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Ethical guidelines and the prevention of abuse in healthcare

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ABSTRACT

Objective: In obstetrical and gynaecological healthcare, patients often find themselves in a vulnerable position. Sensitive issues such as sexual and reproductive health are addressed and certain procedures can be experienced as abusive. According to research a lifetime prevalence of abuse in healthcare (AHC) can be assumed for 13–28% of female patients in the Nordic countries. In the present study we analyse the content of ethical documents for healthcare professionals within obstetrics and gynaecology in Sweden, in order to find out to what extent ethical guidelines consider issues that have shown to be related to the occurrence of AHC.

Study design: We searched the literature to find empirical data on AHC. Guidelines for nurses, midwives and physicians were selected. After developing an analytical framework based on the empirical data the content of the ethical guidelines was analysed.

Results: The various ethical guidelines for staff working within obstetrics and gynaecology differ distinctively from each other regarding their content of issues that are related to AHC. Issues that were mostly disregarded were: considering the patient's perspective and the patients' possible experience of violence, considering power imbalances within healthcare, sexual misconduct, how to deal with other professional's ethical misconduct and how professionals relate to each other. We found the ethical guidelines of the International Federation of Gynecology and Obstetrics (FIGO) and of the International Confederation of Midwives to be those which contained most of the issues that have empirically shown to be important in regard to AHC.

Conclusion: While staff members from different professions may share responsibility for the same patient, their ethical guidelines vary considerably. To become a possible resource for prevention of AHC, we suggest that ethical guidelines in healthcare should be revised following empirical research on ethical conduct. As ethical guidelines cannot be effective by their existence only, we would like to initiate a discussion on the function and use of ethical guidelines in general and regarding AHC in particular. Being aware that ethical guidelines are only a part of ethics in healthcare, however, we envision a broader approach to the aim of preventing AHC, where research is encouraged on how a virtue ethics approach could be applied.

1. Introduction

1.1. Abuse in healthcare

In previous research, abuse in healthcare (henceforth "AHC") has been seen in terms of the patient's subjective experience of a lack of care, implying suffering and the feeling of losing one's value as a human being [1]. There has been broad discussion especially of the abuse of vulnerable patients, e.g. demented or mentally handicapped persons [2] and children with disabilities [3,4], and of abuse assuming the form of sexual involvement between physicians or psychotherapists and patients [5–7]. But such abuse has also been reported from the obstetrical/gynaecological (ob/gyn) sphere [8–10]. A Nordic research network studied different kinds of abuse among gynaecology patients in five Nordic countries using the NorVold Abuse Questionnaire (NorAQ), where AHC was operationalised as in Fig. 1 [11,12]. The results show a lifetime prevalence of AHC ranging from 13% to 28%. Between 8% and 20% of patients reported continued suffering from AHC [12]. Within ob/gyn healthcare, the risk of a patient's feeling abused may seem even more apparent than in other healthcare settings. The patients are in a vulnerable position in that contact with healthcare staff usually involves sensitive issues such as sexual health and reproduction. Discomfort, exposure, certain procedures and certain expressions can be experienced as abusive. Here at least three professional groups share the responsibility for treatment and care of the patients: physicians, nurses and

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Mild abuse	Have you ever felt offended or grossly degraded while visiting health services, felt that someone exercised blackmail against you or did not show respect for your opinion – in such a way that you were later disturbed by or suffered from the experience
Moderate abuse	Have you ever experienced that a 'normal' event, while visiting health services suddenly became a really terrible and insulting experience, without you fully knowing how this could happen?
Severe abuse	Have you experienced anybody in health service purposely - as you understood - hurting you physically or mentally, grossly violating you or using your body andyour subordinated position to your disadvantage for his/her own purpose?

Answer alternatives (the same for all questions)
1 = No
2 = Yes, as a child (<18 years)
3 = Yes, as an adult (ε18 years)
4 = Yes, as a child and as an adult

Note:
Abuse in the healthcare system was defined as having answered yes to one or several of the three questions

Fig. 1. Operationalisation of abuse in healthcare in the NorVold Abuse Questionnaire (12).

midwives. All three are obliged to work in accordance with their respective ethical guidelines. Can ethical guidelines pertaining to ob/gyn staff serve as a resource for working towards the prevention of AHC?

1.2. Ethics and ethical guidelines

Within healthcare, a multitude of ethical guidelines have emerged. For most professionals such guidelines exist on different levels, regional, national and international, but the usefulness of ethical guidelines has been discussed [13,14]. A study concerning physicians from culturally distinct countries showed that there was an overall sense that ethical codes were ineffective, but above all there was a lack of awareness of the content of the relevant ethical documents [14]. In the context of medical education and nursing other approaches such as virtue ethics are being widely discussed [15–18]. Nevertheless, ethical guidelines retain their prominence, and it is against the background of this prominence that our study will focus on their propositions in relation to what is known about AHC.

2. Aim

The aim of the study was to answer the following question: to what extent do the ethical guidelines for healthcare professionals within ob/gyn in Sweden take into account factors that have been shown to contribute to the occurrence of AHC and related suffering?

Table 1
Search terms.

Database	Search term	Additional limits	Number of results
PsychInfo	Health personnel + abuse of power		13
	Health personnel + patient abuse		30
	Health personnel + physical abuse	adulthood	77
	Health personnel + sexual abuse	Adulthood, non-disordered population	77
	Health personnel + emotional abuse	adulthood	21
	Health personnel + verbal abuse		23
	Health personnel + interpersonal control of power/or experienced abuse of power		7
	Abuse in health care[a]		9
PubMed	Professional misconduct + professional–patient-relation + violence		9
	Professional misconduct + professional–patient-relation + sex offences		12
	Professional misconduct + power		11
	Professional misconduct + sex offences		24
	Abuse in health care[a]	Not substance, drug, alcohol, fraud, children	101
CINAHL	Abuse in health care[a]		8
	Professional–patient relation + patient abuse		50
	Professional–patient relation + sexual abuse	All adult Not child Research article	9
	Professional–patient relation + verbal abuse	Research article	12
	Professional–patient relation + physical abuse	Research article	12
	Professional–patient relation + emotional abuse		4
	Professional misconduct + violence	Research article	20
	Professional misconduct + patient abuse	Research article	12

Note: MeSH/CINAHL headings were chosen primarily.
[a] Abuse in health care was used for free text search.

Table 2
Topics of excluded articles.

Abuse of/violence against special groups of people in need of care	Abuse of patients in psychotherapy settings Abuse of patients in psychiatry Abuse of children Abuse in nursing homes/other residential settings Abuse of disabled persons Stigmatization of certain patient groups Patient's being murdered by staff/euthanasia
Staff being affected	Abuse of staff/trainees by staff Abuse of staff by patients Staffs' knowledge about, experiences with and response to professionally working with consequences of abuse
Abuse/violence in special contexts	Human rights violation during totalitarian regimes
Abuse outside health care	Domestic violence Abuse of prisoners
Other issues related to abuse	Medical (somatic) care related to abuse Characteristics of sex offenders Legal aspects of abuse
Other forms of documents	Commentaries, editorials, reviews, case reports

3. Methods

The analysis of ethical guidelines in relation to AHC was conducted in four steps.

3.1. Step 1: Literature search

In order to identify factors of significance for the occurrence of AHC we searched for qualitative and quantitative studies as well as reviews published between January 1996 and March 2011, using the databases PubMed, CINAHL and PsychInfo. We used the search terms as in Table 1. Included were all articles which were related to the abuse of adult patients in somatic healthcare settings and were based on empirical data, included abstracts and were written in English. One eligible article [19] was found in a reference list. Excluded were articles focusing on topics as given in Table 2. Reviews were checked for possible information about studies we might have missed.

3.2. Step 2: Selection of ethical guidelines

We included Swedish and international ethical documents for nurses, midwives and physicians in general and with reference to ob/gyn in particular. Ethical guidelines were obtained from the Swedish National Council on Medical Ethics (SMER) [20] and the websites of the International Council of Nurses (ICN), the International Confederation of Midwives (ICM), the Swedish Medical Association (SMA) and the World Medical Association (WMA) [21–24]. The Swedish Society of Obstetrics and Gynecology (SFOG) refers to the ethical guidelines published by the International Federation of Gynecology and Obstetrics (FIGO) [25]. Of these we chose "General issues in women's health and advocacy" because it covers general aspects of ther relations and responsibilities in healthcare (Table 3).

3.3. Step 3: Generation of analytical framework

First, for each included article, the first two authors, a physician (AZ) and a sociologist (AJB), concertedly singled out issues that characterise aspects of AHC and related suffering. This involved scrutinising the studies in search of information concerning how, when and why AHC happens, how it affects the patient and how it could be prevented. Second, each of the results was transformed into a question directed to the ethical guidelines (Table 4). The total of 14 issues that were transformed into questions constituted the framework for the analysis.

3.4. Step 4: Analysis of ethical guidelines

The contents of the ethical codes included (Table 3) were examined on the basis of our questions (Table 4), line by line. If the particular issue was addressed in one of the guidelines, the corresponding statement was noted. Each of two authors (AZ and AJB) performed an analysis independently. The cases with only partial agreement or disagreement were then discussed by them until consensus was reached.

Table 3
Selection of ethical guidelines.

Profession	Ethical guideline	Year of latest revision	Organisation/author
Physician	International Code of Medical Ethics	2006	World Medical Association (WMA)
	Swedish Medical Association's Ethical Rules (Swedish:"Läkarförbundets Etiska Regler")	2009	Swedish Medical Association (SMA) (Swedish: "Läkarförbundet")
Gynecologist/obstetrician	*Ethical Issues in Obstetrics and Gynecology:* The role of the obstetrician/gynecologist as advocate for women's health	1999	The International Federation of Gynecology and Obstetrics (FIGO) Committee for Ethical Aspects of Human Reproduction and Women's Health
	Violence against women	2007	
	Ethical framework for gynecologic and obstetric care	2007	
	Ethical guidelines in regard to terminally ill women	1999	
	Guidelines regarding informed consent	2007	
	The ethical aspects of sexual and reproductive rights	1997	
	Some ethical issues in the doctor/patient relationship	1997	
	Confidentiality, privacy and security of patient's health care information	2005	
	Professional obligations to fellow obstetrician/gynecologist	2006	
	Ethical guidelines on conscientious objection	2005	
Nurse	The International Code of Ethics for Nurses	2006	International Council of Nurses (ICN)
Midwife	The International Code of Ethics for Midwives	2008	International Confederation of Midwives (ICM)

Note: WMA: World Medical Association; SMA: Swedish Medical Association; FIGO: International Federation of Gynaecology and Obstetrics; ICN: International Council of Nurses; ICM: International Confederation of Midwives.

Table 4
Issues for the generation of questions.

Empirical result (citation/information from article)	Question To what extent does the code consider...
"A general association was found between lifetime experiences of emotional, physical and/or sexual abuse and perceived abuse in the health care system. Adult victims of abuse in the health care system reported experiences of emotional physical and/or sexual abuse in childhood more often than non-victims did" [26]	...the patient's personal experience of violence?
"...the findings suggest that much of it (the abuse) was ritualized and influenced by organisational issues, professional concerns, perceived needs to control the environment and patients, sanctioning of coercive strategies and punishment, and an underpinning ideology of patient inferiority" [10]	...the importance of the value of patients' knowledge and perspective?
"To be motivated to prevent or intervene against AHC staff needs to "enter the patient perspective" [27]	
There is a higher prevalence of AHC among patients who are on sick leave, live on social support, or are retired [19]	...equal treatment of all patients regardless of social background and race?
The discrimination of certain patient groups based on class, race and gender promotes abusive behaviour [9]	
Not acknowledging the patient as a human being can be a cause of AHC [28,29]	...the importance of seeing the patient as a person?
Both men and women experience AHC, but women are at higher risk for AHC and suffering from the event [30]	...the significance of equal treatment of men and women?
AHC can be experienced as a loss of dignity [28,29]	...the protection of patients' dignity?
"Health care staff perceives AHC primarily as ethical lapses. Avoiding responsibility for AHC might lead to a failing recognition of AHC, implying that the problem is not properly dealt with" [27]	...staff's responsibility towards patients and their care?
Sexual contacts with patients have a high potential of being harmful for the patient. [31]	...sexual contacts with patients?
The patient's feelings of powerlessness contribute to AHC [28,29]	...the promotion of patient empowerment?
The empowerment of patients can to a non-abusive encounter contribute between nurse and patient [9]	
AHC can be experienced as loss of autonomy [28,29]	...the protection of patients' autonomy?
Awareness of AHC is higher if staff is aware of the power asymmetry between patients and staff [32]	...power asymmetry between professional and patient?
Staff violates ethical principles frequently, but it is not always perceived as a violation by the patient [33]	...self-reflection concerning staff's ethical conduct?
The empowerment of nurses contributes to a non-abusive encounter between nurse and patient [9]	...the issue of sharing/redressing power imbalances between professionals?
Empowerment of health care staff is necessary in order to prevent mechanisms of generating an identity through exercising power and control over patients [10,32]	
Awareness of AHC is higher if the clinical environment allows to take action	...how to deal with other staff members' misconduct?

Note: AHC: Abuse in healthcare

4. Results

4.1. Issues

Following the criteria for inclusion, our literature search yielded 11 empirical articles (Fig. 2). To enhance comprehensiveness we arbitrarily divided the 14 issues that we had identified in these articles into four groups of issues:

1. *Patient aspects*: patients' personal experience of violence, the importance of the value of patients' knowledge and perspective, equal treatment of all patients regardless of social background and race, the importance of seeing the patient as a person, the significance of equal treatment of men and women
2. *Relationship aspects/responsibility*: the protection of patients' dignity, staff's responsibility towards patients and their care, sexual contacts with patients
3. *Power aspects*: the promotion of patient empowerment, the protection of patients' autonomy, power asymmetry between professional and patient
4. *Staff aspects*: staff's reflection concerning own ethical conduct, the issue of power imbalances between professionals, how to deal with other staff members' misconduct

4.2. Interrater agreement

After the primary analysis of the articles that were included after the literature search, we reached a complete interrater agreement of 61%, a partial agreement of 23% and a disagreement of 16%. Total agreement was reached after discussion.

4.3. Codes

Considerable differences were found between the ethical codes of the different organisations (Table 5).

4.4. Codes for physicians in general

The WMA code is relatively brief and general in its statements. Thus most of its content does not answer our questions explicitly, though general statements were included. Though this code does pay explicit attention to the physician's duty to report unethical behaviour on the part of colleagues, it does not address issues concerning power: there is no consideration of power-imbalance between professionals or between professionals and patients, or of patient empowerment (Table 6). In contrast, the SMA guidelines do address the power asymmetry between physician and patient. On the other hand these guidelines consider none of the following: power imbalance among staff, patient empowerment, how to deal with ethical misconduct on the part of other staff members, staff's reflection on their own conduct, the patient's perspective and seeing the patient as a person. The SMA code takes up fewest of the issues that we have found to be relevant to AHC (Table 7).

4.5. Code for obstetricians and gynaecologists

Of all codes, the FIGO guidelines are the most detailed and explicit, covering almost all of the issues. Only in these guidelines are patients' experiences of violence addressed. Questions of

Disch E, Avery N. Sex in the consulting room, the examining room, and sacristy: Survivors of sexual abuse by professionals. American Journal of Orthopsychiatry 2001 Apr; 71(2):204-17.

Jewkes R, Abrahams N, Mvo Z. Why do nurses abuse patients? Reflections from South African obstetric services. Social Science & Medicine 1998 Dec; 47(11):1781-95.

Kruger L-M, Schoombee C. The other side of caring: Abuse in a South African maternity ward. Journal of Reproductive and Infant Psychology 2010 Feb; 28(1):84-101.

Swahnberg K, Hearn J, Wijma B. Prevalence of perceived experiences of emotional, physical, sexual, and health care abuse in a Swedish male patient sample. Violence and Victims 2009; 24(2):265-79.

Swahnberg K, Thapar-Bjorkert S, Bertero C. Nullified: women's perceptions of being abused in health care. Journal of Psychosomatic Obstetrics and Gynaecology 2007 Sep; 28(3):161-7.

Swahnberg K, Wijma B. Staff's awareness of abuse in health care varies according to context and possibilities to act. Journal of Psychosomatic Obstetrics and Gynaecology 2011 Jun; 32(2): 65-71.

Swahnberg K, Wijma B, Liss PE. Female patients report on health care staff's disobedience of ethical principles. Acta Obstetriciaet Gynecologica Scandinavica 2006 Jul ; 85(7):830-6.

Swahnberg K, Wijma B, Schei B, Hilden M, Irminger K, Wingren GB. Are sociodemographic and regional and sample factors associated with prevalence of abuse? Acta Obstetriciaet Gynecologica Scandinavica 2004 Mar; 83(3):276-88.

Swahnberg K, Wijma B, J H, Thapar-Bjorkert S, Bertero C. Mentally pinioned: men's perceptions of being abused in health care. International Journal of Men's Health 2009; 8(1):60-71.

Swahnberg K, Wijma B, Wingren G, Hilden M, Schei B. Women's perceived experiences of abuse in the health care system: their relationship to childhood abuse. BJOG. 2004; 111(12):1429-36..

Swahnberg K, Zbikowski A, Wijma B. Ethical lapses: staff's perception of abuse in health care. Journal of Psychosomatic Obstetrics and Gynaecology 2010 Sep; 31(3):123-9.

Fig. 2. Included articles.

Table 5
Results: issues addressed.

Group of issues	Question To what extent does the code consider…	WMA	SMA	FIGO	ICN	ICM
Patient aspects	…the patient's personal experience of violence?			X		
	…the importance of the value of patients' knowledge and perspective?	X		X		X
	…equal treatment of all patients regardless of social background and race?	X	X	X	X	X
	…the importance of seeing the patient as a person?			X	X	X
	…the significance of equal treatment of men and women?	X	X	X	X	X
Relationship aspects/responsibility	…the protection of patients' dignity?	X	X	X	X	X
	…staff's responsibility towards patients and their care?	X	X	X	X	X
	…sexual contacts with patients?	X	X	X		
Power aspects	…the promotion of patient empowerment?			X	X	X
	…the protection of patients' autonomy?	X	X	X	X	X
	…power asymmetry between professional and patient?		X	X		X
Staff aspects	…self-reflection concerning staff's ethical conduct?	X		X	X	X
	…the issue of sharing/redressing power imbalances between professionals?					X
	…how to deal with other staff members' misconduct?	X			X	X

Note: X: issue is addressed; WMA: World Medical Association; SMA: Swedish Medical Association; FIGO: International Federation of Gynecology and Obstetrics; ICN: International Council of Nurses; ICM: International Confederation of Midwives.

Table 6
Results WMA International Code of Medical Ethics.

Group of issues	Question To what extent does the code consider…	WMA International Code of Medical Ethics
Patient aspects	…the patient's personal experience of violence?	
	…the importance of the value of patients' knowledge and perspective?	A PHYSICIAN SHALL respect the rights and preferences of patients, colleagues, and other health professionals.
	…equal treatment of all patients regardless of social background and race?	A PHYSICIAN SHALL not allow his/her judgment to be influenced by personal profit or unfair discrimination.
	…the importance of seeing the patient as a person?	
	…the significance of equal treatment of men and women?	A PHYSICIAN SHALL not allow his/her judgment to be influenced by personal profit or unfair discrimination.
Relationship aspects/responsibility	…the protection of patients' dignity?	A PHYSICIAN SHALL be dedicated to providing competent medical service in full professional and moral independence, with compassion and respect for human dignity.
	…staff's responsibility towards patients and their care?	A PHYSICIAN SHALL owe his/her patients complete loyalty and all the scientific resources available to him/her.
	…sexual contacts with patients?	A PHYSICIAN SHALL not enter into a sexual relationship with his/her current patient or into any other abusive or exploitative relationship.
Power aspects	…the promotion of patient empowerment?	
	…the protection of patients' autonomy?	A PHYSICIAN SHALL respect a competent patient's right to accept or refuse treatment.
	…power asymmetry between professional and patient?	
Staff aspects	…self-reflection concerning staff's ethical conduct?	A PHYSICIAN SHALL always exercise his/her independent professional judgment and maintain the highest standards of professional conduct.
	…the issue of sharing/redressing power imbalances between professionals?	
	…how to deal with other staff members' misconduct?	A PHYSICIAN SHALL deal honestly with patients and colleagues, and report to the appropriate authorities those physicians who practice unethically or incompetently or who engage in fraud or deception.

Note: WMA: World Medical Association.

Table 7
Results SMA's Ethical rules.

Group of issues	Question To what extent does the code consider…	SMA's Ethical rules
Patient aspects	…the patient's personal experience of violence?	
	…the importance of the value of patients' knowledge and perspective?	
	…equal treatment of all patients regardless of social background and race?	The physician must never in any way participate in carrying out death penalties, torture or other cruel and inhumane acts (…)The physician must never participate in giving patients or groups of patients undue advantages regarding economy, prioritization or other issues
	…the importance of seeing the patient as a person?	
	…the significance of equal treatment of men and women?	The physician must never deviate from the principle of all human's equal worth and must never expose a patient to discriminating treatment.
Relationship aspects/responsibility	…the protection of patients' dignity?	The physician must never in any way participate in carrying out death penalties, torture or other cruel and inhumane acts. The physician shall treat patients with empathy, care and respect. The physician must not by means of her or his professional authority encroach on the patient's right to decide for her or himself.
	…staff's responsibility towards patients and their care?	The physician shall act in accordance to the patient's health as his or her highest purpose and cure when possible, relieve when possible and comfort always, following the commandment of human kindness and honor.
	…sexual contacts with patients?	The physician must not initiate a sexual relationship or engage in a relation characterized by selfish exploitation with a patient who is under the physician's care.
Power aspects	…the promotion of patient empowerment?	
	…the protection of patients' autonomy?	The physician shall treat patients with empathy, care and respect. The physician must not by means of her or his professional authority encroach on the patient's right to decide for her or himself. The physician shall respect the patient's right for information about her or his state of health and alternatives of treatment. If possible, the physician shall assume informed consent for treatment and refrain from giving the patient information that the patient does not want to receive.

Table 7 (*Continued*)

Group of issues	Question To what extent does the code consider...	SMA's Ethical rules
	...power asymmetry between professional and patient?	The physician shall treat patients with empathy, care and respect. The physician must not by means of her or his professional authority encroach on the patient's right to decide for her or himself.
Staff aspects	...self-reflection concerning staff's ethical conduct? ...the issue of sharing/redressing power imbalances between professionals? ...how to deal with other staff members' misconduct?	

Note: SMA: Swedish Medical Association. The analysis was performed on the original SMA's Ethical rules in Swedish.

power imbalance between professionals are not addressed, however, and no guidance is given on how to deal with another professional's misconduct (Table 8).

4.6. Code for nurses

The ICN Code of Ethics for Nurses lacks five issues, two of them concerning issues of power. Sexual misconduct is not addressed. The ICN code's rather general statements leave much of the content implicit (Table 9).

4.7. Code for midwives

Together with FIGO's guidelines, the ICM code is the most complete concerning the questions in Table 5 but, as in the ICN code, sexual misconduct is not addressed (Table 10).

5. Comment

All the codes address issues having to do with the moral obligation towards the patient: non-discrimination (with regard to

Table 8
Results FIGO's ethical issues in obstetrics and gynecology.

Group of issues	Question To what extent does the code consider...	FIGOEthical Issues in Obstetrics and Gynecology
Patient aspects	...the patient's personal experience of violence?	Violence against women is not acceptable whatever the setting and therefore physicians treating women are ethically obligated to [...] (ii) treat the physical and psychological results of the violence.
	...the importance of the value of patients' knowledge and perspective?	Informing women and obtaining their input and consent, or dissent, should be a continuing process. Even if a woman is unable to decide for herself because of mental incapacity or mental retardation, nevertheless she must be involved in the decision-making process to the fullest extent her capacity allows, and her best interests must be taken into account.
	...equal treatment of all patients regardless of social background and race?	In the delivery of health care to women, justice requires that all be treated with equal consideration, irrespective of their socioeconomic status. Ob/gyn should act as advocates for fair and affordable access to women's health services, in particular to women's sexual health, irrespective of their age, marital, racial, ethnic, socio-economic or religious status.
	...the importance of seeing the patient as a person?	In addition to the provision of medical services, physicians have a responsibility to consider women's well-being and psychological satisfaction with their gynecologic and obstetric care.
	...the significance of equal treatment of men and women?	Women and men have a right to the highest available standard of health care for all aspects of their sexual and reproductive health. The patient's care should take into account the unequal power relationship between men and women, in order to ensure respect for the right of women to make their own choices at the end of life.
Relationship aspects/responsibility	...the protection of patients' dignity?	Physical privacy affirms the right to accept or deny providers the right to examine or treat, but even if permission is given – still requires careful protection from unnecessary or embarrassing bodily contact or exposure.
	...staff's responsibility towards patients and their care?	Practitioners who find themselves unable to deliver medically indicated care to their patients for reasons of their personal conscience still bear ethical responsibilities to them. The primary conscientious duty of obstetrician-gynecologists (hereafter "practitioners") is at all times to treat, or provide benefit and prevent harm to, the patients for whose care they are responsible. In addition to the provision of medical services, physicians have a responsibility to consider women's well-being and psychological satisfaction with their gynecologic and obstetric care. The transition from curative to palliative care may require the primary involvement of physicians with special knowledge of palliative care. However, the obstetrician-gynecologist should continue his or her supportive role for the patient and her family.
	...sexual contacts with patients?	[...], a romantic or sexual relationship is unacceptable at all times and in all circumstances between a physician actively treating a patient and the patient.
Power aspects	...the promotion of patient empowerment?	This imbalance increases patients' vulnerability so that there is a concomitant obligation on the part of physicians to promote independent and informed decision-making by patients.

Table 8 (*Continued*)

Group of issues	Question To what extent does the code consider…	FIGOEthical Issues in Obstetrics and Gynecology
	…the protection of patients' autonomy?	The principle of autonomy emphasizes the important role women should play in the decision-making in respect to their health care. Physicians should try to redress women's vulnerability by expressly seeking their choice and respecting their views. […] it is the ethical obligation of the physician to ensure that [the woman's] human right of self-determination is met by the process of communication that precedes any informed consent. Women and men have the right to make choices about whether or not to reproduce. Autonomy assumes the right of individuals to make decisions on their own behalf. When decisions regarding medical care are required, women should be provided with full information on available management alternatives including risks and benefits. Informing women and obtaining their input and consent, or dissent, should be a continuing process. Even if a woman is unable to decide for herself because of mental incapacity or mental retardation, nevertheless she must be involved in the decision-making process to the fullest extent her capacity allows, and her best interests must be taken into account. When a dying woman prefers to die at home, every effort should be made within the practicality of the situation, medical or social, to comply with her wish and to maintain good palliative care in that environment. Patients have the right to ultimate control over the confidentiality of their data. Competent patients have the right of access to their medical records, and to have the data interpreted for them and to object to the inclusion of specific information.
	…power asymmetry between professional and patient?	Women tend to be vulnerable because of social, cultural and economic circumstances. This is the case within the doctor-patient relationship, because in the past their care has often been dominated by the paternalism of their advisors. Maintenance of strict boundaries in the relationship between patients and physicians is required because of the inherent imbalance in power and knowledge between them.
Staff aspects	…self-reflection concerning staff's ethical conduct? …the issue of sharing/redressing power imbalances between professionals? …how to deal with other staff members' misconduct?	Practitioners have the right both to undertake and to object to undertaking medical procedures according to their personal conscience.

Note: FIGO: International Federation of Gynecology and Obstetrics.

Table 9
Results ICN Code of Ethics for Nurses.

Group of issues	Question To what extent does the code consider…	The ICN Code of Ethics for Nurses
Patient aspects	…the patient's personal experience of violence? …the importance of the value of patients' knowledge and perspective?	
	…equal treatment of all patients regardless of social background and race?	Nursing care is respectful of and unrestricted by considerations of age, color, creed, culture, disability or illness, gender, sexual orientation, nationality, politics, race or social status.
	…the importance of seeing the patient as a person?	In providing care, the nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected.
	…the significance of equal treatment of men and women?	Nursing care is respectful of and unrestricted by considerations of age, color, creed, culture, disability or illness, gender, sexual orientation, nationality, politics, race or social status.
Relationship aspects/responsibility	…the protection of patients' dignity?	Inherent in nursing is respect for human rights, including cultural rights, the right to life and choice, to dignity and to be treated with respect. The nurse, in providing care, ensures that use of technology and scientific advances are compatible with the safety, dignity and rights of people.
	…staff's responsibility towards patients and their care? …sexual contacts with patients?	The nurse's primary professional responsibility is to people requiring nursing care.
Power aspects	…the promotion of patient empowerment?	The nurse shares with society the responsibility for initiating and supporting action to meet the health and social needs of the public, in particular those of vulnerable populations.
	…the protection of patients' autonomy?	The nurse ensures that the individual receives sufficient information on which to base consent for care and related treatment.
	…power asymmetry between professional and patient?	
Staff aspects	…self-reflection concerning staff's ethical conduct?	The nurse at all times maintains standards of personal conduct which reflect well on the profession and enhance public confidence.
	…the issue of sharing/redressing power imbalances between professionals?	
	…how to deal with other staff members' misconduct?	The nurse takes appropriate action to safeguard individuals, families and communities when their health is endangered by a coworker or any other person.

Note: ICN: International Council of Nurses.

Table 10
Results ICM International Code of Ethics for Midwives.

Group of issues	Question To what extent does the code consider...	International Code of Ethics for Midwives
Patient aspects	...the patient's personal experience of violence?	
	...the importance of the value of patients' knowledge and perspective?	Midwives develop a partnership with women in which both share relevant information that leads to informed decision-making, consent to a plan of care, and acceptance of responsibility for the outcomes of their choices.
	...equal treatment of all patients regardlessof social background and race?	This code [...] seeks justice for all people and equity in access to health care.
	...the importance of seeing the patient as a person?	This code acknowledges women as persons with human rights. Midwives respond to the psychological, physical, emotional and spiritual needs of women seeking health care, whatever their circumstances. Midwives ensure that the advancement of midwifery knowledge is based on activities that protect the rights of women as persons.
	...the significance of equal treatment of men and women?	This code [...] seeks justice for all people and equity in access to health care.
Relationship aspects/responsibility	...the protection of patients' dignity?	This code [...] is based on mutual relationships of respect and trust, and the dignity of all members of society.
	...staff's responsibility towards patients and their care?	Midwives are responsible for their decisions and actions, and are accountable for the related outcomes in their care of women.
	...sexual contacts with patients?	
Power aspects	...the promotion of patient empowerment?	Midwives support the right of women/families to participate actively in decisions about their care. Midwives empower women/families to speak for themselves on issues affecting the health of women and families within their culture/society.
	...the protection of patients' autonomy?	Midwives develop a partnership with women in which both share relevant information that leads to informed decision-making, consent to a plan of care, and acceptance of responsibility for the outcomes of their choices.
	...power asymmetry between professional and patient?	This code [...] is based on mutual relationships of respect and trust, and the dignity of all members of society. Midwives develop a partnership with women in which both share relevant information that leads to informed decision-making, consent to a plan of care, and acceptance of responsibility for the outcomes of their choices.
Staff aspects	...self-reflection concerning staff's ethical conduct?	The midwife has responsibilities to herself or himself as a person of moral worth, including duties of moral self-respect and the preservation of integrity. Midwives actively seek personal, intellectual and professional growth throughout their midwifery career, integrating this growth into their practice. Midwives may refuse to participate in activities for which they hold deep moral opposition; however, the emphasis on individual conscience should not deprive women of essential health services. Midwives recognize the human interdependence within their field of practice and actively seek to resolve inherent conflicts.
	...the issue of sharing/redressing power imbalances between professionals?	Midwives support and sustain each other in their professional roles, and actively nurture their own and others' sense of self-worth.
	...how to deal with other staff members' misconduct?	Midwives understand the adverse consequences that ethical and human rights violations have on the health of women and infants, and will work to eliminate these violations.

Note: ICM: International Confederation of Midwives.

gender, race and socioeconomic status), protection of the patient's dignity, responsibility for and loyalty to the patient, patient autonomy, etc. Nevertheless there are clear differences between the codes. Of all the ethical guidelines we analysed, the FIGO and ICM ones contain most issues that are of importance in respect of AHC (Table 5).

Issues that were subsumed under patient aspects and staff aspects were least addressed. Two such issues were acknowledged in only one code (each): women's experiences of violence are named only in the FIGO guidelines, whilst power imbalances between professionals are mentioned only in the ICM code. We turn now to a consideration of the various issues, starting with those that were most often lacking.

5.1. Patient aspects

There is a risk of retraumatisation for female patients with experience of sexual abuse, not only during physical examinations but also in the context of other interactions with medical, legal and social agencies [34–36]. As a patient's background of sexual abuse is most likely not obvious in the encounter with healthcare staff, there is reason to emphasise its importance in ethical guidelines, as

the FIGO guidelines do. It is the FIGO and ICM guidelines that reflect the most holistic view of the patient. The consistent use of the word "woman" instead of "patient" accentuates this impression. Only the "non-physician" codes of the ICN and ICM, however, explicitly address the issue of seeing the patient as a person with psychological, spiritual and other human needs.

5.2. Staff aspects

When it comes to staff aspects it is notably the ICM code which deals with the way in which members of the profession should relate to each other. Its omission from some codes is surprising, as in most cases healthcare implies the interaction of different staff members and unethical behaviour among staff can be harmful for both staff and patients [37,38]. Furthermore it is only the WMA code that explicitly addresses the interconnectedness of healthcare professionals in respect of the question of how to deal with other professionals' misconduct. As staff's awareness of AHC can vary depending on the context [32], how they interact with one another is important, e.g. by giving feedback and creating an atmosphere in which AHC can be discussed openly. Witnessing unethical behaviour can be a source of moral distress for a staff member [39], and patients' suffering after AHC can be prolonged if the matter is left unattended [40]. In not addressing the question of others' misconduct, the ethical codes seem to imply that ethical behaviour is an individual responsibility, ignoring the fact that unethical behaviour can only proceed if supported or tolerated by others [41–43].

5.3. Power aspects

The issue of power asymmetry between professionals and patients, together with that of the promotion of patient empowerment, appears in general propositions in three of five sets of guidelines. The SMA code, for instance, points out that professional authority must not be used to limit a patient's right to decide for himself or herself. Power imbalance may also be maintained, however, through more subtle factors that have an effect on the patient's autonomy, such as the desire to comply and the patient's vulnerability when ill [44]. Only the FIGO guidelines address the power asymmetry between professionals and patients explicitly and repeatedly. Understanding the mechanisms of power in the professional–patient relationship is crucial to the sharing of such power [45].

5.4. Relationship aspects/responsibility

Only the ICM and ICN codes omit mentioning sexual misconduct. The literature on sexual misconduct in nursing is scarce and in midwifery non-existent. It may reflect the prevalence of gender stereotypes excluding the possibility of sexual misconduct by nurses and midwives. Sexual exploitation in health care has been shown to have detrimental effects for patients [31,46]. To remain silent about sexual misconduct within one's own or other professions or to ignore its existence may greatly increase the risk of its perpetuation [47].

5.5. Clinical implications

If ethical guidelines are to offer support and stimulate ethical reflection within the profession [48], and to help prevent conduct that may lead to AHC, they should cover the following issues that are missing from most of the current sets of guidelines: consideration of the patient as a person with his or her own perspective; consideration of the possibility of abuse or violence in the patient's history; power imbalances in healthcare; sexual misconduct; and how to deal with ethical misconduct. If ethical guidelines are to be the centrepiece for practical ethics in healthcare, it is advisable that there should be empirical research on ethical issues such as AHC before the revision of such guidelines or the establishment of new ones. Also, if the guidelines pertain to different professions involved in taking care of the same patient, should they not share a common perspective on the encounter with the patient as well as on intra- and inter-professional co-operation and responsibilities? If guidelines shape ethics in healthcare, professionals must be continuously in tune with them and incorporate them into their everyday work, but regarding ethical behaviour in healthcare it might be naive to rely on guidelines only. Concerning ethics within nursing, van Hooft emphasises the importance of empowering nurses to act in difficult or stressful situations in which explicit guidelines are not available [49]. It is indeed likely that this is the case in most clinical situations, irrespective of the profession involved. So despite the central position of ethical guidelines in healthcare, complementation may be necessary. As argued by virtue ethicists, facilitating action in accordance with moral certainty and with attributes of virtue might support ethical behaviour in general and thus might also help prevent AHC in particular. With guidance, practice and repetition, ethical behaviour would gradually become a natural way of being [16]. Regarding the prevention of AHC, the relevance of virtue ethics approaches needs to be explored in future research.

5.6. Methodological considerations

The study is grounded in empirical data, which strengthen its validity. The development of the analytical strategy is transparent and reliable through its repeatability. Owing to the scarcity of studies, the majority of issues within the framework of analysis are derived from a small number of studies conducted by a few researchers. To obtain a valid and comprehensive tool for analysis we chose not to include studies on specific groups, e.g. elderly or psychiatric patients.

6. Conclusion

Ethical guidelines for staff working within ob/gyn healthcare differ distinctively from each other regard to addressing issues that have been shown to be related to AHC. Issues mostly disregarded were: considering the patient's perspective and the patient's possible experience of violence, power imbalance within healthcare, sexual misconduct by staff, how to deal with the ethical misconduct of others and how professionals relate to each other. The guidelines of FIGO and ICM covered most of the issues that have empirically been shown to be important in respect of the occurrence of AHC. Ethical guidelines that include these issues could serve as a resource for the prevention of AHC. We suggest that ethical guidelines in healthcare should be revised following empirical research on ethical conduct. Being aware of the limitations of ethical guidelines, concerning AHC we envision a virtue ethics approach as a possible complement and as a subject of further research.

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