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The obstetrical nursing identity in a Birth Center[a]

A identidade da enfermagem obstétrica no centro de parto normal

La identidad de la enfermería obstétrica en el centro de parto normal

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Abstract

Objective: to understand obstetrical nursing identity in the area of its performance in a Birth Center. **Method**: a descriptive-exploratory study with a qualitative approach. Semi-structured interviews were carried out between March and August 2022 with 09 nurse-midwives from the *Centro de Parto Normal Haydeê Pereira Sena*, Pará, Brazil. Content analysis and discussion based on Claude Dubar's identity were used. **Results**: two categories emerged: *Professional identity: a matter of social construction*, which portrays the social scope of identity construction through experiences as a student and as a nurse and their relationships in the work process; and *The identity of obstetrical nursing in the field of its performance in a Birth Center*, favoring humanization, scientific evidence for women's autonomy, which is only provided by the birth center's structuring policy, and coping with other professional classes, to guarantee and legitimize nurse-midwives' work. **Conclusion and implications for practice:** understanding nurses' professional identity in the birth center is the central point to ensure their appreciation and their performance with respect, legitimizing their right, because, with a solid identity, greater quality and changes in the hegemonic obstetric model are guaranteed.

Keywords: Professional Identity; Natural Childbirth; Obstetric Nursing; Humanization of Assistance; Humanizing Delivery.

Resumo

Objetivo: compreender a identidade da enfermagem obstétrica no campo de sua atuação no Centro de Parto Normal. **Método:** estudo descritivo-exploratório, com abordagem qualitativa. Realizaram-se entrevistas semiestruturadas, entre março e agosto de 2022, com 09 enfermeira obstetras do Centro de Parto Normal Haydeê Pereira Sena, Pará, Brasil. Usaram-se análise de conteúdo e discussão com base na identidade de Claude Dubar. **Resultados:** emergiram duas categorias: *A identidade profissional: uma questão de construção social*, que retrata o âmbito social da construção da identidade pelas experiências como estudante e como enfermeira e suas relações no processo de trabalho; e *A identidade da enfermagem obstétrica no campo de sua atuação no Centro de Parto Normal*, favorecendo a humanização, as evidências científicas para a autonomia da mulher, que somente é propiciada pela política estruturante do Centro de Parto, e os enfrentamentos com outras classes profissionais, para garantir e legitimar a atuação da enfermeira obstetra. **Conclusão e implicações para a prática:** a compreensão da identidade profissional das enfermeiras no Centro de Parto Normal é o ponto central para garantir a sua valorização e sua atuação com respeito, legitimando seu direito, pois, com a identidade alicerçada, garantem-se maior qualidade e mudanças no modelo hegemônico obstétrico.

Palavras-chave: Identidade Profissional; Parto Normal; Enfermagem Obstétrica; Humanização da Assistência; Parto Humanizado.

Resumen

Objetivo: comprender la identidad de la enfermería obstétrica en el campo de su actuación en el Centro de Parto Normal. **Método**: estudio descriptivo-exploratorio con abordaje cualitativo. Se realizaron entrevistas semiestructuradas entre marzo y agosto de 2022 con 09 enfermeras obstétricas del Centro de Parto Normal Haydeê Pereira Sena, Pará, Brasil. Se utilizó el análisis de contenido y la discusión a partir de la identidad de Claude Dubar. **Resultados**: surgieron dos categorías: *Identidad profesional: una cuestión de construcción social*, que retrata el alcance social de la construcción de la identidad a través de las experiencias como estudiante y como enfermero y sus relaciones en el proceso de trabajo; y *La identidad de la enfermería obstétrica en el campo de su actuación en el Centro de Parto Normal*, favoreciendo la humanización evidencia científica para la autonomía de la mujer, que sólo es proporcionada por la política estructurante del Centro de Parto, y confrontaciones con otras clases profesionales, para garantizar y legitimar el trabajo de las enfermeras obstétrica. **Conclusión e implicaciones para la práctica**: comprender la identidad profesional de las enfermeras del Centro Normal de Parto es el punto central para garantizar su valoración y su desempeño con respeto, legitimando sus derechos, ya que con una identidad sólida se garantiza mayor calidad y cambios en el modelo obstétrico hegemónico.

Palabras clave: Identidad Profesional; Parto Normal; Enfermería Obstétrica; Humanización de la Atención; Parto Humanizado.

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INTRODUCTION

Obstetrical nursing (ON) care is aligned with qualified care, respecting the precepts of humanization of care and respect for women, promoting a welcoming and empathetic relationship with patient-centered care. Having its work based on scientific evidence childbirth and birth physiology appreciation, and its work in Birth Centers, this professional process stands out due to Birth Centers' (BC) structuring policy.[1-3] The construction of its identity is of utmost importance to guarantee the ON specialty legitimacy in the *Rede Cegonha* (RC) component's structuring policy by the Ministry of Health (MoH), which supports humanized childbirth woman empowerment.

For understanding, the term "identity" refers to the process by which individuals become aware of themselves, even in contact with people or groups, with the world of life and their relationships, with whom they interact. Thus, identity is constructed from social relationships with people.[4] Nurse-midwives' identity is socially constructed by a social group they belong to; in this case, by nurses and also by health professionals, which is established in individuals when involved in relationships with others, whether personal or collective, and the scope of the work process perpetuates this social construction of ON's identity in the field of their work in BC.

Thus, considering the need to guarantee access to childbirth care in the Brazilian Health System (SUS – *Sistema Único de Saúde*) health services and complying with the principles of universality, integrality and equity, the MoH created BC through Ordinance MoH/GM 985 of August 5, 1999 to promote humanization and quality in childbirth care without distortion or usual risk, and can operate inside or outside the reference hospital.[1,5,6] This premise favors the implementation of professional assistance combined with family support and the reduction of care risks and consequent complications.

Within this policy, ON valorization is promoted in BC's field of activity in reproductive health. With the aim of promoting changes in care models and the central point for humanization, ON becomes a profession aligned with the values of this transformation for better perinatal indicators.[1,2,7,8]

In this context, BC constitute a welcoming and supportive environment that allows individual care for each woman and family, with women being the main figure in care. This environment allows constructing ON's identity with the relationships established in the work process, which allows legitimacy in its conduct in childbirth and birth care. Thus, the study had the following guiding question: how is the identity process of ON configured within the scope of its work in BC?

In this regard, this study aimed to understand ON identity in the field of its work in BC.

METHOD

This is a descriptive, exploratory study, using a qualitative approach, carried out *at Centro de Parto Normal Haydeê Pereira Sena*, linked to the Municipal Health Department of Castanhal, in the state of Pará, Brazil. BC provide care to women in the pregnancy-puerperal cycle, with actions aimed at prenatal care, labor, childbirth, the immediate postpartum period and newborns (NB) within the SUS, since more than 700 childbirths have already been carried out in the health Service.

Participant selection occurred intentionally among BC nurse-midwives. In this strategy, the researcher sought to identify, in advance, the main groups or conditions of individuals that could contribute significantly to the objective of the study, having as a condition for selection that individuals have experienced experience;[1] in this case, BC's actions. Study stages were initially explained to participants, in addition to the objective of the study, and an invitation was made for their participation.

Participants were nine (09) nurse-midwives from BC, who met the criteria of being specialists in ON and working directly in the context of labor and childbirth. Exclusion criteria took into account the administrative, managerial role or being on leave at the time of data collection. The process of closing data collection and establishing the number of study participants occurred through data saturation, when the meanings arising from nurse-midwives' speeches became convergent, and through the link between meanings, which led to the understanding of the core of the phenomenon studied.[9] It should also be noted that there was no dropout among participants.

Data collection was carried out, using a semi-structured interview guide, from March to August 2022, by the main interviewer, through meetings scheduled at the health service during each professional's working period, taking place in a reserved room, without the presence of third parties, just the interviewer and the participant, guaranteeing complete privacy during the interview. Interviews lasted an average of 40 minutes, with the presence of a script that included nurses' social/professional/academic profile and, subsequently, the following question: tell me about your work in BC, your practice and your relationship with construction of their professional identity within the health service. Data were recorded on a digital device (MP3), with the aim of helping to transcribe the data. After this process and with transcribed data, material organization began to analyze the interviews.

Data organization began with content analysis,[10] which consists of pre-analysis of the meanings described in the 09 interviews carried out, moment in which text skimming was carried out for each one, with the choice of pertinent and representative elements. After this process, the second stage took place with material exploration, where coding interventions were created relating nurse-midwives' speeches with the purpose of categorizing them.[10] In this way, registration units were identified, such as identity formation, professional experience, autonomy, responsibility, social group, action identity, dialogue and sharing, good practices, scientific evidence, humanization, BC culture.

In the final phase of analysis, results, inferences and interpretation were processed so that they became meaningful and valid with the presentation of formulated categories,[10] enabling

the construction of the following thematic areas: *Professional identity: a social construction issue*; *Obstetrical nursing identity in its field of activity at a Birth Center*. The discussion of results was based on sociologist Claude Dubar's framework, which, according to his thoughts, identity is socially constructed through the relationships that individuals have. This process of identity construction is perpetuated by subjects' constant interpretations of themselves and their interaction with people and institutions, which are mediators of this construction.[4] It is mentioned that data analysis was carried out by the main researcher, with the support of four other researchers, which enabled the construction of categories in the analysis used and interpretation of results.

The study was approved by the Research Ethics Committee of the Institute of Health Sciences of the *Universidade Federal do Pará* (CEP-ICS/UFPA), according to Protocol 5.160.498 of December 11, 2021, Certificate of Presentation for Ethical Consideration (CAAE - *Certificado de Apresentação para Apreciação Ética*) 52810421.9.0000.0018, as provided for in Resolution 466/2012 of the Brazilian National Health Council. To preserve secrecy, anonymity and reliability, interviewees were identified with the initial letters of the area (ON), followed by a number corresponding to the sequence in which interviews were carried out (ON1, ON2, ON3, …, ON9), in addition to guaranteeing the voluntary participation by signing the Informed Consent Form (ICF). The COnsolidated criteria for REporting Qualitative research (COREQ) was used for statement quality and transparency when conducting the research.

RESULTS

Among the profile of nurse-midwives, all are female. Regarding age, there was a predominance of five between 30 and 35 years old. Regarding the relationship between undergraduate training, the majority took place in a public institution, with eight participants. Eight nurse-midwives received training between 2012 and 2016. All nurses have a *lato sensu* specialization, with a predominance of residency in ON, and, of these, four have a master's degree in nursing. Regarding length working in the area, eight had worked in the area for between six and ten years. Regarding job tenure in BC, there was a predominance of five participants working between two and five years.

Professional identity: a social construction issue

Professional identity occurs from being identity, having identity as fundamental basis and being shaped from experiences subsequent to its social construction. It is possible to infer that university life and the social relationships acquired there are fundamental for solidification and/or transformation of identity and essential for the development of nurses' professional identity.

> *And, at the same time, I had contact with midwifery internship practices, which was something that at first I refused. So, in my first birth, in my first contact, in my first assistance, I was sure that it was what I wanted to do [...] I was able to experience up close what the assistance was and what the reality of obstetrical nursing was like in Belém. It was something that confirmed that it was really what I wanted for my professional training, that, regardless of adversity, I never thought about giving up.* (ON1)

> *I've always really liked the area of women's health, ever since I graduated. When I discovered the residency program in obstetrical nursing, my interest increased considering the great experience I would have the opportunity to have. I also participated in some events during college, and, during internships, I observed that many practices were outdated; I then saw the opportunity to train myself to be an agent of transformation in the scenarios.* (ON6)

Professional identity is socially constructed within the perspective of training and social relationships in the professional field, which provides the basis for this construction of ON identity through individuals or social group – work group, according to the following statements:

> *I understand that it is everything that a professional needs to have, both in terms of training and conduct, to work in a given service. In other words, they would not just be personal characteristics of professionals, but everything they have been building in their training, in their decision-making to be there in that service*. (ON2)

> *I think professional identity is how we see ourselves in our profession and also as a person and how this person we are influences our practices.* (ON7)

Identity construction can take place socially in the face of everyday relationships with a social group, with nurse-midwives, but also with other groups, with other individuals, but who intertwine in the work process, with the multidisciplinary team, according to the following statements:

> *Well, for me, professional identity is who we are as individuals who work in some capacity. It's how we perform our work, how we perceive ourselves in front of our co-workers and other professionals as well [...] and humanization and quality thin BC brings makes everyone decide in their actions to guarantee the best care, all in favor of a collective*. (ON8)

> *I think it's about the relationship that we start to build in our profession. This relationship concerns not only us as nurse-midwives, but also our profession and multidisciplinary team co-workers. This is how we see ourselves inserted in this professional world [...] because, in BC, humanization becomes a link in our care for women, and this has to be involved in this relationship process with everyone.* (ON9)

Thus, nurse-midwives guarantee their identity construction through social relationships, with their work in health care, with their daily relationships with the ON social group, in addition to encouraging this construction from the first experiences during their graduation.

Obstetrical nursing identity in the field of its activity at the Birth center

BC are an important space for ON's professional activity. In this space, there is a guarantee of autonomy for woman, NB and family care. In this context, such action is based on nurse-midwife identity based on good childbirth practices and scientific evidence, which provides a guiding guide for the social group's action as care within BC.

> *I think thin BC is a space where nurses can better characterize what obstetrical nursing actually is. We were able to put into practice the protocols, CONITEC manuals, good practices, scientific evidence in a broad and complete way, and where we were able to identify the importance of ON.* (ON4)

> *Well, I think that, first, we have a nursing identity in general, and only then, having already had this identity as a nurse, do we begin to construct an obstetrical nursing identity in a more specific way. So, obstetrical nursing identity is primarily "being a nurse", who assists labors and births, in their relationships with patients and families, with other nurses and physicians, with the team of technicians that surround us. I think that guarantees our action based on evidence; this is our difference and our identity.* (ON7)

Another essential point of action of ON is autonomy in BC. This autonomy is based on nursing professional practice with determinations for the ON specialty, and BC have a structuring policy for its legitimized action. Thus, ON identity is facilitated by the autonomy of participants' daily care practice, which, throughout their activities, is socially constructed and given new meaning with the new, changes and scientific evolution.

> *Well, we perceive obstetrical nursing's autonomy as very great, close to other specialties, and in BC, even more so, we feel completely empowered. There is a need to be updated and qualified [...] oh, you know that your partner will be there to support you, support you and act together and equally. And we have the power to deal with the situation in a very broad way. This makes us feel very at ease when working in BC.* (ON2)

> *It is very empowering to see how much our class is valued and esteemed working in BC. I see that this opens doors for us not only as obstetricians, but as nurses first and foremost. I believe that our professional identity is composed not only of us individually, but also of the entire culture that permeates the practices of our specialty, and BC develops and encourages this. Just look at the autonomy we have compared to other places of operation.* (ON9)

In another aspect, humanization of childbirth and health training are foundations for building BC nurse-midwife identity. When there is restriction on ON's activities, as occurs in many Brazilian maternity hospitals, professional identity itself is not established in professional practice, due to the inhibition of the right to act, according to the following statements:

> *Within the hospital, you work with what should be a multidisciplinary team, with common work and mutual respect. But it turns out that nurses do not feel respected in many ways to provide complete care, often influenced by the medical figure of "rushing" the birth, of intervening when they shouldn't. Within BC, we act according to the protocols, what we have learned and within our jurisdiction. There are no other professionals interrupting your work there.* (ON2)

> *Yes, I see hospital work as very passive, it does not share decision-making. And I'm very sad, because they are professionals with the capacity to take action, they have knowledge, and they cannot participate. If someone makes a decision, even if they don't agree, there's not much you can do. I see something very passive, mechanical of a professional with gigantic potential.* (ON3)

Questioning this service is also a process that makes it difficult to construct BC identity, especially without the presence of a medical professional. These are political and other professional situations that make this space inappropriate for offering care to women in the field of childbirth and birth. Despite this, it appears that ON has its own identity to guarantee quality and respectful care:

> *The obstacle is the presence of the Birth Center before the city's medical and political teams. Unfortunately, he is poorly regarded by these figures in the city. So, there is a lot of struggle to work on, we know that we cannot make any mistakes, because there are all these eyes on us. Being a Birth Center in a country that is a champion of cesarean sections is difficult, also because the families of women in labor already instill that cesarean sections are better. We have to explain everything to these women, to try to deconstruct this culture. Often, co-workers, prenatal nurses themselves discourage pregnant women, because there are no physicians here*. (ON4)

> *The big obstacle is the city's culture. Women still don't understand that physicians are not necessary in the birth*

> *center, we often need to explain this. Despite everything, it is a reality that has changed a lot, we promote it on social networks. Culturally, women are also afraid of natural birth. These are the main difficulties.* (ON6)

In this way, nurse-midwives' work in BC, based on good practices, scientific evidence, and her autonomy in this space, with assistance permeated by sharing and dialogue, they allow the guarantee of care centered on women and their rights, this identity being that of ON.

DISCUSSION

The process of forming professional identity is a reflection of the construction of each individual's personal identity. Therefore, there is no way for a nurse-midwife to exist without first having a generalist nurse and, even more so, the person behind the profession. Considering this reasoning, social relationships experienced throughout their life cycles corroborate, in a cyclical way, individual identity formation and constant reformulation. Thus, they constitute internal and external transactions of individuals, with constant interpretations of themselves and the institutions and people with whom they interact.[4]

The way in which this individual distinguishes and deals with the figure of the other begins the first family contacts, going through school life, during childhood and adolescence, throughout the process of primary socialization, and consolidating and expanding during the university years, through exchanges between academics and teachers, with their professional identities already consolidated not only in their area of clinical activity, but also in their role as professors. Identity construction is important in the work and training process that legitimizes its recognition in social identity.[4]

In this regard, nurse-midwife professional identity formation also involves generalist nurse professional identity formation, considering that identity is formed by social processes.[4] Once consolidated, it is maintained and can be modified or even remodeled by social relations.[11] Throughout the undergraduate journey, this construction occurs through the exchange of social relationships between co-workers, i.e., between personal identities already in the process of consolidation, such as between students and professors, with identities in formation and identities already established, and even between students and SUS users, in health units where internships and internship cycles are carried out.

It is in this training process that future nurse-midwives have their first contact with the obstetric model prevalent in teaching hospitals and also with health teams working in their multidisciplinary circle of activity. It is during the first social relationships established in health units, witnessing assistance, whether prenatal or childbirth, that future professionals observe and develop their perspective on the social reality that surrounds them, paying attention to the environment in which each patient and each family is included, also developing a view of themselves as agents of care and, possibly, of transformation of the social environment in which they are inserted.[12] Thus, in this construction, there are acts of belonging that express the type of person individuals want to be – self-identity.[4]

With nurse-midwife professional identity initiated and in the consolidation process, there is an exchange of experiences, sharing of routine and recognition of oneself in others as nurse-midwives working in BC. It is in this reasoning that we can affirm that, in the dialectic between nature and this socially constructed world, the human figure transforms, producing a cyclical reality, and this, in itself, also reconfigures the limits of individuals' behavior and work as nurse-midwives.[1-3,6]

As assistant nurse-midwives in BC, both in the parturition process and in the birth process, conducts are essentially adopted between each other, thus developing a bond of trust and complicity between professionals and co-workers. Thus, this identity is solidified and, often, reconfigured through the exchange of experiences and coexistence between nurse-midwives, corroborating with the authors[11:228] who state that "identity in fact is constituted through socialization processes, which can be remodeled through social relations". Identity is a product of countless socializations, the result of a relational process between individuals and the collective.[4]

Associated with this, there is also the ON role in BC both as an assistant and as a manager within the health team, which is made up of other nurse-midwives, technical nursing professionals and professionals from the support and transport sector. In other words, the nurse-midwife working in BC is constantly exerting influence on other health team members, also receiving their influence.[1,2,5,8,11]

It becomes possible to point out that this so often repeated process, with its particularities, and guided by nurse-midwives, influences and consolidates their identity as professionals who works with a view to promoting qualified and humanized care in BC.

This humanizing and personal character attributed to BC and its professionals results in a high number of positive outcomes and increased satisfaction among women and families with the assistance provided.[12,13] In this regard, nurse-midwives working in BC are the professionals responsible for directing the team towards humanized care, devoid of personal judgments and focused on implementing good practices during labor, childbirth and birth.[1-3,5,8,14,15] Furthermore, they are the professionals responsible for helping the family during the immediate postpartum period, promoting mother-baby bond strengthening, resolving doubts and also working in neonatal care.[14-16]

To carry out care in a full, systematic and humanized way, and with harm reduction, it is necessary for nurse-midwives to have full theoretical and practical training so that they are able to act not only on positive outcomes, but also on complications, if they

occur.[16] This training is obtained through graduate studies, whether in the form of professional residency or even specialization, and also through refresher and qualification courses, participation in congresses, workshops and symposiums, which enable the dissemination of updated scientific evidence so that ON acts based on approved protocols in order to guarantee adequate assistance and also its professional protection. Thus, professional identity is established in this environment, with the search for knowledge specific to its work, but with its social relationship with teachers, who are mediators of this process of consolidating individual identity.[11]

Good practices also value nurse-midwife role in making decisions applicable to BC, delimiting the eligibility of postpartum women and defining from what moment this postpartum woman should be referred to the back hospital, if necessary. Evidence-based action guarantees ON the necessary basis to assist childbirths whose outcomes are favorable, guaranteeing a good birth experience for women and greater satisfaction for families assisted.[13]

The BC model characterizes a strategy to rescue physiological childbirth in its essence, but it also represents a place of action, rescue of autonomy and appreciation of ON professionals.[1,2] This is observed through guidance given by nurse-midwives in their conduct, implementation of non-pharmacological methods to alleviate pain complaints and welcoming of families, considering each patient as an individual and also promoting childbirth personalization. This point is central to nurse-midwives' work as an identity mark that, through non-pharmacological methods for pain relief, ON implements all of its care built in its training and in its real daily work, socially mediated by the process of work.[11]

This is due to the fact thin BC enable its full care to childbirth and also to the unborn child, often neglected when this same category operates in hospitals and maternity wards whose care model is mainly conducted by medical professionals, allocating nurses, even specialists in obstetrics, bureaucratic and secondary tasks.

This social construction of nurse-midwife professional identity is strengthened in BC due to the fact that they take with them the role of active agent in the reconfiguration of a more humanized care centered on women and their families, highlighting decision-making aimed at reducing damages based on scientific rigor and good practices.[17] In this way, nurse-midwives working in BC have their identity constructed, strengthened and reconfigured as being responsible for the health team for application of good practices, dissemination and propagation of a humanized care model. Thus, their professional identity also permeates the importance of their category as an agent of transformation of the predominant obstetric model.

Misinformation and the relationship of power and authority characterize significant obstacles for women to choose BC, as misinformation perpetuation can contribute to women not opting for BC, under the justification that there is no medical action in this care model.

The difficulties present in basic and outpatient care itself, in which prenatal care is generally carried out, in relation to assistant professionals, many of whom are nurses, discourage pregnant women from seeking assistance in BC, under the justification that obstetricians or pediatricians do not work in labor, disregarding nurse-midwives' trained and updated work. This situation demonstrates the lack of knowledge regarding BC's structuring policy and also about public policies for childbirth care and habitual risk births on the part of some fellow nurses and physicians assisting in prenatal care in basic units in the region.

Furthermore, the context of confrontation between classes, with physicians and nurses, also exerts great influence, representing a great challenge for BC consolidation in question. During election periods, it is common to observe cesarean childbirths as a campaign measure and popularize various medical candidates. This situation goes against what is recommended in public policies for childbirth and birth care, disregarding the risks and benefits of cesarean sections without real indications.[18] This process becomes an important challenge to be faced, with changes in health services, guaranteeing nurse-midwives' full work and identity in BC. This social environment always tries to guarantee the medical profession the autonomy of being in this context, but nurse-midwives seek respect for their professional practice and as an agent of transformation, who has full knowledge and training to be promoting their work and identity as nurse-midwives.

In this context of struggle against the health system and class within the scope of public health, the ON operating in BC has an essential role in guaranteeing the rights of women and unborn children, and in transforming the obstetric model, through alternatives based on good practices, opposing inappropriate and proscribed conduct, unnecessary interventions and constant medicalization of childbirth.

FINAL CONSIDERATIONS AND IMPLICATIONS FOR PRACTICE

The findings of this research made it possible to understand ON identity in the field of its work in BC, with the focus on Claude Dubar's thoughts on identity. BC constitute an important space that guarantees ON autonomy conditioned by public policies in the field of reproductive health.

Hence, ON identity with an emphasis on its work with women, NBs and families shows the real importance of the assistance offered, on an individualized basis, based on respect, rights and

individuality of care. This care is individual, but must be constructed based on the way of acting in the care context.

The understanding of identity is related to the social relationships that individuals build throughout their relationship with the world and experiences with people. Thus, nurse-midwife identity within BC is established with experiences in the academic field, as a student with professors, co-workers and health professionals, and with professional experiences, with the social group that are specific to the profession, such as nurses or of the ON specialty or even with the multidisciplinary team.

This identity constructed and socially based on relationships forms a care modus operandi in obstetric care, with respect to women's autonomy and childbirth physiology, based on scientific evidence, recommendations/guidelines in childbirth and birth, and humanization. BC confer this identity through its structuring policy that legitimizes this autonomy for ON. However, there are still factors that try to prevent this identity in action, such as confronting classes and the obstetric model, contributing to the restriction of rights within the scope of their work.

The study had a limitation, since it was developed based on a particular reality of the scenario, and did not allow relationships and generalization, since the guarantee of representative distribution requires statistical proof for sample calculation.

The need for new studies that investigate and deepen ON professional identity and its contributions to the BC assistance model are highlighted, with a view to identifying strengthening points and also vulnerabilities so that this assistance can be gradually improved in terms of refers to the positive effects between women, babies, families and professionals, strengthening bonds and supporting nurse-midwife appreciation and recognition and their care.

AUTHOR'S CONTRIBUTIONS

Study design. Malena da Silva Almeida.

Data collection or production. Malena da Silva Almeida.

Data analysis. Malena da Silva Almeida. Diego Pereira Rodrigues. Valdecyr Herdy Alves. Andressa Tavares Parente. Sílvio Éder Dias da Silva.

Interpretation of results. Malena da Silva Almeida. Diego Pereira Rodrigues. Valdecyr Herdy Alves. Laena da Costa Reis. Clemilda Alves da Silva. Andressa Tavares Parente. Sílvio Éder Dias da Silva.

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