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Articles

Physicians' perception of the dimensions of obstetric and/or institutional violence

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Obstetric/institutional violence (OV/IV) is being widely discussed in Brazil and around the world. The objective of this study was to evaluate the perception of physicians providing childbirth assistance in a public humanized maternity in Brazil on this subject. Based on a qualitative epistemological study, the data was collected by applying a questionnaire to 23 medical professionals. OV/IV was assessed by content analysis and categorized in the following dimensions: individual, institutional, and human relation. In the first dimension, OV/IV occurs in the form of dated practices, negligence, and conducts influenced by the judicialization of Medicine; in the second dimension, it refers to working and infrastructure conditions, especially the lack of hospital bed vacancies and analgesia, and an inadequate ambience; in the third and last dimension, OV/IV shows up in the asymmetries of the human relation and of the patient-doctor relationship when there are disagreements in the decision-making process.

Keywords: Obstetric violence. Institutional violence. Humanized birth. Gender.

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Introduction

In all societies, childbirth has always been surrounded by cultural, social, emotional and affective values[1]. judicialization. Traditionally restricted to the female universe and to the home environment, since the institutionalization of health care in the middle of the twentieth century Medicine entered this field, of whose dynamics it had little knowledge and in which it made countless mistakes[2]. Thus, the female body became the *legal property* of physicians and from a medicalized perspective it has ever since been seen as essentially defective, unpredictable, and dangerous[3]. It is now subject to medical protocols and to various routine interventions, many of which are violent and of dubious efficacy[4]. One explanation for this scenario is that childbirth care is oriented by a strong gender bias, which sees women not as subjects with rights, but as objects of action[5], a view which is further permeated by blame assignment to female sexuality.

A hospital-based, interventionist and overly medicalized delivery model is thus strengthened[6], where the risks inherent to the process of giving birth are replaced by the potential risk of certain treatments and interventions[3], reducing a social, cultural and, health event to a pathological, medical, and fragmented phenomenon[2].

Since 1970, there has been increased recognition of this scenario, and social movements started fighting for "demedicalization", for humanization of care and for females to recover autonomy over their bodies and health[3].

In 1985, the World Health Organization (WHO) published recommendations (reviewed in 1996) for childbirth care, which summarize research evidence, guide the revision of protocols using appropriate technology, and advocate the legitimacy of delivering women's decisions[2,7]. In Brazil, the Ministry of Health (MS) implemented health policies such as the Prenatal and Birth Humanization Program (PHPN) in 2000 and Rede Cegonha (Stork Network) in 2011, which sought to establish a new model of obstetric and neonatal care[8]. Humanization has become a strategic term for dealing with disrespectful practices of prenatal, childbirth, postpartum and abortion care: obstetric or institutional violence (OV/IV)[3].

The term obstetric violence was first adopted in Venezuela in 2017 and was defined as "the appropriation by health professionals of the body and reproductive processes of women, expressed in a dehumanizing treatment and abuse of medicalization and pathologization of natural processes," being recognized as a form of violence against women and an alarming social, political and public problem[9].

The relevance of this type of violence as a legitimate public health problem and violation of women's human, sexual, and reproductive rights was corroborated by a recent statement by the World Health Organization (WHO)[10], and published in six languages: "Prevention and eradication of abuse, disrespect and ill-treatment during childbirth in health institutions." It describes several OV/IV categories and examples associated with the lack of quality and of healthcare resources, as well as poor geographic, financial and cultural accessibility, which are additional forms of structural violence that predispose obstetric violence to occur within health institutions.[10]

Despite efforts of the scientific community and social movements, the implementation of childbirth humanization policies poses many challenges, as in any other process of change[11]. Recently, the survey "Birth in Brazil", the largest study on labor and childbirth ever conducted in our country, interviewed 23,894 women, evaluated 266 hospitals in 191 Brazilian towns, and found unbelievably

high rates of medical procedures not even recommended three decades ago, such as episiotomy (56%), food deprivation during labor (70%), lithotomy position (92%), Kristeller maneuver (37%), and low rates of good practices, such as the presence of an accompanying person (18%) at all times[12].

The OV/IV becomes more relevant and visible when understood by different areas, the social movement being of paramount importance in this process, especially the women's movement and the healthcare consumers' movement[13]. When discussing this subject, they are actively claiming their position as victims and social recognition of the violence they were subjected to[14], which is also shaped as institutional and gender violence[15].

Recently, some measures have been taken to prevent, to raise awareness on, and to problematize this issue. The Brazilian state of Santa Catarina passed bill no. 17,097 in 2017, which provides for the implementation of informational and protective measures for pregnant women and women in childbirth against obstetric violence[16], precisely one year after passing the Doulas Bill no. 16,869 in January 16, 2016, which urges maternity wards to allow the presence of doulas during childbirth, regardless of the presence of any other accompanying person[17].

However, some practices usually are not perceived by medical professionals as being violent, and this ends up making doctors consider many practices acceptable, endurable, or even necessary in daily care, which only contributes to a process of trivialization of institutional violence[18]. Thus, violence usually is neither due to poorly trained teams or individuals, nor is it a behavioral exception, but in most cases it happens when performing procedures that also are part of the healthcare protocol of teaching hospitals[15].

In view of the above, even evidence suggesting that the experience of disrespect and mistreatment of women during childbirth care is widely spread, there is no international consensus on how these problems can be scientifically defined and measured. As a result, their prevalence and impact on women's health are unknown. While governmental and civil organizations around the world stress the need to address this issue, policies to promote respectful obstetrical care have not always been implemented or translated into meaningful action, and they are not specific. Therefore, the WHO recommends studies to better define, measure and understand disrespect for women during childbirth, as well as means of preventing and eliminating it[10].

Considering that most OV/IV studies are focused on the perspective of women – users of prenatal, childbirth, postpartum and abortion care services– and the relevance of the discussion being intrinsically related to the meaning perceived by them–, we suggested a study to identify the perception of physicians, who assist childbirth in a public, humanized teaching maternity ward, on this controversial and current topic, deepening the reflection through the individual and institutional dimensions, as well that of human relationships.

Methods

This is a qualitative, epistemologically based study carried out in a humanized maternity ward of a public teaching hospital in south Brazil between February-September 2016 with a sample of 23 physicians involved in childbirth care. The data was sampled by applying a questionnaire with open questions and Likert scale and analyzed by content analysis, with definition of categories by thematic approach. Descriptive statistics were applied for categorical (rate) and continuous (mean and standard deviation (SD)) variables. The project was approved by the Ethics Committee on Research on Humans under CAAE No. 42365215.3.0000.0121, and those who agreed to participate signed a term of free and informed consent.

The term institutional violence (IV) was used as a synonym for obstetric violence (OV) in order to keep both terms used in data collection, when we chose to use alternatively the term "institutional", as used in previous studies, in order to avoid "epistemological refusal" and not to cause any uneasiness amongst those participants who did not feel comfortable with the term OV. Although they are not synonymous, OV is a form of IV, but it can take place inside or outside an "institution"[19].

Results and discussion

Profile of respondents

The 23 participants in this study are on-call physicians at the obstetrical center of a public maternity ward. Of these, 16 are specialized in gynecology and obstetrics and seven are being trained (medical residency) in this area. Age ranged from 25 to 57 years, with a mean age of 45 years (SD 7.6) for obstetricians and 26 years (SD 1.1) for resident doctors. The sample consisted mainly of women (59%, 13/23). All participants declared themselves to be Caucasian, and most were married (59% = 13/23) and had children. Only two reported having a child born by vaginal delivery.

Among the obstetricians, 60% (14/23) have been working in this field for more than 20 years. The average time working at this hospital was 16 years (SD 7.4) and 65% (15/23) currently work in other professional activities, are in the private clinic, do surgical procedures or diagnosis, and/or teach. On average, these professionals see ten pregnant women in labor per week.

This profile of the participants mirrors the medical demography in Brazil, and in relation to the variable race, it reflects the reality of the Brazilian medical population and of the southern region[20].

Dimensions of Obstetric/Institutional Violence

All participants declared that they knew the term OV/IV, which provided a basis for their perception and included definitions as follows:

> There are several forms of violence and aggression against the pregnant/delivering woman by those who see her during prenatal care, childbirth and after delivery. (M12)

> These behaviors disrespect women's rights and are reinforced by the institution. (M20)

> These acts disrespect the patient and deprive her of her individuality and autonomy. (M6)

> They include hospital measures that over time have not shown to be effective during childbirth, and they may even cause adverse results in the delivering woman and the unborn child. It includes anything and everything that harms human dignity and the humanized obstetric medical practice. (M2)

> It includes a range of behaviors, from physical maltreatment and verbal abuse to failure to follow the best practices in childbirth care. (M13)

Most participants (78%, 18/23) considered OV/IV bad or terrible, and rejection was essentially related to three situations: the term induces controversy, it blames the obstetrician or questions the doctors' "kindness", as obstetrician M16 illustrates:

> I think that such attitudes as a lack of patient privacy are bad for childbirth care, but I also think that to call it *violence* is too much. I think this term is becoming a cliché and the discussion is losing its meaning. Patients already arrive at the maternity ward full of hard-to-undo bias. We must tackle this issue very seriously and not allow it to be trivialized by the tabloid media. (M16)

In the domestic and international literatures, there are different terms to describe OV, such as institutional violence (in childbirth)[13,18], disrespect, abuse, abuse during obstetric care[10], gender violence during childbirth and abortion[21], and violence during delivery[19]. The Network for the Humanization of Delivery and Childbirth (ReHuNa-1993) chose not to speak openly about violence, favoring terms such as "humanization of childbirth" and "promotion of women's human rights", for fearing antagonistic reactions from medical professionals under suspicion of violence[22]. The term violence can be defined as transforming a difference into an inequality in a hierarchical power relationship, in which the other is treated as a subject of action, curtailed in or even denied their autonomy, subjectivity, and speech[13].

The participants' understanding that the term induces controversy arouses curiosity and requires reflection, because we are experiencing a revolution in the way information is produced, consumed, and spread. The new media are faster than the traditional media, making some topics to be spread swiftly and become the subject of discussion[23], as for example OV/IV, which, although being new as a phenomenon, has quickly become a public topic. We observed that most of the participants learnt about the subject through the media (91% = 21/23), their colleagues (69% = 16/23), and at their workplace (65% = 15/23).

By considering the term exaggerated and typical of "tabloid journalism", as put by participant M8, professionals also feel affronted by the blame involving the obstetrician, generating fear, conflict and vulnerability: "This gives the impression of

violence of the doctor against the patient, that all medical procedures are against the patient, are useless or are done merely for the doctor's convenience" (M3).

The Brazilian Federation of Gynecology and Obstetrics (Febrasgo) and its affiliates are critical of the expression obstetric violence, which has outraged countless obstetricians, by impregnating aggression bordering on hysteria[24], and they suggest using the term violence during childbirth, which includes not only the poor conditions of health facilities but all the other players involved in the process as well[25].

There is refusal to accept that violence exists, not least because it has been linked to the authoritarian doctor-patient relationship and to inadequate procedures part of the standard protocol and not to an exceptional occurrence of inappropriate behavior or lack of professional competence. Questioning the paradigm of this model and the obstetric medical culture itself causes upset[15].

It is possible that the term obstetric violence is strategic as a political banner and provides visibility to the problem; however, within a proposal of continuing education or a change of institutional culture, terms eliciting less conflict should be used. The term "obstetric violence" was coined by social movements, more precisely by the women's movement,[21] but obstetricians in general did not validate the term. However, when asked to come up with another expression, the participants in this study found it hard to produce a "name" capable of covering the subject in all its complexity, which seems to mirror the current process of constructing concepts and definitions on this topic.

The purpose of this study was to analyze OV/IV in the individual, institutional, and human relation dimensions, with the individual dimension referring to the professional's action, practice, and individual professional conducts, the institutional dimension referring to work conditions and infrastructure, and the human relation dimension, to aspects of professional-patient interaction, as well as to the perception of women's autonomy, shared decision, and relationship based on rapport. They permeate all possibilities of violence and enable a multidimensional analysis by alternating concepts and aspects of their practice.

We observed that these dimensions are present in the participants' speeches, either in the institutional and individual (M11), or in the human relation (M16) dimensions:

> [OV/IV is] the disrespectful care of a patient in autopilot mode, as is an inadequate ambience, lack of medical supplies, high infection rates, lack of hospital beds, underpaid staff, poor work structure, dated medical practices, or practices of unproven efficacy. (M11)

> To impose conducts/conditions without any dialogue, to abuse of one's authority/condition as a doctor to belittle the patient; to scream, curse, use coarse language; to disrespect the beliefs and opinions of the pregnant woman. (M16)

The human dimension was the most cited dimension (47% = 11/23), followed by the individual (34% = 8/23) and institutional (26% = 6/23) dimensions. Aguiar[18], when studying institutional violence, also reveals that the entrenchment of poor practice in obstetric care is the result of a complicated dynamic between the work

conditions the professionals are exposed to, to established routines, and to a lack of understanding and respect for women's reproductive rights.

In some situations, the individual dimension, which refers to action, seems to take precedence over the dimension of human relation, which revolves around interaction between all players. However, while the former is intended to categorize the practical action of the professional's care, the latter aims at the relational aspects among all persons involved.

When authors refer to materialization of OV/IV as neglect, verbal abuse (intentional threats and humiliation), physical violence (including not using analgesia, and performing unnecessary and unwanted surgeries), as well as sexual abuse[22], we see that the individual and the human relation dimensions may be intertwined.

Although this study focuses on the doctors' perception on this topic, obstetric violence is also committed by other professionals involved in childbirth care[26].

Individual Dimension: Action

In a recent systematic review, it was observed that the quality of care often depends more on the health team than on the institution itself, and that during work in a hospital setting the lead player is the physician[26]. This means that their individual decision with regard to their action is beyond the structural elements to which they are or are not subordinated to[18]. Thus, a change in obstetric care also depends on the willingness of health professionals to change[26].

In the individual dimension, the approach is related to care itself and involves unnecessary procedures not based on the best evidence and related to antiquated and dated routines.

Although many participants have configured dated practices as OV/IV, in Brazil, obstetrics has been marginally permeated by scientific evidence, leading to persisting inappropriate technologies in childbirth care and the perpetuation of unsafe, painful, and unnecessary interventions[27,28]: "[OV/IV are] conducts adopted by health professionals without any scientific basis that bring more suffering to the pregnant/delivering woman" (M18).

A professional's conduct based on value judgments is shared amongst the health team, and often OV/IV is ignored even by its own victims[29] and routinely tolerated by professionals. This practice is much more oriented by individual beliefs, habits, routines, and personal and institutional behaviors rather than based on best evidences[7], and the novelty here is not its occurrence but rather its problematization[28].

The training of health professionals, in particular physicians, has a structuring role in the current design of care and in resistance to change[30] and, therefore, medical practice can be detached from ethical constraint, prioritizing competencies to the detriment of values such as care[22].

In this study, the participants recognized neglect as a common form of OV/IV, as shown below:

> To deny care, to neglect, to disdain, to not recognize the woman's role during labor/delivery. (M12)

> Failure to offer pain relief, unnecessary procedures such as episiotomy or Caesarean section with no indication for it, not contemplate the couple's wishes even when feasible. (M13)

Neglect is the most common form of violence reported in previous studies; it happens almost always by neglect and it can be seen in all three dimensions[26]: in the individual dimension, when there is indifference, disregard and trivialization of pain; in the institutional dimension, in the "hunt" for a hospital bed vacancy or for availability of analgesia; and in the human relation dimension, in the lack of information, guidance and explanations to the patient[18].

Regarding surgical delivery, the participants reported not performing Caesarean section at the request of pregnant women admitted through the public healthcare system SUS, while performing Caesarean section without medical indication in women requesting vaginal delivery:

> The grossest "injustice" the Government does is to tell the media that the "high rate of Caesarean sections in Brazil" is the physicians' fault –these bastards–, who do not want to work and push their poor patients to have a Caesarean section; but at the same time, they "force" patients admitted through SUS to perform vaginal delivery even against their wishes ... this notion is stuck in people's minds: rich people pay Caesarean sections, poor people are forced to deliver in "inhumane" conditions being cared by sadistic and abusive doctors... (however, no one complains about the institution!). (M1)

In the Brazilian health system, it is usual to perform Caesarean section on the grounds that it is the wish of the delivering woman; however, Hotimsky et al.[5] observed that the women's preference is not always the decisive factor in determining the type of delivery, it being primarily a medical decision. There is a disagreement between the initial expectation of women and the outcome of delivery, with a much higher rate of Caesarean section than initially wished for by women. The interventionist health model and the traumatic experience of delivery are factors that predispose to this[15].

In the public health system SUS, the possibility of a woman choosing the type of delivery is limited, and her wish is not considered an indication for a Caesarean section[31], whereas in private clinics this option is available, which is consistent with the hypothesis that the Caesarean section has become a consumer good[5].

The medical-surgical approach to childbirth tends to overestimate the risks of the physiological process, portraying Caesarean delivery as a safe, painless, modern, and ideal type of delivery. Thus, obstetrics currently perpetuates the medical preference for surgical delivery as a prophylactic measure that protects women from the intrinsic risks and the doctor from uncertain outcomes related to vaginal delivery[32]. The higher numbers of interventions to shorten delivery time are seen by courts in a more positive light than vaginal delivery[33].

In contrast, the more technologies are introduced to Medicine and the more one trusts them, the less adverse outcomes is condoned. And the less the patient's participation in the decisions, the more favorable is the setting for the judicialization of medical practice[6], with an actual risk of professional lawsuits[27]. This ends up disturbing

the doctors emotionally, favoring the consolidation of a "defensive Medicine" and a litigious mentality:

> I am very disappointed with our specialty. We are overburdened. We have the "duty" to ensure that everything will always be alright and that the outcome will always be favorable (which is not always the case). Everyone assists during labor and delivery, but if anything goes wrong, it will always be the doctor's fault. (M3)

Institutional Dimension: Condition

The health institution supports the physicians during patient care, and it is responsible for the structural and material conditions, as well as for establishing norms, routines and protocols underlying the health service they provide.

There are several factors related to the institutional aspects leading to OV/IV, and most participants believe that working conditions often are influencing and/or predisposing factors to OV/IV. With regard to the institution where the research was carried out, most participants believe that violence seldom or rarely happens.

When questioned about the institutional situations related to OV/IV, they reported lack of privacy, of available hospital beds and of an analgesia routine as the prevailing situations during their daily work, followed by excess demand. Situations related to accompanying persons, such as not allowing replacements, and to the institution's regulations and routines, which must be abided by without any individualization, were also linked to violence.

Previous studies corroborate aspects related herein to working conditions. Violence in maternity wards regarding infrastructure, and material and human resources, is also a reflection of the system's fragility, which exposes its professionals to poor conditions - such as lack of resources, low pay and excess care demand - as well as restricting access to services offered, incurring, among others, in a "hunt" for hospital vacancies in the public hospital network[18].

The following account describes a doctor's view about the types of OV/IV in the institutional dimension experienced in their daily life: "To work without having enough hospital beds available, overburdened nurses, citizens dissatisfied with the public health system, and a culture in which 'the doctor is to be blamed for everything'" (M11).

Since 2007, Brazilian legislation (Law No. 11.634) provides for the right of the pregnant woman to be informed about the institution where she will receive childbirth care under the SUS system. However, the chronic shortage of hospital beds and the phenomenon of vacancy "hunt" still represent a serious public health problem, and a repeal of pregnant women's rights, therefore, a form of violence[34].

Since the humanization program, the concept of ambience is highlighted, the treatment given to the physical space being understood as a social, professional and interpersonal space. It is related not only to the structure, but also to comfort, privacy and the attitude of the professionals in that ambience[35]. The respondents recognized that ambience-related factors influence OV/IV in the institutions: "[An example of

OV/IV is] the inability of the institution to provide a physical ambience and a prepared staff to provide care of the delivering mothers" (M8).

The management of labor pain is another challenge for those who provide care and experience childbirth. According to the Ministry of Health, adequate pain control during labor is a woman's right, guaranteed by the law (Ordinances no. 2,815 and 572, of 1998 and 2000, respectively)[35], and the pregnant woman's request for labor analgesia implies sufficient indication for providing it[36]. This procedure is listed in SUS' reimbursement table, and to deny it is recognized as a form of OV/IV as per a recent law of the state of Santa Catarina (Law no. 17,097 of 2017)[16].

The non-availability of routine analgesia during childbirth care, the denial of providing it, even where indicated and requested by the obstetricians, and the refusal of anesthesiologists to perform the procedure, was mentioned by most participants as an issue related to OV/IV: "Any anesthesiologist who refuses to perform labor analgesia to avoid "having" to be available in case of an emergency procedure" (M16).

In this struggle, the anesthesiologists' justification for refusing to perform labor analgesia is based on Resolution 1363/93 of the Federal Medical Council (CFM), which considers "an act against medical ethics to perform simultaneous anesthesia on different patients by the same professional, even if in the same surgical environment"[37]. This poses an institutional challenge, both in defining responsibilities and solving this issue and in respecting the medical act without disregarding the suffering of the other. When childbirth pain must be endured, without any possibility of acknowledgement and negotiation, it points towards trivialization of OV/IV[2].

It is crucial to reflect about institutional issues that predispose to violence, since issues of management and health services beyond the individual medical practice have to be addressed, as one enables the other[33]. It is true that there are inadequate working conditions that predispose to OV/IV, representing work endangerment, as put by the participants of this study.

The Human Relation Dimension: Interaction

The human relation involves all aspects of the doctor-patient interaction, permeating communication and shared decision, regard for women's autonomy and agency, and empathy between the parties involved in the interaction established. A professional's performance is not only based on material conditions or on their technical-scientific knowledge, but also on relational tools, the fruit of interactive and communicational ethics[38].

> [To me, OV is] to force conducts/conditions without talking to the delivering woman, to take advantage of the doctor's authority/condition to belittle the patient; to scream, curse, use coarse language; to disrespect the beliefs and opinions of the pregnant woman. (M16)

To Aguiar[13], the most difficult forms of violence to perceive are precisely those in the field of relations. The construction of the relationship between two individuals only has materiality in the act, and it offers a path to better care, with more understanding and open-mindedness, when establishing an active, two-way

partnership marked by transparency and being consummated under the auspices of autonomy[39].

All participants agreed that the woman has the right to question, choose or give her opinion on the procedures and conducts suggested by the care team, being clearly established that the attitude of informing and clarifying is recommended and well accepted by them, who consider this act as an ethical duty in their professional practice.

> It's her body, her life, so she always has the right to have a say/to choose. (M12)

The medical act does not imply an unlimited power over the patient's life or health; therefore, all clarifications in this relation are considered unconditional and mandatory, being the duty to inform a prerequisite to consent[27].

However, when questions, refusals and challenge of the doctor's authority, of the prescribed conduct or of the institution's routines arise, there are disturbances in the understanding of the limits of women's autonomy. In these situations, it is difficult for the professional to respect autonomy[40].

> The woman may [has the right to] question but the explanations she is given should be convincing enough to reassure her (M1).

From the answers of some of the participants in this research, it is clear that the woman's autonomy has limits and that this limit is reached when in the professional's understanding there is risk to the mother's and/or unborn child's health. The medicalized model prevailing in healthcare units is based on the assumption that the doctor has all knowledge and, consequently, the woman, after being informed, should abide by their technical-scientific authority[18]. Medical authority comes up in the participants' speech at various instances, and the asymmetry in the doctor-patient relationship becomes clearer when it comes to decision-making where there is disagreement of opinion.

Several studies on health care in maternity wards show that obedience is a quality expected of the patient[26], and that non-obedience is perceived by professionals as disrespect, ignorance or aggression[13]. A review on this topic pointed out that the model of women's care is hierarchical and institutionally reinforced by the doctor's ascendance over the patient, being a reflection of the way each professional thinks and acts[26]. The arbitrary use that many health professionals make of their authority and knowledge in controlling the bodies and the sexuality of their female patients is one of the major sources of institutional violence to which women are subjected to in health care units[13].

Final considerations

Obstetric and/or institutional violence is a phenomenon known and acknowledged by professionals who participated in this research; however, it is still in the process of

construction regarding definition, categorization and naming, and it is understandable that controversial aspects and disagreement will arise amongst all key players.

The term displeases professionals, who criticize the way obstetricians are blamed and the role of the media in contributing to the controversy about this topic.

When analyzing violence in the individual, institutional, and human relation dimensions, with their respective impacts on action, condition and interaction, it was possible to cover all forms of expressing OV/IV. This proposal of categorization allows a multidimensional analysis of the topic, as well as an interaction between concept and practice, clarifying agents and predisposing conditions.

In the individual dimension, where professional action is the relevant factor, a dated practice and not based on evidence, as well as neglect and conducts influenced by the prevailing judicialization of Medicine, were issues related to OV/IV. In the institutional dimension, the conditions made available may predispose and influence the occurrence of violence, with lack of hospital vacancies, of analgesia and of privacy, as well as others factors related to the ambience and the institution's routines being prevalent. In the human relation dimension, women's autonomy emerges as an unquestionable ethical right, whose limit is set by the professional; and when there is disagreement of opinions in the decision-making process, the asymmetry in the relationship becomes evident.

Despite important advances in the construction, problematization and greater awareness of this topic, a deeper discussion and its better characterization are still crucial, in order to provide a mechanism of listening and understanding among the various players involved in the OV/IV phenomenon.

Authors' contribution

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

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