Australasian Emergency Care 27 (2024) 218–226

Contents lists available at ScienceDirect

Australasian Emergency Care

journal homepage: www.elsevier.com/locate/auec

Systematic review

The significance of paramedic communication during women's birth experiences: A scoping review

Haley J. Findlay [a,*], Judith K. Anderson [a], Karen L. Francis [b], Lisa M. Clegg [c], Sonja J. Maria [a]

[a] Charles Sturt University, Panorama Avenue Bathurst, School of Nursing, Paramedicine and Healthcare Sciences, Panorama Avenue, Bathurst, NSW 2795, Australia
[b] Charles Sturt University, School of Nursing, Paramedicine and Healthcare Sciences, Wagga Wagga, NSW 2627, Australia
[c] Charles Sturt University, School of Nursing, Paramedicine and Healthcare Sciences, 7 Major Innes Rd, Port Macquarie, NSW 2444, Australia

ARTICLE INFO

Article history:
Received 12 February 2024
Received in revised form 9 April 2024
Accepted 10 April 2024

Keywords:
Parturition
Home childbirth
Paramedics
Communication
Birth trauma
Woman-centred

ABSTRACT

Background: Internationally, over one-third of women experience birth trauma, leading to adverse mental health outcomes. Poor communication with healthcare professionals is a primary contributing factor. Paramedics attend various clinical presentations, including childbirth, yet their potential impact on women's birth experiences has been largely overlooked.
Methods: A systematic literature search was conducted following the Joanna Briggs Institute methodological framework. The search identified 1015 potentially suitable articles, and 5 articles met the inclusion criteria. Data was analysed using reflexive thematic analysis from a feminist standpoint.
Results: Three themes were generated: 1. *First Impressions Count:* paramedic demeanour impacted the woman's sense of safety and perception of paramedic clinical competence. 2. *Choice as a Pathway to Control:* when paramedics involved women in decision-making, it led to empowerment, while non-involvement led to women becoming passive participants. 3. *Exposed, Violated and Disempowered:* some paramedics disrespected and abused women, treating them solely as objects for the purpose of producing a baby.
Conclusions: This review highlights the influence of paramedic communication on women's birth experiences. While some paramedics communicated respectfully, other paramedics were the perpetrators of Obstetric Violence. Future research should inform paramedic education and improve outcomes for birthing women.

Introduction

Childbirth is a significant event in a woman's life that should be positive and empowering [1–3]. A positive birth experience reduces the risk of mental health conditions and positively impacts relationships, mother-infant bonding and breastfeeding [1,2,4]. Despite the significant impact of birth, globally, around one-third of women experience birth trauma, with substantial numbers of women reporting the occurrence of Obstetric Violence (OV) [5–7]. OV is violence against women that occurs during childbirth, with reported rates ranging between 17% in the United States to 58% across African countries [8]. A recent Australian study by Keedle et al. [7] revealed that more than 1:10 Australian women experience OV across a range of birth settings.

Both the experience of OV [9,10] and birth trauma can jeopardise family relationships and lead to significant maternal mental health conditions such as postnatal depression and post-traumatic stress disorder (PTSD) [1,4,11–14]. Such an event can impact maternal caregiving, disrupt infant bonding and attachment and affect the child's emotional, social and cognitive development [5,15]. In addition, birth trauma can influence decisions around future birth planning, such as delaying or avoiding pregnancy and delaying or avoiding care [5,16–18].

Qualitative studies across various birth settings suggest interpersonal communication with care providers is a primary factor contributing to women experiencing birth trauma [2,13,19]. Two qualitative meta-analyses found that care provider communication that was perceived as negative was a significant risk factor for PTSD [20,21]. In addition, Harris and Ayers [19] identified care provider communication as the strongest predictor of developing PTSD after childbirth, while Murphy and Strong [1] found that women rated the importance of communication significantly higher than the care

* Corresponding author.
E-mail address: hfindlay@csu.edu.au (H.J. Findlay).

https://doi.org/10.1016/j.auec.2024.04.002

Table 1
Inclusion and Exclusion Criteria focussing on the *PCC framework*.

Inclusion	Exclusion
Participant: Birthing women and emergency ambulance personnel such as paramedics, emergency medical technicians and ambulance nurses	Participant: Not focused on birthing women and emergency ambulance personnel such as paramedics, emergency medical technicians and ambulance nurses. Focuses on healthcare professionals other than emergency ambulance personnel such as paramedics, emergency medical technicians and ambulance nurses
Concept: Communication between birthing women and emergency ambulance personnel such as paramedics, emergency medical technicians, ambulance nurses	Concept: Does not focus on communication between birthing women and emergency ambulance personnel such as paramedics, emergency medical technicians and ambulance nurses
Context: Out-of-hospital/prehospital care setting and interfacility transfers	Context: Hospitals, maternity units, birth centres and other healthcare settings
Peer Reviewed Journal Article	Not a Peer Reviewed Journal Article
Date published is within timeframe (2002- 2023)	Date published is prior to 2002
Language Available English	Language other than English

providers' clinical skills. Supporting these findings, women have expressed the immediate need for improved communication and emotional support from healthcare professionals (HCP) during childbirth [22,23].

Paramedics respond to a wide variety of clinical presentations, including medical and trauma-related incidents. Due to the unpredictable nature of birth, they are also essential in providing care to birthing women [24–26]. However, paramedic involvement in maternity care is uncommon, with one Australian study identifying that intrapartum care represented only 0.5% of the paramedic caseload [24]. Although paramedic attendance during out-of-hospital birth is infrequent, it is vital to listen to the perspectives of all women, particularly because of the significant impact that birth experience has on maternal mental health [1,5,6]. Despite this, research on paramedics' involvement in maternity care is scarce [24]. A study by Flanagan et al. [16] highlighted that paramedics lack the interpersonal communication skills needed to provide adequate emotional support to birthing women, with women reporting feeling violated, disrespected and patronised. The traditional focus of paramedic training on technical skills [27], may not have prioritised the elements of woman-centred care, such as interpersonal communication.

Given the profound impact that HCP interactions have on women's birth experiences and subsequent mental health outcomes [2,13,19], there is a noticeable gap in understanding the role of paramedic communication within the out-of-hospital childbirth setting. This scoping review aimed to explore the concepts surrounding interpersonal communication between paramedics and birthing women, utilising a feminist theoretical lens. The objective was to identify how paramedic communication influences women's birth experiences and to illuminate existing knowledge gaps in the literature. The exploration of this topic is crucial for informing future research and identifying interventions that ultimately enhance the quality of maternity care provided by paramedics and contribute to positive and empowering childbirth experiences for women [28–30].

Review question

How does interpersonal communication between birthing women and paramedics shape the experience of out-of-hospital childbirth?

Inclusion criteria

The 'participant, concept, context' framework (Table 1) was used to define the inclusion criteria. This scoping review focused on communication between paramedics and birthing women. Therefore, only studies that included birthing women and emergency ambulance personnel such as paramedics, emergency medical technicians and ambulance nurses were included in the review. The review considered studies within the out-of-hospital setting where paramedics had been called to provide emergency assistance for either the birthing woman or newborn during labour or immediately following birth. It included unplanned out-of-hospital births, planned home births, free births (where the woman has planned to give birth at home without the assistance of a HCP) and women being transferred to an alternative facility while in labour. The phenomenon of interest was out-of-hospital childbirth; the overarching concept was the experience of communication between the participants. Environments such as hospital settings were excluded from this review unless paramedics were required to care for women in labour during interfacility transfers. No articles were excluded by geographical region.

Methods

This scoping review was conducted following the Joanna Briggs Institute nine-step methodological framework and utilised the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews [28,31]. The protocol for this review was prospectively registered with Open Science Framework – https://doi.org/10.17605/OSF.IO/DQFXG.

Types of sources

This review considered studies that focused on qualitative data, including but not limited to designs such as phenomenology, grounded theory, ethnography, narrative enquiry, qualitative description, action research, and feminist research. In addition, quantitative data and systematic reviews that met the inclusion criteria were also considered for inclusion, depending on the research question. This review did not include text, opinion papers or grey literature.

Search strategy

A three-phase search strategy was employed with the aim of finding peer-reviewed published articles. A total of five databases were searched; firstly, an initial search of MEDLINE (OVID) and CINAHL (EBSCOhost) was undertaken to identify articles on the topic. The text words included in the titles and abstracts of suitable studies and the index terms used to describe the articles were used to design a complete search strategy for MEDLINE (OVID), CINAHL (EBSCOhost), Emcare (OVID), ProQuest Nursing and Allied Health Database and Scopus. These five databases were selected as they were relevant to the paramedicine discipline and the review question. Additionally, Scopus was chosen as a multidisciplinary citation database that covers a range of subjects. The search strategy was adjusted for each specified database. The reference lists of all studies included in this scoping review were screened to identify any further

studies. Only articles published in English, and those studies published since 2002 were included as ambulance service organisations have changed considerably since this date, including paramedics being university-trained and educated. The most recent search was conducted on the 13th of November 2023. Search results for CINHAL (EBSCOhost) are reported in Appendix 1 as an example.

Study selection

Once the search was complete, all selected articles were imported into EndNote Version 20.6 [32], and duplicates were removed. The abstract and citation components of the articles were then imported into the JBI System for the Unified Management, Assessment and Review of Information (JBI SUMARI) [33], where the screening process involved two phases to identify suitable articles. The first phase involved three independent reviewers (HF, SM and JA) screening the titles and abstracts for examination against the inclusion criteria. Each article was screened twice, once by reviewer HF and a second time by either reviewer SM or JA. Any disagreements between the reviewers at each step of the selection process were decided through discussion until a consensus was reached.

Those articles that were identified as potentially suitable were screened in the second phase. These articles were retrieved in full and were uploaded into JBI SUMARI [33]. Two independent reviewers (HF and SM) evaluated the full-text version of the identified articles in detail against the inclusion criteria. The study inclusion process is presented in Fig. 1, PRISMA-SCR flowchart [34]. Fig. 2.

Data extraction

Data was extracted from the articles identified for inclusion in a characteristics table adapted from the JBI template source of evidence details, characteristics and results extraction instrument [28]. Data extracted included author(s), year of publication, country, journal, study design, population, concept and context.

Theoretical approach

A feminist standpoint served as the lens that guided all elements of this review. It was seen as a suitable theoretical approach as a feminist viewpoint can offer an in-depth understanding of women's experiences, influence social and organisational change and reveal inequalities experienced by women [30,35,36]. Feminist standpoint theory recognises the various factors that shape women's experiences through aspects related to gender and power and asserts that knowledge should be grounded in women's lived experiences [35–37]. Therefore, this study was guided by women's voices, as women's perspectives during childbirth play a pivotal role in understanding women's broader societal position [29,36].

Data analysis

Reflexive thematic analysis (RTA) was selected as a robust method to facilitate identifying and interpreting patterns across the dataset of included articles [38]. The articles that met the inclusion criteria were managed manually, and data analysis was completed following Braun and Clarke's [38,39] six phases of RTA, which involved a non-linear systematic process of data coding to generate themes. Reviewer HF used a combination of inductive and deductive analysis. Inductive analysis was used as the predominant approach and involved open coding, while deductive analysis was utilised to ensure the overall direction led towards theory-based meaning. Both semantic and latent coding were used when meaningful data was interpreted by the researcher. There was no critical appraisal of the included studies, as the review aimed not to produce a critically appraised result but to map the current literature relevant to the research question to inform future research [40].

Positionality and reflexivity

Both positionality and reflexivity are important elements in feminist and qualitative research, particularly when researching socially oppressed groups [38,41,42]. The authors all identify as women and are from a range of disciplinary backgrounds, including paramedicine, nursing and midwifery. Importantly, the authors have lived the experience of the phenomena of interest, including being both the attending paramedic (HF, SM and LC) and the birthing woman (HF). The authors recognise that knowledge is situated and unavoidably shaped by the practices of the researcher. Therefore, RTA is inherently subjective, which is considered a valuable and essential aspect of RTA [38]. Because of the subjective nature of RTA, reflexivity was an essential component of all phases of the research project and involved self-awareness and reflection of underlying assumptions, expectations, and actions throughout the research process [41–43]. Reflection involved regular team meetings, journal keeping and the self-interrogation of values, choices, and positionality of the researcher.

Findings

Characteristics of included articles

Studies (n = 5) included women who experienced unplanned out-of-hospital birth either shortly before or after paramedic arrival or women who were transferred to a maternity unit by paramedics while in labour. None of the participants had planned to birth at home. Articles were published between 2012 and 2020 and spanned across 5 different journals, BMC Emergency Medicine (n = 1) [11], Africa Journal of Nursing and Midwifery (n = 1) [44], Midwifery (n = 1) [45], International Emergency Nursing (n = 1) [46] and BMC Pregnancy and Childbirth (n = 1) [47]. Studies originated from 5 different countries, Australia (n = 1) [11], South Africa (n = 1) [44], Norway (n = 1) [45], Sweden (n = 1) [46] and England (n = 1) [47]. A range of qualitative study designs were used, including narrative enquiry, qualitative interview, qualitative questionnaire and explorative descriptive designs. All participants were over the age of 18 and of childbearing age.

Reflexive thematic analysis

Three themes were generated from the data analysis. Theme one and theme two each had two related sub-themes, while theme three stood alone without any subthemes being generated. Table 2 demonstrates the main themes to be discussed.

Theme One: First Impressions Count [11,44–47].

The theme "***First Impressions Count***" explores a core idea expressed throughout the data – that paramedic demeanour directly impacts how women experience birth [11,44–47]. Participants described paramedic demeanour as either calm or stressed, and their experiences were divided based on this distinction. Paramedic demeanour directly influenced the woman's sense of safety and her perception of the paramedic's level of professionalism and clinical competency [11,44–47].

A calm approach was associated with the paramedic being perceived as confident, caring, and compassionate [11,44,46]. Some birthing women valued paramedics, who they described as having a

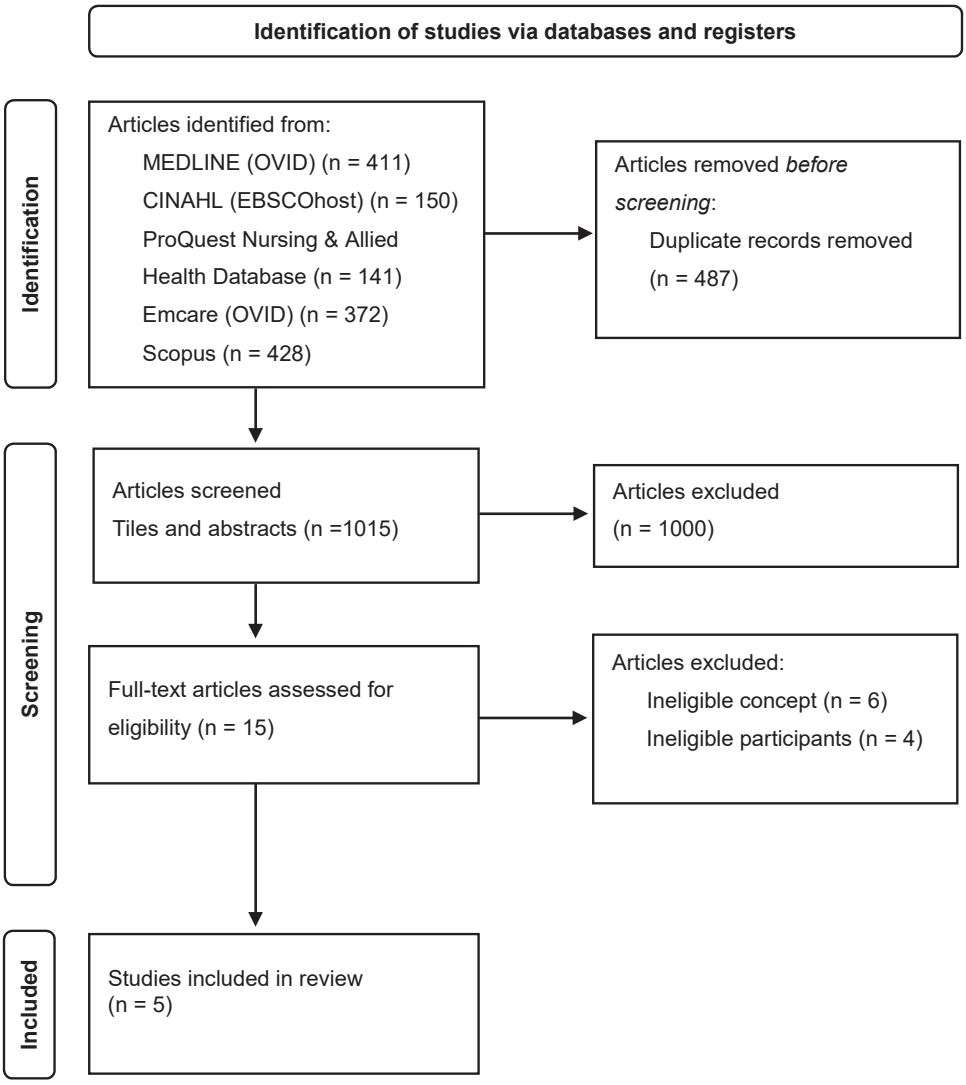

Fig. 1. : *PRISMA-ScR Flowchart.*

calm approach during their birth experience. The approach adopted by these paramedics reflects the positioning of these women as central to their care, which assisted women in maintaining ownership over their birth [47]. Paramedics with a calm demeanour were also more likely to provide reassurance, which was well received and wanted by birthing women [11,44,46,47].

> *"So, what made him amazing? His voice, he just kept on talking to me, kept on talking me through everything and when I got in the ambulance, I was alone with them but not with anyone that I knew, and it was just his voice was very calm and he just kept on talking and reassuring me"* [11].

In contrast, a stressed approach was associated with paramedics being rushed, disconnected, and lacking empathy. Based on these paramedics' stressed and withdrawn approach, women described feeling fearful and uncertain about what would happen [11,45,47]. When paramedics were perceived as stressed, they were also likely to be viewed as untrustworthy, clinically incompetent, and unprofessional by the participants [45].

Safety was a recurring concept reflected in the participants' stories with descriptions of feeling safe or unsafe based on paramedic demeanour [45,46]. Threat to safety is known to contribute to birth trauma or negative birth experience, and this was reflected in the data [45]. A paramedic who appeared stressed resulted in the birthing woman being concerned over the wellbeing of herself or her baby. Some participants stated they were glad the paramedics arrived after the birth based on how stressed the paramedics appeared to be [45]. While calm paramedics reinforced a sense of safety, and left women more likely to speak positively about their birth experience [44,46]. When women were involved in decision-making, they were also more likely to feel safe [46,47] as opposed to fearful when control was taken by the paramedic and choice was removed from the woman [11,45,47].

Theme Two: Choice as a Pathway to Control [11,45–47].

The theme ***"Choice as a Pathway to Control"*** explores a core concept represented in the data – when women were involved in decision-making, it led their birthing experience down a pathway to empowerment [46,47]. In contrast, when a lack of choice was afforded to women, a different pathway was travelled, and these women became passive participants [11,45,47].

Within the data, participants' stories depicted women feeling in control, valued and respected when paramedics gave them options

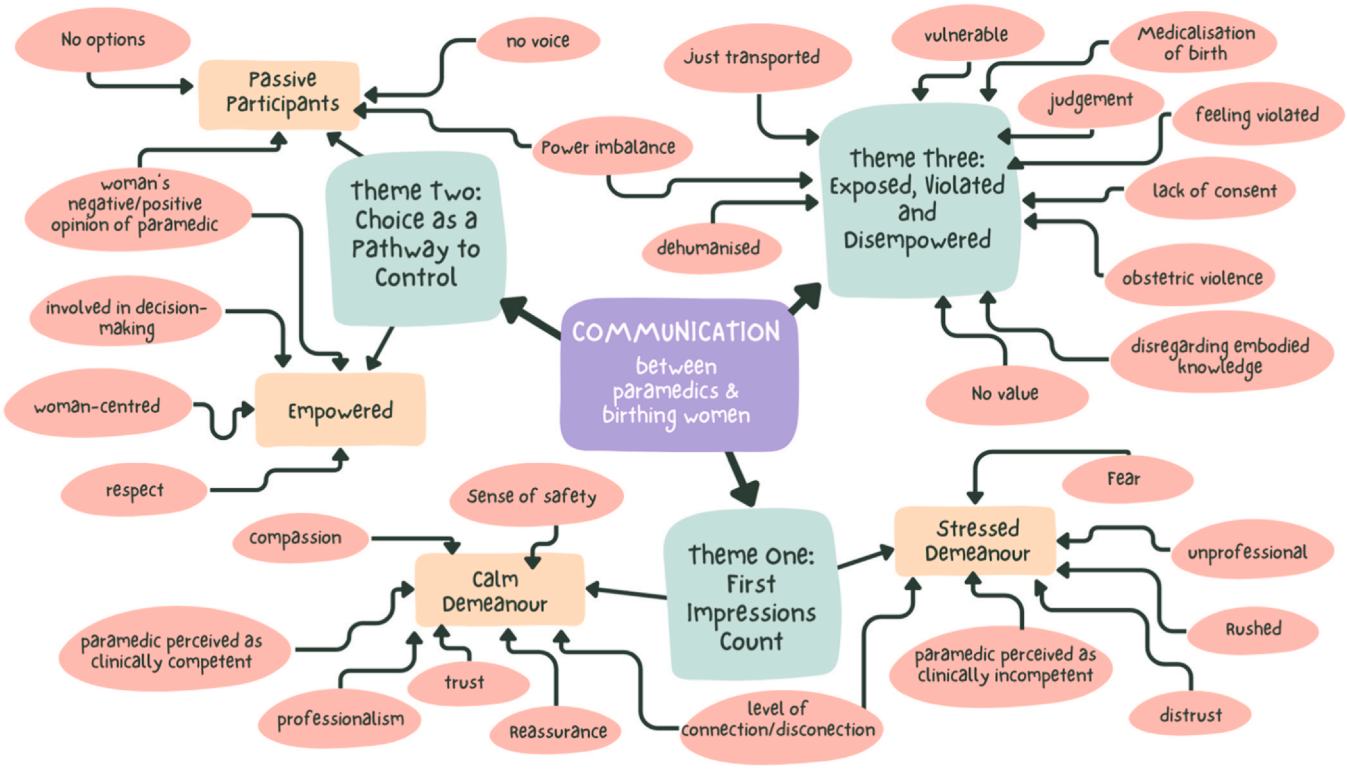

Fig. 2. : *Results.*

Table 2
Reflexive Thematic Analysis – Results.

Themes	Subthemes
Theme 1: First Impressions Count	Sub-theme 1: Stressed Demeanour Sub-theme 2: Calm Demeanour
Theme 2: Choice as a Pathway to Control	Sub-theme 1: Empowered Sub-theme 2: Passive Participants
Theme 3: Exposed, Violated and Disempowered	

[11,47]. When birthing women were in control, they were actively involved in decision-making, which contributed to the woman's sense of holding power, maintaining ownership over her experience and trusting her body's ability to give birth. When women were in a position of control, it allowed them to speak freely and advocate for themselves and their babies. When women were involved in decision-making, such as when paramedics fulfilled their preferences during labour, women were more likely to describe the paramedics positively, such as being *"fantastic"* [11,46].

In contrast, not giving women birthing options resulted in a power imbalance where the paramedics held all the power over the woman's body, her baby and her experience [11,45]. These women felt they needed to ask for permission and comply with the paramedic's agenda. Having no control over their experience left them without a voice, and they could not express their wants and needs [47].

> *I don't think he (the ambulance staff) understood how uncomfortable I was on the stretcher and kind of not being able to move, because I'd been so active throughout the labour…. Even if I could have sat up in the ambulance (it) would have made a difference I think, but I wasn't given an option, it was just like, "Here's the bed, are you on it? Strap on, off we go."…And I think maybe if I'd thought about it more and hadn't been… in such a place in my head, I would have said… "Look, can I sit up? Can I move around, can I do this and whatever?"… but… I just felt that was a bit taken out… of my control because… I just was uncomfortable and didn't feel like I could ask to be different* [47].

When women were not involved in decision-making, they perceived they had no choice and became passive participants [11,45,47]. During these interactions, a hierarchy existed where paramedics remained at the peak. In some cases, this power imbalance was so extreme that it could result in women being disrespected and treated as though only their babies possessed value [11,45].

Theme Three: Exposed, Violated and Disempowered [11,45,47].

The theme ***"Exposed, Violated and Disempowered"*** explores a central concept expressed in the data – that power dynamics created an imbalance where paramedics held authority, and the asymmetry of power sometimes resulted in the mistreatment of women [11,45,47]. Some paramedics communicated with women as though they existed only to serve the purpose of carrying and birthing their babies [11,45]. These women were not valued; they were reduced to just bodies, separate from the spiritual, cultural and psychological dimensions of self. The body, seen as machine-like, was expected to conform and function in a particular way, with expectations set by the paramedic [11,45].

Women's stories express how their intuitive knowledge was frequently disregarded, which was represented when one participant repeatedly stated, "She's coming," as she birthed her baby's head. At the same time, the paramedic responded, "No, she's not", continuing to tell her she was wrong and that her baby was not being born [11]. These women felt "violated" [11,47] and "exposed" [47] as paramedics looked at their naked bodies and touched their perineum without consent [11]. Lack of consent and reports of obstetric violence (OV) were echoed in the stories of these participants [11]. One woman's legs were forced open, and she was physically restrained, unable to move as she was shouted at, being required to give birth in a particular way that was dictated by the paramedic [11].

> *"He starts shouting orders and then he sits back there for quite some time holding my legs open, wouldn't let me move, just holding them open … I was just like shocked at his behaviour"* [11].

These women described feeling subservient to paramedics; they were scolded and patronised for their choices and for not birthing in a hospital where they could be better watched and controlled and the HCPs could take ownership of what they regarded as safe [11]. Women described being "strapped down" on the stretcher, feeling vulnerable and exposed, and being "transported" rather than cared for [47]. Women expressed feeling dehumanised. One participant recalled feeling as though she had been to see a "vet" while medical inventions were carried out on women's bodies and their babies without consent [11].

Paramedics disregarded the unique and multidimensional aspects of the mother, diminishing her value to merely being a body for childbirth. Women were denied fundamental human rights and subjected to violent and abusive care. Paramedics declared ownership over the woman and her body [11].

Discussion

The findings of this scoping review highlight the importance of interpersonal communication between paramedics and birthing women by identifying how these interactions significantly impact women's birth experiences. The results are consistent with a growing body of knowledge across various birth settings, emphasising the relationship between communication and birth experience. Childbirth is a significant event in a woman's life, and inadequate communication and mistreatment by HCPs can lead to birth trauma, which has substantial short and long-term ramifications [3,7,48,49].

In this review, women described the significant impact of communication from the initial engagement with the paramedic. Participants characterised paramedic demeanour as either calm or stressed, and this directly influenced the participants' sense of safety and their perception of the paramedic's level of professionalism and clinical competency [11,44–47]. From an evolutionary perspective, humans are designed to interpret messages from social interactions and determine whether the person is a threat to safety [50]. This survival mechanism is a key element of human social cognition [50,51]. Fiske et al. [50] reveal that social perception is achieved through two universal dimensions of social cognition: warmth and competence. These dimensions are fundamental to human interaction and how people are perceived.

This paper demonstrated how humans are primed to respond innately to these fundamental dimensions that assist in the interpretation of human intent. Paramedics who relayed a calm demeanour were more likely to portray positive attributes associated with the warmth dimension, such as being friendly, compassionate and trustworthy [44,46,47]. As the warmth dimension is associated with perceived intention, these women were more likely to feel safe [50,51]. In contrast, paramedics who appeared stressed lacked warmth and were viewed negatively, being seen as unprofessional and untrustworthy and creating an environment where participants were fearful [45,47]. The second dimension, the competence dimension, captures traits related to perceived ability and skill level [50,51]. Within the data, participants characterised paramedic clinical competency based on paramedic demeanour. Paramedics who were calm were seen as clinically competent, while paramedics who appeared stressed were viewed as clinically incompetent. Again, this proved to have a direct impact on feelings of safety [46].

Safety is a recurring concept echoed in the participants' stories, and the need to feel safe during childbirth is well documented. When women feel safe, they experience more positive emotions and are more likely to have positive psychological outcomes [1,3]. In contrast, a threat to safety is known to contribute to birth trauma [21,22]. Downe et al. [52] explored what women wanted most during childbirth and revealed similar concepts in relation to safety. Women voiced the need for a positive birth experience with key aspects including feeling safe, supported, and respected. The findings of this review aligned with these key aspects. Women spoke positively about paramedics with a calm demeanour, expressing that these paramedics were more likely to offer reassurance and support [44,46,47]. Perceived support during birth is a protective factor against birth trauma and reduces the risk of developing PTSD after childbirth [21,53]. The impact of paramedic demeanour on birth experience highlights the requirement for paramedics to maintain a calm approach even when they are feeling stressed.

The second theme generated in this review illuminated the profound impact feeling in control has on women's birth experiences. Feeling in control came primarily in the form of involvement in decision-making [11,46]. It is well established that feeling in control during childbirth influences how women experience birth and has implications for subsequent well-being [22,23,54]. Green and Baston [23] discuss the elements of "being in control", identifying that involvement in decision-making is a significant aspect. They found that feeling in control during childbirth is strongly associated with the experience of respectful interpersonal communication with HCPs. In addition, Bylund [54] found that a higher level of involvement in decision-making directly correlates to feeling in control and more positive emotions felt during birth.

As was reflected in that data, when women are in control, the inherent power imbalances are shifted, and women are positioned as the experts. Women speak freely, advocating for their needs and sharing their expectations and aspirations unique to their circumstances [13,21,23,55,56]. A meta-synthesis by Montgomery et al. [57] found that feeling in control and maintaining a trusting and safe relationship with HCPs can create an environment where childbirth is experienced as healing for women who have experienced childhood sexual abuse. The healing nature of birth has been well documented not only for sexual abuse survivors but also for women with various trauma backgrounds [58,59]. This emphasises the significance of birth experience and the requirement for trauma-informed care within the paramedic profession and broader healthcare context, particularly because lack of control can contribute to re-traumatisation [1,21,53,57,60].

When women lack control and involvement in decision-making, there are negative implications for how they experience birth. Hollander [22] found that women attributed a lack of control and inadequate emotional support and communication from HCPs as the primary reasons for their birth trauma. This is consistent with the finding of Ayers et al. [21], who highlight that a lack of control during birth is one of the most strongly associated risk factors for developing PTSD after childbirth. Literature on this aspect is resoundingly

clear: a perceived lack of control and lack of involvement in decision-making can contribute to the experience of birth trauma [13,21,22,53,54,56].

Within the results of this paper, there was a concerning narrative involving the mistreatment of women by paramedics and the inability to respect women's embodied birth knowledge [11,45]. Some paramedics communicated with women as though they existed only to serve the purpose of carrying and birthing their babies. A feminist standpoint provided the lens to illuminate how women were not valued; they were reduced to just bodies and were expected to conform and function in a particular way, with expectations set by the paramedic [11,45,47]. Paramedic care provided to birthing women consistently failed to meet the multidimensional aspects of birth, and there was a clear influence of the technocratic healthcare model.

Feminist scholars have highlighted the impact of power within traditional hierarchical healthcare structures, such as the technocratic model, where the HPC is viewed as the "expert" and holds the position of authority [61,62]. The technocratic model separates the mind from the body, and the woman's body is viewed as machine-like [62,63]. This fundamentally differs from the holistic paradigm that promotes the connection of the mind, body and spirit [62]. Globally, the technocratic model of birth dominates maternity care and can lead to women's intuitive knowledge being disregarded and the unnecessary medicalisation of birth, where women are forced into biomedical standards [61,62]. There is disconnection from the woman, and value is placed solely on short-term results, such as a live baby [62]. A feminist standpoint highlights how the influence of traditional hierarchical healthcare systems can exert a hegemonic influence on women's experiences, which can lead to OV and the routine mistreatment of women [7,62–64].

Obstetric Violence was first identified in 2007 by the Venezuelan "Organic Law on the Right of Women to a Life Free of Violence", which describes OV as the experience of childbirth becoming dehumanising, abusive and intrusive [65]. OV results in a loss of autonomy and the ability to decide freely, negatively impacting the quality of lives of women and can result in significant negative mental health outcomes such as PTSD [9,10]. The findings of this review highlight several accounts from women who experienced OV in paramedic care. Some women were subservient to paramedics, scolded and patronised for their choices. Other women reported feeling violated, having their bodies touched without consent, and described their birth experience as becoming dehumanising [11].

Brinceno Morales et al. [64] assert that HPCs are not violent by nature. Rather, OV is a form of structural violence occurring in a social and cultural environment favouring a hierarchical structure, leading to power imbalances between women and HCPs. Sadler et al. [66] discuss the complexities of OV and highlight the potential lack of awareness from the HPC perspective. However, Keedle et al. [7] stress the importance of not minimising the role of the HCP in OV and suggest that HPCs may use their position of power to coerce women into making decisions that comply with institutional guidelines. Therefore, it could be argued that paramedics leverage their power to pressure women into making decisions that adhere to ambulance service guidelines, potentially resulting in abusive care. Ultimately, the quality of paramedic care provided to birthing women must be addressed. Potential contributing factors influencing the prevalence of OV should be identified, along with the need to increase paramedic awareness and review the impact of restrictive ambulance policies [7,66].

Limitations

This review followed the systematic JBI Methodology for scoping views and used previously established search terms on the topic with assistance from an experienced librarian. However, despite comprehensive measures, relevant studies may be inadvertently omitted as there may be other terms that should have been included. Further, discrepancies in indexing keywords and descriptive terms in abstracts may have impacted search results. Additional limitations exist regarding the language being limited to English and that the views and voices of paramedics were not part of the included studies, which may have provided additional insights into interpersonal communication.

Conclusion

There is an existing body of literature that demonstrates the importance of HCP communication during childbirth and the impact on women's birth experiences. Poor communication is a leading factor contributing to birth trauma and subsequent negative mental health outcomes. However, the findings of this review identify a paucity of research exploring this phenomenon in the paramedic context. The results of the review demonstrate that paramedic communication influences the woman's birth experience during out-of-hospital childbirth. It further highlights that while some paramedics provided respectful maternity care, there was also evidence of Obstetric Violence perpetrated by paramedics. Therefore, the evolution away from the traditional hierarchical healthcare structure and move towards a woman-centred framework within paramedicine is crucial to improving women's birth experiences. Future research into paramedics' interpersonal skills, current education and culture surrounding women and birth is essential.

Funding

The authors received no financial support for the research, authorship or publication of this article.

Ethical statement

This is a scoping review; therefore, an ethical statement is not applicable.

CRediT authorship contribution statement

All authors meet the criteria for authorship, and all people entitled to authorship are listed as authors. HF: conceptualisation; data curation; formal analysis; investigation; methodology; writing – original draft; writing – review and editing. JA: data curation; formal analysis; writing – original draft; writing – review and editing. KF: data curation; formal analysis; writing – original draft; writing – review and editing. LC: data curation; formal analysis; writing – original draft; writing – review and editing. SM: data curation; formal analysis; methodology; writing – original draft; writing – review and editing.

Declaration of competing interest

The authors confirm there are no conflicts of interest to disclose.

Acknowledgement

The authors would like to thank Lorraine Rose from Charles Sturt University for her guidance and advice in the search strategy for this project.

Author agreement

We confirm that this work is the author's original work. The article has not received prior publication and is not under

consideration for publication elsewhere. All authors have seen and approved the manuscript being submitted. The authors abide by the copyright terms and conditions of Elsevier and Australasian Emergency Care.

Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.auec.2024.04.002.

References

[1] Murphy H, Strong J. Just another ordinary bad birth? A narrative analysis of first time mothers' traumatic birth experiences. Health Care Women Int 2018;39(6):619–43.
[2] Reed R, Barnes M, Rowe J. Women's experience of birth: childbirth as a rite of passage. Int J Childbirth 2016;6(1):46–56.
[3] Dahan O. The riddle of the extreme ends of the birth experience: Birthing consciousness and its fragility. Curr Psychol 2023;42(1):262–72.
[4] Bell AF, Andersson E, Goding K, Vonderheid SC. The birth experience and maternal caregiving attitudes and behavior: a systematic review. Sex Reprod Health 2018;16:67–77.
[5] Alcorn KL, O'Donovan A, Patrick JC, Creedy D, Devilly GJ. A prospective longitudinal study of the prevalence of post-traumatic stress disorder resulting from childbirth events. Psychol Med 2010;40(11):1849–59.
[6] Soet JE, Brack GA, Dilorio C. Prevalence and predictors of women's experience of psychological trauma during childbirth. Birth 2003;30(1):36–46.
[7] Keedle H, Keedle W, Dahlen HG. Dehumanized, violated, and powerless: an Australian survey of women's experiences of obstetric violence in the past 5 years. Violence Women 2022. https://doi.org/10.1177/10778012221140138
[8] Perrotte V, Chaudhary A, Goodman A. At least your baby is healthy" obstetric violence or disrespect and abuse in childbirth occurrence worldwide: a literature review. Open J Obstet Gynecol 2020;10(11):1544–62.
[9] Martinez-Vázquez S, Rodríguez-Almagro J, Hernández-Martínez A, Martínez-Galiano JM. Factors associated with postpartum post-traumatic stress disorder (Ptsd) following obstetric violence: a cross-sectional study. J Pers Med 2021;11(5):338.
[10] Pérez D'Gregorio R. Obstetric violence: a new legal term introduced in Venezuela. Obstet Gynecol Int J 2010;111(3):201–2.
[11] Flanagan B, Lord B, Reed R, Crimmins G. Women's experience of unplanned out-of-hospital birth in paramedic care. BMC Emerg Med 2019;19(1):54.
[12] Delicate A, Ayers S, Easter A, McMullen S. The impact of childbirth-related post-traumatic stress on a couple's relationship: a systematic review and meta-synthesis. J Reprod Infant Psychol 2018;36(1):102–15.
[13] Reed R, Sharman R, Inglis C. Women's descriptions of childbirth trauma relating to care provider actions and interactions. BMC Pregnancy Childbirth 2017;17(1):21.
[14] Molloy E, Biggerstaff DL, Sidebotham P. A phenomenological exploration of parenting after birth trauma: mothers perceptions of the first year. Women Birth 2021;34(3):278–87.
[15] O'Hara MW, McCabe JE. Postpartum depression: current status and future directions. Annu Rev Clin Psychol 2013;9(1):379–407.
[16] Flanagan B, Lord B, Reed R, Crimmins G. Listening to women's voices: the experience of giving birth with paramedic care in Queensland, Australia. BMC Pregnancy Childbirth 2019;19(1):490.
[17] Patterson J, Hollins Martin C, Karatzias T. PTSD post-childbirth: a systematic review of women's and midwives' subjective experiences of care provider interaction. J Reprod Infant Psychol 2019;37(1):56–83.
[18] Jackson M, Dahlen H, Schmied V. Birthing outside the system: perceptions of risk amongst Australian women who have freebirths and high risk homebirths. Midwifery 2012;28(5):561–7.
[19] Harris R, Ayers S. What makes labour and birth traumatic? A survey of intrapartum 'hotspots'. Psychol Health 2012;27(10):1166–77.
[20] Grekin R, O'Hara MW. Prevalence and risk factors of postpartum posttraumatic stress disorder: a meta-analysis. Clin Psychol Rev 2014;34(5):389–401.
[21] Ayers S, Bond R, Bertullies S, Wijma K. The aetiology of post-traumatic stress following childbirth: a meta-analysis and theoretical framework. Psychol Med 2016;46(6):1121–34.
[22] Hollander MH, van Hastenberg E, van Dillen J, van Pampus MG, de Miranda E, Stramrood CAI. Preventing traumatic childbirth experiences: 2192 women's perceptions and views. Arch Women's Ment Health 2017;20(4):515–23.
[23] Green JM, Baston HA. Feeling in Control During Labor: Concepts, Correlates, and Consequences. Birth 2003;30(4):235–47.
[24] Flanagan B, Lord B, Barnes M. Is unplanned out-of-hospital birth managed by paramedics 'infrequent', 'normal' and 'uncomplicated'? BMC Pregnancy Childbirth 2017;17(1):436.
[25] McLelland G, McKenna L, Morgans A, Smith K. Epidemiology of unplanned out-of-hospital births attended by paramedics. BMC Pregnancy Childbirth 2018;18(1):15.
[26] McLelland G, McKenna L, Morgans A, Smith K. Paramedics' involvement in planned home birth: a one-year case study. Midwifery 2016;38:71–7.
[27] Flanagan B, Pearce J, Barr N, Eastwood K. PP14 An investigation of ambulance clinical recommendations for the management of obstetric emergencies in Australia and New Zealand. Emerg Med J 2021;38(9).
[28] Peters MDJ, Marnie C, Tricco AC, Pollock D, Munn Z, Alexander L, et al. Updated methodological guidance for the conduct of scoping reviews. JBI Evid Synth 2020;18(10):2119–26.
[29] Webb C. Feminist research: definitions, methodology, methods and evaluation. J Adv Nurs 1993;18(3):416–23.
[30] Parker B, McFarlane J. Feminist theory and nursing: an empowerment model for research. ANS. Adv Nurs Sci 1991;13(3):59–67.
[31] McGowan J, Straus S, Moher D, Langlois EV, O'Brien KK, Horsley T, et al. Reporting scoping reviews—PRISMA ScR extension. J Clin Epidemiol 2020;123:177–9.
[32] Team T.E. EndNote. 20.6 ed. Philadelphia, PA: Clarivate; 2013.
[33] Munn Z, Aromataris E, Tufanaru C, Stern C, Porritt K, Farrow J, et al. The development of software to support multiple systematic review types: the Joanna Briggs Institute System for the Unified Management, Assessment and Review of Information (JBI SUMARI). JBI Evid Implement 2019;17(1).
[34] Tricco AC, Lillie E, Zarin W, O'Brien KK, Colquhoun H, Levac D, et al. PRISMA Extension for Scoping Reviews (PRISMA-ScR): Checklist and Explanation. Ann Intern Med 2018;169(7):467–73.
[35] Barnes M. Research in midwifery — the relevance of a feminist theoretical framework. Aust Coll Midwives Inc J 1999;12(2):6–10.
[36] Woliver LR. The political geographies of pregnancy. Urbana: University of Illinois Press; 2002.
[37] Alvesson M, Willmott H. Feminist theory and critical theory: unexplored synergies. United Kingdom: SAGE Publications, Limited; 2003.
[38] Braun V, Clarke V. Thematic analysis a practical guide. London: SAGE Publications Ltd; 2022.
[39] Braun V, Clarke V. Reflecting on reflexive thematic analysis. Qual Res Sport Exerc Health 2019;11(4):589–97.
[40] Munn Z, Peters MDJ, Stern C, Tufanaru C, McArthur A, Aromataris E. Systematic review or scoping review? Guidance for authors when choosing between a systematic or scoping review approach. BMC Med Res Method 2018;18(1):143.
[41] Trainor LR, Bundon A. Developing the craft: reflexive accounts of doing reflexive thematic analysis. Qual Res Sport, Exerc Health 2021;13(5):705–26.
[42] Braun V, Clarke V. Toward good practice in thematic analysis: avoiding common problems and be(com)ing a knowing researcher. Int J transgender Health 2023;24(1):1–6.
[43] Finlay L, Gough B. Reflexivity: A Practical Guide for Researchers in Health and Social Sciences. Newark: Wiley-Blackwell; 2008.
[44] Fouché MS, James S. Experiences of mothers who give birth before arrival at the birthing unit. Afr J Nurs Midwifery 2018;20(1):1–15.
[45] Vik ES, Haukeland GT, Dahl B. Women's experiences with giving birth before arrival. Midwifery 2016;42:10–5.
[46] Svedberg E, Strömbäck U, Engström Å. Women's experiences of unplanned prehospital births: A pilot study. Int Emerg Nurs 2020;51.
[47] Rowe RE, Kurinczuk JJ, Locock L, Fitzpatrick R. Women's experience of transfer from midwifery unit to hospital obstetric unit during labour: a qualitative interview study. BMC Pregnancy Childbirth 2012;12(1):129.
[48] Keedle H, Lockwood R, Keedle W, Susic D, Dahlen HG. What women want if they were to have another baby: the Australian Birth Experience Study (BESt) cross-sectional national survey. BMJ Open 2023;13(9).
[49] Simonovic D. A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence: Note / by the Secretary-General. United Nations General Assembly,; 2019.
[50] Fiske ST, Cuddy AJC, Glick P. Universal dimensions of social cognition: warmth and competence. Trends Cogn Sci 2007;11(2):77–83.
[51] Howe LC, Leibowitz KA, Crum AJ. When your doctor "Gets it" and "Gets you": the critical role of competence and warmth in the patient-provider interaction. Front Psychiatry 2019;10:475.
[52] Downe S, Finlayson K, Oladapo O, Bonet M, Gülmezoglu AM. What matters to women during childbirth: a systematic qualitative review. PloS One 2018;13(4).
[53] Ford E, Ayers S. Support during birth interacts with prior trauma and birth intervention to predict postnatal post-traumatic stress symptoms. Psychol Health 2011;26(12):1553–70.
[54] Bylund CL. Mothers' involvement in decision making during the birthing process: a quantitative analysis of women's online birth stories. Health Commun 2005;18(1):23–39.
[55] Leap N. Woman-centred or women-centred care: does it matter? Br J Midwifery 2009;17(1):12–6.
[56] Baptie G, Januário EM, Norman A. Empowered or powerless? Contributing factors to women's appraisal of traumatic childbirth. Br J Midwifery 2021;29(12):674–82.
[57] Montgomery E. Feeling safe: a metasynthesis of the maternity care needs of women who were sexually abused in childhood. Birth 2013;40(2):88–95.
[58] Beck CT, Watson S. Subsequent childbirth after a previous traumatic birth. Int J Nurs 2010;59(4):241–9.
[59] Chamberlain C, Ralph N, Hokke S, Clark Y, Gee G, Stansfield C, et al. Healing The Past By Nurturing The Future: a qualitative systematic review and meta-synthesis of pregnancy, birth and early postpartum experiences and views of parents with a history of childhood maltreatment. PloS One 2019;14(12).
[60] Montgomery E, Pope C, Rogers J. The re-enactment of childhood sexual abuse in maternity care: a qualitative study. BMC Pregnancy Childbirth 2015;15(1):194.

[61] Davis-Floyd R, Sargent CF. Childbirth and authoritative knowledge: cross-cultural perspectives. Berkeley, Calif: University of California Press,; 1997.
[62] Davis-Floyd R. The technocratic, humanistic, and holistic paradigms of childbirth. Obstet Gynecol Int J 2001;75(1):5–23.
[63] Yuill O. Feminism as a theoretical perspective for research in midwifery. Br J Midwifery 2012;20(1):36–40.
[64] Briceño Morales X, Enciso Chaves LV, Yepes Delgado CE. Neither medicine nor health care staff members are violent by nature: obstetric violence from an interactionist perspective. Qual Health Res 2018;28(8):1308–19.
[65] Mena-Tudela D, Cervera-Gasch A, Alemany-Anchel MJ, Andreu-Pejó L, González-Chordá VM. Design and validation of the percov-s questionnaire for measuring perceived obstetric violence in nursing, midwifery and medical students. Int J Environ Res Public Health 2020;17(21):1–12.
[66] Sadler M, Santos MJDS, Ruiz-Berdún D, Rojas GL, Skoko E, Gillen P, et al. Moving beyond disrespect and abuse: addressing the structural dimensions of obstetric violence. Reprod Health Matters 2016;24(47):47–55.