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# MORAL SUFFERING IN ASSISTANCE TO CHILDBIRTH: SITUATIONS PRESENT IN THE WORK OF NURSES OF OBSTETRIC CENTERS AND MATERNITIES

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## ABSTRACT

**Objective:** to know the situations found in the work of nurses working in maternity hospitals and obstetric centers that can lead to moral suffering.

**Method:** qualitative, exploratory and descriptive study, developed with 14 nurses working in obstetric centers and maternities of two hospitals in southern Brazil. Data were collected from October 2015 to January 2016, through a semi-structured interview, analyzed based on Content Analysis.

**Results:** there was an occurrence of moral distress related to the activities that supplanted nurses' execution capacity, leading them to prioritize administrative and managerial activities, for which they are charged by the institutions, failing to participate directly in the care, an aspect enhanced by the quantitative nursing professionals. Asymmetric relations of power and conflicting interactions compose an atmosphere of toleration for the autonomy of the nurses, preventing them from acting in harmony with their knowledge and moral values. The fruitless attempts to change the dehumanizing context through advocacy and the visualization of disrespectful, interventionist and violent behaviors against women, generate moral suffering.

**Conclusion:** the plurality of nurse actions, reduced autonomy, disrespect for their practice and the visualization of dehumanizing behaviors generate moral suffering. It is important to seek alternatives so that nurses may act and advocate in line with their moral knowledge and values, in an autonomous and empowered way, aiming to provide a dignified and safe childbirth assistance, and an environment that respects the woman and her autonomy.

**DESCRIPTORS:** Moral damage. Humanized childbirth. Ethics. Ethics, nursing. Nursing.

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# **SOFRIMENTO MORAL NA ASSISTÊNCIA AO NASCIMENTO: SITUAÇÕES PRESENTES NO TRABALHO DE ENFERMEIROS DE CENTROS OBSTÉTRICOS E MATERNIDADES**

## **RESUMO**

**Objetivo:** conhecer as situações presentes no trabalho de enfermeiros atuantes em maternidades e centros obstétricos que podem conduzir ao sofrimento moral.

**Método:** estudo qualitativo, exploratório e descritivo, desenvolvido com 14 enfermeiros atuantes em centros obstétricos e maternidades de dois hospitais do sul do Brasil. Os dados foram coletados de outubro de 2015 a janeiro de 2016, por meio de entrevista semiestruturada, analisados com base na Análise de Conteúdo.

**Resultados:** verificou-se ocorrência do sofrimento moral relacionado às atividades que suplantam as capacidades de execução pelos enfermeiros, levando-os a priorizar as atividades administrativas e gerenciais, das quais os mesmos são cobrados pelas instituições, deixando de participar diretamente da assistência, aspecto potencializado pelo quantitativo inadequado de profissionais de enfermagem. Relações assimétricas de poder e interações conflituosas compõem uma ambiência de tolhimento da autonomia do enfermeiro, impedindo-o de agir em consonância com seus saberes e valores morais. As infrutíferas tentativas de mudar o contexto desumanizador por meio da advocacia e a visualização de condutas desrespeitosas, intervencionistas e violentas contra as mulheres, geram sofrimento moral.

**Conclusão:** a pluralidade de fazeres do enfermeiro, a reduzida autonomia, o desrespeito em relação à sua prática e a visualização de condutas desumanizadoras geram sofrimento moral. Destaca-se a importância de buscar alternativas para que os enfermeiros possam agir e advogar em consonância com seus saberes e valores morais, de modo autônomo e empoderado, visando propiciar uma assistência ao nascimento digna e segura, e uma ambiência que respeite a mulher e sua autonomia.

**DESCRIPTORIOS:** Dano moral. Parto humanizado. Ética. Ética em enfermagem. Enfermagem.

# **SUFIMIENTO MORAL EN LA ASISTENCIA EN EL NACIMIENTO: SITUACIONES PRESENTES EN EL TRABAJO DE ENFERMEROS DE CENTROS OBSTÉTRICOS Y MATERNIDADES**

## **RESUMEN**

**Objetivo:** conocer las situaciones presentes en el trabajo de enfermeros que actúan en maternidades y centros obstétricos que pueden llevar al sufrimiento moral.

**Método:** estudio cualitativo, exploratorio y descriptivo, desarrollado con 14 enfermeros que actúan en centros obstétricos y maternidades de dos hospitales del sur de Brasil. Se recolectaron los datos de octubre de 2015 a enero de 2016, por medio de entrevista semiestruturada, y se analizaron en base al Análisis de Contenido.

**Resultados:** se pudo comprobar los hechos de sufrimiento moral relacionados a actividades que suplantam capacidades de ejecución de enfermeros, llevándolos a priorizar las actividades de gestión y gerencial que son cobradas por las instituciones, dejando de participar directamente del cuidado, aspecto que se potencia por lo cuantitativo inadecuado de profesionales de enfermería. Las relaciones asimétricas de poder y las interacciones conflictivas forman un ambiente de parálisis de la autonomía del enfermero, no permitiéndole actuar en consonancia con sus saberes y valores morales. Los infructíferos intentos de modificar el contexto deshumanizador a través de las leyes y la visualización de conductas no respetuosas, intervencionistas y violentas contra las mujeres generan sufrimiento moral.

**Conclusión:** la pluralidad de haceres del enfermero, la reducida autonomía, el no respeto en relación a su práctica y la visualización de conductas deshumanizadoras generan sufrimiento moral. Se destaca la importancia de buscar alternativas para que los enfermeros puedan actuar y abogar en consonancia con sus saberes y valores morales, de modo autónomo y empoderado, con el objetivo de propiciar un cuidado en el nacimiento digno y seguro, y un ambiente en que se respete a la mujer y su autonomía.

**DESCRIPTORES:** Daño moral. Parto Humanizado. Ética. Ética en enfermería. Enfermería.

## INTRODUCTION

The work developed by nurses at different levels of health care encompasses activities that range from direct care, educational practices in / to health, to the administrative and managerial actions required by the organizations, in a direct intersection with the work of other professionals<sup>1</sup> and strongly influenced by public health policies, which guide the care actions and work organization.<sup>2</sup>

In the field of women's health, the work has been guided by the different strategies, programs and policies launched by the Ministry of Health, highlighting those that aim to reorganize the assistance to the pregnancy-puerperal cycle, such as the Humanization Program in Prenatal and Birth, Stork Network<sup>3</sup> and the Adequate Childbirth Project.<sup>4</sup> These initiatives guide the care and stimulate normal delivery, reduction of interventions, unnecessary caesarean sections and the maternal mortality index, as well as the abandonment of practices of dehumanization of care and obstetric violence.<sup>3</sup>

The assistance archetype proposed by the Ministry of Health, which aims at the humanization of care in the pregnancy-puerperal cycle, constitutes a significant advance in obstetric care, encompassing scientific evidence aimed at favoring a decent and respectful birth,<sup>5</sup> being effected through a work that must follow the principles of the holistic model.<sup>6</sup>

However, one still spots in the childbirth care, some characteristic pertaining to Cartesianism, marked by the fragmentation of care,<sup>6</sup> centered on the biomedical model,<sup>5</sup> by the interventionism and submission of the parturient. The biomedical model of childbirth care that regards the women's body as imperfect and incapable of controlling parturition, allows health professionals to use actions that disregard their autonomy and the possibility of involving them in decisions referring to their body and your life.<sup>7</sup> Also, consent to acts of obstetric violence, effected by means of words, expressions of irony, invasive procedures, inadequate conduct, coercion, threat, among others.<sup>8</sup>

When witnessing obstetric violence against women in the context of childbirth assistance, many professionals, including nurses working in obstetric centers (OC) and maternity hospitals, feel powerless and discontented about humiliating scenes, leading to great conflict and anguish.<sup>8</sup> The experience of being inserted in a care context marked by practices that go against the MS advocated in relation to obstetric care can lead them to moral suffering, characterized by painful psychological imbalance resulting from the impediment brought about by the environment so that the same their conduct in accordance with the ethical conduct they deem appropriate.<sup>9</sup>

There are studies in the literature that address the moral suffering of nurses in different contexts,<sup>10-14</sup> as well as issues related to the childbirth humanization,<sup>2,6,8,15-24</sup> but there are no national and international surveys that articulate the two aspects. Based on the foregoing, it is justified to carry out this study, which aimed to know the situations found in the work of nurses working in maternity and obstetric centers that can lead to moral suffering.

## METHOD

This is a reanalysis on the data of the dissertation "Inter-relations between the Workloads present in the Nurse Work Process and the implementation of the National Program of Humanization in Prenatal and Birth",<sup>25</sup> developed through a qualitative, cross-sectional and descriptive approach,<sup>26</sup> in the OC and maternity of two hospitals located in the south of Brazil, being a university hospital, which integrates the service network that makes up the Unified Health System (*Sistema Único de Saúde - SUS*), and a philanthropic hospital that provides care by SUS, health insurances and private individuals.

A total of 14 generalist nurses participated in the study, including those who worked exclusively in maternity and/or OC for a period of more than six months; and excluding those who worked in the other sectors of the hospital, working for less than six months in Maternity and/or OC, or were away

during data collection for vacations or various licenses, with a loss and a refusal in the total universe of workers.

The participants' ages ranged from 24 to 53 years old. As for the work place, four worked in the maternity ward, four worked in the OC and six worked in both environments. Nine participants worked in OC and/or maternity hospitals for a period of one year or less; one had been working for two years; two had been working for three years, one had been working for six years and one for nine years. In terms of qualification years, five were qualified less than five years ago and nine for more than five years ago. None of the participants had specialization in the area of Woman's Health and/or obstetrics, but two were attending the course.

Data were collected through a semi-structured interview, composed of open questions, addressing the contexts of care at childbirth. Although the interview did not explicitly contain questions about moral suffering, it emerged in the set of testimonies, making it possible to look at the aspects that lead to it. The interviews, developed from October 2015 to January 2016, occurred after the signing of the Informed Consent Term, being performed in the work environment of the nurses, on previously scheduled days. They were recorded, having an average duration of 40 minutes, and later transcribed.

The analysis of the data was processed through the Content Analysis, being categorized with semantic grouping,<sup>27</sup> giving rise to the categories: Moral suffering: the multiplicity of tasks and the withdrawal of assistance; Moral suffering from the interpersonal relationships of the multiprofessional team: faces of restricting the autonomy of the nurse; and the emergence of moral suffering in the face of the perpetuation of dehumanizing practices. For the discussion, the situations generating moral suffering were analyzed in articulation with the perspective of the policies, programs and laws that govern the realization of childbirth humanization.

Ethical aspects were respected in their entirety. For preserving the anonymity of the participants, they were codenamed by the initials E, followed by the numbering, according to the order of the interviews: E1, E2, successively.

## RESULTS

Different elements found in the context of childbirth assistance can lead to moral suffering. These range from the plurality of nurse practices, enhanced when there is reduced autonomy in the delivery of care, disrespect for their practice and the visualization of the maintenance of behaviors that contrast with the policies, programs and laws that govern childbirth humanization. In this sense, three categories were constructed that describe the possibility for occurrence of moral suffering in the context of nurses working in OC and maternity hospitals.

### **Moral suffering: the multiplicity of tasks and the withdrawal of assistance;**

This category shows that the work of maternity and OC nurses encompasses the development of different care, administrative and managerial tasks that sometimes supplant their capacity for execution, leading to the prioritization of some activities to the detriment of others. It was verified that, in the ambit of the administrative tasks, the pressure and responsibility for the filling of childbirth forms and documents, the control of the consumption and the replacement of the technologies and the inputs, nursing records related to the prepartum, delivery and puerperium (PDP), control of care flows in normal and cesarean delivery rooms, management of the nursing team and the actions developed by them during care, and management of problems and conflicts of the nursing team. The administration of these elements is difficult when there is an inadequate number of professionals, which potentiates the nurse distancing from the direct actions to the users.

Living in a context where some activities should be carried out as a priority, the majority of which are administrative/managerial, to the detriment of the nurse assistance to the mother-child binomial, seems to have the consequence of reducing the development of humanizing actions, to be postponed or even not performed by the nurse, opposing childbirth logic, characterizing a moral dilemma that leads to moral suffering: *It has to offer more time for each patient, has to put the woman on the ball, take the test fast, be careful to see if the companion is well and therefore things become more racing. Because in order to be able to dedicate more time to the woman, one ends up delaying other things, you stop asking for the material, to do the dressing, from there it delays everything. [...] and what is priority? [...]* (E11).

The duties as manager comprise the coordination of the actions developed by the nursing team, which includes managing problems and conflicts. By prioritizing these actions, nurses can distance themselves from direct care, failing to be close, assisting, guiding, advocating and instrumentalizing the patient who experiences parturition, causing moral suffering: [...] *Many times I think I should and would like to be closer to the patient, listening, making the visit in the beds calmly, guiding, talking with the relatives, seeing the [newborn] RNs and, half of my time, at least, was aimed at solving team problems, which is also a function of the nurse [...]* (E1).

The prioritization of administrative tasks was shown as motivating the nurse withdrawal from contact with users and from the non-execution of humanizing practices by this agent, such as the non-use of non-pharmacological methods of pain relief, leading to moral suffering: *sometimes I want to stay directly with the patient, put her on the ball, in the shower, but I can not because the bureaucracy itself will not let me do that, because it's too much paper to fill, you have to evolve, in truth. The nurse became a bureaucrat, because one fills a lot of paper and the assistance that one should give, one can not do it* (E8); *If I have three pre-delivery patients, I can not provide care, or I assist one or I manage the unit, and if I have one in recovery, then I have to choose what I do, so it is unfeasible. [...] we have a lot of assignments, we already go to the clinic, we already attend the obstetric surgical block, we go to surgery, we go to recovery, we take care of the newborn, we help with the feeding, and we still have to manage, there is no way* (E5).

The inadequate quantity of professionals who have been exposed as causing a moral dilemma that leads to SM, since this context contributes so that the emerging demands supplant the professional ability to act, forcing them to prioritize some activities and not to execute others. Suffering strengthens when inadequacy encourages the non- direct participation of nurses in health care: [...] *as nursing assumes other practices that are advocated and that contribute to the evolution of childbirth labor, such as pain relief measures, for example, I need more time and more staff to meet this, if I have these staff It is perfect, but I do not have it.. This is burdensome and I need to choose what I'm going to do [...]* (E14).

### **Moral suffering from the interpersonal relationships of the multiprofessional team: faces of restricting the autonomy of the nurse**

Different elements compose an atmosphere of tolerance of the autonomy of the nurse, highlighting the conflicting interpersonal relations with the other members of the multiprofessional team, that end up being reflected in the power relations between the different professionals, with the consequence of restricting the actions of the nurse in the assistance, in particular, with regard to the development of delivery humanizing practices. In this context, the nurse is prevented from acting in accordance with the childbirth ideals and with their moral values and knowledge, not providing the users with the actions they understand as appropriate, which leads to the experience of moral suffering.

In the specificity of the interpersonal relations of the multiprofessional team, this one is marked by a climate of tension and by disagreements among the subjects, causing dissatisfaction with the



work and ethical problems that lead to an intense moral suffering, reflected in the lack of autonomy of the nurse and also in the assistance. This configuration is a consequence of power relations in which the nurse is not matched to the other professionals, who see themselves as managers of the nursing process, and end up delegating which activities should be developed by this class. In this context of interactions among the subjects, the nurse starts to revert to the use of humanizing actions, such as the use of non-pharmacological methods of pain relief and even the practice of patient advocacy leading to moral suffering: *My big problem is the personal relationships with teams [...] comes in a moment that you end up measuring force with people, and then when it comes time to measure strength, who screams more takes, there ends up being something that makes me very angry. And it is very difficult for me, and the parturient is the one who always gets the worst, because the fights are so that we [nursing] may put humanization into practice [...] (E5); There is always one that wants to impose more than the other [...] the power relations are a problem really, because everyone would have to help each other, but each one within their room, not one wanting to rule the other one, because this does not work and this interferes with the assistance. At the end it is the parturient who stops going to the ball, ending up receiving oxytocin [...] (E8); I have already left the place crying because of the time when I put the patient on the ball, and I was not supposed to do it. And I answered: I am a nurse, I graduated and I have autonomy for this [...] but now I think twice before putting the woman on the ball [...] (E4).*

Participating in the execution of healthcare practices that are in line with those advocated by PDP strategies, programs and policies, and the knowledge and moral values of nurses, is an ethical problem that generates moral suffering. This aspect is strengthened when the refusal to participate in such acts is disregarded and motivating retaliation by other professionals, leading nurses to feel threatened in their work environment by not having their professional autonomy preserved: *[...] I almost changed my sector because I refused to do a Kristeller. So, being a very old pro in the delivery room, I was threatened to be removed to other sector if I refused to do this again. [...] As long as I can, I will deny, because as long as everyone complies with it, things will keep on happening. [...] but there are other things that even though they are wrong, I have to do (E2).*

Unequal power relations lead nurses to limit their own performance, aiming at preserving the integrity of parturient care, and avoiding exposing it to obstetric violence practiced by members of the multiprofessional team. This behavior can promote childbirth care in a less violent way, but it prevents the full benefits of humanized practices, limiting the rights and autonomy of women in the parturition process, which contrasts with childbirth ideals, characterizing an ethical and generating moral suffering. In addition, it allows for the advocacy actions to remain stifled by the supremacy of other professionals in relation to the management of childbirth, and perpetuates the mechanisms of oppression and submission of women, which remains at the mercy of the actions of other teams: *[...] having to limit yourself to doing certain things so that that woman shall not be treated badly wears the person too much. Not putting her on the ball because the doctor does not like it and I know that if she uses a non-pharmacological method for pain relief, the doctor will yell at her [...] you feel your hands tied in the own work, it is too exhausting, too much, too much. It takes away your entire disposition to work. (E2).*

## **The emergence of moral suffering in the face of the perpetuation of dehumanizing practices**

The nurses of maternity and OC are sometimes inserted in a care context where practices that differ from their moral values and what is advocated by moral suffering are carried out. In this context, they try to advocate for the users, but experience the ineffectiveness of these attempts, which leads them to continue to witness disrespectful, interventionist, derogatory, violent and depersonalizing

behaviors against women, being this context composed of ethical and moral problems that cause suffering moral.

Disrespectful positions toward women, committed by members of the multiprofessional team, through coercion and exposure to derogatory experiences, conflict with the humanizing ideals and moral values of nurses. This context is added to the fact that they do not feel instrumental in changing such a paradigm by virtue of the power relations existing in maternities and OC, because they perceive themselves to be hierarchically inferior to other professionals: [...] *the rights of women are not respected, and this I perceive in the OC, is very present. I feel uncomfortable several times because I think the patient is not being treated in the way that is appropriate; that I would like to be treated if I were the patient, so I think that respect for the person as a human being, is often lacking. It comes before respecting the women, it is respect for the human being. There are things that we see that we do not believe (E1); I think the way doctors act wears me down a lot, it disturbs me a lot. [...] I see that they do not have no patience to perform a delivery here inside [...] so they subject women to things they do not have to go through. Women feel as 'garbage' [...] (E4).*

Another element refers to restricting the autonomy of women and the realization of a vertical professional-user interpersonal relationship, aspects that are antagonistic to childbirth ideals, materializing an ethical infraction that generates moral suffering. Such an understanding reveals his fragile reflection on the ethical problems that surround professional practice, minimizing a serious ethical problem, to a simple acceptable imbroglio. It also points to a limited vision of the potential of advocacy to solve the emerging conflicts of antagonistic interests of women and health professionals, to empower women and create a favorable environment for the exercise of their autonomy: *It is difficult at the time of delivery to say to the patient: 'do not scream', and there are professionals who do it here, I see that here this is so, it is a horror, and I do not think I should order someone to shut up, not screaming [...] (E8); While I realize that the autonomy of women is not being taken into account for protecting the woman's and the baby's health, it is fine. Now, when I see that it is a hierarchical question of power, it bothers me [...] when it involves a question of power: 'I am going to do it because I am so-and-so and I want to do it, because I am the boss here and it does not matter what the woman wants', it annoys me a lot (E5).*

The speech of a nurse reveals the need to adopt a restrictive position on the autonomy of women in order to protect it and avoid exposing it to obstetric violence practiced by other members of the multiprofessional team. This action, despite having a protective intention, demonstrates that nurses can not effectively advocate effectively providing an environment in which female autonomy is valued, even if the woman proves instrumental to the protagonism of her parturition process. Nor are they able to provide women with the execution of multiprofessional assistance free from violent acts, even if such positions are understood by them as inadequate and contrary to their moral values, leading to moral suffering: [...] *Depending on who is on duty and if the woman gets well-informed, empowered, sometimes I need to tell her: 'hold your information a little, otherwise they will treat you poorly.'* (E2).

The perpetuation of interventionist behaviors and the connivance and appreciation of these practices by women are aspects that contrast with humanization ideals related to childbirth. This logic reveals the need to demystify the often misguided views on the childbirth pathways, an action also developed by nurses. However, when this practice is performed, but does not have the desired effect in relation to the opinion of women and the multiprofessional team on the ideal delivery route, the interventionist logic, which already has a great popularity, is perpetuated. Knowing that its action was unable to resolve ethical problems and fully promote what is advocated by strategies, programs and policies aimed at humanized birth, leads nurses to moral suffering: *Some of them speak: 'I want you to make a cesarean surgery, I can not take it anymore', but it is not like that, [...] they do not*



want to know about humanized birth, they want cesarean surgery because they do not want to have pain. So, explaining this to some women is complicated, because they do not want to feel pain, they already arrive here saying that they want cesarean surgery and the subject is off. Then you try to talk: 'because it is not so, because cesarean surgery is a risk, it is risk to you and a risk to the baby, because you will be anesthetized, because you do not know what can happen' [...] (E8); [...] having to watch unnecessary cesarean surgery happening all the time and not being able to do something [...] and disoriented mothers, think that is right. They think it is great. That ends up wearing you because you are seeing a woman telling you something that you know is not true and that if you say the right to her, she will tell you: 'certainly not, this saved my life and that of my daughter' (E2).

The obstacle provided by some members of the multiprofessional team in order to prevent compliance with legislation that guarantees the presence of the accompanying person during PPP is also highlighted. Even with the existence of legal instruments, the submitted context points out to the inability to advocate for the presence of the companion to be guaranteed. This construct contrasts with the right of women, characterizing an ethical problem that generates moral suffering: *People know that the family member can accompany; There are posters saying this and I'm tired of seeing: 'no, no, you are to wait outside', speaking in a tone that people are even afraid of; 'if anything we call you', pushing with a pat on the back. And we are powerless, not knowing what to do [...]* (E1).

The deprivation of the strategies, programs and public policies aimed at the humanization of assistance to the pregnancy-puerperal cycle as a guideline for the standardization of care behaviors, coupled with the variation of professionals who work in these environments due to work organized at shifts, leads to the contrast and even to the antagonism of care practices. This lability of conduct gives margin for not employing the humanizing actions of childbirth, or not fully occurring effectively for all women, depolarizing the quality of care and allowing the rights and autonomy to be extinguished. This context of ethical infractions is adverse to childbirth humanization, leading to MS: *One of the biggest wasting is the lack of standardization of postures within the obstetric center. What is the routine of the obstetrical center? Is this what I want. Is it what the 'A' professional wants? Because on Monday the routine is one, on Tuesday the routine is another [...] There is no value in what the Ministry of Health says, what matters is the will of those who will deliver [...]* (E5).

## DISCUSSION

The actions of work organization are comprised in the multiplicity of activities that involve caring,<sup>1</sup> being intimately linked to the occurrence of moral suffering.<sup>11</sup> The way the work has been organized is often marked by the split between the care and management dimension, generating conflicts in the nurses' work, either with their own practice or in their relationship with the nursing and health team.<sup>2</sup> Work organization seems to move the nurses away from the users,<sup>1</sup> and this may compromise the quality of care,<sup>2</sup> potentially enhancing the experience of moral suffering.

The fragmentation of work, in which each component of the nursing team provides part of the assistance separated from the others, compartmentalizes the actions and needs of the users, duplicating efforts or even taking contradictory actions. However, this dialectic reveals that part of the nursing professionals adimple delegated activities, supporting a limited space of decision, creation and mastery of knowledge.<sup>28</sup> This fragmented doing on tasks is under the managerial control of the nurses.<sup>28</sup> However, these concern management from its negative aspects, the difficulties linked to the function and non-recognition of this practice,<sup>29</sup> as an assignment that distances them from the assistance and that generates moral suffering. This may also be associated with their awareness that they do not correspond to their role before nursing workers as leaders and possible models/ references to the team.<sup>11</sup>

The literature points out that the managerial condition may give rise to the expansion of nurse power in the institution,<sup>30</sup> but the findings in this study demonstrate that this aspect did not materialize in the researched reality, which may be associated with the fact that the participants are generalists, reducing their influence in the institutional context. In this sense, the nurse is prevented from modifying and qualifying care spaces, through the development of advocacy actions also indirectly, through the search for the guarantee of the quality of care, or the demand for better working conditions.<sup>31</sup>

Personnel sizing of personnel is directly related to developing humanization actions, since its inadequacy may expose women to obstetric violence resulting from neglect and inadequate care. This can be understood as institutional violence, since it precludes the fullness of humanization principles,<sup>32</sup> generating MS.<sup>10</sup> The listed factors add up to the rate of alienating work associated with the multiplicity of tasks, which result not only in the physical and emotional exhaustion of the professional, but also in the difficulty in reflecting on their practice<sup>15</sup> and being able to discern, based on their moral values, on the actions to be developed and the actions to be postponed.

It is important to highlight that, in the midst of the fugacity of the processes that involve work organization, expecting and respecting women's time and physiology, dedicating space to the nurses' agenda, disorganizes hospital planning, making dedication to parturition care inconvenient and unacceptable.<sup>33</sup> This is because the way care is delivered is more oriented to the resolution of childbirth quickly than to the satisfaction of the user and her family, with priority being given to procedures to the detriment of the manifestations of subjectivity of the parturient.<sup>7</sup>

This aspect seems to be related to the fact that the nurses feel fragile to make confrontations that they recognize as necessary to assure an action coherent with their moral values,<sup>11</sup> because they are inserted in an organizational environment that disregards the way they experience professional experiences<sup>34</sup> or because they are not instrumentalized or do not have specific training in the area in order to act equitably to obstetrician physicians regarding the choices of obstetric behaviors.

The apparent lack of nurse autonomy within the multiprofessional team also results from the existence of ineffective and disaggregating communication processes among the professional categories, associated to the lack of visibility of the nurse work,<sup>35</sup> which ends up developing care practices that translate into delegated activities,<sup>28</sup> Routine, mechanical, and repetitive.<sup>36</sup>

However, exercising autonomy in favor of patient's advocacy inevitably has a risk for failure,<sup>31</sup> because there are barriers arising from power relations<sup>13,31,37</sup> and the structure of organizations,<sup>13,31</sup> in which, culturally, medical hegemony predominates,<sup>37</sup> which challenges and discourages nurses from acting in line with their knowledge, values and beliefs.<sup>31</sup> While living, the **moral suffering** that originates from the difficulty/inability to advocate for the patient and influence medical decisions<sup>13</sup> for the sake of humanization, nurses finally coexist with the reflexes of this fact, which is revealed by the lack of quality and safety during childbirth care, favoring the strengthening of interventionist and fragmented practices.<sup>16</sup>

This mode of aggression perpetuates itself as a veiled action, that is, not perceived as such by those involved, who often justify their acts as necessary for the organization and conduct of labor.<sup>15</sup> It should be noted that the professional work model involves dynamic processes, influenced by the socialization and cultural history of the institution.<sup>38</sup> These characteristics place them in a social role that is considered hierarchically inferior to the authority of the health professionals, who place themselves as knowledge holders and holders of the childbirth care process. From this construct, professional-user relations marked by obstetric violence emanate,<sup>15</sup> leading professionals who do not share this attitude to moral suffering.<sup>10</sup>

As in the results of this study, the literature indicates recurrent violence practices during birth attendance, with predominance of disrespectful relationships, abandonment in the hospital beds, absence of pain management, lack or denial of information for women, presence of the companion, unnecessary

interventions and caesareans, among others.<sup>17,18,39</sup> Regarding the interpersonal relations marked by disrespect, it should be noted that this, besides generating moral suffering in the professionals,<sup>11</sup> it also triggers suffering in the parturients, weakening their autonomy.<sup>19</sup>

However, justifying acts of violence committed against individuals capable of discerning their bodies and their lives, even if they are involved in a moment of potential fragility, points out to the trivialization of conduct that violates women's rights, causing ethical problems related to these practices are disregarded, making them naturalized and acceptable. This fact warns us on the fragile moral sensitivity of professional performance and on the non-reflection of the subjects about its practice. In this sense, the literature emphasizes the importance of strengthening the knowledge on the moral dimension found in the different actions and omissions,<sup>14</sup> as well as the improvement of the competences that aim to improve the moral sensitivity of professionals before the ethical problems present in their work.<sup>40</sup>

The deprivation of the exercise of their autonomy, understood as an institutional violence, rooted in the cycle of female oppression,<sup>20</sup> is justified by the professionals through arguments that disqualify the woman and place them in a position of ignorance and incapable of deciding about her body and her parturition in a discourse marked by prejudice.<sup>15</sup> This logic gives support to the mechanisms of subordination, keeping them hostage to procedures and medical hegemony,<sup>41</sup> which makes the woman an object for professional intervention.<sup>20</sup> It should be noted that humanizing includes the stimulation of women's role as a right to be preserved,<sup>21</sup> and that the disregard for users' rights leads to MS occurrence.<sup>10</sup>

In order for women to take part in childbirth, it is necessary to create a favorable environment for them, as well as the instrumentalization of women for this action. In this sense, the quality of prenatal care is a criterion *sine qua non*, because it will provide the basis for the woman to decide on her body, agree or disagree with the procedures recommended during the delivery and childbirth care, and even, on the way of delivery.<sup>42</sup> Moreover, adequate prenatal care has the potential to destabilize inappropriate discourse on safe, convenient, and aseptic cesarean culture and the cultural discourse of normal birth that involves risks is painful and time-consuming,<sup>33</sup> that the dissemination of scientific knowledge and strategies, programs and public policies of health directed towards the puerperal pregnancy cycle are shown to be antagonistic.

Regarding the way of delivery, it is emphasized that the cesarean surgery indication is predominantly relative and not based on scientific evidence,<sup>20</sup> which constitutes obstetric violence, especially when the surgical act is performed against the desire of the woman.<sup>43</sup> The choice on cesarean surgery is justified mainly by the personal desires or preferences of professionals, especially physicians<sup>20,44</sup> who do not always consider the knowledge obtained in scientific investigations on the effectiveness and risks of interventional actions and surgical delivery,<sup>32</sup> as well as the desires of women for cesarean surgery.<sup>20,44</sup>

The option of the medical team for cesarean section is related to the fact that these professionals have a significant part of the technical responsibility for the delivery management, leading to a defensive attitude stemming from the fear of being penalized. The fear of being negligent may interfere with the indication of the way of delivery and expose the mother-child binomial to the risks of an unnecessary cesarean surgery,<sup>45</sup> opposing the current logic that aims to reduce the electivity of this procedure without clinical criteria.<sup>21</sup>

As for women, the scientific literature reveals that their expectation in relation to childbirth is based on interventionist assistance, which became naturalized<sup>22</sup> and sometimes sought, since there is a growing discouragement and refusal of normal delivery due to the recurrent associations of this way of delivery with the presence of obstetric violence practices, with the predominance of pain and suffering, the creation of a depersonalized environment, solitary and dissatisfaction for women

and companion.<sup>8,43</sup> It should be noted that women are exposed to the routines and culture of the hospital, leading them to cesarean gradually and through indications that are sometimes so subtle and inadequate that they appear to be a woman's choice, who is already exhausted, agrees with the suggestion of the health professional to perform the surgery.<sup>46</sup>

The reduction in interventionist practices and obstetric violence acts is pointed out as one of the consequences from the presence of the companion.<sup>23</sup> Women with companions during the PPP, act guaranteed by Law No. 11,108, from the year 2005,<sup>47</sup> are more respected and have more participation in decisions about the parturition process.<sup>22</sup>

In addition, they have as a consequence more security and comfort, leaving them more empowered, calm and strengthened to give birth, which helps to reduce labor time and painful sensations, increasing privacy, reflecting positively in the Apgar of the 5th minute in the newborn's life and, finally, their satisfaction with the experience.<sup>23</sup> However, there is no unanimity in the findings of the literature on the fact, because the presence of the companion was not always able to totally inhibit the attitudes of the professionals that characterize verbal, physical and psychological violence.<sup>24</sup> Therefore, in order to achieve good results with the presence of the companion, it is necessary that it be effectively welcomed and recognized as an active subject, who needs to be oriented, prepared and encouraged to participate in the PDP.<sup>3</sup>

The presence of the companion is not always welcomed, and the professionals with more time of service seem to be the most resistant to this practice, because they consider that it disrupts the team, leaving the insertion of this dependent related with the medical authorization.<sup>48</sup> The justifications for not allowing the presence of the companion are diversified, crossing aspects of gender (when the companion is male),<sup>7</sup> inadequate physical structure,<sup>7,48</sup> the lack of staff to provide appropriate care for pregnant women and companions at the same time, the limited number of indoor and surgical clothing, among others.<sup>48</sup>

Adding to those there is the fact that most of the companions ignore, that their presence is the woman's right,, evidencing that this information is little divulged by the health services.<sup>49</sup> This context generates moral suffering in nurses, who are inserted in an organization of work that prevents the participation of the companion, especially when their advocacy actions are not able to change this paradigm, leading to the non-fulfillment of all the advantages that the insertion of this agent could lead to the parturition process.

The submitted frame of disrespect to the parturient, through vertically interpersonal relations, rights restriction, autonomy and participation in the decision-making processes, and the perpetuation of interventionist practices seem to be associated to the lack of assistance protocols in the services, which leads to the lack of behavior uniformity. The literature reveals that there is great variation in the care practices to the delivery, showing intense fragility in the behaviors, which are not based on scientific evidence,<sup>50</sup> causing the care to not being focused on the dynamics of the woman's body, but rather focusing on the decision of the doctor.<sup>46</sup>

Witnessing the submission of the parturient to interventionism, to the isolation and fragmentation of care,<sup>51</sup> due to the lack of care protocols that are consonant with the childbirth humanizing policies, leads the nurse to the experience of moral suffering. It is important to emphasize the importance of advocating for work organization qualification,<sup>31</sup> through implementing care protocols aimed at healthcare humanization.

One understands as a limitation of the study the fact that it has been performed in just two hospitals, which represent a small universe in the national reality, and also, because for using data from an interview script that does not explicitly address questions about moral suffering, a fact that evokes more complete investigations. It should be noted that the participants were generalist nurses and that the non-training in the obstetrical specialty becomes an impediment to for determining some

obstetric behaviors during the childbirth by these professionals, being this aspect collaborative with regard to their lack of autonomy, which constitutes a limitation of the study.

## CONCLUSION

This study allowed us to know the situations present in the work of nurses working in maternities and OC that may lead to moral suffering, revealing that the activities attributed to them supplant the capacities to perform them, leading them to prioritize some activities to the detriment of others. In this context, nurses tend to prioritize administrative and managerial activities, on which they are charged by institutions, failing to take part directly in the care activities. This aspect is potentiated when the number of professionals is inadequate.

Conflicting interpersonal relationships and asymmetrical power relations create an atmosphere of toleration of nurse autonomy, preventing them from acting in harmony with humanization ideals and with their moral knowledge and values, with a consequent restriction of their actions in care and development of humanizing practices.

Considering the size of the issue and the investment of the Ministry of Health to qualify the nurses in the obstetric area, aiming to increase their participation in childbirth, it is suggested to develop new researches with generalist nurses and obstetricians, in order to seek alternatives so that these can act and advocate in accordance with their moral knowledge and values, in an autonomous and empowered way, in order to provide decent and safe childbirth care, and an environment that respects women and their autonomy.

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## NOTES

### ORIGIN OF THE ARTICLE

Article extracted from the thesis - Interrelationships between Workloads found in the Nurse Work Process and the implementation of the National Program of Humanization in Prenatal and Birth, presented to *Programa de Pós-Graduação em Enfermagem, Universidade Federal do Rio Grande*, in 2016.

### CONTRIBUTION OF AUTHORITY

Study design: Biondi HS, Barlem ELD, Pinho EC, Kerber NPC.

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Data analysis and interpretation: Biondi HS, Barlem ELD, Pinho EC, Kerber NPC.

Discussion of the results: Biondi HS, Barlem ELD, Pinho EC, Tavares DH, Kerber NPC, Tomaschewski-Barlem JG.

Writing and / or critical review of content: Biondi HS, Barlem ELD, Tavares DH.

Review and final approval of the final version: Biondi HS, Barlem ELD, Tomaschewski-Barlem JG

### ETHICS COMMITTEE IN RESEARCH

Approved by the Research Ethics Committee of the *Universidade Federal do Rio Grande* (46/2015) and *Associação de Caridade Santa Casa do Rio Grande* (029/2015) and *Certificado de Apresentação para Apreciação Ética* 46806915.9.0000.5324

### CONFLICT OF INTEREST

No any conflict of interest.

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