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The prevalence of the technocratic model in obstetric care from the perspective of health professionals

A prevalência do modelo tecnocrático na atenção obstétrica na perspectiva dos profissionais de saúde

El predominio del modelo tecnocrático en la atención obstétrica en la perspectiva de los profesionales de salud

Marli Terezinha Stein Backes[I]
ORCID: 0000-0003-3258-359X

Karini Manhães de Carvalho[I]
ORCID: 0000-0002-2978-9987

Larissa Nascimento Ribeiro[I]
ORCID: 0000-0003-4303-6823

Tamiris Scoz Amorim[I]
ORCID: 0000-0003-0220-7526

Evanguelia Kotzias Atherino dos Santos[I]
ORCID: 0000-0002-5970-020X

Dirce Stein Backes[II]
ORCID: 0000-0001-9447-1126

[I]*Universidade Federal de Santa Catarina. Florianópolis, Santa Catarina, Brazil.*
[II]*Universidade Franciscana. Santa Maria, Rio Grande do Sul, Brazil.*

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Corresponding author:
Karini Manhães de Carvalho
E-mail: karinimcarvalho@gmail.com

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ABSTRACT

Objectives: to identify the reasons for the prevalence of the technocratic model in obstetric care from the perspective of health professionals. **Methods:** Grounded Theory. Study approved by two Research Ethics Committees and conducted by theoretical sampling, from July 2015 to June 2017. Twenty-nine interviews were conducted with health professionals from two maternity hospitals in the Southern Region of Brazil. Data collection and analysis was performed alternately; and analysis by open, axial, and selective coding/integration. **Results:** the technocratic model still persists because the assistance is performed in a mechanized way, centered on the professionals. There is a lack of systematization of care, and under-dimensioning of the nursing staff. **Final Considerations:** obstetric nurses need to review their performance in obstetric centers, the internal organization, the dimensioning of nursing professionals, and become protagonists of care. Investment in academic training/updating the knowledge of midwifery professionals, based on scientific evidence and user-centered care is necessary.
Descriptors: Health Care; Obstetric Nursing; Health Care Models; Obstetrics; Health Personnel.

RESUMO

Objetivos: identificar os motivos da prevalência do modelo tecnocrático na atenção obstétrica na perspectiva dos profissionais de saúde. **Métodos:** *Grounded Theory*. Estudo aprovado por dois Comitês de Ética em Pesquisa e conduzido por amostragem teórica, de julho de 2015 a junho de 2017. Realizaram-se 29 entrevistas com profissionais de saúde de duas maternidades da Região Sul do Brasil. Coleta e análise dos dados, realizadas alternadamente; e análise mediante a codificação aberta, axial e seletiva/integração. **Resultados:** o modelo tecnocrático ainda persiste porque a assistência é realizada de forma mecanizada, centrada nos profissionais. Falta sistematização da assistência, e há subdimensionamento do pessoal de enfermagem. **Considerações Finais:** enfermeiros obstétricos precisam rever sua atuação nos centros obstétricos, a organização interna, o dimensionamento dos profissionais de enfermagem e assumir o protagonismo da assistência. É preciso investir na formação acadêmica/atualização do conhecimento dos profissionais da obstetrícia, baseando-se em evidências científicas e no cuidado centrado no usuário.
Descritores: Atenção à Saúde; Enfermagem Obstétrica; Modelos de Assistência à Saúde; Obstetrícia; Pessoal de Saúde.

RESUMEN

Objetivos: identificar motivos del predominio del modelo tecnocrático en atención obstétrica en la perspectiva de profesionales de salud. **Métodos:** *Grounded Theory*. Estudio aprobado por dos Comités de Ética en Investigación y conducido por muestreo teórico, de julio de 2015 a junio de 2017. Realizado 29 entrevistas con profesionales de salud de dos maternidades del Sur de Brasil. Recolecta y análisis de datos, realizados alternativamente; y análisis mediante codificación abierta, axial y selectiva/integración. **Resultados:** aún persiste modelo tecnocrático porque la asistencia es realizada de manera mecanizada, centrada en los profesionales. Falta sistematización de la asistencia, y hay sobredimensionamiento del personal de enfermería. **Consideraciones Finales:** enfermeros obstétricos precisan rever su actuación en los centros obstétricos, organización interna, dimensionamiento de profesionales de enfermería y asumir el protagonismo de la asistencia. Es preciso investir en la formación académica/actualización del conocimiento de profesionales obstétricos, basándose en evidencias científicas y al cuidado centrado en el usuario.
Descriptores: Atención a la Salud; Enfermería Obstétrica; Modelos de Atención de Salud; Obstetricia; Personal de Salud.

INTRODUCTION

Since the establishment of obstetrics and gynecology in the 19th century, the exploration and domination of the female body and the construction of knowledge about women's health have been observed. The training of professionals was structured on a misogynistic basis, i.e., of aversion to the feminine, translated into a macho behavioral practice, based on the belief of the superiority of power and the male figure and the maintenance of inequalities and hierarchy between genders. Thus, in the history of women's health, it is noted that health practices demanded their passivity[1].

The feminist movement in Brazil, which emerged in the 1970s, brought visibility to women and marked the commitment of feminists to the ideals of transforming society against racism, sexism, and capitalism and in search of gender equity. Furthermore, it continues to be articulated with other democratic and libertarian movements that denounce the serious violations of human rights[2].

During the civil military dictatorship in Brazil, violence was inflicted against women and men who sought, in defense of the ideals of democracy and freedom, to resist this regime. Women in political militancy articulated themselves to make resistance by engaging in movements in order to fight for their rights and to conquer their private and public space. They sought to break through barriers of several kinds: family, religion, school, labor market, society in general, and the repressive state apparatus. In this way, "they laid the foundations for new political and social structures that also achieved gender equality"[3].

From the 20th century on, with all the actions in favor of women's emancipation, the women's movements, the resistance to the dictatorship periods, Brazil achieved the re-democratization in the 1980's, period in which the feminist movement was engaged in the "formulation of the policy of integral attention to women's health, seeking to overcome the mother-child care line and the 'male power' of gynecology and obstetrics over the female body, preventing women from knowing their own body and accessing their sexual and reproductive rights"[1].

In this sense, considering that, worldwide, there has been a tendency to follow another model of care in the obstetric field, since 1990 humanized childbirth has become more valued in Brazil and, as a result, obstetric nurses have become more recognized in childbirth care, showing empowerment and safety to work in this area[4]. According to the authors, the globalized neoliberal context influenced the government's decision to invest in the insertion of obstetric nurses to work in childbirth care in order to rationalize resources, invest in qualified human resources, and with the use of soft and low-cost technologies in public health. In addition, the objective was to reduce the maternal and neonatal morbidity and mortality rate and improve the quality of obstetric and neonatal care, as measures of the Policy for Humanization of Childbirth and Birth.

Since the 1990s, the Brazilian government has implemented actions, programs and health policies that seek to reduce the medicalization of childbirth, including reducing unnecessary obstetric interventions, promoting the humanization of care, introducing best practices and improving the quality of obstetric and neonatal care. Among these initiatives, the following stand out: encouragement of normal childbirth by limiting payment for cesarean sections in the Unified Health System (UHS); inclusion of the procedure "normal childbirth without dystocia" performed by an obstetric nurse as of 1998 in the UHS Hospital Information System table; implementation of normal childbirth centers or birth houses in the UHS through Decree/GM No. 985 in 1999; The Program for Humanization in Prenatal and Childbirth, in 2000; the National Humanization Policy, launched in 2004; the National Policy for Integral Attention to Women's Health, 2004; the Stork Network, launched in 2011; and the Improvement and Innovation in Obstetric and Neonatal Care and Teaching Project, 2017.

Humanization can be seen either as a social movement or as a public policy. As a public policy focused on humanized care during labor and birth, it was an important social achievement to combat the hegemony of the medicalized care model. However, changing the model of obstetric care is a process that involves a struggle to which professionals may or may not adhere, depending on their training.

In turn, since labor and birth are unique and special moments for the parturient woman, the unborn child, and the family, health professionals involved in the assistance also have an ethical commitment to seek a humanized and differentiated care, which will provide greater safety and satisfaction to women[5].

The concept of "hegemony" was elaborated by Gramsci in a broad way. The authors Dore and Souza show that for Gramsci it operates on the way of thinking and knowing, on ideological orientations, on the economic structure and political organization and serves to analyze the power relations in society[6]. According to them, hegemony is built "on the basis of the ceaseless struggle of dominant social groups to obtain the active consent of subordinate social groups," through concessions to the demands of social movements, subordinating them to the direction of dominant groups. The concept of "counter-hegemony", on the other hand, was created by Raymond Williams, is widespread in several areas of knowledge, and refers to the context of movement war and the force-state, in which political society and coercion predominate. Counter hegemony would be the "experiences, meanings, and values that are not part of the effective dominant culture; alternative and oppositional forms that vary historically in actual circumstances; human practices that occur 'outside' or in 'opposition' to the dominant mode; forms of alternative or oppositional residual culture"[6].

Considering the above, although since the 1990s the change from the technocratic obstetric care model to the humanized model has been desired in Brazil[7], after almost 30 years, why does the technocratic model still persist in the maternity hospitals researched? What is involved in this persistence? In this sense, the present study is focused on obstetric care performed in maternity hospitals that have an Obstetric Center (OC).

OBJECTIVES

To identify the reasons for the prevalence of the technocratic model, in obstetric care, from the perspective of health professionals.

METHODS

Ethical Aspects

The research followed the guidelines of Resolution no. 466/2012 and no. 510/2016 of the National Health Council. The project was approved by the Ethics Committees for Research with Human Beings of the institutions where the study was conducted. All participants were explained the objectives and proposed method, all signed the Free and Informed Consent Term, and none of them were identified in this study.

Theoretical and methodological framework

The theoretical and methodological referential used was Grounded Theory, also called Data-Founded Theory (DFT), systematically developed by North American sociologists at the University of California: Barney Glaser and Anselm Strauss, around 1965. Glaser and Strauss continued to develop the method and later went their separate ways, each with their own version[8]. This study followed Strauss' version[9].

DFT is a qualitative research method that focuses on reality to study it and its main purpose is to generate theory based on collected and analyzed (interpreted) data and based on systematically carried out research[8-9]. To this end, it makes available its own techniques and procedures to collect and analyze data.

Type of study

This is a qualitative approach study. The Consolidated Criteria for Reporting Qualitative Research (COREQ) guide was used.

Methodological procedures

The study was conducted based on the principles of theoretical sampling as recommended by the DFT[8] and was carried out in two large public maternity hospitals, one belonging to the federal network and the other to the state health network, which in this study we call Maternity 1 (M1) and Maternity 2 (M2), respectively. These two maternity hospitals are located in a capital city of the Southern Region of Brazil and are responsible for public care in the area. The instruments used for data collection were semi-structured interviews and non-participant observation. In this study, only the data referring to the interview were considered[7].

Data source

The sample of this study consists of 29 interviews with generalist and obstetric nurses, obstetric physicians, medical residents in obstetrics, neonatology, and pediatrics, and one nursing resident[7]. The interviews were conducted by a single interviewer, who was an obstetric nurse with doctoral level training and was known by some participants.

Collecting and organizing data

As recommended by DFT, data collection and analysis were performed simultaneously from July 2015 to June 2017. The semi-structured interview, conducted in depth and individually with each participant in a face-to-face and reserved manner, took place at the participants' workplace and at the most convenient time for them; it was recorded using a digital recorder and later transcribed in full for analysis. This interview consisted of a main question asked to all participants ("What does the management of care performed by nurses mean to you?"), which was further elaborated on during the research; and some other relevant guiding questions.

Initially, ten nurses were interviewed, in M1, who worked in the Joint Nursing, OC and Neonatal Intensive Care Unit (NICU). After the analysis of the data from this first stage, it was found that M1 works with the philosophy of humanization of care and with the Systematization of Nursing Care, which gives it great prominence in the state of Santa Catarina. However, although some nurses in this institution were already trained and prepared to work in the new model of obstetric care, with the use of good care practices based on scientific evidence, not all had specialization in Obstetric Nursing. And, among those who had, few assisted/conducted low-risk deliveries and some of them still had great difficulty in positioning themselves and lacked autonomy. In addition, in the OC of this maternity ward, the technocratic model in obstetric care still predominated, accompanied by medical hegemony, in which the training of doctors in residency in obstetrics was prioritized[7].

Based on these considerations, the following hypotheses were developed: How does obstetric care happen at M2, which is a state reference in women's health and tertiary reference in obstetric care in the context of the Stork Network? What model of care is used in this institution? Do nurses conduct deliveries? Are good care practices based on scientific evidence according to the recommendations of the World Health Organization used? Do care protocols exist in this institution?

In this way, the second stage began, in which nine nurses were interviewed: six nurses from M2, who worked at the OC, Joint Lodging, Neonatal ICU, and Outpatient Clinic of this institution, which is a reference for high-risk pregnancy care. Two other nurses from the Outpatient Clinic of the institution to which M1 belongs, which is also a reference in the care of high-risk pregnant women; and also a nursing resident nurse who worked both at M1 and M2. It was found that, in M2, nurses had less autonomy and medical hegemony was even more exacerbated. Nurses were not allowed to conduct deliveries, because they also prioritized the Obstetrics Medical Residency training. The nurse ended up conducting deliveries only when several happened at the same time; otherwise, he/she needed the authorization of the doctor[7]. In turn, it seems that the OC team of nurses, at the time of data collection, also did not seek a more effective performance in the conduction of low-risk deliveries.

In view of the above and considering that the nursing team and the medical team in the area of obstetrics and neonatology acted jointly in the maternity hospitals, the following hypotheses were elaborated: How do physicians and medical residents perceive the nurse's performance and the management of nursing care performed by nurses in the care of pregnant women, parturient women, puerperal women and newborns? To answer this question, in the third stage, ten more interviews were conducted, in order to understand the management of care exercised by nurses

from the viewpoint of physicians, medical residents and nursing residents; the professionals performed their activities together with nurses and worked in the same care units. Thus, three care physicians (two of whom were also managers) and six resident physicians were interviewed, both at M1 and M2, including residents in obstetrics, neonatology and pediatrics, and also a nurse from the OC at M1[7].

The average duration of the interviews, considering the three stages, was 42 minutes and 17 seconds. The participants were randomly invited and included, contemplating both day and night shifts, and the inclusion criteria were: being working in the area at the time of data collection and being available for that. The exclusion criteria were: being on vacation or away from work at the time of data collection. There was only one refusal by a nurse manager.

Data analysis

The data analysis was done alternately with the data collection, and the analysis led the process until the theoretical saturation of the data. Open, axial, and selective/integration coding was performed in distinct but integrated and complementary phases[8].

In the open coding, all interviews were analyzed individually, line by line, to separate the data into distinct parts and constantly compare them in terms of similarities and differences, in search of the categories emerging from the data. In the axial coding, the categories originated in the open coding were analyzed, duly classified and associated with their respective subcategories. In the selective coding, phase of data integration, the analytical mechanism called "paradigm" was used. This was advocated by Corbin and Strauss[7,9] as a facilitating tool and involves a schema by organizing data that is gathered and systematically ordered around the components "conditions", "actions-interactions" and "consequences", classified based on the emerging connections[9].

During the development of the study, written records of analysis (memos) were prepared, comprising coding notes, theoretical notes, and operational notes. Diagrams were also created, referring to the visual records that helped to elucidate the relationships between the concepts[7-8].

After data analysis, the substantive theory named "Nursing care management for the quality of obstetric and neonatal care" was elaborated, which comprises eight categories. As contextual conditions: 1) Management of nursing care for the quality of obstetric and neonatal care (the central phenomenon); 2) Implementing current public policies; 3) Managing human and material resources; 4) Professional qualification and continuing education. As strategies: 5) Caring for the mother-child binomial, the family, and the caregiver; 6) Organizing care. As consequences: 7) Seeking to qualify care; 8) Planning and evaluating care[7]. This article is based on the category "Caring for the mother-child binomial, the family and the caregiver", focusing on the obstetric care provided at the OC.

RESULTS

Twenty-nine professionals participated in the study. Of these, there were 20 nurses and 9 physicians. Among the nurses, 5 were managers and 15 were assistants, and 1 was a nursing resident. Among the physicians, one was a manager of the OC; two were assistants (one from the OC and the other from the NICU); and seven were residency students in obstetrics (four), neonatology (two) and pediatrics (one). The participants' age ranged from 24 to 59 years and the time of work in the unit at the time of data collection ranged from 2 months to 27 years.

Based on the analysis of the category "Caring for the mother-child binomial, the family, and the caregiver", focusing on the obstetric care performed in the OC, two subcategories were elaborated: The environment of the Obstetric Center; and The prevalence of the technocratic model in maternity wards.

The environment of the Obstetric Center

This first subcategory demonstrates that the OC is considered an unpredictable work environment, since deliveries/births can happen at any moment, so the team must be prepared to meet any situation. There are times when the unit is crowded and the number of deliveries/births is oscillating, having grown in both maternity hospitals since 2015, possibly due to the increase in population in the municipality.

In the OC of M1, there was an idea of opening more beds to meet the demand, but the nursing staff vetoed the idea with the intention of protecting the woman and the newborn. The patient's safety, the quality of the care provided, and also to avoid the overload of work for the professionals in the sector were thought of, since this overload reinforces the technicism. In M2, according to the participants, there were times when there were seven normal deliveries and two cesareans in just one night. In the OC of this maternity ward, there are seven vacancies for pregnant women, but the team often faces overcrowding in the unit, having had occasions when there were 15 to 20 women hospitalized in the sector. This, in the view of one of the interviewees, is a difficulty for the realization of user-centered care, not only due to the overcrowding of the sector, but also because of the diversity of women with different needs for attention and care.

It was mentioned that health professionals need to be more sensitive and understand that the labor and delivery process is a unique moment for women and that it should be respected. Thus, it is necessary to welcome her from the moment she arrives, introducing her to the OC environment and the team that will assist her, and also orient her about labor and the care that can be provided.

It was evidenced that the parturients lack privacy to give birth, since the maternity hospitals were teaching hospitals, which is why many students are present at this moment. Many interviewees do not think this is positive for care, but they also said that many professionals believe that because the woman is in a teaching hospital, she ends up having to go through this. It was mentioned that both the medical and nursing staff end up neglecting the woman's privacy.

The prevalence of the technocratic model in maternity hospitals

This second subcategory comprises the following aspects: The lack of preparation of parturient women for labor and delivery;

conducting the birth almost exclusively by the medical professional; Divergences in care; and Rushing the care of the newborn soon after birth.

The lack of preparation of parturient women for labor and delivery

According to the participants, the parturients arrive at the OC in labor very insecure, distressed, and afraid. They perceive that this may be related to factors such as the birth itself (their mother's labor) and previous traumatic births experienced by the woman. From there, it was reported that the team tries to understand and act according to the needs, anguish, and fears of each parturient woman. In addition, it seeks to know how the prenatal care of the parturient was and how much she was prepared during pregnancy for childbirth, if she had physical activities and exercises that help in childbirth.

In this study, it was also highlighted that, at the time of labor and delivery, it is necessary to give enough attention to the parturient woman so that she becomes more tranquil, calmer, avoiding leaving her alone and trying to speak more quietly. They also said that it is necessary to guide the woman to relax, to surrender, and to never push harder than she wants, to reduce the risk of vaginal tearing and for the baby to be born with more tranquility.

It was mentioned by the participants that what helps a woman in labor is how much she has done previous reading and studied about it. However, it was reported that most women do not study and do not know what will happen in labor and delivery. Thus, they mentioned that helping the woman in the OC is about accompanying her during labor and that the woman with more knowledge about this process tends to be calmer and know what to do at that moment; and, in this case, the professional is there only to accompany her.

According to the participants, most of the women who come prepared for labor and delivery are because they sought information and sought to prepare their bodies during pregnancy, whether through a group for pregnant women or through sports practices. However, it was also reported by the participants that there are women who, even if they prepare a lot for a normal birth, when they arrive at the OC and feel the contractions, they end up giving up due to fatigue; and, in these cases, many women ask for a cesarean section, but the team intervenes, explaining what is best for her and the baby, and they try to take her to the shower or offer her the pilates ball in order to keep her steady in the process.

A physician interviewed reported that a good part of the women who come to the maternity hospital where she works and in which she was interviewed are not well prepared for childbirth, but she still considers them more prepared than others who arrive in other services that she knows, because they know that this maternity hospital tends to respect the indications for normal and cesarean deliveries. She mentioned that some parturient women arrive accompanied by doulas, but that it is rare for pregnant women to make a birth plan. For her, it is exhausting for the team to have to prepare the woman for labor when the process is already happening and she regrets seeing a woman suffering with labor for not having been prepared for this moment since the beginning of her pregnancy.

Delivery is conducted almost exclusively by the medical professional

It was already pre-established in the obstetric centers where this study was conducted that the preference for conducting deliveries is the medical residents, always seeking to have an assistant physician and a pediatrician at the time of delivery. One of the participants reported that the physician in charge of the residents remains in the hospital when he is on duty, but when the sector is quieter; he leaves the parturient woman and leaves the responsibility for care with the resident physicians.

As for the monitoring of labor by the nursing team, some participants said that, many times, there is no such monitoring due to lack of time of the nursing professionals. On the other hand, they mentioned that when there is only one nurse working in the OC, it is practically unfeasible for him/her to give direct assistance to the mother during labor and delivery, since he/she has several responsibilities and demands at the same time, such as assisting other mother/puerperal women and newborns, attending to emergencies, coordinating the nursing team, and caring for the environment as a whole.

In the maternity hospitals where the study was conducted, there are nurses who conduct the birth, and there are those who only do it in times of absence of the medical professional in the sector, or when more than one birth is occurring at the same time. One of the participants mentioned that for the nurse to have a good experience in conducting the birth, it is necessary that he/she is following the process to acquire skill. In one of the maternity hospitals, it was reported by the participants that the nurses have experience in conducting the birth, which, for one of the participants, counts a lot for the care. Another interviewee reported that there were cases in which the nurse conducted all the labor for a woman, and when the doctor arrived, he let her finish the process, but expressed that if the resident doctor showed interest in performing the delivery, the priority would be his.

Regarding the number of nurses in the OC, in both maternities there is only one care nurse per shift, and this one is mostly an obstetric nurse; and, during the day, there is also a nurse coordinator of the unit. One of the participants believes that if there were more nurses in the sector, the woman would have more support and the reinforcement of non-invasive technologies for pain relief would be better.

Divergences in care

In the obstetric centers in question, the technocratic model in which the medical area is the most valued still prevails. It was mentioned by the participants that many medical professionals do not believe in the work of obstetric nursing. On the other hand, it was evident in the study that there were physicians who agreed with the opinion of the obstetric nurses and others who did not. There are times when the doctor gives the woman orientations contrary to those of the nurse; and, in these cases, the nurse tries not to contradict, but stands by the woman giving her orientations. One of the nurses reported that there have been cases in which the doctor wanted to apply oxytocin, but the nurse intervened, explaining that there was no need, because the

evolution of the birth was favorable. He also mentioned that the nurse warns the doctors about the late cutting of the umbilical cord and explains the importance of this for the newborn (NB).

Another participant pointed out that the lack of systematization of assistance in obstetrics leads to divergences in medical conduct and the predominance of the medical professional's subjectivity; and that this is often observed by the women themselves who are assisted.

Expediting newborn care soon after birth

For one of the study participants, neonatal care begins during labor. And right after birth, according to the interviewees, the time that the NB stays with the mother varies according to the determination of the neonatologist; after the evaluation of this professional, the NB returns to the mother's lap. Thus, it was mentioned that there is, in the maternities, a difficulty in relation to skin-to-skin contact, both on the part of the nursing team and because of the pressure of the neonatologist on the nursing team so that he can perform the evaluation of the NB. When the neonatologist is not present, it is the obstetric nurse who performs the first care with the NB. However, it was highlighted that, many times, this causes work overload for the nurse, generating stress, which is transmitted to the NB during care, because it is performed in a hurry.

During the interviews, it was also revealed that the nursing team does not have patience when it is necessary to exceed the working hours in the case of a birth, or when there is another woman to be attended to during the shift. This is related to the mechanistic model of OC, in which everything is done in a hurry, as one of the participants mentioned.

It was mentioned by a resident physician participating in the study that sometimes there is a lack of time for nursing technicians to be by the woman's side during labor, especially when the unit is fully staffed. Another participant added that the nursing team is trained, updated, and performs with quality.

It is also noteworthy that advances are already occurring in maternity hospitals today, and this is clear in the speech of one of the participants when she mentioned that, at M2, the care of the NB soon after birth has been modified, and procedures such as the administration of Kanakion and the application of ocular topical PVPI were postponed, to prioritize skin-to-skin contact with the mother.

DISCUSSION

In the first subcategory, it was observed that the OC environment is unpredictable and has a variable demand. In a study conducted with puerperal women who had their babies in the OC of a university hospital in Pernambuco, issues related to the OC environment were raised, among which was highlighted the overcrowding of the sector, which provided an uncomfortable hospitalization[10].

Also in the aforementioned subcategory, the overcrowding of the maternity ward is a factor that interferes with the humanization of obstetric care. This is observed in a qualitative study conducted in a maternal and child hospital, also in Pernambuco, in which 22 health professionals were interviewed. Some justified acts of violence in the care of women who requested help with the argument of overcrowding of the obstetric admission unit and work overload[11].

A factor that should be considered as primordial in the humanization of obstetric care is the woman's privacy. In a study in which eight obstetric nurses of a maternity ward of a teaching hospital located in a capital city of the Southern Region of Brazil were interviewed, it was demonstrated that the woman's privacy was often not respected due to the presence of residents, students, and various health professionals who assisted the woman, and this has hindered the creation of a bond and impeded the women's privacy[12]. These results are corroborated by those of this study.

The desire of women to have a normal birth in a comfortable, private, and quiet environment was evidenced in a study conducted in Turkey. In addition, the importance of having health professionals who support them and provide safety and satisfaction was highlighted[13].

In the second subcategory, it was shown that pregnant women arrive in labor unsafe and frightened at the OC; and, most of the time, unprepared for labor and delivery. Corroborating this information, the national hospital-based survey Born in Brazil, conducted between 2011 and 2012, in which 23,940 puerperal women participated, evidenced the insufficient role of prenatal care in relation to the preparation of pregnant women for childbirth. Guidelines on the promotion of vaginal delivery showed low frequency; on the other hand, guidelines on signs of risk were prioritized, which reinforces the biomedical nature of the assistance[14].

From this perspective, in a study conducted in the OC of a teaching hospital in Southern Brazil, the statements of nurses working in this sector highlighted that humanization should go through various spheres of obstetric care, starting with the welcoming of the woman by health professionals, followed during hospitalization by respectful, cordial and quality care, avoiding unnecessary obstetric interventions that sometimes prevent a physiological and safe labor and birth for the mother and her baby[15].

It was evidenced that in the obstetric centers where the study took place, medicine is seen as the top of the pyramid and the work is often still performed mechanically, in a hurried manner, without respect for individuality and in a noisy environment (loud conversations).

This study shows the confrontations of the obstetric nurse in daily care, with the resistance of obstetricians and resident physicians, perpetuating the institutional culture and the non-adherence to good obstetric practices. This is because, in the obstetric centers in question, it is already pre-established that the preference for conducting deliveries is the resident physicians, always seeking to have an assistant physician and a neonatologist at the time of delivery. In addition, the study also revealed that, depending on the team on duty, the parturient woman will or will not have a positive follow-up during labor, and that there are shifts in which there is no concern from the team to give more attention to the parturient woman and improve care.

In a study conducted in the municipality of Volta Redonda, state of Rio de Janeiro, it is the obstetric physician who acts

in deliveries performed in the OC of a public maternity in this location. According to the participants of this study who were members of the nursing team of this sector, although there is the possibility of the insertion of obstetric nursing in the assistance to normal births, this still does not occur, and therefore, it is necessary that there be encouragement for this, since the obstetric nurse is a professional focused on the humanization of birth[16].

Not all OC nurses had a specialist title in obstetrics. Few obstetric nurses attended low-risk deliveries, and some of them had great difficulty to positioning themselves and lacked autonomy. Thus, having a protocol of childbirth care with the detailing of the attributions of each professional of the OC team, especially the nurses and doctors, could be a way to solve the problem. It is also necessary that the empowerment of the OC nurses of the M1.

In addition to the exacerbated valorization of medical professionals in obstetric care, there is no consensus on the conduct adopted by these professionals and by obstetric nurses, which was observed in an ethnographic study conducted in three public maternity hospitals in the state of Rio Grande do Norte, Brazil. One of the obstetric nurses interviewed in this study reported the lack of homogeneity in the professionals' conducts, which caused problems in the team's performance and in the quality of care provided to women[17].

Data from the national survey conducted between 2011 and 2012 in Brazil point out that obstetric care was still based on unnecessary interventions, and routine practices were still performed without taking into account the clinical context of women and the scientific evidence available. The authors highlight the need to change the model of obstetric care, which is the technocratic and predominant in Brazil. Thinking about this transformation, the insertion of good practices in labor, delivery, and birth care is essential, aiming at the empowerment of women and the humanization of obstetric care[18].

In the same direction, a study conducted in Southern Brazil showed that, besides the fact that unnecessary interventions in obstetric care still occur, many women in labor and delivery still do not have access to the good practices recommended by the World Health Organization for labor and delivery[5]. The reality of the scenario where the present study was conducted was not very different at the time of this research, although there were movements in search of changes.

Many health professionals who provide obstetric care are resistant to a new model of obstetric care. In the reports of physicians in a study carried out in Rio de Janeiro, it was observed that the academic and professional training of the physician is focused on the performance of various procedures and interventions, and that if these professionals are not updated and are not willing to change, they will end up continuing the technocratic medicalized and interventionist obstetric care model and will hinder the change to the humanized care model[19].

However, it is known that good practices will only be effectively implanted in a maternity hospital when there is encouragement and political direction of the institution for such. This establishment will occur according to the persistence or not of an entrenched technocratic model of care, in which the medical hegemony prevails and prioritizes training in medical residency and centered on the professional, which certainly does not depend only on obstetric nursing.

In this study, the care to the NB soon after birth was carried out in haste and often prevented skin-to-skin contact with the mother for the recommended time. On the other hand, changes in the work process were also evidenced that point to a new model of care, i.e., the humanized model, which seeks to postpone some procedures such as the administration of Kanakion, to prioritize skin-to-skin contact.

Most of the time obstetric interventions in the NB in the immediate postpartum period are performed unnecessarily to fulfill a routine, without considering the women's clinical demand or international scientific evidence, thus impairing the formation of the affective bond between mother and NB and the health of both[14,16,20].

The synthesis of this study reveals that the technocratic model still predominant in Brazilian obstetric care - with its interventionist characteristics, centered on the hegemony of the medical professional, work overload, overcrowding of the sector, and haste in providing care - goes against the principles of humanization of obstetric care, since it favors acts of violence in the care of women, that is, the lack of care. In addition, it also shows that counter-hegemony still needs to be exercised and strengthened through the feminist movement, in which it is essential to have the effective engagement of women in general and of obstetric nurses for the change of the technocratic model for a humanized and woman-centered care model.

Thus, it is assumed that the force that dominates ends up being accepted as an intellectual orientation and norm of conduct, so that "for subordinate social groups to emancipate themselves and build their hegemony, Gramsci states that a process of identification, splitting and overcoming is necessary; an intellectual and moral reform, that is at the same time a molecular, complex, difficult and violent movement"[6].

Study limitations

The non-inclusion of nursing technicians and assistants as study participants stands out as a limitation of this study, since they also work in the OC. However, as this research was carried out with several professionals of higher education level and in different maternities, it allowed variability in the characteristics of the data; and the quantity and quality of the data enabled the realization of a relevant qualitative analysis.

Contributions to nursing, health care, or public policy

The study contributes to rethinking the current technocratic care model and its transition to the humanized care model, that is, a quality care, of which obstetric nurses should be the managers and protagonists.

FINAL CONSIDERATIONS

In the maternity hospitals in question, the prevalence and persistence of the technocratic care model still occurs for several

reasons, among which the following stand out: the assistance performed in a mechanized and professional-centered manner; the hurried way of performing the assistance, especially the care of the NB soon after birth; the lack of preparation of the parturient women for labor and delivery and their lack of privacy; the conduction of deliveries almost exclusively by doctors; the lack of systematization of the assistance, which makes the conducts subjective and divergent among medical professionals and the sub-dimensioning of the nursing staff, especially nurses.

Thus, the study shows that childbirth care is still centered on physicians, who often perform care with unnecessary interventions. The work in the OC is not yet done in an interprofessional manner. In this sense, the Brazilian obstetric care still lacks further advances in this struggle related to the model of care, to the paradigm change, in the relationship between health professionals. Further clarifications and reflections are also needed towards the humanized care model, which involves tenderness, compassion, empathy, and affection.

Given the results of this study, it becomes an ethical imperative that obstetric nurses review their performance in obstetric centers, the internal organization, and the dimensioning of nursing professionals in these care settings, aiming to assume the protagonism of care rather than waiting for the medical team and managers to recognize their competencies. Likewise, it is necessary to invest in the awareness and academic training of all midwifery professionals and in updating their knowledge, based on scientific evidence and user-centered care.

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