



## NURSES' PERCEPTION ON OBSTETRIC NURSING CARE

### PERCEPÇÃO DE ENFERMEIRAS SOBRE O CUIDADO DA ENFERMAGEM OBSTÉTRICA

### PERCEPCIÓN DE LAS ENFERMERAS SOBRE EL CUIDADO DE ENFERMERÍA OBSTÉTRICA

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#### ABSTRACT

**Objective:** to analyze the way in which obstetric nurses perceive themselves as women, and how this can influence the care relationship between professional and user. **Method:** descriptive qualitative study with 12 obstetric nurses, who participated in an open interview. We conducted a thematic analysis of the discourses and applied a theoretical framework of gender for data processing. This study was approved by the Committee of Ethics in Research, Protocol 1665/2007. **Results:** as main thematic core emerged: *speaking about themselves and to themselves while talking about other women*. Its dimensions included the feminine discourse, the depiction of the mother figure as a female role model, the ambivalence between the stereotypes of idealized and submissive woman. **Conclusion:** it was evidenced that the nurses experience a conflict of identity, which contributes to not recognizing the women they care for as main characters in this context. Thus, they take the role of leading characters and subject the users to the condition of supporting characters in the take care/be cared for relationship. **Descriptors:** Women's Health; Obstetric Nursing; Gender Identity.

#### RESUMO

**Objetivo:** analisar o modo pelo qual enfermeiras obstétricas se percebem como mulheres e como isso pode influenciar na relação de cuidado entre profissional-usuária. **Método:** estudo descritivo de abordagem qualitativa, com 12 enfermeiras obstétricas, que participaram de entrevista aberta. Utilizou-se a análise temática dos discursos e referencial teórico de gênero para tratamento dos dados. Estudo aprovado pelo Comitê de Ética em Pesquisa, protocolo 1665/2007. **Resultados:** emergiu como núcleo temático central: *falando de si e para si enquanto discursam sobre outras mulheres*, cujas dimensões incluíram o discurso feminino, a figura materna como referência de mulher, a ambivalência entre os estereótipos de mulher submissa e mulher idealizada. **Conclusão:** evidenciou-se que as enfermeiras vivenciam um conflito de identidade e isto contribui para que não reconheçam o protagonismo nas mulheres que cuidam. Deste modo, assumem o papel de sujeito e submetem as usuárias à condição de coadjuvantes na relação de cuidar-cuidado. **Descritores:** Saúde da Mulher; Enfermagem Obstétrica; Identidade de Gênero.

#### RESUMEN

**Objetivo:** analizar la forma en que las enfermeras obstétricas perciben a sí mismas como mujeres y cómo eso puede influir en la relación de cuidado entre profesional-usuaria. **Método:** estudio cualitativo descriptivo, con 12 enfermeras obstétricas que participaron de una entrevista abierta. Se utilizó el análisis temático de los discursos y un marco teórico de género para el procesamiento de los datos. Este estudio fue aprobado por el Comité de Ética en Investigación, Protocolo 1665/2007. **Resultados:** se tomó como eje temático central: *hablando de sí mismas y consigo mismas, mientras discurren acerca de otras mujeres*, cuyas dimensiones incluyen el discurso femenino, la figura de la madre como referente de mujer, la ambivalencia entre los estereotipos de mujer idealizada y de mujer sumisa. **Conclusión:** se evidenció que las enfermeras experimentan un conflicto de identidad y esto contribuye a no reconocer el papel de protagonistas en las mujeres que atienden. Así, ellas asumen el rol de protagonistas y sujetan las usuarias a la condición de actores secundarios en la relación cuidar-cuidado. **Descriptor:** Salud de la Mujer; Enfermería Obstétrica; Identidad de Género.

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## INTRODUCTION

The topic: *“the role the female nurse plays in the take care- be cared for relationship with the woman/user of health services in the context of new/renewed paradigms of health care delivery in the field of women's health”*<sup>1</sup> emerged from concerns on the part of the researcher regarding the way the care relationship occurred among female nurses and female users. The researcher wondered: Why do women take care of women so differently? Why are they so distant from each other? Why did female nurses choose to care for women? What are the meanings of this way of caring? Why are female nurses so judgmental? Why do they subject women to so much suffering and so much oppression? Why do they assume the male role? Are they conscious of this authoritarianism?

In the attempt to answer these questions, this study examined the way in which obstetric nurses perceive themselves as women and how this may influence the care relationship established between professional and user.

Using a gender perspective - which guided this study - was necessary, as it supported the analysis of specific issues of being a woman. We believe that the study - through a profound reflection on the way of being a female obstetric nurse - may contribute to the improvement of the relationships established between women, as well as to the quality of care.

Gender is a relational and systemic perspective that dominates the game of construction of roles and identities for both sexes.<sup>2</sup> It is considered a constitutive element of symbolic reasoning. This means that what is seen as culturally masculine only makes sense from a feminine perspective and vice versa. This logic goes through various relational pairs, as man-man, woman-woman and man-woman, expressing standards of masculinity and femininity to be followed. Thus, the identities of man and woman assert themselves according to similarities and differences found when compared to the standard that possesses more power in the culture.<sup>2-3</sup>

Gender has as core definition the connection between two propositions: gender is a constitutive element of social relationships based on perceived differences between the sexes; and gender is a primary way of signifying relationships of power.<sup>3</sup>

Using a gender approach to understand the power relations between men and women is

also important because it shifts the focus from women's issues to an analysis of social relations as a whole. It focuses the mechanisms of subordination of women by men and also by the way social relations are organized. It reaches the legislation, the State, labor relations, social representations, symbolic fields, and operates on macro and micro-social levels.<sup>3-4</sup>

The power exerted in gender relations is the result of representations of women and men that are present in the social imaginary and stem from biological differences between the sexes. These representations progressively make up a system of symbols and values full of stereotypes that dictate what is appropriate for women and for men. They are naturalized and propagated by social institutions (family, school, church, the media), being subjectively incorporated and deeply influencing the formation of gender identity.<sup>3-5</sup>

In the process, men are directed to the public and production world. For this purpose, they need reason, objectivity, power and freedom. Women, on the other hand, are directed to the private space and to reproduction, and need above all: emotion, discipline, affection and obedience to moral codes established socially and culturally.<sup>1,4-5</sup> In this regard, it is important to highlight that using gender as an analytical category becomes vital in order to broaden the discussion of professional training and practice, since it is already being adopted by national and international health organizations, including the Health Ministry.<sup>6</sup>

Another important gender aspect to be considered is the health-illness process of Brazilian women.<sup>5</sup> Women still get sick and die because of pregnancy, childbirth, postpartum, and abortion complications, for example. In 2005, the maternal mortality ratio in Brazil was 74.7%. The number of Caesarean sections is increasing progressively in Brazil. The number of children per woman is decreasing markedly. Since 2004, women have an average of 2 children. Coverage of antenatal care (7 consultations or more) is 67.1% for white women and 44.7% for black women. In 2005, as a consequence of the feminization of AIDS, there were 10 women for every 15 men with AIDS.<sup>6-7</sup>

Actions aimed at overcoming these epidemiological data must consider not only the specifics of the female life cycle, but also the social roles assigned to it, because they are determining factors for the illness and death of some women and not others.<sup>5</sup> It is evident that health goes beyond biological

factors or the reproductive function of women. In this case, there is a great influence of the relationships between genders, as well as of the quality of care received in settings where public policies are implemented.<sup>4,6</sup>

When interpreted in the light of gender, the data reveal: the submission of women to medical control in what concerns the medicalization of the body, the dispossession of the ability to give birth, and sterilizations acquired as consumer goods; the submission to sexual partners who refuse to use condoms; and the social submission, when they must bear alone the burden of a pregnancy. These submissions are independent of social class and economic power.<sup>5</sup>

Regarding the social structure, neoliberal ideology also greatly affects the social position of women. The competitiveness, inherent in this economic model, has led to the undervaluing of women's labor (productive and domestic labor), to poor working conditions, and to the spread of informal work. This is probably due to the increase in the proportion of female heads of household.<sup>6</sup> Gender inequality leads, therefore, to the feminization of poverty and to the precariousness of life.<sup>5</sup> Thus, public policies aimed at women should be formulated and implemented taking into account the inequalities of gender, class, race and sexuality.<sup>5-7</sup>

## MÉTODOS

This article was drawn from a monograph entitled << Women caring for women: a relationship among subjects >> submitted to the Post-graduation Program in Nursing, School of Nursing, University of the State of Rio de Janeiro/UERJ. Rio de Janeiro - RJ, Brazil. 2007

This is a descriptive qualitative study using the life history method, since we only consider the point of view of the interviewees as a factor to be analyzed and in order to understand how the Obstetric Nurse perceives herself as a woman and to which degree this can interfere in the care relationship between the female nurse and the female user.<sup>1</sup>

Data collection occurred from February to August 2007. The interviewees in this study were 12 obstetric nurses who directly provide nursing care to the women population in preventive gynecology and/or during the gravid-puerperal cycle.

The selection of this sample was done in various ways. Initially a letter of invitation was sent to all public hospitals in the city of Rio de Janeiro. Through this letter the study

was made known to nursing managers. In addition to this invitation, the study was advertised in virtual communities (<http://www.orkut.com>) called: *I love Obstetric Nursing*; *Rehuna*; *Obstetric Nurses*; *evidence-based Gynecology and Obstetrics*; *Nurses can make child deliveries*; and *Feminist consciousness*. In these communities, the nurses were informed about the study, invited to participate in it, and provided with contact information for study personnel. The interviews were scheduled at a time and place set by the interviewee.

Due to the method chosen, a predetermined number of reports was not fixed by the researchers. Data collection was terminated after the 12th interview, when the saturation point was reached. This point is defined as the moment when the researcher does not find the inclusion of new information in the reports, at least with regard to the object of research.

The strategy used for data collection was an open interview triggered by the question: "Tell me what you consider important about your life as a woman and that has to do with taking care of women." The respondents were designated as subject (S), followed by the number of the sequential order of the interviews. E.g.: S1, S2,...

In compliance with the provisions of Resolution No. 196/96 of the National Health Council, the study project was submitted to the Committee of Ethics in Research of the University Hospital Pedro Ernesto (UHPE/UERJ) and was approved under protocol No. 1665-CER/UHPE/2007. All respondents were informed in advance about the contents of the study and signed an informed consent form.

We conducted a thematic analysis of the discourses and applied a theoretical framework of gender for data processing. The analysis procedures included verbatim transcription of the interviews and extensive reading in order to identify emerging topics. Once identified, the topics were gathered in peer groups, from which main thematic cores were defined.

## RESULTS

### ◆ Characterization of the interviewees

Only 3 (three) of the 12 (twelve) respondents had no current partner. Ages ranged from 26 (twenty six) to 45 (forty five) years. Regarding the exercise of motherhood, 5 (five) did not have children and 1 (one) was pregnant with her first child. As for the workplace, 7 (seven) worked in the city of Rio

de Janeiro, 4 (four) in other municipalities of the State of Rio de Janeiro, and 1 (one) in the State of Minas Gerais. Training time varied from 2 (two) to 18 (eighteen) years and professional time caring for women ranged from 9 (nine) months to 18 (eighteen) years.

Regarding the profile of the interviewees, it is important to highlight that all have sought and continue to seek technical and scientific knowledge and training in the area of women's health. They are all Specialists and only four (4) did not have post-graduation (*stricto sensu*) degree. The search for knowledge is a constant in the professional lives of these women. This reveals the (sometimes unconscious) search for empowerment. This refers to the professional potential of women, increasing their information, enhancing their perceptions, exchanging ideas and expressing feelings.<sup>8</sup> The quest for knowledge has the broader objective of strengthening capacities, skills, and dispositions for the legitimate exercise of power.<sup>1</sup>

We cannot deny the relevance of the Feminist Movement for actions which ensured and ensure women the right to make choices, question situations and decide what is best for them in the social order.<sup>5</sup> The emancipation of women through sexual liberation legitimized contraception and caused the medicalization of fertility. Thus the woman who decides to combine motherhood and labor-force participation, in most cases, in addition to overloading herself, takes on the male responsibility as family provider, in exchange, most of the times, for poor remuneration.<sup>5,8</sup>

As for the area of practice, all interviewees considered the care experience to be an important element of learning, although only 6 (six) work as caregivers for the female population. 9 (nine) nurses are also worked as professors. All of them taught in the field of women's health.

#### ◆ Speaking about themselves and to themselves while talking about other women

At the end of the analysis, the following main thematic core emerged: *speaking about themselves and to themselves while talking about other women*. We highlight aspects related to what female nurses think about themselves and what is their way of seeing the world when using the collective discourse. Nurses speak about themselves and to themselves while talking about other women. This thematic core constituted relevant

content and was mentioned by all respondents at different times of their life stories.

This category includes the following conceptual dimensions: the female discourse, the depiction of the mother figure as a female role model, the ambivalence between the stereotypes of idealized and submissive woman.

The first conceptual dimension - the feminine discourse - can be illustrated by the Nurses' speech. They typically talk about their own lives in terms of relationships. Women include parts of other people's life stories in their own life stories.

*My husband is a very good person. He is the kind soul back home. He makes us be more focused. (laughs) He is a very calm person. And he taught me to be calmer. (...) It is good when we can live with somebody better than us. This helps us. Makes us try to be better. (S. 10)*

The conceptual dimensions that emerged from the analysis presented, in the first instance, the female discourse. The female discourse differs from the male discourse precisely in the way of seeing the world. Men consider the life they lived as their own, as a series of conscious actions, with well defined goals. They narrate their stories using the active "I", making sure that they are the subjects of their actions by the forms of speech that they employ.<sup>1</sup>

In the conceptual dimension that addresses women's discourse, it was clear that women talk about themselves in the third person, i.e., they talk about other women. They talk about women who seem to be far away from them, as if they were different women, other beings. However, although they use the third person, the indirect speech or the collective discourse, they talk about themselves. This can be understood as an unconscious, unintentional, but extremely real and transparent speech.<sup>1</sup> Talking about oneself means expressing one's truth, not only through the use of words or collective discourse, but also through gestures, through the way one touches one's body, looks down or squeezes one's hands together, through eye contact, through the feelings of sadness or joy.<sup>1</sup>

Thus, they very often use "we" or "us", symbolizing relationships that underlie that part of their lives: "we" = "My parents and I" or "my husband and I" or "my children and I".<sup>1</sup>

It is worth noting that in some cases, besides speaking in the third person, they also use male gender to talk about themselves, as we can observe in the speech below.

*I think that he (the nurse) has a different way of solving problems. It really has to do with the training issue. I think he (the nurse) is (...) he has a "very great" ability to manage problems. (S.02)*

The interviewees also use indirect speech and male gender.<sup>1</sup> The Freudian psychoanalysis drew the attention to the fundamental role of language as part of the symbolism.<sup>1</sup> The unconscious is structured like a language, and the acquisition of personal and sexual identity occurs simultaneously. These foundations are built from early childhood, when the child hears and learns how to speak. Therefore, it is through language that gender identity is constructed.<sup>9</sup>

Thus, masculinity and femininity are imposed to our deepest psyche long before the differences between the sexes have any immediate meaning. This occurs through the unconscious cultural symbolism of gender that is embedded in language.<sup>1</sup> The internalization of these attitudes is clearly revealed in the different ways that men and women use language. In this context, language plays a role of female social control because it expresses the views and perspectives of men and not of women.

The feminine discourse reflects the history of mankind. It is based upon the androcentric vision that lasted for most of life in society.<sup>10</sup> The man is responsible for the public space, the non-domestic work and for providing for the offspring. The woman is responsible for the domestic world, the tasks related to this space and for taking care of the family.<sup>5,8</sup>

In this context, it is vital that Obstetric Nurses become aware of this fragility of identity and reflect on this issue. The absence of empowerment means not taking ownership of rights for the full exercise of citizenship. To have rights is also to have power.<sup>5,10</sup> The humanized care model has as a principle (precisely) the recognition of users as subjects, valuing and encouraging participation in the whole care process<sup>9,11-2</sup> Therefore, the Obstetric Nurse might only provide an "emancipation promoting" care if she herself reflect upon her own weaknesses.

The second conceptual dimension - the mother figure as a female role model - can be demonstrated when nurses talk about the concepts of being a woman. These concepts, which emerged from the life stories, are taught by the family through the generations. Values transmitted through family education had a great impact on the lives of these female nurses, who consider the mother figure as a female model.

*I wanted a totally different life for her (mother). Unfortunately, she was not, therefore, a role model for me. Do you know? (...) And she ... I always looked at her like that ... I do not want to be like her. Because she has always had a life of hardship. She did not know ... She did not know how to change the context of her life in order to improve it. (S.06)*

*(...) seeing a marriage where my mother was very submissive. There have been not serious issues or violence, nothing of the kind! But I always saw my mother very submissive to my father. (...) He (father) was always imposing things and everything. Often contrary to the wishes of my mother. And I always thought that did not want that for my life. (S.07)*

The second conceptual dimension was defined as the mother figure as a female role model. In this dimension, we realize the importance of the values transmitted through family education. Biological, social and cultural reproduction functions in the private space were attributed to the women. In a gender-structured society such as ours, children of both sexes are raised primarily by women.<sup>5,8</sup>

The contemporary family inherited the political needs of the constitution of the private in the early modern era. It emerged as the one that will ensure social order and, above all, allow the formation of the adult individual.<sup>8</sup> In this conception, the hierarchy father-mother-child was naturalized as the primary setting par excellence for the constitution of the subject.<sup>5</sup> In this triad, the woman plays a central role in caring for the family and in controlling domestic tasks.

By assuming her "social role" - caring for the household, husband and children - the women necessarily assume a moral and emotional behavior oriented to the context of the private sphere.<sup>3</sup> This ultimately subject her to ideas of religious nature that emphasize the differences between man and woman - in any aspect related to sexuality, economics, intellectuality, politics, religion, psychology, affectivity, among others - through oppression.<sup>5</sup> This "social role" is culturally constructed in positions linked to biological sex.<sup>3</sup> According to this point of view, women's specific skills are associated with feelings, affect, subjectivity and the relational nature.<sup>8</sup>

Other theories of gender, also based in psychoanalysis, reinforce the critical role of the family in the formation of feminine and masculine personality.<sup>1</sup> These theories argue that, during their formation process and throughout their psychological development,

children (boys and girls) establish different relationships with their mothers. The experience of individualization - one's separation from the person who cared for him/her and with whom he/she is at first psychologically fused- is very different for those who are of the same sex of the mother (as compared to the experience of those of the opposite sex).

It is interesting to note that a maternal model of submission is also used by the interviewees when defining women who care. Female users are powerless, lost and desperate. This image of woman can be interpreted from the statements below.

*I think women are very oppressed. (...) Because we see so many such women, so submissive and so vulnerable to mistreatment, to disrespect ... And they let it happen as if it was natural, you know? (...) Because we see that people like that exist. (...). (S.06)*

*They still have their little babies in an uninformed way. In a way they deep down inside do not want to. (...) I perceive some improvement in middle-aged women (...). (S.10)*

*Being a woman is very difficult. Although she is now an active part of the labor force, (domestic) tasks are not shared at home. (...) I think deep down there were gains but also great losses. (S.11)*

The mother figure, however, was not considered to be an ideal model of woman by the interviewees. On the contrary, this woman was found to exemplify the stereotypical submissive, suffering and miserable woman. From the perspective of psychoanalysis, the identification or not of a woman with her mother, may help determine how her childhood and adolescence was, i.e., how she experienced the castration complex and the Oedipus complex.<sup>1</sup>

Much of the things experienced by girls remain through adulthood and is not adequately overcome in the course of development. Thus, this can be identified, in the way women speak and relate to their mothers. For some women, the affective relationship with the mother resumes after marriage and the birth of a first child.<sup>1</sup>

To be aware of oneself and to reflect on oneself indicates self-knowledge, which is considered one of the qualities of the caregiver.<sup>1</sup> Healthcare professionals should be aware of the occurrences that bother or distress them at some stage of their lives.<sup>1,12-3</sup> They non-observance of this principle may hinder or prevent the flourishing of feelings and spontaneous impulses, which will

negatively influence the Obstetric Nurse's way of caring.

The third conceptual dimension was defined as the ambivalence between the stereotypes of submissive and idealized woman. It is important to highlight that the female stereotype of the submissive and passive woman was also socially constructed over the years, and we sometimes do not realize that it lives with another female stereotype: the reproductive (pregnant, parturient and lactating) woman who bears life, owns the gift of motherhood, is powerful - the idealized woman. The discourse of the female nurses reveals this conflict about what it means to be a woman: sometimes they are submissive, sometimes idealized. We could identify that the interviewees let emerge feelings that evoke motherhood as an ideal for women.

*It is not necessary to take that baby away, whom, theoretically, she does not wish to have, but I think everyone wants it. When you're pregnant who would not want it? Who would not want it? (...) We are taught from birth to be mothers. (S.02)*

*I believe everything in women is easier. And in motherhood is even easier. Everything is life. (...) The woman is born to receive a gift of life, milk is life, the blood she throws away has turned into life. (S.10)*

The third conceptual dimension is characterized by the ambivalence between the stereotypes of submissive and idealized woman. In the first stereotype, the disqualification of female power is verbalized.<sup>9</sup> The denial of this power is still exercised by the media, by health institutions, by the family, among others. They inculcate in women the idea of a "supposed" imperfection of the feminine nature, in order to prevent them from fully exercising their autonomy.<sup>8</sup> These precepts were and still are present in the values transmitted in the family, as we noticed in the discourse of the interviewees.

This stereotype coexists with the stereotype of the reproductive woman (the woman-mother, the maternal instinct, the maternal function) presented by interviewees. It remains in our unconsciousness despite the fact that society keeps emancipating itself and evolving.<sup>14</sup> Taking care of these women is translated into joy and happiness due to their own reproductive ability. Women are powerful and mystical because they can procreate and give birth. This is the stereotype of the idealized woman.

Women have always played a fundamental role for the survival of the species. However,

it was only since the nineteenth century that motherhood and the mother's responsibility for her child started to be valued by society.<sup>5</sup> Some still claim that this feeling exists since the origin of human beings, but not necessarily in all women. It is a human feeling and, for being so, it is uncertain and imperfect, and may or may not be present in the female nature.

It is necessary to mention that this socially constructed panorama strongly influenced the public policies oriented to the women's health in the twentieth century.<sup>8</sup> In women's health, the health-disease process was not viewed as a social phenomenon.<sup>4</sup> Maternal health, reproductive health and feminine health were reduced to the reproductive ability of women, for the purpose of production and reproduction of social bodies as labor force.<sup>2,5-6</sup>

The docility of treating women as reproductive beings also pervaded the training of health professionals. It was necessary to inculcate the idea in health professionals that the woman-mother was a synonymous of personal fulfillment, joy and femininity, nouns that sublimate the woman as a citizen. It would be easier to impose a care model that controlled the reproductive function in order to suit the interests of capitalist society.<sup>11-2</sup>

Thus, the role of Obstetric Nurses is essential in such contexts. They can become "constructors" of rights, by providing female users with tools against the heteronomy they have always been subjected to.<sup>8,10-6</sup> For the Obstetric Nurse care and the way this care is provided contribute to increase or reduce the power to exist, i.e., the power to discover the world, to perceive it and to situate oneself in it.<sup>9,13-4,16</sup> To care is to act on the power to exist, allowing this power to flourish or to vanish.<sup>10</sup>

These women do not seem to be aware of the subliminal fragmentation implicit in the way they speak and in the assumptions they make about their bodies and about themselves. They fail to see these pictures imbued with stereotypes and are unable to resist subliminal assumptions, such as the myth of maternal love, the maternal guilt, the medicalization and the submission.

## CONCLUSION

The study evidenced the way in which obstetric nurses perceive themselves as women, as they talk about being a woman. It also reveals that, at times, they are submissive to the male world, since they use male speech, thus not seeing themselves as

subjects of their own lives. Nurses also live with two antagonistic stereotypes that are strongly influenced by values of social control of the female body, among them, the valorization of motherhood.

This worldview can influence the care relationship between professional and user. Thus, the role played by the nurse in the take care/be cared for relationship is that of the leading character, because the nurses do not recognize themselves as subjects of their own lives. This greatly contributes to not recognizing the women they care for as main characters either. Thus, they take the role of leading characters (in our view, unconsciously), and subject the users to the condition of supporting characters. The speeches of the female nurses are also imbued with stereotypes. They impose these values to the women they care for, and judge those who are opposed to it.

At women's health care sites, the gender problematic shows its complexity in the uniqueness of the lives of each one of these women. Obstetric nursing, specifically, sometimes constructs spaces of social transformation, sometimes maintains the institutional order, reproducing inequalities of class and gender in the professional-user relationship.

From this perspective, it is not enough to recognize the systems of oppression and their mechanisms of maintenance and reproduction. We propose the creation of spaces in health services for the active participation of Obstetric Nurses. Spaces where they can exchange experiences and feelings, discuss subjective topics, in order to humanize relationships and exercise the ethics of care.

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