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Opportunities for nurse midwives to bring change to the hegemonic model of obstetrics

Possibilidades para a mudança do modelo obstétrico hegemônico pelas enfermeiras obstétricas

Posibilidades para el cambio del modelo obstétrico hegemónico por las enfermeras obstétricas

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ABSTRACT
Objective: to describe the use of care technologies by residency-qualified nurse midwives and their relationship with professional praxis. **Method**: in this qualitative study with 13 nurse midwives at two public maternity hospitals in Rio de Janeiro, Brazil, data were collected by individual, semi-structured interview and hermeneutic-dialectic analysis. **Results**: the transition from the interventionist model builds on humanized care by incorporating a model centered on nurse midwives' use of best practices and noninvasive care technologies. Their praxis contributes to qualitative change in this scenario by reinstating physiology, fostering stronger bonding, and empowering women, so as to re-signify the moment of childbirth. **Conclusion**: nurse midwives' praxis and use of noninvasive technologies constitute opportunities to break with the culturally established model hegemonic in Brazil, while a consensus still needs to be built to surmount common sense.
Descriptors: Women's Health; Nurse Midwives; Natural Childbirth; Hermeneutics.

RESUMO
Objetivo: descrever o uso das tecnologias de cuidado da enfermeira obstétrica qualificada na modalidade de residência e sua relação com a práxis profissional. **Método**: estudo qualitativo com 13 enfermeiras obstétricas atuantes em duas maternidades públicas do Rio de Janeiro, Brasil. Dados coletados por entrevista individual, semiestruturada e análise hermenêutica-dialética. **Resultados**: a transição do modelo intervencionista estrutura-se no cuidado humanizado com a incorporação de um modelo centrado nas boas práticas e nas tecnologias não invasivas de cuidado da enfermeira obstétrica. A práxis da enfermeira obstétrica contribui para a transformação qualitativa deste cenário, com resgate sobre a fisiologia, o fortalecimento de vínculo e empoderamento da mulher, ressignificando o momento do parto. **Conclusão**: a prática da enfermeira e o uso das tecnologias não invasivas constituem possibilidades para ruptura do modelo hegemônico culturalmente instituído no Brasil, sendo necessária ainda a constituição de um consenso que supere o senso comum.
Descritores: Saúde da Mulher; Enfermeiras Obstétricas; Parto Normal; Hermenêutica.

RESUMEN
Objetivo: describir el uso de tecnologías asistenciales por parte de enfermeras parteras tituladas en residencia y su relación con la praxis profesional. **Método:** en este estudio cualitativo con 13 enfermeras parteras de dos maternidades públicas de Río de Janeiro, Brasil, los datos fueron recolectados mediante entrevista individual, semiestructurada y análisis hermenéutico-dialéctico. **Resultados:** la transición del modelo intervencionista se basa en la atención humanizada al incorporar un modelo centrado en el uso de las mejores prácticas y tecnologías de atención no invasiva por parte de las enfermeras parteras. Su praxis contribuye al cambio cualitativo en este escenario al reinstaurar la fisiología, fomentar vínculos más fuertes y empoderar a las mujeres, para resignificar el momento del parto. **Conclusión:** la praxis de las enfermeras parteras y el uso de tecnologías no invasivas constituyen oportunidades para romper con el modelo hegemónico culturalmente establecido en Brasil, mientras que aún debe construirse un consenso para superar el sentido común.
Descriptores: Salud de la Mujer; Enfermeras Obstetrices; Parto Normal; Hermenéutica.

INTRODUCTION

There is a fragmentation of care in the reality of health services, where medicalization and the institutionalization of childbirth have made the woman's body the object of interventions, breaking away from care centered on the domestic environment in which affective, cohesive, secure and trust relationships were maintained[1,2].

It is observed that the hegemonic care culture and the influential power of the medical corporation reduce the possibilities of expanding a care modality which modifies this decision-making pattern in the hospital-centric scenario. This culture stems from a technocratic society which is organized based on an ideology of technological progress, associated with the concepts or values of this population[3].

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This paradigm influences the care provided for labor and childbirth today and is based on the obstetric care model, favoring the indiscriminate use of technologies, as well as inappropriate and invasive interventions on women's bodies. The practice of routine cesarean section is a violation of the parturient's rights, reflecting in maintaining a high maternal mortality rate[3]. The excess of obstetric interventions in hospital care failed to consider the emotional, cultural and human aspects involved in this process, which has a particular character and goes beyond the delivery and birthing processes[4]. A medicalized predominance of childbirth persists which prevents comprehensive humanized care[5], despite the argument about humanization in public programs and policies.

There was a need to structure the healthcare system in order to mitigate the number of cesareans and improve obstetric care in the Unified Healthcare System (*SUS*). This care must encompass the political guidelines in a healthcare network aiming to ensure humanized care for women, respect for the physiology of childbirth, early detection of pregnancy complications and reception in maternity hospitals. Care provision at Normal Delivery Centers by multiprofessional teams with insertion and appreciation of the performance of the obstetric nurse must be based on scientific evidence.

The political and educational institutions associated with the performance of nurses with their humanized praxis contributed to changing the current childbirth care model called technocratic, prioritizing care intervention, an abusive use of invasive technology, passivity of women during labor, altering their natural rhythm, preventing women from exercising their role in childbirth and adopting practices without scientific evidence.

In order to overcome this hegemonic care culture and establish a new culture guided by a humanized paradigm of normal childbirth, we seek to encourage training and improvement of obstetric nurses so that they can be active in changing the obstetric model.

It is questioned with what purpose obstetric nurses use care technologies as an intervention in labor and childbirth. Considering the culturally established hegemony relations in childbirth healthcare, an objective of describing the use of care technologies by qualified obstetric nurses in the residence modality and its relationship with professional praxis was outlined.

METHOD

This is a descriptive, exploratory and qualitative study[6] guided by the Consolidated criteria for reporting qualitative research (COREQ)[7]. A total of 13 obstetric nurses graduated from obstetric residency programs working in public maternity hospitals in the city of Rio de Janeiro, Brazil, participated.

Qualitative research deals with the subjective and relational level of social reality and deals with the history, the universe, meanings, motives, beliefs, values and attitudes of social actors. It seeks to faithfully understand and interpret the internal logic of the participants and offers knowledge of its 'truth'. Differences in interpretations often reflect a multifaceted understanding of complex social phenomena[6].

The choice of participants is justified by the need to analyze the performance of these professionals trained in these programs, which was instituted in 2012 as a strategy of the Ministry of Health to encourage training of obstetric nurses in the National Obstetric Nursing Residency Program (*Programa Nacional de Residência em Enfermagem Obstétrica - PRONAENF*). It aims to train specialists in the residency directed to the healthcare of women guided by the health policies in force in *SUS*. The choice of scenarios occurred due to the insertion and professional performance of nurses in providing care in normal risk childbirth and the fact that this constitutes a practical training field for residency courses.

The universe of eligible professionals considered that one of the maternity hospitals had 20 professionals distributed in the reception and delivery room sectors, of which nine were graduates from the residency course. In the other hospital, ten professionals worked in the delivery room and had a direct link with the institution; of these, four were graduates of the residency course. There were 13 research participants. The inclusion criteria were obstetric nurses who graduated from the residency course and were trained after the creation and encouragement of *PRONAENF*, who worked as statutory servants or workers in the field. Nurses who worked as head of the unit and/or were absent due to leave or vacation were excluded.

Semi-structured interviews were used in the course of the investigation, containing open and closed questions referring to the characterization of the socio-professional profile, care practice and the use of technologies in childbirth care. The interviews took place from October 2016 to March 2017, with an average duration of 45 minutes at an available time of the participants and were conducted in a single session after an invitation to the nurses by the researcher. The interview response statements were recorded on mp4 files, stored and later transcribed in full to start the analysis process of the results.

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The material production took place through hermeneutic-dialectic analysis which performs a synthesis of comprehensive and critical processes in qualitative research and analyzes the communication of everyday life and common sense. Hermeneutics deals with the art of understanding texts, seeking understanding and interpretation; while the dialectical method introduces the principle of conflict and contradiction as constitutive of reality and essential for analytical understanding[6].

The methodological analysis flowchart consisted of organizing the data, establishing identification of the empirical material and classifying the data, detecting the central ideas and reading each communication corpus[6]. Next, the different groups were compared and the data were constructed from the theoretical praxis assumptions.

The research protocol was approved by the School Ethics Committees of the institutions involved, under Certificates (CAAE) No. 54184116.0.0000.5238 and 54184116.0.3001.5279 and opinions No. 1,472,357 and 1,506,514, 2016. Participants received alphanumeric coding (N1, N2 ... N13) to preserve secrecy, anonymity, and reliability, and guaranteed voluntary participation by signing the Informed Consent Form.

RESULTS AND DISCUSSION

The participants presented a profile consistent with the period of greatest professional productivity. All were women aged between 26 and 36 and the majority were married. They reported insertion into the job market right after the end of their residency, working in providing care to normal childbirth. There was investment in their training in conducting training courses, training in labor and childbirth, breastfeeding, specialization in neonatology, neonatal resuscitation and obstetrics. In the results it was highlighted that the professionals participate in a qualification once a year, which represents a search for updated knowledge in the obstetric area.

When analyzing the testimony of the obstetric nurses, a consonance of their reports in the sense of contributing to reducing interventions to the parturient was observed. All interviewees cited the main non-invasive care technologies used such as the exercise ball, a warm bath, pelvic balance/birthing chair, aromatherapy, music therapy, penumbra, massage, ambulation, acupressure, tug technique, stool and the use of a bathtub. This practice consolidates its professional praxis and establishes possibilities of change in the obstetric scenario, even though disputes in this field are envisioned. Despite these conflicts, nurses use the available resources in the institutions, some take advantage of the care technologies, those most accessible for care or the knowledge they have, according to the following expressions.

> *Despite the difficulties, we used the ball, birthing chair, aromatherapy, massage, water and acupressure. Hearing and listening is also a technology because sometimes women just want to express themselves. There is no rebozo/shawl here, but I bring it or sometimes I try to use a sheet. (E11)*
>
> *When we did, we used the ball, the bath, walking, birthing chair, salts in the heated water and the bathtub. There are professionals who bring the portable radio and we use music therapy. (E13)*
>
> *As soon as we enter the shower stall we offer a bath, because they already know from the visit by health network and ask. In the puerperium they report that the bath helped. (E2)*

Active listening represents a moment of sharing and making your demands accessible to the parturient; it is also an opportunity for a technology in the delivery care by nurses[8]. This commitment to be available to the other in delivery makes the care a particular experience as a source of expansion, making it possible to change the obstetric care model. The technological concept of obstetric nursing care as relational is built from the reception of the parturient woman, establishing a bond during the visit to the maternity hospital until the moment of providing the use of technologies during labor.

However, nurses' praxis is not limited to the less interventionist care model; it is guided by humanization, in its care competence to choose the best indication for the parturient woman, distancing itself from the biomedical model based on the recommendations of the World Health Organization. Nurses who are aware and secure with the recommended and encouraged practices choose their sphere activity in order to actively contribute to the quality of care for normal childbirth.

Therefore, nursing practice cannot be pragmatically analyzed as a mere objectification of recommended programmatic actions, but as a consciously oriented activity composed of an inseparable theoretical-practical totality constituted by a theoretical ideal side and a properly practical material side[9]. Therefore, they cannot be isolated from each other, which refers to an analysis of the praxis of these professionals; because it is not in an operationalized way, but it understands the attribution of welcoming and implementing the subjective and relational care dimension for women in all care spaces during childbirth. Nurses also described the contribution of practices and technologies used in normal childbirth to political strategies for childbirth care:

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> *Technologies contribute to avoid unnecessary interventionist practices and help humanize childbirth, making it more natural. We have to intervene when we need it and let it flow naturally when we don't. To institute these technologies is to minimize the rate of episiotomy and cesarean sections, improving the quality of delivery. (E1)*
>
> *Our practice contributes to help women. The technologies are for pain relief and discomfort in labor. So, the decrease in cesarean sections and negative outcomes is a consequence of working with our techniques and changes in the obstetric scenario. (E2)*

Public healthcare policies for the female population and professional education institutions point to the urgent need for an effective approach and to (re)define the training of human resources for health. In following the logic of the proposal for healthcare organization in Brazil, the movement towards changing the hegemonic model of biomedical and interventionist care to the model with a lower degree of intervention in childbirth and respect for its physiology was observed in the obstetric care.

This movement is strongly noted in the training of obstetric nurses who, since graduation, are guided by the National Curricular Guidelines and the *SUS* Principles, contributing to them being humanistic, critical and reflective professionals[10]. In this perspective, nurses reported that public health policies have encouraged the change in the obstetric care model and described the role they have in this transformation movement.

> *I was trained in the proposal to change the hegemonic power, to leave the center and work the extremities, to understand that the woman and her family are more important. (E4)*
>
> *Obstetric nursing is in the humanized model that has been discussed for a long time. At the residence, we always had a look ahead, to make sure that the care model was really focused on women, family, needs and co-participation in the birth process. We walk for change and fight to make our space better. (E13)*

In view of the analysis of nurses' praxis, training professionals who have critical thinking about the break in the hegemonic model constitutes a great challenge, as it is associated with coping and overcoming paradigms in the daily lives of institutions which seek to institute changes and redefine knowledge and practices. Articulating a movement which strives to change the medicalized and interventionist model must move towards values centered on the social emancipation of professional classes, on the effective democracy of women's rights and on the use of professionals sustained in an emancipatory practice of autonomous and protagonists. It is expected to be articulated with the institutional political struggle for a State which governs with the civil society organizations by the majorities[11], that meets the needs and demands of women in labor and childbirth.

When rescuing the concept of praxis as man's action on matter and creating a new reality[9], nurses consolidate their activities and their knowledge in a creative (reflective) praxis, qualitatively determining a new reality. They also bring about a change in the obstetric care model in Brazil, and believe that it is possible to break the current hegemony.

Thus, the praxis of obstetric nurses is sustained under developing the capacities to think, produce and transform reality. According to the participants, this break is the contribution of obstetric nursing to a transformative model in constant movement which benefits humanization and the quality of women's healthcare.

> *In my day, care was medicalized. Women were hospitalized with serum, oxytocin and zero diet. Here another proposal started, we put a protocol in which the nurse would not accompany labor which was induced with oxytocin; if it happened, care would be referred to the doctor; and as they don't want to be with all the patients, they complied with our protocol. (E5)*
>
> *Our care is individualized, encouraging normal delivery without violence, explaining the benefits of respecting the body, the physiology and the benefits to the baby. This signifies our care. I see that my practice is different from the dominant model. (E2)*

Nurses demonstrate responsibility, ethics, commitment and dedication to the process of changing the obstetric scenario and are perceived in the actions proposed by public policies. They emphasize that their work process is in conjunction with ministerial initiatives to reduce obstetric intervention rates and recognize the concrete activity with which they assert themselves in this field, since they collaborate for positive outcomes in conducting normal childbirth. They also emphasize that their care changes reality and the fight for change must be daily and everyone involved should encourage a break of the existing model, which are the necessary efforts for an effective transformation.

The participants described the connection between the process of breaking medicalization and technicality and its humanizing praxis, revealing the struggle in the care space for normal hospital birth. This movement evidences a care practice in search of emancipatory recognition[12]. The decision-making to break with the hegemonic model is evident in

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their daily practice in childbirth care by recognizing their own performance in maternity hospitals, the autonomy in exercising their practice, the relationship with the team and with public policy strategies.

In this perspective, there is no intention on the part of the Nurse to exercise dominance in the field, but to share knowledge about the best care practices and to establish partnerships which contribute to improving the quality of care for women.

The testimonies indicate a transitional phase of the obstetric model, as well as changes in medical practice and in the relationship between doctors and nurses. This reality reveals an influence of the nurse's praxis in providing care for normal childbirth and adherence to procedures performed as a dynamic, multifactorial and behavioral process resulting from a set of determinants which depend on subjective factors. It is a moment of decision mediated by personality traits, the intellectual cognitive level, beliefs and social context of the individual. To assume appropriate professional attitudes with encouragement and technical-scientific knowledge is to adhere to the recommended practices beneficial to women assisted in normal birth[13].

> *Here the doctors don't know what the ball is for and ask: "Can it be used? What do you think?" The other day I had a patient with total dilation, but the baby was tall and the doctor said to me: "It's so tall, what do you think you have to do?" She understands that this is necessary, but still does not know how to use this knowledge. (E11)*

The individual and collective attitude, the behavior, and mainly the nurses' competences started to influence implementing procedures and services in maternity hospitals in front of the medical team. At the same time, communication, the relationship between teams and the ease of being in an institution which supports and encourages a different care model contribute to adopting good care practices for normal childbirth. However, these changes enable a complex coexistence for training health professionals, permeated by different interests and power games within the scope of healthcare services[14].

The care provided in hospital deliveries was mainly performed by doctors, but started to be shared with obstetric nurses, being professionals who dominate the care in this specific area. At this time, a new science of care was born focused on humanized perinatal care. The care technologies were developed and improved in order to qualify this care and guarantee the safety of the mother/newborn binomial in the delivery and birthing processes[15]. In this thinking, every new historical organism creates a new structure, whose specialized representatives and spokespersons can only be conceived as the 'new intellectuals', and not as the continuation of the preceding intellectuality. If the new intellectuals place themselves as a direct continuation of the previous one, they are not really new, but conservatives of the historically outdated group[16]. Nurses for scientificity throughout history and the traditional solidity of the profession managed to reach a necessary degree of development to create new structures; however, they still live in the cultural envelope of the old history, meaning that they are immersed in the interventionist and medicalized model.

Despite claiming that they have a respectful professional relationship with the medical team, it is clear that there is a veiled competition in which obstetric nurses seek to gain space and establish their power, while doctors struggle to not lose control of the obstetric scenario.

> *There will always be some clash between the two professions, because they are different people and backgrounds. The clash in other units is great, it will only change when their academic backgrounds [doctors] change, because it is something rooted. The biggest issue is pediatricians who aspirate and handle babies mainly because they say that they are few and don't have time to wait for the baby to make skin-to-skin contact, nor to wait for the placenta to leave or to stop the cord pulsating. (E7)*

Even though the entire delivery process has been assisted by the obstetric nurse with respect to physiology and encouraging the empowerment of women, they still need to establish their space against the power that medical professionals exercise over them at the institutional level. Although they have gained more space in care through the use of care technologies in childbirth for pain relief, diet administration, encouraging skin-to-skin contact, guidelines for breastfeeding and first baby care procedures[17], there is still resistance from other professionals in the care provided throughout the delivery process, hindering their emancipation in this scenario.

Nevertheless, most nurses showed that the experience in these maternity hospitals, even though they experience some decision-making problems, is better when compared to the reality of other institutions where they are unable to act independently. It is worth mentioning that the dispute between professionals only causes harm to women, because it causes an environment of tension which does not favor any of the professional categories.

Every social group which intends to conquer its hegemony needs to go through a process that constitutes its identity and intellectuality, and an education that requires the rigorous construction of a more advanced and socialized knowledge[16]. Evidencing these values and critically analyzing this path in order to understand the contemporary obstetric context is a necessary process which requires nurses to capture instruments that provide knowledge, enable new knowledge and promote confidence in their abilities.

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As a study limitation, there was a reduced number of participants, even covering the entire list of obstetric nurses who graduated from the Residency Course.

CONCLUSION

It was possible to describe the use of care technologies used by obstetric nurses and their relationship with professional praxis in this study. These nurses are aware of their role, and used their critical experience to analyze and decide how to take care of the most diverse situations of daily professional life, in turn building a transformation path to improve the care quality for normal hospital childbirth. The praxis of the obstetric nurse is elaborated under a global view and its practice conforms to the politics, history and knowledge, being considered important in their training and being critical active actors in the obstetric scenario.

Finally, this study strengthens the scientific evidence on inserting obstetric nurses from the residency with regard to the increased use of care technologies for pain relief and their influence on labor and childbirth care. Training obstetric nurses qualifies their performance in the professional practice of humanized practice, requiring interdisciplinary integration in the obstetric scenario.

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