Evidence-Based Maternity Care: Can New Dogs Learn Old Tricks?

Marilyn Curl, CNM, LCCE, FACCE

Judith A. Lothian, PhD, RN, LCCE, FACCE

ABSTRACT

In this article, a Lamaze Certified Childbirth Educator describes her efforts to change the culture of birth in a community hospital in a small Midwestern town. Her experience highlights the challenges and the frustrations involved in creating change. The authors reflect on ways to enhance the success of change and advocacy strategies.

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Over the years, *Navigating the Maze* has explored countless issues that challenge and frustrate childbirth educators and nurses as we work to advance normal birth, to ensure that all women have care that is evidence-based, and to change the culture of birth. Marilyn Curl has more than 30 years of experience first as a labor and delivery nurse and Lamaze Certified Childbirth Educator, and most recently as a midwife. In her latest position as a nurse-manager of a family birthing suite, her experiences highlight the challenges, some quite insurmountable, that we meet when trying to create change in the current maternity care system. Her story provides insights into the challenges including what works and what does not and how we might increase our chances of success as we take on the challenge of changing the culture of birth and providing maternity care that is evidence-based.

MARILYN'S STORY

It seemed like a great match—a magnet hospital with a nurse-driven commitment to evidence-based practice. For the first time in a nursing career spanning more than four decades, I was truly the oldest nurse in the department. I was also the most educated with a graduate degree in nursing and certification as nurse-midwife. Knowing that retirement age was rapidly approaching, I was ecstatic when I was offered the position of manager of the Family Birthing Center (FBC) in a community hospital about an hour away from my home. I wanted to finish out my nursing career where it began—at the bedside of laboring women. With a naïve optimism that embarrasses me now, I hung my “Trust Birth” poster in my office and prepared to guide this group of nurses as they created the perfect place to have a baby.

In 2004, I wrote, “The exceptionally well-written and meticulously researched care practice papers published by Lamaze International could and should

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become the foundation for all childbirth education. They should also serve as a wake-up call for labor and delivery nurses.” (Curl, Davies, & Walsh, 2004). The nursing process has always been the same: assess the situation, make a plan, evaluate the outcome, and modify the plan as needed until the desired outcome is achieved.

In my new role, the first step was to assess the extent that practice was evidence based and how many of the Lamaze care practices for safe, healthy birth were actually part of the standard of care (Lothian, 2009; Romano & Lothian, 2008).

Safe, Healthy Birth Practices: Assessing the Family Birth Center

In contrast to a growing national movement away from elective induction of labor, the physicians in this hospital refused to approve a policy that prohibited nonmedically indicated inductions and scheduled cesareans before the start of the 39th gestational week. The policy, called a “hard stop,” is considered essential for patient safety. They did support a policy allowing a “high-dose” Pitocin protocol that has been associated with hypoxia and fetal distress (Kunz, Loftus, & Nichols, 2013). The cesarean rate fluctuated slightly but was never less than 30%.

Women were not prevented from ambulating during labor but the practice was not encouraged either. Continuous fetal monitoring was the norm and the concepts of intermittent monitoring were poorly understood. Women were being instructed to remain on their backs to ensure that the electronic tracing was good quality. Many of the staff nurses were unsure about the process used to palpate for contractions, relying instead on technology. In some cases, the laboring woman was not believed when she said she was feeling contractions because the monitor did not show contractions.

At the time of my hiring, the staffing guidelines recommended by the Association of Women’s Health, Obstetrics, and Neonatal Nurses (AWHONN) had been given approval by the Chief Nursing Officer (CNO). This meant that labor nurses were assigned only one patient allowing them the time to provide continuous labor support. Despite strong encouragement to remain at the bedside, most nurses remained tethered to the central monitoring station.

Continuous support during labor was undervalued and epidurals were generally encouraged by the

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nurses. The epidural rate was consistently around 80%. At the insistence of the anesthesiologists, clear liquids were the only nourishment allowed during labor.

Everyone received intravenous fluids, Foley catheters were anchored without offering alternatives, all babies were admitted to the nursery for transitional observation or bath, and any deviation provided an excuse to keep the baby in the nursery for the first 24 hours. My request that the unit practice committee look at best evidence to develop a new policy limiting the routine use of rectal thermometers resulted in a six-page letter to the Chief Executive Officer (CEO) written by one of the pediatricians and sent to every physician privileged in the Family Birthing Unit. The intent of the letter was clear and had been written with the encouragement of some of the nursing staff who apparently felt that *talking* about change was as threatening as change itself.

Birthing beds were used with leg supports and sterile drapes. Coached pushing was consistently used with the obligatory counting to 10 routine and audible from the hallway.

Mothers and infants were routinely separated for various reasons—pediatricians insisted exams could only be done in the nursery, night staff encouraged babies be placed in the nursery to allow mothers to “rest better,” and routine lab draws were best done away from parental supervision.

Exploring the Reasons for the Lack of Evidence-Based Care

Identifying the issues, and there were many, was only the first step. Correlating them with an underlying reason came next. It soon became obvious that changing the culture of birth was going to be extremely difficult, in part—I began to suspect—because of the demographics of the staff.

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The Lamaze Healthy Birth Practice papers and accompanying videos can be accessed at <http://www.lamazeinternational.org/HealthyBirthPractices>

Working outside of a clinical setting for the previous 3 years, I had no first-hand knowledge of the changing demographics among nurses, although I had attended several conferences where generational differences were being discussed. Some of the earliest research identified four generations in the workplace for the first time in history (McNeill, 2012).

- Traditionalists – born before 1945
- Baby Boomers – born between 1946 and 1964
- Generation X – born between 1965 and 1980
- Generation Y – born since 1980

There were 37 registered nurses and 6 support staffs under my supervision ranging in age from early 20s to early 60s. There were no nurses in the FBC from the traditionalist group though the hospital itself had several employees in their early 70s. Less than 20% of the labor and delivery staff members were identifiable as “Baby Boomers,” despite national estimates that nearly 50% of the working registered nurses may fall in this age range in part because of not retiring or returning to the workforce later in life (Buerhaus, Staiger, & Auerbach, 2004). A similar number met criteria for Generation Y. Most appeared to be daughters of Baby Boomers collectively called Generation X.

Nearly every nurse in the Family Birthing Unit had been born and raised in this small Midwestern community. They had all attended nursing school within a few miles of their hometown. Almost none of the nurses had ever been employed at another facility. A shared history was the “super glue” holding this unit together. One part of the history was shared with me during my first week: A previous manager had come in and started making changes right away but she didn’t last too long in the role. The next manager was hired from within the unit and she transferred to another position because of pressure to improve patient satisfaction scores. I was the third manager hired in the last 8 years and was clearly an outsider. Retrospectively, I should have had a clearer understanding of the expectations of my role and what kind of support my own

manager would be providing me in meeting those expectations.

As a Baby Boomer myself, I had been trained to respect authority (or at least, to *act* respectful). In this hospital unit, most of the staff made it clear that respect did not come with the position but was to be *earned* and meted out according to an unknown standard. It did not appear to be based on education, experience, or credentials. I realized very early that this was not directed toward me personally—there was an undercurrent of what appeared as disrespect that moved up the hospital hierarchy to its highest levels. When the CNO stood at the desk, staff finished personal conversations before acknowledging her. As I interacted with other departments and other managers, a common thread was “You work in FBC? Good luck with that.” The nurses in the birthing center had a hospital-wide reputation that was not very positive. In the past, I had been considered effective at building relationships with coworkers, another attribute of the Baby Boomer generation. Most of the staff had relationships with each other that did not include me or the few other nurses my age. They used social media to complain about the management in posts to “friends.”

Generation Xers were the nurses who embraced 12-hour shifts and continue to believe that they should be mandatory despite a growing body of evidence that demonstrates patient safety is enhanced by traditional shift assignments (Stimpfel, Sloane, & Aiken, 2012). The full-time staff worked 3 days a week and expected them to be consecutive, a practice that provided full-time pay for essentially part-time hours. This schedule allowed them to be off for extended periods without using paid time off (PTO). In an intergenerational impasse, the nurses who worked 12-hour shifts grumbled when staff assignments had to be reconfigured to accommodate the shorter shifts that the Baby Boomers preferred. Frustration was heightened during the holidays when the Baby Boomers were scheduled their usual 8-hour shifts and the younger staff were scheduled their usual 12-hour shifts. Even though “fairness” is a quality that all three generations valued, how the quality was defined seemed to be elusive. These were issues that might have best been addressed when 12-hour shifts were first introduced. Another gap was education and training in this specialized area.

Although not explored in the literature, I began to wonder if it is possible that the transi-

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tion from 8-hour shifts to 12-hour shifts has had an impact on the acquisition of the skills needed to become proficient in the birthing suite. From an educational perspective, compressed periods of learning followed by extended time off may not be optimal for retention of information. Unlike our counterparts in the United Kingdom, nurses in the United States who want to work in a birth setting are not trained as midwives. Instead, they are educated as generalists and receive training when they are hired into a position in labor and delivery. In contrast to most of the nurses in the department who were oriented while working 12-hour shifts, 3 days a week, the few remaining Baby Boomer nurses had honed their skills caring for laboring women day after day (or night after night, in most cases). They learned to differentiate between normal and abnormal labor patterns. Relying on their senses, rather than technology, they spent hours at the bedside gently probing the uterus as it contracted with precise regularity. They learned to listen to the fetal heartbeat following contractions using a specially designed stethoscope. They learned that labor progressed faster when women were encouraged to change position regularly and to keep their bladders empty to facilitate descent of the baby. They learned to increase comfort by applying counter-pressure to relieve back pain. The cesarean surgery rate was less than 5%, breech babies were still delivered vaginally, and episiotomies were performed on all first-time mothers. These nurses learned to welcome families into the delivery room and later helped design the earliest birthing suites. They moved from handwritten documentation into the world of electronic medical records. Eventually, they became experts in regional analgesia and recognized the cascade of intervention that followed. They accepted change as inevitable and moved on—another common characteristic of this group.

Most of the nurses in the unit had been trained by the same Generation X nurse, an acknowledged informal leader who was by her own description “just not a morning person” even though she filled a coveted position on days. Her surly demeanor set the mood during shift hand-off. Coworkers just tiptoed around her for the first 2 hours. She was also the instructor for the fetal monitoring program and considered the expert on the computerized labor documentation system. Consistent with other Generation Xers, she

was independent and believed in autonomous decision making for patient care. The physicians preferred her to all the other nurses. She valued teamwork but insisted on choosing her own team. During my tenure as manager, I was never able to understand what I needed to do to “earn her respect.” Directed by my immediate supervisor to discuss her unacceptable patterns of behavior resulted in accusations that she was being bullied and verbally harassed. I was sent to leadership class to improve my communication skills. When three new graduate nurses were scheduled for orientation with other nurses (Baby Boomers), it was perceived as retaliation but my rationale was valid. Unlike most of their coworkers, these nurses remained at the bedside of the laboring woman, providing education and support to the entire family. When patient assignments were being made, they requested the woman with a birth plan who hoped for a natural birth experience. They taught childbirth classes on their day off and volunteered for committees and special projects. They worked extra shifts to cover unit needs and supported me in my role as unit manager. They “got” birth.

Working with these new graduates was positive for both the experts and the novices. They learned from each other. Although inexperienced in maternity services, they were enthusiastic and confident about becoming labor nurses. Like sponges, they pulled in information from everyone around them. They helped each other and anyone else who needed assistance. I began to believe that this generation could, in fact, change and reclaim the culture of birth. Their Generation X counterparts remained tethered to the central monitor and continued to get an adrenalin rush from every emergency cesarean surgery, but their influence was limited. Given the opportunity to choose between tradition and technology, Generation X chose technology but Generation Y on this unit chose tradition.

The full picture of Generation Y is still being painted. They will be the most educated generation in history. They are choosing nursing because it calls to them, not because they have no other options. They have been shaped by technology and have demonstrated a willingness to share their skills with others. Like the generation that preceded them, they need feedback from strong leaders who can provide them with clear expectations. In the FBC, the Generation Y nurses demonstrated that

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they have the willingness and desire to learn new tricks from “old dogs.” They also demonstrated that they had the patience and skills to teach old dogs some tricks of their own. They eagerly shared their expertise in all things computer related. Despite their inexperience in labor and delivery, they knew the research and possessed an up-to-date body of knowledge in many other areas of nursing. This benefits everyone, including the patients (Chichester & Dennie, 2010).

After 16 months, my position as manager was eliminated. My duties were reassigned to a nurse on the older side of the Generation X group who has been employed by the hospital for her entire adult life moving from nursing assistant to licensed practical nurse to registered nurse. Last year, she completed her baccalaureate degree thus becoming eligible to enter the management circle. Her insider status will be both a blessing and a curse.

Small Successes

During my time as manager, the Unit Practice Council (led by a Baby Boomer) provided strong evidence in support of prolonged, sustained skin-to-skin contact between mothers and infants leading to a policy change that had not yet received physician approval. A planned renovation will establish space in each postpartum room for baby exams to be completed. Patient satisfaction scores refused to rise and an outside consultant is being brought in to provide direction. The number of early elective inductions decreased significantly to the relief of the Director of Risk Management and to the Director of Continuous Quality Improvement.

Change is never easy. It is facilitated by a clear vision from top to bottom. Without support from the people in authority, middle managers are powerless to make the necessary changes. Outside pressure

may reverse the trend of 12-hour shifts because patient safety in the world of maternity services grows in importance. This change alone could lead to a mass exodus of Generation X nurses who might lack the passion to remain.

Several of the powerful Generation X nurses were enrolled in graduate programs to become nurse practitioners. Despite encouragement from me, not a single one planned on specializing in women’s health or neonatal care. The local college offered a course in family practice and doing anything else was deemed “too hard.” They all planned to leave the FBC when they finished school. As those positions open up, they will be filled by a new generation of labor nurses who are being trained by the few remaining Baby Boomers. Several of those new nurses have long-term goals that include midwifery education, certification as childbirth educators, and having their own birth experiences. Generational conflict may be inevitable, but I see light at the end of the tunnel for childbearing families.

REFLECTING ON MARILYN’S EXPERIENCE

Marilyn’s insights provide some new ways of looking at the challenges of changing the culture of birth. Although it is always dangerous to generalize, the generational characteristics of nurses can help us understand just how complex implementing change can be. Marilyn’s experience suggests that generational differences did influence, to some extent, the culture of the unit, including the embracing of the 12-hour shift.

Generation Y nurses are better educated than the nurses who came before them and this will influence, I believe, nurses’ commitment to providing evidence-based care and advocating in powerful ways for their patients. Baccalaureate nursing programs emphasize research and evidence-based practice. It is not surprising, therefore, that the younger, better-educated nurses on Marilyn’s unit appreciated the Baby Boomers (whose practices we now know are indeed evidence-based). Like those older nurses, the younger nurses trusted birth. The novice nurses will require the support of like-minded nurses including the solid, relentless support of nursing leadership on the maternity unit and high-level nursing administrators.

Bingham and Main (2010) identify that knowledge, attitude, and practice are important barriers

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to implementing change in maternity units. Leaders and clinicians, not just nurses but physicians, must be knowledgeable about best practices, but that alone does not change beliefs and attitudes or practice. The more entrenched and comfortable for the clinicians the usual ways of doing things are, the more difficult it is to change. Marilyn's experience suggests that all three areas were problems.

What was also missing was strong leadership from the top. Without that support, it is extremely difficult to persuade staff nurses to think differently about birth and to do the hard work of changing practice. There needs to be an *expectation* that practice, supported by policies and protocols, will reflect best evidence. This takes time and commitment not just from the nurses at the bedside but from nursing managers and senior leadership. Without the expectation from the top, the nurse at the bedside may be reluctant to change and reluctant to "rock the boat," and with good reason.

In contrast to Marilyn's experience, the nursing leadership at New York University (NYU)/Langone Medical Center in New York City made a commitment to providing evidence-based care in maternity several years ago. The nursing leadership identified nurses at the bedside who would be "champions," and developed a plan to increase knowledge, change attitudes, and ultimately to change practice to reflect best evidence. Bingham and Main (2010) identify discourse (communication) and education as essential strategies when implementing change. One strategy that NYU used was to bring the Lamaze-sponsored *Evidence-Based Nursing and Labor Support* workshop to the hospital with the expectation that all the maternity nurses (labor and delivery and mother/baby) attend the workshop. The workshop is given at least twice a year. The workshop provides the opportunity for education as well as extensive discussion. The day-long workshop provides up-to-date evidence-based information, an opportunity for trying out labor support strategies, and, vitally important, begins the work of identifying what change is needed and how to go about making it happen. A good part of the workshop is dialogue and discussion: deciding what specific changes to work on, grappling with how to overcome barriers, and deciding how

A good part of the workshop is dialogue and discussion: deciding what specific changes to work on, grappling with how to overcome barriers, and deciding how best to communicate with other members of the maternity team

best to communicate with other members of the maternity team. Ongoing data audits provide support for the success of the implementation of the changes and ultimately the improvement of outcomes at NYU.

The focus on safety is pushing hospitals to take evidence-based practice in all areas seriously. Marilyn notes that the Director of Risk Management and the Director of Continuous Quality Improvement were pleased with the small decrease in the number of elective inductions. It is likely that pressure from those departments influenced the decrease in elective induction rates. Outside pressure from the Joint Commission and the National Quality Forum is likely to continue to influence institutional policy in important ways.

Marilyn's experience highlights the challenges at a point in time in one maternity unit, but reflects the challenges of the larger system. It is, as Marilyn came to understand, naïve to expect change to happen quickly. Change is a complex process requiring commitment and strong, relentless, creative leadership within the institution. Our efforts are now being pushed along by pressure from outside sources, like the Joint Commission and the National Quality Forum. Despite the challenges and the inevitable disappointments along the way, it is time to be hopeful and steadfast.

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Information about the Lamaze International's Evidence-Based Nursing Workshop and other continuing education opportunities for nurses and childbirth educators can be accessed at <http://www.lamazeinternational.org/Evidence-BasedNursing>

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MARILYN CURL is a midwife, childbirth educator, and labor and delivery nurse. She is a member of the Lamaze International Certification Council, and Chair of the Lamaze Program Accreditation Committee. She contributes on a regular basis to The Journal of Perinatal Education. JUDITH A. LOTHIAN is a childbirth educator in Brooklyn, New York, Chair of the Lamaze International Certification Council, and the associate editor of The Journal of Perinatal Education. She is also an associate professor in the College of Nursing at Seton Hall University in South Orange, New Jersey.