethnic minorities and those who do not primarily speak English. Disrespect in childbirth leads to increased rates of postpartum depression and lower healthcare utilization.

Methods Semi-structured qualitative interviews were conducted with 18 maternity health care providers at Massachusetts General Hospital in Boston, Massachusetts. Respondents included physicians, midwives, and nurses. Transcripts of the interviews were coded using an inductive approach, and themes were developed from the codes.

Results Four major themes emerged: (1) patient-provider communication and dynamics, (2) structural and organizational drivers of care, (3) patterns in disrespect, and (4) clinician knowledge and beliefs about respectful and disrespectful care. Key barriers to respectful care included workload, facility infrastructure, and constraints in the provision of clinical care. Providers perceived that certain social vulnerabilities (e.g., race, age, ethnicity, language) predisposed some patients to greater levels of disrespect. Consent processes and procedures were also identified to be a crucial leverage point in preventing disrespectful maternity care.

Conclusion Although respondents generally perceived care to be of high quality, they noted that challenges to respectful maternity care are present even in high-resource settings. Future research in disrespect and abuse in maternity care is necessary to further develop sustainable solutions. It is imperative to continue exploring the perspectives of maternity care providers, as they are key stakeholders and are uniquely positioned to identify root causes of mistreatment in care provision.

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Plain English Summary

In the United States, approximately 1 in 5 birthing people report being mistreated during childbirth. To fully understand the issue of disrespectful care in childbirth, it is necessary to include the perspectives of health care providers. This study interviewed physicians, midwives, and nurses at a hospital in Boston, asking them about their opinions on respectful and disrespectful care as well as root causes of mistreatment. The interviews were analyzed and organized into four themes: (1) patient-provider communication and dynamics, (2) structural and organizational drivers of care, (3) patterns in disrespect, and (4) clinician knowledge and beliefs about respectful and disrespectful care. In conclusion, providers reported striving for respectful care, but finding it difficult to always provide the type of care they wished to.

Keywords Childbirth, Respectful maternity care, Disrespect and abuse, Obstetrics

Introduction

Respectful maternity care (RMC) encompasses care in childbirth that maintains dignity, privacy, autonomy, and support of birthing people [1]. The World Health Organization (WHO) has prioritized RMC not only as a human right, but also as a strategy to ensure optimal and safe care in childbirth [2]. Unfortunately, a growing body of evidence reveals the global presence of disrespect and abuse (D&A) in childbirth [3]. Experiences of D&A can impact birthing people's birth experiences, health outcomes, and future behaviors. Those who perceived their care as disrespectful report higher rates of postpartum depression and post-traumatic stress disorder [4]. They also report that fear of disrespectful care lessens desire for future children [5], and leads to disengagement with the healthcare system and reduced utilization, both for themselves and for their children [6].

To date, research on RMC/D&A has primarily focused on low-resource settings [7]. Findings from these studies may not be generalizable to high-resource settings. Nevertheless, disrespectful care is also prevalent in high-resource settings, including the United States [8]. Studies of birthing people's experiences in the United States have found that approximately 17–30% reported being mistreated [9, 10]. 45% of women refrained from asking or sharing any concerns during their pregnancy and delivery. Black or African American birthing people and birthing individuals who do not speak English as a first language report higher rates of mistreatment [11]. These disparities and impacts of D&A are of particular importance given the context of high maternal mortality in the United States, where mental health conditions underlie 22.7% of maternal deaths and 80% of maternal deaths are preventable [12]. Furthermore, the rate of maternal mortality in Black Americans is nearly three times that of White Americans [13].

Perspectives of health care providers on respectful and disrespectful maternity care in the United States remain largely unexplored. Providers are crucial to understanding the context of RMC/D&A and are key stakeholders in achieving the goal of respectful maternity care for all.

Previous research has examined perspectives of nurses and doulas, who corroborate patient reports of D&A, ranging from verbal abuse to discrimination to aggressive, unnecessary intervention [14, 15]. While quantifying and categorizing D&A is important to understanding the phenomenon, it is also vital to examine the drivers of disrespectful care. Recent research has analyzed structural and environmental drivers of D&A in the U.S. from the patient perspective [16]. Providers can, however, specifically offer insights into both individual patient-provider interactions as well as the structural context within their hospital institutions and the U.S. healthcare system. The aim of this study is to examine nurses, midwives, and physicians' knowledge and perception of respectful and disrespectful childbirth care, as well as their root causes.

Methods

Recruitment and sampling

This article presents results of qualitative interviews with health care providers (physicians, midwives, and nurses) working at Massachusetts General Hospital (MGH) in Boston, Massachusetts. These interviews were conducted as part of a mixed-method study that also included a quantitative survey, the results of which have been published separately [17]. Providers who had been working on labor and delivery for at least one year were eligible to participate. Resident physicians with at least a year of experience were also eligible. Participants were recruited through department newsletters, emails, and flyers. Consent was obtained electronically prior to scheduling the interview; participants were provided a written statement about the research (Appendix A) and were prompted to indicate their preference to have their interview transcribed by hand or automatically, and to have their interview recorded. Consent was again reviewed and verified by the interviewer prior to recording the interview. Massachusetts General Brigham (MGB) Human Research Committee approved the study protocol.

Study instrument and data collection

Researchers used a semi-structured interview guide (Appendix B) to conduct interviews. Questions covered

Table 1 Demographic characteristics of participants

Variable	N
Occupation	
Nurse	5
Midwife	5
Physician	8
Age	
20–29	2
30–39	7
40–49	3
50+	6
Gender	
Male	2
Female	16
Race/ethnicity	
White	15
Hispanic/Latino	2
Black	1
Years of experience at MGH	
1–5	8
6–15	4
16+	6

provider perceptions of the presence of disrespectful care, experiences with training, and the role of facility infrastructure and resources on respectfulness of care. Interviews were conducted between April 2023 and January 2024. They took place over Zoom video call and lasted between 30 and 60 minutes. Interview recordings were first transcribed using Otter.ai, an automatic transcription software, then the automatic transcriptions were reviewed, corrected, and de-identified by research assistants.

Data analysis

Dedoose qualitative analysis software version 9.0.107 was used to code the transcripts. A thematic approach, detailed by Braun and Clarke [18], guided data analysis.

First, a subsample of transcript was coded with an inductive approach, coding for any concepts of interest [19]. The inductive approach develops a model from specific primary observations. This generated a list of first-order codes with no pre-established organizational

theme. Each transcript was coded by two people independently: one research assistant and one clinician (either a nurse or a physician). After the subsample of transcripts was coded, researchers discussed coding decisions, organized these codes into categories, and developed an initial theoretical framework and codebook. The remainder of the transcripts were coded, each by two people independently, using the developed codebook. Researchers met periodically to discuss difference in coding until consensus, and to adjust the framework in an iterative process.

Results

A total of 18 interviews were analyzed: 5 from nurses, 5 from midwives, and 8 from physicians. The term “provider” is used for doctors, midwives, and nurses. The ages of participants ranged from 24 to 68. Demographic information is detailed in Table 1 below.

Findings

Four primary themes were developed from the data: (1) patient-provider communication and dynamics, (2) structural and organizational drivers of care, (3) patterns in disrespect, and (4) clinician knowledge and beliefs about respectful and disrespectful care. Each primary theme also included subtheme(s). Themes and sub-themes are shown in Table 2.

Patient-provider communication and dynamics

Informed consent

Consent and patient counseling were noted by participants as vital aspects of respectful care. Some providers perceived a difference between technical consent and what one participant called “full informed consent,” in which patients had adequate time, knowledge, and empowerment to ask questions and consider their options. Providers stressed the importance of obtaining at least some form of consent as long as a patient is conscious, even in the case of medical emergencies:

“I mean, I’ve heard doctors doing the consent running down the hall with the patient in the stretcher

Table 2 Themes and sub-themes

Theme	Sub-theme
1. Patient-provider communication and dynamics	A. Informed consent B. Language barrier
2. Structural/organizational drivers of care	A. Staffing norms B. Facilities C. Clinical guidelines D. Organizational culture
3. Patterns in disrespect	A. Discriminatory care
4. Clinician beliefs and knowledge about respectful and disrespectful care	A. The meaning of disrespect and abuse B. Healthcare provider experiences

being wheeled back to the OR. There's always time even to get the basic information out." -Midwife, 40s
"Informed consent in emergencies is really hard. In an emergency, like you do the best you can, and then you debrief with the patient afterward, and provide them with resources to process." -Nurse, 20s

"I think we as a medical system, and this is beyond MGH, don't know how to do it [informed consent] well. I think when we do informed consent, it's almost like it's for ourselves. Because honestly, I don't know how much, especially in these acute moments, I don't know how much patients are able to take in, in terms of really understanding what they're accepting." -Physician, 40s

Providers, however, also commented on how shortcuts and concessions sometimes need to be made during acute scenarios and emergencies:

"I think that it's hard, because even with the most informed patient who knows what's going on, you're always doing like an abbreviated version of that consent inherently because like you don't have time to just sort of sit there and go through every small little thing. Of course, you're painting in broad strokes, I think that gets more and more difficult. And whether it's someone with more limited healthcare literacy or a non-English speaking patient, just because inherently your time is limited so you have to sort of choose what you're talking about and how, and also the way that you're saying it, hopefully in a way to convey like the urgency of the situation." -Physician, 30s.

Language barrier

Though experienced providers noted that care for non-English-speaking patients had improved since the adoption of virtual interpretation services, language was still noted often as a major barrier to good communication and therefore to true informed consent. This was attributed primarily to the time constraints of procuring a translator, especially in urgent or emergent situations.

"Language concordant care is often, especially in emergency settings, people will not... people will do things without asking, without speaking to a patient in their language and in a way that they would never do in English, with the assumption that it's what a patient wants or needs" -Physician, 30s

"So maybe the white English-speaking patient will get that counseling that the, you know, Hispanic and Spanish-speaking patient would not. And there is the language barrier, a big one, I see that all the time where people, you know, at all levels will say,

Oh, yeah, we're just going to do that I don't have the interpreter right now, or whatever it is, I mean, that's just a big barrier where people feel more inclined, I think, to not have the discussions with the patient to make decisions together, and therefore, again, loss of control, making decisions for them." - Midwife, 40s

"Particularly for patients who are unconscious, they can lose enough blood rapidly on labor and delivery, and that's not an unreasonable scenario, right? And if their baby is dying before you, I would say that is another problem. As good as our translation is for someone who's not speaking English, that is a problem. Because the time even if it's 30 seconds to get that translator on board, that's 30 seconds, that baby is dying." - Physician, 50s

"So I can quickly run through a risk list, list a list of risks and say, you know, bleeding, requiring transfusion, the possible need for hysterectomy, the risk of infection, injury to surrounding structures and need for additional C sections in the future and a small risk of injury to the baby. And I can say that in English pretty quickly, but like, obviously, with a language interpreter, and you're trying to move quickly, that entire communication is broken down." -Physician, 30s

Providers emphasized the importance of a trusting relationship and good rapport with their patients. They reported feeling drained and demoralized when their relationship with patients felt untrusting or antagonistic. Patient refusal of intervention sometimes elicited discomfort, frustration, or fear from physicians and midwives; however, some midwives reported more comfort with managing labor without medical intervention.

"On the provider side, it can feel really scary for somebody to not want to engage with any of the limited tools that we have at our disposal to like, monitor them and like help support them through this process in the setting that we're in. You're kind of like, well, why are you here? Why are you asking for our care, or choosing to participate in our care, if there's actually nothing that you want?" -Physician, 30s

"It's a teaching hospital. So the residents are taught, like, really, they need to go and check the patients every four hours. But midwives have a different approach. We're like, well, we're not going to change anything we're going to do right now. So we don't need to do a vaginal exam. Like there's nothing, no intervention that we're thinking that we have to make in order to facilitate the progress the labor. So we have a little different kind of view." -Midwife, 60s

A dynamic often commented upon was the gap between the provider's intention and their patients' perception of interactions. Respondents emphasized that harm was often unintentional. They did not invalidate the perceptions of patients who felt disrespected but emphasized that providers acted out of concern for their patients.

"I think it's one of those things that if the patient perceives this, that's the case for them. So, you know, that feels uncomfortable. I think that as a provider, sometimes there is a little bit of a disconnect, in my mind, between what patients might view as being sort of abusive or disrespectful." -Physician, 40s

One type of unintentional harm was perceived threatening remarks. Providers emphasized the difficulty of properly communicating to their patients the risks and consequences of not following medical advice. The line between a clear explanation of risks and a threat can be blurry.

"I think there's ways of presenting potential risk if our advice is not followed. I guess that I think about that can be, you know, we can be unintentionally threatening, or more intentionally, maybe if we really feel strongly about something and some advice that we're giving, and it's not followed. But we have to do that respectfully." -Midwife, 60s

"In my mind, we don't threaten patients. But we'll paint them what I believe to be an honest picture, which I'm sure to the patients they feel like is threatening at points." - Physician, 30s

Structural/organizational drivers of care Staffing norms

Almost all respondents noted that the floor was busy and needed more staff. A large volume of patients and high level of medical need meant that providers were not able to spend as much as time with patients as they would like, or that they had to "budget" their time with patients. Experienced providers noted that the labor and delivery floor has been particularly strained in recent years, exacerbated by the pandemic, the departure of experienced staff, and the large number of new staff.

"They see the highest risk possible pregnancies, so that has increased the acuity. And that increases the stress [...] Your sense of impending doom is constant. And your running around is constant. So, I mean, oftentimes, people here go without eating, they go without a coffee break, they go without running to the bathroom, like people can get to four o'clock and

they haven't had a meal yet. Your resiliency wanes as you hit the end of the shift." - Midwife, 60s

"I think lack of time, having days that are too busy, clinics that are too busy, labor floors that are so busy that you don't have the opportunity to take the time to make sure a patient understands what's going on, or just get time to process things. Because you're being told that, you know, this labor has to move along, or you have 10 patients waiting in the waiting room. And that's really challenging, because it's not respectful to the other patients who are waiting for their care either. So, you're sort of between a rock and a hard place there. There's no way to then practice respectfully, if you're either making patients wait for hours, or, or not spending enough time with them." Midwife, 30s

"So you're sort of dealing with an acute situation, or there's a lot of other acute situations happening. And the situation in that particular room is not very acute, but that room is taking a disproportionate amount of time because of various reasons. And so then you feel that, like, oh, I can't really budget this amount of time to like, explain every different, you know, intervention to this great of an extent when this is sort of standard care, so I'm not going to go in that room until I know that I have 10 minutes free. And then that patient may not get as much attention either, you know, unless something acute happens. It can be challenging to give every person the amount of time that that person wants and might merit." Physician, 40s

Nevertheless, some found that staffing was not necessarily a primary driver of D&A, noting that staffing ratios are well-regulated to support adequate care. They acknowledged challenges but cautioned against using staffing as an "excuse" for disrespect:

"The nature of obstetrics is that volume and busyness is unpredictable and there are times when it can be busy. But again, doesn't excuse violations of privacy and respect, but makes it part of the art and what one learns to do provide important elements of care, respectful care, informed consent despite busyness." -Physician, 60s

"It's certainly, I think, much more difficult to be your best and kindest and most understanding self when you're feeling stressed from another negative interaction or from time pressure or from fatigue. I think we shouldn't use it as an excuse, because like the settings that we're providing care in are going to be inherently stressful and probably our patients are feeling some level of stress just by being there. So, I think it's important to like acknowledge that those

things are potentially playing a role. But we should be coming up with ways to actively counteract those effects rather than being like, welp, I'm stressed, I have an excuse to be an asshole." – Physician, 30s

Facilities

Hospital infrastructure was also perceived as a contributor to respectfulness of care. The floor layout, with its private rooms and curtains, was noted to provide privacy to patients. However, the waiting area and triage area were not always conducive to privacy, both when performing procedures or when having sensitive conversations.

"Our waiting area for triage is basically just a bench. And then the triage itself is actually pretty small. So, I do think that sometimes can feel uncomfortable in a hospital setting, where most people are expecting to have like private rooms all the time, that can feel very public and relatively undignified." Physician, 30s

Clinical guidelines

In addition to infrastructural challenges, some participants found the hospital's clinical guidelines about recommended interventions and elective induction of labor to be problematic. Midwives, who operate as independent practitioners with full practice authority at MGH, especially noted conflicts between rigid guidelines and the midwifery model of care. The midwifery model emphasizes birth as a natural physiological process that calls for an individualized approach to each patient. Medicalization of birth was noted as an issue in the field of obstetrics that prioritized and normalized an interventionist approach over physiological childbirth. This approach cultivates a "checklist mentality" at the expense of patients.

"Clinicians are put in a really difficult position where we feel that there are guidelines that are immovable, and that we don't have the time or the resources or the support to help patients understand why certain things might be recommended or develop safe alternatives that we feel like won't put us at liability." -Midwife, 30s

"I think if you look at like a major academic medical center that has a busy labor and delivery unit, you see that people sort of turn birth and labor into a checklist of things to do to be the most efficient and move on." -Nurse, 30s

Organizational culture

Even as participants noted structural challenges with staffing, infrastructure, and clinical guidelines, they found the organizational culture generally positive. Though some noted the presence of interprofessional hierarchy based on age and profession, most pointed to the team-based collaborative approach as being supportive of respectful care.

"On our unit, we're lucky enough to have like everyone on the floor where you have the doctors, anesthesia, all the nurses, so I like how it's kind of like a cohesive unit where we're all working together to try and make a great experience for the patients." – Nurse, 20s

"In general, it is a unique place in the way that it functions because of our team approach. I think that most generally people do feel like they were taught as part of our insurance to do scenarios and work through simulations, which fosters a team approach and taking care of the patient. And I think that we actually work in a very positive manner to try at all times, to do more good work for patients and advocate. Sometimes the nurse will be more of an advocate, sometimes the physician." – Physician, 50s

Patterns in disrespect

Discriminatory care

Providers noted several patient attributes that were associated with higher likelihood of disrespectful care. Some acknowledged biases in the medical field based on race, age, culture, social status, or body size, even if they did not note any specific instances witnessed at MGH. Non-English-speaking patients were also noted to be vulnerable.

"I haven't seen anything that feels like explicitly like lesser care given to someone because of their race. That being said, I come from a background in which I might be less equipped to identify that type of discriminatory abuse. What I have most noticed, is like, more specific to the determinants of health that some races are more predisposed to being be like, impeding factors, like lesser medical literacy, and language barriers, or like immigration status, cultural differences. I think that like, those things are more obvious as things that make someone more vulnerable to abuse." – Nurse, 20s

"I think some cultures might be more vocal in labor, and that sometimes can trigger their providers to maybe be a little bit more angry, you know, and get upset with them. But that's just the cultural way that they deal with labor. You know, I think when

we interpret, and not just any, I think any race if we see or any cultural background, if we feel that they're not following our directions, they're not following our instructions, or they're noncompliant. That can be frustrating." – Midwife, 60s

Patients who were significantly younger or significantly older, as well those who had many children, reportedly faced judgement for their reproductive choices. This judgment took the form of commentary between providers, rather than verbal disrespect directly to the patient.

"I think definitely people who've had many babies before, there's always a lot of commentary about that. And I think people who have most of those characteristics that you mentioned, are much more likely to be dismissed, especially if they're younger, like, oh, you know, they're just being dramatic." – Midwife, 30s

Those with a history of substance use were noted as particularly vulnerable to disrespect, not only because of stigma from providers, but also because of the involvement of the criminal justice system:

"I think they separate moms and babies, they do an assessment and we have to report things that fall under the categories of reportable events. But I think that's a massive trauma for people and very, a really disrespectful process from what I understand. I think that can perpetuate more trauma down the road. So, I think it's the substance use patients and their interactions with DCF [State Department of Children and Families]." – Midwife, 40s

"But I would say our, you know, substance use disorder patients, who also often have a lot of mental health issues, and again, tie up a lot of resources. So I can see from that point, it's sometimes, it's difficult for everyone." – Midwife, 60s

According to providers, patients with lower health literacy in general were less empowered to advocate for themselves. However, when patients with high health literacy advocated strongly for themselves, this could also frustrate providers:

"I think our bias is really quickly formed against the patients who question the recommendations. So that can honestly sometimes be on the other end of the spectrum, very health literate patients who want to make sure they understand all of their options, all of their rights. And I think people think that type of patient can almost become polarizing." – Midwife, 30s

"You know, I think there's a perception of the patients, what do you call it, their 'compliance' is a term that's used a lot. And whether or not the patient is going to go along with what you're presenting, or not. And I think all of that feeds into why providers do what they do or how they how they do it. Perceived compliance or response to the discussion." – Midwife, 40s

"Those patients get a lot of, I would say, pushback, more emotionally than medically, from providers, I think. More like, the response seems more emotional from the provider, in the sense that they're kind of offended, or their feelings are sort of hurt that somebody disagreed with them or didn't just blindly agree to whatever plan this doctor has set forth, whether they've been a doctor for, you know, five minutes or 50 years." – Nurse, 30s

Clinician beliefs and knowledge about respectful and disrespectful care

The meaning of disrespect and abuse

Most providers were familiar with the term "disrespect and abuse in childbirth," while fewer were aware of the term "obstetric violence." Providers defined disrespect and abuse in different ways, including ignoring patients' agency, verbally or physically assaulting them, or performing procedures without consent. Providers expressed varying degrees of knowledge and comfort with terms like "disrespectful care," "abuse," and "obstetric violence." Some were skeptical of the terminology, finding it too strong or too subjective.

"Obstetric violence... Well, I guess it depends on who you're talking to, because obstetricians don't really believe in it. Most people believe that being admitted to the hospital and labor and delivery is consent to do anything that you want to your body because you have arrived. And obstetric violence is really the epitome of that, right?" – Nurse, 30s

"You know, I think 'violence' is a pretty strong word, first of all, so I sort of I take that with a grain of salt, that word. I think it means disrespect. What's the word I'm looking for...disrespect? overpowering?" – Midwife, 60s

"As someone who goes into a field to help women or pregnant people, birthing people, it just feels bad when you hear these things, and that's not the intent. So like, I do think disrespectful maternity care and abuse exist in Boston, because patients feel that they do. I think, I hope that it's relatively rare, that sort of, you know, deliberately disrespectful care is provided. And so sometimes I feel like the truth is, like in between providers have things to learn. And also

we have to be careful how to use words like 'abuse,' 'assault,' 'birth rape,' in ways that are acknowledging like some people are raped in life. And what would it mean to someone who was raped if you said an emergency C section is birth rape? So, I think terminology can be problematic, I guess, is sort of what I'm saying." -Physician, 40s

Especially among those who had witnessed more overt abuse in other settings, the disrespectful care witnessed at MGH was perceived as relatively mild.

"You hear cases in other parts of the country where people have taken someone to C- section against their will, when there's like a fetal bradycardia. And I've never been in a situation that was even close to that egregious or that much of a violation." - Physician, 30s

"I worked with way worse, you know. I mean, unbelievable stuff. Like women routinely having mediolateral episiotomies cut, you know, as a routine. Doctors making comments directly to the patient about their weight or that, you know, they should have trimmed better before they came in. I mean, stuff that was just truly awful [...] So it's not like universally that here by any stretch of the imagination, but it could be better." - Midwife, 60s

Healthcare provider experiences

Even when providers recognize that the care they provide may be distressing to patients, they expressed a limited ability to provide the type of care they would like. Many clinicians highlighted the moral distress and burnout they felt as a result, whether they find the care too interventionist, time too insufficient to connect with patients, or the relationship between patients and providers too oppositional.

"And so, you know, they come in [for inductions]. Like I literally write to my friends, I committed another crime against nature today. Because we do not feel good about it." - Midwife, 60s

"It's so difficult to articulate how much of an effect this job has on you and how much you recognize that things should be better and could be better. But at the same time talking about it and like broad speaking terms, it's like yes, I feel like for the most part, I can identify the problem. But then if you asked, like kind of for meaningful solutions, some of them, you feel like you come up short over and over again." - Physician, 30s

Discussion

This study examined health care providers' perceptions and perspectives of barriers to respectful maternity care in a tertiary care hospital in Boston. Providers placed great importance on respectful care, particularly regarding informed consent. Facility-level barriers to respectful care included workload, infrastructure, and clinical constraints. Patients who had existing social vulnerabilities were perceived to be more likely to experience disrespectful care. While knowledge of respectful care was high and care provision was generally perceived as positive, respondents noted a need for improvement.

Results of this study of providers complement previous studies of patient perspectives. A 2024 study found that 1 in 5 surveyed patients felt neglected during their birth [11]. These patient perceptions of neglect are consistent with providers' experiences of being rushed from patient to patient. Non-English speaking patients, and Black, Hispanic, and multiracial patients were more likely to report experiencing discrimination [11], a pattern corroborated by providers' perception of these patients' increased vulnerability. Providers ascribed the root cause of this discrimination not solely to individual provider bias but also to logistical challenges of communicating with non-English speaking patients. Both patients and providers noted communication issues: a survey found that about 45% of birthing people in the U.S. hesitated to express their questions or concerns to providers during birth [10]. Providers, for their part, noted negative reactions when patient questioned recommendations, as well as a lack of time to fully address patient concerns. Participants noted that standard obstetrical practices can present barriers to providing respectful care, a finding also noted in a study of U.S. patient experiences [16].

The perspectives of health workers in the U.S. provides an informative point of comparison with previous research in other settings. Most investigations of respectful and disrespectful care in childbirth have focused on low- and middle-income countries [7]. Lack of resources is a primary driver in many of these settings, where limited space may preclude privacy, and a severe shortage of providers may lead to patients being neglected. While facility and financial constraints still play a role at MGH, the fact that it is a very high-resource facility allows for other contributing factors to emerge. This study reveals that disrespectful care in childbirth is not driven by finances alone. Medicalization of birth and normalized intervention during birth play a role. Departure from medicalized interventions was often implicated in disrespect, for example when patients were perceived as noncompliant or when an explanation of the risks of nonintervention could come off as threatening. Even when clinical guidelines are aligned with contemporary

evidence, they can be perceived by patients as overbearing and undermining.

Another key finding in this study was the moral distress of providers. Moral distress occurs when a provider knows the morally correct action but is constrained from doing so [20]. In addition to negative emotional reactions and physical symptoms like exhaustion, moral distress can result in career burnout and negative coping mechanisms like avoiding patients [20]. The phenomenon has been found to be more common in nurses than in physicians, likely because nurses have less authority in patient care decision-making [20]. Time limitations, brought on by high patient census and acuity coupled with limited staff, were the primary source of constraint. With lack of time to connect with patients and to fully address their concerns, providers were often aware of presenting as disrespectful, or at least dismissive, but felt they had too many competing responsibilities to fully attend to any single patient. The presence of rigid clinical guidelines was another facet of care that led to provider moral distress. Providers did not feel empowered to support their patients in a physiological birth when the patient's choices went against clinical guidelines. This seemed to weigh especially heavily on midwives, whose training tends to emphasize holistic care.

Limitations of this study include possible selection bias. Because the study was advertised to feature questions about barriers to RMC, it is unlikely that participants who saw no need for RMC improvement would choose to participate. Furthermore, since they were discussing the quality of care they and their colleagues provided, social acceptability bias may have played a role. This was minimized by ensuring anonymity and conducting interviews by research assistants who did not work on labor and delivery. Finally, the study sample was primarily white and female, reflecting the skew of demographics of the MGH labor and delivery staff at large. Individuals with these identities and experiences may perceive RMC differently from providers of color, which is especially important given the well-documented role of structural racism and unconscious bias in shaping the experiences and outcomes of U.S. birthing patients of color, especially Black patients. Additionally, the differences in lived experiences amongst providers of more diverse backgrounds may color their perceptions regarding the provision of RMC and how hierarchy and bias play a role [21].

Research into both patient and provider perceptions of RMC and D&A in the U.S. continues to emerge. It is vital to not only describe and quantify RMC/D&A, but to delve into its root causes. Interventions need to focus on increasing provider and patient resources. In addition, both providers and patients could benefit from an organized space to debrief after traumatic birthing events.

Conclusion

Physicians, midwives, and nurses reported experiencing barriers to providing respectful care. These included patient acuity, shortage of time, issues with communication, and medicalization of birth. They also reported witnessing disrespectful care, especially in socially vulnerable groups like non-English-speaking patients.

Abbreviations

D&A Disrespect and Abuse
RMC Respectful Maternity Care

Supplementary Information

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Supplementary Material 1.

Supplementary Material 2.

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Authors' contributions

The study was conceptualized by AG and CD. Interviews were carried out by SN and KF. Qualitative coding and thematic analysis were performed by KF, SN, ST, KVK, ATL, AC, PB, and AF. The original article draft was prepared by KF and SN, and edited by ST and AG.

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Data availability

Deidentified data underlying this article will be shared upon reasonable request to the corresponding author.

Declarations

Ethics approval and consent to participate

The study protocol was approved by Mass General Brigham Human Research Committee (Protocol # 2022P003287).

Consent for publication

All respondents signed an online consent form (Appendix A), granting permission to publish their quotations.

Competing interests

The authors declare no competing interests.

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