Difficulties for the obstetric nurse autonomous performance in Brazil

Dificuldades para a atuação autônoma do enfermeiro obstetra no Brasil

Dificultades para el desempeño autónomo de la enfermera obstétrica en Brasil

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REVISA

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RESUMO

Objetivo: Compreender as limitações da atuação autônoma do enfermeiro obstetra no Brasil. **Método:** Trata-se de uma revisão integrativa da literatura, a partir de publicações científicas de enfermagem, a partir da BVS, indexadas nas bases de dados BDENF e LILACS, publicadas em periódicos nacionais, sem recorte temporal. Seguindo os critérios de inclusão e exclusão, 10 estudos primários compuseram a amostra. **Resultados:** Foram encontrados como fatores que limitam a autonomia do enfermeiro obstetra: a dicotomia entre a prática profissional e a legislação, a resistência do profissional médico frente a atuação do enfermeiro obstetra e o déficit na formação e capacitação do enfermeiro obstetra. **Considerações Finais:** Constata-se que, a compreensão dessas dificuldades pode subsidiar possível mudança na realidade atual, assim como a ampliação dos estudos referentes a este tema, uma vez que, a falta de autonomia do enfermeiro obstetra constitui um fenômeno que atinge profissionais e pacientes, debilitando o sistema de saúde do país.

Descritores: Enfermagem Obstétrica; Legislação de Enfermagem; Autonomia Profissional; Competência Profissional.

ABSTRACT

Objective: To understand the limitations of autonomous performance of obstetric nurses in Brazil. **Method:** This is an integrative literature review, based on scientific nursing publications, based on the VHL, indexed in the BDENF and LILACS databases, published in national journals, with no time frame. Following the inclusion and exclusion criteria, 10 primary studies comprised the sample. **Results:** The following factors were found to limit the autonomy of the obstetric nurse: the dichotomy between professional practice and legislation, the resistance of the medical professional to the performance of the obstetric nurse and the deficit in the training and qualification of the obstetric nurse. **Final Considerations:** It appears that the understanding of these difficulties can support a possible change in the current reality, as well as the expansion of studies related to this topic, since the lack of autonomy of obstetric nurses is a phenomenon that affects professionals and patients , weakening the country's health system.

Descriptors: Obstetric Nursing; Nursing Legislation; Professional Autonomy. Professional Competence.

RESUMEN

Objetivo: Comprender las limitaciones del desempeño autónomo de las enfermeras obstétricas en Brasil. **Método:** Esta es una revisión bibliográfica integradora, basada en publicaciones científicas de enfermería, basada en la BVS, indexada en las bases de datos BDENF y LILACS, publicada en revistas nacionales, sin marco de tiempo. Siguiendo los criterios de inclusión y exclusión, 10 estudios primarios comprendieron la muestra. **Resultados:** Se encontró que los siguientes factores limitan la autonomía de la enfermera obstétrica: la dicotomía entre la práctica profesional y la legislación, la resistencia del profesional médico al desempeño de la enfermera obstétrica y el déficit en la capacitación y calificación de la enfermera obstétrica. **Consideraciones finales:** Parece que la comprensión de estas dificultades puede apoyar un posible cambio en la realidad actual, así como la expansión de los estudios relacionados con este tema, ya que la falta de autonomía de la enfermera obstétrica es un fenómeno que afecta a profesionales y pacientes. , debilitando el sistema de salud del país.

Descriptores: Enfermería Obstétrica. Legislación de enfermería. Autonomía profesional. Competencia profesional.

REVIEW

Introduction

Childbirth, recognized as a physiological and natural event, had for a long time been assisted in a family environment in a humanitarian manner, by midwives who obtained their knowledge through tradition, passed from generation to generation and based on empirical experience.[1] With the obstetrical forceps invention at the 16th century end, obstetrics becomes a technical-scientific discipline of interest and appropriation of medical hegemony, then there is a gradual decline in the performance of midwives and the consequent predominance of intervention and hospitalization of childbirth.[2]

In the 19th century, when nursing education was regulated in Brazil, the profession gained space and respect, mainly in the attention to women's health, due to its qualification and humanitarian assistance, however over the years, as with midwives, the obstetric nursing declined due to the increase in invasive medical procedures, becoming secondary in this assistance.[2]

The institutionalization of childbirth, initially helped in the reduction of maternal and neonatal mortality, however it abruptly modified the birth scenario, depriving women of their individuality and autonomy, submitting them to a hospitalization ritual, where they pass from subject to institutional object and obstetric care is organized as a production line.[1] In this context, excessive medicalization proves to be unnecessary and harmful, contributing to the increase in maternal and perinatal morbidity and mortality rates, which combined with the excessive number of caesarean sections, overloaded the country's social and financial systems.[2-3]

The Obstetric Nurse (ON) plays a counterpoint role in this interventionist and exclusively medical model, as his training and practice seek to redirect childbirth as physiological, so that women can experience it safely and with dignity.[3-4] In view of the current scenario, the World Health Organization (WHO), which carries out constant research on childbirth and birth, encourages harmony between technological advances and human relations, expressing that the objective of childbirth assistance is to promote the least possible interference, and that any intervention must have a valid reason to be carried out.[4] It recognizes ON as the most appropriate professional, with the best cost-effectiveness to assist pregnancy and normal childbirth at usual risk, assessing risks and complications.[4]

The Ministry of Health (MOH) ratifies the WHO recommendation, defining that childbirth care must guarantee the benefits of science, but fundamentally allow the exercise of female citizenship, rescuing the autonomy of women in childbirth.[4] As a strategy to cope with the high rates of maternal and child morbidity and mortality, since 1999 it has been encouraging and financing specialization courses in obstetric nursing in health departments across the country.[2]

The ON, is legally qualified to assist normal childbirth at usual risk, being able to perform procedures such as, "consultation, admission, touch exam, application of local anesthetic, perineal suture and maneuvers to assist in fetal detachment".[3]

In view of the above, when analyzing the exercise of this professional over the years, we see that despite several determinations it is still rare to find a health service in which normal childbirth with normal risk is effectively performed by

ON. We observe constant controversies about his performance, and the devaluation of his work by classmates, other classes and society, which creates difficulty and tension not only for those who practice the profession, but also for the women assisted by these professionals.[5]

In this context, understanding the obstacles faced by ON and the need for the insertion of this professional in the performance of normal delivery as an improvement in Brazilian obstetric care, this study aimed to understand the limitations of the autonomous performance of obstetric nurses in Brazil. Upon reaching this objective, it will be possible to offer critical-reflective subsidies to professionals for a possible contribution to changing this reality.

Method

This study is an Integrative Review (IR), which allows the synthesis of multiple published studies and allows general conclusions regarding a particular area of study.[6]

For the development of this present IR, six steps were followed: establishment of the research problem, sample selection, categorization of studies, analysis and interpretation of studies and presentation of results.[6]

The first phase took place through the elaboration of the following research question: "What are the limitations for the autonomous performance of the Obstetric Nurse in Brazil?"

In the second phase, the sample was selected. Two databases from the Regional Portal of the Virtual Health Library (VHL) were used: Brazilian Nursing Databases (BDENF) and Latin American and Caribbean Literature in Health Sciences (LILACS), with no time frame, in order to expand the possibility of identifying studies related to the theme. These bases were chosen because they are national and thus meet the objective of the study.

For the studies selection, health descriptors were first identified through the VHL Decs: “Enfermagem Obstétrica”, “Legislação de Enfermagem”, “Autonomia Profissional” and “Competência Profissional”, which were grouped as follows: “enfermagem obstétrica” and “legislação de enfermagem”, “enfermagem obstétrica” and “autonomia profissional”; and “enfermagem obstétrica” and “competência profissional”.

The inclusion criteria were: original articles, Brazilian, regardless of the methodology applied for the study and as exclusion criteria: articles of integrative or narrative review and duplicate articles in the cited databases. The selection of the material took place from October to November 2019.

Initially 109 articles were found, after applying the inclusion and exclusion criteria, reading the titles and abstracts, 6 articles from the BDENF database and 4 articles from the LILACS database were selected. The selected works were published in the period from 2002 to 2019 and were coded by an alphanumeric sequence to facilitate their identification (A1, A2, A3 and so on).

Then, the IR third phase was carried out. A private instrument was devised, designed by the authors, for data extraction, containing the article identification, database, objectives and results, as shown in (Chart 1).

The level of evidence was assigned based on the recommended classification7: level I – evidence from the meta-analysis of controlled and randomized clinical studies; level II - evidence obtained from an experimental

design study; level III - evidence obtained from quasi-experimental research; level IV - evidence from a descriptive study or with a qualitative methodological approach; level V - evidence obtained from case reports or experience reports; level VI - evidence based on expert opinions or based on rules or legislation.

In phase four, the data were analyzed, considering their contents and excerpts that constitute scientific evidence, grouping the similarities, convergences of the studies and dividing them into 3 thematic categories, as described and presented in (Chart 2).

To carry out phase five, the reviewers, through the interpretation of the analysis results, brought up the discussion, subjects that demonstrated greater relevance to the theme, comparing it with theoretical knowledge, identifying conclusions and implications.

Finally, in the sixth phase, with the delimitation of the conclusions drawn in the review, the synthesis of knowledge is presented through the main results obtained.

Results

10 articles were selected, presented and organized in Chart 1. The sources of publication were varied, totaling 9 journals, namely: Latin American Journal of Nursing, Public Health Notebooks of Rio de Janeiro, Revista Cogitare Enfermagem, Revista da Escola de Enfermagem from USP, UEPE Nursing Magazine, Anna Nery School Magazine, Journal Of Research: Fundamental Care Online, UERJ Nursing Magazine and UFSM Nursing Magazine.

Such productions were published in the national territory, 60% in the Southeast, 10% in the Northeast, 20% in the South and 10% in the Midwest. Regarding the academic background of its authors, it is observed that 82.75% are from the nursing area, 3.44% are from the Sociology area, 3.44% are from the Social Service area, 3.44% are from the area of Psychology, 3.44% are in the area of Nutrition and 3.44% are in the area of Bachelor of Obstetrics.

In addition, a higher prevalence of qualitative methodological approaches was noted, with a percentage of 80%, while the quantitative approach obtained a percentage of 20%. All studies demonstrate evidence level IV.

Chart 1 - Identification of the sample of studies according to code / year, title and database, objective (s) and results. Sao Paulo, 2020.

Article code / Year of publication	Title and Database	Objectives (s)	Results
A1[8] 2002	Professional trajectory of midwifery nurses from the University of São Paulo School of Nursing: a focus on social phenomenology. BDENF	To understand the experience of former students of qualification or specialization courses in obstetric nursing at EEUSP.	The study contrasts professional autonomy with the fact that obstetric nurses cannot perform activities that are within their competence guaranteed by the Professional Exercise Law itself, which generates

			conflicts, dissatisfaction and demotivation.
A2[9] 2003	Knowledge and practices of nurses and obstetricians cooperation and conflict in childbirth care LILACS	Understand representations of obstetricians and nurses about teamwork	The possibilities of building teamwork in obstetric care depend on improving the technical training of nurses to strengthen professional autonomy.
A3[10] 2006	The medical professional's view on the role of the obstetric nurse in the obstetric center of a teaching hospital in the city of Recife-PE BDENF	To analyze the view of medical professionals on the role of obstetric nurses in the obstetric center of a teaching hospital in the city of Recife-PE.	The lack of knowledge about the legislation that regulates the performance of obstetric nurses is undoubtedly a problem that goes beyond medical questions, and is also an obstacle at the level of management, leading to a conflicting situation as teamwork.
A4[11] 2010	Perceptions of obstetric nurses about their competence in care for normal hospital birth BDENF	To know the perception of obstetric nurses about their competence in the care for normal birth (NP) in hospitals.	The understanding of how Obstetric Nurses perceive their competence, whether in relation to direct delivery care, or other aspects of their professional experience in the field of hospital obstetrics, can contribute to overcoming the conflicts and contradictions currently present in the obstetric scenario.
A5[12] 2010	Qualified care during childbirth: profile of nursing professionals in maternity hospitals in Alfenas, Minas Gerais, Brazil BDENF	To identify the profile of nursing professionals who care for parturients in maternity hospitals in Alfenas-MG.	Nurses correspond to 41.7% of nursing professionals responsible for assisting parturients and the majority 58.3% are mid-level professionals, there is no obstetric nurse attending parturients in the maternities of Alfenas-MG. Informal training does not enable mid-level professionals to legally pursue this activity. The lack of training of these professionals directly

			compromises qualified delivery care, increasing the risk of maternal and perinatal morbidity and mortality.
A6[13] 2012	Professional responsibility in childbirth care: discourse of obstetric nurses LILACS	To identify the knowledge of obstetric nurses in relation to professional responsibility in childbirth care.	The obstetric nurses participating in the study have insufficient information about professional responsibility, since they are largely unaware of the applicability of the legislation that regulates their activities and, even less, about the legal repercussions of their failures in the exercise.
A7[14] 2013	The implications of the professional practice of obstetric nurses graduating from EEAN: the quality of care LILACS	To analyze the implications of the professional practice of these nurses graduating from CEEO of EEAN / UFRJ for the healthcare quality for women.	The autonomy of childbirth assistance is limited by its lack of knowledge about the legal support to act in this area of care, due to the impediment and prejudice in the professional practice from health institutions and the medical team through verbal violence and its derivations, generating negative implications for the quality of care and its practice.
A8[15] 2014	Education and professional insertion of the graduates of the residency course in obstetric nursing BDENF	To describe the assessment of training and professional insertion of the graduates of the Residency Course in Obstetric Nursing at the Universidade do Estado do Rio de Janeiro.	The nurses' previous expectations were fully met by the course, but the training requires improvements in the theoretical contents and in the direct supervision of the preceptorship. Regarding professional practice, 42.2% considered exercising the profession with autonomy. However, professional barriers in the health system still persist, such as the restricted labor

			market, resistance of doctors, little professional recognition and precarious conditions. of work.
A9[16] 2018	Permanent health education as a strengthening of obstetric nursing BDENF	Highlight the importance of Permanent Education in Health to strengthen Obstetric Nursing.	Permanent Education in Health proved to be an important tool in the qualification of obstetric nurses, promoting autonomy for differentiated assistance in the care of normal childbirth. Thus, it can contribute as a strategy to solve the challenges in the implementation of the Cegonha Network.
A10[17] 2019	Perception of obstetric nurses about the care model and practice in a philanthropic maternity hospital LILACS	To know the perception of obstetric nurses about the care model and practice in a philanthropic maternity.	With this study, it was found that nurses work autonomously as a team, do not name a model of assistance and point out the service demand and the technocratic model as difficulties.

Discussion

After analyzing and interpreting the data, aiming to answer the guiding question of the research, 3 thematic categories emerged: Dichotomy between professional practice and legislation, Resistance of the medical professional to the performance of the Obstetrical Nurse and Deficits in training and qualification, as described in (Chart 2).

Chart 2- Distribution of thematic categories according to the codes of the studies and the percentage present in each category, São Paulo, 2020.

Thematic Categories	Study Code	%
Dichotomy between professional practice and legislation	A1, A2, A3, A4, A5, A6, A7, A8, A9, A10	100
Resistance of the medical professional to the performance of the Obstetric Nurse	A1, A2, A3, A4, A6, A7, A8, A9, A10	90

Deficits in the training and qualification of obstetric nurses	A1, A2, A3, A4, A6, A8, A9, A10	80

Dichotomy between professional practice and legislation

The subject that defined the first category in this integrative review was addressed in all articles (100%), highlighting its relevance.

The obstetric nurse performance is supported by law No. 7,498 / 86 that regulates the professional practice of nursing in Brazil at the time when it differentiates the ON from other categories, assigning it exclusive activities. In addition to this law, there are several laws such as Ordinances of the Ministry of Health and Resolutions of the Federal Nursing Council (COFEN), which corroborate the possibility of OSs to act autonomously in assisting normal childbirth without dystocia.[10]

One study defined as the autonomy the sum of intellectual independence with the right to be governed by its own laws. It is added that it is important to have autonomy so that the nurse can develop personally and professionally through exercise without obstacles and the power of decision on the measures that must be adopted in the obstetric area.[14]

However, there is a difference between what is described in the law and the reality experienced in professional practice[8], being pointed out as the main challenges: precarious working conditions, the need for professional recognition, medical resistance, lack of qualifications and the absence of specific public tenders. The places where ON is most active in childbirth care are large maternity hospitals, in other places this performance is incipient or does not exist.[12,15] This reduced amount of ON providing birth assistance, makes it difficult to implement the actions recommended by the Ministry of Health.[16]

It is also noticed that the procedures valued in training are not performed on a daily basis.[11] In a study that deals with the medical view on the role of the ON, reports suggest that the same should be supervised by the doctor, which contradicts the Nursing code of ethics and shows the prevalence of an imposed hierarchical relationship.[10] The lack of recognition of the ON in a hospital environment and the non-acceptance of the exercise of the functions of the specialty appears as a veiled discrimination of the team and institution.[13]

Although this reality is prevalent, research has shown that EOs, from a philanthropic institution, have autonomy to perform their functions15, another study emphasizes that ON holds autonomy through knowledge and competence, and that institutional support is a factor facilitator and provider of this autonomy through Standard Operating Procedure (POP) and continuing education.[17] Positive evaluations are new data in relation to the theme and can be considered a harbinger of advances in the exercise of the specialty.[15]

Finally, this category also showed that the lack of knowledge about the legislation is undoubtedly a problem that goes beyond medical questions. It is extremely necessary to disclose the role of ON within the team for a free and better performance in the obstetric center.[9]

Resistance of the medical professional to the obstetric nurse performance

This thematic category emerged from 90% of the articles (A1, A2, A3, A4, A6, A7, A8, A9 and A10) and deals with the difficulties faced by the obstetric nurse in the performance, in the face of medical resistance.[15] With the creation of medical schools in Brazil in 1808 and the medicalization process of childbirth, this was classified as high, medium and low risk, an opportunity in which the doctor became a protagonist in obstetric care. However, with Law 7,498 / 86 the responsibility for carrying out childbirth is now also attributed to the ON.[10] In addition, the WHO, based on the less interventionist characteristics of ON, declares it to be the most appropriate professional for assisting childbirth with physiological evolution (usual risk) [14], being the physician responsible for dystocic births and severe cases that require more complex interventions.[16]

However, there is a clear medical resistance regarding the autonomy of ON in assisting childbirth at usual risk.[8] A study confirms that conflicts are greater where the risks are lower, the clash actually occurs when the obstetric nurse assumes and performs the physiological deliver.[9] Some medical professionals consider the ON to be an adjunct to assistance and mention their work as a mere "help", not reporting themselves as a professional working in childbirth.[10]

Medical practice is essentially based on the scientific / male model, in which to carry out an accurate and correct assessment, it is necessary to move away from any personal and emotional factor, both of the professional and the patient. Thus, the anxiety, tension and fear experienced by the parturient will be little valued by the doctor. The definition of male model, does not mean that all or only men work in this way, but it makes this association, for them traditionally, more than women, to value this “impersonal over personal” thinking, this model also puts the professional as: rational, dominant and self-confident, while characterizing the parturient as: emotional, dependent and submissive.[9]

The training and performance of nurses, on the other hand, is oriented towards care and not towards intervention, structured on humanization, which values physical care, individuality and the right to choose. [11]

In general, obstetricians and EOs agree that teamwork is fundamental to the quality of obstetric care, the valorization of the collaborative model occurs through the policy of comprehensive care to health needs. These professionals also agree that the implementation of this model of interdisciplinary joint action has not been successful, but the reasons for the failure differ in their opinions.

While doctors emphasize technical aspects such as delegating functions and responsibilities, nurses talk about greater relational appreciation, cooperation, respect and trust in the technical capacity of the colleague, they emphasize the rational use of human resources and the underutilization of their qualification.[9]

Doctors disagree with the responsibilities defined by Organs management bodies and express that the technical competence in conducting childbirth must be exclusively medical. For nurses, teamwork does not happen because doctors do not share responsibilities, and have difficulty in incorporating the philosophy of good, less interventionist practices. These attitudes generate conflicts, making it difficult to implement the collaborative model of teamwork.[9]

Another determining factor is the physician's lack of knowledge about the legality of the ON's performance. Even when the physician realizes the benefits of ON assistance, it is not clear what the competence of the ON is. The study also highlights the doctors' belief that ON has no responsibilities (civil, criminal and administrative), therefore, in the face of negative outcomes, they would not assume the consequences.[10]

It is important to remember that the ON, like the doctor and other team professionals, has responsibilities and is subject to civil, criminal and ethical-administrative liability. In negative delivery outcomes, caused by negligence, recklessness or malpractice by health team professionals, they may respond in any of the spheres, and the signature is not the only way to prove the link between the author and the damage.[13]

Another study clearly demonstrated the difficulty of incorporating good practices and the imposition of a hierarchy that does not exist, from the doctor to the nurse.[9]

The last determinant factor to medical resistance identified in the articles is the dispute for power and possession of the clientele, which can be perceived, among other aspects, by verbal violence.[14]

In this way, the importance of locating physicians regarding the competencies of the ON as well as the new international guidelines for childbirth assistance is emphasized, in order to reduce friction and effectively implement strategies to reduce maternal and perinatal morbidity and mortality.[17]

Deficits in the training and qualification of obstetric nurses

The last category of this IR refers to "deficiencies" in continuing education and training and was present in 80% of the articles (A1, A2, A3, A4, A6, A8, A9 and A10).

Until recently, many specialization courses in Obstetric Nursing offered inadequate and insufficient practical part to develop technical competence, which generated insecurity.[11] This reality changes with COFEN Resolution No. 516 of the year 2016, in which it is mandatory to carry out at least: 15 (fifteen) prenatal nursing consultations, 20 (twenty) deliveries with full monitoring of labor, delivery and postpartum and 15 (fifteen) visits to the newborn in the delivery room; proven through an official document of the authority that issued the diploma or certificate.[16]

The Residence appears in a study as a new type of specialization in obstetric nursing, a Postgraduate Latu Senso, which is based on in-service teaching, with a workload of 60 hours per week and a minimum duration of 2 years, according to Resolution nº 2 / 2012, from the Ministry of Higher Education of MEC. A teaching proposal with the greatest potential to qualify nurses with technical skills based on the principles of humanization and scientific evidence. However, the field study on this type of training demonstrates that despite the graduates, in general, consider that the course met their expectations, there is still a need to improve training and pedagogical strategies.[15]

The insertion of practical training in the formation of the ON represents a great advance in teaching, however, specialization courses need to develop in their students the multidimensional character of competence, which is composed

of technical competence, which consists of "knowing how to do" more than "Knowing how to be", humanizing as a personal search for an ethical sense of work, competence by intuition, which is related to the clinical view, and relational competence that refers to the interaction with the parturient and the health team.[11, 13] The reorientation of teaching practice is a condition for achieving ON's professional autonomy.[10]

Another relevant factor in this category is the scarcity of permanent health education (EPS), which is defined by the Pan American Health Organization - PAHO as: "learning at work in which learning and teaching are incorporated into the daily lives of organizations. " Although EPS was expanded as a SUS policy and strategy, with a focus on promoting changes and improvements, it proves to be non-institutionalized, as maternity hospitals rarely develop educational activities effectively.[16]

Updating the professional through permanent education provides improvements in the work process and in the interaction with the team, knowledge gives confidence in the care attitude. Permanent education also helps to resolve or minimize conflicts between the team.[17]

Finally, it was found that the insertion of ON as an autonomous professional in childbirth care of usual risk is a slow, difficult and quite heterogeneous process, which is affected by interference, including by the nursing team, assistants, technicians and other nurses, that because they do not understand the role of the ON and do not know the legal precepts of nursing itself, they end up making this process more difficult.[9]

This lack of knowledge, on the part of the nursing team, of the legislation that supports the performance of the ON, generates the feeling of non-belonging, having appeared in an article the expression "strangers in the nest" to designate this feeling that results in insecurity and loneliness.[8]

This category demonstrated that there is a deficit in training when nurses participate in specialization, as well as after starting professional practice, as there is no permanent health education instituted.

Final Consideration

This Integrative Review enabled the construction of a synthesis of scientific knowledge about the obstacles that limit the autonomy of obstetric nurses in Brazil, demonstrating the need for the insertion of ON in the performance of normal childbirth at a free and autonomous way as a determining factor to improving obstetric care and reducing current maternal and perinatal morbidity and mortality rates.

First, we can highlight a dichotomy between professional practice and that described in the legislation that supports the performance of ON, the result of the low number of obstetric nurses working in direct delivery assistance, coupled with the lack of professional recognition, presenting itself as a veiled discrimination of team and institution.

The EOs face a great resistance from the medical class that has difficulty in recognizing the autonomy given to the NB in the scenario of normal childbirth of habitual risk, because their backgrounds are very different, one focused on

care and the other on intervention. In addition, there is a supposed hierarchy of the doctor over the nurse that is often imposed in the form of verbal violence, revealing a dispute for power and ignorance of the legislation that regulates nursing.

The lack of professional autonomy is also due to deficiencies in the training and qualification of EOs that need improvement in the development of multifactorial competence. It was also revealed that permanent education does not occur routinely in institutions, which makes it difficult to develop a collaborative attitude and teamwork. The ethical-political intervention in the classroom and the professionals' awareness of an affable coping stance, based on competence and legal support, will bring new strategies for change in the current context.

The understanding of these difficulties faced by the obstetric nurse offers subsidies to enable a change in the current reality.

The present study had as a limitation the sample size, only 10 articles, revealing a scarcity of the literature. Therefore, it is necessary to expand the studies related to this theme, since the difficulties that limit the autonomous performance of the ON constitute a phenomenon that affects both professionals and patients, which impacts the entire health system.

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