

Taking off the lab coat”: ethnographic notes on obstetric practices in a university hospital

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Abstract: The study aimed to describe and analyze everyday aspects of childbirth care in a university hospital in southern Brazil. The expression “taking off the coat” serves as a metaphor to illuminate the process of converting the obstetrician nurse into a researcher in a hospital environment. This is a qualitative research work that made use of the perspective socio-anthropology as a theoretical and methodological framework. The results showed a recurrent lack of information about medical conduct and decisions given to women, disregarding them as subjects of rights, despite what the policy of humanization of childbirth, revealing nuances of childbirth and birth based on the model assistance technocracy. This current care model in teaching hospitals requires important changes through the incorporation of practices with scientific foundations, the inclusion of obstetric nurses and respect for women as the protagonists of this event.

► **Keywords:** University hospital. Obstetrics. Participant observation. Ethnography.

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Introduction

Excessive intervention on pregnant performed at the time of parturition is a practice that cause important and persistent effects in their lives. Unnecessary procedures routinely used by professionals in hospital birth such as episiotomy or genital mutilation and the use of oxytocin are among the behaviors considered as physical and sexual violence because they are inadequate technologies in obstetric care (SANFELICE, 2014).

In this interventionist model, supported by technocratic ideals, the woman becomes the object of action, without autonomy over the childbirth process of their babies. The abuse of procedures, sometimes extreme, generated by bodies violating practices, but also by the prohibition of expressing themselves against the veiled or explicit mistreatment of health professionals. Is usually what raises criticism of the practices of these professionals and to the process of dehumanization of pregnant that occur in the hospital environment (DINIZ *et al.*, 2015).

More than the abuse of women's vulnerability by medical staff rooted in obsolete professional behaviors witnessed by the first author's work over 25 years as an obstetric nurse, tensions related to professional identity also emerged in this process. Finding the practice itself strange and positioning oneself critically in the face of obstetric violence raised new questions about the role of nurses in a teaching hospital. "Taking off the lab coat" and becoming an observer of childbirth in that family environment allowed me to distance myself and gain a new perspective on the obstetric universe, revealing many nuances of childbirth in that environment. The phrases said by professionals considered old and experienced as "because I've always done it this way" started to echo in a different way.

Despite the changes in contemporary obstetric practices, an essential part of work remains unchanged: the professionals training who pass through this health institution. The discomfort with the objectification of women's bodies put into question the scope of medical power, the exclusive nature of their decisions and the asymmetries between the professions in the health area. In addition to exposing the "dehumanizing" face of obstetric practice, the ethnographic research revealed constitutive tensions in the field itself in which the exercise of obstetrics takes place, a discussion that this article intends to contribute.

This article is structured around two axes. The first highlights the dynamics of the Obstetric Center (OC), highlighting aspects of medical decision-making process in relation to pregnant. The effort was to understand it, based on the perceptions left by the interlocutors and taken from the field diary notes. The OC was chosen because it is considered a sensitive point in the delegation of obstetric care in the hospital. The intention was to reveal the mishaps of pregnant women who travel through obstetric centers subjected to abuses of medical-hospital staff at the time of giving birth. Next, the article deals with the tensions and consequences of “taking off the lab coat”. In particular, in seeking an anthropological view of that environment, the main objective was to carry out a study that would sensitize readers and authorities to the violence practiced against women, who, although known, still seem to be shrouded in silence and invisibility.

Methodological path

Fieldwork was carried out between January and April 2017 in a teaching university hospital (HU) in the interior of Rio Grande do Sul. The investigation is part of a doctoral thesis and was duly registered under number CAEE57867616.9.0000.5240 and approved by the Ethics Committee.

The author's prolonged coexistence with the multidisciplinary team of the OC, which includes nursing, medical, medical residents and multidisciplinary residency team, was privileged and took place in all shifts, in periods of more than 6 hours interacting with the individuals studied in this research. These interactions occurred both at the time of obstetric procedures and in informal conversations, rest periods during shifts, and other spaces outside the hospital environment, such as, for example, seminars promoted by the institution, team celebrations and festive dates. From this systematic observation of the context and behavior of people, the aim was to apprehend the interactions between the team and the pregnant in several possible dimensions. This research modality allowed the practice of “strangeness”, since, due to the link between the main author and the HU, she would be easily identified as a hierarchically superior employee in that context, which could make difficult the interaction with the research interlocutors.

The contributions of Geertz (1989), DaMatta (1978) and Tornquist (2004) on ethnographic fieldwork served as references that guided the research. As an ethnologist's

apprentice and a health professional, it was challenging for me, to exercise the double task of transforming the familiar into the exotic and vice-versa, distancing oneself as much as possible from a position of holder of specialized and technical knowledge. To this end, “taking off my lab coat” and visiting less care environments and delivery rooms, and more spaces where professionals met during breaks and changes in shifts, such as the rest room. Between one and another mate, conversations began, not only about the service routine, but also exchanges on various subjects, including general and personal issues. This promoted a certain detachment from the image of a nurse, emphasizing more the role of researcher in the field. Therefore, it took a new outfit – “no lab coat” – to start this ethnographic adventure.

Aware that the identity as a health professional of the hospital in question could not be completely erased, in the fieldwork it was important to approach professionals recently hired by a public company, who were not part of my work team. In this way, believed that they would not be impregnated with previous perceptions about the attributions as an obstetric nurse, such as the management and nursing care in the pregnancy-puerperal cycle. It was perceived that it was the right choice, as the new professionals presented the service routine as if it were for someone who did not know them. Gradually, this reintegration into a known field became stranger, and the nurse who had worked for many years, began to build a new identity: that of a researcher in a teaching hospital.

The participation of a key informant, new to the team was crucial to start the field research. This figure was a multidisciplinary physiotherapy resident who was very receptive to telling me about how the obstetric center worked. And I was introduced by the nursing staff in service as a doctoral student and hospital employee. My previous role, as a tutor and preceptor in the Integrated Multiprofessional Residency Program in Health, facilitated this approach and created a climate of trust by sharing the same experiences. Thus, the interlocutor felt free to report the various problems found in the residence, such as the lack of preceptors with direct supervision, the difficulty of implementing the program's pedagogical project, the precarious professional interaction in the work teams, caused by the character fragmentation of training, but also due to an inefficient intersectoral and interinstitutional interaction in different levels of complexity of the health system.

The idea behind “taking off the lab coat” condensed several issues in me. Issues related to the subjectivity present in the ethnographic fieldwork provoked a certain

feeling of strangeness in a comfort zone. Therefore, this metaphorical image is used as a key point for the discussion and to signal this transit between different spheres, the double insertion that operated during the research, conditioning the look at pregnant women.

Results and Discussions

The Obstetric Center

As already described, the institution where the observation was carried out, a HU, is considered one of the main scientific structures for the transmission of knowledge by medicine. The HU is considered a nodal institution of contemporary societies whose effects are felt even outside it, because it is viscerally involved with biopower (TORNQUIST, 2004). It includes professors of medicine who form the medical elite of thinkers and scientists in the scientific medical field in Brazil, exerting a strong influence on professional recognition for this specificity (PAGLIOSA, 2008).

The obstetric centers of university hospitals are units that are characterized by being references for high-risk pregnancies, but they also attend women at habitual risk. Because they have this peculiarity, they follow an interventionist line in care, that is, they base their care always on the assumption that pregnancy needs treatment and control. However, the delivery care of high-risk pregnant can incorporate practices of care for the usual risk delivery that seek not to interfere in the physiology of the female body (LEMOS, 2012). In this context of delivery and birth care, there is the university hospital of the present study, which is a regional reference in obstetric care. In 2017, that establishment had a cesarean rate of 53.3% higher than the national average of 41.9% (4). The high rates of cesarean sections recorded in recent decades in Brazil (BRASIL, 2013) can be read as a sign of the loss of women's role in the birth scenario.

Violence in obstetric practices can manifest itself in different ways. One of them is how the birth environment is arranged. The physical plan of the observed OC did not fit the important items recommended by Resolution RDC 36, of June 3, 2008, for the humanization of maternity environments, where PPP rooms are implemented (Partum, Pre-partum, Puerperium), that is, the clinical periods of childbirth are assisted in the same environment (BRASIL, 2008). It was in this place that it was observed, in the expulsive period of childbirth, a woman being forced to control

the involuntary pushing¹ so as not to give birth on the way, as she would need to be transferred to a delivery room.

Parturients lose their privacy because the environment is separated only with curtains. This generates anxiety among pregnant who are not in labor, as well as in companions who hear the moans and screams, caused by the routine use of oxytocin, and the parturients' requests for cesarean section. Under these conditions, the request for a cesarean section is often induced by fear. Even if it is a request without clarity of intention, a lack of understanding of what is "normal" for parturients was noticed. When they see and hear the use of procedures that cause pain such as oxytocin, denounced by the facial expressions of the other women, they want to shorten their time in the OC by performing a cesarean section.

This behavior was observed in women who experienced normal birth previous trauma. A case that helps to understand the nuances of this dehumanizing process is that of a pregnant who requested a cesarean section for fear of going through the situation of obstetric violence again. In 2009, she had a pregnancy with several complications that culminated in the birth of her second daughter in a traumatic normal birth. The 33-year-old woman was 36 weeks pregnant and wanted a cesarean section due to the trauma. During a conversation with the researcher, she sadly recalled: "they mended my vagina with my anus". The pregnant woman received vaginal examination by several professionals at short intervals, in addition to performing an episiotomy, without her consent. The fear that the story would repeat itself made her seek the Public Defender's Office of the Union to obtain a cesarean, as this was initially denied by the HU. According to mental health professionals at the HU who evaluated her to understand the real reason for her request for a cesarean section, she had what is called "tocophobia". This was because the patient had been forced, in the previous delivery, to push beyond her capacity for her baby born, which resulted in her teeth loosening and sexual problems with her partner.

Begging for a cesarean to escape a violent delivery is a reflection of these painful procedures attributed to the woman without need, such as episiotomy, considered a traumatic experience that leaves sequels due to the intense pain of the suture (ALVES *et al.*, 2000). Associated with this is the professionals' lack of preparation to deal with the physiological situation at the time of conducting the parturition process. This is a factor that triggers an immeasurable anxiety of feelings for women, professionals and companions who are present in that birth environment.

The choice of cesarean sections for women in the supplementary network and normal delivery for those assisted in the SUS demonstrates the difference between the proposals for women, according to their social class. However, in both cases the woman is not able to decide what she wants. This fragile woman undergoes and even requests a cesarean to avoid the physical and emotional pain caused by fears and procedures. The reversal of this situation involves the review of physician training, the inclusion of obstetric nurses in delivery place, above all, the actions that strengthen the autonomy of women (ANGULO-TUESTA *et al.*, 2003; PEREIRA; FRANCO; BALDIN, 2011).

Allied to these factors of insecurity regarding the conducts, the OC is a restricted, closed sector. To enter, you need to enter a password next to the door and there are no windows to the outside. There is cell signal only in some points, places where patients and companions do not have access. In this way, the parturient is incommunicable, which also generates tension, since they are women who abandon their chores at home or outside. It is a relatively small space, with a large number of people circulating, which makes relationships very close and, therefore, subject to wear and tear that are exacerbated even more when there is overcrowding.

Another negative and dehumanizing factor is that there is only one bathroom for all women who are hospitalized, including those who need isolation. At various times during the research, the presence of blood and secretions in the toilet was witnessed. Even so, this place was being used by parturients: first, because there was no other way at that moment and, second, because of the urgency, which resulted in the lack of time for the adequate cleaning service.

In the observation of the OC, pregnant hospitalized or waiting to be evaluated seemed confused and exhausted by the excessive approach of many people and professionals, who frequently asked for data regarding their health status. Several times, different professionals were questioned, asking questions that had already been asked, without sticking to the previous reading of the chart. Another fact that was repeatedly observed was the way of approaching, of a general cold and impersonal manner, as if they were doing the woman a favor, which could be considered a form of veiled violence.

Regarding the disagreement in conduct between team professionals in the same work shift, the following episode was observed in the OC, recorded in a note in the researcher's field diary: a doctor was in favor of maintaining the conduct for

vaginal delivery and the other wanted to refer the woman for cesarean section. The parturient did not understand very well what happened at times, she was instructed to stop eating, as there is a need for fasting time to perform the surgery, and then be instructed to resume eating. His reaction, then, was to express his dissatisfaction loud and clear: “This is a joke, someone comes here and tells me to stop eating, in a little while he says: 'you can eat'. "People go crazy in here.”

Most practices did not follow the guidelines² that were considered the gold standard in scientific evidence, which reveals a marked empiricism in the teaching-learning process. This refers to the issue of the training process in obstetrics, with several uncertainties about the roles to be performed by professionals at their various hierarchical levels, that is, the competences between residents and doctoral students who are part of the hospital's medical workforce and the staff team, composed of doctors, nurses, technicians and nursing assistants, psychologists, physiotherapists and social workers. Professional hierarchies are also sources of tension, which collaborate some health professionals to have limited autonomy for decision-making in care.

The excess of procedures considered harmful to patients, and, as already said, unnecessary in most cases, are known and recognized by professionals. The report of a doctor corroborates this statement: “There are preceptors who teach how to perform an episiotomy in all women, so it depends a lot on the professional who is teaching (P4 doctor)”.

If for the medical team the manipulation of pregnant's bodies is a training and acquisition of knowledge, for the pregnant it means discomfort and humiliation. Every unauthorized touch, repeated to exhaustion, reinforces the inequality in doctor-patient relationships. Thus, if the pregnant have their autonomy restricted in the parturition process, medical discretion is criticized by the professionals themselves who resent the absence of defined protocols to work in the services:

There is no homogeneity in the practices, the conducts are done according to each preceptor, there are no protocols (P6, nurse).

[...] but we really have very heterogeneous behaviors [...] so maybe this disturbs, combined with the lack of clear protocols and routines in the service, this also ends up disturbing [...] (P5, doctor).

The absence of protocols jeopardizes the safety of mother and child and a greater exposure to potential dangers (DAVIS, 2004), from the technological arsenal

available in obstetric centers. During the period of field observation, it was possible to verify the diversity and changes in conduct that were carried out by medical professionals, a professional category that holds responsibility for their outcome. The fact that there are professionals from other areas does not change this scenario, since there is a growing trend towards the medicalization of normal childbirth, including the incorporation of technologies without proven effectiveness.

“Taking off the coat”: tensions in the face of dehumanized births

As mentioned, my training as an obstetric nurse facilitated the entry into the field and the acceptance of the research by the individuals, but the emotional charge appears in several episodes when there was a confrontation with procedures considered unnecessary and violent practiced on the pregnant. In these moments, it can be said that there was a precarious balance between the nurse and the researcher, making the issue of estrangement necessary for the analysis of the researched universe more complex.

A dilemma was posed between intervention and understanding in the face of the drama of violence that occurs in the field of obstetric care in Brazilian maternity hospitals. Familiarity with the medical-hospital environment sometimes made it difficult to maintain the distance required for ethnographic fieldwork. In this sense, it can also be noted that the status of observer interacted with that of health professional, even though throughout the period of stay in the field it contributed to a ‘badge change’, from nurse to researcher. However, there was not, so to speak, a significant temporal distance between what was experienced as a nurse and the period in which the observation began. Therefore, it cannot be said that there was a clear distinction between the status one had before (as a health worker) and what occurred at the time of observation and after visits to the obstetric center (as a doctoral student), in search of empirical evidence to support analytical arguments.

One of those situations experienced with a lot of tension was of a pregnant who arrived at the obstetric center at 39 weeks and 8 cm dilated and had signs that she was about to give birth. The parturient was alone in the care box and, in addition, she spent an excessive amount of time with a device attached to her body,³ unable to move and feeling pain. The application of oxytocin to increase the contractions that, according to the resident, were spaced out, resulted in pain and immobility at a time when the parturient needed to be able to move freely.

Vaginal examination was always performed. Even at the end of delivery, with rotating movements, without checking the previous notes. This shows that there is no care regarding the time between each touch performed: often, they happen in very short intervals, which can be considered an abuse of the technique by students in training. The average time in labor after admission is 5-6 hours. In many cases, no more than two vaginal examinations are required, as recommended by the WHO, to conduct labor (WHO, 1996). In addition, this type of procedure needs to be recorded on a partogram, which also assesses fetal heart beat (FHB), integrity of the water bag (broken or intact), characteristics of the amniotic fluid (clear or with the presence of meconium), descent of the presentation (De Lee plan), frequency of contractions, drugs and fluids infused and analgesia, if used (BRASIL, 2001).

Excessive testing can lead to an operative vaginal delivery (forceps delivery) or cesarean section due to unnecessary intervention. In the present case, the requirement of a horizontal position and the incessant command of the residents for the patient to push beyond her body capacity did not facilitate the baby's exit at all. The medical team's decision to perform a vaginal cut in the perineum intensified the parturient's distress, which was further aggravated by the suturing without sufficient anesthesia to withstand the pain. One can imagine how much this torment could have been avoided if some of the procedures were not carried out this way, as recommended by some guidelines of the Childbirth Humanization Policy.

However, despite the ideals of Brazilian policies on childbirth and the bases of humanist thinking as premises of these policies, it is clear that in the observed childbirth, there was a high degree of interference in the physiological processes of the woman, under the allegation that such procedures were necessary to help give birth. The successive touches performed on her body, without the patient being consulted or even clarified, showed a quite naturalized form of medical power over certain bodies. In the conversation with the parturient in the postpartum period, the fragility to react against the ways in which her body was controlled was evident: "I did everything that was requested by the health professionals (...) to help us". This reveals a little of the power relations that were ongoing from her entry into the obstetric center until delivery. Probably time for this woman was of a different order than chronological. It was an emotional time, in which waiting for her child was the only thing that mattered. She seemed to give her body to the interventions without being aware of the violence perpetrated and was aware

of the medical power exercised over her body, even granting it legitimacy. The observation of the conduction of obstetric procedures in the UH corroborates the vision of Robbie Davis Floyd (2001) on the biomedical model of childbirth care based on technocratic procedures. It is thought of as a pathological event, practiced within a hospital institution, seen as a place of healing.

A study carried out with 555 women from an exhibition of photographs and videos of childbirth called “Sentidos do Nascer”(senses of being born), shows in the participants' reports that their childbirths occurred with non-consensual interventions, undignified care and resentment of not having received affection, attention, understanding and support from the team during childbirth, which can be termed a form of obstetric violence (LANSKY *et al.*, 2019). The problem of high maternal and neonatal morbidity and mortality rates, as discussed by LEAL *et al.* (2014) is emblematic of the challenges to ensure safety, dignity and respect for pregnant.

Proposals that aim at other ways of giving birth, more connected to the choices and preferences of each woman, taking into account their demands, are recommended by the Ministry of Health in the Humanization of Childbirth Policy (BRASIL, 2001). Therefore, if, on the one hand, there are guidelines that recommend the “construction of a humanistic paradigm” that would make possible an advance in the conditions of childbirth, on the other hand, systematic practices of violation of female bodies were not proscribed. They persist and are naturalized in hospital environments. Perhaps it can be assumed: is there an unavoidable tension between the dignity and safety of pregnant and specialized knowledge?

Final considerations

The realization of ethnography in the hospital formed a kind of biographical commitment with the change of a “social problem”, that of obstetric care crossed by the medicalization of pregnancy. The dual position of insider and outsider followed my researcher-nurse's entire journey, evidencing an insoluble tension, expressed in the passages in which I critically positioned myself regarding unnecessary practices, routinely performed by professionals in that context.

The distanced observation made it possible to analytically elaborate one's own experience as a health professional in another time and in another place, thus creating

a contrasting picture with the present to be analyzed. In this sense, it was also found that the status of observer interacted with that of health professional, although throughout the period of permanence in the field, it enabled living and acting as a researcher. At various times, these conflicts between the researcher and the health professional were intertwined in the investigation process of those practices and in the gaze directed at peers and interlocutors. The duty-work contained in the memory as a care professional was juxtaposed to the role of an ethnographer with a distant view, exercising the ability to relativize a given reality. Feeling what ethnographers never tire of repeating: reciprocity with the researched configurations, which transformed and transform the researcher throughout the research process. In this way, it was inevitable to experience a deep restlessness on the part of the main author and to question about the intersections between the personal and the political, subjectivity and social structure, micro and macro, research and intervention.

Practicing social distancing, experiencing a certain distance from the position of a nurse, transforming what was very familiar into exotic as DaMatta (1978) would say, evidenced the important role that reflexivity plays in the ethnographic research model. The use of the ethnographic approach as a source of data for research on obstetric practices, imposed the constant evaluation and reassessment of some presuppositions of the researcher-health professional, bringing to light the influence of autobiography in the definition of what was researched and in the development of investigation.

The approach chosen demanded the recognition of the nurse's involvement in the field, of being affected by the experience, moving away from any pretension of a neutral and impersonal point of view, supposedly supported by a more formal and predetermined research design, making use of the "ideal of objectivity."

It can be seen, therefore, in these final considerations that "taking off the coat" was a good metaphor to think about and express the impossibility of having a detached observation of the researcher's experiences and feelings, being himself part of the ethnography; they would be the unexpected guests of the research, but they need to be incorporated as rich sources for the understanding of the meanings given by the actors to the social world. Contrary to what Chazam (2005) observed, no one asked to "wear the lab coat", but on the other hand, it was not completely abandoned during the fieldwork. It would be naive to assume that previous training as an obstetric nurse did not interfere in the elaboration of the conclusions of this research.

We hope to have been able to contribute to the discussion of some methodological details of research in a hospital environment, carried out by a “native”.⁴

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Notes

¹ Parturient feels pressure on the perineum and the need to push as if she were going to have a bowel movement.

² Guidelines developed in a systematic way, aiming to assist professionals and patients in the decision making regarding the most appropriate alternative for the care of their health in specific clinical circumstances. (FIELD; LOHR, 1990).

³ Cardiotocography consists of a graphic recording of fetal heart rate and uterine contractions.

⁴ L. F. Chourabi: conceived the study, carried out the fieldwork and participated in the writing of the article. F. Cecchetto and K. Njaine: conceived the study and participated in the writing and review of the article.

Resumo

“Tirando o jaleco”: notas etnográficas sobre as práticas obstétricas em um hospital de ensino

O estudo teve como objetivo descrever e analisar aspectos do cotidiano da assistência ao parto em um hospital universitário no Sul do Brasil. A expressão “tirando o jaleco” serve como uma metáfora para iluminar o processo de conversão da enfermeira obstetra em pesquisadora em um ambiente hospitalar. Trata-se de uma de pesquisa qualitativa que lançou mão da perspectiva socioantropológica como referencial teórico e metodológico. Os resultados mostraram uma recorrente ausência de informações sobre condutas e decisões médicas dadas as mulheres, desconsiderando-as como sujeitos de direitos, a despeito do que preconiza a política de humanização do parto, revelando nuances do parto e do nascimento pautadas no modelo tecnocrático de assistência. Esse modelo de assistência vigente nos hospitais de ensino requer importantes mudanças através da incorporação de práticas com fundamentos científicos, da inclusão de enfermeiras obstetras e do respeito à mulher como protagonista deste evento.

► **Palavras-chave:** Hospital universitário. Obstetrícia. Observação participante. Etnografia.

