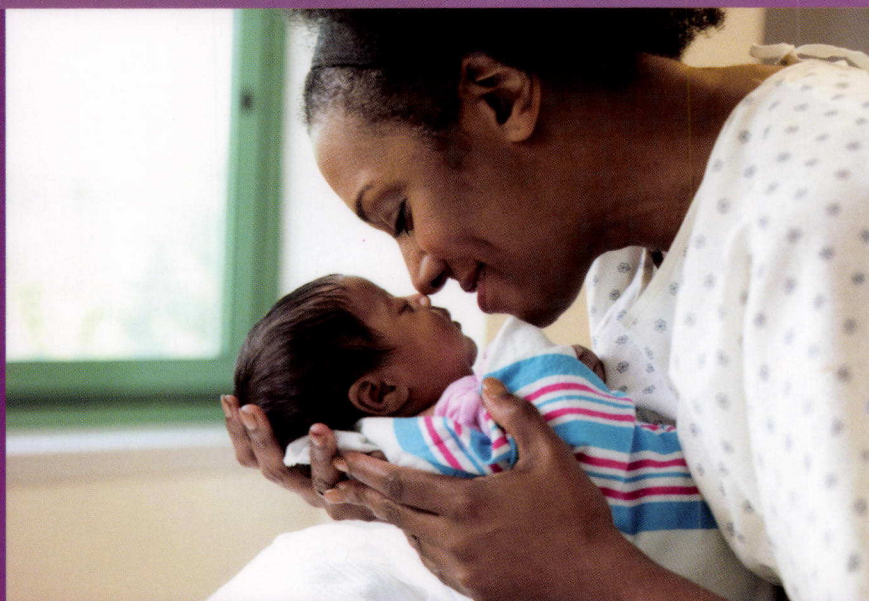


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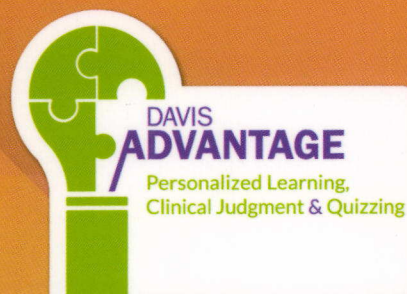
Maternal-Newborn Nursing

Critical Components of Nursing Care

FOURTH EDITION



Durham • Chapman • Miller



DAVIS ADVANTAGE for Maternal-Newborn Nursing

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DAVIS ADVANTAGE for
Maternal-Newborn
Nursing

Critical Components of Nursing Care

The authors are grateful more than ever for the tireless work of all nurses and faculty for their role in ensuring every patient receives the care and dignity they deserve regardless of race, sexual orientation, status, or illness.

To my parents, Raymond and Virginia "Ducky" Durham; husband, Douglas Fredebaugh; and sisters, Ginny Durham and Dr. Patricia Durham Taylor, as well as friends and family in the Bay Area and Hawaii. Thank you for your love and support. Aloha

To my husband and best friend, Chuck: Thank-you for a lifetime of love, happiness, and fun adventures. You were and are there to love and support me through my many educational and academic endeavors, and life events. I love you.

*To my mother, Lena Winter; husband and love of my life, Mike; sons Colin and Ross; daughter, Aubrey; and grandchildren, Bray and Dakota. Thank you all for your constant love and support while allowing me to follow my dreams!
Love, Connie, Mom, and Mimi.*

Preface

FOCUS

In this fourth edition of *Davis Advantage for Maternal-Newborn Nursing: Critical Components of Nursing Care*, we continue to emphasize the basics of maternity nursing, focusing on evidence-based practice for all levels of nursing programs. Because we realize that today's students lead complex lives and must juggle multiple roles as student, parent, employee, and partner, we developed this textbook, with its accompanying electronic ancillaries, to present the critical components of maternity nursing in a clear and concise format that lends itself to ease of comprehension while maintaining the integrity of the substantive content. It may be particularly useful for programs designed to present the subject of maternity in an accelerated or condensed way.

We revised the textbook based on the recommendations of those who have used it—faculty from various states and students in all types of programs—and our own experiences. Revisions include enhanced rationales for nursing actions in all chapters, increased content in pathophysiology in many areas, and expanded high-risk content. We have updated content to keep current in standards in practice, including new guidelines for management of pregnancy complications, management of postpartum hemorrhage, management of intrapartum fetal heart rate abnormalities, assessment and care of the late preterm infant, and assessment and care of the newborn. We have expanded sections on patient education, patient teaching resources, and complementary and alternative therapies. Professional standards of care for maternity nurses are based on current practice guidelines and research. We have also expanded the discussion of social determinates of health.

Although the words *woman* and *women* are used herein, the authors recognize the existence of diverse gender identities. To provide culturally appropriate, respectful, and sensitive care, the maternity care provider should always ask individuals what words they use to describe themselves, their bodies, and their health-care practices.

CRITICAL COMPONENTS

This textbook focuses on the critical components of maternity nursing. Critical components are the major areas of knowledge essential for a basic understanding of maternity nursing. The critical components were determined from the authors' combined 60 years of teaching maternity nursing in both traditional and accelerated programs and years of clinical practice in the maternity setting. Current guidelines and standards are integrated and summarized for a pragmatic approach to patient- and family-focused care. This focus is especially evident when discussing complications.

The focus of the text is on normal pregnancy and childbirth. Chapters on low-risk antenatal, intrapartum, postpartum, and neonate conditions are followed by chapters on high-risk events and complications in each area. Complications germane to the nursing domain and childbearing population focus on understanding and synthesizing the critical elements for nursing care.

CLINICAL JUDGMENT

Highlighting clinical judgment is a new feature of the book. The term *clinical judgment* is based on Tanner's definition to mean an interpretation or conclusion about a patient's needs, concerns, or health problems, or the decision to take action (or not), use or modify standard approaches, or improvise new ones as deemed appropriate by the patient's response. Because students need help to gain clinical knowledge related to key factors that impact patient outcomes, we have highlighted specific information to help the student in recognizing the practical manifestations of signs and symptoms, recognizing quantitative and qualitative changes in particular patient conditions, and learning qualitative distinctions among a range of possible manifestations, common meanings, and experiences.

ORGANIZATION

This evidence-based text utilizes theory and clinical knowledge of maternity nursing. The conceptual framework is based on family developmental theory and presents substantive theory that forms the foundation for maternity care. The book is organized according to the natural sequence of the perinatal cycle: pregnancy, labor and birth, postpartum, and neonate. We have taken a biopsychosocial approach dealing with the physiological and psychological adaptation, and the social, political, and cultural influences impacting childbearing families, with emphasis on nursing actions and care of women and families. We believe childbirth is a natural, developmental process.

Nursing is an ever-changing science. New research and clinical knowledge expand knowledge and change clinical practice. *Davis Advantage for Maternal-Newborn Nursing: Critical Components of Nursing Care* reflects current knowledge, standards, and trends in maternity services, including the trend toward higher levels of intervention in maternity care. These standards and trends are reflected in our chapter on tests during the antepartal period, as well as a chapter devoted to fetal assessment and electronic fetal monitoring. We have devoted a chapter to the care of cesarean birth families, as nearly one-third of births in the United States are via cesarean.

This textbook clusters physiological changes, nursing assessment, and nursing care content in each chapter. Typically, a chapter is divided into systems in which the physiology; nursing care, including assessment and interventions; expected outcomes; and common variations of one subsystem are presented. Psychosocial and cultural dimensions of nursing care are highlighted in each chapter with an increased focus on social determinants of perinatal outcomes. The authors and contributors recognized childbirth, and becoming a mother, is a liminal and transformative life experience, a psychological and social experience with impacts for women, infants, and family members. Becoming a parent can bring overwhelming joy and life fulfillment for some, whereas for others it can lead to the onset, continuation, or exacerbation of stressors, adversity, and complications. We have attempted to present a balanced and nurse-centered approach to issues in the care of perinatal families. It is important to state here that there are people in the country who do not identify as women but who desire to have a child or are currently pregnant or in the postpartum period. While we use the term *mother* in this textbook, we must reiterate that all birthing people are equally deserving of patient-centered care that helps them attain their full potential and live authentic, healthy lives. For care to be successful, nurses, providers, and health-care institutions must work toward more inclusivity and best practices that are free of judgment and predetermined norms.

Nurses are uniquely positioned to lead evidence-based health equity efforts specific to the improvement of perinatal health disparities. The power of nursing and our priorities in improving outcomes is aligned with strategies, bundles, and tool kits developed to improve perinatal outcomes in partnership with the most impacted communities. Ethical care of all persons in the perinatal, prenatal, postpartum, and preconception periods requires a well-educated and diverse workforce with foundational knowledge of social determinants of health, health disparities, health inequity, and community engagement. This edition makes an effort to highlight that information and strategies to improve outcomes.

FEATURES

This textbook presents the critical components of maternal-newborn nursing in a pragmatic, condensed format by using the following features:

- **Bulleted format:** For easy-to-read content
- **Figures, tables, boxes, concept maps, and clinical pathways:** Summarize information in a visual way
- **Learning Outcomes:** Identify what the reader will know and be able to do by the end of the chapter
- **Concepts:** Identify the key concept areas discussed in the chapter
- **Critical Components:** Highlight critical information in maternal-newborn nursing
- **Evidence-Based Practice:** Highlights current research and practice guidelines related to nursing care
- **Case Studies:** Tie it all together by applying critical components in clinical context

- **Clinical Judgment:** Provides tips on applying critical thinking in a clinical setting
- **Safe and Effective Nursing Care (SENC):** Highlights SENC concepts as they apply to the chapter content:
 - **Cultural Competence:** Stresses the importance of cultural factors in nursing care
 - **Understanding Medication:** Highlights commonly administered medications used during pregnancy, labor and birth, postpartum, and neonatal periods
 - **Patient Education:** Reflects current evidence-based practice guidelines and recommendations
- **Evidence-based health equity efforts** specific to the improvement of perinatal health disparities for all persons are presented.

APPENDICES

The appendices include:

- **Laboratory Values**
- **Preeclampsia Early Recognition Tool (PERT)**
- **Cervical Dilation Chart**
- **Temperature and Weight Conversion Charts**

THE TEACHING AND LEARNING PACKAGE

How students learn is evolving. In this digital age, we consume information in new ways. The possibilities to interact and connect with content in new, dynamic ways are enhancing students' understanding and retention of complex concepts.

In order to meet the needs of today's learners, how faculty teach is also evolving. Classroom (traditional or online) time is valuable for active learning. This approach makes students responsible for the key concepts, allowing faculty to focus on clinical application. Relying on the textbook alone to support an active classroom leaves a gap. **Davis Advantage** is designed to fill that gap and help students and faculty succeed in core courses. It is comprised of the following:

- **A Strong Core Textbook** that provides the foundation of knowledge that today's nursing students need to pass the NCLEX® and enter practice prepared for success.
- **An Online Solution** that provides resources for each step of the learning cycle: learn, apply, assess.
 - **Personalized Learning** assignments are the core of the product and are designed to prepare students for classroom (live or online) discussion. They provide directed learning based on needs. After completing text reading assignments, students take a preassessment for each **topic**. Their results feed into their *Personalized Learning Plan*. If students do not pass the preassessment, they are required to complete further work within the topic: watch an animated mini-lecture, work through an activity, and take the postassessment. The personalized learning content is designed to connect

students with the foundational information about a given topic or concept. It provides the gateway to help make the content accessible to all students and complements different learning styles.

- **Clinical Judgment** assignments are case-based and build off key Personalized Learning topics. These cases help students develop Clinical Judgment skills through exploratory learning. Students will link their knowledge base (developed through the text and Personalized Learning) to new data and patient situations. Cases include dynamic charts that expand as the case progresses and use complex question types that require students to analyze data, synthesize conclusions, and make judgments. Each case will end with comprehensive feedback, which provides detailed rationales for the correct and incorrect answers.
- **Quizzing** assignments build off Personalized Learning topics (and are included for every topic) and help assess students' understanding of the broader scope and increased depth of that topic. The quizzes use NCLEX-style questions

to assess understanding and synthesis of content. Quiz results include comprehensive feedback for correct and incorrect answers to help students understand why their answer choices were right or wrong.

- **Online Instructor Resources** are aimed at creating a dynamic learning experience that relies heavily on interactive participation and is tailored to students' needs. Results from the postassessments are available to faculty, in aggregate or by student, and inform a **Personalized Teaching Plan** that faculty can use to deliver a targeted classroom experience. Faculty will know students' strengths and weaknesses *before* they come to class and can spend class time focusing on where students are struggling. Suggested in-class activities are provided to help create an interactive, hands-on learning environment that helps students connect more deeply with the content. NCLEX-style questions from the **Instructor Test Bank** and **PowerPoint** slides that correspond to the textbook chapters are referenced in the Personalized Teaching Plans.

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Acknowledgments

We are grateful to the following people, who helped us turn an idea into reality:

- Our husbands—Douglas Fredebaugh, Chuck Chapman, and Michael Miller—for their ongoing support and love
- Our colleagues at Samuel Merritt University, and the University of Arizona, who helped us develop from novice to expert teachers
- Our colleagues at the California State University, East Bay, and the University of Arizona College of Nursing for their suggestions and support
- Our teachers and mentors—Katharyn A. May, RN, DNSc, FAAN, Ramona T. Mercer, RN, PhD, FAAN, and Melissa Goldsmith, PhD, RNC-MN
- Our F.A. Davis team—Jacalyn Sharp, Amanda Minutola, and Andrea Miller—for their guidance
- Our contributors for sharing their expertise

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UNIT

1

Maternity Nursing Overview

Trends and Issues

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LEARNING OUTCOMES

Upon completion of this chapter, the student will be able to:

1. Discuss evidence-based nursing care that promotes optimal outcomes in labor and birth.
2. Examine maternal and infant health outcomes in the United States and analyze how the social determinants of health impact outcomes and lead to health disparities.
3. Identify leading causes of maternal and infant morbidity and mortality in the United States.
4. Create a framework for the provision of women's health and gender health services that are representative, comprehensive, and holistic.
5. Identify the primary maternal and infant goals of *Healthy People 2030*.

CONCEPTS

Addiction
Behaviors
Caring
Clinical Judgment
Collaboration
Communication
Evidence-Based Practice
Health Policy
Health Promotion
Leadership and Management
Mood and Affect
Population Health
Professionalism
Reproduction and Sexuality
Self-Care
Stress and Coping

WELCOMING AND INCLUSIVE CARE

"Health is a state of complete physical, social and mental well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being, without distinction of race, religion, political beliefs or economic and social conditions" (World Health Organization [WHO], 2006).

Welcome to the newest edition of *Maternal-Newborn Nursing*. This textbook introduces the fundamental principles of maternal-newborn nursing and women's health. Recognition exists on both the national and global levels that a more

comprehensive understanding of health—one that recognizes the intersection between the social determinants of health and health outcomes—is critical to promoting optimal health and eliminating health disparities (American College of Obstetricians and Gynecologists [ACOG], 2018; U.S. Department of Health and Human Services, 2021; WHO, 2021b).

Nowhere is this truer than in the promotion of health and wellness for women, infants, and childbearing families in the presence of significant health disparities that exist in the United States due to differences in the social determinants of health (Fig. 1–1). These include:

- Housing and neighborhood environment
- Economic stability

Social Determinants of Health



Social Determinants of Health
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Healthy People 2030

FIGURE 1-1 Social Determinants of Health.

- Access to health care and quality of care
 - Access and quality of education
 - Community and social context, including the impact of racism
- (U.S. Department of Health and Human Services, 2021).

Obesity, for example, can lead to significant morbidity and mortality for both women and infants, including increased risk of gestational diabetes, gestational hypertension, miscarriage, stillbirth, and birth defects (Mahutte et al., 2018; Pickett-Blakely et al., 2016). To address these risks, nurses must prepare to assess every person for access to healthy food, safe environments to exercise, and affordable prenatal care, then work with the health-care team and community partners to optimize a patient's resources and outcomes.

In discussing the social model of health, we recognize the importance of the medical model of health. This text incorporates the best evidence both models offer to current nursing practice.

Nurses must also be prepared to serve as change leaders and advocates for improved health-care systems and evidence-based health policies that make health outcomes more equitable at a societal level. For example, nurses endorsed the *Protecting Moms That Serve Act* that was introduced in 2021 to improve maternal outcomes for veterans (American Association of Birth Centers [AABC], 2021). Thus, this chapter will explore the urgent health issues in maternal-newborn health from both an individual and societal context and will introduce the *Healthy People 2030* goals to guide the conversation.

Finally, this chapter will examine what it means to provide welcoming and inclusive care to everyone. Welcoming and inclusive care in this context means gender-affirming care to all

people, including gender-diverse and transgender individuals. Some people do not identify as women but desire to have a child or are currently pregnant or in the postpartum period. Although we use the term *mother* in this textbook, we advocate for all birthing people to receive patient-centered care that helps them attain their full potential and live authentic, healthy lives.

Welcoming and inclusive care is also provided to all childbearing people and families who identify as LGBTQIA+ (Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual) in recognition that health-care provider attitudes and practices significantly impact health outcomes for members of the LGBTQIA+ communities (Fenway Institute, 2016). Currently, 12% of the U.S. population identifies as LGBTQIA+. That number is significantly higher (20%) for the Millennial generation (Gay and Lesbian Alliance Against Defamation [GLAAD], 2017).

New nurses must face many challenges and opportunities. The COVID-19 pandemic has clarified that issues such as racism, violence, and climate change significantly impact health outcomes. This chapter is an introduction to these issues as they affect maternal, newborn, and gender health and prepare students to address these issues in nursing practice.

ISSUES IN MATERNAL-NEWBORN AND GENDER HEALTH

Childbirth in the United States

During the past 100 years, care of the childbearing family has undergone profound changes as childbirth moved from the comfortable setting of the home to the unfamiliar setting of the hospital. This change was driven by the medicalization of birth and the systemic discreditation of Indigenous midwives and midwives of color, who were responsible for the health and well-being of not just women in labor but also their communities (Davison & Joseph, 2020). This loss of the traditional healers and health providers in communities of color is recognized as one of the key factors that has resulted in ongoing health disparities for communities of color in the United States, especially for Black, Hispanic, and Indigenous communities (Davison & Joseph, 2020).

As noted in Table 1-1, less than 5% of births in 1900 took place in the hospital. By the late 1930s, this had increased to 75% of births (Wertz & Wertz, 1979). Women and childbearing families began to advocate for a return to physiological labor and birth and less medical intervention in the 1950s, and by the 1960s childbirth education became formalized (Lothian, 2016). The birth center movement developed in the early 1970s to provide safe and effective care to families seeking a birthing environment that supported normal physiological birth (AABC, 2016). The past 60 years have seen nurses take a leadership role in evaluating the evidence that supports appropriate medical interventions while also using evidence to support non-intervention in uncomplicated physiological or normal birth (American College of Nurse-Midwives [ACNM], n.d.).

TABLE 1-1 Past and Present Trends

PAST TRENDS	PRESENT TRENDS
Nursing: Focus on physiological changes and needs of the mother and infant	Family-centered maternity nursing: Focus on both the physiological and psychosocial changes and needs of the childbearing family
Primarily home births	Primarily hospital births, with increasing home and birth center births
Women labored in one room and delivered in another room	Women labor, give birth, and recover in the same room
Delivery rooms cold and sterile	Birthing rooms warm and homelike
Expectant fathers and family excluded from the labor and birth experience	Expectant partner, family, and friends involved in the labor and birth experience
Expectant fathers or family members excluded from cesarean births	Expectant partner or family members in the operating room during cesarean births
Labor pain interventions: natural childbirth, amnesia, or “twilight sleep”	Labor pain interventions: natural childbirth, labor support techniques, analgesics, epidurals, nitrous oxide
Hospital postpartum stay of 10 days	Hospital postpartum stay of 48 hours or fewer, birth center stay of 6 hours, in-home birth
Infant mortality rate of 50.1 per 1,000 live births in 1915 (Bureau of the Census, 1917)	Infant mortality rate of 5.7 per 1,000 live births in 2020 (OECD, 2021)
Diarrhea and enteritis: Number one cause of infant death in 1915 (Bureau of the Census, 1917)	Birth defects, prematurity, and low birth weight (LBW) are the leading causes of infant mortality in 2018 (March of Dimes, 2021e)
Maternal mortality rate of 607.9 per 100,000 live births in 1915 (Bureau of the Census, 1917)	Maternal mortality rate of 17.4 per 100,000 live births in 2018 (CDC, 2020b)
Induction of labor rate of 9.5% in 1990 (Martin et al., 2006)	Induction of labor rate of 24.5% in 2016 (Maternal Safety Foundation, 2021)
Cesarean section rate of 20.7% in 1996 (Martin et al., 2006)	Cesarean section rate of 31.7% in 2019 (CDC, 2021a)
Low probability of survival for infants born at or before 28 weeks of gestation	Increased survival rates for infants born between 24 weeks and 28 weeks of gestation

Nurses have been change leaders in these key developments in childbirth practices:

- Electronic fetal monitoring (EFM) during labor, which began in the 1970s. Nurses, nurse-midwives, and nurse researchers helped establish that EFM is effective for confirming fetal well-being for high-risk births and that intermittent fetal monitoring with auscultation is safe and effective for monitoring low-risk births.
- La Leche League International (LLI), started in 1956 by a group of women who wanted to promote breastfeeding during a time when bottle-feeding was recommended by medical practitioners over breastfeeding (LLI, 2021). Nurses helped lead the movement to reestablish breastfeeding as the best method of infant feeding when possible. All nurses working with childbearing patients and families must be trained to provide “equitable, culturally sensitive, gender-affirming breastfeeding support” (Association of Women’s Health, Obstetric and Neonatal Nurses [AWHONN], 2021b) and address the cultural concerns related to breastfeeding for patients and families in their care.
- The AWHONN, established in 1969 to “empower and support nurses caring for women, newborns, and their families through research, education, and advocacy” (AWHONN, 2021a). For more than 50 years, AWHONN has helped transform maternal-newborn care, establishing best practices on critical issues such as postpartum depression screening and prevention of complications such as postpartum hemorrhage (AWHONN, 2021a).
- The Baby-Friendly Hospital Initiative, developed by the WHO and the United Nations Children’s Fund (UNICEF) in 1991. This initiative focuses on hospital and birth center practices that protect, promote, and support breastfeeding and nurses and has been instrumental in helping organizations receive the Baby-Friendly Center accreditation (see Chapter 16).
- The Back to Sleep campaign, initiated by the National Institute of Child Health and Human Development (NICHD) in 1996 to educate parents about the importance of placing infants on their backs to sleep to reduce the risk of sudden infant death syndrome (SIDS).

- In 2012, the NICHD's Safe to Sleep campaign, which built on the Back to Sleep campaign (see Chapter 15).
- An increase in collaboration over the past decade among professional organizations that care for women in recognition of the urgency to address maternal and infant morbidity and mortality in the United States. This has led to multiple consensus statements and bundles to standardize best practices for all care providers, uniting educators, researchers, physicians, nurse-midwives, and maternal-newborn nurses to improve outcomes (AWHONN, 2021a).
- Community-led initiatives by people of color and national organizational initiatives such as those of the ACNM to address the severe disparities in health outcomes for women and infants of color. These programs seek to mitigate racism in maternal health care and increase the number of maternal-newborn health-care providers who are people of color (American College of Nurse-Midwives, Black Mamas Matter Alliance, and International Confederation of Midwives [ACNM, BMMA, & ICM], 2020).

Advances in science and health care have tremendously impacted the number of maternal and infant deaths in the past century, with maternal mortality rates declining from 607.9 per 100,000 live births in 1915 to 17.4 per 100,000 live births in 2018 (Centers for Disease Control and Prevention [CDC], 2020b) and infant mortality rates declining from 50.1 per 1,000 live births in 1915 to 5.7 per 1,000 live births in 2020 (Organisation for Economic Co-Operation and Development [OECD], 2021). In contrast, cesarean births increased from 20.7% in 1996 to a rate of 31.7% in 2019 (CDC, 2021a). Induction of labor rates increased from a low of 5% in 1970 to a rate of 24.5% in 2016 (Maternal Safety Foundation, 2021).

It is critical to understand that while maternal and infant outcomes have significantly improved in the United States compared with the previous century, the nation still has the highest maternal mortality rate of any high-resource country in the world, and is the only country in the world, other than Afghanistan and the Sudan, where the maternal mortality rate is rising (Center for the Study of Social Policy, 2019). Women in the United States are more likely to die during pregnancy and the first year after birth than women in 48 other high-resource countries (ACNM, 2021). Similarly, despite the 14% decrease in infant mortality from 2007 to 2017, the United States is experiencing slower improvements than in other high-resource countries and has wide disparities in mortality based on race, ethnicity, and geographic location (Drexel University, 2020). Causes and potential solutions to these concerning outcomes will be discussed in the text that follows.

Fertility and Birth Rates

Total fertility rate (TFR) is “the average number of children that would be born per woman if all women lived to the end of their childbearing years and bore children according to a given fertility rate at each age” (Central Intelligence Agency [CIA], 2022). TFR is an indicator of population change; greater than 2 indicates that the country's population is growing, whereas lower than 2 indicates a population decreasing in size. The 2020 U.S. TFR is 1.64. In 2010, it was 1.98, and in 2018 it was 1.73 (CDC, 2019b). TFR decreased significantly in 2020 during the COVID-19 pandemic, with a 4% decrease from 2019 to 2020 (CDC, 2021a). Recent TFR indicates that the U.S. population is decreasing in size and that its members are growing older.

Birth rate is the number of live births per 1,000 people. Since 1960, U.S. birth rates have significantly declined (Table 1-2). In 1960, the birth rate was 23.7. In 1970, it was 18.4, and in 2020, it was 10.9. The United States saw decreases in both the fertility rate and the birth rate between 1960 and 2020, which accelerated in 2019 and 2020 (CDC, 2021a). During this period, the TFR decreased 54%, from 3.7 to 1.7 children born/woman. The birth rate during this same period decreased 58%, from 23.7 to 10.9 live births per 1,000. This decline is attributed to:

- Availability of a variety of highly effective contraceptive methods
- More women delaying reproduction to pursue careers, having fewer children, or remaining child-free
- Legalization and availability of elective abortions
- The rising cost of raising children, leading to smaller families

An interesting trend is noted regarding birth rate and the mother's age for the 30-year period from 1990 to 2020. Birth rates decreased for women aged 15 to 29 but increased for women aged 30 to 45 and older. The greatest increase was seen in women aged 40 and older. The greatest decrease was in women aged 15 to 19. This trend is influenced by the increasing number of women who have delayed childbirth due to career choices or socioeconomic reasons and the increased availability of contraceptives for younger women.

The United States had a total of 3,605,201 births in 2020 (women ages 15–44) (CDC, 2021a). The percentages of these births by race are:

- American Indian or Alaska Native: 0.747%
- Asian: 6.07%
- Native Hawaiian or other Pacific Islanders: 0.266%
- Hispanic: 23.96%
- Black: 14.66%
- White: 51.02% (CDC, 2021a)

TABLE 1-2 Birth Rates, United States of America, 1960–2017

	1960	1970	1980	1990	2000	2010	2015	2017
Birth rate	23.7	18.4	15.9	16.7	14.4	13	12.5	12.5

CIA, 2018a; Hamilton et al., 2007, 2009, 2011, 2016.

These percentages reflect the multicultural population of the United States and present an important challenge to health-care workers, who must provide culturally appropriate care to a wide variety of childbearing families while working to eliminate health disparities among populations.

Preterm Births

Preterm births are divided into three classifications:

- Very premature: Neonates born at less than 32 weeks of gestation
- Moderately premature: Neonates born between 32 and 33 completed weeks of gestation
- Late premature: Neonates born between 34 and 36 completed weeks of gestation

Globally, it is estimated that 15 million premature births occur each year, with a global preterm birth rate of 10.6% (WHO, 2018b). Complications related to preterm birth are the leading cause of death for children younger than 5 (WHO, 2018a). In the United States from 2000 to 2015, preterm births decreased by 24% to a total preterm birth rate of 9.62; however, the preterm birth rate has begun to increase since 2015 and saw a 2% increase from 2018 to 2019 to a rate of 10.23% (CDC, 2021a).

Despite widespread advances in perinatal care, the preterm birth rate remains high in the United States compared with that of other high-income countries, such as Canada, Japan, Australia, Israel, and Norway. The effect of social determinants of health is stark when looking at preterm birth by race: Black, non-Hispanic women have a 50% higher rate of preterm birth (14.35%) than Hispanic women (9.83%) or non-Hispanic White women (9.10%) (CDC, 2021a) (Table 1-3).

These rates substantially contribute to racial and ethnic disparities in maternal and infant health outcomes, discussed later in this chapter. Premature birth impacts the well-being of parents, the childbearing family, and the community as well as the length and quality of life for the preterm infant. A shorter gestational period increases the risk of complications related to immature body organs and systems that have lifelong negative effects, including but not limited to:

- Respiratory disorders
- Cerebral palsy
- Vision and hearing disorders
- Developmental delays

Of all infant deaths, 36% are related to preterm birth (CDC, 2016). Parents of preterm infants also face economic, social, and educational challenges in caring for a premature infant.

Neonatal Birth Weight Rates

Neonatal birth weight rates are reported by the CDC in three major categories: low, normal, and high. Normal birth weight is between 2,500 and 3,999 grams; high birth weight is 4,000 grams or greater; low birth weight (LBW) is below 2,500 grams. LBW is divided into two categories:

- LBW is defined as birth weight that is lower than 2,500 grams but greater than 1,500 grams. The percentage of LBW neonates has increased from 8% in 2014 to 8.3% in 2019 (CDC, 2021a; March of Dimes, 2021).
- Very low birth weight (VLBW) is defined as a birth weight of lower than 1,500 grams. The percentage of VLBW neonates has remained stable at 1.4% in 2014 and decreased slightly in 2019 to 1.38% (CDC, 2021a).

The weight of neonates at birth is an important predictor of future morbidity and mortality rates, including increased lifetime risk of diabetes and heart disease (March of Dimes, 2021a). Neonates with birth weights between 4,000 and 4,999 grams have the lowest mortality rate during the first year of life. VLBW neonates are 100 times more likely to die during the first year of life than are neonates with birth weights greater than 2,500 grams.

Infant Mortality Rates

Infant mortality is defined as a death before age 1. Globally, infant mortality has decreased from 65 deaths per 1,000 live births in 1990 to 29 deaths per 1,000 live births in 2016 (WHO, 2021a). Infant mortality rates in the United States decreased from 26 per 1,000 live births in 1960 to 5.7 in 2018 (CDC, 2021a). This decrease is related to improvement and advances in knowledge and care of high-risk neonates, notably:

- Advances in medical technology such as extracorporeal membrane oxygenation therapy (ECMO), used for respiratory distress in preterm infants (see Chapter 17)
- Advances in medical treatment such as exogenous pulmonary surfactant (see Chapter 17)
- Improved prenatal care
- Increased infant sleep safety education

Although this is a significant decrease, the infant mortality rate remains too high for a nation with the available wealth and health-care resources of the United States. The leading causes of infant deaths are listed in Table 1-4. Infant deaths related to SIDS significantly decreased between 1995 and 2018. The decrease can

TABLE 1-3 Premature Births by Race: United States, Provisional 2020

AMERICAN INDIAN OR ALASKA NATIVE	ASIAN	BLACK	HISPANIC	NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDERS	WHITE
11.57	8.51	14.35	9.83	11.98	9.10

CDC, 2021a.

**TABLE 1-4 Leading Causes of Infant Deaths and Mortality Rates
(Rates per 100,000 Live Births)**

CAUSE OF DEATH	1995 RATE	CAUSE OF DEATH	2015 RATE	CAUSE OF DEATH	2020 RATE
Congenital malformations and chromosomal abnormalities	168.1	Congenital malformations and chromosomal abnormalities	121.3	Congenital malformations and chromosomal abnormalities	111.9
Disorders related to short gestation and LBW	100.9	Disorders related to short gestation and LBW	102.7	Disorders related to short gestation and LBW	86.9
Sudden infant death syndrome	87.1	Sudden infant death syndrome	39.4	Sudden infant death syndrome	38.4
Respiratory distress of newborns	37.3	Newborns affected by maternal complications of pregnancy	38.3	Accidents	33.0
Newborns affected by maternal complications of pregnancy	33.6	Accidents	32.4	Newborns affected by maternal complications of pregnancy	30.9

Anderson et al., 1997; Kochanek et al., 2016; Murphy et al., 2012; Murphy et al., 2021

be attributed to Safe to Sleep, a public education program led by NICHD and other initiatives to teach parents safe newborn sleep habits, such as placing the child in the crib on their back.

In 1995, infant death from respiratory syndrome (RDS) was the fourth leading cause of death in newborns. In 2018, it was the ninth leading cause of infant death (CDC, 2020a). The decrease in RDS-related death rates reflects advances in medical and nursing care of preterm infants.

Maternal Death and Mortality Rates

The Department of Health and Human Services uses several definitions of maternal death:

- Maternal death is defined by the WHO as the death of a woman during pregnancy or within 42 days of pregnancy termination caused by conditions aggravated by the pregnancy or associated medical treatments. This category excludes death from accidents or injuries.
- Direct obstetric death results from complications during pregnancy, labor, birth, or the postpartum period, including deaths caused by interventions, omission of interventions, or incorrect treatment. An example of this category is death caused by postpartum hemorrhage.
- Indirect obstetric death is caused by a preexisting disease or a disease that develops during pregnancy without direct obstetrical cause but is aggravated by the pregnancy. One example is death related to complications of systemic lupus erythematosus worsened by pregnancy.
- Late maternal death occurs more than 42 days after termination of pregnancy from a direct or indirect obstetrical cause.
- Pregnancy-related death is the death of a woman during pregnancy or within 1 year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiological effects of pregnancy (Hoyert, 2007). An example

is a pulmonary embolism related to deep vein thrombosis that leads to death during or after pregnancy.

Maternal mortality ratio (MMR) is defined as the number of maternal deaths per 100,000 live births. In the United States, MMR had significantly decreased from 607.9 in 1915 to 12 in 1990 (Hoyert, 2007); however, MMR has risen significantly since 2015 to a current rate of 17.4 (Commonwealth Fund, 2020). The United States ranks last among all high-resource countries in maternal mortality rates (Commonwealth Fund, 2020). Most concerning are differences in mortality rates based on race: The MMR for Black women (37.1) is 2.5 times higher than in White women (14.7) and three times higher than for Hispanic women (11.8) in the United States (Commonwealth Fund, 2020). Inconsistency in reporting by the states resulted in a lack of thorough official data from the National Vital Statistics System (NVSS) on maternal mortality rates from 2007 to 2017, so the full scope of the problem may be lacking (Hoyert et al., 2020). Maternal morbidity has also increased significantly in the United States in the past decade: 700 women will die every year due to conditions related to their pregnancy, and 500,000 more will experience severe complications during pregnancy, birth, and the postpartum period (ACNM, 2021).

Research has clearly demonstrated that social determinants of health, which include systemic racism and health-care biases toward people of color, have significantly contributed to the health disparities in maternal-infant health in the United States (ACNM, BMMA, & ICM, 2020). A Black mother with a college education has a 60% greater risk of maternal death than a White or Hispanic mother without a high school education (Commonwealth Fund, 2020). Black women are also twice as likely to experience severe maternal complications such as cardiomyopathy, eclampsia, and embolism (CDC, 2019d). Similarly, American Indian and Alaska Native women also have

three to four times higher maternal mortality rates and two times higher rates of maternal morbidity, including postpartum hemorrhage and preterm birth (National Partnership for Women and Families, 2019). Behind all these statistics are real people and families who experience the devastating effects when poor outcomes occur for women and infants. Addressing racism and health care to improve outcomes will be discussed in the next section of the chapter.

Globally, the decrease in maternal mortality in developing countries is attributed to increased female education, increased contraception use, improved antenatal care, and increased number of births attended by skilled health personnel (WHO, UNICEF, UNFPA, World Bank Group and United Nations Population Division, 2015). Primary causes of maternal deaths worldwide are:

- Severe hemorrhage
- Infections
- Eclampsia
- Obstructed labor
- Complications of abortions
- Other causes, such as anemia, HIV/AIDS, and cardiovascular disease (WHO, UNICEF, UNFPA, World Bank Group and United Nations Population Division, 2015)

ISSUES

Primary issues affecting the health of people, mothers, and infants in the United States include teen pregnancy, tobacco and electronic cigarette use, substance abuse during pregnancy, medications use during pregnancy, obesity, violence, sexually transmitted infections, climate change, depression and perinatal mood disorders, racism, and health disparities.

Teen Pregnancy

As shown in Table 1-5, the birth rate for teenagers in the United States has been declining since 1990:

- The birth rate for teenagers aged 15 to 17 has decreased 83.2% from 1990 to 2020, with a decrease of 36% from 2010 to 2020.
- The greatest percentage of change occurred in ages 10 to 14, with a decrease of 85.7% from 1990 to 2020.

TABLE 1-5 Birth Rates for Teen Females: Births per 1,000 Live Births

AGE	1990	2005	2010	2015	2020
10–14	1.4	0.7	0.4	0.2	0.2
15–17	37.5	21.4	17.3	9.9	6.3
18–19	88.6	69.9	58.3	40.7	28.8

CDC, 2021a; Hamilton et al., 2011, 2016.

- The introduction of long-acting reversible contraceptives (LARCs), including the contraceptive implant and intrauterine devices (IUDs) for teens, has been key to reducing unintended pregnancy rates in this population.
- The teen birth rate in the United States in 2020 was higher than in other developed countries, with 17 births per 1,000 females aged 15 to 19 compared with Switzerland's rate of 3 and Canada's rate of 9.

Implications of Teen Pregnancy and Birth

Teen births can have adverse long-term effects on both the mothers and children, presenting challenges to teen parents and society. These include:

- Educational issues:
 - 50% of teen mothers receive a high school diploma compared with 90% of women who did not give birth during adolescence (CDC, 2019a).
 - Only half of teen mothers earn a high school diploma by age 22 and less than 2% finish college by age 30 (National Conference of State Legislators, 2016).
 - Poverty and income disparities:
 - 66% of teen mothers are poor and 25% begin receiving welfare within 3 years of the birth of their first child (National Conference of State Legislators, 2016).
 - 17% of teen mothers will have a second child before age 20, which further decreases their ability to complete school and qualify for well-paying jobs (National Campaign to Prevent Teen Pregnancy, 2016a).
 - Risk of sexually transmitted illnesses, including HIV, which can impact neonatal and maternal outcomes, including prematurity
 - Increased risk for hypertensive disorders of pregnancy
- Children born to teen mothers are at increased risk for:
- Health problems related to prematurity or LBW, including infant death, respiratory distress syndrome, intraventricular bleeding, vision problems, and intestinal problems
 - A higher mortality rate for infants of women younger than 15 compared with infants born to women of all ages
 - Behavioral problems
 - Placement in foster homes
 - Lower school achievement and dropping out of school
 - Incarceration during adolescence (Youth.gov, 2016)
 - Increased risk of becoming a teen mother themselves

Teen fathers have a 30% lower probability of graduating from high school than boys who are not fathers (Youth.gov, 2016). In addition, teenage males without an involved father are at higher risk for being incarcerated, dropping out of school, and abusing drugs or alcohol.

Tobacco and Electronic Cigarette Use During Pregnancy

Tobacco use during pregnancy is associated with increased risk of LBW, intrauterine growth restriction, miscarriage, abruptio

CLINICAL JUDGMENT**Teen Pregnancies**

Teen pregnancies have short-term and long-term adverse effects for teen mothers, teen fathers, their children, their community, and society. Nurses can help address the rates of unintended pregnancies among U.S. teens by advocating for and providing comprehensive sexuality education that increases adolescent knowledge of reproduction and healthy sexuality. Nurses should also educate all teens who are sexually active where pregnancy is a risk on the differing forms of contraception, their efficacy, and their right to obtain birth control independently, depending on the statutes of their state.

placenta, premature birth, SIDS, and respiratory problems in the newborn.

- Cigarette smoking during pregnancy declined from 19.5% in 1989 to 7.2% in 2016 (CDC, National Center for Health Statistics, 2017).
- Women who smoke during pregnancy are less likely to breast-feed their infants.
- Of women who smoked before pregnancy, 20.6% quit during pregnancy (Curtain & Mathews, 2016).
- Based on age, the highest smoking prevalence rate is among women aged 20 to 24 (Curtain & Mathews, 2016).
- Based on race, the highest percentage of female smokers is among American Indians and Alaska Natives (Curtain & Mathews, 2016).
- Based on educational level, the highest percentage of female smokers are women with less than a high school education (Curtain & Mathews, 2016).

Electronic cigarettes (e-cigarettes) are increasingly prevalent in the United States, but they are not considered safe in pregnancy and the CDC has advised against all e-cigarette use, including in pregnancy (CDC, 2019c). E-cigarettes are not controlled by the Food and Drug Administration (FDA) and contain carcinogenic and toxic compounds (healthychildren.org, 2019). Nicotine, which is present in e-cigarettes, is a health danger to both the pregnant woman and her fetus and can adversely affect the developing fetal brain and lungs. E-cigarettes have not been demonstrated to be effective in helping women quit smoking, so nurses should advise against all e-cigarette use in pregnancy (ACOG, 2020; healthychildren.org, 2019).

CRITICAL COMPONENT**Tobacco and E-Cigarettes**

Nicotine is a health danger for pregnant women and their developing fetuses. Pregnant women should not use any tobacco product or e-cigarettes because nicotine is toxic to developing fetuses and impairs fetal brain and lung development (CDC, 2018).

Substance Abuse During Pregnancy

In the general U.S. population, the use of illegal drugs and cannabis is greatest in women aged 18 to 25, and the use of alcohol is greatest for women aged 26 to 34. With the rapidly changing regulatory status of cannabis in many states, the rate of use has more than doubled in pregnant women from 2010 to 2017, with 12.1% of women reporting use in the first trimester and 7.0% reporting use overall in pregnancy (National Institute on Drug Abuse, 2020). Evidence shows that regular cannabis use can affect fetal growth and cause LBW. The current recommendation is to discontinue marijuana use during pregnancy and in women considering pregnancy until more data is available on safety in pregnancy (National Institute on Drug Abuse, 2020). Substantial evidence shows that use of illegal drugs such as heroin, cocaine, methamphetamine, and MDMA can cause stillbirth, preterm birth, and birth defects. All women should be screened in pregnancy for drug use and abuse, with 5% of women in the United States reporting illegal street drug use (AWHONN, 2018; March of Dimes, 2021b).

Use of alcohol and illegal drugs during pregnancy can have a profound effect on the developing fetus and the health of the neonate. Fourteen percent of women report use of alcohol during pregnancy and 5% of women report binge drinking during pregnancy (CDC, 2022). Exposure to alcohol during pregnancy places the developing fetus at risk for fetal death; LBW; intra-uterine growth retardation; mental retardation; and fetal alcohol spectrum disorders (FASDs), “a group of conditions that can occur in a person whose mother drank alcohol during pregnancy” (CDC, 2017). The impact of substance use on pregnancy and neonates is addressed in relevant chapters. For more information on FASDs, which have physical, behavioral, and cognitive effects, see Chapter 17.

Exposure to illegal drugs during pregnancy is associated with preterm birth, abruptio placenta, drug withdrawal for the neonate, and congenital defects. Cocaine use during pregnancy can cause strokes and seizure in the developing fetus and affect cognitive performance, information processing, and attention to tasks in children (March of Dimes, 2021b). Marijuana use during pregnancy may cause preterm birth, LBW, and neural tube defects (March of Dimes, 2021d).

Medication Use During Pregnancy

Although much focus is given to the use of tobacco, alcohol, cannabis, and illegal substances, it is equally important to assess women for use of prescription and over-the-counter (OTC) medications, including prescription medications that may belong to another person. Of the six million pregnancies in the United States each year, 9 in 10 women will use an OTC or prescribed medication in pregnancy (National Institute on Drug Abuse, 2020). Most drug trials do not include pregnant women due to ethical considerations and potential risk of harm to the fetus, so the majority of OTC and prescribed medications have not been tested in pregnant women; thus, all substances

including supplements and herbal preparations should be discussed with a health-care provider before use in pregnancy (National Institute on Drug Abuse, 2020). In keeping with the opioid crisis in the United States, the number of women who had a use disorder at the time of birth quadrupled between 1999 and 2014 (CDC, 2018b).

Nursing Actions

Nurses can help reduce the negative outcomes from cigarette, alcohol, substance abuse, and improper medication use with preconception counseling for all women considering pregnancy in addition to routine screenings for substance use and abuse throughout pregnancy, the postpartum period, and for breast-feeding women.

Overweight and Obesity

Overweight is defined as a body mass index (BMI) of 25 to 29, obesity is defined as a BMI greater than or equal to 30, and severe obesity is defined as a BMI greater than 40. In the United States, the percentage of adults and youth who are overweight and obese is increasing exponentially. In 2000, 30.5% of adults and 13.9% of youth were obese compared with the current rate of 42.4% of adults, with the rate of severe obesity increasing from 4.7% to 9.2% in 2018 (CDC, 2021c). Maternal and infant health are among the areas most impacted by the obesity epidemic: overall, 28% of pregnant women meet the criteria for obesity and 75% of pregnant Black women meet the criteria for being overweight or obese (Pickett-Blakely et al., 2016). The impacts of obesity on pregnancy, labor, birth, and postpartum are addressed in relevant chapters.

CRITICAL COMPONENT

Obesity

In the United States, obesity is a major health concern for both adults and youth. Pregnant women who are overweight or obese are at higher risk for complications such as diabetes and cesarean birth. Infants born to women who are overweight or obese are at higher risk for complications such as intrauterine fetal death and birth injuries related to macrosomia.

Obesity in childbearing women has adverse effects on both the women and their children. Pregnant women who are overweight or obese are at higher risk for:

- Infertility (two times greater risk)
- Spontaneous abortion (miscarriage)
- Gestational hypertension
- Preeclampsia (two to three times greater risk)
- Gestational diabetes (two to three times greater risk)
- Thromboembolism
- Cesarean birth
- Wound infection
- Shoulder dystocia related to macrosomia (birth weight more than 4,000 grams)

- Sleep apnea
- Anesthesia complications
- Maternal death (Mahuette et al., 2018; Pickett-Blakely et al., 2016)

Fetuses and infants of overweight and obese pregnant women are at higher risk for:

- Fetal abnormalities, including spina bifida, heart defects, anorectal atresia, and hypospadias
- 20% increased risk for oral cleft defects, 39% increase in neural tube defects, and 50% increase in spina bifida (Mahuette et al., 2018; Pickett-Blakely et al., 2016)
- 20% increase in stillbirth
- Intrauterine fetal death
- Birth injuries related to macrosomia
- Childhood obesity and diabetes
- Increased lifetime risk of obesity, hypertension, and diabetes

Nursing Actions

Addressing the obesity epidemic is a national priority and evidence has demonstrated that change must occur at the population level.

- Addressing the social determinants of health that lead to obesity, including funding for access to healthy foods, safe living and play environments, equal access to affordable and effective health care, and increased educational and employment opportunities (National Partnership for Women and Families, 2019)
- Preventing lifetime risks for infants by addressing maternal obesity
- Providing preconception counseling and care with targeted weight loss before pregnancy
- Referral for specialized care if failure to lose weight with lifestyle modifications
- Preventing excessive weight gain in the first pregnancy through education regarding diet, exercise, and danger of being overweight

Violence

Intimate partner violence (IPV), sexual assault, and trauma are also key factors that impact maternal and child health, as well as the health of women and LGBTQIA+ communities in the United States. The scope of the problem is profound:

- More than one in three women will experience IPV, rape, physical violence, verbal abuse, and stalking in their lifetime. Ten million incidences (both women and men) of IPV occur in the United States each year (ACOG, 2012; National Coalition Against Domestic Violence [NCADV], 2021a).
- One in six pregnant women experience IPV before and during pregnancy (Agency for Healthcare Research and Quality [AHRQ], 2015; March of Dimes, 2021a), and more than 320,000 pregnant women experience abuse each year (ACOG, 2012; March of Dimes, 2021a). Women who experience abuse during pregnancy are at higher risk for inadequate

weight gain, substance abuse, depression, posttraumatic stress disorder (PTSD), suicide, and homicide, whereas infants are at risk for LBW, preterm birth, small for gestational age (SGA), and neonatal death (ACOG, 2012; March of Dimes, 2021a).

- One in five adolescents who identifies as female reports having experienced dating violence and 1.5 million teens will experience IPV in dating relationships each year (NCADV, 2021b).
- Older women who are dependent on caregivers are also at increased risk, with an estimated 1 in 10 older adults experiencing elder abuse each year (ACOG, 2021).
- Immigrant women are at increased risk and health-care providers must be aware of the cultural, linguistic, economic, and legal barriers for immigrant women and people to report IPV and assault, especially when there is a fear of deportation (ACOG, 2021).
- Women with disabilities are a population at increased risk as well, and health-care providers' lack of education and biases against women with disabilities leads to low screening rates. Women with disabilities experience sexual assault and abuse at three times the rate of the general population. In fact, 83% of women with disabilities will be sexually assaulted in their lifetime, and half of women with developmental disabilities who have been sexually assaulted are assaulted more than 10 times in their lifetime (Disability Justice, 2021).

Nursing Actions

- Screen all women (especially pregnant women) for IPV and assault at the initiation of prenatal care, in each trimester, and at the postpartum visit (ACNM, 2021; ACOG, 2012).
- Provide counseling, home visits, and mentoring support to pregnant women experiencing IPV (AHRQ, 2015).
- Provide routine screening for PTSD, depression, and suicide risk during prenatal care, postpartum visits, and well-woman examinations (ACNM, 2021).
- Make IPV screening an integral part of all health visits, inclusive of all women, including older women and women with disabilities (ACOG, 2012).
- Screen for adverse childhood experiences (ACE) and history of trauma as part of all prenatal care and well-infant care (Mersky & Lee, 2019; Olsen, 2018).
- Know the risk for homicide increases five times if IPV is occurring and there is a gun in the home. Screen for the presence of guns in the home (Everytown for Gun Safety, 2020).

Perinatal Depression and Mood Disorders

Depression, anxiety, and other perinatal mood disorders create a significant patient safety issue for women and infants:

- One in seven women experience postpartum depression.
- Between 13% and 21% of women experience perinatal anxiety.
- Two of three young pregnant women report one or more mental health issues.

- Around 20% of postpartum deaths are from suicide (Kendig et al., 2017; Slomain et al., 2017).

Maternal outcomes from perinatal mood disorders can include decreased participation on care, smoking and substance abuse, decrease in self-care and care of infant, discontinuation of breastfeeding, and suicide (Kendig et al., 2017).

Infant outcomes include poor weight gain; increased illnesses; decreased mother–infant bonding; sleep disorders; delays in motor, cognitive, language, and social development; and infanticide (Kendig et al., 2017; Slomain et al., 2017). The impact of depression and mood disorders on pregnancy and postpartum is addressed in relevant chapters.

Nursing Actions

- Implement the Consensus Bundle on Maternal Mental Health (Kendig et al., 2017):
 - Readiness
 - Recognition and Prevention
 - Response
 - Reporting and Systems Learning
- Screen for mood disorders in all three trimesters and for 1 year after birth.
- Initiate earlier and more frequent postpartum visits.
- Perform universal screening and education for postpartum depression (PPD) and mood disorders before every discharge.
- Create and support community services for treatment of PPD and perinatal mood disorders.

Sexually Transmitted Infections

The onset of COVID-19 created “pandemics within pandemics” with significant increases in the number of drug overdoses, rates of IPV, and the transmission of sexually transmitted infections (STIs). Here are the key findings on STIs from the latest data:

- Reportable STIs increased 30% between 2015 and 2019.
- The most significant increase was in congenital syphilis, which quadrupled from 2015 to 2019.
- Congenital syphilis neonatal deaths have increased by 22%.
- Health disparities exist among different population groups, with a five to eight times higher rate of STIs in 2019 for Black Americans; three to five times higher rate for American Indian, Alaska Native, and Pacific Islander women; and one to two times higher rate for Hispanic women (CDC, 2021d).
- Emerging data shows that HPV infection may increase the risk of preterm birth and maternal complications (Niyabizi et al., 2020).

Nursing Actions

Health-care providers must take the lead in preventing, screening, diagnosing, and treating STIs to reduce maternal and neonatal morbidity and mortality. Nurses should lead in health promotion and STI prevention through education on vaccination, safe sex practices, informed consent, and violence reduction.

Climate Change

Climate change is a significant and increasing threat to maternal and neonatal health, as well as global health, and nurses need to be educated on how to assess this threat and effectively respond (Kincaid, 2017; Public Health Institute, 2016; U.S. Global Change Research Program, 2016). Low-resource countries and communities are at increased risk for the negative health effects of climate change, and both globally and nationally these nations and communities are advocating for recognition of the specific harms to their communities and a reduction in global warming (Public Health Institute, 2016; U.S. Global Change Research Program, 2016). The six areas of climate change that impact maternal and child health are:

- Extreme heat
- Outdoor air quality
- Flooding
- Vector-borne infection
- Water quality, drought, and water-related illnesses
- Mental health and well-being (Public Health Institute, 2016; U.S. Global Change Research Program, 2016)

Although the exact causes of COVID-19 are not yet fully determined, significant evidence shows that climate change increases the risk of the emergence and transmission of new infectious diseases, mostly through deforestation and loss of habitat that brings animals and humans in closer contact (Harvard School of Public Health, n.d.; The Lancet, 2021). Data has demonstrated that people living in areas with poorer air quality are more likely to die from COVID-19, and future outbreaks of novel diseases will be prevented in part by addressing climate change, protecting the environment, and preserving biodiversity and natural habitats (Harvard School of Public Health, n.d.; The Lancet, 2021).

Nursing Actions

- Educate patients on climate change and how to mitigate the effects on maternal and child health.
- Know the specific threats in your communities and participate in disaster planning.
- Advocate for policies that address climate change and global warming.
- Advise pregnant women and childbearing families to monitor heat exposure and hydration during periods of extreme heat.
- Monitor the Air Quality Index and avoid being outside when critical.
- Create an emergency response plan.
- Reduce exposure and limit travel to avoid vector-borne illnesses (Public Health Institute, 2016; U.S. Global Change Research Program, 2016).

CRITICAL COMPONENT

Extreme Temperatures

Pregnant women are vulnerable to temperature extremes and susceptible to dehydration, which releases labor-inducing hormones.

Health Disparities, Racism, and Discrimination

In any discussion of health disparities in the United States, it is critical to name and address the role that racism and discrimination play in adverse outcomes. Although it is essential to identify these disparities to prepare nurses to provide effective care to all people, it is also imperative to create nursing interventions that systemically address inequities, starting by partnering with communities as they create their own solutions to the urgent health-care issues affecting them.

LGBTQIA+ Care

Health-care disparities and discrimination based on sexual orientation, gender identity, and sexual practices are routinely experienced by LGBTQIA+ individuals (Fenway Institute, 2016). Although data shows that LGBTQIA+ individuals are at higher risk for smoking, substance abuse, violence, and obesity, research demonstrates that these disparities do not result from individual vulnerabilities but from societal discrimination and abuse, which extends to health-care biases and discrimination (Fenway Institute, 2016). Comprehensive reform at the societal level as well as in health-care policy and practices is needed to support LGBTQIA+ individuals and communities in optimal wellness.

Extensive disparities in health outcomes exist for the LGBTQIA+ communities, and it is imperative that nurses and health-care professionals proactively screen for these disparities using the social determinants of health framework, avoiding actions or statements that confer individual blame or judgment (Healthy People.gov, 2021). Examples of disparities include:

- In a study that focused on sexual minority birth outcomes, 59% of women who identified as bisexual and 31% of women who identified as lesbian reported giving birth. However, study findings demonstrated higher rates of miscarriage, preterm birth, LBW, and stillbirth for bisexual and lesbian women (Everett et al., 2019).
- LGBTQIA+ youth have a two to three times higher rate of suicide than non-LGBTQIA+ youth (HealthyPeople.gov, 2021).
- LGBTQIA+ individuals have the highest rates of tobacco, alcohol, and drug use in the United States (Healthy People.gov, 2021).
- LGBTQIA+ individuals have higher incidences of asthma (21% of adult population), diabetes (20% of adult population), and uninsured status (17% of adult population) as compared with the non-LGBTQIA+ population. These conditions have led to worse health outcomes overall, including increased risk of severe COVID-19 infection (Fields, 2021).
- One in two transgender people report discrimination by health-care providers, which has led to 40% postponing or avoiding preventive health care (Medina, 2021).

Nursing Actions

- Advocate for policy changes that remove legal discrimination against LGBTQIA+ people at the local, state, and national level.

- Create LGBTQIA+ welcoming and gender-affirming environments, which include inclusive forms, signage, and office practices.
- Revise electronic health records (EHRs) to be inclusive of all people and collect data on gender identity and sexual orientation.
- Publicize nondiscrimination policies in patient materials, Web sites, and waiting areas.
- Provide training to all health-care staff to treat LGBTQIA+ patients in a caring and respectful manner, including using preferred names and pronouns.
- Recognize that facilities that participate in Medicare or Medicaid are required to let patients choose who can visit them and make medical decisions on their behalf, irrespective of sexual orientation, gender identity, or marital status (Fenway Institute, 2016).

Racism and Discrimination

The purpose of evidence-based care is to identify root causes of health disparities and systemically address these causes to achieve health equity. This discussion of racism and discrimination as it applies to maternal and infant health outcomes is based on decades of research and evidence that have demonstrated that systemic racism and discrimination in the United States is a key contributor to worsening maternal and infant outcomes for women of color (ACNM, BMMA, & ICM, 2020; ACOG, 2018; California Maternal Quality Care Collaborative, 2020).

At a physiological level, systemic racism and ongoing discrimination create persistent stressors in the body that cause biological weathering, including elevated cortisol levels, increased blood pressure, and shortening of telomeres in women of color—especially Black women—in the United States (Martin & Montagne, 2017). These impacts contribute to maternal complications such as hypertension, preterm birth, and earlier onset of chronic diseases that affect birth outcomes.

Similarly, women of color, specifically Black women in the United States, experience racism and discrimination that directly impact social determinants of health and, thus, negatively affect maternal and infant health outcomes. Seventy-four percent of Black women in the United States, for example, give birth in hospitals that care for predominantly Black patients. These hospitals are often in areas of historical segregation, score lower on maternal outcomes, and have higher levels of maternal morbidity and mortality (Creanga et al., 2014; Howell et al., 2016; Martin & Montagne, 2017).

Finally, research has clearly demonstrated that health-care providers, including nurses, are affected by systemic racism in the United States and exhibit biases against women of color while providing health care that causes harm and leads to poorer outcomes. Examples of biases against women of color that lead to health disparities include reduced rates of screening for diabetes in the postpartum period, significantly less pain medication given during labor and postpartum, and lower rates of epidural administration for women of color (Choo, 2017).

It is difficult to overstate the severity of racism's impact on maternal and newborn outcomes in the United States. These statistics are included to clarify that this is an ongoing and

worsening national crisis, but similar to the disparities seen with LGBTQIA+ communities, these statistics must be seen as a call to action—led by communities of color—and not as a criticism of the people and communities experiencing these outcomes.

- Black women have three to four times higher maternal mortality rates and two times higher rates of severe maternal complications, including cardiomyopathy, embolism, and eclampsia (ACNM, BMMA, & ICM, 2020).
- Black infants have two times the rate of infant death of White infants (Taylor et al., 2019).
- American Indian and Alaska Native women have three to four times higher maternal mortality rates and two times higher rates of severe maternal morbidity, including postpartum hemorrhage and preterm birth (National Partnership for Women and Families, 2019).
- Maternal morbidity and mortality rates for Black women are independent of education, income, or other socioeconomic factors (ACNM, BMMA, & ICM, 2020).
- A college-educated Black woman is three times more likely to experience severe maternal complications than a White woman without a high school education (Choo, 2017).

Communities and organizations composed of people of color are leading the effort to address the racial disparities and inequities in maternal and infant health outcomes in the United States, and health-care and governmental organizations are joining the effort to prioritize equitable health outcomes for all women of childbearing age, especially women of color (ACNM, BMMA, & ICM, 2020).

Nursing Actions

1. Increasing the number of maternal health-care providers that are people of color significantly improves maternal outcomes (ACNM, BMMA, & ICM, 2020).
2. Community-led initiatives significantly improve maternal outcomes (California Maternity Care Collaborative, 2020; Choo, 2017).
3. Leadership by people of color significantly improves maternal outcomes (ACNM, BMMA, & ICM, 2020).
4. Addressing racism in practice is critical (ACNM, BMMA, & ICM, 2020).
5. Racial equity trainings that focus on addressing racism at both an interpersonal and institutional level help to improve maternal outcomes (National Birth Equity Collaborative, 2021).



SAFE AND EFFECTIVE NURSING CARE: Cultural Competence

Community Resources

Organizations such as the Black Mamas Matter Alliance and Sister Song: Women of Color Reproduction Collaborative are instrumental in creating community-led initiatives to improve infant and maternal health for people of color at a local, state, and national level (Black Mamas Matter Alliance, 2021).

TABLE 1-6 Healthy People 2030 Maternal and Infant Health Goals

OBJECTIVES	BASELINE	2030 TARGET
Reduce rate of fetal deaths at 20 or more weeks of gestation	5.9 per 1,000 live births and fetal deaths	5.7 per 1,000 live births and fetal deaths
Reduce maternal deaths	17.4 maternal deaths per 100,000 live births	15.7
Reduce cesarean births among low-risk women with no prior cesarean births	25.6%	23.6%
Reduce total preterm births	10.2% of live births	9.4%
Increase proportion of pregnant women who receive early and adequate prenatal care	76.7%	80.5%
Increase abstinence from alcohol among pregnant women	89.3% past 30 days	92.2%
Increase abstinence from cigarette smoking among pregnant women	94%	95.7%
Increase abstinence from illicit drugs among pregnant women	93%	95.3%
Increase the proportion of women of childbearing age who get enough folic acid	82.6%	86.2%
Increase the proportion of women delivering a live birth who had a healthy weight before pregnancy	41%	47.1%
Increase the proportion of infants who are put to sleep on their backs	78.7%	88.9%
Increase the proportion of infants who are breastfed exclusively through age 6 months	24.9%	42.4%

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. *Healthy People 2030*. <https://health.gov/healthypeople>

MATERNAL AND CHILD HEALTH GOALS

The health of a nation is reflected in the health of pregnant women and their infants. Identifying interventions to improve social determinants of health, reduce health disparities, and improve maternal and infant outcomes are all integral to the *Healthy People 2030* goals for the nation. The CDC and Health Resources and Services have set national maternal and child health goals in *Healthy People 2030* (Table 1-6). Reviewing these goals helps nurses focus their nursing care and advocacy to achieve health outcomes at the population level, and improving the health of mothers and children will have lifelong effects on the health of the nation.



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Ethics and Standards of Practice Issues

2

Roberta F. Durham, RN, PhD

LEARNING OUTCOMES

Upon completion of this chapter, the student will be able to:

1. Debate ethical issues in maternity nursing.
2. Explore standards of practice in maternity nursing.
3. Describe legal issues in maternity nursing.
4. Analyze concepts related to evidence-based practice.

CONCEPTS

Caring
Clinical Judgment
Collaboration
Comfort
Communication
Evidence-Based Practice
Family
Grief and Loss
Health Policy
Health-Care Systems
Leadership and Management
Professionalism
Quality Improvement
Safety
Self

INTRODUCTION

Maternity nursing is an exciting, dynamic area of nursing practice. There are unique ethical challenges in maternity nursing, with an obligation to practice safe, evidence-based nursing care that is responsive to the needs of women and their families. This chapter presents the foundational principles set forth by the American Nurses Association (ANA, 2015a) Code of Ethics and addresses specialty practice standards from the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN, 2019), which outline duties and obligations of obstetric and neonatal nurses. The chapter reviews ethical principles within the context of perinatal dilemmas and ethical decision making and presents common issues in maternity nursing litigation. Finally, the chapter explores evidence-based

practice (EBP) and challenges in research utilization in the perinatal setting.

ETHICS IN NURSING PRACTICE

The terms *ethics* and *morality* are often used interchangeably, but they have different meanings. Morality is very personal and can be adaptable over time; in a pluralistic society, there are many different standards of morality. Ethics, however, are the results of a disciplined study of morality expressed in systemic norms (Stephenson, 2016). In nursing, current professional ethical standards are codified in the ANA Code of Ethics (2015a). These standards are based on universal ethical principles (Stephenson, 2016) and are binding to nurses, regardless of whether they agree with a nurse's personal morality.

TABLE 2-1 Overview of American Nurses Association Code of Ethics

Provision 1	The nurse practices with compassion and respect for the inherent dignity, worth, and uniqueness of every person.
Provision 2	The nurse's primary commitment is to the patient, whether an individual, family, group, or community.
Provision 3	The nurse promotes, advocates for, and strives to protect the health, safety, and rights of all patients.
Provision 4	The nurse has authority, accountability, and responsibility for nursing practice, decisions, and actions consistent with the nurse's obligation to promote health and provide optimum care.
Provision 5	The nurse owes the same duties to self as to others, including the responsibility to promote health and safety, to preserve wholeness of character and integrity, to maintain competence, and to continue personal and professional growth.
Provision 6	The nurse, through individual and collective effort, establishes, maintains, and improves the ethical environment of the work setting and provides quality health care.
Provision 7	The nurse, in all roles and settings, advances the profession through research and scholarly inquiry development of professional standards and policy.
Provision 8	The nurse collaborates with other health professionals and the public to promote human rights and health diplomacy and to decrease health disparities.
Provision 9	The profession of nursing, collectively through its professional organizations, articulates nursing values, maintains the integrity of the profession, and integrates the principle of social justice into nursing and health policy.

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ANA Code of Ethics

The ANA Code of Ethics describes the goals, values, and obligations of nursing. This code applies to all nurses and is intended to be adaptable to areas of specialty nursing. The purpose of the Code of Ethics is to be a:

- Nonnegotiable ethical standard for the profession;
- Reflection of the profession's own understanding of its commitment to society;
- Statement on the ethical duties and obligations of every nurse;
- Resource for nurses confronted with ethical dilemmas.

Table 2-1 lists the fundamental values and ethical principles of the nursing profession as described in the ANA's 2015 Code of Ethics. The ANA offers interpretive statements to further clarify the nine basic provisions outlined in the table and how they should be applied.

Ethical Principles

In addition to medically sound care, nurses are called on to provide compassionate and ethically sound care. This is not always an easy task. Maternity nursing is unique in that the nurse is caring for two patients at the same time, the woman and fetus, and decisions are often complicated by the timeline of fetal development. Medical decisions that were ethical in the 12th week of gestation may no longer be ethical at 35 weeks' gestation and vice versa. Technological advances in the neonatal intensive care unit (NICU) blur the line of viability, defined as the moment when a fetus is developed enough to survive outside of the uterus with a reasonable probability of growing and developing as a

human being; this definition adds another dimension of complexity (Stephenson, 2016).

Understanding the ethical principles that form the basis of a code of ethics can help guide nurses confronted with ethically complex situations (ANA, 2015a). Although the principles are not difficult to define, they can become complicated and mutually contradictory in some circumstances:

- **Beneficence:** The obligation to do good. In maternity nursing, this applies to both the woman and the fetus and is usually uncomplicated. Educating your patient about interventions and behaviors that benefit both her and her fetus is an example of beneficence.
- **Nonmaleficence:** The obligation to do no harm to either the woman or the fetus. For example, helping a mother understand the potential consequences of drug abuse or alcohol ingestion during pregnancy is an act of nonmaleficence.
- **Fidelity:** Being accountable for your responsibilities and loyal to your commitments, such as ensuring your patient has appropriate care from your relief nurse before going off shift.
- **Veracity:** Being truthful. This can mean being honest with your patient about risks and benefits of a cesarean or admitting that you need assistance to give appropriate care.
- **Autonomy:** The right to self-determination. It is related to free choice and personal decisions and is the basis for informed consent in health care. This applies only to the pregnant woman, as the fetus is not able to conceive of or express preferences.
- **Justice:** This is related to allocation of resources and ensures that resources are used equitably. What is considered equitable,

however, may be subjective and cause conflict. For example, at the societal level justice relates to which initiatives or programs are funded, whereas at the individual level justice may influence who receives an organ transplant.

Ethical Approaches

Ethical principles can compete in every area of nursing. In maternity nursing, this is compounded by the nurse's responsibilities to both the woman and the fetus. A woman's autonomy can include her right to make decisions that are not in the best interest of the fetus. In contrast, she may forgo necessary therapies for herself until after her delivery despite her own best interests, such as chemotherapy treatment for malignant cancer that would harm the fetus. A nurse is not in a position to voice approval or disapproval of the decisions the woman makes but should advocate for a woman to make informed decisions.

When considering the best approach to managing limited resources, there are three primary philosophies to consider (ANA, 2015a): utilitarianism, libertarianism, and egalitarianism. Each has its own strengths and weaknesses, and they can all be effective decision-making strategies in various situations:

- **Utilitarianism:** This is the principle of distributing resources to produce the greatest good for the most people and opposes using large amounts of resources for the benefit of a few.
- **Libertarianism:** This philosophy promotes the idea that some people are more valuable to society than others and thus need to be given the resources they require to survive. To do otherwise is to waste resources.
- **Egalitarianism:** This moral principle focuses on the belief that all people are equal. This principle emphasizes distributing resources according to need to protect those in society who are marginalized and vulnerable.

Consider the situation of a premature but healthy infant who needs extensive and expensive technological support to survive for the first few weeks. Should the infant's access to lifesaving support be dependent on the family's ability to pay? What if the infant is not healthy and will likely be severely disabled even if the child survives, requiring lifelong care and intensive resources? Does that change the decision to provide resources for the child to survive infancy? Should it change the decision? These situations can be very challenging to nurses as they advocate for both mothers and infants and navigate ethical dilemmas.

Ethical Dilemmas

Ethical dilemmas occur in all areas of life. Although they can be addressed in many ways, nurses must consider their clear obligations and duties to their patients. Because maternity nurses must advocate for both maternal and fetal well-being, it may not be possible to "do the right thing" for both. Ethical dilemma refers to when there is difficulty in deciding which action takes precedence over the other. A dilemma has been described as a situation requiring a choice between what appears to be equally desirable or undesirable alternatives (Aderemi, 2016). It can also

be described as a situation in which the patient's rights and the professional's obligations conflict.

Ethical dilemmas occur in maternal and child health nursing as they do in other areas of nursing. Such situations are common in perinatal and neonatal care because the well-being of both the mother and her neonate must be considered. Most believe pregnancy is not an exception to the principle that a patient capable of making decisions has the right to refuse treatment, even treatment needed to maintain life. Therefore, a capable pregnant woman's decision to refuse recommended medical or surgical interventions should be respected (American College of Obstetricians and Gynecologists [ACOG], 2016). The most suitable ethical approach for medical decision making in obstetrics is one that recognizes the pregnant woman's freedom to make decisions within caring relationships, incorporates a commitment to informed consent and refusal within a commitment to provide medical benefit to patients, and respects patients as individuals. This ethical approach recognizes that the primary duty is to the pregnant woman. This duty most often also benefits the fetus. However, circumstances may arise in which the interests of the pregnant woman and those of the fetus diverge, demonstrating the primacy of the provider's duties to the woman (ACOG, 2016).

Some ethical dilemmas may be more easily avoided. Implementing safe practices according to evidence-based practice (EBP) guidelines, helping to establish a culture of safety and professionalism in your workplace, and reporting both individual and system errors can prevent many ethically challenging situations. Consider the example from earlier in which the mother requires chemotherapy that may harm the fetus or the ethics of deciding to terminate a severely abnormally developed fetus. Is it ethical to delay treatment for a pregnant woman with cancer, potentially shortening her life? Or, in the other situation, is it ethical to continue a pregnancy with a nonviable fetus that results in a painful, short life for the newborn? How does one balance advocating for the mother and the fetus if the mother insists on continuing with high-risk behaviors during her pregnancy? There are no simple answers to such situations, yet maternity nurses must help mothers and families navigate these and other ethical dilemmas. Practice dictates that the primary advocacy role of maternity nurses is on behalf of the mother. Obligations to the fetus are tempered by the context of the mother's decisions, and that can be complicated. As individuals with their own ideas of morality, maternity nurses may not agree with the mother's choices, yet their duty to respect her autonomy will help guide them in managing the consequences. Adding to the challenge is the fact that while caring for women and their families, nurses encounter diverse cultural practices, spiritual beliefs, and attitudes toward health and health care. Patterns of communication and decision making are influenced by culture, so cultural awareness and cultural humility can help nurses navigate decision making with patients and families. Striving to support women's choices is a fundamental moral responsibility for nurses. Awareness of the broader context that influences health supports patient-centered care and can help reduce health inequities (ACOG, Committee on Health Care for Underserved Women, 2018).

Other issues in which maternity nurses will be required to help educate, guide, and ultimately advocate for patients include:

- Court-ordered treatments that infringe on the pregnant woman's right to autonomy.
- Criminalization of pregnant women with substance use disorders.
- The difficult decision to withdraw life support from the infant or the mother.
- Treatment of genetic disorders or fetal abnormalities.
- Systemic inequities that prevent or delay pregnancy care during the previsible period.
- Equal access to prenatal care.
- Genetic engineering, cloning, and surrogacy.
- Navigating decisions such as sanctity of life versus quality of life for extremely premature or severely disabled infants, including whether to resuscitate borderline-viable infants.
- Fetal reduction and preconception gender selection.

An ethics committee in hospitals is an advisory group appointed by the hospital medical executive board. The multidisciplinary ethics committee represents the hospital and the community it serves. Most hospitals have an ethics committee, made up of doctors, nurses, lawyers, and clergy, which can get together to help families or health-care workers when difficult ethical questions arise. Staff and family members can request an ethics committee consultation at many hospitals.

CLINICAL JUDGMENT

Evidence shows that nurses who understand and internalize professional nursing ethics are less likely to suffer from a loss of confidence and self-esteem as a result of facing these difficult situations (Aderemi, 2016; Iacobucci et al., 2013). Nurses can experience moral distress from situations in which their core beliefs conflict with providing care. Moral distress occurs in the day-to-day setting and involves situations in which one acts against one's better judgment due to internal or external constraints. Putting aside one's values and carrying out an action one believes is wrong threatens the authenticity of the moral self. Unfortunately, situations of moral distress are common in health care, and damage to providers' moral integrity occurs with alarming frequency (Tessman, 2020) (Box 2-1). This negotiation between individual conscience and patient responsibility arises in many circumstances (e.g., abortion, near viability infant resuscitation, end-of-life care, informed refusals, and withdrawal of treatment and medical assistance in dying). The opportunity to develop these skills in relationship to an individual's own moral conscience is an important part of nursing and nursing education (Swartz et al., 2020). A nurse who demonstrates moral courage speaks up and asks questions when discussing decisions about care with patients and with colleagues. She practices self-reflection about personal, health-related values and beliefs to increase the capacity to respect the same in others (Ruhl et al., 2016). The goal is to preserve moral sensitivity and integrity by recognizing, valuing, and hearing staff.

BOX 2-1 | Clinical Examples of Perinatal Ethical Dilemmas

Ethical dilemmas occur in all areas of nursing. However, because maternity nurses must advocate for both maternal and fetal well-being, there is not always a clear path for doing the right thing for both the mother and the fetus. Examples include:

- Court-ordered treatment
- Withdrawal of life support
- Harvesting of fetal organs or tissue
- In vitro fertilization and decisions for disposal of remaining fertilized ova
- Allocation of resources in pregnancy care during the previsible period
- Fetal surgery
- Treatment of genetic disorders or fetal abnormalities found on prenatal screening
- Equal access to prenatal care
- Maternal rights versus fetal rights
- Extraordinary medical treatment for pregnancy complications
- Using organs from an anencephalic infant
- Genetic engineering
- Cloning
- Surrogacy
- Drug testing in pregnancy
- Sanctity of life versus quality of life for extremely premature or severely disabled infants
- Substance abuse in pregnancy
- Borderline viability: to resuscitate or not
- Fetal reduction
- Preconception gender selection
- Sex selection

Ethics in Neonatal Care

Care of extremely sick infants is especially challenging. Maternity and NICU nurses have an ethical obligation to care for the infant and respect parental decisions regarding the infant, but also have a duty to do no harm (Fig. 2-1). Categories for neonates in the NICU may include:

- Infants for whom aggressive care would probably be futile, where prognosis for a meaningful life is extremely poor or hopeless.
- Infants for whom aggressive care would probably result in clear benefit to overall well-being, where prevailing knowledge and evidence indicate excellent chances for beneficial outcomes and meaningful interactions.
- Infants for whom the effect of aggressive care is mostly uncertain.



FIGURE 2-1 Extremely premature baby in the NICU.

An especially important related ethical issue concerns futility (Chervenak et al., 2013). Families sometimes request inappropriate or futile care for their newborns. However, this does not relieve nurses of their ethical duty to advocate for appropriate care. Identifying the neonate's status will help guide the perinatal nurse's parental counseling and decision making. It is critical to remember that veracity is one of the ethical principles binding the nurse; keeping parents fully informed supports their ability to make the best choices for themselves. Withholding information, even to protect the parents from emotional pain and disappointment, may be well-intentioned, but makes assumptions about what is best for the mother and her family without giving them a chance to participate in that decision. This represents a form of paternalism, in which an authority figure, in this case health-care personnel, makes choices for others; this is considered disrespectful and inappropriate (Chervenak et al., 2013; Stephenson, 2016).

Parents often lack the expertise to make fully informed decisions regarding the care of their neonate, so communication and collaboration are critical. The parents are the ones who must manage the long-term consequences of decisions, whether that means grieving over the death of their child or adapting to the difficult realities of having a child who may require lifelong care. Developing a consensus for the plan of care that incorporates parental wishes, ethical standards, and realistic assessments of available resources requires a team approach between the appropriate health-care professionals and parents, in which parental concerns are acknowledged and validated. Such a plan will minimize needless harm or suffering for the neonate and ethical dilemmas for the NICU nurse, as well as give parents a sense of participation and control.

Nurses must keep parents fully informed of all developments and respect parental decisions, but they also have a duty to the neonate. This may require counseling the parents, offering support, and referring them to additional resources. At times, balancing these obligations can lead to an ethical dilemma. Nurses are the primary link between neonates in the ICU and their parents, and they interact more with families than any other health-care professional, putting them in a unique position to help identify

and ensure the best possible outcome (Mattson & Smith, 2016). Sensitivity to the ethical contexts and being receptive to parental concerns can help the nurse navigate these situations. A common goal in neonatal units is to increase parents' participation in daily care and decisions regarding the health care of their infants and empowerment of parents. This improves the quality of health care for newborns and parents and is conducive to successful development of the parental role (Wisner et al., 2019).

Additionally, moral distress is prevalent in the NICU, where decisions regarding end-of-life care, periviable resuscitation, and medical futility are common. Advances in medical technology have allowed the smallest, sickest neonates to survive. The treatment for critically ill infants is no longer simply limited by the capability of medical technology but also by moral and ethical boundaries of what is right for a given child and family. Shared decision making and the zone of parental discretion can inform and challenge the NICU team to balance the complexities of patient autonomy against harm and suffering. Limited ability to prognosticate and uncertainty in outcomes add to the challenges faced with ethical dilemmas. Subjective views of quality of life and personal values in these situations can lead to moral distress if the plans of care and the validity of each path are not fully explored. Differences in opinions and approaches between members of the medical team can strain relationships and affect each individual differently (Mills & Cortezzo, 2020).

In the NICU, disagreements about whether life-sustaining treatment can ethically be withheld or withdrawn are not uncommon. Usually, the dilemma comes down to questions about the value of life with severe physical or cognitive impairments. Disagreements can go in both directions. Sometimes providers recommend treatments and parents refuse. Sometimes parents request continued treatment that providers think is inappropriate (Lantos, 2019). These disagreements can cause moral distress among physicians and nurses and debates about the ethical justifiability of unilateral decisions that treatment is futile and should be withdrawn. Usually, disagreements are resolved by ongoing discussion between the NICU team and parents, by bringing in other family members, or by consulting an ethics committee.

From an ethics perspective, traditionally when treatment is clearly beneficial, the baby's right to treatment outweighs parents' rights to make medical decisions for their baby. When benefits of treatment are less clear, ethicists (and courts) defer to parental choices (Lantos, 2018).

Decision making in the NICU has recently shifted to focus on the process rather than the results. A newer approach recommends that care providers help parents discern their own values and ethical commitments as they face an unanticipated situation and a series of life-altering decisions (Lantos, 2018). The goal is to help parents understand their child's clinical situation and prognosis as well as the meaning of the choices they face in light of that clinical situation.

Ethical Decision-Making Models

Clinical situations that raise ethical questions are a challenge to navigate, with multiple clinical facts to consider. In addition, patient and family values, concerns, and preferences must be

considered. In some cases, a decision is needed quickly. When faced with these difficult clinical situations, a systematic approach can help health-care providers reach an ethical decision or recommendation (Schumann & Alfandre, 2008). One common approach for ethical decision making in clinical settings is the Jonsen model, widely referred to as the “four topics method” (Jonsen et al., 2002).

The four topics method was developed to provide clinicians with a framework for sorting through and focusing on specific aspects of clinical ethics cases and connecting the circumstances of a case to their underlying ethical principles. Each topic—medical indications, patient preferences, quality of life, and contextual features—represents a set of specific questions to be considered in working through the ethical conflict or case. The purpose of the four topics method is to sort out data to determine what is central to the discussion (Jonsen et al., 2002). The boxes do not give us an answer, but point us to areas of confusion or contention. When you finish sorting the data, ask, “In which quadrant does the problem seem to lie?” This provides guidance for physicians and nurses on where to gather more resources and how to intervene. The next sections review the four topics, relate them to ethical concepts, and present relevant questions.

Medical Indications

Clinical ethics case analysis using the four topics method begins with an articulation of the medical facts of the case, including the diagnosis, prognosis, treatment options, and how the patient can benefit, if at all, from treatment (Schumann & Alfandre, 2008). This topic relates to the ethical principles of and consideration of beneficence and nonmaleficence. Relevant questions include:

- What is the patient’s medical problem? History? Diagnosis? Prognosis?
- Is the problem acute? Chronic? Critical? Emergent? Reversible?
- What are the goals of treatment?
- What are the probabilities of success?
- In sum, how can this patient benefit from medical and nursing care, and how can harm be avoided?

Patient Preferences

This topic focuses on the expressed or presumed wishes and values of the patient, including respect for patient autonomy. Although the United States prioritizes the autonomy of the individual, most cultures value the family, the community, and the overall population in concert with the individual. Relevant questions include:

- Has the patient been informed of benefits and risks, understood this information, and given consent?
- Has the patient expressed prior preferences, such as advance directives?
- Is the patient unwilling or unable to cooperate with medical treatment? If so, why?
- In sum, is the patient’s right to choose being respected to the extent possible in ethics and law?

Since the women’s health movement (WHM) of the 1960s, a primary goal has been to improve health care for all women at all reproductive stages of their lives. Despite challenges and setbacks in reproductive rights, significant gains were made in women’s health at the federal policy level during the 1980s and 1990s (Nichols, 2000). For example, women gained more control over their reproductive rights. Abortion was legalized, although restrictions remain, and new contraceptive technology became available. Gender-based research emerged as an important area of biomedicine. Violence and discrimination against women have been recognized as a significant problem worldwide. Progress has been made, but we still have much to accomplish. Nursing has always led in the development of needed and effective programs for women’s health during the 20th century and play an important role as political activists in promoting the WHM and gender equity, empowering women to be active in their own care (Nichols, 2000).

Many “traditional” but outdated ways of providing care to childbearing women have been replaced with partnerships. The patriarchal culture that tells women what to do, expecting them to follow without questions and treating them disrespectfully when they are unable or unwilling to comply, is being slowly transformed to include women and their families as true partners in care. Nurses are in an ideal position to take a leadership role in improving maternity care in the United States and reducing risk of preventable adverse outcomes (Simpson, 2021).

Quality of Life

In clinical ethics case analysis, it is important to consider what effect the indicated treatment will have on the patient’s quality of life (Schumann & Alfandre, 2008). However, how does one define quality of life? Clearly, this is a question of perspective as perceptions of quality vary significantly from one person to the next. To honor a patient’s idea of quality of life, the principles of beneficence, nonmaleficence, and respect for autonomy should be considered. Relevant questions include:

- What are the prospects, with or without treatment, for a return to normal life?
- What physical, mental, and social deficits will the patient likely experience if treatment succeeds?
- Do biases exist that might prejudice the provider’s evaluation of the patient’s quality of life?
- Is the patient’s present or future condition such that continued life might be judged as undesirable?
- Are there plans for comfort and palliative care?

Contextual Features

The final step in the four topics method is consideration of the larger context in which the case is occurring and determining whether any contextual features are relevant to the case and its ethical analysis (Schumann & Alfandre, 2008). The context of a case is determined by multiple social factors including (among others) the dynamics of the family, the living situation of the patient, and the cultural and religious beliefs of the patient and the family. This includes consideration of the concepts of loyalty and fairness.

Health Disparities

Awareness of the contexts that influence health supports respectful, patient-centered care that incorporates lived experiences, optimizes health outcomes, improves communication, and helps reduce health and health-care inequities. Although genetics and lifestyle play an important role in shaping the overall health of individuals, researchers have demonstrated how the conditions in the environment in which people are born, live, work, and age are equally important in shaping health outcomes. These factors, referred to as social determinants of health, are shaped by historical, social, political, and economic forces and help explain the relationship between environmental conditions and individual health. Recognizing the importance of social determinants of health can help health-care providers better understand patients, effectively communicate about health-related conditions and behavior, and improve health outcomes (ACOG, Committee on Health Care for Underserved Women, 2018).

Health equity requires addressing equity not only in health care but in all human-made and modifiable determinants of health. Justice and fairness as the foundations of equity demand correcting injustices. Injustices may occur among marginalized or excluded groups of people based on their multiple and intersectional identities or other characteristics closely linked with social exclusion, marginalization, and social disadvantage (Jackson et al., 2020).

Nurses are uniquely positioned to lead health equity efforts specific to the resolution of perinatal health disparities. The power of nursing including our code of ethics is aligned with strategies, bundles, and tool kits developed to improve perinatal outcomes in partnership with the most impacted communities. Specifically, the ANA Code of Ethics (2015a) outlines the role of the professional nurse and includes the concept that nurses practice with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, without exceptions for socioeconomic status, personal attributes, or the nature of the individual's health problem.

Data clearly show disparities in perinatal outcomes for Black women (Scott et al., 2019). The ANA Code of Ethics guides practice for all nurses and is one of many documents to inform ethical principles in the care of Black women. Ethical perinatal care for all pregnant women is clearly outlined in the ANA Code of Ethics; however, social determinants of health, including structural racism and discrimination, are not equally experienced by pregnant women. According to the Centers for Disease Control and Prevention (CDC), health equity is when everyone has the opportunity to be as healthy as possible (CDC, 2020). By extension, birth equity is “the assurance of the conditions of optimal births for all people with a willingness to address racial and social inequalities in a sustained effort” (National Birth Equity Collaborative, 2019, p. 1).

Multiple determinants underlying inequities in health and health care result in worse health outcomes and lower quality of health care for marginalized populations. Population health disparities are rooted in interconnected systems and interactions that occur on multiple levels. Individual population health disparities include socioeconomic status, race and ethnicity, gender, behaviors, beliefs, biology, and genetics. Intermediate factors

include neighborhoods, communities, and social networks, whereas distal or structural factors comprise social and political policies and health-care institutions (Howell et al., 2018).

Relevant questions include:

- Are there family issues that might influence treatment decisions?
- Are there financial and economic factors?
- Are there religious or cultural factors?
- Are there problems of allocation of resources?
- How does the law affect treatment decisions?

Cultural Humility

A core value of nursing is cultural humility. This principle informs the ways in which people build trusting and intentional relationships with each other. Cultural humility governs language, behavior, and interactions with our partners within the health-care system. Tervalon and Murray-Garcia (1998) first defined cultural humility, which requires a commitment to four core tenets:

- Critical self-reflection and lifelong learning
- Recognizing and mitigating inherent power imbalances
- Developing mutually beneficial nonhierarchical clinical and advocacy partnerships with community members, amplifying the expertise of the residents in the community
- Creating institutional alignment and accountability

We challenge nurses to reflect on these four tenets as they engage in the care of women and their families in the childbearing period.

In summary, the four topics approach helps to highlight areas of controversy and clarify the principles underlying the circumstances of a clinical ethics case, which in turn guides discussion among care team members, patients, and families toward achieving a resolution that respects the patient's values and preferences.

Ethics and Practice: Nurses' Rights and Responsibilities

The AWHONN is the professional nursing association representing nurses in neonatal nursing. AWHONN supports the protection of an individual nurse's right to choose to participate in any reproductive health-care service or research activity. Nurses have the right under federal law to refuse to assist in the performance of any health-care procedure in keeping with personal moral, ethical, or religious beliefs (AWHONN, 2016b).

However, as AWHONN considers access to affordable and acceptable health-care services a basic human right (AWHONN, 2016a), it also advocates that nurses adhere to these principles:

- Nurses should not abandon a patient nor refuse to provide care based on prejudice or bias.
- Nurses have the professional responsibility to provide high-quality, impartial nursing care to all patients in emergency situations, regardless of the nurses' personal beliefs.
- Nurses have a professional obligation to inform their employers of any attitudes and beliefs that may interfere with essential job functions.

The core values defined by AWHONN (2019), aligned with the Code of Ethics, are as follows:

- Commitment to professional and social responsibility
- Accountability for personal and professional contribution
- Respect for diversity of and among colleagues and clients
- Integrity in exemplifying the highest standards in personal and professional behavior
- Nursing excellence for quality outcomes in practice, education, research, advocacy, and management
- Generation of knowledge to enhance the science and practice of nursing to improve the health of women and newborns

These core values, denoted by the acronym CARING, are foundational to excellence in nursing practice and support environments that promote optimal patient outcomes and staff engagement.

STANDARDS OF PRACTICE

The ANA is charged with maintaining the scope of practice statement and standards that apply to the practice of all professional nurses. The ANA defines nursing as: “the protection, promotion, and optimization of health and abilities, prevention of illness and injury, facilitation of healing, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, groups, communities, and populations” (ANA, 2015b, p. 1). In addition to the Scope and Standards of Practice general practice standards and the Code of Ethics from the ANA (2015a, 2015b), practice standards from AWHONN help to guide professional nursing practice.

The standards summarize what AWHONN believes is the nursing profession’s best judgment and optimal protocol based on current research and clinical practice (Box 2-2). AWHONN believes that these standards are helpful for all nurses engaged in the functions described.

As with most or all such standards, certain qualifications should be considered:

- These standards articulate general guidelines; additional considerations or procedures may be warranted for particular patients or settings. The best interest of an individual patient is always the touchstone of practice.
- These standards are but one source of guidance. Nurses also must act in accordance with applicable law, institutional rules and procedures, and established interprofessional arrangements concerning the division of duties.
- These standards represent optimal practice. Full compliance may not be possible at all times with all patients in all settings.
- These standards serve as a guide for optimal practice. They do not define standards of practice for employment, licensure, discipline, reimbursement, legal, or other purposes.
- These standards may change in response to changes in research and practice.

- The standards define the nurse’s responsibility to the patient and the roles and behaviors to which the nurse is accountable. The definition of terms delimits the scope of the standards (Table 2-2).

The standards of practice for women and newborns describe a competent level of nursing care and consist of the six components of the nursing process: assessment, diagnosis, outcomes, planning, implementation, and evaluation (ANA, 2015b). Standard 5: Implementation has additional subcomponents—5a: Coordination of Care and 5b: Health Teaching and Health Promotion—that are new to this edition and consistent with ANA’s Standards, Third Edition. Each component and subcomponent is presented with a goal statement and a list of competencies specific to the health care of women and newborns in the context of woman-, newborn-, and family-centered care. The goals and corresponding competencies reflect the values and priorities of AWHONN and relate broadly to the nurse’s responsibility to the health-care consumer (AWHONN, 2019). The standards of practice are set forth to define the roles, functions, and competencies of the nurse who strives to provide high-quality service to patients. The Standards of Professional Performance delineate the various roles and behaviors for which the professional nurse is accountable. The standards are enduring and should remain largely stable over time because they reflect the philosophical values of the profession (ANA, 2015b).

LEGAL ISSUES IN DELIVERY OF CARE

Because of an ever-changing practice care environment and ethical and legal dilemmas inherent in the profession, nurses have an increased risk of being named in a malpractice litigation process. Current trends in medical malpractice lawsuits suggest that the gold standard is evidence-based practice (EBP).

The charge of “failure to communicate” is a major issue in most malpractice suits against nurses. Nurses have been found negligent for placing patients in harm’s way by failing to communicate issues and concerns to colleagues, charge nurses, and physicians (Brown, 2016).

Despite increased awareness in the health-care community about preventable errors, reports indicate they still occur at alarming rates. Communication issues, most notably between providers, have been identified in nearly half of cases and include lack of timely acknowledgment and effective communication. Other factors were lack of appreciation for clinical significance or decline, variation in willingness to escalate concerns about care, and poor communication due to lack of team structure and function that often led to delays in care management and effective response (CRICO Comparative Benchmarking Report, 2018). Recent trends indicate a substantial decline in medical malpractice cases on OB, indicating multidisciplinary initiatives on communication and electronic fetal monitoring (EFM) are reducing medical malpractice claims.

BOX 2-2 | Standards for Professional Nursing Practice in the Care of Women and Newborns

Standards of Care

Standard 1. Assessment

The nurse collects pertinent health data in the context of woman-, newborn-, and family-centered care.

Standard 2. Diagnosis

The nurse analyzes assessment data to determine actual or potential diagnoses, problems, and issues relevant to the health of women and newborns.

Standard 3. Outcome Identification

The nurse identifies expected outcomes for the patient and creates an individualized plan of care in the context of woman-, newborn-, and family-centered care.

Standard 4. Planning

The nurse develops a plan of care that includes interventions and alternatives to attain expected, quantifiable outcomes for women and newborns in the context of woman-, newborn-, and family-centered care.

Standard 5. Implementation

The nurse implements the identified plan to promote woman-, newborn-, and family-centered care in a safe and timely manner.

Standard 5(a). Coordination of Care

The nurse coordinates care delivery within their scope of practice.

Standard 5(b). Health Teaching and Health Promotion

The nurse employs health teaching strategies that promote, maintain, or restore health within the context of a safe environment.

Standard 6. Evaluation

The nurse evaluates the progress toward attainment of expected outcomes in the context of woman-, newborn-, and family-centered care.

Standards of Professional Performance

Standard 7 Ethics

The nurse's decisions and actions on behalf of women, fetuses, and newborns are determined in an ethical manner and guided by a sound framework for ethical decision making.

Standard 8. Culturally Congruent Practice

The nurse practices in a manner that is congruent with cultural diversity and inclusion principles when caring for women, newborns, and families.

Standard 9. Communication

The nurse communicates with women, families, health-care providers, and the community in providing safe and holistic care.

Standard 10. Collaboration

The registered nurse collaborates with women, families, health-care providers, and the community in providing safe and holistic care.

Standard 11. Leadership

The nurse should serve as a role model, change agent, consultant, and mentor to women, families, health-care consumers, and other health-care professionals.

Standard 12. Education

The nurse acquires and maintains knowledge and competencies that reflect current evidence-based nursing practice for women, newborns, and families.

Standard 13. Evidence-Based Practice and Research

The nurse generates or integrates evidence to identify, examine, validate, and evaluate interprofessional knowledge, theories, and varied approaches in providing care to women and newborns.

Standard 14. Quality of Practice

The nurse systematically practices, evaluates, and, if indicated, implements new measures to improve the quality of nursing practice for women and newborns.

Standard 15. Professional Practice Evaluation

The nurse evaluates their own nursing practice and participates in the evaluation of others in relation to current evidence-based consumer care information, professional practice standards and guidelines, statutes, rules, and regulations.

Standard 16. Resource Utilization

The nurse studies resource factors related to safety, effectiveness, technological advances, and fiscal responsibility when planning and delivering care to women and newborns.

Standard 17. Environmental Health

The nurse practices in an environmentally safe and healthy manner when planning and delivering care.

Association of Women's Health, Obstetric and Neonatal Nurses (2019).

Because intrapartum care is inherently dynamic and nuanced, crucial evidence gaps exist. Therefore, road signs may be unclear or change quickly, leading providers to have completely different interpretations of the right course of action. Conflicting approaches are easily exacerbated by the dynamic nature of labor. Differences of opinion and prioritization are bound to occur. Data suggest that despite encouraging progress in developing cultures of safety in individual centers and systems, significant

and necessary work will be required to reverse overt disruptive behaviors in labor and delivery and to correct more subtle forms of systemic disrespect. It has been suggested that hospitals need to transparently address deficiencies in interpersonal interaction and clinical performance to achieve optimal care of childbearing women (Lyndon et al., 2014).

Maternity nursing is the most litigious of all practice areas. Contributing to this is the complexity of caring for two patients