ORIGINAL ARTICLE

Interprofessional education and collaborative practice: reflections on the Brazilian obstetric scenario

Danielle Menezes da Silva [1]
https://orcid.org/0000-0002-2591-4197

Corina Helena Figueira Mendes [2]
https://orcid.org/0000-0002-2344-3328

[1] Departamento Materno-Infantil. Centro Biomédico. Faculdade de Enfermagem. Universidade do Estado do Rio de Janeiro. Rua Boulevard 28 de Setembro, 157. Vila Isabel. Rio de Janeiro, RJ. Brazil. E-mail: danielle.docente.uerj@gmail.com
[2] Instituto Nacional de Saúde da Mulher, da Criança e do Adolescente Fernandes Figueira. Fundação Oswaldo Cruz (IFF/FIOCRUZ). Rio de Janeiro, RJ. Brazil.

Abstract

Objectives: this study aimed to reflect on the relation between physicians and obstetric nurses in the childbirth setting based on the training process of obstetrics residents from both categories.

Methods: an exploratory qualitative approach study, based on consultations with specialists through focus groups. Eleven professionals from the medical and nursing categories participated. Data interpretation was conducted through reflective thematic analysis.

Results: the content produced was categorized into five emerging themes: Whose childbirth is it? The woman at the care center; Practice scopes and care continuity; Knowledge in favor of communication and trust: the role on scientific evidence; Communication and training aspects; Equal footing on unequal parties: autonomy, leadership, and decision-making.

Conclusion: the reflections prompted by this research reinforce interprofessional education as a strategy to promote a collaborative obstetric care model, while also revealing that collaborative practice in the Brazilian context is a complex process that unfolds over time and is influenced by cultural, social, political, and economical aspects, requiring interventions in various levels.

Key words *Obstetrics, Obstetric nursing, Medical residency, Interprofessional education, Interdisciplinary placement*

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Introduction

Collaboration among professionals from different areas is essential for combining expertise to achieve better outcomes in the care of individuals, families, and communities.[1–3] Downe *et al*.[1] define obstetric collaboration as "efforts by obstetric nurses and physicians to work together with the aim of sharing responsibilities and providing safe, rewarding, and effective care to women and their families" (p.251). The integrated practice of the obstetrician and the obstetric nurse constitutes the collaborative model of obstetric care, contrasting with the traditional model, which centralizes on the physician as the sole provider.[4] Shared care among obstetricians and obstetric nurses predominates in developed countries[4] and in Brazil, where most births occur in a hospital setting; this is the model proposed for hospitals in the *Sistema Único de Saúde* (SUS) (Public Health System).[5]

The inclusion of obstetric nurses is a strategy for changing the care model; however, just simply bringing professionals together does not imply an improvement in quality nor does it result in collaborative practice.[6,7] Collaboration must be a voluntary and natural behavior among staff members,[6] pointing to the necessity in reflecting on interprofessional education (IPE).

According to the World Helth Organization (WHO),[8] "IPE occurs when students from two or more professions learn about, with, and from one another to enable effective collaboration and improve health outcomes" (p.7). It is a powerful strategy for developing collaborative competencies and training professionals capable of integrating knowledge critically and ethically, addressing the complexity of healthcare demands. Collaborative training produces better problem-solving responses, focusing on the users' needs and the perspectives of comprehensiveness and equity.[9] Discussing training from the IPE perspective is fundamental for changing the intended care model and strengthening the *Sistema Único de Saúde* (SUS).[10] (Public Health System)

Although all professionals should collaborate in providing a human and safe childbirth experience, the reality is often marked by tensions, disputes of power, and disagreements over conduct. Considering that it is imperative to align perspectives on the collaborative model in the childbirth setting, this research integrates parts of the results from a Master's thesis developed in the *stricto sensu* graduate program in women and children's health at the *Instituto Fernandes Figueira* (IFF-FIOCRUZ), who proposed to develop collaborative competencies for the interprofessional education of obstetrics residentes, including medical and nursing students for childbirth and birth care.

Methods

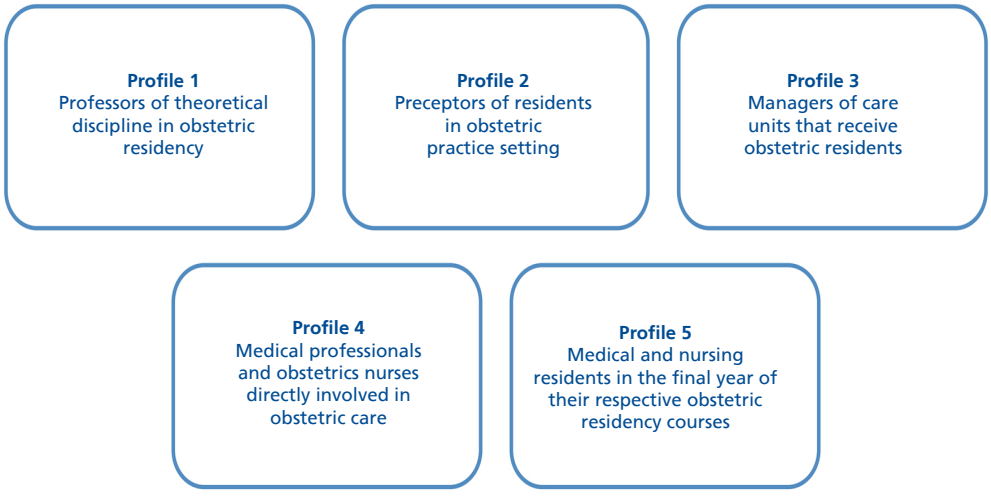
This exploratory study with a qualitative approach, based on consultations with experts through focus groups, sought to discuss desirable collaborative competencies for medical and obstetric nursing residents. The methodological approach was based on structured expert interviews, a technique designed to explore the perceptions and experiences of professionals with specific expertise regarding a given phenomenon.[11,12]

Conducted in accordance with Resolution 510/2016 of the *Conselho Nacional de Saúde* (National Health Council) and approved by the Ethics and Research Committee on Humans. The methodological steps followed the criteria of the Consolidated Criteria for Reporting Qualitative Research (COREQ).

The definition of "expert" referred to individuals with academic and/or professional expertise on the topic, not necessarily with a high specialization degree.[11] To compose the groups, five profiles of professionals involved in the training of obstetrics residents were defined (Figure 1).

Figure 1

Profiles of professionals with residency training in obstetrics.

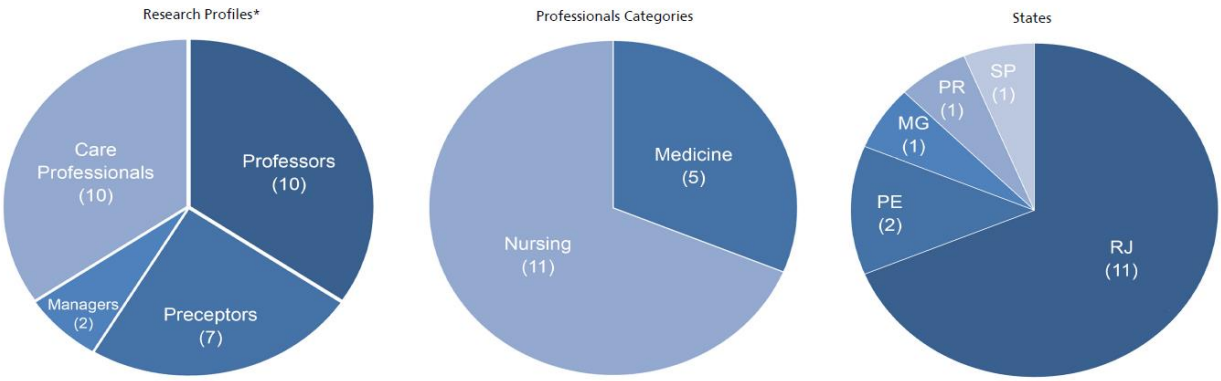


The search was based on the snowball sampling technique, beginning with professionals previously known to the researchers for their acknowledged expertise in the field of obstetrics and involvement in the training of residents, but without any supervison or hierarchical ties that could compromise their freedom of expression within the groups. Initial contacts were intentionally selected from the researchers' professional networks, including faculty members and preceptors with publications in the field and/or more than five years of experience in training obstetrics residents. Although this technique is appropriate for identifying participants with specific profiles, we acknowledge its limitations, particularly the potential for sample homogeneity bias and the influence of the researchers' social networks on the final composition of the groups.

The identification and search for experts began in February 2021, mapping contacts from professional networks. A total of 103 strategic informants were identified across the five macro-regions in Brazil; they were contacted by phone, email, and/or WhatsApp to present the study and request referrals based on the defined profiles. Recruitment was concluded in August 2021 with 16 professionals (Figure 2) who confirmed their participation and received via email a summary of the project and the researchers' credentials, a sociodemographic form, and an Informed Consent Form, with participation contingent upon their express acceptance. Recruitment was concluded due to the network exhaustion after six months, as the referral network was unable to generate new contacts to those who met the predefined profiles and were available to participate. We emphasize that the final number of participants was considered satisfactory, given the research objective and the nature of the methodological design.[13]

Figure 2

Participants' profile.



* The participants could have more than one profile.

RJ=Rio de Janeiro; PE=Pernambuco; MG=Minas Gerais; PR=Paraná; SP=São Paulo.

The interviews utilized the focus group technique[12] which seeks to promote interaction among participants, inducing discussions, questions, and reflections on the topic. The groups were led by the main investigator (an obstetric nurse with eight years of professional experience and a Master's student) and the PhD advisor (physician and faculty member of the post graduate program), who took notes, with a support from an IT technician to manage the virtual environment. Participants were divided into two groups that met on separate days via Zoom® platform, with sessions lasting two to three hours. The first group consisted of five experts (all nurses) and the second, six experts (three physicians and three nurses), totaling 11 participants.

Of the 16 professionals initially recruited, five were unable to participate in the focus groups due to scheduling conflicts (n=3), urgent professional commitments (n=1), and unspecified personal reasons (n=1). Analysis of the profiles of the absent participants revealed that three were obstetric physicians (two preceptors and one program coordinator) and two were obstetric nurses (one preceptor and one coordinator). This loss represented 31.25% of the initial sample and resulted in a final composition with a predominance of obstetric nurses (8/11 - 72.7%), which may have influenced the discussions, placing greater emphasis on the perspectives of obstetric nursing. This limitation was taken into account in the analysis and interpretation of the results.

The dynamic consisted of stimulating reflections and discussions on collaborative work in the Brazilian obstetric setting. Excerpts from the literature were presented with trigger statements so that the dialogue would revolve around

the concepts of interprofessional collaboration. During the group sessions, the participants' remarks and dialogues emerged freely, without intervention from the researchers.

The audio recordings on the platform were transcribed in full and manually subjected to reflexive thematic analysis.[14] The analytical process followed these steps: (1) familiarization with the data through repeated readings of the transcripts; (2) initial inductive coding, identifying relevant units of meaning; (3) grouping of codes into preliminary themes; (4) review and refinement of themes through triangulation among the researchers; (5) final definition and naming of thematic categories; (6) production of the analytical report. The reliability of the analysis was ensured through independent coding by both researchers, followed by meetings to discuss and reach consensus on the emerging categories. No member checking (returning transcripts or results to participants for validation) was performed, a decision justified by the exploratory nature of the study, which, at this stage, prioritized capturing the experts' initial perceptions of interprofessional collaboration without seeking consensus or collective validation of the findings. The content was categorized into five emerging themes (Table 1).

Considering that all participants specialized in obstetrics, and given the overlap in the research profiles, we chose to identify participants' statements according to their professional category, followed by the identification of the focus group they belonged to, namely: Nurse – Group; Physician – Group. This coding allows us to understand the context of the interaction and the different perspectives according to the position held within the multidisciplinary team.

Table 1

Thematic categories, identified codes, and observed interaction of dynamics in the focus groups

Thematic Category	Identified Codes	Observed Interaction of Dynamics
1. Whose birth is it? The woman at the care center	Territorial dispute Ownership of childbirth Women's leadership Power relations Bodily autonomy	**Group 1** Sharing of similar experiences; Movement toward mutual validation of experienced frustrations. **Group 2** Critical consensus on interventionism; Diplomatic search for convergence; Avoidance of direct confrontations regarding differences in conduct.
2. Scopes of practice and continuity of care	Professional boundaries Mutual unfamiliarity Fragmentation of care Shared responsibility Continuity versus transition	**Group 1** Mutual validation of frustrations regarding poorly defined boundaries; Critical analyses of institutional structures; Collective narrative regarding professional delegitimization **Group 2** Self-criticism by the medical profession regarding the fragmentation of care; Joint development of solutions when there is a safe space for dialogue.
3. Knowledge in support of trust: scientific evidence	Evidence-based practice Cultural capital Hierarchy of knowledge Shared protocols Scientific updates	**Group 1** Sharing of similar experiences regarding limited access to scientific literature during training; Criticism of the hierarchical model of the multiprofessional team **Group 2** Collective recognition of knowledge asymmetries regarding each other's practices,

		Group 1 Critical analysis of the perpetuation of biases in medical training.
4. Communication and aspects of training	Isolated training Interprofessional interaction Professional identity and ethos	**Group 2** Tension in the discussion of medical resistance with careful choice of words; Embarrassment within the medical profession when acknowledging integration difficulties; Empathetic acceptance of the nursing profession, through frank and respectful dialogue
5. Equal relationships among unequal parties: autonomy, leadership, and shared decision-making	Professional hierarchies Structural inequalities Autonomy versus Subordination Shared leadership Women's empowerment	**Group 1** Discussion focused on structural and educational inequalities and criticism of hierarchical relationships. **Group 2** Agreement among participants from both categories regarding socioeconomic inequalities Optimistic outlook on future changes; Female leadership as a factor of convergence between professional categories.

Source: authors, 2025.

Results and Discussion

Whose birth is it? The woman at the care center

In both groups, participants understood that care is focused on the woman's needs, built through a horizontal relationship, based on the recognition of the right to bodily autonomy and active participation is a value that should guide practice in the obstetric setting, a view corroborated by several authors.[7,9,15-17] When mentioning the difficulties inherent in this process, participants highlighted the challenges professionals face in recognizing the woman as the central figure in care, given that historically this relationship has been conceived in a vertical manner, with the professional in a superior position, acting as the conductor of the process. Phrases involving the idea of childbirth ownership are frequent in these scenarios and reveal intrinsic issues in power relations, articulated by various hierarchies, such as those of gender, race, and social class, and the dispute among professional categories over the obstetric field.[18]

> *"[...] there is a discussion about who and what will be done. It is important to focus on how we will do it and for whom we will do it"* (Male Physician - Group 2)
>
> *"[...] it gives the impression, from a temporal perspective, that now it is mine, now it is not mine, now it is with me, now it is not with me"* (Male Nurse - Group 2)

The existing dichotomy between medical and nursing practices in the obstetric field also emerged as one of the elements that generate disputes and negotiations in the childbirth setting and which, as they contribute to prioritize conflicts among professionals at the detriment of the woman's needs, that they ended up not recognizing her or depriving her of the protagonism that she should occupy. The beliefs and values that both professions attribute to childbirth, present significant divergences and are inherent to the training process itself: while physicians are trained to handle situations involving complications and perinatal risk, and therefore, perceive childbirth as a potentially dangerous event requiring interventions to control possible unforeseen events, obstetric nurses are trained to provide care for low or no risk situations and thus, they understand childbirth as a physiological process requiring little or no intervention, where women's autonomy and protagonism should be encouraged.[18,19] The very way in which professionals describe their role in childbirth is a significant indicator of this difference: the physician "performs" or "conducts" the delivery, while the nurse "assists" (in this case, the one who will perform the delivery, is the one in labor)[18](p.71).

This dispute over territory in the obstetrics' field is strongly linked to the professional ethos - a set of

characteristics and traditions built up through a complex process of social legitimization, which allows the individual to recognize themselves and be recognized as belonging to that professional community - of each category, in addition to involving economical, political, structural, and institutional issues.[18] Proposing a model of childbirth care that shifts the protagonism in the process for the woman, meaning to promote a profound change in beliefs and values regarding the birth process, for both professionals involved in labor and delivery care and for the women in labor.[15,18] Although, the participants noted that, the change in the care model has been strongly driven by a movement of the women themselves who have begun to seek knowledge and demand dignity in care, this is not the prevailing reality, given that many of them still find it difficult to question the professionals and the practices adopted. This could attribute to the lack of autonomy these women have over themselves in their daily lives, related to the misogynistic social context that historically curtails their sexual freedom and reproductive rights, in addition to the knowledge gap regarding the childbirth process and good obstetric practices. For some professionals, women who begin to have access, understand, and articulate this knowledge and are capable of asserting themselves and having their will prevail, tending to become an inconvenience, and are even punished for this behavior.

> *"[...] There was a normal delivery full of interventions and I questioned them all. And I paid the price for those questions"* (Female Nurse - Group 1)

This idea of power between health professional and patient is observed in Foucault[20] when analyzing the knowledge used by the physician as an instrument of control over the patient's body and appropriating of their autonomy, a phenomenon entrenched in modern medicine and seemingly so deeply rooted in the popular imagination that it produces the belief that the professional is the sole holder of knowledge, which is unattainable to the patient. This communication gap between the professional and the woman in labor fosters the belief that interventions are synonymous with good obstetric practice under any circumstances, with the absence of such interventions being viewed as a deprivation or inadequacy of care, linked to the notion that women of lower socioeconomic classes do not have the right to access certain types of technologies.[18]

According to Agreli *et al*.,[17] the success of therapeutic conducts is related to the establishment of a bond of trust between professionals and patients, with the degree of patient's involvement and participation in care linked to how comfortable they feel by questioning professional authority. This statement aligns with the participants' views, who believe that professionals with an imposing demeanor, who are unclear about the conducts adopted, and who disregard women's needs, are unlikely to build this bond.

Conveying information in accessible and respectful language, practicing active listening, understanding women's needs beyond what they verbalize, and comprehend the feelings implicit in their behavior, which can facilitate or hinder the care process, are some of the characteristics of a behavior that participants termed "being available" to women, which should be recognized as the main party in the process. By shifting their focus away from themselves, professionals are able to see that care requires an integration of knowledge that is only possible through shared practice.

Scopes of practice and continuity of care

Clarity of roles and responsibilities is described by several authors[9,15,16,21–23]as one of the fundamental concepts in promoting collaborative interprofessional practice and IPE. It occurs when students/professionals understand their own role and the roles of others and use this knowledge appropriately to establish and achieve the goals of the patient, family, and community.[9]

When addressing the topic, some participants pointed a lack of understanding of the scope of practice of the other category as a factor that generates mistrust and limits communication among professionals. One of the participants shares her perception:

> *"[...] in this process of introducing the obstetric nurse, what we noticed the most was, the medical staff's lack of knowledge about the nurse's competencies. About what she could do and, how far she could go..."* (Female Nurse - Group 1)

According to Waldman *et al*.[22] the scope of practice refers to legally permitting limits of a healthcare professional's practice to be defined by statutes, regulations, and educational guidelines. In a scenrio, where professionals from different categories work together sharing common functions, a lack of knowledge of the other's scope of practice tends to have doubts about who should or can perform certain actions. The idea that the physician would supposedly have to "fix" whatever the obstetric nurse did wrong, is common in practice and stems from mistrust among professionals and a lack of knowledge regarding each other's limits of practice, as illustrated by one of the participants:

> *"[...] they would say: 'now that things are going wrong, you're calling out to me,' but that's not it; one of the first steps in managing dystocia was to call for help, which meant calling the medical professional, as described by Coren [...]"* (Female Nurse - Group 2)

These communication failure have direct consequences for the woman receiving care, such as compromising the continuity of care. A study that sought to analyze the quality and safety of obstetric care, identified communication failure, lack of multidisciplinary interaction, fear and apprehension about causing conflict, and the poorly coordinated co-existence of different models of obstetric care as indicators of unsafe care.[24] Continuity of care depends not only on effective communication, but also on building trust, shared goals, and focus on the woman.[25] For the participants, this is a crucial aspect of collaborative practice and a point of contention. While some believe that understanding the scope of practice is essential for mutual trust, others argue that establishing overly rigid and "set-in-stone" roles (Nurse - Group 1) can generate conflicts, as some professionals limit themselves by acting only within their scope of practice, leading to fragmented care, or even shirk responsibility for certain actions, since another professional is responsible for the care. This divergence of opinions among participants highlights the complexity of the issue and the lack of consensus regarding the ideal boundaries of practice within the collaborative model. Furthermore, the lack of continuous care throughout the entire period of care undermines the woman's trust in the professional and the team and reflects the marginalization of the woman as the center of care:

> *"[…] most of the labor monitoring, whether for routine or high-risk cases, in the places where I worked was handled by the obstetric nursing staff. When full dilation was reached and it was a high-risk case, she had to be transferred to the medical staff. There was no continuous care throughout the labor, and this made it very difficult for the woman to trust the process. Because she spent an entire period with one professional and suddenly, […], another professional would come in and those who had been with her would leave the scene"* (Female Nurse - Group 2)

In a collaborative model, it is important to understand that all professionals are part of the continuous care process, regardless of the severity of the condition and the complexity of the actions, being with the woman is the responsibility of the staff and not of a specific professional at any given moment. Organizing work processes to include more joint meetings, starting from the moment of arrival, sharing responsibility and the decision-making process, would allow for comprehensive care and, therefore, eliminate the necessity to transfer care.

When describing the obstetric setting in which they work at, one of the participants reported that communication occurs effectively, which fosters respect and trust among the staff. Although, not all professionals are present in the same space or participate in all the processes, everyone is aware of the woman's condition throughout the entire period, so that in a situation of an unfavorable progression, there is no transition of care but there is continuity.

> *"[...] if we suddenly need to hand this case over to the on-duty [doctor], and her condition takes a turn for the worse [...] there is no kind of argument, such as for example 'you notified us too late.' That isn't even brought up in the communication because there is already trust in our work"* (Female Nurse - Group 2)

For Rossit *et al*.,[26] defining one's scope of practice does not mean demarcating territory in an authoritarian and competitive manner; on the contrary, it means recognizing one's limits facing the patient on specific demands and, upon perceiving the need for complementarity, knowing the exact moment to request collaboration.

Knowledge in favor of trust: The role of scientific evidence

For the participants, trust is an essential component of collaboration, and when asked what factors lead them to trust another professional in the workplace, the building of trust was frequently associated with practice based on scientific evidence. Knowledge was identified as a potential source of conflict in the obstetric setting, but when well-articulated, with the aim of building trust and good communication, it functions as a facilitator of collaborative practices. It was noted that the distance between different categories is deepened by the gap in access to knowledge.

> *[...] I could tell the difference, for example, when I was a resident with a medical resident. There was an institutional gap, but I also believe there was a huge gap*

> *in terms of knowledge. I didn't have access to indexed articles published in the English language that reflected current global practices. I had access to whatever was in the textbook and repeated as a tendency of the medical training"* (Male Nurse – Group 2)

For a long time, nursing education was tied to the knowledge and experience of physicians, especially in specialties, such as knowledge was derived from medical practice, systematized in publications which became references for the field as a whole. It was only from the 1990s onward that the concept of evidence-based practice[27] became widely disseminated, although, in the field of obstetrics, the idea had already been introduced in a 1985 WHO publication, which discouraged the practice of certain procedures due to the lack of evidence that was beneficial or necessary.[27] Knowledge as cultural capital was theorized by Bourdieu[28] when describing how individuals positioned themselves within the structure of a relationship according to the volume and quality of capital they possess and how this could lead to disputes among different fields. According to the participants, there is a division between the categories of medicine and nursing related to the way knowledge is expanded and applied in both categories. Nursing education, influenced by medical education, results in a care process structured around pathological diagnosis and consequently places the medical professional in a hierarchically superior position.

> *"[...] which doctors know how to discuss nursing diagnosis in the same way that nurses do to some extent, are they able to discuss the physician's pathological diagnosis?"* (Male Physician - Group 2)

It appears to be a need for nursing to appropriate medical knowledge, which does not occur in the opposite direction, and this reflects on the trust between these two professionals, creating the perception that the nurse's practice is devalued and that she must constantly "prove" to other staff members that she is capable of performing her duties, and to do so, she must demonstrate a level of knowledge that goes beyond her scope of practice. This behavior was described by King *et al*.[29] when noted that medical students are rarely introduced to the roles of other members of the healthcare team, while obstetric nursing students tend to demonstrate knowledge of the obstetrician's role, even though, formal exposure to the professional cultures of other health disciplines is not traditionally part of the training curricula for these categories.

In the field of obstetrics, the body of knowledge is not exclusive for physicians, since the obstetric nurse has been introduced into the setting and now shares this formal knowledge.[18] While medical training has historically been based on personal experiences, the authority of the individuals, in the traditionalism of the profession,[18] the training of obstetric nurses is rooted in the need to break away from the previously dominant interventionist practice, as for such practice, based on scientific evidence, is intrinsic to their training.[30] Currently, access to scientific evidence in obstetrics is not restricted to specific categories, and it is recommended to be adopted by all professionals in the obstetric field.

On the other hand, participants report that a lack of trust also arises when they perceive that another professional may be resistant to adopt evidence based practices or even demonstrate a lack of knowledge regarding current evidence.

> *"[...] some nurses also have a certain difficulty working with a doctor too, because they feel that that doctor will always work in a different way that is believed to be correct [...]"* (Female Nurse - Group 1)

When describing her experience in a maternity hospital where, in her opinion, interprofessional collaboration occurs effectively, one of the participants explains that care protocols are constantly being updated based on publications of new evidences. This constant updating requirement seems to prevent knowledge gaps among professionals. The institution of protocols and guidelines developed interprofessionally has shown to reduce harm to patients, as they standardize actions and improve communication. The existence of a clearly articulated common goal is not sufficient if there are different opinions among professionals regarding how to achieve that goal. Scientific evidence in this context would serve as a tool, capable of standardizing practice, fostering horizontal communication, and aligning approaches to facilitate shared decision-making, which promotes safety and mutual trust for both professionals and women in labor.

Although, there is a global consensus regarding the outcomes produced by evidence-based obstetric practice, this is not yet a reality in many regions of Brazil, according to the results of the *Nascer no Brasil* (Born in Brazil) survey.[5] Numerous factors can be listed as barriers to the implementation of evidence based practice, including behavioral aspects, such as limited familiarity with the scientific community, which restricts understanding on research methods and interpretation of results, and resistance from some professionals.[18,27]

Communication and training aspects

Interaction with others was also highlighted by participants as important for building trust and good communication among professionals, and they reported difficulties in the relationships between the categories studied.

> *"[...] the problem is when obstetric nurses join the care team, they weren't shown before how it would work; often we're thrown to the deep end, [...] I start a shift where I don't know the nurse, and she is on a shift where she doesn't know me [...]"* (Female Physician - Group 2)

The participants believe that it is through interaction with others that the exchange of knowledge and experiences, communication flow, the appreciation of skills, and consequently trust occurs. These attributes would be capable of characterizing professionals from different categories as a team and guiding them toward collaborative practice. It is important to highlight what was pointed out by one of the participants, who noted that professionals from the same category, even if they have no acquaintance or prior interaction, when they come together in the same work environment, it seems easier to work collaboratively, and this is possibly due to the training environment already denoting an affinity among these professionals. These are professionals who already expect to find some similarity in knowledge and values conveyed during the training process; whereas, when encountering a professional from another category in a multidisciplinary team, the lack of knowledge regarding how that training process unfolded leads to immediate mistrust. This observation relates to the process of constructing the *ethos* and professional identity of the categories and highlights the relevance of proposing changes in training based on the IPE.[26]

Aspects of training were invariably mentioned by participants when addressing difficulties and solutions for interprofessional collaboration in the obstetric field. One of the participants, described his experience at a facility that until then had only accepted medical residents in obstetrics, reports that from the moment the obstetric nursing residency program began, the students took a negative stance:

> *"[...] they [physicians] left, wrote a letter stating the difficulty of having another professional sharing the care, that they did not want to be in a place where care was shared [...]."* (Female Nurse - Group 2)

This fact reflects how much health education remains individualized and leads professionals to isolate themselves in centers, in addition to indicate the perpetuation of this practice among preceptors and students, who may one day also be preceptors, contributing to the maintenance of the dysfunctional structure in these relationships.

Equal relationships on unequal parties: autonomy, leadership,and decision-making

The participants highlighted autonomy as something to be valued for, but also as a factor that complicates relationships as the obstetric nurse expands the autonomy and the obstetrician perceives this shift as a loss of influence and dominance. According to Maia,[18] "the loss of liberal autonomy lies at the heart of most discussions about contemporary changes in medical work and *ethos*" (p. 168), and emphasizes that liberal autonomy is not synonymous with good care, since full autonomy does not exist. The more autonomy the medical professional possesses, the greater the likelihood of an interventionist practice, as they tend to maintain control over the unpredictability of labor events and the duration. The obstetric nurse, in turn, has limited autonomy due to the risk, albeit minimal of complication during routine labor that requires medical intervention.[18]

In addressing the issue of autonomy in collaborative health practice, D'Amour[7] notes that even though professionals desire to work together toward a common goal, there is a parallel need as a professional category to preserve a certain degree of autonomy that takes precedence. With the introduction of the obstetric nurse, childbirth ceases to be an individualized event, where the physician holds total autonomy, and becomes a shared process with a category that historically and culturally occupies a subordinate position.[18]

The participants mentioned what they call a "primary addiction" in believing that some should not question others, which would be related to the existence of a hierarchical structure in the relationships among professionals and between professionals and women.

> *"[...] it is very difficult for a professional to be questioned regarding a prescription or the autonomy of choice [...] many medical professionals are taught to be superior not only to the patient but to the rest of the staff [...]"* (Male Physician - Group 2)

Women's autonomy was also highlighted as a growing trend within the obstetric setting and recognized as a force of transforming the model of care, such as the relation in the childbirth and birth setting:

> *"[...] when we look at those women who arrive for childbirth, who have studied, who have prepared themselves, who know what they want and what they don't want and they say so, the professional is startled the first, second, and the third time, but suddenly they realize: she is making choices, taking ownership [...] so, as women gain access to knowledge, the staff will have to transform as well [...]"* (Female Physician - Group 2)

Other elements contributing to inequalities among the categories were observed by the participants and involve the areas of recognition, leadership, and decision-making. Smith[16] and Baquião *et al*.[3] believe that collaborative practice is shaped by cultural, social, political, and economic factors. In the Brazilian scenrio, these factors include inequalities highlighted by the neoliberal capitalist model, which prioritizes capital and profit and has become increasingly predominant in the context of healthwork. These inequalities tend to establish a hierarchical relationship between medicine and nursing as for example, the insufficient number of obstetric nurses to join interprofessional teams and economic devaluation, the social and professional disparities in obstetric nursing, as reflected in the gap between pay and working conditions in both categories.

> *"[...] it's also about pay; as long as we have unequal pay, it will be very difficult for us to discuss this, because we live in a capitalist world that judges people by what they earn, so I think this is one of the sticky points in collaborative work"* (Female Nurse - Group 2)

> *"[...] more than a conflict, it's a war, a dispute over the obstetric field, especially if it comes to money [...]"* (Male Physician - Group 2)

Leadership and decision-making are frequently claimed by physicians on the grounds that their training period is longer and the image of power and decisiveness that common sense associates with medicine.[18] However, while physicians desire to be in a leadership position, they seem to struggle in sharing responsibilities of women in labor and being cared for by obstetric nurses, in cases of complications requiring a physician's presence or the transition from routine to high-risk care, as observed by the participants through this expression, "*you call me now that things are going wrong,"* (Male Nurse – Group 1), a phrase frequently uttered by physicians when called upon by obstetric nurses during the course of care.

According to the participants, professionals used to working in a conflict-ridden environment, struggle when faced with a different setting. Given that all conflict triggers defensive reactions in those involved, if left unaddressed, this behavior can lead to even greater estrangement and contribute to the perpetuation of this dynamic.

Interaction of dynamics and its implications for collaborative practice

A comparative analysis of the interaction of dynamics among the groups revealed distinct patterns that influenced the content and depth of discussions on interprofessional collaboration (Table 1). In Group 1, composed exclusively of obstetric nurses, greater spontaneity was observed in the verbalization of frustrations related to professional hierarchies, with collective critical narratives regarding professional delegitimization and territorial disputes, such as the nurse who felt safe by sharing her experience as a womanin labor, having been cared for by a staff composed of physicians. The participants quickly reached consensus and mutually validated experiences of professional subordination, which allowed for a deeper exploration of power asymmetries in the obstetric setting and the identification of challenges.

In contrast, Group 2, with a mixed composition, was characterized by a diplomatic search for common ground, with discussions about ownership of childbirth and women's leadership framed in terms of philosophy regarding care and professional identity. Initially in this group, both groups avoided pointing out confrontational behaviors on the part of the other group, sometimes engaging in self-criticism and other times referring to problematic attitudes common to both groups. Once the initial discussions and mutual recognition were over, a certain relaxation among the participants was observed, which opened the door to less measured remarks, especially from the nurses, such as "you call me now that things are going badly," to illustrate a disrespectful attitude on behalf of the physicians. This produced some awkwardness and self-critical remarks from the medical group regarding the fragmentation of care, a culture stemming from medical training, and subordinated relationships. The codes that generated the most heated discussions in this group were: interprofessional interaction, professional identity and *ethos*, and resistance to collaborate. However, the simultaneous presence of physicians and nurses generally moderated the intensity of the criticism. Discussions about wage inequalities and disputes over the obstetric field,

when addressed, were framed in structural and systemic terms, with careful words of choice to preserve respectful dialogue.

The mutual recognition and validation observed in Group 1, and the diplomacy observed in Group 2, suggest that homogeneous spaces organized by category may be necessary for certain sensitive issues to emerge more openly, while mixed spaces foster self-criticism and the collaborative development of practical solutions. This finding has direct implications for the design of interprofessional education strategies: training programs can benefit from alternating between moments of intragroup reflection (by professional category) and moments of intergroup dialogue, allowing each category to develop its perspectives before negotiating them collectively.

This study presented limitations that should be taken into account when interpreting the results. The fact that the research was conducted during the period of social isolation resulting from the COVID-19 pandemic significantly influenced the data collection process. The pandemic context limited the availability of health professionals, who were overwhelmed by the emergency care demands, and may have contributed to the high rate of absences in the focus groups. Additionally, the need to conduct the focus groups in a virtual environment, although it enabled the participation of professionals from different geographic regions, may have influenced the spontaneity of interactions and limited the capture of non-verbal communication nuances relevant to the analysis of the group dynamics.

The snowball sampling technique, initiated through the researchers' professional networks may have favored the participation of professionals with similar profiles and convergent perspectives on interprofessional education, limiting the diversity of opinions and experiences represented. The loss of five participants, predominantly obstetricians, resulted in a final composition comprising 72.7% obstetric nurses (8/11), which may have placed greater emphasis on the perspectives of obstetric nursing. This imbalance may reflect a greater reluctance on the part of the medical category to engage in discussions about interprofessionality, a phenomenon documented in the literature that points to physicians' historical resistance to interprofessional collaboration.[31] Such resistance may be related to the traditional medical training model, which historically emphasizes individual autonomy and the leading role of physicians, generating discomfort in discussions that challenge established hierarchies.[31]

Final considerations

The collaborative model invites both groups to move beyond the individualization of practices, and the implementation of IPE as a strategy to promote interprofessional collaboration in the field of obstetrics aligns with the international movement already underway in this direction. However, the same results that enabled us to start a path toward the development of collaborative competencies for the interprofessional training of obstetrics residents revealed the need to broaden the debate on issues related to the culture of professional relations between medicine and nursing, based on the particularities of the Brazilian obstetric scenrio.

The reflections raised by this research reinforce interprofessional education as a fundamental strategy for promoting the collaborative model of obstetric care, revealing it to be a complex process that requires interventions across multiple domains. It is recommended that interprofessional curricula be implemented in obstetrics residency programs, including joined activities; the development of care protocols collaboratively developed by the teams; the establishment of regular forums for case discussion attended by obstetric physicians and nurses; the training of preceptors to facilitate collaborative practices; and the review of public and institutional policies that perpetuate hierarchy and asymmetries between the categories.

Authors' contribution

Silva DM and Mendes CHF: Project design, execution, data analysis and interpretation; Drafting of the article and critical review of the intellectual content;

All authors approved the final version of the article and declare that there is no conflict of interest.

Data availability

The entire dataset supporting the results of this study was published in the article itself.

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