Taxonomy of Human Dignity in Institutional Childbirth

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ABSTRACT

In the endeavour to ensuring quality health care services, various issues arise that are linked to human dignity and human rights. Human dignity in health care is recognized as the most important non-clinical and intangible dimension. In a qualitative research that is based on grounded theory, we have explored the dignity violations in institutional childbirths in Kerala, India. Key informants interviews, interviews with birthing women and participant observation of six months in labour rooms/wards are the data collection methods employed. It is found out that dignity violation is rampant in these institutions and a general theory of dignity is developed based on the findings. Recognise as a human being, regard as an individual rather than as a tool/machine, freedom from exploitation by medical care providers were common concerns of all the participants. Further, the class differences in their experiences are captured where lower class women raised concerns about discrimination, humiliating language/tone, shouting, usage of numbers/caste names, physical violence and objectification of body. The upper class women focused more on information sharing, autonomy, use of unwanted and avoidable medical technology and financial exploitation by the health care providers. This research work also contextualises the above-mentioned issues where the conditions that promote dignity violation are present in the asymmetrical relationship between care providers and the patients. Health care providers used very reductionist approach to define human dignity of their patient. The over and inappropriate medicalisation of childbirth, lower budget allocations in the government sector, high profit orientations of the private hospitals etc., make the situation further more complex. These findings will help in developing policies to ensure more women oriented dignified birthing experiences.

Key Words: Human dignity, Grounded theory, Institutional childbirth, Class, Health care


Introduction

Human dignity in health care is recognized as the most important non-clinical and subtle element. Lack of respect for human dignity obstructs effective reach of public health programs. Research has demonstrated that people who believe that they were treated with dignity were more likely to complete the treatment and had a positive attitude towards seeking preventive health care in future.¹ Human dignity-based perspective in public health is necessary not only to bring out who is at disadvantage but also to check whether disparity in health is due to any injustice. Dignity is a highly complex phenomenon, and as far as health care documents and policies are concerned, the term is often used without proper understanding and without explicitly stating its meaning. Dignity is central to the new group of bioethics that emerged in health care; Universal declaration of human rights has placed human rights and human dignity in proper perspective.² The Universal Declaration of Human Rights gives the actual credibility and context to dignity and human rights related issues.³ In the developing countries like India where gender inequality and health care infrastructure related problems are realities, the case of dignity and human rights is rampant during institutional childbirth. The aim of this paper is to develop a general nomenclature about human dignity and dignity violation specific to institutional childbirth setting and understand the context and dynamics within which it operates.

The paper has its genesis in the works of pioneer of human right activist Janathan Mann (1998) who made a call to social scientists to use the concept of human dignity as an explanatory mechanism for many issues related to public health.⁴,⁵ Carrying forward a call by Mann in 1998 to social scientists to conduct further research to identify, understand and measure dignity and its connection with well-being, Chilton tried to develop a quantitative instrument to measure dignity violations.⁶ She operationalised dignity as a dynamic sense of worth that is socially and politically mediated but failed to develop any instrument to define/measure dignity. Taking theoretical inputs from Mann and Chilton I decided to approach and explore...
human dignity from a qualitative paradigm. The paper follows Mann’s call that aimed at developing a taxonomy of dignity: “a coherent vocabulary and framework to characterize dignity” and its violation.5

Methods

Grounded theory approach13,14 is used to develop an understanding about the meaning, language, forms and context of human dignity. Qualitative methods like semi-structured interviews, participant observation is used to collect data and constant comparison is done to identify major themes and aspects. Concepts are identified and categories are formed. Grounded theory approach also focuses on variations, complexity and links it to the contextual conditions. Grounded theory “fosters [the integration of] subjective experience with social conditions,” it is a valuable tool for social justice research.3

This paper has used four methods for data collection. It began with an exploratory and analytical review of the concept of human dignity, which evidently was interdisciplinary in nature. The participants of this study were women who visited public and private hospitals in Kerala for childbirth. Key informants interview also helped to contextualise dignity related issues in the Indian context. Academicians and political scientists who worked extensively on this area, three human right activists, three health activist who specialised in women’s health issues were contacted via email and telephone as these people were known as human dignity and rights champions in the respective society.

The next step involved interview of 200 pregnant women who attended one public and one private hospital in Kerala, India for their prenatal check-ups. They were interviewed to develop an understanding about health issues, pregnancy related issues and quality of care they received in the hospital. The third and important step of data collection consisted of selecting 40 pregnant women who were willing to have in-depth interviews on the issue of dignity, birth experiences and was willing to accommodate the researcher in the labour room to observe the childbirth. The third stage study with 40 women had three means of data collection viz interview at the eighth month of pregnancy, observation of childbirth in the labour room and another interview after three weeks of childbirth. Participant observation in the labour room was used as a method of data collection to gain first hand experience about dignity violation in the labour room.

Each interaction lasted for about 45-60 minutes where focus was on addressing some issues and questions such as - do women have a dignified interaction with the healthcare system when they give birth in a hospital?; what does dignity mean?; what happens to women if their dignity is not respected during the birthing process? Almost in all the cases, it was observed that women from different classes conceptualise human dignity differently. Women were eager to talk about human dignity because in most of the cases their dignity was under threat at some point during the interaction with the health care system. Getting access to the labour room of any hospital was not an easy task so personal contacts had to be used to get access to hospitals for three months and therefore purposive sampling was used to select the participants. Similarly, the respondents’ willingness to continue with the study for three months was crucial, which was possible only with this method of sampling. All the interviews were recorded with the written consent of the participant and confidentiality of all stakeholders was maintained. Necessary institutional ethical clearances and permissions were obtained. These include ethical clearance from Ethics Committee of the University (where the study was supervised and submitted) and Ethics Committee of both the hospitals gave permissions after necessary clarifications and modifications in the methodology and the process of data collection.

Findings

Dignity Violation/Promotion in Institutional Childbirth

Individuals are engaged in continuous, cyclical interactions; they are recording, understanding and interpreting each other’s physical and inter-personal markers. When the two people involved in an interaction are of not same hierarchy then the chances of dignity encounters and dignity violation are more. In health care system, position of vulnerability of the health care seeker (here pregnant women) and position of knowledge and power of the health care providers define and decide the level and intensity of dignity violation. The relationship is of hierarchy and asymmetric in nature. In Indian context, apart from knowledge, power and authority the structural/social variables like caste, religion and class also play important role where the health care seekers (pregnant/birthing women) face dignity encounter.

Dignity protection and promotion takes place when the health care providers are in a position of consideration ie. kind, open minded and maintain ethics of the profession. Health care seekers should be in a position of assurance ie. information rich, confident and calm. The next aspect that affect dignity violation/promotion is the setting in which the interactions take place. Further this level of setting (here health care setting) is part of larger social system which has certain characteristics and features that are very particular. All these features, traits and power dynamics between actors affect human dignity in any interaction.

Articulating dignity- perceptions and experiences of health care seekers

Women possess an inherent dignity and if this inherent dignity is not protected it is injustice.6 Analyses of participants’ narratives show that the following were the pointers with which women explained dignity encounters/violations. All the women irrespective of their social
background mentioned four variables as most important as follows.

- **Recognise as a human being** with own rationality and thinking capacity—A generalized sense of disrespect and a gratuitous nastiness was widely observed in the labour rooms which demean the human worthiness of women.

- **Regard as an individual rather than a tool/machine** ideally, dignity is absolute and no social forces should be able to take it away. Women appreciated the healthcare system when the doctors showed a genuine concern rather than using them as tools to meet targets assigned to them by the management or insurance companies.

- **Ensuring an equal consideration/priority** only the medical condition of the woman should be the basis on which priority is accorded to her. In actual healthcare setting factors like ability to pay bribes, caste and religion decided who get access to the resources available in the public healthcare facilities.

- **Freedom from exploitation** The humiliating experiences and injustice faced are considered as exploitation which is clearly violating human dignity. The feeling that doctors used them as objects for training was also regarded as exploitation.

The women belonging to the lower class who accessed public healthcare facilities used the following constructs to explain dignity violation.

- **Absence of discrimination in the hospital** when the respondents experienced some kind of discrimination in the services they received, they challenged it using the concept of equality. Discrimination was in bed allotment, access to doctor, availability of drugs/free food.

- **Language of indignity and humiliation** Shouting and brutal speech, usage of number, name of the caste and body shape to identify the woman, contempt, rudeness and indifference shown and reflected in the behavior and interaction were regarded as highly demeaning ways.

- **Physical Violence and assault as a threat to dignity** Using physical force to damage or demean an actor’s body and the spirit. Women reported cases of physical violence, wherein they were pinched and beaten, hit on their cheeks and face, and they were pinched in between their legs. Sometimes, a small needle was used to strike their feet.

- **Objectification of body and violating bodily integrity** the consideration of a woman as without a self, treating a birthing woman as though she is disgusting or tainted. The intrusion and transgressing a person’s bodily boundaries was not appreciated.

- **Rest during pregnancy and after childbirth, maternity benefits and job security** post childbirth also considered as part of human dignity.

- **Contempt and Disregard** treating the person as a thing rather than individual and accord no value and approach the person, as she has no existence/make the person voiceless and low confident.

- **Objectification and Intrusion** treating an individual as a thing, not as a human being. Violating the bodily integrity and personal boundaries at the level commonly expected in the society.

The women belonging to the upper class who accessed private healthcare facilities used the following constructs to explain dignity violation.

- **Appreciating the fact that a birthing woman is unique and complete individual** the feeling of being abandoned, indifferent attitude of medical staff, not allowing to speak and clear doubts, labelling and groups etc., was unacceptable.

- **Information Sharing and Being Part of Decision-making** by “information sharing”, the respondent meant sharing information after each check-up, allowing the woman to ask questions and clarify her doubts. When women are informed they feel more confident to face the birthing process. By restricting the information that reaches the patient, it is not only the disease that takes over the body but also the unknown medical system.\(^{10}\)

- **Autonomy and Dignity** talking down to “someone or speaking to an adult “like a child was unacceptable to most of the women. Ignoring or discounting birthing woman’s knowledge, skills, perceptions, concerns, needs, and feelings finally resulted in she being passive in the birthing process.

- **Use of unwanted/avoidable medical technology as an attack on dignity** considering women as weak and promoting painless labour/caesarean sections. The excessive and unnecessary use of medical technology on their bodies created many physical problems for the women in the postnatal period. This included severe backache, nausea and infection in the vagina.

- **Privacy, Confidentiality** women considered maintaining privacy and confidentiality as utmost important to ensure dignity in the interaction process.

- **Abjection and culture specific insensitivity:** Forcing a birthing woman to humble herself by compromising closely held beliefs or by forced association with material or practices considered unclean.

**Dignity of Women and Childbirth Experiences: From the Perspective of Healthcare Providers**

**Articulating dignity - perceptions and experiences of health care providers**

The interviews revealed that healthcare professionals use a very reductionist approach to define the dignity of birthing women. According to them, all women are entitled to informed consent and a safe childbirth. Healthcare
providers agreed that all women have dignity, but asserted that they have graded dignity. All women are entitled to be considered a “patient” and fellow human being. This was the level of dignity to which every woman is entitled. According to them, this can be ensured by a) Considering the “patient” as a human being and listening; b) Nurses dedicating some personal time; c) Obtaining informed consent; d) Preventing other medical staff from violating the patient’s dignity.

Medical staff reported that it was not possible to maintain this level of dignity for all women because of sheer numbers, workload and infrastructural limitations. The private hospital staff reported that they themselves are “objects”, so how could they protect the dignity of others? They themselves are objects of inhuman indignified treatments because of targets they were given – for caesarean sections, painless childbirth, number of clinical tests to be prescribed and so on.

Healthcare providers mentioned a “second level” of dignity. This meant that not all women had “this level of dignity”. There was a developed set of images that contrasted one group of women with another and with men. These “labels”/“images” served to justify the differential/inequitable treatment/services rendered. The following are the terms and images that were used by healthcare professionals to “grade” women. Women were accorded treatment and care depending upon their position in this hierarchy.

- Intelligence – intelligent, less intelligent and fool;
- Birth order – first child, second child, more than two children;
- Self – selfless, selfish;
- Family – from a good family or not (“good” defined in terms of education, dress and caste);
- Sexuality - hyperactive, optimal, less active;
- Education – degree, school education;
- Obedience – unconditionally obedient, questioning some aspects, disobedient;
- Patience – patient, sometimes impatient, impatient;
- Birth control – ready to sterilise (“good woman”), not ready to sterilise (“bad woman”);
- Responsibility – responsible for pregnancy and pays attention to medical instructions, in some ways responsible, irresponsible.

This system helped the healthcare providers to stigmatise and enforce medical wisdom with different levels of coercion and persuasion strategies are used.

**The Context of Dignity Violation in Health Care**

The next step is to analyse the context of dignity violations by linking it to the actors involved and by understanding the interests of different stakeholders in the health care system. The stakeholders include health care seekers, health care providers, health care industry and policy makers. The dignity violation has to be explored and contextualised at micro and macro level so that a general theory on dignity violation can be developed.

The violation of dignity happens in the following context: relationship between health care seeker and provider is unequal. Further, the health care seeker is in a position of vulnerability because of the physical condition and lack of authentic knowledge. The relationship is asymmetrical and hierarchical in nature where the health care seeker is facing a tough time in harsh medical condition.

Public hospital healthcare providers blamed infrastructural limitations, while healthcare providers in the private hospital claimed that medical wisdom was superior and objective whereas women’s decisions as subjective emotions. The relationship between birthing women and health care providers is of asymmetrical and hierarchical as far as knowledge and power is concerned. In the same way, the health care industry mainly consisting of Pharmaceuticals/insurance/medical equipments have their own business interests and preferences which makes dignity violation a more complex issue. In public hospitals, lack of space, infrastructure and other medical facilities coupled with shortage of staff and low remuneration ensure that health care providers work under pressure, stress and anxiety, which intensify dignity violations and humiliations. In the private hospital, the staff are given targets to meet coupled with job insecurity and low remuneration which make the health care providers themselves vulnerable and they are unable to protect the dignity of their patients. Diagram No 2 represents the linkages between over medicalisation, commercialisation and dignity violation in brief.

As per the analysis of interviews of policy makers, the dignity violation in health care setting is rampant and it is due to three reasons viz. disparity between needs-resources, disparity between autonomy-authority. Another component of dignity violation is structural in nature. As explained earlier in this paper, inequality ensures dignity violation/humiliation and abuse and health care systems are also part of social system.

**Discussion and Conclusion**

The taxonomy of human dignity in this paper explained the elements of dignity, actors involved in dignity violation/promotion, the conditions and the social context in which these interactions takes place. Further it codifies how different stakeholders viz. Health care providers and health care seekers articulate about human dignity. The context of dignity violations in health care and its consequences for health care seekers is also elaborated and discussed.

Given this data, it is possible to develop a general framework on dignity in relation to health care system in general and institutional childbirth in particular.
First, Health, dignity and well-being are interconnected. Human dignity is linked to infrastructure and if infrastructure is inadequate to cater the demands of the patients’ then dignity is at stake. At present, there is no alternative to the system, which forces the patients to completely submit to a regime of medical care; it considers health care seekers as machines and humiliates them to the extent where human dignity is at stake. Second, the social determinants such as class and caste are also important because the above findings show that women from different classes and castes highlight entirely different tangible pointers to explain their experiences relevant to dignity violation.

Third, although compared to experience of dignity violations by health care seekers it maybe less painful, dignity of health care professionals who hold considerable power and authority are also confronted at various levels/stages depending upon hierarchy. The hierarchical nature of health care workplaces means that those at the bottom often are discriminated against or treated with disregard by those at the top. For example, health care seekers explain that when they are undergoing unwanted/avoidable medical procedure it is violation of their dignity. The staff nurse, who conducts the procedure, explains that she has to meet the target assigned to her, or else her job will be threatened then her dignity is also at stake. The rhetoric use of the term human dignity in health care is a dangerous pattern and need to be curtailed. In the neo-liberal era, people are viewed as a means to increase the profit and health care is considered purely as an investment to ensure better returns.

Fourth, dignity as a concept should be considered at a pragmatic level apart from discussing its philosophical moorings. From a pragmatic angle, it is important to realize that when institutional child birth is encouraged from a programmatic angle and for the wellbeing of the mother and child, such grave and dangerous violations are not visualized or addressed. The experiences of women reported in this paper do point to the need for a much more humane approach to the birthing process in the institutional setting apart from realizing the new dimensions of dignity in the health care setting.

The limitations of this taxonomy are also important to be mentioned here. While, the paper focused on taxonomy and developing categories the context of dignity violation is lost and so are interplay and interactions. Second, this taxonomy may or may not be exhaustive and universal, as it is already explained earlier in this paper that dignity also has a culture specific dimension. In this regard, it becomes important to study human dignity across cultures and across other social interaction settings.

The taxonomy presented in this paper has several implications in the field of health care and human rights. It thoroughly proves that the stakeholders who are in weaker position of power hierarchy (here birthing women) expects dignified interaction with the health care system; the dignity violation brings in lot of physical and mental health related trauma and problems. Apart from health impact due to dignity violation, attention can also be drawn to the health policy and health care on human dignity and human rights. The dignity theory and the taxonomy explained in this paper will serve as guideline to the stakeholders of health system and human rights activists who are engaged in health and human right protection.

Conflict of Interest: None declared

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