Intrapartum Nurses' Attitudes in Tertiary Care Settings

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Abstract

While childbirth and newborn care is one of the leading reasons for hospitalization in the United States (Wier & Andrews, 2011), the US maternal health system is in need of some advancement. A major issue surrounding maternity care in the United States consists of the medical field’s medicalization of the birthing process. Although technological advances surrounding maternal healthcare benefit those with high-risk pregnancies, they can hinder the birthing experiences of those with low-risk pregnancies (McCool & Simeone, 2002). A force in advancing the US maternal healthcare system, are intrapartum nurses working directly with patients, obstetricians, midwives, doulas, and administrators. These nurses can only help to cause a positive change if they have the attitude and behaviors that are favorable to that change. Using Dr. Icek Ajzen’s theory of planned behavior that states one’s attitude can explain his or her behaviors (Ajzen, 1991) as the theoretical framework, this paper describes the importance of maintaining favorable attitudes among intrapartum nurses in tertiary care setting to ensure the optimal birth experience for patients. This paper also examines the resources that must be established in tertiary care settings for intrapartum nurses to maintain such favorable attitudes surrounding the normalcy of birth (Turnipseed & Turnipseed, 1991; Ivancevich & Matteson, 1980; Lee & Ahktar, 2007). These resources include: continuous learning opportunities, clear job descriptions and performance feedback, supervisory support and counseling assistance programs, and team support (Ivancevich & Matteson, 1980; Lee & Ahktar, 2007).

Keywords: childbirth, medicalization, optimal birth, interventions, nurse, attitudes, resources, labor and delivery, intrapartum
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Introduction

Childbirth and newborn care is one of the leading causes for hospitalization in the United States (Wier & Andrews, 2011). The quality of the maternal health system in the US is essential to ensure the vitality of our future population; however, the US maternal health system is in need of some improvement. As of 2011, when compared to countries with at least 100,000 births annually and a healthcare expenditure of at least $1,500 per capita on healthcare, the United States ranks last, (17/17), for the infant death rate (OECD, 2012; Hoyert & Xu, 2012; Declercq et al., 2014). How can a country with such an advanced healthcare system be leading in the infant death rate among similar countries? Many variables exist in this complex problem, including socioeconomic disparities, healthcare availability, medical training, and medical culture with no absolute solutions. Nonetheless, it is an interdisciplinary issue that must be addressed to ensure the advancement of quality healthcare.

A major concern surrounding maternity care in the United States consists of the medical profession’s medicalization of the birthing process. Through the years, the maternity care delivery system in the country has gone through great technological advances. Although these technological advances benefit those with high-risk pregnancies, they can hinder the birthing experiences of those with low-risk pregnancies (McCool & Simeone, 2002). The maternity care system in the US must create appropriate models of care for low-risk mothers. It must holistically assess and care for each patient while encouraging an interdisciplinary team, including doulas, lactation consultants, midwives, nurses, and obstetricians. Most importantly, the maternal health system must allow for patient autonomy regarding medical decisions and treatment.
Maternity healthcare has experienced many recent improvements. One example of an innovation is the acceptance of the Baby-Friendly Initiative among many hospitals, including 243 hospitals and birthing centers across the US (Baby-Friendly USA, 2015). The Baby-Friendly Initiative, a global initiative of the World Health Organization [WHO] and the United Nations Children's Fund, is aimed to promote breastfeeding and culturally sensitive care for new mothers and their infants. While this initiative is important for overall improvement in maternity care and newborn outcomes, it does not address the major issues surrounding the disparities in the maternal healthcare system. While the maternal healthcare system is making changes, the system is saturated in a medical culture that is stalling change (Martin et al., 2012; Agência Nacional de Saúde Suplementar, 2008; Malheiros, Alves, Tainara, Range, & Vargens, 2012).

For example, the National Vital Statistics Report found that the cesarean section rate has finally decreased to 32.8% in 2010 after sixteen years of increasing rates (Martin et al., 2012). Furthermore, in a study conducted by Malheiros et al. (2012), researchers found that healthcare providers admit to not following the recommended policies constructed by the World Health Organization to humanistically care for patients. These healthcare providers feel that there must be a change in the paradigm to adopt such practices.

The maternity care system must make a great change to modify the training of obstetricians in order to create appropriate models of care for low-risk mothers. It must also change to holistically assess and care for patients while encouraging an interdisciplinary team. It is essential that the maternal care system move away from the medical-illness model and observe birth as a natural process. Lower rates of intervention must be achieved, especially surrounding the rate of cesarean section. Additionally, more patient autonomy must be allowed regarding medical decisions and treatment. By reducing the rate of intervention, observing birth as a
natural process, and providing more holistic care, it is likely that maternal and neonatal outcomes will improve.

A major force in changing the culture of maternity care are intrapartum nurses working directly with patients, obstetricians, midwives, doulas, and administrators. Labor and delivery nurses can only help to cause a positive change if they have the attitude and behaviors that are favorable to that change. When looking at Dr. Icek Ajzen’s theory of planned behavior, it is explained that one’s attitude can explain his or her behaviors (Ajzen, 1991). The theory of planned behavior can also be used to illustrate a correlation between nurses’ attitudes and their behaviors in a clinical setting. As a result, it can be argued that nursing attitudes directly impact the rate of medical intervention and the quality of a woman’s birthing experience. Maintaining a knowledgeable, favorable attitude is the driving force of the nurse’s proficiency and advocacy on the labor and delivery unit (Blamer, 1999). A favorable nurse attitude observes birth as a natural process, allows for patient autonomy in treatment decisions, advocates for the patient within the healthcare team, and pursues knowledge surrounding current evidence-based practice. Unfortunately, these favorable attitudes can be difficult to maintain when working in a tertiary care setting, where a medicalized labor and birth is more prevalent because of the abundance of high-risk cases on the unit (Liva, Hall, Klein, & Wong, 2012; Behruzi, Hatem, Goulet, & Fraser, 2014). Resources must be established in tertiary care settings for labor and delivery nurses to utilize to maintain favorable attitudes surrounding the normalcy of birth and the advocacy of their patients to ensure quality care and improved health outcomes throughout the nation (Turnipseed & Turnipseed, 1991; Ivancevich & Matteson, 1980; Lee & Ahktar, 2007).
Methods

For this paper a literature search was conducted using PubMed, PsychInfo, CINAHL, and Google Scholar. The search terms used include: nurse attitudes, nurse perceptions, nurse burnout, rate of intervention, cesarean section rate, social cognitive theory, theory of planned behavior, medicalization, electronic fetal monitoring, epidural analgesia, humanization, labor and delivery, and intrapartum. Inclusion criteria consisted of full text, peer-reviewed journals and textbooks. Over 200 abstracts were reviewed and over 100 articles were used in this paper.

Background

Medicalization of Childbirth

In the nineteenth and early twentieth centuries, childbirth in the United States followed a ‘social childbirth philosophy,’ a philosophy common in the entire history of birth among most cultures (McCool & Simeone, 2002). This ‘social childbirth philosophy’ consisted of home births attended by supporting female friends, relatives, and midwives, all of whom sustained the strength and progress of the mother through this defining period of labor and birth (Papagni & Buckner, 2006; McCool & Simeone, 2002). The mother would labor down, independently progressing her labor through position changes and ambulation. Following the birth of her child, it was a custom for the mother to stay with her female support while she recovered and bonded with her newborn child (McCool & Simeone, 2002). During the mid-twentieth century, because of technological advancements and the insurgence of the educated male physician, birth switched from the social model to a medical-illness model. This model looked at labor as an illness that needed to be treated (MCool & Simeone, 2002; Davis-Floyd, 2001; Papagni & Buckner, 2006). The mother was anesthetized and unconscious while a male physician delivered babies in a
sterile environment (McCool & Simeone, 2002). Forceps began being widely used in the 1920s and anesthesia was almost exclusively used in 1940s and 1950s with women unconscious to their own birthing experiences (McCool & Simeone, 2002). This progression of technological advancements laid the foundations for the modern medical-illness model of the obstetric culture today. The increased technological advancements and use of interventions have benefitted women with high-risk pregnancies; however, it has caused more harm than beneficence for mothers considered low-risk (Yale, 2002).

The medicalization of birth was reinforced as providers began to face legal pressures of malpractice cases causing obstetricians to use “defensive practice” resulting in the use of excessive intervention (Johanson, Newburn, & Macfarlane, 2002, p. 893). Today, because of the medical-illness model of the obstetric culture as well as these legal pressures, the training of obstetricians now centers on the complications of the childbirth process rather than the natural female process (ANSS, 2008; Malheiros et al., 2012; Monari, Mario, Facchinetti, & Nittorio, 2008). Some experts say that this training results in the belief that all childbirth cases are a high-risk illness while only fifteen percent of all women develop complications (ANSS, 2008; Yale, 2002; Monari, Mario, Facchinetti, & Nittorio, 2008). Additionally, this approach to training may contribute to the culture of the medicalization of childbirth with the use of excessive intervention and the absence of holistic, quality care. There appears to be a difference in the perceptions of normal birth among the different maternal health care disciplines. For example, in a study by Monari, et al. (2008), researchers discovered that while two thirds of midwives perceived their unit’s cesarean section rate too high, only one third of obstetricians found their unit’s rate to be too high. Furthermore, this same study found obstetricians are less likely to suggest a vaginal birth after cesarean section (VBAC) than midwives (Monari et al., 2008). Training of physicians
must include the ability to treat all patients holistically and provide the best quality care instead of treating all patients as high-risk cases needing maximal intervention (ANSS, 2008).

**Excessive Intervention and Implications**

Authors have suggested that, as a result of the excessive use of intervention, there is an increase in iatrogenic morbidity and the dehumanization of care for laboring women (Villar, Valladares, & Wojdyla, 2006). This use of excessive intervention such as, analgesic epidurals, continuous fetal monitoring, and cesarean sections has been shown to prolong the labor process and resulted in negative physiological outcomes (Simkin, Whalley, Keppler, Durham, & Bolding, 2010; Jacobsen et al., 1990; Hale, 2008; Riffe, 2014; Alexander, Sharma, McIntire, & Leveno, 2002; Kukulu & Demirok, 2008; Ros, Lichenstein, Belloc, Petersson, & Cnattingius, 2002; Simpson, Lawrenson, Nightingale, & Farmer, 2001; Hebert et al., 1999; Allen, O'Connell, Liston, & Baskett, 2003; Thompson, Roberts, Currie, & Ellwood, 2002). More importantly, routine use of medical interventions has been shown to increase unnecessary risks to the women and infants of low-risk pregnancies (Simkin et al., 2010; Anim-Somah, Smyth, & Jones, 2011; Jacobsen et al., 1990; Hale, 2008; Riffe, 2014; Alexander et al., 2002; Kukulu & Demirok, 2008; Ros, et al., 2002; Simpson et al., 2001; Hebert et al., 1999; Allen et al., 2003; Thompson et al., 2002).

One intervention being commonly used across the United States is the analgesic epidural. The analgesic epidural is a pain-reducing technique involving the injection of an anesthetic into the lumbar region of the spine making labor pain less intense. In the national survey, *Listening to Mothers*, 2,400 English-speaking women who gave birth vaginally in US hospitals were surveyed about the use of interventions during their childbirth experiences. This survey found
that 83% of women elected to use some type of pain medication and 67% of mothers used an analgesic epidural (Declercq, Sakala, Corry, Applebaum, & Herrlich, 2013). While the availability of pain relief medications is an ethical right and a great source of relief for laboring women, obstetricians as well as patients must understand the possible side effects of these pain-reducing interventions before they are presented as an option.

Some studies suggest that epidural analgesia has many possible effects on labor, including a decrease in blood pressure, the inability to ambulate, a longer labor, a longer pushing period, fever, and the increased risk of Pitocin augmentation, vacuum extraction, forceps extraction, and cesarean section (Anim-Somah et al., 2011). In a systematic review involving 38 studies and 9,658 women, researchers Anim-Somah et al. (2011) found that the use of epidural analgesia offers great pain relief but is associated with an increased risk of assisted vaginal birth, decreased blood pressure, fever, urinary retention, longer labor, Pitocin augmentation, and an increased risk of caesarean section. As a result, informed consent should be standardized for all mothers and include: the nature of the proposed care, the benefits, risks, or side effects of the proposed care, the likelihood of reaching the goal of the proposed care, alternatives to the proposed care, the risks, benefits, and side effects of the alternatives to the proposed care, and limitations to confidentiality (Joint Commission on Accreditation of Healthcare Organizations, 2003). Healthcare providers must provide full disclosure to patients about all possible side effects before continuing with this pain relief method. The use of this written informed consent will allow mothers to receive more information about the potential risks of her choices in pain relief. One researcher found that information used by obstetricians and midwives to educate women before signing an informed consent lacked information on labor-altering effects and side
effects of pain medication. Healthcare providers are responsible for presenting all essential information for ethical care (Lowe, 2004).

Another intervention often debated is electronic fetal monitoring (EFM). EFM is a form of monitoring that tracks the infant’s heart rate while tracking the frequency and duration of maternal contractions. During this procedure, two monitors are attached to the mother’s abdomen and are connected to a machine via wires. EFM may either be continuous or intermittent. Continuous EFM requires that the mother be attached to the monitors throughout the entire labor, which can restrict mobility and options such as water therapy for the mother. Although continuous EFM is recommended for high-risk patients, it has become the standard of practice in the US for all laboring mothers. No evidence has been found to support the use of continuous EFM for low-risk patients (Lothian, 2014; Alfirevic, Devane, & Gyte, 2013; Devane, Lalor, Daly, McGuire, & Smith, 2012). In a systematic review, Alfirevic et al. (2013) found that among low-risk, high-risk, and preterm pregnancies, continuous EFM had no significant effect on perinatal death rate; however, continuous EFM did show a significant increase in the rate of cesarean section because of false interpretations of the EFM for emergent situations. Intermittent EFM is used in low-risk pregnancies, where the mother and fetus can be monitored intermittently depending on the healthcare provider’s orders. Intermittent EFM allows for more mobility and less restrictions for the mother. While there is an ACOG protocol for intermittent EFM with clear guidelines for low risk mothers, these protocols are not often implemented (ACOG, 2009; Malheiros et al., 2012). Furthermore, intermittent auscultation of fetal heart tones is recommended for low-risk mothers; however, researchers Declercq, Sakala, Corry, and Applebaum (2007) found that intermittent monitoring is only used for about 3% of laboring women in the US (ACOG, 2009). No studies indicate that EFM use reduces perinatal or
neonatal mortality rates (National Institute for Health and Care Excellence, 2007; Hale, 2008; Haverkamp, Thompson, McFee, & Cetrulo, 1976; Kelso et al., 1978; Haverkamp et al., 1979; Vintzeileos et al., 1993). Nonetheless, in 2002, researchers concluded that EFM is being used among 85% of laboring women compared to 45% in 1980 (Martin et al., 2003).

Continuous EFM has many side effects, including increased maternal anxiety, increased risk of cesarean section, limitations in ambulation and position changes, decreased pain tolerance and decreased ability for fetal rotation (Simkin et al., 2010; Riffle, 2014; Alfirevic, Devane, & Gyte, 2006; Ward, 2001). The potential additional anxiety as well as the inability to ambulate and increased pain caused by the EFM can also cause the shunting of blood away from the uterus resulting in fetal hypoxia (Ward, 2001). In addition, some experts question the use of continuous EFM as it does not directly measure fetal oxygenation status (Hale, 2008) and there are no strict guidelines and poor inter-observer consistency regarding the interpretation of the EFM (Riffle, 2014; ACOG Committee, & Macones, 2010; McKevitt, Gillen, & Sinclair, 2010; van Geijn, 2005). In a study conducted by McKevitt et al. (2010), researchers found that many experts agree that specialized skills, communication, and collaboration are needed to correctly interpret EFM. Furthermore, these experts expressed concern over the lack of evidence surrounding the use of EFM as well as the possible ‘false alarms’ resulting in unnecessary intervention and a disappointing birthing experience (McKevitt et al., 2010). False positives for fetal hypoxia and distress increase the risk for unnecessary and financially costly interventions, including cesarean section and extractions (Riffle, 2014; Jansen, Gibson, Bowles, & Leach, 2013; Equy, Buisson, Heinen, & Schaal, 2012; McKevitt et al., 2010). While EFM is a convenient tool for obstetricians and midwives to use, great thought and consideration must be given to its interpretation before intervening with the birthing process.
The most controversial intervention being used in the United States is the cesarean section. The World Health Organization has set a goal of a 15% cesarean section rate for first time births. After sixteen years of increasing rates, 2009 saw the first reduction in the rate of cesarean section at 32.8% since 1996 when the rate was at 21% (Osterman & Martin, 2014; Martin et al., 2015). From 2010 to 2012, the rate was stagnant at 32.8%. In 2013, the average cesarean section rate in the US dropped again to 32.7%—a second rate reduction (WHO, 1985; Martin et al., 2015). Furthermore, in 2013, the cesarean section rate for low-risk women (singleton, term, and vertex first births) was 26.9%, down from 27.3% in 2012. These reductions in cesarean section rate may be related to increased awareness among providers and a changing maternity care culture.

While cesarean section is a vital intervention in protecting maternal and fetal viability in high-risk cases, it is also associated with a high financial cost and increased physical risks for the infant and mother. The healthcare system must make reducing the rate of cesarean section a major priority. Cesarean sections are a costly intervention. The Truven Health Analytics group (2013) found that cesarean sections cost an estimated $13,000 per birth compared to an estimated $9,000 per vaginal birth for private insurers in the year 2010. Aside from increased cost, women who undergo a cesarean section are at risk for postpartum hemorrhage, infection, blood clots, and placental abnormalities (Ros et al., 2002; Simpson et al., 2001; Hebert et al., 1999; Owen & Andrews, 1994; Allen et al., 2003; Rossen, Okland, Nilsen, & Eggebo, 2010; Wu, Kocherginsky, & Hibbard, 2005). In a retrospective cohort study looking at an unselected population of 41,000 birthing women, researchers found that the risk of severe hemorrhage was twice as likely after cesarean section than after vaginal delivery (Roseen et al., 2010). Another study conducted by Leth, Moller, Thomsen, Uldbjerg, and Norgaard (2009) found that there is a five-fold risk for
acquiring postpartum infection, such as wound infections, urinary tract infections, and bloodstream infections, following a cesarean section compared to vaginal birth. Furthermore, after examining nearly 400,000 births, Simpson et al. (2001) found that women undergoing cesarean section are four times more likely to develop deep vein thrombosis compared to women undergoing a vaginal delivery. Successive cesarean sections also increase the risk for morbidity in women. This risk continually rises with each successive cesarean section and significantly increases with the fifth and sixth cesarean section having a major risk of placenta previa, placenta accreta, and hysterectomy (Makoha, Felimban, Fathuddien, Roomi & Ghabra, 2004). Placenta accreta is a placental abnormality that causes the placenta to become adhered to the myometrium tissue instead of the uterine decidua tissue, which can cause serious health issues and damage to other organs (Rosen, 2008). A study by researchers, Wu, Kocherginsky, and Hibbard (2005), found that fifty percent of women who suffer from placenta accreta during their pregnancy had a cesarean section during their prior pregnancy. There is overwhelming evidence that cesarean sections are a serious procedure with many present and future risks to consider.

While the cesarean rate is high in the US, access to vaginal births after cesarean section (VBAC) is becoming increasingly difficult as well. This difficulty is partially because of the unwillingness of physicians to offer the option to mothers, the bans that hospitals are placing on the procedure, and the inability of units to meet the ACOG recommendations for doing the procedure—immediately available surgeons and anesthesiologists (International Cesarean Awareness Network, 2009; ACOG, 1999; Roberts, Duetchman, King, Fryer, & Miyoshi, 2007; Leeman & King, 2011). The VBAC rate dropped from 28.3% in 1996 to 8.5% in 2006; this drop in VBAC may have attributed to the increase in cesarean section rate that we have seen over the years (Martin, Hamilton, & Sutton, 2009; Leeman & King, 2011). It may be necessary to first
face the issues surrounding VBAC access in order to reduce the rate of cesarean sections performed throughout the country.

Because a cesarean section is a major abdominal surgery, it also causes a lengthened hospital stay (Hebert et al., 1999; Lydon-Rochelle, Holt, Easterling, & Martin, 2001; Silver, 2004). The length of stay for a mother experiencing a cesarean birth is typically one to two days longer than for a vaginal birth (Lydon-Rochelle et al., 2001). Mothers experiencing a surgical birth may also be at risk for negative psychological effects. Soderquist, Wijma, and Wijma (1997) found that many women suffer from traumatic stress following emergency cesarean sections or instrumental vaginal deliveries. While other studies have found that all forms of childbirth may be emotionally strenuous and cause posttraumatic stress-like symptoms, DiMatteo, Morton, and Lepper (1996) found that women undergoing cesarean section are more likely to have a disappointing birth experience (Olde, van der Hart, Kleber, & van Son, 2005). Furthermore, women undergoing cesarean section are also at risk for increased pain, which also can have detrimental effects on the overall childbirth experience and psychological outcome (Thompson et al., 2002; DiMatteo et al., 1996; Johnstone, Boyce, Hickey, Morris-Yatees, & Harris, 2001; Murphy, Stirrat, & Heron, 2002). A study by Fisher, Astbury, and Smith (1997) looking at 242 primiparous women found that all women who underwent cesarean sections used narcotic pain medication while only 11% of the women who underwent vaginal deliveries used narcotic pain medications. The use of pain medication can negatively impact bonding between the mother and infant, resulting in dissatisfying experiences (Fisher et al., 1997; DiMatteo et al., 1996). Lastly, a cesarean section can cause fertility difficulties. A study observing nearly 4000 women, discovered that women who undergo cesarean section are likely unable to conceive for more that one year (Murphy et al., 2002). Cesarean sections have a major physical and
psychological impact on the mother that may result in a feeling of discontent surrounding her birthing experience.

Cesarean sections can also present challenges to the newborn. A study observing of over 580,000 women found that women undergoing cesarean section could be twice as likely to have difficulties breastfeeding than those delivering vaginally (Towner et al., 1999). Cesarean section can cause a delay in the skin-to-skin contact between the mother and infant. This skin-to-skin contact encourages bonding, stabilizes the infant’s temperature, and aids in the establishment of breastfeeding (Moore, Anderson, Bergman, & Dowswell, 2012). Breastfeeding provides essential nutrients, specifically the consumption of colostrum, and can aid in the initial bonding stages between the infant and mother (Simkin et al., 2010; Moore, Anderson, Bergman, & Dowswell, 2012). Furthermore, infants delivered via cesarean section are at an increased risk for respiratory difficulty and asthma (Levine, Ghai, Barton, & Strom, 2001; Hakansson & Kallen, 2003; Bager, Melbye, Rostgaard, Benn, & Westergaard, 2003). Researchers, Levine et al. (2001), studied an estimated 30,000 births and found that transient tachypnea is three times more likely after a cesarean section than after a vaginal delivery. Additionally, another study looking at 40,000 children who were delivered by cesarean section found that these children of cesarean section were 30% more likely to be admitted to the hospital for asthma (Hakansson & Kallen, 2003). This increased risk of asthma is also likely to persist into adulthood (Bager et al., 2003). Cesarean sections are an essential technology that has decreased maternal and neonatal mortality rates tremendously; however, this technological procedure is a serious surgery that is overused and has many risks and negative effects on the mother and infant that must be carefully considered (Castro & Clapis, 2005). Given the WHO recommended cesarean rate of 15%, the maternal healthcare system must reduce the cesarean section rate in the US to ensure greater
maternal and neonatal outcomes. By reducing the rate of intervention, observing birth as a natural process, and providing more holistic care, it is possible that the cesarean rate can improve and the nation will have an improved maternal health care system.

**Nurses Drive the Change**

Experts agree that modern obstetrical care has had a beneficial impact on reducing maternal and perinatal mortality and morbidity rates in the United States among high-risk cases (Castro & Clapis, 2005; Terhaar, 2005). Nonetheless, the model has evolved into a culture that promotes maximal intervention regardless of the risks, the necessity, and at times, regardless of the patients’ wishes (Periyakoil, Neri, Fong, & Kraemer, 2014). Because of the current medical culture and the focus of the medical training, obstetricians may have difficulties approaching childbirth as a normal process making them unable to care for the patients in a humanized manner (ANSS, 2008). Additionally, this culture may instill a bias in obstetricians causing them to disregard patient autonomy, which is essential to patient empowerment and the healthy progression of a woman’s labor (Periyakoil et al., 2014; Malheiros et al., 2012). For example, the training of obstetricians often focuses on the complications of pregnancy and childbirth rather than the birth as a natural process and how to provide humanized care (ANSS, 2008; Malheiros et al., 2012). As a result, it may be the case that women’s voices are being overlooked because of the obstetricians’ fear of complications.

There are signs that stakeholders in the maternity care delivery system are interested in adapting the current system of care; however, it is taking immense diligence from the researchers, administrators, healthcare team, and public to make a positive impact on the system. The World Health Organization and the Healthy People Initiative have taken significant steps
towards directing this change (WHO, 2002; U.S. Department of Health and Human Services, 2014). The maternal health care culture, consisting of hospital administrators, providers, and public opinion, is attempting to change towards a complementary, humanistic model to augment the current the medical-illness model (Castro & Clapis, 2005; Behruzí et al., 2014; Malheiros et al., 2012). For example, in a study by Malheiros et al. (2012), where researchers interviewed various physicians, some obstetricians expressed that there is a need for a shift in the paradigm that includes adapting the training of obstetricians away for the medical-illness model. This humanistic model promotes a more holistic and respectful medical culture giving control to the woman in regard to her childbirth and the decisions that must be made through that process (Behruzí et al., 2014; Deslandes, 2005; Page, 2000; Umenai & Wagner, 2001).

Page (2001), a nurse midwife, explains in her article on humanized care that the humanization of childbirth can be defined as “treating each mother as an individual and respecting her right to be involved in decisions about her care and showing sensitivity to her desires and feelings” (p. 87), all of which are essential for the optimal childbirth experience. An optimal birth is the gold standard for labor and delivery care. This optimal birth experience includes a birth that has a reduced risk of harm and intervention as well as full parental involvement and family support (Terhaar, 2005; Sewell, 1998). Because of the current medical culture, obstetricians may struggle to provide this optimal birthing experience through humanized care because they lack the tool and training. However, nurses, who are with the patient throughout the labor and delivery process and who have more patient-centered care, have the ability to provide this humanized care and advocate for their patients’ decisions to be followed and respected (Johanson et al., 2002; Malheiros et al., 2012). Therefore, nurses play a significant role in creating change toward a patient-centered model of maternity care.
The Impact of Nursing Attitudes

The majority of hospital labor and delivery units in the United States function through the model of nurse-managed labor. The nurse-managed labor model is used to describe a labor and delivery nursing practice in which nurses have an autonomous role where he or she is required to make clinical decisions surrounding patient care with little input from the obstetricians (Edmond & Jones, 2012; James, Simpson, & Knox, 2006). In low-risk situations, the obstetrician is only needed when the patient gives birth to the infant (Edmond & Jones, 2012; James et al., 2006). As a result, nurses have a great ability to have an effect on the women’s childbirth experience and birth outcomes (Gagnon, Meier, & Waghorn, 2007; James et al., 2003; Edmond & Jones, 2012; Payant, Davies, Graham, Peterson, & Clinch, 2008). For example, in a study in which researchers interviewed twenty pregnant women, it was found that nursing behaviors and quality care promote dignity of the laboring patient and provide the necessary environment for an optimal birthing experience (Mathews & Callister, 2004). Moreover, in a qualitative study involving 33 childbearing women, researchers found that many women who change their pain management preference during labor do so for many complex factors, including lack of nursing support, length of labor, and exhaustion (Carlton, Callister, & Stoneman, 2005). Quality nursing care makes an impact on such outcomes. Carlton et al. (2005) highlighted the need for respectful nursing care that advocates for the patient and educates the patient on the implications of such interventions to improve our maternal healthcare system. With the weight of the nurse’s role on such medically significant and transformative events, the nurse’s behaviors must promote an optimal birthing experience for the woman and for the healthcare profession.
Theory of Planned Behavior

Many theorists support the idea that one’s perceptions or attitudes are greatly linked to his or her behavior (Ajzen, 1991; Arnold, 1946; James, 1890; Piaget, 1946; Dijksterhuis & van Knippenberg, 1998). Dr. Icek Ajzen’s theory of planned behavior, which states that one’s attitude can explain his or her behaviors, can be used as a framework to guide the discussion surrounding the importance of nurse attitudes in relation to nurse behaviors and care outcomes (Ajzen, 1991). Because one’s attitude can explain his or her behaviors, there is a correlation between nurses’ attitudes and their behaviors in a clinical setting (Ajzen, 1991). Therefore, maintaining a knowledgeable, favorable attitude is essential for nurses to provide quality, holistic care, which directly impacts the rate of medical intervention and the caliber of the birthing experience. A favorable nurse attitude observes birth as a natural process, allows for patient autonomy in treatment decisions, advocates for the patient within the healthcare team, and is pursues knowledge surrounding current evidence-based practice. It has been found that nursing care does impact the type of delivery the laboring woman will have (Edmonds & Jones, 2012). Researchers have also found that nurses carry specific intervention rates and neonatal outcomes (Radin, Harmon, & Hanson, 1993; Hodnett et al., 2002). The attitudes and behaviors of nurses have an impact on the quality of care that patients receive, including the amount and type of intervention used and the neonatal health outcome. As a result, favorable nurse attitudes must be maintained because of their impact on nursing behaviors, which have a major impact on the birthing experience and maternal and neonatal outcomes (Ajzen, 1991; Edmond & Jones, 2012; Radin et al., 1993; Hodnett et al., 2002).

Intrapartum Nursing Attitudes
Researchers, Levine and Lowe (2013), discuss the emergence of the concept surrounding nurses’ attitudes toward childbirth. The term attitude can be defined as a concept describing the “mental or emotional ‘state of mind’ that indicates a tendency to act or react in a certain way” (Levine & Lowe, 2013, p. 93; Altmann, 2008; Attitude, n.d.a.; Attitude, n.d.b.). In this article, the authors relate that intrapartum nurses have an individual attitude surrounding childbirth that is developed from previous experiences, opinions of friends and family, education, and media (Levine & Lowe, 2013). Given the theory of planned behavior, nurses’ behaviors are impacted by their attitudes through five key belief themes, including: use of childbirth interventions, the primary patient, the use of childbirth technologies, the safety of vaginal birth, and the role of the woman in her own labor and birth (Levine & Lowe, 2013). As a result, the attitude of the nurse directly impacts the rate of intervention, the amount of advocacy for the patient, and the birth experience for the laboring mother.

Furthermore, expert nurses with attitudes that support the optimal birth experience for the laboring mother are aware of their role in the labor and childbirth process (James et al., 2006). Researchers James et al. (2006) found that these expert nurses understand their role to be understanding the intuitive nature of care during the woman’s labor, understanding how to enable the woman’s own body to guide labor, advocating for the mother, and having the ability to confidently participate in the nurse-managed labor model. Zanna & Rempel (1988) explain, however, that attitudes are not stable or predisposed, but are a dynamic construct that can change based on various internal and external favorable, including cognition, affect, and past behaviors. As a result, the ability to maintain to such favorable attitudes surrounding the optimal birthing experience is a top priority for healthcare organizations. The performance of an organization is dependent upon the behaviors of the employees (Hoogervorst, van der Flier, & Koopman, 2004);
therefore, the quality of the organization is dependent upon the maintenance of favorable employee attitudes.

Negative Impacts of the Tertiary Care Setting on Nurse Attitudes

While favorable nurse attitudes are essential to quality maternity care and the optimal birthing experience for laboring women, maintaining such attitudes can be difficult for some nurses because of the inundation of high-risk maternity care exposure seen in tertiary care settings (Ross, 2014; Liva, et al., 2012; Behruzi et al., 2013). This frequency of exposure to the high-risk model of care can make it difficult for nurses to care for low-risk mothers with a different model of care consisting of less stress and intervention.

Tertiary care settings encompass more specialized care equipped to treat high-risk cases as well as low-risk cases. Depending on the level of the hospital, or its ability to care for specialized, critical cases, nurses are exposed to varying degrees of intervention and processes, which have great impact on nurse attitudes (Liva et al., 2012). In tertiary care settings, nurses are likely to see more uncommon high-risk cases on a regular basis, which may result in a skewed sense of reality involving increased intervention and increased maternal and neonatal death as well as an increased risk for occupational burnout. The environment of these highly specialized tertiary settings may even psychologically alter a person’s opinion on the birthing process to a more sterile and medical procedure that is less humanized for both low-risk and high-risk women (Behruzi et al., 2013).

Some researchers argue that low-risk patients are more likely to have an increased rate of intervention at tertiary hospitals than at community hospitals. Janssen, Klein, and Soolsma (2001) found that women were 3.4 times more likely to have a cesarean section at a tertiary
hospital compared to community hospitals and have a higher rate of epidural use at tertiary hospitals than at community hospitals; however; other experts attribute this to increased availability of these options (Liva et al., 2012). Given the impact of nursing care on patient outcomes, it is possible that nurse attitudes in tertiary care settings compared to community hospital settings also plays a role in the differing rates of intervention. Through a cross-sectional survey, researchers, Liva et al. (2012), found that nurses working in tertiary care settings were more positive about epidural analgesia and least positive about the importance of vaginal birth. This study also concluded that nurses working in a tertiary care setting were more likely to choose an obstetrician rather than a nurse midwife for their own maternity care and had less favorable attitudes towards the safety of birth and more favorable attitudes toward electronic fetal monitoring and episiotomy (Liva et al., 2012). This study draws a clear picture illustrating how a nurse’s work environment shapes his or her perceptions on the birth process and may alter nurse attitudes.

The Maintenance of Favorable Nurse Attitudes

Because favorable nurse attitudes are essential to quality maternity care and the optimal birthing experience for laboring women, maintenance of favorable nurse attitudes and avoidance of burnout syndrome is essential to quality care and the optimal birthing experience for laboring women.

The Impact of Organizational Structure and Culture

Behruzi et al. (2013) explained that practicing the humanization of birth allows one to cope with the specialized technology to maintain interpersonal relationships, communication,
and as a result the advocacy for the patient. The humanization of birth consists of respecting the laboring woman and providing her with autonomy surrounding her birthing decisions (Behruzi et al., 2013; Deslandes, 2005; Page, 2001). To provide this humanized care in tertiary settings, nurses must provide holistic care considering both physiological and psychological needs—respecting the fears, beliefs, values, and needs of the women and their families (Behruzi et al., 2013). This practice enables the nurse to cope with the dehumanized modern technology surrounding her and maintain humanistic relationships and communication with the patient and healthcare team (Behruzi et al., 2013). While practicing this type of care aids in the coping process for nurses, it can be difficult to maintain this practice when morale declines.

For employees to maintain a favorable attitude towards this type of holistic care, their perceptions must align with the desired behavior. Maintenance of favorable nurse attitudes and the humanization of childbirth in a tertiary care setting is possible given a well defined organizational structure and culture as well as ample availability of coping resources through collegial support and camaraderie, managerial support, and opportunities for continued learning and support (Lee & Ahktar, 2007; Hoogervorst et al., 2004). Establishing a well-defined, consistent organizational structure and culture is essential to maintaining favorable employee behavior and subsequent quality organizational performance (Hoogervorst et al., 2004). Scholl (2003) defines the culture of an organization as a pattern of behavior that is based on its values and beliefs, all of which determine the organization processes and the quality of care provided to its patients (Scholl, 2003). The organization must clearly articulate the desired attitude and behavior of its employees in order for the employees to fully adopt that given attitude and behavior. Researchers Hoogervorst et al., (2004) found that the consistency of an organization’s message to its employees (explicit communication) and the organization’s actual culture
(implicit communication) is necessary for the desired behavioral and performance outcomes to be met. Beer, Eisenach, and Spector (1990) as well as Ghoshal & Bartlett (1997) also conclude that the organizational culture and structure must be the target in establishing and maintaining a favorable behavioral context rather than solely focusing on employees directly. Examples of labor and delivery units adopting such a consistent culture are those that have enacted the Baby-Friendly Initiative (Baby-Friendly USA, 2015). This initiative helps to promote positive attitudes surrounding a natural birth regardless of high-risk or low-risk labels among patients and staff. While there are many other areas for improvement, the Baby-Friendly Initiative is a step in the right direction. Given a well-defined, consistent organizational structure and a culture fostering favorable attitudes surrounding the optimal birthing experience, the maintenance of nurse attitudes will follow with proper coping resources.

Coping with Stress: Resources and Strategies

Because of the stressors and risk for occupational burnout of working in a tertiary care setting, nurses must be knowledgeable about coping resources and have access to coping strategies (Pearlin & Schooler, 1978; Hammer, 1988). Coping resources are inherent traits that allow nurses to handle stress more effectively, including personality, age, and religion (Hammer, 1988), whereas coping strategies are mechanisms nurses can use to work through the stress that has already occurred, including exercise and personal growth (Pearlin & Schooler, 1978; Ivancevich & Matteson, 1980). In a study reviewing the effectiveness of coping resources (cognitive, social, emotional, spiritual, and physical) in negatively impacting symptoms of occupational burnout, Turnipseed & Turnipseed (2007) found that most resources are negatively related to emotional exhaustion and depersonalization and are positively related to personal
accomplishment. Furthermore, it was concluded that cognitive coping resources, such as self-efficacy and reframing, are positively related to age and experience (Hammer, 1988) and decrease the likelihood of burnout syndrome (Turnipseed & Turnipseed, 2007). This suggests that coping resources can be developed through experience naturally (Turnipseed & Turnipseed, 2007). Therefore, younger intrapartum nurses may lack adequate coping resources and may need additional support such as coping strategies.

Coping strategies are a vital part of any nursing unit to prevent occupational burnout and promote maintenance of favorable attitudes especially among younger nurses (Turnipseed & Turnipseed, 2007). Healthcare organizations can instill many resources for nurses to access so they can cope with such work stressors. These resources include continuous learning opportunities, clear job descriptions and performance feedback, supervisory support and counseling assistance programs, and team support (Ivancevich & Matteson, 1980; Lee & Akhtar, 2007). Experts Lee and Akhtar (2007) conducted a survey studying 2,267 nurses working in 43 different public hospitals in Hong Kong. They discovered that while job demands, lack of recognition, role conflict, and patient care responsibilities most contributed to stress and risk of burnout syndrome, self-efficacy, social support, job control, and supervisory support were found to be the best coping strategies for avoiding burnout syndrome.

It is in the best interest of healthcare organizations to offer continuous learning opportunities for its employees to promote growth and self-efficacy (Lee & Akhtar, 2007; Lee and Ashforth 1996; Litt, 1988; Ivancevich & Matteson, 1980). Nurses must have confidence in their ability to provide quality care to maintain such favorable attitudes and behaviors. By promoting continuous learning for nurses, the organization is not only reducing the risk of
occupational burnout among nurses through increased self-efficacy, but it is also encouraging nurse autonomy and the growth of the healthcare institution.

Clear job descriptions, performance feedback, and support from managerial staff are also essential to decrease nurse stress surrounding occupational uncertainties (Lee & Ahktar, 2007; Dijksterhuis & van der Knippenberg, 1998; Bandura, 1986; Ross, Altmaier, & Russell, 1989). Employees must understand their role and how they are expected to behave in order to have confidence and a direction (Lee & Ahktar, 2007; Dijksterhuis & van der Knippenberg, 1998). A clear job description as well as a thorough orientation will help to clear up any ambiguity that may be present to avoid the stress of uncertainty (Lee & Ahktar, 2007). Frequent feedback, performance recognition, as well as raises will help promote wanted behaviors and decrease stress.

According to Bandura’s Social Cognitive Theory, even with self-efficacy, individuals may still not exhibit the favorable behavior without an incentive (Bandura, 1986). Recognition from management and financial incentives can act as an incentive for employees to continue this desired behavior and continue to strive for excellence. Furthermore, management must be supportive to nurses by understanding constraints, giving attention to individuals who recently witnessed a traumatic event and, if necessary, organize a referral to a specialist to address the event (Lee & Ahktar, 2007). Counseling services and management workshops may be beneficial for the organization to offer and for the managers to advertise to promote employee health and wellbeing (Lee & Ahktar, 2007; Embriaco et al., 2007). Researchers Ross et al. (1989) found that managerial support decreases the risk of occupational burnout and increases self-efficacy. The management staff is a representative of the organization and must show sincere care and
concern for the nurses to maintain trust in the organization and loyalty to its mission (Lee & Ahktar, 2007).

Another coping strategy that is beneficial in reducing stress and the risk of burnout syndrome while promoting favorable attitudes is team support (Lee & Ahktar, 2007; Lee and Ashforth 1996; Eastburg, Williamson, Gorsuch, & Ridley, 1994; Jackson, Schwab, and Schuler 1986; Embriaco et al., 2007). Experts say that social support consists of the encouragement and guidance that individuals in the support group provide to one another through feedback and technical assistance (Pines & Aronson, 1988). This type of social support can be multi-faceted and include career and professional support as well and emotional and personal support (Lee & Ahktar, 2007). Social groups can also be fostered by the organization by promoting unit birthday celebrations, picnics, and dinners (Lee & Ahktar, 2007). Even organizing unit exercise groups to promote social and physical activities greatly improve the stress of its members (Ivancevich & Matteson, 1980). This form of social support can be successful in promoting favorable nurse attitudes based on the concept that individuals often alter their attitudes to mimic the attitudes of those around them (Baldwin & Holmes, 1987). Furthermore, experienced nurses can educate new nurses on effective coping resources and strategies that can be used to maintain such favorable attitudes. Social support and camaraderie may help to spread the desired culture and quality of care throughout the organization.

Combating occupational burnout syndrome and maintaining favorable nurse attitudes can be challenging for many nurses, especially those working in a tertiary care setting (Liva et al., 2012; Behruzi et al., 2013). Establishing a well-defined organizational structure and culture as well as providing the means to coping resources and coping strategies are essential to maintaining favorable employee behavior and quality organizational performance (Hoogervorst
et al., 2004; Pearlin & Schooler, 1978; Hammer, 1988; Ivancevich & Matteson, 1980). While difficult, maintenance of favorable nurse attitudes and the humanization of childbirth in a tertiary care setting are possible with organization intervention and a talented, motivated workforce (Lee & Ahktar, 2007; Hoogervorst et al., 2004).

**Conclusion**

An evidence-based maternal health system in the US is essential to ensure the vitality of our future population. Intrapartum nurses can only help to cause a positive change in this healthcare area if they have the attitude and behaviors that are favorable to that change. Dr. Icek Ajzen’s theory of planned behavior acts as a framework to guide the discussion that nurses’ perceptions surrounding the optimal childbirth experience determine their behaviors and quality of care (Ajzen, 1991). Maintaining a knowledgeable, favorable attitude is the driving force of the nurse’s proficiency and advocacy on the labor and delivery unit. Because these favorable attitudes can be difficult to maintain when working in a tertiary care setting, where there is an abundance of high-risk cases, resources must be established for labor and delivery nurses to utilize so that they may maintain favorable attitudes surrounding the normalcy of birth (Turnipseed & Turnipseed, 1991; Ivancevich & Matteson, 1980; Lee & Ahktar, 2007; Liva, Hall, Klein, & Wong, 2012; Behruzzi, Hatem, Goulet, & Fraser, 2013). Maintenance of favorable nurse attitudes and the humanization of childbirth in a tertiary care setting are possible given a well defined organizational structure and culture as well as ample availability of coping resources and strategies through collegial support and camaraderie, managerial support, and opportunities for continued learning (Lee & Ahktar, 2007; Hoogervorst et al., 2004).
Future research must be conducted on the actual perceptions of nurses in varying types of maternity healthcare settings. Research gaps may include a comparison of nursing perceptions in a tertiary setting versus a community setting as well as a longitudinal study examining the effects on nurses’ ability to cope with stress and burnout syndrome given varying experiences. Additionally, future research should include the impact that different coping resources and strategies for nurses have on the actual maintenance of nurse attitudes. Further research must be conducted to show how these resources and subsequent nurse attitudes and behavior impact the quality of care and outcomes in the maternity care setting—specifically concentrating on the quality of the maternal experience, rate of intervention, and maternal and neonatal mortality and morbidity outcomes. Additionally, current research surrounding nurse performance, burnout, and culture are not specific to maternity care settings. More research must be conducted on intrapartum nurses regarding nurse performance, burnout and culture.
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