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FERNANDA LABRICHOSA DE FREITAS VIDAL

# KEEPING THE PRACTICES IN A SCENARIO OF INSTITUTIONAL COMPLEXITY

SÃO PAULO

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Dissertação apresentada à Escola de Administração Empresas de São Paulo da Fundação Getulio Vargas, como requisito para a obtenção do título de

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Orientador(a): Profª. Drª. Eliane Pereira Zamith Brito

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## RESUMO

O reconhecimento de que instituições e arranjos institucionais exercem grande influência sobre os ecossistemas de serviços abriram um amplo campo de estudo para acadêmicos interessados em entender os mecanismos dessas redes. Um campo recente de pesquisa concentrou-se no entendimento das consequências da complexidade institucional, ou da coexistência de múltiplos arranjos institucionais, no ecossistema de serviços. No entanto, até agora, pesquisadores se concentraram em situações nas quais a complexidade institucional resultou em mudanças de práticas e mudanças no próprio mercado e menos em cenários em que o mercado e as práticas permaneceram similares. Por meio da análise dos serviços de parto no Brasil, um ecossistema de serviço que apesar de enfrentar a complexidade institucional consegue manter a prática rotineira de parto cesárea, esta pesquisa coloca luz sobre esse tópico negligenciado. Usando entrevistas fenomenológicas para capturar o ponto de vista dos principais atores da rede - paciente, médico, hospital e governo - esta pesquisa demonstra que a complexidade institucional afeta diretamente a co-criação de valor, prejudicando o seu resultado, e também evidencia que um ator focal pode ter sucesso em manter as práticas de um ecossistema de serviço atribuindo status de "recursos" a recursos potenciais, como emoções e costumes culturais, para serem trocados com outros atores durante a transação de serviços.



**Palavras-chave:** teoria institucional, lógica dominante de serviço, ecossistema de serviços, complexidade institucional, serviços de saúde.

## ABSTRACT

The acknowledgement that institutions and institutional arrangements have a great influence on service ecosystems have opened a wide field of study for scholars interested in understanding the mechanisms of such networks. A recent stream of research has focused on understanding the consequences of institutional complexity, or the co-existence of multiple institutional arrangements, to the service ecosystem. However, until now, scholars have engaged on situations in which the institutional complexity resulted in changes of practices, and changes of the market itself, and less on scenarios where the market and practices remained similar. Through the analysis of the childbirth services in Brazil, a service ecosystem that although facing institutional complexity succeeds in keeping the routinized practice of cesarean sections, this research throws light on this overlooked topic. Using phenomenological interviews to capture the point of view of the main actors within the network – patient, doctor, hospital and government- this research demonstrate that the institutional complexity affects directly the of co-creation of value experience by constraining its outcome and it shows that a focal actor can prosper in keeping the practices of a service ecosystem attributing "resourceness" to potential resources, as emotions and cultural behavior, to be traded with other actors during the service exchange.



**Key words:** institutional theory, S-D logic, service ecosystem, institutional complexity, health-care

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# 1 INTRODUCTION

In March 2014, in the small Brazilian city of Torres, a 29 year-old woman was conducted by policemen into a hospital to have an involuntary c-section. A few hours before, she was in labor at the same hospital but after doctors denied performing a vaginal birth, she decided to leave the facilities and wait for the birth labor development at home. Since physicians failed to connect with the patient and to find a solution, they recurred to the Justice in order to bring the patient back to hospital, and to surgery room. This event reached the national media coverage and exposed the complicated scene of birth delivery services in Brazil.

In 1970 the c-section rate was around 14,5% but in the 80's this number started to grow exponentially (Abdalla, 2018). In 2016, there were 2.79 million births in Brazil (IBGE, 2016) and around 56% through a c-section (Ministério da Saúde, 2016). The World Health Organization (WHO) argues that only 10% of deliveries should be done this way. Given the history of the number of this type of birth delivery in Brazil, the WHO adjusted this expectation rate to Brazil to around 25%, but it is still far below the actual rate. When we analyze only deliveries performed in private hospitals, mostly with coverage of health insurance, this number rises to 84.6%, which cannot be attributed to medical necessities (ANS; IHI, ABIBHAE, 2016).

Annually, it is estimated that around 840 thousand women pass through major surgery without medical indication, and, apparently, without the intention to do so: 70% of women desire a vaginal birth at the beginning of the pregnancy (Leal & Gama, 2014).

Several public campaigns have been held to stimulate women to pursue a vaginal birth and this movement has been gaining space in social media, through profiles dedicated to expose the benefits of this type of child delivery. This clashing scenario had led the Brazilian government to work for more than a decade in sensitizing the health agents in reducing such rates (ANS; IHI; SBIBHAE, 2016). One of the latest initiatives is a program developed in partnership with global health support institutions, and a cutting-edge Brazilian hospital. The program is called "Programa Parto Adequado" (adequate childbirth), and it is based on information diffusion and training. It was designed to change the birth delivery model, especially in private services, which presents the most dramatic figures. The efforts have been made to sensitize the most important

actors of this service provision: patients, hospitals, and physicians. However, the numbers of c-section remain stable and still problematic. In 2018, c-section rate was around 83% within the private service (ANS, 2020).

The birth scene of Brazil, populated by groups with conflicting ideologies that do not cooperate, and the ineffectiveness of efforts to change this scenario, is a good example of a service environment experiencing a high level of instability mostly due to institutional complexity.

Since Vargo and Lusch presented the term Service Dominant logic to frame the process of service provision where the value is co-created by the interaction of multiple actors, in a service ecosystem structure, a great number of scholars have worked to keep gaining understanding of the concept. One of the main additions it is the acknowledgement that institutions and institutional arrangements play a pivotal role in maintaining and disrupting the service ecosystem since they constrain and coordinate the values of the actors and, ultimately, the practices within an ecosystem (Vargo & Lusch, 2016).

While the presence of a dominant institutional arrangement can bring stability to a service ecosystem, the existence of contradictories institutional arrangements can lead to an institutional complexity, diminishing the influence of the predominant institutional arrangement and jeopardizing the maintenance of the *status quo* within the service ecosystem. When the ecosystem is facing an institutional complexity, one of the two outcomes is expected: either it changes its practices and the market itself, or it keeps the procedures and practices (Siltaloppi, Koskela-Huotari, & Vargo, 2016). Although a lot of advancements had been done to explore the first scenario, the scenario where the service ecosystem suffering from institutional complexity maintains its practices still lacks understanding.

The Brazilian birthing scenario is an interesting context to explore the topic. The literature and the data point to a situation of institutional complexity, in which actors possess conflicting views and clear dissatisfaction with the solutions. However, the studies until date are not able to fully explain the resilience of the practices within the Brazilian context.

This present research fulfils this gap by advancing the understanding of Institutional Complexity within a service ecosystem and the resilience of its practices.

The research question that guided the study is the following: **How does a service ecosystem can maintain its practices even in Institutional Complexity?** To answer this question, some sub questions also guided the data collection:

**What are the Institutional Arrangements that influence the most this ecosystem?**

**How does the Institutional Complexity manifest within this ecosystem?**

**What are the focal actors and their motivation to change or to keep the practices?**

**What are the mechanisms utilized by the focal actors to maintain their practices?**

This research contributes to studies of institutional theory, service dominant logic and specially the stream of research that examines the influence of institution in service ecosystems with highlight to understand the influences of institutional complexity. Also, it contributes to the field of study of Health Care decision making.

In the following pages, first it will be presented a literature review focusing on the Service Dominant Logic and the influence of institutions in the service ecosystem. Second, in the method session, details about the data collection and analysis will be presented. Then, the empirical findings will be shown in detail, followed by the discussion section where the empirical findings will be connected to the literature. Finally, the conclusion it will be presented, including the research limitations and directions for future research.

# 2 THEORECTICAL BACKGROUND

Post Modernity brought new ways to see the world, affecting marketing dynamics and changing the way the discipline addresses the relationship between firms and customers (Fırat & Dholakia, 2006). Marketing has empowered consumers in constructing meanings and substance in life which leads to a different approach from organizations, one of partnership and emphasis on the interactive process (Fırat & Dholakia, 2006).

A central thought in this new era for the discipline, is the acknowledgement that the customer is always a co-creator of value in any market transaction (Prahalad & Ramaswamy, 2000; Prahalad & Ramaswamy, 2004; Vargo & Lusch, 2004). This process is known as value co-creation and many scholars have explored its specificities throughout the years. One of the most diffused and accepted frameworks is the Service-Dominant Logic (S-D Logic), introduced by Vargo and Lusch (2004). The framework describes a service-centered view of market transaction, replacing a goods-dominant view (G-D Logic), a vision that the value of a product is delivered to the customer by the provider.

In the following sections I present a brief description of S-D Logic and how the acknowledgement of the influence of institutions over the processes described by this framework helps us to understand market reformulation in the service industry.

## 2.1 Service-Dominant Logic (S-D Logic)

The underlying assumption of S-D Logic is that people apply their competences to benefit others and, at the same time, to benefit from other's applied competences, which is understood as a service-for-service exchange. In this process, the value can only be obtained once the transaction is completed, and the good or service is consumed. The customer, as the ultimate beneficiary, is always a fundamental piece of this process of value creation, which is a result inherent to every market transaction (Vargo & Lusch, 2004). The provider role is to enable the beneficiary to customize their own collection of resources, based on needs and other available resources (Vargo & Akaka, 2012).

### 2.1.1 S-D Logic and the generic role of actors

The value creation process can involve many actors who are engaged in the value chain including, but not limited, to the customer and the provider. This dyadic view of customer-provider has its roots in the good-dominant logic, and it ignores the systemic nature of the process and the overlapping activities of the participating actors in this service-for-service exchange. This systemic view of the value co-creation acknowledges that actors do not have a limited role and responsibility in the process: they can be understood as "generic actors", that assume fluid roles and identity to the unique characteristics of service exchange configuration. It surpasses the provider-customer denomination and the paying and non-paying customers differentiation, making those divisions irrelevant (Wieland, Koskela-Huotari, Vargo, 2016; Vargo & Lusch, 2011, 2016).

The term generic should not be understood as all the actors being identical neither in status nor influence. Instead, scholars have advanced the understanding that co-creation takes place in a social system in which all actors already possess positions and social status that influences their thinking and behavior that conceptually implies an asymmetric position of the actors (Edvardsson, Tronvoll, & Gruber, 2011). The acknowledgment of this asymmetry is important to understand why a central actor has the power to influence the whole value creation chain, even in adverse situations. Also, critical perspectives are calling attention for the risk of service providers engaging customers in a staged co-creation process, where the customer is influenced by authority and controlled participation (Cova, Dalli, & Zwick, 2011).

### 2.1.2 The networked view of S-D Logic

Related to the rejection of the dyadic view of the S-D Logic is its network perspective that assumes that people, like firms, are dependent and connected to others, so the process of value creation is also interactive (Vargo & Lusch, 2008, 2011). In these networks, popularly known as service ecosystem, multiple actors engage and contribute with resources to create value through a systematic engagement of many seemingly distinct actors. Such networks should be understood as dynamic systems and not as static

aggregations: they are temporarily and circumstantially, formed to exchange service and co-create value in a specific setting. Once the result is accomplished, and the value created, this network may be dissolved (Vargo & Lusch, 2011).

The network is formed around the purpose of the maintenance of such network, and not around a collective intent. The commonality is not an important aspect of it; instead individual wellbeing has a much higher influence contributing to this dynamic network (Vargo & Lusch, 2017). The greater the alignment of individual intentions among the actors, the greater the cohesion of the network.

### 2.1.3 The resources applied by the actors in the service exchange

To be an active actor within a service ecosystem, she/he must contribute with resources, which are everything that actors can bring to be exchanged in the service ecosystem to co-create value to the party. The S-D Logic conceptualizes two types of resources: the operand and operant resources: operand resources are tangible things that require action taken upon them to be valuable, and in the specific case of firms, goods, or raw materials are examples of this type of resource; operant resources refer to intangible and usually invisible things, such as core competences, knowledge, skills, and capabilities (Arnould, Price, & Malshe, 2006), and they can act on other resources to contribute to value creation.

Consumers also possess both kinds of resources while consumer's operand resources are mainly their possessions and financial situation. The consumer's operant resources are also intangible and comprehend three levels: physical, social, and cultural. The physical level comprehends physical and mental endowments or the capacity and potential of individuals' bodies and intellect to perform some tasks. The social resources are entire social networks in which customers take part, such as family groups, friends, and co-workers. Virtual and conceptual groups, such as brand community and subculture of consumption, are also social operant resources activated by customers in the marketplace transactions. Lastly, the cultural resources are the cultural knowledge and capital, skills, and goals of an individual (Arnould, Price, & Malshe, 2006).

Although the list of potential resources may be comprehensive, it is important to analyze which resources are being used in the service ecosystem. According to Koskela-

Houtari and Vargo (2016) the ability of a potential resource to be activated and enable the accomplishment of something desirable (resourceness) is contextual and determinate by the availability of complementary resources that can work as inhibitors or triggers of the resources in a determinate setting. A popular example of a complementary resource is the actor's ability: a person can be very descriptive of the features he looks for in a shoe purchasing in his native language but is incapable of doing so in a different country, where he does not possess the language resource. Other important elements that may inhibit or trigger the "resourceness" are the institutions and the institutional arrangements.

### 2.1.4 The influence of Institutions over the service ecosystem

The service ecosystem perspective and its networked and contextual view of the resource integration allowed some structural details of the value chain to stand out. The most relevant feature is the acknowledgment of the influencing effect of institutions and institutional arrangements (Vargo & Lusch, 2016).

Institutions are humanly conceived rules, norms, and beliefs that guide human behavior through both constraining and allowing actions. It can be formal laws, informal social norms, conventions, or any other system that routinely provides a shortcut to cognition and judgment and make life predictable and meaningful. They typically exist and manifest as part of a broader, interdependent institutional arrangements (Vargo & Lusch, 2016).

Vargo and Lusch (2016) calls institutional arrangements what the organizational theory has been calling institutional logics for years. Drawing from the advancements of this field of work is possible to better understand the institutional arrangements, or logics, and how they impact the service exchange in a service ecosystem perspective. Ocasio, Thornton and Lounsbury (2017, p. 510) describe institutional logics as:

> The socially constructed, historical patterns of cultural symbols and material practices, assumptions, values and beliefs by which individual produce and reproduce their material subsistence, organize time and space, and provide meaning to their daily activity.

The building blocks of institutional arrangements are theories, frames, narratives and practices, both materials and symbolic, and ideologies that work in its preservation (Ocasio, Thornton & Lounsbury, 2017).

The institutional arrangements constrain and coordinate the actors within the resource exchange, for example giving "resourceness" to a resource, meaning to a symbol or power to an actor. They can be simple understood as the "rules of the game" (Vargo & Lusch, 2016). The arrangements also allow the actors to perform a considerable amount of service exchange and co-creation of value under time restriction, mainly because since the actors share their dogmas, the institutional arrangement acquire a coordination role in the network and act as moderators of self-interest (Ocasio, Thornton & Lounsbury, 2012). The more actors share an institution the stronger is the coordination potential of this service exchange since they provide the shared basis for cooperation (Vargo & Lusch, 2016; Siltalloppi, Koskela-Huotari & Vargo, 2016).

Institutional arrangements have the power to shape individual preferences, collective interests, and overall practices. Dominant institutional arrangements are known as "embedded agency", the idea that an actor´s agency is constantly framed by a structure (Thornton, Ocasio & Lounsbury, 2012). Importantly, the institutional arrangements dictate the practices that should be performed to co-create value within a service ecosystem. Those practices, which are aligned with the predominant institutional arrangement, became institutionalized shared practices (Wieland, Koskela-Huotari, Vargo, 2016).

However, institutionalized shared practices can lead to a lack of reevaluation of the appropriateness of practices for the context. So, institutional arrangements can lead to ineffective ideologies and creeds (Vargo & Lusch, 2016). But markets suffer continuous changes through the activities of the actors, who work in translation and interpretation of institutional arrangements and enactment and conformation to new practices. (Vargo & Lusch, 2016; Wieland, Koskela-Huotari, Vargo, 2016). These activities lead to instabilities within the service ecosystem, and on the one hand, it can be the trigger for changes within it; in the other hand, it can work for the consolidation of institutionalized shared practices.

## 2.2 Institutional Complexity and the trigger for reflection in Service Ecosystem

The process of value co-creation is not optional and it is not immune to an analysis of its efficiency in delivering benefits to all the parties in the ecosystem. As mentioned above, the process is driven by the integration of resources and ultimate service exchange among actors who have different views and are continually assessing what is valuable for them. (Vargo, Wieland & Akaka, 2015)

Analyzing the value co-creation process through the institutional lenses brings the clarity that markets are not static, instead are continually being performed and shaped by the interaction of the actors (Vargo & Lusch, 2016 p. 18). Every activity performed within a service ecosystem changes the nature of the system at some level and, consequently, it changes the context for the next value co-creation development (Vargo, Akaka & Wielad, 2015; Kouskela-Houtari & Vargo, 2016). Since they are dynamic, the ecosystem is under constant scrutiny, which puts their resilience in check.

Two of the main forces that test the resilience of a service ecosystem are the institutional pluralism and institutional complexity. The former is related to the presence of various institutional arrangements with different degrees of complementarities, which enables institutional multiplicity. The latter is related to the existence of conflicting institutional arrangements, diverse in its beliefs and prescriptions (Ocasio, Thornton & Lounsbury, 2017).

The existence of institutional complexity or the co-existence of contradictory institutional arrangements is a key to understand instabilities within a context (Kouskella-Houtari & Vargo, 2016; Siltaloppi, Kouskella- Houtari & Vargo, 2016). The institutional complexity facilitates change by interrupting the automatic compliance with the norms, evoking reflection and agency (Thornton, Ocasio & Lounsbury, 2012).

The institutional complexity can manifest in several ways: first, in situations where actors present conflicting views, each derived from different institutional arrangements, preventing collaboration; second, actors may be dissatisfied with the inefficiency of solutions originated from predominant institutional arrangements; third, actor's conformation to a set of institutionalized practices may jeopardize his adaptation within a broader ecosystem. Those three manifestations are examples of how the predominant institutional arrangement ceases to provide feasible repertoire of action,

triggering reflection, evaluation and quest for a new viable solution. A fourth manifestation is an example of how an alternative institutional arrangement can cause the same reaction: certain actors may find a dissonance between their goals and expectations and the solutions from predominant institutional arrangements, while identifying with a different institutional arrangement (Siltaloppi, Kouskella- Houtari & Vargo, 2016).

Presenting one or more manifestations of instability within the structure, one of the two outcomes is expected for the service ecosystem: either important disruptions occur, changing somehow the dynamics of the service ecosystem, or it is maintained stable, without salient changes in practices.

The stream of work that investigates the first scenario, of changes occurring in the service ecosystem, has been growing in the past couple of years, since the acknowledgment that the institutional arrangement is sources and triggers of market reformulation (Vargo, Akaka & Wieland, 2015).

Wieland, Koskela-Houtari and Vargo (2016) depart from the idea that markets are continually shaped by the activities of broader sets of actors to state that those actors are always working on translating, interpreting, and adapting the institutional arrangements through the ratification of practices of co-creation of value. As a result, practices, and institutions suffer change. The authors advance the dialogue of market reformulation by recognizing the agency of the actors in translating and adapting the institutional arrangements.

Koskela-Houtari and Vargo (2016) recognize that actors combine the multiplicity of resources applied to the exchange by seemingly different actors to result in "new" resources. Since resources are contextual, like everything else in the service ecosystem, when this system is under an institutional complexity, actors may *"draw on multiple institutional arrangements as alternative frames to make sense of the "resourceness" of potential resources"* (p.172). The authors recognize the agency and creativity of the actors in reorganizing different resources until creating a new one, possibly to be activated in the service exchange and ultimately reformulate the market.

Siltaloppi, Koskela-Huotari and Vargo (2016) state that although the multiplicity of institutional arrangements – also called institutional complexity - exposes the problems within a service ecosystem, they also make available means of finding new solutions. According to the authors, each institutional arrangement has its own "toolkit", which are

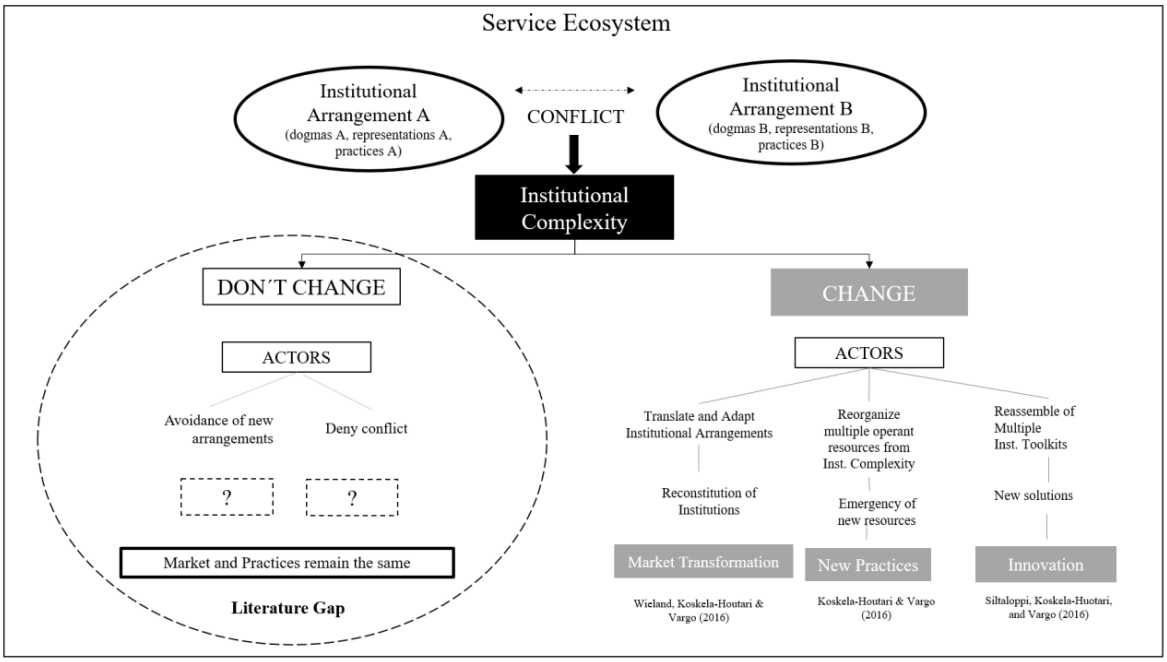
*cultural symbols, shared assumptions and meanings, material practices and routines, and institutionalized strategies of action that guide (and constrain) action within the institutional arrangement* (p. 337). Once multiple toolkits, from multiple institutional arrangements, are available in institutional complexity, it can be reassembled to create new solutions and probably new practices.

The second scenario recognizes that since institutional complexity is not an assurance of change but only a trigger, it is possible that instead of reorganizing the value co-creation process and practices, actors' efforts are on maintaining the existing practices. Such efforts can be materialized in forms of avoidance of a particular (new) procedure or denying some conflicting practices. Those actions can be understood as being motivated by the eagerness to protect one's self-interest, the fear of change, or simply by the inability to find new solutions (Siltaloppi, Kouskella-Houtari & Vargo, 2016). The resilience of a predominant institutional arrangement is a direct result of the degree of how nested and overlapping it is: the more institutions are part of this arrangement, more influence it will have among the actors within the service ecosystem.

Although the authors acknowledge the potential outcome of the maintenance of the status quo in a situation of Institutional Complexity, they do not further develop this line of thought, neither their underlying mechanisms that may result in keeping the practices.

Figure 1 illustrates this literature gap: the study of service ecosystems which experience institutional complexity have been concentrated in situations where this complexity results in changes, portrayed in the right side of the figure. The left side of the figure, which represents the stream of study of situations where the institutional complexity does not result in change, is far less developed.

Figure 1 - Literature gap




Source: the author

This research gap was observed by Vargo and Lusch (2017) in their article "Service-Dominant Logic 2025", in a call for scholars to contribute with more mid and micro range theories in the S-D Logic.

The Health care context presents a solid opportunity to begin to answer these gaps. Since it touches virtually every human at some point, the multiplicity of context to be studied is enormous; also it is gradually becoming more people centered, closer to the S-D logic perspective (Anderson et al., 2013).

## 2.3 Institutional Complexity in the Health Care Ecosystem

Health care has been in the discussion of value co-creation since its beginning. Prahalad and Ramaswamy (2004) have noticed the empowerment of the patients in their co-creation conceptualization: patients have access to a greater amount of information and are expecting to engage in an open dialogue and negotiation with doctors. In this new era for the medicine, the value for customers is not through use of medical intervention but through a dynamic relationship that takes their conditions and preferences into

account (Joiner & Lusch, 2016). Within the field of social sciences that new perspective of patient participation has been noticed even earlier, conceptualize it as a "consumerist approach" (Lupton, 1997).

Regarding patient participation, physicians defend that patients do not possess the specialized knowledge regarding diseases and treatments, what is called "asymmetry of knowledge" (Lupton, 1997; Prahalad & Ramaswany, 2000; Joiner & Lusch, 2016). Due to the importance of the topic, recent research has been focusing on new resources and resource exchange activities in order to understand how patients can engage in a successful co-creation with their health providers.

New resources are emerging to change the ecosystem and, consequently, overcome the barrier created by the asymmetry of knowledge. For instance, the use of new information communication technologies (ICTs) for both monitoring health conditions and sharing patient's emotional and social realities with physicians have shown the potential to humanize the attention, enhancing the quality of life of patients (Tian et al., 2014).

Regarding the activities performed by patients, McColl-Kennedy et al. (2012) showed that patients might engage in a range of co-creating activities aimed at improving health and quality of life. Those activities comprehend the integration of resources from distinct actors such as firms, government, alternative health care settings, and social groups, as well as their self-generated activities. The issue of customer effort in contributing to co-create value evolved even further, to a "hierarchization" of such activities, showing different levels of difficulty and linking those to customer satisfaction with the service (Sweeney et al., 2015).

The issues of the institutions and institutional arrangements that influence the health care practices have also been exploited, even before its conceptualization from Vargo and Lusch in 2016. For instance, in the context of the natural health marketplace, cultural myths were studied to understand how they can be leveraged to create marketplace mythologies that work for ideological interests (Thompson, 2004). The institutional constraints were also the focus of attention in understanding how the structures, or institutional arrangements, limit marketplace actor's ability to co-create value in the specific case of sperm donation (Sobande, Mimoun & Trujillo Torres, 2019).

Although the issue of customer co-creation of value within the health care setting has been in debate for quite a long time, physicians seem to deny the existing conflicts originated by S-D Logic (Joiner & Lusch, 2016).

In the obstetrician field, studies had exposed the power of institutions and institutional arrangements for the practices. Two of the predominant institutional arrangements within the literature are the medicalization of childbirth and the humanized childbirth. Those contradicting institutional arrangements found within the obstetrician literature reflects a long-time struggle between two conflicting logics in the Health Care field: the care and the science logics. The former is related to the knowledge that is generated through scientific research and manifested in terms of innovative procedures and treatments. The latter is related to the embodied knowledge and manifested in holistic and preventive care always interested in improving the patient's quality of life (Ertimur & Coskuner-Balli, 2015)

In the middle of 20th century, birth has gone from being a natural event in women's lives to a pathologic-like state that needed to be managed by those who possess the technical expertise and equipment (Rutherford & Gallo-Cruz, 2008). In this scenario, the hospital birth became the institutionalized practice of giving birth and the physician replaced the midwife as responsible for the procedure. Medical and technological interventions arise, serving as means to display the technical skills of the doctor (Thompson, 2005). Within this context, the c-section was no longer seen as an emergency procedure but instead, as the safe and modern way of giving birth (Abdalla, 2019). All of this marked the growth of the medicalization of care (Thompson, 2005).

The humanized childbirth movement also appears largely in the literature, as a contradictory force of influence seeking to neutralize medicalized birthing culture, and as an expression of the anxieties of a population leveraged by dehumanizing technological care (Thompson, 2005) and women looking for being more protagonist of their children's birth. Their discourse is aligned with women's empowerment and feminist movements (Abdalla, 2019). The natural birth movement had influenced obstetrician practices in a broad spectrum, ranging from most radical practices, as an entirely drug-free home birth to a more conservative practice, as simply meaning vaginal birth without epidural anesthesia in hospital facilities (Rutherford & Gallo-Cruz, 2008).

It is important to acknowledge the role of new actors of this service ecosystem in contributing to this kind of practice and institutional arrangement. It is the case of doulas, childbirth educators and lactation consultants operate through empowering and enabling women to assume the decisions regarding birth while also amplifying women's responsibility for the birth outcomes (Abdalla, 2019).

In sum, the existent literature was able to portrait some confrontation and institutional contradictions among the institutional complexity in the birth delivery service system, however it is not enough to fulfill the theory gaps regarding what makes a service ecosystem resilient. Significant gains can come from studying the specific case of childbirth in the Brazilian context, a market that has been facing contradictory influences from institutions but until today has been successful in keeping its existing practices.

# 3 METHOD

Before detailing the research method, I start this section by clarifying my relationship with the topic as a mother and a researcher. As a mother of two toddler girls, it seems impossible to nullify my birth deliveries experience from the study. At the same time, I understood from the beginning that I should avoid any judgmental contamination of the data that I would be collecting. Here is where I, as a researcher, resort to Gould's metacognitive introspection or the exercise of *being aware of one´s own awareness and following it* (Gould, 2008, p. 409). By thoughtfully observing and making notes of my embedded experiences from present and past time, taking account of the feelings that emerge and how it may change the insights, I isolated my experience as a mother in the accomplishment of this research. In the same matter, I tried to isolate the most my personal experience not only in the analysis but also when selecting subjects of my interviews. The details will be presented within the correspondent section.

## 3.1 Ethical Protocol Statement

In the quality of the main researcher of the present study, I confirm to be aware of the ethical protocol for research, and I assure that it has been approved by the FGV Ethics Committee, in a deliberation occurred in June 2018, based on my commitment to ensure the quality and integrity of my research: all the participants of the study are voluntaries and consented with their participation, giving written consent; the confidentiality and anonymity of the respondents will be ensured, and the names presented in the paper will be fictional; the results of this research aims to contribute with the knowledge of marketing discipline so it will be independent and impartial.

## 3.2 Research Strategy

Considering the nature of the theme to be explored and the research question that I propose to be answered, an exploratory study was conducted and it assumes a constructivist view. Social constructivists believe that individuals seek understanding of the world in which they live and work. Individuals develop subjective meanings of their experiences and these meanings are varied and multiple, leading the researcher to look

for the complexity of views rather than narrowing meanings into a few categories or ideas. In this approach, researchers recognize that their own backgrounds shape their interpretation, and they position themselves in the research to acknowledge how their interpretation flows from their personal, cultural, and historical experiences. (Creswell, 2014).

## 3.3 Data Collection

The data collection had the challenge to portrait the point of view of the distinct actors of this service ecosystem, with emphasis on the doctor and the patient perspectives. Although both actors are pivotal to answer the secondary questions related to the research question, to avoid a narrow view of the subject, the interviews were expanded to encompass the standpoint of other important actors of the service ecosystem - the hospitals and government. The interviews were all in personal, except from one mother whom I interviewed through Skype. All the respondents lived in the city of São Paulo, place where the interviews were conducted as well, and the meetings occurred from July 2018 to September 2019. Regarding their length, the interviews with patients lasted between 33 minutes and 1 hour and 35 minutes. In relation to the interviews with professionals, the length was between 23 minutes and 50 minutes. The interviews resulted in 261 pages of transcription, single spaced.

The primary research strategy was the phenomenological interview to obtain a first-person description of each respondent's experience without recurring to unconscious explanations (Goulding, 2005; Thompson, Locander, & Pollio, 1989). Existential-phenomenology implies that experience is something different than response patterns or cognitive structures, providing a method free of all presuppositions, leaving aside questions about their causal origins and their nature outside the act of consciousness itself (Moreira, 2004).

Although supported by an interview guide containing the main topics to be covered, the respondents largely set the course of the dialogue instead of following a predetermined path. The analysis included not only the verbal description of the experience but expressed feelings, thoughts, and desires.

Regarding the interview with the mothers, I recruited women who have gone through childbirth recently (less than 12 months) or were pregnant to ensure a rich description of the phenomenon. Following my commitment to avoid my personal experience to contaminate the interpretation of the data, although the women were recruited with the help of my social circle, I did not interview any relative or close friend whom pregnancy I accompanied closely. I interviewed women of different profiles to ensure different points of view, including women in their first pregnancy and those experiencing their third pregnancy. I used two important filters when selecting these women: a) all women had private health plans, which would take care of the big majority of the expenses related to the babies' births, and reflected the desired service ecosystem: private childbirth services; b) the pregnancies could not be considered to be risky since in such cases, the influences regarding the type of childbirth are considered to be atypical (multiple pregnancies are included here).

Table **1** contains the respondents' profiles.

Table 1 - Mother profiles

| **Name** | **Age** | **Occupation** | **Condition** | **Children** | **Interview Date** |
|---|---|---|---|---|---|
| Ana | 34 | architect | pregnant | Andre 5 y-o and Ana 2 y-o | July 2018 |
| Bella | 34 | yoga teacher | pregnant | Beatrice 2 y-o | August 2018 |
| Carol | 33 | engineer | pregnant | none | August 2018 |
| Daniela | 37 | marketing manager | recent mother | Dario 3 y-o and Diego 1 month | September 2018 |
| Ester | 37 | lawyer | pregnant | none | September 2018 |
| Flavia | 28 | business administrator | recent mother | Fernanda 4 months | September 2018 |
| Gisele | 22 | pedagogue | pregnant | none | October 2018 |
| Heloisa | 32 | architect | recent mother | Helio 1 month | May 2019 |
| Isabel | 36 | architect | recent mother | Isa 3 y-o and Icaro 7 months | June 2019 |
| Joana | 37 | coaching | pregnant | João 7 y-o and Julia 4 y-o | June 2019 |
| Laura | 38 | parental coaching | recent mother | Luis 3 y-o and Lalo 6 months | June 2019 |
| Monica | 36 | advertising manager | recent mother | Mario 6 months | September 2019 |
| Nadia | 37 | graduation teacher | recent mother | Nivea 5 months | September 2019 |

Source: the author

Regarding the interviews with doctors, I interviewed four doctors to capture the point of view of the professionals regarding the topics. I selected physicians with different professional experiences and time of practice to ensure potential diversity in points of view, although all the professionals should have a private clinic and/or accept

health insurance payment. Two of the doctors had performed the births of two mothers I interviewed to the research. Although the contacts were initiated through these women, I did not mention to the doctors that I had also interviewed their patients, to avoid any contamination in responses. Here, also I avoid contamination of my personal experience by preventing interviewing the doctor who performed my child deliveries. Table 2 contains the doctors interviewed profile.

Table 2 - Physicians profiles

| Name | Age | Time of Practice | Service Locations | Interview Date |
|---|---|---|---|---|
| Dr. Thiago | 32 | 7 years | Private clinic | September 2019 |
| Dra. Ana Cecilia | 75 | 50 years | Private clinic | September 2019 |
| Dra. Vanessa | 42 | 15 years | Private clinic | September 2019 |
| Dra. Katiane | 50 | 24 years | Private clinic and Public Hospital | September 2019 |

Source: the author

As I mentioned previously, this research also had the goal to encompass the point of view of two important actors of this service ecosystem - the hospitals and the government. Since the attempts of contact with both CEOs from hospitals and members of government turned out to be unfruitful, their standpoints were collected through two interviews with stakeholders that orbit such actors. Both are physicians that possess administrative positions. One is the head of a public and private program to educate distinct actors about the benefits of natural labor. The other is a partner in a firm that outsources the operations of the maternity sections in private hospitals. Table 3 contains their profiles.

Table 3 - Interview with physicians with administrative positions

| Name | Age | Administrative Position | Interview Date |
|---|---|---|---|
| Dra. Beth | 55 | Head of Public and Private Program of stimulus to Natural Birth | August and October 2018 |
| Dr. Arnaldo | 46 | Outsourced Operations Manager for 12 private maternity hospitals | September 2019 |

Source: the author

Other possible actors of the ecosystem, such as the child father, other women relatives, and nurses were not included due to time constrain. I address this limitation in the Research Limitations section.

## 3.4 Data Analysis

Following Creswell's (2014) methodology to organize and analyze qualitative data, I pursued in the data analysis an approach from the specific to the general, using an abductive approach. The literature and my interpretation as researcher were fundamental in this interactive process of analysis, recurring to the theory and data continually.

The process was developed in phases. First, I read many times each transcript, the first time was meant to have a general perception of the interviewee's tone, credibility, and her/his logic. Following that, I did a more careful reading to deeply understand what each interview had to contribute to the research. This detailed analysis generated codes that emerged from the interviews, from the expressions and feelings I was able to capture. Table 4 portraits some examples of codes that emerged from the interviews.

Table 4 - Examples of Codes that emerged from Interviews

| **Codes in Portuguese** | **Meaning in English** |
|---|---|
| "morrer na praia" | When women didn´t succeed in having the desired vaginal birth |
| "confiar desconfiando" | The contradictory feeling some women experience in relation to their doctors |
| "cultura da cesária no Bras | The routinized practice of c-section in Brazilian society |
| "medo da dor do parto" | The fear of a painful birth experience |
| "maturidade pós 1o filho" | The conscience, usually after first childbirth, that the way of delivery is not the most important in the whole birth experience |
| "sou guerreira" | The feeling of accomplishment of women who ended up succeeding the vaginal birth |
| "pagamento do parto" | Issues related to payment of birth services |

Source: the author

Following that phase, I recurred to the literature, and guided by the research questions, a list of categories was generated. The categories were created based on their potential to contribute to answering the research question and to how the literature had explored the themes. Table 5 illustrates the categories that were created.

Table 5 - Categories Generated through the Analysis of the Literature

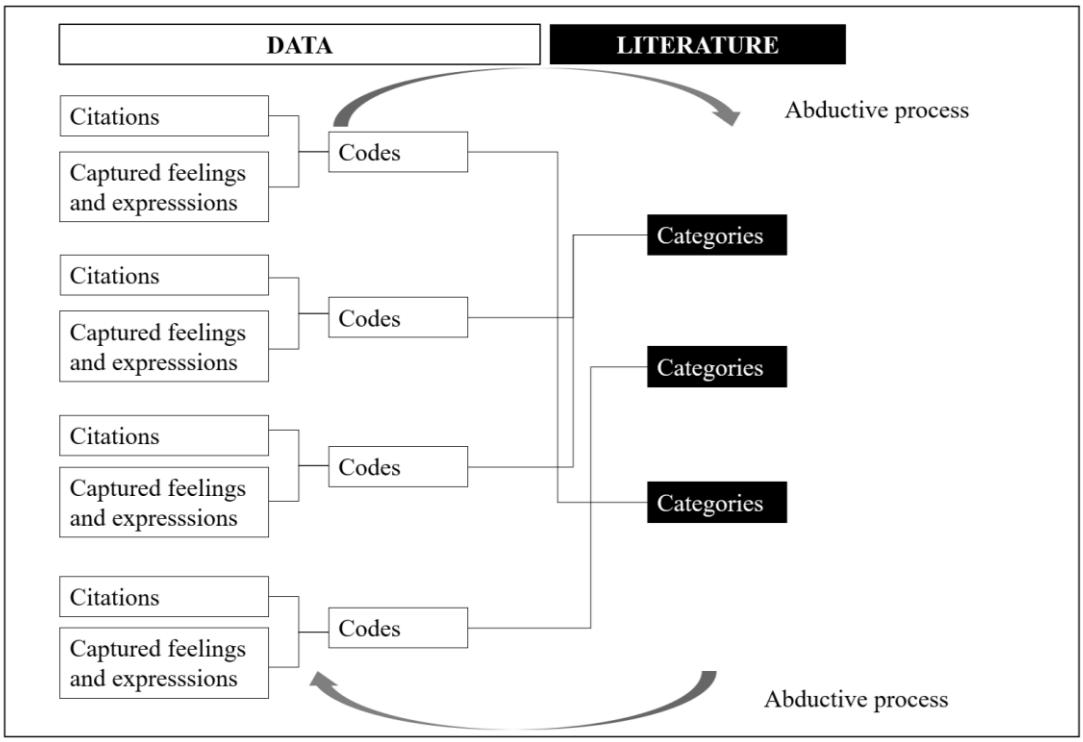
| **Categories Generated** | | |
|---|---|---|
| Profitability of Humanized Birth | Laws and regulations | Physician built of Trust |
| Profitability of C-Section | Conflicting point of views | Physician built network |
| Socialization of Birth | Alternative solutions for the desired birth | Fear of Birth |
| C- Section Convenience for mother | Insatisfaction with C-Section | Health Insurance payment method |
| C-Section Convenience for physicians | Physicians motivations | Birth workers |
| Safety of C-Section | Patient motivations | Patient lack information |
| Unconveniency of Natural Birth | Hospital motivations | Patient vulnerability |
| Return to Natural | Governement motivation | Lack of Participation of the father |
| Medicalization of pregnancy | Patients New Source of Information | Distrust about the doctor |
| Goodness of Natural Birth | Patient payment method | |

Source: the author

Following, I performed a match between the codes emerged from the data and the categories created with the support of the theory. The codes that did not present a fit with the categories were excluded, since they did not help to answer the research questions.

The categories represent the multiple perspectives of respondents about the main themes of the research and they were corroborated by numerous citations. The analysis process included various rounds of reading and coding, while I attributed and revised the meaning of codes and categories and established their relationship. The iterative analysis moved between data from one transcript and the understanding of the entire set of textual data (Thompson & Arsel, 2004, p. 632). This approach interprets consumption meanings in relation to both a customer's sense of personal history and a broader narrative context of historically established cultural meanings (Thompson, 1997). Figure 2 illustrates the process of analysis described above.

Figure 2 - Process of Analysis




Source: the author

# 4 RESULTS

## 4.1 Institutional Arrangements and their influences on childbirth service

In the previously mentioned literature, two main institutional arrangements were presented as influencing the obstetrician field: the medicalization of birth and humanized childbirth. These present empirical results corroborate these propositions: in the interviews with mothers and healthcare professionals, five major institutional forces, and some minor ones, could be identified as contributing to these arrangements. The institutional forces that contribute to the logic of medicalization of birth are: a) dependence on the doctor; b) the strong relationship between doctor and mother and c) the convenience of the cesarean delivery. As minor institutional forces are d) C-section seen as safe and e) socialization of childbirth.

Regarding the institutional forces that contribute to the influence of humanized childbirth are f) return to natural practices and g) goodness of vaginal birth. As a supporting institutional force, identified only in interviews with professionals, we find g) the profit generated by the humanized childbirth. Below, we present those influences in more detail.

### a) The Dependence on the Doctor

The medicalization of care as identified in the literature, manifests so very consistent in the stories of the women interviewed. It draws attention not only to its recurrence in the different reports, but its scope in all phases of care. The routinized tests seem to have been assimilated by the patients, even for those women who have a more naturalistic profile, averse to excessive interventions.

In the spotlight of the prenatal tests is the ultrasound, which no longer seems to be a limited-edition test to detect possible anomalies, but instead, it is been carried out in accordance with the will of mothers as a tool to calm their anxiety and satisfy their curiosity. This is an example of a common Brazilian practice that causes a great dependence on the doctor since he is responsible for the application, implementation and analysis of the exam. In the passage below, a deposition of a patient who considers herself to be focused on natural practices, but she requests ultrasounds to her doctor to calm her curiosity:

> My doctor has a naturalistic profile. Every month we had two or three ultrasounds. He prescribed some for fun and the ones that were really necessaries. So, when I was yearning to see the baby, I used to do one for fun. It was really fun. (Laura)

In interviews of doctors, we observed that some recognize this extreme dependence of women to the doctor, but far from being seen as a problem, just happens to be analyzed as something deeply rooted in care processes. According to them, doctors are very used to focus on problems, diseases, anomalies and end up reflecting this in the treatments as reported by a gynecologist:

> The doctor is trained to see problems. So when the woman comes to prenatal care, the doctor starts talking about problems, problems, problems... he scares the patient (...) the births took place at home, they took place in the convents; nurses and nuns used to perform it; and when they had a complication, who did they call? The doctor (...) so, for us, childbirth has a lot of risk. It is a bias. (Dr. Beth)

b) The Strong Relationship between the Mother and the Doctor

Another recurring factor in interviews that demonstrates the patient's dependence on the doctor is the close relationship that the Brazilian patient develops with her obstetrician gynecologist. Usually, this professional develops a long-lasting relationship with her, dealing with medical issues far beyond gynecological ones and treating her for a long time.

The nature of gynecological care also means that the woman has to expose much of her intimacy to the doctor, so she searches for a professional that she really identifies with and trusts, often after interviewing several doctors.

During pregnancy a strong doctor-patient relationship occurs for various reasons, ranging from psychological issues such as women's vulnerability at this time, as a practical matter, since the meetings are at least monthly. Whatever the reason, the bond is formed and this patient feels cared for by this professional and confident in giving her the most important moment in her life: the birth of her baby. Doctors appreciate this dependency relationship and recognize the power they hold and may direct the treatment.

> The patient does not want to win her baby, the most important moment, with another person (doctor). So she prefers to give in to these wishes and have her delivery scheduled with her doctor. (Dr. Arnaldo)

Obstetrician is a specialty that still carries much of the image of "priesthood" of the doctor, the one who advises, monitors and is always next to the patient, hyper dedicated, as shown by the speech of a doctor to tell her choice of obstetrics and gynecology:

> Yes, because I sought that bond. I did not want to be the dermatologist you visit once in a lifetime. I enjoyed being a doctor, to me it was important this thing to be the reference of the doctor patient, you know? (Dr. Thiago)

c) The Convenience of The Cesarean Delivery

The high rates of caesarean section have caused this type of delivery became the ordinary format of childbirth in Brazil. Embedded in this practice are its convenience and predictability features that reversed the pregnant woman's values and expectations in relation to its delivery: the birth ceased to be an event led by the baby, for an act controlled by doctors and mothers. Even women who consider themselves to be less interventionist see the benefit of the convenience of cesarean section, especially in ending anxiety and discomfort at the end of pregnancy.

Doctors affirm that cesarean section is not only chosen for its convenience, but also for the predictability, considering superstitions about the best days for the baby to be born. Even more explicit is the convenience offered by cesarean section to doctors. There are recurrent quotes from women who came across doctors who only agreed to have a cesarean delivery, alleging a lack of availability to accompany normal labor. Many interviewees cited stories of acquaintances that had to change doctors in the middle of pregnancy in order to have the chance of a normal delivery, a situation experienced by one of the interviewees who describes the moment when her former doctor communicated this fact to her:

> My lifetime doctor, when I got pregnant with Luke I said:" Doctor, are we going to talk about childbirth? "; “Oh, I only perform cesarean” (...) He said “I'm far too old for this, I won't wake up in the middle of the night with you screaming. I just I schedule (a c-section) and I schedule during the day. (Laura)

Often this preference for the convenience of cesarean section is not made explicit by the professional, remaining veiled, and it is up to the patient to try to discover the doctor's practice. An example of this is the passage below of a pregnant woman who could not have a conversation about the type of delivery with her doctor:

> My doctor never asked what birth I want. It was something I think I knew about the births she had done (...) more cesarean. (Joana) .

Doctors recognize the tendency of professionals to prefer cesarean sections because of the convenience. The passage below, taken from the interview with a physician, demonstrates that the issue of the convenience of the surgical delivery is decisive:

> When you have a female patient in labor and you must be eighteen hours with her in the hospital, this will make you clear up all your agenda, right? (This need) may be interrupting an entire day of the clinic, he (the doctor) has to cancel twenty appointments, or may interrupting a family Saturday that he has a series of things to do with his children, right? (Dr. Beth)

d) C-section seen as safe

The high number of caesarean births in Brazil also increased the myths and beliefs regarding vaginal delivery. The idea of extreme pain and sequelae of lacerations in the body are still widespread in much of the population. This is shown by the speech bellow from a mother who was considered eccentric by friends for choosing to perform two vaginal deliveries.

> It's because I don't have many friends who had a “normal” birth (...) And I was always considered the crazy one who want it."Are you crazy!? It must hurt like

> hell!" I always heard that, but I was always faithful to my position. It never shook me to hear that. But 90% of my acquaintances had cesarean sections. So, it was "so what? It was "normal"? How was it?". Nobody knew what it had been like. (Isabel)

As a direct solution to this negative image of vaginal childbirth, there is the image of a safe procedure that the cesarean section possesses. Despite the authorities consider the normal delivery as the safest, this is not the image that women have, in contrast, cesarean section is seen as free from complications.

e) Socialization of Childbirth

Unlike other countries, it is common for the Brazilian families to attend to the baby delivery, and this issue of socialization of childbirth in Brazil adds to the anxiety in the end of pregnancy, to make the predictability of cesarean section even more attractive for mothers. The maternity hospitals themselves have already adapted to this tradition, transforming the delivery rooms in theaters, where the audience can follow the birth show. The passage bellow shows the spontaneity with which a pregnant woman refers to this practice:

> What was great about the maternity I had my previous children is that there was a little window (in the delivery room) that after the baby is born they open this window and my entire family was always there… so you share it with your loved ones. (Ana)

The institutional forces described above contribute to the institutional arrangement of Medicalization of Childbirth to have such strength and influence in the childbirth service ecosystem in Brazil. However, conflicting forces have been gaining ground and contributing to the growth of a contradictory institutional arrangement, the Humanized Childbirth.

Below we describe the institutional forces that contribute to this competing institutional arrangement.

f) Return to Natural Practices

It can be observed in the interviews a strong influence of professionals and women who want a more humanized delivery, focused on the most natural and less interventionist practices, which preach home birth, without unnatural medications and performed by midwives, for example. Characters from popular culture that had this type of delivery, also permeates the popular imagination and influence women.

This movement is widely propagated by the social network, with profiles of professionals such as doulas and yoga teachers totally dedicated to this. In this environment, these practices are defended not only for the benefits to babies, but also for increasing the role and the pleasure of women in the experience of childbirth. An example of this is the passage bellow in which a woman describes what her doula said about the humanized delivery:

> (The doula convinced her) that at the time of the delivery there are women who enter in this state of grace and do not feel pain. As if you were having an orgasm. There are people who talk about “partolândia” (birthland) as if it was to enter in that state of grace. (Bella)

This advocacy for humanized childbirth generates contradictory feelings in many women: on the one hand it generates a certain alienation, from the idea that humanized childbirth is very extreme, insecure and, therefore, is not suitable for them. On the other hand, it introduces different values in society besides the ones being propagated in relation to childbirth, putting in check some of the most widespread dogmas of cesarean section, such as the need for predictability and the role of the doctor.

Doctors analyze the humanized childbirth practice in a more negative way and draw attention to the number of complications that occur in these types of delivery, which, according to them, are information that women do not have access to.

g) The Goodness of Vaginal Birth

Apparently, there is a growing appreciation in society of the benefits of vaginal delivery with a widespread of its benefits among Brazilian women, as the faster woman's

recovery and the benefits for the newborn's health. The stories of normal births reported by friends and relatives have a great influence on this appreciation, as shown in the report below:

> My mother asked me what I had chosen (in terms of baby delivery) or what I was thinking and then I told her that I would try to have a “normal” birth. My mother had me through a vaginal birth and my brother through a surgery. Then she said that normal was much better, there is no recovery from surgery and so on, but I didn´t felt influenced by it because I already had a formed opinion. (Gisele)

To those women, there is a sense of the growing interest in vaginal birth among society in general, withdrawing this type of childbirth from a niche practice and placing it in the spotlight of the social debate.

> I talk, I have friends who first made a cesarean section and then a normal or vice versa, and the reports are always that normal birth is much better than a C-section, not for the sake of the baby and such, but for the experience. They say that the experience of normal birth is an amazing thing that is a hallucination. (Ester)

### h) The Profit Generated by the Humanized Childbirth

It could also be observed in some interviews with doctors, a growing distrust about physicians who perform humanized birth. According to the interviewed, these professionals are more interested in profiting from the procedure because women accept to pay higher prices to have this type of delivery. Below, the testimony of a doctor who observes this movement among colleagues:

> There are people who advocate, especially in the digital world, for the natural childbirth. There are non-medical professionals (...) Doulas, midwives, some doctors (...) this is a niche market, okay? So there is a group that their motivation is very commercial, since it has a huge market for this. (Dr. Thiago)

## 4.2 The Manifestations of the Institutional Complexity in the Service Ecosystem

The dichotomy of institutional logics identified above, distinct in their dogmas and prescriptions, generates a conflict and turbulence environment that can be described as an example of an institutional complexity setting. It can be identified various manifestations of instability in that service ecosystem, the main ones being: a) dissatisfaction with the current practice of cesarean section, b) conflicting views, c) distrust of mothers in relation to the doctor d) laws and regulations aimed at changing practices and finally, e) alternative solutions found by mothers. Below, all the manifestations are in detail.

a) Dissatisfaction with the Current Practice of Cesarean Section

Apparently, among women, there is a widespread dissatisfaction with the practices and routines established by cesarean section. Even among women who did not have a predilection for vaginal delivery, some practices such scheduling the delivery, separating the baby from the mother shortly after birth and the disrespect for the natural time of the labor, often speeding up the delivery, are examples of the routinized practices of cesarean section that are beginning to be questioned by women.

A point much criticized and repeatedly cited by interviewees, was the implemented routine *postpartum*, where mothers are separated from their babies and end up after surgery are put alone in the recovery room. This procedure, described as cold, lonely and impersonal by women, seems to be an example of the protocol and cold practice that the act of giving birth has become in the country. Moreover, this time generates frustration on women, who had the expectation that after the birth of children now would be something warm and welcoming.

> My husband left the room with him (the baby), to the nursery; the doctor stayed there sewing me. There was even a conversation ... she was talking to me, but then she started talking amenities with another doctor. I was feeling tied up for a while.

> I said: “man, why am I here alone? What am I doing here? I scream? Does anyone get me out of here?” so it was a bit of a boring situation. (Heloisa)

This feeling of dissatisfaction with the cesarean section seems to be gaining so much importance that consequences arise for those who choose it as a way of delivery or are forced to perform this procedure. In the first case of women who decide for a c-section, especially scheduled, it begins to appear a negative judgment between the acquaintances and in the case of women who ended up not achieving vaginal delivery, despite they desire to do so, they described this outcome as frustrating:

> But I had a baby who sat down and didn’t leave this position. So I had no choice but to have a cesarean, I still had to deal with this frustration of “oh, my God, there won't be a water break, there won't be any rush to the hospital, there won't be any of that”. You know? What you will have is a surgical center, scheduled delivery and such. (Nadia)

As a more immediate response to this dissatisfaction, especially regarding the procedures adopted in the cesarean section, it was noted a spread of a concept called humanized cesarean. Despite being constantly cited by interviewees, this practice seems to lack a clear definition, as shown in the following passage taken from a respondent who was frustrated by not having your desire to have a humanized cesarean attended by the doctor.

> I didn't make it clear what was humanized for me. She didn't make it clear what was humanized for her. So, for her, that delivery was humanized, as she is used to do. But there was light in the entire room, there was no focus on the belly. (Laura)

b) Conflicting Views

This institutional complexity scenario is also manifested in the various conflicting views of the actors of this service ecosystem. It is noted that the issue of delivery type is politicized: on one side those who campaign for humanized birth, on the other, those who

advocate the benefits of caesarean section, all washed down the news propagated by the mass media and both sides' campaigns, financed by several actors. All seem to have to take a stand, as shown by the testimony of that mother who was surprised by the polarization that was found and seek information to be able to position:

> In this state of total ignorance that I found myself, and that I imagine that most pregnant women do, the woman is the weakest point of this whole relationship. The childbirth debate is something extremely politicized, there are people who raise the flag of humanization, on the other hand, people who raise the flag of cesarean section and you stay there in the middle without really understanding what is what, without feeling comfortable to decide and often on the dependence of the doctor, who is the surreal power. (Nadia)

This discussion seems to have taken such a large proportion, the mode of delivery appears to be as important or even more than other issues such as the general health of mother and baby after birth, as evidenced by the following quote:

> When people visit me at the hospital, the first question was not: "Is the child okay? Is the mother okay? ", It was: "was the delivery normal or cesarean?"; people don't want to know if the mother is okay, if the baby is okay (...).(Monica)

This polarization affects the relationship between the pregnant woman and her obstetrician in the sense that he feels pressured by the patients and does not like it when their conduct is put into test. The testimony bellow from a patient corroborates this feeling of discomfort from her doctor when she asked about his conduct in childbirth:

> I realized that...when I asked about normal childbirth he didn't like being asked that (...) I don't know, but I felt that he was there: "My god, one more who will ask that" (Flavia).

In addition to being uncomfortable, doctors seem to be feeling somehow trapped, in a scenario where they are being accused by the high number of C-sections in the country and with difficulty in indicating this procedure when there is a need.

> Obstetrician today is a bit complicated because people talk about normal delivery with vehemence and vehemence is never good, because in my understanding the virtue lies in the middle. Everything is indicated. So, the cesarean section should be performed when indicated and today it is very difficult for you to indicate. (Dr. Ana Cecília)

d) Distrust of Mothers in Relation to The Doctor

The widespread perception of being the doctor responsible for the high rates of cesarean section caused the patient to distrust the doctor's predisposition to perform a vaginal delivery, even among those who claim to have a close relationship with the doctor. The feeling of pregnant women is that even agreeing with your doctor for vaginal birth, they will only be sure of the doctor's commitment at the time they are in labor. This situation is different for women in the second or third pregnancy, as they have been able, or not, to prove their doctors' commitment to their wishes.

> In the first (delivery) I already said: “what is she going to do? Will it work? Will she end up deciding for a C-Section? ", You know? I was a little scared. The first was very insecure, despite of my will and confidence that I would go until the end (of vaginal labor), I was very insecure. (Ana)

There are several mentions within the interviews about acquaintances who, according to them, would have been deceived by their doctors to have a cesarean section, even if they decided to have a vaginal delivery. There is always a mixture of impotence, indignation and insecurity in these reports, as they know they have little power of decision at the time of delivery. Below is a version about situations experienced by acquaintances:

> A month earlier (the doctor) says" it will not happen (vaginal birth); we are going to cesarean section ". This happened to two friends of mine. I can't tell you the name of the doctor, but then, one of them (friends) who really wanted and had ever chance to be (vaginal birth), changed doctors in the last month of pregnancy. (Isabel)

Doctors are aware of this distrust and feel somehow victimized by this fame, which according to them, would have the participation of the mass media in spreading the idea that the doctor is the solely responsible for these high rates, when they believe that those rates are a consequence of the culture of the Brazilian society as a whole:

> That it is a (mass media) speech against the doctor. So, you see several and several debates that always say that the rate of cesarean sections in Brazil is very high, very far from what the world health organization recommends, very far from what other countries do, but there is all of this behind (not only the doctor's willingness). (Dr. Arnaldo)

e) Laws and Regulations Aimed at Changing Practices

Another manifestation of institutional complexity is the government's efforts to regulate the birth delivery services, as for example, the creation of programs, public and private ones, that aim not only to spread the benefits of vaginal birth to health professionals and patients, but also to influence the entire system responsible for these high c-section rates, as exemplified below a passage taken from the interview with the doctor responsible for one of these programs:

> We (the program) act from four perspectives, we talk about the systemic problem; it is not sufficient just to convince the patient about the vaginal birth neither to say that it is all doctor's fault. It is not, it is the system. And what about the hospital responsibility? There is no space for the patient (in labor) to walk, the delivery rooms did not have bathrooms for you to put her in the shower. (Dr. Beth)

Parallel to these programs, laws and regulations were created, as is the case of the regulation that only allows scheduling a birth after 39 weeks of gestation. Although doctors evaluate this regulation positively, they do not believe in the efficiency of these actions in increasing the number of vaginal births, as they understand that the problem has to be handled on several fronts, with the education of the doctor and the patient as the basis of change.

The growing number of lawsuits in the area of obstetrics is also a factor of concern for doctors and many prefer to go to a practice that they consider safer and routinized like cesarean section instead of pursuing a procedure with a high degree of unpredictability. The passage below corroborates this idea:

> So it is the concern of the obstetrician not going to a law suit (...) medicine is full of law suits, obstetrician is rich in the process. I can avoid this very easily; I attend the patient if she wants a cesarean. This is also a factor that can be attributed to the several limitations that doctor place in performing a vaginal birth. (Dr. Arnaldo)

f) Alternative Solutions Found by Mothers

Among women, there is an effort to achieve the desired delivery in the face of this scenario of complexity and the difficulty in finding solutions favorable to all. According to the interviewees, the most common practice among those who want to have the guarantee of being able to try a vaginal delivery is to pay for a private delivery, outside the payment agreed by the health plans. In these situations, while she guarantees the availability of her doctor to monitor her labor, she ends up leaving the primary service system, where health plans are responsible for paying the professionals. This practice is widely accepted and desired by doctors, as we can see in the quote below:

> There are doctors who charge really high prices for (vaginal) delivery, availability. And these guys can, but they charge a lot for each appointment (...) so he can afford to have few patients in the clinic, because it pays off, and he manages to be available to these patients. (Dr. Arnaldo)

However, only a small portion of the population can afford the high costs of a private birth. For the majority of health plan clients who wish to have a normal delivery, the solution may be to have the delivery with the maternity staff on duty, instead of the obstetrician who did your prenatal care. The passage below exemplifies this position chosen by this pregnant woman:

> She (her physician) is not going to deliver my baby. She doesn't do deliveries. I'm going to go to the maternity hospital (...). She (her physician) does but she would charge. And then there was no way I could afford it (to pay separately). (Gisele)

Even home birth appears as a suppressed desire to find a solution to the complexity of the scenario. Although none of the interviews carried out this type of delivery, there were some quotes about its benefit, as the interviewee's speech below that reported her disenchantment with her hospital delivery, and according to her, with the pressure to accelerate the progress of the delivery:

> If I had the courage and the confidence that everything was going to work out, I would have my baby at home. I thought that it was out of question before and nowadays I understand why people have babies at home. Because you are more comfortable, you are in your environment, you do not feel that people (hospital staff) are looking at you "oh my God, what time will it end because I have to go. (Flavia)

As a reflection of this, it is the fact that other labor professionals are gaining prominence in this type of service, as the fact that a large medical school is offering the midwife course, as an action to meet a demand for a different procedure than what has been offered.

### 4.3 Actors' Motivations to maintain or change current practices

The situation of institutional complexity described in the previous session is fueled by the motivations of the actors in this service ecosystem to change or maintain current practices. In the interviews it was also possible to identify these four main actors' motivations: physicians, patients, hospitals and the government. Regarding the motivations to change practices, we observed that the actors who are more interested in this change are the patients and the government, followed by hospitals and doctors. In the case of motivations for maintaining practices, the situation is different: doctors seem to be the most motivated. Below, we detail the identified motivations.

### 4.3.1 Motivations to change the practice of cesarean as the preferred method

For most of the women interviewed the time of delivery is endowed with a lot of expectations and dreams. They cite the desire to complete this special stage of pregnancy in the best possible way for them, inciting their curiosity about vaginal delivery.

Women have a rich imaginary in relation to vaginal delivery, describing it as a unique bodily and emotional experience, which can only be explained by those who manage to perform it. Some women, who have had success in having this type of delivery, consider themselves almost like warriors, who have proved to themselves and to others that they are capable of overcoming pain and adversity to live this experience, as the passage below shows a patient who managed to perform her desired normal delivery:

> So it's kind of my thing, but it was worth it. I won, you know? It is an experience. (...) Because I really wanted to face this, you know? People said it would hurt a lot, in the end I would give up. (Ana)

It is noted that this idealization of the moment of delivery is stronger among women who are in their first pregnancy. Women who have already gone through their first delivery, be it normal or cesarean, apparently have a less romantic view of that moment and come as something punctual in the experience of motherhood. The following passage shows this difference in thinking in a woman in her second pregnancy:

> I think there are two different experiences, right? (...) In the first pregnancy we have a very romantic vision and several things are idealized and when we are born we see that it has nothing to do, it is a cold shower, and we fall into various contradictions. (Bella)

Another actor who has strong motivations to change the established practices is the government, as the country is constantly questioned by international health-related agencies about its high rates of cesarean sections. The government pressures the NHA (National Health Agency) to work with health plans in reducing those rates, in addition to promulgate several laws and regulations, as mentioned earlier. This motivation, although not clear to patients, is very latent in the speech of doctors, as we can see in the

speech of a doctor responsible for one of the programs linked to the government to change these practices, who cites financial issues as a reason for doctors not offering a more personalized and adequate service for each case:

> The government needs to do something because if the system is adapted for the doctor to arrive and directly perform a cesarean, it is because the health insurance companies are not paying the hospitals; they are not paying the professionals properly. If assistance is bad, they are not paying well. And the Government understood this and started a lawsuit against HNA. (Dr. Beth)

Hospitals have a great deal of power to change or maintain practices within this service ecosystem. They regulate the activities of doctors working in their facilities and require constant updating from accredited doctors, who need to meet the requirements not to be disqualified from the hospital. Note that large hospitals are adapting their structures to receive more vaginal deliveries, investing in prepared childbirth rooms to accommodate to the procedures. This movement is noticed by doctors and patients, as shown in the speech of a doctor:

> (Hospital) Einstein has it (rooms); (Hospital) Pro Matre has it. Everyone goes with the flow; nobody wants to be left behind (...). And this room has everything you need. It can be transformed into an emergency room, it has a monitor, it has a doula, it has a bathtub, (...) the patient stays as if she was in her house, and the only difference is that she is inside a hospital. (Dr. Katiane)

According to the interviewed physicians, this movement can be attributed to a financial motivation to attract more patients who seek this type of care. In addition, with a higher percentage of vaginal births, there is a higher turnover of patients, as they need to stay less time in hospital than patients who undergo a cesarean delivery.

Regarding doctors, we identified few motivations for wanting to change current practices. However, it could be noted that the bargaining power of patients is increasing, forcing them to accept requests for normal childbirth so as not to lose patients. Moreover, they claim that provide good care is important because much of their clientele comes from

indication of old patients. The following passage was taken from the interview with a doctor and show this concern with the statement:

> Success (in childbirth) is 400% happiness: 100% from the father, 100% from the mother, 100% from the healthy baby and 100% from myself as to have reached this 300%. I think that's it. Doesn't matter if it was cesarean or normal delivery. (Dr. Vanessa)

### 4.3.2 Motivations for Maintaining the Routinized Practice of C-Section

The analysis of the motivations for change practices showed that the actor with greater motivation were the patients but when analyzing the motivations to keep the routinized practice of cesarean the physicians appear as the greatest motivation, followed by hospitals.

Regarding the doctors' motivations, two main reasons stand out: the financial and the convenience of the cesarean section. On the first, the doctors say normal birth, as it is done today in Brazil with the accompaniment of the labor done exclusively by the patient's physician, demands the professional to be available for many hours, limiting his/her number of appointments throughout the day, and consequently its revenue. Following a statement from a doctor who supports this idea:

> The doctor that bills the health insurance company doesn't earn well, to perform a childbirth he earns about R$ 700 and then if he performs three cesareans in a row, he earns three times that value. (Dr. Vanessa)

Some professionals charge for a more personalized service for those patients who want a vaginal delivery. However, this amount must be paid entirely by the patient, without the participation of the health plan. The passage below, extracted from the interview of a doctor responsible for the operation of several maternity hospitals, exemplifies this practice:

> Are there colleagues who still encourage the patient to have a normal delivery? Yes, there is, but it is a minimum portion and generally charging extra for the availability. At the beginning of prenatal care, you already tell the patient. You say: “do you want a normal birth? Okay, I will charge you for availability, you can call me for the entire pregnancy when you have a problem and the day you are admitted I will be available. (Dr. Arnaldo)

The second reason, the convenience of cesarean delivery, also appears with great importance in the statements of doctors. The issue of the need of availability jeopardizes their personal lives. The restrictions posed by it make the predictability of cesarean delivery a very strong motivation to maintain this practice in Brazil. Doctors who decide to satisfy patients' wishes for vaginal birth end up having to adapt their lives:

> I used to travel when I had no childbirth coming soon, but I can´t do it anymore due to the number of patients I have today. So, I started to plan my vacation at least with 9 months in advance. (Dr. Thiago)

Concerning the hospitals, as it was previously mentioned, while they demonstrate motivations to change practices, they demonstrate motivation to maintain cesarean section practices. The reason to do so is financial, because with the decrease in cesarean sections, neonatal ICU admissions, which represents a great source of revenue for maternity hospitals, are also reduced. The following statement from a doctor responsible for a program to encourage normal childbirth shows that one of her challenges is to change this mentality of hospitals.

> (With the decrease in cesarean sections) you will decrease the admissions of babies in neonatal ICUs, babies over 2.5 kg. We reduced by 23% admission in neonatal ICUs just waiting for labor, making women go into proper labor; and we increased vaginal deliveries by 16% in a year and a half, in 35 hospitals. They (the CEOs of maternity hospitals) said: “how about my hospital revenue? Because I'm earning money from the operator in the neonatal ICU. (Dr. Beth)

## 4.4 Physicians' resources to maintain the practice of cesarean section

This session aims to identify what resources are used by doctors to maintain cesarean section as the usual practice in the Brazilian delivery service, even in the scenario of instability presented.

Through the analysis of the interviews, it was detected that emotions and cultural customs are being activated as resources by doctors. More specifically, we were able to observe six relevant resources: a) fear of childbirth; b) vulnerability of the pregnant woman; c) confidence that women place in their doctors; d) Inconvenience of Normal Childbirth; e) Lack of active participation of the Father in decisions and f) Lack of information for pregnant women. Below, we detail each of these six features in greater detail.

a) Fear of Childbirth

The issue of fear related to childbirth was a theme strongly present in the interviews with women, of all profiles, both in women of the 1st pregnancy and in women in their second and third pregnancies. It is noted that childbirth is something very unknown, endowed with myths and assumptions, but with little information about what really happens at that moment.

Fear manifests itself in two modalities: fear of something going wrong during the procedure and fear of pain. In relation to the first, it is a fear that was also noted in relation to cesarean section, however in normal delivery, this fear ends up being amplified, as the procedure is endowed with apparent unpredictability of events.

In relation to the fear of the pain of childbirth, it is very much fueled by the media and by the pregnant woman's social circles. Although childbirth itself is not a widespread topic, the issue of pain in vaginal childbirth is rather replicated and amplified in all spheres.

Among women in their first pregnancy, they have the image that it is a difficult pain to undergo, and there is a certain doubt about being able to follow the plan of vaginal delivery or ending up not being able to overcome the pain, as in the following statement:

> I had that crystalized in my head, that it was extremely painful to have a normal birth, almost unachievable. (Bella, 34 years-old, yoga teacher- August 2018)

Some women know that they need to overcome this fear of pain and end up watching childbirth videos published on the internet, to better understand this issue. In general, they understand that there is no way to have a vaginal delivery without any pain, and the clarification about the possibility of taking anesthesia has a fundamental role in making them feel confident.

Within the reports from women and doctors, there was little evidence of efforts from physicians to alleviate this fear in women, but on the contrary, it was noticed that this fear was somehow fueled by them. The passage below, taken from a doctor's testimony, demonstrates this approach:

> The patients (in labor) come screaming and it seems that we (doctors) are mistreating, we are giving her this pain. I look at her and say “daughter, have you read the bible? Didn't you see that there is no way of having children without pain? Am I giving you this pain? It's not me. So here we (doctors) want to do everything to ease your pain. Now, if you think you are in no condition… (to follow a vaginal birth) . (Dr. Katiane)

b) The Vulnerability of Pregnant Women

The issue of the of the pregnant woman vulnerability is connected to the idea that they are not in control of the situation, regarding the development of pregnancy itself and the decisions about treatments and procedures.

This susceptibility is noted both at the beginning and at the end of pregnancy. When they are in early pregnancy, there is a great fear of losing the baby, which causes them to totally change their lifestyles and follow medical recommendations. At the end of pregnancy, this vulnerability appears very much linked to the moment of delivery, the uncertainties of events. In presenting any anomaly during pregnancy, the vulnerability is even more prominent, as shown in the quote below, taken from the interview with a mother who describes the feeling of vulnerability that she experienced at a given moment in pregnancy:

> I called my husband and said that the doctor said that I need to go to the hospital for another exam. At this moment I started to cry and said: “help me! I don't know what to do!” and he said: “Go to the hospital and let's do whatever she (doctor) says!” (Joana)

When talking to doctors, it’s clear that they are aware of this vulnerability during pregnancy and the decision power they have in their hands. The excerpt below, taken from the interview with a doctor, is an example of this awareness as he describes how he convinced women to continue with their scheduled cesarean section:

> For normal delivery I cannot be sure that I will be present during your labor. On the contrary, if we are going to schedule a delivery, I can assure you that I will be there. Agreeing to schedule a C-section the patient is already safe. (Dr. Arnaldo)

c) The Confidence That Women Place in their Doctors

The confidence that women have on their obstetricians is linked to the close relationship between doctor and patient in Brazil as mentioned previously. Most of the interviewees stated that they fully trust their doctors and their decisions, even using expressions such as “he was a very human person”, “he looked me in the eye” to describe this trust.

The tools used by doctors to build this trust are closely related to the assistance provided during pregnancy, such as being available for contact on the cell phone, asking about the patient's marriage and professional life, worrying about emotional issues and solving all doubts about the pregnancy. There was less mentions about technical training or medical conduct. The following passage exemplifies this:

> It is not because she asks for all the exams that I feel safe, it is because she is careful, it seems that she is more careful (...). She asks: “How are you? And the baby clothes? (...) So it was more in this sense of caring. (Gisele)

Doctors are aware of this trust and work hard to preserve it. The passage below shows this awareness of professionals:

> Once she (patient) has confidence in the doctor, she will follow whatever you say. There are patients who says “Doctor, I don't even want to know, you decide (about treatments and procedures). (Dr. Katiane)

In the interview with a doctor responsible for a chain of maternity hospitals, he mentioned the doctor's power to make decisions related to childbirth and at the same time making this woman feel responsible for such decisions:

> It is the doctor who normally educates the patient throughout the pregnancy, about where the delivery will take place, where it is better to do it. He will make recommendations on safety for the baby and also educates about the type of delivery, which is all related to the financial part. (Dr. Arnaldo)

d) The Inconvenience of Normal Childbirth

The lack of convenience of normal delivery, compared to comfort of the cesarean delivery, is also widely cited among the interviewees, even those who are in favor of vaginal birth. This inconvenience is due both to the prolonged duration of labor and to the waiting of the last weeks that ends up feeding these mothers' anxiety. Below, the testimony of a woman who despite having spent many hours in labor she ended up having a cesarean section and, in this excerpt, she describes the relief of having recurred to a quick procedure such as a cesarean:

> “For me it was like: ten minutes and it’s done!” What a relief ... everything happened so fast. Because I had been there (in labor) for a long time. (Monica)

In the passage below, this woman describes the feeling of exhaustion and anxiety that women experience in the last weeks of pregnancy:

> (The pregnancy) is great, except for this last weeks, which, you are already super tired and you want this to end soon. (Heloisa)

e) Lack of Active Participation of the Father in Decisions

The lack of father's participation in decisions related to pregnancy and childbirth was noted since the beginning of this research. |During the phase of interviews with the women, the absence of this figure in the decision-making was made clear.

There is a difference between couples of the first pregnancy in relation to couples of second or third pregnancies. In the case of the former, there is a greater participation of fathers in doctor's appointments and exams, in the latter, this participation is more punctual. However, even in first pregnancy, the decisions related to childbirth are in the hands of mothers, as shown in the excerpt below:

> So, in fact, my husband always says that he had only 20% of the decision. Within the process he had only 20% of the decision. He left a completely open space for me to decide what I wanted to do, and he supported and accompanied me. (Nadia)

This scenario is a fertile environment for the doctor to exercise his influence, since the woman is alone with the responsibility to make important decisions.

f) Lack of Information for Pregnant Women

Pregnancy and childbirth are topics unknown to most women before becoming pregnant. During pregnancy women seem very focused on understanding what is happening to their bodies and babies during this time. Consultations with websites specialized in maternity, books and doctor's appointments are usually focused on solving those doubts.

In relation to childbirth, this misinformation is even more accentuated and, contrary to the lack of information related to pregnancy issues, these are not usually anticipated by doctors, who are rarely proactive in bringing information about childbirth. This misinformation about childbirth can be carried on until the day of delivery if the pregnant woman does not actively seek for other sources of information. This is what happened to this informant who went into labor and was unaware of the triggering of events that would follow:

> I think it was due to lack of knowledge, out of ignorance. I didn't know that first I was the contractions and then the water break. I thought that the contractions happened after the water break. I thought that if my water break the contractions would start and it would give the indication that it could be a normal delivery. (Joana)

This asymmetry of information is felt by women and some even verbalize it, as is the case of the patient below:

> The feeling I have is that the pregnant woman is very lost in the middle of the flood of information and in the relationship with these professionals (doctors). Because the knowledge gap, the vulnerability because you are physically sensitive - the body is very different - and also full of fears, the dialogue is always very hierarchical. You are dealing with a powerful figure (doctor) who will make all the decisions for you. (Nadia)

In this scenario of asymmetry of information, the doctor finds a fertile soil to make the decisions he wants in relation to childbirth. This is what a doctor responsible for a chain of maternities verbalizes when describing why doctors do not seek to resolve the doubts of pregnant women:

> So the doctor is aware of this (the pregnant woman’s lack of information), if he did prenatal care correctly, he would solve those doubts, but he doesn’t want this (correct) guidance, because he will not be able to do the labor he desires. (Dr. Arnaldo)

# 5 DISCUSSION

The present research went deep into the birth delivery ecosystem to understand how a service ecosystem can maintain its practices in a situation of institutional complexity. There were four research questions that guided the fieldwork: What are the Institutional Arrangements that influence the most this ecosystem? How does the Institutional Complexity manifest within this ecosystem? What are the focal actors and their motivation to change or to keep the practices? What are the mechanisms utilized by the focal actors to maintain their practices? Those sub questions were pivotal to build the complete scenario and thus to understand what the underlying mechanisms actors use to keep the practices. Following, we present the answer to those four sub question built through the confrontation of the data with the recent literature.

## 5.1 The expansion of the Medicalization of Childbirth influence

The existing literature had already pointed out to two main institutional arrangements that influenced the birth scenario: the medicalization of childbirth and the humanized birth (Rutherford & Gallo Cruz, 2008) and both could be observed by this present research, although focusing only on the private childbirth services.

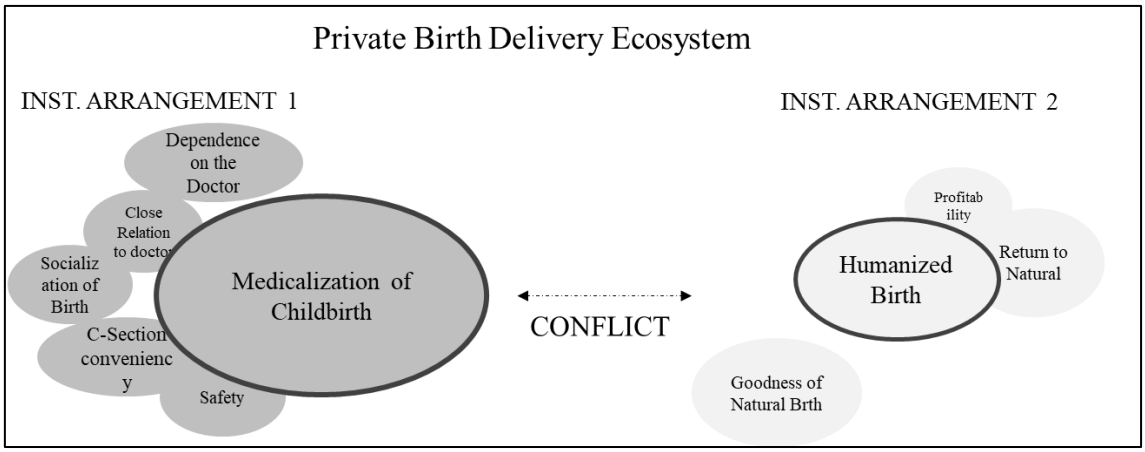
Vargo and Lusch (2016) affirmed that the more nested and overlapping the institutions that form an institutional arrangement are, the more convergent in meaning and intention they are and, consequently, more power such institutional arrangement possess to influence the service ecosystem.

The results of this present research show empirically that the institutions forming the medicalization of birth arrangement possess a much higher degree of convergence and communality in its beliefs and purposes. We could identify five interdependent institutions that strongly converge: dependence on the doctor, close relation to the doctor, socialization of childbirth, C-section convenience and perceived safety of C-section. They converge in meaning, intentions and prescription, and together reinforce the medicalization of childbirth.

In the other hand, we observed that the conflicting institutional arrangement - the humanized birth - counts with three converging institutions: the goodness of natural birth,

the return to natural practices and the profitability of humanized birth. In addition to being outnumbered, they are less convergent in intention: for instance, although the institution goodness of natural birth relates with the humanized birth, it diverges to this institutional arrangement in some degree, especially in relation to the practices of humanized birth, as no pain medication and delivery performed by doulas, considered somehow extremes. Figure 3 is a representation of the nested scenario of the medicalization of birth and the somehow more loose convergence of the humanized birth.

Figure 3 - Influence of medicalization of childbirth within the service ecosystem




Source: the author

The influence of the medicalization of childbirth is so strong that this interventionist routine stopped being only at the moment of birth to permeate the entire pregnancy, with the excess of exams, doctor´s appointments and interventions. Such procedures became accepted by the patients, hospitals and including health insurance companies that present almost no difficulty in accepting to pay for all of it. This interventionist routine increases the mother´s dependency in relation to the doctor and the influence of the doctors over the patients since they lead this process.

As already pointed out, the prevailing literature talks about the Medicalization of Childbirth as a process by which the childbirth has gone from being a natural event to a pathology-like state that needed to be managed by doctors (Rutherford & Gallo Cruz, 2008; Thompson, 2005). The data of this research points to the expansion of the influence of the Institutional Arrangement that prevails within the Brazilian childbirth service

ecosystem, going from the Medicalization to Childbirth to the Medicalization of Pregnancy and Birth.

Although minor in its level of influence, the humanized birth arrangement was able to promote some changes within the ecosystem, especially in promoting practices more aligned with the natural birth. One of the main changes is regarding the infrastructure of hospitals which is becoming more vaginal birth friendly. Scholars had already pointed out that institutional complexity interrupts the automatic compliance with prevailing norms and evokes reflection and agency (Thornton, Ocasio & Lounsbury, 2012) but in this specific context, those changes were not enough to change deeply the established practices. One of the reasons may be the negative image of some routines and procedures that humanized birth has within the Brazilian society, as the practice of homebirth and about the myths that it carries, as births being performed at a waterfall, all stimulated by the doctor´s discourse.

## 5.2 Institutional Complexity Prevents New Path to Emerge

One of the biggest manifestations of institutional complexity has been the dissatisfaction with the routinized practice of cesarean section by the patients. Bureaucratic is a concept that describes well the feelings towards this procedure: indifferent, formal and dehumanizing. Thompson (2005) had already pointed out to such that dissatisfaction with the technological care expressed by a community in favor of natural birth but my results indicates a wider of scope of such dissatisfaction, with manifestations outside this community, encompassing even women that elected the c-section as a preferred method.

At the same time, the practice of humanized birth has been criticized by professionals and patients due to the lack of a safe infrastructure to support it. There were several mentions, by patients and physicians, regarding how improvised such childbirths are.

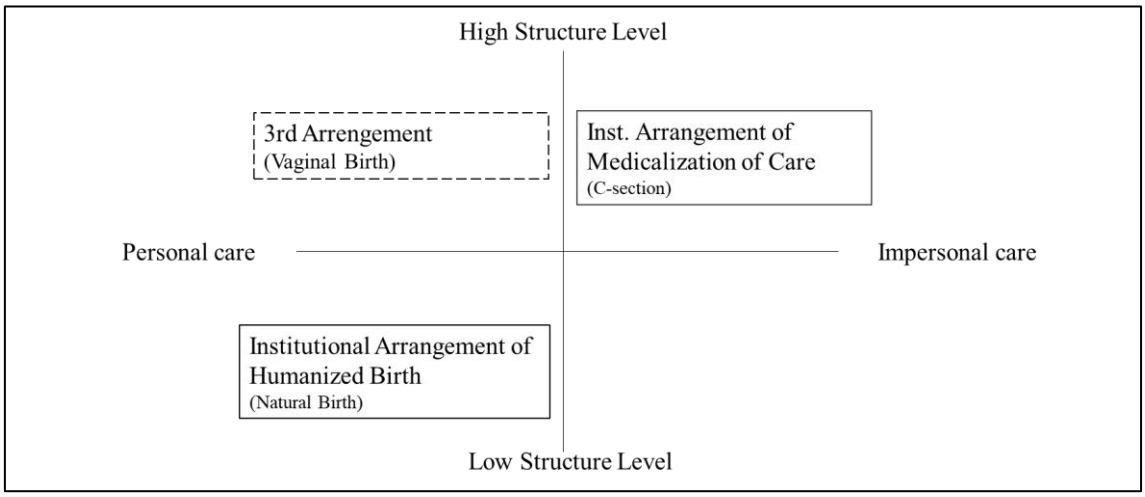
The issue of c-section versus natural birth has become polarized: the supporter of one practice defends it so vociferously, together with its dogmas and procedures, and at the same time, completely avoids the practices of the opposite arrangement.

This harsh criticism is a representation of the polarization of both institutional arrangement, Medicalization of Care and Humanized Birth, as already mentioned by the previous literature (Thompson, 2005; Rutherford & Gallo-Cruz, 2008). Both arrangements - and their practices, operate under different prescriptions in terms of structure and personalized care. Structure relates to the level of infrastructure that are available to the procedure, and it is highly related to the hospital's facilities. Personalized care is regarding the quality of the care provided by the birth professionals, being highly subjective and dependent on how women perceive their service as humane and warm. While the Medicalization of Childbirth operates in a logic of support from a high-level infrastructure, the Humanized Birth in Brazil turns to facilities with improvised infrastructure, such as Delivery Centers or even households. The same distance occurs when analyzing the level of personalized care: while the Medicalization of Childbirth operates in a logic of cold and impersonal care, the Humanized Care promotes highly personalized care to the women.

This conflicting situation avoids the emergence of a third arrangement where the women could benefit from a top-level infrastructure and the same time, have highly gentle care with full respect to their willingness which, ultimately, we can infer that it would facilitate the vaginal birth. Siltaloppi, Koskela-Houtari and Vargo (2016) had already cited that conflicting views derived from different institutional arrangements could prevent collaboration and this present research observes it empirically. The results of my research advances this understanding by pointing out that the scenario of institutional complexity, and its manifestations, impact directly the co-creation of value from the women´s perspective. The co-creation of value is compromised, since it constrains the development of a service experience that she desires.

Figure 4 is portraits the new path that could be a solution to the customer dissatisfaction with the marketplace, but which is prevented by the Institutional Complexity.

Figure 4 - The avoidance of a 3rd Institutional Arrangement




Source: the author

The women, who want to have careful childbirth at the same time enjoying the benefits of the hospital facilities, have to find other solutions, many times paying separately for a doctor who is willing to give her the birth delivery that she wants. In those situations, she engages in a separate service ecosystem, a spin-off from the main ecosystem, in which different actors take part, and different resources are exchanged. In this sense, the practices of the main service ecosystem are maintained since a new ecosystem is formed to attend the desires of those women.

## 5.3 The Doctor´s Status and the Service Ecosystem Inertia

In the previous item, we saw that the manifestations of the institutional complexity avoid the development of a solution for the service ecosystem. Now, we will discuss how the motivations of a focal actor can prevent this change.

The literature had already advanced its understanding that networks are not stable instead, they are suffering continuous pressure to change, adapt and even disrupt (Vargo & Lusch, 2011). The main purpose of the network is the maintenance of such network, and it does not serve a collective intent. Actors that participate in such network have individual intentions that may be aligned with other actors' purpose and may influence the change (Vargo & Lusch, 2017).

In the specific case of this research, it was evident the motivations of the women to change the practices within this ecosystem of service. They desire a warmer and personalized childbirth that respects the timing of her baby and hers. At the same time, the motivations of the doctors to keep practices as it is was also noted, because c-sections are more profitable and convenient to accommodate their clinic appointments and personal life. How the motivations of one actor prevail over the motivation of others is a topic that has been discussed by scholars that applied the social construction theories to the principles of the service for service exchange. Edvardsson, Tronvoll and Druber (2011) state that every service exchange network is embedded in a social structure, with already determined social roles and positions, and the roles of the actors may change according to the circumstances. For instance, within the present context, patient and doctors are both active actors of the service network, but their positions are not interchangeable and the actor with professional position may influence the meaning and value of the whole ecosystem of service. The present data shows that the position of the doctor, as the holder of the technical training and title, gives him the power to exercise domination over other actors, specifically the women, and over the ecosystem itself. In addition to that, physicians are main point of contact that patients have within this service ecosystem, with great influencing power over the costumer and the other actors, like hospitals and health insurance companies that have more of a background participation in the service provision.

## 5.4 Physicians create new resources to be activated within the ecosystem

The existing literature on institutional complexity focuses on studying circumstances when the service ecosystem changes its practices when facing such instabilities. One of the main tenets of this stream of work states that actors within the service ecosystem can use the orientation of the various institutional arrangements that influence this ecosystem to attribute "resourceness" to things that at first would not be resources (Koskela-Huotari &Vargo, 2016). In this line of thoughts, the institutional complexity provides the scenario and the different institutional arrangements provide the frames of reference. However, the actors possess the ability and creativity to transform something in a resource, possible to be activated in the service exchange and, ultimately, lead to market reformulation.

Although this present research is about a scenario of institutional complexity when practices do not change, a similar movement has been observed. Physicians attribute "resourceness" to things, like feelings and cultural behaviors, making those new resources activated in the service exchange, to achieve their goals of keeping practices consolidated. Those feelings and cultural behaviors could only be transformed in resources due to frames provided by both institutional arrangements influencing this specific service ecosystem: the Medicalization of Birth and the Humanized Childbirth.

The logic of Humanized Childbirth, identified in the literature and corroborated by empirical data, propagates a natural delivery, without interventions neither to give comfort to the mother. We could see that this ends up aggravating the image of suffering of normal childbirth with women. In this scenario, physicians use this image to make women's latent feelings towards the birth delivery, to transform it in resources to be activated by them in continuing with the practice of cesarean section.

Birth is still surrounded by myths, and women lack real information about what happens at this moment. At the same time, the pain of childbirth is something very disseminated in the social circle and cultural productions. In this scenario, the physicians who possess the technical training and the expertise do little to soften their fears. Doctors activate the fear of birth and the fear of the pain as resources, to avoid the development of the service in ways not desired by them.

In the same manner, the Medicalization of Childbirth allows doctors to frame feelings and cultural habits as new resources to be activated in the service ecosystem. The vulnerability of the pregnant is a feeling activated as resources by doctors: women feel susceptible, uncertain, and aware of their lack of control about how the childbirth will develop itself. At this moment, when doctors promote a c-section as the right and safe procedure in their situation, they find almost no resistance.

In the same manner, as it was mentioned in the previous section, the routinized practice of c-section has shaped the idea of childbirth in Brazil and introduced matters of convenience and predictability in baby delivery within the society. Through this frame of reference, the natural labor seems inconvenient mainly due to its lack of predictability about when the labor will start and the usual high duration of it.

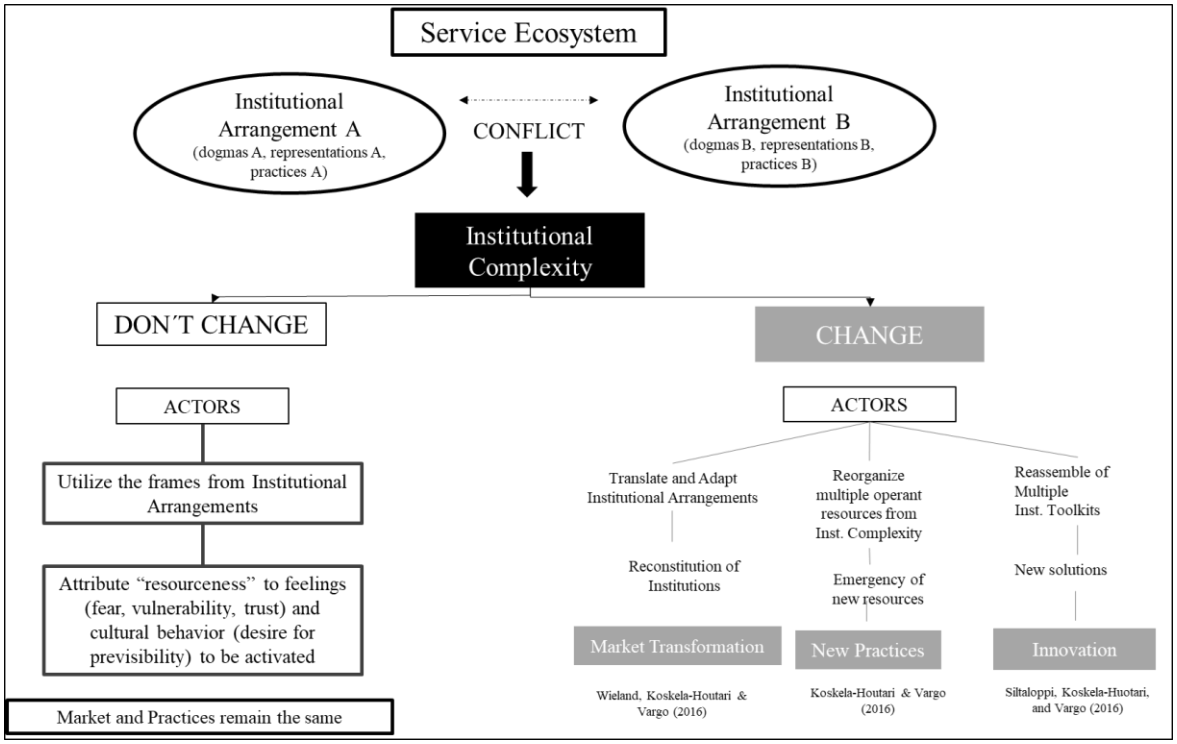
The inconvenience of natural labor is a resource that has been activated by doctors in different stages of the service. Since the beginning of the pregnancy, women are

stimulated to pre-book a c-section to a convenient time for both, patient and doctor. At the end of their pregnancy, they are also stimulated to go to surgery to end up the discomfort related to the last weeks and calm their and their family's anxieties. And women, who are already in labor, at the hospitals, are pressured to rush the labor and go a c-section due to time and space constraints.

Lastly, an important resource utilized by the doctors is the feeling of trust that pregnant women deposit on their doctors. The nature of the treatment, intimate and life-changing in its outcome, makes women search for a professional that she relies on to be her guide in this path. Added to this, the expansion of the Medicalization of Birth to the moment of pregnancy, described previously in this chapter, makes women increasingly dependent on those professionals who act as technical experts, counselors, advisors, and even couple therapists. This scenario makes it possible for the doctors to frame this trust as a resource to be activated within the service exchange. During their nine months interaction, instead of solving women´s doubts about vaginal birth, lightning their fears, and denying the myths that surround it, the physicians use this time period to build the pregnant woman's trust in their service. Doctors activate this truth as a resource. In the moment of childbirth, women will rely on the doctor's recommendations.

This research empirically shows that actors utilize the frames of the different institutional arrangements to attribute "resourceness" to potential resources also in cases where the intention is to keep the market stable, with no significant changes. **Figure 5** portraits the contribution of this research to the field of institutional complexity.

Figure 5 - Research contribution to the institutional complexity literature




Source: the author

# 6 CONCLUSION

The study of S-D Logic and its specificities still stimulate a great number of scholars around the world. The influence of institutions over the process and outcomes of the service exchange is a stream of research that has grown in the last decade.

Although many advances have been made, the observation of the consequences for the market in situations where conflicting institutional arrangements act upon the service ecosystem causing instability is still somehow focused on situations where the market experience a change, in the form of new practices, innovation or even market reformulation. Scholars have studied how the emergence of new resources within the service ecosystem changes the practices within it (Koskela- Houtari & Vargo, 2016), how actors translate and adapt the conflicting institutional arrangements to cause a market a transformation (Wieland, Koskela-Houtari & Vargo, 2016) and how the actors reassemble de multiple toolkits from different institutional arrangements breaking Innovation within the service ecosystem (Siltaloppi, Koskela-Huotari, and Vargo, 2016).

However, scholars have not paid the same attention in analyzing markets that face institutional complexity and the practices and the market itself remain unchanged. This present research placed a light on this topic, analyzing a characteristic case of institutional complexity, the birth delivery scene in Brazil.

Through this research it as possible to conclude that although Brazilian birth scene faces a scenario of conflicting institutional arrangements - Medicalization of Birth and Humanized Birth -, the influence of the former is much bigger, encompassing not only the moment of birth but the stage of pregnancy as well, dictating practices and procedures. It was possible also to observe how the status of a focal actor within the service ecosystem, can ensure that their motivations prevail over other actor´s motivations to keep the market stable.

It was also observed how the conflicting situation between the two institutional arrangement prevent cooperation and impact directly the value co-creation for the customer, who cannot count with a stream of service that would better meet her necessities and desires.

But perhaps the greater contribution of this research lies on the clarification of the process conducted by a focal actor whom a market transformation does not meet his plans: the attribution of "resourceness" to potential resources, made possible through the frames of references of the multiple institutional arrangements, the same arrangements that destabilized the service ecosystem.

Until now, the mechanism of "resourceness" had only been attributed in cases where the market transformation occurred. The present research contributes to the further understanding of a neglected stream of work: markets that even experiencing institutional complexity did not experience significant changes in its practices neither in the market itself.

In the matter of contribution to the practice, the study of the Brazilian birth delivery context may shed a light on the mechanisms utilized by the doctors to avoid the growth of the influence of the movements' pro vaginal birth that has been happening within the country. The acknowledgment of such mechanisms may be useful to break the influence of the doctors.

Besides, it is clear that other important actors should engage more fiercely in this battle, as is the case of the hospitals, which still show shy motivations and actions to do so. Hospitals are important actors of this ecosystem, which possess a great amount of resources, tangible and intangible, that could influence the behavior of physicians. Another keynote actor is the Health Insurance companies who are responsible for the physician´s payment. It is mandatory to adjust the values paid for doctors performing birth deliveries, especially the vaginal birth. Finally, the government should play more actively to create good conditions for this practice to develop.

## 6.1 Limitations of the Research

This research took place among private health insurance customers in the city of São Paulo, a city that possesses different economic and cultural characteristics from the rest of Brazil.

Another limitation was the impossibility to achieving the cooperation of members of the government and high-level hospital employees. Their point of view is somehow

captured by the interview with other informants, but to have their direct deposition would enhance the scope of the findings. In the same manner, other possible actors of the ecosystem, such as the child father, other women relatives, and nurses, were excluded due to time constrain.

## 6.2 Directions for Future Research

As mentioned, this stream of research is still in its beginning, and it presents many opportunities for future research.

One main opportunity is the exploration of other possible mechanisms utilized by actors to keep the market and its practices stable. In this research, we acknowledged the mechanism of "resourceness" but it is possible to infer that many others are being utilized within markets.

This research presented a very characteristic context of institutional complexity where the institutional arrangements were such controversies that it prevented collaboration. As mentioned, this lack of collaboration jeopardized the value co-creation outcome for customers. A stream of work for future research would be to understand how can markets facing institutional complexity change from a logic of conflict to a logic of collaboration and ultimately lead to purposeful value co-creation activities.

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# APPENDIX

## APÊNDICE A – GUIA DE ENTREVISTA MULHERES

## TÓPICOS A SEREM COBERTOS

- A experiência da gravidez (sentimentos, desejos, medos, dúvidas);
- Descrição sobre o parto (momento que surge, pessoas que participam, percepção sobre a legitimidade de cada uma dessas pessoas, instituições que vêm à tona);
- Sentimentos que trazem o parto (medos, desejos, etc)

1) Por favor, conte sobre a SUA experiência geral da gravidez, desde quando decidiu ser mãe até agora.
   (Ficar atenta a relatos de **desejos** que surgiam, **medos** e **dúvidas** que apareceram no processo_ pedir relato mais **específico de como surgiu**, em qual **momento**, se **alguém** mais participou. Entender os **sentimentos** que surgiram através de descrição detalhada)
   a. Você tinha ideia de como seria esse momento? Vc imaginava esse momento? Por favor, descreva o que você imaginava.

2) Por favor, descreva como foi o **acompanhamento médico** durante a gestação (descrição das visitas ao médico: diálogos, dúvidas, comentários, ensinamentos (dados apresentados, informações sobre gestação e parto) , recursos demonstrados pelos médicos, preocupação com as ansiedades da mulher, as expectativas, o estado emocional)
   a. Você se sentiu ouvida? Você acha que ele te envolvia nas decisões?

3) Você procurou mais algum profissional durante a gestação para te ajudar nesse momento (doulas, enfermeiras, professoras de ioga, fisioterapeuta) ? se Sim, me descreva como foi a experiência, desde o momento que surgiu a ideia até os últimos encontros (o que elas aportaram? O que elas contaram que você não sabia? Qual a diferença entre o acompanhamento médico e o delas?

4) **(Se não surgir no relato da gestação):** Me fale por favor a respeito do parto: no caso de <u>ainda estar grávida</u> me conte o que você já pensou/viveu a respeito dele? No caso de <u>já ter tipo o bebê</u> me conte como foi a experiência desde quando você começou a pensar/ conversar a respeito dele.
   (Pedir descrição do **momento** que esse tema surgiu, **quem** trouxe o assunto, quem **participou** da conversa; explorar os **sentimentos** que possam estar envolvidos _ **medo**, **ansiedade** através de descrição dos momentos e situações que foram experienciados)
   a. O medo da dor estava presente? Se sim, desde quando? Como você trabalhava isso? Quem te ajudava?

5) (Caso já tenha tipo o bebê**): E como foi o seu parto?**

(Pedir uma descrição detalhada de como aconteceu, quem participou, como os eventos se desencadearam. Ficar atenta aos sentimentos que surgiram e pedir descrição detalhada)

a. Você se sentiu acolhida? Como seus desejos respeitados?
b. Você mudaria alguma coisa dessa história?

6) De maneira geral, como você se sentiu tratada em todos os encontros que você teve durante sua gestação e parto? Se sentiu ouvida? Acolhida? Sua opinião contou? Por favor, dê exemplos.

## APÊNDICE B – GUIA DE ENTREVISTAS COM OS MÉDICOS

1) **Apresentação do profissional**: nome, idade, escola de formação, tempo de trabalho, tipo e local de atendimento (consultório particular, consultório hospitalar, plantão hospital particular, plantão hospital público etc).

2) Principais fontes de informação do médico sobre as práticas atuais (Congressos? Artigos? CRM? Colegas? Como as informações circulam?)

3) Informações gestantes-

   a. Na visão de médico como as **mulheres escolhem um GO**. O que elas levam em conta (perguntas mais frequentes nas primeiras consultas, fatores de decisão, importância da recomendação?

   b. Principais **dúvidas da gestante**/ quais são essas dúvidas? mudam de acordo com a quão avançada está a gestação?

   c. Como o **médico se prepara para responder**? Qual o grau de detalhe dado a ela (info técnica, artigos científicos?)

   d. **Fonte e Informação da Gestante-** quais são essas fontes? Como elas chegam em matéria de informação?

   e. **Profissionais** que elas buscam- fisio? Doula? Enfermeira obstetrícia?

4) Como são **decididos os detalhes do parto** (Tipo? Semana? Procedimentos utilizados? Profissionais que auxiliarão).

   a. **Recursos do médico**- O que é importante deixar claro para a paciente? tipo de informação? Experiencia previa? Estudos?

   b. **Recursos da paciente**- o que é importante que a paciente traga para a conversa a) **capacidade física** (ex- faz exercício/ alta resistência pra dor? bem estar geral na gravidez) b) **recursos culturais** (ex -medos? Expectativas? Estilo de vida? Pesquisas que tenham feito?) c) **recursos sociais** (ex- Experiencias previas? histórias que tenham escutado)

   c. **Objetivo da Paciente**- o que ela busca no final? (realização de um sonho/ atendimento personalizado/)

   d. **Plano de Parto**- o que é ? É um recurso utilizado?

   e. Em uma palavra **qual o papel de cada um nessa decisão** (médico/ paciente)

5) Características de um **atendimento de sucesso**? E de um **atendimento não tão bom**?

**6) Partos no Brasil**

a. Qual sua leitura sobre os partos no Brasil

b. Como você vê o movimento do **Parto Humanizado**? Cesária Humanizada

c. Mudanças na **estrutura de atendimento** (hospitais com salas de parto/ partos com médicos plantonistas/ Movimento do Parto Adequado)