Research Article
Artigo de Pesquisa
Artículo de Investigación

DOI: http://dx.doi.org/10.12957/reuerj.2024.80274

Clinical factors of women in labor well-being: deontological and bioethical principlism perspectives

Fatores clínicos do bem-estar de mulheres em parturição: perspectivas deontológicas e da bioética principialista

Factores clínicos del bienestar de la mujer en trabajo de parto: perspectivas deontológicas y de la bioética principialista

Chrisne Santana Biondo[I]; *Maria Madalena Souza dos Anjos Neta*[I]; *Sérgio Donha Yarid*[I]

[I]*Universidade Estadual do Sudoeste da Bahia. Jequié, BA, Brazil*

ABSTRACT
Objective: to evaluate the clinical factors associated with women's well-being during labor and delivery in the light of bioethics principlism and deontology. **Method:** a cross-sectional study with a quantitative approach was conducted. It involved 396 postpartum women admitted to a municipal hospital in the southwest of Bahia. Data were collected from January to May 2023, after approval from the research ethics committee. The data were tabulated using Excel software and analyzed using SPSS v.25 through Multinomial Logistic Regression. **Results:** majority of the sample exhibited well-being with health care assistance. Women who underwent delivery performed by non-medical professionals showed higher chances of "adequate" levels of well-being. Additionally, women who did not undergo cesarean delivery showed increased chances of well-being. **Conclusion:** It is necessary for professionals to reflect on their actions, conditioning them to the humanization of childbirth, according to bioethical principles.
Descriptors: Ethics, Professional; Patient Satisfaction; Labor, Obstetric**;** Maternal Welfare.

RESUMO
Objetivo: avaliar os fatores clínicos associados ao bem-estar das mulheres durante o trabalho de parto e parto à luz da bioética principialista e da deontologia. **Método:** estudo transversal com abordagem quantitativa. Participaram 396 puérperas internadas em um hospital municipal do sudoeste da Bahia, e os dados foram coletados no período de janeiro a maio de 2023, após aprovação do comitê de ética em pesquisa. Os dados foram organizados no *software* Excel e analisados via SPSS v.25. a partir da regressão logística multinomial. **Resultados:** a maior parte da amostra apresentou bem-estar com assistência em saúde, mulheres que tiveram parto realizado por profissionais não médicos apresentaram mais chances de níveis de bem-estar "adequado". E mulheres que não tiveram a via de parto cesárea apresentaram aumento de chances de bem-estar. **Conclusão:** é necessário que os profissionais reflitam sobre suas ações, condicionando-as à humanização no parto, em observância aos princípios bioéticos.
Descritores: Ética Profissional; Satisfação do Paciente; Trabalho de Parto**;** Bem-Estar Materno.

RESUMEN
Objetivo: evaluar los factores clínicos asociados al bienestar de la mujer durante el trabajo de parto y parto a la luz de la bioética y la deontología principialista. **Método:** estudio transversal con enfoque cuantitativo. Incluyó 396 puérperas ingresadas en un hospital municipal del suroeste de Bahía. Recolección de datos de enero a mayo de 2023, con aprobación del comité de ética en investigación. Los datos se tabularon en el software Excel y se analizaron mediante SPSS v.25. utilizando regresión logística multinomial. **Resultados:** la mayoría de las participantes de la muestra presentó bienestar con la atención para la salud; las que tuvieron partos realizados por profesionales no médicos tenían más probabilidades de tener niveles "adecuados" de bienestar; las que no tuvieron parto por cesárea tenían mayores probabilidades de tener bienestar. **Conclusión:** es necesario que los profesionales reflexionen sobre sus acciones y las adecuen para humanizar el parto, respetando los principios bioéticos.
Descriptores: Ética Profesional; Satisfacción del Paciente; Trabajo de Parto; Bienestar Materno.

INTRODUCTION

Well-being in childbirth is a complex, multidimensional phenomenon, also dynamic and interdependent on a woman's satisfaction during the process of parturition, which results from a series of interconnected situations organized around good treatment in health care assistance[1]. Well-being is subject to changes depending on the reality and experiences constructed by the woman.

When well-being is not achieved, it can be understood that ethical problems permeate health care assistance in the unit. Therefore, ethical issues in childbirth and immediate postpartum can be understood as actions that affect physical and moral integrity, causing harm to women and their families, and the lack of teamwork that may damage the relationship with health care assistance. In this context, it is the ethical duty of the professional to provide care based on scientific evidence and best practices in childbirth management, respecting the woman's autonomy.

Corresponding author: Chrisne Santana Biondo. E-mail: tity_biondo_enf@hotmail.com
Editor in chief: Cristiane Helena Gallasch; Associate Editor: Juliana Amaral Prata

Received: Nov 20th 2023 – Accepted: Jan 29th 2024

DOI: http://dx.doi.org/10.12957/reuerj.2024.80274

When there are situations that violate women's human rights, related to medicalization processes or devaluation of the female body, disregarding the physiology of childbirth, it is considered obstetric violence. These situations are directly linked to negative maternal and perinatal outcomes, leading to inadequate well-being[2], and are considered ethical problems in childbirth.

Thus, obstetric violence can be experienced in diverse forms, as evidenced by a literature review. *Verbal:* through treatment that exposes women to embarrassment. *Psychological:* evidenced in threatening attitudes, authoritarian and hostile treatment, imposition of decisions, provision of dubious information or lack of information. *Physical:* through repetitive or aggressive vaginal examinations that cause pain, unnecessary cesarean section surgery, Kristeller maneuver. *Sexual:* such as unnecessary exposure of body parts or without the woman's consent. *Institutional:* characterized by seeking care across multiple institutions, inadequate infrastructure, imposition of institutional routines that violate rights or cause harm to the parturient. *Financial:* by charging for normal childbirth care. *Discriminatory:* by deprecating or denying care due to racial or social prejudice or the woman's socioeconomic condition[3].

Thus, in the occurrence of ethical problems characterized by rights violations, it becomes important to discuss the well-being of women in labor from the perspective of bioethical principlism In this regard, bioethics, as a systematic study of human conduct and a foundation for several ethical professional behaviors contained in deontological codes, provides space for professionals to reflect on their practice.

Therefore, bioethical principlism utilizes four principles that guide health care practice. In labor, the beneficence principle can be seen with the objective of promoting benefits to the patient in physiological, psychological, and spiritual aspects, making the experience satisfactory through comprehensive care.

Autonomy involves respecting the patient's decisions, providing information so that the woman can make informed choices based on recommended best practices[4].

Nonmaleficence principle entails that health care professionals should not use their knowledge to cause harm to the patient, communicating available alternatives as well as their advantages and disadvantages to the patient. It involves always seeking alternatives that provide benefits[5].

Lastly, equity in access to health care is a concern of bioethics, respecting the principle of justice in ensuring that all women have quality access to childbirth assistance without having to seek services across the network.

In this sense, evaluating the well-being of women in labor and delivery helps understand whether bioethical and deontological principles are observed based on the assessed criteria. Thus, contextualizing ethical problems through the perspective of postpartum women is necessary, as this approach assists in recognizing the impacts of care assistance on satisfaction with care. Moreover, unsatisfactory experiences of health care can reproduce situations of discomfort, fears, and anxieties when faced with similar situations.

With this study, it is expected to understand the ethical problems arising from assistance and well-being considered by women in labor, so that there can be reflection on professional practice, with modifications of behaviors that better serve this population. Thus, it converges towards a practice where bioethical principles and professional ethics contained in medical and nursing codes of ethics are respected, with health care assistance free from malpractice, negligence, and imprudence.

Therefore, the study's aim is to evaluate the clinical factors associated with the well-being of women during labor and delivery in the light of principled bioethics and deontology.

METHOD

This is a cross-sectional, descriptive study of an observational nature with a quantitative approach. The research setting was a municipal hospital in the southwest of Bahia. The sample was non-probabilistic, convenience sampling, consisting of 396 postpartum women who were in the joint accommodation from January to May 2023.

The inclusion criteria observed were: being 18 years old or older; remaining in labor for a minimum of 4 hours in any unit within the maternity ward to experience care in the study location; having more than 4 years of education, as the rating scale used was self-administered; and having their delivery performed by an Obstetrician-Gynecologist or Obstetric Nurse. The exclusion criteria were: women who underwent elective and scheduled cesarean deliveries, and postpartum women who were not emotionally stable to respond to the questionnaire.

DOI: http://dx.doi.org/10.12957/reuerj.2024.80274

Women who met the inclusion criteria and agreed to participate in the study were assessed for sociodemographic and clinical data, as well as well-being conditions during labor, using a sociodemographic questionnaire, obstetric data questionnaire, and the Assessment of Maternal Well-being in Labor and Delivery (BMSP2) - abbreviated Brazilian version adapted and validated in Brazil by Jamas *et al*[6].

Data were tabulated in Excel software and analyzed using SPSS v.25. The Multinomial Logistic Regression analysis was conducted considering the predictive model of contextual variables and sociodemographic markers on the level of well-being of postpartum women in the hospital. Initially, the assumption of multicollinearity, inherent to multinomial logistic regression analysis, was tested. This study approach focuses on discussing the predictive model with contextual variables.

This model included the Independent Variables (IV) of the logistic regression model, considering: a) Planned pregnancy: Yes or No; b) Prenatal care attendance: Yes and No; c) Number of prenatal care consultations: Less than 5 and 6 or more; d) Received guidance about delivery: Yes and No; e) type of delivery: Vaginal, Cesarean section, and Forceps (Assisted vaginal delivery); f) Choice by will: Yes and No; g) Type of professional: Physician, Nurse, and Not informed; h) Postpartum period: Less than 12 hours, between 12 hours and 48 hours, between 2 and 5 days, and more than 5 days; i) Number of children: Only child, 2 or 3 children, and more than 3 children; j) Reason for hospitalization: Postpartum, reason related to the mother, and reason related to the baby; and k) Reason for cesarean section: Vaginal, Labor did not progress, Fetal distress, Transverse or breech position, Abnormal Fetal Heart Rate (FHR), Maternal diseases (Systemic Arterial Hypertension (SAH) or Diabetes Mellitus (DM)), Other reasons, and reasons not informed.

Furthermore, dummy variables were created for the variables "type of delivery", "professional who performed the delivery", "reason for hospitalization", and "reasons for cesarean sections". This methodology is commonly used in predictive models where independent variables are nominal categorical ones, meaning variables that cannot be ordered. In this regard, new variables were created, encoded as presence or absence, with values assigned as 1 = presence and 0 = absence.

This study consists of a subproject of the research titled "Ethical Problems Evidenced in the Assessment of Women's Satisfaction and Well-being During Delivery", approved by the Research Ethics Committee of the institution involved, in accordance with ethical principles governing research involving human subjects.

In order to respect autonomy, nonmaleficence, beneficence, and justice, participants provided their consent by signing the Informed Consent Form (ICF) after being informed about the risks and benefits they were exposed to. It was clarified that the research would not cause any harm to the participants, and if any harm occurred, it would be the responsibility of the researchers. Additionally, confidentiality, anonymity, and the participant's right to withdraw from the research at any stage were ensured.

RESULTS

The study involved 396 women aged between 18 and 45 years old (μ=27,62±5,97). Tables 1 and 2 present the profile of the sample considering the clinical questionnaire.

Table 1: Clinical profile of women during pregnancy in a public hospital in a municipality of Bahia. Vitória da Conquista, Bahia, Brazil, 2023.

Variables		n	f(%)
Planned pregnancy	Yes	193	48.74%
	No	202	51.01%
	Missing	1	0.25%
Pre-natal	Yes	389	98.23%
	No	7	1.77
	Missing	0	0.00%
Prenatal appointments	five or less	58	14.65%
	six or more	334	84.34%
	Missing	4	1.01%
Received childbirth guidance	Yes	300	75.76%
	No	92	23.23%
	Missing	4	1.01%

DOI: http://dx.doi.org/10.12957/reuerj.2024.80274

Table 2: Clinical profile of women during childbirth in a public hospital in a municipality of Bahia. Vitória da Conquista, Bahia, Brazil, 2023.

Variables		n	f(%)
Type of delivery	Vaginal	218	55.06%
	Cesarean	172	43.43%
	Forceps	6	1.51%
Choice of delivery type	Yes	234	59.09%
	No	161	40.65%
	Missing	1	0.25%
Professional	Physician	291	73.49%
	Nurses	54	13.64%
	Does not know	41	10.35%
	Missing	10	2.52%
Postpartum period	Less than 12 hours	39	9.85%
	Between 12 and 48 hours	295	74.49%
	Between 2 and 5 days	54	13.64%
	More than 5 days	8	2.02%
Number of children	First child	191	48.11%
	Two or three children	165	41.57%
	More than three children	39	9.82%
	Missing	2	0.50%
Reason for staying in the Joint Accommodation	Postpartum	282	71.21%
	Reason related to the mother	26	6.57%
	Reason related to the baby	87	21.97%
	Missing	1	0.25%
Reason for cesarean section as reported by the mother	Labor did not progress	46	11.62%
	Fetal distress	11	2.78%
	Transverse/pelvic position	18	4.54%
	Abnormal Fetal Heart Rate (FHR)	15	3.79%
	Maternal diseases (SAH/DM)	41	10.35%
	Others	46	11.62%
	Could not inform	3	0.76%
	Missing	1	0.25%

The majority of the sample reported well-being (52.89%), followed by adequate (31.49%) and malaise (15.62%), and attended prenatal care (98.23%), with six or more consultations (84.34%).

The multinomial regression analysis, considering the predictive model with contextual variables, is shown in Table 3. The initial results indicate the absence of multicollinearity among the independent variables. However, the "vaginal delivery" variable was removed from the regression model due to high levels of multicollinearity according to the analysis.

Subsequently, the indicators of the multinomial regression analysis showed that the model did not exhibit superior predictive capacity compared to the null model, according to the likelihood ratio χ^2 results [$\chi^2{}_{\chi^2 Likelihood}(44)=38.304$, p=0,714]. However, the Pearson's χ^2 test yielded contrasting results [$\chi^2{}_{Pearson}(468)=491.554$, p=0.218], indicating the adequacy of the statistical model. Additionally, the Nagelkerke's Pseudo-R^2 the Nagelkerke's Pseudo-R^2 results showed considerably low values (Pseudo-R^2=0.111). From this, it was possible to infer significant influences of the variables "cesarean delivery" (-2LL=589.695, p=0.018), and the reasons for cesarean section "SAH/DM" (-2LL=589.225, p=0.022) and Others (-2LL=587.592, p=0.051**), on the postpartum women well-being levels.

The analysis of direct effects indicated that postpartum women who had delivery performed by non-medical professionals were 276.5% more likely to have "adequate" levels of well-being compared to those who had delivery performed by doctors (B=1.326, Wald=3.673, p= 0.055**, OR=3.765). Similarly, postpartum women who had cesarean delivery were 1,656.30% more likely to have adequate levels of well-being compared to those who had non-cesarean delivery (B= 2.866, Wald=6.472, p=0.011, OR=17.563).

On the other hand, postpartum women who did not have Labor did not progress as the reason for cesarean section showed a decrease of 91.0% in the chances of having "adequate" levels of well-being compared to those who had "Labor did not progress" as the type of delivery (B=-2.412, Wald=4.325, p=0.038, OR=0.090). Postpartum women who did not have "Fetal position" as the reason for cesarean section showed a decrease of adequate levels of well-being compared to those who had "Fetal position" as the reason for cesarean section (B=-2.547, Wald=3.925, p=0.048,

DOI: http://dx.doi.org/10.12957/reuerj.2024.80274

OR=0.078). Similarly, postpartum women who did not have "FHR" as the reason for cesarean section showed a decrease of 97.0% in the chances of having adequate levels of well-being compared to those who had “FHR” (B=-3.494, Wald=4.780, *p*=0.029, OR=0.030).

Table 3: Predictive model results with contextual variables. Vitória da Conquista, Bahia, Brazil, 2023.

		-2LL	χ^2	df	*p*	Tolerance	VIF
Plan. Pregnancy		583.825	2.196	2	0.333	0.903	1.108
Pre-natal		584.573	2.944	2	0.229	0.931	1.074
PN consultations		582.482	0.853	2	0.653	0.882	1.134
Guidelines		584.720	3.091	2	0.213	0.923	1.084
Desire		583.308	1.679	2	0.432	0.807	1.239
Professional							
	Physician	586.166	4.537	2	0.103	0.480	2.084
	Nurses	584.433	2.804	2	0.246	0.485	2.061
Type of Delivery							
	Cesarean	589.695	8.066	2	0.018*	0.121	8.295
	Forceps	583.063	1.434	2	0.488	0.931	1.074
Postpartum period		587.610	5.981	6	0.425	0.582	1.720
Number of children		582.764	1.135	4	0.889	0.908	1.101
Hospitalization							
	Mother	582.906	1.277	2	0.528	0.729	1.373
	Baby	582.523	0.894	2	0.640	0.702	1.425
C-section							
	Labor	586.489	4.860	2	0.088	0.239	4.188
	Fetal distress	584.535	2.906	2	0.234	0.651	1.537
	Position	586.266	4.637	2	0.098	0.452	2.213
	FHR	588.700	7.071	2	0.029*	0.471	2.123
	SAH/DM	589.225	7.596	2	0.022*	0.249	4.011
	Others	587.592	5.963	2	0.051**	0.234	4.280
Intercept		581.629					

Legend: * significant values (p < 0.05). ** borderline significance level (p = 0.05)

Postpartum women who did not have "SAH/DM" as the reason for cesarean section showed a decrease of 95.4% in the chances of having adequate levels of well-being compared to those who had "SAH/DM" as the reason for cesarean section (B=-3,069, Wald=6,590, *p*=0,010, OR=0,046). Finally, postpartum women who did not have other reasons (unspecified) for cesarean section had a decrease of 92.7% in the chances of having adequate levels of well-being compared to those who had other reasons (unspecified) for cesarean section (B=-2.615, Wald=4.908, *p*=0.027, OR=0.073).

Furthermore, regarding the chances of well-being, postpartum women who did not have cesarean delivery had an increase of 1,088.9% in the chances of experiencing well-being compared to those who had cesarean delivery (B=2.476, Wald=5.599, *p*=0.018, OR=11.889). On the other hand, postpartum women who did not have "FHR" as the reason for cesarean section showed a decrease of 96.8% in the chances of experiencing well-being compared to those who had "FHR" as the reason for cesarean section (B=-3.429, Wald=5.177, *p*=0.023, OR=0.032). Finally, postpartum women who did not have other reasons for cesarean section had a decrease of 90% in the chances of experiencing well-being compared to those who had other reasons for cesarean section (B=-2.305, Wald=4.499, *p*=0.034, OR=0.100).

It is important to note that the other tested effects did not show statistical significance, and the predictive model with contextual variables had a predictive capacity of 91.4% for well-being levels, 21.1% for adequate levels, and only 6.8% for malaise levels, with an average of 55.4%.

DISCUSSION

A discussion on the health care quality evaluation is pertinent in today's reality, and among the dimensions of quality, patient satisfaction with care is significant. Therefore, when patients report achieving well-being during childbirth, it can be inferred that they are satisfied with the care received. In this sense, well-being is an important mental health indicator and essential in all stages of life, as people who are more satisfied are more likely to be healthy. In the context of childbirth, better bonding with the newborn and adaptation to motherhood are facilitated, and the likelihood of postpartum depression is reduced[7].

DOI: http://dx.doi.org/10.12957/reuerj.2024.80274

For the studied sample, it was observed that the majority achieved adequate well-being during childbirth. This is consistent with another study evaluating 200 women in primary care regarding the assessment of childbirth care, where the care was considered good (60.5%) or very good (27%). This suggests that there was compliance with access to services and aspects that classify care as satisfactory[8].

However, despite the majority of the sample considering a good level of well-being with their childbirths, it was possible to identify some ethical issues such as lack of quality information provided to laboring women, a specific number of women who did not choose the type of delivery by their own will, and an increase in the use of cesarean section, higher than the rate recommended by national and international health organizations.

In the context of childbirth care, bioethics plays an important role, as it involves issues regarding pregnant women's rights, the safety and well-being of both mother and newborn, while also considering the cultural, social, and emotional aspects involved in this significant moment in family life. Therefore, bioethics focuses on ensuring that women have access to quality information throughout childbirth, with autonomy to decide on the delivery type and care they wish to receive, with their choices respected by health care professionals.

Within this discussion, the data from this study revealed a lack of information, as some women did not know the reason for their cesarean section (0.76%) and which health care professional attended to them (10.35%). Additionally, it is noteworthy that the missing data (2.52%) for this question were from women who marked both doctor and nurse as the attending professional during childbirth, highlighting the uncertainty about who was accompanying them during labor.

Thus, the nursing code of ethics advocates as a professional duty to "provide adequate information to individuals, families, and communities regarding the rights, risks, benefits, and potential complications related to nursing care"[9], reaffirming the ethical and moral obligation of the health care professional to provide all necessary information, including introducing themselves to the pregnant woman and her companion, addressing the laboring woman by name or as she prefers to be called, as guided by best practices for normal childbirth[10].

Another finding demonstrated that women's autonomy is not always respected, as indicated by the high number of women who did not choose the delivery type voluntarily, hindering the achievement of well-being for postpartum women. Therefore, women should receive information about the procedures, risks, and benefits involved in childbirth, allowing them to make informed decisions and actively participate in the care process.

This finding contradicts what is advocated in the medical code of ethics, which prohibits the professional from preventing the woman from deciding about her body, as stated in Article 24, "fail to ensure that the patient exercises the right to decide freely about his or her person or well-being, as well as exercising authority to limit it" [11]. The nursing code also provides an article that clearly mentions the importance of maintaining the patient's autonomy, stating, "respect, recognize, and take actions to ensure the right of the individual or their legal representative to make decisions about their health, treatment, comfort, and well-being."[9]

Therefore, the bioethical principles as mentioned by Beauchamp and Childress[12], understand autonomy as the acceptance that the individual makes decisions about their treatment, providing them with sufficient information to exercise the power of choice, taking into consideration their beliefs, desires, and inherent values. Beneficence establishes the moral obligation to do good to others, while non-maleficence refers to the professional not causing harm or damage to the patient. Justice entails equality in health care, considering the specific needs of the individual. Bioethical references such as utility, confidentiality, truthfulness, and fidelity are also considered[13].

Another finding highlighted in the study was that care provided by non-medical professionals resulted in a 276.5% higher chance of achieving "adequate" levels of well-being compared to laboring women who had childbirth attended by doctors. This data demonstrates the importance of other professionals, such as obstetrics nurses and midwives in obstetric care.

Supporting these findings, a Cochrane review[14] comparing continuous obstetric care led by midwives with other care models showed that women attended by midwives were less likely to receive regional analgesia, instrumental vaginal delivery (vacuum extractor and forceps), amniotomies, and episiotomies, and had a higher likelihood of having a spontaneous vaginal delivery. Furthermore, the majority of studies included in this review refer to greater maternal satisfaction with midwifery care[14]. Thus, the above reveals adherence to the principles of beneficence by judiciously using invasive procedures during childbirth and non-maleficence by not utilizing their knowledge to provide assistance that poses unnecessary risks to women's health.

DOI: http://dx.doi.org/10.12957/reuerj.2024.80274

However, the literature indicates an asymmetry in health care delivery due to the medical hegemony in childbirth assistance, privileging their role at the expense of other professionals, which hinders the practice of obstetric nurses[15]. This is understood as a barrier to care, highlighting a bioethical issue. In response, the Ministry of Health encourages the development of courses and residencies in this area, while hospital managers need to provide conditions for the integrated and joint work of obstetric physicians and nurses due to the advantages, such as reduced interventions and greater satisfaction among women, fostering teamwork and conflict resolution.

Another important finding is the increase in cesarean section deliveries, although still lower than the quantity of vaginal deliveries, it exceeds the recommendations of the World Health Organization (WHO). This could be justified by the fact that the study field is a referral center for high-risk pregnancies. However, it is observed that this increased cesarean section rate is common. A study comparing two projects - the "*Nascer Saudável*'' [Healthy Birth] and "*Rede Cegonha*'' [Stork Network] from 2017, and the "*Nascer no Brasil*" [Birth in Brazil] from 2011 to 2012 - investigated approximately 4,798 women and found a reduction in antepartum cesarean rates, with a 50% increase in intrapartum cesareans in the public sector and 136% in the private sector, which also saw an 85% increase in vaginal delivery rates[16].

In the study evaluating childbirth by users of primary healthcare, there was an increase in cesarean sections (37.5%) – although lower than the rate of vaginal deliveries (60.5%)[8], Nonetheless, it still exceeds the recommendation of the WHO. The acceptable cesarean section rates are between 10 and 15%. Higher values do not contribute to reducing maternal, perinatal, or neonatal mortality, disrespecting the principle of non-maleficence. However, in the Brazilian context, it is estimated that the reference rate is around 29%[17]. However, Brazilian data indicate a percentage higher than expected, with cesarean sections accounting for 57.01% in 2021, and preliminary data for 2022 showing 58.15% cesarean deliveries[18].

Furthermore, the data from this study indicated a 1088.9% increase in well-being among postpartum women who had non-cesarean deliveries, demonstrating that the mode of delivery influences well-being related to the childbirth experience. Moreover, the reasons for performing cesarean deliveries can interfere with well-being, as shown by the data indicating that abnormalities in FHR would lead to better well-being, as postpartum women who did not have this reason experienced a 96.8% decrease in well-being levels.

That said, one of the premises for reducing cesarean sections in Brazil is to improve assistance during labor and vaginal delivery to promote autonomy, empowerment, and well-being of women, encouraging best practices over unnecessary interventions. In relation to bioethical principles, ensuring recommendations in childbirth can be seen as a way to promote beneficence and justice, as well as providing autonomy to women to make informed choices, thereby establishing proportionality of interventions during childbirth.

Cochrane review revealed that the implementation of clinical guidelines and education of physicians by obstetricians reduced the risk of elective cesarean section with high evidence. However, the evidence was low for educational activities carried out with women and couples[19].

Therefore, the dissemination of knowledge about childbirth physiology and women's rights during pregnancy and childbirth should be encouraged. This is because lack of knowledge, often related to low maternal education and socioeconomic status, interferes with women's expectations regarding childbirth and their perception of care, which constitutes a barrier in combating obstetric violence[15].

Therefore, the importance of understanding bioethics and its principles is evident, especially when it comes to guaranteeing the rights of laboring women, as they will guide actions aimed at providing humanized care, based not only on techniques that allow women to give birth. For this reason, it is important to provide guidance and training to professionals assisting in childbirth based on scientific evidence and recommendations for best practices in childbirth.

Study limitations

This study limitation is rooted in the desire bias and social desirability, as women evaluated the service of the facility where they were still hospitalized. However, due to the sample size, the results become representative.

CONCLUSIONS

The well-being of the participants was recognized, classified as excellent with the assistance received during childbirth. However, when associating clinical factors with well-being, the occurrence of ethical problems became evident, characterized by an increased rate of cesarean sections and a lack of presentation of the professional to the woman. These attitudes demonstrate the need for reflection among professionals about their actions, conditioning them to adhere to best practices in childbirth.

DOI: http://dx.doi.org/10.12957/reuerj.2024.80274

Therefore, to ensure humane care, it is recommended that bioethical principles be used for clinical practice, respecting women's autonomy in all stages of childbirth, as well as maternal and neonatal well-being. It is necessary to use professional identification and presentation to women, as well as the use of measures that favor female physiology and women's empowerment in childbirth, using necessary and informed interventions.

The results of this study contribute to expanding the knowledge of professionals who work in labor and delivery, encouraging equitable care centered on the individual needs of each woman, intensifying professional awareness to fully assist patients, using bioethical principles to guide their decision-making, in line with deontological aspects.

REFERENCES

1. Pontificia Universidad Católica De Chile. Escuela de enfermaría, Departamento de salud de la mujer. Concepto subjetivo de bienestar materno. Departamento de Derechos intelectuales. Registro Propiedad intelectual, 2077; nº 162651.
2. Zanardo GLP, Uribe MC, De Nadal AHR, Habigzang LF. Violência obstétrica no Brasil: uma revisão narrativa. Psicol. Soc. 2017 [cited 2023 jun 25]; 29:e155043. DOI: https://doi.org/10.1590/1807-0310/2017v29155043.
3. Souto REM, Brito NS, Sousa LSD, Brandão JC, Damasceno AKDC, Melo ESJ, et al. Forms and prevalence of obstetric violence during labor and delivery: integrative review. Rev. enferm. UFPE on line. 2022 [cited 2023 Jun 25]; 16:e253246. DOI: https://doi.org/10.5205/1981-8963.2022.253246.
4. Santos ALS, Paz CT, Fraga BGG, Barreto FL, Gramacho RDCCV, da Silva Borges AJ. Bioética e parto humanizado: concepções e práticas de enfermeiras obstetras. Textura. 2019 [cited 2024 Jan 25]; 13(21):93-103. DOI: https://doi.org/10.22479/desenreg2019v13n21p93-103.
5. Castillo RH. Bioética y derecho en el cuidado del recién nacido durante el parto. Quaestio Iuris. 2021 [cited 2024 Jan 25]; 14(04):1845-63. DOI: https://doi.org/10.12957/rqi.2021.55388.
6. Jamas MT, Ferretti-Rebustini REDL, Rebustini F, Gonçalves IR, Gouveia LMR, Hoga L AK. Validity evidence of the Bienestar Materno en Situación de Parto Scale. Acta Paul. Enferm. 2021 [cited 2023 May 20]; 34:APE02843. DOI: https://doi.org/10.37689/acta-ape/2021AO02843.
7. Silva RCF, Westphal F, Assalin ACB, Silva MIM, Goldman RE. Satisfaction of pregnant women in relation to children and birth care. Rev enferm UFPE online. 2020 [cited 2023 Oct 25]; 14:e245851. DOI: https://doi.org/10.5205/1981-8963.2020.245851.
8. Silva MJS, Silva TDS, Souza DRS, Souza AMG, Santos Ferreira TL, Andrade FB. Quality of care the childbirth and postpartum on the user's perception of primary health care. Rev Ciênc. Plural. 2020 [cited 2023 Jul 20]; *6*(1):1-17. DOI: https://doi.org/10.21680/2446-7286.2020v6n1ID16292.
9. Conselho Federal de Enfermagem. Resolução COFEN Nº 564/2017. Dispões sobre o código de ética do profissional de enfermagem. 2017 [cited 2023 Oct 25]. Available from: https://www.cofen.gov.br/resolucao-cofen-no-5642017/.
10. Brasil. Diretriz nacional de assistência ao parto normal ministério da saúde versão preliminar Brasília – DF, 2022 [cited 2023 Oct 25]. Available from: https://www.febrasgo.org.br/pt/noticias/item/download/615_9c68b60515aeb7bb1f3f022505721f2b.
11. Conselho Federal de Medicina. Código de Ética Médica: Resolução CFM nº 2.217, de 27 de setembro de 2018, modificada pelas Resoluções CFM nº 2.222/2018 e 2.226/2019 / Conselho Federal de Medicina – Brasília: Conselho Federal de Medicina, 2019 [cited 2023 Oct 25]. Available from: https://portal.cfm.org.br/images/PDF/cem2019.pdf.
12. Beauchamp T, Childress J. Principles of Biomedical Ethics. 5. ed. Oxford: Oxford University Press, 2001.
13. Schlemper Junior BR. Bioethics in the reception of psychoactive drug dependents in therapeutic communities. Rev Bioética. 2018 [cited 2023 Jul 20]; 26(1):47-57. DOI: https://doi.org/10.1590/1983-80422018261225.
14. Sandall J, Soltani H, Gates S, Shennan A, Devane D. Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database of Systematic Reviews 2015 [cited 2023 jun 15]; 9:CD004667. DOI: https://doi.org/10.1002/14651858.CD004667.pub4.
15. Oliveira CF, Ribeiro AÂV, Luquine Junior CD, Bortoli MC, Toma TS, Chapman EMG, et al. Barriers to implementing guideline recommendations to improve childbirth care: rapid review of evidence. Rev Pan Salud Pública. 2020 [cited 2023 Aug 18]; 44:e132. DOI: https://doi.org/10.26633/RPSP.2020.132.
16. Leal MDC, Bittencourt SDA, Esteves-Pereira AP, Ayres BVDS, Silva LBRADA, Thomaz EBAF, et al. Progress in childbirth care in Brazil: preliminary results of two evaluation studies. Cad Saude Publica. 2019 [cited 2023 Jun 15]; 35(7):e002230018. DOI: https://doi.org/10.1590/0102-311X00223018.
17. Ministério da Saúde (Br). Diretrizes de atenção à gestante: a operação cesariana. Brasília: MS; 2015 [cited 2023 Jun 15]. Available from: http://conitec.gov.br/images/Consultas/Relatorios/2015/Relatorio_PCDTCesariana_CP.pdf.
18. Ministério da Saúde (Br). Painel de Monitoramento de Nascidos Vivos segundo Classificação de Risco Epidemiológico (Grupos de Robson). 2023 [cited 2023 Jun 14]; Available from: https://svs.aids.gov.br/daent/centrais-de-conteudos/paineis-de-monitoramento/natalidade/grupos-de-robson/
19. Chen I, Opiyo N, Tavender E, Mortazhejri S, Rader T, Petkovic J, et al. Non-clinical interventions for reducing unnecessary caesarean section. Cochrane Database of Systematic Reviews. 2018 [cited 2023 Jun 14]; 9:CD005528. DOI: https://doi.org/10.1002/14651858.cd005528.pub3.

DOI: http://dx.doi.org/10.12957/reuerj.2024.80274

Authors' contributions

Conceptualization, C.S.B, M.M.S.A.N and S.D.Y.; Methodology, C.S.B, M.M.S.A.N and S.D.Y; Software, C.S.B; Validation, C.S.B, M.M.S.A.N and S.D.Y; Formal Analysis, C.S.B, M.M.S.A.N and S.D.Y; Investigation, C.S.B; Resources, C.S.B; Data Curation, C.S.B; Manuscript Writing, C.S.B.; Writing – Review and Editing, , C.S.B, M.M.S.A.N and S.D.Y.; Visualization, C.S.B, M.M.S.A.N and S.D.Y.; Supervision, C.S.B, M.M.S.A.N e S.D.Y.; Project Administration, C.S.B. All authors read and agreed with the published version of the manuscript.