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Communication in maternal near miss cases: an analysis based on Habermas

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Abstract *This study sought to understand the network of meanings mutually experienced among women who survived maternal near miss due to lapses in care during pregnancy, labor and birth, based on Habermas' theory of communication. A qualitative methodology was selected, with the participation of 14 women who survived maternal near miss by means of the autobiographical narrative interview proposed by Schutze, based on the Communicative Action theory of Jurgen Habermas. From the analysis, two categories emerged: "Selective listening, clashes and negligence" and "Blaming the Patient and Violent Communication." The narratives reveal that the interpersonal relationship was not based on dialogue, but on superior knowledge as opposed to acknowledging the other, reflecting an authoritarian, non-reflexive posture of the professionals, without self-criticism or genuine critical freedom, with important repercussions on user care. The primacy of strategic rationality and the defense of verticalized technical success contributed to important communication lapses in the care of women who progressed to maternal near miss.*

Key words *Communication in health, Women's health, Near miss*

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Introduction

Person-centered care, including effective communication between professionals and patients, is an important strategy to reduce maternal morbidity and mortality[1,2]. However, ineffective and/or violent communication experiences are common in the narratives of postpartum women who have developed negative outcomes, such as in Maternal Near Miss cases[3,4].

Maternal Near Miss is defined as situations in which a woman survives after the occurrence of serious clinical complications that put her life at risk during pregnancy, childbirth, or postpartum. Most pregnancies end without complications, but a small proportion do present complications, and maternal death is the final stage in a chain of events that begin with severe hypertensive and hemorrhagic disorders, classified as potentially life-threatening conditions[5].

A fraction of women with potentially life-threatening conditions will develop clinical deterioration, a worsening of laboratory parameters, and/or the need for intensive care due to organ dysfunction or failure. These women are included in Maternal Near Miss cases, according to the criteria established by the World Health Organization (WHO)[4-6], a portion of which will evolve to death.

Because they survived and presented a similar profile to those who died, the narratives of these survivors of Maternal Near Miss contain relevant information about which aspects of care need to be improved[6], including those related to communication between professionals and women[4].

Despite studies that highlight the role of interrelationships in the continuity of care and quality of care[7,8], communication problems are frequently reported in the literature, reaching values between 40% and 66% of the reports in prenatal care[3,4]. Here, it is highlighted that communication failures can also give rise to episodes of obstetric violence directly related to the occurrence of Maternal Near Miss[9].

In this context, the question arises: Why are communication lapses still frequent in health care, particularly in care during pregnancy, labor, and childbirth? What are the communication lapses common in the narratives of women who evolved to negative outcomes? How do these communication lapses relate to attitudinal lapses in care processes?

To answer these questions, let us begin with Jürgen Habermas, communication paradigm[10], for whom the modes of intersubjective communication differentiate the types of social action. Habermas presents his theory as a way of understanding the set of moral rules that structure both language and human action.

To this end, Communicative Action corresponds to actions geared towards mutual understanding, in which the social actor both initiates the circular process of communication and is a product of the socialization processes that construct it, beginning with processes of mutual and consensual understanding. By contrast, Strategic Action includes actions guided by individual interest in success as the core purpose of interaction[11,12].

Taking this into account, the present study aimed to understand the network of meanings constructed intersubjectively by women who survived Maternal Near Miss concerning lapses in care during pregnancy, labor, and childbirth, based on Habermas' communication theory.

Methodology

Study type and participants

This is a qualitative study based on the Autobiographical Narrative Interview technique proposed by Schütze[13], using Jürgen Habermas' Theory of Communicative Action[10-12,14] as a theoretical framework.

Women who were hospitalized during pregnancy or postpartum, between January and July 2020, in the Intensive Care Unit (ICU) of one of the three tertiary maternity hospitals in the city of Fortaleza and who met the criteria for Maternal Near Miss[15] were invited to participate in the study. The first contact with each participant was by telephone, during which the objectives of the study and the voluntary nature of participation were explained. After acceptance, face-to-face contacts to read and sign the Informed Consent Form and schedule the interview took place in the maternity hospitals while they were waiting for their postpartum appointment. Twenty participants were contacted. Six patients refused to participate and were not asked about the reason for their refusal. Fourteen women, aged 15 to 41 years, living in municipalities in the Metropolitan Area of Fortaleza, participated in the study, including five residents of the capital. Eight were married and six were single, six self-identified as white, six as black, and two as indigenous. The number of prenatal consultations ranged from 3 to 9 (Chart 1). The combined duration of the interviews totaled 780 minutes.

These women were identified and recruited during a preliminary quantitative survey carried out in three tertiary maternity hospitals linked to the Brazilian Unified Health System (SUS) in the city of Fortaleza. The interviews took place between January and September 2020.

Data collection

The interviews were conducted by an obstetrician with experience in qualitative interviews and who did not participate in the care of any of the participants. These interviews were set up in three stages (Figure 1). In the first stage, the participant was asked to give a spontaneous account based on a generative question[16], namely: "I am researching the life stories of women who had serious complications during pregnancy, labor, or after childbirth. To do this, I would like to ask you to tell your story in the best way you see fit. Tell me your entire journey from your prenatal care to your ICU admission and what happened after you were discharged. You can take as much time as you want, start and end your story as you wish, telling your life story in a way that allows me to understand who you are. For you to tell your story freely, I will not interrupt you. You must tell me when the story ended and only then will I ask some questions to clarify what I did not understand well. Okay?"

Next, immanent questions were asked to clarify ambiguities, doubts, and narrative lapses. In the third stage, exmanent questions were asked, which required the informant to rationalize and theorize about the event in question[13,16]. The audios were transcribed after each interview, adding the notes obtained from the exmanent questions and the interviewer's observations to the material.

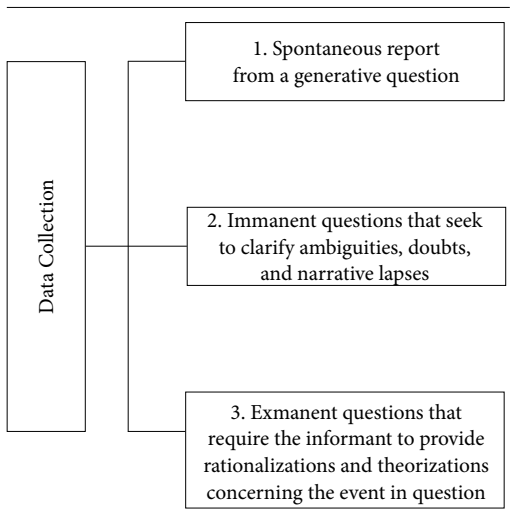

Figure 1. Data collection stages.

Source: Jovchelovitch, Bauer[16].

Chart 1. Demographic characterization of a sample of women with maternal near miss in the state of Ceará in 2020.

Participant	Age	Municipality of origin	Gestational age upon hospital admission	No. of Prenatal appointments	Marital status	Self-reported skin color
M1	37	Fortaleza	36	5	Married	White
M2	32	Fortaleza	36	3	Married	Black
M3	32	Caucaia	35	5	Married	Black
M4	38	Aquiraz	32	4	Married	White
M5	28	Fortaleza	36	6	Married	Black
M6	41	Fortaleza	38	4	Single	Black
M7	22	Cascavel	38	6	Single	White
M8	15	Maracanaú	40	8	Single	White
M9	23	Guaiuba	30	4	Single	White
M10	39	Maranguape	Postpartum	4	Married	Black
M11	19	Caucaia	Postpartum	9	Single	Indigenous
M12	20	Pacajus	36	9	Married	White
M13	24	Caucaia	35	6	Married	Indigenous
M14	32	Fortaleza	37	8	Single	Black

Source: Authors, 2020.

Narrative framework and content analysis

The analytical process was based on Schütze's proposal[13] in triangulation with the Thematic-Categorical Content Analysis[17].

The process began with the construction of narrative texts by each participant, with a subsequent separation of the indexed material (rational and concrete content) from the non-indexed material (subjective content, such as value judgments, feelings, and reflections)[13,16]. The indexed material was then ordered sequentially and, for each biographical event listed, hypotheses and counter-hypotheses were developed about what could have influenced the context, the actions, and the studied outcome, considering the possible consequences of the objective events. Based on this structure, the first narrative text was produced, combining objective data situated by contextual aspects. This first text was again presented to the participants for validation purposes and adjustments of any dubious points about the objective facts.

Next, the first intersection with the Thematic Content Analysis took place. The recordings were listened to several times and the transcribed text was read in a fluid manner, characterizing the pre-analysis[17]. During this stage, in addition to returning to the initial hypotheses, emerging hypotheses were identified. The segments were then classified according to the textual type into argumentation, description, and narration, as proposed by Schultze[13]. Next, the material was explored with the identification of thematic cores[17], based on aspects related to obstetric care and Care Networks as well as Habermas' theory of communication[10-12,14].

In the narrative construction stage, the aim was to highlight the rationalization processes that guided discourses and actions, from the perspective of the interviewees (how it was said and why it was said that way), as well as the temporal, causal, and thematic connection between the segments of the text[18]. These thematic axes and the representative text fragments were then organized sequentially, producing the narrative of lived experience. The lived biography was then compared with the first narrative, along with the hypotheses put forward, so as to highlight similarities and discrepancies, making sense and meaning of the biographical processes emerge. After the contrastive analysis, the final text of each narrative was constructed (Figure 2).

This process was carried out in all interviews, and each narrative, from the second onwards, was contrasted with the previous ones in order to identify similarities and differences, making it possible to identify the moment of data saturation. Our study considered data saturation to be when no new thematic axes emerged[19]. Saturation was reached in the twelfth interview, and two additional interviews were conducted. The contrastive analysis also enabled a categorical ordering of the thematic cores and their final interpretation based on the theoretical lens guiding this study.

To maintain anonymity, the participants were identified by the letter M followed by the number that represents their sequence in the interviews. It is important to note that this research was approved by the Ethics Committee of the University of Fortaleza, logged under opinion no. 1,865,363, CAAE 60900216.9.0000.5052, funded by FUNCAP, through the research program for the SUS, call date 01/2017.

Results and discussion

From the analysis, two categories emerged: "*Selective listening, clashes, and neglect*" and "*Patient Blaming and violent communication*". The adoption of Habermas' communication theory as a theoretical lens made it possible to understand the narratives, based on the different rationalities that guided arguments, antagonisms, and assumed positions.

Selective listening, clashes, and neglect

The narratives revealed communication gaps that compromised mutual understanding through limited listening and devaluation of the patients' statements. Let us take as an example M1, 37 years old, who developed Maternal Near Miss in her third pregnancy, but with a history of complications due to hypertensive disorders in her second pregnancy. According to her narrative, it was noted that the professional was not very open to dialogue:

She only responded that everything was normal, that it was due to the pregnancy. I said that my other pregnancies were not like that and she responded 'not all pregnancies are the same' (M1).

The establishment of a communicative situation demands symmetry of participation, with equal rights to speak and the absence of coercion, with dialogue existing when there is a mutual exchange of questions and answers[11,12]. For the principle of reciprocity to be met, actors must be

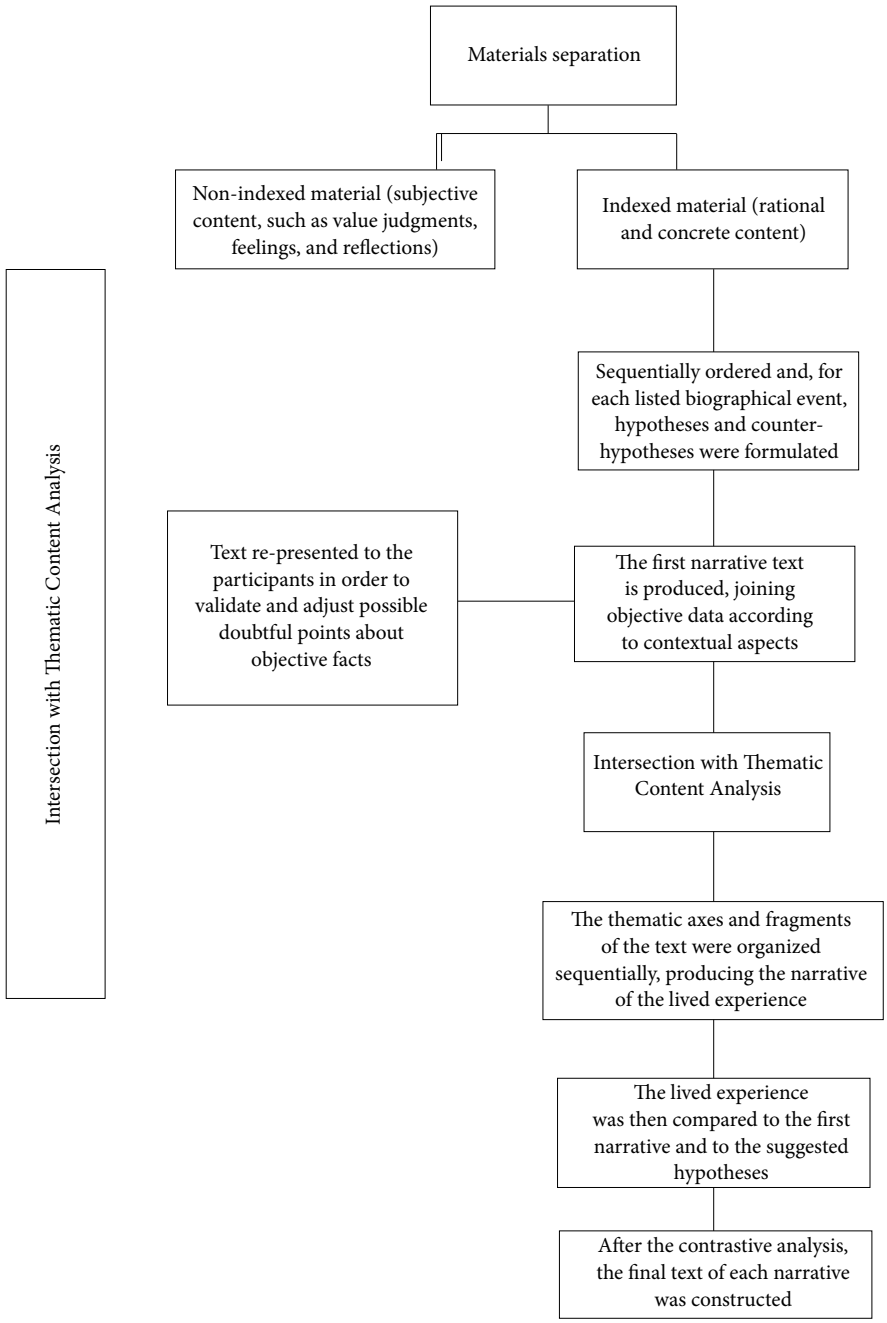

Figure 2. Data analysis triangulation.

Source: Bardin[17].

able to act actively – speaking, acting, intervening – with freedom of communication. This type of construction, identified by Habermas[10] as discursive ethics, was constantly hampered in M1's relationship with the health professional.

The lack of mutual understanding, however, should not be understood here as passive acceptance on the part of M1. Having experienced serious hypertensive complications at the end of the previous pregnancy, she knew the warn-

ing signs, but she had doubts about her current condition and about the relationship of recent symptoms with a possible new case of worsening. Because she did not feel that her questions were being heard, the patient sought information from other sources, which increased the friction with the health professional.

In the previous pregnancy, my blood pressure was always low and only went up towards the end. This time, my blood pressure was between 130x90 and 140x100. It was never lower than that. I had headaches and felt very nauseous throughout the pregnancy. At the 20-week appointment, I asked if these symptoms weren´t due to the blood pressure, since these were the symptoms I felt when my blood pressure went up the last time. She said it was not due to the blood pressure, that it was due to the pregnancy. But I looked it up on the internet and talked to other people, and I didn't understand why it couldn't be due to the blood pressure. She got angry when I insisted and didn't even let me finish. She interrupted me, gave me the prescription and ended the appointment. [...] I went to the emergency room, and they also told me it was due to the pregnancy. So I gave up asking the doctors. I kept controlling it with my teas (M1).

Technically, Preeclampsia (PE) – a hypertensive complication with the potential to progress with severity criteria – only sets in after 24 weeks[20] and M1's symptoms at the beginning of pregnancy had likely resulted from other causes. M1's doubt, however, had a context that was ignored by the professionals (if these symptoms were associated with the hypertensive disorder in the previous pregnancy, why is it different in this one?). Furthermore, to the extent that she argues against imposing communication, M1 brings her own rationality to the communication process[10,21].

By trying to impose her rationality on M1's, the professional's actions demonstrate the action of one over the other – and not with the other – with the intention of subjugating him with a view to a specific end. The simplistic answer ("it's not the pressure") was not aimed at mutual understanding, but at the mere operational fulfillment of a function that would culminate in "technical success"[22].

For Habermas[10], action in the social world can be strategic or communicative. Strategic action recognizes the possibility of decisions by rational opponents, but it treats the social world and communication in a utilitarian sense, with the action focused on success as the intended outcome. Success in this form of care delivery would be achieved by the acceptance by the other of a scientific reason in an imposing way, through the ethical and esthetic exercise of authority, characterizing Strategic Acting[11,12].

In communicative action, the actors build a mutual understanding and harmonize their action plans. During perinatal management, when Communicative Action predominates, one actor is rationally motivated by the other to take action and adhere, consolidating the process of co-responsibility and contributing to the reduction of risks and maternal mortality from pre-delivery to the end of the postpartum period[23], which did not happen in the case of M1. On the contrary, the systematic invalidation of her statements and the lack of reciprocity led her not to seek emergency care when warning signs appeared in more advanced stages of pregnancy, when they could already be associated with PE.

Close to the last appointment, I started to feel dizzy, with a lot of headache and the urge to vomit. It wasn't constant, it came and went. I didn't go to the emergency room before because they kept telling me that it was normal for this pregnancy. I measured my blood pressure and it was 150x90. But they said I should only worry if it was over 160. So I was taking dipyrone and lemon balm tea for the headache [...]. Until the day I had a seizure, and they took me to the hospital (M1).

Although in the case of M1 the rationality assumed in the communication process contributed to the late identification of the hypertensive disorder, it is not possible to characterize negligence *per se*, but it is emphasized that the quality of prenatal care and the presence of complications that lead to late access to health services emerge as important factors associated with Severe Maternal Mortality (SMM)[24]. Imminent risk perceived in the narrative of M9, 23 years old, in her first pregnancy, coming from another municipality, also with hypertensive complications:

[...] every time they said everything was fine. They listened to my heart, measured my belly, and everything was fine. At 6 months I was very swollen and I asked. They said it was normal. I asked again, because my blood pressure was 130x80 and before it was 90x70 and my legs were very swollen. It was only then that he looked at my legs. Even so, he said that the pressure was because I was nervous and that I should put my legs up to reduce the swelling. One day I had a really bad headache and went to the hospital. My blood pressure was 180 (M9).

Although edema of the lower limbs and elevation of systolic pressure to 130 are not diagnos-

tic criteria, they are factors of suspicion, which were ignored by the health professional[20]. In this case, in addition to Strategic Action, the actions led to negligent care practices.

Negligence and trivialization of women's reports were also present in reports about the postpartum period, even during hospitalization, as observed in the narratives of M8, 15 years old, in her first pregnancy, and M12, 20 years old, in her second pregnancy, who receive medical care in different institutions and municipalities and who presented symptoms of Maternal Near Miss associated with genital hemorrhage:

I was bleeding a lot. My mother warned me many times. But they said it was normal. A nurse came to look at my tampon, but said it was normal. In the early morning, I was white. My mother screamed that I was bleeding and no one did anything. [...]. I fainted when I tried to get up (M8).

My daughter was born fine, but I started bleeding. I told the nurse, but she said it was normal. In the early morning, I started bleeding more. I went to get up to go to the bathroom, and I fainted (M12).

In Communicative Action, rationality refers to the ability of subjects to adopt a reflective and critical attitude[21]. Strategic rationality, on the other hand, has a clear focus on success[10]. Considering that the two main causes of maternal death in Brazil are precisely complications related to Hypertensive Syndromes and Hemorrhages[25], the negligence of professionals regarding reported signs of potentially life-threatening conditions is striking. What success is possible with this type of negligence that is recurrent in the narratives?

For this interpretation, I use a short fragment of text that was repeated, with the same or equivalent words in 11 of the 14 narratives: *He/She said that he/she was the professional, that he/she had studied for this.*

Following this statement, in all cases an attempt at invalidation followed, exemplified by the segment of the narrative of M12, a 20-year-old woman with hemorrhagic complications:

[...] she told me to stop asking, because what needed to be done had already been done. I asked what had been done, and she left pretending she hadn't heard (M12).

It turns out that every action aims to manage fragments of the world according to a theme or situation, which emerges, in turn, from the interests of the actors[10,11]. Thus, the speech situations and action plans portrayed in the narratives suggest that professionals and women, in these cases, presented different themes (objectives). This inference is apparently paradoxical, considering that both should aim for the best therapeutic outcome. At this point, it is worth asking what would be the main focus for each of the actors.

In communicative action, action plans require the understanding of the world of the object, the social world, and the subjective world, allowing the differentiation between what is intersubjective and what is constructed by the content of communication and rationally validated[10]. By contrast, in strategic rationality, the world is interpreted from a specific perspective. By not admitting criticality, in strategic action, any means are justified to achieve an end. In this sense, M1 and M8 argue:

It is as if nothing we say has any value. It only has value if it comes from another doctor or nurse. We are really nothing (M1).

As soon as I said that my experience was different, his attitude changed completely. I feel like he was more concerned with being right than with understanding what I was trying to say (M8).

The statements suggest that as the method of action is questioned — considering that strategic rationality does not admit criticism — the defense of this method becomes an end in itself, even justifying negligence[10,11,14], as a mechanism of retaliation, as argued by M8:

If you call, complain, or question something they do or the way they do it, you are considered a nuisance, and they simply start to ignore you. I was hospitalized for many days and saw this happen to several women. When the woman or the companion is considered a nuisance, everything is delayed, from medication to food (M8).

The women's insistence on bringing their rationalities to the surface, despite the attempts to override the professionals' reason, leads us to a historical look at the humanization of care, which is still under construction. Where hegemonic obstetrics, consolidated in the biomedical model, is contrasted by a care model focused on the pregnancy-postpartum cycle, with women participating autonomously and as protagonists in their pregnancy, childbirth, and postpartum processes[26].

Patient blaming and violent communication

Another phenomenon present in the narratives was the transfer of responsibility for any failures exclusively to the patient, as reported by M2, who presented complications related to a difficult-to-control diabetes condition during

pregnancy, which evolved with serious metabolic complications and fetal death:

I knew I had diabetes and that it was uncontrolled. I asked to be sent to the endocrinologist, but I was on the waiting list, and the doctor said I should go to the high-risk prenatal care. I asked to adjust my medication, but again he said that I should go to the high-risk prenatal care. But they sent me very far away. I was unable to go on the day of the appointment. When I went back to the health center, the nurse said that if my baby died it would be my fault, that I was irresponsible. [...] When I realized that my baby had died, I remembered that phrase and, to be honest, I think it was really my fault [she said crying] (M2).

There is no questioning the importance of high-risk prenatal care in cases such as M2. However, the accusatory nature of the statement ignored the numerous lapses in the system, from the difficulty in scheduling an appointment with an endocrinologist to flaws in the regionalization system, with referrals for care in a location out of the patient's reach.

Holding the patient responsible for potential negative outcomes, as in this case, cannot achieve communicative rationality, since it does not value mutual understanding. On the contrary, by placing the blame exclusively on the patient, removing any responsibility from the service, the blame acts in defense of technical success and, consequently, of strategic action[10,27]. In this sense, violent communication may present a protective intention on the part of the sender, as M10 argued:

I feel like they transfer the responsibility to you. Like saying that they told us to do it, and if we don't do it, it's our fault [...] But I don't think they explained it to me properly, and I think that's the main fault, because I didn't understand (M10).

This transfer of responsibility also constitutes a coercive strategy of persuasion, and is therefore a violent and, as the narratives show, ineffective communication. We observe, therefore, that the search for one reason to prevail over another as an end can culminate in aggressive forms of communication. This violence can manifest itself both in the choice of words and in the attitudes that make up communicative performances, as we can see in the speech of M3, who also presented a case of Gestational Diabetes:

When I came back with the first tests, my sugar was higher than normal, but it was not diabetes level. She told me to go on a diet. I was doing it, but I kept gaining weight and the doctor started to be quite rude. [...] The consultation was like this: I would arrive in the room with my weight and blood pressure on a little piece of paper, she would look at it and say 'do you want to die? If you want, stay at this weight. You are being irresponsible with your child' [...]. I was doing what I could (M3).

According to M3, she was not referred to a nutritionist, nor was she questioned about her eating habits. On the contrary, her stance was always accusatory.

I said I was cutting everything out, and she responded mockingly: 'all fat people say they go hungry. It's amazing' (M3).

It should be noted that, contrary to what was observed in some previous cases, there was no negligence in the care provided to M2 and M3. On the contrary, the conduct inferred from the narratives and the analysis of the prenatal cards was technically appropriate, which does not exempt them from violence. The term violence allows for multiple interpretations, but generally refers to a coercive and intentional action that disrupts a natural order, causing harm or suffering[28].

The alleged lack of intentionality is often used to discredit violence as such. It is worth noting, however, that the intention in this case refers to the use of force or coercion and not necessarily to causing harm itself[29]. Therefore, to the extent that there is an intention of coercion to the detriment of mutual understanding and that this results in harm or suffering, there is violence.

The subject of utilitarian actions uses all possible means to impose his or her perspective, whether through the threat of sanctions, persuasion, or skillful manipulation of alternatives for action, only allowing consensus when it is obtained vertically. It turns out that understanding, sought unilaterally with the reservation of instrumentalization for success, does not meet the conditions for a consensus reached in a non-coercive manner.

The recurrence of ineffective and often violent communications in reports from different women, assisted by different teams, shows that the habit of therapeutic communication, although highly relevant, is not a comfortable conduct for many professionals.

This inference is supported by the idea that violence is normally instrumentalized and frequently carried out in favor of collective goals of a group.

In the case of health professionals, it is aligned with the objective of maintaining an illusion of power. I say illusion because, as Arendt[32] (p. 44) reminds us, "Power and violence are opposites. Where one rules absolutely, the other is

absent. Violence appears when power is in danger, but left to its own devices." In this way, the unreflective belief in the primacy of professional discourse – and the illusion of power that accompanies it – culminates in strategic actions that ultimately aim to disqualify the need for mutual understanding in the face of a supposed superiority of technical knowledge.

The co-responsibility developed between the professional and the patient becomes part of the therapy and fosters a symmetrical position in the dialogue. This stance in no way directs excessive power to the patient. On the contrary, communicative action reduces inequalities, humanizes conduct, and promotes health. This stance consolidates therapeutic adherence and has many benefits, including a better identification of problems, thus strengthening the diagnosis and medical recommendations. It facilitates the patient's understanding of the conduct and treatment, promoting adherence and strengthening the professional-patient relationship[33].

Final considerations

The findings of this study reveal how the primacy of strategic rationality and the defense of verticalized technical success contributed to significant lapses in communication in the care of women who evolved into Maternal Near Miss.

The lack of attitudinal reflection and the construction of verticalized care establishes an asymmetrical communicative situation that seeks to sustain itself on the unilaterality of discourse and the passivity of patients. Although all people are endowed with rationality, when they do not adopt an attitude of passivity and break the illusion of understanding through these means, the defense of the means turns them into an end in themselves, which can culminate in coercive communications.

These violent ways of communicating and acting are combined with the attempt to restore an illusion of power. We say illusion, since real power and authority would not require coercion. The unrestricted defense of the professional's discourse thus culminates in actions that, ultimately, aim to disqualify the need for mutual understanding. The lack of this alignment, however, culminates in ineffective communication, associated with worse outcomes, as identified in the narratives.

Coollaborations

All authors cited in this study contributed to all stages of the article, from its conception to the final draft.

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