Experiences Influencing upon the Significance of Obstetric Care in Mexican Nurses

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Objective. This work sought to learn which and how are the professional experiences that influence upon significance processes of obstetric care in nurses working in toco-surgery rooms. **Methods.** This was a qualitative study with grounded theory approach. Individual interviews were conducted with 16 nurses who work in two public hospitals in a border city in northern Mexico. Data analysis was performed according to that proposed by Strauss and Corbin. **Results.** Four categories were identified that explain the relationship established among the professional experiences and the significance processes of obstetric care; these are: *Dilution of borders and demand for interculturality, Modification in the scale of values associated to care, Institutional and public policy crises, and Violence endured within the work setting*. Obstetric care is signified within an imaginary that recognizes the existence of a globalized context, which requests problematizing the worldview not of the "other" but of "many others", and not merely from those receiving care, but also from other

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professionals who participate in institutional care. **Conclusion.** Significance processes analyzed show how the socio-historical situation and current policy require new attitudinal skills and knowledge for nursing to participate efficiently in obstetric care.

Descriptors: nursing; obstetrics; obstetric delivery; delivery rooms; experiences; qualitative research.

Experiencias que influyen en la significación del cuidado obstétrico en enfermeras mexicanas

Objetivo. Conocer cuáles y cómo son las experiencias profesionales que influyen en los procesos de significación del cuidado obstétrico en enfermeras que se desempeñan en salas de toco-cirugía. **Métodos.** Estudio cualitativo con enfoque en la teoría fundamentada. Se realizaron entrevistas individuales a 16 enfermeras quienes laboraban en dos hospitales públicos de una ciudad fronteriza en el norte de México. Se realizó el análisis de la información según lo propuesto por Strauss y Corbin. **Resultados.** Se identificaron cuatro categorías que explican la relación que se establece entre las experiencias profesionales y los procesos de significación del cuidado obstétrico, estas son: *Dilución de fronteras y exigencia de interculturalidad, Modificación en la escala de valores asociados al cuidado, Crisis institucional y de políticas públicas, y Violencia padecida dentro del espacio laboral*. El cuidado obstétrico es significado dentro de un imaginario que reconoce la existencia de un contexto globalizado que exige problematizar la cosmovisión ya no "del otro" sino de "muchos otros", y no sólo de quien recibe el cuidado sino también de otros profesionales que participan en la atención institucional. **Conclusión.** Los procesos de significación analizados muestran como la situación socio-histórica y la política actual exigen nuevas competencias actitudinales y de conocimiento para que enfermería participe de manera eficiente en el cuidado obstétrico.

Descriptores: enfermería; obstetricia, parto obstétrico; salas de parto; experiencias; investigación cualitativa.

Experiências que influem na significação do cuidado obstétrico em enfermeiras mexicanas

Objetivo. Conhecer quais e como são as experiências profissionais que influem nos processos de significação do cuidado obstétrico em enfermeiras que se desempenham em salas de toco-cirurgia. **Métodos.** Estudo qualitativo com enfoque na teoria fundamentada. Se realizaram entrevistas individuais a 16 enfermeiras que trabalham em dois hospitais públicos de uma cidade fronteiriça no norte de México. Se realizou a análise da informação segundo o proposto por Strauss e Corbin. **Resultados.** Se identificaram quatro categorias que explicam a relação que se estabelece entre as experiências profissionais e os processos de significação do cuidado obstétrico, estas são: *Diluição de fronteiras e exigência de inter-culturalidade, Modificação na escala de valores associados no cuidado, Crise institucional e de políticas públicas, e Violência padecida dentro do espaço laboral*. O cuidado obstétrico é significado dentro de um imaginário que reconhece a existência de um contexto globalizado, que exige problematizar a cosmovisão já não "do outro" senão de "muitos outros", e não só de quem recebe o cuidado senão também de outros profissionais que participam na atenção institucional. **Conclusão.** Os processos de significação analisados mostram como a situação sócio-histórica e a política atual, exigem novas competências atitudinais e de conhecimento para que a enfermagem participe de maneira eficiente no cuidado obstétrico.

Descritores: enfermagem; obstetrícia; nascimento; salas de parto; experiências; pesquisa qualitativa.

Introduction

Obstetric care has been conceptualized in different manners; one of the most accepted is that referring to it as a practical experience supported on a series of critical judgments necessary to provide humanized care to the mother-child binomial, whose final objective is for both to reintegrate the family nucleus under the best conditions of physical, psychological, and social health.[1] This care, like care in general, is a cultural and scientific practice that takes place in particular socio-historical contexts. Derived from the aforementioned, during the 21st century, obstetric care was dramatically reconfigured, becoming technological and associating invariably to higher maternal and perinatal survival. Modernization and technology also brought along socioeconomic changes that affected the transformation of society and generated direct impact on the professions, demanding the development of new skills and – even – a redefinition of the disciplinary roles.[2]

Within this context, obstetric care presented important transformations; from being a function recognized as appertaining to nurses and midwives, it passed on to being conceived as a branch associated to gynecology; from being a practice framed within principles of respect and mystique associated to being a woman, it passed on to being considered a pathological process and, in that sense, to being excessively medicalized. Stemming from this reconfiguration of obstetric care, the delivery wards are spaces to where attention has been recently drawn, indicating the existence of a social phenomenon called *obstetric violence*, a theoretical, conceptual, and legal construct that questions the pertinence of a series of health practices in violation of human, sexual, and reproductive rights, during the institutional care of pregnancies and deliveries.

Although a vast diversity of conceptualizations exists regarding what should be understood as "obstetric violence", for the purpose of this research, it is understood from the concept established by the Legislation on Access for Women for Life Free from Violence from the state of Chihuahua, Chih. Mexico:[3] "Any action or intentional omission by the health staff, which during the exercise of their profession or trade, harms, hurts or denigrates women during pregnancy, delivery. and puerperium, as well as negligence in their medical care and altering the natural process of low-risk delivery, through the use of acceleration techniques and practicing caesarean deliveries, when conditions exist for natural delivery, without obtaining voluntary, expressed, and informed consent from the woman". Social recognition of this type of violence, obligates reflecting on the sense of a series of practices that have been incorporated as part of the obstetric care provided by nursing in hospital institutions. Has modernity imposed violent actions against women during the implementation of care? Or has this always been so in reality, but there were no arguments to account for this? Which and how are the experiences that have influenced on the significance processes of obstetric care in nurses who currently work in toco-surgery rooms?

Although obstetric violence has been broadly documented, its approach has centered practically exclusively on the medical staff, associating abuse with the existence of a symbolic power exerted from the masculine toward the feminine, with sexist and androcentric profile.[4] Contrary to this, not many studies have addressed the role of nurses, even though some studies indicate that the nursing staff is identified with the greatest amount of abuse against users in the labor and delivery wards,[5] a situation that results contrary to the function of advocacy and defense of human rights that international organizations associate with nursing.[6] In that sense, the International Nurses Council establishes that it is their duty: "to actively preserve and promote the rights of all people, at all times and places … including the obligation of making sure that adequate care is provided, according to the resources available and in keeping with ethics … in cases in which nurses go into conflict between their duties and professional obligations with their employer or other authority, their primordial responsibility is with the people who need care".

The aim of this research was to learn which and how are the professional experiences that influence upon the significance processes of obstetric care in nurses who work in toco-surgery rooms. Said knowledge will permit identifying institutional and academic actions that can favor the significance of obstetric care closest to the humanism paradigm.

Methods

This was a qualitative study from grounded theory. The pertinence of conducting this study from the symbolic interactionism that supports grounded theory, stems from, for this school, that the significance things have for individuals is what determines action, which makes people respond one way or another against a specific phenomenon.[7]. The study was conducted from November 2014 to November 2016, a period during which interviews were conducted with nurses who regularly work in toco-surgery rooms from two general hospitals in a border city in northern Mexico. The decision to carry out the research in these hospitals was made because these provide care to an open population, besides being supported by the Popular Insurance program, which makes them institutions with a high demand for delivery care, given that prenatal care and delivery have no cost.

The informants were 16 nurses selected through theoretical sampling,[8] understanding such as a data collection process to generate theory and which implied, on the one hand, inviting to participate nurses who were considered due to their experiences that they would contribute significantly to understanding the phenomenon of interest, while on the other hand obligating the researchers to select, encode, and analyze through constant comparison of the findings with the theory, to find sense of that communicated. The number of informants was defined in function of the criterion of theoretical saturation,[9] that is, information collection was stopped once no new data emerged, and when the relations among the categories were well established and validated to achieve understanding the internal logic. In all cases, enough information was produced during a single approach.

The interviews were held individually and carried out by the first author, who is a nurse and PhD candidate in Nursing Sciences. To conduct the interviews and perform their analysis, the interviewer was trained during 120 h on theoretical, methodological frameworks and techniques on qualitative research. A semi-structured guide was developed prior to conducting the interviews. As the interviews were administered, the guide was improved to explore the categories identified in the constant comparison process during analysis.

The participants were contacted initially within the toco-surgery services, where a first appointment was agreed on to explain thoroughly the nature of the study and collect the informed consent. All the meetings to hold the interviews were carried out in the homes of the informants or in the university library. During the research, the consistency value was sought through systematic comparison between the results and the theoretical

frameworks identified as pertinent to interpret the findings; this theoretical construction process enabled the creation and consolidation of each of the categories developed.[10] The interviews were transcribed fully and upon completing the analysis these were eliminated to guarantee protection and confidentiality of the information provided.

The analysis was performed as proposed by Strauss and Corbin;[9] through participation from two researchers, open, axial, and selective coding was applied to the data. In the open coding, the interviews were revised several times and the data reduced to codes. The categories were obtained in traditional manner from the codes and notes on the conceptual and theoretical ideas that emerged during the course of the analysis. Through axial coding, the data were fractioned into new ways of making connections between categories and subcategories. Finally, selective coding identified a central category and its interrelations. During analysis, the note technique was used to propose the hypothesis of connections among categories and their properties to integrate these connections into other categories to generate the theory.[11]

The ethical principles contained in the Helsinki declaration and the General Health Legislation in México were considered to conduct this study, which was classified as "minimum risk" given that no techniques and methods were employed that would intentionally modify the physiological, psychological, and social variables of those participating. Their right to autonomy was respected at all times, written informed consent was requested, and identity confidentiality was guaranteed. The project was revised, approved, and supervised by the Ethics Committee of the Secretary of Health from a border city in northern Mexico (Reg. 000176).

Results

During the open coding stage, 698 codes emerged *in vivo* that after several re-readings were combined to arrive at the axial coding, where 17 subcategories emerged. In the selective encoding, similar codes or those with similar meanings and concepts were catalogued into four categories to proceed to the analysis. The categories presented ahead include narrations considered nutritious to enhance the categories developed.

Category 1: Dilution of borders and demand for interculturality

In Mexico, as in many Latin American countries, health, education, and employment services have centered in urban regions; likewise, health communication on issues of health prevention and promotion continues being conducted in Spanish, with little regard for the existence of Indigenous languages. The aforementioned implies for nurses an important challenge when providing care: *It is different when you have to care for the Tarahumara [women]; some will understand you and others will not, they hardly answer you and, well, you almost do not speak with them because that is how they are* (Nurse 11). The informants recognize that language and world vision differences place women at a disadvantage for care. The limitation lies on the fact that they cannot be understood, do not have the institutional resources to do so, or rather, the language and ethnic diversity is too broad to be addressed with the scarce resources in the institutions: *It is difficult and no way of talking to a translator; I think it's like seven different languages and they do not understand themselves, so with lots of work and you must deal with this* (Nurse 3). The high demand for care in populations from different ethnicities becomes a challenge for which the informants report not being prepared, given that they have not been trained for such and do not access refresher courses in interculturality: *Well, it is a bit more difficult because some do understand you and others do not; you do what you can, but nobody told us how ...you have to guess ...we do not know how* (Nurse 15).

Category 2: Modification in the scale of values associated to care

For nurses it is a complete challenge to live and work with professionals who, due to issues associated

to generational evolution, apply and prioritize differently values associated to care. This difference regarding the prioritizing of values when providing care is associated to their training and to the care, as well as to the profile of the academic programs in which they have been prepared as human resources for health. In this sense, the informants underscore that the medical staff is trained from a biological, mechanized, highly technical, and not very reflexive approach from the paradigm of ethics and human rights: *There are many new people [interns and residents] that yes, are very biological, and not us, we see the sensations patients have … they tell the patient everything in medical terminology and make bad expressions, and I don't agree with that; I also don't agree with questioning the patient without the privacy they deserve, they do so in front of many people and even raise their voices* (Nurse 1).

Additionally, nurses attribute this lack of values necessary to provide obstetric care, associated to the social dynamics that prevail in the contexts in which the new generations of professionals work; which produces problematic discourses as in modern youth (denominated by sociology as millennials), a series of values associated to care are prioritized differently from how it had historically been done: *They [physicians and nurses in training] need to be aware that they have a commitment with society, the discipline and the objective of reestablishing the women's health. These generations have more disposition to social interaction, dancing, and parties and that takes away from their performance; they don't have enough rest, don't have enough studies, nor the initiative or disposition, or sufficient knowledge* (Nurse 5). Additionally, they point to the institutions that train human resources as co-responsible of this crisis of values, and indicate that it is necessary to readjust the programs to enhance the skills of the new generations for humane care: *Additionally, we must start at the schools; we must impact upon the youth because I sometimes see them lost regarding what caring for another is. There is not much love for what is done… it would be combining former training adjusting it to the new; I know times change, but care never changes, because we do not stop being people and train more students who advocate for those without a voice, who make themselves heard, who have autonomy and are not intimidated* (Nurse 10).

Category 3: Institutional and public policy crises

The informants refer to the lack of conditions of infrastructure, inputs and human resources to carry out public policies that aim for the humanization of delivery care: *Because more personnel is needed, it is stressful to not have supplies to work with and you complain; and you don't give quality to your work because something gets out of control and you are always running and nobody outside knows what is happening inside, and you are running and getting things. Look, you will say these are different things, but as a whole it affects how women are cared for* (Nurse 13). They reiterate in their narrations that federal and state policies do not agree with the needs of the public institutions where they work, the most mentioned was the policy on "*Zero Rejection*", which has to do with the obligation all public and private health institutions have on guaranteeing emergency care to pregnant women or women in labor, independent of their having or not having social security. Policies, like the aforementioned, represent – according to the informants – the pressure that, even with said units being saturated, they must continue caring for women without spaces, inputs, and resources to do so: *Because we cannot reject, we as an institution and the universalization of care to obstetric patients, given that we cannot reject no one, even if you have no beds or capacity, inputs, clothing, or anything* (Nurse 1).

Another policy that emerges as a challenge from the nurses' narrations has to do with the "*Federal strategy to strengthen post-obstetric event anticonception (APEO, for the term in Spanish)*", which demands complying with specific goals in terms of coverage of Family Planning Methods (FPM) upon discharge of the patient hospitalized due to obstetric event. This demand has obligated them to establish a type of imposition for FPM use,

which they themselves identify as an attack from the framework of sexual and reproductive rights: and *the woman would say, I don't want! So... [Mentions the nurse with emphasis] Your patient must exit with a device! What do the girls do [nurses]? They start to pressure, but pressure steadily and they are not aware of the patient's culture!* (Nurse 2). In this sense, they manifest that even when they confront highly complex phenomena in their daily work, they continue focusing care on the physiological needs of the moment, omitting psycho-emotional and social needs highlighted by the clinical practice standards or guides.

The informants report that the care they provide in the institution becomes more complicated, within the framework of the Mexican health system that lacks a preventive approach and is weak in the first level of care, which has repercussions on the fact that women arriving at the institutions have a high incidence of complications and – worse – have no idea of how to participate in their deliveries: and *this should come from the prenatal consultation [psycho-prophylaxis], this should already have been asked and explained; it is a preparation, she [the woman in delivery] should already know the information, she should leave there [first level of care] informed because she did not go there [health center] once or twice, at least for the popular insurance to cover the delivery, there should five consultations* (Nurse 1).

Category 4: Violence endured within the work setting

Demystifying the image of nursing as exclusively involved with the physician's care practice has turned out to be a great challenge, according to that stated by the nurses. Although this image is being renewed, there is still a lack of openness by the medical staff to respect the professional proposals from nursing when providing care: *The interns and physicians sometimes do not want, that is, do not accept a proposal from us, I don't know, could it be because we are nurses? And they tell you, right in front of the people, so that everyone is aware that they know and we do not* (Nurse 5). The nurse-physician work relation is affected by hostile behaviors, which are manifested by intimidating and threatening actions and this, according to the informants, complicates care extremely and generates in them professional frustration: *When we are not on the same line [physician-nurse], situations arise when you remain quiet to avoid problems, but you know it is not okay, you get frustrated from seeing actions that have nothing to do with care and you have to stay quiet* (Nurse 4).

The fact that the nurses themselves experience violence and do not speak of it, report, or communicate such to their supervisors, permits accounting for the complexity in which is circumscribed their function in defense of the rights of patients. It is impossible for nurses who are not empowered to report their own experiences, denounce or advocate for the rights of the users to live their delivery processes free from actions that attempt against their rights: *The doctor treated me as he wished; that [being mistreated] affects me as a person and not only as a nurse, it frustrates me, gets me angry, stresses me, so it makes me feel like this [makes facial expression of displeasure] to care and perform my work* (Nurse 5).

Furthermore, the informants reported feeling violated when the physician boasts superiority over them; hence, they see themselves not only as witnesses to the violence, but also as victims, which affects them as persons and professionals, and is reflected on how they provide care to the women and on the relationships they keep with their colleagues: *Well, the doctors' tempers; if you say something, they scream at you in front of the patient and it is no longer the same, or some colleague having differences with you and you both get upset, it does affect, it affects because now you don't smile and you think they don't realize it* (Nurse 9).

Discussion

The objective of this research was to learn which and how are the professional experiences

that influence upon processes of significance of obstetric care in nurses who work in toco-surgery rooms. The results evidence that obstetric care is signified through a series of experiences that take place within contexts which conjugate in complex manner the reality of globalization and migration, the modification in the scale of values of current society, institutional and public policies crises, and – finally – but not least important, the trend to increased violence and its recognition within institutional settings.

Nurses currently confront demands for intercultural care that they only confronted in the rural health units. This tendency to the complexity of care from migration and globalization has also been indicated by other researchers who contemplate in it a challenge for the discipline and for society.[12] The trend to increased population mobility demands development of interculturality skills in the nursing staff, given that it is necessary to recognize and respect the different cosmogonies to understand in their complex dimension the health-disease processes; without achieving this, it is impossible to speak of genuine interactions between professionals and users.[13] The aforementioned needs to be problematized in a Mexico in which most of the curricular plans for the formation of human resources in health lack assignments that prepare future professionals in interculturality skills.[14] Thereby, interculturality results in a desirable skill no merely from the ethical-legal framework, but also from the responsibility nursing has in promoting health and communicating risk. Other researchers have documented that the health staff tends to speculate on the motivations people have to position themselves one way or another with respect to health-disease processes, establishing value judgments supported on a series of social stereotypes and are not very concerned with understanding them from an intercultural paradigm.[15] The prior situation currently represents one of the most important communication barriers for the health staff and the user population.[16]

Nurses also identify that obstetric care becomes complex in function of the existence of two social generations that share space within the toco-surgery rooms, but which provide care from very different parameters of prioritizing values associated to care. Generational changes seem to impact upon the meaning of care and not only upon that, but – in general – on the operation of organizations. Currently, Mexico faces significant changes with respect to pension and retirement policies, which has brought along that within health services professionals coexist from social generations with different perspectives on what care is and on the values upon which it must be framed. The aforementioned complicates intergenerational coexistence processes within organizations, and with it, impacts on the dynamic in which obstetric care is practiced within the maternity wards.[17]

For older nurses, the problem of inadequate care in obstetrics wards is related to personality characteristics in the current generation (millennials), which has been associated to the search for continuous satisfaction of the "ego", leaving aside contact with others and which hinders their establishing relationships of commitment with those they are in charge of, given that they relate best with technology and/or through it.[18] In turn, younger nurses report feeling frustrated upon the demand to insert themselves and adapt to professional contexts in which an institutional medical culture prevails that privileges the biomedical approach to care, after recognizing that they were educated within a nurse culture, which is less biologist and more holistic.[19]

Obstetric care was identified also associated in its meaning with the existence of a series of public policies that in discourse tend toward the humanization of the delivery, but which are implemented within contexts that in crisis do not have the necessary element to carry them out. In this sense, public policy not only creates false expectations among users, but also frustration among those who provide care, given that they do not have the necessary resources to offer that which users expect and which the State "demands", the quotations are added, given that the very State recognizes that what is proposed in

public policy has no conditions to be exercised.[20] Finally, the findings herein support the evidence from other studies, which have indicated the prevalence of violent contexts in delivery wards,[21,22] however, requiring – unlike these studies – this work views that violence is not aimed specifically upon the users, but it is also aimed at the nurses, from both the medical staff and among colleagues.

The conclusion in this study is that the meaning upon which nursing care is based within the maternity wards is dynamic and is readjusted according to what has been evidenced in this study in function of the economic, social, political, and cultural changes that prevail in each context in particular. Nurses identified as the principal experiences contributing to the re-significance of nursing care, globalization and the dilution of borders, restructuring in prioritizing personal and professional values, institutional and public policy crises, and – lastly – although not least important, the violent context experienced within the very institutions, not only against the population of users, but against the nurses themselves or their colleagues. States and their institutions – particularly health institutions and those in charge of training human resources in health – must consider that to fully comply with the expectation of avoiding incidences related to the violation of rights in maternity wards. Although it is necessary to train and sensitize the staff with respect to the theme, it is also mandatory to seek harmonious institutional environments that enable full personal and professional development; only under these conditions will it be feasible to speak of hospital environments free from violence.

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