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RESEARCH

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LIVING DISORDERS IN THE PRACTICE OF OBSTETRIC NURSE CARE: THE COMPLEX LOOK AT THE PHENOMENON

Vivenciando as desordens na prática do cuidado do enfermeiro obstetra: o olhar complexo ao fenômeno

Vivenciando los desordes en la práctica del cuidado del enfermero obstetra: la mirada complejo al fenómeno

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ABSTRACT

Objective: Understand the disorders experienced by nurses in their practice of childbirth care, in the light of Complexity. We used the Grounded Theory as a methodological reference and the Complexity Theory as theoretical support. **Method:** Qualitative study. We used the Grounded Theory as a methodological reference and the Complexity Theory as theoretical support. We interviewed 31 participants in three sample groups of nurses, health managers and physicians. **Results:** Obstetric nurses experience disorders in relation to their autonomy, the power of the doctor and obstetric violence in the birthing process, the lack of support from the health management and maternity management, the lack of organization of the network and, as a consequence, they experience feelings performance. **Conclusion:** These should be overcome as a possibility of change in the care model of the obstetrician nurse.

Descriptors: Nurses; Obstetric nursing; Nursing care; Hospital administration.

RESUMO

Objetivo: Compreender as desordens vivenciadas pelo enfermeiro em sua prática do cuidado no parto, à luz da Complexidade. **Método**: Estudo qualitativo com delineamento da Teoria Fundamentada nos Dados como referencial metodológico e a Teoria da Complexidade como suporte teórico. Foram entrevistados 31 participantes de maternidades do Rio Grande do Norte, Brasil organizados em três grupos

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amostrais de enfermeiros, gestores de saúde e médicos. **Resultados:** Os enfermeiros obstetras vivenciam desordens em relação à sua autonomia, ao poder do médico e a violência obstétrica no processo de parto, à falta de apoio da gestão de saúde e gestão das maternidades, à falta de organização da rede e, como consequência, vivenciam sentimentos negativos na atuação. **Conclusão:** Essas deverão ser superadas como possibilidade de mudança no modelo de atenção do enfermeiro obstetra.

DESCRITORES: Enfermeiro; Enfermagem obstétrica; Cuidados de enfermagem; Gestão hospitalar.

RESUMEN

Objetivo: Comprender los desórdenes vivenciados por el enfermero en su práctica del cuidado en el parto, a la luz de la complejidad. Se utilizaron la Teoría Fundamentada en los Datos como referencial metodológico y la Teoría de la Complejidad como soporte teórico. **Método**: Estudio de naturaleza cualitativa. Se utilizaron la Teoría Fundamentada en los Datos como referencial metodológico y la Teoría de la Complejidad como soporte teórico. Se entrevistó a 31 participantes organizados en tres grupos muestrales de enfermeros, gestores de salud y médicos. **Resultado**: Los enfermeros obstetras experimentan desordenes en relación a su autonomía, al poder del médico y la violencia obstétrica en el proceso de parto, a la falta de apoyo de la gestión de salud y gestión de las maternidades, a la falta de organización de la red y, como consecuencia, experimentan sentimientos negativos en la actuación. **Conclusión**: Estas deben ser superadas como posibilidad de cambio en el modelo de atención del enfermero obstetra.

Descriptores: Enfermeros hombres; Enfermería obstétrica; Atención de enfermería; Administración hospitalaria.

INTRODUCTION

Science has brought to the universe, over time, the great discoveries and extraordinary progress and together with them the world of certainty. However, from the nineteenth century, there was a concern, through the physical sciences, about the idea of the possibility of uncertainties in phenomena to cope with the unexpected and the unexpected. It then emerges from the complex paradigm, characterized by the perspective of order and disorder as a challenge and a motivation to think.[1]

In this sense, the performance of nurses in childbirth, characterized by processes of ordering, but also of disorder, brings reflection in a perspective of innovation, creation and the achievement of favorable conditions for the search for order and balance of processes, without disregarding the uncertainties and contradictions present in the studied phenomenon.

The disorders experienced by obstetric nurses during their practice also bring a relevant concern in obstetric nursing in the state of Rio Grande do Norte (RN), as these often make it impossible for this professional to practice in the context of physiological birth, based on humanization of care policy and especially considering the protagonism of women.

Starting from a feeling of concern about the difficulties or disorders experienced by obstetric nurses in their work in the State of RN, the importance of this professional for the improvement of birth processes and being sensitive to the possibilities of changes in management processes, the research question arose: How do nurses understand the disorders they experience in their work? In order to answer this question, the present study aimed to understand the disorders experienced by nurses in their care practice in childbirth, in light of complexity.

METHODOLOGY

This is a qualitative study, conducted by the Grounded Theory (GT). GT is a descriptive qualitative research method to be used when the purpose of investigation is the elaboration of new understandings and / or expressions of a phenomenon. Thus, they classify it as a theoretical construction method based on the data.[2]

As for the theoretical framework, complex thinking supported the research. Complex thinking predisposes principles of disjunction, but also of conjunction and implication.[1]

The study was conducted in maternity hospitals of the NB, according to the inclusion criteria; have the performance of the obstetric nurse and who had a history of humanization in care, making a total of five maternity hospitals. The study also had 31 participants, belonging to three sample groups. The first, consisting of obstetric nurses, totaling 16 professionals; the second, from health managers and maternity directors, totaling eight professionals; and the third group comprising a total of seven doctors. Thus, the second and third groups emerged from the hypotheses that were built since the first data collection and analysis of the group of nurses, as well as the need for abstraction of concepts and their density at the level of properties and dimensions.

To guarantee the anonymity of the participants, we chose to designate the nurse of interview number 1 as E01, following the interviews, and so on; of G01 the manager of interview number 1, following the interviews, and so on; and from M01 the first obstetrician interviewed, following the interviews, and so on. The collection and analysis occurred simultaneously, as guided by the assumptions of GT.

Data analysis began with microanalysis, word for word, line by line. Codes were created as much as needed through open coding. Subsequently the codes were grouped by similarities according to their properties and dimensions; This phase, called axial coding, thus relating categories to subcategories around an axis, also called axis. Subsequently, selective coding defines the most general categories, until the integration and delimitation phase of the central category.

Fundamental TFD resources were also used in analytical processes such as memos and diagrams. Thus, the memoranda were essential in the process, for the emergence of concerns and formulation of hypotheses. The diagrams facilitated the graphical visualization of the relationships between the concepts.

The collection was initiated after approval by the Research Ethics Committee of the Federal University of Santa Catarina, through Opinion No. 507.327, with the date of approval on February 10, 2014 and respecting the ethical principles of research with human beings.

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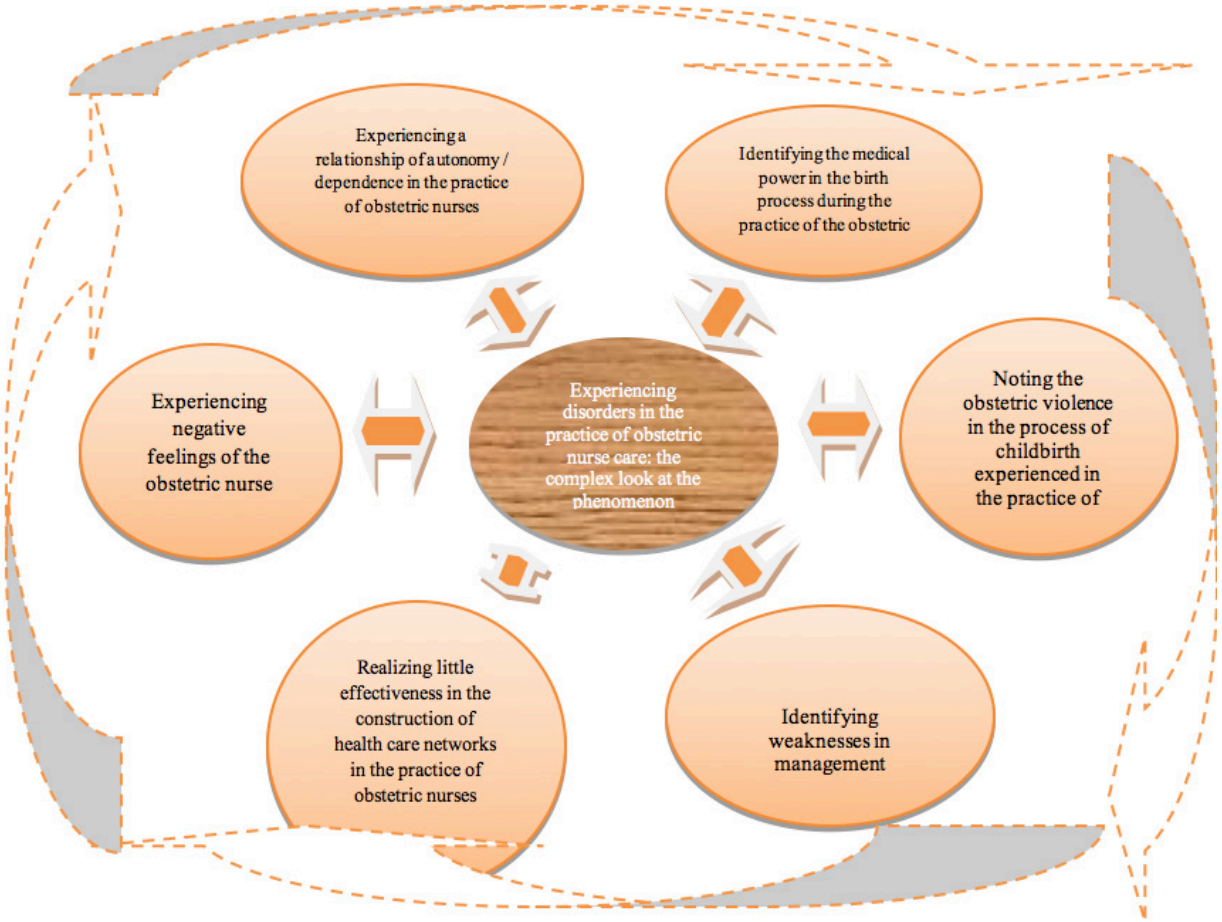
Living disorders in the practice of obstetric nurse care...

RESULTS

The category experiencing disorders in the practice of obstetric nurse care: the complex look at the phenomenon consisted of six subcategories, described below.

Figure 1- Experiencing disorders in the practice of obstetric nurse care: the complex look at the phenomenon



Subcategory 1 - Experiencing a relationship of autonomy / dependence in the practice of obstetric nurses

The practice of obstetric nurses in the care of childbirth at normal risk is permeated by important disorders that have contributed to the weakening of the professional category.

> *[...] here in Rio Grande do Norte we have a figurative work. We participate in all care, care plan, care, only we have no autonomy within the delivery room, no autonomy within the operating room [...].* (E14)

> *And on the other hand there are also nurses who do not feel encouraged to do and even specialize in the area, because they claim they have no field, are afraid to bear the responsibility of the act too [...]. But, when there is a problem, the nurse may be penalized for it [...].* (G06)

This reality is faced in most maternity hospitals in the state of Rio Grande do Norte. Understanding autonomy by making a parallel autonomy / dependence is necessary to provoke reflection on the incident.

Subcategory 2 - Identifying the power of the physician in the delivery process during the practice of obstetric nurses

Other barriers also influence autonomy / dependence. Medical hegemony, the power of this professional and often the lack of support from managers.

> *These doctors who are so full of themselves, who think they have all the power in the world, who they say loud and clear: 'I am a doctor' so proudly. Of course, they have their duties, but health is not just about a professional, it's about a team.* (M02)

[...] avoid this almost reaction to this kind of care by the medical corporation [...]. (G1)

Sometimes the residents, the doctors, they have resistance about it there (the father cut the cord), but, when we are giving birth, there is no problem with the first contact there with the baby. encourage the companion, especially if it is the parent. (E08)

Therefore, as a weakness in obstetric care, the remnants of medical dissatisfaction that hinder the work of other health professionals are perceived as a threat to the medical power exercised over the years, weakening the work of nurse.

Subcategory 3 - noting the obstetric violence in the childbirth process, experienced in the practice of nurses.

Obstetric violence denotes weaknesses in the processes of birth and, therefore, impairing the practice of nurses, as he becomes powerless before the power exercised by the doctor in conducting the usual risk delivery:

[...] there are many doctors who do terrible deliveries, laborious deliveries without any condition, but they have the name of doctor, they have a CRM, they are allowed to do, and they end up doing things that are completely inadequate to be done with that patient. (M02)

In general, health professionals are constantly confronted with obstetric violence without realizing it, as it is already part of their daily lives, and this practice becomes trivialized by professionals and services, thus believing that often violent conduct is normal.

Subcategory 4 - Identifying weaknesses in management processes in obstetric nurse practice

Other weaknesses are experienced as a result of management processes. Ministerial Policies are well planned, but operationalizing at the state, municipal and local levels has significant obstacles.

Actually the policies are very well designed, only the system ... It is not used to it; You do not know these policies. And the system has offered no structure, even for the conventional model itself; how much more for this new model to be built [...]. (E06)

[...] these colleagues who made their specializations and fled the practice was due to one thing: that calls pro-labore, or in other AIH states, because this is a market dispute and the doctor, for being, by tradition, this pro-labore has already been achieved, this AIH [...]. (E10)

Barriers are present in the municipal management of Natal (RN) and state health management of the state of Rio Grande do Norte, when they provide a pro-labore to the doctor, characterized by remuneration for the professional for delivery performed. This has led to the dehumanization of birth, as these professionals compete with each other and with the nurse, because the more births they perform, the better paid they will be. In this context, there is a distortion in the quality of births, because births are deliberately accelerated (amniotomy, use of oxytocin, use of maneuvers) so that the professional on duty performs as many procedures as possible.

Subcategory 5 - realizing little effectiveness in the construction of health care networks in the practice of obstetric nurses

Health care networks are fundamental to the implementation of the policy. Even today I think one of the major problems with network proposals is that they have had little effectiveness. (G01)

These women continue this itinerary from corner to corner, walking in these ambulances, falling apart, sometimes suffering from high blood pressure, dying in ambulances, giving birth in ambulances. So where's the policy, where's this stork net doing nothing either. (E07)

However, in women's health, the stork network still has little effectiveness. Women still suffer pilgrimage at the time of delivery, without resolution and with difficulties of reference.

Subcategory 6 - Experiencing negative feelings of obstetric nurses

Given the difficulties experienced during the performance of nurses, when he can not have autonomy in conducting childbirth, there is the awakening of negative feelings of sadness, anger, fear, frustration, anguish and injustice.

[...] anguish and even a revolt, you know, because we know we could contribute so much, but understanding that environment doesn't let us. (E03)

[...] but at the same time there is no partnership with us [the doctors], so it turns out that many times we get scared. (E08)

Well, at first [I] feel frustrated, because we only have leftovers [...]. (G07)

The ways in which obstetric nurses express feelings are through refusal to perform procedures, through accommodation, discouragement to keep fighting, and

diverting their activities to other focuses. This discouragement causes the weakening of the category, in the sense of not strengthening spaces of action, through the technical, political and ethical conquest.

DISCUSSION

The relationship of autonomy/dependence in the practice of obstetric nurses must be understood and faced for professional advancement. The subject is itself autonomous, but at the same time dependent, considering that he is inserted in the cultural and social conditions of a society.[1]

The nurse faces difficulties regarding the technical autonomy in conducting the usual risk delivery, because they report that the indication of procedures, the prescription of behaviors and the attention to childbirth are little developed by them.[3] On the other hand, their experiences and values affect the daily practice of professional practice, directly interfering in their autonomy. [4]

When the obstetric nurse reaches the autonomy and consequently the right to perform the delivery, he should automatically be taking responsibility for the possible failures in the procedures. This professional is supported by specific legislation that delimits his performance and provides for responsibilities. [5]

The reality of the practice of obstetric nurses without autonomy should be overcome. Submission is the opposite of freedom and autonomy. The obstetric nurse, during his work, needs to overcome this condition, because it prevents him from thinking and is materialized by mechanism, without initiative. Submission is generated not only by those who have power, but by us as human individuals who allow themselves to be submissive.[6]

Other obstacles identified in the research scenario regarding nurses' autonomy are medical hegemony, the power of the referred professional and often the lack of support from managers. The institutionalization of childbirth resulted from the development of medical knowledge and medicalization processes.[7] It is also observed that in situations of divergence of opinion between the professional and the parturient woman, medical knowledge is prioritized.[8] Thus, this power was once again reinforced in the contexts of birth. Consequently, the presence of unnecessary interventions and the strengthening of the fragmented and physician-centered delivery care model. Thus, the incorporation of good practices is still insufficient in the country.[9]

Today attempts at change are slow and along with them corporate resistance. The medical act, a bill that aimed to concentrate as private functions the skills and competences exercised by other health professionals, although not approved, interfered negatively in the advances in relation to birth processes and consequently in the acceptance delivery by the nurse and the incorporation of good practices.

Medical hegemony brings important disorders to the performance of obstetric nurses, making it impossible to change models in childbirth care.[10]

It was also identified in the research elements the resistance of physicians in relation to the stimulus to good practices and consequently resistance to the possibility of less intervention.

Man, with his physical, biological, psychological, spiritual, social and cultural needs, is divided into fixed structures. Specializations also promote body / mind separation and it is not understood that body and mind can bring about modifications to each other. Thus, there are difficulties in articulating, interacting and then being contextualized in its complex whole, characterizing the simplifying paradigm.[6,11]

According to Morin1, the appreciation of specialization induces reductionism that tries to understand the whole by worrying only about the quality of the parts. He also emphasizes that holism also neglects the parts to understand the whole and that these linear movements make it difficult to understand the phenomenon. Nowadays, nurses inserted in new models of care have facilitated the understanding of the importance of good practices in childbirth care and, in our research field, portrays the importance of the complexity of the phenomenon. Complex thinking is concerned with circular motion, with multidimensional knowledge. It is necessary to complexify the way of knowledge of medicine. [6]

The physician in his work process tends to be more interventionist than the nurse and some obstetric rituals, in this context, often become aggressive. In this relationship, the nurse can do a more humane work focused on encouraging natural childbirth, with the minimum of interventionist techniques, since he is only responsible for performing the usual risk births, and can devote more time to the parturient when delivering the childbirth. However, the speeches of the research participants revealed that there was resistance from doctors to devise new ways to encourage more natural and respectful deliveries in relation to women's autonomy. Thus, they point out that nurses are the professionals noticeably more recognized by parturients and professionals themselves as the most present, considering their performance important. [12]

The dehumanization of childbirth care, as well as obstetric violence and non-care, is characterized by consented violence, as women find themselves in a subordinate relationship and fear for their baby and care.[13]

According to the perspective of complex thinking, in the hospital organization, there is the presence of hyperspecialization (obstetrics) and hierarchical organization (nurse subordinate to the medical team), preventing saving transgression in extreme cases, besides placing the patient in a relegation relationship, reducing them to passivity. It is necessary to mobilize professionals, clients and managers in hospital environments.

Regarding the organization of health care, we will discuss the importance of the implementation of Health Care Networks in SUS. This organization must counteract the fragmented systems of care, which are founded on isolated points of health care that do not communicate with each other and do not respond to the demands of the population.[14] There is insufficient implementation in relation to the organization

of the delivery care network, as well as difficulties faced by rooted practices resisting scientific evidence and principles of the humanization policy of birth.[9,15]

In the state of Rio Grande do Norte, the process of consolidation of the network presents operational difficulties. Referrals are slow and yet the effectiveness is embryonic. There is a lack of obstetric nurses. Women have difficulties in accessing and referrals to the place of delivery, often causing overcrowding in the most complex hospitals. There are few maternity hospitals located in the interior of the state that perform the usual risk delivery, as well as maternities that provide support for risky deliveries. The practice of referrals often results in risks for parturients and babies, considering the poor quality of transport, in addition to the common risk of childbirth occurring during the journey, or, when they can reach a maternity ward, they have to be referred to a third destination, causing the pilgrimage of women. These disorders are important disorders that need to be rethought.

Health management should look to the usual risk maternity hospitals to ensure the quality of childbirth, free of interventionist techniques, but with the regulatory system in full operation. Thus, one of the alternatives is the investment in obstetric nurses, having the apparatus of the medical team for situations of need for interventions. It is observed that managers recognize the importance of obstetric nurses in maternity hospitals, but still have difficulties in incorporating these professionals. [7]

Another important point for discussion is regarding the negative feelings experienced by obstetric nurses in their professional practice. Frustration and discouragement occur when nurses do not have the support of managers to enable them to guarantee spaces for action to reduce maternal and child morbidity and mortality.[4]

This discouragement experienced by nurses in most maternity hospitals in Rio Grande do Norte has hampered the consolidation and growth of obstetric nursing. Faced with this reality, there should be a concern about understanding the disorders, in order to aim for a mobilization for change.

Thus, the existing contradictions, uncertainties, and diverse disorders present in the phenomenon translate the need for understanding through complex thinking, in order to visualize the perspective of order in context. Thus, it is necessary to conceive order and disorder together in order to be able to identify, in complexity, the understanding of the organization, as well as its interactions. Thus, complex thinking gives us the opportunity to realize that disordered phenomena are important to enable the construction of ordered phenomena.[1,6]

CONCLUSION

The disorders faced during nursing care practice demonstrate the difficulty present in the work process of the professional responsible for conducting natural childbirth, which is usually at risk. The nurses' lack of autonomy in their work, the medical hegemony in the birth processes, the negative feelings experienced by the nurse in their work, the obstetric violence present in the birth processes, the disorders in the management processes in childbirth care and the lack of effectiveness in the construction of childbirth care networks signal the discontent of nurses in their daily work in birth care in the state of Rio Grande do Norte and characterize the research phenomenon as complex.

The complexity brings the look to the phenomenon related to the disorders experienced in the professional practice of nurses and points to the need to rethink the improvement of care processes in childbirth. Thus, the obstetric nurse, other health professionals and health managers should be aware of their responsibilities in the change process.

However, these struggles will not be promising, if there is no initiative of the obstetric nurse, as a professional, to make decisions and especially to achieve freedom.

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