



Texto & Contexto Enfermagem

ISSN: 0104-0707

textoecontexto@contato.ufsc.br

Universidade Federal de Santa Catarina
Brasil

Junqueira Oliveira, Virgínia; de Mattos Penna, Cláudia Maria
DISCUSSING OBSTETRIC VIOLENCE THROUGH THE VOICES OF WOMEN AND
HEALTH PROFESSIONALS

Texto & Contexto Enfermagem, vol. 26, núm. 2, 2017, pp. 1-10

Universidade Federal de Santa Catarina
Santa Catarina, Brasil

Available in: <http://www.redalyc.org/articulo.oa?id=71451212032>

- How to cite
- Complete issue
- More information about this article
- Journal's homepage in redalyc.org

redalyc.org

Scientific Information System

Network of Scientific Journals from Latin America, the Caribbean, Spain and Portugal

Non-profit academic project, developed under the open access initiative

DISCUSSING OBSTETRIC VIOLENCE THROUGH THE VOICES OF WOMEN AND HEALTH PROFESSIONALS

Virgínia Junqueira Oliveira¹, Cláudia Maria de Mattos Penna²

¹ Doctoral student, *Programa de Pós-Graduação em Enfermagem, Universidade Federal de Minas Gerais (UFMG)*. Professor, Nursing Program, *Universidade Federal de São João Del Rei*. Divinópolis, Minas Gerais, Brazil. E-mail: viju.oli@gmail.com

² Ph.D. in Nursing Philosophy. Professor, *Escola de Enfermagem, UFMG*. Belo Horizonte, Minas Gerais, Brazil. E-mail: cmpenna@enf.ufmg.br

ABSTRACT

Objective: to analyze the discourses of women and health professionals regarding care during childbirth, considering the situations experienced and the interactions between them during labor and delivery.

Method: this is an interpretative study with a qualitative approach. Discourse Analysis was used as the research method. The research scenarios were seven maternity hospitals, belonging to the public network of the Central-West region of Minas Gerais. Interviews were conducted with 36 laboring mothers, 10 midwives and 14 obstetricians. The collected data were submitted to discourse analysis.

Results: the data were organized into three categories: 1) Witnessed obstetric violence described in the discourse of the midwife: which discusses that even acknowledging the presence of this, they talk of the difficulty of guaranteeing the rights of the mother in labor in the scenario of childbirth; 2) Today everything is obstetric violence: it shows the denial of the existence of this phenomenon in the professional-patient relationship; 3) Here we have no voice: obstetric violence is present, but there is a certain consent the part of women who, in the presence of the birth, forget the way they received assistance.

Conclusion: hostile treatment is one of the obstacles of the humanization of childbirth care, interfering with the choice of delivery method, and it is necessary to review the concept of obstetric violence, considering all its specifics and nuances.

DESCRIPTORS: Midwifery. Women's health. Violence against women. Humanizing delivery. Discourses. Qualitative research. Birth.

O DISCURSO DA VIOLÊNCIA OBSTÉTRICA NA VOZ DAS MULHERES E DOS PROFISSIONAIS DE SAÚDE

RESUMO

Objetivo: analisar os discursos de mulheres e profissionais de saúde sobre a assistência ao parto, considerando as situações vivenciadas e as interações construídas entre eles durante o trabalho de parto e parto.

Método: trata-se de um estudo interpretativo, com abordagem qualitativa. Utilizou-se a Análise de Discurso como método de pesquisa. Os cenários de investigação foram sete maternidades, pertencentes à rede pública da Região Centro-Oeste de Minas Gerais. Foram realizadas entrevistas com 36 parturientes, dez enfermeiros obstetras e 14 médicos obstetras. Os dados coletados foram submetidos à análise de discurso.

Resultados: os dados foram organizados em três categorias: 1) A violência obstétrica presenciada no discurso da enfermeira obstetra: que discute que mesmo reconhecendo a presença desta, falam da dificuldade de garantir os direitos das parturientes na cena do parto; 2) Hoje tudo é violência obstétrica: mostra a negação da existência desse fenômeno na relação profissional-paciente; 3) Aqui a gente não tem voz: há presença da violência obstétrica, porém há certo consentimento por parte das mulheres que, na presença do nascimento, esquecem a forma da assistência recebida.

Conclusão: o tratamento hostil constitui um dos obstáculos à humanização da assistência ao parto, interferindo na escolha da via de parto, sendo necessário rever o conceito de violência obstétrica, considerando todas as suas especificidades e nuances.

DESCRIPTORES: Tocologia. Saúde da mulher. Violência contra a mulher. Humanização do parto. Discurso. Pesquisa qualitativa. Enfermagem obstétrica. Nascimento.

EL DISCURSO DE LA VIOLENCIA OBSTETRICA EN LA VOZ DE LAS MUJERES Y DE LOS PROFESIONALES DE LA SALUD

RESUMEN

Objetivo: analizar los discursos de mujeres y profesionales de salud sobre la asistencia al parto, considerando las situaciones vividas y las interacciones construidas entre ellos durante el trabajo de parto y parto.

Método: investigación cualitativa, del tipo interpretativo. Se utilizó del análisis del discurso como método de investigación. Los escenarios de investigación fueron siete maternidades, pertenecientes a la red pública de la región Centro-oeste de Minas Gerais. Fueron realizadas 36 entrevistas con mujeres parturientas, diez enfermeras obstetras y 14 médicos obstetras. Los datos fueron sometidos a análisis de discurso.

Resultados: los datos fueron organizados en tres categorías: 1) la violencia obstétrica presenciada en el discurso de la enfermera obstetra: que discute que aunque reconozca la presencia de esta, habla de la dificultad de garantizar los derechos de las parturientas en la escena del parto; 2) Hoy todo es violencia obstétrica: muestra la negación de la existencia de este fenómeno en la relación profesional-paciente; 3) Aquí uno no tiene voz: hay presencia de la violencia obstétrica, sin embargo, hay cierto consentimiento por parte de las mujeres que, en la presencia del nacimiento, olvidan la forma de asistencia recibida.

Conclusión: el tratamiento hostil constituye uno de los obstáculos a la humanidad de la asistencia al parto, interfiriendo en la elección de la vía del parto, siendo necesario rever el concepto de violencia obstétrica, considerando todas sus especificaciones.

DESCRIPTORES: Tocología. Salud de la mujer. Violencia contra la mujer. Parto humanizado. Habla. Investigación cualitativa. Enfermería obstétrica. Parto.

INTRODUCTION

Up to the beginning of the last century the childbirth scene, was essentially feminine. The assistance to the woman and the newborn was exercised by the experienced hands of the midwives, in the privacy of the home and in the presence of persons known and trusted by the woman. In the 1940s, after World War II, there was a trend towards the institutionalization of childbirth, and by the end of the century 90% of births were performed in hospitals.¹

The delivery in the hospital environment, combined with the technological availability in health care, contributed to the organization of care as a production line, accentuating the medicalization of childbirth, whose capacity to choose becomes the sole responsibility of the physician, despite the desire of women, who loses their privacy and autonomy.²

This phenomenon is also observed in other countries, such as Spain, where one in four births (24.9%), is carried out by caesarean section.³ In an Italian study in the Province of Reggio Emilia, it was observed that women who had their deliveries attended at private centers were subjected to a greater incidence of medicalization of labor, which did not lead to better perinatal outcomes.⁴ A survey of South African maternity hospitals revealed that inhumane and exploitative care is more prevalent in public maternity hospitals in developing countries.⁵

Nowadays in Brazil what can be called a perinatal paradox exists: while there are significant improvements in the expansion of women's access to health services and the availability of diagnostic technologies, there is an intense medicalization of labor and delivery, with the maintenance of high

rates of maternal and perinatal morbidity and mortality. This indicates a poor quality of care for prenatal care and childbirth. The rate of 53.7% of cesareans in Brazil is one of the most emphatic examples of this reality.⁶

It is known that reducing the number of cesarean sections and other unnecessary interventions in childbirth care is a complex task that is beyond the spectrum of health. It involves issues of gender equality, access to income and education.

Within this context several movements against the medicalization of pregnancy, intensified by women and activists have intensified since the nineteen nineties. The number of Blogs and Non-Governmental Organizations has grown in support of normal birth and delivery. The Ministry of Health intensified its actions in an attempt to re-discuss this assistance model and guarantee access to health practices based on scientific evidence and recognition of the autonomy of pregnant women throughout the pregnancy/post-partum process.⁷

However, despite all this movement, many obstacles hamper advances in childbirth care, such as: maintenance of the medicalization of childbirth, abuse of technologies, insufficient funding, poor system regulation, fragmentation of actions and health services, the persistence of high rates of maternal and perinatal morbidity and mortality, and indifference to the presence of hostile treatment against women in public and private hospitals throughout the country.⁸

According to the survey "Brazilian women and gender in the public and private spaces," one in four women suffer from some form of violence during childbirth. The most commonly described

situations of violence are being screamed at, painful procedures without the consent of the pregnant women, lack of analgesia and even negligence.⁹

At the same time, the number of complaints made to the Public Federal Prosecutor's Office increased, which chose to create a public civil inquiry to investigate cases of disrespect and violence at the time of childbirth.

In the field of health, discussions on unnecessary interventions in childbirth care have intensified, which gives rise to the emergence of the concept of obstetric violence, understood as any act or unnecessary intervention directed at the woman or the newborn, practiced without the consent of the woman and / or disrespecting their autonomy, physical or psychological integrity, going against their desires and options.¹⁰

When reflecting on this reality in the attention to women during childbirth, and considering that, on the one hand, there are norms and hierarchies, not always perceived as offensive and violent and, on the other, there are the experiences of the subject, based on their everyday relationships that often contradict the normalization imposed on it, it is questioned: How has the discourse on labor and childbirth been established in the relationships of health professionals and women in labor.

Considering that the phenomenon of obstetric violence is the product of a complex situation and of environments that fosters aggressive and hostile discourse and placing opposite sides of women and health professionals, this study aims to: analyze the discourses of women and professionals of care about childbirth care, considering the situations experienced and interactions built between them during labor and delivery.

METHOD

A interpretative research using discourse analysis method, according to Foucault's perspective, seeing that the fundamental question is to analyze the discourse constructed in the relationship between the health professional and the woman in labor.

In seeking diversity, seven public maternity hospitals in the municipalities of the central-western region of Minas Gerais were chosen as research scenarios. The choice was purposeful, considering the fact that research of this magnitude is usually developed in large centers and little is known about childbirth care in small hospitals.

The established inclusion criteria established to define the participants of the research were, in

relation to the professionals: to be included in the staff of the public maternity and to provide direct assistance to the women in labor and delivery; being a midwife or obstetrician. For women: having given birth in one of the maternity-settings of this study; having had a normal or cesarean birth, with a minimum of six hours; Being in the puerperium stage and being between 15 and 45 years old.

Due to it being a qualitative study, it was not intended to be concerned with the quantification of participants, but with they represented. However it was established that at least one nurse practitioner and a doctor from each scenario would be invited to participate, as well as a post-partum mother. However, to finalize the data collection the saturation of the data was considered through a pre-analysis that showed congruences between the discourses obtained for the presented questions. Thus, the participants of this study included 36 women and 24 health professionals, 10 midwives and 14 obstetricians.

Data collection was performed through interviews, with a semi-structured script for professionals and one for women, with the following questions: Report how the birth of your child was for you; Describe how you see the relationship between you and the health care provider who cared for you during childbirth; Describe an event that left an impression on you in your service. What does it mean to be obstetrician/midwife? Can you describe a situation which you experienced in the delivery room that involves you and the patient?

The interviews were recorded on a digital apparatus and transcribed in full for the analysis and interpretation of the discourses. In addition, observation of situations which occurred during labor and delivery was used, seeking to emphasize the dialogue established among female health professionals, which were recorded in a field diary. Data collection occurred between September 2014 and March 2015.

The analysis of discourse¹¹⁻¹² was comprised of three stages: The 1st) Organization, transcription and arrangement of discourses in full; The 2nd) Vertical reading, which comprises of exhaustive reading of each individual discourse to understand the central ideas; 3rd) Horizontal readings to determine the ideas or meanings that are similar or not to the organization of the convergent data in common themes, determining the categories and subcategories

In this methodological approach, the analysis of statements must go beyond textual analysis, including the socio-institutional conditions of its production. The discourse contributes to the consti-

tution of all the dimensions of the social structure that shape and restrict it, being a practice of representation and signification of the world.¹¹

In a discursive approach, Foucault revealed the connection between discourse, desire and power, and emphasized that in this imbricated relationship, not everything can be said, it depends on the circumstances and who says. There are those who can and those who can not speak.¹²

To guarantee anonymity, the participants were identified in an alphanumeric form, according to the first letter of the category to which they belonged. For example: M for women. In order to identify the health professionals, it was decided to use the conventional abbreviation, that is, Med for Physicians and Enf for Nurses, all being followed by a number in relation to the order of the interviews.

In the last stage of the analysis the results were interpreted, establishing the discussion of the results found with the existing literature and the experience and knowledge of the researchers, setting up a dialectical movement and seeking to reveal the determinations and specificities that are expressed in reality.

The fieldwork began after approval of the Ethics and Research Committee of *Universidade Federal de Minas Gerais* - opinion number 791.265 CAAE: 3252471420000.5149, and its construction was done in compliance with the requirements of resolutions 196/96 and Resolution No. 466/2012 of the National Health Council Regulates, the guidelines and regulatory norms of research involving human beings.

RESULTS

The participants' perspective on violence in childbirth which were revealed in the discourses are organized into three categories described below.

Obstetric violence witnessed in the discourses of the midwife

The midwives' discourses showed that they share the experiences of witnessing violence. The difficulties faced in guaranteeing the laboring mothers' rights, the fear of coping with co-workers, and the aggressive and less tolerant treatment that permeates care during labor and delivery are present.

Some moments in the delivery room are difficult for the nursing staff. Because we are on this side and the patient on the other side, it is complicated. She is feeling pain, fragile, tired, asking for help. I have already witnessed negative events, what makes me sad is when

the patient is in the expulsion period, and the doctor and the nurses scream at her to force her, they say that it is not the time to stop, that the baby has to be born, they do The Kristeller maneuver, and we have to follow what the doctor is asking for (Enf 1).

I have witnessed negative situations, especially from the medical side, the doctor tells them to shut up, tell them if they shout he will leave, leave them, he will not provide assistance, or do some type of medication so that the patient gets a little more doped and not be able to scream and not get so hysterical, then there are still these situations (Enf 3).

These findings demonstrate that the limits established by the medical/nurse hierarchy in the hospital institution are still very evident, restricting and controlling their space in the care of delivery and childbirth.

Some professionals become irritated with the patient, without understanding the other side, weakness, fear. And it turns out you hear verbal assaults, which at that moment, you cannot do anything. As you will catch the attention of the doctor in front of the patient, being that he is in front of anything, he is there to do the delivery. This is bad, because we are present and whatever happens, whether or not you are involved in the patient's dissatisfaction and everything else. It is this verbal violence that happens when the patient is agitated, tired and unable to keep going (Enf 9).

For those who are present in the delivery room, listening to offensive words can hurt and persist more than physical aggressions, because of their invisible dimension, which projects itself in the moral and psychological field, and to involve everyone in a conspiracy of silence, which implies to not say what you think or what you think is fair, in respect of the other.

One shocking thing to me was a primigravida in labor, who did not collaborate and she was turned over on the table and the doctor lost her patience and began to speak things that hurt the team, that she was not a fighter, that she did not know how to play, because the patient is exhausted. Because of that situation, I thought it was better to take the patient and go back to the ward where was able to give birth and the child was born well! So something that stays in the memory, a doctor saying these kind of words with the patient, it made us feel bad (Enf 10).

It also points out that just as childbirth can be traumatic for the woman, it can also be for the team.

In the end she despaired, she wanted analgesia and the anesthetist was resistant. She was screaming and the doctor started putting pressure on her uterus, and she did not want to, she knew what Kristeller was, epi-

otomy. She shouted, 'I do not want that hand there,' she repositioned herself, and the doctor yelled at her several times. And the husband was there, a young couple, who had scheduled a wonderful birth, and had a horrifying experience there in the delivery room and everyone started kind of losing their temper with her (Enf 8).

An inhuman birth is not traumatizing only for the woman, but for the whole team that is there and for the baby, because look at the situation that this baby was born into, how it was taken away. Even today when I remember, it makes me very angry (Enf 4).

We forget neither good nor evil. I think the negative is remembered a lot more. You have to be careful, because it's a routine for us, but for women it's a unique experience. We see the unnecessary intervention, I do not know if it is the working hours, that there is no time to be there on the side. And I have already witnessed the imposition itself, screaming "open this leg, stay there, don't get up" (Enf 7).

There is also a metaphorically made up violence found in the work routine in the maternity hospitals.

When we talk about obstetric violence, it exists in all institutions, by all professionals, every day, some more explicit, others more made up, most are not denounced because the patient or professionals do not understand violence, and it stays among the professionals of the institution, but it is with speeches, with attitudes, with conducts, all this is conducive to violence (Enf 8).

The discourses emphasize that the delivery room presents itself as a space where irrational and automated actions can occur, insofar as the process of childbirth and birth becomes habitual and commonplace for those who are there on a daily basis.

I have the greatest difficulty putting the companions in the delivery room, it seems that you are doing a favor, and then if you insist, the violence turns against me (Enf 3).

In the delivery room it is rare to let a companion enter. It is only when the hospital is empty that it is allowed, depending on the behavior of the companion. Now, to be honest it happens more when the delivery is private, then the obstetricians allow the companions enter more (Enf 4).

I will talk about my place of work. From the moment I cannot allow the husband to accompany the labor I am going against a federal law, which is clear and has a purpose, she says that the patient has to have an escort who she chooses during the labor and childbirth, if I do not allow it, I am committing violence. If I want to shorten the delivery to go to rest and start doing a lot of intervention, this is obstetric violence (Enf 8).

As a common procedure, childbirth ceases to be understood as a process that may require numer-

ous adaptations, permeated by distinct subjectivities, both of the woman and of the professionals who assist her, interfering, even, in guaranteeing the right of free choice of who will be the companion in the delivery room.

Today everything is obstetric violence

Speaking about his profession, the doctor expresses a displeasure with the expression *obstetric violence*, understood in his discourse as a derogatory term, exacerbated by the media and which neglects the autonomy of the obstetrician and classifies all medical practices as hostility against the woman and not as a benefit in favor of the health of the woman in childbirth and the newborn, which negatively influences the daily work of the maternity hospitals and in the relationship between the doctor and in the woman in childbirth.

Today anything you do with the patient can be viewed as obstetric violence. If you have a normal birth, it is violence, if you have a cesarean, it is violence. I do not think it's this way. You have to understand that it is a context, we do not want anyone to feel pain or suffering. It is much bigger than the media, than one case. I think obstetrics is complicated, we are here to do the best, to come up with a good solution for everyone. The patient wants you to give care without examining, how can this be fair. I do not agree with this type of obstetrics (Med 6).

The physician-patient relationship is commonly permeated by a dissymmetric discourse between a doctor who is presumed to know everything with a patient who is presumed not to know anything. The physician believes he has sufficient scientific knowledge to conduct labor and deal with the adversities and complications that may arise at this time.

Today the boss is the patient, you do not have recognition. My biggest difficulty is with the companion, because today he knows more than the doctor, they search the internet. Then he arrives and determines what should and should not be done and this brings me much displeasure, having to work with this type of patient (Med 1).

The woman is not prepared for what she will face. Most of them come with a lack of information and end up having a mismatched idea between what we propose and what the woman expects. Obstetrics is the second highest area of medicine for legal litigations and this creates a defensive position for the doctor and the patient, and ends up disturbing the doctor / patient relationship (Med 5).

They are difficult people to work with because they don't prenatal care right, and they demand it. Some relationships are difficult. There are women who do not want to listen to what you say, they do not help in childbirth

and are unprepared. There are pregnant woman who do not let you touch them, they start fighting at the time of childbirth, lie on the ground, don't do what is needed, bite, scratch the nurses with their nails (Med 7).

When he is questioned by the companion of the mother, the doctor feels confronted and indignant, because he has his knowledge as an absolute truth, to which the patients' bodies are docilely submitted so that they can be controlled, transformed and perfected.

I have been disappointed because I want to do one thing and the women prefer another. there is a city that I worked for which I have acquired the reputation of executioner, which doesn't perform caesarean sections and lets the woman suffer until they are exhausted (Med 8).

You are often threatened by the patient and the companion. There are patients who attack not only verbally. There was a situation in which the baby's grandmother pushed the doctor. The function of the chaperone is not that of curiosity, it is a way of intruding in the conversation of others. I am not a friend. I am an extremely serious doctor, I do not like joking at any moment (Med 6).

The construction of the relationship between the physician and the woman is conflictive and aggravated by a lack of information about the physiology of childbirth, lack of reciprocity, responsibility and affectivity in the interaction between the actors involved in the process, which is reflected in the disagreement between the desire of the woman and what is proposed by the doctor.

Here we have no voice

Although the medical discourse reports on the presumed autonomy of women at the time of childbirth, and as far as saying that "today who commands is the laboring mother", the narrative of women opposes this discourse. The women who experience a situation of violence in the delivery room are dumbfounded by a hostile or authoritarian attitude of the health professionals.

I did not like it. At the time the doctor said he was going to call the guardianship council, I was afraid of them taking my little baby, I felt threatened, but I was quiet because I was wrong, I didn't do any prenatal care! It made me nervous. He called me irresponsible. But it's normal, we work too hard to have the baby, it's a lot of pain, you do not know which position to stay, they don't let you stay in any old position (M20).

I did not like the way the doctor talked to me, it was very rude. I think in that moment of pain, I did not need to be talked at like that. He could have been more polite,

because in the hour of pain, you despair, you talk nonsense. It felt like I was a piece of rubbish there, that he was obligatorily touching me, he had cursed me in the room, then he went into the delivery room, to say everything he had said: if having a hissy fit helped anything, that my tears were false, I was fake crying, you know (M5).

The discourse signals consensual violence, even if there is embarrassment with the aggressive treatment received initially. The aggressive attitude of the health professional is attributed to the strenuous pace of work in childbirth care and the out-of-control behavior she had faced with the pain during labor.

It is very tense, I did not expect it to be like this, I imagined that I would receive guidance from the team. I found it difficult. For some women it is easier, but I had difficulties to put it into practice. I think I may have been because of me, I was tense, nervous, wanting to cry, give up, that's it (M3).

Because there are no good moments, it hurts a lot. It was all within the normal, but labor is not a pleasurable experience, it's very difficult, and cesarean section is not indicated, so we have a normal delivery, but it's very difficult (M19).

The examination to see the amount of dilation, it is necessary, but it is horrible! I think it's one of the worst things you have to experience (M14).

Despite the neglect of recognized rights or situations of violence, women's discourse shows the difficulties of making themselves heard in a moment of pain and vulnerability, in which they find themselves immersed in during childbirth. They declare themselves as without voice and without time, before the norms and rules, which are imposed by the hospital institution, needing someone to speak for them at this moment.

The furthest they allowed her to go was the maternity ward, after they went to the delivery room they already barred my mother who was with me. Because it is an extra security because you are in that pain, suffering. And the problem is this: if we are feeling pain, it is our companion that has to impose themselves to put their foot down, because it is our right! And we do not have a voice here! (M31).

The labor was fine, I stayed home until the last moment. But when I got to the hospital, everything went awry, the nurse asking the questions, the doctor wanting to do the examination. And all the while hearing: you cannot do this, you cannot do that, and ignoring my birth plan, making no point in acknowledging it. The doctor started to quarrel with me because I had put a hot water bottle to ease the contraction, and to say 'that we get these

people who know nothing to stay with us', 'that the doula put my baby at risk', and it was like that, the baby being born and they are causing me that terror (M35).

The moment the team encounters well-informed women, who have drawn up their birth plan and who refuse interventions act with hostility to the woman's desire and start labeling this woman and extorting her rights.

I was already 10 cm dilated and they were worried about writing a report. They said: 'That girl who came with Doula, who wants everything natural, who brought the birth plan', in addition to the lack of respect for everything. The doctor say: 'girl, I'm the boss here', he says not to worry about the birth plan to see what I wanted, to say that everything was wrong, that I was putting my child at risk (M35).

Even acknowledging that there have been negative or even violent situations, women say that this does not dampen the joy of being able to give birth. The satisfaction of being with the baby, safe and sound in their arms, is so gratifying that it seems to erase everything negative that happened in the period before the moment of childbirth.

Although there were unpleasant situations, even violence, this did not dampen it at all, it did not take away the joyful moment of the experience, but also because I also didn't allow it, I did not allow the situation to continue (M36).

At the prenatal clinic the doctor said something that I was afraid of. He said this 'when you go to get your baby, if it's my shift I will not give birth', but thank God it happened the other way around, he delivered my baby and everything was fine. It's over and I have my little son safe and sound (M23).

After some time, after elaborating what occurred during the labor process and the birth, women perceive the experienced situation with more clarity and discernment. They even affirm, in their discourse, that they would not allow the negative situation to persist and that they reacted to a situation of disrespect.

DISCUSSION

The results of this study allowed us to reflect on childbirth care from the perspective of women and health professionals. The themes that emerged indicated an observed and silenced violence in the nurses' narrative. A perspective which is similar to that of the women, that when they speak about a consensual violence, they try to justify it with different arguments. This perspective is opposed to the medical discourse, which denies obstetric violence

because it believes that this form of violence does not happen in the same dimension nor does it have the repercussion that is represented by the media, Blogs and other organizations.

The phenomenon of obstetric violence emerged more emphatically with the programs of humanization of childbirth and birth, whose strategies used at the time already represented a subtle way of addressing this type of violence. At present, the term Obstetric Violence is considered strong and has caused outrage in the field of obstetrics, believing that the term directs a certain hostility against this professional category, and that can contribute to the undoing of all the achievements and technical advances incorporated by medical care, due to the hypothetical autonomy of women in childbirth.¹³ Even the World Health Organization (WHO) prefers to use the term hostile, aggressive or disrespectful treatment when referring to obstetric violence, as it is still necessary to define its different facets in order to illustrate this concept better.¹⁴

But what this research has shown is that, although metaphorically made up, authoritarian conducts and the use of derogatory words, as well as threats and reprimands against the women in childbirth are common in the daily work in maternity wards. Health professionals tend to confuse the exercise of authority with a difficult context of work.¹⁵ The difficulty of having an available anesthetist, for example, may lead the health professional to disregard the pain reported by the woman, not offering methods of relief, since it is considered to be inherent in childbirth.

It should be noted that compliance with neglect of care and even silence in the face of situations of disrespect can be understood as symbolic violence: an abuse of power, based on the consent that is established and imposed through the use of symbols of verbal authority, discrimination and harassment practices, used by institutions and professionals as strategies of power.¹⁶

In the discursive bias silence also means it is not the absence of words.¹⁷ Speaking and silencing go together. When they are silent in the face of the violence witnessed at childbirth, the nurse demonstrates fear of sustaining an opinion in which he/she believes.

For Foucault, institutions such as schools and hospitals have become privileged places to disseminate hygienic and disciplinary measures in a normative way and to create docile and submissive bodies. In defining the genealogy of power, the body became the target of power the human body enters

a machinery of power that scrutinizes, disarticulates and recomposes it shaped, the body becomes as useful as it does repressed. This technique of disciplining and controlling bodies comprises a modality of power and domination.¹⁸

Thus, the body becomes the target of power in health institutions. It has been found that through interventions, it is possible to accelerate labor through invasive techniques such as vaginal interventions. The body can be measured, investigated in every detail, and subjected to various forms of manipulation, to become as useful, docile, and repressed all at once.¹⁹

In describing her work as an obstetrician in a birthing situation, one of the participants uses "metaphor midwifery/bullfighter". When referring to the figure of a bullfighter, in her discourse, the health professional compares the scene of the birth experienced. This analogical figure leads one to think of the scene of childbirth as a spectacle of horror, like a grotesque scene, with fear and provocation, since, in a bullfight, the bulls are provoked by the bullfighter, so that they go against them until they are slaughtered or overthrown.

Included in the context of maternity hospitals, violence manifests itself through norms and work routines, or in the ironic and impersonal behavior of the health professional. This subtlety in acting obscures the perception of the subjects who experience it, and starts to bother the reason and the feelings of the people involved, becoming present in every organization modality of institutions.²⁰

Another nuisance resulting from the violence witnessed in the delivery room is the inconsistency between the actions and convictions of the health professional, which can be identified as moral suffering, a painful feeling that commonly arises from an ethical conduct that cannot be fulfilled, contradicting the professional's perspective and interfering with the subject's constitution of herself and her moral life experience.²¹

The reality narrated in the participants' discourse characterizes childbirth as a problem to be solved and the relationship built between women and health professionals and is considered asymmetric and hierarchical, and these power relationships do not occur in isolation, but in sequence or in constellations, which is consistent with the literature that defines the model of attention to childbirth as a medical and technological event, according to which the woman is treated as a patient and the deliveries mostly occur in hospital, and the physician is responsible for their execution. Measuring

inequalities of different exchanges is not easy, nor predictable.²²⁻²³

Finally, when considering the extent and complexity of obstetric violence in Brazil, it is necessary to adopt measures of prevention,²⁴ such as individual and collective actions to protect against the excess of medical interventions, instrumentalization of other professionals in deliveries such as Family Health Strategy professionals and midwives contributing to the elaboration of the birth plan and the promotion of the autonomy and empowerment of the mother in childbirth.

Another strategy for coping with conflict situations, such as obstetric violence, is the nurse's role in patient advocacy. Although this practice is still incipient in Brazil, this action emerges as a moral obligation of nurses to advocate for the patient²⁵ - a professional attitude that can help women to make decisions, guarantee the quality of care and strengthen the bond between the patient and the health environment.

The study may limit the fact that it has been developed in small municipalities of one of the Brazilian states and it possibly reveals a specific cultural reality. However, it is believed that this is a reality found in other maternity hospitals, in other municipalities and Brazilian states, and that could also be scenarios of studies like this.

CONCLUSION

Considering the results found in this study, it can be said that violence is present in the daily activities of the delivery room. The discourses are expressed in the silence of the nurses when witnessing a hostile treatment; In the consent of the women, who seek to justify the aggressiveness and difficulties experienced as an inherent part of the birth and birth process and in the invisibility in the eyes of the health professional, who believes that violence is only an isolated case, and that it does not happen in large proportions as it is spread by the media.

It is hoped, therefore, that this work contributes to raise the visibility of the problem of obstetric violence in childbirth care, and allows the discussion of the public policy of attention to women and the reflection of the health professionals involved in the care of childbirth and the improvement of quality of maternal and child care. It is understood that this change will come when it is possible to change the logic of understanding of childbirth, when it stops being seen only as a medical and hospital event and can be understood as a human event, because, only

from this recognition, there will be the possibility of making the women's voice heard, rescuing the autonomy and the ability to deliberate on issues related to their labor and birth process.

REFERENCES

1. Rattner D. Humanização na atenção a nascimentos e partos: breve referencial teórico. *Interface - Comunic, Saude, Educ* [Internet]. 2009 [cited 2015 Jan 22];13(supl 1):595-602. Available from: <http://www.scielo.br/pdf/icse/v13s1/a11v13s1.pdf>
2. Munis BMV, Barbosa RM. Problematizando o atendimento ao parto: cuidado ou violência? In: *Anais do Memórias Convención Internacional de Salud Pública. Cuba Salud*, 2012 Dec 3-7 [Internet]. Palacio de las Convenciones de La Habana: Habana; 2012 [cited 2015 Aug 22]. Available from: <http://www.convencionsalud2012.sld.cu/index.php/convencionsalud/2012/paper/view/744/321>
3. Padilla J. Las Cesáreas em España: um problema em feminino plural. *El Diario* [Internet]. 2014 Mar 14; Zona Crítica [cited 2015 Jan 25]. Available from: http://www.eldiario.es/zonacritica/cesareas-Espana-problema-feminino-plural_6_238736174.html
4. Bonvicini L, Candela S, Evangelista A, Bertani D, Casoli M, Lusvardi A, et al. Public and private pregnancy care in Reggio Emilia Province: na observational study on appropriateness of care and delivery outcomes. *BMC Pregnancy and Childbirth* [Internet]. 2014 Feb [cited 2015 Nov 12]; 14(72):1-12. Available from: <http://www.biomedcentral.com/1471-2393/14/72>
5. Kruger L M, Schoombee C. The other side of caring: abuse in a South African maternity ward. *Journal of Reproductive and Infant Psychology*. 2010 Feb; 28(1):84-101.
6. Lansky S, Friche AAL, Silva AAM, Campos D, Bittencourt SDA, Carvalho ML, et al. Pesquisa nascer no brasil: perfil da mortalidade neonatal e avaliação da assistência à gestante e ao recém-nascido. *Cad saúde pública* [Internet]. 2014 [cited 2015 Nov 13]; 30(Suppl.):S192-207. Available from: <http://www.scielo.br/pdf/csp/v30s1/0102-311X-csp-30-s1-0192.pdf>
7. Leão MRC, Riesco MLG, Schneck CA, Ângelo M. Reflexões sobre o excesso de cesarianas no Brasil e a autonomia das mulheres. *Ciênc saúde coletiva* [Internet]. 2013 Aug [cited 2015 Dec14]; 18(8):2395-400. Available from: <http://www.scielo.br/pdf/csc/v18n8/24.pdf>
8. Victorio CG, Aquino EML, Leal MC, Monteiro CA, Barros FC, Szwarcwald CL. Saúde de mães e crianças no Brasil: progressos e desafios. *Lancet* [Internet]. 2011 May [cited 2015 Dec 11]:32-46. Available from: <http://dms.ufpel.edu.br/ares/bitstream/handle/123456789/279/15%20Sa%C3%BAde%20de%20m%C3%A3es%20e%20crian%C3%A7as%20no%20Brasil%20progressos%20e%20desafios.pdf?sequence=1>
9. Serviço Social do Comércio, Fundação Perseu Abramo. Pesquisa de opinião pública: mulheres brasileiras e gênero nos espaços público e privado [Internet]. São Paulo: Sesc/FPA; 2010 [cited 2016 June 11]. Available from: http://novo.fpabramo.org.br/sites/default/files/pesquisaintegra_0.pdf
10. Silva MG, Marcelino MC, Rodrigues LSP, Toro RC, Shimo AKK. Violência obstétrica na visão de enfermeiras obstetras. *Rev Rene* [Internet]. 2014 July/Aug [cited 2015 Jun 25];15(4):820-8. Available from: <http://www.periodicos.ufc.br/index.php/rene/article/view/1121/1079>
11. Foucault, M. A arqueologia do saber [Internet]. 7th ed. Rio de Janeiro: Forense Universitária, 2005 [cited 2015 Dec 13]. Available from: <http://www.uesb.br/eventos/pensarcomveyne/arquivos/FOUCAULT.pdf>
12. Gregolin MR. Foucault e Pêcheux na análise do discurso: diálogos e duelos. 3ª. ed. São Carlos: Claraluz; 2007.
13. Melo VH. Obstetrícia: especialidade em extinção. *Jornal do CRM-MG* [Internet]. 2014 July/Sept [cited 2015 Dec 21];52:10. Available from: <http://www.flip3d.com.br/web/pub/crmmg/index.jsp?ipg=152129>
14. Souza JPD. As diferentes faces da violência obstétrica. *Resc* [Internet]. 2015 Mar [cited 2016 Jan 28]; 2(3):e84. Available from: <https://saudenacomunidade.wordpress.com/2015/03/03/resc2015-e84/>
15. Aguiar JM, D'Oliveira AFP, Schraiber LB. Violência institucional, autoridade médica e poder nas maternidades sob a ótica dos profissionais de saúde. *Cad saúde pública* [Internet]. 2013 Nov [cited 2015 Oct 26]; 29(11):2287-96. Available from: <http://www.scielo.br/pdf/csp/v29n11/15.pdf>
16. Bourdieu P. O poder simbólico. Rio de Janeiro: Bertrand Brasil; 2010.
17. Mello, R. O silêncio faz sentido. In: *Anais do XI Simpósio Nacional e I Simpósio Internacional de Letras e Linguística*, 2006, Uberlândia, Brasil [Internet]. Uberlândia (MG): UFU; 2006 [cited 2015 Sept 25]. p. 2588-94. Available from: http://www.filologia.org.br/ileel/artigos/artigo_146.pdf
18. Foucault M. O nascimento da clínica. 6th ed. Rio de Janeiro: Forense Universitária; 2008.
19. César MRA. Pensar a educação depois de Foucault. *Cult* [Internet]. 2010 Mar [cited 2015 Fev 12]; 134. Available from: <http://revistacult.uol.com.br/home/2010/03/pensar-a-educacao-depois-de-foucault/>
20. Barazal NR. Sobre violência e ser humano. *Convenit Internacional (USP)* [Internet]. 2014 May/Aug [cited 2015 Nov 11];15:77-86. Available from: <http://hottopos.com/convenit15/77-86NeusaRB.pdf>
21. Barlem ELD, Lunardi VL, Lunardi GL, Tomaschewski-Barlem JG, Silveira RS, Dalmolin GL. Sofrimento

- moral em trabalhadores de enfermagem. *Rev Latino-am. Enferm* [Internet]. 2013 Jan/Feb [cited 2015 Oct 24]; 21(spe):79-87. Available from: http://www.scielo.br/pdf/rlae/v21nspe/pt_11.pdf
22. Patah LEM, Malik AM. Modelos de assistência ao parto e taxa de cesárea em diferentes países. *Rev saúde pública* [Internet]. 2011 Feb [cited 2016 Jan 28];45(1):185-94. <http://www.scielo.org/pdf/rsp/v45n1/1759.pdf>
23. Gomes ML, Moura MAV, Souza IEO. Obstetrical practice by nurses in institutional childbirth: a possibility for emancipatory knowledge. *Text context enferm* [Internet]. 2013 Jul-Sept [cited 2015 Jan 12]; 22(3):763-71. Available from: <http://www.scielo.br/pdf/tce/v22n3/v22n3a24.pdf>
24. Tesser CD, Knobel R, Andrezzo HFA, Diniz FA. Obstetric violence and quaternary prevention: what it is and what to do. *Rev Bras Med Fam Comunidade* [Internet]. 2015 June [cited 2015 Nov 21];10(35):1-12. Available from: <https://www.rbmf.org.br/rbmfc/article/viewFile/1013/716>
25. Tomaschewski-Barlem JG, Lunardi VL, Barlem ELD, Ramos AM, Silveira RS, Vargas MAO. Como enfermeiros vêm exercendo a advocacia do paciente no contexto hospitalar? - uma perspectiva Foucaultiana. *Texto Contexto Enferm* [Internet]. 2016 Mar [cited 2016 Jun 15]; 25(1):e2560014. Available from: <http://www.scielo.br/pdf/tce/v25n1/0104-0707-tce-25-01-2560014.pdf>