You Can Make a Difference

Shannon E. Perry, RN, PhD, FAAN

SHANNON PERRY is a professor in the School of Nursing at San Francisco State University in San Francisco, California, and the author of three maternity-women's and maternal-child health nursing texts.

Abstract

Inaccuracies, injustices, bad advice, and insensitivity are irritating. Most of us feel powerless to do anything about such situations or don't have the time or energy to try to make changes. A strategy is described that allows the author to address her concerns. Examples are given of changes that occurred because of her efforts through writing letters. Childbirth educators become aware of policies and situations that need change; as advocates, they are encouraged to take the risk and enjoy the challenge of creating change.

Journal of Perinatal Education, 9(3), 30–37; change, empowerment, influence, correspondence.

Introduction

Inaccuracies, whether in the newspaper, on television, or in books and journals, irritate me and sometimes really upset me—so do injustices, bad advice, and insensitivity. Most of us feel powerless to do anything about such situations or don't have the time or energy to try to make changes. I have a strategy that works for me—I write letters. While it might seem old-fashioned in today's world of telecommunications, I find this approach to correspondence personally engages both my addressee and me and, by so doing, lets me state my concern and makes me feel better. Sometimes, things change because of my action; at other times, I just feel better because I tried to do something and no longer feel powerless. Sometimes I receive a response that helps me to understand why the situation is the way it is.

I've written many letters to the editors of newspapers and journals (a number of which have been published)

and to textbook editors. I don't always complain; sometimes I provide compliments for something that pleased me or for assistance that I received. For example, I wrote to the mayor of New York to compliment him on the friendliness of New Yorkers and the helpfulness of riders on the subway; to Charles Schulz to send a valentine to Charlie Brown who, once again, had not received one; and, most recently, to Lady Bird Johnson (wife of the late President Lyndon B. Johnson and former first lady) to express my appreciation for her work in beautifying Texas with her efforts to plant and preserve wildflowers. (The mayor, Charles Schulz, and Mrs. Johnson all responded to my letters—very positive feedback.)

The remainder of this paper provides an example of correspondence that resulted in changes in a major medical textbook.

The Comfort of the Physician is of Primary Concern

In 1979, as director of a new, high-risk maternal-infant graduate program in nursing, I sought after a textbook that would be appropriate for the students. At that time, there were no nursing texts that exclusively addressed high-risk maternity, so I examined medical texts for their suitability for use in our classes.

In the review of several textbooks, I came across one that included some sections that I perceived to contain inaccuracies or deficiencies and some statements with which I did not agree. Then I came across the following statement: "Use of the lithotomy position has two purposes: It makes maintenance of asepsis easier and it contributes greatly to the convenience of the obstetrician. These advantages more than compensate for the somewhat unphysiologic posture and the discomfort of the position itself" (Danforth, 1977, p. 591). At that point I knew I had to do something. What kind of person

At that point I knew I had to do something. What kind of person would think that his comfort is more important than his patient's, I wondered, or that his comfort would make up for the problems of an unphysiologic position?

would think that his comfort is more important than his patient's, I wondered, or that his comfort would make up for the problems of an unphysiologic position? And this is what was being taught to new generations of physicians? I was incensed and had to write a letter to the editor of the text.

In that letter, I noted the following items of concern and my suggestions (in italics below, the original did not include italics) to remedy the problems:

October 19, 1979

David N. Danforth, MD
Watkins Professor of Obstetrics and Gynecology
Department of Obstetrics and Gynecology
Northwestern University Medical School
Chicago, Illinois

Dear Dr. Danforth,

I am using *Obstetrics and Gynecology* in a course I am teaching and have noted a few inaccuracies, deficiencies, and statements with which I do not agree and am taking the liberty to bring these to your attention.

1. On page 278, column 2, paragraph 1—"The areolar and linea nigra changes do not regress after pregnancy is terminated." *These changes do regress. Some exceptions do occur in dark skinned individuals.*
2. On page 585, column 2, paragraph 2—"The patient's pubic, vulvar, and perianal hair should be shaved off; long hair in these areas makes it impossible to maintain asepsis . . ." *I do not believe that statement is documented by research. If absolutely essential, hair can be clipped with a scissors, but ordinarily cutting hair is not necessary. (See "Why Shave a Mother Before She Gives Birth," MCN, The American Journal of Maternal Child Nursing, 1977, 2, 189-190 in which research studies are quoted.) A brief description of cleansing of the vulva prior to vaginal examination would be appropriate here.*
3. On page 591, column 2, paragraph 3—"Use of the lithotomy position . . . These advantages more than compensate for the somewhat unphysiologic posture and the discomfort of the position itself."

I think the "convenience of the obstetrician" is inadequate justification for the lithotomy position. The discomfort and actual pain of muscle cramps and pressure on the great vessels seem to me to be adequate justification to preclude use of that position. I would recommend the sidelying position. You have obviously never spent 1½ to 2 hours with your legs in stirrups or you would recognize that someone's convenience is inadequate justification. [Note. I would not recommend this wording in future correspondence; the statement "You have obviously . . ." could be perceived as inflammatory and result in the person discarding the suggestion.]

4. On page 605, Natural childbirth—I think this section should be extended and expanded to describe psychoprophylaxis in obstetrics and the physician's role in cooperating with the couple to facilitate a healthy childbirth outcome. Some mention of homebirthing and trends in such care would also be appropriate.
5. On page 709, Urinary tract—Patients may also have difficulty voiding because of perineal pain or discomfort. If the patient is medicated, she will frequently be able to void within the hour.
6. Chapter 36 needs to be expanded to include emotional changes and needs, including sleep, during the puerperium.
7. On page 710, column 2, paragraph 1—"The ejection of milk from the breast is commonly called the let-down reflex." *The let-down reflex is the release of milk into the main milk sinuses under the nipple. The milk may also spurt or drip from the nipples at the same time, but this is not the let-down. Let-down can occur with no milk coming from the nipples until the infant suckles (or is otherwise expressed).*
8. On page 717, column 2, paragraph 2—"Nursing . . . need not be discontinued . . ." (p. 717). *I think there must be a typographical error. Nursing is ordinarily discontinued on the affected breast. It may be continued on the uninvolved breast.* [Note. This was an error on my part; Dr. Danforth did give justification for his statement in his reply to my letter.]

9. In Chapter 36, especially page 721—*Some discussion of discharge instructions would be appropriate, including a discussion of when it is OK to resume sexual relations. At the 6 weeks' visit, it is too late to broach the subject of family planning since telling her to wait till the 6-week checkup to resume sex is, in many instances, advice which is certain to be disregarded.*
10. *No mention is made of behavioral manifestations immediately postpartum, that is, chills, fatigue, sleep needs. No mention is made of the kinds and amount of lochia to be expected, or that retained tissue and subsequent bleeding or passage of clots may occur, or that hemorrhage may be present and aggravated by the delivery.*

I hope these comments are useful.

Sincerely,

Shannon E. Perry, RN, MS
Director
Graduate Maternal-Infant Nursing Program

I had no expectation that I would hear from the editor; after all, I was a nurse criticizing a medical textbook, he was a physician, and the tone of the letter was rather sharp. However, I felt much better after writing the letter. To my surprise, within 3 weeks, I received a response to the letter.

November 6, 1979

Dear Ms. Perry:

I am grateful for your thoughtful letter of October 19th, and apologize for being so tardy in responding; it only reached me on November 1st. [Note: I had sent the letter to the publisher.] The letter is very helpful, and it comes at a most opportune time as we are now engaged in preparations for the fourth edition of *Obstetrics and Gynecology*. Unfortunately it will be several months before I am finished with the entire manuscript, and the new edition will not appear until early 1981.

Your criticisms are well taken, and I believe that all have been or will be dealt with in the revision.

1. I enclose a copy of the first draft of the revision for the chapter on the conduct of labor. I am uncertain you will wish to wade through it in its present unfinished shape, but in it I have considered such subjects as shaving, lithotomy position, family-centered maternity care, bonding, and several other points that needed change. Please return it at your convenience. Any suggestions will be appreciated.
2. Doctor Easterling's chapter on the puerperium has been heavily revised, and the new chapter now contains discussion of lochia, postpartum bleeding, and expanded sections on systemic changes in the puerperium. Your references to pigmentary changes and let-down reflex are correct and I will speak to Doctor Quilligan and Doctor Easterling about them. Ditto the need for mention of postpartum chills, fatigue, ambulation, diet and discharge instructions.
3. With regard to the propriety of nursing in the presence of acute mastitis, I cannot quote an article, but it is our practice to permit it. I have checked with our two busiest pediatricians and find it has always been their practice to permit nursing from the affected side, skipping a feeding or two if the mother wishes. None of us has encountered any problems with this practice. Suppurating mastitis or abscess is another matter.
4. The class content, objectives, and results of psychoprophylaxis are considered in the revised chapter on the conduct of pregnancy. Unfortunately, space will not permit us to present the detail of the exercises, but I believe the new New York Maternity Center booklet is excellent, and the footnote to this will remain.
5. The new chapter by Robert Kinch on counseling in obstetrics and gynecology contains a section on the emotional changes and needs of pregnancy and the puerperium, and I believe this is well done and sufficient for our purposes. Cross-references to this will appear in the chapters on the conduct of pregnancy and the puerperium.

Again, I am grateful for your letter. This kind of criticism is really needed if we are to have the kind of book

we want. Unfortunately, the individual authors are at a disadvantage, for the only ones who know what is in different chapters are the editor and the associate editors. As carefully as we try to be certain everything is in, things do slip by or are omitted unless our attention is directed to them. Thank you again, and do let me know of other deficiencies.

Very sincerely,

D. N. Danforth, PhD, MD
Thomas J. Watkins Professor

November 14, 1979

Dear Dr. Danforth:

Thank you for responding to my suggestions and for the opportunity to review the chapter on the conduct of labor. I very much appreciate your willingness to accept suggestions.

I have reviewed the chapter and have made comments and some editorial suggestions on the manuscript. I think the inclusions you have made are a decided improvement. One concept that is not dealt with and which may affect conduct of labor and delivery is the increasing number of women who wish (demand?) some control over the process, who want to be given choices and participate in decision-making.

Best wishes with the work of revising the text.

Sincerely,

Shannon E. Perry, RN, MS
Director
Graduate Maternal-Infant Nursing Program

(The following letter is a reconstruction; I did not keep a copy of the original.)

October 7, 1982

Dear Dr. Danforth:

I have reviewed the new edition of *Obstetrics and Gynecology* and feel that I can now recommend it to my students. The chapter on conduct of labor has been markedly improved. Thank you again for giving me the

You Can Make a Difference

opportunity to review the chapter and for being willing to make significant changes.

Sincerely,

Shannon E. Perry, RN, PhD
Academic Director
Maternal-Infant Graduate Program

October 14, 1982

Dear Dr. Perry:

I am extremely grateful for your thoughtful note of October 7, and I appreciate most especially your excellent criticisms that caused me to take a long look at the whole chapter and, literally, to begin it anew.

It seems a very long time since we corresponded before. The closing of Harper & Row's Hagerstown plant, and the transfer of everything to Lippincott's in Philadelphia caught us in the middle of copyediting, with the result that the book appeared about a year later than we intended. Fortunately, we were permitted to make extensive changes in galley proofs, so I think the book is current, despite all of the problems.

A fifth edition of *Obstetrics and Gynecology* is tentatively scheduled for 1986, which means that before many more months we will have to begin gathering our thoughts as to how it can be changed to advantage. Your ideas were so extremely helpful before that I do hope you will drop me a note if you should have any notions of what can be done to make it more useful.

With my sincere thanks,

Very sincerely,

D. N. Danforth

Did My Criticisms Really Make a Difference?

The following paragraphs offer examples of some of the changes incorporated in the fourth edition.

The full text of the original description of the use of the lithotomy position was as follows: "Use of the lithotomy position has two purposes: It makes maintenance of asepsis easier and it contributes greatly to the convenience of the obstetrician. These advantages more than compensate for the somewhat unphysiologic pos-

ture and the discomfort of the position itself" (Danforth, 1977, p. 591).

In the 1982 edition, position for delivery was described in the following way: "For spontaneous delivery, a flat surface is usually preferred; if the woman is on a delivery table, the end should not be 'broken,' and she may assume whatever position is most comfortable. In England, the left lateral recumbent (Sims) posture has been preferred for many years and is probably most physiologic, since it avoids the pressure of the gravid uterus on the inferior vena cava. The supine posture is most commonly used in the United States.

"For operative delivery, including delivery by outlet forceps, the lithotomy position is preferred because it improves exposure and provides easier access . . . The stirrups that are usually used are not without hazard, and the legs should not be put into them until delivery is immediately imminent; prolonged pressure from stirrups and straps may cause thrombosis in leg veins or damage to important nerves. A desirable alternative to the use of stirrups, if both scrub nurse and assistant are available, is to hold the legs in the manner shown . . ." (p. 649).

The 1977 statement that "The areolar and linea nigra changes do not regress after pregnancy is terminated" was changed in the 1982 edition to "The areolar and linea nigra changes may not regress completely after pregnancy is terminated" (p. 334), a qualification that improved the accuracy of the statement.

The 1982 edition contains a paragraph on lochia, a topic completely omitted in the 1977 edition.

Early in the 1982 chapter titled "Conduct of Normal Labor," there is a discussion of women's reactions to hospital conditions that led some to seek home delivery and that necessitated changes in hospitals to provide family-centered care (women were assuming more control of their labors). A description of what family-centered care encompasses is included: presence of husband or support person, rooming-in, visiting for children, early discharge, breastfeeding, infant contact immediately after birth, and birthing rooms. The author suggested that obstetricians must be aware of emotional needs of patients and that "reassurance and support, both emotional and physical, are keystones of the successful conduct of labor" (p. 643). The tenor of this section is in marked contrast to the earlier edition. A separate paragraph on psychological support is included (p. 640), as well as sections on maternal-infant bonding

and LeBoyer's Birth Without Violence (p. 656). The editor before my letter included some of those changes, but others were based on my input.

The 1977 edition stated, "The patient's pubic, vulvar, and perianal hair should be shaved off; long hair in these areas makes it impossible to maintain asepsis during vaginal examinations and delivery and complicates the repair of tears or episiotomy" (p. 585). This statement was changed in the 1982 edition to read, "It was formerly thought that asepsis required shaving the pubic, vulvar, and perineal hair, but it is now agreed that this is uncomfortable and unnecessary. Accordingly, the shave is limited to the area of the intended episiotomy, and long pubic and vulvar hair is clipped with scissors" (p. 644).

The chapter on obstetric analgesia and anesthesia in both editions contains descriptions of the Dick-Read method, psychoprophylaxis, and hypnosis. In the 1982 edition, a section called "Prepared Childbirth" was added to the chapter titled "Course and Conduct of Normal Pregnancy."

No changes were made in the section on the urinary tract.

The chapter on the puerperium in the 1977 edition was purely physiologic. The 1982 chapter added sections called "Desirability of Breastfeeding" and "Discharge Instructions," which included subtopics of activity, sitz baths, sexual intercourse, contraception ("... condoms are most suitable until the postpartum office visit..."), and exercises.

In the 1977 edition, the let-down reflex was described as follows: "Oxytocin then stimulates contraction of myoepithelial cells surrounding the alveoli and the larger ductal reservoirs causing milk to be ejected from the nipple. This ejection of milk from the breast is commonly called the let-down reflex" (p. 710). In the 1982 edition, this reads: "... oxytocin then stimulates contraction of the myoepithelial cells surrounding the alveoli, causing milk to be moved into the larger reservoirs beneath the nipple. This may be accompanied by ejection of milk from the breast and is commonly called the let-down reflex" (p. 790)—very similar to my suggestion.

The section of mastitis in the 1977 edition included the statement, "Nursing from the involved breast need not be discontinued until after the acute phase" (p. 717). The 1982 section reads, "Nursing from the involved breast need be discontinued only until after the acute phase" (p. 717).

Lessons Learned

From this experience, I learned that editors and authors *do* listen to those who criticize their work, even when the editor is a physician and the one who criticizes is a nurse. In fact, I was given the opportunity to provide an in-depth critique of a chapter. While I welcomed the opportunity, I also felt nervous, as if the editor were "calling my bluff." However, I did not find the review difficult. I make a point of staying up-to-date with the clinical and research literature in my area. This makes it possible for me to detect errors in the texts under review or provide more contemporary thinking and to suggest adjustments that are evidenced-based. This knowledge base also makes it possible to reference my suggestions, which greatly enhances my credibility as a reviewer. My suggestions reflected current thinking and incorporated a more humanistic and behaviorally oriented approach. The great majority of my suggestions were incorporated in the revision, and the editor expressed several times his gratitude for the suggestions for improvement and noted in the preface that the chapter on conduct of normal labor was largely rewritten.

... editors and authors do listen to those who criticize their work ...

I felt very good about the experience and its outcome. I felt empowered and encouraged to continue to try to make a difference. In addition, I learned something from Dr. Danforth. While my first letter was critical and somewhat sharp in tone, he did not respond in kind; instead, Dr. Danforth was appropriately receptive to my concerns. In future letters, I would word my criticisms more diplomatically.

Based on my current experience as editor of three nursing textbooks, editors *welcome* such comments. My personal goal as editor is to produce a perfect text; that is, one that is accurate, up-to-date, and includes no typographical or other errors (we're not there yet!). Comments related to omissions and notification of inaccuracies in tables or figures are very useful. While editors review the material several times in the process of writing a book, errors do creep in and may be missed in the review process. I have received correspondence from stu-

You Can Make a Difference

dents who have noticed errors. For example, in one edition, two photos were switched and the legends were therefore incorrect. I was quite pleased that the student had read the text that carefully and had understood enough to detect errors. Specific comments and suggestions are helpful; a general statement that "Your book is awful!" would not be useful.

While my first letter was critical and somewhat sharp in tone, he did not respond in kind. In future letters, I would word my criticisms more diplomatically.

Recommendations for the Reader

You *can* make a difference. While you need to "pick the battles to fight," choose to fight some. Whenever you read something that causes a significant reaction, think about what needs to be different and what you can do to facilitate the change from a need into a reality. Writing letters to the editor of the local newspaper, journals, or books provides an outlet that immediately makes me feel better and may lead to change.

In another instance, the new director of the state health department was a female physician. When quoting her or referring to her actions in her job, the newspaper referred to her as *Mrs.* rather than *Dr.* An adjoining column contained an article about a male physician with no official position who was referred to as *Dr.* I wrote a letter to the editor stating that the director of the health department was a professional and needed to be addressed by her professional title. Soon after, she was again referred to as *Mrs.* I again wrote to the editor, stating that the director of the health department did not receive her job because of her marital status but because she was a physician. She deserved to be ad-

Whenever you read something that causes a significant reaction, think about what needs to be different and what you can do to facilitate the change from a need into a reality.

dressed by her professional title. That letter was published in the newspaper and I never again saw her referred to as *Mrs.* A small victory for womankind!

Taking a stand in a meeting for something in which you believe, presenting an alternative viewpoint, introducing a new topic, suggesting additions to agendas, and contributing to or working for a political candidate are all ways in which you can participate in effective, positive change. Don't assume that your first efforts will generate the result for which you were hoping. You need to be willing to be challenged, ignored, mocked, or even reprimanded occasionally when you start to change your approach to the status quo. You must also make a conscious decision to believe that, as a whole, people are reasonable, and you must be prepared to have that belief shaken from time to time. Employing a sense of humor is invaluable for its positive effects on strained interpersonal relationships. Finally, maintaining your "cool" while making the effort to introduce change and deal with those who are not willing to take on the same challenges is critical to the achievement of your broader goal of changing knowledge and attitudes in a manner that persists over time. In a recent article, Meyers (2000) documents an emergency department nurse's efforts, challenges, and ultimate success in changing a rule that prevented family from being present during resuscitative efforts. She challenged us to "stretch beyond your comfort zone and take the risk" (Meyers, 2000, p. 9).

Childbirth educators become aware of many rules and policies that need to be changed, including many that are not within the hospital system. For example, newspapers have reported instances of breastfeeding women being asked to leave restaurants or shopping malls because they nursed their babies "in public." Change is slow, even when some person or group of people is actively working to bring that change about. It may never occur unless someone notices an inequity or an archaic rule and decides to do something about it.

Finally, the following has been said about maneuvering in a new situation: You can get by on charm alone for 15 minutes; after that, you'd better know something. In other words, once you have your foot in the door of "the system," you need a foundation of clinical and evidence-based data to support the ideas you propose. Staying current and well-read is perhaps the biggest challenge for the would-be change agent. Yet, without that foundation, we only have isolated, anecdotal data to

support our suggestions, and these sources provide only a shallow and easily refuted foundation.

These efforts often do pay off and, when you do succeed in influencing someone or introducing change, the feeling is exhilarating and addicting. Have fun with your quest.

Acknowledgements

Dr. David N. Danforth died in Chicago on January 22, 1990, shortly after the publication of the sixth edition of *Obstetrics and Gynecology*. He was 77 at the time of his death. In addition to editing six editions of *Obstetrics*

and *Gynecology*, Dr. Danforth served as chair of the Department of Obstetrics and Gynecology at Northwestern University Medical Center. I remain grateful to him for allowing me the opportunity to effect positive change.

Also, I extend my appreciation to the reviewers for their helpful comments.

References

- Meyers, T. A. (2000). Why couldn't I have seen him? *American Journal of Nursing*, 100(2), 9.
- Danforth, D. N. (Ed.). (1977). *Obstetrics and gynecology* (3rd ed.) with 73 authors. Hagerstown, MD: Harper & Row.
- Danforth, D. N. (Ed.). (1982). *Obstetrics and gynecology* (4th ed.) with 75 authors. Philadelphia: Harper & Row.