Obstetrical nurses' perceptions of their competence in assisting hospital delivery*

PERCEPÇÕES DE ENFERMEIRAS OBSTÉTRICAS SOBRE SUA COMPETÊNCIA NA ATENÇÃO AO PARTO NORMAL HOSPITALAR

PERCEPCIONES DE ENFERMERAS OBSTÉTRICAS SOBRE SU COMPETENCIA EN LA ATENCIÓN DEL PARTO NORMAL HOSPITALARIO

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ABSTRACT

The perception that obstetrical nurses have of their competence in assisting hospital deliveries has been investigated in this qualitative study. Data collection was performed through individual semi-structured interviews at a university hospital in Porto Alegre, and was then submitted to content analysis. The analyses were grounded on frameworks that define professional competence as the ability to mobilize different kinds of knowledge, depending on the practice problems to be solved. The obstetrical nurses understand competence in attending hospital deliveries as something multidimensional, although they have emphasized its technical dimension. This emphasis is justified through insecurity resulting from a lack of space to provide nursing care to hospital delivery, due both to disputes with physicians and to deficiencies in nurses' training. The desire to be competent in providing care during hospital deliveries has not been translated into awareness of their responsibilities in changing that scenario. This suggests that in order to act towards those desired changes, it would be necessary to develop not only technical but also ethical-political competence.

KEY WORDS

Obstetrical nursing.
Professional competence.
Nurse's role.
Parturition.
Humanized delivery.

RESUMO

Investiga-se a percepção de enfermeiras obstétricas sobre sua competência na atenção ao parto normal (PN) hospitalar. Os dados foram coletados em pesquisa qualitativa, através de entrevistas individuais semi-estruturadas, realizadas em um hospital universitário de Porto Alegre, e submetidos à análise de conteúdo. A análise foi embasada nos referenciais que definem competência profissional como a capacidade de mobilizar diferentes conhecimentos, dependendo dos problemas da prática a resolver. Para as entrevistadas, a competência para atender o PN hospitalar é multidimensional, embora tenham enfatizado sua dimensão técnica. Essa ênfase é justificada pela insegurança resultante da falta de espaço para realizarem este atendimento, em função de disputas com médicos e deficiências na formação. O desejo de serem competentes no atendimento ao PN não se traduz, porém, na consciência das suas responsabilidades na transformação deste cenário. Isso sugere que, para agir nesta direção, seria necessário, não só desenvolver competência técnica, mas também ético-política.

DESCRITORES

Enfermagem obstétrica.
Competência profissional.
Papel do profissional de enfermagem.
Parto.
Parto humanizado.

RESUMEN

Se investiga la percepción de enfermeras obstétricas sobre su competencia en la atención del parto normal (PN) hospitalario. Los datos fueron recolectados en investigación cualitativa, a través de entrevistas individuales semiestructuradas realizadas en un hospital universitario de Porto Alegre, Rio Grande do Sul, Brasil, y sometidos al método de análisis de contenido. El estudio se basó en los referenciales que definen la competencia profesional como la capacidad de movilizar diferentes conocimientos, dependiendo de los problemas de la práctica a resolver. Para las entrevistadas, la competencia para atender el PN hospitalario es multidimensional, aunque tenían enfatizada su dimensión técnica. Dicho énfasis se justifica en la inseguridad resultante de la falta de espacio para realizar este proceso de atención, en función de disputas con médicos y deficiencias en la formación. El deseo de ser competentes en la atención del PN no se traduce en la conciencia de sus responsabilidades en la transformación de este escenario. Eso sugiere que, para actuar en esta dirección, sería necesario no sólo desarrollar competencia técnica, sino también competencia ético-política.

DESCRIPTORES

Enfermería obstétrica.
Competencia profesional.
Papel del profesional de enfermería.
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INTRODUCTION

Childbirth is currently perceived as a pathological process, which has led to the adoption of the technology of assisted delivery in which the woman is generally semi-immobilized with her legs open and raised, deprived of orally ingested food and liquids, subject to the use of drugs to induce labor and routine episiotomy and possibly the use of forceps. This is the most common mode of care provided in "normal" delivery and almost always performed by a physician in a healthcare facility and that is why it is often called normal hospital delivery[1].

This reality contradicts the guidelines set out in 1996 by the World Health Organization (WHO)[2], which emphasize that childbirth is a natural event that does not need to be controlled but cared for. Based on this understanding, WHO[2] recommends a greater participation by the Obstetric Nurse (ON) in labor care, taking as a reference the idea that her education is oriented for care and not for intervention.

In Brazil, the intention to reduce unnecessary medical interventions in the care of Normal Delivery (ND) was expressed by the Ministry of Health (MH), in the Hospital Information System of the Single Health System[3], through the inclusion of ND without dystocia performed by an Obstetric Nurse. In addition to this measure, the MS in 1999 initiated financial support to universities and State and City Health Secretaries to provide Courses of Specialization in Obstetric Nursing throughout the country.

Despite these government initiatives, the Brazilian situation in terms of nursing care in obstetrics presents problems and contradictions. The obstetric education offered to obstetric nurses, focused on Normal Delivery without dystocia, does not coincide with the professional practice after specialization, which is dedicated to management and care activities, while the ND is included in the latter[4].

The importance of the notion of competence for the health sector has been highlighted in the literature, acknowledging that professional competence is related to technical-instrumental skills, but is not restricted to it. It is rather a set of associated knowledge in addition to technical knowledge. The valorization of the focus of competencies in the health context is actually related to the enlargement of the boundaries of what is defined as competence in health practice, a need imposed by a new perspective on quality in health. Such quality is based on equally new parameters, including the humanization of care[5]. From this perspective, this study holds that competence is *the capacity to act effectively in a given situation based on knowledge, but not limited to it*[6].

In a more general context, the emergence of the notion of competence in the job market in the last decades of the 20th century is a response to the need to update the concept of qualification, worn out with the crisis of the Taylorism/Fordism model of work organization[5]. This model, predominant in the 20th century and still currently influential, is characterized by the realization of specialized and routine tasks, without a view of the whole process in which workers cannot autonomously intervene in the work process[5].

Obstetric nursing has experienced a similar scenario in Brazil. In general, each professional has a well-defined role in the care provided in Normal Hospital Delivery. Each professional acts at a specific moment and in a pre-determined way, characterizing a fragmented care practice that little values the individuality of each woman and the particularities of each labor[7]. As emphasized in the literature, practices performed without competence in this context result in a mechanistic care, organized as an assembly line and consequently are incapable of considering the uniqueness of each human being[1]. It is worth noting, considering the notion of competence used in this study, that competence is not constructed and is not revealed only in technical knowledge, rather it is a set of different and associated knowledge, equally valuable, that should reflect on practice[6].

The perception of Obstetric Nurses about their competence, whether in relation to direct assistance to childbirth or other aspects of their professional experience in the field of hospital obstetrics, can contribute to overcoming current conflicts and contradictions in the obstetric situation.

The importance of the effective inclusion of obstetric nurses in direct assistance to normal childbirth and of transforming the hegemonic model of assistance in Normal Hospital Delivery, which depends among other factors on the acknowledgement of these professionals' competence, is that these confer relevance on obstetric nursing as a research field. From this viewpoint, we understand that the perception of Obstetric Nurses about their competence, whether in relation to direct assistance to childbirth or other aspects of their professional experience in the field of hospital obstetrics, can contribute to overcoming current conflicts and contradictions in the obstetric situation. In addition, exploring the phenomenon of the competence of Obstetric Nurses in practice in this context, taking into account their own experiences, can be very valuable in enabling reflection on the competencies developed in programs of specialization in obstetric nursing. Based on these arguments, this study aimed to know the perceptions of Obstetric Nurses concerning their competence in the care delivered for Normal Hospital Delivery.

METHOD

Given the interest in investigating subjective aspects of the experiences of the study participants and considering the social context of these experiences, we opted for an exploratory study with qualitative approach.

The study was carried out in 2005 with ten Obstetric Nurses who work in the Obstetric Center of a university hospital in Porto Alegre, RS, Brazil. This facility is subject to the Ministry of Health and Ministry of Education and a Federal University. It offers programs for supervised training to undergraduate nursing and medical students and residence in the most diverse medical specialties. This facility is considered excellent for high-risk pregnancies, where 3,960 childbirths were performed in 2005, 65% of these were vaginal deliveries and the remaining 35% were cesarean births[8]. Two hired physicians, one anesthesiologist and one neonatologist in addition to three resident physicians in obstetrics (R1, R2 and R3) work in the Obstetrical Center. The nursing team is composed of ten ONs and 38 nursing technicians spread over the morning, afternoon and night shifts (night 1, 2 and 3). The obstetric nurses work in managerial, administrative and care activities in the follow-up of women in labor but not during childbirth per se.

The following inclusion criteria were used: specialization in obstetric nursing, working in the studied hospital obstetric center and a minimum experience of two years in the obstetric field. A two-year period was considered sufficient for professionals to acquire a deeper view of the context of their practice.

The facility currently hires only specialist obstetric nurses, though before this requirement was established nurses without specialization were hired. However, those hired before this requirement attended specialized programs in the course of their professional practice at the hospital, which allowed them to participate in the study.

The study was approved by the Ethics Committee for Research with Human Subjects at the studied hospital. Participants were informed about the study's objectives and signed free and informed consent forms. They were also ensured anonymity and the confidentiality of obtained data.

The following questions guided the investigation process: how the competence of the obstetric nurse is defined; which resources are mobilized for this competence; which aspects are implicated in the process of constructing this competence; and finally, what is the sphere of this competence?

Data collection was carried out by one of the researchers through semi-structured individual interviews that followed a flexible script with an average of 30 minutes of duration. The site of the interviews was one of the rooms of the Obstetric Center, the nurses' own workplace. The interviews were recorded, transcribed and submitted to thematic content analysis[9]. The analysis sought to interpret the reports of the participants through an objective and systematic description of the reported content[9]. After exhaustive reading of the transcriptions, we proceeded to pre analysis and exploration of material, then the text was divided into units of meaning and thematic categories, which culminated in the analyzed themes and subthemes.

RESULTS AND DISCUSSION

Characterization of participants

Six out of the ten interviewed nurses graduated from the Federal University of Rio Grande do Sul (UFRGS) and the remnant graduated from other institutions. Seven attended the Obstetric Nursing course at the UFRGS; two attended the course at the Paulista Medical School and one at the School of Public Health in Porto Alegre. Nine graduated from their specialization course more than ten years ago and only one graduated three years ago. The average time of their experience in obstetric nursing varied from 14 and 18 years, the longest experience was 24 years and the shortest was three.

Data analysis resulted in three main themes: *The competence of the Obstetric Nurse; The Construction of Competence and The Professional Role of the Competent Obstetric Nurse.*

The Competence of the Obstetric Nurse

The analysis of the interviews suggest that the study's participants consider that the competence of Obstetric Nurses is multidimensional, constituted by technical competence, humanizing competence, competence of intuitions and relational competence. Among these elements, technical competence was emphasized indicating the predominance of a conception of competence focused on the *know-how-to-do* – on the performance of care procedures or practices – instead of the *know-to-be*, that is, on the use of professionals' subjective resources.

From this perspective, *technical competence*, understood as a competence based on academic knowledge and professional practice was, oftentimes, reported as if it was the only dimension of the Obstetric Nurse's competence. The valorization of technique was evidenced, for instance, in the understanding that for one to be competent in Normal Delivery assistance, one mainly needs to have practical knowledge and show manual skill. The emphasis on technical skills probably originates in the initial education of these nurses. As stressed in the literature, the technical-scientific dimension of nursing competence is still highly valued in nurses' education[10], despite the acknowledgment that being a nurse implies becoming involved with aspects of life that go beyond the boundaries of the clinical-care model[10].

This focus on the competence to *know-how-to-do* in nursing has been criticized in the literature. As one study[10] states, *care is much more than a act, it is an attitude*, which involves social responsibility and therefore, requires other types of knowledge. The reference to competencies corroborates this argument, emphasizing that despite the fact that technical competence is the substrate for the development of other competencies, professional competence depends on the simultaneous mobilization of a diversity of

quality knowledge and cannot be considered one-dimensional competence[11].

In relation to the *humanizing competence*, the participants related it to acknowledging the human character of parturient women and oftentimes perceived as opposed to dehumanization, which characterizes the normal hospital delivery. In this view, they highlighted that competent Obstetric Nurses are those who manage to ally technical skills with humanization skills.

> We have to gather our theoretical knowledge, put it together with practice and join to all this the respect to this woman who is experiencing something unique, who is going to face an unfamiliar environment. Respect, empathy, good sense and individualized care (Viviane).

Such emphasis seems to be related to a personal search for an ethical sense to their work in assisting Normal Delivery. The valorization of the individuality of women in labor, suggested in many of the reports as an indication of a humanized obstetric care, reveals a critique of the impersonality and inflexibility of the hegemonic model of labor care, valuing a care practice more directed to the particular needs of each woman. The notion of competence highlighted in these reports has the potential to contradict, given its emphasis on a more individual approach, the technocratic model, which postulates the need for a more passive role of the woman in labor and is characterized by impersonality[1].

The understanding that obstetrical nursing competence in assisting normal hospital delivery is a result of humanization skills and knowledge, suggests a conception of competence that surpasses the traditional dichotomy existent between caring for the woman and caring for the pregnant woman[10]. When one acknowledges the individuality of each woman in labor, one also acknowledges the specificities of their needs and particularities of each situation, enlarging the set of knowledge and competencies that should be mobilized in the care process. This competence, when brought into the context of obstetrical practice, can promote a more individualized and less authoritarian care, where women can occupy a less passive position than that which has currently characterized the scenario of labor care[7].

Competence by intuition, linked to intuitive knowledge, appeared in the interviews as a constituent of professional competence of the Obstetrical Nurse in assisting Normal Hospital Delivery. Data suggest that there is, for some participants, a relationship between *being competent* and having a capacity to obtain an immediate knowledge about a given situation of work based on quick observation. It was explicit in several references to a *sixth sense* and *clinical eye* as the following excerpt illustrates:

> I always say that we have a sixth sense so good that just by looking at and evaluating the patient, I know if the baby is about to born or not (Carla).

The concept of automation present in the theoretical reference of competence can contribute to the understanding of this notion of competence linked to intuition. The beginning of the establishment of a competence is characterized by conscious decisions, hesitation, trials and by making the same errors; however, with the development of a competence automation sets in, a point at which the professional *can rapidly solve certain simple problems, without thinking, rapidly integrating an impressive range of parameters*[6]. From this perspective, data suggest that, when obstetric nurses identify in their practice an intuitive competence, some of them demonstrate that the work routine has provided opportunities for the exercise of obstetric nursing and the learning of relevant knowledge and practice. The valorization of this intuitive skill, originating in a set of tacit knowledge, learned and legitimated in the their experiences of life, suggests the acknowledgement that the competence of Obstetric Nurses goes beyond the sphere of technical skills.

The data analysis also indicated the *relational competence* as a constituent element of the competence of obstetric nurses to assist normal delivery in a hospital environment. It refers both to the interaction with the parturient (already emphasized in the category that highlights humanization), as well as interaction with the health team. In the interaction with the parturient, competence appears related to the act of

> Putting yourself by the patient's side [...], always, trying to provide good care (Amanda).

In the relationship with the health team, participants highlighted the importance of

> A good competence, in terms of relationships, trust in the medical team, in the employees (Cláudia).

The valorization of the relational dimension of the competence of Obstetric Nurses suggests they are concerned with the interpersonal character of nursing work and, once more, the awareness that to be competent in assisting Normal Hospital Delivery an Obstetric Nurse needs to use knowledge and skills that are not restricted to the technical sphere only. Additionally, the emphasis on competencies necessary to a good relationship with the work team seems to reveal the acknowledgement that the individual professional competence to be developed, exercised and updated, depends on the competence of other professionals, members of the team. As stressed in the literature, professional competence goes beyond the ability to correctly perform procedures, it is also necessary to mobilize and inter-relate the *emotional, interpersonal, and the organizational* aspects of this context[12]. The valorization of contextual aspects of work in the definition of what is professional competence reinforces the importance of interpersonal relations in this field.

The data analyzed so far suggest that the competence of Obstetric Nurses to assist normal hospital delivery is constructed of a set of knowledge learned, employed, shared and updated in the diverse experiences in the routine of

their practice and life in general, including initial and continuing education. From the point of view of education in obstetric nursing, what becomes clear in this initial analysis is that for the Obstetric Nurses to competently play their role, meeting the expectations of improving quality and transforming the current model of labor care, it is necessary to enlarge the focus of teaching. This teaching should address, with equal emphasis, the physiological, emotional and sociocultural[13] aspects involved in issues of reproductive health in addition to specific aspects of the dynamics of nursing work (law, teamwork, interdisciplinary care, etc.)

The construction of competence

The recurrence of the focus on *know-how-to-do* evidenced in the interviews is mainly due to the perception that technical competence, although essential, still needs to be developed. At least two limitations on the development of technical competence were noted. The first refers to the incapacity of obstetric nursing specialization programs to develop such competence, a perception shared by Obstetric Nurses of other regions in the country[14]. Many participants reported frustration in relation to this fact, which is more evident in the reports of those who graduated in the 1980s, that is, longer ago. We perceive that the problem is that nurses are having fewer opportunities to perform procedures related to labor care since then as shown in the following reports.

> I had to perform a childbirth in order to graduate. So, it was erased… one-time experience. You think I'm going out there performing childbirths? Because here you can see how many childbirths residents do […] (Amanda).

When they are not allowed to perform this competence as it is expected in their educational programs, the Obstetric Nurses do not feel secure performing the procedures necessary to the care provided during a normal delivery. At the same time, the current structure establishes for normal hospital delivery, centered on the physician, does not require of them the full development of this competence, especially in relation to the second labor stage. Thus, although they are encouraged by their awareness of the gaps in their education, to develop their professional competence in normal delivery care, nurses do not find stimulus or opportunity for that in the job market.

The second limitation is related to the lack of space for the practice of labor care in their professional routine. Nurses reported that obstetric procedures valued during their education – such as episiotomy, episiorrhaphy and cervical examination – are not performed in their daily practice due to disputes for space with the medical class and the unequal relations of power between physicians and nurses.

> Since I came to the OB, these things [cervical examination], were the obstetricians those who performed it. Usually, if you did it and they found out about it, you'd be censured, got a reprimand. So, you get insecure – I'm not going to do this, it's not my job. So, with this repetitive no, you lose your confidence and even your training (Amanda).

In another study carried out with Obstetric Nurses, this issue relating to few opportunities to provide direct assistance to labor was indicated by the participants as one of the main difficulties found after their specialization[14]. For the Obstetric Nurses participating in this study, the solution to develop technical competence in this scenario would be to face the situation and fight for space in labor care. However, none of them reported any initiative in this direction. The opportune reflection here is that the origin of this lack of initiative goes beyond the issue of dispute of space with physicians. It is also related to the insecurity that results from an education perceived as insufficient and to the lack of political positioning of Obstetric Nurses to defend their rights and that of the subjects of their actions, a situation also reported in another study[14].

The following report illustrates this rationale, indicating a scenario in which medical consent is necessary in order for obstetric nurses to perform cervical examination, a procedure that their education in obstetric nursing prepares them to do.

> We don't do cervical examination. When there's a large demand, some physicians ask us to do it, and if it is completed, take mothers to the room. But the majority of them don't accept it. You warn them that the baby is about to be born, that it has crowned, but the resident has to go there and do it to free the baby (Anita).

The subordination of the nurses' work to the physicians in the context of hospital delivery is a situation that is reproduced in other regions in the country[7], which evidences the inequality of power established in the field. As defended in the literature, the lack of nurses' participation in decisions regarding labor care, confer on the work of these professionals a role that is instrumental in the physician's work[7]. The data analyzed here suggest that, in this context, obstetric nurses acknowledge the supporting role they assume in the team that care for the woman in labor, though it is not appropriately questioned.

The Professional role of the competent ON

There are different, and sometimes, contradictory understandings among the participants, about the relation of the professional role emphasized during education, that exercised in practice and professional competence. Some nurses stated that they desired to reacquire their technical competence to perform childbirths, which was lost after years of not performing the required procedures. Performing a childbirth as well as physicians do, including performing routine interventions, seems to be the essence of the competence expected by the majority of Obstetric Nurses as the following report shows:

> My competence will be demonstrated when I'm re-trained again and practice it [delivery]. I'm sure that we perform a normal delivery with episiotomy as well as a resident (Márcia).

The sphere of obstetric nurse competence here appears superimposed on that of the physician. The report is in agreement with the characteristic discourse of interventionist education[1].

A second group of participants criticize the dehumanization that results from the assisted delivery, stating they are not interested in performing childbirths in the hospital context. In this context, the report of Carla is emblematic:

> I guess that our role is not to perform the delivery per se, but to provide care (Carla).

At another point, Carla clarifies her disagreement with this kind of care provided in normal delivery that predominates in the facility in which she works:

> I'm not in favor of the delivery we perform here. I think that we transformed it in pathology, an atypical thing. If I ever worked with childbirths, it'd be in a totally different from the way we do it here (Carla).

When Carla affirms that the role of nurses is not to perform deliveries but rather to provide care, is she suggesting that performing deliveries is not the same of providing care? Perhaps, the answer is in the contextualization of the obstetric practice of this nurse. The distinction between delivery and care might refer to the perception that childbirth performed in the institution she works for does not fit in the model of labor care she believes is the ideal one, probably more consistent with her notion of care. Despite some obstetric nurses sharing a similar position to Carla, they show skepticism and hopelessness in relation to the possibility of participating in an ideal childbirth:

> We have potential to do much more, but this is an achievement that depends on a legal authorization so you can do it and on medical consent. For us, only if we could create a birth house. I don't expect anything bigger. Not in this structure here (Amanda).

This report suggests that the professional experiences of the participants do not recommend expecting the development of the competence and a more active participation in the care assistance to normal delivery in the way they wish. It would be utopia. The literature acknowledges this association between utopia and professional competence. The rationale is that since competence is a condition permanently unfinished, it needs to be constantly sought as an ideal to be achieved[15].

The technical competence – *know-how-to-to* – needs meaning if it is not oriented by an ethical dimension, that is, something that answers the question: what for?[1] When they suggest they are dissatisfied with the way delivery is performed in the institution they work for, the obstetric nurses are establishing a reflection of ethical character: why do I do this, since I don't like it and it is not the best? The ethical perspective emerges in the consideration of the common good, as from the technique. However, without a political dimension, a perspective, even a utopian one, of effectively performing this common good, ethics still needs meaning in the same way technique does.

This political aspect is also a component of the concept of the post-modern midwife, who

> adopts a realist posture in relation to the biomedicine and other knowledge systems, moving easily among them to help women they care for. She is aware, culturally competent and politically engaged[16].

As the literature suggests, to be able to deal with this complexity, one needs to invest in an education, which, in addition to seeking competence in clinical-care, is also concerned to develop an awareness of the social commitment of nursing professionals[10]. From this same perspective, it is defended that competence for teaching in nursing is related, among other aspects, to the political quality of teaching, based on a social ethics that should go beyond the technical aspect[17].

Such considerations reinforce the idea that professional competence is a technical-ethical-political totality[10-11,13-14]. The relative absence of a political compromise with the acknowledged needs to transform the technocratic model of care to the parturient, suggested in the analysis of the interviews, seems to indicate the need for developing a political dimension of their competence as obstetric nurses[15]. Political competence is understood here, according to one of the authors who is part of the theoretical reference of this study, as a competence to dream, because dreaming is by excellence, a political act[18].

FINAL CONSIDERATIONS

The participants evidenced in their reports the difficulties they face in playing their professional roles in the care delivered in normal hospital delivery such as a lack of space due to disputes with physicians and also deficiencies in nurses' education. On the other hand, they do not seem to acknowledge their responsibility in the production, reproduction and necessary transformation of this reality.

The development of a reflective posture of Obstetric Nurses about the circumstances in which their difficulties, in being included in *labor practice*, are concretized, as the construction of a collective utopia (taken from the most restrictive level of nursing team to the broadest level of the professional category), based on hope, would perhaps result in attitudes more consistent with their desire for change. However, this task requires commitment, as the participants put it, and not only from obstetric nurses who work in the hospital context. This commitment should also be assumed by the faculty members of undergraduate nursing programs and specialization in obstetric nursing programs, and the Ministry of Health itself, who are those who represent the desires of society for a more humanized labor.

The educational programs assume that the participation of obstetric nurses in the direct assistance to the labor

care will be easily and automatically accepted, and for that to happen, it is crucial that nurses develop technical skills. However, the obstetric scenario at a state and national level – medicalized, interventionist and marked by competition for space – seems to suggest that other competencies are also important for coping with the reality of professional practice.

It would be so in the case of ethical-political competence, of extreme relevance to the education of competent obstetric nurses in the field of labor care. The transformation of aspects considered unfavorable for the practice of obstetric nurses in assisting normal hospital delivery depends also on nurses' awareness and exercise of power. And it has to do with the process of developing professional competence in which it is important not only *to know*, but also *one has to know that he/she knows* - the awareness of one's own knowledge, which is the condition of autonomy.

The competence of obstetric nurses is not constructed and is not revealed only in their technical knowledge, but rather in a set of knowledge, equally valuable, which should be manifested in practice in an associated and connected way. From this perspective, it is extremely important that the education of Obstetric Nurses value in its curricula the multidimensional character of professional competence, emphasizing the need for constant development. In a more general sphere, it is expected that this valorization have repercussions for the competence and visibility of nursing as a profession and in its capacity to reorganize and reflect about its responsibility in the field of health care in general, and more specifically in the obstetric scenario.

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