

Physicians' perception of obstetric or institutional violence in the subtle dimension of the human and physician-patient relationship

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Initiatives in search of effective changes in obstetric care and the claiming for social recognition of obstetric or institutional violence are current phenomena, the result of a multidimensional reflection on what constitutes the act of giving birth. In order to identify the perception of obstetricians who provide childbirth assistance in a humanized maternity in South Brazil, this research was proposed on a qualitative epistemological basis. The data was collected by means of a questionnaire answered by 23 physicians and analyzed by the content analysis method by thematic approach. We deepened the aspects of obstetric violence perceived in the dimension of the human and medical-patient relationship during their encounter and interaction, the limits of women's autonomy in a professional perspective, the challenges when there is disagreement of opinions for decision-making, as well as reflections on the violence to which the medical professionals perceive themselves being submitted to.

Keywords: Obstetric violence. Institutional violence. Humanized birth. Women's health. Doctor-patient relationship.



Introduction

To bear children and to be born are fundamental phenomena¹, but they definitely are not mere physiological processes². They are complex social and cultural events, expressed in an intimate, personal, sexual, emotional and spiritual experience³, which involve interactions between individuals, social groups and institutions, with different powers and legitimacies².

After medicine became consolidated as scientific knowledge, a new type of medical practice with the social control through the human body was established⁴. In this medicalization process, populations were culturally transformed, and their ability to cope autonomously with conditions related to health was reduced⁵. More than a structural change, there was a change of aesthetics and values¹. Scientific knowledge, technological interventions and medical answers about events of pregnancy and childbirth were now seen as unquestionable, better, more efficient; they would mean legitimate solutions and we, while a consumer society, began to demand medical diagnoses and explanations¹.

Medicine based on technics and biomedical knowledge, in a context in which medical practice is understood as the output of work, and not as the implementation of knowledge⁶, have led to the worsening of human relations in healthcare industry, especially in the doctor-interaction. This configures a space potentially pervaded by conflicts⁷, supported by a model of hierarchical technical care institutionally reinforced by the medical dominance over the client, and debasement of the intersubjective relationship taking place there³.

On the other hand, new forms of subjectivity, developed in the age of the “cyborg” (post-human creature), a metaphor understood as the result of the mechanization process of the human being and of the subjectivation of the machine, also make childbirth a social event pervaded by scientism and technology⁸.

From the 1970's onwards, an international social mobilization began, in which women dissatisfied with the fact that their bodies and their health are being interpreted and guided by doctors, as well as having a fragmented view of their corporality, begin to claim a less pathological, reproductive and interventionist view that recognize their sociability, culture, beliefs, singularities and existence⁹.

The approach “humanization” was inspired by the women's movement, evidence-based medicine, and modern forms of childbirth¹⁰, and emphasizes the need to redefine human relations in healthcare by reviewing the understanding of the human condition, rights and care, in addition to an adequate use of medical interventions and technologies¹¹.

In this context, the doctor-patient encounter and relationship is a special process of human interaction, involving technical, humanistic, ethical and aesthetic dimensions. As an essential part of medical practice, it is not an insignificant human relationship, since it is surrounded by various feelings such as anxiety, fear, doubt and establishes a dialectical relationship between all players within bioethical principles, amongst which autonomy, which plays an essential role in shared decision-making^{12,13}.

At present, what is being discussed is a change in the childbirth care, with the introduction of new practices, the discussion of reproductive and sexual rights, and the involvement of women in all levels of decision-making¹⁴. However, the integration of safe and effective practices is slow and the reports of obstetric or institutional violence



(OV/IV) gain more visibility¹⁰. According to a publication by the World Health Organization (WHO)¹⁵, addressing the prevention and elimination of mistreatment, disrespect and abuse during childbirth in health institutions worldwide, women experience attitudes of disrespect during childbirth care, and in Brazil, one-fourth of the women who had vaginal delivery in maternity hospitals report having suffered obstetric violence¹⁶.

Motherhood is a biological and social function of the female body, which is also permeated by a symbolic construction, so that all violence in this sphere is basically a gender-based violence⁴, which amounts to a violation of women's fundamental human rights, as described in the regulations and principles of human rights adopted worldwide¹⁵. Therefore, to speak about humanization is also a strategy to talk about gender violence and other violations of rights perpetrated in healthcare institutions against their female users¹¹.

In 2007, Venezuela was the first country to adopt the term 'obstetric violence' in a process of institutional recognition of violence against women and as a social, political and public problem¹⁷. The law in Argentina and Venezuela are similar in their factual definition of obstetric violence: "appropriation of the body and reproductive processes of women by healthcare professionals, expressed in a dehumanizing treatment and abuse of the medicalization and pathologization of natural processes." However, in Venezuelan law, the concept is complemented by consequences or causalities: "bringing with it the loss of autonomy and the ability to freely make decisions concerning their bodies and sexuality, and having a negative impact on women's quality of life"¹⁸ (p. 37). Recently in Brazil, in order to inhibit, raise awareness and problematize the subject, the state of Santa Catarina passed the law 17097, which requires the implementation of measures to inform and protect pregnant women and women in childbirth against obstetric violence¹⁹.

Unfortunately, everyday practice is strewn with behaviors that can become violent²⁰, which is often a reflection of a process of "naturalization", which refers to the trivialization of OV/IV²¹. These practices usually are not perceived by professionals as being violent, but rather as an exercise of their authority in a context considered "difficult"²², and violence continues to be replicated as another way of work routine. Healthcare workers have also been reported as a professional category highly vulnerable to various forms of violence, especially psychological violence²³. The most reprehensible forms of violence often mask other less scandalous scenarios which have been around for a long time without being objectively problematized and which were protected by reputable ideologies or institutions²⁴.

Violence can be defined as transforming a difference into an inequality within a hierarchical relationship of power, in which an opponent is made the object of action, with their autonomy, subjectivity and speech prevented or negated. Communication problems involve a disruption of the interaction between the healthcare professional and the patient, due to the invisibility of the other's subjectivity or of their objectification²².

In the context of healthcare practices, power is wielded in a hierarchical relationship, which extends to the doctor-patient relationship established in care⁴. The physician is seen as the person who holds the greatest scientific and technical authority over the human body, and its source of power rests on the scientific legitimacy of their



knowledge and the dependence of individuals on them¹. However, medical authority should be acknowledged only in the technical-scientific sphere, since in the moral sphere, both subjects are on equal terms²².

Discussing “obstetric violence” is relatively recent, and its concept, definition, and categorization still demands better clarification, as this topic is still invisible, “naturalized” and poorly identified, even among women themselves¹. Thus, this research aims to identify the perception of doctors dealing with childbirth in a public and humanized maternity clinic on this controversial and recent issue, deepening the reflection on various aspects of human relationships and in especial the doctor-patient relationship, as these are the most subtle and less understood forms of OV/IV.

Methods

This research, with a qualitative epistemological basis, was carried out in the humanized maternity ward of a public teaching hospital in south Brazil between February-September 2016. The data was collected by means of a questionnaire prepared by one of the authors, with open questions and/or Likert-scale answers, and the sample included 23 physicians involved in childbirth care whose profiles was presented by means of descriptive statistics, with the categorical variables being described in terms of rates and the continuous variables as mean and standard deviation.

The other data were evaluated by content analysis, with the definition of the following categories and subcategories by thematic approach: (1) The woman and the doctor: a special human relationship; (2) The doctor as a victim of violence: another point-of-view; Subcategories: 2.1 Victim of the institutional structure; 2.2 Victim of the victims; (3) Who chooses? On autonomy, clarification and decision-making; (4) Suggestions for change: how to prevent obstetric and/or institutional violence.

The term institutional violence (IV) was used as a synonym for obstetric violence (OV) in order to keep in the research both terms used in data collection, when we chose to use alternatively the term “institutional”, as used in previous studies^{4,22}. in order to avoid “epistemological refusal” and not to cause any uneasiness amongst those interviewees who did not feel comfortable with the term OV. However, they are not synonymous; OV is a form of IV during childbirth, but it can happen inside or outside a structure considered an “institution”^{1,23}.

The research project was submitted to and approved by the Ethics Committee on Research with Human Beings under the number CAAE 42365215.3.0000.0121. The professionals who agreed to take part in the study signed the Free and Informed Consent Form, in accordance with resolution 196/96/MS of the Brazilian National Health Council.

Results and discussion

Profile of respondents

The 23 participants in this study are on-call physicians at the obstetrical center of a public maternity ward of a teaching hospital in south Brazil, of which 16 are specialists in gynecology and obstetrics and 7 in the process of *lato sensu* training at



medical residency level in this area. Age ranged from 25 to 57 years, with the mean age of 45 years (SD 7.6) for obstetricians and 26 years (SD 1.1) for resident doctors. The majority of the sample consisted of women (59% = 13/23), all participants were self-declared white, most were married and had children (60% = 14/23).

Only two professionals reported having a child born from vaginal delivery. Among the obstetricians, 60% (14/23) have been working in this specialty for more than 20 years. The average working time in this hospital is 16 years (DP 7.4) and 65% (15/23) work in other professional activities, private practice, surgical procedures or diagnosis and/or teaching. On average, these professionals see ten pregnant women in labor per week.

The woman and the doctor: a special human relationship

It is easier to deal with the patient when there is mutual rapport. (M2)

In the context of childbirth care, a relationship is established between two or more individuals, a personal and professional interaction that transcends the objective aspects of the institutional routines or care practice. The production of healthcare acts is a living work field, where light technologies prevail - of relationships, of encounter and of living work in act - to the detriment of hard technologies - equipment and structured knowledge²⁵. This relationship involves different feelings, emotions and judgments, with the diversity of expressions – sometimes harmonious, sometimes challenging – being justifiable.

In a study about the satisfaction of women with childbirth care, the relationship with the team of health professionals was one of the main factors that negatively affected the memory of those women who had recently given birth in relation to the experience²⁶.

In childbirth, women are the main characters and they do not rationalize their way they act, as they are involved in a primeval, visceral and dramatic event, in which all social rules and appropriate behavior that dictate human interaction are not consciously processed, leading the woman e.g. to shout and do things she would never do under different circumstances²⁷.

In this study, 52% (12/23) of the participants reported that women well informed, prepared and oriented prior to childbirth were the easiest to deal with during hospital stay and that prenatal care is the best time for this information and preparation to take place. Other aspects that facilitate care is the patient having a good relationship with and trusting the team, being ready to dialogue and be collaborative, as shown below:

The easiest patients to deal with are] well-oriented and informed and have a good relationship with the medical and nursing staff. (M3)

The well-informed patients who are aware that many procedures may be needed if well indicated. (M4)



Who had a good prenatal care and were are well-informed, in addition to having common sense. (M9)

In contrast, not accepting the medical prescriptions and routines of the healthcare facility are behaviors from patients that the medical professionals label as objectionable: "Questions about essential procedures such as vaccines, Credé procedure, Konakion, use of oxytocin when indicated, episiotomy and caesarean section when indicated, etc" (M3).

If, on the one hand, doctors say that "well-informed women" is a condition that contributes to the prevention of OV/IV, on the other hand, they point out that women question and reject indications because they are radical and/or influenced by information received previously, and that these patients are difficult to deal with.

To refuse well-established medical practices due to "fads" or media influence. (M9)

Excessive questioning, abusive childbirth plan, refusal to understand that that is a teaching hospital. (M14)

When the patient questions or refuses practices or procedures claiming to have been informed during prenatal care. (M10)

Those who know everything about obstetrics. They are radical and do not cooperate. (M2)

Those who exaggerate autonomy and refused to have their beliefs questioned. (M20)

While studying the childbirth plan experience of SUS, the Brazilian Unified Healthcare System, Andrezzo¹⁰ observes that the patients' demand for autonomy can be taken as a defiance, and predisposes the medical staff to malpractice, a staff that often is not prepared to deal with this bioethical right of the patient in taking their own decisions. Information received from various sources during prenatal care is crucial for women to identify inadequate procedures and to demand safe care. In this context, the childbirth plan mentioned by one of the questionnaire's participants as being "abusive" and being usually "frowned upon" by the medical professionals in such a way as even undermining the care relationship serves as an educational tool that organizes information regarding childbirth care and helps to identify situations of violence¹⁰.

Another hurdle in the doctor-patient relationship are the threats due to differences in opinion regarding procedures.

Demand that the doctor performs a caesarean section without any indication and behave in a such a way as to blame the doctor "should anything bad happen". (M12)



In Aguiar's thesis⁴, which also evaluated the doctors' perception of institutional violence, patients referred to as "easier" are the ones who are more collaborative and tolerant, establishing a profile of a good patient, which means that these patients is always seen as those who obey without questioning, while a difficult patient is one who has doubts, questions, and persistently voices her will⁴. On the other hand, women interviewed in Sena's survey¹ reported having been abused when voicing their refusal to undergo certain procedures, although few of them said that they were in no emotional shape at the time of delivery to challenge the medical team. The patient's refusal was interpreted by the medical professionals as an insult or appropriation, and generally brought about harsh comments in order to establish a power hierarchy¹.

The signs of verbal and non-verbal communication coming from the patient in labor are not understood and accepted by the professionals, and the patients' pleas are sometimes branded with an insinuation of bad behavior and inability to understand and take part in the childbirth process²⁸.

It is known that patients use different strategies in an attempt to protect themselves during the clinical interview, with some of them using knowledge and study as tools, while others try to conform to the behavioral patterns they believe the health professionals expect from them²⁹. More than mere medical authority is being questioned in this relationship, since compliance is a quality expected of the patient³⁰, and, in this sense, it can harm the hierarchical relations of social class, status and gender, when challenging the healthcare professional's authority and given higher value to their own knowledge²⁹.

This difficulty of the physician to deal with the patient's questioning and refusals is related to the patient's challenge of the doctor's professional and moral authority, who in turn finds it difficult to adapt his views to the new patients' demands¹⁰. Another important question concerns the patients' strategy of opposition to all and any forms of oppression experienced and the dual power they are subjected to: as women, to male dominance and, as patients, to the dominance of medicine over their bodies⁴.

The doctor as a victim of violence: another point-of-view

I suggest that violence against the doctor should also be assessed by the family, the patient and society. (M2)

All doctors interviewed perceive that they are victims of violence in their professional activities and 78% (18/23) realize that this happens often or very often.

It was possible to analyze the doctors' perspective of the as victims, in the subcategories of victim of the institutional structure or victim of the victims. The first is related to the difficulty brought about by poor working conditions, shortage of hospital beds, unreasonable workload, undermanned and inadequate prenatal care.

To work without having enough hospital beds available, overburdened nursing staff, citizens dissatisfied with the public health system, and a culture in which "the doctor is to be blamed for everything". (M11)



Few first care rooms in the triage area vs. stress caused by the delay in being taken care of. Few high-risk beds, staff in charge of triage is burdened with the responsibility of deciding which patient will be refused admission. (M1)

In the subcategory victim of the victims, this violence happens in the form of contempt, abuse, threat, disrespect, hostility and bad behavior, whether or not related to disagreement about medical practice and outcome. More often, the discussion takes on the form of a threat, when there is a difference of opinions regarding what the patient wants and what the doctor prescribes, and the professional is held responsible for any misfortune resulting from the care. The doctors interviewed report that they are subject to violence in several ways, as for example:

Verbal threat regarding medical practice, verbal abuse for not agreeing with the practice. (M15)

Frequent threats from patients: "If anything happens to the baby ... it's your fault." The doctor as sole responsible for the bad outcome. (M3)

Threat by a family member forcing hospital admission or medical procedures (caesarean section) without medical indication. (M4)

This situation is common in relation to the decision to admit the patient or to persist with labor after admission, as the following well illustrates:

During triage, when you release the patient who is not in labor, the patient or her companion verbally abuses your medical practice. During labor progress, when the patient or her companion wants to solve the patient's "pain" and abusively demands a caesarean section. (M21)

Due to the radical change in the childbirth care movement, with the implementation of new practices and the exaltation of the reproductive and sexual rights of the pregnant woman, together with the, highly technical and centralized work conditions in a hospital, lacking almost any structure for providing personalized care, obstetricians are experiencing violence against their professional category as they are being held responsible and blamed for all and any events that do not comply with the new care proposal¹⁴. Health workers are a professional category very prone to be subject of occupational violence, and if they are being abused at their workplace or when working (abuse at the workplace), it is because conditions allow this to happen. This is a little discussed issue and there are specific policies to prevent this²³.

Staff is threatened with retaliatory legal action because of different outcomes than those expected. (M23)

Thus, physicians tend to act in a way as to protect themselves from these threats (which are understood as a legal action), which leads them to choose procedures that are well looked upon by judges and peers¹⁰. The phenomenon of juridification



- although it represents the misuse of the legal system for the social resolution of conflicts and the building of autonomy in the doctor-patient relationship³¹, brought with it the consolidation of a “defensive medicine”, resulting in an unreasonable use of exams, in refusing to perform higher risk procedures, in emotional imbalance of physicians and, in the end, an increase in health costs to health professionals and patients³¹. On the other hand, patients began to seek their legal rights, moving away from their usual submissiveness to the undisputed authority of health professionals³¹.

In any case, the relationship between doctor and patient is asymmetrical and hierarchical, a relationship involving unequal powers in which the patient is under the influence of medical authority⁴.

Who chooses? On autonomy, clarification and decision-making

To talk and to inform the patient is the best medicine. (M16)

Joint decision-making with the medical staff help improve the doctor-patient relationship. (M2)

All physicians interviewed agree that a woman may make questions, choose or comment on the medical procedures and practices indicated by the medical staff. It is clear from their reports that informing and clarifying the patient is behavior recommended and well accepted by the professionals, even deeming it their professional obligation.

The patient should always be informed and, whenever possible, exercise her autonomy. (M11)

Informed or shared decision-making, with a focus on respect for the patients' values and preferences, is a means to deal with naturalized paternalism among health professionals¹⁰, which results from the asymmetrical character of the doctor-patient relationship, characterized by the power the former and weakness of the latter³¹. The choices should be focused on female experience, supported by scientific evidence, and based on respect for the reproductive rights of women³².

However, in those events in which the patient questions the prescribed medical practice and perhaps refuses to follow the recommendations, the doctors' understanding is that there is a limit to the women's autonomy, a limit which is primarily drawn by the doctor in his/her assessment of a potential risk to the mother and/or the unborn child.

Merhy²⁵ explains that:

This happens because the health acts always deal with a high degree of uncertainty and with a not insignificant degree of autonomy of the health workers. It is precisely this characteristic that provides a great potential for strategies that allow the development of new values, understandings and relationships, since there is room for innovation. (p. 11)



[...] If stifled by rules or pushed towards the production of procedures, the health worker might address the patient as an object or part of the body, on which the best evidenced-based intervention as identified in similar situations must be produced. His action goes only in one direction: from him to the other as his object, denying the action of the other and their knowledge (referred to as “belief”), because it is of lesser scientific significance. (p. 13)

The medicalized model prevailing in healthcare units is based on the assumption that the doctor holds all knowledge and, consequently, the woman, after being informed, should abide by their technical-scientific authority. Several authors have pointed out the arbitrary use that many health professionals make of their authority and knowledge in controlling the bodies and the sexuality of their female patients as one of the major sources of institutional violence to which women are subject to in healthcare units³⁰.

The woman may choose whenever possible from a medical point-of-view. (M20)

But she should show respect for the professional's knowledge and experience. (M9)

In many reports, it was possible to observe the importance that the professional gives to the maternal and fetal well-being, but that they not once recognized that the woman in labor and her companion are also interested in a good fetal outcome. It is as if they must defend their own female patients from their excessive autonomy, which could endanger the life of the child.

The woman may have an opinion provided this opinion does not put mother and child at risk. (M22)

Fetal well-being! How much are the baby's neurons worth? Obstetric violence focuses only on procedures on the mother. It strikes me that little is said about the impact on fetal well-being. (M14)

Cadernos HumanizaSUS, a publication by the Brazilian Ministry of Health (MS), recommends that it should be clear to the woman that her wishes are important and that they will be respected, as long as they do not result in substantial risks to herself or the child, risks that should be adequately explained in an ethical commitment to reflect the truth³³. The baby, as a rule, is considered the most important product of this entire process, and the risk discourse is used to make pregnant women submit to medical advice³⁰. In the professionals' understanding, the patient seems to want to assert her interests over the child's well-being, but most of them at this point also fear dying or losing their child, which forms the basis for their dependence on medical authority⁴.

With this rationalization, we see an objectification of the woman: her body is owned by medicine and, left aside as a subject, she is seen merely as a reproductive body²². This prerogative may explain the increasing use of technology and medical



prescription for the pregnant woman in favor of the fetus and to the detriment of women's own desires and rights. However, the outcome of the birth of a healthy baby makes up for any maltreatment suffered during care¹⁶.

The asymmetry in the doctor-patient relationship becomes clearer when it comes to decision-making³. According to Foucault (apud Aguiar)⁴, this relation is hierarchical by definition, and at its top there is the doctor, who wields the highest authority over body, health, care and treatment of the patient. This medical (cultural and moral) authority over society is so to say the source of medical power, and is based not only on scientific and technological knowledge but also on cultural values and beliefs, which are viewed as true³.

The two pillars which support medical authority are legitimacy and dependency. The first is based on the patient's belief that the doctor has a knowledge about her body, which she does not have. This is mainly due to the fact that health has undisputed importance and that historically it has been the monopoly of medicine. Dependence, on the other hand, is based on the patient's fear that she will suffer adverse consequences if this authority is not heeded⁴.

Winning back one's autonomy should include ensuring the rights in the public policies agenda, strengthening of social movements, and not merely based on a purported empowerment that would come to the rescue of "women's knowledge and powers", as demanded by part of the movement for the humanization of childbirth, since such concepts are based on a biological understanding of women, disregarding their role as a political subject²⁰.

Suggestions for change: how to prevent OV/IV

Improvement of prenatal care, better educate of the citizens, improve hospital structure and training of the entire staff. (M9)

That legal responsibility should be not only the obstetrician's, but also extended to those providing orientation to the patient during the prenatal period, for example, support groups for pregnant women. (M10)

The suggestions given by the interviewees to prevent OV/IV fall into three categories of action: education and information of patients and medical professionals, improvement of institutional infrastructure, and accountability of other non-medical professionals as well. All mentioned education and information of both professionals and patients as prevention strategies. Among others, the adequacy of structure and environment, the availability of hospital beds, sufficient number and quality of caregivers, as well as the accountability of other agents previously involved in the care, whether prenatal care, support groups for pregnant women, among others.

Preparedness of the entire team of doctors, nurses, technical staff to manage work according to the new guidelines on labor, as well as a physical structure of the maternity ward adapted to humanized childbirth. (M8)



These same strategies of prevention and fight against violence were proposed by Aguiar⁴, not only in the field of professional training but in the institutional field as well⁴. It is crucial that an ongoing education of the health staff is implemented, so that all women have access to the same rights and the same humanized approach³². Actions to disseminate, raise awareness and denaturalize obstetric violence by creating safe and permanent paths for denunciation, nonexistent so far, are vital for preventing OV/IV¹⁶.

Broad discussion of this matter with society and the Judiciary, and greater participation of women as responsible (while full-aged persons) for their delivery, and taking this role from the doctor. (M12)

In this context, the delivery plan recommended by the World Health Organization restates its importance as it brings innumerable benefits, amongst others, promoting women's understanding of delivery and offering a clear communication of the patient's wishes, configuring an important tool for shared decision-making¹⁰.

Tornquist²⁰ states that in order to change childbirth care, the paradigm that supports the practice, the hospital routines and the medical training itself must change. However, there must be a change where the priority is to women win back their autonomy and have their rights over their own bodies and access to information restored, in order to provide a counterpoint to the medicalized culture, which counts on the desire of the woman herself of what will undermine their autonomy²⁰.

Conclusions

The OV/IV in the dimension of human and doctor-patient relationship as perceived by obstetricians is subtle and subjective, and encompasses different aspects of the health act, of the encounters between agents and the opportunities for expression, and requires reflection and availability of all who are involved in order to acquire a deeper understanding.

The human relationship established in childbirth care between the woman and the doctor is full of feelings and judgments. The better accepted patients are those who are well-informed, have a good relationship with the medical staff and required little care. On the other hand, when there are questions, refusals and confrontation of the medical authority or hospital routines, the woman is labeled inconvenient and the professional has a hard time in respecting the patient's autonomy.

All interviewees understand that they are victims of violence during their work; either in relation to the institutional structure and poor working conditions - regardless of their relationship with the patient - or as "victim of the victims", and in relation to the threats, contempt and disrespect received from patients, disagreement in relation to practice and its outcome, which threatens to end up in juridification as a way of settling any crisis that might have arisen in doctor-patient relationship.

When it comes to autonomy and shared decision-making, we observe that, in theory, doctors believe that every woman has the right to choose, but when there is disagreement of opinions, their medical authority should be heeded for there to be a good outcome for mother and baby.



As strategies for preventing OV/IV, the participants of this study look beyond conflicts in the doctor-patient encounter and interaction, suggesting not only actions in education and information, but also adapting the physical structure and environment, as well as making all persons involved in the pregnant woman's care accountable.

As evidenced by Carrio³⁴, the doctor-patient relationship goes beyond technical competence and work skills, since it requires ethical communication and ethics in communication, based on rapport and respect for autonomy^{13,34}, which we perceive as the core of this human relationship.

Authors' contribution

All authors participated actively in all stages of the manuscript's preparation.

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