interface
comunicação, saúde, educação
https://www.interface.org.br
eISSN 1807-5762

Editorial

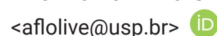
Institutional violence, human rights and technical-scientific authority: the complex childbirth situation for women

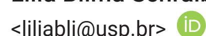
Violência institucional, direitos humanos e autoridade tecno-científica: a complexa situação de parto para as mulheres

Violencia institucional, derechos humanos y autoridad tecnocientífica: la compleja situación del parto para las mujeres

Janaína Marques de Aguiar[a]
<jamaragui@gmail.com>

Yuri Nishijima Azeredo[b]
<yuri.azeredo@usp.br>

Ana Flávia P L d'Oliveira[c]
<aflolive@usp.br>


Lilia Blima Schraiber[d]
<liliabli@usp.br>


[a, b, c, d] Departamento de Medicina Preventiva, Faculdade de Medicina, Universidade de São Paulo. Avenida Dr. Arnaldo, 455, Cerqueira César. São Paulo, SP, Brasil. 01246-903.

Brazil's National Humanization Policy, launched in 2003, emerged as a proposal to combat institutional violence in the area of health. It concluded a long historical process for recognition of rights that had been initiated by two important social movements: the women's movement, related to choices and equity in childbirth or pregnancy/abortion conditions, and the movement led by people with mental disorders, related to possibilities and equity in treatment conditions beyond the problematic asylum hospitalizations. Many other radical situations of disrespect for human rights have been added to these two, so much so that the name 'institutional violence' seems more adequate, and the violence women suffer during childbirth constitutes a specific modality of institutional violence. This new extended scenario to refer to the disrespectful treatment of patients has clearly revealed, in different clinical situations, that people are approached as 'bodies without subjects' in 'dehumanized' practices.

Aguiar JM, Azeredo YN, d'Oliveira AFPL, Schraiber LB. Institutional violence, human rights and technical-scientific authority: the complex childbirth situation for women. Interface (Botucatu). 2020; 24: e200231
https://doi.org/10.1590/Interface.200231

Humanization was the word chosen to symbolize the necessary recognition that the bodies approached in care provision are social subjects who have rights: the right to receive explanations regarding their illnesses and the right to choose from correlate treatments. Having a strong communicational impact, the notion of humanization was rapidly encompassed by the critical discourse to refer to those situations of violence; however, its meaning was not clear in terms of its distinction from the same institutional conditions, of childbirth or asylum hospitalization, that had also been the product of human choices[1,2].

Therefore, how can we distinguish between these two types of historical processes: the one in which such institutionalized care emerges as a product of human choices aiming to improve assistance and the one in which the improvement is annulled? Annulled because it has ceased to constitute a choice made by patients and professionals together; rather, it has become practically a compulsory indication of those types of institutionalized care. Can the origin of this type of violence lie here?

Rights or fates?

Recently, the public debate about rights in maternity care became fierce again due to two new regulation situations: Bill no. 435, sponsored by the Congresswoman Janaina Paschoal, and Resolution no. 2232 of the Federal Council of Medicine. The Bill proposes to guarantee that the parturient can choose the cesarean section as mode of delivery from the 39th week of gestation. The Resolution, published on July 17, 2019, addresses ethical rules for refusal of treatment, including pregnant women among the possible cases in which the refusal cannot be accepted by the physician because it characterizes “abuse of rights”.

In the first case, the Bill passed and became State Law no. 17137 of August 23, 2019. In its first paragraph, the Law provides that cesarean delivery on maternal request is a right of the patient and her autonomy must be respected; furthermore, the condition for the exercise of this right is that the patient must be duly informed and oriented about the risks of “successive C-sections” and the “benefits of normal delivery”[3]. We would like to highlight some issues referring to the perspective of rights and the conditions for their exercise.

First, the Law merely mentions the requirement of informing the patient about the risks of successive C-sections, disregarding the risks of the procedure itself, even if it is a single event in a woman’s life. Furthermore, the way in which the choice is presented to the woman, with mention to risks and benefits, indicates that it cannot be viewed simply as a choice for a consumer good. The immediate background is the issue of the quality of the provided information about cesarean delivery and normal delivery, and, obviously, the quality of the very working conditions of professionals as the effective context where such choices occur, as we know the preferences of both obstetricians and parturients due to conditions that are not technical-scientific, like access to anesthetics or to the elective C-section, among others. In these situations, it is important to ask whether human and social rights can be reduced to consumer rights. The preferences of professionals, like the elective C-section, are not related to rights in care production; they regard choices considered more opportune for personal reasons, which is totally different from the situation in which the choice of surgical delivery derives from a clinical need.

Studies have shown that Brazil is one of countries with the highest number of elective C-sections in the world, with a prevalence of 45.5% in women with low obstetric risk[4]; the figure increases to almost 90% in the private sector[5]. Despite the recommendation of the World Health Organization that the cesarean section rate should not be higher than 15%, rates of this mode of delivery in Brazil reveal that the decision about type of delivery is strongly influenced by non-clinical factors[5]. Among these factors, there is the understanding, on the part of women, that the C-section is a "painless" and less violent mode of delivery[6] and, on the part of professionals, that it is safer and allows greater control of risks, higher optimization of their work in terms of time and productivity, and less physical "harm" to the woman[7].

Thus, the Law does not provide for the main clinical issue at stake in this choice: the professional must evaluate the clinical need of such indication, but in good working conditions. Moreover, the professional must share his or her evaluation with the parturient, in a clarifying conversation in which he/she listens to her in order to consider, in the decision, women's desires and fears. The Law fails to address the most important issue, disregarding aspects that are substantive and not trivial to the professional's work and to women's health. In this sense, the Law transforms the right to choose into practically an imposition of fate. Who will choose a mode of delivery with lower healthcare quality?

As for the second situation, the resolution of the Federal Council of Medicine was received by part of the scientific community, jurists and humanized childbirth militants as a threat to women's autonomy in the choice of procedures, under the risk of coercion to receive undesired treatments and compulsory hospitalization, as the resolution provides that the competent authorities must be called to take measures in order to ensure the treatment proposed by the physician. In this scenario, it is inevitable to compare the situation to the case of Adelir, the pregnant woman who refused to have a C-section and was taken from her home back to the hospital by police officers under warrant, after the hospital called the competent authorities.

In December 2019, the Resolution provisions specifically related to pregnant women were suspended by the Judiciary after the Public Prosecutor's Office filed a public-interest civil action against the Federal Council of Medicine, as it understood that such provisions ignore the legal requirement of imminent danger of death for imposing treatments on unwilling patients. Such provisions also contradict the childbirth humanization policies of the Ministry of Health, which could favor the adoption of unnecessary procedures.

The fact that the Public Prosecutor's Office had to get involved in the defense of women's rights in the field of obstetric care calls our attention. On the one hand, the pregnant woman's impossibility of expressing her will before the State via the Judiciary is revealed, as she had to be represented by the Public Prosecutor's Office against institutions that are well supported in social, economic and legal terms, having access to lawyers to represent them, as was the case of the Federal Council of Medicine. On the other hand, we can say that the Council ended up eliminating the character through which medical authority is legitimized in society. This legitimation is given by the spontaneous acceptance, free of constraints, of the physician's healthcare decision in his or her clinical judgement. This happens because the healthcare proposal is offered to the patient in her individual medical care, always with the character of advice, not of

imposition. It is that acceptance that progressively makes the patient depend on the scientific basis that underlies clinical judgement, in a social process in which science is legitimized as competent knowledge and the physician is legitimized as competent agent in the use of this scientific basis[8-10]. Due to this, imposing the decision means, in fact, undermining the legitimate authority.

We would like to invite you now to imagine another healthcare situation, more common than the two childbirth situations examined here. Consider the situation of choice between normal childbirth and C-section when the physician, who is treating a parturient who wants to have a normal delivery, decides to perform a C-section and convinces her that she must have it, using the justification that the C-section's quality is technologically superior than that of normal delivery. The physician acts in this way not because of personal interests or immediate interests of an economic or political nature, but because he or she believes that, technically, he/she would control the childbirth process in a better way, despite the risks involved. Such evaluation may be due to the fact that the maternity hospital where the physician works is better qualified to perform C-sections in comparison to normal deliveries, or to the fact that it was the procedure he/she practiced most in his/her university education, or even because the physician believes that scientific technology is always better than traditional care with low technological incorporation.

This situation shows that the physician is more concerned about his or her safety than about the patient's safety, and does not take into account, nor presents to the patient, scientific evidence according to which the use of high technological incorporation not always guarantees the best quality of healthcare. And the physician does not take this evidence into account either because it is a very recent movement in the history of medicine, or because this movement emerges after a long historical process that consolidated the belief that incorporating more technologies will always be the best form of intervention.

In the case in question, the professional, by using this belief, transforms an advice into an imposition, and does so on behalf of his or her authority as a physician. But is this an exercise of authority?

Violence or authority?

According to Azeredo[11], many researchers in the field of Collective Health who defend human rights and humanization understand that institutional violence is connected with physicians' excessive authority and power and that the proposal of tackling the problem would involve the horizontality of the physician-patient relationship.

But what horizontality? Horizontality of power? And where, in a horizontality of power, would authority itself be situated? These are not minor problems in healthcare practice, as they involve the credibility of the sciences and their appropriation by their technological agents - the health professionals. These questions deserve a wide and profound debate, even though they have not been presented in this way about humanization, except very recently in studies based on Hannah Arendt's thought[11-13]. Conceptual distinctions differentiating authority, power and violence have not received much attention so far; due to this, these distinctions should be considered here, especially based on the study conducted by Azeredo[11].

To Arendt[14-16], authority is a special type of relationship grounded on the mutual recognition of the asymmetry that constitutes that relationship. Therefore, this means that the relationship of authority cannot be one between equals, as there is a recognition, legitimized by the participants, of the hierarchy relationship represented by authority. In the case of healthcare, users attend the service because they legitimize and recognize knowledges and techniques that the professional has and that can be useful, for example, in the childbirth situation, constituting a hierarchic relationship with the professional. The constituted hierarchy does not allow the professional to impose a certain conduct on the patient, as, according to Arendt[15], authority produces a type of discourse that is "more than advice and less than a command" (p. 165). It is in this way, as a consented technical and moral authority, that classic studies about the medical profession deal with the socially and historically constructed relationship between physicians and patients[10]. Thus, imposing, instead of advising, a conduct, even if the physician sees it as a technical-scientific need, is out of the question in individual medical care (which obviously acquires a totally different meaning in the case of Public Health and of the State's power and authority in situations of social danger, such as epidemics). In these terms, when the professional compels the patient to follow his or her conduct, what is at stake is the deflation of his/her authority and not its increase.

According to Arendt, power is different from violence in that "out of the barrel of a gun grows the most effective command, resulting in the most instant and perfect obedience. What can never grow out of it is power"[16] (p. 77). In this sense, power and violence have a proportionality relationship: as power increases, violence decreases. To the author, power emerges from the orchestrated action of women and men; it is the very purpose of politics. Violence, in turn, is always understood as a means to achieve a certain end.

In the childbirth situation considered to illustrate our reflections, what is the end to be achieved? When the physician compels the patient to accept some kind of care, imposing, for example, the C-section as the only alternative, either due to the low quality of childbirth care in view of the lack of anesthetists, or due to the dynamics of the professionals' workday or mode of occupation of hospital beds, or due to any reason other than the precise indication of a C-section because of the urgent needs of the fetus or the mother - does it still correspond to the C-section as a technological creation to improve childbirth care? Well, it was in this way that the C-section emerged as a technology for the good of life and gained recognition and legitimacy as a childbirth practice.

Therefore, we should bear in mind that using technology when it represents an improvement in the care provided for a certain individual case is different from the universal use of technology as a good in itself, that is, independently of the singular conditions in which it will be used in each case[17]. And what distinguishes one situation from the other is in the service of what the technological resource will be used.

The capacity to distinguish the usefulness of the technological resource in each clinical situation, present in liberal medicine as new intervention technologies were progressively created[9], has been, in historical terms, gradually replaced by the belief in technology as a good in itself[8], shifting it from the condition of a component of medical practice to be used in its service to the position of an autonomous entity that presides it[17]. This process through which technological medicine was implemented and developed, has engendered, in the reifying autonomization of technology, the

progressive alienation of physicians as subjects of their practices. Thus, technology as a human product to improve the intervention practice was dialectically transformed into a dehumanized device, as it denies its character subordinated to the social subject that is its agent of practice. Consequently, technology presides this agent in his/her intervention, dehumanizing the very condition of the physician in his/her practice. The physician starts to be an instrument or a means for the fulfilment of technology[1,2].

In the current practice of the highly technological medicine, the physicians were led, by historical processes of which they were also actors as social subjects, to the position of always valuing the armed practice of technologies[9]. And, as they did this, their importance as agents of medical practice gradually decreased: from subjects capable of deciding and making choices regarding the use of these resources through the faculty of judging, they gradually directed themselves to a subsidiary role of means of access to technologies, whose use they do not necessarily choose anymore. As Schraiber show us, the shift from liberal medicine to technological medicine corresponds to a crisis of interactions in the physician-patient relationship, among others, generating the 'crisis of bonds of trust' created in liberal medicine and based on the legitimation of the physician's authority, as we mentioned above. Thus, the crisis of trust can be interpreted as a deflation of the medical authority itself. In a society that deeply adheres to and believes in science, due to its technological products rather than to the knowledge it produces, the authority over knowledge about diseases and therapeutic treatments is disembodied from the subjects who operate the health technologies and is deposited on the technologies themselves. Thus, in technological medicine, the user looks for the service, not for the physician. On the other hand, the physician does not have 'his' or 'her' patient anymore; the patient belongs to the service now. Due to the protagonism of technologies to the detriment of professionals and even of patients, they are now socially viewed not only through the clinical decision-making, but also as a right - the women's right of having access to them - and as a product - a consumer product.

It is within this historical transformation of the roles assumed by technology in the field of health that the debate about the cesarean section as a women's right emerges, as a consumer product and as clinical indication. And it is in this historical process that we witness professional authority being unsettled by the reification of technologies related to medical practice.

Authors' contributions

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

Copyright

This article is distributed under the terms of the Creative Commons Attribution 4.0 International License, BY type (https://creativecommons.org/licenses/by/4.0/deed.en).

References

1. Gomes RM. Humanização e desumanização no trabalho em saúde. Rio de Janeiro: Editora Fiocruz; 2017.
2. Gomes RM, Schraiber LB. A dialética humanização-alienação como recurso à compreensão crítica da desumanização das práticas de saúde: alguns elementos conceituais. Interface (Botucatu). 2011; 15(37):339-50.
3. Brasil. Assembleia Legislativa do Estado de São Paulo. Lei nº 17.137, de 23 de Agosto de 2019. Garante **à** parturiente a possibilidade de optar pela cesariana, a partir de 39 (trinta e nove) semanas de gestação, bem como a analgesia, mesmo quando escolhido o parto normal. São Paulo: Assembleia Legislativa do Estado de São Paulo; 2019.
4. Leal MC, Pereira APE, Domingues RMSM, Theme Filha MM, Marcos Dias MAB, Nakamura-Pereira M, et al. Intervenções obstétricas durante o trabalho de parto e parto em mulheres brasileiras de risco habitual. Cad Saude Publica. 2014; 30 Supl:17-47.
5. Torres JA, Domingues RMSM, Sandall J, Hartz Z, Gama SGN, Theme Filha MM, et al. Cesariana e resultados neonatais em hospitais privados no Brasil: estudo comparativo de dois diferentes modelos de atenção perinatal. Cad Saude Publica. 2014; 30 Supl:220-31.
6. Diniz CSG, Chacham A. O "corte por cima" e o "corte por baixo": o abuso de cesáreas e episiotomias em São Paulo. Questoes Saude Reprod. 2006; 1(1):80-91.
7. Aguiar JM, D'Oliveira AFPL, Diniz CSG. El parto como "atropellamiento": ideología médica**,** visión pesimista del parto normal y violencia obstétrica In: Arguedas G, Palomo LRB, Castro R, Frias SM, Presas ALG, González MF, et al. Violencia obstétrica en América Latina: conceptualización, experiencias, medición y estrategias. Buenos Aires: EDUNLa Cooperativa; 2020. p. 131-44.
8. Schraiber LB. O médico e suas interações: a crise dos vínculos de confiança. São Paulo: Hucitec; 2008.
9. Schraiber LB. El médico y la medicina: autonomia e y vínculos de confianza en la práctica profesional del siglo XX. Buenos Aires: Editorial Lugar; 2018.
10. Azeredo YN, Schraiber LB. El poder médico y la crisis de los vínculos de confianza en la medicina contemporánea. Salud Colect. 2016; 12(1):9-21.
11. Azeredo YN. Saúde coletiva e filosofia: contribuições de Hannah Arendt para o debate de humanização [dissertação]. São Paulo: Universidade de São Paulo; 2017.
12. Aguiar J, d' Oliveira AFPL, Schraiber LB. Violência institucional, autoridade médica e poder nas maternidades sob a ótica dos profissionais de saúde. Cad Saude Publica. 2013; 29(11):2287-96.
13. Azeredo YN, Schraiber LB. Violência institucional e humanização em saúde: apontamentos para o debate. Cienc Saude Colet. 2017; 22(9):3013-22.
14. Arendt H. A condição humana. 10a ed. Rio de Janeiro: Forense Universitária; 2001.
15. Arendt H. Entre o passado e o futuro. 7a ed. São Paulo: Perspectiva; 2003.
16. Arendt H. Sobre a violência. Rio de Janeiro: Civilização Brasileira; 2013.
17. Schraiber LB. A tecnologia no pensamento de Ricardo Bruno Mendes-Gonçalves. In: Ayres JR, Santos L, organizadores. Saúde, sociedade e historia. Ricardo Bruno Mendes-Gonçalves. São Paulo, Porto Alegre: Hucitec, Rede Unida; 2017. p. 251-6.

Translator: Carolina Siqueira Muniz Ventura

Submitted on 04/24/20.
Approved on 06/16/20.