# Report of the **Irish Maternity Support Network** to the UN Special Rapporteur on Women on

# **Mistreatment and violence against women during reproductive health care with a focus on childbirth**

17 May 2019

<https://www.ohchr.org/EN/Issues/Women/SRWomen/Pages/Mistreatment.aspx>

## Introduction

Reproductive healthcare has been the subject of considerable public commentary in Ireland in recent years. From the controversial handling of the symphysiotomy redress scheme; to the publicisation of the appalling abuses perpetrated against women and children in mother and baby homes; and the long awaited and hard won process of liberalisation of the laws on termination of pregnancy – the mistreatment of women in the context of reproductive health care has been very much to the fore of public discourse. As recently as April 2019 a national radio talk show devoted two full weeks of programming to women who called in to describe their experiences in Irish maternity hospitals, and the national health service, the Health Service Executive, issued a public apology stating “The HSE apologises to those women where our service has failed to meet their expectations.”[[1]](#endnote-1) The recurring thread throughout all of these controversies has been a fundamental failure to listen to and to believe women: to hear and believe their wishes; their preferences; and their accounts of what happened to them.

## Snapshot of Reproductive Healthcare Services in Ireland

Ireland is a stable modern democracy considered to have a high standard of living and a young and well educated population. There is a system of universal healthcare through which all citizens are entitled to access care. However, problems with waiting lists for non-emergency treatments and with waiting times to access acute treatment, as well as with access to certain treatments and to choice of place, provider, and type of treatment have led to the growth of a significant private healthcare industry and a significant proportion of the population purchase private health insurance products.

Reproductive health care and care during pregnancy and childbirth is provided to all pregnant people free of charge under the Maternity and Infant Child Scheme.[[2]](#endnote-2) For the majority of pregnant people what this provides is ante natal care shared between their General Practitioner (GP) and an obstetric unit either in a standalone maternity facility or within a larger hospital setting; and labour and delivery and post-partum care in the obstetric unit. In some areas of the country pregnant people can access midwifery led care either through a midwife-led unit attached to an obstetric unit; or via community midwifery services either through a domiciliary midwife service run from an obstetric unit or by engaging a self-employed community midwife. There are also private midwifery services available through independent enterprises to access homebirth care where the State supported homebirth service is unavailable by reason of geography, scarcity, or the strict exclusion criteria applied.

The Maternity and Infant Child Scheme provides care to all pregnant people at all stages of pregnancy. Gynaecological care is provided under the free public health care system run by the Health Service Executive (HSE). Fertility treatments are not provided on the public health care system and can only be accessed privately. Until 2018 termination of pregnancy services were strictly curtailed and available only in extremely limited circumstances. Following a referendum vote to change the Constitution of Ireland, a termination of pregnancy service was introduced in January 2019. This is a GP-led service up to 12 weeks’ gestation and a hospital-led service thereafter. The service is available on the public health care system.

There are approximately 67,000 births every year in Ireland. This includes figures for stillbirths and ectopic pregnancies. It does not include the figures for miscarriage. The rate of miscarriage is internationally accepted to be above 25% of all pregnancies. This indicates the total number of pregnancies in Ireland is approximately 95,000 each year. (The Irish Maternity Indicator System 2015)

There are 19 maternity units in Ireland. Three of these are dedicated tertiary maternity hospitals based in Dublin. A further 14 maternity units are located within general hospitals throughout the country. There are two midwifery led units, one of which is co-located alongside an obstetric unit in a general hospital. Almost all maternity care is obstetric led although usually delivered by midwives. There are no independent midwives in Ireland and home birth is provided by self-employed community midwives (SECMs) under contract to the to the Health Service Executive. Many areas of the country have no state provided or private home birth service. A limited homebirth service is also provided by Domino clinics

There are two full time perinatal psychiatrists one in Dublin and one in Cork.

While all maternity care is provided free of charge on the public health system, certain medications for pregnancy related conditions are not universally freely available.

The National Maternity Strategy was launched in 2017 and sets out a ten-year vision for maternity care in Ireland. Funding for this project has been re-allocated to other related areas, which has implications for its development and implementation.

High levels of understaffing, particularly of midwives has a detrimental impact on the quality of care that women receive throughout the maternity services. In comparison with internationally accepted standards there also a lack of consultants throughout the service.

Midwifery received professional recognition in Ireland in 2011. All midwives practising in Ireland must have completed a four year BSc in Midwifery or a Higher diploma in Midwifery post BSc Nursing and are registered by the Nurses and Midwives Board of Ireland (NMBI).

The National Perinatal Epidemiology Centre audits clinical data from the maternity services for review.

## Cases of mistreatment and violence against women during childbirth

### ***Please indicate whether in your country there are cases of mistreatment and violence against women during reproductive health care, particularly facility-based childbirth. If so, please specify what kind of cases and describe your country’s response and any good practices, including protection of human rights;***

**Women's Experiences of Mistreatment and Violence in the Irish Maternity System.**

The incidence of reports of disrespectful and abusive treatment in the Irish maternity system during labour and childbirth has become increasingly persistent in the last few years. The advent of social media has contributed to women sharing and documenting their experiences and led to women feeling less isolated and alone and able to speak out and feel understood and supported. There is very little recorded data in relation to these reports, partly due to the intangible nature of the experiences and partly due to the isolation experienced by women who believed they were alone in their experiences and that no-one would believe them. Having not being listened to and their concerns dismissed, they were discouraged from complaining or articulating their distress. Following the death of a woman and her baby in a maternity unit in January 2019, as recently as April 2019, a woman phoned a national radio station to describe her own experience of mistreatment and neglect and unsafe conditions during her own recent labour and birth. This programme aired on national radio for 75 minutes each day from the 2nd to the 10th of April and for these almost 2 weeks it was exclusively dedicated to women describing their own experiences of unsafe care, disrespect, abuse and mistreatment in the Irish maternity system. Following the initial phone call more than 1000 women contacted the programme of which only a small number could be accommodated to tell their stories on the national airwaves. The experiences and testimonies of these women are now on record but as yet need to be documented and analysed. They cover instances of abuse ranging from verbal abuse, humiliation, shaming, neglect, coercion, lack of consent, to intimidation, aggressive and threatening behaviour, the withholding of pain medication, practice of unsafe, outdated, non-evidence-based procedures, dismissal of their concerns, restraint and emotionally abusive behaviours such as emotional blackmail and ‘gaslighting’. In addition, they reported vindictive remarks and abuse, being treated with lack of dignity and respect, being exposed in public, not being informed of what was happening and not being asked or consulted about decisions which directly affected their labours and births. Most seriously, they were frequently not listened to, - their concerns and experiential knowledge of when something was wrong was ignored and dismissed, often resulting in adverse outcomes for themselves or their babies which they felt could have been avoided. Their input and experience in their own labour and birth experiences was dismissed and ignored and their valuable information about their own and their babies’ health was not listened to, in some cases leading to tragic outcomes. They frequently reported feeing silenced. When they followed up with complaints, it was almost universally the case that crucial aspects of the events which had occurred were not documented. Many women reported being frightened and in shock and describe their labours and birth as extremely traumatic experiences. Many continue to experienced post-traumatic stress disorder which they attribute to the events surrounding labour and birth and the mistreatment they received in childbirth. Women also consider that experiences of fear, isolation and helplessness they felt during labour contributed in no small measure to the high levels of postnatal depression and anxiety they subsequently have experienced. Women have been left with life-changing injuries as a result of not being listened to and further silenced when records are lost and incomplete and events denied.

Silence can act as a tool of oppression. Women felt unable to speak of their experiences for fear of judgement, manipulated out of guilt to feel they have no right to complain when they should be grateful that they have a healthy baby, even though their mental, physical and emotional health may have been so badly damaged that they are barely able to function and yet they continue to put a brave face on it and look after their babies and families. Furthermore, psychological supports for perinatal mental health are almost non-existent and state counselling services very limited and difficult to access in many parts of the country. This may be slowly improving but voluntary and charitable organisations often attempt to fill the gap, which is a far from satisfactory situation.

The innumerable instances of obstetric violence which women describe are systemic and often deeply embedded as part of the institutionalised culture which historically has demonstrated a misogyny which has manifested in many scandals of gender-based cruelty and violence since the foundation of the State. These include, among others, the practice of Symphysiotomy which continued until the early 1990s and for which many victims have still not received redress and the Neary scandal, where hysterectomies were performed on women, many after their first child, for no medically indicated reason and without their knowledge or consent.

The experiences of obstetric violence women have reported go back as far as sixty years. They cover the entire spectrum of disrespect, abuse and violence which goes unacknowledged and for which no individual or institution can be held accountable for. The experiences women describe demonstrate a consistent attitude of disrespect emanating through all areas of maternity care. This disrespect manifests as verbal abuse, cruelty, lack of awareness and an absence of motivation to change on many levels. The lack of understanding of the process of consent and how it should be applied in maternity situations is also very evident.

Women describe the lack of compassionate care and disrespect as being a major contributing factor in these traumatic experiences. Very often, they state that it is not the actual events of the birth which cause them distress and trauma but, rather, how they are treated. What might appear to be a traumatic birth to a professional – one which is complicated or suddenly changes, may not be experienced or perceived as excessively traumatic or difficult for the women if she receives supportive care. Whereas, what might seem to be a relatively straightforward birth may be a cause of severe distress with consequent implications for her physical or mental health if she has experienced disrespectful, neglectful and abusive care.

Health professionals should be aware of the impact their presence and care has, not only on the immediate welfare of the woman and her baby, but also of the far reaching consequences it can have on her well-being and that of her family and in effect on the wider community. In the midst of the most traumatic experience, a woman will often speak of one specific person who showed her even a moment of kindness and care. A maternity system needs to be developed where disrespect will not be tolerated, where there are robust mechanisms for ensuring respect and communication are respectful and compassionate at all times, and where feedback both positive and negative is used to improve the system for all.

A culture that supports everyone involved in maternity care should be developed and nurtured, recognising the more intangible outcomes as well as the measurable outcomes – putting the woman at the centre of her care and supporting the health professionals in providing such care.

While obstetric violence is generally considered to be abuse and violence towards women during labour and childbirth, it also pervades the maternity system in other ways. There are very many caring compassionate and conscientious professionals within the maternity system in Ireland striving to provide woman-centred, safe, evidence-based, respectful maternity care. However, the environment in which they seek to provide this care is often itself the cause of trauma and distress to these caring professionals. They are overworked, working in an understaffed, highly stressful environment. It was recently reported that three midwives were caring for thirty one women and their babies at a major maternity unit (Irish Times 29 March 2019), and similar instances have been reported elsewhere, often with recently qualified midwives feeling overwhelmed. They often in turn experience distress and trauma when they continually witness the treatment that women are subjected to on such a frequent basis and feel powerless to provide the care they entered the profession intending to provide. They feel guilty and overwhelmed and unsupported. Bullying at all levels within the maternity system has been reported. The effects of all this neglect on the maternity system and the lack of funding and resourcing and management issues can be seen in the large numbers of midwives that are leaving due to burnout and stress. Student midwives, in particular, leave either before completing their studies or as soon they have completed their studies, reporting the working conditions and unsafe environment as being a major factor in their decision. In the face of such inhospitable and difficult working conditions, such professionals still mange to provide care with kindness and respect, clearly demonstrating that there is no excuse for disrespectful or abusive care under any circumstances – either towards the women and babies they care for, or towards colleagues.

## Consent

### ***Please specify if full and informed consent is administered for any type of reproductive health care and if these include childbirth care;***

Irish law provides that full and informed consent must be provided for any medical procedure it is proposed to perform on a competent patient. This is provided for both in case law precedent in the civil law of torts[[3]](#endnote-3) and also at statute in the Non-Fatal Offences Against the Person Act 1997.[[4]](#endnote-4) Ireland has also ratified the European Convention on Human Rights and Fundamental Freedoms and adopted its provisions into domestic law in the ECHR Act 2003, thereby also adopting the European Court of Human Rights jurisprudence on the rights to dignity and privacy and their consequential applications to the right to give and to withhold consent to a medical procedure.

All of the professional bodies of the medical professions in Ireland provide in their codes of professional conduct that consent must be sought and received for medical procedures.[[5]](#endnote-5) The HSE’s National Consent Policy 2017[[6]](#endnote-6) reiterates this position. In relation to reproductive healthcare specifically, the National Consent Policy in § 7.7.1 ‘Refusal of treatment in pregnancy’ still retains on paper a provision that significantly limits the scope of pregnant people to refuse consent to treatment that may impact on the unborn child. The provision in question [[7]](#endnote-7) curtailed a pregnant woman’s ability to refuse a proposed medical treatment if a health care practitioner believed that not accepting the treatment would pose a risk to the life of her unborn foetus, and provided that the appropriate forum for mediating any disputes that might arise between a woman and her health care providers in this context would be the High Court. This provision was necessary in the National Consent Policy because of the constitutional protection of the right to life of the unborn child provided for in Article 40.3.3 of the Constitution of Ireland 1937. In the wake of the referendum decision in May 2018 to repeal Article 40.3.3, § 7.7.1 of the National Consent Policy is no longer necessary and is considered defunct. However, certain pieces of legislation remain on the statute books that were drafted prior to repeal and necessarily made similar provision for the curtailment of the maternal right to give or to refuse consent to medical treatment during pregnancy. The Assisted Decision Making (Capacity) Act 2015 is one such example. This legislation, which has been enacted but not fully commenced, deals with the introduction of advance healthcare directives to Irish law. In its treatment of the right to make advance care directives regarding medical treatment in the event of a possible future loss of capacity, the 2015 Act in section 85 (6) provides that any treatment specified in an advance healthcare directive can only be administered to an incapacitated pregnant person if it does not negatively affect the right to life of the unborn, and that an application must be made to the High Court in the event of any uncertainty. It will be necessary for the Irish government now to reconsider the provisions of section 85 (6) in the light of repeal of Art. 40.3.3, as to commence this provision unamended now would breach the legislature’s obligation not to knowingly enact unconstitutional legislation.

**Women's Experiences of Consent**

Women frequently report procedures which have been carried out without their consent. Some examples are described below.

The practice of Membrane Sweeps (also known as Stretch and Sweep) Is often performed without women's knowledge or consent, often under the guise of vaginal exams. There Is no evidence that this procedure is effective In Inducing labour. A membrane sweep Is frequently presented to women as an alternative to other forms of Induction which may be avoided If they accept it, leaving them feeling they are in a position where they must accept it to avoid the alternative. This does not satisfy the criteria for informed consent

Artificial rupture of membranes (ARM/AROM) is routinely performed as standard procedure during Active Management of Labour (AML), usually without explanation or consent being sought and presented as an Inevitable part of inducing or moving on labour (see Hamilton v HSE).

Use of Admission CTG: This Is routinely insisted on at admission and women are intimidated Into accepting it as refusal can often lead to further pressure or fear of further consequences or lack of support as labour progresses. The Institute of Obstetricans and Gynaecologists recommendations for admission CTG state 'The current evidence base dos not support the use of the admission CTG In low risk pregnancies and Is, therefore, not recommended as a routine.'(Institute of Obstetricians and Gynaecologists, Intrapartum Fetal Heart Rate Monitoring, June 2012:9). These guidelines are frequently not adhered to.

For continuous CTG monitoring in labour, the Institute of Obstetricians and Gynaecologists recommendations for low-risk women are: 'For a woman who Is healthy and has an uncomplicated pregnancy (low risk), Intermittent ausculation should be offered and recommended In labour using either a Doppler ultrasound or a Pinard Stethoscope.' (Institute of Obstetricians and Gynaecologists, Intrapartum Fetal Heart Rate Monitoring, June 2012:9).

There are many other examples during labour and childbirth care in the Irish Maternity system where consent Is not considered or sought for procedures. An example of this Is the routine use of syntocinon to induce or augment a labour which Is not progressing according to the standardised timeframe used In the Active Management of Labour model - which originated In Ireland and is used throughout the maternity units.

Women have a natural expectation that the healthcare professionals that attend them in labour and childbirth are fully cognisant of the most up-to-date guidelines and best international practice standards and will therefore generally comply with what is suggested. Women want the best for themselves and their families at such an important time. That this Is always uppermost for women during pregnancy and birth is illustrated by the fact that antenatal care never needs to be incentivised. Globally, women will endure hardship, discomfort, lengthy queues and other obstacles to avail of antenatal care. They have a right to expect that comprehensive and accurate information is given to them by their health professional in order to make the informed decisions that are right for themselves and their family. Withholding this information is denying women this right to fully informed decision making.

The factors that are necessary for fully Informed consent are frequently not present in the interactions and attitudes of many within the system when caring for women. These include ensuring that full Information is provided, in a way that is clear and understandable for the pregnant person; that both the benefits and the risks of a procedure are clearly explained; that the option for declining or refusing is given without intimidation, and that the power dynamic is recognized and accounted for. Additional training should be provided to healthcare professionals on a regular basis in order to ensure that best practice with regard to facilitating informed consent at every stage of labour and childbirth for the pregnant person and to effect change within the culture at the institutional as well as at the individual level.

## Accountability mechanism

## *Please specify whether there are accountability mechanisms in place within the health facilities to ensure redress for victims of mistreatment and violence, including filing complaints, financial compensation, acknowledgement of wrongdoing and guarantees of non-repetition. Please indicate whether the ombudsperson is mandated to address such human rights violations;*

## The accountability systems within the health facilities and the National Health Service Executive are experienced as being inadequate in addressing the complaints of those who experience mistreatment in any form.

## Under the Data Protection Act (2018) and The Freedom of Information Amendment Act (2003), medical records must be provided to service users of a public body. Under Section 9 of the Data Protection Act, there is also a facility to have these notes amended where the service user disputes them and this must be recorded, even in the event of the provider disputing the fact. In reality, there are often delays in providing the notes, notes are often incomplete and/or inaccurate and it can be a lengthy and obstructive process to acquire them. In cases which go to court, it often takes many months and high costs in legal fees to secure them through the courts.

## Many hospitals have a complaints procedure, which generally consists of a written complaint which must be responded to within a specified timeframe. This can be followed up with a meeting if the service user wishes. However, there is no mechanism in place to ensure guarantees of non-repetition. Frequently, service users report that the meeting appears to have been held in an attempt to prevent the complainant taking further legal action. More recently, as a result of awareness and advocacy, these meetings appear to be a more genuine attempt to recognise the woman’s distress and concerns, although fall far short of acknowledge the failings in care or ensuring change in practices. There is currently no mechanism in place to monitor or implement changes.

## People may also complain to the Health Service Executive, although once again, there are no mechanisms for further action to be taken in implementing changes.

## The only facility for redress or financial compensation is through the judicial system. As this is a lengthy and costly process, people generally only take this option when financial support is necessary to support and care for a child gravely injured at birth due to failings in care.

## It is proposed that a Mandatory Open Disclosure Policy for the Health Service will be in place by legislation by the end of 2019, although this is not certain. However, it will provide for a statutory duty of candour on individual healthcare professionals and organisations. It does not directly address implementation of changes.

## At present, when all other avenues of complaint have been followed, complaints can be made to the Ombudsman’s Office where they will be investigated. Women are advised of this option but it seems to be seldom utilised.

### In the case of professional fitness to practice, complaints may be made to the professional bodies. In the case of doctors, this is the Irish Medical Board, who will address the complaint and apply sanctions. The Nursing and Midwifery Board of Ireland address complaints and professional standards regarding midwives and nurses.

### Excepting in the case where a complaint goes to court, when women make a complaint about the standards of care they receive, they are generally attempting to achieve two objectives – 1. An acknowledgement, recognition, and where possible an apology for the mistreatment and lack of care; and 2. An assurance that changes will be put in place to ensure that it is not repeated and that other women and families do not have to go through a similar experience.

## National policies v WHO guidelines and standards

### *Does your health systems have policies that guide health responses to VAW and are these in line with WHO guidelines and standards on this issue, see:*[*1*](https://apps.who.int/iris/bitstream/handle/10665/259489/9789241513005-eng.pdf;jsessionid=87D2C09FA4E78A6C623ADA9989B2E34E?sequence=1)*|*[*2*](https://www.who.int/reproductivehealth/publications/violence/9789241548595/en/)

Active Management of Labour is still practised widely in Ireland, where it originated. Policies to change this in line with the latest WHO guidelines are not in evidence.

Continuity of carer, in line with the WHO guidelines is not available to women in maternity units throughout Ireland and due to the structure of the maternity system and the current staff shortages is unlikely to be implemented in the near future.

There are very many issues which need to be addressed to bring the policies of the Irish Maternity system in line with the WHO guidelines and standards.

Aspects such as clear communication by maternity staff, mobility in labour and position of choice, respect and dignity and the avoidance of unnecessary medical intervention if mother and baby are in good condition, along with the forced hastening of labour are issues which need to be addressed.

Other issues such as respectful communication and provision of evidence-based care are also of great importance.

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1. https://www.thejournal.ie/childbirth-joe-duffy-4585612-Apr2019/ [↑](#endnote-ref-1)
2. https://www.hse.ie/eng/services/list/3/maternity/combinedcare.html [↑](#endnote-ref-2)
3. *In Re a Ward of Court* (withholding medical treatment) (No. 2) [1996] 2 IR 79 [↑](#endnote-ref-3)
4. http://www.irishstatutebook.ie/eli/1997/act/26/enacted/en/html [↑](#endnote-ref-4)
5. In the context of reproductive healthcare, see the *Guide to Professional Conduct and Ethics for Registered Medical Practitioners*(Medical Council, 2018) available at https://medicalcouncil.ie/News-and-Publications/Reports/Guide-to-Professional-Conduct-and-Ethics-8th-Edition-2016-.pdf; *Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives* (An Bord Altranais, December 2014) available at https://www.nmbi.ie/NMBI/media/NMBI/Code-of-professional-Conduct-and-EthicsAd\_2.pdf?ext=.pdf [↑](#endnote-ref-5)
6. https://www.hse.ie/eng/about/who/qid/other-quality-improvement-programmes/consent/national-consent-policy-august-2017.pdf [↑](#endnote-ref-6)
7. The full text of § 7.7.1 reads as follows: “The consent of a pregnant woman is required for all health and social care interventions. However, because of the constitutional provisions on the right to life of the “unborn”, there is significant legal uncertainty regarding the extent of a pregnant woman's right to refuse treatment in circumstances in which the refusal would put the life of a viable foetus at serious risk. In such circumstances, legal advice should be sought as to whether an application to the High Court is necessary.” [↑](#endnote-ref-7)