

THE LIVING OF THE PROCESS OF THE CESAREAN SECTION UNVEILED BY NURSES

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ABSTRACT

This study aimed to understand meanings and reveal senses of nurses who experienced the process of their cesarean sections. Qualitative research, phenomenological approach with the methodological/philosophical contribution of Martin Heidegger and Jean Watson's Theory. Participants were nine nurses who underwent cesarean delivery within the Zona da Mata of Minas Gerais, using the snowball technique at phenomenological meetings in the months of June/August 2016. Participants were inauthentic in choosing the possibilities of childbirth during the cesarean section, because they were not protagonists in the decisions of the birth process and did not have their autonomy and freedom of choice respected. The dialogue between the woman and the obstetrician proved to be distant, and medical hegemony overcame the woman's will. The fear was unveiled when they reported fear of making the decision of delivery route on their own and the fear of anesthesia. Scientific knowledge was not enough for the nurse-woman to become empowered in the choice of the delivery route and the delivery itself. The woman as an existential being was shown in the impropriety in the occasion of the choice by the way of delivery and during the caesarean itself.

Keywords: Cesarean section. Nurses. Women's health.

INTRODUCTION

The ideal rate of cesarean section, considered since 1985 by the international medical community, is around 10% to 15%. The rate of cesarean operation in Brazil is approximately 56%, with wide variation between public and private services⁽¹⁾. Recent studies by the World Health Organization⁽²⁾ suggest that population rates above 10% do not contribute to the reduction of maternal, perinatal or neonatal mortality.

In Brazil, cesarean rates have regional inequalities, since they are higher in women in the South, Southeast and Central West regions, with higher age and schooling, and have had prenatal care in private services⁽³⁾. Preference for delivery may vary from the beginning to the end of gestation. A population-based study with 11074 postpartum women showed that 66% of the women interviewed preferred vaginal delivery at the start of pregnancy, 28% reported cesarean delivery, and 6.1% did not have a well-defined choice. However, 51% of the women had at least one cesarean section as the final delivery method,

66% of which were cesarean sections without labor⁽⁴⁾.

Caesarean section is a surgical procedure performed from a transverse or longitudinal incision on the skin above the pubic hair line, aiming to remove the fetus from the uterus of the pregnant woman⁽⁵⁾. This procedure is a factual intervention to save the lives of mothers and babies and, among the indications are: delayed labor progression, acute fetal distress, fetal-pelvic disproportion and high-risk pregnancies. Like any surgical procedure, there are immediate and long-term risks⁽¹⁻⁴⁾.

The preparation of the pregnant woman includes the incorporation of a set of care and activities that aims to offer the woman the possibility of experiencing the childbirth as a physiological process, feeling the protagonist of all this moment. In this sense, adequate attention to parturition is a fundamental right and represents an essential step to ensure that women can exercise the process of giving birth safely and comfortably⁽⁵⁾.

The health team should be prepared to welcome the woman, her partner and her family, respecting the

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meanings that this moment brings, to facilitate the creation of a bond with the pregnant woman, giving her confidence and tranquility. Such experience will depend on a series of factors, from those intrinsic to each woman and pregnancy, to those related to care⁽⁶⁾.

In this context, the health professionals involved in the process play an important role in care, from prenatal to puerperium. They are co-adjuvants, who recognize critical moments and the need for interventions, apply their knowledge to ensure the health and well-being of the woman and the baby. They participate in the child birth, being the first to touch the newborn and to witness a mother, father and family rising⁽⁶⁾.

Thus, the quality of care provided to the mother-child binomial during gestation, delivery, puerperium and the good experience of this cycle can impact on the life of both. Natural birth is healthy for the newborn and one of the most intense experiences in a woman's life, based on the humanized care, dignity, respect and autonomy of the woman in her decisions and her body⁽⁶⁾.

However, in the face of the model of interventionist obstetric care, the woman has been losing control and decision-making over her own birth delivery, becoming the object of this action. The choice of the way of delivery is directly related to the autonomy of the woman, since this deliberation comes from information and dialogue between the pregnant woman and the health professionals about the scientific evidence that indicates the best course in a certain situation⁽⁷⁾.

Motherhood represents for women a special, unique and proper moment marked by the new mission, of being a mother⁽⁸⁾. However, if she is also a professional, taking on remunerated activities outside the domestic space, other connotations and roles are attributed to this period, which may cause conflict, since women need to reconcile all these obligations.

The advancement and recognition of women's autonomy and their new role in the family and society have corroborated the progressive increase in women's participation in the choice of delivery method, believing that the inclusion of their preferences in such a decision would influence the increase in number of caesarean sections in the world⁽⁹⁾. However, in the last few years, numerous factors not specifically defined cooperated for a consistent increase in the number of caesarean indications. The personal preferences of obstetricians and patients appear in relation to the other technical-scientific foundations as possible factors that

contribute to the paradoxical increase in the rate of cesarean deliveries⁽¹⁰⁾.

When considering how it is the experience of childbirth for the nurses who are directly involved in the care of other pregnant women, it is noticed that there is a lack of knowledge about their experiences in relation to the conduction of the own childbirth. Thus, when searching the scientific literature about the experience of nurses in their cesarean sections, a gap has been perceived in the publications that approach this topic. As the Solo of Tradition⁽¹¹⁾, which is the previous position in the literature on the subject of study of research, was not able to reach the problem of study, since it is philosophical.

In this sense, Jean Watson's Theory of Transpersonal Care⁽¹²⁾ proposes that nursing, seeking to be founded as a science of care, guides its actions in humanistic philosophies and value systems. In his works, there are references to the phenomenology of Martin Heidegger, seeking to base the construction of the science of care on humanistic factors.

In constructing the theory, it was used seven assumptions and ten factors of primary care⁽¹²⁾. It should be emphasized that care is intrinsically related to the satisfaction of human needs and that it must be practiced interpersonally, and it is up to the nursing to practice this care. The care factors point to a humanistic value system, the construct of a relation based on help-trust and the use of the principles of existentialist phenomenology. It means that care must be truthful with the other and empathic with the evidenced feelings. Phenomenology suggests that we consider people the way they express themselves, as they are and from their references⁽¹¹⁾.

Thus, this research is justified by the increasing demand for nursing care for parturient women, the knowledge and experiences of nurses in their own delivery that may help in the obstetric nursing behavior, reflecting in evidence for the care provided to the mother-child binomial. In view of the above, the subject of this research was the understanding of nurses in the experience of their cesarean process in the light of Martin Heidegger and of Jean Watson's Theory to understand meanings and reveal senses of nurses who experienced the process of their cesarean sections at light of Martin Heidegger.

METHODOLOGY

Qualitative research anchored in the methodological and philosophical reference of Martin

Heidegger⁽¹¹⁾ and Jean Watson's Theory⁽¹²⁾, for understanding the existential movement regarding the lived by the female nurses during the process of the cesarean section itself. The option for the inclusion of the Theory of Watson is justified by the possibility of approximation of the subject investigated for the perspective of Nursing, since this referential is consistent with the Heideggerian phenomenological approach.

Nine nurses who experienced the cesarean section participated. The number of deponents was not predetermined, their statements and its respective analysis, the quantitative of interviews was satisfactory to reach the proposed objective. It was adopted as inclusion criterion to be a nurse and to experience gestation with cesarean outcome. It was considered exclusion criterion for the deponent to present alteration in the level of consciousness to the point of not expressing herself with coherence, which would make it impossible to perform the phenomenological encounter.

Data collection took place between June and August 2016. The possible speakers were referrals by nurses from a post-graduate course in nursing, through the snow-ball technique. This way, telephone contacts were made inviting them to participate in the study and by verbal acceptance, they were scheduled on a convenient day and time. The meetings were individual, in an atmosphere that allowed the phenomenological encounter. At this moment, an empathic posture, suspension of assumptions and values (époque), mediated by intersubjectivity, was kept. The technique of phenomenological interview was used from the guiding question: how was the experience of your process of cesarean delivery?

The meetings were recorded in digital media. And, field journal was also adopted to record expressions, senses and nonverbal and verbal messages captured, observing the varied ways of speech, such as silence, gestures, reticence and pauses in speeches. The speeches were transcribed respecting the original language of the deponents, which were mediated by the program Word for Windows. It should be noted that the analysis occurred concomitantly with the collection.

From the careful reading of the testimonies, the construction of two methodical moments was developed. In the first, it occurred to the factual description of the phenomenon lived through the approximation of the essential structures of the speech, arriving at two units of signification. These units refer

to the vague and median understanding and are in the ontic dimension of being, allowing the understanding of the lived, emerging the possibility for building the thread of hermeneutics. In the second, after the construction of the conductor and the comprehensive analysis, the aim was to unveil the senses of being through interpretation in light of the proposed concepts⁽¹¹⁾.

The study approved by the Ethics and Research Committee of the Federal University of Juiz de Fora, under opinion number 1,556,346/2016, in accordance with Resolution 466/2012. Initially the purpose of the investigation was explained to the participants and what their participation would consist of. The Free and Informed Consent Term (TCLE) was read and the possible doubts resolved. Thus, the acquiescence of the deponents was registered signing it.

RESULTS

Nineteen nurses who underwent cesarean sections, aged between 24 and 46 years, mean of 36.3 years were interviewed. The number of pregnancies ranged from one to three. Only one participant experienced abortion. Five deponents went through a cesarean section and four of them, two. All reported prenatal care, four of them received guidance on cesarean section and five had no information. Five had planned pregnancies, and among the nine, only two participated in groups of pregnant women.

From the nurses' statements, the following Units of Significance emerged⁽¹¹⁾: The decision was made by the physician; The cesarean section was a programmed and mechanical act.

The decision was made by the doctor

It was noted that the decision on way of delivery was not up to the deponents, but to the obstetrician who attended them. At first, the nurses wanted normal birth, but this was not considered by the obstetrician. The decision for cesarean section in some cases occurred during the prenatal follow-up and, in others, at the time of labor. However, some did not feel safe to make such a choice, being comfortable with the doctor's decision by caesarean section.

When I tried to talk about natural birth, the obstetrician told me that the cesarean section would be better. So, it turned out that just before my son was born, I had already decided on the Caesarea section. He examined me and said, "Look! Let's do Caesarean!" I said: Cannot it be natural? He said: No, it cannot! E1

I already solved your life! I have already scheduled your Caesarean section. It's going to be eight o'clock tonight. Then my eye filled with tears. Then I thought: Oh my God, it's tonight. I had no option to have it naturally, but I would not make a choice either. I had to have a Caesarean section. I had to. E2

I had worked hard on my mind and my health so that I could accomplish this {natural birth}. But since it does not just depend on us, then there is no way. He thought it was better not to do that. I was okay because one of the things that bothered me, and a lot, is to decide to have a cesarean section on my own. E3

I wanted natural labor. I did not intend to have a cesarean section at any time! Then he said that there was only eight hours to go to Caesarean section and such. Then I said not to insist. Let's go to Caesarean section! There I went. E5

Cesarean section was a programmed and mechanical act

At the phenomenological meeting, when mentioning about cesarean section, the nurses meant it as a surgical, little humanized, programmed, mechanical and rude, in which the doctor makes an incision and withdraws the baby, which can damage the bond between mother and child. The absence of a companion was highlighted as a negative factor during the birthing process, raising feelings of loneliness and helplessness.

The anesthesia caused the loss of sensation, causing the sensation of vulnerability. At this moment they stated that they did not feel pain, but that they noticed the movements performed by the doctor during the surgery.

At times, they referred to the importance of the knowledge and experience of the medical professional, because as nurses they witnessed interferences due to the inexperience of professionals.

I did a cesarean and I was scared to death of that anesthesia. Afraid to go wrong! Now I'm going to have a Caesarean section and I must take anesthesia. E5

I was very anxious! Mad for her to be born. I realized that my pressure was also falling, I was getting very nervous. We realize what they are doing. Although we do not feel the pain, we feel the movements. The surgery itself I found very tense and very sad for not having someone there on my side who could be supporting me, even calming me down. E6

It could be someone inexperienced too, who would suddenly make forceps and break my son's neck, as I

have seen a lot. I was anesthetized, anesthetized and there I died. If the hospital goes on fire now. I cannot even run because I am dead from the waist down. E7

And then it was a more mechanical thing. It's not very human. The cesarean you will enter as if it was a very rude care. Go, get a cut, take the baby, have a scheduled time, have a scheduled day. E8

DISCUSSION

The exhaustive reading and listening of the statements made it possible to understand that the female nurses meant that the decision in favor of the cesarean section occurred during the prenatal period or during labor generated by the uncertainty about the possibility of a successful delivery and motivated the acceptance of the determination of the cesarean by the doctor, although doubly this alternative did not always correspond to her desire and the deponents tried to argue in favor of natural childbirth. In this sense, the experience of the cesarean was conceived as a programmed and mechanical act, and the absence of the partner interpreted as unfavorable and that generated the feeling of solitude at that moment.

Using the phenomenological trajectory, the understanding of the concept of being⁽¹¹⁾ allows the elaboration of the guiding stream that allows to bring to light the still obscure meanings in the testimonies that are still veiled. Presence is a possibility to dissociate, however the entity always makes other beings come in proximity, since it does not seek to see itself far from those with whom they identify. The world of being-there is world-with, in such a way that "being-in is being-with others"⁽¹¹⁾.

Thus, the woman who is being-in-the-world passes through innumerable possibilities, including the possibilities of the way of birth. For when confronted with this choice the woman showed herself in the way of being of impropriety by disregarding herself as a being of possibilities and capable of choice. By waiting and even allowing the obstetrician to make the decision by the way of birth, the woman transferred the possibilities to assume their expectations, decisions and the care of themselves⁽¹¹⁾. Letting others and the characteristic circumstances of life make decisions for themselves, leading their thinking and even their acting, has characterized it as inauthentic. Inauthenticity does not mean something negative; only reveals one of the modes of being, in which the woman has the responsibility to determine and be herself in the care of herself⁽¹¹⁾.

The doctor, when being-with the woman, made medical hegemony prevail over the will of the parturient, since relations were not narrowed, and dialogue became impaired. Such circumstances caused frustrations and insecurity to the woman during pregnancy and childbirth. This fact can be evidenced, in their testimonies, when reporting the distancing of the medical professional, who did not consider their real needs and expectations regarding the outcome of gestation, showing the obstetrician's fragility to being-with-the-pregnant-woman and the being-with-the-parturient-woman⁽¹¹⁾.

The time when the woman was launched to the cesarean section deprived the being-with of the parturient with a companion of her choice, bringing fear, loneliness and helplessness at the time of the birth of her child. It is known that being-there-withothers can come to the encounter of *dasein* in different ways: staying around, called by Heidegger's ways-of-being of the occupation or coming in against the being-there-with in the world, in the pre-occupation ways-of-being. By disregarding the woman's will and by overcoming her hegemony over the parturient's desires and perspectives, the physician engages in that entity that is there, leaving it in the public world, the same world in which the professional is found – where it is everybody's and nobody's place. Launched in advertising, the obstetrician's gaze was directed only at the physical dimension of being-there-woman-parturient, disregarding the existential being⁽¹¹⁾.

From the testimonies emerged the inappropriate anguish. Being-there can deviate in its understanding of being and decaying in the world, allowing the fear, which is interpreted as improper anguish⁽¹¹⁾. In this study, the woman felt fearful in deciding about the way of delivery, dodging her wishes and feeling more at ease when the doctor took her choice, showing herself in the way of being of impropriety. Fear of anesthesia was also noted, revealing itself in one of the three modes of fear: dread, horror and terror⁽¹¹⁾. In this way, the state of dread is revealed, since the anesthesia was known by women-nurses.

Thus, to base nursing care on the Theory of Transpersonal Care⁽¹²⁾, makes it possible to look beyond the physical body of the parturient. Placing women at the center of care and starting from a self-relationship allows women to transform and empower their care, capable of recognizing the real needs, dispensing the authentic care and permeated by the way of being of concern⁽¹¹⁾.

Autonomy and freedom of choice is a priority so that the person can achieve self-control and self-knowledge⁽¹²⁾. It was perceived that the will of women was not considered, contrary to the presuppositions of the theory that still emphasizes the need for care to be detached and selfless based on humanistic principles, from women's perspective, their experiences and beliefs. In this sense, the absence of this assistance was perceived and how serious this fact was for the choice and the experience of the cesarean section.

The theory allows one to have another look at the parturient woman, allowing her not to be seen as an object, devoid of feelings, desires and will, but that she becomes a subject with possibilities of choice and can express her feelings, providing her personal growth and appreciation of the most significant interpersonal relationships⁽¹²⁾.

There is evidence that the inclination of pregnant women for natural delivery, under normal conditions, contrasts with the high rates of cesarean sections found in the municipality studied, indicating the existence of other factors that influence the decision. When experiencing a cesarean section, puerperal women may find their recovery difficult and this may lead to late contact between mother and baby, besides being an obstacle to the more comfortable positions for breastfeeding, to become an obstacle to self-care, to the care of the newborn and to the daily activities of women⁽¹³⁻¹⁷⁾.

The use of care based on quantum conceptions refers to a holistic and human care, considering the autonomy and freedom of those who are cared for. From this perspective, the person's real needs are identified, allowing care to be based on the humanistic nurse-person relationship⁽¹²⁾. Concluding that the premises for choosing the delivery method are similar, it is necessary to provide information on the risks and benefits, with the aim of contributing to pregnant women's knowledge about the subject, since the indication based on medical criteria may not include women's preference⁽¹⁷⁾.

A study on the medicalization of childbirth⁽¹⁸⁾ highlighted the need to change the paradigm of the obstetrical medical model and pointed out the qualification of professionals for the conduction of physiological delivery, as well as the displacement to the home birth, centers or birth homes. When considering that the deponents are professionals in the nursing area and do not manifest opposition to the medical decision to perform cesarean section, showing themselves in their inauthenticity⁽¹¹⁾, it is necessary to

rethink if the relations between them and the obstetricians are based on bases of power to the point of inhibiting them from positioning themselves or insisting on their argument and the fulfillment of their desire, as to the type of delivery in situations in which their health and their concept are not at risk.

In this sense, it is recommended that obstetricians be able to provide subsidies regarding the risk they are exposed to when this occurs, enabling and empowering them to make a joint decision about the best option (delivery or cesarean section) according to the care of their needs in an individualized way, if such a need to choose a caesarean section for their safety or for their child is evident.

CONCLUSION

The woman, as an existential being, has shown herself to be fallen and cast into impropriety at the time of the choice for surgical delivery and during her own cesarean, which was remembered as a cold, dry, mechanical moment and the testimonies were flanked by this memory, showing how significant the

mechanics of the cesarean section were, overlapping the being-woman-parturient. This fact expresses and corroborates the impropriety of the woman during the birth of her child.

The Theory of Transpersonal Care comes to collaborate for the autonomy and respect of the parturient and to clarify the bases in which the relation obstetrician/parturient must be structured, because the care only becomes effective if there is a relation between caregiver-care. The nurse as a caregiver must have the parturient as his/her focus and not just the technologies. In this sense, the experience of cesarean delivery by nurses can influence positively the way of caring for these professionals, making possible the redirection of care in a conception of the being-there-with the woman parturient and her singularities.

This research presented as limitations the quantitative variety and parturition status of the deponents, however, what was sought was attended, as possibilities were evidenced for the nursing care of the parturient women, based on phenomenological and humanistic values.

O VIVIDO DO PROCESSO DA CESARIANA DESVELADO POR ENFERMEIRAS

RESUMO

Este estudo objetivou compreender significados e desvelar sentidos de enfermeiras que vivenciaram o processo de suas cesarianas. Pesquisa de natureza qualitativa com abordagem fenomenológica com o aporte metodológico/filosófico de Martin Heidegger e a Teoria de Jean Watson. Participaram nove enfermeiras que realizaram o parto por cesárea no interior da Zona da Mata de Minas Gerais, por meio da técnica de bola de neve em encontros fenomenológicos, nos meses de junho/agosto de 2016. As participantes mostraram-se inautênticas na escolha das possibilidades de nascimento do filho e durante a cesariana, pois não foram protagonistas nas decisões da via de parto e não tiveram sua autonomia e liberdade de escolha respeitada. O diálogo entre a mulher e o obstetra mostrou-se distante, e a hegemonia médica se sobrepôs sobre a vontade da mulher. O temor foi desvelado ao relatarem medo de tomar a decisão pela via de parto por conta própria e o pavor da anestesia. Os conhecimentos científicos não foram suficientes para que a mulher-enfermeira se tornasse empoderada na escolha da via de parto e do próprio parto. A mulher como ser existencial mostrou-se lançada na impropriedade na ocasião da escolha pela via de parto e durante a própria cesariana.

Palavras-chave: Cesarean section. Nurses. Women's health.

LO VIVIDO DEL PROCESO CESÁREO REVELADO POR ENFERMERAS

RESUMEN

Este estudio tuvo el objetivo de comprender significados y revelar sentidos de enfermeras que vivieron el proceso de sus cesáreas. Investigación de naturaleza cualitativa con abordaje fenomenológico con el aporte metodológico/filosófico de Martin Heidegger y la Teoría de Jean Watson. Participaron nueve enfermeras que realizaron el parto por cesárea en el interior de la Zona da Mata de Minas Gerais-Brasil, por medio de la técnica de bola de nieve en citas fenomenológicas, en los meses de junio/agosto de 2016. Las participantes se mostraron inautênticas en la elección de las posibilidades de nacimiento del hijo y durante la cesariana, pues no fueron protagonistas en las decisiones del tipo de parto y no tuvieron su autonomía y libertad de elección respetada. El diálogo entre la mujer y el obstetra se mostró distante y la hegemonía médica se sobrepuso sobre la voluntad de la mujer. El temor fue demostrado al relatar miedo de tomar la decisión por el tipo de parto por su cuenta y el pavor de la anestesia. Los conocimientos científicos no fueron suficientes para que la mujer-enfermera se volviera empoderada en la elección del tipo de parto y del propio parto. La mujer como ser existencial se mostró tirada en la impropiedad en la ocasión de la elección del tipo de parto y durante la propia cesariana.

Palabras clave: Cesárea. Enfermeras. Salud de la mujer.

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