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The teaching of good obstetric practices from the Residency preceptors' perspective

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Abstract *The aim of this study was to understand how the topic of good obstetric practices is taught in residency programs according to the preceptors' perception. This is a descriptive, exploratory study, with data triangulation, with a qualitative approach. A total of 35 professionals participated in the study, of which 21 were physicians and 14 nurses. Data were collected from March to June 2018. The analysis was supported by NVivo software. The nuclei of meanings and categories were identified in the different stages, in pedagogical projects: the structuring aspects, competence profile and guiding policies for normal childbirth; in the interviews: theoretical-practical approach and the practices present in the training and, in participant observation: aspects related to the structure of the scenarios and the use of practices. Possibilities and limits were observed in the role of preceptors in the training process, constituting an area that requires continuous attention, aimed at the strengthening of the pedagogical processes in order to expand the disruptive potential of new health professionals.*

Key words *Health human resource training, Natural childbirth, Obstetrics, Women's health*

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Introduction

The health education scenario is a considerable pedagogical challenge to be faced by residency programs[1]. The fragmentation of health care persists, prioritizing super-specialization and sophistication of procedures, ignoring pedagogical strategies based on problematized teaching and the construction of collective knowledge[2]. Professional training in health is a complex process. Moreover, this model has enhanced the technical and social division of health work[3].

The training in the "residency in health" modality is considered a modality of in-service training, which is based on learning through daily practice, from exposure to situations that are specific to training, and represent moments of professional daily life, planned in a didactic manner[1]. In addition to contributing to the ideological construction guided by ethics and professional identity, its understanding is not limited to an isolated educational project of specialization, but also aimed at training the workforce in institutions that maintain programs and a health policy space[4].

In the context of training in obstetrics, there is a distinction between the Medical Residency and Health Professional Areas (Uniprofessional – Obstetric Nursing), which are postgraduate teaching modalities characterized by in-service training and supervised by qualified professionals. They are considered the gold standard of *lato sensu* postgraduate courses, a practice characterized by the progressive acquisition of technical and relational attributes in the development of professionalism. They are regarded as a differentiated professional qualification, as they enable the development of knowledge and professional skills, add security in the development of work and satisfaction with the profession[5,6].

In the health production scenario, the Brazilian health system still faces major challenges in providing comprehensive and quality care to women. However, scenarios with the potential to act synergistically for an effective change in delivery and birth care are identified, with the implementation of good perinatal practices as public policy[1,7]. Evidence-based practice is an effective strategy to improve the quality of obstetric care[8], but it is not always an easy process to encourage health professionals to change routine interventions in accordance with these practices.

Considering that the change in the delivery care model can occur through the adequate training of new professionals, based on the expertise of good obstetric practices, it is essential to reflect on training perspectives that go beyond the technical-pedagogical approaches, as the educational process is essentially a social, relational, communication and political one[9,10].

Thus, given the potential of the training process to change the obstetric model and to reduce maternal and neonatal morbidity and mortality, this study aims to understand how the topic of good obstetric practices is taught in residency programs (nursing and medicine) according to the tutors' perception.

Method

This is a descriptive, exploratory study, with data triangulation, with a qualitative approach. We aimed to disclose social processes that remain little known, based on the reports of the tutors of the residency course in obstetrics. The qualitative approach showed to be adequate, as it meets very particular questions. It is concerned with a level of reality that cannot be quantified[1,11]. Data triangulation emerged as a dialogue strategy, capable of enabling the intertwining between theory and practice and aggregating multiple sources of evidence in relation to the same set of questions, aiming to corroborate the same finding[1,12]. The study was carried out with tutors from a higher education institution in the Federal District. The participants were obstetricians and obstetric nurses, who work as preceptors in the Residency Course. The participants' inclusion criteria were defined as: working as a preceptor of medical residency or obstetric nursing courses and agreeing to participate in the study.

A total of 35 preceptors participated, of which 14 were nurses and 21 physicians. Preceptors from all services were invited, which characterizes the amplitude of the research. The sample was a non-probabilistic one and adopted convenience sampling[1,13]. The depletion of new subjects in the respondents' discourse was used as a sample saturation parameter[1,14].

Data collection from the interview and participant observation were carried out between March and June in 2018. The search for pedagogical projects required a longer time and started in August 2017. When analyzing the documents, we aimed to answer the following question: Are the recommendations of the national and international guidelines for childbirth care textually included in the pedagogical projects of residency courses in obstetrics? For the analysis of the

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pedagogical projects, the usual content analysis techniques were used aiming to decipher, in each text, the emerging nucleus that would meet the purpose of the research. This stage consisted of a codification, interpretation process and inferences about the information contained in the projects[1,11].

Face-to-face interviews, with a mean duration of thirty minutes, were guided by a semi-structured questionnaire. The questionnaire included the following agenda: How are good practices in labor and birth care addressed during the residency program (What is taught? How is it taught?)? What evidently useful practices are used by residents when working with patients in labor?[1] The interviews were recorded on digital media for subsequent transcription and data analysis. The software NVivo13 was used to support the qualitative data analysis in the process of content analysis[15].

Participant observation was carried out in the eight investigated scenarios, with the aid of a field diary, and two thematics were identified: the structure of the birth scenario (space for walking, use of a birthing stool, ball, rocking birthing chair, shower and PPP [pre-, peri- and postpartum] beds) and the use of practices for conducting the labor and birth (category A-practices that are demonstrably useful and should be encouraged; category B-clearly harmful or ineffective practices; category C-practices without sufficient evidence to support a clear recommendation; and, category D-practices frequently used inappropriately. Participant observation allows obtaining a holistic and natural perspective of the assessed topic[16]. This technique was performed with the help of a guiding script, and the items categorized as "yes" or "no" aimed to show whether certain actions were performed or not by the preceptors in the obstetric residency course. The presence or absence of aspects related to environment and use of practices was considered for the analysis.

Data triangulation between the three research products allowed an aggregation of the analysis and the acquisition of a certain reality from different angles, allowing the assessment of information, aiming to minimize biases resulting from a single analysis perspective[12].

This study followed the determinations of Resolution 466, of December 12, 2012, of the National Health Council, which provides guidelines and regulatory standards for research involving human beings. The project was approved by the Research Ethics Committee of the Health Secretariat of the Federal District – CEP/SES/DF under Opinion N. 2,166,900 of July 10, 2017.

Results and discussion

Pedagogical projects of the courses

The search for the pedagogical projects of the residency programs was carried out upon request by electronic mail (e-mail) sent to the course coordinators. A political-pedagogical project implies strategies and practical proposals for action. In order to educate, it is not enough to indicate a destination and a path to get there. It is necessary to indicate how to get there and walk the path together. The project must indicate broad perspectives, which values guide the educational action, the ideologies at stake, and a discussion of the local, national and international context. It must portray the aspirations, ideals and hopes of the academic community[1].

In the residency teaching modality, 80% to 90% of the courses take place in the context of care practice, which requires planning of the actions of the pedagogical project, not only about what is taught, but how it is taught[1]. For Freire [17], under the conditions of true learning, students are transformed into real subjects of construction and reconstruction of the taught knowledge, alongside the preceptor, who is also the subject of the process.

Regarding the political-pedagogical projects, we aimed to verify whether public policies related to childbirth and birth were contemplated, in accordance with the recommendations of the Ministry of Health (MH) and the World Health Organization (WHO). Initially, the material was organized, the projects were read while looking for coincident and divergent syntheses of ideas and, subsequently, the following analysis categories were defined: structural aspects of the projects; graduates' competence profile and, finally, public policies guiding normal birth[1].

Chart 1 shows the two categories identified in the medical residency projects, followed by the registration units. The structuring aspects of the pedagogical project, as well as the competences to be developed by the graduates, are similar in the projects of the analyzed medical residency programs. In addition to the content, it is necessary to insist that the meanings of educational objectives cannot be limited to the content established by accumulated traditions, but that they can and should be revised and modified[1,18].

Although Brazil has edited policies, programs and strategies since the 1980s, as well as other Latin American countries, there has been an alarming increase in the rates of Caesarean sections, making this the main type of delivery. Of the 3 million births that occur annually, 55.5% occur by Caesarean section, although Normal Birth Centers have been increasingly created and movements in favor of normal birth have gained strength[1,19].

Faced with a scenario of discussion regarding the autonomy of women and medical professionals, the Federal Council of Medicine (CFM, *Conselho Federal de Medicina*) gave its opinion through Resolution N. 2,144/2016, clarifying that, as long as she has received information about the risks and benefits of both vaginal and Caesarean deliveries, it is the pregnant woman's right to choose to undergo the Caesarean section in elective situations (from the 39th week of gestation)[1,20].

Chart 2 shows the three identified categories, followed by the registration units. The political -pedagogical project of the nursing residency course brings, in a contextual manner, all MH programs and policies to encourage the promotion of normal and humanized childbirth[1].

It refers to government programs developed to improve maternal health concentrating on childbirth and birth care, with a strong potential for the reduction of maternal mortality. It addresses the Comprehensive Assistance Program for Women's Health (PAISM, *Programa de Assistência Integral à Saúde da Mulher*), considered a reference program in going beyond the maternal -infant perspective and treating women further than their reproductive specificity[1,21].

It mentions the Technical Report "Care in normal birth: a practical guide" (WHO, 1996) which classifies the practices according to usefulness, efficacy and risk, to guide the professional's conduct in the management of labor and delivery. Based on this document, it was possible to urge professionals to rethink childbirth as an event that transcends the strictly biological aspects[1,22].

It addresses the Program for the Humanization of Prenatal Care and Birth (PHPN, *Programa de Humanização do Pré-natal e Nascimento*), which has as its central objective to establish adequate procedures for the care of childbirth and birth and include working with Traditional Midwives; it also highlights the importance of the *Cegonha* Network, which incorporated the actions from previous programs, to ensure access, embracement and effectiveness in care during labor and birth, the growth/development of the child up to 24 months and access to reproductive planning[1,21].

Chart 1. Political-pedagogical projects of the Medical Residency Program. Brasília, DF, 2019.

Structural aspects	Graduates' competence profile
Pedagogical guidelines	To know and interpret the main epidemiological, demographic and socio-economic-cultural aspects that affect women's health
General and specific objectives	To develop knowledge for an adequate understanding of the relationship between psychological alterations and tocogynecological disorders
Student evaluation process	Practicing low- and high-risk prenatal care; and training in the prevention, diagnosis and treatment of the main clinical and obstetric complications
Program self-assessment	To develop the capacity of judgment and discernment to indicate effective and efficient tests and treatments
Faculty/year	Capacity to communicate with patients, colleagues, professionals in the field and other people involved in the treatment
Theoretical and practical program	Capacity to work harmoniously in a team
Duration and total workload	Compliance with ethical principles
Supervisor's attributions	Professional commitment and responsibility
Preceptor's attributions	To train specialists with knowledge, skills and competences to work in the SUS and private health network
Graduate's profile and competence	Comprehensive and humanized care in women's health
Criteria for completion of the MRP and board certification	Promote greater teaching-service interaction

Source: New Trends in Qualitative Research 3 (2020, p. 97).

Chart 2. Political-pedagogical project of the Residency Program in Obstetric Nursing. Brasília, DF, 2019.

Structural aspects	Perfil de competências dos egressos	Políticas públicas norteadoras da promoção do parto normal
	Graduates' competence profile	Public policies guiding the promotion of normal childbirth
Pedagogical guidelines	To know and apply the Public Policies of Maternal and Perinatal Health	To use the guiding references for the promotion of normal birth
General and specific objectives	To provide assistance and nursing care in a systematic, comprehensive and humanized way to women in the pregnancy-puerperal cycle, as well as to their newborns and their families, in the context of primary and secondary care	Comprehensive Women's Health Care Program
Student's evaluation process	To assist women in obstetric emergency situations	WHO/MH Technical Report – Assistance in Normal Childbirth: a practical guide
Program self-assessment	To assist women and their families in situations of violence	Prenatal and Birth Humanization Program
Faculty/year	To assist the woman with clinical complications and obstetric pathologies in the pregnancy-puerperal cycle	National Policy for Comprehensive Care in Women's Health
Theoretical and practical program	To develop critical-reflective capacities related to professional practice	Cegonha Network Program
Duration and total workload	To plan and implement educational programs for users and the nursing staff	
Graduates' competence profile	To provide care based on scientific evidence, striving for the ethical principles of the profession. To encourage the promotion of changes in care paradigms, aimed at health practices based on scientific evidence	

Source: New Trends in Qualitative Research 3 (2020, p. 98).

As the last update of the political-pedagogical project of the nursing course was in 2016, it does not include, therefore, the National Guidelines for Care in Normal Childbirth, the most recent document from the MH, prepared in partnership with scientific societies and representatives of civil society, which proposes evidence-based recommendations on issues related to the types of delivery. The creation of the Guidelines followed systematic methods described in the literature to adapt existing clinical guidelines to the local reality[1,20].

Therefore, the pedagogical project of the nursing course has contents that support the promotion of changes in care paradigms, aimed at health practices based on scientific evidence[1]. For Leal[23], the presence of an obstetric nurse as part of the delivery care team is associated with better results in labor and delivery, reduces unnecessary interventions, including Caesarean sections, increases women's satisfaction, the appropriate use of beneficial technologies and positive perinatal outcomes.

Interviews with the preceptors

Within the proposed objective, we aimed to assess in the preceptors' speech how the good practices are discussed in the residency program, what is addressed, how it is addressed, and which practices are most frequently used in the service. The interviews were carried out between March and June in 2018; the participants were identified by their professional category (P = Physician and N = Nurse), followed by a cardinal number (E1 or M1, and so forth)[1].

Chart 3 is a synthesis of responses related to how good practices are addressed during the residency program (What is taught? How is it taught?) and which practices are used. We sought to establish an interaction between the content manifested in the documents with the content of the respondents' statements.

According to the preceptors, they teach the best practices recommended by national and international guidelines for assisting normal birth and seek alignment between theory and practice

from the classroom to practical scenarios. However, when analyzing the pedagogical projects of medicine, there are gaps in the description of public policies related to the promotion of good practices in normal birth[1]. This discrepancy between what is contained in the pedagogical pro-

Chart 3. The teaching of good practices in the residency program, according to the preceptors. Brasília, DF, 2019.

Thematic	Categories	Registration units
Alignment between theoretical content and practice	Programmatic content	"We have an entire program, a programmatic content, revised annually, which is the pedagogical project, and in the content, the topic of good practices is addressed" (N1)
		"During the residency development, they have a workshop, they are tutored on good practices, which would be the theoretical part and they come to apply them, [...] then they are taught by us, with all the resources and mechanisms that facilitate good practices and they learn together with us, watching us do it and performing these good practices with us" (N13)
		"One of the first modules they have in the theoretical program of medical residency is childbirth care and in this module, they have all the items related to good practices in childbirth care. Moreover, during the practical activity, the theoretical part is put into practice. It is seen in theory and at the moment of practice" (P1)
	Theoretical and practical moment	"We address it at all times, in lectures and during practice, every time we provide assistance, we use good practices and pass this on to the residents" (N3)
		"Currently, practice is more in line with theory and since the beginning, from the public policies of the first module, we see the protocols, the evidence [...] the residency is guided by them, it is grounded on these Good Practices" (N4)
		"It is seen in the theoretical-practical program together with the other items that are part of the theoretical program and then it is taught in daily practice" (P9)
Practices in normal birth care	Evidently useful practices	"The non-pharmacological methods, we try to use all of them" (N12)
		"The presence of a companion and free-choice doula" (N5)
		"[...] skin-to-skin contact, delayed clamping of the cord, breastfeeding within the first hour of delivery" (P9)
		"[...] I ask, talk to the woman, look her in the eye, listen to what she has to say, because that is where you will guide your practice, [...] bonding is the main way, in In my opinion, of providing qualified assistance under the precepts of humanization, of a respectful delivery, because it does not help to have a 'one-size-fits-all' approach with everyone, not all things are the same" (N11)
		"In relation to harmful or ineffective practices that must be eliminated and are worthless in this service is the use of routine intravenous infusion, the lithotomy position and directed pushing" (E5)
	Clearly harmful practices	"Nowadays, there is no such thing as routine induction [...]" (E7)
	Practices without evidence that should be used with caution	"The Kristeller maneuver is rarely done, but it still happens" (E11)
	Inappropriately used practices	"In the nursing residency, we have eradicated the episiotomy, it is not done" (E2)
		"Vaginal examinations by more than one professional are done because we need to teach, don't we? [...] so the examination is done twice – by the evaluating physician and the student" (M10)

Source: New Trends in Qualitative Research 3 (2020, p. 100).

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ject and the practices declared by the tutors signals the reproduction of the hidden curriculum in the training of residents, a fact that also occurs in undergraduate medical school[24].

The curriculum of a training program consists of multiple dimensions. The official dimension or official curriculum stands out, corresponding to what is written in an institutional document, with a legal and normative framework, which provides the pedagogical plan that teachers must put into practice. It constitutes a reference for the managers. However, there is the operational dimension of the curriculum, which consists of what is taught and evaluated in practice, involving all the factual actions between teachers and students and differs from the previous one because each teacher makes an interpretation. And there is the hidden curriculum, which is one that exists in the learning process but is not embodied in the formal curriculum and, therefore, it is not officially recognized. It can have a greater impact on the student, as it is related to ethnicity, gender, religion or other issues that are unknown [25]. It results from the interpersonal relationships that develop in the academic sphere, with emphasis on those that emerge from everyday situations and are not established in the set of knowledges included in the formal curriculum[24].

It is considered that part of today's preceptors are still the result of the old training model that they experienced as resident students and that reproduce biomedical models, avoiding the promotion of the problematizing practice that leads the student/resident to question and reflect on the facts that they face, leading to the formation of a critical consciousness. And thinking is not just "reasoning" or "calculating" or "debating", as we have been taught, but above all it is to make sense of who we are and to what happens to us[1,26]. Thus, an in-depth and continuous analysis of the educational and professional training experiences that constitute the several dimensions of the residency program curriculum is required, especially those that occur unintentionally, mainly related to the development of values and attitudes, which constitute the "background" of the learning process[24].

The need for change in professional training with theoretical-practical support for a humanized obstetric care is one of the strategies devised by *Rede Cegonha* (the "Stork" Network)[21] for the implementation of care that favors the well-being of the pregnant woman and the newborn. Additionally, this model seeks to be as little invasive as possible, considering both the physiological and psychological processes and the sociocultural context[1].

One considers that relearning is much more difficult than learning in the initial training, and that the change in the delivery care model can occur through the adequate training of new professionals, based on the expertise of good obstetric practices. Based on this, it is essential to reflect on training perspectives that go beyond the technical-pedagogical approaches, as the educational process is essentially a social, relational, communication and political one[1,8].

According to Merhy[27], some trainings are necessary for the acquisition of certain work techniques and can be supplied without much difficulty. This author states that health education and health work literally intermingle, that one produces the other, both for the construction of the worker's competence and for the expression of their place as a care-producing subject. For Feuerwerker[28], one practice enhances the other; one does not happen without the other. Therefore, it is not possible to think about changes in training without the concomitant production of many action processes in territories and units that are built in a shared manner. According to Freire's[17] ideas, it seems that tutors have possibilities and limits, as historical and unfinished beings who undergo conditioning caused by the sociocultural and economic context to which they belong, while developing a strong potential for change.

Participant observation

In the participant observation, it was possible to understand the performance scenarios of the residency tutors, as well as to verify the presence or absence of resources available in the use of practices and which practices are guided in childbirth and birth care. The participant observation makes it possible to understand the relationships between individuals and between individuals and institutions, as well as the practices, perspectives and opinions of the research subjects, which would not be possible to comprehend through other techniques[11].

Of the eight practical scenarios of the residency programs, only two had a planned physical structure for patient ambulation during labor management. The others, despite the lack of a suitable environment, make this practice viable in the physical space of the Unit's corridors. PPP (pre-, peri- and postpartum) beds are present in the environment of all scenarios, helping the mother to have her privacy preserved throughout

the process of labor and delivery and can welcome the companion of her choice, whether they are male or female.

The use of practices identified in participant observation is in line with the interview responses. Soft care technologies are offered by preceptors through non-pharmacological pain relief methods. The mother has access to the ball, the rocking birthing chair, the warm shower, the massage and the birth stool as alternatives to the verticalized positions for birth. However, each woman, depending on her culture, beliefs and religion, chooses the ones that bring more comfort and well-being during the birth process.

In addition to the benefits of support in labor and delivery for the perinatal outcomes, women with companions report having suffered less violence during childbirth and demonstrate more satisfaction with the care they received. The presence of an obstetric nurse as a member of the delivery care team has a positive impact on the reduction of Caesarean sections and on the use of good practices recommended by the WHO and MH[23]. Studies consider that the successful alignment depends on the preceptor's skill, which must go beyond technical knowledge for the provision of a humanized, safe, adequate and timely care[29,30]. The scientific literature provides evidence supporting the importance of good preceptorship in obstetrics[31].

A systematic review of qualitative studies[32] showed that women want emotional support; they want to be informed and participate in decision-making about the birth of their children. Teaching these aspects requires the preceptor's skill, allowing them to understand when interventions become necessary because they have valid indications and, above all, that the patient must be aware of the needs and risks, through informed consent[33].

Although much progress has been made regarding the use of good practices by preceptors, it was disclosed that some practices considered to be evidently harmful still persist, such as the use of the lithotomy position and the efforts of prolonged and directed pushing. Vaginal examinations by more than one professional, a practice that was classified among those that are inappropriately used, is still used with the justification that they are performed in teaching hospitals.

Belizan[34] identified barriers that prevent professionals from adhering to evidence-based practices: barriers due to the difficulty of accessing up-to-date information, barriers due to the chronic shortage of human resources, which limits the time to study them, because they believe that practices do not change; barriers because they do not notice the bad results obtained with the current practices; barriers because they see the pressure to change the practice as an imposition; and due to the lack of explicit clinical guidelines, among others.

Any intervention performed in a normal situation is unnecessary. At best, it is useless. At worst, it is harmful to both mother and baby because it increases the risk of complications. It is evidently known that unnecessary interventions, performed without indication, impair the natural progression of labor and lead to iatrogenic events[35].

For Koblinsky[36], despite the diversity of models of care provision, the starting point is the same for all countries: to ensure that every woman, anywhere, is placed in a safe environment. Every service needs clear norms about the care that must be provided to women in the pregnancy-puerperal cycle. The implementation of these protocols supports the increase of access to good care practices by pregnant women.

Final considerations

According to the preceptors' perception, they address the thematic of good practices recommended by national and international guidelines for normal birth care, from the classroom to practice scenarios. It was observed that the political-pedagogical project of the nursing course includes the recommendations by the MH and the WHO. The course has as its guiding axis the ideology of woman-centered care, the encouragement of the use of good obstetric practices, the reduction of unnecessary interventions, the demedicalization of health care, the promotion of autonomy and the protagonism of women. As for the political-pedagogical projects of medical residency, they do not yet textually include the recommendations of the MH and the WHO related to the topic of good practices in childbirth and birth.

It was demonstrated that the use of some evidently harmful practices persists; that residency education requires continuous attention aimed at strengthening pedagogical processes in the different curricular dimensions, qualification of the actors involved in the training and the organization of childbirth care services; that institutional support is important in that it allows professional improvement, which is conceived in practice, but have a universe of action, of knowledges and

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skills that go beyond the teaching knowledge and must be researched, systematized and developed.

It is confirmed that these courses represent a strong potential for the change in the model of childbirth care, as long as the MH policies and programs are included in the political-pedagogical project of these courses, in practical-assistance teaching, and ingrained in the professional body of knowledge constructed and produced in the subjective interactions of the work team, comprising the operational and hidden dimensions of the curricula. Collaborative efforts between educators, health professionals and management are essential for the successful implementation of the teaching of good practices in natural birth care, which are addressed both in theory and in clinical practice.

Finally, we recommend improving the teaching-service articulation, so that the Teaching Institution can offer better conditions that will allow the preceptor to reformulate their practice, through the construction of new concepts that are recreated in a theoretical-methodological dimension with an adequate support.

Collaborations

LBD Göttems designed the study. EMP Carvalho collected the data. D Guilhem, LBD Göttems and EMP Carvalho conducted the analysis. EMP Carvalho wrote the first version of the manuscript and all authors contributed and approved the final version.

References

1. Carvalho EMP, Göttems LBD, Guilhem DB. A temática das boas práticas obstétricas no contexto do projeto político-pedagógico da residência. *NTQR* 2020; 3:93-104.
2. Meneses JR, Ceccim RB, Martins GC, Meira IFF, Silva VM. Residências em saúde: os movimentos que as sustentam. In: Ceccim RB, Meneses LBA, Soares VL, Pereira AJ, Meneses JR, Rocha RCS, Alvarenga JPO. *Formação de formadores para residências em saúde: corpo docente-assistencial em experiência viva;* Porto Alegre: Rede UNIDA; 2018. p. 33-48.
3. Melo CMMD, Florentino TC, Mascarenhas NB, Macedo KS, Silva MCD, Mascarenhas SN. Autonomia profissional da enfermeira: algumas reflexões. *Esc Anna Nery* 2016; 20(4):e20160085.
4. Feijó LP, Fakhouri Filho SA, Nunes MDPT, Augusto. Resident as a teacher: an introduction to teaching. *Rev Bras Educ Med* 2019; 43(2):225-230.
5. Lima GPV, Pereira ALF, Barros GNF, Progianti JM, Araújo CLF, Moura MAV. Expectativas, motivações e percepções das enfermeiras sobre a especialização em enfermagem obstétrica na modalidade residência. *Esc Anna Nery* 2015; 19(4):593-599.
6. Silva LS, Natal S. Residência multiprofissional em saúde: análise da implantação de dois programas pela Universidade Federal de Santa Catarina, Brasil. *Trab Educ Saude* 2019; 17(3):e0022050.

7. Carvalho EMP, Amorim FF, Santana LA, Göttems LBD. Avaliação das boas práticas de atenção ao parto por profissionais dos hospitais públicos do Distrito Federal, Brasil. *Cien Saude Colet* 2019; 24(6):2135-2145.
8. Iravani M, Janghorbani M, Zarean E, Bahrami M. Barriers to implementing evidence-based intrapartum care: a descriptive exploratory qualitative study. *Iran Red Crescent Med J* 2016; 18(2):e21471.
9. Paula L, Mello R. A práxis histórica de Paulo Freire como fundamentação para as pesquisas sobre formação de educadores. *REA* 2018; 26(1):6-23.
10. Carvalho EMP. *O processo de formação de enfermeir@s e médic@s na modalidade residência obstétrica a partir da percepção dos preceptores* [Tese]. Brasília: Faculdade de Ciências da Saúde; 2020.
11. Minayo MCDS. *O desafio do conhecimento*: pesquisa qualitativa em saúde. São Paulo: Hucitec; 2014.
12. Santos KDS, Ribeiro MC, Queiroga DEUD, Silva IAPD, Ferreira SMS. O uso de triangulação múltipla como estratégia de validação em um estudo qualitativo. *Cien Saude Colet* 2020; 25(2):655-664.
13. Vergara SC. *Projetos e relatórios de pesquisa em administração.* São Paulo: Atlas; 2009.
14. Flick U. *Introdução à pesquisa qualitativa.* Porto Alegre: Artmed; 2009.
15. Bardin L. *Análise de conteúdo.* São Paulo: Edições 70; 2011.
16. Mónico L, Alferes V, Parreira P, Castro PA. A observação participante enquanto metodologia de investigação qualitativa. *CIAIQ* 2017; 3:724-733.
17. Freire P. *Pedagogia da autonomia: saberes necessários à pratica educativa.* Rio de Janeiro: Paz e Terra; 2018.
18. Sacristán JG. *Saberes e incertezas sobre o currículo.* Porto Alegre: Penso; 2013.
19. Mascarenhas VHA, Lima TR, Silva FMD, Negreiros FS, Santos JDM, Moura MAP, Gouveia MTO, Jorge HMF. Evidências científicas sobre métodos não farmacológicos para alívio a dor do parto. *Acta Paul Enferm* 2019; 32(3):350-357.
20. Vidal AT, Barreto JOM, Rattner D. Barreiras à implementação de recomendações ao parto normal no Brasil: a perspectiva das mulheres. *Revista Panamericana de Salud Pública* 2020; 44(164):1-7.
21. Leal MDC, Szwarcwald CL, Almeida PVB, Aquino EML, Barreto ML, Barros F, Victora C. Saúde reprodutiva, materna, neonatal e infantil nos 30 anos do Sistema Único de Saúde (SUS). *Cien Saude Colet* 2018; 23(6):1915-1928.
22. Organização Mundial de Saúde (OMS). *Assistência ao parto normal: guia prático*. Genebra: OMS; 1996.
23. Leal MDC, Bittencourt SDA, Esteves-Pereira AP, Ayres BVDS, Silva LBRAD, Thomaz EBAF, Domingues RM SM. Progress in childbirth care in Brazil: preliminary results of two evaluation studies. *Cad Saude Publica* 2019; 35(7):e00223018.
24. Santos VH, Ferreira JH, Alves GCA, Naves NM, Oliveira SL, Raimondi GA, Paulino DB. Currículo oculto, educação médica e profissionalismo: uma revisão integrativa. *Interface (Botucatu)* 2020; 24:e190572.
25. Muñoz YG, Vanegas NAR. *Factores del currículo oculto en la práctica formativa de pregrado de medicina*. Bogotá: Universidad El Bosque; 2019.
26. Freitas DA, Santos EMS, Lima LVS, Miranda LN, Vasconcelos EL, Nagliate PC. Saberes docentes sobre processo ensino-aprendizagem e sua importância para a formação profissional em saúde. *Interface (Botucatu)* 2016; 20(57):437-448.
27. Merhy EE. O desafio que a educação permanente tem em si: a pedagogia da implicação. *Interface (Botucatu)* 2005; 9(16):172-174.
28. Feuerwerker LCM. *Micropolítica e saúde: produção do cuidado, gestão e formação.* Porto Alegre: Rede Unida; 2014.
29. Gismalla MDA, Kaliya-Perumal A-K, Habour AB, Mohammed MEI. Does perception of clinical competency correlate with perception of training efficiency? *Journal of Medical Education* 2017; 16(4):221-226.
30. Campbell OM, Calvert C, Testa A, Strehlow M, Benova L, Keyes E, Donnay F, Macleod D, Gabrysch S, Rong L, Ronsmans C, Sadruddin S, Koblinsky M, Bailey P. The scale, scope, coverage, and capability of childbirth care. *The Lancet* 2016; 388(10056):2193-2208.
31. Lukasse M, Lilleengen AM, Fylkesnes AM, Henriksen L. Norwegian midwives' opinion of their midwifery education – a mixed methods study. *BMC Med Educ* 2017; 17(1):80.
32. World Health Organization (WHO). *Recommendations non-clinical interventions to reduce unnecessary caesarean sections*. Geneva: WHO; 2018.
33. Jansen L, Gibson M, Bowles BC. First do no harm: interventions during childbirth. *The J Perinat Educ* 2013; 22(2):83-92.
34. Belizan M, Meier A, Althabe F, Codazzi A, Colomar M, Buekens P, Belizan J, Walsh J, Campbell MK. Facilitators and barriers to adoption of evidence-based perinatal care in Latin American hospitals: a qualitative study. *Health Educ Res* 2007; 22(6):839-853.
35. Çalik KY, Karabulutlu Ö, Yavuz C. First do no harm -interventions during labor and maternal satisfaction: a descriptive cross-sectional study. *BMC Pregnancy Childbirth* 2018; 18(1):415.
36. Koblinsky M, Moyer CA, Calvert C, Campbell J, Campbell OM, Feigl AB, Graham WJ, Hatt L, Hodgins S, Matthews Z, McDougall L, Moran AC, Nandakumar AK, Langer A. Quality maternity care for every woman, everywhere: a call to action. *The Lancet* 2016; 388(10057):2307-2320.

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