SUBJETIVIDADES
e-ISSN: 2359-0777
Universidade de Fortaleza
Research Report

The Perspective of Obstetricians on the Relationship with Patients and Family Members

O Olhar de Médicas(os) Obstetras sobre a Relação com Pacientes e Familiares

La Mirada de Médicas(os) Obstetras sobre la Relación con Pacientes y Familiares

Le Point de Vue des Obstétricien·ne·s sur la Relation Avec les Patients et leurs Familles

10.5020/23590777.rs.v25i1.e16977

Jéssika Sonaly Vasconcelos Barborsa de Melo
BA in Psychology, State University of Paraíba (2014). MSc (2016) and PhD (2023) in Social Psychology, Federal University of Paraíba (UFPB) and USP, respectively.

Paulo César Zambroni de Souza
BA in Psychology, Federal University of Rio de Janeiro (UFRJ, 1992); MSc in Psychology, UFRJ (1997), advised by Prof. Maria Luíza Lo Presti Seminério; PhD in Social Psychology, Federal University of Rio de Janeiro (UERJ, 2006).

Amanda Dias Dourado
MSc and PhD in Social Psychology of Work, UFPB. BA in Psychology, João Pessoa University Center.

Thaís Augusta Cunha de Oliveira Máximo
PhD in Social Psychology from the Graduate Program in Social Psychology at UFPB. Professor in the Graduate Program in Social Psychology and the Department of Psychology at UFPB.

Anísio José da Silva Araújo
BA in Psychology, UFPB (1983); MSc in Administration, UFPB (1991); PhD in Sciences, Oswaldo Cruz Foundation (2001); postdoctoral fellowship, UERJ.

Abstract

Obstetrics is embedded in a social, cultural, and historical event of great significance: birth. Consequently, professionals in this field face constant pressure to deliver good outcomes. Added to this is the Brazilian context, marked by multiple challenges in childbirth care within the public health system, which affects the interpersonal relationships established between obstetricians and the users of their services. This article aims to understand physicians' perspectives on the obstetrician–pregnant patient relationship — and on interactions with families and companions — within the Unified Health System. Data were collected using a semi-structured interview guide and analyzed through thematic content analysis, grounded in the psychodynamics of work. The study identified work overload stemming from precarious working conditions in public healthcare, which is one reason the physician–patient relationship is compromised. We also found that relationships with pregnant women, their families, and companions are ambivalent: at times difficult, conflictual, and even violent; at other times calm, rewarding, and marked by recognition — yielding, in line with the psychodynamics of work, benefits for professional identity and mental health.

Keywords: health workers, obstetrics, medicine, psychology, work.

Resumo

A obstetrícia faz parte de um evento social, cultural e histórico de grande estima para a sociedade: o nascimento. Dessa maneira, os profissionais que atuam nessa área vivenciam uma pressão constante por bons resultados. Soma-se isso o contexto brasileiro, marcado por diversas dificuldades no atendimento ao parto no âmbito da assistência pública à saúde, o que traz implicações nas relações interpessoais

estabelecidas entre a médica(o) obstetra e as usuárias dos seus serviços. Dito isto, este artigo objetiva compreender o ponto de vista de médicas e médicos sobre a relação obstetra-gestante e seus familiares e acompanhantes no Serviço Único de Saúde. Utilizou-se como instrumento de coleta de dados um roteiro de entrevista semiestruturado, analisado pela perspectiva da análise de conteúdo temática, com o aporte teórico da psicodinâmica do trabalho. A partir deste estudo, foi possível observar a existência de sobrecarga devido às condições precárias de trabalho na assistência pública à saúde, sendo esta uma das razões pelas quais a relação médica-paciente é prejudicada. Em vista disso, foi possível verificar que a relação da(s) médica(s) com as gestantes, familiares e acompanhantes apresenta ambivalência: ora difícil, conflituosa e violenta; ora tranquila, prazerosa e com reconhecimento, estabelecendo, conforme a psicodinâmica do trabalho, ganhos para a identidade profissional e para a saúde mental.

Palavras-chave: *trabalhadores da saúde, obstetrícia, medicina, psicologia, trabalho.*

Resumen

La obstetricia hace parte de un evento social, cultural e histórico de gran estima para la sociedad: el nacimiento. De esta manera, los profesionales que actúan en esta área experimentan una presión constante por buenos resultados. Se suma esto al contexto brasileño, marcado por diversas dificultades en el atendimiento al parto, en el ámbito de la atención pública a la salud, lo que trae implicaciones en las relaciones interpersonales, que son establecidas entre médico(a) y usuarias de sus servicios. Dicho esto, este artículo tiene el objetivo de comprender el punto de vista de médicas y médicos sobre la relación obstetra-gestante y sus familiares y acompañantes en el Servicio Único de Salud. Se utilizó como instrumento de recogida de datos un guión de entrevista semiestructurado, que fue analizado por la perspectiva del análisis de contenido temático, con el aporte teórico de la psicodinámica del trabajo. A partir de este estudio, fue posible observar la existencia de sobrecarga, debido a condiciones precarias de trabajo en la asistencia pública a la salud, siendo esta una de las razones por las cuales la relación médica-paciente es perjudicada. Así, fue posible verificar que la relación médica con las gestantes, familiares y acompañantes presenta ambivalencia: ora difícil, conflictiva y violenta; ora tranquila, agradable y con reconocimiento, estableciendo, según la psicodinámica del trabajo, ganancias para la identidad profesional y para la salud mental.

Palabras clave: *trabajadores de la salud, obstetricia, medicina, psicología, trabajo.*

Résumé

L'obstétrique fait partie d'un événement social, culturel et historique de grande estime pour la société : la naissance. De cette façon, les professionnels œuvrant dans ce domaine subissent une pression constante pour obtenir de bons résultats. À cela s'ajoute le contexte brésilien, marqué par diverses difficultés dans la prise en charge de l'accouchement au sein du système de santé publique, ce qui a des implications sur les relations interpersonnelles établies entre le/la médecin obstétricien·ne et les utilisatrices de leurs services. Cela dit, cet article vise à comprendre le point de vue des médecins sur la relation entre l'obstétricien·ne et la femme enceinte, ainsi que ses proches et accompagnateurs dans le Système de Santé Unifié. Un guide d'entretien semi-structuré a été utilisé comme instrument de collecte de données, qui a été analysé selon la perspective de l'analyse de contenu thématique, avec l'apport théorique de la psychodynamique du travail. D'après cette étude, il a été possible d'observer l'existence d'une surcharge due aux conditions de travail précaires dans le secteur de la santé publique, ce qui constitue une des raisons pour lesquelles la relation médecin-patient est affectée. Dans ce contexte, il a été possible de vérifier que la relation médicale avec les femmes enceintes, les membres de la famille et les accompagnants présente une ambivalence : tantôt difficile, conflictuelle et violente ; tantôt sereine, agréable et avec reconnaissance, établissant, selon la psychodynamique du travail, des bénéfices pour l'identité professionnelle et pour la santé mentale.

Mots-clés : *travailleurs de la santé, obstétrique, médecine, psychologie, travail.*

The medical profession is commonly associated with recognition, power, and social prestige (Petrarca, 2017). Among its specialties, obstetrics holds a prominent place, as it contributes to the birth of a new life — an event that is not only biological but, above all, social, and steeped in cultural, emotional, and affective meanings (Sens & Stamm, 2019).

At the same time, practice in this field is marked by multiple conflicts. Obstetrics involves a diversity of actors and interests, differing conceptions of childbirth, and various models of care. These raise questions about which technical guidelines should guide practice, which professionals are best qualified, which settings and equipment are safest, and a range of issues linked to reproductive rights (Hotimsky & Schraiber, 2005).

This work context becomes even more complex for public-sector health workers, who face constraints that hamper the proper course of their work — low pay, inadequate conditions, precarious contracts, among others (Santini et al., 2017). Such conditions reverberate not only in professional practice but also in the quality of care itself (Bonassi & Melgaço, 2020; Pereira et al., 2017). Pregnant women often struggle to secure adequate care and treatment throughout maternity (Menezes et al., 2006). As a result, the public's perception of the shortcomings of the public system is frequently directed at the workers themselves, who consequently bear the brunt of negative reactions (Lancman et al., 2007).

Bonassi and Melgaço (2020) report that 87.5% of pregnant women experience anxiety about the future, with signs of depression and stress. They attribute the poor mental-health outcomes in part to insufficient professional training, generalized care practices, and limited prenatal guidance. By contrast, Martins and Remoaldo (2014) found that pregnant women often have a friendly relationship with the obstetric nurse, who is seen as essential support during childbirth.

Regarding the obstetrician–patient relationship specifically, Flores and Mello (2023) argue that it is conflict-ridden. For these authors, obstetric violence has been a recurring topic of analysis since the 1980s. It refers to a veiled form of violence in which the physician acts aggressively under the justification of providing care, especially in disputes over the route of delivery. From another angle, Maganha et al. (2023) discuss the important role obstetricians can play in preventing obstetric violence. Through a trusting relationship, good communication, and health education, patients can feel safe and supported and gain a clearer understanding of appropriate childbirth care.

In addition to these studies, others point to violence suffered by pregnant women — known as institutional or obstetric violence — perpetrated by health professionals through unnecessary interventions and mistreatment during childbirth care (Aguiar et al., 2020; Carvalho & Brito, 2017; Lansky et al., 2019). Nevertheless, it is important to reflect on the tendency to blame individual professionals and to consider a form of violence that is not inherent to the medical act itself but arises from state omission—failure to ensure beds, analgesia, privacy, and adequate conditions for safe care (Palharini, 2017; Sens & Stamm, 2019).

Because of the impact of physician–patient relationships on work activity, it is essential to understand and reflect on physicians' perspectives. The interest in this topic stems from the observation that this professional group — surrounded by an atmosphere of status and prestige — faces, in daily practice, a conflict-laden context that calls their craft and professional activity into question.

Accordingly, this article — based on the first author's master's dissertation — aims to understand physicians' views on the obstetrician–pregnant patient relationship, including interactions with families and companions, within Brazil's Unified Health System (SUS). The theoretical foundation is the psychodynamics of work, an approach that holds that work organization is not rigid but dynamic and constantly changing, since real work situations are complex and multifaceted and can generate both harms and benefits for people. In other words, work can be a source of pathogenic suffering and illness or of pleasure and fulfillment (Areosa, 2019).

A Psychodynamic Lens on Relationships at Work

The psychodynamics of work—whose principal representative is Christophe Dejours — offers a framework for understanding how work shapes mental health. It is a scientific approach that analyzes work experience as fundamental to the production of subjectivity (Gernet, 2021). Dejours (2017) argues for the centrality of work, considering multiple levels at which both positive and negative aspects must be considered. This duality had already been discussed by Marx (1993), who contended that work can bring out both the best and the worst in human beings.

Although people are not passive and develop strategies to prevent illness, when the organization of work does not allow workers to change potentially harmful situations, a psychic wear-and-tear sets in — a futile struggle against suffering (Dejours, 2017; Demaegdt, 2020; Gueguen & Debout-Cosme, 2020). This scenario affects one's subjective relationship to work, alters the semiology of psychic defenses, and contributes to the growing number of workers who fall ill from work-related psychopathological decompensations (Duarte & Dejours, 2019).

Working involves subjective engagement to respond to the constraints imposed by the real. Such mobilization is spurred by the symbolic recognition granted for the work accomplished — not for the person. Thus, it is possible to judge someone's work positively and grant recognition without necessarily liking the person (Areosa, 2019). Even so, because it is a judgment on activity, it can still affect identity. Feedback from users, supervisors, and — above all — colleagues shapes the dynamics of relationships at work and resonates in one's sense of personal accomplishment (Dejours, 2012a).

Recognizing that work is built through relationships highlights its collective character. Professional identity is validated by the milieu. Working therefore always carries expectations and concerns about others' judgment and recognition of the activity performed. Such recognition can transform suffering into pleasure and help build armor for mental health at work (Dejours, 2013). D'Avila and Melo (2022) examined features of social psychology of work and its links with distinct theoretical–methodological approaches centered on subjectivity. They place the psychodynamics of work within a clinical perspective that seeks to analyze the articulation between subject and society, tied to psychic and unconscious phenomena (Nunes & Silva, 2018).

Working in Obstetrics

The complexity of childbirth care lies in the substantial set of activities and responsibilities to be managed under policies of humanized care and evidence-based guidelines. The International Confederation of Midwives (ICM) underscores the importance of strengthening obstetric services and ensuring qualified personnel to reduce maternal and neonatal morbidity and mortality, preterm births, and stillbirths (Cintra & Riesco, 2019).

Even with all due care, Foucault (2010) notes that every medical approach comprises instruments and techniques that can have both therapeutic and harmful effects. Obstetrics, as a medical specialty, is subject to numerous ethical implications. The maternal–fetal dyad exposes professionals to the risk of error due to the unpredictability of severe conditions that can endanger the life of the patient and the fetus/newborn (Boyaciyan, 2018).

According to the Regional Council of Medicine of the State of São Paulo, obstetrics is the specialty with the largest number of complaints and proceedings related to medical malpractice. Complaints and disciplinary cases focus primarily on the quality of childbirth care (Boyaciyan, 2018).

In Brazil, childbirth has come to be framed pathologically, with an emphasis on pain and traumatic experiences such as obstetric violence (Sens & Stamm, 2019). Public agencies and women's social movements have denounced inadequate care provided to parturients, in a context of overuse of procedures and violations of sexual and reproductive rights. Obstetric violence is therefore considered a public health problem (Palharini, 2017). This context helps explain Brazil's high cesarean rate, sustained in the popular imagination by the idea that surgical birth is painless, modern, and safe (Hotimsky & Schraiber, 2005).

Part of the biomedical discourse also invokes the risks of vaginal birth to justify procedures as necessary to good obstetric practice (Palharini, 2017), maintaining that medical interventions serve individual and collective health and well-being rather than their opposites (Boyaciyan, 2018). Professional practice thus unfolds on terrain marked by uncertainty, controversy, conflict, and negotiation among obstetrics, the health-service structure, and users. It is therefore necessary to understand the implications of these relationships from the workers' perspective.

In this study, our interest lies in the very act of working performed by these professionals in the concrete work situation (Guérin et al., 2001). While the literature documents multiple forms of workplace violence in this field, our focus was to understand how obstetricians — at a particular public maternity hospital — relate to their work and even to life outside work.

Here we use not only the noun "work," but the substantivized verb "working," following Dejours (2012a). This signals that we are not dealing with something static, but with a process in constant transformation — one that also transforms those who do it, individually and collectively, wherever this working takes place. It is an opportunity for each person to develop their life and health, since

> "working constitutes a second opportunity after childhood to expand the powers of the body to experience itself and to take pleasure in itself. But the passage from the experience of work to the formation of new registers is not mechanical. On the contrary, it presupposes a mobilization of the whole of subjectivity (…) in order to transform oneself and acquire new registers of sensitivity, new professional skills" (Dejours, 2012a, p. 200).

In the case of the obstetricians who took part in this research, we sought to understand what happens to them when they go to work and encounter not only pregnant and laboring women but also violence.

Method

This research is essentially qualitative. Doing science rests on the tripod of theory, methods, and techniques, which condition one another and depend on the object of analysis (Minayo, 2012). Based on this understanding, adopting a qualitative perspective to build knowledge in this study converges with the theoretical foundation that guides it: the psychodynamics of work.

According to Becker (1992), studies in the human and social sciences that employ qualitative methods necessarily involve developing a methodology that is feasible — i.e., a "viable science" — without losing rigor. In line with that reasoning, one may reflect that method is to researchers what prescribed work is to workers: an important means that orients how to understand/know an object. However, over the course of this investigative action, the encounter with the real always collides with the need for reformulation — a feature intrinsic to human activity, to life and living—and research work is no different (Masson, 2007).

In this sense, the envisioned method is neither a finished tool nor its object pure and neutral. This research is therefore a living process of inquiry and study through a "viable science."

Participants

Thirteen obstetrician[1] physicians participated in the study. Inclusion criteria were physicians specialized in gynecology and obstetrics with an employment relationship in the public health system. Accordingly, all participants work at a public maternity hospital located in a medium-sized city in the interior of a Northeastern state.

Data Collection Procedures and Ethical Considerations

Data were collected using a sociodemographic questionnaire and semi-structured interviews with open-ended questions developed by the authors. Interviews were conducted individually in the hospital wards of the maternity unit and lasted an average of 35 minutes. The interview guide was prepared in advance around the following thematic axis: relationships with service users and their implications for mobilization to exercise the profession as well as for the unforeseen events of the activity.

In general, the psychodynamics of work does not employ the "individual interview" (Dejours, 2004, p. 79), as it privileges group procedures. However, in certain cases, resorting to them becomes necessary, as in Dejours and Jayet (1994, p. 70), where they present "dual interviews," and in Dejours and Bègue (2010), where they discuss "individual interviews" (p. 121) used as a "stage of the investigation" (p. 117). In this study, we used individual interviews because this approach allowed closer contact with the professional group, considering participants' limited availability to dedicate a portion of their time to discussing their work. Although the theoretical perspective of this research prioritizes collective encounters, field constraints emerged for two reasons: (i) the maternity unit's on-call shift has a small number of obstetricians for a considerable number of patients, meaning that when they are on duty they cannot devote time to anything other than their tasks; and (ii) these professionals hold other jobs, making meetings outside work hours unfeasible.

Thematic saturation determined the number of interviews conducted (Minayo, 2017). After approval by the human research ethics committee, participant recruitment used a referral procedure known as snowball sampling, in which participating workers referred colleagues, and so on. Initial contact with the maternity unit occurred through the hospital's human resources department, which provided the staff roster and corresponding work schedules. With this roster in hand, we were able to invite professionals to participate during their shifts.

With participants' consent and upon signing the informed consent form, interviews were audio-recorded and later transcribed in full.

Interview Analysis

Analysis followed thematic content analysis (Laville & Dionne, 1999), encompassing: initial transcription and reading, segmentation of statements into units, definition of analytical categories, final categorization, and analysis and interpretation. Thematic content analysis enables the identification and interpretation of informational patterns through an expository and explanatory organization (Souza, 2019). To ensure anonymity and confidentiality, participants were assigned randomly chosen pseudonyms — for example, Letícia, Adriana, Fernanda, Rafael, etc.

Results and Discussion

Participant Profile

Participants' ages ranged from 31 to 61 years. Regarding sex distribution, 10 participants were female and three were male. The average time spent in training (undergraduate degree, specialties, and residencies) was 10 years. Time in the profession ranged from 1 to 40 years, and eight participants had more than 15 years of experience. All interviewees reported some involvement with teaching; seven are professors at public or private medical schools, and the remainder serve as preceptors for interns and residents. On average, participants reported three employment ties and a fixed weekly workload of at least 40 hours and at most 80 hours (summing all workplaces in addition to the maternity unit studied). Eight obstetricians hold permanent civil-service posts, and the others are on fixed-term contracts.

The analysis identified the following categories: recognition and personal fulfillment; the clash of frustrated expectations with relationships driven by the social imaginary surrounding the medical profession; and psychological violence and the development of defense mechanisms.

[1] Although the medical specialty is termed obstetrics and gynecology, here we opted to simplify the terminology by using only the area most closely related to our object of study.

Recognition and Personal Fulfillment through Workplace Relationships

When asked about their relationships with pregnant patients, participants initially reported positive interactions, as in the account from Letícia:

> I have a very good relationship with my patients… Yesterday I was at the mall and a man came up — I delivered three births for his family, two for his wife and one set of twins — and he said: "Look, go hug her; she's the one who brought you into the world." That, to me, is gratifying.

Words and gestures of affection are seen as an important source of recognition at work. As Dejours (2012a) notes, although material compensation matters, it is through symbolic retribution that feelings of recognition flourish in workers, fostering professional engagement and promoting mental health.

Thus, symbolic recognition takes on special salience in obstetrics, since physicians take part in an event that is not merely biological but also deeply affective and social. The birth of a new life unfolds amid expectations embedded with cultural and historical elements (Sens & Stamm, 2019). In line with obstetricians' experiences, nurses also report receiving recognition from patients and families — a source of satisfaction and pleasure in daily practice that validates their work and reinforces professional identity (Duarte et al., 2021).

In hospital care, the caring process is reciprocal and involves mutual exchange; there must be availability, trust, and receptivity on both sides — professionals and users/families. When this partnership materializes, recognition of the professional entails appreciation of the effort and suffering invested in delivering care, generating meaning in work and yielding not only financial but also symbolic returns (Duarte et al., 2021).

The symbolic power afforded by recognition results not only from workers' subjective mobilization but also from others' judgments (Areosa, 2019). According to Dejours (2012a), recognition through a "judgment of utility" may be conferred not only by superiors and subordinates but also by service users, when they acknowledge the worker's contribution to agreed-upon goals. Recognition from peers — through an "aesthetic judgment" — is also central to identity and mental health.

As Dejours (2013) argues, a judgment of utility confers status within the organization. Interviewee Ana observed:

> I'm not someone with very high self-esteem; I'm not usually one to praise myself. But I always hear, "Ah, she was born for this." Then I think, maybe I really was. And that's fine (laughs). The fact that I feel satisfied with it — and the feeling is mutual — makes me sure I'm in the right place.

This statement highlights how work contributed to building the worker's identity, confirming the centrality of work in people's lives: working is never only about transforming something "out there," but above all about transforming oneself — building an identity and acquiring new skills and competencies (Areosa, 2019). Revuz et al. (2021) emphasize the collective character of work — the "being with others" — in consolidating individual and collective identities, since human beings are moved by what they do and how they do it. Work is therefore not only central but constitutive in their lives.

Difficulties when Expectations Collide with the Realities of Work

"I think I have a good relationship with patients — at least I try to; you can't please everyone." Adriana's words signal that relationships with pregnant women do not always yield thanks, recognition, or job satisfaction. Her phrase "at least I try" acknowledges the effort she mobilizes in the face of obstacles posed by the real of work.

In carrying out their activity, workers face various constraints: technical contingencies; disruptions arising from the environment and from users; relational difficulties; lack of supplies; and so on (Dejours, 2012a, 2013). In the face of such difficulties, the worker mobilizes their psychic economy to overcome the unexpected and may experience a sense of failure — an opening for ingenuity and practical intelligence to be mobilized to confront what is not prescribed and to surmount obstacles and suffering (Gernet, 2021). Accordingly, conflicts in the physician–patient relationship are permeated by difficulties imposed by the realities of work, as Fernanda relates:

> Theory is very different from practice. Every physician dreams of working in a cutting-edge hospital with cutting-edge technology, where nothing's missing, right? But reality is something else — very different — especially in Brazil, in the public system. Sometimes they arrive already on the defensive with us. Sometimes they've come from the countryside, traveled for hours, gone from hospital to hospital, hand to hand; so when they get here, they arrive all braced for a fight, expecting us to fix everything. And we can't always fix everything.

Working conditions make it hard for obstetricians to do their job as they would like. As a consequence, the lack of infrastructure in public health generates friction with pregnant women, their families, and companions, who often hold physicians responsible for their suffering. They expect their pregnancy-related problems to be solved and their demands

met, but the "infidelities of the milieu" (Canguilhem, 2016) — amplified by the scarcity of the unit — limit clinicians' ability to resolve problems, and unexpected, catastrophic events can occur.

For the psychodynamics of work, grasping the dynamics of workplace relationships is essential (Dejours, 2017). Every activity is exposed to others' gaze and judgment, and negative feedback breeds a sense of frustration (Areosa, 2019). In medicine, the interaction between physician and patient determines the construction of a bond of trust that is crucial for the delivery of care and for professional satisfaction (Campos & Fígaro, 2021).

Another axis of conflict concerns choosing the most appropriate conduct for childbirth and the patient's wishes, as Ana explains:

> Family members think they can tell us what conduct to take. They arrive and say, "No! It has to be a C-section." And it's not like that. There's a pathway, a step-by-step; there are indications for a C-section, but they want to make that call, you know? They want us to do it; and when we don't, they say, "Oh, you're dragging things out." But that's not how it works — every profession has its protocols, right? So that's the hardest part for me. It's not even dealing with the patient directly; it's dealing with this external pressure to do what people want.

This speaks to a broader moment in medicine. As Aguiar et al. (2020) note, technological medicine operates in a context where technologies take center stage, sidelining professional practice. This produces a crisis of trust in clinical decision-making if it is not accompanied by technological use. Added to this is a social belief that surgical delivery is the safest and least painful option for mother and baby (Hotimsky & Schraiber, 2005). This is not only a desire to avoid pain; above all, it is a demand for dignity, since "natural" birth has often been experienced as traumatic (Maia, 2010).

At the same time, expanding public knowledge has enabled citizens to understand—and rightly claim — their health rights. Alongside this progress, however, there has been a rise in aggressive, confrontational behaviors that create discomfort in the physician–patient relationship, often stemming from a lack of trust in professionals (Rocco, 2010). This context contributes to pathogenic suffering (Dejours, 2013). Participants in this study described the difficulty of reconciling pregnant women's and companions' wishes with medical evidence and with deficiencies in public provision.

Conversely, treating pregnant women's wishes as a complicating factor is criticized by Palharini (2017), who argues that medical authority is often construed as unquestionable and absolute, disqualifying any dissenting discourse. From this perspective, the physician–patient relationship becomes precarious when one subject is assigned legitimate authority and the other is assumed to know nothing. Sens and Stamm (2019) observe that many maternity-care studies show obedience is expected of patients, while non-obedience is interpreted as disrespect or aggression. Hence the need to reflect on better strategies for fostering welcoming, empathetic, and comprehensible communication between physician and patient.

Relationships Shaped by the Social Imaginary about the Medical Profession

As Sens and Stamm (2019) note, professional performance is grounded not only in material conditions or technical-scientific knowledge but also in human relations — an interpersonal ethic. Respectful, empathetic relationships are therefore vital in practice. For Aguiar et al. (2013), better care hinges on mutual understanding and tolerance; absent reciprocity, violence within interactions becomes more common.

The obstetricians interviewed reported difficult interpersonal contexts in their work. Terms such as "mercenary" (Cecília), "killer" (Bárbara), "incompetent" (Luís), "butcher" and "criminal" (Bruna), and "murderer" (Priscila) were cited as labels applied to them by patients and companions and circulating in the media. In the psychodynamics of work, recognition is fundamental to building life and health through work (Dejours, 2015, 2016; Dejours & Bégue, 2010). Facing insults in place of recognition is frightening and distressing for these professionals.

Participants unanimously reported that, because they encourage vaginal birth (in line with official guidelines and norms), they are seen as those who produce suffering and even mistreatment; as unfeeling; and as proof that everyone working in the studied maternity unit works poorly or does not want to work. In such situations, the precarious public service "disappears" from families' view, and the physician confronts verbal violence and the fear of physical violence. Even in France — where the welfare state is far more developed than in Brazil — public-service precarization occurs, with daily consequences for medical work (Dejours, 2015). Professionals must therefore devise strategies to avoid collapse (Dejours, 2012b), since there are always more patients in need of care than professionals available to provide good-quality assistance in the public maternity setting. Bruna illustrates:

> The media doesn't publicize good things — it only shows what went wrong, never what went right. So people think everything done here is wrong; that every professional who works here works badly; that every professional here is a butcher who wants to mistreat, who treats people poorly. How can you change that image? After all, this is our profession. But because of the system, the lack of information, this idea that we're all criminals — that nowadays physicians are seen as criminals — there's no respect anymore, so we're afraid.

As Dejours et al. (1993, p. 99) argue, when we ask what someone's job is, a social imaginary about the profession is invoked. Work is "not only a way to earn a living; it is a social status to which are sometimes attached a specific attire, a particular vocabulary," and it also sets the tone for solidarity or conflict between professionals and their users. For the participant quoted above, the media feeds this conflict by tarnishing the maternity hospital's reputation and, by extension, its staff, so that patients and companions arrive "ready for an argument." As Fernanda put it: "they already arrive at the maternity ward 'armed'."

Research by Aguiar et al. (2013) on institutional violence in public maternity hospitals corroborates that the physician–pregnant patient relationship can be conflictual. The authors point to a two-sided difficulty: physicians who do not communicate well, and patients who verbally aggress professionals because they arrive at public services fearing mistreatment — whether due to prior experiences or warnings from others. Priscila observed: "It depends a lot; it depends on how people arrive, on how things are. Sometimes we end up giving back what we receive, right?"

Suffering can also impel resistance and action. Although the participants' responses suggest that lived conflicts have not led to subjective demobilization, they do exact a high psychic cost for remaining at work. Ana expressed her engagement this way:

> We struggle with how maligned the maternity hospital is, right? So we — let's put it this way — I always do a lot of propaganda on its behalf. I'm part of this place; I work here. If you saw my chart notes, I'm always talking a lot with patients; I explain everything to them; I give them a lot of attention — to demystify this "slaughterhouse" idea.

When affectivity is wounded, suffering ensues — an experience inseparable from confronting what is not prescribed (Gernet, 2021). Such suffering becomes the target of specific psychic processes — sublimation, possibilities for pleasure and development at work — so that subjective experience does not become harmful. Ana's suffering did not turn pathogenic; it spurred her to resist the real, defend the maternity hospital, and do her best. This is ingenuity and practical intelligence mobilized to overcome obstacles.

Psychological Violence and the Development of Defense Mechanisms

We identified four recurring situations that generate friction among physicians, pregnant women, and companions: proposing vaginal birth instead of a cesarean; a pregnancy evolving into an urgent/emergent situation; delays in hospital discharge; and cases in which the pregnant woman and/or fetus die or suffer sequelae. Such points of tension in physician–patient interaction can lead to violence and aggression — both from patients toward professionals and from professionals toward patients (Aguiar et al., 2013).

The expectation of a new life can end in irreversible tragedy. As Bárbara notes, "Obstetrics is difficult in that way. The family doesn't accept it, right? And they want to blame someone, and it's not always our fault." Her words show that tragedy may stem both from the unpredictability of events and from the worker's own action. Luís described these dilemmas as follows:

> To give you an idea — without exaggeration — we are threatened every day. Obstetrics is threatened every day. Before long you'll see a companion yelling at us: "Why won't you operate on the patient? Why won't you resolve this? Why is the patient still hospitalized? And if something happens to the baby, you're going to pay!" That's a veiled threat. So all of us are threatened day and night in the public service.

Chappell and Martino (2006) define workplace violence as situations in which people are abused, threatened, or assaulted in circumstances related to their work. Psychological violence may take the form of threats, promises, or insinuations aimed at coercing, inhibiting, or constraining a person or group. Participants reported that, during labor, for example, companions may "shake their foot impatiently" (Carlos), threaten legal action, or call the media. Many also reported frequent threats to their lives — not only verbal ones; one episode involved a threat with a bladed weapon.

Such situations become more fraught when the companion is male, heightening concern that threats may be carried out. For Dejours (2004), verbal abuse constitutes a threat of violence, since one cannot predict whether it will remain at the level of discourse or escalate to physical abuse — provoking fear in the worker. As Luana recounts, "Many times companions arrive intoxicated… They intimidate us, threaten us, yell at us. They really don't respect our profession, our conduct, or us as people."

Still according to Dejours (2004), when the risk of aggression is present at work and becomes trivialized — part of the task — the worker must seek to neutralize it as far as possible. Thus, continuing the work in another environment to preserve oneself from risk has become part of medical activity. In addition, when threatened, all participants reported trying not to argue with patients or companions — amounting to an informal work rule. Otherwise, the atmosphere becomes even more unpleasant, as Carlos explains: "If you argue with a patient — if you get into it with a patient—it becomes extremely unpleasant for you. Any annoyance you have during a shift will stick with you for the entire shift." This conduct functions as a collective defense strategy, preserving the psychic balance needed to carry on.

Such a scenario demands strategies to ward off violence and continue working despite imminent risk — possible only when mutual support and protection exist among colleagues (Dejours, 2019). "Working is not only producing; it is also living together" (Dejours, 2012a, p. 85). Hence the importance of relationships, belonging, and the rules and values that constitute a work collective in forging defensive strategies to protect mental health and strengthen occupational identity. Given the unpredictability of work situations, these professionals must manage opposing feelings — now of pleasure, now of suffering — as Luís describes:

> The relationship with patients is sometimes love–hate. You go from heaven to hell in seconds. In obstetrics this is very clear. For example, we were in the delivery room; there was an emergency; we moved her to the OR, did the work, and it all went well. The patient and her family were extremely grateful. Then, as soon as we stepped into the pre-delivery area, a companion of another patient said, "See that doctor there? He's incompetent; he doesn't know anything." So you went from heaven to hell in 30 seconds.

Thus, at times the obstetrician is recognized for good work; at others, discredited. This ambivalence generates divergent feelings that physicians must learn to handle. As Priscila reports: "A patient's mother calling out to us: 'You're murderers, you're murderers.' It's hard, right? You need a lot of psychology for that."

Work mobilizes affects, and psychoanalysis addresses subject formation based on the infant's ambivalent love–hate relation with the mother—complementary feelings that shape the person (Dejours, 2009). Hate plays a structuring role in development: through anxiety, tolerance grows. From the sensations that produce love and hate arises a creative force capable of managing the discomfort of displeasure (Freud, 1996). At the organizational level, such ambivalent relations can yield benefits — creativity, problem-solving, and decisional accuracy — precisely what emerged among participants in this study.

Final Considerations

This study examined obstetricians' work, focusing on relationships with pregnant women, families, and companions. Participants' accounts revealed complex physician–patient dynamics, encompassing both affection and conflict/threat. Despite recurrent impasses — and the distress they often cause — participants remain engaged in their profession. We surmise that experiences of pleasure and recognition help support them in the face of threatening situations at work.

The study contributes to understanding the viewpoints of those who are the true protagonists of this activity. It is necessary to broaden our lens to the social context in which this professional group operates, especially in public health. Obstetricians face a daily landscape of controversies and disputes that puts their craft and practice in question, in the midst of pathogenic suffering that can lead to mental illness. Media coverage compounds these complex relations by emphasizing adverse events — particularly those related to vaginal birth.

As for limitations, conducting group meetings with the category proved difficult due to time constraints — not only during shifts but also because weekly workloads often exceed 40 hours. We suggest future research deepen understanding of the physician–patient relationship through collective dialogues about work.

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How to cite:

Melo, J. S. V. B., Souza, P. C. Z., Dourado, A. D., Máximo, T. A. C. O., & Araújo, A. J. S. (2025). The Perspective of Obstetricians on the Relationship with Patients and Family Members. *Revista Subjetividades, 25*(1), e16977. https://doi.org/10.5020/23590777.rs.v25i1.e16977

Correspondence address:

Jéssika Sonaly Vasconcelos Barborsa de Melo
E-mail: jessikasonaly@gmail.com

Paulo César Zambroni de Souza
E-mail: paulozamsouza@yahoo.com.br

Amanda Dias Dourado
E-mail: amandadouradorh@gmail.com

Thaís Augusta Cunha de Oliveira Máximo
E-mail: thaisaugusta@gmail.com

Anísio José da Silva Araújo
E-mail: anisiojsa@uol.com.br

Received on: *07/05/2023.*
Accepted on: *10/10/2024.*