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RESEARCH

HUMANIZATION ACTIONS OF THE OBSTETRIC NURSES FROM MINAS GERAIS: RESISTANCE AND COUNTER-CONDUCT TO THE MEDICALIZATION OF CHILDBIRTH

AÇÕES DE HUMANIZAÇÃO DAS ENFERMEIRAS OBSTÉTRICAS MINEIRAS: RESISTÊNCIA E CONTRACONDUTA À MEDICALIZAÇÃO DO PARTO

ACCIONES DE HUMANIZACIÓN DE LAS ENFERMERAS OBSTÉTRICAS DE MINAS GERAIS: RESISTENCIA Y CONTRACONDUCTA A LA MEDICALIZACIÓN DEL PARTO

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ABSTRACT

Objective: to analyze the practices of humanization in childbirth care, developed by nurse midwives, capable of constituting actions of resistance and counter-conduct to the medicalization of the female body. **Method:** this is a descriptive and exploratory research, with a qualitative approach and genealogical inspiration. The research was developed in the context of hospital care. Research data were produced through semi-structured interviews with 11 nurse midwives and submitted to Discourse Analysis. ***Results:*** the actions of the first obstetric nurses conformed as resistance and counter-conduct to the medicalization of childbirth, as they were based on confronting interventionist medical practices, defending the physiology of childbirth, and providing comprehensive care. **Conclusion:** it is recognized that, in their daily professional practice, obstetric nurses need to adopt resistance and counter-conduct actions capable of going beyond the concept of the body under the biomedical paradigm.

Keywords: Obstetric Nursing; Humanization of Assistance; Medicalization; Professional Practice; Maternity.

RESUMO

Objetivo: *discutir as ações de enfermeiras obstétricas e seu potencial de resistência e contraconduta à medicalização da assistência ao parto.* ***Método:*** *pesquisa descritiva e exploratória, de abordagem qualitativa e fundamentação genealógica. A coleta dos dados foi feita, por meio de entrevistas semiestruturadas, junto a 11 enfermeiras obstétricas. Os dados foram analisados pela técnica de Análise de Discurso.* ***Resultados:*** *as ações de humanização das primeiras enfermeiras obstétricas se conformaram como resistência e contraconduta à medicalização do parto, uma vez que eram pautadas no enfrentamento das práticas médicas intervencionistas, na defesa da fisiologia do parto e na integralidade do cuidado.* ***Conclusão:*** *reconhece-se que, no cotidiano da prática profissional, enfermeiras obstétricas precisam adotar ações de resistência e contraconduta como tentativa de subversão do paradigma biomédico, o qual impõe a medicalização da assistência e a apropriação do corpo feminino, cerceando a autonomia das mulheres no processo de parturição.*

Palavras-chave: *Enfermagem Obstétrica; Humanização da Assistência; Medicalização; Prática Profissional; Maternidades.*

RESUMEN

Objetivo: *analizar las prácticas de humanización de las enfermeras obstétricas, caracterizadas como acciones de resistencia y contraconducta a la medicalización del cuerpo femenino.* ***Método:*** *investigación descriptiva y exploratoria, con enfoque cualitativo e inspiración genealógica, desarrollada en el contexto de la atención hospitalaria. Los datos de la investigación se produjeron a través de entrevistas semiestructuradas con 11 enfermeras parteras y se sometieron al Análisis del Discurso.* ***Resultados:*** *las acciones de las primeras enfermeras obstétricas se conformaron como resistencia y contracultura a la medicalización del parto, ya que se basaban en enfrentar las prácticas médicas intervencionistas, defender la fisiología del parto y brindar cuidado integral.* ***Conclusión:*** *se reconoce que, en la práctica profesional diaria, las enfermeras obstétricas necesitan adoptar acciones de resistencia y contraconducta para superar el concepto de cuerpo bajo el paradigma biomédico.*

Palabras clave: *Enfermería Obstétrica; Humanización de la Atención; Medicalización; Práctica Profesional; Maternidades.*

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INTRODUCTION

The concept of medicalization understood by the field of medicine for events of the human condition transforms non-medical issues into medical problems, imposing a standardization of bodies and social and sexual practices. [1] Historically, the medicalization of the female body is related to the construction of this body as an object and exclusive knowledge of medicine, transforming aspects of everyday life, such as menstruation, pregnancy, and childbirth, into social medical purposes[2].

In this context of medical intervention on the female body, the French philosopher Michel Foucault explains the process of hysterization, in which there is an interest in social control over the female body, "endowed with responsibility for the health of their children, the solidity of the institution family and the salvation of society". [3:98] For the author, hysterization implies scrutiny of the female body by disciplinary techniques, procedures, and regulatory knowledge, such as those of medicine and morality[1,3].

Regarding childbirth and birth, medicalization, using a scientific discourse, constitutes the vision of the female body as incapable of the parturition process, being considered potentially dangerous and pathological[4]. When the 21st century started, childbirth passed to be considered a hospital event, driven mainly by the expansion of obstetric techniques and maternity hospitals, which normalized the performance of cesarean sections, especially among the middle classes and the urban population[5].

In Brazil, the medicalization of obstetric care has led to an increase in unnecessary interventions in the parturition process and to high rates of cesarean sections, without clinical indication. Today, the country is one of the world leaders in cesareans, with a rate of 55% in the public system and 86% in the private healthcare sector, contrary to the adjusted reference rate for the Brazilian population, which is 25% to 30 %[6]. However, since 1980, with the movement towards the humanization of labor and birth, a search has been underway in the Brazilian scenario to reduce the high rates of surgical deliveries. Humanization is based on the protagonism given back to women, with the expansion of female participation in health care, with responsibility and freedom, and in comprehensive and interdisciplinary care, based on scientific evidence[4,7].

The perspective of this movement, in addition to welcoming and respectful assistance to the parturient, proposes a change in the health care model, which considers childbirth as a medical event, risky and that needs to be treated in hospital institutions, for care centered on care concerning the autonomy and encouragement of women's protagonism as recommended by the World Health Organization (WHO) and the Ministry of Health (MS- Ministério da Saúde)[8]. In this context, the Brazilian humanization movement contributed to the encouragement of normal childbirth. This was based on discussions about the need for training and performance of obstetric nurses and the defense of the implementation of practices based on scientific evidence in childbirth care. This movement generated clashes in the obstetric field, mainly in the medical category[9-11]. Such conflicts permeate the dispute over space for professional practice since medical conduct (which is predominant) is based on interventionist practices while midwifery training defends humanized actions that promote the physiology of childbirth[11].

Thus, this study was guided by the following research question: "Which actions of obstetric nurses are configured as resistance and counter-conduct to the medicalization of childbirth?". The premise of Foucault's thought was adopted "In which there is power, there is resistance"[12:91], considering resistance, in a strategic field of relations, as moving and transitory points, understood as actions that diverge from the status quo and characterized by tensioning in relationships and in the quest to transform reality. On the other hand, counter-conduct is understood as an attitude that is different from instituted and normalized modes, as different forms from those inscribed and expected in dominantly instituted social practices[13,14].

Therefore, this study aims to discuss the actions of obstetrical nurses and their potential for resistance and counter-conduct to the medicalization of childbirth care. The relevance of the study lies in understanding the performance of obstetric nursing in promoting humanization and changing the model of obstetric care, from the perspective of power and resistance relations

METHODOLOGY

TThis is descriptive and exploratory research, with a qualitative approach and genealogical inspiration, developed in the city of Belo Horizonte, in Minas Gerais, as part of a doctoral thesis[15]. We used the criteria proposed by the Consolidated Criteria for Qualitative Reporting Research (COREQ).

Currently, in Belo Horizonte, there are 7 public maternity hospitals, which have undertaken the commitment to implement childbirth care practices based on scientific evidence and with assistance provided by doctors and obstetric nurses[16]. This commitment has been built since 1994, with the institution of the Perinatal Commission, linked to the Municipal Health Secretariat and

dedicated to the monitoring and coordination of health actions aimed at pregnant women, postpartum women, and newborns. Based on this Commission, the city's health institutions entered ethical commitments, transforming health care with the implementation of evidence--based practices, encouraging normal delivery, and including midwives in the functional staff, protecting women's rights and of the child in labor and birth[16].

Research data were obtained through semi-structured interviews conducted with 11 obstetric nurses who worked in 7 public maternity hospitals in Belo Horizonte,Brazil. The participants were selected based on their identity and experiences and memories about the beginning of the insertion and professional performance of Obstetric Nursing in these researched institutions; therefore, they are considered key individuals for the study. Thus, as an inclusion criterion, all individuals who were still alive and experienced the insertion of obstetric nursing in these institutions were considered eligible. The exclusion criterion was not being involved with Obstetric Nursing in the state of Minas Gerais. There were two refusals to participate in the research.

Data collection was carried out from August 2021 to June 2022, after identification and from the survey, in written documents, of the key names of potential individuals to participate in the study. After their consent, the interviews were conducted by the authors using a script containing five guiding questions. These questions addressed the participants' memories about the beginning of the practical performance of Obstetric Nursing in childbirth care in the institutions surveyed between 2000 and 2010. Due to the nature of the research, there was no training or implementation of a pilot test, considering that the understanding of the phenomenon could emerge in the first contact with the interviewees.

Due to the covid-19 pandemic, the interviews were conducted in person and online, occasionally, and according to the availability of the participants. Nine face-to--face interviews were carried out in a place chosen by the participants, respecting the security measures to contain the pandemic. The places of the interviews were the home, the physical space of the Memory Center of the UFMG School of Nursing, and the hospital institution where the participants work, at different times of the work shift. Two online interviews were carried out in virtual rooms through the Google Meet platform, at times agreed between the participants and the researcher. The interviews were recorded in audio and later transcribed and validated by the participants, with an average duration of 1 hour and 48 minutes and a total of 4 hours, 22 minutes, and 55 seconds.

The problematization of the data was carried out from the conceptual operators of genealogical research, seeking to give visibility to tensions, disputes, clashes, articulations, discourses, practices, subjectivization, and power relations. The Foucauldian analysis focuses on forms of power: “in their multiplicity, in their differences, in their specificity, in their reversibility: studying them, therefore, as relations of force that intersect, that refer to each other, converge or, on the contrary, they are opposed”[17:71]. Foucault's genealogical problematization is approached in a dispersed way in his publications, but the principle is the text “Nietzsche, genealogy and history”, from 1971. In this work, the author rescues, explores, and discusses the German philosopher's proposal of genealogy for the analysis of historical provenances and the emergence of forces. Thus, Foucault uses genealogy from a Nietzschean perspective as a method of analyzing discursive formations, power relations, the constitution of bodies, and subjectivities[3,18].

Thus, to achieve the proposed objective, the interviews transcribed and used as a source for this research were submitted to Foucault's Discourse Analysis (DA). The choice for this mode of analysis was due to the relationship with the adopted theoretical-philosophical framework and its critical and emancipatory ontology, which seeks to go beyond the understanding of discourse as a set of signs, understanding it as a socio-historical practice and a production dimension of social reality[18].

Given the principles of DA and having Michel Foucault's genealogical reference as a guiding principle, the analysis process of this study, influenced by Prado Filho[17] and Carabine[19], was organized in two stages: selection of sources and knowledge of data and genealogical DA. The genealogical DA was divided into themes and objects of the speeches (humanization actions carried out by the precursor obstetric nurses in the researched institutions) and strategies and techniques of the speeches (discursive elements: narrative construction, choices of certain lexical terms that allowed identifying the actions of resistance and counter-culture to the logic of the medicalization of childbirth).

The study complies with Resolution nº 466/2012 of the National Health Council (CNS) of Brazil and was approved by the Research Ethics Committee of the higher education institution to which it is linked, under CAAE opinion nº 45061821.0.0000.5149. All participants received full guidelines and signed the Informed Consent Form (ICF). For the description of the results, coding was used

with the initials I (interviewee), followed by the number indicating the order in which the interviews were carried out, with secrecy and anonymity throughout the process.

RESULTS

The reports of the research participants address the experiences and memories related to the beginning of the insertion and professional performance of Obstetric Nursing in public maternity hospitals in Belo Horizonte. In this context, the humanization actions implemented by these professionals during the first decade of the 2000s stand out. The speeches indicate that the obstetric nurses based their work on scientific knowledge and their knowledge, seeking to reduce interventionist practices at the time of childbirth. In addition, they sought to respect the physiology of childbirth and promote the dissemination of practices based on scientific evidence.

The participants characterize the birth care scenario at the beginning of the insertion of obstetric nurses as a "concentration camp" and "a horror show", marked by interventions and the deprivation of analgesia during labor. Based on their professional work, obstetrical nurses took actions to try to change this scenario, using non-pharmacological methods for pain relief and excluding interventionist practices in childbirth care, such as the Kristeller maneuver (application of pressure in the upper region of the uterus) and enema (intestinal lavage).

> She had to fast, she couldn't drink water, she couldn't do anything! And they were there screaming the whole time! There was no analgesia, nothing! It looked like a concentration camp! [...] Then, I started to work with them... because I said: 'No, I have to do something!' Then, I worked with them on massage, breathing, right? ... then it started but with a lot of confrontation! (E9).

> Kristeller maneuver, right? They did it! [...] A horror show! Then, I gathered the team and explained what the maneuver was, the risks (E7).

> We were the ones who managed to eliminate the enema, which was still widespread at the time [...]. We started a schedule showing that we didn't need it (E6).

The interviews reveal discursive formations that show an environment of dispute in the obstetric scenario of Minas Gerais. In this context, medical practice dominated delivery care, especially normal delivery, limiting humanization actions by nursing. The speeches describe medical interventions such as the routine rupture of the amniotic membranes and the unnecessary administration of oxytocin: "In all patients, I broke the water, turned on the oxytocin". Participants also mention the difficulties faced by obstetrical nurses in implementing actions to humanize childbirth such as offering non-pharmacological methods for pain relief and allowing the mother to be in a vertical position, expressed in: "I put them in the shower and the obstetrician kept passing on the door", "the woman could not stand up, because otherwise the baby would fall to the ground and die" and "at the time of delivery all the patients were lithotomy".

> I tried to do some practices there, which the people thought was absurd! [...]. I put it in the shower and the obstetrician kept walking by the door: 'This baby is going to be born in the bathroom, this baby is going to be born in the bathroom!' My heart was in my mouth! So, that was an absurd thing there (E4).

> Then, at the time of delivery, all the patients were lithotomy! And then it was like this: 'Don't move a millimeter so we don't have a problem, your baby is going go up!' That terror over the woman! (E2).

The reports show conflicts and confrontations between obstetric nurses and physicians regarding the suspension of practices such as trichotomy (hair shaving) and skin-to-skin contact between mother and child after childbirth. The speeches reveal the daily resistance strategies of obstetric nurses, who sought, scientifically based on the physiology of labor and birth, to promote changes in the way of caring for women and newborns.

> And then several things changed: first the issue of trichotomy... I remember it was like this: A CHAOS! Because when a baby is born and the doctor is shouting: 'Get a quick trichotomy here, do it!' Then I said: 'Doctor, hair won't hold a baby from being born!' Then, they saw that the baby was born without a trichotomy! (E9).

> We had a cold stainless-steel table where the babies were placed when they were born... and there the pediatricians provided care. Then, the tables were spoiling... and then I was the one who ordered this material, and I started not asking for a replacement! They said: 'You have to ask for it!' one day the pediatrician said: 'It will contaminate the baby if I put it on top of the mother!' Then I said: 'Thank God, right doctor? The baby will contaminate with her flora and not with mine, full of multi-resistant bacteria, right?' (E6).

In addition to the moment of delivery, the participants described the actions of obstetric nurses in assisting women. Such actions involve family care, prenatal care, newborn care, and family planning. In the speeches, expressions stand out that show the scope of care provided by obstetric nurses and the encouragement of women's protagonism. Attentive listening, welcoming, and inclusion of companions freely chosen by the woman are actions highlighted by the participants to characterize the performance of obstetric nursing and actions of the integrality of care, announced as a "differential", in opposition to the "point of view of medicine ".

> [...] This is the vision that the obstetric nurse was able to show, right? Her assistance! And that made a difference! Look at the woman, look at the woman's family, right? So... if it's from a medical point of view, no! It's punctual! (E3).

> [...] it wasn't just the care, it was comprehensive care for the woman, and comprehensive care was listening, welcoming, and assisting, in full, both her and the newborn (E5).

> You couldn't have a male companion; it could only be a woman... but we started to respect the woman's wishes! Then we started to include the companion of her choice [...] (E6).

> [...] Our performance was not just inside the delivery room, it went beyond! We held meetings with pregnant women, visits to communities, and churches, where we would talk about the importance of prenatal care, and we did the prenatal care, family planning, and consultation with babies (E8).

The participants once again emphasized the importance of the actions of obstetrical nurses, which aim at comprehensive care in childbirth care, as an element to guarantee humanization. Comprehensive care at all stages of a woman's life, not just the pregnancy-puerperal cycle, and family involvement in care are identified as important factors to be explored for the transformation of the obstetric scenario. With the difficulties in changing the interventionist delivery care model, the participants' speeches indicate the lack of knowledge of other health professionals about humanization, including obstetricians, as well as the difficulty of changing a social culture for the integration of obstetric nursing.

> [...] Our work cannot be focused only on the delivery room! we need to see the woman before, during, and after pregnancy [...] These points are important! (E1).

> So, I saw that we must talk, not only with women but with health professionals. So, one time the doctor said: 'Ah, this humanization thing is like giving birth in the jungle!', I said: 'No! You need to better study the concept of what humanization is!' So, I think the professionals lack knowledge, right? (E10)

> Because I think that the introduction of midwifery and our impact on care is a very LONG-term thing, very long-term! Because we are not going to change just rules and protocols, we are going to have to change a whole culture, which is already rooted, right? In women, in women's minds, they don't even mention obstetricians, right? (E11)

DISCUSSION

The results of the study reveal the actions undertaken by the first obstetric nurses who worked in public maternity hospitals in Belo Horizonte,Brazil during the first decade of the 2000s, aiming at the humanization and transformation of the interventionist and medicalized obstetric model of childbirth. The medicalization of childbirth involves seeing the female body as unprepared for the act of giving birth, resulting in the pathologization of childbirth. From a feminist perspective, this medicalization is analyzed as a mechanism of social control that permeates reproductive processes and women's health, establishing an interconnection between medicine and society[2].

In Foucault's analysis, the social control disseminated in medical discourse involves the premise of an "ideal of health", whose knowledge-power ensures an authority over life. So saying, this phenomenon legitimizes the discourses instituted by medicine and has repercussions on the loss of autonomy of individuals by establishing a political-medical domain over the management of life and bodies so that the patient starts to assume a subordinate condition[7]. From this perspective, the discourse of risk control, a product of the knowledge-power of medicalization based on the argument of safety, shapes interventionist attitudes towards the female body during parturition. The idea of risk is configured as an instrument to legitimize a discourse on the imperfect functioning of the parturient body, which requires preventive and curative practices and technologies to avoid unfavorable outcomes[20,21].

In this way, the speeches reveal that the actions implemented by obstetric nurses in favor of humanization when they were inserted in public maternity hospitals in Belo Horizonte were formed as resistance and counter-conduct[13]. That is, the actions of these professionals, concerning the physiology of normal childbirth and in line with the recommendations of good practices in childbirth care, represented a new way of conducting childbirth care in a field hegemonically characterized by fragmented and interventionist behaviors.

In the context of primary care, health promotion practices are also characterized as actions of resistance and counter-conduct to neoliberal governmentality. The problematization of the social determinants of health, the appreciation of collective achievements, and the promotion of culture and local community habits are identified as actions that can rescue the collective peculiarity of health demands and that imply co-responsibility of the State in facing the factors that cause the health problems. Such practices represent points of resistance, in a field in which discourses of individual responsibility for health care emerge, and of counter-conduct, when building other ways of producing health in primary care[14].

In this study, the actions of obstetrical nurses for the humanization of childbirth were against the medicalized discourse of risk control that, under the argument of the pathologization of birth, acted in the control of the pregnant body. Medical practice was defined by a discourse that pathologized the parturient bodies, guiding interventionist attitudes, considered to prevent possible complications in parturition — even if they were not concrete threats to restrict the nurses' performance. For the beginning of the implementation of more humanized care for the woman, the obstetrical nurses took on clashes with the medical category, employing coping strategies, guided by the defense of scientific knowledge and the physiology of labor and birth. In power relations, coping strategies are understood as antagonistic mechanisms put into practice[22].

In the genealogical perspective, the antagonism of coping strategies can be a starting point, a stimulus for the analysis of actions and discourses involved in the expression of different forms of power[3,10]. Given this, from the antagonism of the actions of the integrality of the care of the obstetrical nurses and the assistance of the medical category restricted to the moment of childbirth, it is observed a tension in the frontiers of the territories of performance of these professionals.

Studies show the importance of defending comprehensive care for women, beyond their maternal function, to build emancipation and autonomy. The integral action of care is permeated by dialogue, acceptance, and listening, as opposed to the simple prescriptive act that standardizes and normalizes conduct[23]. In this logic, the actions performed by obstetric nurses are guided by the comprehensiveness of care and the encouragement of Women's protagonism are presented in the speeches as a differential, assuming a counter-conduct in the assistance instituted in the mode of punctual attention at the moment of childbirth.

Obstetric nurses, by defending comprehensive care, and overcoming the reductionism of the hegemonic model of women's health care, centered on the pregnancy-puerperal cycle[20,21], confronted the restricted and fragmented conceptions of biologicism, which support the medicalization of the body feminine. Furthermore, based on their experiences, the participants point out the challenges to be faced to change the hegemonic model of interventionist practices in childbirth care. These challenges include the lack of knowledge of other health professionals about humanization (including obstetricians) and sociocultural difficulties in valuing the performance of obstetric nurses.

The themes of humanization and change in the interventionist model of childbirth care are addressed by the hegemonic medical discourse with great resistance[24],exemplifying the complexity of power relations that constitute Brazilian obstetrics. Power relations between health professionals and women are influenced by the legitimized domain of interventionist technical-scientific knowledge of medicine, resulting in restrictions on women's decision-making power. Demedicalization enables to correct authoritarian and hierarchical behaviors, reducing the asymmetry in relationships and guaranteeing women's autonomy and protagonism during pregnancy, childbirth, and the puerperium[21,25].

The limitations of this study are related to the analysis of the discourse of only a particular group of midwives, limiting the generalization of the findings to other contexts. However, it is assumed that these findings have critical-analytical potential to awaken reflections in similar scenarios and contexts, enabling the understanding of the power relations involved in the process of training and professional insertion of the first midwives in Minas Gerais.

FINAL CONSIDERATIONS

The humanization actions carried out by the first obstetrical nurses in public maternity hospitals in Belo Horizonte activated resistance and counter-conducts in the

face of the model of the medicalization of childbirth. Such practices confronted the fragmentation of care for women and the pathologization of childbirth, supported by the discourse of risk. Assistance based on scientific evidence and the physiology of birth, the adoption of non-invasive technologies, and the proposal for comprehensive care favored the beginning of a movement for change in obstetric care in Minas Gerais.

As implications for the practice of obstetrical nursing, the study reinforces the importance of actions of resistance and counter-conduct in professional daily life as an effort to subvert the biomedical paradigm that imposes the medicalization of childbirth care and the appropriation of the female body, restricting women's autonomy in the childbirth process. Therefore, obstetrical nurses must engage in practices that promote the humanization of care, respect the physiology of childbirth, ensure the active participation of women in decision-making, and seek ways to challenge and question the norms and practices that perpetuate excessive medicalization. Searching for joint strategies for more humanized and respectful assistance is essential in the practice of obstetric nursing.

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