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## CASE REPORT ARTICLE

### COPING THE OBSTETRICAL VIOLENCE AND ITS REPERCUSSIONS ON THE PRACTICE OF NURSES OBSTETRICIANS

### O ENFRENTAMENTO DA VIOLÊNCIA OBSTÉTRICA E SUAS REPERCUSSÕES NA PRÁTICA DE ENFERMEIRAS OBSTETRAS

### EL AFRONTAMIENTO A LA VIOLENCIA OBSTÉTRICA Y SUS REPERCUSIONES EN LA PRÁCTICA DE ENFERMERAS OBSTETRAS

Júnia Aparecida Laia da Mata Fujita<sup>1</sup>, Priscila de Lima Nascimento<sup>2</sup>, Antonieta Keiko Kakuda Shimo<sup>3</sup>

#### ABSTRACT

**Objective:** reporting the experience of nurses obstetricians in coping obstetric violence seen, witnessed and experienced in the health service and its repercussions on the practice of these professionals. **Method:** report of the experience that took place in a public maternity hospital in southern Brazil. The study followed the rules of Resolution 466/2012 of the National Health Council, ensuring the confidentiality of the institution and those involved. **Results:** it was found that the inclusion of the obstetric nurse in the health service, with the fulfillment of its legal duties and exercise of its role as free and dignified way represents a very difficult task. It was noticed that when coping obstetric violence, this professional is subject to being victimized by bullying, a situation that makes difficult the change of the care model of maternal and child health. **Final thoughts:** it is essential that the category constitutes a support network, to be possible getting stronger, winning the recognition and autonomy to act with freedom and respect. **Descriptors:** Violence; Power (Psychology); Feminism; Obstetric Nursing; Interpersonal Relationships.

#### RESUMO

**Objetivo:** relatar a experiência de enfermeiras obstetras no enfrentamento da violência obstétrica observada, presenciada e vivenciada no serviço de saúde e suas repercussões na prática destas profissionais. **Método:** relato da experiência que se deu em um hospital-maternidade público da Região Sul do Brasil. O estudo seguiu as normas da Resolução 466/2012 do Conselho Nacional de Saúde, garantindo o sigilo da instituição e dos envolvidos. **Resultados:** constatou-se que a inclusão da enfermeira obstetra no serviço de saúde, com o cumprimento de suas atribuições legais e o exercício de seu papel de modo livre e digno, representa uma tarefa muito difícil. Percebeu-se que ao enfrentar a violência obstétrica, esta profissional está sujeita a ser vitimizada pelo assédio moral. Situação que dificulta a transformação do modelo de atenção à saúde materno-infantil. **Considerações finais:** é fundamental que a categoria constitua uma rede de apoio, para que seja possível se fortalecer, conquistando o reconhecimento e a autonomia para atuar com liberdade e respeito. **Descritores:** Violência; Poder (Psicologia); Feminismo; Enfermagem Obstétrica; Relações Interpessoais.

#### RESUMEN

**Objetivo:** presentar la experiencia de enfermeras obstetras en el afrontamiento de la violencia obstétrica observada, presenciada y con experiencia en el servicio de salud y sus impactos en la práctica de estas profesionales. **Método:** informe de la experiencia que tuvo lugar en una maternidad pública en el sur de Brasil. El estudio siguió las normas de la Resolución 466/2012 del Consejo Nacional de Salud, garantizando la confidencialidad de la institución y de los involucrados. **Resultados:** se encontró que la inclusión de la enfermera obstétrica en el servicio de salud, con el cumplimiento de sus obligaciones legales y ejercicio de su papel de manera libre y digna es una tarea muy difícil. Se observó que en el afrontamiento a la violencia obstétrica, esta profesional está sujeta a ser víctima de acoso moral, que impide la transformación del modelo de atención a la salud materna e infantil. **Consideraciones finales:** es esencial que la categoría constituye una red de apoyo, por lo que puede hacerse más fuerte, ganando el reconocimiento y autonomía para actuar con libertad y respeto. **Descriptor:** Violencia; Poder (Psicología); Feminismo; Enfermería Obstétrica; Relaciones Interpersonales.

<sup>1</sup>Obstetric Nurse, Doctoral Student of Nursing, State University of Campinas/UNICAMP. Campinas (SP), Brazil. Email: [jumata.2905@gmail.com](mailto:jumata.2905@gmail.com); <sup>2</sup>Nurse, Midwifery Specialist. Curitiba (PR), Brazil. Email: [priscila.lnascimento@gmail.com](mailto:priscila.lnascimento@gmail.com); <sup>3</sup>Obstetric Nurse, Professor of Nursing, School of Nursing, State University of Campinas/UNICAMP. Campinas (SP), Brazil. Email: [akkshimo@gmail.com](mailto:akkshimo@gmail.com)

## INTRODUCTION

Motherhood is a significant existential moment in the female life cycle, which can give the woman the opportunity to achieve new levels of integration and development of personality.<sup>1</sup> Give birth is a natural body process that integrates female sexuality and closes the period of pregnancy, giving birth to a new being.<sup>2</sup>

Historically, midwifery was a female activity, restricted to the home environment and family intimacy. The mothers were accompanied by midwives, mothers and/or sisters, experienced women who had already experienced childbirth. The knowledge of this event was passed from generation to generation and its physiological essence kept it out of the field and control of medicine.<sup>3</sup>

Attention to parturition and birth has undergone many transformations over the centuries, a fact observed in historical and scientific records on the subject, revealing its medicalization and migration to hospitals. There has been a rapid expansion in the development and use of various practices designed to correct the dynamic, accelerate, regulate or monitor the physiological process of parturition, in order to get better maternal and neonatal results.<sup>4</sup>

The routine use of obstetrics, from the twentieth century, legitimized the birth technologization and the female body area for obstetrics, strengthened by the stereotypical look of professionals that the woman is a being empty of knowledge and unable to understand what is occurring with her own body.<sup>5</sup>

Given these changes, the act of giving birth, before a deeply subjective experience lived in the home environment (private), the woman and her family, turned to experience in hospitals (public)<sup>3</sup>, surrounded by rules and routines often plastered, which examine, manipulate and control women's bodies.

In Brazil, about 98% of births occur within health institutions. Statistics show that caesarean rates reach 52%<sup>6</sup>, a situation that reveals the prevalence of hospital birth and interventional and surgical procedures, more customary in obstetric care.

In this scenario, participants have recognized some obstetric practices as problematic, causing discussions on assistance during parturition and birth. Noteworthy is the Ministry of Health (MOH) has published in 2001 the manual "Birth, Abortion and Puerperium: Humane Assistance to Women", which aimed to disseminate concepts and practices of childbirth care among health

professionals, rescuing the idea of female leadership and promoting the reduction of interventionist measures in this process for their good conduct and promotion of maternal and child health.<sup>7</sup>

One pole of dissatisfaction is certainly the feminist movement, which strongly criticizes the paradigm technocratic childbirth. Since the 1980s questioned the medical model of childbirth care, considering it focused on women's design as primarily condition "flawed" and that, based on this judgment, this birth as pathological and risky, using aggressive, invasive technologies and potentially harmful.<sup>8</sup>

In their fight for improved care during parturition and birth, the feminist movement shows the loss of women's autonomy over their bodies for healthcare institutions and professionals.<sup>8</sup>

A researcher points to the existence of three obstetric care models today: the technocratic, which is based on the concept of separation of mind and body, model in which the body is treated as a machine; humanistic, which recognizes the interconnection between mind and body; and holistic considering the oneness of body-mind-spirit.<sup>9</sup>

In Brazil, there is a predominance of the technocratic model. Born in the country has not been a natural experience or poor or rich. Vaginal birth, more frequent in public hospitals, almost always with a lot of pain and excessive intervention. In private establishments, cesarean section, surgery often unnecessary and almost always pre-scheduled has constituted an option to minimize that suffering.<sup>10</sup> The country leads the world ranking of cesarean and have to reduce drastically its rate to conform to the recommendations of the World Health Organization (WHO).

In the research "Born in Brazil", it was found that cesarean section has become a way to quickly resolve childbirth, both in low-risk women (45,5%) and for the others (60,3%). For women stratified as low risk, another way to shorten the parturition is attempted through the use of interventions, often not based on scientific evidence, that give agility, lightness and speed to the care process, such as amniotomy and oxytocin infusion in the period expansion, Kristeller maneuver and episiotomy on the fetal expulsion.<sup>11</sup>

The cesarean epidemic in the country is old and has been the subject of various initiatives. The search "Born in Brazil" clarified the picture of the poor results obtained after years of effort.

The constant interventionism practiced during labor, especially without consent, has been set up on violence against women within the health services.

Obstetric violence is not a recent problem in Brazil, it has long been felt and perceived, especially by groups of activists and feminists; however, recently gained visibility. There are few studies on this topic in the country, compared to the scientific literature on violence against women in general.

This type of violence is committed against women and their families in health services during prenatal care, childbirth and postpartum, cesarean section and abortion. It can be psychological, physical or even sexual and expressed in different explicit or veiled forms. It is strongly conditioned by gender bias, manifesting mainly as follows: coerce, humiliate, swearing, abuse, embarrass, depriving the woman and her family; making disparaging comments to her body, race or on her socioeconomic status; perform procedures/pipes without clarification or disregard the informed refusal; improperly use practices to accelerate births and wander beds; provide care without observing the best scientific evidence; subjecting the woman to fast, nudity, shaving pubic hair, enema during labor; not offer conditions for the skin to skin contact with the healthy baby and breastfeeding; violate the rights of women guaranteed by law; among others.<sup>12</sup>

According to a study by the Foundation Perseu Abramo in 2010, one in four Brazilian women suffers violence in childbirth. Internationally violence in childbirth is defined as any act or intervention, focused on the laboring woman or her baby, practiced without the explicit and informed consent of the woman and/or disregard for her autonomy, physical and mental integrity, her feelings and choices.<sup>13</sup>

Many initiatives have emerged in Brazil in order to change this scenario, including: the creation of the Program for Humanization of Prenatal and Birth (PHPN) through Ordinance GM No. 569 of June 01<sup>st</sup>, 2000, main objective of ensuring better access, coverage and quality of prenatal care, birth care and postpartum and newborn care, from the perspective of rights citizenship<sup>14</sup>; the Law 11.108, of April 7<sup>th</sup>, 2005, which guarantees to pregnant women the right to the presence of an accompanying person, free choice during labor, birth and postpartum under the Unified Health System (SUS)<sup>15</sup>; the Collegiate Board Resolution (RDC) No. 36 of June 3<sup>rd</sup>, 2008, which provides for technical regulation for the functioning of obstetric and neonatal care

services, including the ambience, hospitality and humanization actions to maintain this setor<sup>16</sup> services; Ordinance No. 1459 of June 24<sup>th</sup>, 2011, establishing the Stork Network, reinforcing the proposal of PHPN, plus the health care of children up to two years of life.<sup>17</sup>

The Stork Network aims to ensure accessibility to health services, qualified, humane and safe care in pregnancy and childbirth and the child's right to safe birth and healthy growth and development.<sup>17</sup>

The country has invested in public policies that support the concept of autonomy of women in childbirth, respect for their rights and the care based on best practices of care during parturition and birth. Moreover, it has supported the inclusion and the role of midwives in the public health service.

In a systematic review published by the Cochrane Library, it was found that the birth models of care for low-risk women involving midwives (midwives or direct entry midwives) were associated with lower rates of interventions, lower risk of episiotomy and instrumental birth, greater sense of control by the woman, more likely to initiate breastfeeding and shorter duration of neonatal hospitalization.<sup>18</sup>

The WHO also has mobilized to face the obstetric violence. In 2014 issued a statement calling for greater action, dialogue, research and action on abuse, disrespect and ill-treatment during childbirth in health institutions.<sup>19</sup>

Several studies have established the presence of violence in assistance to parturition.<sup>3,20,21,22,23,24</sup> Last year, the authors of this report dedicated to addressing this problem in a public health service, in southern Brazil.

In this experiment, the following issues emerged: the victimization that nurses obstetricians suffer by challenge violence against pregnant women and their families.

It was noticed that the nurses obstetricians who are militants, fighting for the cause of humanization and 'non-violence' in childbirth and birth, taking a humanistic posture and/or holistic within the health service, suffer often violence in most diverse expressions, especially bullying. Situation that the researchers have seen, experienced and felt several times.

Bullying is any abusive conduct (gesture, word, behavior and attitude) to watch out for repetition or systematization, against the dignity or psychological or physical integrity of

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an individual, threatening his job or degrading work environment.<sup>25</sup>

It is believed that the harassment suffered by midwives fighting obstetric violence contributes to reinforce the dominance of the technocratic model of childbirth care, being an impediment to occur advances needed for the transformation of practice and care directed to women in parturition.

Given the above, the aim of this study was to reporting the experience of nurses obstetricians in coping obstetric violence seen, witnessed and experienced in the health service and its impact on practice of these professionals.

## METHOD

It is an account about the experience of coping obstetric violence against obstetric nurses in the health service.

The experience took place in a public maternity hospital located in southern Brazil. Since the inception of these professionals on the scene was observed, witnessed and experienced situations of obstetric violence that directly echoed in the professional practice of the researchers.

The study followed the rules of Resolution 466/2012 of the National Health Council, ensuring the confidentiality of the institution and involved.

## RESULTS AND DISCUSSION

### • The Lived and Suffered by Nurses Obstericians

In 2013, midwives were placed in a SUS maternity hospital in southern Brazil, with the proposal to change the obstetric care model offered to the population served by the institution. Idealized up the opportunity to change the care and combat obstetric violence within the health service.

Under the shoulders of these professionals was deposited the responsibility of "change of obstetric model", which was observed in the statements of managers, the media disclosures of the institution and the dynamic work. There were great expectations regarding the role of midwives, so they were subjected to pressure for productivity, constantly checked their behavior, their safety in relation to the care and posture in front of other employees.

The dedication was the first step taken by these professionals, who saw the opportunity to implement humanizing and holistic practices in compliance with parturition and birth. However, the inclusion of the category

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on the scene was not done in a systematic way, which led to great difficulties.

The general nurses, doctors and technical staff had not, at that time, the opportunity to be sensitized about the integration of obstetric nurses and the "new model of care". This was a trigger for the emergence of conflicts.

Insert up, socialize, seek to be understood and accepted were challenges faced by newly integrated service. At first there was great estrangement from health team members, as some were unaware of the existence of the category "nurse obstetrician", her functions and how she could be integrated in the health care of the mother-infant dyad. Therefore, several clashes occurred.

For months, the nurses obstetricians experienced intense wear, in a constant search for affirmation as competent and qualified professionals to meet childbirth without dystocia, identify complications and join the team in the care of obstetric and neonatal emergencies, among other duties.

One can make an analogy of the situation experienced by the researchers with a climbing. In this experience, the mountain to be overcome was much larger than anyone had imagined. There were thick clouds that prevented see its peak and that sometimes made us believe that would soon rise and that conclude successfully.

The challenge of transforming the obstetric care model was bigger than imagined, because the technocratic paradigm was impregnated in professional and on the walls of that hospital. For months it was invested by midwives production protocols, the awareness of staff and the reorganization of the service, but, gradually, emerged strongly in relations an issue that would affect the possibility of advances, "power struggle".

The exercise of power was becoming ever more evident in relations between the professionals involved in caring for users and their families.

The power exists only through the production of truth, that part of a social network of individuals in a given society, constituting a network of power and knowledge and perspectives seen as true, generating specific effects of power.<sup>26</sup>

From this perspective, the "truths" legitimized over the centuries within the obstetrics field (for example, childbirth is a risky event, dangerous, it needs control, monitoring and a series of interventions), held up strongly present routines of the institution, examining the performance of obstetricians

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nurses seeking work in the holistic and/or humanized model.

It was in the exercise of disciplinary power, guaranteed by controlling the behavior, attitudes, speeches and threats of "punishment", the midwives began to oppose the practices of some professionals and routines that were not in accordance with the maternal and child health policies proposed by the Federal, State and Municipal spheres; and in the presence of resistance to change started to happen.

The direct management of the institution adopts the speech that it was necessary to humanize and deploy good childbirth care practices, abolishing interventionism and supporting the activities of nurses obstetricians. However, work processes and daily relations about this speech were not sustained.

The so-called autonomy of obstetric nurses to work and contribute, within a perspective of working as a team, to improve obstetric care, was illusory. There was an effort on the part of these professionals to deploy best practices and act humanization/holism; however, it could not move.

It is believed that our reality is a cutout of living for many Brazilian nurses obstetricians. Worrying situation because we have not only the challenge of coping with obstetric violence in everyday life in hospitals, but also the violence experienced and felt on the skin for labor, which also hurts and brand.

In this experiment, we can see that the great interference to achieving the successful integration of nurses obstetricians was implemented management model, therefore the power, centered at one point, was exercised in a disjointed manner and without co-participation of significant actors in the process change, such as those related workers directly care.

It is argued that, in the implementation of new practices within a health service are critical awareness and the training of all professionals, preceding the opening of any initiative.

In the case of the integration of best practices in care parturition and birth, collective discussion and reflection about the daily life of each individual involved in care can avoid judgments and prejudiced attitudes on the reproductive behavior of women and humanistic and/or holistic practices the nurses obstetricians, besides enabling the eradication reprehensible and unethical conduct in the care offer.

The HumanizaSUS journal, published in 2014, explicitly makes investment experiences in changing the obstetric and neonatal care model within the SUS institutions. This institutional support was the motive for the actors and the collective involved, questioning established values, denaturing practices and thus produce new forms of assistance and prenatal management, obstetric and neonatal SUS.<sup>27</sup>

Many successful experiences are presented in the above material, and the big difference compared to our report was the *modus operandi* of management, which operationalized conscientiously, participatory, cooperative and prudent model of the change process.

### Feelings on the Bullying

With the inclusion of obstetric nurses, users of the service began to notice positive changes in the care offered at the hospital. Thus, they began to demand the guarantee of their rights and better quality of care. Especially after the production of a popular documentary, produced by one of the researchers on the inclusion of these professionals and good practices recommended by the WHO in the institution, which was made available via the Internet to the population.<sup>4,28</sup>

According to the National Program for the Humanization of Hospital Care, in assessing the public, the form of service, the ability demonstrated by health professionals to meet their demands and expectations, there are factors that are even more valued than the lack of doctors, space in hospitals or medicines,<sup>29</sup> what corroborates this experience.

The obstetric nurses began to be known regionally and requested by users during the service, which seems to us, it was not well seen by some members of the healthcare team in different categories such as: general nursing, medical, and coordination and service management.

It was from there that bullying experienced by nurses obstetricians, no longer implied and became explicit and routine work of the same. In addition to observing, witnessing and experiencing obstetric violence, perpetrated by some professionals against women, emerged the interpersonal relationship of the issue strongly marked by bullying.

According to the MOH manual, bullying can be configured in hostile relations, insulation and attack the integrity, expressing itself in the deprivation of autonomy of the victim; systematic challenges of all its decisions; critical about the work of unfair and

exaggerated; withdrawal from work that normally falls to the worker; subject pressure to do not assert their rights (holiday schedules, awards); granting the victim of tasks incompatible with their health; moral, psychological, physical damage, among others, in their workplace; disregard of the medical order of recommendations given by the occupational physician; warning to the victim because of medical certificates or rights complaint; lack of dialogue between superiors and colleagues with the victim; separation of the person from others; prohibition of colleagues talk to the worker; using disdainful allusions to disqualify the individual; conducting contemptuous gestures before the person (sighs, scornful looks, shrug); worker discrediting front of colleagues, superiors and subordinates; spreading rumors about the worker; criticism of the private life of the employee; aggression in the form of screaming; among others.<sup>25</sup>

Along the months, we felt many of these aggressions. Unfortunately, soon appeared perceive the presence of bullying in our professional practice. Seems to have been a time of denial in which we believed that lived was part of the change, the "acceptable strangeness of some professionals", the non-recognition of the obstetric nurse within the health service, something naturalized and necessary in the model transformation process attention.

The invisibility of this violence remained present in our day to day until our disciplined bodies begin to respond to stressors, generated by the harassment suffered constantly.

The work is one of the sources of satisfaction of several basic human needs such as self-realization, maintenance of interpersonal relationships and survival. On the other hand, it can also be a source of illness when it contains risk factors for workers' health and not have sufficient information to enable the protection against these risks.<sup>30</sup> It carries itself dual role, because at the same time can provide the opportunity for personal development, the ability to acquire personal and professional development, when performed under inadequate conditions can cause damage to health, trigger disease, reduce life expectancy and even lead to death.<sup>31,32</sup>

Multiple risk factors can trigger occupational diseases, such as: physical, chemical, biological, ergonomic and psychosocial. It is noteworthy here psychosocial, favoring the occurrence of stress, understood as a complex reaction to

physical and psychological components resulting from exposure to situations that exceed the individual's coping resources. When extend its causes and coping resources are insufficient, this problem can progress to more severe stages, when the body becomes vulnerable to various diseases.<sup>33</sup>

Stress is a permanent challenge for the nurse has repercussions on their health and quality of care provided to the service user.<sup>34</sup>

Stressors at work are often linked to organization, as pressure for productivity, retaliation, abusive relationship between supervisors and subordinates, among other circumstances,<sup>35</sup> imposing the employee a high demand to reckon with.

Several times the researchers felt censorship and repression perpetrated by their peers and superiors, in order to make them back down on militancy and fighting the humanization of obstetric violence. It is believed that such a situation arose not only because of opposition to the "new" model of care, but the resistance to the rise of "other" and power struggle.

There was a will to move forward, but we felt as if our hands were tied and could not continue the climb. It is exactly this feeling that we soaked. And for a long time, annul us, we had fear and insecurity. We think about quitting, move to another area, away from it all. But resistance remained within us, feeding an inner strength that not imagined existed.

After reflecting about the experienced harassment, we found that it was necessary to untie the knots of the ties that prevented us from acting with autonomy and freedom. We start saying "no" to demand our rights and strengthen us.

It is interesting how we deny within us the harassment suffered confront one of the most vicious expressions of violence, which strongly affects the life of a woman, obstetric violence. How many nurses obstetricians go through the same situation? How the health service can adopt a more humane speech compliance with parturition and birth and dehumanize the way they treat their workers? How can we ensure the humanization of care and tackle obstetric violence, if violence suffered by our peers? How to produce health for the population, if the service itself sickens their workers?

These are questions that have emerged in the experiment described, which have intrigued us and we believe mark the daily lives of many nurses obstetricians who work in Brazilian hospitals. It is necessary to research and think this problem.

Awakening to the impact that bullying can have on the life and practice of obstetric nurses, valuing the experiences, may enable the design of appropriate strategies to insert them in the hospital / maternity wards, ensuring a dignified and autonomous operation, minimizing injuries. It is essential to understand these workers in this existential entirety. Such factors may promote the transformation of the obstetric and neonatal care model, as this public policy area.

### ● Resistance Attitudes and Perspectives of Change

Given the described experiences, they took a position of strength. We worked only based on scientific evidence, demanding respect for our rights and seeking for the exercise of our profession with dignity, freedom and autonomy.

We started to explicitly oppose the interventionist and violent practices and attitudes that they configured in harassment of workers.

Currently, the confrontation has been great, but we have supported in the law of professional nursing practice, the code of ethics, the current Brazilian laws that support the organs and defenders of women fighting violence.

Despite the Ministry of Health recognize, since 1998, attendance at childbirth by midwife and have standardized the remuneration of these professionals within the SUS<sup>36</sup>, the health service becomes extremely difficult to ensure its performance in a dignified manner.

Several studies have shown that, when accompanied by midwives, women need fewer painkillers, there are fewer interventions and outcomes are better than those produced by conventional medical care.<sup>18,37</sup> The care provided by these professionals makes a difference, contributes to the rescue of feminine autonomy in childbirth and respect for their physiology.

In obstetric there is an overlap of functions, some of which activities are the responsibility of both the doctor and the midwife, triggering a power struggle between these professionals.<sup>38</sup> However, this experience was noted that the power struggle permeates all relationships among nurses obstetricians, doctors, nurses and general managers.

It is felt that it is necessary to join forces in the professional category to strengthen it and that there is a long and arduous path until the midwives have their autonomy recognized to act with freedom and respect.

This report highlights the great importance that the management model is in change processes within the health service. The exposed situation might be different with a focused management on teamwork, the collective construction, with power and shared responsibility among stakeholders in the process, through reflections, decisions and assessments built collectively, as proposed by the National Humanization Policy.<sup>39</sup>

### FINAL NOTES

The insertion of the obstetric nursing care during parturition and birth is shown as an alternative to improving care, reducing the number of interventions and increased satisfaction of users during the service. In this report, it was found that the inclusion of this category in the health service, with the fulfillment of its legal duties and exercise its role as free and dignified way, it is a very difficult task. In addition, it was noted that in the face of obstetric violence, the obstetric nurse is responsible to be victimized by bullying.

It is observed the lack of much of the health care team about the role of nurse obstetrician in attention to mother-infant dyad. It is believed that this factor strangeness trigger, which in turn may result in conflicts.

Before the Brazilian context of obstetric care, where it dominates the technocratic model, focused on doctor's figure, the obstacles for change seem to be even greater. Despite the scientific evidence shows that the care provided by the midwife helps to respect the physiology of labor and the rescue of feminine autonomy during this process, the confrontations are constant and hinder the transformation of care.

The violence experienced and felt by professionals is more an impediment to progress from happening. To say "no" and demand our rights and women in our care, we need resilience.

It is essential that category constitutes a support network, so you can think about these issues and strengthen, thus seeking recognition and autonomy to act with freedom and respect, aimed at improving the quality of obstetric and neonatal care offered to users of the health service. In addition, it is important that health organizations exercise a management that encourages the participation of actors that produce health linked to care or not, decision-making and implementation processes.

Implement new practices within an institution without the participation,

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awareness and preparation of teams for the "new", is how to put a wallpaper to cover a infiltrated structure, the wall will look good for a while, but the problem will still be present, and soon will come to the fore, causing inconvenience and requiring major adjustments.

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#### **Corresponding Address**

Júnia Aparecida Laia da Mata Fujita  
Av. Presidente Affonso Camargo, 2125  
Ap. 141  
Bairro Cristo Rei  
CEP 80050-370 – Curitiba (PR), Brazil