Every Change Needs a Champion

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ABSTRACT

Lamaze International is pleased to launch the newly revised and updated (as of May 2007) six care practice papers that synthesize best practices that promote, support, and protect normal birth, bonding, and breastfeeding for pregnant women and their support teams. The updated six care practice papers are available as resource materials to start and support conversations of change. Childbirth educators are encouraged to be change champions and to incorporate the six care practices into the maternity care that women receive in their communities.

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Detailed and evidence-based descriptions of all of Lamaze International's updated six care practices are presented in this issue of The Journal of Perinatal Education (see pp. 11–43).

The Six Care Practices That Support Normal Birth have guided the work of the Lamaze Institute for Normal Birth over the past 4 years and have proved to be an invaluable resource for childbirth educators, other birth professionals, and, most important, childbearing women. Lamaze International is pleased to launch the newly revised (as of May 2007) care practice papers that synthesize best practices that promote, support, and protect normal birth, bonding, and breastfeeding for pregnant women and their support teams. The updated six care practice papers have been developed as resource materials to start and support conversations of change. Soon, the Lamaze Institute for Normal Birth will launch a full set of tip sheets based on the six care practices for expectant women and their support teams, as well as provide sample policies and/or protocols for care providers and hospital administrators. Lamaze International's goal is to continue to support all of you as you lead change to maintain best practices at the local level.

When we read the updated care practice papers, it is obvious and troublesome that, 4 years after their first publication, major gaps continue to exist between what the research demonstrates and the care women report they receive when they give birth (Declercq, Sakala, Corry, & Applebaum, 2006). Let's all work to make sure that, 4 years from now, we will see the research-to-practice gap reduced.

FORCES FOR CHANGE

For many reasons, there is no better time than now to be change champions and let our voices be heard. The public is more aware now than they were 4 years ago that there are many flaws in our health-care system, that much of the care provided in hospitals is not based on evidence, and that many providers exhibit poor performance that leads to poor outcomes (Institute of Medicine, 2001). We can add power and pressure to the quality movement by working to include maternity-care measures in the national quality agenda. Specifically,

we can insist that there be better alignment between quality and incentives (e.g., pay-for-performance for vaginal births rather than increased reimbursement for cesarean sections); that the quality indicators be evidence-based (e.g., eliminate the routine use of continuous electronic fetal monitoring in low-risk populations); that there be public disclosure (e.g., identify which hospitals have the highest third- and fourth-degree laceration rates); and that there be increased transparency of care and outcomes.

Many corporations, insurance agencies, government agencies, accreditation agencies, providers, advocates, and hospital administrators are deeply committed to quality care and to aligning practice with the latest evidence.* Unfortunately, there are also many forces at work to silence us and to discourage our change-champion efforts. Forces that hamper our efforts may be both internal and external.

INTERNAL FORCES PUSHING AGAINST CHANGE

Sometimes, we are our own worst enemy: We silence ourselves. The reasons we silence ourselves vary: We may remain silent because we lack confidence that we can make a difference, and we are afraid that the forces against us are too great and that our efforts are not going to make much of a difference anyway. Margaret Mead pointed out how powerful individuals and small groups are, not simply at changing a hospital, but in *changing the world* when she said, “Never doubt that a small group of thoughtful,

committed citizens can change the world. Indeed, it is the only thing that ever has.”

EXTERNAL FORCES

Powerful external forces are working to silence our voices. We all have witnessed the significance of the outside pressures from providers and hospitals. It is difficult for an individual childbirth educator to stand firm, to work incrementally and strategically for change within a hospital, and to push for change with the physicians on whom they depend financially for referrals to their classes. However, the outside pressure on childbirth educators to remain silent is an indication of the amount of power we have and the power of our words.

When I was the director of nursing for two hospitals in New York City, one of the changes I made was to keep mothers and babies together. I asked the childbirth educators to help me move the change forward by informing patients during childbirth classes about the new policy that their healthy babies could stay with them throughout their hospital stay and never needed to go to the well-baby nursery. The childbirth educators were excited and also hesitant to change what they were teaching because they were afraid that they would change patients’ expectations, that there would be serious push-back from the nurses and doctors, and that the nursing staff would disappoint mothers by not complying with their requests. I wanted to encourage patients to stand up for themselves and put pressure on the system to change. What this story illustrates is what most childbirth educators, hospital administrators, and providers know: *What childbirth educators teach women affects how women respond to and understand their birth experiences.*

We have to wonder about the values of a system that pressures childbirth educators to skew what they teach in order to make patients more compliant. We also need to wonder what it does to the heart and souls of childbirth educators who silence themselves and allow themselves to be co-opted into misrepresentation or withholding of information about the latest research evidence and the wisdom of women after centuries of childbirth. We know that childbirth educators helped change hospital practices in the past and that childbirth educators can truly mobilize communities. For example, fathers are now allowed to be part of the birth experience, and women who give birth vaginally are no longer routinely strapped down.

For more resources and to download a copy of each updated care practice paper, visit the Lamaze Institute for Normal Birth link at Lamaze International's Web site (www.lamaze.org).

* Some specific examples of this are: 1) The Leapfrog Group is coordinating efforts with corporations around the country, and Suzanne Delbanco, PhD, CEO, told me on May 21, 2007, that maternity care is a great interest of their work and of the corporate leaders they represent; 2) The Institute for Healthcare Improvement’s perinatal bundles are focused on improving family-centered care and lowering the rate of induction; 3) The Maternal Child and Adolescent Health/Office of Family Planning Branch, California Department of Health Services, has started the California Maternity Quality Care Collaborative, a statewide quality-care collaborative to improve maternity care for the approximately 350 hospitals in California where women give birth; 4) The Coalition for Improving Maternity Services is working on making maternity outcomes more transparent; 5) The Association for HealthCare Quality and Research, a government agency, is devoted to improving health care; and 6) The California Hospital Assessment and Reporting Taskforce recently added publicly reported maternity quality-indicator rankings on all hospitals in California.

We also know that changing a culture or an organization requires action and the effort of brave and determined individuals who are willing to “drive” ideas forward and be “change champions” (Buchanan et al., 2005; Rogers, 2003). Change begins through relationship-based efforts of individuals who are willing to start conversations of change (D. Ford & L. Ford, 1995).

Some simple opportunities for each one of us to be strategic change champions and to start conversations of change that promote evidence-based maternity care include:

1. Speak up and correct misinformation. For example, every time someone tells us that the high cesarean rate is due to patients’ choice, we need to reply that this is not true. The evidence shows that the rise in cesarean sections is most affected by how labor is managed, by the lack of informed consent for patients regarding risks and benefits of surgical birth, and that “maternal request” for medically unnecessary cesarean surgery is extremely rare (Declercq et al., 2006; Main et al., 2006; Weaver, Statham, & Richards, 2007).
2. Tell women, hospital administrators, and providers the truth about the research evidence. You can do this easily by explaining and distributing Lamaze International’s six care practice papers.
3. Find like-minded people who you can partner with and who will support you. Perhaps there is a grassroots birth network in your community. If not, consider starting one.
4. Find or design a principled work environment where you can practice in a manner consistent with the evidence and your personal ethics.
5. Be brave, strategic, and creative in sharing information with women, providers, and hospital administrators (Bingham, 2005a).
6. Find something you want to change and start to work on it. Big changes are made by taking small steps.
7. Mobilize the community to help work toward change (Bingham, 2005b).

Spreading ideas has the power to change what people do and think; when people think differently,

they see the world differently and will act differently (Weick, 1979). The power of one individual to shift a conversation, to help people see new things, and to implement change should never be underestimated. Every change needs a champion. *What changes will you champion in your sphere of influence?*

REFERENCES

- Bingham, D. (2005a). Helping hospitals change: Part 1: What childbirth educators can do. *Journal of Perinatal Education*, 14(3), 39–44.
- Bingham, D. (2005b). Helping hospitals change: Part 2: Childbirth education techniques to empower women. *Journal of Perinatal Education*, 14(3), 51–55.
- Buchanan, D., Fitzgerald, L., Ketley, D., Gollop, R., Jones, J. L., Saint Lamont, S., et al. (2005). No going back: A review of the literature on sustaining organizational change. *International Journal of Management Reviews*, 7(3), 189–205.
- Declercq, E. R., Sakala, C., Corry, M. P., & Applebaum, S. (2006). *Listening to mothers II: Report of the second national U.S. survey of women’s childbearing experiences*. New York: Childbirth Connection.
- Ford, J. D., & Ford, L. W. (1995). The role of conversations in producing intentional change in organizations. *Academy of Management Review*, 20(3), 341–370.
- Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: The National Academy of Sciences.
- Main, E. K., Moore, D., Farrell, B., Schimmel, L. D., Altman, R. J., Abrahams, C., et al. (2006). Is there a useful cesarean birth measure? Assessment of the nulliparous term singleton vertex cesarean birth rate as a tool for obstetric quality improvement. *American Journal of Obstetrics & Gynecology*, 194(6), 1644–1651; discussion 1651–1642.
- Rogers, E. M. (2003). *Diffusion of innovations* (5th ed.). New York: Free Press.
- Weaver, J. J., Statham, H., & Richards, M. (2007). Are there “unnecessary” cesarean sections? Perceptions of women and obstetricians about cesarean sections for nonclinical indications. *Birth*, 34(1), 32–41.
- Weick, K. E. (1979). *The social psychology of organizing* (2nd ed.). Reading, MA: McGraw-Hill.

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For information on how to form a birth network in your community, log on to the Lamaze International Web site (www.lamaze.org).