

# Ethos and pathos in the delivery room

*O ethos e o pathos na sala de parto*  
*El instituto ethos y el pathos en la sala de parto*

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## ABSTRACT

**Objective:** To understand the ethos and pathos in the discourses of pregnant women and healthcare professionals in the context of the delivery room.

**Method:** This is a qualitative and interpretative study. The research approach was discourse analysis. The study participants were 36 women and 24 health workers from seven maternity hospitals in midwestern Minas Gerais, Brazil.

**Results:** The discourses indicate the notion the women have of childbirth, centered in the eyes of others and in their representations. The nurses have difficulty operationalising care and building a professional image. The medical discourse stresses the skills, the ability to intervene in high-risk situations, and changes in the status of the profession.

**Conclusions:** The construction of the ethos of physicians and nurses to essential to design more flexible fields of knowledge and ensure a professional performance that is consistent with their role, committed to the ethical and legal issues of obstetric care.

**Keywords:** Midwifery. Women's health. Discourses. Qualitative research. Health personnel.

## RESUMO

**Objetivo:** Compreender o *ethos* e o *pathos* presentes nos discursos de mulheres parturientes e profissionais de saúde no contexto da sala de parto.

**Método:** Pesquisa qualitativa do tipo interpretativa. Utilizou-se o método da Análise do Discurso. Participaram das entrevistas 36 mulheres e 24 profissionais de saúde de maternidades do interior de Minas Gerais.

**Resultados:** Os discursos sinalizam a concepção que as mulheres têm do parto, centrada no olhar do outro e nas suas representações; as dificuldades das enfermeiras para operacionalizar o cuidado e construir uma imagem profissional autônoma. O discurso médico enfatiza a especialidade, a capacidade de intervir em situações de risco e as mudanças no status da profissão.

**Conclusões:** A construção do *ethos* de médicos e enfermeiros é fundamental para o delineamento de campos de saberes mais flexíveis e para uma atuação profissional condizente com os seus papéis e comprometida com os preceitos éticos e legais do cuidado obstétrico.

**Palavras-chave:** Tocologia. Saúde da mulher. Discursos. Pesquisa qualitativa. Pessoal de saúde.

## RESUMEN

**Objetivo:** Comprender el ethos y el pathos presente en los discursos de las mujeres embarazadas y los profesionales de la salud en el contexto de la sala de parto.

**Método:** Estudio sobre el enfoque cualitativo, el tipo de interpretación. Participado en las entrevistas con 36 mujeres y 24 profesionales de la salud. Los escenarios fueron siete maternidades en el interior de Minas Gerais.

**Resultados:** Los discursos indican la concepción que tienen las mujeres de parto, centrada en los ojos de los demás y en sus representaciones. Las dificultades de las enfermeras en operacionalizar el cuidado y construir con una imagen profesional. El discurso médico destaca la habilidad, la capacidad de intervenir en situaciones de riesgo y los cambios en la condición de la profesión.

**Conclusiones:** la construcción de la ética de los médicos y de las enfermeras es fundamental para el diseño de campos de conocimiento más flexibles y un desempeño profesional coherente con su función y comprometida con los problemas éticos y jurídicos de los cuidados en obstetricia.

**Palabras clave:** Tocología. Salud de la mujer. Discursos. Investigación cualitativa. Personal de salud.

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## ■ INTRODUCTION

This work is the result of the doctoral thesis, "*O sensível e o insensível na sala de parto: interdiscursos de profissionais de saúde e mulheres*"<sup>(1)</sup>. It analyses the ethos and pathos in the discourse of women and health workers to characterise its constitution and tone of discourses about childbirth care with emphasis on how these discursive subjects are presented and communicated in the delivery room.

Ethos and pathos are terms borrowed from Aristotle's rhetoric. Ethos, in discourse analysis, is the presentation of self in discursive interaction. When speaking, the subject must ensure the words are acknowledged as being authentic. The concept of pathos can be defined as an emotional overflow, in which its proximity with the magical speech enables the possibility of persuasion and produces an emotion in the listener or audience<sup>(2)</sup>.

In this perspective, the discourse delivered by the subject assigns an institutional position and delimits a relationship of knowledge between those involved. In the discourse, the speaker uses language to transform the facts and exasperate or minimise feelings of anger or affection, thus constructing an emotional attitude capable of attributing pathos to things and people<sup>(3)</sup>.

Using these concepts to analyse the discourse on childbirth care is a challenge that requires some thought on how health workers and women in labour support and situate their discourse.

One of the problems of childbirth care is the inability of health workers and women to distinguish clearly from where they are speaking when establishing a discourse that is not supported on the appearance of authority, fear, submission or cries, but that is capable of producing sensitive effects.

There is a strong discourse in obstetrics that relates the experience of giving birth to female empowerment. Throughout pregnancy, efforts to create a scenario to justify intervention in childbirth care can create more alleged risks than real risks, like big baby and nuchal cord, where the fragile mother must decide while faced with the power of persuasion of the physician<sup>(4)</sup>.

This discursive relationship between health workers and woman in labour has become so conflicting that it was classified by the World Health Organization as a type of mistreatment toward women, thus characterising verbal aggression within the concept of obstetric violence, equally considered one of the emerging problems of public health and human rights<sup>(5)</sup>.

There is a pre-discursive image of childbirth, anchored in collective representations, that defines the experience

as something horrible, unpredictable, and painful, and that must therefore be deleted. These beliefs about a woman's body and the process of childbirth are reflected in care practices, in the organisation of the service, and in the institutional ethos, configuring the childbirth care model of Brazil<sup>(6)</sup>.

When we reflect on this discursive issue in care for women in labour, it is important to acknowledge the perspectives of birth care that are taking shape in the discourse of women and health workers. Reflection on this problem leads to the question: How is the discourse of labour and birth established in the relationship between health workers and women in labour?

In the field of health, the image that society constructs of the physician and the nurse is closely related to the modalities of their discourse. The figure of the physician as the authoritarian, arrogant, evil executioner juxtaposes the image of a care-giving nurse who assists the physician and becomes the mother's guardian. It is understood that the image that health workers have of themselves is intimately related to the activation of these socially generated stereotypes<sup>(1)</sup>.

Like in a collective crystallised scheme, these ready-made images mediate the subject's relationship with reality. Emphasising the notions of ethos and pathos in the discourse of health allows us to understand and characterise the manner of feeling and speaking of these subjects involved in delivery and reveals how the pathos is attributed to the discourse of childbirth.

This reflection on the image and construction of an emotional attitude in the delivery room should allow us to know the difficulties mentioned by these subjects. With this knowledge, we can establish a new childbirth care model and unmask the challenges the political game brings to health workers in their routine work at health-care institutions.

The aim of this paper was to understand the ethos and pathos in the discourses of women in labour and health workers in the context of the delivery room. This understanding can reveal the manner health workers and women in labour construct their self-image and the image of others, according to their interlocutors and conditions of discourse production in the delivery setting.

## ■ METHODOLOGY

The methodological approach adopted in this study was French discourse analysis from the perspective of Foucault and Maingueneau, as they understood that the image and feeling subjects reveal about themselves in the

discourse is important for the success of discussions and points of view in interaction-oriented processes, like the relationships between health workers and women in labour.

Qualitative research refers to an interpretative approach to the world<sup>(7)</sup> and the discourses, and represents the concrete world, while evoking possibilities that are different from reality<sup>(8)</sup>.

In a discursive approach, it is considered impossible to construct an object of speech without simultaneously creating an emotional attitude towards the object<sup>(2)</sup>, here represented as childbirth, from the perspective of women and health workers.

The study scenario was seven small maternity hospitals in the interior of Minas Gerais, given the lack of knowledge on care and studies in these locations, and because they were excluded from the national childbirth survey.

In all, 36 women and 24 health workers (physicians and obstetric nurses) participated in the study. Since this is a qualitative study, there was little concern with the number of participants, but rather with their representativeness, a priori. The final sample was created using theoretical saturation, when no new information can be added to the obtained information. Regardless, the sample did include at least one professional physician and one nurse from each scenario.

The inclusion criteria for the health workers was to be part of the maternity ward staff, provide direct care to women in childbirth, and be an obstetric nurse or physician. The criteria for the women in labour was aged between 15 and 45, to have delivered a child at one of the maternity hospitals, to have delivered a child vaginally or by C-section, and to have stayed at the hospital for at least 6 hours.

Data were collected through interviews with a semi-structured script for the health workers and another for the women, with the following questions: Please introduce yourself. Who are you? Tell us how you experienced the birth of your child. Describe how you view the relationship between you and the health professional that provided care in childbirth. Tell us about an event that marked you during care. What does it mean to be an obstetric (physician or nurse)? Can you tell us about a situation you experienced in the delivery room involving you and the user?

The interviews were recorded on a digital device and transcribed in full for analysis and interpretation of the statements. We also observed the situations that occurred during labour and delivery to detect and emphasize the dialogue established between the health professionals and the women. These dialogues were recorded in a field journal. Data collection occurred from September 2014 to March 2015.

The anonymity of the participants was guaranteed using alphanumeric identification, according to their segment, as follows: M for women, Med for physician, and Enf for nurse, followed by a number according to the order of the interviews.

The field work was initiated after the approval of the research ethics committee of the Universidade Federal de Minas Gerais – opinion number CAAE 791.265: 3252471420000.5149, and data collection occurred after the participants or legal guardians signed an informed consent statement, in accordance with resolution 466/2012, which states that children and adolescents cannot participate in a study without proper permission from a responsible adult. In these cases, the study was explained to the adolescents and their legal guardians, who later signed the approved consent statement.

The discourse analysis consisted of three stages: 1<sup>st</sup>. Organisation, transcription, and arrangement of statements in full. 2<sup>nd</sup>. Vertical reading, including exhaustive reading of each discourse to apprehend the central ideas. 3<sup>rd</sup>. Horizontal reading to determine the ideas or meanings that resemble or not the organisation of converging data in common topics, determining the categories and subcategories<sup>(7)</sup>.

The final step of analysis was a constant exercise of interpretation about what was said and not said. The ethos and pathos of the women and health workers are revealed as the social construct intertwined with the discourses, as truths, that label forms of being and feeling a woman and different ways of being and caring as a nurse or an obstetrician.

## ■ RESULTS AND DISCUSSION

The analysis revealed three categories arranged as follows: Ethos in the discourse of self and the pathos in the interdiscourse of women in the delivery room; Ethos in the discourse of self and pathos in the interdiscourse of the obstetric nurses in the delivery room; Ethos in the discourse of self and pathos in the interdiscourse of obstetricians in the delivery room.

### **Ethos in the discourse of self and the pathos in the interdiscourse of women in the delivery room**

Before experiencing birth, women have already constructed a pre-discursive ethos, which is the image of a woman who is afraid, fragile, and submissive. The point of view of others is the ethos, or the image that women construct of themselves, while the pathos is supported by the look and interdiscourse of others, mobilising emotion. The discourses

of the women indicate that their conception of childbirth lies more in the eyes of others than in their own eyes.

*I was lucky because when I got pregnant people said: They force birth a lot, when you get there don't scream, push to deliver quickly, if you scream they mistreat you. (M 28)*

*I came with the idea it would be quick, that it wouldn't be so painful, but the women who were already mothers looked at me with sadness. It's the same with everyone you talk to. (M 19)*

The way the women who participated in this investigation conceived the care they received translates into the model of disciplinary power, described by Foucault as an action on the body, through the control of gestures, behaviour, the normalisation of pleasure, and the interpretation of the discourse to compare and rank, thus constructing a power relationship<sup>(9)</sup>.

Since childbirth is an experience that is also experienced in the body, analysis of the narratives indicates the representations women have of the biological processes, their bodies, and the discourse of scientific knowledge. The women make an analogy between the hospital and a butcher's shop.

*We get scared, people insist on saying this is a butcher's shop, we have that in mind and think this, this, and this will happen. (M23)*

*The population and some doctors put fear in pregnant women, they say things to disrupt the already troubled mind of pregnant women: you're going to have a baby here, this hospital is a butcher's shop, and the person arrives fighting, looking angry. Saying that if the baby dies, they will kill the doctor. (Med 7)*

By making the analogy between the hospital and the butcher's shop, they present childbirth as a traumatic event that can harm their health and body image. By referring to the image of a butcher's shop, their discourse indicates the fear of a disfigured and slashed body as an image usually seen in the butcher's shop: a heap of hanging, cold, and inert flesh.

Another representation of this analogical figure in the discourse is reducing women to their bodies, as the only potentiality of interest at that moment. They are a mere body capable of creating life and giving birth that must be controlled to supply the anthropological machine of the discourse, which defines life and the human being<sup>(10)</sup>.

The discursive ideologies are contained in the social discourses and reproduced in the statements by affirming that the quality of childbirth care is mediated by market values, such as meritocracy and individualism.

*I thought it would be absurd, lots of people judge the SUS for being a horrible service and in that anguish both you and he end up saying things that shouldn't be heard. (M12)*

*As it's through the SUS, we are left to our own resources, it's not good. If it were private, I think through the health plan they treat people better than the SUS. (M34)*

The relationship between the health workers and the women is permeated by exchanges. Quality care is attributed to a standard value. Expecting mothers pay for a better delivery and better healthcare, the inheritance of a capitalist society. The violent circumstances of childbirth care, which are embarrassing and marked by unnecessary interventions, transform the experience of giving birth and being born into a terrifying experience, where women feel alienated and powerless<sup>(11)</sup>.

This reality is seen in many services of the SUS (Brazilian Unified Health System), where, despite all the strategies to improve care, continue with the prevailing model considered unsafe and devoid of scientific evidence. Moreover, it is often marked by an interpersonal, authoritarian relationship, which includes inhuman or degrading forms of treatment<sup>(12)</sup>.

It is believed that the mere commitment of medical care with the logic of the pharmaceutical and medical equipment industry cannot explain the unnecessary interventions performed in childbirth care. It is necessary to question other aspects, such as the ideological bias of technical progress, that trivialize unsafe practices without scientific evidence and create gaps in knowledge for the population<sup>(13)</sup>.

The discourse of the women is conflicting, and the feelings that permeate the experience of childbirth, due to the singularity of each woman, have made it very intense. Although they feel pain and fear during labour, the women tend to feel relieved and grateful after the birth of a healthy baby, which, according to them, outweighs any bad treatment received during care.

*When I heard his first cry, it was the best moment for me, because I was too scared. (M10)*

*We can't even speak. It's a lot of pain, but it's exciting, the cry..., when you see that little face, we suffer... but it is beautiful. (M19)*

*The moment he was born was the best thing in the world... I felt relieved, calm. It's a lot of tension, a lot on my mind... (M27) As soon as they took him out, our Lady, poor thing, what a relief for me and for him. (M31)*

*A true miracle, I get emotional... I didn't expect to have a child, I never wanted to be a mother. But now he is my life. I get all emotional just thinking about the scene. (M32)*

The plenitude and pleasure of being able to give birth is intensified with the cry of the baby. This feeling of plenitude is so intense that the memory of the birth scene is described as a miracle, without limits and unexpected. Miracle in Latin comes from the verb 'mirare', or marvel. Childbirth can be compared to a miracle in the perspective of the women because this event has no place in scientific explanations. In addition to the birth, from the standpoint of the mothers, it can be said that by giving birth, the women rekindle their anxieties and affections. The feelings are ambivalent; and love and pain become allies in the experience of being a mother<sup>(12)</sup>.

Childbirth should be understood as a process that must be viewed from beyond the objective conceptions of reality of the facts, based on human experiences<sup>(1)</sup>. Thus, the care of woman in labour must be built on a more human relationship, closer to the mother.

### **Ethos in the discourse of self and pathos }in the interdiscourse of the obstetric nurses in the delivery room**

The image that society constructs of the nurse is generalised by stereotyped impressions that include figures such as saints, heroes, and prostitutes. They relate it to the position of doctor's assistant, the gentle, friendly person who can provide the necessary support. In addition to the preconceived image of the social idea, the nurses created another image of themselves and their work with essentially feminine characteristics, such as emotion, sensitivity and care for others and from others, which depicts the pathos.

*Being an obstetric nurse a professional, personal achievement, I don't see myself doing anything else, it is what I've always wanted, to see the baby being born, that magical moment of life, the happiness of the parents. (Enf 1)*

*It means helping to give life, comfort. It is about making a difference in her life, making the moment even more special. The birth is natural, if there's no one there it happens. (Enf 4)*

*I love my job, I like to take care of other, to me natural childbirth is exciting and gratifying. (Enf 6)*

*Motherhood fascinates me, it's an area I work in because I like to, everything that comes from birth is wonderful. (Enf 7)*

*It's not just liking, it's about love, passion. We're different from the doctor, he takes care of the complications, of the pathology, of what went wrong, we provide care with touch, with our eyes. (Enf 8)*

The discourses are attributed pathos by the passion and fascination that labour causes in those who provide care. By saying they are obstetric nurses, they sublimate possible difficulties and challenges to the professional field. The narratives are mobilised by the emotion that labour causes.

Care from the perspective of obstetric nurses generates the possibility of construction, based on sharing and listening, which allows the expression of emotions, both of the women and of themselves, and the meaning of childbirth care goes beyond the technical and involves only the best of the human side<sup>(14)</sup>.

For some authors<sup>(2)</sup> it is impossible to construct an object of discourse without simultaneously creating an emotional attitude toward this object, here represented as childbirth, that is, from their perspective, the object of passion, of care.

*Being a nurse is working with love, it requires a lot of zeal, patience. (Enf 10)*

However, to mediate this emotional discourse with reality, we know that nurses, in their professional experience, feel passionate about their work, need to develop skills and competencies, acquire technical safety, and perceive the complexity involved in the process of giving birth. The care of women with affection, empathy, and safety demands a unique professional with an ethical, humanistic, and scientific education<sup>(15)</sup>.

When narrating the routine work at the maternity units, the nurses signalled the difficulties they experience when providing care.

*I try to optimize my time for them, but it is not always possible. I provide care in the outpatient clinic, in the shared rooms, in the nursery, in the administrative part. I can't do everything at the same time (Enf 3).*

*Labour sometimes happens without me being in the sector, as a nurse I'm not just in the maternity ward, some-*

*times I am in paediatrics, the milk bank, resolving bureaucratic problems. (Enf 5)*

*I try to be all the time next to the patients, but in our maternity unit it is difficult, the nurse has to provide assistance in other wards. (Enf 10)*

In this area of work, the difficulties encountered by nurses to provide quality care exceed the operationalisation of time in an attempt to reconcile care with the administrative activities.

It is observed that there is a deficit in the knowledge and action in obstetrics often attributed to the biomedical influence in their education and practice, which can contribute to the use of best practices recommended by scientific evidence in childbirth<sup>(16)</sup>.

In the field of health, the limit of knowledge is imprecise, in which one professional always seeks support in another for the accomplishment of their tasks. There is an emerging need to build more democratic practices and to establish social identities for the professions and fields of knowledge<sup>(17)</sup>.

There is, however, a need to support the execution of practices and the legitimization of scientific knowledge.

*Obstetric nursing has no specific protocol, it does not take a case. I can't make an assessment, I do the follow up, but she defines the type of delivery. (Enf 3)*

*I like to use the protocols of the Ministry of Health, because it's our endorsement, it opened the doors for us. Use of the partograma (graphical record of labour and delivery data on a single sheet of paper) is not routine here. I have tried to establish it... but the partograma used here is confusing, you can't see the evolution of childbirth. (Enf 4)*

It is observed that the absence of protocols and the lack of institutional support mentioned in these discourses prevents a certain attitude of empowerment of care for the women in labour. Moreover, the insertion of obstetric nurses in care practices recognised as useful and recommended by international organizations is still timid<sup>(18)</sup>.

The issue of ethos and pathos of nurses emerges beyond the discourse signalled in the statements of the experts. It implies the need for investments in better training and the permanent professional qualification of this category, the reorganisation of services, and the incorporation of care protocols to enhance care<sup>(14)</sup>.

The nurses need not make a self-portrait or configure their ethos to talk about their profession, as the image

that they construct of themselves crosses the view and discourse of the physician, which configures the pathos of the nurses. The crystallised image of the obstetric nurse does not belong to one look, but rather to a crossover of different looks.

*In our service it is just the obstetrician who works, the nurse is there to hand the gloves, medication, does not interfere in childbirth. I don't know if they don't let her do it, or if they don't want her to. I think the nurse would help a lot more if she had a greater practice. The only thing they do is the same as any nurse in clinical medicine. (Med 4)*

*I feel like working with an obstetric nurse, for her to help monitor the labour and indicate the caesarean section using the partogram. I haven't managed that, although I have one here, but she only does the bureaucratic work. (Med 8)*

*We don't have obstetric nurse here doing labour, we have one that handles the entire maternity ward. It's part of our requirements to have a nurse in the prenatal, taking care of the patients, helping us, for a more humanised care. (Med 12)*

For the physicians and obstetric nurses, in addition to being an assistant, there is another more bureaucratic, supervisory work they must do to fulfil administrative requirements. The discourse in healthcare persistently addresses the hegemonic knowledge characterised by the continuous production of an epistemological difference, which does not recognise knowledge on an equal footing and, for this reason, establishes a hierarchical relationship and generates silencing, exclusions, and liquidations of other knowledge<sup>(16)</sup>.

The representation that the mothers have of the obstetric nurses is configured in the pathos, an image created from something present in the other that affects, moves, and raises awareness in oneself.

*I had two fundamental workers at my delivery: the obstetric nurse and my obstetrician. The nurse was great, made my husband and my sister active in my delivery, helping me exercise on the ball, go to the shower. I say it was God who put her on duty. (M 36)*

*The only good thing, besides seeing the face of my daughter, was the nurse having accompanied me, massaging, comforting, there are times when you need a friendly word. I can only thank for her helping me. (M5)*

Humanised childbirth care provided by nurse, and their ability to listen, support and comfort, are all important aspects of a good delivery. Their action enables the active participation of the pregnant woman in labour, and her involvement with the people who are most important to her at that moment.

This interpretation is corroborated by a study conducted in Portugal about the social representations of obstetric nurses<sup>(19)</sup>, that portrays their image with relational qualities capable of promoting interaction. The representations reaffirm nurses as the people with the professional experience and the capacity to easily transmit knowledge and stimulate the active participation of women in labour.

The results suggest that for the obstetric nurse, the meaning of care is not restricted to procedures. Empathy, providing guidelines, performing practices to support the humanised model, and contributing to a satisfactory experience of childbirth are all strategies that build a harmonious relationship between the women and the health workers, and give visibility to the work of the nurse, still so restricted, in the scenarios investigated in this work.

### **Ethos in the discourse of self and pathos in the interdiscourse of obstetricians in the delivery room**

In the constitution of institutional ethos and in the organisation of the work process, social, more complex functions are assigned to the physician, who delegates manual activities to other team members. Values such as the domain of knowledge, decision-making capacity, and impartiality are used to define the status of physicians.

The physicians' discourse reflects the specificity of their work of diagnosing, deciding, and intervening in risk situations. Their emotions or pathos is distinguished by technocracy and power in discursive interaction.

*It moves me... childbirth, when things don't go well and you have to take certain actions. (Med 2).*

*I've had complications in the delivery room dystocia, pelvic delivery, but the physician has a preparation, to be cold and endure through the difficult time. (Med 12)*

*It is gratifying to deal with a detached placenta, a cord prolapse that you run with the patient, you see that if you didn't act, if you weren't there to act on time... (Med 13)*

Given the diversity of work specifications in healthcare, we noted that the physicians, in the performance of an ac-

tion, simultaneously mobilise their knowledge and ways of being and acting. This way of acting is influenced by specific knowledge, due to the social-historical setting, the hegemonic paradigm of science, and the professional and institutional culture<sup>(17)</sup>.

A statement brings inherent practices to each subject, and it is possible to identify the language of a given class or category in the discourse. This explains the similar status, as in the case of physicians, and the similar way of acting in the face of complicated and risk situations<sup>(9)</sup>.

The image of the obstetricians suffered important changes that affect their status and their perspective regarding the profession, revealing this other facet of the ethos and pathos of physicians from the viewpoint of themselves and their population.

*It is a difficult option, almost a priesthood, donation, you have to give up things, your life is watched, you're obligated to be physician 24 hours, forget that you have a social life, kids, a wife. (Med 6)*

*It is a huge sacrifice, an intense specialty, not-so-great compensation in comparison to other specialties, but there is joy. (Med 9)*

In the discourse, the physician uses the metaphor of priesthood to portray the self-denial the profession demands, despite the joy it gives. It seems difficult, in his perspective, to dichotomise being a physician from public and private life. This association of medicine with priesthood can be attributed to the semantic origin of the word, which means an authority who acts on behalf of God with generosity and selflessness, in the execution of a mission. Moreover, medicine was practiced by priests who, like historical figures, perpetuate in the memory of the physician.

This discourse contrasts with the current reality of the profession, practiced by paid professionals with responsibilities to a health institution. The professionals are subjected to criticism and lawsuits for any malpractice or medical error in childbirth care.

*It's hard to do obstetrics, the patient doesn't want to feel pain, if you use a forceps to help her, she says, "the doctor almost killed me". The doctor is afraid of lawsuits, not much with the patient. But I like it, despite the criticism, not getting paid enough. (Med 10)*

*Obstetrics is the second specialty with most lawsuits, this is leading to a defensive position with patients and gets in*

*the way of doctor-patient relations. You cannot always express yourself. (Med 5)*

*You have to be very careful because any little thing that happens in obstetrics is the obstetrician's fault. (Med 13)*

The responsibility of the physicians during childbirth and the fear of being penalized ultimately interfere with the relationship of physicians with the women in labour, and lead to a defensive attitude on the part of these professionals. The fear of being neglectful can interfere with the indication of type of delivery and expose mothers and babies to the risk of unnecessary caesarean section, as well as significantly increase healthcare costs<sup>(20)</sup>.

One realises that the main obstacles of quality care in childbirth are conflicting doctor-patient relationships, difficulties establishing bonds, and the social discourses contained in the aggressive and unnecessary discourse of the team when characterising the attitude of women as a non-responsibility with little collaboration.

*It is a personal achievement, despite the obstacles, you have to like it. It is a profession that is becoming increasingly difficult in terms of the relationship with the patient, the working conditions. (Med 11)*

*It's hard, we work because we like it. And you have to hear things like, "Who told you to get pregnant, why did you that way? whatever" I think people who say that are ridiculous. If I accept to work in the SUS, no matter who comes, I have to do my job well and support those who need me. (Med 14)*

*Obstetrician, for those who come looking for help. It's not to deliver the baby for her, as if the obstetrician were responsible for the delivery. And it's not the mother continues to be responsible, she has to cooperate. The entire delivery room is the patient. (Med 4)*

Here we identify the discursive capacity of relativising from pathos in ethos and from ethos in pathos, in an attempt to persuade and convince. One can infer that the discourse of the healthcare workers characterises the women's behaviour in light of regulatory and preconceived approaches, without demonstrating the ability to establish care strategies that trigger the emotions needed to change attitudes.

Despite the specificities, work in childbirth care is collective, woman-centred, and provided by professionals who are trained and qualified to conduct fundamental ac-

tivities for the maintenance of the institutional structure. Therefore, the absence of an interdisciplinary coordination fragments care and hinders progress.

## ■ CONCLUSIONS

Every discourse has a tone, a corporeality that attributes legitimacy to the discourse based on cultural stereotypes and the values of a given social group. The ethos in the discourse of the health workers is the origin of the workers' disposition for ethical and political care, while the emotions configure the pathos like a score that governs the discourse of women in the context of childbirth.

The narrated reality reveals that redefining ethos and pathos in the configuration of the professional image essentially requires institutional support, the commitment of managers with public policies, and the qualified training of both categories. It is believed that the construction of the professional ethos of physicians and obstetric nurses is critical to design more flexible fields of knowledge, so the practices of these professionals are consistent with their roles in the reorganisation of the model and commitment with the ethical and legal precepts of obstetric care.

There are still many latent aspects in the professional disciplines involved in women's care that need to be investigated in more depth, such as issues of gender, class, and condition of the women in the public service scenario. Such characteristics are closely related to the constitution of the ethos of women in labour and health workers.

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