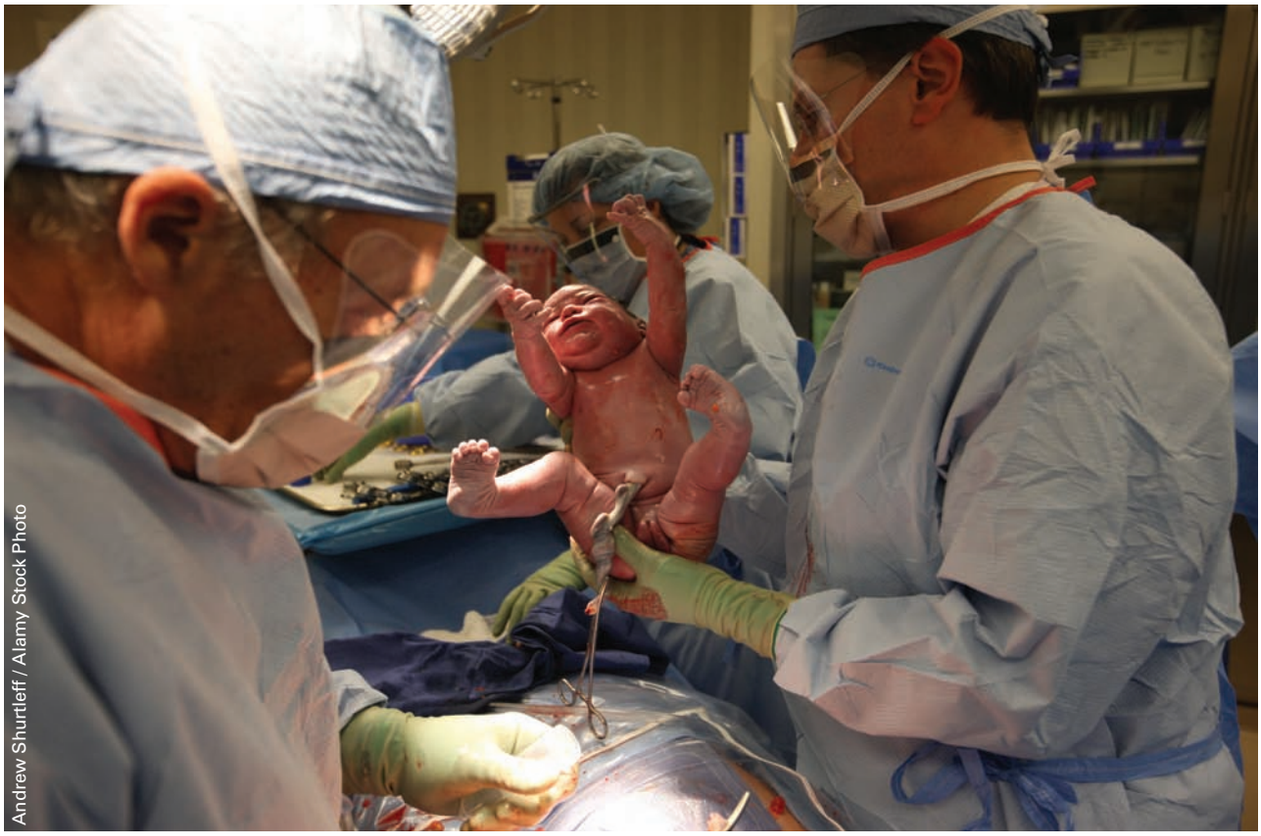

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LABOR NURSES' VIEWS OF THEIR INFLUENCE ON CESAREAN BIRTH

CE 1.5 ANCC Contact Hours

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Abstract

Background: As part of an ongoing study about nurse staffing during labor and birth sponsored by the Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN), outcomes that may be linked to aspects of labor nursing were considered. The purpose of this study was to see if labor nurses felt they influenced whether a woman has a cesarean birth. These data were used to determine if cesarean birth should be included as an outcome measure in the multistate labor nurse staffing study.

Methods: Focus groups were used to explore the role of labor nurses and cesarean birth. Participants were attending the AWHONN national convention in 2015. Two open-ended questions were asked: 1) Do labor nurses influence whether a woman has a cesarean? 2) What specific things do you do as a labor nurse to help a woman avoid a cesarean?

Results: Two focus groups were held (n = 15 and n = 9). Nurses overwhelmingly agreed nursing care can influence mode of birth. They described multiple strategies routinely used to help a woman avoid a cesarean, which were categorized into three main themes: support, advocacy, and interactions with physicians. Support was emotional, informational, and physical. Advocacy involved advocating for women and helping women advocate for themselves. Nurses tried to focus on positive aspects of labor progress when communicating with physicians. Descriptions of interactions with some physicians implied less than optimal teamwork and lack of collaboration.

Conclusion: Labor nurses are likely influential in whether some women have a cesarean. They reported consistently taking an active role to help women avoid a cesarean. Promoting vaginal birth as appropriate to the clinical situation was a high priority. Trust, partnership, and respect for roles and responsibilities of each discipline were not evident in some of the clinical situations nurses described.

Key words: Cesarean birth; Labor nurses; Nurse–physician communication; Nurse staffing.

Do labor nurses influence whether women have cesarean or vaginal birth? Because labor nurses spend the majority of time with women in labor compared with other members of the perinatal clinical team in most hospitals in the United States, it would seem that their care would be a major influencing factor. However, the decision for cesarean rests with the responsible certified nurse midwife or physician. Some researchers have attempted to quantify the role of the nurse in cesarean birth (Gagnon, Meier, & Waghorn, 2007; Gagnon & Waghorn, 1999; Gagnon, Waghorn, & Covell, 1997; Hodnett et al., 2002; Radin, Harmon, & Hanson, 1993), whereas others have used qualitative methods to ask nurses directly about their role (Edmonds & Jones, 2013; James, Simpson, & Knox, 2003; Simpson, James, & Knox, 2006; Sleutel, 2000; Sleutel, Schultz, & Wyble, 2007). Results have been mixed. Nurses have expressed opinions about their influence, but measuring it has proven challenging.

The largest study, a multicenter randomized controlled trial (RCT) of 6,915 women conducted in the United States and Canada, found no difference in the cesarean rate when comparing women randomized to one-to-one nursing care by a nurse specially educated in labor support techniques who was at the bedside at least 80% of the time after enrollment and women randomized to routine care during labor (usually involving the nurse having more than one patient) (Hodnett et al., 2002). This was a rigorously designed RCT with a large diverse sample of various types of units and patients. Women in the study had many medical interventions including continuous electronic fetal monitoring (77%), epidural anesthesia (75%), and oxytocin for induction or augmentation of labor (62%). The researchers concluded that continuous labor support by registered nurses was unable to overcome high rates of routine medical interventions and associated unit culture to affect method of birth (Hodnett et al.).

The Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN) has been sponsoring a multiphase study about nurse staffing during labor and birth since 2012 (Simpson, 2016). Various potential outcomes related to staffing were under consideration for inclusion as outcome measures in the next phase of the study, including cesarean birth. As part of the study, 11 focus groups of labor nurses were held, during which participants described numerous implications of inadequate staffing (Simpson & Lyndon, 2016). In the context of short staffing, labor nurses mentioned promoting vaginal birth, but did not specifically discuss their strategies to help women avoid cesareans (Simpson & Lyndon). Two focus groups of new mothers and two focus groups of physicians also were convened to include representatives from various stakeholders in the study of labor nurses and their potential to influence birth outcomes (Simpson). Both new mothers and physicians felt labor nurses played a prominent part in mode of birth (Lyndon, Simpson, & Spetz, 2016). In light of gaps in data about how nurses viewed their role in avoiding cesarean birth from the first set of focus groups of nurses, we chose to ask labor nurses explicitly about this issue. The purpose of this study was to determine if labor nurses felt they influenced whether a woman has a cesarean birth or vaginal birth and if so, what specific aspects of their care were involved. The plan was to use these data to inform the next phase of the AWHONN nurse staffing research.

Methods

Setting and Participants

Two focus groups of labor nurses were held at the annual AWHONN convention in Long Beach, CA, in June 2015. After obtaining institutional review board approval, nurses registered to attend two convention presentations focused on labor were recruited via an email that briefly explained the study. Inclusion criteria were 1) at least 2 years as a labor nurse and 2) actively caring for women in labor in a staff nurse role. Nurse managers, nurse educators, clinical nurse specialists, and other labor nurses in nonstaff nurse roles were excluded. The first 30 registrants who met inclusion criteria and agreed to participate were given instructions on timing and location of the focus groups. Participants were assigned to one of the two groups. An email reminder was sent 2 days before the sessions were scheduled. Lunch was offered as a token of appreciation.

Data Collection

Written informed consent was obtained and inclusion criteria were verified prior to beginning the

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Nurses offer emotional support, advocacy, and information on what to expect to women in labor as part of their efforts to help them avoid cesarean birth.

sessions. The following open-ended questions were asked of the participants in this order: 1) Do labor nurses influence whether a woman has a cesarean? 2) What specific things do you do as a labor nurse to help a woman avoid a cesarean? Once discussion of first question was complete, the second question was asked. Field notes were taken and focus group discussions were audio recorded and transcribed verbatim. All participants' potentially identifying information was deleted. The two investigators alternated between observer and focus group facilitator.

Analysis

We reviewed the transcripts and the field notes taken as observers. Data were analyzed using inductive coding methods (Hesse-Biber & Leavy, 2004) and thematic analysis of responses (Braun & Clarke, 2006). These methods were used to seek understanding from the perspective of nurses directly involved in care of women during labor how they felt about their role in whether a woman has a cesarean birth. Key ideas and quotations generated from the data were merged. Themes were identified, reviewed, and refined in an iterative process until consensus was reached on analysis. Credibility of findings was supported by consistency of themes identified independently by the researchers from the data.

Results

Two focus groups of labor nurses were held with 15 nurses in the first group and 9 in the second. Participants were very experienced nurses ranging from 7 years to 36 years of experience as labor nurses and 10 to 46 years as nurses (Table 1).

In both groups, there was an immediate general consensus that labor nurses influence whether a woman has a cesarean birth. Participants were eager to share strategies they routinely use to help women in labor avoid a cesarean. There were several comments that some women and some clinical situations warrant cesarean birth and the associated responsibilities to advocate for a cesarean in these cases to promote safe care. Discussions flowed freely with animated comments and enthusiastic participants. There did not seem to be any hesitation in sharing their thoughts even though participants did not know each other prior to the sessions. Participants represented 17 states in all regions of the country and various levels of perinatal services and birth volumes.

Themes

Actions and care that nurses provide to help women avoid a cesarean were classified into three themes: support, advocacy, and interactions with physicians.

Support

Three main types of supportive care were described by participants including emotional support, labor support techniques, and information support. Although similar in nature, there were distinct features of each.

Emotional support included making the woman feel safe, empowering her, reassuring her that she can do it, being continuously present, *bonding* with her, building trust, and caring for her as an individual. *Just being continuously present with the mom can really help her psychologically with her pain.* Nurses noted the calming effect they offered that was often needed for success. *They need you and they focus right on you and they're listening to everything you say. They need that calming.* Developing a trusting relationship was mentioned as a significant factor in being able to care for a woman in labor. *By the time she delivered, we had developed such a sense of trust because I think she really felt that I really cared about her and her experience.*

Table 1.
Years of Experience of Focus Group Participants

Years of Experience as Labor Nurse	*N* (%)
2 to 5 years	0
>5 years to 10 years	5 (20.8)
>10 years to 20 years	9 (37.5)
>20 years to 30 years	7 (29.2)
>30 years	3 (12.5)
Years of Experience as RN	
2 to 5 years	0
>5 years to 10 years	4 (16.7)
>10 years to 20 years	7 (29.2)
>20 years to 30 years	6 (25.0)
>30 years	7 (29.2)

There was much discussion about various types of labor support techniques including ambulation, frequent repositioning, use of the peanut ball or birthing ball, passive fetal descent, hydrotherapy, giving the woman enough oxytocin but not too much, and letting women know that pain medication is sometimes needed by revisiting the options for pain relief. Repositioning and ambulation were considered to be essential for labor progress. *Definitely position change works. That peanut ball is awesome. You know this baby is OP or OT, so you do the things you know with labor support to assist that baby's rotation coming down.* Nurses reported taking an active role in encouraging both. *Rotating her side to side often, then position changes and if she doesn't have an epidural, assisting her with ambulating. We use a telemetry monitor if she can get on the birthing ball; we get her in the shower.* A number of nurses mentioned using a holistic approach to labor care. *I look at the four P's, the power, the passenger, the pelvis and her psyche.*

Passive fetal descent in second-stage labor generated a lot of discussion within the theme of labor support and in communication with physicians.

> *Laboring down in the second stage is important. A lot of physicians, especially those that are more old school, want active pushing right away. Some women and babies just cannot handle active pushing for prolonged periods, so nurses are huge advocates for laboring down.*

Careful titration of oxytocin to promote labor progress to vaginal birth, but avoid complications was discussed in detail.

> *Use of Pitocin effectively and correctly, not oversaturating her uterus, but at the same time, giving*


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Common labor support techniques include frequent repositioning, ambulation, the peanut ball, hydrotherapy, and passive fetal descent.

her enough so that a physician doesn't come in and say, "Okay, I need to go home. She needs a c section," and as a nurse, I didn't give her enough Pitocin and she never really got an adequate labor, so now she had a cesarean.

Nurses felt that women in labor may not have all of the facts they need to make decisions and to know what to expect. Nurses offered informational support by fully explaining what was going on, preparing women for the unexpected, and keeping women and their families up on all options as labor progressed. Better education in the community during the preconception and prenatal period and more participation in prepared childbirth classes were thought to be ways to better inform women about labor.

Nurses can educate women that instead of looking at the hospital that's the prettiest, what's their cesarean rate? Do they allow you to have the type of birth experience that you want? Can you get in the tub?

Setting that expectation before they come to the hospital that childbirth is normal. Your body was created to do this. Your body knows what to do. You can move, because it can be very intimidating when we strap them down with all these monitors and then expect them to change positions. The nurse's role in patient education prior to birth makes a big difference.

Patient education in the hospital was cited as important for helping women know what to expect with labor and if there are potential complications.

Triage is an opportunity for education. Patients ask "How will I know when to come back?" When you explain the labor process to them, one patient said, "Wow. No one's ever told me that." All they want to know is what's going to happen.

Several participants indicated they often warned women what might happen if more caregivers rushed into the room, if needed, for changes in the fetal heart rate tracing or for neonatal resuscitation. *Preparing them for the unexpected is important so they know the neonatal team might come in at birth if needed.*

Advocacy

Nurses mentioned advocating for women's wishes, speaking up on behalf of women, coaching women to advocate for themselves, empowering women to say what they want to the physician and be able to say "*I don't want a cesarean right now,*" helping to prevent interventions that can *lead down the wrong path*, and advocating not to admit women too early to the hospital when they are not in active labor. There seemed to be an equal mix of comments about helping women to advocate for themselves and advocating for women on their behalf. Nurses reported encouraging women to feel that they *could do it* so they were able to articulate that clearly to the physician when there was consideration for a cesarean. *The more you encourage her that she can do it, everything's fine, she's fine, baby's fine; that helps them so when the doctor comes in they feel empowered to say "I'm doing fine, I want to keep going."* Nurses spoke on behalf of patients to advocate for care they thought best to minimize risk of a cesarean.

Advocating to not admit them too early; maybe they're four centimeters as a multip but they're obviously not in active labor. And so if someone arrives and gets admitted, then they're tied there. They don't have the same freedom. So advocating for them by telling the physician "Why don't you send her home? She lives five minutes from the hospital, she's been 4 centimeters for a week now, this isn't a change."

Dynamics of Nurse–Physician Interactions

The tone and content of the discussions about physicians suggested that nurses did not always believe physicians and nurses had the same goals for the woman they were both caring for during labor. The comment of one participant reflects the overall views expressed by nurses in both groups. *Sometimes we're working around them rather than with them.* Nurse midwives were not mentioned. Communication with physicians was described as careful-

ly crafted messages with selected information that promoted positive aspects of labor progress and more time if needed to achieve vaginal birth. Discussions reflected a level of mistrust of some physicians by nurses. Nurses felt some physicians were too quick to perform cesareans. Prominent topics included avoiding the appearance of questioning physicians' authority, speaking about patients in private, keeping physicians updated but away from the bedside as much as possible to avoid perceived unnecessary interventions, and not being completely truthful about labor progress to avoid pushing when conditions are not perceived to be favorable for pushing.

Some of the nurses wanted more autonomy than their physician colleagues were willing to allow, whereas others felt they were able to make important decisions about labor management. *Physicians should not be micromanaging the labor (Why is she on her side?; Why does she have that ball?; She needs a section because it's been 4 hours and she's not complete yet).* Nurses recognized there were differences among individual physicians that influenced nurse autonomy. *There are some doctors I can sit and talk to and they will listen to me. Then there are other doctors that say, "But I'm the doctor."* Those differences also were related to unit culture.

> *How much you can help a woman depends on the culture where you work. I've worked in places where physicians say call me when you see hair that doesn't belong to her. Do what you can do safely and if you need me, I'm here. They give you a lot of autonomy.*

Some nurses described hierarchical communication styles that hindered open discussion when clinical conditions were deteriorating. *He said "I'm the doctor and I'm the captain of the ship." So I said to myself, "Well, you better get off your ship because it's sinking." Once he reviewed the tracing, we had a cesarean.*

Nurses were careful not to appear to be questioning physician authority while trying to advocate for their patient. Privacy during discussions about care options was seen as vital to getting what nurses considered was best for the patient. *Consult with them away from the patient; it goes better. They're more open to suggestion when you discuss things in private.* Discussions that may potentially involve a disagreement or conflict were thought to be best held out of patients' rooms. *I don't want them to feel like I'm trying to make him look stupid in front of the patient or questioning his authority.*

Keeping the physician out of the room was an often-mentioned strategy to avoid perceived unnecessary interventions including cesarean birth. *You have to approach it correctly to kind of keep them of out of the room.* Some nurses described going so far as to use misleading measures to delay the physician from seeing the patient until they had more time to progress in labor.

> *We would have our charge nurse page that particular kind of provider out of the room so that we could buy more time. "We need you to evaluate something, anything." "I just want to do a strip review with you." "What do you think? I don't understand these gases. Can you come explain?" "I need your expertise."*

Focusing on the positive aspects of labor and maternal–fetal status in communication was felt to be a key to success.

> *A lot of times it's not the information that we present to the physicians. It is how we present it. You can tell a physician you're having recurrent variable decelerations but with moderate variability and accelerations or you can tell him you're having recurrent variable decelerations.*

Withholding information or misrepresenting cervical status was discussed as one way to allow for passive fetal descent and thereby avoid a cesarean for "failure to progress," "arrest of descent," or "maternal exhaustion" in second stage.

> *You have to tell them nursing lies. You learn, pretty early on that technically she's complete but I'm going to say that she's 9 because she can labor down and I don't have somebody coming in and making me push. So you learn to just bend the truth a little bit in order to advocate for your patient because you know what the outcome is if you say she's complete.*
>
> *We will know that the patient's fully dilated. The patients will tell us they feel some rectal pressure. We'll know from the tracing and we won't let the physician know. We'll kind of just delay; "Oh yeah, finish your dinner time. We'll check her in a little while." So then instead of kind of making her fully dilated, when we know she's fully dilated, to give a little more time and then everyone's at the same understanding. He doesn't think she's fully or she doesn't think she's fully dilated and we know that they are and we're allowing laboring down if everyone's saying okay and doing okay.*
>
> *I hate that we're tricking them, but….*

Table 2. Techniques Used by Nurses to Help Women in Labor Avoid Cesarean Birth

Emotional Support (*You can do it. I'm here with you*)
Labor Support (Ambulation, Frequent Repositioning, Hydrotherapy, Peanut Ball, Birthing Ball, Passive Fetal Descent in Second Stage Labor, Appropriate Titration of Oxytocin for Induction and Augmentation of Labor)
Information Support (Sharing Adequate and Accurate Information about What to Expect)
Advocating on Behalf of Women
Preparing and Encouraging Women to Advocate for Themselves
Communicating with Physician Colleagues on Positive Aspects of Labor Progress

Discussion

Labor nurse participants in this study were quite vocal in expressing their opinions that they influence whether or

Clinical Implications

Labor nurses felt strongly that they significantly influenced whether a woman in labor they were caring for had a vaginal birth or cesarean birth.
Labor nurses use multiple strategies to promote vaginal birth and avoid cesarean birth including support, advocacy, and encouragement.
Labor support techniques are commonly used to help with normal labor progress.
Communication between physicians and nurses during labor and birth described by participants was reminiscent of outdated physician–nurse interactions sometimes referred to as the doctor–nurse game.
Contemporary interdisciplinary communication involves open dialogue, healthy discussion, and transparency.
Based on participants' responses, cesarean birth may be a nurse-sensitive measure of care during labor and birth.

not women under their care have a cesarean. They clearly detailed various strategies and communication methods they used to help women avoid cesareans (Table 2). Our findings about supportive care such as specific labor support techniques, emotional and informational support, and patient advocacy were similar to those of other researchers (Edmonds & Jones, 2013; James et al., 2003; Lyndon et al., 2012; Simpson et al., 2006; Sleutel, 2000; Sleutel et al., 2007). Labor nurse–physician conflict is likewise not a novel finding (James et al.; Lyndon et al.; Simpson et al.; Simpson & Lyndon, 2009; Sleutel; Sleutel et al.). Misrepresenting cervical dilation in communication with physicians has not been discussed as much but is known to occur when nurses perceive that the physician being informed of accurate cervical dilation will result in undesirable consequences; for example, 3 cm means the patient is not yet eligible for epidural anesthesia; 10 cm will likely initiate an order to begin active pushing (Simpson et al.).

It was discouraging that highly experienced labor nurses in 2015 sometimes did not feel safe or valued enough as a colleague to honestly convey their opinions about how labor was progressing to physicians and what they could do together as a team to promote vaginal birth. Instead of straightforward communication, interactions reminiscent of the "doctor–nurse game" were described. Nurses reported that giving incomplete information or "fudging the facts" when communicating with some physicians seemed to be considered a reasonable approach when needed to achieve desired goals for patient care. Labor nurses were not always convinced that the physicians felt vaginal birth was as much of a priority as they did. Perceived physician impatience for normal labor progress and perceived tendencies toward unnecessary interventions were thought by some nurses to be obstacles that had to be overcome to stay on course for vaginal birth. Teamwork and collaboration toward a mutual goal were often missing.

Nurses have reported that the supportive aspects of care such as providing information, emotional support, and labor support techniques may be the first aspects of care that get delayed or missed when staffing is inadequate (Simpson & Lyndon, 2016). Together these findings support the contention that organizational factors such as short staffing impinge on nurses' ability to influence patient outcomes during labor and birth, including cesarean birth.

This study has limitations. Participants were labor nurses attending their professional association's national convention and likely highly engaged in keeping current with their nursing knowledge and skill. Participants' descriptions of behaviors may differ from their actual clinical practice. Social desirability bias can be a concern in focus group studies, and participants knew the investigators were in a research relationship with AWHONN. However, participants' frank discussions of sometimes deceptive practices suggest that desire to please investigators was not an overriding concern in these focus groups.

Clinical Implications

Labor nurses are likely influential in whether or not some women in labor have a cesarean. They reported routinely taking an active role in helping women avoid cesareans. Based on participants' responses, cesarean birth may be a nurse-sensitive measure of care during labor and birth; however, many of the strategies and actions identified by participants in this study would be challenging to measure directly. Trust, partnership, and respect for roles and responsibilities of each discipline were not evident in some of the discussions of clinical situations described by participants. Their accounts of communication with physicians were of concern because honest, accurate, and precise transfer of key clinical information between nurses and physicians during labor is critical to safe care. Despite considerable local, state, national, and professional association efforts at improving communication, teamwork, and safety in perinatal care, our results suggest more work is needed to enhance the contemporary nurse–physician relationship. Nurse and physician leaders need to role model effective respectful interdisciplinary communication and collaboration and take active steps toward improvement. Administrators must provide institutional commitment to and support for positive interprofessional relationships and infrastructure for continuous safety improvement. The best interests of mothers and babies are not well served when all members of the perinatal team do not share the same stated goals, are not communicating honestly, and are not working together to achieve the same outcome.

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