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### The art of not doing wrong and doing the right thing!

Timely and strategic, Leal et al.'s article "*Obstetric Interventions During Labor and Childbirth in Brazilian Low-risk Women*", intend to assess on a national level one of the most currently discussed issues: how to assist childbirth, and what should or should not be done for the safety and well-being of the woman and the newborn. Worldwide, this discussion has extreme and opposite impacts: in places with very few human resources and poor infrastructure, where childbirth without any professional care keeps killing women, and, in the other extreme end, in places where, for the sake of "care", interventions turned childbirth a standardizes process, with "routine" interventions whose evaluation of effectiveness are being the subject of permanent investigations, as mentioned by the authors and other systematic reviews carried out by Cochrane, recently published and mentioned at the end of this comment 1,2,3,4,5,6,7,8.

The results presented in this article disclose, in a summarized way, that the so-called good practices are less frequent than interventions during labor and delivery, which go against the evidences found in the investigations about the effectiveness of such actions. Aside from considerations about regions and other variables, my contribution in this comment seeks to expand the basis necessary to address the so-called obstetric care model for both, the public and the private sector, with the incorporation of evidence-based practices, and, particularly, with the revision of the initial concept that turned childbirth from a natural process into a medicalized procedure, filled with interventions.

As well indicated by the authors, a very small proportion, 5.6% of low-risk women, and 3.2% of nulliparous women of this group managed to have a normal vaginal delivery, in a natural way, with no intervention in the physiology of labor. In other countries, such proportion may range from 15% to 35% in Australia to 41.8% to the total births in England. For almost 95% of the women in Brazil, the mere fact of being in a hospital means to be subjected to procedures, most of them expensive and unwarranted. Thus, the basic principle for discussion of the necessary shift in care model is the autonomy of the woman, the ownership of childbirth and its needs. Calling it a model is an approximation, inadequate and categorizing, in the discussion about the unique and always particular experience of giving birth.

The existence of hospital routines that "standardize" this moment brings along that the idea of a woman in labor, and the delivery itself, for those who work at a hospital, should be accompanied by what is familiar to the practitioners: lying on the bed, fasting, use of IV saline, etc. A significant part of the knowledge and practices established in the past decades sought to develop a set of guiding standards, based on the idea that childbirth is a "medical problem". Transforming this model into an anti-model, for the sake of safety, well-being, and proper results will require much more than regulations, guidelines and systematic reviews. It is fundamental to review the meaning of such moment from the point of view of the women, who, in fact, play the main role in childbirth. The responsibility of the health system, health officials and practitioners is to match the expectations of the women, even though, many a time, they believe the best care is the one more medicalized. The fact that the women acknowledge obstetric abuse and are unhappy with the care they receive shows that changes are wanted and expected, even though most of them are not able to experience a model alternative to the one in place today.

The authors will find, in the suggested systematic reviews, more arguments to advocate for the classification used in the article: good practices, as the name says, should be broadly employed, and there should be clear, precise indications for interventions such as amniotomy or oxytocin use. The idea of women's childbirth ownership is not broadly accepted, or even discussed, by health practitioners, so the strategy to change that should consider the reason why some of the good practices are not implemented, or why some unwarranted practices are still performed. The common explanation is that "*this is hospital regulation*". Extirpating this rule is a huge task that should be tackled.

Overall, medical teaching and practices require significant changes, but, at least, in academic circles that are more concerned with good results, the use of evidences is a reality. The incorporation of simple recommendations, such as walking or not using a venous line routinely may be an opportunity for a most needed reflection, in this setting where technicism prevails, so that practitioners may develop a more preventive and somewhat "contemplative" care. The incorporation of scientific-based practices that respect childbirth ownership may be very rewarding also for health practitioners. It implies the unselfish attitude of being open to relearning, which can certainly impact the current practitioners model of asymmetrically establishing their power and knowledge with the owner of the body. It would

also be important to listen how health practitioners feel; after all, they also have feelings.

The authors, in the article under examination, have not related the presence of good practices and interventions with maternal and perinatal outcomes, and whether or not establishing such relationship is possible from the collected data. This is a suggestion I make for a future article.

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