ORIGINAL ARTICLE

WOMEN AND DELIVERY: MEANINGS OF VIOLENCE AND THE OBSTETRIC NURSING APPROACH*

MULHER E PARTO: SIGNIFICADOS DA VIOLÊNCIA OBSTÉTRICA E A ABORDAGEM DE ENFERMAGEM
LA MUJER Y EL PARTO: SIGNIFICADOS DE LA VIOLENCIA OBSTÉTRICA Y EL ENFOQUE DE LA ENFERMERÍA

Mariana Roma Ribeiro de Oliveira¹ , Elayne Arantes Elias² , Sara Ribeiro de Oliveira³

ABSTRACT

Objective: to appreciate the meaning of obstetric violence for women. **Method:** this is a qualitative study with a Heidegger's phenomenological approach, with women in the reproductive phase. Data were collected through recorded interviews, using a guide and analyzed under the perspective of phenomenology. **Results:** the Meaning Units were formed from interviewees' statements and thus grouped together. The obstetric violence meant for women: << Meaning Unit 1: Being known by hearing about in courses, lectures, internet, reports of friends and suffered by herself; << Meaning Unit 2: Hurting the physical, psychological, and exerting a pressure; << Meaning Unit 3: Feeling annoyed, helpless, feeling hurt in delivery and having no attention. **Conclusion:** there is need for strengthening of prenatal consultation provided by nurses, covering various reflexive topics, and offering a comprehensive quality, curative and preventive health care. **Descriptors:** Violence against Women; Women's Health; Humanizing Delivery; Nursing; Prenatal Care; Empathy.

RESUMO

Objetivo: compreender o significado da violência obstétrica para mulheres. **Método:** trata-se de um estudo qualitativo, com abordagem fenomenológica heideggeriana, com mulheres em fase reprodutiva. A coleta de dados foi por meio de entrevistas gravadas, guiadas por um roteiro e analisadas sob a perspectiva da fenomenologia. **Resultados:** as Unidades de Significação foram constituídas a partir das falas das depoentes e assim agrupadas. A violência obstétrica significou para as mulheres: << Unidade de Significado 1: Ser conhecida por ouvir falar em cursos, palestras, internet, em relatos de pessoas amigas e sofrida por ela mesma; << Unidade de Significado 2: Machucar o físico, o psicológico e exercer uma pressão; << Unidade de Significado 3: Sentir-se incomodada, sem ter ajuda, sentir-se machucada no parto e não ter atenção. **Conclusão:** evidenciou-se a necessidade de um fortalecimento da consulta de pré-natal proporcionada pelo enfermeiro, abordando temas diversos e reflexivos, e ofertando uma saúde integral de qualidade, curativa e preventiva. **Descritores:** Violência contra a mulher; Saúde da Mulher; Parto Humanizado; Enfermagem; Assistência Pré-Natal; Empatia.

RESUMEN

Objetivo: comprender el significado de la violencia obstétrica a las mujeres. **Método:** este es un estudio cualitativo con un enfoque fenomenológico de Heidegger, con las mujeres en la etapa reproductiva. Los datos fueron recolectados por medio de entrevistas grabadas, utilizándose un guía y analizados bajo la perspectiva de la fenomenología. **Resultados:** las unidades de significado se formaron a partir de los testimonios de las entrevistadas y así agrupados. La violencia obstétrica significaba para las mujeres: << Unidad de Significado 1: Ser conocida por oír hablar en cursos, conferencias, internet, en informes de amigos y sufrido por ella misma; << Unidad de Significado 2: El daño físico, psicológico, y ejercer una presión; << Unidad de Significado 3: Sentirse molestas, sin ayuda, sentirse heridas en el parto y no tener ninguna atención. **Conclusiones:** Se evidencia la necesidad de un reforzamiento de la consulta prenatal proporcionada por enfermeras, cubriendo diversos temas y reflexivo, y ofreciendo una atención médica integral de calidad, preventiva y curativa. **Descriptor:** Violencia contra la Mujer; Salud de la Mujer; Parto Humanizado; Enfermería; Atención Prenatal; Empatía.

^{1,2,3}Censupeg College. São Fidélis (RJ), Brazil. ¹ <http://orcid.org/0000-0003-4536-0678> ² <http://orcid.org/0000-0003-2101-2740> ³ <http://orcid.org/0000-0002-4518-1277>

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INTRODUCTION

The relationship between women and giving birth, due to misinformation, tends to be a big problem, and, thus, information must be provided to expectant mothers during the prenatal, labor, delivery and puerperium, based on updated scientific evidence, for the decision of the pregnant woman regarding the form of birth, respecting her autonomy.¹

The vaginal delivery is a natural process, beginning spontaneously and with low risk, where the baby is born instinctively, typically from 37 to 42 weeks. This delivery ensures the minimum of interventions in the natural process, aiming to preserve the health of the mother and the baby.²

In mid-20th century, the delivery process was institutionalized, migrating from home to the hospital environment. When the birth was inserted in the hospital process, certain routine and protocol practices were integrated, such as episiotomy, trichotomy, enema, induced delivery, procedures carried out without scientific evidence.³

With this, it is important that each pregnant woman receive information about the risks and benefits of the types of delivery, pointing updated data from scientific studies, aiming to ensure that every woman has a better understanding about each procedure, thus being able to make decisions based on the information received.⁴

The frequency of cesarean sections in Brazil has pointed out the high number of the procedure since the mid-1990s. During the year 2009, the number of cesarean sections surpassed the relevance of vaginal deliveries in the country, reaching more than half of all deliveries. The size of the cesarean section demonstrates an abnormal distribution, whose choice often occurs without clinical indications.⁵

The assistance to delivery should encourage reflection to pregnant women on which delivery is the most suitable, in order to ensure the safety of the woman and baby, considering the risks and complications backed by evidence. The nursing team professionals are responsible for ensuring the parturient's rights, how to obtain the presence of a companion during labor, delivery and immediate postpartum, not performing any procedure without her prior knowledge and providing a relationship of trust, asking her about her expectations and desires, being supported in her decision⁶ and ensuring that, regardless of the type of delivery, this woman receive a humanized treatment.

The Obstetric Nurse is responsible for the integral reception of the pregnant woman and her companion, from pre-natal to puerperium, evaluating, respectively, her health conditions, including fetal health. That professional is also responsible for providing a care model that

considers the autonomy and role of women⁷, always leaving evident that any type of delivery can and must be humanized, since the humanization is not only a natural delivery with minimal medical interventions, but also a delivery that respects the woman's dignity.

The Obstetric Nurse is responsible for enabling a favorable environment for the delivery, with positions chosen by the woman, avoiding the use of drugs without indication, keeping the perineal integrity, promoting skin-to-skin contact of the mother with the newborn, supporting breastfeeding soon after birth and respecting the woman in her ethnic cultural context.⁷

The Nursing Consultation during the pre-natal is an instrument that favors the interaction between nurses and the woman, in order to provide a suitable environment for the instruction of pregnant women about benefits of normal delivery for maternal-fetal health.⁸

During the pre-natal, it is necessary to develop educational actions and guidance on the advantages of normal delivery, considering the benefits for the mother-baby health, in short and long term, answering the questions of pregnant women who are unaware of beneficial points offered by natural delivery.⁸

The Brazilian Ministry of Health involves government spheres in order to promote a safe process of natural delivery in accordance with the specificities of each woman. A strategy is the *Rede Cegonha*, which aims to extend the access and quality of attention to reproductive planning, prenatal care, delivery and puerperium, in addition to improving the monitoring of the child until 24 months of life in a humanized manner.²

The humanization and the respect for autonomy are fundamental elements in health care with women since sexuality in the process of giving birth. The reproductive health advocates the idea that people are prepared to have a safe and satisfactory sex life, with the possibility to reproduce and the autonomy to decide to do so if they wish, when and how many times they want. This condition covers the individual right of men and women to have access to information and methods of family planning.⁹

Regarding respect and humanization, the obstetric violence goes against such attitudes. The term "obstetric violence" covers various actions of aggressive practices during labor, mainly carried out by health professionals. It encompasses physical, verbal, psychological abuse, and use of unnecessary and invasive procedures. Various attitudes disregard women's dignity, and they should be reviewed and penalized.¹⁰

It is scientifically proven that good practices during delivery favors the reduction of maternal-fetal morbidity and mortality. The woman's body is able to give birth, and, many times, does not

require the use of those procedures, such as the lithotomy position, use of oxytocin, episiotomy, fundal pressure, among others, which may bring harm to the health of pregnant women³, and, when used without consent and knowledge of women, are also considered obstetric violence.

The guiding question of this study is: how do women understand obstetric violence?

OBJECTIVES

- To appreciate the meaning of obstetric violence for women.
- To identify women’s knowledge of obstetric violence.
- To know possible cases of obstetric violence.
- To clarify the ways of obstetric and violation of women’s right aiming to avoid new cases.

METHOD

The present study is a qualitative research with an emphasis on Heidegger’s phenomenological approach. Heidegger’s phenomenology deals with a broader sense of the profound relationship of the being with the world, through the very essence¹¹, affirming that the man is in the world in conjunction with the other things, being the “being-in-the-world”, with one’s own ways of expression and experience. Thus, the research with a phenomenological approach seeks the meanings expressed by the person through his/her experiences.

The participants were 10 women. Women underage and those who were already in menopause did not participate, due to the time since the occurrence. The number of participants was not previously established, because the

phenomenological approach highlights the sufficiency of data to achieve the objectives, i.e., the step ends when the objectives are achieved.

For ethical reasons, the possible risks of this research focused on the discomfort and emotional instability arising from the theme of violence and women’s health, which usually causes reflection, questions and varied feelings in people. If this occurred at the time of the interview, the researcher would solve it. In contrast, the research presents several benefits, such as: contribution to scientific research in the area of woman’s health nursing, dissemination of knowledge and contribution to avoid different levels of violence against women.

Data collection was carried out through visits with the open interview recorded, according to a guide. The interview in the phenomenological modality seeks the subjectivity of the subject; therefore, some open questions are used to allow the participants to speak freely, without any interference from the researcher.

The project of academic character and the Informed Consent Form (ICF) were presented to each volunteer, as advocated by Resolution of the National Council of Health 466/12. For a better understanding of data, there was the confection of what we called historiography to the phenomenology, a demonstration of the characteristics of the interviewees, a passage of narration from oral form to writing (Figure 1). The anonymity was preserved and the participants were identified by codes - I1, I2, I3, and so on.

The project was submitted to the Research Ethics Committee through *Plataforma Brasil* and, after approval, the step was initiated. The project was approved with opinion n. 3.694.885.

RESULTS

Intervi ew	Age	N. of childre n	How often do you seek the health professi onal?	Have you ever heard of obstetric violence?	Whom did you hear of obstetric violence from?	Pre- natal?	Was obstetric violence ever addressed during pre- natal?	Did you hear/pass through something that bothered you during the delivery?	Whom from?
1	27	2	Not much	Yes	Course	Yes	No	Yes	Doctor
2	28	3	In case of disease	Yes	Internet and at home	Yes	No	Yes	Health professi onals
3	29	8. 6 deceas ed and 2 alive	Only in pregnan cy	No	-	Yes	No	Yes	Nursing staff
4	31	1	Not much	Yes	Courses and college	Yes	No	Yes	Doctor
5	26	2	Not much. Only in case of	Yes	Social networks and pre- natal	Yes	Yes	Yes	Doctor

6	30	2	diseases	Not	Yes	A friend	Yes	No	Yes	Doctor
7	23	1	Monthly	Monthly	Yes	Herself, when suffered it	Yes	No	Yes	Doctor
8	21	2	Not much.	Only in case of diseases	Yes	Television	Yes	No	Yes	Doctor
9	21	2	When necessary	frequently	Yes	Internet	Yes	No	Yes	Nurse
10	22	1	Only	pediatrics	No	-	Yes	No	Yes	Nurse

Figure 1. Historiography Chart. São Fidélis (RJ), Brazil, 2019.

Ten women were approached, whose age ranged from 21 to 31 years, and were all mothers. Of the interviewees, only one seeks the service with frequency, the others, only when they feel something. Concerning the term obstetric violence, two of the ten women had never heard of, and the others heard of through virtual environment, lectures or from another person. One woman claims she had suffered obstetric violence, and thus knows the meaning of the term.

All women attended pre-natal and only one reported having talked about obstetric violence at the call. All the interviewees reported having heard something annoying at the time of delivery from nursing professionals (three reports), from the doctor (six reports) and from the staff of health professionals (one report).

For the attainment of the objectives regarding the understanding of the meaning of obstetric violence for women and the knowledge of possible occurrences of obstetric violence, the Meaning Units were formed from interviewees' statements and thus grouped together. The obstetric violence meant for women:

♦ Meaning Unit 1: Being known by hearing about in courses, lectures, internet, reports of friends and suffered by herself.

- Yes. A lot. I've heard of at the nursing technician course and at lectures of community health workers. I1
- Yes. Internet and at home. I2
- Yes, at college and at the course I've attended (nursing technician). I4
- Yes. Social networks and pre-natal follow-up. I5
- Yes, a lot! From a friend who had suffered it and from what I went through. I6
- Yes. From myself, when I suffered it. I7
- Yes, from television. I8
- Yes, mainly from the internet. I9

♦ Meaning Unit 2: Hurting the physical, psychological, and exerting a pressure.

- I think it's the psychological pressure we suffer during the delivery, at pre-natal calls. [...] I1
- [...] Not just physical, but words can also be considered obstetric violence. I4
- [...] Pushing the person's belly, even not being allowed, because it's hard and hurts even more. It's the person in pain, needing a call and hearing unnecessary things. Verbally and physically. I9
- Physical violence. I10
- ♦ Meaning Unit 3: Feeling annoyed, helpless, feeling hurt in delivery and having no attention.
- [...] I felt sick the whole night, I was breathless [...] Afterwards, Nathália said the nurse had called the doctor to see me. I almost fainted. I was almost dying. I had a bleeding [...] You have to stay alert 24 hours, but not there, they didn't even come to see me [...] Nathália saw and said "guys, this girl is feeling sick", and she kept telling me to stand up and take a shower and I was there, in crisis. If I had the third, I would die there. I3
- [...] And the way they handled the situation, it was a type of obstetric violence. Because they could've given me more attention. It was neglect. I5
- The person that doesn't leave us at ease in that moment. I8

DISCUSSION

The phenomenology, approached in this study, relates to nursing researches, because it gives a voice to subjectivity, in addition to the biological aspect. Heidegger's phenomenology externalizes characteristics of the latent and immediate. It points to several axes of the experiences of human existence.¹² It relates to what those events mean for the researched, in a more expanded way, comprising the totality of language, gestures and established relationships.¹¹ From then on, the vague and median understanding indicates the analysis and reflection on the meanings of obstetric violence for women.

Most interviewees did not seek the health professional with certain frequency, but rather

<http://www.ufpe.br/revistaenfermagem/>

when feeling something. It depicts a deficiency with respect to health promotion and prevention. The search for the health professional should happen even if the individual is healthy, to have attitudes toward health care and not to become ill.

Aiming to promote the prevention of obstetric violence, good actions should be inserted in the nursing team, including: explain each procedure in an accessible vocabulary, describe the clinical picture and the interventions to be taken; decrease the performance of invasive and unnecessary procedures; listen to the patient and provide a quality teamwork; guide on the reproductive rights and those related to motherhood; keep always updated and qualified.¹³

All deponents attended pre-natal, which constitutes an effective care with the mother and the baby, besides being an opportunity to address other women's dimensions, including their feelings about delivery and after it. The prenatal consultation can be performed by the physician and the nurse, and can be alternated between the professionals.

During the reception in pre-natal, the nurse must perform practices of humanization, thus fully respecting the woman, listening to her fears, longings and desires, without intervening, considering her thoughts and opinions. In addition to making the woman the protagonist, family members should also be included in this process, thus facilitating the continuity of treatment.¹³

The obstetric violence seemed to be known by women, although only one participant reported having suffered it. Among the means of learning about obstetric violence, there were informal means, such as news, in addition to a seminar of technical training course. The technology is one of the important tools to generate knowledge, but does not replace the contact and the empowerment of people on the health care of themselves. Therefore, 90% of all interviewees did not receive any advice on ways of preserving their autonomy and reproductive and sexual rights, during the pre-delivery, delivery, and postpartum.

The theme of obstetric violence should be discussed in relation to knowledge of women about their rights of their delivery, whether natural or by cesarean section. Health professionals, including nurses, are fundamental parts for this woman acquire knowledge of health laws and policies and have autonomy for the parturition moment. With knowledge, the woman can expose her feelings, expectations and desires at the time of delivery, within the possibilities of a healthy safe delivery, respectful and with the least possible interventions.

As well as children have the right to safe birth and development, women also have the right to humanized care throughout pregnancy, until

postpartum, as ensured by the *Rede Cegonha*, which is a program of the Ministry of Health, whose purpose is to rearrange the attention to maternal and child health in the Brazilian territory², and, for that to happen, it is necessary to recognize the role and the appreciation of the autonomy of women.

All interviewees went through experiences that fall in cases of obstetric violence at various levels, and they include verbal violence, violence of health care omission, psychological violence and physical violence. The data indicate that those acts were mostly committed by medical professionals, followed by nursing professionals. After questioning "*What does obstetric violence mean to you?*" and "*What comes to your mind when you hear of obstetric violence?*", none of the interviewees were able to respond with accuracy the various axes of obstetric violence, emphasizing only some of them, and the most frequent were: verbal violence, physical violence, and omission of health service, although cases of psychological violence had also been cited.

The obstetric violence is constituted by the sum of pain and suffering, which can be preventable, covering physical, psychological, sexual and verbal factors, and the latter is the set of attitudes that relate to the body and to the reproductive right of women.¹⁴

The obstetric violence also occurs when the interventions considered unnecessary happen. Between 2011 and 2012, results of the research *Nascer no Brasil*¹⁵, whose purpose was to analyze obstetric interventions in usual-risk pregnant women, revealing that, in the pre-partum, on average 40% received oxytocin and amniotomy for delivery acceleration and 30% received spinal and epidural analgesia. Concerning the interventions during labor, the lithotomy position was used in 92% of cases, the Kristeller maneuver in 37% of cases, and episiotomy in 56% of cases.¹⁶

In the interviewees' opinion, when asked "*How could the nursing professional contribute to avoid cases of obstetric violence?*", there were several answers, citing: be able to chat and inform; have empathy; have humanity; accompany the patient; be attentive and supervise the possible occurrence of cases of violence. The professional needs to be aware of his/her role, enforcing the public policies geared to women's health, including care humanization. The obstetric violence is defined by the lack of humanization of health professionals, expropriating the woman from her own body and decisions, namely: clinical, sexual and reproductive. It happens by acting or omitting services and care.¹⁷

Another way to avoid obstetric violence is the planning of delivery and the achievement of actions of humanization of delivery and puerperium. The plan of delivery should also be

used as a reflexive tool to the staff about the reality of the delivery care in the region, in order to understand women's fears and needs, reflecting on relevant information and offering support to users of health services.¹⁸

In relation to the last objective, there were dialogs during the interviews, when the various axes of the obstetric violence were clarified, as well as its levels, pointing out flaws in the treatment received by women during the pre-natal, during labor and postpartum and the legal aspects.

Thus, in the phenomenological perspective, the obstetric violence meant for women a common thread: known from its approach in courses, lectures, internet, in reports of friends and suffered by herself; hurting the physical, psychological, and exerting a pressure; feeling uncomfortable, helpless, feeling hurt in delivery and having no attention.

The present study aimed to understand the meanings of obstetric violence, and, in this sense, the interpretative analysis, i.e., the hermeneutics, will not be contemplated beyond the vague and median understanding.

CONCLUSION

The study revealed the lack of instructions to pregnant women received during the pre-natal until the postpartum period, by the nursing staff, as well as the scarcity of information disclosed in the count through formal information, such as newspapers and publications on social networks of scientific character, making the thematic of obstetric violence more accessible.

The nurse should become an updated and humanized professional, thus reflecting his/her qualities in the actions, protecting women's against any inhuman treatment, ensured by the National Policy of Pre-Natal, Delivery and Puerperium Humanization. Thus, the women's role is respected and the nurse does assert his/her autonomy and visibility in the care with women's health.

Women need a qualified and enlightening pre-natal regarding physical, ethical and legal aspects in the process of giving birth. In this way, the nurse becomes responsible for providing information to pregnant women about their rights as users of the health service, affirming the need for training and awareness of this professional and the rest of the health staff.

The nurse is responsible for ensuring women's health and dignity throughout the call, whether in Basic Health Units or in hospital units. The prevention of obstetric violence must be built with the health staff, respecting women's role and dignity throughout the prenatal period until her discharge. For this to occur, it is also important to

prepare the multidisciplinary staff, covering topics such as empathy, humanization and ethics.

The Basic Care is the device that allows for actions of health promotion and prevention, in relation to women and the process of giving birth, because it is the primary call, thus being able to implement lectures, meetings, or in the nursing consultation, adding a necessary differential, such as reflexive, critical issues, giving voice to the woman, since the discovery of pregnancy until the puerperium.

The scope of these improvements are in line with the guidelines of the *Rede Cegonha*, which reduces maternal and infant morbidity and mortality, enables the woman's bond with the location where she wants to give birth, how she wants to give birth, the use or not of certain procedures, the right to a companion and humanized treatment far from any disrespectful act.

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Corresponding author

Mariana Roma Ribeiro de Oliveira

Email: marianaroma@live.com

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