

Psychic workload in the process of work of maternity and obstetric centers nurses



Cargas de trabalho psíquicas no processo de trabalho de enfermeiros de maternidades e centros obstétricos

Cargas de trabajo psíquicas en el proceso de trabajo de enfermeros de maternidades y centros obstétricos

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ABSTRACT

Objective: To identify the psychic workload present in the work process of nurses working in Maternity and Obstetric Centers.

Method: A descriptive qualitative study developed with 14 nurses working in obstetric centers and maternity units of two hospitals. The data were collected through a semi-structured interview, developed from October of 2015 to January of 2016, and exploited based on Content Analysis.

Results: The results were grouped into two categories: the nurses' working process and their psychic workload; and the maintenance of (in)appropriate practices such as psychic workload, demonstrating that the psychic workload is materialized in multiple elements of the work process, passing through assignments, interpersonal relationship and maintaining inadequate pipelines.

Conclusions: It was identified that the psychic workload in the nurses' work process in the studied context is related to the perpetuation of dehumanized practices and to the challenge of maintaining humanized practices.

Keywords: Workload. Humanizing delivery. Occupational health. Nursing.

RESUMO

Objetivo: Identificar as cargas de trabalho psíquicas presentes no processo de trabalho de enfermeiros atuantes em Maternidades e Centros Obstétricos.

Método: Estudo qualitativo descritivo, desenvolvido com 14 enfermeiros atuantes em Centros Obstétricos e Maternidades de dois hospitais. Os dados foram coletados por meio de entrevista semiestruturada, desenvolvidas de outubro de 2015 a janeiro de 2016, e explorados com base na Análise de Conteúdo.

Resultados: Os resultados foram agrupados em duas categorias: o processo de trabalho do enfermeiro e sua carga psíquica; e a manutenção de práticas (in)adequadas como carga psíquica, demonstrando que as cargas de trabalho psíquicas concretizam-se em múltiplos elementos do processo de trabalho, passando as atribuições, as relações interpessoais e a manutenção de condutas inadequadas.

Conclusões: Identificou-se que as cargas de trabalho psíquicas no processo de trabalho de enfermeiros no contexto estudado estão relacionadas à perpetuação de práticas desumanizadas e ao desafio para manutenção de práticas humanizadas.

Palavras-chave: Carga de trabalho. Humanização do parto. Saúde do trabalhador. Enfermagem.

RESUMEN

Objetivo: Identificar las cargas de trabajo psíquicas en el proceso de trabajo de los enfermeros que trabajan en centros de maternidad y de obstetricia.

Método: Estudio cualitativo y descriptivo, desarrollado con 14 enfermeros que trabajan en centros de obstetricia y en unidades de la maternidad de dos hospitales. Se recolectaron los datos a través de entrevistas semiestructuradas, desarrolladas de octubre de 2015 a enero de 2016, y se analizaron los mismos a través del análisis de contenido.

Resultados: Los resultados se agrupan en dos categorías: El proceso de trabajo del enfermero y su carga psíquica; y Prácticas de mantenimiento (in)adecuada como la carga psíquica, lo que demuestra que las cargas de trabajo psíquicas se materializan en múltiples elementos del proceso de trabajo, atraviesan las tareas, la relación interpersonal y dan continuidad a las prácticas inadecuadas.

Conclusiones: Se identificó que las cargas de trabajo psíquicas en el proceso de trabajo de los enfermeros, en el contexto estudiado, están relacionadas a la perpetuación de prácticas deshumanizadas y al desafío de mantener prácticas humanizadas.

Palabras clave: Carga de trabajo. Parto humanizado. Salud laboral. Enfermería.

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■ INTRODUCTION

This study deals with the psychic workload (WL) that is present in the work process (WP) of nurses working in Maternities and Obstetric Centers (OC).

The WP encompasses a set of procedures and actions where, through working instruments, the human being operates a transformation in the object, which is subordinated to a certain purpose⁽¹⁾. In the specificity of the nurse's WP, this transitions between the development of direct care activities to the patient, family or community and the managerial responsibilities required by the organizations, at the intersection with the work processes of other health workers, producing a service marked by human interaction and affective work⁽²⁾.

The WP developed by nurses is strongly influenced by public health programs and policies that guide practices and the work organization. Assistance to the pregnancy-puerperal cycle has, as one of its guiding principles, the Prenatal and Birth Humanization Program (PBHP). The PBHP seeks the integrality of obstetric care and women's rights through the reorganization of care, increased access, quality assurance, and a minimum set of procedures⁽³⁾.

From the WPs developed by the Nurses of Obstetric Centers and Maternities, guided by the PBHP, the Workload (WL) specific to this context emerges. The WL consists of elements that dynamically interact with each other and the worker's body, generating adaptation processes that translate into wear, understood in this study, based on the reference of Laurell and Noriega⁽⁴⁾.

The adopted framework explores the interrelations between the context of the production processes and their interface with the workers' health, articulating the WL, work organization, and the WP as aspects determined by the production process, considering them in relation to the worker's body and the work context of the worker⁽⁴⁾.

The WL has different natures regarding the way it acts on the worker's body, encompassed in two groups: the WL of external materiality; and the WL of internal materiality. The first group refers to physical, chemical, biological and mechanical WL. In the second, the WL is physiological and psychic⁽⁴⁾.

The psychic WL is expressed in the relationship between the worker and the elements that constitute his work process, as the relations between the subjects and environments. These WLs only materialize through the human body in their psychic and bodily processes and can be classified in psychic overload and psychic underload⁽⁴⁾.

The psychic WL, elucidated by the theoretical referential, generates negative transformations⁽⁴⁾, that is, psychic

wear in nurses, due to the particularities and scope of this work. In this sense, it is considered that the context of restructuring the WP that is necessary to meet the guidelines of the "Rede Cegonha" can be a trigger for wear.

Based on this assumption, the need to respond to the following research question arose: What is the psychic workload present in the work process of nurses working in maternity hospitals and obstetric centers?

Even in view of the relevance of the scientific literature on the wear and tear of work contexts^(2,5-6), there is a lack of studies that address the specificities of the WL in the Maternity and OCs context; especially considering that the humanization of the child care is a major challenge, which requires the preparation of workers and respect for the true meanings of that moment, and that is when the importance of this study arises.

From this issue, the present study aims at identifying the psychic workload present in the work process of nurses working in Maternities and Obstetric Centers.

■ METHODOLOGY

This study was taken from the master's dissertation entitled: "Interrelations between the Workload Present in the Nurses' Work Process and the Effectiveness of the National Humanization Program in Prenatal and Birth"⁽⁷⁾; of descriptive cross-sectional character⁽⁸⁾, developed in the OC and Maternity of two large hospitals, located in the south of the country, being them a university hospital and a philanthropic hospital. Nineteen nurses participated in this study, including those who worked exclusively in Maternity and/or OC; and it excluded those who were away during the period of data collection, due to vacations and different leaves, or who did not act solely in these environments.

The data collection was performed through a semi-structured interview, composed of open questions addressing the identification of psychics WL in the WP and their interference in the effectiveness of PBHP, as well as the characterization of the participants. The interviews, developed from October of 2015 to January of 2016, occurred after the signing of the Free and Informed Consent Term, being performed in the nurses' work environment, on previously scheduled days. They have been recorded and subsequently transcribed after authorization. In order to preserve the anonymity of the participants, they were codenamed by the acronym E, followed by the numbering, according to the order of the interviews: E1, E2, successively.

The data analysis was done through Content Analysis. This method consists of three major steps: pre-analysis; exploration of the material; and treatment of the results and

interpretation. The pre-analysis was processed through floating reading and the elaboration of indicators used to support the interpretation of the data. After this step, the material was explored, with the data coding, from the registration units, observing its pertinence and exclusivity⁽⁹⁾.

During the treatment of the results, they were categorized through semantic grouping, beginning the interpretation process⁽⁹⁾, which was guided by the theoretical reference of Laurell and Noriega⁽⁴⁾, regarding the Psychic WL in the WP. For the discussion of the data, the identified loads were analyzed in a joint perspective from the same theoretical framework and the policies that govern the implementation of the PBHP.

The study received a favorable opinion from the Research Ethics Committee in the Health Area (RECHA) of the institutions involved under the respective protocol numbers 46/2015 and 029/2015. In addition, the aspects of THE Resolution 466/12 of the National Health Council for human research were respected.

■ RESULTS

Different elements present in the work process of nurses of maternity and OCs are in psychic WL, affecting the aspects related to its direct action, the relationship with other health workers and users, the visualization of inappropriate behaviors, among others. These aspects will be presented in the categories: the nurse's work process and its psychic load; and the maintenance of (in)adequate practices as psychic load.

The nurse's work process and its psychic load

Different aspects related to the work process of nurses in the maternity and OC sectors were revealed as psychic WL.

The work process that includes acting as manager and the difficulty to reconcile administrative and care actions were described as psychic WL. This aspect leads to the detriment of the nurse's direct role in care:

One thing that really wears me out, that exhausts me a lot, it is the leadership role, the nurse has to manage her team. So it is shift management, conflict management among team members, conflict between teams of different work shifts. [...] I often think of how I would like to be closer to the patient, listening, making the visit in the beds calmly, guiding, talking with relatives, seeing the babies and, at least half my time, was aimed at problem solving that is also the job of the nurse. [...] (E1)

If I have three pre-delivery patients, I cannot provide care, or I assist one or I manage the unit, and if I have any recovery, then I have to choose what I do, so it's not feasible. [...] we have a lot of assignments, we already attend the consultation, we already attend the obstetric surgical block, we go to surgery, we attend recovery, assist the babies, assist in the feeding, and we still have to manage, there is no way. (E5)

Sometimes I want to stay directly with the patient, but I cannot because the bureaucracy itself does not let me do that, because there is a lot of paper you have to fill in, you have to evolve, and it is a lot of paperwork, actually. The nurse became a bureaucrat, actually. Because you fill in a lot of paper and the assistance that you should give, you cannot give. (E8)

The lack of autonomy of the nurse to perform her work in the logic of the humanization of birth, through the execution of humanized practices and avoiding the exposure of women to harmful practices, was revealed in the speech as a psychic load/burden.

[...] to have to do certain things so that that woman is not mistreated wears too much. Since from not putting her on the ball because the doctor does not like it and I know that if she uses a non-pharmacological method for pain relief, he'll yell at her [...] you feel tied hands in your own work, it's too much exhausting, too much, too much. It makes you lose the will to work. (E2)

I left here crying because of the time I put the patient on the ball and that was not for me to have put. And I said: I am a nurse, I graduated and I have autonomy for this [...] (E4)

The different actions developed in order to address the emerging demands of the work context, seen as necessary for the effectiveness of the care, appear as psychic WL. Most of these actions are pertinent to support services, but end up falling, at certain moments, in the nursing process:

[...]The nurse is the "do it all"; the maintenance is with the nurse, the nurse is a social worker, a psychologist, he is everything in the team, he is the reference. So the patient's relative does not have the money to eat, and the social worker has left at five in the afternoon, but the nursing is here all the time and who does it? The nurse. So, on holiday, weekend, all these problems are solved by the nursing, because there isn't psychology, there isn't social worker, and this is a depletion, because you feel alone, you, the pro-

blem, the patient and nobody else. You have no support from anyone to solve that with you. (E1)

The heterogeneity of the postures and behaviors of the Maternity and OC workers is indicated as a psychic load/burden:

One of the major wear and tear reasons is the lack of standardization of postures within the obstetric center. What is the obstetric center routine? Is it what I want? Is it what the "A" professional wants? Because on Monday the routine is one, on Tuesday the routine is another [...] (E5)

We do not have the time to talk about things, about the way we attend here, so each one answers in a way. (E8)

The difficulty of the joint action and unison of the multiprofessional team regarding the different responsibilities of the members that make up the same also appears as psychic WL:

[...] Here there is a very big problem, the doctors run the nursing and they do not see that they are doctors and we are nurses and we are different, we have different jobs. I am not a doctor's secretary. [...] (E4)

Where there is more than one person in the team involved, where it does not depend on you alone, it gets more complicated. Depending on the goodwill of others to get your work done is exhausting. That is what affects me the most. (E11)

In the midst of the work process, the relationships among workers appear to be conflicting because of power relations:

The interpersonal relationships, I will not say with certain professionals, with doctors, with nurses, no. My big problem is the personal relationships with teams [...] it comes at a time when you end up measuring strength with people, and then when it comes time to measure strength, the one who yells, takes it, then it's something that gets me very angry. And it's very difficult for me. [...] (E5)

There is always the one that wants to rule more than the others [...] Power relations are a problem, because everyone would have to help themselves, but each one is within their square, not one wants to rule the other, because it does not work [...] (E8)

Power relations become even more conflicted when other workers are posed for coercion by the denial of the

nurse to collaborate in the execution of harmful and inappropriate practices:

[...] I was almost traded because I refused to do a Kristeller. So, because it was a very old professional in the delivery room, I was threatened to be traded if I refused to do it again. And I will deny myself and I will continue to deny it, because as long as everyone complies with it, things will continue to happen. [...] I have thought several times about giving up, because you get to work and you see that it happened again and the people were conniving again, and you see that only you are screaming for something that everyone should scream, and you see yourself alone in a sea of people doing wrong things. (E2)

The psychic WL is also triggered by the lack of recognition of the users regarding the nurse's role in the care context:

Sometimes they ask why I do not study a little more to be a doctor, sometimes they call us a doctor, then I say, "No, do not confuse me, because I do not want to be a doctor, I'm a nurse, I want to be what I am" [...] (E8)

The relations established between the woman and the experienced situation, be it gestation, childbirth or breastfeeding, accentuated by the context of social inequities that she has experienced, reveal themselves as psychic WL, since the nurse identifies in her work process that certain decisions of the woman are based on lack of orientation and in unpreparedness of the woman, going against the ideals of the PBHP:

Sometimes there are mothers who did not want that child, mothers who do not want to breastfeed, do not want anything; drug users; HIV-positive mothers who knew they had HIV and did not go through treatment during the gestation by choice and are not going to treat that child at home later. So there are critical situations that we face and that we do not like. You know that kid's going to get out of here, he's going to have a lot of trouble in life, and we do not like it. (E1)

One thing we should always advise about is breastfeeding, but they do not want to breastfeed, you want to guide them, you want to explain to them, but they do not want to, and that discourages us. (E8)

Some of them say, "I want to have a cesarean, I cannot take it anymore", but it's not like that, [...] they do not want to know about a humanized birth, they want the cesarean

because they do not want to feel the pain. So, you explain this to some women, and it's complicated, because they do not want to feel pain, they already come here saying that they want a cesarean and that's it, and then you try to talk, because that's not the way it is, because the cesarean is a risk, it is a risk to you and a risk to the baby, because you will be numb, because you do not know what may happen. [...] (E8)

Aspects regarding the operation of support services and lack of materials are psychic WL:

[...] Support services is another thing that we do not have, and it is another burden [...] I get to the end of the day and I am exhausted because I begged for the sanitation to clean the bed, I begged the laundry to give me a sheet, [...] it's all like that. It looks like you beg people's favor. Then you have to explain to that mother as if it was your fault, apologizing, and you have to justify yourself as if it was your fault. (E1)

When there is a bad baby, who was born bad, you also get very stressed, because sometimes you do not have the materials that you need, you do not have a respirator, you do not have an incubator, it is very tiring. (E8)

The maintenance of (in)adequate practices as a psychic load

The execution of inappropriate, harmful or ineffective practices during birth care reveals itself as psychic WL to nurses. Among the mentioned aspects are the unnecessary interventionist behaviors, fomented by the lack of knowledge of the users:

[...] having to watch unnecessary cesareans happening all the time and I cannot do anything [...] and the misguided moms think that's right, and that ends up wearing you out, because you're seeing a woman tell you something that you know is not true and that if you say the right thing to her, she will tell you: "Of course not, he saved my life and my daughter's life." (E2)

It bothers me to see the doctor cutting an episiotomy unnecessarily, because the baby has not come down yet, he cannot see if he needs it and he has already cut it. [...] (E4)

The adoption of disrespectful and vertical positions, in which the worker becomes the owner of knowledge, corroborating with the subordination of the woman, configu-

res psychic WL, potentialized by the devaluation of rights and autonomy:

The wear regarding the women's rights not being respected I realize in the OC, and this brings me wear, yes. I feel uncomfortable several times because I think the patient is not being treated the way I think she should; the way I would like me to be treated if I were the patient, so I think that the autonomy of the women and respect for the person as a human being is often lacking. It comes before respecting the women; it is respect for the human being. There are things you see that you do not believe. That bothers me a lot there in the OC. [...] (E1)

I think the way doctors do it wears me down a lot; it gets in the way a lot. [...] I see that they do not have the patience to perform a birth here [...] so they subject women to going through things they do not have to go through. (E4)

While I realize that the autonomy of women is not being taken into account in the sense of protecting the health of the women and the baby, it is okay, but, when I see that it is a hierarchical power issue, it bothers me [...] When it involves a question of power: "I'm going to do it because I'm so-and-so and I want to do it, because I'm the boss here," it annoys me a lot. It makes me very angry. (E5)

It's difficult at the time of the delivery to say to a patient, "do not scream", and there are professionals who do it here, I see it's like this, it's a horror, I do not think we should shut them up, ask them not to scream [...] (E8)

Because of the context in which some workers place themselves higher than the user, the nurse adopts protective measures to prevent the patient from being exposed to non-recommended practices and obstetric violence:

[...] Depending on who is on call, and if the woman is well informed, empowered, I sometimes have to tell her: "Hold your information a little; otherwise he'll treat you badly." (E2)

The lack of rights to the user with regard to the presence of the companion is pointed out as psychic WL:

We know that the familiar can follow; there are signs saying it there and I'm tired of seeing, "no, no, you're waiting outside," speaking in a tone that people are even afraid of; "if there's anything we call you," pushing him with a pat on the back. (E1)

However, the presence of the companion can also become psychic WL, especially when they present fragilities for the experience of the moment of birth:

[...]The patient was already very calm and her husband was in panic, it seemed that he was going to give birth. So this creates a workload because you end up being stressed, because you are seeing that person is going to faint, you know that person will faint, but he insists that he wants to stay there. And we cannot prevent obviously, I cannot prevent, nor will I prevent. [...] (E2)

■ DISCUSSION

The psychic WL appeared in multiple elements that permeate the work process, being, above all, sources of stress directly related to the dynamics and organization of this process⁽⁴⁾, with a strong bias inherent in nurses' work, such as management and care, as well as aspects related to the humanization of birth. Emerging ethical dilemmas of the WP, effected through fragilized interactional contexts, have also proved to be psychic WL, however, such aspects will not be discussed by extrapolating the purpose of this research and they deserve better detail and further study in later researches.

The need to act in parallel between management and care actions can be understood, in the context of the speeches, as a psychic overload. According to the adopted framework, the psychic overload is caused by situations of prolonged tension, such as a load that is characterized by exceeding the conditions for the maintenance of the psychic balance⁽⁴⁾.

When perceiving the managerial and assistance demands that overcome their immediate capacities, the nurse is faced with the need to prioritize actions to the detriment of others, characterizing the split of these two dimensions of the work process, also revealed in the literature⁽⁵⁾. This context is based on an everyday work based on criteria of better performance, flexibility and versatility⁽²⁾.

The multiplicity of functions of the nurse prevents them from developing activities directed to the care, a fact that can be understood as promoting the distancing of the purpose of this worker's work⁽⁶⁾. In this perspective, there are demands emerging from the context of the work that relate to nursing care, but which are not, in essence, attributions of the nurse, but rather of the support services. This range of tasks widens the range of elements that cause psychic wear and disrupts the development of the WP of these workers, who are imbued with attributions beyond management and care practices.

Failure to provide material grants and assistive technologies necessary for the implementation of practices that permeate the nurse's WP during care⁽⁶⁾ also reveals itself as psychic WL. This aspect permeates the impracticability of the execution of different actions, be they of high or low complexity, affecting the assistance, bringing risks to the users and compromising the management of the emergencies experienced in the context of maternity and OC. The psychic WL related to the lack of material resources may also be related to the nurse's responsibility for such aspect, since the management of the subsidies used in the assistance is one of the duties of this worker⁽⁶⁾.

The organization and management of the work in health are elements that, at times, distract the nurses from the users, this being a characteristic that meets the satisfaction at work⁽⁶⁾ and the one recommended by the PBHP⁽³⁾, translating into psychic WL. In this sense, the literature reveals that nurses are concerned with management from its negative aspects, from the difficulties associated with the function⁽⁵⁾ and from the lack of social recognition of its practice^(2,5).

The psychic WL concerning the lack of visibility of the nurse and the poor recognition of the profession by the other workers of the health team and the users, seems to generate negative implications to the work context, manifested through the dissatisfaction and lack of motivation, besides the establishment of bonds of trust and implying the effectiveness of the quality of care⁽¹⁰⁾.

The lack of visibility of the nurse within the multi-professional team⁽¹⁰⁾, associated with the establishment of ineffective communication processes among these workers, culminates in the absence of nurse's autonomy. Thus, the nurse feels suffocated in their proposals for changes⁽¹¹⁾, developing assistential practices that translate into delegated activities, routinely, mechanically and repetitively, maintaining limited decision space, creation and mastery of knowledge, typical of the dominated professional work⁽¹²⁾. This conjuncture refers to the existence of the psychic underload, described by the referential adopted as caused by the limited use of the worker's knowledge and skills, which prevents them from developing their work in all its potentiality and manifests itself through the loss of control over it⁽⁴⁾.

In the context of the lack of autonomy, conflict situations arise in a scenario of attitudinal restraint or by the depreciation of the other, of their thoughts and propositions⁽¹¹⁾, anchored in the power relations between workers. Such conflicts disarticulate the actions during the development of the birth assistance, giving place to the execution of inadequate or ineffective practices, in which the actions

can sometimes be antagonistic and opposed to the one recommended by the PBHP⁽³⁾.

It is emphasized that, in order to guarantee the integrity of the assistance, it is essential to develop teamwork⁽³⁾. However, the work process of the different agents promoting care is organized in a fragmented way, with fragile articulations. Teams tend to develop their work process based on the individualization of actions, without the space defined for activities that integrate different workers, fundamental for the organization of a work process that favors the integral care⁽¹³⁾, and that is in line with the PBHP⁽³⁾. This causes the assistance and autonomy of the users to be compromised and the conflicts between the workers are accentuated.

Conflicts stemming from the disarticulation of practices may be a consequence of the lack of institutional protocols with respect to conduct, allowing for the adoption of divergent and dehumanized practices. However, the personal stance adopted by some workers, - preventing the establishment of respectful interpersonal relationships among them, as well as co-leading to collaboration in the development of inappropriate practices - accentuates conflicts and fosters the lack of autonomy, causing psychic wear, which may interfere in the assistance.

The interpersonal relationships developed between the nurses and the users are also found in psychic WL, especially when the woman's position contrasts with the guidelines given by the nurses and with what is recommended in public health policies for the pregnancy-puerperal cycle, such as the PBHP⁽³⁾. However, when he is involved in this WL, the nurse seems to be limited in his perspective, not visualizing that, in choosing not to follow the guidelines, the woman is exercising her autonomy, even if based on disinformation and unpreparedness.

The impediment of the exercise of women's autonomy also reveals itself as psychic WL. In this case, the psychic WL is related to the position adopted by other health workers, who disrespect the decision of the woman, through verticalized interpersonal relationships.

The limitation of the autonomy of women is achieved through the authoritarian position assumed by the workers, who present themselves as owners of truth and knowledge⁽¹⁴⁾. This mechanism of subordination and oppression assumed during the care to the birth is accentuated by the resignation originating from the ignorance about the physiological process of the delivery by the women⁽¹⁵⁾.

In the traditional model of birth care, which takes the physiological character of the birth, making it a medical procedure, workers and women experience labor in different ways. This is because this care model ignores the

real meanings that women give to the experience of pregnancy and childbirth. Thus, in the relationship between workers and users, it is quite evident the different way in which issues related to childbirth are faced by each of these actors⁽¹⁶⁾.

In the lack of autonomy construct, there is intense routinization of inadequate, clearly harmful or ineffective behaviors. These include: the indiscriminate use of intravenous oxytocin and routine use of episiotomy, among others, without the information and prior consent of women⁽¹⁷⁾, co-substantiating obstetric violence⁽¹⁸⁾. These positions have historical roots, based on a biological model that fragments the body and the needs of the woman, and still today they are revealed in the birth care⁽¹⁹⁾. The visualization of these practices can be understood as triggering of intense stress, being able to configure psychic overload⁽⁴⁾.

However, nurses reveal that they sometimes limit women's autonomy in order to prevent other healthcare workers from adopting inappropriate practices during the care of the user. This practice contrasts with the one advocated by the PBHP regarding the preparation of women during the prenatal period, for the exercise of autonomy during birth⁽³⁾. This seems to reveal a lackluster and subordinate position of the nurse in relation to other professional categories that, instead of helping women to exercise their autonomy, foment the women's mechanisms of oppression and submission.

This same aspect can be observed when one perceives the disrespect to the right of the woman in relation to the presence of the companion. The professionals are resistant to the presence of the companion, and his insertion often ends up depending on the medical authorization. Failure to allow the presence of the companion is justified by the lack of workers in order to provide adequate care for the parturient and accompanying persons at the same time⁽²⁰⁾. In this sense, the presence of the companion configures psychic WL, as revealed by the nurses.

Although the presence of the companion is valued, in view of the real benefits that it can provide for women, with highlights for safety, comfort and tranquility, there is a restricted view among health workers. The presence and participation of this new social actor are often not understood as a right, but rather as something that would require previous preparation and minimal knowledge about the birth process, so as not to interfere with the assistance offered. In this perspective, the companion is seen as an agent that should not be involved in the birth scenario because he may interfere in the work of the health team⁽¹⁷⁾. This position does not consider that many women plan, during the entire gestation, the participation of a parti-

cular person to give her the support that she wants and needs to receive⁽²⁰⁾.

■ FINAL CONSIDERATIONS

This study allowed us to identify that the psychic workload present in the work processes of nurses working in Maternities and OCs are directly related to the elements that make up the work process, as well as the perpetuation of dehumanized practices and the challenges in maintaining humanized practices.

Regarding the WP of the nurse, stood out as psychic WL: the difficulty of reconciling the administrative and assistance functions, the multiplicity of actions, the lack of autonomy, the difficulty of working as a team, power relations, conflicts, non-standardization of care behaviors, poor visibility and social recognition of the nurses' practice, the postures adopted by the users in the exercise of their autonomy, the demands related to the functioning of the support services, and lack of materials.

Regarding the maintenance of (in)adequate practices, the psychic WL is related to the execution of inappropriate, harmful or ineffective practices during the birth care; the adoption by workers of disrespectful and vertical positions; and the restriction of women's autonomy and rights as a protective measure or as an imposed practice.

A limitation found in the study refers to the magnitude of the problem analyzed, which raises more extensive investigations. It should be highlighted that this study was performed in two hospitals in the country; thus, the reality portrayed in the research, reveals perceptions of nurses' experiences, configuring a small universe in the work process of the national nursing. However, it is believed that the reality studied in this research is capable of portraying, although with singularity, the main psychic WL in the studied context.

The present study contributes to the area of health services management and to the elaboration of public policies and programs, since it reveals dissonances regarding the parturition care, which meet the PBHP recommendations and possibly bring psychic exhaustion due to the realization of a uniform WP among workers. Not only does it provide subsidies for managers to act on a planned transformation of the WP, according to the needs of the health team, in order to solidify the welfare practices in a humanized way. In this sense, it is suggested the elaboration of assistance protocols that direct and standardize the assistance to the parturient.

Considering the comprehensiveness of the psychic WL in the WP of nurses of OCs and Maternity, it is suggested the development of new studies in order to find alterna-

tives to attenuate the elements of the WP that cause wear and promote the implementation of practices proposed by PBHP, respecting women and their autonomy.

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