The Impact of SARS on Childbirth Education

Deana Midmer, BScN, EdD, FACCE

DEANA MIDMER is an assistant professor and research scholar in the Faculty of Medicine's Department of Family and Community Medicine at the University of Toronto in Canada. She is also the prenatal coordinator for the Prenatal and Family Life Education Program at Mount Sinai Hospital in Toronto.

Abstract

The SARS (Severe Acute Respiratory Syndrome) crisis in Toronto in the spring of 2003 had major consequences for prenatal learners. Classes in hospitals were cancelled; many couples were left without any prenatal education. This paper outlines the decision-making process of one programme that was determined to keep classes open. The impact of SARS on hospital procedures is also described. Childbirth educators are encouraged to prepare for future public health emergencies. Strategies to prepare for conducting childbirth education classes during times of crisis are outlined.

Journal of Perinatal Education, 12(3), 1–6; SARS, public health crisis, childbirth education.

During the spring of 2003, Toronto was faced with a serious public health and hospital crisis in the form of SARS (Severe Acute Respiratory Syndrome). SARS is a severe form of pneumonia, resulting in high morbidity and mortality among some affected individuals. At the time of writing this paper, the causative agent for SARS has not yet been identified; however, it is believed that, for the most part, SARS is spread by airborne droplets from or face-to-face contact with an infected person, although other routes of transmission (fecal-oral) are being investigated. Symptoms typically begin after an incubation period of 10 days and include a fever of more than 38° Celsius (100.4 ° Fahrenheit) and any or all of the following: muscle aches and pains, extreme fatigue, a severe or blinding headache, dry cough, and shortness of breath. At this time, other than supportive therapy, no known definitive treatment for SARS exists. Updates

on this information are available from the World Health Organization Web site (www.who.int).

SARS reached into every arena of clinical care, including prenatal education. Classes in affected hospitals were closed down, and many couples were left without access to prenatal education. In this paper, I will outline the decision-making process undertaken by the Prenatal and Family Life Education Programme (PFLEP) at a large tertiary care centre in order to maintain ongoing prenatal classes. Because of current global concerns about inadvertent or terrorist disease transmission, I will also outline contingency strategies for childbirth educators when another public health crisis emerges.

SARS reached into every arena of clinical care, including prenatal education.

Programme Background

The hospital's PFLEP serves under the umbrella of Family Medicine. I am the Lamaze International certified program coordinator and have a program manager/administrator as well as a staff of childbirth educators. In contrast to another hospital-financed program answering to obstetrics/nursing, the PFLEP is a cost-recovery program. Teachers are contracted to facilitate the following classes: labour and birth, breastfeeding, newborn characteristics and care, parenting classes, sibling classes, fathers' classes, and postpartum classes. Most of the teachers in the PFLEP are certified through Lamaze International, and many also function as doulas, lactation consultants, and counsellors. The PFLEP fully ascribes to the Lamaze International (1993) philosophy of birth, a philosophy shared by the family physicians who practice obstetrics.

The Unfolding of the Crisis

The first SARS case was identified in Toronto in an individual who had recently returned from China. Although this individual eventually died from the disease, the disease was not identified and precautions were not implemented immediately. Clustering of patients with

shared symptomology did not occur for some time. The hospitals became the source of contagion. Hospitals were affected by persons admitted through patient transfer and through the emergency department. As the disease became recognized as SARS, measures were implemented to curtail access to hospitals in order to halt a widespread outbreak. Elective surgery was postponed, many clinics closed, and access to health care providers was limited.

Impact on Prenatal Classes

The hospital did not allow prenatal classes on its premises. The hospital-financed program simply shut its doors. However, this posed a dilemma for the PFLEP on two levels. The first, and most important, factor was philosophical: We believe childbirth education can empower a woman to make choices about birth that reflect her belief that birth is normal and natural and that she has the inner wisdom to succeed. The second factor was financial. As a cost-recovery program, we relied on class fees to maintain our solvency, and reserves in our current account have never been abundant. Although the programme has designated funds available for use as shut-down expenses (fee reimbursement, staff stipends, etc.), I was disinclined to drain this contingency account. Cancelling classes was not an option for us.

Crisis Management

With the determination that classes would continue, I began to search for suitable space in community venues. I found space at a local medical learning institute, albeit at an exorbitant rental rate, only to learn the next day that SARS fears had shut down this building as well. I tried to find space at a local community centre, but with less than a week's notice, little suitable space was available, and any space was very expensive. Consequently, I decided to hold classes in my own home.

I had taught Lamaze classes for many years at home and was comfortable with having prenatal learners in my house. However this decision was not taken lightly. I checked with the family practitioner-in-chief and the physician who chairs the obstetrical group of family physicians at the hospital. I was advised that no public health order prohibited holding classes per se, but that I had better make sure my liability insurance was up to

date. Further checking with the public health authorities supported this view: Classes could be held, but screening (as outlined below) was necessary.

Screening Measures

The Province of Ontario ordered mandatory screening measures. All hospitals initiated front-door-screening procedures by staff members who were gowned and masked. Anyone entering the hospital (staff, patients, and visitors) needed to complete a questionnaire on his or her risk of exposure. Questions included:

- Had they visited an identified health care unit within the past two weeks?
- Did they have any of the symptoms of SARS (headache, cough, etc.)?
- Had they had close contact with a probable case of SARS?
- Had they traveled to Hong Kong, China, Vietnam, Singapore, or Taiwan in the last 10 days?

In addition, their temperature was taken and documented on the form along with their name, address, time of visit, and area of the hospital visited. Visitors were only allowed into pediatrics, intensive care, and palliative care units. No visitors were allowed on obstetrical units.

Except for temperature screening, this same process was used for the prenatal classes. Couples entered the house, completed the form individually, were offered a mask, and were told to wash their hands with a germicidal agent at the beginning and end of the classes and after using the bathroom. These procedures were employed at the beginning and end of each class.

Getting Organized for Home Classes

Deciding to have the classes at my home at very short notice was not without stress. My husband and I spent two days shampooing the recreation room carpet and spring-cleaning an area previously used almost exclusively by my 18-year-old son. All furniture needed to be moved to the outside walls or stored in other areas. Although I taught some classes myself, another teacher taught two, full-day Saturday classes in my home and

Checking with public health authorities and hospital authorities was important for our peace of mind.

another taught in her home. During classes, my husband and I were exiled to the upper level of the house, with the dog banished to a bedroom. We all had issues relating to our own safety and the safety of our families. Checking with public health authorities and hospital authorities was important for our peace of mind.

We needed to transport teaching aids from location to location. Fortunately, I have a flip chart and white board, and there is a television and VCR readily available for showing birth videos. Twelve couples participated in each class, which proved to be a space challenge during the practice of relaxation and comfort measures. In addition, all teaching aids that were handled by learners needed to be disinfected after each class.

Classes in homes are considerably different from those in hospitals and other institutions. The teacher is no longer anonymous. Her family and life are up for scrutiny, and she becomes full-fleshed and more personal. My colleagues and I discovered that, in contrast to teaching in the hospital, couples did not want to leave at the end of the session. They were comfortable in their surroundings and wanted to socialize. This comfort extended into the classes themselves, with more discussion around all issues. The energy levels in the classes were very high; couples were so grateful that the classes had not been cancelled and appeared to be bonding through a shared adversity.

Classes in homes are considerably different from those in hospitals and other institutions.

Impact on Labour and Birth

The affected hospitals did not allow fathers to attend prenatal appointments, except in the case of fetal concerns or for specialized tests, such as amniocentesis. Fa-

thers could not attend ultrasound appointments. Women were only allowed to bring one person with them when they entered the obstetrical ward. This was problematic for a woman who had engaged a doula or alternative support person for the birth. She had to choose between her partner and her specialized support agent. A favourable consequence of this was that women stayed at home as long as possible in order to receive support from a doula or others, arriving at the hospital in established active labour.

However, whomever the woman chose to attend the birth, he or she was required to wear a mask while in the hospital. As mentioned above, no visitors were allowed in obstetrics and postpartum. This restriction may have benefited some women who might have been overwhelmed by too many visiting family members and distressed others who needed support during birth and the early postpartum period. No siblings were allowed to see their new family member. In at least one Toronto hospital, at the height of the SARS crisis, fathers were not allowed in the delivery room.

Outside food was not permitted, making it difficult for mothers with dietary or cultural food restrictions to re-energize during labour or after birth. All well babies stayed with their mother at all times. This mandatory rooming-in may have had positive consequences for some mothers (breastfeeding, bonding), and it may have been difficult for others to relax and sleep without support from family and friends. In addition, room sharing was not allowed, even in the semi-private wards.

Volunteers were not permitted into hospitals, so flowers and gifts were not accepted for delivery. Although this was more an inconvenience than a hardship, the celebratory components of birth were severely constrained by this restriction. In addition, all hospital personnel were gowned and masked. In the case room, providers also wore goggles and, in some cases, full-face shields. It was not so much a return to the “twilight sleep” of yesteryear, but more an entry into the “twilight zone.” Surrounded by faceless strangers, women in labour were the only ones not wearing masks.

For midwives and doulas, positive outcomes occurred from this crisis. Midwives were considered ideal providers, and home births became a sought-after option—a public relations coup for midwives. Time will tell whether this new acceptance and desire for home births will be sustained. Doulas working with couples sup-

ported them at home as long as possible. This had positive outcomes insofar as women went to the hospital in very active labour. One of the doulas in my programme reported an instance of a woman labouring at home until she reached very established labour, making a quick trip to the hospital, and enjoying a wonderful birth with few interventions and no analgesia.

Contingency Planning

This health crisis has tested the resources of everyone in the medical community. I am happy to report that we rose to the occasion. Part of our ability to manage in the face of serious obstacles was our resolve that the classes would continue. Another part was our financial base, which would not allow much income loss. Finally, the fact that my staff and I were used to teaching in a home environment was very important. Outlined below are some issues to consider in attaining readiness for future emergencies should hospital premises not be available.

Hospital Programs

- Determine whether or not it will be a policy to hold classes outside the hospital, if safe to do so.
- Discuss this policy with teaching and programme administration staff.
- Check with hospital administration about the legality and liability issues of teaching offsite.
- Consult with hospital and public health officials about running classes during the healthcare crisis that’s unfolding, and follow any screening procedures and reporting requirements.
- Determine if a budget is available to pay for outside space rental and develop a contingency fund.
- Seek out several alternate teaching sites in the community as backup locations.
- Identify teachers in the community for referral should the hospital programme shut down.
- If no community classes are available, develop teaching audiotapes (or a video of a class series) that can be given to couples for home learning.

- Have multiple copies of teaching aids in portfolios or cases for easy transport.
- Investigate distance-learning facilities and real-time broadcasting of classes.

Community Classes

- If you teach on your own or with a community group, determine policy on the provision of classes during crises.
- Consult with public health officials about the safety of holding classes.
- Consider the impact of having couples in your home during public health crises.
- Check with authorities on screening procedures and for any other health advisory cautions.
- If you operate on a cost-recovery basis, begin to set aside money should you need to refund class fees.
- Look into event cancellation insurance.
- Check with your insurance provider about liability during health crises.
- Develop a screening form and administer it at the beginning of each class.
- Maintain meticulous records.

The SARS crisis arose from contagion at hospital sites. Other epidemic or health crises may arise in the wider community. If classes are not possible at any location, consider implementing the following measures:

- Assemble a slide show with an accompanying audiotape for private learning.
- Check into the costs of conference calling for use with a slide show.
- Use e-mail discussion groups with case studies to help develop problem-solving skills.
- Develop audiotapes with relaxation strategies, imagery/visualization scripts, labour rehearsals, etc. for dissemination to couples.

Doula Concerns

- Develop strategies in the event you are not allowed into the hospital.

- Include mention of these contingencies in any waiver or contract you use with clients.
- Model all support behaviours and comfort measures for the woman's partner to the extent that they have developed the necessary skills for use during labour.

Summary

The SARS crisis was a serious public health emergency in Toronto. Everyone was caught off guard and needed to scramble for alternatives to their care routines. The full story on SARS is still unfolding. Epidemiological data need to be analyzed; vaccines, if possible, need to be developed; causative agents need to be identified; and treatments need to be developed. The Toronto SARS epidemic in 2003 was an event of historical significance for the public health systems throughout the world, and rich research possibilities now exist because of this event.

The full story on SARS is still unfolding.

Many patients, from those waiting for elective surgery to those awaiting treatment of diverse diseases, were left with few medical resources. Expectant couples were also left adrift with no opportunities for childbirth education. It was interesting to observe that, when brainstorming the components of an ideal birth, for the first time in many years the couples identified "father at birth" on the list and, for the first time ever, "no SARS."

The Prenatal and Family Life Education Programme continued to run because of our deep belief in the importance of childbirth education. Many lessons were learned, some through trial and error. We have now weathered the storm, and classes are once again being held in the hospital environment. Things will never be "back to normal" because we are now much wiser about how to manage in the face of global health threats. It is naïve to think that we will never be in this position again. Developing strategies now for future contingencies is good programme management. Other crises will occur,

and being prepared with a comprehensive “disaster plan” will make transitions much easier.

Acknowledgments

I acknowledge the outstanding commitment of Denise Hoo Ellis, Programme Manager of the PFLEP, and teach-

ers Pat McCarthy, Sandi Cole, and Anne Marie Desjardins.

Reference

Lamaze International. (1993). *Philosophy of birth*. Washington, DC: Author. Retrieved June 2, 2003, from <http://216.119.92.84/About/documents/Birth.pdf>