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## STRATEGIES OF POWER IN THE CONTEXT OF CARMELA DUTRA MATERNITY HOSPITAL - FLORIANÓPOLIS-SC (1956-1986)<sup>1</sup>

Vitória Regina Petters Gregório<sup>2</sup>, Maria Itayra Padilha<sup>3</sup>

<sup>1</sup> This manuscript presents the results of the thesis - *A historicidade das práticas de cuidado na Maternidade Carmela Dutra (1956-2001)* [The historicity of the care practices at the Carmela Dutra Maternity Hospital (1956-2001)], presented in the Nursing Graduate Program at Federal University of Santa Catarina (UFSC), in February of 2011.

<sup>2</sup> Ph.D. in Nursing. Professor of the Nursing Department at UFSC. Santa Catarina, Brazil. E-mail: [vitoria@ccs.ufsc.br](mailto:vitoria@ccs.ufsc.br)

<sup>3</sup> Ph.D. in Nursing. Associate Professor of the Nursing Department at UFSC. Research with the CNPq. Santa Catarina, Brazil. E-mail: [padilha@ccs.ufsc.br](mailto:padilha@ccs.ufsc.br)

**ABSTRACT:** The objective of this study was to analyze the power strategies within the context of the Carmela Dutra Maternity Hospital (Florianópolis, Santa Catarina, Brazil), in the period between 1956 and 1986. This is a qualitative study using a socio-historical approach. Eight nurses were interviewed using the Thematic Oral History technique. The data were categorized using Thematic Content Analysis and based on the Foucauldian framework. Three categories emerged: the power in the birth space; using the uniform as a power strategy; and the medical visit: a space of power-knowledge. The results indicate that the nurses' work in the maternity hospital helped to consolidate their professionalization, thus showing the movement and flexibility of power. Everyday, within the institution, nurses deal with disputes, interests and repressions that are rooted on social, cultural and political contexts, revealed within the care practices.

**DESCRIPTORS:** Obstetrical nursing. Nursing history. Care.

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## AS ESTRATÉGIAS DO PODER NO CONTEXTO DA MATERNIDADE CARMELA DUTRA - FLORIANÓPOLIS-SC (1956-1986)

**RESUMO:** Este estudo objetivou analisar as estratégias do poder no contexto da Maternidade Carmela Dutra, Florianópolis, Santa Catarina, Brasil, no período de 1956 a 1986. Pesquisa qualitativa com abordagem sócio-histórica na qual foram entrevistadas oito enfermeiras, utilizando a técnica de História Oral Temática. Os dados foram categorizados utilizando-se Análise de Conteúdo Temática e com base no referencial foucaultiano. Emergiram três categorias: o poder no espaço de parir; o uso do uniforme como estratégia de poder; e visita médica: espaço de poder-saber. Os resultados indicam que a atuação da enfermeira na Maternidade foi consolidando sua profissionalização, evidenciando o movimento e a flexibilidade do poder. A enfermeira convive no cotidiano da instituição com disputas, interesses e repressões enraizados nos contextos sociais, culturais e políticos revelados no interior das práticas de cuidado.

**DESCRIPTORES:** Enfermagem obstétrica. História da enfermagem. Cuidado.

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## LAS ESTRATEGIAS DE PODER EN EL CONTEXTO DE LA MATERNIDAD CARMELA DUTRA - FLORIANÓPOLIS-SC (1956-1986)

**RESUMEN:** Este estudio tuvo como objetivo analizar las estrategias de poder en el contexto de la Maternidad Carmela Dutra, Florianópolis, Santa Catarina, Brasil, durante el período de 1956 a 1986. Investigación cualitativa con abordaje socio-histórico. Fueron entrevistadas ocho enfermeras, utilizando la técnica de Historia Oral Temática. Los datos fueron categorizados utilizando Análisis de Contenido Temático, con base en el referencial foucaultiano. Emergieron tres categorías: el poder en el espacio de parir; el uso del uniforme como estrategia de poder; visita médica: espacio de poder-saber. Los resultados indican que la actuación de la enfermera en la Maternidad fue consolidando su profesionalización, evidenciando el movimiento y la flexibilidad del poder. La enfermera convive en el cotidiano de la institución con disputas, intereses y represiones arraigados en los contextos sociales, culturales y políticos revelados en el interior de las prácticas de cuidado.

**DESCRIPTORES:** Enfermería obstétrica. Historia de la enfermería. Cuidado.

## INITIAL CONSIDERATIONS

Analyzing the power strategies constructed in the relationships within the hospital context is one way to reveal the everyday care practice developed at the Carmela Dutra Maternity Hospital (CDMH), located in Florianópolis, Santa Catarina. Several authors have discussed about the power relationships established within the contexts of health institutions, among the various professionals practicing at that location.<sup>1-3</sup> Through their knowledge and practice, the different health professionals or specialists produce specific territories which imply certain orders connected to specific knowledge mixed with strategies and games of power.

According to the Foucauldian perspective, power strategies refer to the "set of means used to operate or maintain a power device. One can also refer specifically to the strategy of power relationships as they comprise forms of action regarding the possible, occasional, and expected action of others".<sup>4:152</sup>

This movement can serve to improve the workers' productive capacity and control their behavior, strengthening the relation of docility-utility, thus promoting the management of the individual and making him/her disciplined.

Discipline is a technique of the exercise of power. If we revisit history, we would find discipline in ancient ages; however, in the 18<sup>th</sup> century, the fundamental principles of this practice were improved into a new technique to manage men. Discipline is the analysis of the setting, the inclusion of bodies within individualized and classificatory spaces; it exerts a meticulous control over activity, implies constant surveillance of the individual and involves a continuous record of activities. Therefore, discipline is a set of techniques used in power systems in which individuals are both the target and the outcome. It is the power of individualization that has examination as its main instrument.<sup>5</sup>

The object of analysis in the present study is the CDMH, open on July 3<sup>rd</sup>, 1955. However, due to the lack of personnel, the institution only started providing services to parturient women and newborns in February of 1956. CDMH was built with the purpose to provide care to the indigent population. The name is an homage to Carmela

Leite Dutra, the wife of the then president of Brazil, General Eurico Gaspar Dutra (1946-1951).

In February 1956, the first professionals who occupied the CDMH settings were the Sisters of Devine Providence, physicians, midwives and professionals trained at the institution. Subordinated to the Department of Health and Social Work, the administration and organization of the CDMH was performed by the Sisters of Devine Providence, with Sister Hortênsia, as the Mother Superior, and physician Biase Agnesino Faraco as the main director.<sup>6-7</sup> In April of the same year the first sister nurse joined the staff, Sister Cacilda Hammes,\* who worked until September of 1957. Other nuns followed her in the Maternity Hospital, such as: Sister Lúcia Boing, Sister Rita Rigo, Sister Áurea Schmitz, and Sister Cacilda returned in 1966. The staff arrangement of sister nurses was changed in 1968, when their contract with State Government ended, and, thus, they left the institution.

From there on, the coordination of nursing services was performed by practical nurses, but in the Delivery Rooms the care practices were still organized by physicians and midwives; the latter were trained at the institution or attended a physician-guided midwifery training course at another maternity hospital in the city. In 1973, when the first obstetrical nurse joined the staff in the Delivery Room, the dispute for spaces and power strategies becomes evident, showing the mobility that exists in the power-knowledge network.

In 1974, when the obstetrical nurse left the team, other general nurses became head of the Delivery Room, but without any influence over midwives, who, at a greater number, organized the service with the approval of the obstetricians. In 1985, another obstetrical nurse is included in the Delivery Room team, and a new organization is observed, with new forces working in the power network. In 1986, the nurse profession is made official,<sup>8</sup> and, thus, there was a restriction to the practice of midwives, hence a new staff arrangement emerged in the Delivery Room, resulting in a more flexible power-knowledge network. Since then, many other events and ruptures occurred within the context of the Maternity Hospital.

It is observed that the history of the CDMH and of the individuals responsible for the care

\* The nuns are identified by the names they received from the Congregation of the Sisters of Devine Providence.

underwent several changes throughout the studied period, and power strategies were used to make those changes. These observations are what encouraged us towards studying the topic; hence we herein propose to analyze the power strategies within the context of the Carmela Dutra Maternity Hospital, in Florianópolis, Santa Catarina, Brazil in the period between 1956 and 1986. Therefore, the time marker contemplated the initial period of 1956, with the entrance of the first nurse in the CDMH, Sister Cacilda, and the final period of 1986, when nursing became a regulated profession. Although the historical period is long (1956-1986),

it is justified by the small number of nurses at the institution. Until around the first half of the 1970's there was only one nurse in the staff at the CDMH.

## METHODOLOGY

This qualitative study was performed using a socio-historical approach. Data collection was performed using the Thematic Oral History technique.<sup>9</sup> The participants were eight nurses who worked at the CDMH between 1956 and 1986. Chart 1 lists the subjects' identification, in the order of their entrance to the institution.

**Chart 1 - Identification of the study subjects. Florianópolis-SC, 2011**

Sister Cacilda	Head of Nursing. Nun of the congregation of the Sisters of Devine Providence. Remained in the institution from April to September of 1956 and from 1966 to early 1969. She was the first nurse to work in the referred maternity hospital.
Nilsa	Head of Nursing; entered the CDMH in April of 1968, transferred from the Children's Hospital. Remained until June, 1972. Graduated by the <i>Madre Justina Inês</i> School of Nursing, in Caxias do Sul, RS.
Coleta	Head of Nursing and Head of Nursery, from January of 1972 to 1974. Newly graduated from the Federal University of Santa Catarina (UFSC).
Ana Maria	Head of the Delivery Room and Obstetrical Inpatient Unit. First Obstetrical Nurse to work at the CDMH. Remained in the institution from June of 1973 to August of 1974. Obtained a specialist title at Federal University of Rio Grande do Sul (URGS) in 1972.
Doraci	Head of Nursing. Remained in the institution from March of 1976 to April of 1979. Graduated by <i>Madre Leonor</i> Nursing School, in Curitiba, PR. Had worked at the Florianópolis Hospital.
Evanguelia	Head of Nursing and Head of the Rooming-in Unit. Newly graduated from UFSC, remained in the CDMH from July of 1976 until April of 1999. She returned to the Institution as the Director from 2001 to 2002.
Sônia	Head of Nursery. Worked from May of 1979 to September of 2007. Newly graduated by UFSC.
Odaléa	Head of the Delivery Room. Entered the institution if February of 1985, and remained until 1993. She was the second Obstetrical Nurse to work in the institution. Graduated by UFSC. Transferred from the Joinville Regional Hospital. Obtained a specialist degree by <i>Universidade do Vale do Itajaí</i> (UNIVALI), in 1988.

The interviews were performed between February and July of 2009, using the snowball technique<sup>10</sup>, until achieving data saturation. The subjects determined the locations of the interviews, which lasted in average three hours and were recorded using a digital device. The recorded interviews were transcribed, and validated between July and September of 2009. Other documental sources were also used, such as: newspaper, shift-exchange records, occurrence records, and photographs. The data were organized using the Thematic Content Analysis technique.<sup>11</sup> Data analysis was founded on the theoretical-philosophical

framework of Michel Foucault, who established a dialogue with contemporary philosophical and historical grounds when pondering on events in the past, from the perspective of shedding light on history to interpret it.<sup>12</sup> Foucault's books "Discipline and Punish"<sup>13</sup> and "Microphysics of Power"<sup>4</sup>, which address the disciplinary power, were the fundamental references for the data analysis.

Three categories emerged from the data analysis: the power in the birth space (space of discipline); using the uniform as a strategy of power (disciplinary power); and the medical visit: a space of power-knowledge (the examination).

The research proposal was approved by the Ethics Committee on Human Research at UFSC under protocol number 003/09. All participants signed the Free and Informed Consent Form and the Cession Letter regarding the interview and the use of photographs, according to Resolutions 196/96 and 251/97 of the Brazilian National Health Council. The nurse participants were identified by their first names, upon their authorization, followed by their date of entrance to the Carmela Dutra Maternity Hospital.

## RESULTS AND DISCUSSION

The analysis of the interviews revealed three categories regarding the power strategies within the context of the CDMH, as described below.

### The power in the birth space (space of discipline)

In this category we focused on the Delivery Room, a setting where physicians, nurses and midwives performed activities that most clearly denoted relations of power-knowledge, fights and resistances, aiming at assuring a professional space, and the hegemony of power of some over others.

Based on the Foucauldian perspective, we understand that power is not property or a privilege of no individual or social class. Power is relational and is present in the social body. Power does not result from an achievement, but from a continuous and diffuse fight; it does not present a fixed configuration, permitting an inversion in its relations. New subjects emerge with new powers and knowledge, showing that the relations of power are in constant movement. Power is something that propagates, and only functions within a network.<sup>5,14</sup>

From this perspective, we aim to analyze the strategies of power that occurred in the Delivery Room of the CDMH, based on the premise that the setting involved conducts, procedures, norms and the control of the professionals' practice. It was possible to observe how power emerged within the care practices, where it circulated, manifested and became effective. The nurses' discourses evidenced some of the power strategies that occurred within that context.

*Until my arrival, there wasn't a nurse responsible for the obstetric center, the physician on duty and the resident physician were the main references, but the midwives were very much free from any management in this department. Therefore when I assumed, I had the*

*pleasure to feel I was respected, but also the displeasure of having to deal with the midwives' resistance [...]. Like I said, there were only three resident physicians and I always turned to them to solve my doubts, [...]. They [the residents] alerted me: the midwives know a lot about the practice but they lack scientific groundings. You are very young and you are starting in the profession; if you ask them, perhaps they won't understand this and think you don't know anything (Ana Maria, 1973).*

The inexperienced obstetrical nurse was concerned about strengthening her power in order to manage the nursing service, after years of power by the sister nurses. Without that power, an obstetrical nurse would never withstand performing deliveries and competing with physicians and midwives. Therefore, in order to strengthen the nursing service, and, consequently, her power, it as necessary to form an alliance with physicians, as they were stronger than midwives.

*[...] the residents often supported the midwife; they didn't criticize very often. The midwives' work was reduced because they would come and perform the delivery, but they (midwives) knew a lot more than them (physicians). They (midwives) taught them (Doraci, 1976).*

It is observed that nurse acknowledges the midwives' practice, despite the physicians' recommendation for nurse to not become close to midwives. The physician needed to absorb the midwives' knowledge and did not want the nurses to obtain it.

*I sometimes avoided going in with the midwives. I usually entered the delivery room with the residents, because I observed that despite the competence that the midwives had regarding the practice, in terms of theoretical knowledge [...] they were somewhat limited [...]. Sometimes I remember situations in which the midwife left the woman in a gynecological position and went to answer the door, and I, as a nurse, was the one who felt accountable for the service, so I would come over and say 'look, you can't do that, what if the birth progresses and the newborn falls?' [...] Then, sometimes they would say, right to my face: 'Right, but since you are a nurse and head of the service, why don't you come in for the delivery?' [...] so a lot went by unquestioned, because in some cases there was no produced knowledge about it. In fact, at the time we followed a practice according to the treaty of obstetrics, called Neme e Rezende, which also recommended shaving and performing an enema in every woman. We did not have scientific publications, or at least we did not have access to it because international literature is where it was informed it was not a beneficial practice (Odaléa, 1985).*

It is detected that the nurses used a strategy to strengthen the medical power in the care to birth and delivery in the hospital setting. The statement shows the alliance established between the nurse and the physicians through her recognition of their knowledge, which, in fact, she included into her practice. Nurses did not recognize the midwives' knowledge and started to adopt the medical model of care to women in labor.

These statements reveal the micro relationships between nurses and midwives and nurses and physicians, and how they established micro powers in their everyday practice. The midwives' power is observed by their practice and the dispute for space when the obstetrical nurse steps in. The nurses recognized the importance of scientific knowledge for the development of the activities, and also recognized the physicians and their knowledge, because they competed with the midwife in delivery care and wanted to stand out as the head of the department. It is realized that at the CDMH, before nurses were included in the Obstetric Center, all the decisions related to the care were divided among midwives and physicians. The physician recognized the midwives' practice, but not their knowledge, as they admitted there was a lack of scientific knowledge. However, the nurse reports that the midwife was often the one who taught the physician, because of their greater practical experience, which assigned them a certain power in the Delivery Room. This shows that the power in the Delivery Room, in that historical moment, was not centered on the physician or the nurse, but circulated among them, guided by the midwives' practice.

As the head of the Delivery Room, the nurse solved her doubts in the obstetrical field with the physicians, who, with time, took over the practice of midwives, expanding their space of power. In the case of the nurse, the "real" discourse, that is, "types of discourses that professionals agree with and make work as something real",<sup>15,86</sup> started to be constructed based on medical knowledge.

But the nurses began to feel uncomfortable with some women's care practices that opposed their objectives of providing risk-free nursing care. As a power strategy, she sought to update her knowledge through specialization courses, also as a way to expand her knowledge in the field of obstetrics and obtain the legal support for her practice, which agrees with the Foucauldian<sup>5</sup> view that subjects can change the power relationships, or react to them. To fight with the physician, she

needed to obtain specific nursing knowledge.

In 1986, nursing became a regulated profession through Law 7,498, including the practice of obstetrical nurses.<sup>8</sup> At that time, in Santa Catarina, there were no regular specialization courses, which took place with about a five-year interval.

However, despite the efforts made to prepare specialist professionals, there were difficulties regarding their freedom of practice,<sup>2</sup> which suggests that in the birth space crystalized power relationships circulate, rooted on the growing centrality of the physician figure.

Within this context, it is observed that several strategies are used to strengthen the power of the physician as well as of the nurses. Regarding the physician, the first was the entrance of the nurse in the Delivery Room, disputing space with the midwife; the second was convincing the nurse that the midwife was not qualified to care for women during labor; and, finally, having the nurse as an ally and defender of their practice and knowing what was absorbed from the midwife. However, at the CDMH, in order to obtain power during the studied period, the nurses evidenced the strengthening of the medical power as a strategy to eliminate the midwife from the Delivery Room, and also strengthen the nursing service.

### **Using the uniform as a power strategy (disciplinary power)**

According to the nurses' discourse, since the opening of the maternity hospital, they were required to wear a uniform that differed according to occupation: the assistants wore a blue dress; nursing aides and midwives wore a white dress; physicians wore white clothes. The Sisters of Devine Providence wore a white habit; a long, simple dress with no adornment. Other workers, such as janitors, nutritionists and from the laundry wore a beige uniform.

In the late 1960's, when the Sisters of Devine Providence left the maternity hospital and a practical nurse entered, there were some changes to the uniforms of nursing professionals. This conduct reveals a power strategy used by the nurses to strengthen their power at the CDMH: the imposition of discipline over her subordinates through the uniform.

*The uniforms were provided by the maternity hospital. The assistants wore a blue dress, buttoned on the front, and nursing aides and midwives wore a white dress. Nurses, like me, for instance, wore white. [...] I*

then requested uniforms, and though of pants to give more freedom of movement. That is because we had to crouch, and some workers and one nurse wore dresses that were too short. So it was: assistants wore light blue pants and a blue coat, and the nursing aides, midwives and nurses wore white pants and a white coat. And that's how I introduced the uniforms. [...] I asked permission to the directors and they agreed (Nilsa, 1968).

In addition to the uniform, it is also observed that nursing workers were required to not wear any adornments and keep their hair tied up and fingernails short. These behavior rules represented what the nurses 'must be', that is, an honest, disciplined and submissive professional, roles that were constructed historically.<sup>16</sup>

*If you had long hair, you had to wear it up, keep their fingernails short and use only light shades of enamel. Sometimes some women would show up with their nails painted in a dark color, and I would then ask them to remove it. Then they mixed I think it was benzene with alcohol and removed it (Nilsa, 1968).*

Regarding the uniforms in the everyday practice, the nurse realized that the dress restricted the professionals' movements, besides sometimes exposing their bodies, which made her decide to standardize uniforms that were more practical and appropriate for the moral principles of the time. The statement expresses the need to implement the uniform to identify the different professional categories, in addition to providing an esthetically appropriate presentation that reflected the standard behaviors and attitudes of the time.

*The assistants wore a blue uniform, which differentiated them from the other members of the nursing team, who wore white uniforms. There were a total of 100 nursing workers, and they were all women (Evanguelia, 1976).*

The uniform also expressed a position of power and knowledge of each individual at the Institution. The standardization of a posture by using a uniform can be seen as a strategy to strengthen the invisible presence of the disciplinary power permeated in the relationships of power at the CDMH.

The standardization of clothing determined, besides the hierarchy, well-being, comfort, and the respect to moral principles. Therefore, the uniform represented the decency of the nursing professionals, who were adequately dressed to perform care practices.<sup>15</sup> It is also possible to assure the strengthening of hierarchy and specify each worker's role in the everyday practice of care.<sup>17</sup>

*If they arrived without the uniform, I had to talk to them, I mean, I never fired anyone, I only talked and explained they had to wear their uniform to work. [...] one thing I always fought for if that nobody came to work wearing sandals, but always wearing shoes, preferably closed shoes (Doraci, 1976).*

Closed shoes were also recommended as a protection barrier for healthcare professionals. Therefore, the nurse sought to advise the nursing workers in the sense of protecting their bodies against accidents and infections, avoiding any punishing measures. In this case, the measure was essentially corrective, supporting intensified learning, often repeated. But, in other occasions, the nurses did use punishments, and did not allow the professionals to work if they were not in their uniform.

*We were required to wear a uniform. [...] we had to wear white shoes and white clothes. [...] assistants had to wear blue uniforms and black shoes. They did not work without a uniform, they were sent back home [laughter] [...]. What the most forgot about were the shoes. [...] but that became a lesser requirement because the institution did not provide the workers' shoes (Sônia, 1979).*

The requirement to wear shoes confronted the purchasing power of the workers to buy the shoes considered adequate for the institution. The rule slowly changed, mostly due to the workers' financial issue than because of the concerns towards hygiene or workers' safety. The participants saw punishment as a strategy to correct the behavior of workers who did not respect the rules. As a strategy of the disciplinary power, punishment has the role of evaluating ones compared to others. Little by little, nursing professionals learned, in addition to their duties, their rights at the institution, because what happened is that with their power-knowledge, the workers sometimes resisted the norms imposed by the institutional power.

In the health institution, using a white uniform represents a "position of power in relation to the other professionals. It is understood that individuals who wear a white uniform, in a hospital, hold differentiated knowledge"<sup>18:42</sup> The white and the blue evidenced a distinction between the roles performed in nursing. Therefore, considering the power strategies described by Foucault<sup>5</sup>, it is inferred that the holder of knowledge is that who exerts the power. Knowledge and power imply on each other mutually, and there is no relationship of power without the creation of a field of knowledge, just as every new knowledge constitutes new relationships of power.

Within the context of the CDMH, discipline was used to mole and control the workers' behavior through the established rules and norms, comprising a profile observed since Florence Nightingale, who established behavior norms associated with the idea of body cleanliness and hygiene.<sup>19</sup>

Nurses were constantly observing the workers' compliance with wearing the uniform, in addition to their behavior and conduct. Through the examination technique, the disciplinary power permitted them to see each individual and differentiate them from the others and apply punishments if necessary. To do this, the examination combined hierarchy techniques, which permitted nurses to exert authority and training.

### **The medical visit: a space of power-knowledge (the examination)**

The CDMH has the original characteristics of a therapeutic hospital, conceived as an instrument of cure, in which the physician is seen as the main character responsible for its organization.<sup>5</sup> Therefore, the religious community slowly left this context, while the presence of the physician was reaffirmed and strengthened. This inversion of hierarchical relations emerges in the ritual of the visits, in which the physician, in the front, leads the visits to each patient's bed, followed by all the subordinates.

In the 18<sup>th</sup> century, however, the hospital's directives specified where each person should be. The nurse, for example, should be at the door of the ward and follow the physician, and make all the records of their daily practice, building a documental field. In the hospital setting, discipline reveals the individual as the object of knowledge and target of intervention, which should be supervised, trained, used and occasionally punished, whereas the hospital was a place of cure and of knowledge development.<sup>5</sup>

At the CDMH, the nurse also followed mainly obstetricians during visits to parturient inpatients, and pediatricians during visits to newborns in the High-Risk Nursery. Hospitalization, of the parturient woman as well as of the newborn, was essential to build knowledge, because it allowed performing a meticulous examination of the individuals during the visiting procedure.

*The individual medical records were kept at the nursing post. The nurse, when following the physician in the visit, took the records along [...]. We followed the*

*medical visit and he kept asking the patients, close to us: Mam, did you take two shots yesterday, one dark one here on your arm and another in your vain? I mean, he was suspicious. So I stopped following him in his visits (Sister Cacilda, 1956).*

This attitude was a way to show her disapproval of the physician's behavior and resistance to her hegemonic power. The sister nurse was newly graduated when she started working at the CDMH, and the physicians had no experience of working with nursing professionals with a university degree. The physicians had already worked with nuns, midwives, and nursing professionals trained at the workplace, but with no formal education. The nuns and midwives did not ask questions, they only followed the physician's orders. Religious nursing did not have a questioning character, it accepted the dogmas and did not present any resistance.

At the CDMH, the records were centralized at the nursing post, and nurses should accompany them through the medical visits in the Obstetric Inpatient Unit. The physician's suspicion regarding the nursing practice could be understandable because in 1956 the service at the CDMH was in the beginning. But it is noticed that in 1973, in a laic context, conflicts continued to exist during the obstetrician's visit to the unit, which evidences the persistence of the obstetrician in marking spaces that nurses are permitted to enter or not, thus generating their resistance:

*[...] On morning, when at the unit for the visit, the obstetrician approached me about the possibility of discharging his patients. I went on reporting about their conditions, which was already written on their medical records: Mrs. So-and-So if feeling too weak, she's pale and today she fainted during her bath. And he asked: and what do you suggest? I though 'he is testing me' and answered: I suggest an hematocrit. 'No, you don't suggest anything, he told me, because you can't suggest anything'. I answered: well, I'm sorry but I learned that I can. I learned in my school, don't get me wrong, you asked me what I suggested; if you hadn't asked me, I wouldn't have told you, but you asked. He continued: 'who has ever heard of a team coach getting a suggestion from a player?' I answered: look, if it's for the good of the team, I don't see any problem. I learned that I should advocate for my patient. 'He continued: well now you should learn that you can't suggest anything, you are just a nurse [...] [raised finger] (Ana Maria, 1973).*

It is noticed that during the visit, the obstetrician does not read the nursing notes on the records, rather, he makes verbal questions about

the information. The patient's record is formal means of communication of the clinical condition of the parturient- puerperal inpatient. In this situation, the physician did not show any interest in the nursing notes, underestimating the nurse's work and indicating that the written records are only for those who hold central knowledge, whereas oral transmission is for those with a more peripheral knowledge. It is a way to reduce the nursing work to merely answering orders and minimizing their importance in the health team.<sup>17</sup>

With Ana Maria, the first obstetrical nurse at the CDMH, it was observed there is a difficulty in the power-knowledge relation, because the obstetrician does not admit discussing the cases with the nurse, only prescribing.

As soon as the nurse shows scientificity in the care to the puerperal patient, the physician feels affronted, and does not accept any knowledge that is not his own. For the physician, the nurse, in this case, has a behavior that does not comply with the rules of the institution, where the physician controls the daily practice, expecting other professionals, particularly nursing professionals, to show a submissive and uncritical behavior. When a nurse shows resistance, conflicts emerge in the power relationships. Several authors<sup>1-3</sup> have discussed the difficulties in the relationships between the obstetrician and the obstetrical nurse in the setting of care for the parturient and puerperal patient, in the sense of pointing at ways to reduce or neutralize these conflicts. The practical nurse discussed and presented resistance to the medical power, starting conflicts and creating new configurations in the power networks, in a position of exerting but also suffering from its action.

Those nurses' progress of scientific knowledge generated dissatisfaction among the physicians, who saw nursing as a profession subordinate to medicine in the working process. The physician-nurse relationships constructed with time in terms of the legitimation of their body of technical-scientific knowledge appear to not have evolved, because they produce, within the care practices, the same power-knowledge asymmetry.<sup>20</sup>

The nurse deals with the everyday practice at the institution involving disputes, interests and repressions rooted on social, cultural and political contexts revealed in the power relationships, but fights for gaining recognition of their knowledge-power that is founded on the practice of care.

Regarding the physician-nurse relationship, it is observed that, in the CDMH settings, it was not

always a conflicting one. Regarding the pediatrician, a different behavior is observed, including dialogues with the nursing team, which develops knowledge expressed from several looks:

*[...] then the physician [pediatrician] visited, made his evaluation and the prescription. He read my report and asked for information when necessary. I followed him during the visit and after it I would revised the care plan (Coleta, 1972).*

*Actually, my greatest difficulty was during the daily morning visits, because at that time the pediatricians visited the patients together late in the morning so that they could all interact and discuss about the patients' treatments [newborns]. As a newly graduated nurse, it was a lot of new information. In the first months I didn't participate so much in the discussions about the cases and treatments. Little by little, with a lot of study and dedication, I started to participate more actively, in the medical visit as well as in managing the department and the staff (Sônia, 1979).*

The visit is a field for knowledge development in which the physician and the nurse contribute to developing a strategy to strengthen the power-knowledge relations. It is observed there is a change of paradigm in which the different professions start working together with the purpose to improve the care practices offered to the parturient- puerperal woman and the newborn.

Discipline is an example of the positive character of the Foucauldian analysis, as it collaborate with understanding it from a positive perspective, in terms of the effects it is capable of producing.<sup>5,21</sup> From this perspective, discipline works as a background that permits communication and working together in the hospital setting.

## FINAL CONSIDERATIONS

The present study revealed the everyday care practice by analyzing the strategies and power games constructed through the relationships within the context of the CDMH. The practice of sister nurses to practical nurses slowly solidified the professionalization, giving evidence of the movement and flexibility of power.

This evolution, over the studied period, denotes relationships of power, fights and resistances that had the objective to guarantee professional space and the hegemony of power. It is the microphysics of power, constructed in everyday relationships, with the lines of power suggesting different, but each dependent on the others, coexisting and mutually supporting



each other, constructing a professional that is productive, disciplined and standardized. The disciplinary power appears to have defined the care practices to parturient-puerperal women and newborns, submitting nursing professionals to power0knowledge devices based on constant supervision and on the standardization of behavior, modeling the subject.

Therefore, from the Foucauldian perspective, the history of these nurses demonstrated that power resulted from a continuous and diffuse fight that extended throughout the everyday power-knowledge relations within the context of the institution.

## REFERENCES

1. Rocha TA, Bonilha ALL. Formação das enfermeiras para a parturição: implantação de um hospital universitário na década de 80. *Esc Anna Nery Enferm.* 2008 Dez; 12(4):651-57.
2. Monticelli M, Brüggemann OM, Santos EKA, Oliveira ME, Zampieri MFM, Gregório VRP. Especialização em enfermagem obstétrica: percepções de egressas quanto ao exercício profissional e satisfação na especialidade. *Texto Contexto Enferm.* 2008 Jul-Set; 17(3):482-91.
3. Bonadio IC, Koiffman MD, Minakawa MM, Oliveira MAF. Da relação conflituosa ao respeito mútuo: a consolidação do papel da enfermeira obstétrica na assistência ao nascimento e parto. In: *Anais do 8º Simpósio Brasileiro de Comunicação em Enfermagem.* [online], 2002 [acesso 2008 Mar 03]; São Paulo, Brasil. Disponível em: [http://www.proceedings.scielo.br/scielo.php?pid=MSC000000052002000100039&script=sci\\_arttext](http://www.proceedings.scielo.br/scielo.php?pid=MSC000000052002000100039&script=sci_arttext)
4. Castro E. Vocabulário de Foucault. Um percurso pelos seus temas, conceitos e autores; tradução Ingrid Müller Xavier; Belo Horizonte (MG): Autentica Editora, 2009.
5. Foucault M. *Microfísica do poder.* Rio de Janeiro (RJ): Edições Graal; 2012.
6. Inauguração da Maternidade Carmela Dutra. *A Gazeta*, 1955 Jul 3; 3-12.
7. Maternidade Carmela Dutra. *Diário da Tarde*, 1955 Jun 4; 29.
8. Ministério da Saúde (BR). Lei n. 7.498, de 25 de junho de 1986. Dispõe sobre a regulamentação do exercício da Enfermagem e dá outras providências. *Diário Oficial da República Federativa do Brasil*, 26 Jun 1986. Seção 1.
9. Meihy JCSB. *Manual de história oral.* São Paulo (SP): Loyola; 2002.
10. Fink A. *How to sample in surveys: the survey kit (6).* Thousand Oaks (US): Sage; 2003.
11. Minayo MCS. *O desafio do conhecimento: pesquisa qualitativa em saúde.* São Paulo-Rio de Janeiro: HUCITEC-ABRASCO; 2004.
12. Foucault M. *Arqueologia do saber.* 6ª ed. Rio de Janeiro (RJ): Forense Universitária; 2007.
13. Foucault M. *Vigiar e punir: nascimento da prisão.* Petrópolis (RJ): Vozes; 2009.
14. Farhi Neto L. *Biopolítica em Foucault [dissertação].* Florianópolis (SC): Universidade Federal de Santa Catarina. Mestrado em Ética e Filosofia Política; 2007.
15. Revel J. Michel Foucault: conceitos essenciais. São Carlos (SP): Clara Luz; 2005.
16. Padilha MICS. *A mística do silêncio: a enfermagem na Santa Casa de Misericórdia do Rio de Janeiro no século XIX.* Pelotas (RS): Ed. Universitária/UFPEL; 1998.
17. Carapineiro G. *Saberes e poderes no hospital: uma sociologia dos serviços hospitalares.* Porto (PT): Afrontamento; 2005.
18. Rezende MCC. *Processos de subjetivação na experiência de uma equipe de enfermagem em oncologia [dissertação].* Belo Horizonte (MG): Pontifícia Universidade Católica de Minas Gerais, Programa de Pós-Graduação em Psicologia; 2010.
19. Padilha MICS, Sobral VRS, Leite LMR, Peres MAA, Araújo AC. *Enfermeira - a construção de um modelo a partir do discurso médico.* *Rev Esc Enferm USP.* 1997 Dez.; 31(3):437-51.
20. Florentino FRA, Florentino JA. *As relações profissionais entre enfermeiro e médico no campo da saúde.* [online] [citado 2010 Dez 10]. Disponível em [http://www.unioeste.br/prppg/mestrados/letras/revistas/travessias/ed\\_006/CULTURA/PDF/As%20rela%20e%20sociais%20PRONTO.pdf](http://www.unioeste.br/prppg/mestrados/letras/revistas/travessias/ed_006/CULTURA/PDF/As%20rela%20e%20sociais%20PRONTO.pdf)
21. Veiga-Neto A. *Foucault e a educação.* Belo Horizonte (MG): Autêntica; 2003.

Correspondence to: Vitória Regina Petters Gregório  
Rua João Pio Duarte Silva n 1070 ap. 504 Bl D  
88037-001 - Córrego Grande, Florianópolis, SC, Brazil  
E-mail: vitoria@ccs.ufsc.br