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RESEARCH

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Women-centered care in high-risk pregnancy during childbirth from a nursing perspective

Cuidados centrados na mulher com gravidez de risco durante o parto na perspectiva da enfermagem

Cuidado centrado en la mujer con embarazo de riesgo durante el parto en la perspectiva de la enfermería

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Abstract

Objective: to describe the nursing team's perspectives on women-centered care during childbirth and its attendance practice of high-risk pregnant women. **Method**: a descriptive study with a qualitative approach. The participants were nine nurses and eleven nursing technicians who worked in a tertiary maternity hospital in Rio de Janeiro. Data were obtained through semi-structured interviews from July to August 2020. Qualitative content analysis and Concepts of Person-Centered Care Practice were applied. **Results**: the following categories "Conceptions of women-centered care during childbirth" and "Perceptions about the practice of women-centered care during high-risk pregnancies" emerged from the analysis. The concepts included values of respect for women and their rights to protagonism and centrality in care. The perceptions covered professional, organizational, and sociocultural barriers, as well as environmental conditions that facilitate practice. **Conclusion and implications for practice**: the participants showed adherence to the humanistic values of woman-centered care, but perceived professional challenges and organizational barriers that require changes in cultures and processes to enable this care viable for women with high-risk pregnancies.

Keywords: Pregnancy; Humanization of Assistance; Parturition; Quality of Health Care; Nursing Theory.

Resumo

Objetivo: descrever as perspectivas da equipe de Enfermagem sobre os cuidados centrados na mulher durante o parto e a sua prática no atendimento às gestantes de risco. **Método**: estudo descritivo, com abordagem qualitativa. As participantes foram nove enfermeiras e 11 técnicas de Enfermagem que trabalhavam em uma maternidade terciária do Rio de Janeiro. Os dados foram obtidos por meio da entrevista semiestruturada, no período de julho a agosto de 2020. A Análise de Conteúdo qualitativa e os Conceitos da Prática dos Cuidados Centrados na Pessoa foram aplicados. **Resultados:** as categorias: "Concepções sobre os cuidados centrados na mulher no parto" e "Percepções sobre a prática dos cuidados centrados na mulher com a gestação de risco" emergiram da análise. As concepções contemplaram os valores de respeito às mulheres e aos seus direitos de protagonismo e centralidade nos cuidados. As percepções abarcaram as barreiras profissionais, organizacionais e socioculturais, assim como as condições do ambiente facilitadoras para a prática. **Conclusão e implicações para a prática**: as participantes denotaram uma aderência aos valores humanísticos dos cuidados centrados na mulher, mas perceberam os desafios profissionais e as barreiras organizacionais que exigem as mudanças de culturas e de processos para viabilizar estes cuidados para a mulher com a gestação de risco.

Palavras-chave: Gravidez; Humanização da Assistência; Parto; Qualidade da Assistência à Saúde; Teoria de Enfermagem.

Resumen

Objetivo: describir las perspectivas del equipo de enfermería sobre la atención centrada en la mujer durante el parto y su práctica en la atención a embarazadas de alto riesgo. **Método:** estudio descriptivo, con enfoque cualitativo. Las participantes fueron nueve enfermeras y once técnicas de enfermería que trabajaban en una maternidad de tercer nivel en Río de Janeiro. Los datos se obtuvieron a través de entrevistas semiestructuradas, de julio a agosto de 2020. Se aplicaron el análisis de contenido cualitativo y Conceptos de la Práctica de los Cuidados Centrados en la Persona. **Resultados**: las categorías "Concepciones sobre la atención centrada en la mujer durante el parto" y "Percepciones sobre la práctica de la atención centrada en la mujer con embarazos de alto riesgo" surgieron del análisis. Los conceptos incluyeron valores de respeto a las mujeres y sus derechos al protagonismo y centralidad en los cuidados. Las percepciones abarcaron barreras profesionales, organizativas y socioculturales, así como condiciones ambientales que facilitasen la práctica. **Conclusión e implicaciones para la práctica:** las participantes demostraron adherencia a los valores humanistas de la atención centrada en la mujer, pero percibieron desafíos profesionales y barreras organizacionales que requieren cambios en culturas y procesos para posibilitar esta atención para las mujeres con embarazos de alto riesgo.

Palabras clave: Embarazo; Humanización de la Atención; Parto; Calidad de la Atención de Salud; Teoría de Enfermería.

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INTRODUCTION

Person-centered care (PCC) is considered an important component of quality and safety in health care, including in the areas of sexual and reproductive health, maternal health, and obstetric care.[1-3]

PCC encompasses care that is responsive and respectful of women's preferences, values, and needs. In maternal health, PCCs tend to be referred to as Woman-Centered Care (WCC), as they reflect the values of humanistic care that enable women to exercise choice and control during pregnancy and childbirth, make informed and shared decisions, and enjoy relationships based on mutual trust and respect, to promote their protagonism and recognize their personal capacity.[2,4]

PCCs have a long association with nursing because the profession's humanistic values guide it to treat people as individuals, respect their rights, and develop therapeutic relationships, including in obstetric nursing care.[3,5] From this perspective, McCormack and McCance developed the Theory of Person-Centered Nursing, in which the centrality of the person is an approach to practice that is based on the values of individual rights, self-determination, and understanding.[5,6] Subsequently, with advances in research and the development of a transdisciplinary framework, they developed the Theoretical Framework of Person-Centered Practice.[7]

Despite these assumptions, the PCC approach is still an incipient movement, despite having interfaces with the principles of humanizing care.[8] In 142 countries investigated, professional standards in Nursing and Midwifery showed that the use and application of the PCC concept are limited or absent.[9]

In addition, negative experiences during pregnancy and childbirth continue to be reported, such as disrespect and abuse, due to pregnant women feeling fragile in the face of organizational and professional power.[10,11] Pregnant women at risk deal with the unpredictability of the occurrence of gestational complications and are faced with restrictions on their capacity for control, protagonism, and opportunities for negotiations and concessions in the hospital environment.[11,12] As a result, the role and clinical decisions of professionals prevail in care.[12]

Therefore, the adoption of MCC requires changes in the way obstetric care is provided to women, including those with high-risk pregnancies. Considering this, the following research question was posed: What are nursing professionals' perspectives on women-centered care during childbirth and their practice in caring for high-risk pregnant women?

In this sense, the study aimed to describe the nursing team's perspectives on woman-centered care during childbirth and their practice in caring for high-risk pregnant women.

METHOD

This is a descriptive study with a qualitative approach. This approach recognizes the subjective nature of the problem and seeks to understand a phenomenon of interest or the perspectives and worldviews of the people involved.[13]

The research team was made up of nurses, two of whom were nursing professors at a Brazilian public university. This team was trained in research methods and techniques, to develop research into women's health and obstetric nursing.

The study was carried out in a tertiary public maternity hospital located in the municipality of Rio de Janeiro, the capital of the state of Rio de Janeiro. This maternity hospital is a reference for the care of high-risk pregnant women and has clinical protocols for the quality and safety of care during labor, delivery, and the postpartum period. The maternity ward's nursing team is made up of nurses and nursing technicians. This health unit was selected because it is a reference service for teaching, care, and research in nursing in the area of obstetric care.

The participants in the study were 20 female nursing professionals who worked in the Obstetric Center (OC) and the Joint Accommodation (JA) of the maternity hospital: 11 nursing technicians and nine nurses. The following inclusion criteria were adopted: nursing professionals who provide direct care to women during labor, delivery, and the first few hours of postpartum. Those excluded were professionals with less than two years' employment at the institution, those who were in the process of qualifying for a residency program, and those who were off work during data collection. A total of 12 nursing professionals and five resident nurses were excluded.

Nursing professionals were informed about the study and its purposes before data collection, both in person and via messaging app. Data collection took place between July and August 2020.

It should be clarified that the start of data collection took into account the uncertainties caused by the start of the COVID-19 pandemic in March 2020. The study was followed up with the dissemination of ministerial protocols and professional training on COVID-19 protection and control measures, both for maternity professionals (including nursing staff) and for the nurse responsible for obtaining the data, the second author of this research. It should be noted that this nurse and the other authors of this study had no employment relationship with the field of research.

The sample studied was intentional and the selection of participants began with the most experienced professionals in the OC and JA nursing teams. These sectors of the maternity ward were selected on the assumption that they best served the purposes of the research, where nursing assists women during labor, delivery, and the first hours of the postpartum period.

The interview script was semi-structured and consisted of closed questions about the socio-professional profile of the participants and two open questions: "Explain to me your vision of WCC during childbirth care" and "Tell me about the implementation of WCC with high-risk pregnancies". This script also covered the topics to be covered in the interviewees' responses, such as the characteristics of women-centeredness, aspects of the care environment, interpersonal relationships, behaviors, and attitudes of women and professionals during care.

The instrument was previously tested with two nursing professionals working in different sectors of the maternity ward,

OC and JA. These interviews were discarded, even though they did not indicate the need for any changes.

After accepting the invitation and expressing her preference for the day and time of the individual interview, the invited professional was taken to a meeting room by the researcher responsible for data collection close to the JA to ensure her privacy and safe environmental conditions in the face of COVID-19. There was no refusal to grant the interview. The interviews were audio-recorded using a digital recorder and lasted between 27 and 58 minutes. No interviews had to be repeated.

The Qualitative Content Analysis approach was applied, which aims to develop knowledge and understand the phenomenon under study and enables the description and interpretation of textual data through a systematic coding process.[13]

The interviews were transcribed and proofread by two researchers to ensure the accuracy of the audio transcripts, and each interview was considered a unit of analysis. After reading and re-reading the transcribed texts, the textual segments of interest were selected, and the Meaning Units (MU) were identified. The condensed MUs were then abstracted and labeled with a code. Each segment and its corresponding code were transported to Microsoft Office Excel® 2019 software, where the various codes were compared based on differences and similarities, and classified according to the manifest and latent, internally homogeneous and externally heterogeneous contents of the research object.[13] This phase was validated by two researchers and culminated in the construction of the study's categories.

The criterion for ending the interviews was inductive thematic saturation when no new codes were identified during the exploratory phase of the analysis.[14] Therefore, the saturation of the sample was determined during the process of analyzing the transcribed statements and occurred in the twentieth interview.

Finally, the data was interpreted based on the first three domains of the PCC Practice theoretical framework, namely: 1) the prerequisites relating to the nurse's attributes; 2) the person-centered processes during care, and 3) the care environment, as the context in which care is provided. These three domains made it possible to achieve the expected results, which created a therapeutic culture capable of providing the person with involvement in the care process, satisfaction with care, and well-being.[5-7]

This study complied with the legislation on ethics in research with human beings, through the opinion of the Research Ethics Committee (REC) of the State University of Rio de Janeiro (UERJ), under No. 3.241.465. The participants signed a Free and Informed Consent Term. Coding was adopted according to the abbreviations of the professional category and the numerical order of the interviews, such as NUR. N1, TE. N2, and so on.

RESULTS

The 20 nursing professionals interviewed were public servants, with a statutory employment contract and aged between 34 and 62 years (an average of 41.9 years). The participants had been working as nurses for between seven and 34 years (average of 17.2 years) and had been working in the tertiary maternity ward for between three and 20 years (average of 9.4 years). Of the nine nurses interviewed, five worked in the OC and four in the JA, with their specializations in the areas of Obstetrics (6), Neonatal (2), Surgical Center (1), and Intensive Care (1). As for the nursing technicians (11), six worked in the OC and five in the JA.

The two categories of the study are presented below: "Conceptions of woman-centered care in childbirth" and "Perceptions of the practice of woman-centered care in high-risk pregnancies".

Conceptions of woman-centered care in childbirth

The participants emphasized that professional competencies are the indispensable prerequisites for providing WCC. For them, the acquisition of knowledge and technical skills takes place through the professional's initiative to study continuously, take qualification courses, take part in the training offered by the institution, and learn by exchanging experiences with the other professionals on the team in search of the movement between theory and practice, together, that underpins care.

Specialized skills and professional experience in a variety of women's health and obstetrics care settings were also recognized as relevant to the quality-of-care practice and the exchange of knowledge between professionals, as the following statement explains:

> *It's very important to have knowledge. Most of the nurses here are obstetric nurses and work in women's health in general*. (TE. N4)

Interpersonal skills emerged in the testimonies and were represented by adequate communication between the nurse and the woman, both verbally and non-verbally. This communication was necessary for the interaction between the two to form a bond and a relationship of trust and for the woman to feel safe with the care. Non-verbal interactions were exemplified by looking, touching, and listening during care.

> *If I don't listen and look at her* [the woman] *in a different way, I won't understand her and offer the best I can. [...] That's why two things are important to me: looking and listening. Touch sometimes says a lot, too.* (NUR. N13)

In addition to these competencies and skills, meanings emerged concerning the professional's aptitude, commitment, and humanistic values for exercising person-centered care, as shown in the following statements:

> *In any profession or anywhere you are, you must be interested in the person because if you're not interested, nothing flows. You may have knowledge, but you have to go with an open heart to give your best to that person.* (NUR. N2)

In line with these values, the participants considered that respect for women's uniqueness and their central position in

childbirth care are the attributes that characterize WCCs and become indispensable for the personalization of care.

> *To provide woman-centered care, respect is fundamental. You have to understand the processes she is going through and that she is the main character in what she is experiencing*. (NUR. N19)

From this perspective, meanings were revealed regarding women being welcomed, cared for in an empathetic way, and respected in terms of their values and beliefs (including religious ones); the right to enjoy their preferences regarding care, including through the team valuing their birth plan; exercising their choices and participating in care decisions to promote their well-being and their bond with the baby and their family.

> *I think it's very important for her* [the woman] *to take part in care decisions. Here, the birth plan is offered by the prenatal nurse to all patients.* (ENF. E9)

> *It's about looking at this woman without judgment and in a global way [...]. Promoting her well-being in general, stimulating her bond with the baby and interaction with the family, and being available to help whenever necessary.* (TE. N1)

Perceptions on the practice of woman-centered care for high-risk pregnancies

It was noted that the practice of WCC is permeated with barriers to its implementation in the care of high-risk pregnant women. Among the perceived barriers, the participants highlighted the failures of prenatal care to provide women and their companions with information about pregnancy, labor, and childbirth, including the care that can be provided during hospitalization for childbirth. For professionals, misinformation reinforces the fear of childbirth and undermines the care process at the time of delivery.

> *When the woman is not worked with during prenatal care, as well as the companion, this influences a lot, and labor becomes more complicated.* (NUR. N17)

Negative experiences in previous pregnancies and births were listed by nursing professionals as barriers, both those experienced by high-risk pregnant women and those experienced by other women in their social environment. For these professionals, negative experiences corroborate women's fear and insecurity during childbirth and hinder the relationship between them and the professional.

> *What makes it more difficult is the woman's insecurity, because we can't interact well when she feels insecure about herself or because she's afraid of what she's heard or of previous* [negative] *experiences*. (TE. N10)

Difficulties in the interpersonal relationship between the woman and the professional emerged in the testimonies as a barrier to the practice of WCC because they restrict communication, interaction, and the formation of the professional-woman bond. These difficulties involved women's mistrustful attitudes due to fear and insecurity, as well as professional attitudes of disinterest or disrespect for the person, which include inadequate approaches influenced by gender, race, and class issues. Cultural and linguistic barriers also corroborate this barrier, when the parturients are immigrants and not fluent in Portuguese.

> *The looks are different, some look and say: "One more? She only knows how to make* [children]*". There are patients who want to have a [tubal] ligation, but it's not authorized due to the lack of family planning. And sometimes the one who verbalizes and asks is humble and doesn't have the* [financial] *means* (NUR. N9)

> *What gets in the way is the different nationalities* [...]. *It's difficult to communicate. Sometimes, there are Chinese people, and their culture is different too.* (TE. N6)

> *I can see that there is color discrimination, but also from other professionals. Yes, women are treated differently, they look at them superficially and speak in a derogatory way.* (NUR. N16)

Difficulties in teamwork were also indicated as a barrier to WCC practice, as they involve restrictions in communication, cohesion, and integration of the members of the multi-professional team. The interviewees mentioned that social work and psychology professionals should be more integrated into daily care. As for the doctors, they felt that they had greater decision-making power over clinical conduct and that some devalued care aimed at humanizing labor and childbirth.

From the participants' point of view, the centrality of medical conduct limits the participation of both high-risk pregnant women and nursing staff in clinical decisions, although they recognize that these women have less negotiating power than nursing professionals, as they are in the role of patients and are weakened by the obstetric risk condition.

> *What makes it difficult is that some professionals don't listen to others and there is no exchange between teams*. (NUR. N2)

The lack of standards and guidelines on WCC was pointed out as a barrier, as the institutional protocols do not specifically address how the multi-professional team should make it possible

for women with high-risk pregnancies to be centralized in the care process, which hinders the convergence of professional perspectives on the role of women in planning and conducting care.

> *I think what hinders the implementation of centered care is the lack of a well-structured document with well-established attributions and behaviors of the multi-professional team.* (NUR. N18)

The inadequacies of the health system were listed as barriers to the practice of WCC. In the view of the participants, the public health network has limited conditions to meet the demands of access and care for the obstetric population, especially for childbirth. In their opinion, these inadequacies cause a surplus of admissions to maternity hospitals, women's pilgrimages to give birth, a lack of material resources, overworked teams, and damage to the quality and safety of care, which leads to unfavorable conditions for offering WCC.

> *In public hospitals, sometimes there's no material and no room. They say that their biggest fear was arriving at the time of delivery and there being no room.* (NUR. N12)

> *As all the women seen here have some kind of comorbidity, it is difficult to develop focused care with a small number of professionals.* (TE. N1)

Despite the greater prominence of barriers to the practice of WCC in the testimonies, the participants also mentioned the facilitating conditions for the practice of this model of care for pregnant women at risk, such as the service having an adequate physical structure to offer a private environment for childbirth, as well as having trained professionals and standardized care aimed at humanizing childbirth, which encourages dialogue and integration of the multi-professional team.

Concerning high-risk pregnant women, the professionals considered that qualified prenatal care and the provision of information on the pregnancy-puerperal cycle favor the acquisition of knowledge by high-risk pregnant women and contribute to them feeling safer, more confident, and more participative during hospitalization for childbirth.

> *I think what makes it easier is prenatal care that covers all these issues* before [giving birth and postpartum]. *So, she arrives with more security and prior knowledge.* (TE. N6).

> *The physical structure contributes to the development of centered care. In the antepartum, the room is individualized; there is a private bathroom, and they can stay with a companion, listen to a radio, and watch television if they want to.* (TE. N20)

DISCUSSION

The conceptual framework of PCC practice establishes the professional attributes or prerequisites of nursing, such as competence, interpersonal skills, commitment to work, and personal characteristics. Competence is demonstrated through knowledge, skills, and attitudes that enable the professional to negotiate care options and effectively provide holistic care, which covers the global spectrum of the person's health needs.[5,6]

Knowledge and technical competence in Obstetrics have been conceived as essential in developing a relationship of trust between the woman and the nurse. Professional competence encompasses the knowledge, skills and attitudes needed to make decisions and prioritize care, which includes high-level clinical reasoning, ethical awareness, altruism, and the ability to carry out the highly qualified technical aspects of practice.[3,9,15]

The interpersonal skills developed reflect the ability to communicate on various levels. Effective communication demonstrates that the professional can share complex and sensitive information during the practice of care. Communication with people in care and their families is implicit in the sensitive and humanistic care model,[5-7] and is highlighted by the interviewees. However, interpersonal communication within the health teams themselves did not emerge in the testimonies as one of the PCC's attributes, even though it is essential for information to be shared and for relationships and the provision of care to be favored.[15]

Intentionality and commitment are linked to personal values of providing the best patient care, as the professionals interviewed emphasized. Professionals' proactive behaviors are indispensable for quality care. These behaviors are related to complementary work and organizational aspects, such as alignment with the impulses and values of health professionals, autonomy, supportive supervision, appreciation, respect, good interpersonal relationships, opportunities for growth, and the professional's desire to be a professional.[16]

In addition to these prerequisites, the theory of PCC practice highlights the importance of the professional's self-awareness and reflection on action, as this contributes to their ability to develop therapeutic relationships, greater understanding of themselves and others, communication skills and qualified management of care situations, as well as the recognition that they and people are immersed in historical, structural and organizational health contexts. Thus, the professional can demonstrate clarity of beliefs and values and have an understanding of how these can impact the decisions made by the patient about the care provided.[5-7] These prerequisites did not emerge from the testimonies of the participants in this study.

Thus, when considering person-centered processes, the nursing professionals highlighted respect for the woman's person and her centrality in childbirth care. Person-centeredness is anchored in the values of respect for human uniqueness and the right to self-determination in the development of practice, which reflects the ideals of humanistic care.[5-7] PCC aims to ensure that women exercise choice and control during their pregnancy and childbirth experience and to promote their empowerment. In addition, this

care takes into account shared decision-making with the patient, which is based on evidence and enables improvements in health outcomes for both the woman and the newborn.[4]

From this perspective, it was found that the centrality of the person is present in the assumptions of the WCC and in the principles of the humanization of care, such as the autonomy and protagonism of the subjects.[2,3] In this sense, when developing humanized practices, nursing seeks to guarantee unique, personalized, and comprehensive care through a relationship of trust and the formation of a bond with women, with sensitive listening and attention to their health demands and needs; the appreciation of scientific evidence and the physiology of pregnancy and childbirth; the use of technologies aligned with humanization and the use of health education strategies to enhance quality, safety and satisfaction with care.[3,4]

Health education and effective communication are necessary to ensure women's participation in clinical decisions.[2] Shared decision-making is one of the constructs of PCC practice, and includes valuing partnership, cultural sensitivity, self-care, and women's right to self-determination, as well as promoting the acquisition of accurate and up-to-date information about pregnancy and childbirth for patients, to enable them to make informed choices. To respect women's wishes and shared decision-making, valuing and including birth plans in the care process must be ensured,[3,12] as recognized by the professionals interviewed.

In addition to these conceptions of PCC, the participants' perceptions of the barriers to practicing this care for women with high-risk pregnancies also emerged. They felt that there were shortcomings in the information and guidance provided to women about pregnancy and childbirth during prenatal care, which caused them to feel insecure and hindered the care process during labor and childbirth.

The risk approach begins during the prenatal period and confidence in the woman's ability is challenged the moment the pregnant woman becomes involved in an increasing number of obstetric screening practices and is labeled as "high-risk pregnant", and this favors a caring approach that encourages medical intervention. In this way, professionals tend to spend more time focusing on the clinical conditions affecting the pregnancy than on offering the support and guidance needed to increase the woman's confidence in her ability to conceive and give birth.[9,10,16] This tendency leads to missed opportunities to raise awareness and reduce the client-professional bond and the empowerment of pregnant women, which restricts their access to information and opportunities for respectful and satisfactory care.[2,4]

Women who have experienced an unsatisfactory birth of their baby and a loss of control over their own body may consider childbirth to be a frightening event. Fear of childbirth can also be "inherited" due to stories told by their mothers or acquaintances. A disrespectful, depersonalized approach to care, with a focus on unnecessary interventions and fulfilling tasks, is related to fear of childbirth[16]. Therefore, WCC, continuity of care, teamwork, and communication should be considered key components of a safe and respectful care culture.[10]

Gender stereotyping on the part of professionals has a negative influence on the care of women and their companions. The lack of autonomy during childbirth and the violent acts to which they are subjected during pregnancy, childbirth, and the puerperium also show the cultural bias of social inequalities, especially concerning gender, class, and race, since poor and black women are the most exposed to health inequities.[12,16] These inequalities are also reflected in the work environment, which directly interferes with the social relations of health workers and involves discrimination between professional categories, such as those uttered by some doctors towards obstetric nurses. These behaviors cause restrictions on autonomous decision-making and the social appreciation of women's professions and generate tensions in the context of teamwork.[16,17]

Barriers perceived by American nurses to providing PCC in complex care settings were reported, such as lack of professional experience in the specialized area and in-service training; communication problems due to the patients' native language being different from that used by the nurses; lack of material resources to carry out care and provide health education to patients; patients' social inequalities and gender issues influencing care; conflicts between nurses and doctors; clients' fear and uncertainties; professionals' physical and mental exhaustion; and patients' and families' negative behaviors, such as unrealistic expectations and disrespectful attitudes.[18] Some of these barriers were also mentioned by participants who care for high-risk pregnant women.

Concerning the constructs referring to the care environment, some of them emerged in the perceptions of the participants in this study as influential conditions in the practice of WCC with high-risk pregnancies, both among the barriers and among the perceived facilitating conditions. The professionals' perspectives highlighted interpersonal relationships and are anchored in the assumptions and principles of humanizing care, as was expected given that Brazilian health policies and programs recommend this approach to care.

The theory of PCC practice encompasses the professional, relational, procedural, and organizational dimensions of care, and provides clear and objective support for changing practice by clarifying the concepts and characteristics involved in these dimensions.[5-7] As a result, the intended change in care can be hindered if professionals' relationships with women, interprofessional relationships, or relationships between teams are given greater emphasis in actions, with the aim that the procedural and organizational dimensions take a back seat.[16]

The characteristics of the care environment have the potential to improve or hinder PCC, as they encompass layers of cultures that interact with each other, creating a complex web of perspectives, relationships, and behaviors. These characteristics and cultural layers should not be ignored when thinking about person-centeredness, as not addressing these issues can denote a naïve view of their complexity and harm the process of working in health and caring for clients.[5,6]

PCCs are more likely to be effectively implemented when the institution's management is engaged and committed to offering clients this care, in addition to the leaders' awareness of their central role in developing the work and achieving the goals of change.[5,6] The results described here indicate that nursing professionals recognize the humanistic values of WCC practice and make reference to some of its constructs. However, these nurses face the professional and organizational challenges of the health service and system and need the support of their leaders to implement this practice of caring for pregnant women at risk.

Pregnant women at risk demand guidance on care during pregnancy, childbirth and the puerperium, as well as on their risk status, the implications for their health, and the treatment modalities indicated. Women also want to see an effective improvement in health systems and resources that enable: welcoming, privacy, continuity of care, consistency of information, and safety of care. This emphasizes the importance of the infrastructure of facilities for respectful obstetric care.[2,10,17] However, this care and the encouragement of normal childbirth are challenged by the influence of the medicalized and interventionist approach to obstetric care in Brazil and around the world.[17]

Therefore, health services must design organizational strategies to guarantee respect for women's rights, improvements in the training and continuing education of professionals, the adoption of better care practices, the availability of the necessary resources, and the commitment of managers to offering respectful, focused and satisfactory care to women, to achieve better health results.[18]

CONCLUSIONS AND IMPLICATIONS FOR PRACTICE

Nursing professionals conceive of woman-centered care during childbirth as that which contemplates the values of respect for women and their rights to self-determination, protagonism, and centrality in care. This care must be provided by competent professionals with technical and humanistic skills. The conceptions of these professionals were incomplete in terms of the constructs of the theoretical structure of the practice of person-centered care.

The perceived barriers to the practice of person-centered care for women with high-risk pregnancies were shortcomings in prenatal care, difficulties in interpersonal relationships and teamwork, the lack of standards and guidelines for this model of care, and the inadequacies of the health system. They recognized that the facilitating conditions are: women being well informed during prenatal care; the existence of a private environment for childbirth; and the presence of adequately qualified professionals. The barriers identified can support the planning, implementation, and evaluation of strategies to change cultures and processes to offer this model of care in obstetric care.

The results suggest that nursing professionals adhere to the humanistic values of women-centered care, but they are faced with professional and organizational challenges in the health service and system. Nurses must therefore increase their self-awareness of their role in care, strengthen teamwork, expand their collaborative skills to deal with interprofessional conflicts, and contribute to improving care for high-risk pregnant women, including by applying the theoretical frameworks that guide their own profession.

Finally, the limits of this study must be taken into account when assessing its results since the professionals interviewed were statutory employees of a tertiary maternity hospital, which may have limited the capture of the breadth of the nursing team's perspectives on the different contexts of work and care for high-risk pregnant women. Despite these limitations, we believe that it has the potential to be transferable to similar social realities, especially for professionals working in a reference maternity hospital located in an urban metropolis.

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The data is available on demand to authors.

CONFLICT OF INTEREST

No conflict of interest.

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