Obstetric Violence on the Labor and Delivery Unit:

An Open System Approach

Caitlin Goodwin

This paper will describe a unit and identify an appropriate problem within a hospital unit using a systems theory model and terminology. This paper will discuss relevant professional standards to the issue at hand. The problem will be addressed, goals and objectives to solve the problem, resulting in policies and procedures for the unit, and the desired outcome. Finally, the proposed resolution will meet the health care system’s mission and values and improve the culture and climate.

Nursing Services Delivery Theory

The Nursing Services Delivery Theory can be applied to many types of health care organizations and supports multi-level phenomena and cross-level effects. The hospital is an open system characterized by many forces at work, including inputs, throughput, and output factors that influence the exigencies placed on the nursing staff at the point of care. The health care organization is a cohesive framework that blends clinical, organizational, fiscal, and outcome variables from a nurse viewpoint. These factors affect the energy, dynamics, and overall delivery of health care (Meyer & O’Brien, 2010).

In the Labor and Delivery unit, there are a variety of inputs that affect the influx of energy from the external environment into the department. Inputs include the people, materials, resources, and information that provide power to the unit (Meyer & O’Brien, 2010). The people involved include staff (nurses, physicians, surgical technicians, environmental services, management, and the unit administrator) and care recipients, as the patients are usually young and healthy, this provides a different type of energy than you may find in other areas of the hospital. The materials on the obstetric include medical supplies, surgical instruments, obstetric care, and office supplies. The resources are part of a not for profit company and funding come from the health insurance reimbursement under the umbrella health care organization. The information is another input in open systems theory. In the labor and delivery unit, this deals with labor market conditions. Labor market conditions in healthcare deal with all health care professionals and hospital staff. However, due to nursing being the largest component of staff, nursing shortages, attrition, and large influx of new hires affect the health care organization. (Evans, 2016)

Throughputs in the labor and delivery unit are energies within the health care organization that are changed by restructuring the inputs, like generating materials, processing merchandise, or delivering services (Meyer & O’Brien, 2010). A major throughput in nursing care is nursing interventions. These interventions are imperative to transform health and directly affect energy. The output is exported to the outside environment (Meyer & O’Brien, 2010). In the unit level at the hospital, outputs include clinical outcomes and patient safety, which directly affect nursing care.

The system as a cycle of events is the idea that the process of exchanging energy must renew the system and create a repetitive cycle of activities. It is generated by system outputs or activities (Meyer & O’Brien, 2010). These outputs are revenues, and activities are achieving accreditation criteria. Finally, there is negative feedback. This is internal communication concerning organization operation used as a remedial tool to regulate energy consumption and disbursement (Meyer & O’Brien, 2010). This can be seen in the labor and delivery unit by organization performance indicators and assessments.

In the grand scheme of maternity care, obstetric violence has been an increasingly discussed and litigated issue. Diaz (2016) defines obstetric violence as a “systemic problem of institutionalized gender-based violence” (p. 56). In obstetric care, provider preference is often used instead of evidence-based practice.

In the labor and delivery unit, it passively occurs due to the comfort of the staff with invasive internal exams and interventions. For example, a physician routinely cuts episiotomies by making non-medical justifications at the time of birth (Sadler, et al., 2016). A nurse performs vaginal exams without informed consent. The culture is often permissive and the loss of a woman’s autonomy is pervasive.

The problem inputs include staff involved with direct patient care (nurse, physicians, surgical technicians, and management), patients, materials involved in interventions (amniotomy hooks, internal fetal monitors, and sterile gloves), resources (funding from health insurance determined by patient satisfaction scores), and information (nursing hires, shortages or attrition). Throughputs involve the invasive interventions themselves, informed consent, and patient education regarding obstetric interventions.

The outputs in this issue include clinical outcomes and patient safety. If these interventions are not evidence based and have possible for patient harm, the outputs are an important consideration in this problem and the open systems approach. The event cycles involves meeting accreditation criteria and producing revenue. Both are threatened if patient autonomy, informed consent, and careful patient education are not being promoted (Sadler, et al., 2016). Negative feedback can be seen by the quality and hospital indicators for patient care.

The desired outcome for the unit is that women who enter the obstetric unit must have access to evidence-based information about potential interventions and give thorough informed consent. Subsequently, this paper will identify the goals and objectives that facilitate this outcome. The goals are to provide every women with evidence based and unbiased information about potential interventions; give the woman ample time to ask any questions and give true informed consent without coercion; and ensure staff are held accountable to these goals.

The first objective is for health care personnel provide evidence-based and unbiased information about interventions prior to performing them. Careful informed verbal consent should be obtained before any intervention and documented n the medical record. Finally, holding staff accountable by providing mandatory education and peer review boards to enforce appropriate, sensitive, and supportive professional behavior.

The objectives should be translated into policies and procedures for the labor and delivery unit. This includes providing research-based and impartial education to each patient before performing any intervention, with special sensitivity given to invasive examinations. This education should not include coercion or threats to the health or safety of the baby that cannot be substantiated in the obstetric literature. At minimum, education should be given prior to the following interventions: amniotomy, fetal monitoring, intravenous access and infusion, urinary catherization, and vaginal exams. All other interventions, such as surgery, medications, and any medical procedure should receive in depth education and consent.

Next, verbal informed consent must be carefully obtained and documented in the medical record. The patient’s consent should be verbally given and not implied. Finally, all staff should undergo an initial and annual education about obstetric violence, the rampant sexual assault statistics affecting the patient population, how to provide evidence-based education, and how to receive true informed consent.

The World Health Organization (2015) issued in a professional statement stating that women experience disrespectful treatment during childbirth in facilities worldwide. This violates the rights and safety of women during a particularly vulnerable time. They do not receive care with integrity, respect, and free from discrimination. The World Health Organization calls for more action, awareness, research, and advocacy on this significant issue.

The mission of the University of California, Los Angeles health care facility is to “deliver leading-edge patient care, research, and education”. The values “ensure Integrity, Compassion, Respect, Teamwork, Excellence and Discovery in the work we do daily” (University of California, Los Angeles, n.d.). Providing these policies and procedures to improve patient care, advocate for a vulnerable population, and elevate patient satisfaction will improve the culture and climate of the obstetric patient and care provider experience.

In conclusion, the open systems approach is an excellent theory to apply to large healthcare organizations and smaller scale units. It can be used as a change agent to improve hospital systems. Obstetric violence minimization can be achieved as a direct result of open systems theory applied to the nursing perspective.

References

Diaz, F. (2016). Invisible wounds: Obstetric violence in the United States.

*Reproductive Health Matters, 24*(47), 56-64. doi: 10.1016/j.rhm.2016.04.004

Evans, M. (2016, January). Hospitals give mixed report on labor market. *Modern*

*Healthcare*. Retrieved from http://www.modernhealthcare.com/article/20160113/NEWS/160119944

Meyer, R. M., & O’Brien-Pallas, L. L. (2010). Nursing services delivery theory: An

open system approach. Journal of Advanced Nursing, 66(12), 2828–2838.

Sadler, M., Santos, M. J., Ruiz-Berdun, D., Rojas, G. L., Skoko, E., Gillen, P., &

Clausen, J. A. (2016). Moving beyond disrespect and abuse: Addressing the structural dimensions of obstetric violence. *Reproductive Health Matters, 24*(47), 47-55 doi: 10.1016/j.rhm.2016.04.002

University of California, Los Angeles. (n.d). Mission, Vision, Philosophy. Retrieved on

December 7, 2017 at https://www.uclahealthcareers.org/working-here/mission-vision-philosophy/

World Health Organization. (2015). The prevention and elimination of disrespect

and abuse during facility-based childbirth. *World Health Organization Statement*. Retrieved from www.who.int/reproductivehealth/topics/maternal\_perinatal/ statement-childbirth-govnts-support/en/