



The uses of ultrasonography in relation to foetal malformations in Rio de Janeiro, Brazil

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ABSTRACT

The world-wide diffusion of prenatal ultrasound has encountered local historical, cultural and political particularities. The purpose of this article is to study the varied uses of this technology in cases of detection of a foetal anomaly, in Rio de Janeiro, in a context of generalized access to ultrasound, restrictive legislation on abortion and major social inequalities. An ethnographic approach was chosen combining from 2009 to 2011, observations of prenatal consultations and interviews with specialist physicians and pregnant women, in both public and private sector institutions. Analysis of the data allowed us to identify three ideal-typical moments in the trajectory of the pregnant women when a foetal malformation was detected. The first moment occurs before the detection of the anomaly, when an initial ultrasound is carried out, essentially in private centres. The standardized actions of pregnancy monitoring are performed in the background while practitioners use the technology to support the local culture of praise to motherhood and the family. The second ideal-typical moment shows how detection of an anomaly leads to fragmentation of the foetus at the public referral centre for foetal malformations. But far from depersonalizing the consultation, the formalism of the diagnostic procedure is considered by some professionals as a political lever to empower women from poor neighbourhoods as they acquire knowledge and comprehension of the situation despite their lack of decisional autonomy. During the third ideal-typical moment, professionals put the data produced by the image into the larger perspective of the logic of care: the focus is no longer on access to knowledge and autonomy, but on the joint collaboration of women and professionals towards solving the problems of everyday life. The combination of these three moments in time illustrates a process whereby the malformed foetus is humanised, dehumanised and re-humanised with respect to the technological tool.

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Introduction

Over the last thirty years, prenatal ultrasound has crossed the borders of the most developed countries and established itself as part of the pregnancy monitoring process throughout the world. Initially introduced to prevent and control “obstetric risks” by accurately predicting the age of the pregnancy, identifying twin pregnancies or abnormal placental positions (Whitworth, 2010), prenatal ultrasound has also become, through improved technical performance, the preferred tool for diagnosing foetal malformations. This latter use – not easily separated from the previous one – was developed in countries of the North in direct relation to legislation that decriminalises abortion and thus makes termination of pregnancy possible in case of foetal anomaly.

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Recourse to prenatal ultrasound examinations is rooted in the broader context of the biomedicalisation of clinical practice (Clarke & Shim, 2011). The diffusion of techniques and knowledge is part and parcel of a globalised market; the increased performance of imaging techniques combined with the computerisation of measurement produce new forms of knowledge, both expert and lay, that transform the experience of maternity (Duden, 1993) and perception of the foetus (Williams, 2005). Yet the world-wide diffusion of these technologies encounters local historical, cultural and political particularities. Many countries, essentially in the southern hemisphere, use ultrasound even when abortion is not allowed or very restricted, thus increasing social inequalities that are already significant (Ballantyne et al., 2009). Few studies have examined the specific issues raised by the diffusion of prenatal ultrasound in these countries, especially in cases where routine pregnancy monitoring reveals an anomaly in the embryo or foetus that, in the northern hemisphere, might provide access to termination of the pregnancy.

The purpose of this article is to study how physicians use prenatal ultrasound in Rio de Janeiro, Brazil and how this use varies in different situations of pregnancy monitoring and diagnosis of foetal malformations. Ultrasound is examined from the perspective of “technology in practice”: we focus on the dynamic relationship between actors and their technical tools, within local contexts that regulate the use of this technology and convey cultural representations of maternity (Timmermans & Berg, 2003).

A world-wide diffusion of know-how and images

The ultrasound scan has been systematically used to monitor pregnancies in most European and North American countries since the 1980s. It has been accompanied by special training programmes and diplomas dispensed by universities, learned societies and manufacturers, and by a standardisation of practices based on the development of norms related to foetal growth and foeto-placental exchanges. With improved understanding and performance of imaging, numerous foetal anomalies can now be detected during pregnancy. Ultrasound has gradually become a tool in the “prevention” of disability, through early postnatal care for certain malformations (Rosano et al., 2000) and through termination of pregnancy of other malformations, in countries where this is allowed. This second use of prenatal imaging has led to the introduction of professional standards and recommendations. Training, knowledge and reference standards circulate among professionals on a very wide scale via traditional modes of exchange (publications, conferences) and also over the Internet, where ultrasound schools (<http://www.thefetus.net>) are available for free, and offer training in the imaging of foetal malformations, the diagnosis of their cause, and their medical management.

Yet the huge success of prenatal imaging does not always seem to be in direct proportion to the benefits it brings to people’s health. Indeed, the utility of the technique in preventing obstetric risks is generally recognised by public health policies in developed countries, the benefit generated by the diagnosis of foetal malformations is still being debated and often depends on how care is organised (Levi, 2002). The World Health Organization (2007) does not recommend systematic ultrasound examinations during pregnancy, given that the priority in many countries of the southern-hemisphere remains that of reducing maternal and infantile mortality by improving the conditions for clinical monitoring of pregnancy and delivery.

Local appropriation of prenatal ultrasound imaging

Although prenatal ultrasound and the knowledge it has helped to produce have become globalised, its uses are established within local contexts, where the organisation of care is itself rooted in specific representations of maternity and childbirth, of biological and spiritual life. Thus, the intensive recourse of Vietnamese women to prenatal ultrasound examinations (up to 30 during the course of a pregnancy), which is available without medical prescription and at low cost, must be interpreted in terms of a cultural representation of the foetus as a fluid and shifting entity, capable of rapid changes (Gammeltoft, 2007). In the private sector in Brazil, an ultrasound examination is a festive event, which consecrates the unborn child and introduces it to its family; the images produced are put into the family photo album, and the videos are shown on birthdays. On the other hand, in public hospitals, the ultrasound examination is used strictly for the medical surveillance of pregnancy and as a mean of transmitting technical expertise to physicians in training (Chazan, 2011).

The Brazilian context

The considerable social disparity that exists in Brazil conditions the provision of health care (Paim et al., 2011). Through the Unified Health System (SUS: Sistema Unico de Saude), every pregnant woman has access to free monitoring in the public sector. Wealthier women, who have private health insurance (convênios), and very rich women, are monitored in the private sector, and their gynaecologists are their preferred point of reference, in a frequently paternalistic mode of relationship (Sanabria, 2010).

Ultrasound is not explicitly recommended by state authorities (Caderno prenatal e puerperio 2005). Professional societies nevertheless recommend an ultrasound and a morphological examination during the first half of the pregnancy. The Federal Council of Medicine (CMF) requires that the main indicators of pregnancy-monitoring be recorded in a report. Hospital departments, which serve as referral centres, are overworked and the care relationship is often impersonal (Chazan, 2011; McCallum & dos Reis, 2006). So most women go to private ultrasound centres. The offer of commercial ultrasound services is substantial (Bonfim, 2009). Although such exams are always performed by a physician, they are not subject to quality control and their cost varies enormously (from 20 to 200 USD). Women and their families – whose principal aim is to discover the sex of the unborn child and see its face (Chazan 2010) – are given little information about the medical objectives of the exam.

Despite the recent diversification of family models in Brazil (Machado, 2001), women remain in charge of the home and of caring for and educating the children. Pregnant women enjoy a privileged position (Freire, 2008) and the new-born child is pampered. This consideration is further increased by the rapid demographic transition that has led to a sharp drop in the fertility index (IBGE, 2011). In such a context, the use of prenatal ultrasound for the routine monitoring of pregnancies is, in part at least, diverted from its medical objectives in order to support the cultural values of praising maternity and family (Chazan, 2007).

As in several South-American countries, Brazilian legislation considers abortion to be a crime (with the exception of rape or risk to the mother’s life). Back-street abortions are nevertheless frequent, with substantial consequences for women’s health (Diniz, Correa, Squinca, & Braga, 2009; Diniz, Penalval, Faúndes, & Rosas, 2009; Guilhem, 2007; Victora et al., 2011). Religious environment and the role of various churches in Brazil’s political life contribute towards making it particularly difficult to challenge the law. However, for lethal foetal malformations, it has been possible since 1999 to apply to the courts for an exceptional authorisation to abort (Diniz, 2007; Faundes et al., 2002). Such a request requires a medical referral centre to prepare a highly detailed file, after performing an ultrasound. Only partial data are available on the number of such requests, the verdicts and how the pregnancies end (Diniz, 2007; Gollop & Pimentel, 2004). The first judicial authorisations were delivered for cases of foetal anencephaly, followed by other types of lethal pathology such as the absence of both kidneys. The termination of pregnancy is thus presented as an anticipation of the delivery, act that makes it possible to “provide relief” for women facing the “moral torture” of a hopeless pregnancy (Diniz, Correa, Squinca, & Braga, 2009; Diniz, Penalval, Faúndes, & Rosas, 2009).

Apart from this strict procedure, termination of pregnancy due to foetal pathology is otherwise illegal. Several studies nevertheless allow us to assert that abortions do take place without judicial authorisation, outside public circuits and without it being possible to identify the foetal pathologies involved (Costa, 2006; Novaes, 2000). The termination of pregnancy due to foetal malformation is less accessible to women who are poor and who have a lower level of education (Ramos Guerra, 2008).

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