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"*They were quick, insipid, and stuck to the typical medical checkups*": A Narrative Study on Women's Expectations and Experiences of Maternity Care in Bangladesh

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Abstract

The quality of healthcare service delivery is generally determined by how patients' expectations were met successfully. This narrative study explores how women perceive and experience healthcare during childbirth in the context of Bangladesh. This study is inspired by Clandinin and Connelly's three-dimensional paradigm of narrativity that combines temporality, social interaction, and place. To unearth patient-driven narratives, the researcher purposely picked 12 women who gave birth in different private and public health facilities in Bangladesh. Four themes standout from the women's narratives. Excerpts of women's stories have been included in discussing the themes as well as author's conviction on this phenomenon. Most of the participants experienced a shared level of difficulty in choosing the health facilities (private vs public), motivated primarily by delivery costs and social background. Women with a higher level of education and financial means often opted to give birth in private facilities due to their negative perception and experience of the public facility. There was evident discontent when doctors decided for cesarean deliveries. Women were dissatisfied by providers' general lack of empathy and vicarious emotion. However, those women who gave birth in public hospitals expressed some degree of satisfaction which might be attributed to their low expectations and moderate social standing. Women's stories also delved into how societal norms, taboos, and elderly relatives put them in uncomfortable situations. To improve patient–provider interactions, healthcare practitioners should prioritize patient-centered care and collaborative decision-making. Reducing healthcare disparity and resolving superannuated pregnancy norms are also critical challenges.

Keywords

narrative inquiry, healthcare decision-making, patient expectations, experiences, patient-provider interaction, societal norms

Introduction

Patients' healthcare experiences—how they are treated, and their preferences are recognized in healthcare decision-making—have long been a topic of concern, even more so in resource-constrained settings. Patient experiences are frequently seen as a crucial indicator of healthcare quality due to the perceived importance of patient satisfaction.[1] While healthcare delivery in low- and middle-income countries (LMICs) has improved, rising expectations and persistent health needs are pressuring health systems to run more efficiently to satisfy patients.[2] Patient happiness depends on positive interactions, consideration of complaints, compound cleanliness, and easy admission and discharge regulations. Patients clearly dislike tokenistic involvement in their healthcare decisions, especially when they feel their choices are ignored, surreptitiously pushed to accept, or decision has already been taken.[3]

In resource-constrained settings, it has been reported by several studies that the level of care women receive during the critical stage of their pregnancy and childbirth is below standard.[4,5] The number of maternal deaths in LMICs is frightful, and many women complain about the poor quality of care and services, which further jeopardize their chances of seeking maternity care.[5] The maternal healthcare

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service use in Bangladesh is still very low,[6] and it is important to understand this phenomenon from the women's perspective. The research on women's interactions with prenatal care and childbirth services in Bangladesh has been limited, despite the potential insights these narratives could provide into the reasons behind women's reluctance to utilize essential healthcare services. The utilization of health services can be improved by including women's narratives and shared experiences into the planning process. However, it is crucial for planners to approach this topic with prudence in order to achieve desired outcomes for the nation. The utilization of maternity care services and the attainment of improved health outcomes are also contingent upon effective communication and meaningful contact between individuals and healthcare professionals.[7] Understanding and measuring women's perceptions of maternity services, especially the level of interaction with providers, is essential for monitoring the quality of care provision.[8] One study in Bangladesh exploring married adolescent women's healthcare-seeking behaviors by using socio-ecological approach found myriads of factors ranging from individual, interpersonal, community, and organization level affects healthcare decision-making. The study expressed concerns on the limited qualitative evidence exists on the attitudes and practices of utilizing maternal health services.[9] The use of narrative analysis on this study group is scarce and can be proved vital in designing and implementing any future interventions.

The present study, therefore, explores women's expectations and experiences of the healthcare services in their last childbirth in the context of Bangladesh's private and public health sectors. In the specific setting of Bangladesh, public hospitals are generally considered as more economically accessible and geographically convenient for maternal and childcare services. Nevertheless, there is a prevailing worry regarding the quality of these services when compared to those offered by private hospitals. Private hospitals generally exhibit superior nursing care in terms of availability, responsiveness, and professionalism. Additionally, they tend to offer better fundamental amenities of care, such as cleanliness and the provision of utilities. Notably, private hospitals ensure the availability of healthcare providers round the clock.[10,11] A comparative study on the provision of emergency obstetric care (EmOC) has indicated that private hospitals possess a greater level of readiness in offering comprehensive EmOC services, in contrast to public hospitals which frequently face deficiencies in essential equipment, laboratory capacity, and staffing, including anesthesiologists and resident surgeons. Hence, in the light of dissatisfaction with the quality of treatments provided by public hospitals, people with the means to afford it often choose for private healthcare facilities, despite the much higher expenses involved.[12] This study aims to examine the experiences of women who have delivered in both types of facilities so that the similarities and dissimilarities can be understood, if there any. The study aims to synthesize women's narratives of being pregnant in their societal structure, the underlying issues that facilitate their healthcare choices (private/public), how they perceive and experienced the services. The choice of this narrative study is motivated by the fact that it provides a deeper understanding of the issue from their past experience, present standing and future expectations, which traditional survey might fail to deliver.

Methods

Study Design

The study used narrative inquiry, an effective qualitative research method for delving into human experience through storytelling. The theoretical underpinnings of this study are based on Clandinin and Connelly (2004), who characterized narrative inquiry as a viable tool for expressing and comprehending experiences that reflect social contexts rather than attempting to reconstruct life objectively. The emphasis is on the content of the experiences as a studied phenomenon, with narratives serving as a data analysis tool, and the technique takes precedence over the findings.[13] The goal of narrative researchers is to see their subjects' and their own lives as a whole, into which fragmented tales can be blended and absorbed.[14]

Participants' unique life experiences and narratives can be viewed via the lens of a three-dimensional framework that connects temporality, social interaction, and places in order to comprehend the phenomenon under inquiry. Temporality depicts that each event, story, or experience might be relevant to the past, persist with the present, and have a long-lasting effect on the future.[15] Personal and social interaction is a means of expressing the participant's and researcher's emotions, expectations, wants, anguish, moral obligations, and the reciprocity of understanding between them. Place conjures up the location of the occurrence.[15] The current study examines these three elements in order to chronicle women's expectations and experiences with healthcare services. Women's desire, hopes, agonies, struggle (against societal norms regarding pregnancy and delivery decisions), indecision around the choice of health facilities, disappointment in the interaction with health providers are rendered. This study took inspiration from a narrative analysis that portrayed women's child labor pain experience and how it could be managed.[16]

Study Location and Population

Twelve women who delivered within the last 6 months in different health facilities in Bangladesh were purposively selected to participate in the study. Three women gave birth in various private health facilities in the capital Dhaka city. Seven women delivered in a public-funded Upazila (sub-district) health complex (UHC) and two other women had their child delivered at home through skilled health providers in Feni district; however, they visited private health facilities for check-up while they were pregnant. The three women who delivered in private facilities were selected via

personal acquaintance as it was assumed that they might have a deep understanding of health service care and can best inform the research topic. The head of the UHC selected three women based on their availability in the hospital premises; hence, the non-response rate was not sought for. The other six participants were selected by the Upazila Health and Family Welfare (local government) from where mothers receive some government-approved cash incentives, generally given to poor families. Basically, UHC provides primary-level care, mostly outdoor-based service, at the subdistrict level with very limited beds, and medical staffs. UHC's refers patients to district general hospital (DGH), secondary level of care, when necessary for higher level of medical set up.

Data Collection and Analysis

The principal researcher (PR) conducted the interviews face-to-face as well as via Zoom/WhatsApp video calling application when mothers were unable to join in person; a research associate (RA), who had experience of field research before, was present with the participants to facilitate the interview process. Face-to-face interviews were for around 30-50 min. Women who delivered in public facilities were interviewed in the same facility premises; three of the women were interviewed by the RA in person while the PR joined via WhatsApp to facilitate the interview process. One woman who delivered in a private facility was interviewed online (via calling through Zoom) as she was unable to be interviewed in person; the interview spanned around an hour. The other two women were interviewed in their own residence. Written approval was taken from the head of the UHC to conduct the study. Verbal and written consent of participation were collected from most of the participants except the one who were interviewed online; she provided her verbal consent upon sharing all the information regarding ethics and her rights. Participants had the rights to not discuss anything they feel uncomfortable about, and they could quite anytime of the interview process or refrain from answering any questions that they do not want to. They were aware that their shared information would be taken care of very confidentially and anonymously.

For the privacy of the narrative stories, pseudonyms for all the participants were used. Interviews were conducted in the participant's local language (Bengali), which was later translated into English. Data were collected through notes taking and keeping journals throughout the interviews. My own reflection as a public health researcher and a doctoral student has also been included in these narratives as I have also had a long history of working in maternal and child healthcare. In the narrative study, both participants and researchers are the co-composure of the narrative accounts.[17] Being there in different public and private facilities and overseeing their operation methods compelled me to open up about some of the issues that resonated with some of the participants, especially with participants who delivered in private facilities. I have used a conversation guide (six questions) to facilitate the women's stories so that I can encourage them into expressing the issues under study. One sample interview was conducted with a participant (not included in the final study) to adjust the conversation guide and to explore the process of conducting the interview. During interview, we have given participants enough space to veer away from the issue so that they can unclog and express themselves freely. This is probably why some women talked about cultural issues and barriers that they have faced during their pregnancy, which somehow influences their healthcare decision-making. After the session, the researcher read out some key points for the participants to ponder on and possibly add to. Interim texts were prepared immediately after the interview, and the final texts were written after carefully assessing all the notes and journals to check if anything was overlooked. MAXQDA 2020 software was used to manage and analyze the data. Data were read numerous times to find common or distinct themes after initial and axial coding. Following the completion of coding, the process of generating inductive themes was undertaken by the PR through the application of Braun and Clarke's six steps of thematic analysis approach. The process starts from data familiarization, followed by generation of codes, themes, review of themes and rationally naming them, and finally summarizing them.[18] The RA assisted PR in the data management and analysis process who independently also coded the data after verifying the transcripts to find out any possible discrepancy to solve through discussion.

The analysis and discussion part compared the narrative threads to previous research findings. For qualitative credibility, the written texts of interviews were shared with the RA (peer debriefing) to find any discrepancy with the notes and journals. The study selected 12 participants purposively, but we do not claim that the findings have reached full saturation, although there are certain aspects that we believe have come out strongly which we discussed in the following sections. Narrative studies also do not worry about data saturation, per se, rather focus on the provision of rich understanding of the matter under scrutiny, we suppose.

Findings and Discussion

Based on Clandinin and Connelly's three dimensions of narrativity, this study focuses on four elements that emerged from all the women's stories about their pregnancy and delivery experiences. I have tried to gather together all the important aspects that were reflected on the narrativity in this section with my added personal experiences and cognition of the whole issue.

Socio-cultural Juggernaut Around Pregnancy

Most of the women mentioned social norms and cultural practices that bothered them throughout their pregnancies. These cultural norms have been around for ages that may

not have a scientific background, yet they are difficult to avoid because of their relevance with culture and religion. One mother (pseudo name: Razia) who delivered in a private facility expressed her opinion like this:

> *"I am a manager at a top-level organization in Bangladesh. Yet sometimes, I feel that my choices and preferences (health issues or not) in my household do not get valued. The support a pregnant woman receives from her husband and in-laws can be more empathetic (I am not only talking about myself; I am talking from my experience). Ever since a woman gets pregnant, there starts a whole new journey which rarely gets the desirable level of support the way women would have wanted or the way I wanted". "Can you feel why I mentioned all these? That's because all these stigmatizations creep in when we attempt to make any healthcare decision. The delivery cost in private hospitals is something to worry about in our country. And, of course, everybody wants to deliver at an affordable cost, and here come all the suggestions even if it compromises the quality of care."*

Another woman who delivered at home (Pseudo name: Maksuda) expressed that she liked to have her child delivered at home (her previous two children were delivered home) as her elder sister convinced her to do so. This trend of delivering at home with unskilled (not professionally acknowledged) local dai/aya (birth attendants) is very prevalent in Bangladesh's rural communities[19] which is mired by cultural practice.

According to one study, even when medical services were accessible, women in Ghana were reported to rely on spirituality for their obstetric demands and complications.[20] Cultural beliefs, values, and traditions can significantly affect individuals' attitudes towards modes of delivery, their definitions of different modes, and the decisions they make in this regard.[21] Besides family traditions, husband and mother-in-law's perceptions, beliefs and knowledge also affect the decision-making. In many occasions, family want to welcome the baby within their environment in the presence of local birth attendance as long as there areno complications[9]; these findings also resonated in the narratives of some of the women.

Dilemma Around Choosing Hospitals and Women's Expectations

It was evident from the reaction of most of the women that financial issues and social status triggered the whole decision-making around choosing the hospitals. There are considerable questions regarding the quality of obstetric care in government-funded public hospitals, and women from well-off families are typically seen to choose private facilities. However, there are questions to be asked around doctors' attitudes to convince or attempt to persuade women for cesarean section delivery in private facilities. Tamanna, who delivered in a private facility, expressed her opinion about public hospitals this way:

> *"Public hospitals are crowded, there are not enough hospital beds, and I am not sure there are doctors available 24/7. So, I am not going there, nope, thank you."*

There is not enough trust in them on obstetric care, at least from women who have financial abilities to go to private. One study confirmed which resonated with what Tamanna had expressed. The study raises concerns regarding the disparities between public and private hospitals in terms of affordability, cleanliness, privacy, provision of utilities, responsiveness of nurses, and availability of duty doctors. While public hospitals are often more affordable than their private counterparts, they significantly fall behind in these aforementioned aspects.[10] It entails an indirect societal structure that distinguishes wealthy/middle class from the lower middle class/poor. Razia reiterated that issue a few times:

> *"The problem of public hospitals are lies in their overall environment, the cleanliness, hygiene, and lack of privacy. It's difficult to see myself there delivering my child. Plus, there are a long line of patients everywhere. I have been there many times, and I am not confident of going there for my child's delivery."*

Well, that says a lot about her expectations and experiences of public hospitals. One study conducted to assess the technical efficiencies of DGH's in Bangladesh reported concerns on the efficiency of the service provision, and judicial usage of resources, and recommended regular assessment of the efficiency level of health facilities.[22] Another study resonates the study findings which reveals that quality of care receives significant influence while choosing the health facilities; however, the decision is also influenced by the financial costs around it. However, one woman who delivered in public facilities were seen to be happy:

> *"I am happy with the services I have received here. The nurses were cordial, and my delivery went well. So, there is no point in bragging. I already visited this place before, knowing how the service they provide and content with it." Tamanna had an interesting thought about it: "I live in a Sadar Upazila (main district point), and district general hospitals (DGH) are not equipped with C-section; so, if I had to go for C-section at any point (if situation gets to that point), I eventually had to move to private hospitals. So, I saved the hassle. Probably UHC is better in handling pregnancy cases than the DGH."*

It could also be interpreted that woman who delivered in UHC might have low expectations of the services and normalized with it. They seemed very shy, not very confident of their surroundings, and very pragmatic to show their emotions. One study revealed such findings, which demonstrated

that low expectations of ANC services were found with women of poor education, low income, and younger than 26 years exposed to partner violence.[23] Many women voice no expectations of existing care indicative of disillusionment from the existing healthcare system.[24] Patients with low income and education often perceives health providers as an expert, less interested to engage with them (poor interaction due to low confidence), and less likely to question healthcare management. One study revealed that poverty is among one of the important reasons decisive for home delivery to save money for their families.[9] It is also to be noted that, public hospitals are more frequently utilized by the marginally poor people than the economically well-offs in Bangladesh.[22,25] There is also evidence of healthcare inequity in the private facilities as private health providers largely favors the richer socioeconomic groups in Bangladesh; an indication of why people from richest quintiles prefers to visit private facilities.[25]

To talk about expectations, and interactions with providers, Razia had clear expectations from the hospitals, and her expectations were not fulfilled despite being delivered in one of the high-end hospitals. She looked a bit dejected and made her concluding remarks like this:

> *"I really felt bad that I cannot remember my doctor touched me to check my physical status. There was always a distance; I do not know why. Even they did not check my hand and feet to see if I had developed any edema (water deposition) or not. They also failed to figure out my jaundice because of their lack of attention to detail. They rarely talked about the danger signs of pregnancy, and eventually, I had to deliver before the expected date of delivery (EDD) on both occasions. I'd expected a lot more, I thought-why shouldn't I be disappointed?"*

Both Razia and Tamanna expected good patient–provider interaction, but they somehow were disappointed. Understanding their expectations and matching them with expected care is critical to improving the quality of care as well as for better maternal health outcomes.[24] Women who had their child delivered at their homes also contemplated about the delivery options. However, they decided not to deliver at either of public or private facilities as they do not have many expectations from the services. Rather they kept contact with one doctor who works at a private clinic and took help from one nurse of the same facility for their child delivery. Coincidentally both the women who delivered at home were sisters, and senior sister actually encouraged her younger one that there is no need to deliver at hospitals. Their in-laws, wholeheartedly, backed up their decisions and they successfully made it out alive.

Sumaiya (pseudo name), who did not complete higher secondary school and got married before age of 18, delivered in a public health facility (UHC). Her husband works in a furniture shop, and they must consider delivery options very cautiously. *She says, "Of course, I have to think hard on where to deliver. My husband has limited financial abilities, and we do not want to be in debt due to our choice of delivery options. The private hospitals are known to charge very high, and there is a very high chance that they might deliver in C-section, which obviously I do not want and afford."*

Method of Delivery, Health Providers' Discretion, and Infliction

The participants have shown serious concerns over the delivery method and the resulting dissatisfaction that it brings. Two of the participants who delivered in private health facilities expressed their most profound discontent regarding the doctors' decision. Although they did not say it out loud, however, from their expression, it felt like doctors did not wait or try enough for the normal delivery that the mothers wanted. Is it for doctors' interest? That is hard to answer and difficult to explain, in my opinion. However, if women feel like that, they must be taken seriously and look for causes for this extreme indiscretion. Tamanna has to say about this: "*I felt doctor has culminated to the decision too quickly without a justified clinical indication. Notwithstanding, we remained calm."*

> *"What happened, after that, will always be agonizing. The doctor who is supposed to oversee my delivery situation came in the ward, and after observing my situation, she wanted to talk to my husband. She said our child is too big (head's too big or something like that, I can't remember properly) to deliver via normal process and her suggestion is 'C-section.' Upon that point, it will be our decision because she had made her decision already. Well, that was quick. My husband got nervous, which he was supposed to be. He talked to me and said we shouldn't take any chance; we are talking about two lives. Please try to understand. At that point, I had no option but to agree to the C-section, even if I wanted to wait and try despite the unbearable pain."*

It was evident from her expression that she was left perplexed how things have had turned out for her unexpectedly. That's the moment when she started to question the doctor's motive and decision-making abilities.

One study pointed out hospitals with higher profits per cesarean delivery are associated with an increased number of C-sections, which implies that financial incentives might determine opting for C-section delivery.[26] Before making any further remarks on this sophisticated issue that targets physicians' motives and incentives, much need to know. However, this should be studied further as C-sections in Bangladesh have been in a continuing trend. The number of cesarean deliveries was very high among the women of higher educational attainment and from the wealthiest households,[27] which has been the case for Razia and Tamanna to some extent. Another study conducted in Bangladesh revealed that women were seen to be concerned about the

hospital delivery because of their perceived fear of C-section delivery. Lack of privacy, male doctors observing women body in the presence of others and that's why many women prefer to stay home for their delivery.[9]

A Way-out (or Not?)

Listening to all women's narratives and their personal feelings, struggles, expectations, and disappointments made me realize what we can do more to support women who deserve to be treated the way they should be. It's one of the most important times of their life, yet they live it in fear, anxiety, uncertainty, which mostly ends up in disappointment. A pregnant woman who longs for care and affection, not just from her near and dear ones but from the society she lives in, the doctors she visits, and the healthcare she belongs to. A healthcare system should ensure the safe delivery that every woman wants to have. If there are medical reasons for C-section delivery, doctors should consult their patients accordingly with proper reasoning, not making them panicked and stressed. These experiences should affect women's future healthcare service use and their decision-making which has been implied by Clandinin and Connelly's temporal, social interaction, and place effect (experience of past affects present and leverage future decisions).[15]

Policies should be developed to foresee the C-section cases so that unwanted and unnecessary C-sections can be prevented. Patient–provider interaction lies in the middle of this, and it's essential to diminish the interaction gap that creates so much uncertainty. As one of the participants implied, "Doctors need to listen to the patients properly and patiently because there is a lot at stake as far as my health is concerned."

The healthcare system should strive to improve their facilities, including their workforce, maintain cleanliness and privacy as well as their overall image of service delivery provision. Also, the difference in infrastructural and administrative quality between private and public health facilities should be reduced to ensure equitable care. Rural-urban difference of service facilities and health inequity due to household wealth should also be taken into account as one study confirmed that women with richest household has 23 times higher chance of using desirable level of maternal health service than women who belongs to family with low level of wealth.[28] Health planners should also work on the existing cultural barriers, taboos, and misconceptions that confuse women during pregnancy rather than giving comfort. It is high time societies put healthcare at the core of every planning to safeguard the mothers and the next generations. Plus, the quality of care should be at the center of the planning as the care people receive is often inadequate, and common across conditions and vulnerable people are often the worst victim of it.[2]

There is a number of maternal deaths reported every year in a country like Bangladesh, and pregnant women and their families worry about that because the health system cannot be trusted, which is mired by over costing, hasty medical decisions, maltreatment, and discrimination.[29] We have to translate all these expectations of mothers into reality if we are to see an equitable society that ensures the quality of care for everyone, irrespective of color, race, religion, and geographical boundaries. There is no escape if we cannot do that, and our women will be circled around the same vicious cycle which does not ensure safe and sound child delivery.

Despite our efforts to present a comprehensive narrative account of women's expectations and experiences, together with a thorough thematic analysis of their narratives, it is important to acknowledge certain limitations that should be reported. PR were not being able to conduct all the interviews face-to-face in person, hence, due to that there could be some expressions that PR could have missed. The proportion of women who delivered in private health facilities is lower in comparison to those who delivered in public facilities. Hence, the authors refrain from asserting that the study has achieved absolute saturation, as the introduction of new individuals may introduce diverse perspectives or viewpoints. The primary objective of our study was to offer a comprehensive and detailed account of the narratives. Consequently, extending the data collection process to achieve data saturation may result in excessive lengthiness, perhaps overwhelming the readers. We also express our caution in utilizing study findings, as these conclusions are inherently subjective and are not intended to cause harm or offense to any particular group. It

Table 1. Themes and Selective Participants' Excerpts Related to the Themes.

Themes	Selective Quotes
Socio-cultural juggernaut around pregnancy	*"There was a time I was not allowed to eat or drink or cannot go out, like in the evening when the sun sets. There was a belief that if I ate more, the child would not have enough space on my belly, and it could not grow much. It is important to have a normal delivery because it will be difficult to deliver through the normal (vaginal) process if the child gets bigger. They also do not stop giving us countless suggestions to where we should deliver." (Razia)*
Dilemma around choosing hospitals and women's expectations	*"Public hospitals are crowded, there are not enough hospital beds, and I am not sure there are doctors available 24/7. So, I am not going there, nope, thank you". (Tamanna)*
Method of delivery, health providers' discretion, and infliction	*"I felt our doctor has culminated to the decision too quickly without a justified clinical indication. Notwithstanding, we remained calm." (Tamanna)*
A way-out (or not?)	*"When would they (doctors) start to care more, the way we want will remain as a question. Obviously, the care we are receiving is not enough, something gotta give." (Razia)*

is anticipated that health planners will duly acknowledge our findings and endeavor to integrate women's experiences into their interventions and policy modifications aimed at strengthening maternal health services (Table 1).

Conclusions

Women's narratives expressed concern over their bittersweet childbirth experience in health facilities in Bangladesh. There was an evident gap between who seeks public and private health facilities, and there seems to be societal pressure around it. Women education, working status, and financial abilities were seen to have influenced healthcare choices. Poor interaction between patients and providers regarding the C-section decision needs to be further studied to ascertain doctors' tendency towards C-section delivery and possible indictment. There were issues of delivery costs that influenced whether to seek private or public healthcare. Women also exhibited displeasure towards some of the cultural practices, family traditions, and role of elderly, which provided them discomfort, and tended to make a forced decision regarding the choice of healthcare. More qualitative narrative research might be helpful to understand women's viewpoints, their sufferings, and the struggles they have been through our health system. Proper context-specific plans can be adopted to reduce health inequity, improve patient–provider interaction, and develop an evaluation system that considers patients' complaints to make everyone accountable for their decisions in the health system.

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Ethical Approval

The study was approved by the ethical committee of the Noakhali Science & Technology University, Bangladesh (Approval no: NSTU/SCI/EC/2022/93). Participant's verbal and written consent was taken according to the rule of conduct.

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