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RESEARCH

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Lack of motivation in the use of non-invasive technologies by the nursing team in high-risk maternity wards

Desmotivação no uso das tecnologias não invasivas pela equipe de enfermagem na maternidade de alto risco

Falta de motivación en el uso de tecnologías no invasivas por parte del equipo de enfermería en maternidades de alto riesgo

Juliana Amaral Prata[1]
Midian Oliveira Dias[1]
Sônia Regina da Silva Gonçalves[1]
Tatiana Beatriz Leandro de Castro[1]
Débora Cecília Chaves de Oliveira[1]
Danielle Gonçalves Ferreira[1]

1. Universidade do Estado do Rio de Janeiro. Rio de Janeiro, RJ, Brazil.

Abstract

Objective: to understand the lack of motivation among nurses to use non-invasive care technologies in high-risk maternity wards. **Method**: a qualitative study with seven nurses and eight nursing technicians from the obstetric center of the maternity ward of a university hospital in the state of Rio de Janeiro. Data were produced through focus groups in July 2019 and submitted to thematic content analysis. **Results**: participants felt unmotivated in the face of: conflicts and disrespectful attitudes displayed by physicians; lack of support from nursing management, expressed in feelings of helplessness in the face of adversities in the work environment, scarcity of resources used in some technologies, and lack of incentives for professional development; and hospital routines that interfere with good practices during childbirth. **Final considerations and implications for practice**: the lack of motivation of the nursing team in high-risk maternity wards can be modified through actions by management to provide opportunities for problematizing the work reality, with the participation of the nursing and medical team, making routines more flexible, and providing material resources that strengthen nursing autonomy.

Keywords: Culturally Appropriate Technology; High-Risk; Hospitals, Maternity; Nursing; Pregnancy, Nursing Care.

Resumo

Objetivo: compreender a desmotivação da enfermagem para o uso das tecnologias não invasivas de cuidado na maternidade de alto risco. **Método**: estudo qualitativo com sete enfermeiras e oito técnicas de enfermagem do centro obstétrico da maternidade de um hospital universitário do estado do Rio de Janeiro, Brasil. Os dados foram produzidos através de grupos focais, em julho de 2019, e submetidos à análise de conteúdo temática. **Resultados**: as participantes se mostram desmotivadas diante de: embates e atitudes desrespeitosas manifestadas pelos médicos; falta de apoio da chefia de enfermagem, expressa no sentimento de desamparo diante das adversidades do ambiente laboral, da escassez de recursos utilizados em algumas tecnologias e da ausência de incentivos à atualização profissional; e rotinas hospitalares que interferem nas boas práticas no parto. **Considerações finais e implicações para a prática**: a desmotivação da equipe de enfermagem na maternidade de alto risco pode ser modificada por meio de ações das chefias, para oportunizar a problematização da realidade laboral, com a participação da equipe de enfermagem e médica, flexibilizar as rotinas, e disponibilizar recursos materiais que fortalecem a autonomia da enfermagem.

Palavras-chave: Cuidados de Enfermagem; Enfermagem; Gravidez de Alto Risco; Maternidades; Tecnologia Culturalmente Apropriada.

Resumen

Objetivo: comprender la falta de motivación de los enfermeros para utilizar tecnologías de atención no invasivas en maternidades de alto riesgo. **Método**: estudio cualitativo con siete enfermeros y ocho técnicos de enfermería del centro obstétrico de la maternidad de un hospital universitario del Estado de Río de Janeiro. Los datos fueron producidos a través de grupos focales, en julio de 2019, y sometidos a análisis de contenido temático. **Resultados**: los participantes aparecen desmotivados ante: enfrentamientos y actitudes irrespetuosas expresadas por los médicos; la falta de apoyo de la gestión de enfermería, expresada en el sentimiento de impotencia ante las adversidades del ambiente de trabajo, la escasez de recursos utilizados en algunas tecnologías y la falta de incentivos para el desarrollo profesional; y rutinas hospitalarias que interfieren con las buenas prácticas de parto. **Consideraciones finales e implicaciones para la práctica**: la falta de motivación del equipo de enfermería en maternidades de alto riesgo puede ser modificada mediante acciones de la gerencia, para brindar oportunidades de problematización de la realidad laboral, con la participación del equipo de enfermería y médico, flexibilizando rutinas y proporcionando recursos materiales que fortalezcan la autonomía de enfermería.

Palabras clave: Atención de enfermería; Embarazo de Alto Riesgo; Enfermería; Maternidades; Tecnología Culturalmente Apropiada.

Corresponding author:
Midian Oliveira Dias.
dias.midian@gmail.com

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INTRODUCTION

Pregnancy is a physiological event in women's reproductive life that, from fertilization onwards, involves physical and emotional transformations that require technical care and emotional support from healthcare professionals. However, when there are real or potential risks to maternal and fetal well-being due to clinical and/or obstetric conditions prior to conception that arise or intensify during the gestation and birth process, as well as socioeconomic, environmental and psychological conditions that add vulnerabilities women's and newborns' health, pregnancies are classified as high risk. In these cases, specialized monitoring in high-risk maternity hospitals is often necessary, since these environments offer resources for the timely management of complications and advanced life support.[1,2]

In view of public policies aimed at improving maternal and neonatal healthcare, humanizing care and reducing cesarean section rates and unnecessary interventions, nursing-midwifery has been standing out on the world stage as a strategy for reducing mortality.[1,3,4] In this regard, these specialists develop practices that promote female leading role and the physiology of labor and birth, opposing the medicalization characteristic of the biomedical model predominant in obstetric services, which attributes a medical and pathological character to natural aspects of life, such as childbirth, with a focus on the figure of healthcare professionals, dominating and controlling female bodies.[5,6]

Thus, nursing-midwifery practices drive the demedicalization of care through non-invasive nursing care technologies (NINCTs), which consist of intentional actions involving knowledge, techniques, procedures and relational skills, developed with an ethical attitude, which enable the establishment of therapeutic, welcoming and empathetic relationships, centered on women's and their families' demands, resulting in a dignified, empowering and respectful care process.[7-9]

From this perspective, in order to provide non-invasive care that respects women's physical and mental integrity, as well as their freedom of decision, NINCTs correspond to the following professional actions, which are not exclusive to nurses: demonstrating availability; welcoming with empathy; encouraging companion participation; valuing subjectivities; respecting women's leading role and centrality; offering emotional support; providing guidance; developing sensitive and continuous monitoring; and promoting well-being. Furthermore, it is considered that some of these actions can be mediated by instruments, such as a Swiss ball, a birthing stool, a shower, a bathtub, a stool and essential oils.[7,9]

Despite scientific evidence showing positive obstetric outcomes resulting from the care provided by nurses-midwives with NINCTs, these specialists often faced difficulties related to the use of these technologies, especially in high-risk maternity hospitals, where risk discourses, biomedical knowledge, rigid routines, indiscriminate use of hard technologies and interventions predominate, as well as hierarchical professional relationships, and it is common to see inadequacies in the physical structure and environment, as well as low motivation for the development of humanized practices.[1,4,7-9]

It is important to clarify that these issues are barriers to the development of shared care from the perspective of interprofessionality, which depends on dialogue between medical and nursing teams' knowledge and practices, and the sharing of information, responsibilities and decisions, with recognition of contributions that the different disciplines add to the comprehensiveness, humanization, quality and safety of care.[10]

In view of this, and understanding the importance of nurses' work, with NINCTs, with high-risk postpartum women, this article aimed to understand the lack of motivation among nurses to use non-invasive care technologies in high-risk maternity wards.

METHOD

This is a qualitative study conducted with the nursing team of the obstetric center of the maternity ward of a university hospital in the state of Rio de Janeiro, Brazil, which is a reference in the care of high-risk pregnancies and in professional training. The sector is staffed by physicians, nurses-midwives, general nurses and nursing technicians, based on protocols that guide the use of NINCTs by the nursing team in the care of high-risk postpartum women in labor, with stable clinical conditions and favorable medical indication. However, given the risk stratification of the clientele served by the institution, deliveries are predominantly monitored by physicians.

Participants were seven nurses and eight nursing technicians. The inclusion criterion was having worked in the sector for more than six months, understanding that this is the minimum period for workers to adapt to the service dynamics. Professionals who were on sick leave, maternity leave or on vacation during the data collection period were not allowed to participate.

For data collection, the focus group technique was chosen, which allows data production through interactions of interinfluence between group members in sharing opinions and beliefs, enabling the construction of consensus and the identification of disagreements regarding the topics and themes addressed.[11]

Participants were recruited through prior contact for a brief explanation of the research, followed by an invitation to participate. After acceptance, three focus groups were formed, organized for convenience according to the shifts of nursing professionals working day and night. The dates for the sessions were presented to participants in each group in order to assess their availability.

In the presence of two authors and members of each focus group, data production took place from July 8 to 16, 2019, through three meetings with each group, which took place in a room in the maternity ward, with privacy and free from external interference, where the chairs were arranged in a circular shape, which favored participant interaction.

Two authors, one a professor with experience in conducting focus groups and one a nurse-midwife, a resident at the time of data production, acted as facilitators of the activities, following a previously established script guiding the group meetings. For the first session, discussions were triggered by the question "Talk about the use of NINCTs by nursing in high-risk maternity wards",

with the aim of problematizing daily care. The second session focused on identifying problem situations related to the use of NINCTs, through the following question: "What are the difficulties faced regarding the use of NINCTs in high-risk maternity wards?". In the last session, discussions were based on the correlation of problem situations with their respective critical nodes.

With participants' permission, photographic records were made of the focus group sessions, which lasted an average of 90 minutes, totaling four and a half hours of audio recording. All material was transcribed in full, using a Word processor, after the end of each meeting and subsequently presented for participants' knowledge and validation, without the need for modifications.

The material produced was analyzed using the thematic content analysis proposed by Minayo,[12] which involves the following stages: pre-analysis, proceeding with an exhaustive and attentive reading of content homogeneity; exploration and categorization, when the recording and context units were identified, the representative excerpts were chosen and the categories defined; and data treatment and interpretation, which was characterized by the critical analysis of results based on concepts from Christopher Dejour's Psychodynamics of Work, which considers the relationship between the work environment and the forms of work organization as determinants of workers' subjectivities and, consequently, of the experiences of pleasure and suffering related to work.[13]

Three categories emerged from this process: "Conflicts with the medical team"; "Lack of support from nursing management"; and "Hospital routines not aligned with the proposed actions of nursing-midwifery".

It is clarified that the present study followed the ethical assumptions of research involving human beings. It was submitted to the *Universidade do Estado do Rio de Janeiro* Research Ethics Committee, under Opinion 3,154,474, dated February 19, 2019. All participants signed the Informed Consent Form, and their anonymity and confidentiality of information were guaranteed. In order to preserve participant identity, a coding was adopted, using the letters "Nur.", referring to generalist nurses, "Nur.-Mid.", referring to nurses-midwives, and "Nur. Tech.", for nursing technicians, followed by the letters A, B and C, representing, respectively, focus groups one, two and three, in the order in which they were constituted.

RESULTS

Fifteen professionals from the nursing team of the obstetric center participated in this study, including seven nurses (one generalist and six specialists in nursing-midwifery) and eight nursing technicians, all female, with an average age of 35 years. Group A consisted of three nurses-midwives and four nursing technicians. Group B consisted of two nurses (one generalist and one specialist in nursing-midwifery) and two nursing technicians. And group C consisted of two nurses-midwives and two nursing technicians.

Conflicts with the medical team

Nurses and nursing technicians reported situations of direct and indirect clashes with medical professionals, who demonstrated disrespectful attitudes towards the work of the category, especially when assisting women in labor.

> *Interaction with the nursing team is tense and conflicting… some medical professionals demonstrate obstetric practices that are not recommended and outdated, not based on evidence! Physicians who do not respect the pregnant woman's birth plan. Their lack of respect for nursing work.* (Nur.-Mid. A)

> *I had a problem with a physician who treated me disrespectfully. I was with the patient in the shower, he came in, turned on the light and asked her to lie down…* (Nur.-Mid. A)

> *I think they know that we can act during labor; they just don't want to give us that space. Disrespect for our actions! They have knowledge, but they simply don't respect it...* (Nur.-Mid. A)

> *I observe difficulty in maintaining care until the end of labor, as physicians take away nurses' autonomy and do not respect practices, despite so much evidence.* (Nur. B)

Furthermore, participants perceive that the disrespect is even more evident in relation to nurses' actions with NINCTs, indicating that physicians do not recognize their actions in assisting high-risk postpartum women.

> *The lack of recording of incidents for the shift… not recording the situations of conflict when using technologies as care.* (Nur.-Mid. A)

> […] *interference of the medical team in the actions of the nursing team during the application of technologies [refers to NINCTs], often due to their lack of knowledge.* (Nur. Tech. B)

> *Our main problem is the interference in the use of technologies. The multidisciplinary relationship… most of the medical team does not respect it, they see the woman only as a mechanical being in childbirth.* (Nur. Tech. B)

Lack of support from nursing management

Group participants report that management is absent in the sector and they feel helpless in situations of conflict with the medical team related to the use of NINCTs by nursing:

> *They don't ask how we are, if we need anything* [...]. *The issue is for them to be more present.* [...] *we don't get that feedback. That feedback from management doesn't happen.* (Nur. Tech. Group A).

> *Even if sporadically, if management were present, we would have a feeling of support.* (Nur. Tech. Group A)

> *If you have a conflict with a physician, she* (the boss) *asks you to make a report, saying who went, what they did and what they didn't do. But in our everyday, this effective participation doesn't happen.* (Nur. Group A)

> *We don't want our bosses to take on our role and make noise for us. We want our bosses to make noise with us!* (Nur. Group A)

Furthermore, the statements indicate that the lack of support from nursing managers is also reflected in the scarcity of material resources necessary for the use of some NINCTs and in the absence of incentives for professional updating and training on the subject:

> *There are things that are expensive, like laser and acupuncture, but we don't even have the basics, like essential oils, hot water in the bathrooms, music, stools, massage cream...* (Nur.-Mid. Group A)

> *If you don't have a course, you don't have a lecture... you don't have support! There is no question of socializing nursing work in the institution.* (Nur. Tech. Group A)

> *I notice the lack of training for those who are not nurses-midwives to clarify when and how to use each method.* (Nur. Group B)

> *There is a need to update the nursing team. The preparation of the nursing technician on the right time to intervene and how to intervene with technologies.* (Nur. Tech. Group B)

> […] *give instructions on the use of warm baths, massage, walking... birthing stool and ball; in my case, knowledge is limited.* (Nur. Group B)

> *There are things that I have no idea how to do! For instance, massage, that's fine, but aromatherapy says that for each fragrance, there is a moment...* (Nur. Tech. Group C)

Hospital routines not aligned with the proposed actions of nursing-midwifery

The statements in this category show that the groups recognize the requirement to use a chair or stretcher to transport a clinically stable patient from the pre-delivery ward to the delivery room or surgical center as a requirement of a patient safety protocol that interferes with the proposed nursing action.

> *You don't need to take the patient in a chair if she has no movement restrictions and there is no situation that requires her to take a bath in a chair. After all, this would defeat one of the purposes used here. The patient will be sitting in a cold chair!* (Nur. Tech. Group A)

> *The woman is about to have her baby… it is important for her to walk, to stand up, if she is able to. Then the person says that patients should be transported in wheelchairs! In other words, you break everything that you as a nurse-midwife believe in and want to implement.* (Nur. Tech. Group A)

> *We have to find out about this! There is an ANVISA manual that is specific to obstetrics… Brazilian National Patient Safety Program in the obstetrics service!* […]. *Because, really, we have no way of applying this issue to obstetrics…* (Nur.-Mid. Group A)

> *Only those who have used a stretcher know what it's like. You go in for a C-section with your belly that size, up, suffocating, the person anxious, just watching the lights go by... wouldn't it be better for that patient to walk? Talk? Distract herself? She is extremely anxious, whether from the surgery or the anesthesia and everything else! She is accompanied by her husband or someone else she herself chose... if she had them at that moment, by her side... even accompanied by us to help calm her down? Now, she's going to lie down, to be on the outside in front of everyone* (Nur. Tech. Group A)

DISCUSSION

The lack of motivation among nursing staff to use NINCTs was mainly associated with conflicts with the medical team. This finding reveals that, despite the advances achieved in the Brazilian obstetric field, tensions persist between these categories, which are challenges for interprofessional collaboration, described as a way of organizing health work that requires respect for different knowledge, effective communication, the existence of common objectives and the sharing of decisions among professionals to ensure comprehensiveness, quality and safety of care.[14,15]

In childbirth care, clashes between physicians and nurses arise from the coexistence of different world views, and it is common to observe disputes, disrespect and lack of cooperation.[16] From this perspective, physicians are followers of the biomedical model, characterized by interventionist and medicalized practices, with professional-centered decisions, especially in the context of care for high-risk pregnancies.[14,15] On the other hand, nurses-midwives are dedicated to producing demedicalized care, through the use of NINCTs, developing practices to promote the physiology of childbirth and women's autonomy in line with the principles of the humanistic model, regardless of pregnant women's risk stratification.[7,9]

Thus, the medical attitudes identified in this study can be seen as a lack of recognition of nurses-midwives' practices in the care of high-risk postpartum women, especially when it involves the use of NINCTs. In light of psychodynamics of work, this lack of recognition can trigger experiences of suffering, due to the lack of social significance related to their work activities,

with the potential to destabilize the professional identity of these workers.[17-19]

In the case of nurses-midwives, NINCTs are identity references that generate a sense of belonging, conferring distinctions on their care and creating representations for society, which allow these specialists to be recognized among other healthcare professionals. Therefore, as a way of containing the dissemination of the demedicalized model and preserving the medicalized logic, physicians manifest imposing actions and disrespect the space of action in an attempt to disqualify the care process of nurses-midwives.[20]

From this perspective, it is noted that work organization in the high-risk maternity ward of this research is characterized by gender inequalities, as the knowledge associated with the feminine is seen as hierarchically inferior to that of masculine origin, evidencing the domination of the feminine by the masculine in the power relations between medicine and nursing.[21,22] In this way, the statements reveal the forms of power exercised by physicians who, as representatives of a male profession, try to repress the manifestation of the feminine, expressed in demedicalized care and in the use of NINCTs by nursing-midwifery, a female specialty in a profession that is mostly composed of women. As a result of the nature of these relationships, the nursing team appears unmotivated to care from the perspective of these technologies.[7-9]

In view of these issues, management plays a fundamental role for professionals, as it mediates the work prescribed by the institution with workers' subjectivity and creativity to deliver the real work. During the execution of tasks, workers must use personal devices to transform the prescribed work, that contained in the job description, into prescriptions, guidelines or planned instructions, formally imposed by the work organization. In the case of the nurses studied, NINCTs are part of the prescribed work, however they face barriers to using them, given the clashes with medical professionals, representing the real work, which deals with the concrete reality of the work activity, i.e., it is the work performed by workers on a daily basis, imprinting personal elements in the way actions are performed, adapting it, and overcoming setbacks and unforeseen events.[23]

Furthermore, nurses who occupy a leadership position is committed to creating and maintaining an organizational environment that is favorable to the development of activities that permeate work and to establishing a relationship of partnership, affection, respect and reciprocity with their subordinates, promoting creative and integrative actions capable of articulating individual and collective work to achieve institutional objectives, with greater possibilities of worker satisfaction, given the freedom to express their creativity and, thus, promote improvements in the work process, as highlighted by nursing professionals in this study.[17-19,23]

At the same time, it is worth highlighting that service managers are responsible for the following actions: continuing education, referring to the provision of courses and training, to promote the updating of workers' knowledge, which aims at technical and instrumental improvement through verticalized pedagogical activities; and permanent education, which seeks learning at work, understanding it as a source of knowledge in which managers and workers collectively construct significant learning, through the problematization of daily work processes.[24,25]

Supporting the findings of studies with nurses-midwives from other maternity hospitals,[26-28] the workers in this research perceive that the lack of support from management is reflected in the scarcity of training and material resources related to the use of NINCTs. If, on the one hand, this finding refers to the possibility that some professionals, such as generalist nurses and nursing technicians, do not feel able to use certain technologies available in the service, which raises concerns about the safety of care for postpartum women, on the other hand, the work context described by participants points to the devaluation of nursing work.

In other words, workers in this study do not identify forms of symbolic retribution for their work, for instance, through investments in professional development, expressions of trust, and demonstrations of gratitude and support from leaders. It is worth noting that this type of recognition generates feelings of belonging and satisfaction in workers, based on the perception of usefulness and contribution to a collective good, but, in the absence of such recognition, suffering sets in, with demotivation for work as a form of expression,[29,30] as verified among participants.

In the case of the nursing professionals in this research, it was found that the lack of motivation to use NINCTs in high-risk maternity wards also comes from the inconsistency between routines for intra-hospital transport of women in labor and the right to free movement of women during labor and delivery.

Although the Brazilian National Patient Safety Program recommends the development of initiatives to reduce the occurrence of incidents and adverse events in healthcare, it is highlighted that the adoption of preventive measures for falls must consider local specificities and the assessment of risks to which users are exposed in hospital environments.[31,32] Specifically in obstetric services, it is important to consider the high risk of falls among women, as postural instability is a physiological change in pregnancy that remains in the postpartum period, with falls being the most frequent among postpartum women undergoing surgery.[33]

Thus, preventing falls in maternity wards involves professionals' clinical judgment and the use of risk assessment and stratification tools, with a view to implementing individualized actions to promote a safe environment, based on educational guidelines aimed at women and staff.[33] For these reasons, it is understood that some actions adopted in the scenario of this study are subject to review, with a view to meeting patient safety regulations in maternity hospitals and recommendations for humanized care.

The guidelines for humanizing obstetric care are centered on the needs of women, families and the community, with an emphasis on respecting their autonomy and the physiology of childbirth. From this perspective, good practices based on scientific evidence emerge, which point to sharing decisions, offering a welcoming environment, with flexible routines that favor free movement and the expression of expectations and feelings, and respecting

singularities, beliefs and values, providing a positive and safe experience, whether with childbirth or cesarean section.[2,26,27]

In this logic, hospital environments are also fundamental for motivation and satisfaction related to work, encompassing adequate physical spaces, with guaranteed furniture, equipment and supplies necessary for humanized practices, as well as professional and interpersonal spaces that incorporate the subjectivities of health work, promoting human, welcoming and problem-solving relationships.[32]

It is known that work is developed based on the dialectical relationship between pleasure and suffering. Pleasure is linked to the achievement of meanings and gratification through work, materializing through appreciation, recognition, interpersonal relationships, professional autonomy and a sense of purpose in carrying out daily tasks. In contrast, there is suffering, which is linked to inadequate conditions for carrying out work activities, lack of recognition, an inhospitable relational climate, authoritarian bosses and overloads. The intensification or sum of these elements can trigger stress and exhaustion, contributing to suffering and even illness.[34-36]

Considering the complexity of this relationship and that work organization plays a central role in the sublimation of suffering, the results of this research reveal that the experiences of suffering are more evident in the group studied and the lack of motivation of the nursing team to use NINCTs comes from the professional devaluation in the context of high-risk maternity, given the lack of recognition of their practices by physicians, and the lack of material and symbolic support from management, which could act to control and modify the conditions that cause or catalyze suffering.[34-36]

FINAL CONSIDERATIONS AND IMPLICATIONS FOR PRACTICE

It was evident that the lack of motivation of the nursing team to use NINCTs in high-risk maternity is associated with: clashes and disrespect shown by physicians; perception of lack of support from nursing managers, expressed in their absence in situations of conflict with the medical team; scarcity of material resources necessary for the use of some NINCTs; lack of incentive for professional updating and training on the subject; and the existence of routines that interfere with good practices, further discouraging the use of these technologies.

Given these situations of work organization in high-risk maternity wards, it is considered that demotivation is the result of the predominance of experiences of suffering among the nursing team, which have the potential to cause psychophysical illness among these workers. However, this configuration can be modified through actions implemented by management, in order to: provide opportunities for problematizing the work reality, with the participation of nurses, technicians and physicians; establish regular meetings between management and nursing and medical professionals; make routines more flexible; and strengthen the nursing team's professional autonomy, through the purchase of the material resources necessary for NINCTs.

In addition to these strategies, the importance of promoting interprofessional learning spaces in daily work is reinforced, which will contribute to the establishment of horizontal and respectful interpersonal relationships, including from a gender perspective, capable of promoting collaborative practices, which are fundamental in the context of assistance for high-risk pregnancies.

Concerning the study limitations, it is worth noting that the research was conducted in only one high-risk maternity hospital, which makes it impossible to generalize the results. Therefore, it is recommended that research be conducted in obstetric services with the same care profile and/or in other university hospitals. In relation to the setting of this study, it is suggested that research be conducted that focuses on coping strategies adopted by nursing teams to overcome suffering and prevent illness amid lack of motivation for work.

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DATA AVAILABILITY RESEARCH

The contents underlying the research text are included in the article.

CONFLICT OF INTEREST

None.

REFERENCES

1. Pereira ALF, Ares LPM, Prata JA, Progianti JM, Lopes GCC, Silva GB. Experiences of high-risk parturient women with the use of non-invasive care technologies. Texto Contexto Enferm. 2024;33:e20230202. http://doi.org/10.1590/1980-265x-tce-2023-0202en.
2. Nunes FJ, Rodrigues DP, Paiva AM, Coelho NP, Costa AE, Nascimento JP et al. Being a pregnant with gestational hypertension and its social representations about nursing care. Enferm Foco. 2024;15:e2024137. http://doi.org/10.21675/2357-707X.2024.v15.e-2024137.
3. Luo L, Wang L, Zhang M, Liao B. Application of obstetric nursing-sensitive quality indicators in continuous quality improvement. Am J Transl Res. 2022;14(1):643-55. PMid:35173882.
4. Curtin M, Murphy M, Savage E, O'Driscoll M, Leahy-Warren P. Midwives', obstetricians', and nurses' perspectives of humanised care during pregnancy and childbirth for women classified as high risk in high income countries: a mixed methods systematic review. PLoS One. 2023;18(10):e0293007. http://doi.org/10.1371/journal.pone.0293007. PMid:37878625.
5. Carregal FAS, Schreck RSC, Santos FBO, Peres MAA. Historical rescue of the advances in brazilian obstetric nursing. Hist Enferm Rev Eletrônica [Internet]. 2020; [citado 2024 nov 22];11(2):123-32. Disponível em: https://pesquisa.bvsalud.org/portal/resource/pt/biblio-1292061

6. Nicida LRA, Teixeira LAS, Rodrigues AP, Bonan C. Medicalization of childbirth: the meanings attributed by the literature on childbirth care in Brazil. Cien Saude Colet. 2020;25(11):4531-46. http://doi.org/10.1590/1413-812320202511.00752019. PMid:33175060.
7. Prata JA, Ares LPM, Vargens OMC, Reis CSC, Pereira ALF, Progianti JM. Non-invasive care technologies: nurses' contributions to the demedicalization of healthcare in a high-risk maternity hospital. Esc Anna Nery. 2019;23(2):e20180259. http://doi.org/10.1590/2177-9465-ean-2018-0259.
8. Monteiro AS, Martins EM, Pereira LC, Freitas JC, Silva RM, Jorge HMF. Practice of obstetric nurses in humanized childbirth care in a high-risk maternity. Rev Rene. 2020;21:e43863. http://doi.org/10.15253/2175-6783.20202143863.
9. Ares LPM, Prata JA, Progianti JM, Pereira ALF, Mouta RJO, Amorim LB et al. Non-invasive technologies in assisting high-risk parturient women: nurse-midwives' perceptions. Rev Rene. 2021;22:e61385. http://doi.org/10.15253/2175-6783.20212261385.
10. Rayburn WF, Jenkins C. Interprofessional collaboration in women's health care: collective competencies, interactive learning, and measurable improvement. Obstet Gynecol Clin North Am. 2021;48(1):1-10. http://doi.org/10.1016/j.ogc.2020.11.010. PMid:33573781.
11. Alves JG, Braga LP, Souza CS, Pereira EV, Mendonça GUG, Oliveira CAN et al. Online focus group for qualitative research data collection: experience report. Esc Anna Nery. 2023;27:e20220447. http://doi.org/10.1590/2177-9465-ean-2022-0447pt.
12. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 14. ed. São Paulo: Hucitec; 2014.
13. Dejours C, Bensaïd A, Guiho-Bailly MP, Lafond P, Grenier-Pezé M. Psicodinâmica do trabalho: casos clínicos. 1. ed. Porto Alegre: Dublinense; 2017.
14. Peduzzi M, Agreli HLF, Silva JAM, Souza HA. Teamwork: revisiting the concept and its developments in inter-professional work. Trab Educ Saúde. 2020;18(1):e0024678. http://doi.org/10.1590/1981-7746-sol00246.
15. Habre MA, Dolansky M, Lotas M, Allam S, Fitzpatrick J. Interprofessional collaboration among nurses and physicians in Lebanon. J Interprof Educ Pract. 2023;32:100627. http://doi.org/10.1016/j.xjep.2023.100627.
16. Belarmino AC, Rodrigues MENG, Vieira LJES, Silva MRF, Anjos SJSB, Ferreira Jr AR. Collaborative practices in normal delivery centers: a qualitative study with nurses. Rev. Eletr. Enferm. 2024;26:77017. http://doi.org/10.5216/ree.v26.77017.
17. Marra AV, Lara SM, Teixeira MB, Magalhães TS. Perceptions of pleasure and suffering at work and managerial action. Rev Gest Tecnol. 2023;23(1):276-97.
18. Albarello BA, Freitas LG. The psychodynamic clinic of work and adaptations made by researchers in Brazil. Rev Psicol Organ Trab. 2022;22(2):2039-46.
19. Gonçalves FC, Vieira Jr N. The Influence of management on the dynamic of pleasure and suffering at work. Trab. Educ. 2023;32(1):45-62. .
20. Almeida MS, Rodrigues DP, Alves VH, Reis LC, Silva CA, Parente AT et al. The obstetrical nursing identity in a birth center. Esc Anna Nery. 2023;27:e20230024. http://doi.org/10.1590/2177-9465-ean-2023-0024en.
21. Francisco Jr WE, Souza AA, Ferreira MS. Gender relations in Higher Education: how do students perceive them? Rev Inter Educ Sup. 2022;10(00):e024033. .
22. Villegas-Pantoja MA, Mendez Ruiz MD. Orden de género: un reto histórico y actual para la enfermería. Rev Chil Enferm. 2022;4(2):87-103. http://doi.org/10.5354/2452-5839.2022.67816.
23. Cummings GG, Lee S, Tate K, Penconek T, Micaroni SPM, Paananen T et al. The essentials of nursing leader ship: a systematic review of factors and educational interventions influencing nursing leader ship. Int J Nurs Stud. 2021;115:103842. http://doi.org/10.1016/j.ijnurstu.2020.103842. PMid:33383271.
24. Mattos MP, Campos HMN, Gomes DR, Ferreira L, Carvalho RB, Esposti CDD. Permanent health education in psychosocial care centers: integrative literature review. Saúde Debate. 2020;44(127):1277-99. http://doi.org/10.1590/0103-1104202012724.
25. Shinners J, Graebe J. Continuing education as a core component of nursing professional development. J Contin Educ Nurs. 2020;51(1):6-8. http://doi.org/10.3928/00220124-20191217-02. PMid:31895463.
26. Oliveira CF, Ribeiro AAV, Luquine Jr CD, Bortoli MC, Toma TS, Chapman EMG et al. Barriers to implementing guideline recommendations to improve childbirth care: rapid review of evidence. Rev Panam Salud Publica. 2020;44:e132. . PMid:33337446.
27. Oliveira OS, Couto TM, Oliveira GM, Pires JA, Lima KTRS, Almeida LTS. Obstetric nurse and the factors that influence care in the delivery process. Rev Gaúcha Enferm. 2021;42(spe):e20200200. http://doi.org/10.1590/1983-1447.2021.2020-0200.
28. Vieira MLC, Prata JA, Oliveira EB, Rodrigues FAB, Almeida BCDS, Progianti JM. Strategies of nurse-midwives in relation to working conditions in maternity hospitals. Rev Bras Enferm. 2021;74(1):e20200201. http://doi.org/10.1590/0034-7167-2020-0201. PMid:33787793.
29. Dejours C, Zambroni-de-Souza PC, Barros VA. Centrality of work for mental health. Cad Psicol Soc Trab. 2023;26:e213340.
30. Rodrigues RG, Benati MAFNO, Rodrigues RG. Psychodynamics of work and the work routine: literature review based on dejours theory. Farol [Internet]. 2022; [citado 2024 nov 22];16(16):67-77. Disponível em: https://revista.farol.edu.br/index.php/farol/article/view/395
31. Ministério da Saúde (BR). Documento de referência para o Programa Nacional de Segurança do Paciente. 1. ed. Brasília: Ministério da Saúde; 2013.
32. Silva SCD, Morais BX, Munhoz OL, Ongaro JD, Urbanetto JS, Magnago TSBS. Patient safety culture, missed nursing care and its reasons in obstetrics. Rev Lat Am Enfermagem. 2021;29:e3461. http://doi.org/10.1590/1518-8345.4855.3461. PMid:34190951.
33. Risso S, Soares T, Marques-Vieira C. Scoping review of fall risk assessment tools for women who receive maternity care. Obstet Gynecol Clin North Am. 2024;53(3):234-44. http://doi.org/10.1016/j.jogn.2023.11.012. PMid:38176683.
34. Pimenta CJL, Silva CRRD, Bezerra TA, Costa TFD, Oliveira JDS, Costa KNFM. The impact of work on the health of nursing professionals. Rev Esc Enferm USP. 2020;54:e03584. http://doi.org/10.1590/s1980-220x2018046103584. PMid:32813822.
35. Oliveira LAF. The pleasure-psychic suffering at work and the perspective of Christophe Dejours. RPS]. 2019;8(11):360-9. http://doi.org/10.3333/ps.v8i11.846.
36. Franco MF, Farah BF, Amestoy SC, Thofehrn MB, Porto AR. Meaning of work from the perspective of hospital nurses. Rev Bras Enferm. 2021;75(2):e20201362. http://doi.org/10.1590/0034-7167-2020-1362. PMid:34705989.

AUTHOR'S CONTRIBUTIONS

Study design. Juliana Amaral Prata. Midian Oliveira Dias. Sonia Regina da Silva Gonçalves. Tatiana Beatriz Leandro de Castro. Debora Cecilia Chaves de Oliveira. Danielle Gonçalves Ferreira.

Data acquisition. Juliana Amaral Prata. Sonia Regina da Silva Gonçalves.

Data analysis and interpretation of results. Juliana Amaral Prata. Midian Oliveira Dias. Sonia Regina da Silva Gonçalves. Tatiana Beatriz Leandro de Castro. Debora Cecilia Chaves de Oliveira. Danielle Gonçalves Ferreira.

Manuscript writing and critical review. Juliana Amaral Prata. Midian Oliveira Dias. Sonia Regina da Silva Gonçalves. Tatiana Beatriz Leandro de Castro. Débora Cecília Chaves de Oliveira. Danielle Gonçalves Ferreira.

Approval of the final version of the article. Juliana Amaral Prata. Midian Oliveira Dias. Sônia Regina da Silva Gonçalves.

Tatiana Beatriz Leandro de Castro. Débora Cecília Chaves de Oliveira. Danielle Gonçalves Ferreira.

Responsibility for all aspects of the content and integrity of the published article. Juliana Amaral Prata. Midian Oliveira Dias. Sônia Regina da Silva Gonçalves. Tatiana Beatriz Leandro de Castro. Débora Cecília Chaves de Oliveira. Danielle Gonçalves Ferreira.