

Potentialities and Limitations of The Roles of Obstetric Nurses in the Normal Birth Center: Qualitative Study

Potencialidades e Limitações da Atuação do Enfermeiro Obstetra no Centro de Parto Normal: Estudo Qualitativo
Potencialidades y Limitaciones de la Actuación del Enfermero Obstetra en el Centro de Parto Normal: Estudio Cualitativo

RESUMO

Objetivo: Conhecer as potencialidades e limitações na assistência do enfermeiro obstetra no Centro de Parto Normal. **Método:** Estudo descritivo e qualitativo com 13 enfermeiros obstetras de um hospital no Rio Grande do Norte, por meio de entrevistas semiestruturadas. A análise seguiu a Análise de Conteúdo de Bardin, gerando três categorias relacionadas a assistência, potencialidades/limitações e tomada de decisões. **Resultados:** Destacaram-se valorização da autonomia do enfermeiro e trabalho colaborativo com a equipe multiprofissional. Entre as potencialidades, vínculo com a parturiente e escuta qualificada. As limitações envolveram resistência médica às práticas de enfermagem e dificuldades no acolhimento pelo setor de classificação de risco. **Conclusão:** A atuação do enfermeiro obstetra no Centro de Parto Normal avança na humanização do parto, mas ainda há desafios estruturais e institucionais que afetam a autonomia e a qualidade do cuidado.

DESCRIPTORES: Parto Normal; Enfermagem Obstétrica; Autonomia profissional.

ABSTRACT

Objective: To explore the potential and limitations of obstetric nurses' roles in Normal Delivery Centers. **Method:** Descriptive, qualitative study with 13 obstetric nurses from a hospital in Rio Grande do Norte, using semi-structured interviews. Content analysis identified three categories: care, potential/limitations, and decision-making. **Results:** Nurse autonomy and collaborative teamwork were valued. Potentials included bonding with the parturient and active listening. Limitations involved resistance from medical staff to nursing practices and challenges in risk classification reception. **Conclusion:** Obstetric nurses contribute to the humanization of childbirth, though structural and institutional challenges still affect autonomy and care quality.

DESCRIPTORS: Natural Childbirth; Obstetric Nursing; Professional Autonomy.

RESUMEN

Objetivo: Conocer las potencialidades y limitaciones en la asistencia del enfermero obstetra en el Centro de Parto Normal. **Método:** Estudio descriptivo y cualitativo con 13 enfermeros obstetras de un hospital en Río Grande del Norte, mediante entrevistas semiestructuradas. El análisis de contenido identificó tres categorías: asistencia, potencialidades/limitaciones y toma de decisiones. **Resultados:** Se valoraron la autonomía del enfermero y el trabajo colaborativo con el equipo multiprofesional. Las potencialidades incluyeron el vínculo con la parturienta y la escucha activa. Las limitaciones fueron la resistencia médica a las prácticas de enfermería y dificultades en la recepción del sector de clasificación de riesgo. **Conclusión:** Los enfermeros obstetras contribuyen a la humanización del parto, pero persisten desafíos estructurales e institucionales que afectan la autonomía y la calidad del cuidado.

DESCRIPTORES: Parto Normal; Enfermería Obstétrica; Autonomía Profesional.

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INTRODUCTION

Historically, childbirth was seen as a natural, home-based event, assisted by a midwife close to the family, and requiring the presence of a medical professional only in case of complications. From the 20th century onwards, this event began to be institutionalized within a hospital setting. This change allowed for the introduction of invasive practices and surgical techniques, transforming childbirth into a "medical phenomenon."¹

Since the 1980s, women's health policies have promoted the gradual restoration of their autonomy in childbirth. In 1999, Ordinance No. 985 institutionalized the Normal Birth Centers (CPN - Centros de Parto Normal) within the Brazilian Unified Health System (SUS), focused on providing humanized care for non-dystocic natural births, and capable of operating within or outside of a hospital setting.²

The Obstetric Nurse (ON) with a postgraduate degree (Stricto or Lato Sensu) in Obstetric Nursing and registration with COFEN (Brazilian Federal Nursing Council) works in the peri-partum period, assisting pregnant women, normal deliveries without dystocia, postpartum women, and newborns.³ COFEN Resolution No. 672/2021 supports its practice in low-risk childbirth at the CPN and/or Birthing Center, from admission to hospital discharge.⁴

The autonomy of the ON (Obstetric nurse) is shaped by scientific evidence guiding decision-making in the technical-scientific field, ensuring safe and high-quality childbirth and delivery, by reducing unnecessary and scientifically unfounded interventions, thus impacting the reduction of health indicators.⁵

This demonstrates the importance of the role of Obstetric Nurse in a humanized birth, throughout the entire process, as it provides the woman in labor with greater security, comfort, and freedom by reducing anxieties about normal labor.⁶

Although there have been advances in the performance of Obstetric Nursing, there are still limitations in its professional practice, such as resistance from the medical profession, which is unaware of the autonomy of Obstetric Nursing in assisting with low-risk childbirth, and gaps in training, including in continuing health education for Obstetric Nursing professionals.⁷

Research shows that qualified and humane care promotes normal childbirth, reduces the cesarean section rate, and contributes to a decrease in maternal and infant morbidity and mortality in Brazil.⁸ By analyzing the role of the ON, the study supports professional training and the development of public policies, strengthening safer and more mother-centered care.

Thus, this study seeks to understand the potential and limitations of ON assistance in the CPN.

METHOD

This is a descriptive study with a qualitative approach, developed according to the parameters established by the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist. The investigation was carried out at the Pediatric Center (CPN) of a hospital located in Rio Grande do Norte, a reference institution in gynecological and maternal-infant care in the region.

Thirteen nurses working in the aforementioned unit participated in the study; all were included in the sample and interviewed in their entirety. The inclusion of these professionals in the sample met the following criteria: holding a postgraduate degree in Obstetric Nursing and providing direct care to parturients in the CPN. Nurses who, during the data collection period, were on leave, maternity leave, or absent for any other reason were excluded from the research.

Data collection was carried out by a nursing graduate working as a resident at the CPN in question. The interviews took place in a private location within the studied sector, in order to preserve the privacy and safety of the interviewee, and lasted an average of 15 minutes. To obtain the data, the interviewees' voices were recorded, with their prior consent.

The data collection instrument was carried out in two stages. First, a questionnaire was applied to characterize

the sociodemographic characteristics of the respondents. In the second stage, an interview was conducted using semi-structured questions.

The responses were typed in Microsoft Word (version 2024) and processed using Bardin's Content Analysis, organized into three phases: I- Pre-analysis; II- Analysis of the material; III- Treatment of results, inference and interpretation. Thus, the presentation of the results was organized by common themes among the respondents' statements. The discussion was carried out in comparison to other studies already published.

The study was submitted to and approved by the Research Ethics Committee via opinion number 7.078.327 and CAAE 82070024.8.0000.5568. Respect for ethics and the anonymity of participants was guaranteed through the signing of the Informed Consent Form and the Voice Recording Consent Form.

RESULTS

The results were obtained through interviews with 13 nurses, of whom 11 were women (85%) and 2 were men (15%). The average age was 39.38 years. Of the participants, 61% (8) had a postgraduate degree in Obstetric Nursing and 39% (5) had residency training; of these, 39% (5) also had a master's degree in the area.

Regarding experience time, 2 professionals (15.3%) had between 2 and 5 years, 7 (53.8%) between 5 and 10 years, and 4 (30.7%) between 10 and 17 years. The length of time working in the hospital's CPN ranged from 2 months to 2 years, with an average of 1 year and 5 months. Regarding previous experience in CPN, only 5 professionals (39%) had it, with a time between 3 and 12 years.

Regarding the content analysis of the interviews, three thematic categories emerged, namely:

Category 1: Obstetric Nurse Assistance in the Normal Delivery Center

When questioned about the role of the Obstetric Nurse in the CPN (Prenatal Care Center), some participants listed that their duties include admitting pregnant women with low-risk pregnancies to the unit, offering non-pharmacological methods for pain relief, assessing the progress of labor through vaginal examination and monitoring uterine contractions. They also assist with the delivery itself and accompany the mother-child dyad until hospital discharge.

[...] If any incident occurs, we are the first to act, and if we see that a medical evaluation is needed, we call the team – which we call support – because the doctors at the CPN act more as support, so the nurse has the autonomy to perform

vaginal examinations, if an amniotomy is needed, [...] if we see that this intervention is necessary, right?! (ON3)

[...] Our role here at CPN is...predominantly that of an obstetric nurse, right?! But if there are any complications, we contact the doctor and manage it according to their profile [...], in cooperation with the multidisciplinary team, especially the women's health physiotherapy team, which is a great partner." (ON5)

[...] is... within the CPN, we have the freedom to discuss cases with the medical team. If we need an evaluation, I think our work is very collaborative, because we have physiotherapy in partnership with us, right?! [...]. We also have the medical team present when we, at the CPN, need an evaluation, and we have the obstetric nursing team, along with the residency program, with whom we work very closely together, I think everything we do is very collaborative. (ON11)

Category 2: Potential and limitations of the Obstetric Nurse's assistance in the Normal Delivery Center

Regarding the potential and limitations related to the ON's role in the CPN, these were grouped and presented in Table 1.

Table 1. Potential and limitations regarding the ON's role in the CPN.

Potentialities	ONs' Discourse
Autonomy and freedom in assessing the parturient, in assisting with childbirth, the postpartum period, and the newborn.	<i>[...] here is the only place [in the state] that has a CPN and that still has a certain autonomy for the nurse, a certain space for action, where he/she evaluates, admits the patient, re-evaluates, and his/her evaluation is respected. (ON4)</i> <i>In relation to potential, I think that the nurses here [...], they have this capacity to provide assistance to normal childbirth, with everything that the patient needs, safety, doing something based on what is quality, on good practices [...]. (ON6)</i> <i>The potential, like this... having this autonomy, having a public that needs the health service, totally entrusted to you, so you have a very large freedom of action. (ON9)</i>
Good communication and teamwork with the multidisciplinary team.	<i>[...] And potential also lies in the good communication we have today with the doctors, right?! The issue of them respecting space. (ON1)</i> <i>[...] The multidisciplinary team that we have is able to work with all categories [...]. (ON10)</i>

Support from management and the existence of institutional protocols that underpin the ON's actions.	<i>[...] I also think that the freedom regarding nursing management, we realize that it has improved a lot, we have better access, an ease in relation to dialogue, to discuss situations, [...] this is a positive point that I perceive here, and I think it will improve more and more. (ON5)</i> <i>I think there is an organization of the management itself in relation to this, right?! So the management itself already opens up this space so that we have autonomy in the service, right?! And they are also very concerned about this, about those who don't yet have so much experience, that they are really trained within the unit [...]. (ON11)</i>
Physical structure, environment, and resources available in the sector.	<i>The main potential lies in the structure, right?! [...] especially the CPN beds, it's something wonderful, isn't it?! We see the patient's expression when she enters, how much she benefits from having a bed of this size, right?! (ON8).</i> <i>[...] There's also the advantage of the physical structure of a CPN; we have CPN rooms that can give the patient both comfort and privacy, right?! There's a more equipped room with a bathroom and everything else, so we have a very good physical space. These are aspects of the facilities that I notice during my work. (ON13).</i>
Limitations	ONs' Discourse
Lack of recognition, on the part of some professionals, regarding the profile and purpose of the CPN.	<i>[...] I feel the lack of reception [in the sector], sometimes they put patients in the CPN who are not [the right profile]. Sometimes they put a patient in labor who is not in active labor, she is still in prodromal labor [...]. (ON1).</i> <i>I think that because it is the first CPN here [in the state], the biggest difficulty is the understanding of the doctors and even the nursing professionals. We have a renewed staff in obstetric nursing here, some nurses didn't know the CPN as the CPN itself. So, they still need to create this autonomy, that childbirth assistance is also done by us, they are still understanding this process. I think the biggest limitation is knowledge, then understanding how the CPN process works [...]. (ON3).</i>
Relaxation of eligibility criteria for assistance.	<i>Sometimes, certain situations are not respected regarding what truly fits the profile of a patient requiring prenatal care. For example, you arrive at your shift, and the patient is already admitted, and when you examine her, you find some alteration in her prenatal care or some exam that, in fact, disqualifies her from the profile. However, you won't stop managing this woman because of that. So, the problem is that you see that there are some signs that could lead to this labor becoming high-risk (ON5).</i> <i>[...] If we take into account the Ministry of Health's manuals, we have several prerequisites for patients to be classified as CPN (Prenatal Care Center), but unfortunately, due to the quality of prenatal care...if we follow the rules literally, the number of patients who qualify will be very low...but to meet the demand, we had to be flexible in some areas, and this causes insecurity because if I know that the patient has no risk whatsoever, most likely that delivery will be much more peaceful, especially in the outcome, for the newborn and for the woman, when I become more flexible, I no longer have that certainty. (ON8).</i>

Source: Study data

Category 3: Decision-making versus respect for the role of the Obstetric Nurse in the Normal Delivery Center

Based on the reports, it is clear that, for the most part, the decisions of the ONs (Obstetric nurses), regarding the conduct adopted, are respected by other professional categories.

I believe that here at CPN we have a great deal of autonomy; in fact, other professionals only intervene here, generally, at our request. So, when the nursing staff observes that there is a problem, that it could lead to a problem during labor, we ask for help, either from the physiotherapists or the obstetrician, and we are promptly assisted. (ON9)

Yes, I even feel very honored because, when the medical team or the physiotherapy team, or the psychology team, arrives and reports: "What do you think?", "How is it going?", "Do you be-

lieve it's possible to proceed this way?," then I think those decisions are very respected [...]. (ON12)

Although nurses reported that there is respect in the handling of cases, they still face difficulties with medical professionals.

[...] We can't generalize and say "oh, it's not respected by everyone," because most people respect it, but one or two feel more... "empowered" by the knowledge to interfere, to impose... interventions that we, in our care, would find unnecessary. (ON6).

I think we work together with physiotherapy. Doctors, at times, no, they aren't respected. Some situations happen, for example, when oxytocin is prescribed and we suggest waiting a little longer, right?! And no, they insist, they impose, situations of that kind, I think. (ON10).

Yes, during this time here I've noticed a certain respect [...] Very few times it has happened, in terms of "clash" of approaches. In fact, we share the patient with other professionals, which is what should happen, then, like, the professional decides to start oxytocin and I think not, right?! A matter of divergence of approaches. I think nurses will always prioritize non-intervention, and medical professionals tend to be more interventionist, right?! [...] (ON4).

DISCUSSION

Category 1: Obstetric Nurse Assistance in the Normal Delivery Center

The assistance provided by the Maternal and Child Health Team (ON) during low-risk deliveries at the CPN is humane and safe, from the arrival of the patient, her companion, and her family, until hospital discharge. The ON's work at the CPN is essential, as

it guides the monitoring of labor and the postpartum period, respecting the parturient's preferences and encouraging her autonomy, in addition to promoting the use of non-pharmacological methods.^{6,9}

Most ONs highlighted the use of non-pharmacological methods for pain relief to reduce the duration of labor and provide comfort to both mother and fetus. These included warm showers, immersion baths, breathing exercises, exercises with a birthing ball, massage, music therapy, mobility exercises, position changes, and ambulation.¹⁰

Childbirth assistance at the CPN offers opportunities to use these methods, the presence of a companion, freedom to adopt different positions during labor, and skin-to-skin contact with the newborn in the first hour of life.¹⁰

The ON is responsible for comprehensive care during low-risk deliveries, making their practice autonomous within the CPN. Furthermore, they also identify potential complications and alert the medical team, which acts in the background, intervening only in situations of unforeseen events during physiological labor.¹¹

A assistência às parturientes no CPN é realizada de forma integrada pela equipe multiprofissional, destacando-se a fisioterapia, que acompanha o trabalho de parto, atuando no gerenciamento e redução da dor através de exercícios pélvicos, técnicas manuais e orientações de posições para facilitar encaixe fetal durante a expulsão.¹²

Category 02: Potentialities and limitations in the care provided by the Obstetric Nurse in the Normal Delivery Center

The autonomy and freedom highlighted in interviews as positive differentiating factors in the performance of the Obstetric Nursing staff at the CPN stand out as strengths.

This is because this environment legitimizes and supports the autonomous practice of obstetric nursing, in accordance with the specialty's guidelines.¹³

Similarly, effective communication with the medical and multidisciplinary team is crucial, as proper interaction between professionals involved in care can reduce the risk of harm to patients' health. This becomes an essential tool for ensuring patient safety and providing quality care, as it is linked to engagement and effective teamwork.¹⁴

Institutional support is essential, integrating management and care. Management facilitates professional practice by promoting trust, valuing skills, and encouraging continuing education, fundamental elements for the quality of nursing care.¹⁵ Furthermore, protocols that support the nurse's performance in low-risk childbirth are fundamental for evidence-based care and humanized assistance, being recognized as tools for adherence to good practices.¹⁶

The physical structure and ambience of the CPN stood out, organized according to the PPP (Pre-partum, Partum, and Postpartum) model. Adjustable beds and bathtubs for water births promote the autonomy and empowerment of women in a welcoming environment.^{17,18}

Despite this, inadequate screening of pregnant women by the Obstetric Risk Classification and Assessment (ACRO - *Acolhimento e Classificação de Risco Obstétrico*) is a challenge to the professional practice of the Obstetrician in the CPN. Therefore, the presence of the Obstetrician in this sector is crucial, given their training in correctly identifying patients with the appropriate risk profile for the CPN.¹⁹

The poor quality of prenatal care and the relaxation of usual risk criteria are obstacles to fitting the profile. Research also reveals regional

inequalities in the poor performance of prenatal care, with lower coverage in the North and Northeast regions among pregnant women with low levels of education. In these regions, the main difficulties are related to access to services, and not to a lack of knowledge about the pregnancy.²⁰

Analysis of the profile of pregnant women in a primary care center in the Central-West region revealed that only 73.5% of women had the minimum number of prenatal visits (six), as recommended by the Ministry of Health. This indicates shortcomings in the coverage and quality of health-care for pregnant women in Brazil, corroborating the results of the present study.²¹

Although autonomy is recognized by nurses as a potential strength, the restriction on performing inpatient care limits their role in the CPN, hindering the work of the ON (Obstetric Nurse), who has legal backing. According to COFEN Resolution No. 672/2021, the care of routine risk childbirth in the CPN or Birthing Center is the responsibility of the Nurse, ON, or Midwife, from admission to discharge, including the issuance of Hospital Admission Authorization (AIH) for procedures without dystocia.

Although the delivery is conducted by a nurse, who is trained and has the autonomy to assess and manage routine-risk deliveries, their care at the CPN is still marked by dependence on the doctor, who prescribes medication and issues hospital discharge orders.²²

Most respondents stated that their decisions are respected by other categories, reflecting the use of evidence-based practices and the constant pursuit of technical improvement, which strengthens their autonomy and excellence.²³

Category 3: Decision-making versus respect for the role of the Obs-

tetric Nurse in the Normal Delivery Center

The interviews reveal conflicts regarding the definition of the work process, generating gaps in the team's alignment regarding best practices in childbirth and delivery.²⁴ In the biomedical model, childbirth was a pathological event, requiring invasive interventions and centralized medical care. With the inclusion of nurse-obstetricians in the delivery rooms of prenatal care centers, there are changes towards prioritizing physiological childbirth and valuing care with minimal intervention. However, resistance persists due to a lack of legal knowledge, making it essential to promote awareness about this issue.⁷⁻²⁵

Therefore, continuing education strategies and multi-professional di-

alogue promote the clarification of roles and competencies. Institutional recognition of the ON strengthens evidence-based practices and humanized care, increasing the safety and quality of childbirth and newborn care, and driving change in the current care model.²⁴

CONCLUSION

The role of the Obstetrician in the Birth Center is fundamental for humanized and safe obstetric care, based on professional autonomy, adequate structure, institutional support, and multiprofessional communication, favoring the protagonism of women and good evidence-based practices.

However, limitations such as dependence on physicians for admission

and discharge, low quality of prenatal care, and failures in referring pregnant women to the Birth Center still compromise the full exercise of the Obstetrician role. Overcoming these challenges is fundamental to consolidating their autonomy and improving the quality of obstetric care.

The main limitation of the study refers to the sample restricted to a single birth center. Despite this, it contributes to the understanding of the Obstetrician role in the Birth Center, highlighting potential and challenges faced, offering theoretical and practical support for future research on professional autonomy, interprofessional communication, and the implementation of evidence-based practices.

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