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How the workers of a birthing center justify using harmful practices in natural childbirth*

COMO OS TRABALHADORES DE UM CENTRO OBSTÉTRICO JUSTIFICAM A UTILIZAÇÃO DE PRÁTICAS PREJUDICIAIS AO PARTO NORMAL

MODOS EN QUE LOS TRABAJADORES DE UN CENTRO OBSTÉTRICO JUSTIFICAN LA UTILIZACIÓN DE PRÁCTICAS PERJUDICIALES EN EL PARTO NORMAL

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ABSTRACT

This study was performed with the objective of understanding the reasons why workers of a birthing center in southern Brazil use natural birth practices considered harmful by the World Health Organization. This exploratory study was performed in July 2009 through interviews with 23 workers. The analysis revealed three themes: *Actions and behaviors dependent on health workers*; *Routine practices as facilitators of work*; and *Restricting the parturients' participation in the decision-making process*. Some justifications for using the practices were: perpetuation of inappropriate models, facilitation of the care provided during delivery and authoritarianism that some workers impose over parturients in the erroneous belief that workers have all the knowledge.

DESCRIPTORS

Natural childbirth
Humanizing delivery
Women's health
Obstetrical nursing

RESUMO

Este estudo busca entender as justificativas dos trabalhadores de um Centro Obstétrico do Sul do Brasil para a utilização de práticas do parto normal consideradas prejudiciais pela Organização Mundial da Saúde. A pesquisa é do tipo exploratória, desenvolvida em julho de 2009, por meio de entrevista com 23 trabalhadores. Na análise, houve a conformação de três núcleos temáticos: *Ações e condutas na dependência do trabalhador de saúde*; *Práticas rotineiras como facilitadoras do trabalho* e *Restrição da participação da parturiente no processo decisório*. Algumas justificativas para o emprego das práticas: perpetuação de modelos inadequados, facilitação para a assistência no momento do parto e autoritarismo que alguns trabalhadores exercem sobre a parturiente por acreditarem serem detentores do conhecimento.

DESCRITORES

Parto normal
Parto humanizado
Saúde da mulher
Enfermagem obstétrica

RESUMEN

Este estudio busca entender las justificaciones de los trabajadores de un Centro Obstétrico del Sur de Brasil para la utilización de prácticas de parto normal consideradas perjudiciales por la Organización Mundial de la Salud. La investigación de de tipo exploratoria, desarrollada en julio de 2009, mediante entrevistas con 23 trabajadores. En el análisis, hubo conformación de tres núcleos temáticos: *Acciones y conductas en la dependencia del trabajador de salud*; *Prácticas rutinarias como facilitadores del trabajo* y *Restricción de la participación de la parturienta en el proceso decisorio*. Algunas justificaciones para el empleo de las prácticas: perpetuación de modelos inadecuados, facilitación para la atención en el momento del parto y autoritarismo que algunos trabajadores ejercen sobre la parturienta por creer ser quienes detentan el conocimiento.

DESCRIPTORES

Parto normal
Parto humanizado
Salud de la mujer
Enfermería obstétrica

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INTRODUCTION

The Ministry of Health (MS), aiming at improving the quality of obstetrical and neonatal healthcare, through ordinance 569/2000, created the Program for Humanizing Pre-Natal Care and Childbirth (*Programa de Humanização do Pré-Natal e Nascimento* - PHPN). The main strategy of the PHPN Program is to ensure better accessibility, coverage and quality of care in the prenatal period, delivery and puerperium[1].

The PHPN Program is founded on the premises that humanizing obstetrical and neonatal care is key to promoting appropriate care in the delivery and puerperium period. Humanization comprises at least two essential aspects: the first refers to the health units' duty to welcome women, their family members and the newborn with dignity. This goal calls for an ethical and sensitive attitude from health workers and the organization involved, in order to promote a welcoming environment, while also breaking with the isolation usually imposed on the women. The second aspect refers to adopting measures and procedures known to benefit the process of following labor and childbirth, avoiding unnecessary interventionist practices that, despite being traditional, do not bring any benefit to the women or the newborns[2].

Hospitals continue using many techniques considered harmful by the Ministry of Health, thus characterizing a care model that has no connection with scientific evidence[3-6].

Hospitals continue using many techniques considered harmful by the Ministry of Health, thus characterizing a care model that has no connection with scientific evidence.

One study[6] performed with nurses working in institutions located in eastern São Paulo indicated that oxytocics, episiotomy and lithotomy position are common practices, all of which are considered to harm the delivery, according to the Ministry of Health.

Another investigation[7], which included a bibliographic review on SciELO, found that, in Brazil, healthcare to women in the pregnancy-puerperium cycle is centered on the biomedical model of care, and this has contributed with the growing number of unnecessary invasive and interventionist procedures.

It is understood that humanized childbirth does not refer merely to a procedure that does not use unnecessary practices. In order to be truly effective, the parturient must be respected in every aspect, and she should participate in the decisions that involve the care she is receiving. When women's rights and desires are not respected, humanized healthcare is not being implemented[8-9].

This aspect is emphasized in the Brazilian National Policy for Obstetrical and Neonatal Healthcare, as the principle that humanization should be understood as adopting the value of autonomy and centering the care on the subjects, establishing co-responsibility between them, having solidarity towards the established attachments, respecting users' rights and collective participation in the management process. It also states the duty of health services and professionals to welcome women and newborns with dignity and focus on them as the subjects of rights[10].

For humanized practice to occur, the client's autonomy cannot be neglected[9]. Every health institution should guarantee the healthcare model recommended by the Brazilian Ministry of Health, with intense respect for women as human beings. Health workers should adjust to this new healthcare paradigm to promote the policy of humanizing delivery, which implies the need to make changes in educational institutions and improve hospital infrastructure and working conditions[11].

It is understood that health workers have an important role in implementing humanized delivery, as they are mediators of this process. Therefore, their involvement is essential to make delivery as natural as possible[5]. Humanizing delivery care is largely associated with the health workers' relationship with the woman and her relatives[12].

In this sense, the present study emerges, with the objective to understand the justifications presented by health workers of a birthing center of a hospital located in southern Brazil for using some natural delivery practices that the WHO considers inefficient or harmful for the parturients' autonomy during labor and delivery. We believe that, this understanding will promote the possibility of making the necessary effective changes, in the physical structure of the institutions as well as in the relationships between workers and users, aiming to achieve the healthcare model recommended by the Brazilian Ministry of Health.

METHOD

The present study uses a qualitative approach and is characterized as exploratory and descriptive. It was performed in a birthing center of a university hospital located in southern Brazil.

The study subjects were 23 workers of the referred birthing center, six of which were obstetricians, also known as preceptors, six resident physicians of the Residency Program in Gynecology and Obstetrics of the university with the referred hospital, five nurses, and six nursing technicians. At the referred university hospital, physicians are responsible for performing the delivery and establishing the conducts, but the whole team working in the sector was included in the study with the purpose of obtaining their perception of how the studied practices are performed, as it is understood that they should all participate in the working process.

First, all subjects received the Free and Informed Consent Form. Then, an individual interview was performed with the workers in July 2009 by a group of nursing students, who had received proper training. The interviews were previously scheduled and performed at a time and place according to the preference of the interviewee, with no relationships with the specific moment when the parturient was being cared for.

The interviews were recorded with the consent of the participants, and later fully transcribed, for a better understanding of the data. The subjects were asked about the use and justification for performing some procedures considered harmful for natural childbirth according to the Brazilian Ministry of Health, and, therefore, should not be a common practice, which include: enema, hair removal, and administering oxytocin before labor, and using the lithotomy position and performing episiotomy in the delivery. For each practice the subjects reported being performed, they were asked if the parturients were consulted regarding their use.

The study complied with Resolution 196/96, which regulates the norms for research with human beings. The study was authorized by the Research Ethics Committee at Federal University of Rio Grande (FURG), according to review number 31/2008.

To guarantee the subjects' anonymity, in the study they were referred to after their profession, i.e., preceptor physicians (PP), resident physicians (RP), nurses (N), and nursing technicians (NT), followed by the number of the order in which they were interviewed.

First, the collected data were subjected to a pre-analysis, in which a brief reading of the interviews was performed, so that the researcher could be in contact with the content for a first time. After this first reading, a data coding system was designed. A table was created, containing the identification of the study subjects, the main topics, consisting of the questions used in the script, according to the analysis proposed in terms of the organization of the data[13]. In the second stage, three themes were formed based on the justifications regarding the harmful practices that were or were not performed, according to the participants' statements. In the third stage, the data were interpreted, and a correlation was established with the themes ranked with the recommendations of the WHO and the Program for Humanizing Pre-Natal Care and Childbirth, in addition to the studies developed in this area.

RESULTS

In the following section we present three themes that emerged from the analysis of the birthing center workers' statements about their justifications for performing or not the ineffective and harmful practices investigated in the present study.

Action and behaviors dependent on health workers

The analysis of the subjects' statements indicated that some of the childbirth practices considered harmful were related to the worker on duty. In the studied unit, there is no care protocol to work as a guide for the working process when caring for parturients. This aspect is observed in the workers' reports about their performing an enema:

> (...) it depends on the behavior of each preceptor, some want it to be done, others don't, and sometimes it depends on the behavior of the workers themselves (...) (PP2).

> (...) it depends on the behavior of the physician on duty, some physicians use it (...) (NT 2).

> (...) it depends on the physicians, they follow their own routine (NT3).

It also becomes clear when workers refer to hair removal:

> (...) the physician instructs us, and we have to follow each physician's routine (NT1).

> It depends on the physician, on the resident, depends on the nursing staff, on the patient, because some follow one model, some follow another... (PP4).

> (...) the medical practitioners rather have it done. They say it isn't recommended, but here they still prefe*r having it done (N2)*.

Furthermore, when they refer to episiotomy:

> It depends, at some services (RP2).

Another element that arises in this theme nucleus regards the reproduction of the care model adopted by the preceptor physician and resident physicians. Sometimes, due to a lack of autonomy, the resident physician performs certain practices, though knowing they are not appropriate, following the conduct determined by the preceptor physician, with no questioning, as shown in the following statement:

> The fact is I am a resident, so there are things that is I decided alone I wouldn't do, but because I have the preceptor, I have to do what he wants ... (RP4).

Routine practices as facilitators of work

It is evidenced that certain practices are used in the period before labor with the purpose to facilitate the worker's routine in the delivery, without considering the individual need of each parturient and without thinking if using those practices is actually beneficial for the woman and her baby. This becomes clear, for example, by observing the statements referring to episiotomy:

> (...) Many preceptors want us to do it in every parturient (...) (RP4).

> They do it in every parturient, only when for some reason they really can't (...) (NT 1).

Ina addition, when they report performing hair removal in every parturient:

> Hair removal must be performed, because in fact, when performing the episiotomy, all that hair is a problem (...) (PP5).

> Usually, it is a routine in parturients having natural childbirth, when they arrive at the birthing center, for the hair removal and enema (...) (PP2).

> (...) later, she will have some kind of impediment, some kind of difficulty, that if we have to do something here or there, even a caesarean delivery, or a vaginal delivery with episiotomy, it adds a technical difficulty (...) (RP2).

However, it appears that some workers develop a view that performing these practices indiscriminately is not an appropriate attitude. It is also evidenced that, slowly, changes are being made in their working practice:

> Episiotomy should be performed only if necessary, but here it is a routine... What I'm saying is what is the routine here, and not what I think is right (PP1).

> (...) actually, it is a routine, and it shouldn't be (...) (NT 6).

> Here it is a routine. That doesn't mean it is right to do it (PP1).

> (...) it used to be (reporting it was once a routine). Because, as stated in the literature, and everyone agrees, it will be the same with hair removal (...) (N2).

> (...) At our service it is treated as a routine, and this has changed a little, but it is still a routine (...) (RP2).

Restricting the parturient's participation in the decision-making process

By analyzing the workers' statements, it was found that women are made passive during the delivery. Most workers perform the procedures without asking the parturient about them. According to the workers, the patient is informed about the procedures, but they are not given a chance to participate in deciding about performing them (the procedures). The parturient does not participate in the conducts and actions developed during the time thy stay at the birthing center in labor, as observed in the following statements:

> No, I don't think so. We do inform them, but only to prepare them, without giving too many explanations (RP7).

> We explain what we are going to do (PP2).

> We don't ask her any questions, we just inform them about the procedure (N1).

The following statement of a resident physician shows the authoritarianism of the workers over the parturients during the delivery. No questions are asked to the women, and they are not given the chance of stating their opinion about the care they receive.

> They are not asked, we say what is necessary and they agree, there was never a parturient who did said she did not want it (RP3).

In this theme nucleus, a differential emerges that reinforces the authoritarianism of the unit's workers in terms of the parturients' power of decision. When the workers were asked about performing the episiotomy, physicians were unanimous in affirming that the decision about performing this procedure does not concern the parturient:

> No. The episiotomy is an obstetrical indication (RP7).

> No, we evaluate what is necessary (PP3).

In the following statements, by the preceptor physicians, we observed that the current thought at the unit is that the physician has complete power to decide anything involving the birth process, without any participation of the parturient in the decisions made at this time. This aspect is observed in the following statement:

> No, it is a medical decision (PP1).

> No, we evaluate what is necessary (PP3).

Workers have an idea that the woman going through labor is in no condition to give her opinion about what is best for herself and her baby. The following statements demonstrate this perspective:

> No, because the episiotomy is not decision for the patient to make, you can't ask the patient, she is in no condition to answer. Patients in pain cannot think right, and then you are asking her if she wants the episiotomy, you can't, it is unfeasible (RP4).

> No, the poor thing, they don't even know what is going on at that time (NT2).

DISCUSSION

By analyzing the workers' statements, it becomes evident that most do not take the recommendations of the WHO and Ministry of Health about natural childbirth into consideration and continue using childbirth practices considered to be harmful. One of the aspects that becomes clear is that, at the studied unit, some workers' opinion became true and was considered above the recommendations of the ministry of health. It appears evident their choice of practices depends on the belief and knowledge of the professionals on duty.

It should be emphasized that the place of study is an educational institution that is responsible for preparing future healthcare workers. For this reason, the hospital should have the Ministry of Health are their guide, once it is the highest organization that directs all healthcare actions in the country. And, as an educational institution:

> One would expect the university to be the *locus* of the search for knowledge, and that these institutions would

quickly incorporate evidence-based practices to teaching, healthcare and research. It so happens that these practices were initially adopted and determined in public healthcare services with the SUS (national health system) and, paradoxically, one of the major focus of resistance for its becoming effective is academia: medicine professors of important universities have published, in the media, editorials disqualifying the humanization proposals of the Ministry of Health [14].

The lack of an evidence-based healthcare protocol favors the perpetuation of this model that is currently used at the unit. The hospital must guide its workers to provide appropriate and quality healthcare. Furthermore, despite the unit not having a healthcare protocol for parturients, it is evident that there is a concealed routine in place, because the workers gave similar answers when asked about the harmful practices.

The current routine of the unit is harmful, because it is a hindrance to making changes. The behaviors are passed on across generations over time and accepted as true, which makes it more difficult to implement behavior (conduct) changes among the workers. Routines that are perpetuated for too long are difficult to be changed, and it is necessary for someone, in this case a worker or administrator, to take the initiative to start a discussion process with the purpose to promote the change in behavior. This change may be *slow because familiar rules and routines are comforting, and because it takes time to develop and agree with new policies*[15].

The statement by a resident physician indicates that he does not agree with the care that is delivered. However, he complies with it, according to the instructions of his preceptor. This is a reason for concern, because it is observed that an inappropriate model is being taught to the new workers. Furthermore, we highlight the lack of preparation of some workers, who require permanent technical training, considering that most of them, after graduating, do not keep up to date[16].

The students may be actors for the change in behavior, because they have access to scientific literature that demonstrated the practices that should or should not be used. Therefore, should they not discuss with and ask their professors about the reason why those practices continue being used? At the same time, we understand that students reproduce what they are taught in the classrooms and fields of practice, in fact, they often acts as if there was no technical and scientific foundation for changing traditional practices, such as episiotomy or hair removal. A study in which the researchers followed classes in a college of medicine found that the professor recommended the referred practices, and founded their use only on his professional experience[17].

In the place of study, it was observed that practices harmful for the delivery had become a routine, with the purpose to facilitate delivery care for the worker, and not as a way to provide benefits to the parturient and her baby. We emphasize that the objective of delivery care is to perform the lowest level of interventions while ensuring the mother's and baby's health[17].

The individual evaluation of each parturient, and, particularly, making the correct diagnosis in the beginning of labor are fundamental parameters to avoid the excessive use of practices that harm delivery[17]. Therefore, using routine recommendations is inappropriate, because the worker providing delivery care must make an individual evaluation of each parturient. The healthcare worker should follow a non-interventionist healthcare model, review the parturient care practices considering scientific evidence, and respect each woman's singularity[4]. In some places, there is an image that using fixed protocols is better and safer, for both patients and physicians[17].

The workers' statements evidence that some already realize the harms caused by the referred practices. However, they appear to be discouraged to make any changes in the routine of the institution. By exposing the parturients to unnecessary risks, workers are violating one of the principles of bioethics: non-maleficence. This principle determines the duty to never cause intentional harm, i.e., not impose harm risk[18].

Another concerning factor in the studied institution relates to the lack of participation of the parturients in the decisions about their delivery. It appears that workers disregard the fact that the women are the center of the delivery setting. They state, at some moments, that the parturients are informed about the procedures being performed. However, they do not allow their (women's) participation in the decision-making process regarding the practices being adopted. Therefore, the workers are breaking a principle of bioethics, which is to respect autonomy.

Autonomy is a person's right to state their opinions, make choices and act based on their values and beliefs[18]. The same authors refer that the major difficulty to respect this principle in the biomedical contexts is associated to the patient's condition of being dependent and the worker's position of authority.

One investigation[19] found results similar to those of the present study. These authors concluded that healthcare workers only explain or instruct patients about the routines of healthcare, without giving the parturients the chance to choose the events in her delivery.

Another study, performed at a Teaching Hospital in the interior of Minas Gerais, confirmed the lack of information and participation of the parturients in the decision-making process about performing episiotomy, in that 81.3% of the interviewed women reported they did not receive any type of information regarding the intervention[3].

Seeing a woman as unique, respecting her rights and desires, and recognizing that she and her baby are the

center of childbirth are attitudes that healthcare workers should assume. Quality delivery does not refer merely to natural childbirth, i.e., a vaginal delivery; rather, it is the delivery that takes the rights of the parturients and her relatives into consideration[8].

Furthermore, it was also observed by the workers' statements that they see these women as passive during delivery and that the women do not even recognize their rights so, for this reason, they are unable to claim them. In a study developed in Londrina, in the state of Paraná, the authors evidence this same finding, and affirm that the workers treat the parturients as passive objects of the actions that offer no resistance[20].

The women's lack of information and knowledge regarding their rights may be a result from the failures in the pre-natal care they received. Healthcare workers providing pre-natal care must prepare women for the delivery, giving them information about it and regarding the routine procedures, teaching them how to relax and providing them with information about how they can help make the delivery easier.

The Delivery, Miscarriage and Puerperium Handbook published by the Ministry of Health reinforces that the women's opinion in the delivery must be respected. For this to happen consciously, women must receive information in the pre-natal period[21], which would help them make choices in such an important moment of their lives.

Another fact that really draws attention is that it appears that the workers disregard the patients' rights. According to the Health Users' Rights Letter, created by the Ministry of Health, every patient has the right to concur or refuse procedures performed on him or her, providing free, voluntary and clarified consent, counting with the appropriate information[22].

When this issue of parturient autonomy is addressed, it is necessary to clarify an aspect of this worker/parturient relationship. Medical practitioners emphasized that the decision for performing procedures such as episiotomy does not concern the parturient, as it is a decision of the obstetrician on duty. One of the studies that address this issue also highlights physicians as holding the power of decision[17].

Unquestionably, the final decision about performing certain practices is exclusive to the obstetrician present during the delivery, who has the appropriate qualification to evaluate the need for intervention and avoid complications in the delivery. However, it is necessary to highlight that making certain procedures routine, without the women's consent, and without providing them with appropriate information, shows the workers' disregard towards the parturients as subjects of this process.

In this perspective, workers assume an attitude of domination and a power relationship regarding the parturient. This concept is mainly associated with the position assumed by the worker, as the one with all the knowledge, and this restricts the possibility of patient autonomy[9].

The parturient, in this situation, is a receptacle of an authoritarian action, without any possibility of interfering, or stating their opinion, or claiming their rights and desires. Scientific competence and technology are more highlighted than patients' quality of life or well-being[9].

It seems clear that workers are sure that during the delivery, women are not in condition to give an opinion of what they believe is best for themselves, therefore this decision concerns only them (workers). This understanding was present in almost all the presented results.

As a final statement in this discussion, it should be emphasized that the Program for Humanizing Pre-Natal Care and Childbirth was planned and discussed as a *national policy for women's rights, aiming to implement a fundamental action to improve the quality of obstetrical care and reduce maternal and perinatal mortality*[16].

CONCLUSION

This study proved, through the workers' reports that some harmful birth practices continue being performed in the care to parturient, with the justifications being the perpetuation of inappropriate models, facilitating delivery care and the authoritarianism that some workers assume towards the parturients, as they believe that they have all the knowledge.

Another relevant factor that emerged throughout the discussion was the lack of respect regarding the parturient's rights, demonstrated by the fact that the woman is not informed about the procedures being performed and does not have the chance to give her opinion about it. It is also evidenced that the ethical principles of non-maleficence and autonomy are not complied with.

It appears that the interviewed workers disregard the recommendations of the World Health Organization and of the Ministry of Health, as they consider daily practice and experience above those indications. In order to change this reality, it is necessary to invest in improvement courses and showing successful humanized delivery experiences to these workers.

In order to promote change in the current reality of delivery care, it is necessary for the institution, which is accounted for most part of the changes in behavior, performed an intervention in the sense of creating a protocol to guide these workers' conducts and how they should provide care. Furthermore, the present study evidences the need to perform an investigation of the curricular structure of medicine and nursing courses to verify if their approaches contemplate the perspectives of humanization regarding healthcare in the pregnancy-puerperium cycle, as in gynecology and obstetrics residence programs at the studied institution.

By investing in workers' training, students' education, and in the structure of services it is possible to improve the quality of care to users, and, thus, also ensure a continuous promotion of technical and scientific development.

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