Journal of Human Growth and Development
2015; 25(1): 117-124

"YOU TAKE CARE OF THE BABY'S CLOTHES AND I TAKE CARE OF THE DELIVERY" – COMMUNICATION BETWEEN PROFESSIONALS AND PATIENTS AND DECISIONS ABOUT THE MODE OF DELIVERY IN THE PRIVATE SECTOR IN SÃO PAULO, BRAZIL

Helena da Costa Lino[1], Simone G. Diniz[2]

DOI: http://dx.doi.org/10.7322/jhgd.96825

ABSTRACT

High rates of cesarean sections and invasive interventions in labor and delivery, disregarding recommendations on safety and quality of healthcare characterize childbirth care in the Brazilian private sector. We aimed to understand how professionals and patients communicate about risks and benefits of the interventions and take decisions in the Internet era. We interviewed 28 professionals and female users of the private health sector in São Paulo, including those we will call "typical" and "atypical" of the national scenario. The communication about procedures among "typical" patients was scarce, biased or actively blocked, tending to strengthen a behaved attitude. "Atypical" patients sought further information from professionals and peer groups and used more Internet resources (discussion lists, evidence websites and narrative banks). The availability of such information allows more women to seek a care aligned to their values and notions of rights, frequently confronting the medical authority, creating needs to be (or not to be) satisfied.

Key words: natural birth, cesarean, supplementary health, satisfaction with care, gender.

INTRODUCTION

The childbirth scenario in Brazil has been characterized by high rates of cesarean sections, an aggressive management of normal birth, high rates of maternal morbidity and mortality that are stagnant for at least a decade[1], and for the frequent disregard for rights of patients, as in the case of the companion of choice in childbirth. Occasionally some campaign promotes normal delivery as the most beneficial and safest way for mother and baby, apparently without any effectiveness. The lack of effect of these campaigns is also due to the fact that what is called "normal birth" in Brazil includes unnecessary and painful routine interventions, making the experience of childbirth unnecessarily traumatic, and far from "normal"[2-4]. This "pessimização" of the childbirth experience is useful to make routine cesarean section a more acceptable alternative, compared to a traumatic delivery[5]. However, studies show that even in the private sector, and even considering this aggressively managed childbirth, most women report that they prefer a vaginal delivery than a cesarean section in early pregnancy, going to accept cesarean section during the antenatal care, or even at during childbirth[6,3].

The right to an informed choice should apply both to the majority of women (the healthy ones), as well as those facing a health problem[7]. However, in the present scenario there is little room for women to express their doubts and preferences. Most are unaware that they have rights and often accept unnecessary and / or aggressive interventions that are made as part of a care routine, without any chance to question or negotiate these routines. This scenario reflects the historical development of medical practice and Brazilian obstetric and its institutional ethos[8].

This research focused on the childbirth care in the private health sector, in which a form of intervention has become almost mandatory: elective cesarean section. Its occurrence, according to DATASUS, reaches in this sector national rate of

"The authors worked together in all stages of production of the manuscript."

1 Psychologist. Master in Public health.Rua Cayowáa, 1590, apartamento 21. Sumaré, São Paulo, SP.
2 MD, PhD, Associate Professor, Department of Maternal and Child Health, School of Public Health. University of São Paulo.
Corresponding author: sidiniz@usp.br

Suggested citation: Lino HC, Diniz SG. "You take care of the baby's clothes and i take care of the delivery" – communication between professionals and patients and decisions about the type of labor in the private sector in São Paulo, Brazil. *Journal of Human Growth and Development.* 25(1): 117-124
Manuscript submitted Oct 08 2014, accepted for publication Feb 22 2015.

84, 6%, remaining above 90% in considerable part of the services, and raising the national average to 54% in 2011. Despite the fact that cesarean section in Brazil is seen as consumer good, the scientific evidence shows that for uncomplicated pregnancies, it offers greater risks to the health of mother and baby[9]. This is admittedly a matter of public health, because the way we define the quality of public health programs in a given period should be compatible with the enjoyment of health equivalently by future generations[10].

There is, however, a growing community of professionals and consumers who are opposed to this model, constituting an organized social movement that helps women access a more evidence-based, humanized model of care. Since this model of care that promotes spontaneous delivery has been supported by the World Health Organization and the Ministry of Health, the recommendations of these bodies are used as technical and political argument for these movements[11]. They have created many information resources, including face-to-face groups and courses, books, videos, websites with written and video narratives, information on evidence-based care and electronic lists for pregnant women, with increasing reach particularly among the population more "digitally included" and with higher income, those who were our research focus.

This study aimed to describe and analyze comparatively the different perceptions about what health professionals working in delivery care in the private sector, and their patients, consider to be a good birth experience, and a bad one (an emotionally traumatic birth), and what they think that contributes to their occurrence. The hypothesis raised is that satisfaction with the birth experience depends on the information and the expectation that women have. The expectations also direct the choice of provider by the patient according to the experience that she wishes, and will be in constant preparation in the doctor-patient relationship, depending, among other things, on how communication is or not possible in the relationship, the role of other sources of information and the " communities of peers" found by the woman.

METHODS

We start from a perspective guided by the gender approach, considering that gender biases impregnate maternal health care[5]. We understand gender as socially constructed sex - the set of arrangements by which a society transforms biological sexuality (and we add, reproduction) into products of human activity, and in which these transformed sexual (and reproductive) needs are satisfied[12]. These gender biases are expressed in maternal care of two articulated movements: first, the under estimation or even the complete denial of the woman in labor's abilities to deliver a baby by herself, resulting in models of care focused on the "correction" of the female body, flawed and in need of protection, with a whole set of corrective interventions; and second, we have the over estimation of the benefits of technology, under estimating or denying the discomforts and adverse effects of interventions. Thus, interventions in childbirth and how patients and professionals interpret them are oriented by a set of prior expectations about the female body, socially constructed, which will also lead women (and professionals) to consider themselves more or less satisfied with the experience of assisting or of being assisted during delivery[5].

This is a qualitative study, based on the analysis of semi-structured interviews with predefined themes, from the literature, with openness to emerging issues. We created two interview guides, one used for the mothers and the other for professionals. We selected a purposive sample of 28 subjects, including 14 patients of the private health sector and 14 professionals serving this sector. Respondents comprised intentionally four subgroups with seven members each, the patients (typical and atypical) and professionals (typical and atypical), classification that we will discuss below. The number of members of each group was defined in the process, from the internal consistency of beliefs about the care provided, which proved to be quite high, as well as the patterns of answers in each group.

The terms "typical" and "atypical" were chosen by exclusion, since other terms ("active" and "passive", "humanized" and "non-humanized", "evidence-based" and "non-evidence-based", for example), appeared excessively normative. For 'typical' patients we understand those who had chosen to be assisted by professionals with more prevalent approaches, more typical of the general population, who had their deliveries via caesarean section (the majority), or vaginally with a series of interventions, such as oxytocin, analgesia and episiotomy. Two of the informants in this group were nominated by people in the circle of friends of one of the authors (HCL), and from them, we performed the snowball method, in which each subject indicates another one to be interviewed, with comparable characteristics.

The "atypical" patients were those who chose to be assisted by providers who were supporters of natural childbirth, with minimal interventions possible, and sought a lot of information before making decisions concerning their deliveries. We made the selection of this group through electronic mailing lists of pregnant and postpartum women searching a normal birth on the internet. The coordinator of the lists sent an email explaining the research and asking who would be interested in participating, and we selected positive responses from the participants. There was a concern to diversify the profile of respondents, comprising women who chose to have hospital and home births as well as a postpartum woman who, despite having private health insurance, chose to take his birth in a public birth center.

The women who made up these two groups had had their births between three months and two years before the interviews. The literature on the distance of the event "birth" and their narratives ("halo" effect) indicates relative advantages and

disadvantages to the interviews closer of more distant from the event[7]. In this way, given the consistency between the narratives, we believe this broad range was a good choice. It is noteworthy that the patients in both groups who had hospital births, mostly, were treated at hospitals considered models of excellence, the highest standard in the city of São Paulo,

The third group comprises doctors that we call typical, that is, supporters of more traditional methods of childbirth care, such as caesarean sections in most cases, and occasionally vaginal deliveries with interventions. There was much difficulty in recruiting subject to this group. First, we approached older and more experienced, but they proved almost inaccessible, refusing to participate. Considering this, we invited younger doctors for the interviews, and this was possible because people who were friend with one of the researchers (HCL) nominated them; we believe that this proximity was very advantageous because it allowed the subjects to stay more comfortable to express themselves. They also had experience maternal care in the public sector, allowing the comparison between models considered appropriate in each sector.

The fourth and final group consisted of professionals who we will call atypical, including obstetricians, neonatologists, pediatricians and a midwife. The criteria for inclusion in this group was that they were supporters of natural childbirth, who worked based on scientific evidence, and considered the woman as the protagonist of his birth, characteristics of a self-defined "humanized" community of providers. There are not many providers working in this perspective, therefore we selected those most active in the area, whose names appeared frequently in the childbirth narratives of the atypical mothers.

This study complied with the ethical principles of confidentiality and anonymity of the participants, according to the Law 196/96, and the Research Ethics Committee of the Public Health School of the University of São Paulo approved the project. The names of patients and professionals were replaced to ensure their anonymity.

To analyze the data we used thematic analysis[13], guided by the above described gender perspective, undertaking a detailed reading of each interview and a categorization of data according to the axes that guided the interview. From this categorization, we could draw a profile of each subject interviewed and their understanding of the experience of having children or its assistance. We then aimed to compare the answers given by the respondents in each group. From these comparisons refined the analytical categories that we describe below.

RESULTS AND DISCUSSION

Information and choice: the ideal patient

There is a belief that in the public sector the doctor defines the mode of delivery that the patient will have ("clinical indication"), and in the private is the patient who makes that choice. However, it was not what we found. If it is evident that if the patient wants a caesarean section in the public sector it causes discomfort, the private sector patient who wants a normal delivery raises the same discomfort. In this research, 5 out of 7 of the typical women, and all atypical ones, have declared preference for vaginal delivery in early pregnancy. However, 5 out of 7 typical women had a caesarean section, which roughly corresponds to demographic data of the private sector[3]. Reflecting the intentionality of the sample, all atypical women made possible the desired vaginal births, but not without many obstacles, as we shall see.

Typical and atypical providers, have their ideal patient. Typical providers value those calm and "collaborative". They seem to offer mainly information if and when demanded by the patient, and prioritize that information confirming their preferences on the assistance. They believe it is important that patients are well informed, but understand information by women "being aware that birth hurts" and that they "will have to collaborate." For them, the more information the less fear that the patient feels, and so she is more collaborative. In such cases, the meaning of the "collaborative" often coincides with the still, silent ("that does not scream", "does not make a scandal," "is not making a show"). This overlapping of meaning between "collaborative" and "silent" was very explicit in the speech of several providers:

> *"She has to know that she will feel pain [in normal birth], but I think it are women that start crying when the baby will be born, start screaming, they want to give a show." (NAIR, typical professional)*

Typical professionals describe the patients who are "troublesome" as being resistant to medical treatment, "wanting to impose their conduct over the doctor". They indicate having major problems in the public sector, because of the lack of analgesia, and the difficulty in dealing with patients who want cesarean "right away" (something not allowed in public hospitals, although almost mandatory in the private sector), which would hinder the collaboration to achieve a normal birth. They argue that the private sector these issues are quickly resolved, the patient spoke up, screamed in pain or something, and cesarean section appears as a solution. However, population data show that in practice, the woman who gets into labor is an exceptional situation, with about 17% in the private sector[3].

Atypical providers say that they value the autonomy of their patients, expect them to be jointly responsible for the decisions about childbirth, and report that they provide the greatest amount of information possible, through face-to-face groups, brochures, books, videos, sites about evidence-based information and electronic lists of consumers. In this case, the "troublesome" patients would be those who delegate the leading role to the provider. They value those who seek to be in the center of

their birthing process, and actively participate in decision-making regarding the care.

The "lay" patient and the "expert" patient

Just like typical and atypical providers value certain aspects in their patients, patients also have their preferences about the providers. Typical women seem to feel comfort and satisfaction in a position of passivity and dependence, valuing the professional who takes control of the situation.

In several interviews, the typical professional, although speaking about the importance of communication with the patient, does not seem to encourage it. Often patients do not ask, doctors do not respond, and everyone is satisfied, as if a pact of silence. In the words of one of a typical patient:

> *"Actually she did not discussed it with me, she did not ask what I thought, I also did not ask. The cut [episiotomy] she also said that it is a thing to check in the moment, but we also did not discuss. I think that, I have a lot of confidence in her, what she had to do she was going to do it, you know? Then I also did not say if she wanted to cut or would not cut. This is something that I think the doctor have to decide, I think it's something that we have not ... I'm completely lay, so I have not even an opinion, what is good, what is best , which is not. So I think if she spoke to me I would agree anyway ". (CAROLINA - typical patient)*

Both typical and atypical professionals considered important to establish a relationship of trust, complicity and communication between them and the patients. The difference between the two groups is the notion of trust: atypical encourage the patient not only trust on the provider, but also in herself. The patient would be an "expert in herself" and in her needs.

"Your baby may be suffering, but fortunately we can rescue him"

In the Brazilian institutional culture, there is a discourse that overestimates the risks of vaginal delivery or the continuation of pregnancy, reflected in the frequent communication, in the end of antenatal care, about the need to terminate the pregnancy immediately and by the surgical route. More often, this risk is attributed to the baby, which "shall enter into fetal distress if we do not have cesarean section now". In these cases, rarely a pregnant woman, especially if less informed, would be able to question this information or contradict the doctor. More veiled or more explicit, this threat to the baby's safety is highly effective in doubling the woman's desire for a normal delivery[5,14,15]. As the testimony below of a typical patient, who reported that initially wanted a normal delivery:

> *"There are doctors who wait a week or two, but she did not, she is quite radical, because she thinks the baby can start running some risk. And on the day that I completed 40 weeks I went to do an examination and the placenta was already level 2, the placenta liquid was already aged and he could begin to suffer a bit with it and I had no ... No labor sign, no contraction, no dilation, no broken water, nothing happened. (...) She said she even thought of inducing, but as I had no dilation and the placenta was old, she said I could take many hours and the baby would be in distress, then she decided for the cesarean "(FERNANDA - typical patient).*

When the information is based only on what the doctor communicates in antenatal care, chances of distortion of "choice" seem to increase. We realize that both in typical as in atypical cases, interests tend to be are aligned with their respective information concepts on assistance. The speech Dimitri, a typical professional, shows this quite clearly:

> *The patient first has to be well targeted and informed, either by the obstetrician, the nurse, by family. A patient who is well informed is a safer patient, quieter. That is, she is not afraid of pain, not afraid of the medication, not afraid of oxytocin, analgesia, or of the doctor.*

Among the typical provider, "well informed" means compliant, without resistance or questioning the routines of the provider´s preference. It is noteworthy that reporting about the intervention, even if it is not for questioning, is a more advanced position than just do it without any explanation.

The privacy and emotional dimensions of experience

In all groups, there is an appreciation of relationships based on affection, tenderness, although this is more emphatic in the reports of atypical groups. One of the typical women, who had a vaginal delivery with several interventions, when asked about examples of good treatments given to her, described a Kristeller maneuver (fundal pressure) by the anesthetist:

> *"And it was the whole team around me, the anesthesiologist was pushing my belly, pushing the baby down" (CAROLINA).*

Note that medical obstetrics books contraindicate the Kristeller maneuver for involving risks for mother and baby, and even then, probably due to information, was experienced by this woman as positive, as an expression of affection and care, and highly valued. Once again, it seems that a passive attitude that typical patients adopt towards their childbirths is comforting: decisions remains with the professionals, and this delegation of responsibility sounds very reassuring.

Among atypical professionals and patients, there is a more intense appreciation of the emotional aspects of delivery including two features, both considered strongly negative in the hospital setting. The first is the permission of emotional expression, hugs and physical affection between partners during labor and birth. The second is a caring and relaxed

attitude about the pain of childbirth, including allowing for freedom of cries and shouts.

Studies in Brazil and other countries, show that expressing intense feelings (pain, fear) through crying and shouting is considered highly undesirable in hospital settings, where women feel watched and repressed, more subtly or more explicitly, with frequent occurrence of verbal abuse of a sexual nature if they express their pain or their fear ("when making you were it, it was good, why are you now crying?")[16-18].

While these occurrences of cries and shouts in the typical model are considered very problematic and disturbing, called "decompensation of the patient", in the atypical model, they are expected and even desirable, because it is believed that they merely reflect the fact that the birth is a physically and emotionally intense process. Several atypical women said that after much research, they found no hospital that offered such privacy, and opted for home birth.

Gender and "prevention of communication" about childbirth: "Take care of baby clothes, let me take care of delivery"

The dissatisfaction of atypical patients in the interaction with professionals led in some cases to the breakdown of the relationship in antenatal care, even in advanced stages of pregnancy. This change may have been triggered because the patient did not perceived any openness for negotiation of what she wanted; or she felt that what she wanted to could even be expressed. It is a change in search for satisfaction, which requires that the woman gather all her courage to insist on asking, having repeatedly received a cold or hostile treatment to her questions.

Below, we see the story of Tania, an atypical patient and information professional (journalist) on her dialogue with the doctor typical, quite representative of the other speeches, and of the obstacles to communication:

> *I used to ask about the delivery and he would say, "What do you want to know?" I said that I wanted to know how it was going to be, and he said, "You do not have to worry about it, it´s too early." I asked if it was okay to have normal birth and he would say yes. (...) He was very laconic, always answered very shortly (...) Everything he replied "but is too far away, do not worry about it now, we will see in the course of pregnancy" and he spoke "what more do you want to know?" And with that I was frozen. Because it was not a one-off thing, I wanted to know everything. (...) It looked more like a "I'm in a hurry, either be objective or go away," he gave no opening to see if I was scared or worried.*

Providers often treat their preferences in childbirth care as scientific truths, repudiating the questions of women and delegitimizing their search for alternatives, which becomes more problematic nowadays when websites about scientific evidence inform the opposite of what they claim. Sometimes providers become increasingly irritated if women insist on asking, or they may feel challenged, and even simply refuse to answer, making "deaf ear":

> *(...) I asked if it was possible to give birth without analgesia delivery and he said, "Today there is no delivery without analgesia," he just answered that. "And episiotomy?" He said "I do, I routinely do, because otherwise what can happen is that with the effort you will have a tear from the vagina to the anus and episiotomy is a controlled cut, easier to repair," so I got intrigued. My husband asked, I did not dare, he said "what is your rate of cesarean delivery?" Then he said that these days women prefer to schedule the cesarean section, it is more convenient because women work and cannot wait (...) but did not said the rate. My husband repeated the question and I was sweating, I just wanted to run out of the room, and he did not said his rate. (TANIA - atypical patient)*

The same phrase "Do not worry about it," that can reassure and relax the typical patient, may sound like an offense to the atypical one, because she feels that the professional is disregarding her intelligence and her rights as a woman and citizen, identified by the woman as an example of the doctor's machismo:

> *Oh, and it was a phrase that was too bad, which crowned the situation, he said, "why are you so worried about giving birth? I think you should worry about room decor, with baby clothes, let me be in charge of the delivery. "It seemed that macho thing when you are in traffic and speak "Hey Lady, go take care of your kitchen, go wash your clothes" you know? As if the woman could not be inserted in these things, even in such an event that is so womanly. (...) I hated that. (TANIA)*

The hierarchies based on gender are strongly interrelated with other social hierarchies. In a study in Bahia[19], shows that obstetricians believe that women in the private sector have the right to autonomy and choice (although, as we have seen, such a belief is very questionable), for being "different" and more educated, while women in the public sector, because they are poorer, less educated and non-paying, would not be able to exercise this right, so the decision about the delivery belongs to the doctor. However, confirming previous studies[20,6,3], we find in the private sector a constant discrepancy between what women declare that they prefer and what they get at the end.

The placebo effect and the nocebo effect: the role of communication in the well-being of the baby and woman

Some interviewees reported experiences where communication served as causing discomfort

and suffering, and there were recurrent threats, veiled or explicit, that a normal delivery would mean harm to the baby's well-being. These situations were interpreted by the woman as if her choice of delivery would make her a "bad mother", guilty of a decision that fails to protect the health or life of the child, a judgment capable of shaking the serenity of any woman in labor. As in the case below of a baby born healthy:

> *He had a cord around his neck. Hence the nurse arrived and I was with all those cardiotocography things in my belly and she said [interpreting the cord in the neck as suffering] "the baby is suffering, I'll call the doctor." (...) Was about 3 hours before he was born. I started crying, "my God, am I doing something wrong? I want a normal delivery so badly (...). Am I crazy? "(MIRIAM - atypical patient)*

As we have seen, communication can promote self-confidence, or promote fear and guilt. We can think of the effects of patient-provider communication through dialogue, but also through silences, omissions, facial expressions and other forms of non-verbal communication, understanding how it can be empowering or, on the other hand, its power to destabilize the well-being of the woman in labor. The communication in maternal care can have either a "placebo effect" or a 'nocebo effect "[21]. If we consider the communication as an aspect of care, seemingly irrelevant actions can have intense, negative or positive effects on women, as described below:

> *It was my choice, I knew my risk, I knew all this was a possibility, but during contractions and all, look at her face [professional] was an amazing thing, I even joked with her afterwards and said "you is a natural anesthesia "because she had a face that was in control,* there was noting going wrong*. (RUTH - atypical patient)*

Wanting or not wanting to know is also a choice: "best not to think about birth"

Typical patients reported that they answered their doubts, if there were any, with their doctors in antenatal visits. Of the seven typical women, three said they seek information on the Internet or in courses in hospitals, which typically tend to omit the controversial issues, reinforcing the misinformation of patients and their socialization to the acceptance of interventions. Sometimes, potential questions seemed to fall into a gray area of silence and dullness, which not necessarily bothering them:

> *I do not know, I think I never had any doubt. I do not know if it was because I am also in the health field, but I do not know, I had no doubt to ask, and he told me something ... He should have said, yes, because it is well detailed in these things, but I do not remember. (JULIA - typical patient)*

The search for information did not appear to be an important issue for some of them; the position of no curiosity, or of a desire not to know, not to think, or not to remember the experience, seems to bring comfort to some women:

> *"But she said me to let it go. 'Do not get nervous thinking about what kind of birth it will be. When times come, you may have normal delivery, or try and not get it and have to do cesarean section.' Therefore, I stopped thinking. Let it happen, what will be will be "(KELLY - typical patient, who had a cesarean).*

COMMUNICATION, EXPECTATIONS AND CHOICE

Expectations built throughout life, but particularly in the set of interactions developed in pregnancy strongly influenced the satisfaction with the experience of childbirth, and the positive or negative evaluation of the event by women. In the two groups, two relatively distinct models of care were offered to women, who sought them based of their values and beliefs.

Confirming previous studies, we found that the model of more interventionist medicine (typical) was characterized by an overestimation of the risks to the baby as the main reason for the acceptance of a cesarean section. At the end of pregnancy, clinical elements without scientific basis are argued to conclude that the spontaneous labor in that particular case would be an unsafe and potentially harmful choice for the vitality or the baby's survival, and that the best care would be to prevent it through elective caesarean section, before a woman can go into labor. That is what most women understood about their cases, even if this is not what the typical professionals reported, since most of them claims to recognize the superiority of the outcomes of normal birth.

Among typical providers, this overestimation of the need for interventions is done through the emphatic statement of their beliefs about the inevitability of interventions, confirming the inadequacy of the pregnant woman's participation in care choices. Thus sets up a conflict of interest: for the patients "buy" a care model (elective cesarean for non-medical reason) scientifically recognized as potentially harmful, it is important to ensure that such matters (the medical indication) are not allowed in the dialogue. The impediment to communication is done through various mechanisms, such as the disempowerment of maternal speech (such as "lay" ignorant), the harassment of the insistence of women and couples in their questions, and ridicule of maternal concerns and their expressions of fear and pain ("who want to give the show"), among others.

We also see that for some women, a more passive stance, including the submissive acceptance of information (or to disincentive to search for information, "not think", "leave it to the doctor," or "leave it to see when it comes"), can be comforting and satisfying. Here it is clear the importance of

alignment between the values of women and their caregivers, and their role in shaping expectations.

Once the expectations of respondents regarding their deliveries modeled their satisfaction, we realized that patients seek, more active or more passively, the providers who fit the type of care they want to have. If the idea that someone is taking responsibility for them seems to reassure the typical women who tend to a more obedient stance, atypical women require greater participation and interaction of themselves and their caregivers, and take more responsibility. The possibility of negotiating the selective use of interventions, and privacy for emotional expression and physical contact during childbirth appeared as a differential in their choice.

Both typical and atypical providers also value patients that place themselves in the position that they consider most appropriate, respectively, more passivity or with greater autonomy. Typical patients reported to be less informed and had fewer expectations about the outcome, and partly tended to be more satisfied with their deliveries, even when they were different than they had imagined. When they chose not to want to decide or to inquire, this stance is also a choice that should be respected. This finding seems to reflect what Gutman[22] calls the amnesic effect of satisfaction in childbirth – the underestimation or even the suppression of negative feelings or memories, so that women can survive psychically the experience, at times of extreme symbolic violence, in medicalized birth.

Atypical patients, in general, wanted to know every detail of their births, lived it intensely and planned carefully the experience. For these, who had more informed choices, when something happened outside of the planned, it appeared to be lived as a limitation, a small or a great one, depending on the case. For these women, stress, uncertainty or physical pain were not necessarily associated with dissatisfaction, but were valued as part of the process. In each of the groups, satisfaction with the childbirth experience depended largely on the quality of relationships between those involved, and the sense attributed to them by the women, their families and their caregivers.

CONCLUSIONS

The communication about procedures among "typical" patients was scarce, biased or actively blocked, tending to strengthen a behaved attitude. "Atypical" patients sought further information from professionals and peer groups and used more Internet resources (discussion lists, evidence websites and narrative banks). The availability of such information allows more women to seek a care aligned to their values and notions of rights, frequently confronting the medical authority, creating needs to be (or not to be) satisfied.

REFERENCES

1. Victora CG, Aquino EML, Leal MC, Monteiro CA, Barros FC, Szwarcwald CL. Maternal and child health in Brazil: progress and challenges. Lancet. 2011; 377(9780): 1863-76. Doi: http://dx.doi.org/10.1016/S0140-6736(11)60138-4
2. Diniz SG, Chacham AS. "The cut above" 1 and "the cut below": the abuse of caesareans and episiotomy in São Paulo, Brazil. Reprod Health Matters. 2004; 12(23):100-10.
3. Dias MAB, Domingues RMSM, Pereira APE, Fonseca SC, Gama SGN, Theme Filha MM, et al. Trajetória das mulheres na definição pelo parto cesáreo: estudo de caso em duas unidades do sistema de saúde suplementar do estado do Rio de Janeiro. Ciênc Saúde Coletiva. 2008; 13(5): 1521-34. Doi: http://dx.doi.org/10.1590/S1413-81232008000500017.
4. Leal MC, Pereira APE, Domingues RMSM, Theme Filha MM, Dias MAB, Nakamura-Pereira M, et al. Intervenções obstétricas durante o trabalho de parto e parto em mulheres brasileiras de risco habitual. Cad Saúde Pública. 2014; 30 (Supl. 1): S17-32. Doi: http://dx.doi.org/10.1590/0102-311X00151513
6. Barbosa GP, Giffin K, Angulo-Tuesta A, Gama AS, Chor D, Dorsi E, et al. Parto cesáreo: quem o deseja? Em quais circunstâncias? Cad Saúde Pública. 2003; 19(6): 1611-20. Doi: http://dx.doi.org/10.1590/S0102-311X2003000600006.
7. Hodnett ED. Pain and women's satisfaction with the experience of childbirth: a systematic review. Am J Obstet Gynecol. 2002; 186(5 Suppl): 160-72. Doi: ttp://dx.doi.org/10.1016/S0002-9378(02)70189-0.
8. Maia MB. Humanização do Parto: política pública, comportamento organizacional e ethos profissional. Fiocruz; 2010.
9. Enkin M, Keirse MJNC, Neilson J, Crowther C, Duley L, Hodnett E, et al. Guia para atenção efetiva na gravidez e no parto. 3a edição, Rio de Janeiro: Guanabara Koogan; 2005.
10. Atrash K, Carpentier R. The evolving role of public health in the delivery of health care. Rev Bras Crescimento Desenvolv Hum. 2012; 22(3): 396-399.
11. Diniz SG, Bick D, Bastos MH, Riesco ML. Empowering women in Brazil. Lancet. 2007; 370(9599): 1596-8. Doi: http://dx.doi.org/10.1016/S0140-6736(07)61671-7.
12. Rubin G. O tráfico de mulheres: notas sobre a economia política do sexo. Recife: SOS Corpo; 1993.
15. Salgado HO, Niy DY, Diniz CSG. Groggy and with tied hands: the first contact with the newborn according to women that had an unwanted C-section. J Hum Growth Dev. 2013; 23(2): 190-97.
16. Hotimsky SN. A formação em obstetrícia: competência e cuidado na atenção ao parto. Interface (Botucatu). 2008; 12(24): 215.

17. Aguiar JM, d'Oliveira AFPL, Schraiber LB. Violência institucional, autoridade médica e poder nas maternidades sob a ótica dos profissionais de saúde. Cad Saúde Pública. 2013; 29(11): 2287-96. Doi: http://dx.doi.org/10.1590/0102-311x00074912.
18. Yajahuanca RSA, Fontenele CV, Sena BF, Diniz SG. Parto no posto de saúde e em casa: uma análise da assistência ao parto entre as mulheres Kukamas Kukamirias do Peru. Rev Bras Crescimento Desenvolv Hum. 2013; 23(3): 322-33.
19. Diniz SG, d'Oliveira AFPL, Lansky S. Equity and women's health services for contraception, abortion and childbirth in Brazil. Reprod Health Matters. 2012; 20(40): 94-101. Doi: http://dx.doi.org/10.1016/S0968-8080(12)40657-7.
20. Faúndes AE, Cecatti JG. Operação cesárea no Brasil: incidência, tendência, causas, consequência e propostas da ação. Cad Saúde Pública. 1991; 7(2): 150-73. Doi: http://dx.doi.org/10.1590/S0102-311X1991000200003
21. Sakala C. Letter from North America: understanding and minimizing nocebo effects in childbearing women. Birth. 2007; 34(4): 348-50. Doi: http://dx.doi.org/10.1111/j.1523-536X.2007.00196.x.

RESUMO

A assistência ao parto no setor privado brasileiro se caracteriza por altos índices de cesáreas e intervenções invasivas no parto, contradizendo recomendações sobre segurança e qualidade das ações. Buscamos entender como profissionais e pacientes se comunicam sobre riscos e benefícios das intervenções, e tomam decisões, na era da internet. Entrevistamos 28 profissionais e usuárias do setor privado em São Paulo, incluindo aqueles que chamaremos de "típicos" e "atípicos" do quadro nacional. A comunicação sobre procedimentos entre pacientes "típicas" foi escassa, enviesada ou ativamente bloqueada, tendendo a reforçar uma atitude comportada. As pacientes "atípicas" buscaram mais informações dos profissionais e grupos de pares, e usaram mais recursos da internet (listas de discussão, sites de evidências e bancos de narrativas). A disponibilidade destas informações permite que mais mulheres busquem um cuidado alinhado com seus valores e noções de direito, frequentemente confrontando a autoridade médica, criando novas necessidades a serem (ou não) satisfeitas.

Palavras-chave: parto normal, cesárea, saúde suplementar, satisfação com o cuidado, gênero.