

Discursive practices about the decision-making power of women in childbirth

Práticas discursivas acerca do poder decisório da mulher no parto (resumo: p. 16)

Prácticas discursivas sobre el poder de decisión de la mujer en el parto (resumen: p. 16)

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This article analyzed the decision-making power of women in childbirth expressed in the discursive practices of nurses and resident physicians in the area of obstetrics. Qualitative study with 22 residents of a maternity hospital. Data were collected through interviews and submitted to discourse analysis following Michel Foucault's views. The discursive practices focus on risk control and normalization of the cooperative behavior of the parturient woman, culminating in restrictions on the decision-making power of women. They also value the humanization of childbirth, through the protagonism and co-responsibility of women, stressing the medical knowledge-power. It was evident an anchor in medicalization, reproduced by midwifery teaching, and in the neoliberal logic, associating women's self-government to consumption. Autonomy and health as rights need to be strengthened by the social actors of midwifery teaching and assistance.

Keywords: Personal autonomy. Parturition. Health human resource training. Humanization of care. Health policy.



Introduction

Women's empowerment as well as reproductive health have been global concerns since the Beijing Platform for Action in 1995. However, since no country has been able to achieve gender equality, these issues remain among the Sustainable Development Goals of Agenda 2030¹.

Being key to social, economic, and sustainable development, women's autonomy is influenced by gender inequalities and social context, which interfere with reproductive health decision-making and the freedom to make free and informed choices^{1,2}. The power of women to position themselves and make decisions is important for the achievement of improvements in maternal and newborn health, with impacts on psychological well-being, birth outcomes, and adaptation to the maternal role^{2,3}.

A positive experience in parturition is achieved when women are put at the center of care and involved in the decisions of care, in a safe environment, and with empathetic and competent health professionals. However, women's low control in environments with gender discrimination and cultural practices restricting their autonomy are associated with poorer health outcomes^{2,4}.

Brazilian women have difficulties exercising their autonomy in childbirth due to cultural factors related to gender inequalities and the obstetric care model, characterized by the routine use of unnecessary interventions, under the argument of making childbirth safer⁵. Moreover, it is noteworthy the influence of medicalization in this process, turning everyday issues of life into objects of biomedical knowledge, bringing with it the institutionalization and the hygienic conception, commented by Michel Foucault when analyzing the social control associated with medical power, contributing to reflections about the relationships between male gender and medicalization, de-medicalization and the natural conception of birth⁴.

Medicalization constituted the view of the female body as defective and unprepared to give birth and of childbirth as a potentially dangerous and pathological event. From this perspective, power relations and phenomena are anchored in the biomedical paradigm, under the curative, individualistic, mercantile, excluding and male structuring logic^{3,5}.

Feminist criticism considers that social control is a central element in the medicalization of reproductive processes and women's health^{3,5}. Regarding this control, Foucault⁶⁻⁹ analyzes that the medicalization of life is founded on power relations and involves an "ideal of health" conveyed in the health discourse. In this discourse, knowledge is the authority ensured by the power over life, called biopower, which manifests itself in forms of knowledge implicit in the process of social medicalization and transformation of the hospital into a therapeutic instrument^{6,7}. By providing this place with disciplinary mechanisms, it produces repercussions in the loss of autonomy of the individual, who assumes the role of patient^{6,7,10}.

In this sense, professional discourses tend to persuade and control women's behavior during childbirth, subjecting them to inappropriate, abusive, and disrespectful practices. It is noteworthy that these discourses are built beginning with the professional training in obstetrics, when practical teaching focuses on hospital settings with women admitted for childbirth^{11,12}.



Considering that this training can be influenced by discourses that interfere with women's decision-making possibilities during parturition, we questioned: How is the decision-making power of women in childbirth constituted in the discourses of nurses and doctors who are in their qualification stage in the obstetric area?

The present study aimed to analyze the decision-making power of women in childbirth expressed in the discursive practices of nurses and medical residents in the obstetrics area.

Methodology

This is a qualitative study developed in a public maternity hospital in the city of Rio de Janeiro, located in the west zone of the city of Rio de Janeiro, which offers care to "usual risk" pregnant women and to those with associated risk, serving mostly women from low-income groups.

The choice of this research setting is justified because this institution hosts one medical and two nursing residency programs in the obstetrics area. Registered with the Ministry of Education, the first program is coordinated by the Municipal Health Secretariat (SMS), while the obstetric nursing programs are managed by two public universities, in partnership with the SMS.

The participants were 11 resident nurses in obstetric nursing and 11 resident physicians in obstetrics. Inclusion criteria were: being enrolled as a resident in medical and nursing residency programs in the area of obstetrics. We excluded residents in elective internship, which corresponds to the period of practical learning in an institution different from the residency program headquarters.

The recruitment of the participants began with a survey of the nominal list and sector of assignment of nursing and medicine residents at the unit's study center. Subsequently, one of the researchers approached all 11 nurses and 12 resident physicians assigned to the maternity ward during the data collection period, from April to June 2017. It is noteworthy that there were no professionals in elective internship in the maternity ward and that a first-year doctor of the residency program refused to participate.

Among the twenty-two study participants, 20 were between 20 and 29 years old. All the nurses were women, and the group of physicians consisted of six women and five men. In this study, the male gender designation was chosen for the participants from the medical profession. As for education, the majority (seven) of the nurses graduated from a public university, while all the physicians came from a private university. Among the nurses, eight were in the first year of residency (R1) and the others in the second year of the program (R2). As for the resident physicians, five were in R1, three were in R2, and three were in the third year of the program (R3). It should be highlighted that the residency program in obstetric nursing does not have a third year.



The individual interviews were conducted with the support of a semi-structured script divided into two parts: the first containing questions about age, institution where they graduated and the year of the residency program they were attending; and the second with open questions about the possibilities, limits and situations involved with the woman's decision-making power in childbirth care. It is noteworthy that the instrument was previously tested and that no adjustments were necessary.

The interviews lasted an average of 22 minutes and were carried out by one of the authors, a master's student at the time, in a reserved place outside the care environment, in the team's room, in order to avoid interruptions and embarrassment. The statements were recorded, using an MP3 player, and later transcribed.

The analytical process was anchored in the Foucauldian Discourse Analysis (FDA), which uses conventional data collection techniques and analyzes the content of texts focusing on how they were constructed, ordered, and shaped in terms of their social and historical situation¹³.

Following M. Foucault, knowledge is closely linked to power, understood as a productive concept and not simply a repressive one, because it operates as a network allowing knowledge to be produced and manifested^{8,9,13}. Discourse, on the other hand, refers to the ways of thinking and talking about aspects of reality, being a social practice that has defined conditions of production, therefore building discursive frameworks to think, write, and talk about aspects of this reality¹³.

From this genealogical perspective, FDA makes it possible to analyze knowledge in terms of power strategies and tactics, since discourse is implicated in the process by which human beings are made subjects and, as a result, it guides particular ways of seeing the world and ways of being in the world. Therefore, FDA is interpretive of power relations and discourses expressed in discursive practices, i.e., the process by which reality at a given historical moment comes to be systematically constructed by subject/object formulation practices, involving systems that allow the emergence of utterances, as events that manifest constitutive effects¹³.

Operationally, the transcribed texts were read thoroughly and the statements were selected and thematized. After that, we re-read the statements based on the main questions: How is the woman's decision-making power in childbirth constituted in the discourses? Which discourses are used? What are the relations established and the possibilities of action? What position do the subjects occupy? Finally, we proceeded to the theoretical-conceptual reflection about the biopower and knowledge-power in Foucault for thematic composition and re-composition.

The research was approved by the Research Ethics Committee and, to preserve anonymity, the statements were coded by professional category, followed by the year of residency and the order in which the interviews were granted.



Results and discussion

Discourses of risk control

Medicalization has led pregnancy and childbirth to be seen as biological phenomena and as risk factors for maternal and neonatal health³. Based on this conception, health professionals adopt interventionist attitudes, considered preventive of possible complications in parturition, even if these are not shown as concrete threats:

[...] oftentimes, it's the doctor speeding up the birth a little, because of inexperience or fear of fetal distress. But I think there are many interventions that we do that are not necessary. We still have a lot of fear of letting the birth occur normally. (Physician R1/E1)

I think that the woman doesn't have many decision possibilities. When she enters the prepartum with the desire to have a normal birth, this is put on standby. But if there is any evolution and the doctor decides, he will intervene even if it is not really necessary (Nurse R2/E4)

We verified among nurses and medical residents that uncertainty and fear of unfavorable outcomes and complications threatening maternal and fetal well-being sustain the recurrence of the discursive practice of risk control, which is produced by the knowledge-power of medicalization, making it inexorable to act in the face of the probability of undesirable events in obstetric care^{3,5,7}.

Since modern obstetrics, the biomedical discourse holds that women's bodies are prone to dysfunction and, therefore, submitted to preventive and curative technologies, to avoid that imperfect functioning implies in negative perinatal outcomes. Based on this assumption, labor monitoring has been configured as a care norm to ensure that the "product" of the parturient 'at-risk' body is the healthy birth of a new patient¹⁴.

From this perspective, the notion of risk is configured as an instrument in the distinction between the physiological and pathological, materializing in control attitudes of the pregnant body^{6,7}. Thus, under the argument of safety in childbirth, the hospital emerges as a privileged space where professionals use rules, knowledge and practices to control women's bodies. In other words, it is the disciplinary power that is exercised, not necessarily through coercion, but through implicit social norms that lead to the disciplining of bodies through surveillance and knowledge^{3,14}. Risk control was therefore justified:

She [the woman] can opt for vaginal delivery, but up to the limit of fetal distress [...], when there is a cardiotocography that indicates it, due to very severe oligohydramnios, failure to induce normal labor, cephalo-pelvic disproportion or placenta previa. I think these are the main indications and she really doesn't have the right to choose, unfortunately. (Physician R1/E17)



Considering the surveillance posture due to the probability of risk and not due to the medical contraindications for normal delivery mentioned above by the resident, Foucault states that the professionals' readiness in the face of imminent danger reveals the disciplinary power. This power is operated by the "glance" symbolized in Jeremy Bentham's panopticon, whose prison architecture was the model of hierarchical surveillance for modern institutions, such as schools, asylums, and hospitals. The constant sensation of surveillance and the power exercised through "seeing without being seen" leading people to self-discipline^{6,7}.

It should be noted that discipline does not necessarily involve coercion, but it is a reference for the classification, differentiation, hierarchization, and exclusion of individuals considered to be outside normal standards. The normalizing sanction, on turn, consists in the disciplinary norm, which qualifies and represses a set of behaviors, as well as delimits the boundary between the normal and the abnormal. The combination between the hierarchical gaze and the normalizing sanction is materialized in the examination, when the individual becomes a case and, as such, can be watched, described, measured, compared, and normalized through a disciplinary ritual⁶⁻⁸.

It is verified that these mechanisms of power are present in the discursive practices of residents, since they intervene on the female physiology and impose obstetric practices, through observation and recurrent examinations in order to produce docile bodies that can be manipulated unchallenged, in order to mitigate the probability of risks of undesirable maternal and perinatal outcomes. From the women's perspective, it is worth highlighting that these actions to discipline the bodies can be seen as a punishment, since they interfere with the exercise of their right to choose and decide on childbirth care^{3,11,12}.

It is key to consider that the discourses of risk control have been reproduced in the context of midwifery education:

The focus in [undergraduate] teaching was on interurrences, when the bleeding and the motor [uterine contractions] are not OK. My experience was with interventional professionals. I understand that there is a need to know about interurrence, to act at the right time, but I think that we have to believe in physiology. (Nurse R2/E14)

We learn [in residency] the alert situations and the emergencies. What you have to look at and be alert. I think that is what we see the most. (Physician R2/E9)

It can be seen that, as professionals in training, the residents themselves are under the disciplinary power of the training institutions, which provide the acquisition of competencies, skills and attitudes, controlling what is taught and using predominantly quantitative assessment based on the number of procedures performed in a period of time, to the detriment of qualitative criteria that allow the procedural monitoring of performance¹¹.



In Brazil, the qualification in obstetrics prioritizes the hierarchical view and the normalizing sanction, by directing training to learning techniques of observation and surveillance of body signs in childbirth, as elements of clinical practice that are indispensable in decision making for the use of interventions, especially in the hospital environment^{5,11,12}.

Therefore, the female body is a useful body that is perceived by professionals as an object to be manipulated, analyzed, controlled, and improved through their knowledge-power. From this point of view, the body is the locus of power actualization and the hospital is configured as a healing environment and an instrument for the production, accumulation, and transmission of knowledge and consequently, of power^{6,7}.

In this sense, risk works as a cultural resource of objectification and subjectivation through which health professionals are inserted into the network of micro powers existing in the hospital, where biopower, disciplinary power, and institutional power operate. The latter produces norms, routines, structure, hierarchy, and bureaucracy that govern power relations within the organization, determining discourses to govern perceptions, experiences, and human actions^{6,7,14,15}.

Discipline and biopolitics are dimensions of the exercise of biopower. Biopolitics is not focused on the individual, but on the population as a whole, the social body. Biological issues related to births, deaths, health, diseases, and demographic descriptions, such as race, class, and gender, became managed and ordered by government. The forms of governing were called governmentality by Foucault, understood as the techniques of control exercised over others and the techniques of the self⁶⁻⁸.

Therefore, the residents' discursive practices express that in-service training in the hospital is operated by biomedical knowledge, which manifests itself as a discourse of truth produced and sustained by systems of knowledge-power, determining unequal relations between women and professionals^{3,4}. On the other hand, the normalization of clinical practice tends to occur through norms and protocols, determining tensions and hierarchies in interprofessional relationships. As a persuasion of an "ideal of health", the biopolitics of medicalization values risk and its management as ways to manage life through its own agenda and power dynamics^{6,7}.



Discourses of normalization of women's behavior during childbirth

Normalization refers to the construction of idealized forms of behavior through the development and implementation of surveillance and control technologies⁶⁻⁸. The ideal of the "good parturient" emerged in the discourses, when it is expected that she presents behaviors of obedience, understanding and cooperation with the professional for the good progress of care. These speeches externalize the subjectivation and objectivation of the woman to the disciplinary power, constituting her subjectivity as passive, docile and obedient, and the objectivation of her body by the professional knowledge-power:

She has to be very calm, relaxed and waiting for it [normal birth]. It's good for her to be cooperative and push. Because when she's not, there's no way we can do the work for her. (Physician R1/21)

A pregnant woman that is understanding and understands that what we are saying to her is the best because we don't want the worst for anyone. (Physician R1/E3)

On these idealized forms of conduct, women are particularly affected by gender norms, which construct models of behavior, attributes, and social roles. Gender operates by normalizing male or female subjects and by intersections with other social markers, which involve power relations and produce subjectivity¹⁶. In parallel, social characteristics create hierarchies that maintain power structures, which manifest themselves in health systems and produce asymmetries between individuals who may have more power, while others are more likely to be disempowered or marginalized^{11,12,16}.

This hierarchical logic is present in the care to women during childbirth, since the mother is expected to behave obediently and follow the professionals' commands, submitting to their authority expressed in technical knowledge. Gender inequalities in society, rigid hospital routines, and the hierarchical system of professions corroborate that those women have little support and have difficulties in exercising their rights and participating in decisions during childbirth, leaving them more exposed to situations of disrespect, abuse, and aggressive interventions^{11,12,16}. Women's lack of support and autonomy were thus highlighted:

When the woman enters the institution, she ends up having to follow more or less a pattern. So, she doesn't have much choice, or if she does, the staff may be uncomfortable with her options. (Nurse R1/E8)

For Foucault, power is only exercised over free subjects, because freedom, at the same time that it is a condition for the existence of power relations, enables the undertaking of resistance tactics to the norms, institutions, techniques and procedures, constituted through discourses and knowledge as technologies of surveillance. Therefore, where there is power, there are strategies of subversion⁶⁻⁸.



Feminine behaviors resistant to disciplinary norms cause tensions between parturients and professionals, who react with control tactics expressed in institutional rules, as is the case of the signing of the consent form to hold the woman responsible for the risks of her decision, safeguarding the professionals from ethical and legal implications:

[...] if the baby is under life-threatening conditions and the mother really wants a normal birth, she can't! Let's talk to her as much as possible! If she says: "Oh, I don't want a C-section at all! She will have to sign a term or something like that. (Physician R2/E9)

During the processes of decision-making about care, individuals can actively react in the face of attempts by health professionals to dominate them. In this sense, some pregnant women adopt resistance strategies to maintain some control over the situation, resorting to the aggregation of obstetric, reproductive, and social information to avoid disrespectful maternal care and protect their body autonomy¹⁷.

When parturients manifest exasperated behavior in the face of labor pain, they are perceived as inappropriate by medical residents, because they represent an explicit confrontation with the discipline expected by them. In these situations, they label them as hysterical, irrational, and disoriented:

They come in hallucinated, they ask just to cut and pull the baby out. So, you can't take much into consideration at a moment of desperation, it has to be a moment of coldness and rationality. (Physician R1/E13)

I think that if she could choose what she wants, she would act in the ideal way. Since they can't choose and don't always want a normal delivery at all, then they act with hysteria and get stressed. (Physician R3/E12)

[...] here, as we have a target public that is very disoriented, they don't have much choice, they don't even know what will happen, how much is the total dilation. We may explain, but they don't understand much. (Physician R2/E6)

Androcentric discourses conceive an appropriate femininity and produce stereotypes when women's behavior reveals resistance to disciplinary power, since hysteria can be a rebellion. Labeling as "hysterical" insinuates that they are entirely "body" and therefore act irrationally and are unable to conduct themselves by reason or logic. On the other hand, it can also signal attitudes that are not very sensitive to pain in parturition, resulting in possible limitations in the supply of methods, pharmacological or not, for pain management, especially in public maternity hospitals^{17,18}.



Moreover, the residents' speeches suggest the intersection between gender and social class when they classify women from popular segments as lacking knowledge, disoriented, unable to understand the phenomena of childbirth and, therefore, unable to make choices and decisions. The intersection of gender and social inequalities can influence how health professionals perceive and interact with women in labor, and also interfere in their clinical decisions and obstetric practices^{17,18}.

Gender and social inequality issues may involve restrictions in access to maternal care and increased exposure to situations of discrimination in care. Moral judgments about who is a "good" or "bad" patient tend to be incorporated during training, especially in relation to socially disadvantaged groups. The attitude of denying support to parturients can denote the attempt of professionals to maintain their power, control and authority over them. Not providing information is also another way to prevent women from actively participating in decisions and exercising their autonomy in childbirth, thus demarcating professional power from biomedical knowledge^{3,12,17}.

Discourses regarding the humanization of childbirth and women's protagonism

Even though it was initially directed to obstetric care, humanization has become a public policy across all programmatic areas of the Brazilian National Health System (SUS)³. Therefore, humanization is a governmental discursive practice that constitutes a particular form of rationality, technical procedures, and instrumentalization to govern citizens^{6,7}.

The incorporation of these discourses in women's health policies has produced discursive practices that aim to expand their responsibility over their reproductive life, contemplate the ideals of natural birth, encourage female protagonism, promote responsible motherhood and fatherhood, and enable the inclusion of other actors in the delivery scene, such as companions, doulas, obstetricians, and obstetric nurses^{3,17}.

From a Foucauldian perspective, discourse encompasses statements that define conditions of existence, strategic devices of power relations, and forms of subjectivation^{8,9}. Currently, cultural norms and modes of expertise to govern citizens are determined by the dominant neoliberal logic, and this is also true in Brazil. In health, neoliberalism uses the concept of individualization and autonomy, making subjects responsible for promoting and maintaining their well-being^{17,18}.

The discourses of humanized childbirth also value the autonomy, participation and co-responsibility of women, as well as attempt to change the ways of regulating the female body and subjectivity, through educational practices that aim to instrumentalize the exercise of their rights and the development of self-care and their babies².

From this point of view, residents expressed their appreciation for the decision-making power and autonomy of women in labor, emphasizing their educational role so that they are able to make informed choices and decisions during childbirth:



We must empower her [the woman] so that she can know her own body and the process of childbirth. And, when the delivery comes, that she knows what is happening with her body, to have the autonomy to do what she wants, to empower herself and be the protagonist. (Nurse R1/E18)

We always have to give guidance about everything that can happen during birth [...]. She has the decision, the right to choose and can choose not to induce [labor] and choose, in this case, the route of delivery. (Physician R1/E21)

In pregnancy and childbirth, a woman's autonomy encompasses attributes that determine self-efficacy and power related to self-control and decisions that affect her. The internal attributes refer to the belief in her own abilities to achieve meaningful goals and act on the situational context. The external attributes are gender equality, qualified information, facilitation of choices and decisions in care^{2,12}.

Moreover, the exercise of autonomy requires an environment free of violence, the recognition of women's human rights, and guaranteed access to the resources necessary to promote gender equality. Therefore, educational actions are essential to expand women's abilities to deal with new situations and challenges of pregnancy, parturition, and maternity, providing them with opportunities to make choices, with confidence and free of coercion².

As part of biopolitics, the norms and protocols for the humanization of childbirth determine the reduction of cesarean sections, excessive interventions and practices without scientific support^{3,4}. However, these recommendations, which express government control over obstetric care, are perceived by resident physicians as curtailing their professional knowledge-power and women's freedom of choice regarding the surgical route of delivery, as they explain:

This thing of having a normal birth at any cost, that you can't do episiotomy, you can't do oxytocin, you can't do whatever... These things are there for us to do at the right time. And no one knows better the moment to do it than the professional. (Physician R1/E3)

It is to be able to choose if she [the woman] wants a cesarean section or epidural analgesia in the public health system. I see that there is a lot of reluctance to have the epidural. This should not be so. (Physician R3/E20)

Different from what happens in private practice, where we are freer, we can even do what the patient wants, and sometimes even what we think is more correct. (Physician R1/E13)



Medical residents see the policy of humanization of childbirth as restrictive to their professional autonomy and to the presumed freedom that women have to choose a cesarean section. They suggest that users of public services are more exposed to painful and analgesia-deprived childbirth experiences, as reported in Brazilian studies^{3,5,11,12}.

Therefore, we note the interconnection between the discourses of medicalization of childbirth and the neoliberal logic in health, since the discursive practices of cesarean section and analgesia are presented as a consumption privilege for those who can pay for procedures that abbreviate the suffering in parturition, to which parturients from public maternity hospitals tend to be more subjected^{3,11,12,18}.

In contrast, resident nurses produce discourses aligned with the biopolitics of humanization, by placing themselves in defense of female autonomy and normal birth as instinctive and natural:

I think we [women] own our bodies, we know how to give birth and our children know how to be born. So, a woman doesn't necessarily have to be in a hospital to be able to give birth. She can choose where and how she wants to give birth. (Nurse R1/E1)

Obstetric nurses, obstetricians and doulas tend to develop care related to the promotion of maternal health and the preparation of women for childbirth and motherhood, playing the role of experts who exercise a particular form of power to promote female training and “empowerment”. In this sense, they act as “behavioral experts” and neutralize the medicalized culture, expanding the options for women in labor and their responsibility for reproductive health and birth outcomes¹⁸.

Today, discourses and technologies of power operate on individual freedoms. Based on neoliberal conceptions, health governance establishes cultural norms and modes of expertise to lead individuals to optimize their self-government competencies. To this end, expertise is configured as the key technology to foster self-regulation through educational interactions and regimes of health-promoting behaviors guided by experts^{3,6,18,19}.

From this perspective, women's freedom and decision-making power are important elements for the exercise of autonomy, which requires a protective environment that promotes their human rights and recognizes the influences of the sociocultural, economic, and political context in which they are inserted, because the internal belief in themselves is fundamental in the experience of empowerment^{2,3}.

Even though health policies encourage humanized discursive practices, Brazilian women face restrictions of the right to dignified, respectful and evidence-based maternal care^{3,5,11,12,19}. They also encounter systemic barriers in obstetric services, such as lack of protocols, absence of guidelines, and inadequate infrastructure, which limit the possibilities of positive birth experiences. Moreover, barriers related to social inequalities have impacted especially black, low-income, and less educated women. Moreover, private hospitals are less likely to adhere to scientifically backed practices and initiatives to reduce unnecessary cesarean sections^{4,19-21}.



Given this reality, Brazilian social movements in defense of normal birth have been mobilized towards a dignified and respectful care that promotes women's autonomy. At the same time, some women have demanded home birth care as an alternative to the excessive medicalization of public and private services. However, this choice is possible among those with higher education and income to pay health insurance¹⁹⁻²¹.

Thus, the humanization discourse corroborates to expand the sense of freedom, responsibility, and active female participation in health care as opposed to body control, excessive interventions, and medical centrality disseminated by the medicalized discourse. However, both discursive practices address the possibility of offering alternatives based on the individual purchasing power of women, such as elective cesarean section and analgesia for beneficiaries of health insurance plans, despite government regulations; and the search for training for home delivery, since this type of care is not available at SUS.

These possibilities of consumption in childbirth care are anchored in the individualistic, consumerist, and apolitical logic, which accentuates inequalities in health and penalizes, in particular, women who depend solely on public services, where they find limited opportunities to have their say and decide about their care. Although these inequities are widely known, it was found that residents tend to naturalize and reproduce them.

Closing remarks

The discursive practices of nurses and doctors reveal restrictions on women's decision-making power in childbirth in the face of biopower, disciplinary power, and professional knowledge-power. Although medicalization remains the discourse of "truth" in obstetrics, the policy of humanization of childbirth values female protagonism and constitutes active maternal subjectivity, but create stress with professional authority and incites attitudes of resistance, especially among doctors.

The neoliberal logic in health care is underlying the discourses of medicalization and humanization of childbirth. The former defends medical knowledge-power and evoke arguments of greater liberality to women's choice of cesarean section. The latter value preparation techniques for natural childbirth aimed at developing self-government skills in women, but also create consumer demands for care routes outside the health system, such as the maternal home.

These results demonstrate the complexity of the network of power relations that constitute Brazilian obstetrics and the reproductive tendency in the field of teaching, signaling that the human rights of women and the principles of SUS should be problematized and strengthened by social actors involved in training, management and care. It is also suggested that the coexistence of public and private subsystems, coupled with the neoliberal order of our society, potentiates the inequalities of gender, class and race, as well as contributes in the maintenance of the challenges of the policy of humanization of childbirth.



It is also noteworthy that this research has limits because it analyzes the discourses of a particular group of nurses and doctors who are specializing in obstetrics and because of the average length of the interviews, which may have limited the apprehension of complementary discursive practices. These limitations make it impossible to generalize its results, but its analytical potential for promoting critical reflection in similar scenarios and contexts is believed.

Authors' contribution

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

Conflict of interest

The authors have no conflict of interest to declare.

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Associated editor

Aylene Emilia Moraes Bousquat

Translator

Félix Héctor Rigoli

Submitted on

03/09/22

Approved on

05/20/22

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Este artigo analisou o poder decisório da mulher no parto expresso nas práticas discursivas de enfermeiras e médicos residentes da área de obstetrícia. Estudo qualitativo com 22 residentes de uma maternidade. Os dados foram coletados por meio de entrevistas e submetidos à análise do discurso à luz de Michel Foucault. As práticas discursivas enfocam o controle dos riscos e a normalização do comportamento cooperativo da parturiente, culminando em restrições no poder decisório das mulheres. Também valorizam a humanização do parto, por meio do protagonismo e da corresponsabilização feminina, o que tensiona o saber-poder médico. Evidenciou-se que há ancoragem na medicalização, reproduzida pelo ensino de obstetrícia, e na lógica neoliberal, associando o autogoverno das mulheres ao consumo. Autonomia e saúde como direitos precisam ser fortalecidos pelos atores sociais do ensino e da assistência em obstetrícia.

Palavras-chave: Autonomia pessoal. Parto. Capacitação de recursos humanos em Saúde. Humanização da assistência. Política de Saúde.

Este artículo analizó el poder de decisión de la mujer en el parto expresado en las prácticas discursivas de enfermeras y médicos residentes del área de obstetricia. Estudio cualitativo con 22 internos de una maternidad. Los datos se colectaron por medio de entrevistas y se sometieron a análisis del discurso a la luz de Michel Foucault. Las prácticas discursivas enfocan el control de los riesgos y la normalización del comportamiento cooperativo de la parturienta, culminando en restricciones del poder de decisión de las mujeres. También evalúan la humanización del parto, por medio del protagonismo y de la corresponsabilización femenina, lo que causa tensión sobre el saber-poder médico. Se puso en evidencia que hay anclaje en la medicalización, reproducida por la enseñanza de la obstetricia y en la lógica neoliberal, asociando el autogobierno de las mujeres al consumo. La autonomía y la salud como derechos necesitan ser fortalecidas por los actores sociales de la enseñanza y de la asistencia en obstetricia.

Palabras clave: Autonomía personal. Parto. Capacitación de recursos humanos en salud. Humanización de la asistencia. Política de salud.