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## ETHICAL IMPLICATIONS OF OBSTETRIC CARE IN HUNGARY:

### Results from the Mother-Centred Pregnancy Care Survey

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*Background:* Informed consent plays an important role in clinical decision making. It is a basis of self determination in health care. In ideal situations health care professionals inform their patients about all relevant aspects of care and alternative care options, map the value system of the patients, and adjust the information process accordingly.

*Objectives:* Our objective was to see the frequency of selected interventions (birth induction, caesarean section, episiotomy, forced supinal position during birth, and the consent process associated to these interventions.

*Methods:* 1,257 women (with childbearing capacity) between the age of 18 and 45 with children under the age of 5 were surveyed online.

*Results:* Caesarian section was done without permission in 10.2% of women.

Labour was induced in 22.2% of all deliveries and it was done without permission in 25.4% .

Episiotomy was done in 39.9% of women having vaginal delivery in the *Sample 2* group and in 72.2% of women having vaginal delivery in the *Sample 1* (representative) group. Women undergoing episiotomy were not asked for consent in 62.0% in the *Sample 1* group and in 57.1% in the *Sample 2* group. Freedom to choose labour position for women having vaginal birth was restricted in 65.7% in the *Sample 1* group and in 46% in the *Sample 2* group.

*Discussion and Conclusions:* We have found that the right of women to informed consent and best available treatment is frequently and seriously violated in obstetric practice in Hungary in the given period. These findings should serve as an important basis for improving the quality of maternity care.

**Keywords:** respectful maternity care, midwifery model, informed consent, unconsented care, caesarean section, episiotomy, labour induction

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## 1. Background

Informed consent plays an important role in clinical decision making. It is a basis of self determination in health care. In ideal situations health care professionals inform their patients about all relevant aspects of care and alternative care options, map the value system of the patients, and adjust the information process accordingly. Patients and health care professionals have shared responsibility in the process, both parties have obligations and responsibilities but apart from some exceptional situations the ultimate decision is in the hands of patients.

The principle of self determination was formulated by the Supreme Court of the United States as early as 1891:

No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law. To compel any one, and especially a woman, to lay bare the body, or to submit it to the touch of a stranger, without lawful authority, is an indignity, an assault, and a trespass. (United States Supreme Court 1891)

Ethical norms of maternity and obstetric care include a) the right of the mother to the best (available) care b) the right of the foetus to the best (available) care, c) the right of the mother to all relevant information necessary to her decision making, d) the right of the mother to informed consent. These rights are universally accepted and supported in various national and international documents, including ethics guidelines and effective legal regulations (FIGO 2012; WHO 1996).

In clinical practice, however, these norms may occasionally come into conflict with one another; one of the most frequent problems arises when the life of the foetus is in danger, but her mother does not want to consent to the recommended medical intervention the health care personal finds necessary to introduce interventions to prevent substantial health damage or life-threatening conditions. The legal solution for this conflict varies in different countries. The effective legal norm of Hungary restricts the right of women in these situations, allowing interventions of the health care personnel to support foetal life against the wishes of the mother.

The 1997/154 law on health care (*1997. évi CLIV. Törvény az egészségügyről*) stipulates that patients are entitled to the right of self-determination. This right can be restricted by law only in special situations. Given the right of self determination, patients are free to decide whether they want to demand health care services and if so, which of them they consent to or refuse.

The right of refusal of health care interventions, however, is restricted in, among others, the following cases:

- The patient cannot refuse a life-saving or life-sustaining intervention if she is pregnant, and presumably able to carry out the pregnancy. 20. § (1) (6)

- The patient is at least 24 weeks pregnant and the omission of the intervention would seriously jeopardize her or her foetus's health or bodily integrity.
15. § (2)

To analyse obstetric care, researchers in medical sociology and anthropology use different models, such as the medical and midwifery models (*Table 1*). While these models are different, the ethical dimensions around maternal autonomy should certainly be the same. Even though obstetricians deal predominantly with pathological pregnancies, the principle of self-determination should still apply.

*Table 1*  
Medical and midwifery models complement or conflict?

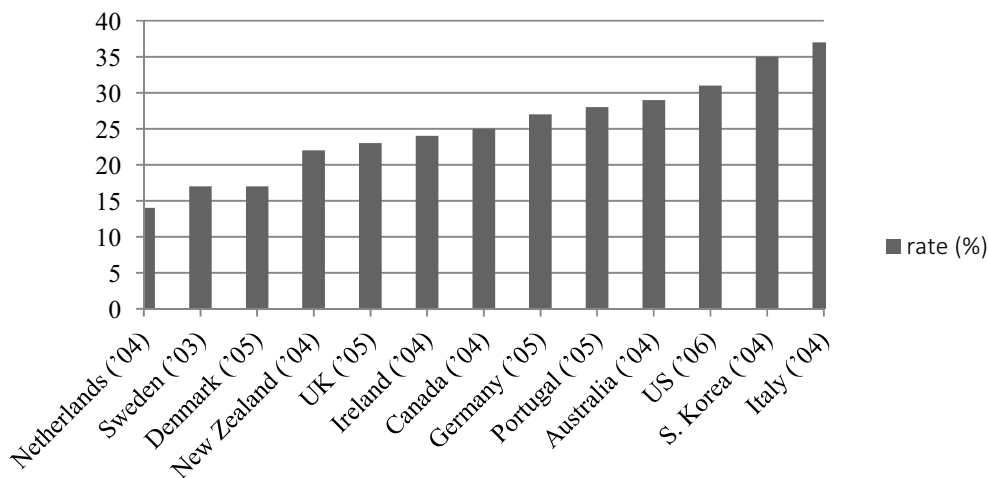
<i>The Midwife Model of Care</i>	<i>The Medical Model of Care</i>
<p><i>Definition of Birth</i></p> <ul style="list-style-type: none"> <li>• Birth is a social event, a normal part of a woman's life.</li> <li>• Birth is the work of the woman and her family.</li> <li>• The woman is a person experiencing a life-transforming event.</li> </ul>	<ul style="list-style-type: none"> <li>• Childbirth is a potentially pathological process.</li> <li>• Birth is the work of doctors, nurses, midwives and other experts.</li> <li>• The woman is a patient</li> </ul>
<p><i>Birthing Environment</i></p> <ul style="list-style-type: none"> <li>• Home or other familiar surroundings.</li> <li>• Informal system of care.</li> </ul>	<ul style="list-style-type: none"> <li>• Hospital, unfamiliar territory to the woman.</li> <li>• Bureaucratic, hierarchical system of care.</li> </ul>

The medical model emphasises the pathological processes, medical risks and the necessity of preventive measures related to pregnancy and birth, whereas the midwifery model looks at these events from a holistic perspective emphasising the importance of psychosocial aspects. The medical model of obstetric care is often criticised with the following arguments. Birth is a medical event: pathology is presumed from the start and a normal birth can only be diagnosed in retrospect. Interventions are used to prevent and manage the inherently risky nature of childbirth.

Obstetric care has become depersonalised, the process of giving birth has been industrialised. In many aspects, the model of obstetric care is reductionist, it focuses solely on biomedical processes disregarding psychological aspects of patients. Obstetric care has become physician-centred, obstetricians dominate care, in spite of the fact that professional recommendations and legal requirements emphasise the need of broadening the role of midwives (WHO 2009).

Medical interventions are often motivated by fear from litigation and financial factors. These result in an increased rate of unnecessary interventions, such as labour

induction, episiotomy, oxytocin administration, caesarean section. (See *Figure 1* for the number of excessive C-Sections).



Data from the Organization for Economic Cooperation and Development health data 2007, United States birth data for 2006 are preliminary.

*Figure 1*  
Caesarean rates in industrialised countries, 2003–2006.

Informal payment potentially plays a major role in medical decision making in the maternity care context. As BAJI and her colleagues (2017) have shown, having a chosen doctor, thus providing informal payment for obstetric care, have increased inductions of labour, caesareans, and episiotomies. However, the probability and amount of payment was not affected by these procedures. Only having an epidural increased the probability and amount of payment. Nonetheless, concern remains that informal payments may incentivise providers to perform unnecessary procedures.

Inability to change non-evidence based practice: interventions such as shaving pubic hair, forcing mothers into a supine position during birth, and routine episiotomy are all non-evidence based, thus outdated practices, still frequently administered in Hungary (MITENIECE et al. 2017). Restrictive episiotomy policies, for example, appear to have a number of benefits compared to routine episiotomy policies. There is less posterior perineal trauma, less suturing and fewer complications, no difference for most pain measures and severe vaginal or perineal trauma, but there was an increased risk of anterior perineal trauma with restrictive episiotomy.

Women experienced less severe perineal trauma, less posterior perineal trauma, less suturing and fewer healing complications at seven days (reducing the risks by from 12% to 31%), with no difference in occurrence of pain, urinary incontinence, painful sex or severe vaginal/perineal trauma after birth (CARROLI & BELIZAN 1999).

Still this practice is widely accepted in obstetric care in several countries, including Hungary. Here we find a 62% rate (Születésház Egyesület 2012), while based on the recommendations of the World Health Organisation, this number should be lower than 10% (WHO 1996). Deeper analysis of the medical and midwife models have shown significant differences in terms of caesarean rates: a doubling in the number of midwives per head was found to be associated with a 14% (−4% – 32%) decrease in the caesarean delivery rate. Moreover, the financial model of obstetric care had beneficial effects as well: a doubling in the share of health expenditure derived from government sources was found to correspond to a 29.8% (9.6% – 50%) decrease in caesarean rates (LAUER et al. 2010).

The thrice-administered Listening to Mothers survey was the first nationally representative sampling of women's perspectives on childbirth in the United States through which 2,400 18–45-year-old internet-using US women with hospital deliveries were asked how decision making process about maternity care and obstetric practice was influenced by women's experiences (DECLERCQ et al. 2014).

Another survey exploring women's preferences regarding health care providers, place of birth, and decision making style was the Changing Childbirth study in British Columbia (Canada) (VEDAM et al. 2015).

## 2. Objectives

We do not have systematic data about pregnant women's preferences and values. Our survey was planned to explore:

- (1) Women's preferences in prenatal-, birth-, and postpartum care
- (2) Content of care  
Including overuse of interventions and informal payment
- (3) Respectful maternity care  
Coercion, discrimination, consent
- (4) Factors which support or hinder women's ability to make decisions during their care
- (5) The specific nature of obstetric care in Hungary

In this paper we describe our results regarding informed consent and coercion in prenatal and birth care.

Our objective was to see the frequency of selected interventions (birth induction, caesarean section, episiotomy, forced supinal position during birth, and the consent process associated to these interventions).

## 3. Methods

We have developed the 'Mother-Centred Pregnancy Care' questionnaire to explore women's preferences and experiences related to their pregnancy and maternity care in Hungary. The questionnaire collected information on characteristics of birth care

including type of provider present at birth, mode of delivery, labour interventions, the process of decision-making, and several measures of respectful care (informed consent, discrimination, autonomy). Here we addressed issues related to respectful care (informed consent and autonomy) only. Women also reported prenatal and obstetric risk factors and socio-demographic characteristics. Finally, women reported when they paid informally, who they paid and how much, and they also selected their most important motivations to make such payments. Results of research related to informal payment is published elsewhere (BAJI et al. 2017).

Details on survey construction and content validation are published elsewhere (RUBASHKIN et al. 2017). The majority of the items were selected from two previously validated English-language maternity care surveys, *Listening to Mothers III* and *Changing Childbirth in BC* (DECLERCQ et al. 2014; VEDAM et al. 2015). The instrument was content validated by a bi-lingual, multi-disciplinary panel of 11 Hungarian maternity care experts. Items were scored by the experts, and those items were selected that exceeded the threshold for importance, relevance, and clarity. The final questionnaire was systematically translated into Hungarian, using the process of 5-way sequential translation with a final back translation to English checked by a native speaker, and the final version of the survey was piloted with 5 women. Prior to administering the survey to participants, an Ethics Institutional Review Board approval was obtained from Semmelweis University Regional and Institutional Committee of Science and Research Ethics (Nr. 99/2014).

During our qualitative research we conducted a descriptive analysis, where frequency and percentage of data was calculated. We calculated the data of valid responses only. Data were analysed with the help of SPSS statistics software.

This study examined factors supporting or hindering women's decision making with different providers in different birth settings, however, neither this study, nor the Listening to Mothers Study survey included birth centre or home birth. We selected four indicators for assessing consent in obstetric care. All these are mother-baby friendly indicators discussed in the international literature (WHO 2015).

Caesarian section, the practice of forcing woman in supine position during vaginal delivery, episiotomy and labour induction. All these four indicators are hard indicators, it is easy to define them and easy to assess whether they occurred during labour or not. Similarly, the recollection of the existence of these events by women is easy. Moreover, these indicators serve as quality indicators of care, thus having normative importance beyond the question whether women gave consent to these interventions or not. Since Hungarian women are not routinely asked about the perspectives on the quality of informed consent in delivery care, we conducted a survey with self-reported outcomes. While self-reported outcomes have limitations, there is no similar available data source in Hungary and our survey represents the highest quality data currently available.

The existence of these indicators is certainly binary, however, informed consent to them is not. Still, it is hard to assess with a simple survey the real depth of information given about these interventions. Therefore we simply asked whether permission had been asked to perform the given interventions:

– *Before performing the induction of labour/C-section/episiotomy, did your provider obtain your permission to perform the induction/C-section, episiotomy?*

It is obvious that the existence and quality of ‘informed consent’ cannot be assessed by the answers to these questions, however, we thought even the mere existence or lack of permission to these interventions reflects the level of respectful care and has therefore serious ethical implications.

Similarly, in the case of forced supine position we simply asked:

– *Was the birth position freely chosen by you?*

With a yes/no answer option, and knowing that a lack of freedom in this case means forced supine position in clinical practice. We did not assess whether women had been informed about the advantages and disadvantages of freely choosing their position because we thought this tiny detail was beyond the scope of our survey.

Caesarian section was chosen for obvious reasons: it is a major surgical intervention that prevents life threatening conditions. However, the existing discussion around an optimal rate of C-section indicates that C-section may be used for non medical reasons, and the use of it may not always be in the best interest of women or their babies (GIBBONS et al. 2010), whereas overuse is a barrier to universal coverage. Informing women about a planned or imminent C-section is certainly a must in clinical practice, but the decision and consent of women may be exceptionally restricted or disregarded if it is a life-saving intervention in imminent medical emergency. Since C-section may be sometimes indicated in emergency cases, the ideal consent ratio could be lower than 100%, considering time restraints and legal limitations of women’s rights.

The practice of forcing women into supine position during labour has symbolic as well as (patho)physiological importance. Practice guidelines emphasise the importance of respecting the freedom of women to choose their position freely (reference WHO guideline), offering women not only the psychological advantage of control over the process of birth but also the additional force of gravitation if squatting position is chosen. Moreover, there is no kind of medical advantage associated to supine position. On the other hand, supine position is more convenient for the health care personnel, because they do not have to bend down when checking or accepting the baby. Here we see a clear conflict between the interests of the health care personnel and women in labour. Thus the ratio of allowing women to choose a posture they prefer or – better formulated – respecting women’s decision is an important indicator when assessing ethical implications of care.

Forcing supine position is a symbol of exerting superiority of the staff, emphasising their interests and dominance. On the other hand, supine position is often forced simply because of institutional traditions in hospitals. Still, forced supine position is a marker of disrespecting women’s rights. If there is no medical indication for supine position than the ideal ratio of forcing women into this position is zero.

Episiotomy is also a well researched invasive surgical intervention. It is rarely a life-saving intervention in medical emergency, thus providing information about it and requiring consent from women is a basic ethical and legal norm. The necessity of the intervention itself is heavily criticised given its vague advantages and frequent disadvantages, practice guidelines therefore recommend a restrictive use of it: the overall ratio of it should not exceed 10% in vaginal deliveries (WHO 1996). Since this intervention is a rarely indicated life-saving measure in medical emergency, the consent of women is a basic ethical and legal requirement, thus the ideal consent ratio should be close to 100%.

Labour induction – similarly to the practice of episiotomy – is heavily criticised because of its frequent side effects in terms of increasing the ratio of further (unnecessary) medical interventions during labour (BONSACK et al. 2014). Unnecessary medical interventions may cause harm, in fact, they can cause harm only. Labour induction is rarely a life-saving intervention in medical emergency, thus providing information about it and requiring consent from women is a basic ethical and legal norm. The ideal consent ratio should therefore be close to 100%.

#### **4. Sample and survey administration**

The data collection was carried out in October 2014 by a survey firm (Ipsos Hungary). Ipsos maintains a survey panel with more than 70,000 members, representative of Hungarian Internet users based on age and geographical location. The panel contains basic information about the potential respondents, based on which women (with childbearing capacity) between the age of 18 and 45 with children under the age of 5 were selected as ‘target population’. Women who had had a miscarriage and no children under 5 were excluded. To ensure representativeness, invitations were sent out using quotas developed based on the distribution of age, marital status, household size, income, education, region, and the ratio of urban/rural population in the target population. Balancing the resources and time available to conduct the study with recruitment of a sufficient sample size to support robust analysis, our target sample size was 600 women that met the inclusion criteria. After 892 e-mail invitations from IPSOS had been sent out to members of the target population, 600 women submitted responses (response rate = 67%). Out of the 892 women who opened the link, 63 (18.3%) terminated the survey early, 115 (12.9%) did not participate and 14 (1.6%) began the survey after we had achieved our target sample size. Prior to initiating the survey all respondents signed an electronic informed consent form that explained the study objectives and mechanisms to preserve confidentiality (BAJI et al. 2017). This sample is therefore representative regarding distribution of age, marital status, household size, income, education, region, and the ratio of urban/rural population among Internet user women between the age of 18 and 45 with children under the age of 5.

We also collected sample from (N = 657) women, a convenience sample collected with snowball method (obtained via social media networks of birth and parenting organisations). Since women in this sample had higher educational level and



their preference for midwifery care and home birth was more frequent compared with the Hungarian average, we did not mix the results of these two groups unless indicated otherwise (*Table 2*). Ipsos Hungary managed data collection for this convenience sample (N = 657) as well. Recruitment of participants lasted till the end of month October 2014. All respondents gave informed consent online. Women were offered the possibility to terminate the survey at any time without negative consequences.

*Table 2*  
Who responded to the survey?

	<i>Total</i> <i>N= 1257</i>	<i>Sample1</i> <i>N= 657</i>	<i>Sample2</i> <i>N= 600</i>
<i>Age (y)</i>	33.5	33.8	33.3
<i>Less than &lt;7 grade</i>	17 (1.4)	0 (0.0)	17 (2.8)
<i>Grade 8</i>	16 (1.3)	0 (0.0)	16 (2.7)
<i>Trade school</i>	101 (8.0)	9 (1.4)	92 (15.3)
<i>High school</i>	336 (26.7)	91 (13.9)	244 (40.7)
<i>College</i>	423 (33.7)	256 (39.0)	167 (27.8)
<i>University diploma</i>	355 (28.2)	301 (45.8)	64 (10.7)
<i>Capital</i>	404 (32.1)	304 (46.3)	100 (16.7)
<i>County Seat</i>	219 (17.4)	95 (14.5)	124 (20.7)
<i>City</i>	351 (27.9)	151 (23.0)	200 (33.3)
<i>Village</i>	283 (22.5)	107 (16.3)	176 (29.3)

Level of education was defined being either low, middle or high. ‘Low’ means women had a maximum of 8 years of elementary schooling, ‘middle’ means women graduated from high school, whereas ‘high’ means women had at least a bachelor’s degree.

## 5. Results

An N = 600 panel sample labelled as ‘*Sample 1*’ and an n = 657 one labelled as ‘*Sample 2*’ totalling a sample of 1257 were analysed. As described above, *Sample 1* is representative regarding distribution of age, marital status, household size,

income, education, region, and the ratio of urban/rural population among internet user women between the age of 18 and 45 with children under the age of 5.

The *Sample 2* population was better educated than that of *Sample 1*, and most of them were recruited in the capital (Budapest) or in other urban areas (*Table 2*).

During prenatal care, most of women (58.8%) in the representative sample had chosen a doctor either in a private setting or in state facilities. In the *Sample 2* group choosing a doctor was even more important (63.3%), while 12i5% of this group favoured to choose an independent midwife for their prenatal care (*Table 3*).

*Table 3*  
Who was your most important prenatal provider?

	<i>Total</i>	<i>Sample 1</i>	<i>Sample 2</i>
	<i>N = 1257</i>	<i>N = 600</i>	<i>N = 657</i>
<i>Chose doctor in a private hospital</i>	12 (1.0)	2 (0.3)	10 (1.5)
<i>Chose doctor in a private praxis</i>	454 (36.1)	167 (27.8)	287 (43.7)
<i>Chose doctor in a state hospital</i>	303 (24.1)	184 (30.7)	119 (18.1)
<i>I did not chose doctor, I went to the local clinic</i>	223 (17.7)	155 (25.8)	68 (10.4)
<i>Chose (hospital) midwife</i>	106 (8.4)	28 (4.7)	78 (11.9)
<i>Independent midwife</i>	85 (6.8)	3 (0.5)	82 (12.5)
<i>District nurse</i>	70 (5.6)	58 (9.7)	12 (1.8)

The service provider during birth was predominantly an obstetrician (88.2% in the *Sample 1* group) paired with a hospital midwife in 58.7% of the cases. Home birth was chosen in 9.6% of women in the *Sample 2* group, far superseding the *Sample 1* ratio (0.5%) (*Table 4*).

*Table 4*  
With whom did you give birth?

	<i>Total</i>	<i>Sample 1</i>	<i>Sample 2</i>
	<i>N = 1257</i>	<i>N = 600</i>	<i>N = 657</i>
<i>Obstetrician/Gynaecologist</i>	264 (21.0)	177 (29.5)	87 (13.2)
<i>Hospital midwife</i>	74 (5.9)	34 (5.7)	40 (6.1)
<i>Obstetrician/Gynaecologist &amp; Hospital midwife</i>	761 (60.5)	352 (58.7)	409 (62.3)
<i>Home-birth midwife</i>	66 (5.3)	3 (0.5)	63 (9.6)
<i>Other</i>	89 (7.1)	33 (5.5)	56 (8.5)
<i>Not sure</i>	3 (0.2)	1 (0.2)	2 (0.3)

In the *Sample 1* group, the place of birth was 0.5% at home (planned home birth) and 0.5% at a birth centre in line with the national average (1%), while the *Sample 2* group had 10.8% home- and birth centre births (*Table 5*).

*Table 5*  
Where did you give birth?

	<i>Total</i>	<i>Sample 1</i>	<i>Sample 2</i>
	<i>N = 1257</i>	<i>N = 600</i>	<i>N = 657</i>
<i>Hospital, planned</i>	1158 (92.1)	589 (98.2)	569 (86.6)
<i>Hospital, transfer home</i>	18 (1.4)	2 (0.3)	16 (2.4)
<i>Home, planned</i>	65 (5.2)	3 (0.5)	62 (9.4)
<i>Home, unplanned</i>	1 (0.1)	0 (0.0)	1 (0.2)
<i>Birth Centre</i>	12 (1.0)	3 (0.5)	9 (1.4)
<i>Other</i>	3 (0.2)	3 (0.5)	0 (0.0)

With regard to the outcome of birth, the *Sample 1* group had a 41% caesarian section rate (above the national average of 33% in these five years), while the 23.4% rate of the convenience sample was well below the national average (*Table 6*). The ratio of refusal was very low – 1.3% in the whole sample.

Table 6  
Birth Outcomes

	<i>Total</i>	<i>Sample 1</i>	<i>Sample 2</i>
	<i>N = 1257</i>	<i>N = 600</i>	<i>N = 657</i>
<i>Vaginal delivery</i>	831 (66.1)	491 (74.7)	491 (74.7)
<i>Forceps or Vacuum</i>	26 (2.1)	12 (1.8)	12 (1.8)
<i>Cesarean</i>	400 (31.8)	154 (23.4)	154 (23.4)
<i>Induction of labour</i>	279 (22.2)	115 (17.5)	115 (17.5)
<i>Epidural Anaesthesia</i>	397 (31.6)	163 (24.6)	163 (24.6)
<i>No interventions</i>	106 (8.4)	93 (14.2)	93 (14.2)
<i>Episiotomy</i>	463 (36.8)	205 (31.2)	205 (31.2)
<i>Pressured to accept interventions</i>	142 (11.3)	109 (16.6)	109 (16.6)
<i>Birthing position</i>			
<i>Lying on side</i>	420 (33.4)	187 (28.5)	187 (28.5)
<i>Lying on back w/stirrups</i>	108 (8.6)	27 (4.1)	27 (4.1)
<i>Semi-sitting</i>	169 (13.4)	123 (18.7)	123 (18.7)
<i>Upright</i>	87 (6.9)	80 (12.2)	80 (12.2)

Results about consent to different interventions were the following: 11.8% of women in the *Sample 1* group and 9.1% of women in the *Sample 2* group reported that the cCaesarian section was done without their permission. Labour was induced in 27.3% of all the deliveries in the *Sample 1* group and 17.5% of all the deliveries in the *Sample 2* group. Women undergoing labour induction were not asked permission about the intervention in 26.2% of the *Sample 1* group and in 24.3% of the *Sample 2* group. The rate of refusal was below 1% (*Table 7*).

*Table 7*  
Birth Outcomes: Consent and choice

	<i>Total</i>	<i>Sample 1</i>	<i>Sample 2</i>
<i>Before your caesarean, did your doctor ask for your permission?</i>	N = 400	N = 246	N = 154
<i>Yes</i>	338 (84.5)	207 (84.1)	131 (85.1)
<i>No</i>	43 (10.8)	29 (11.8)	14 (9.1)
<i>Refused</i>	5 (1.3)	1 (0.4)	4 (2.6)
<i>Don't Remember</i>	14 (3.5)	9 (3.7)	5 (3.2)
<i>Before your induction, did your provider ask for your permission?</i>	N = 279	N=164	N = 115
<i>Yes</i>	195 (69.9)	112 (68.3)	83 (72.2)
<i>No</i>	71 (25.4)	43 (26.2)	28 (24.3)
<i>Refused</i>	1 (0.4)	1 (0.6)	0 (0.0)
<i>Don't Remember</i>	12 (4.3)	8 (4.9)	4 (3)

Episiotomy was done in 39.9% of women having vaginal delivery in the *Sample 2* group and in 72.2% of women having vaginal delivery in the *Sample 1* group. Women undergoing episiotomy were not asked for consent in 62.0% of the *Sample 1* group and in 57.1% of the *Sample 2* group. It is interesting to note that 2.2% of women refused to undergo episiotomy, still it was done in spite of explicit refusal. Freedom to choose labour position for women having vaginal birth was restricted in 65.7% of the *Sample 1* group and in 46% of the *Sample 2* group (*Table 8*).

Table 8  
Birth Outcomes: Consent and choice

	Total	Sample 1	Sample 2
<i>Before your episiotomy did you doctor ask for your permission?</i>	N = 463	N = 258	N = 205
<i>Yes</i>	152 (32.8)	84 (32.6)	68 (33.2)
<i>No</i>	277 (59.8)	160 (62.0)	117 (57.1)
<i>Refused</i>	10 (2.2)	2 (0.8)	8 (3.9)
<i>Don't Remember</i>	24 (5.2)	12 (4.7)	12 (5.9)
<i>Was your labour position freely chosen by you?</i>	N = 919	N = 394	N = 525
<i>Yes</i>	383 (41.7)	119 (30.2)	254 (50.3)
<i>No</i>	501 (54.5)	259 (65.7)	242 (46.1)
<i>Don't Remember</i>	35 (3.8)	16 (4.1)	19 (3.6)

We also analysed the possible connection between education level of women and the rate of unconsented labour induction. Merging the data of the two groups has found that women with a low and middle level of education had a higher chance of having unconsented labour inductions: the unconsented ratio was 31.8% in the low education level group and 32.9% in the middle education level group, while women with a high education level had a ratio of only 19.6% (Table 9).

Table 9  
Before performing the induction of labour,  
did your provider obtain your permission to perform the induction?

	Education level			Total
	low	middle	high	
<i>Yes, they asked for it and I gave my permission.</i>	28 (63.6)	49 (59.8)	118 (77.1)	195 (69.9)
<i>No, they did not ask for my permission.</i>	14 (31.8)	27 (32.9)	30 (19.6)	71 (25.4)
<i>I refused the induction but they still did it.</i>	1 (2.3)	0 (0.0)	0 (0.0)	1 (0.4)
<i>I don't remember</i>	1 (2.3)	6 (7.3)	5 (3.3)	12 (4.3)
<i>Total</i>	44 (100.0)	82 (100.0)	153 (100.0)	279 (100.0)

Similarly, the ratio of unconsented episiotomy was higher in the low education level group (76.9%), 62.3% in the middle education level group, and the lowest in the high education level group (55.1%) (Table 10).

Table 10  
Permission to do episiotomy

	Education level			Total
	low	middle	high	
<i>Yes, they asked for it and I gave my permission.</i>	8 (15.4)	47 (32.2)	97 (36.6)	152 (32.8)
<i>No, they did not ask for my permission.</i>	40 (76.9)	91 (62.3)	146 (55.1)	277 (59.8)
<i>I refused the induction but they still did it.</i>	1 (1.9)	1 (0.7)	8 (3.0)	10 (2.2)
<i>I don't remember</i>	3 (5.8)	7 (4.8)	14 (5.3)	24 (5.2)
<i>Total</i>	52 (100.0)	146 (100.0)	265 (100.0)	463 (100.0)

Restricting the freedom of choosing a birth position was the highest (77.2%) in the case of obstetrician- and hospital midwife-attended births, while it was 0% when the birth was attended by a home-birth midwife (Table 11).

Table 11  
Was the birth position freely chosen by you?

	Yes	No	<i>I don't remember</i>	Total
<i>An obstetrician/gynaecologist alone</i>	20 (5.2)	53 (10.6)	2 (5.7)	75 (8.2)
<i>A hospital midwife alone</i>	33 (8.6)	36 (7.2)	3 (8.6)	72 (7.8)
<i>An obstetrician/gynaecologist and a hospital midwife together</i>	235 (61.4)	387 (77.2)	27 (77.1)	649 (70.6)
<i>A home-birth midwife</i>	66 (17.2)	0 (0.0)	0 (0.0)	66 (7.2)

Unconsented caesarian section was the highest in the middle education level group (15.3%), and lower in the other two groups: 9% in the high level education group, and 7.4% in the low level education group (Table 12).

Table 12  
Permission to perform caesarean section

	Education level			Total
	low	middle	high	
<i>Yes, they asked for it and I gave my permission.</i>	47 (87.0)	98 (79.0)	193 (86.9)	338 (84.5)
<i>No, they did not ask for my permission.</i>	4 (7.4)	19 (15.3)	20 (9.0)	43 (10.8)
<i>I refused the induction but they still did it.</i>	0 (0.0)	2 (1.6)	3 (1.4)	5 (1.3)
<i>I don't remember</i>	3 (5.6)	5 (4.0)	6 (2.7)	14 (3.5)
<i>Total</i>	54 (100.0)	124 (100.0)	222 (100.0)	400 (100.0)

## 6. Discussion

Caesarian section is a major surgical intervention thus requiring explicit informed consent. The legal regulations in Hungary described above allow physicians to perform medical interventions on pregnant women without their explicit consent even in spite of their explicit refusal. Women in our research reported that in the case of 1 of 10 women caesarian section was done without consent, and 1 percent of them explicitly refused to undergo C-section. This seems to be a troublesome finding, since it is unlikely that C-section was considered as a medical emergency with such a frequency.

The findings with labour induction and episiotomy can be considered even more troublesome, since these are not life-saving interventions, save episiotomy in very rare cases. The *Sample 1* group had a 72% episiotomy rate which can be considered very high given that the routine use of episiotomy is not recommended. The unconsented ratio of this intervention is again very high (62.0%). It is interesting to note here that this is an intervention that is useless or harmful with some rarely occurring exceptions, still it is done with high frequency and it is done without the consent of women in a great majority of the cases. We have identified some women who had to undergo episiotomy in spite of their explicit refusal.

Based on our findings, the practice of episiotomy therefore is a violation of respectful care, it disrespects ethical norms of informed consent and effective legal requirements. Note that this group is a representative sample thus its conclusions are powerful.

Lack of time is often the justification for urgent and unconsented interventions, however, this can hardly be an acceptable justification in the case of episiotomy: this intervention can be planned, details and consent regarding this intervention can be planned prior to the commencement of labour. Moreover, it is unlikely that women would consent to episiotomy if they were informed about its advantages and disadvantages in a professional manner.



The case is similar with labour induction: 1 of 4 women were given labour induction without consent. Again an intervention with a questionable medical benefit is done unconsented with high frequency. We could not find any acceptable justification for this practice, even the time factor is an unlikely justification, since this intervention does not have to be done with urgency.

Restricting the freedom of women to choose labour position is again a policy not justifiable with medical evidence. A practice that may cause harm in many cases is again a symbol of disrespectful care.

The phenomenon of unconsented interventions during childbirth is, however, not restricted to Hungary. Many women worldwide experience poor treatment; having unconsented interventions is actually only one of seven categories of disrespectful care (physical abuse, non-consented clinical care, non-confidential care, non-dignified care, discrimination, abandonment and detention in health facilities) (BOHREN et al. 2015).

Findings regarding the educational level of women and the frequency of unconsented interventions raise interesting questions. We could not find conclusive evidence about causal relationship, still women with a higher education seem to have some advantage if they want to avoid unconsented interventions.

It is a limitation of our study that we had access to Internet users only; Internet illiterate women were excluded from the survey. We do not have reasons to hypothesise that the consent ratio among Internet illiterate women was better than described above, however we believe this aspect of our research deserves further analysis in the future.

Moreover, the respondents' recollection of events may be inaccurate, in spite of the fact that the birth of their children had been born within five years. We still think that these limitations cannot be made responsible for all the troublesome findings.

Another argument regarding consent is frequently cited in clinical practice: patients (women) are requested to sign an informed consent form at admission to hospital. This practice is criticizable for its legal and ethical validity since at admission women may not know about the nature and extent of interventions planned for them, therefore we cannot accept this 'consent' practice as a valid consent.

## **7. Conclusions**

We have found that the right of women to informed consent and the best available treatment was frequently and seriously violated in the obstetric practice in Hungary in the given period.

One may think that the publication of these unfavourable results may result in furthering hostility against obstetricians and the health care system in general. On the contrary, we believe that revealing bad practices regarding legal, ethical and professional norms may facilitate the obstetric community to review and reassess their practice to enable corrective measures to improve the quality of maternity care and reinforce trust in the maternity service.

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