


Using Institutional Ethnography to Explicate the Everyday Realities of Nurses' Work in Labor and Delivery

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Abstract

Fetal health surveillance is a significant everyday work responsibility for labor and delivery nurses. Here, nursing care is increasingly focused on technological interventions, particularly with the use of continuous electronic fetal monitoring. Using Institutional Ethnography, we explored how nurses conduct this work and uncovered the ruling relations coordinating how nurses “do” fetal health surveillance. Analysis revealed how these powerful ruling relations associated with the biomedical and medical-legal discourses coordinated nurses’ fetal monitoring work. Forms requiring documentation of biophysical data caused nurses to focus on technological interventions with much less attention given to holistic and supportive care measures. In doing so, nurses inadvertently activated and participated in these powerful ruling discourses. The practice of ensuring the safe birth of the baby through advances in technological surveillance and medical interventions took priority over well-established approaches to holistic nursing care.

Keywords

nurses’ work, labor and delivery, fetal health surveillance, institutional ethnography, Canada

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Introduction

Fetal health surveillance is one of the prominent aspects of nurses’ work in labor and delivery given the emphasis on a “safe” delivery for both the woman and the fetus (Dore & Ehman, 2020). While fetal health surveillance can be performed by many health care providers including, nurses, physicians, and midwives, the responsibility often remains with labor and delivery nurses (Association of Women’s Health, Obstetric, and Neonatal Nurses [AWHONN], 2018; Canadian Nurses Protective Society [CNPS], 2002). Fetal health surveillance can be accomplished through two methods: intermittent auscultation (IA) and electronic fetal monitoring (EFM). The Society of Obstetricians and Gynecologists Canada (SOGC, 2020) clinical practice guidelines state intermittent auscultation (IA) should be used for all low-risk labors (Dore & Ehman, 2020). IA involves listening periodically (i.e., every 15–30 minutes) and evaluating the fetal heart rate with a handheld device. This is to assess fetal well-being and at the same time uterine contractions are palpated by hand. The use of IA during labor provides women freedom of movement, position change, and upright positioning, all known to assist with the

progress of labor (Lawrence et al., 2013; Simkin, 2007). IA also offers opportunity for support along with assessment of other biophysical considerations such as maternal skin tone, temperature, and direct fetal movements (Lewis & Downe, 2015). The EFM involves the use of a machine with two separate transducers. One transducer records the fetal heart rate and the other toco transducer records uterine activity trans abdominally (Rivard & Morin, 2017). The use of the EFM usually requires women to be restricted to the birthing bed limiting their movements and position changes (Alfirevic et al., 2017; Hollins-Martin & Martin, 2013), which are known to assist with labor progress (Lawrence et al., 2013; Simkin, 2007).

Our decision to pursue this research, stemmed from the time Kelly (i.e., the lead author) returned to work following

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a maternity leave and began working as a nurse educator teaching an undergraduate maternity course. Kelly rarely witnessed the use of IA by labor and delivery nurses. Instead, she observed many women on the birthing unit in active labor and appearing to be lying comfortably, but almost immobile in the birthing bed. Laboring women were connected to tubes, wires, and machinery, and with intravenous lines infusing fluids and/or, medications. Students shared how their labor and birth practicum rotation entailed sitting in the birthing room and learning how to interpret the graphic printouts of the EFM that was continuously connected to laboring women. Kelly also noted, how the EFM machine appeared to be the major focus of attention of nurses as they cared for their laboring patients and wondered why so many women were connected to the continuous EFM (CEFM¹) despite evidence (i.e., Cochrane reviews) not supporting this practice (Alfirevic et al., 2017; Devane et al., 2017).

Review of scholarly literature tells us that the CEFM is only recommended for women in high-risk labor or who are at risk for adverse perinatal outcomes (Dore & Ehman, 2020). The routine use of CEFM is correlated with rising rates of instrumental vaginal and cesarean births (Devane et al., 2017) which are linked to adverse effects for both women (Curtin et al., 2015; Jansen et al., 2013; Karlström et al., 2013; O'Mahony et al., 2010; Sandall et al., 2018) and their babies (Jansen et al., 2013; Karlström et al., 2013; Neu & Rushing, 2011; O'Mahony et al., 2010). Despite this, the use of the CEFM remains the primary method of fetal health surveillance, regardless of women's risk level, in many high-income countries, including Canada (AWHONN, 2018; Chuey et al., 2020; Public Health Agency of Canada [PHAC], 2009; Snelgrove-Clarke et al., 2015; Ward et al., 2016). We were puzzled as to how nurses' and laboring women's realities did not align with the clinical practice guidelines from the SOGC. Further examination revealed the SOGC clinical practice guideline on fetal health surveillance (Dore & Ehman, 2020) was authored by both a registered nurse (who was the first author) and a physician. Knowing this generated a sense of unease for us. Despite the SOGC clinical practice guideline being written for registered nurses, midwives, and physicians, and includes specific supportive interventions (i.e., one-to-one labor support), we wondered how the biomedical model infiltrates into nurses' practice? How does biomedical knowledge take priority and undermine nurses' own nursing knowledge? This created a *disjuncture* for us as we grappled with the contradiction between what Kelly *actually witnessed was happening* in the clinical setting versus what is *supposed to happen*. We wondered "How is the biomedical model creeping into labor and delivery nurses work?" This disjuncture became the *problematic* for our study. The problematic is a "puzzle" in the social world, in which disjunctures are explored with the aim of discovering how lives of individuals involved are socially organized to occur as they do (Smith, 2005, p. 39). The multi-layered, complex components that influence labor and delivery nurses

fetal health surveillance work are not apparent. Therefore, we concluded that an investigation was warranted to uncover the external and underlying factors that influence labor and delivery nurses to carry out fetal health surveillance as they do.

We elected to understand nurses' fetal health surveillance work by staying close to the data gathered about everyday work experiences. This investigation started at the ground level by studying the standpoint² expert experiential knowledge of registered nurses performing their everyday work activities in an urban tertiary care labor and delivery unit located in an eastern Canadian province. The research question for this manuscript is: *What are the everyday experiences of labor and delivery nurses related to fetal health surveillance and how are these experiences socially organized?* To explore this, we chose institutional ethnography (IE) which is a systematic, empirical method of exploration developed by Smith (1987, 2005, 2006), a Canadian feminist sociologist. Findings presented in this manuscript are part of a larger study completed during Kelly's doctoral program.

Research Approach: Institutional Ethnography

Smith (2005) first proposed IE as an *alternate sociology* to explain how people's lives are structured by social interactions or social relations that shape the work of people in local settings, outside the purview of one's knowledge and everyday experience. It is a method of inquiry that is theoretically informed by Marxist theory (Marx & Engels, 2008), ethnomethodology, symbolic interactionism, and feminist standpoint theory. IE reveals how things work—with emphasis on how they are *actually* put together as opposed to *why* things happen (Smith, 1987). The methodology involves learning from people about how their work activities are coordinated and "regulated to occur" as they go about their daily lives. For IE researchers, the term "work" is considered as practical and generous and refers to "anything done by people that takes time and effort, that they mean to do, that is done under definite conditions and with whatever means and tools, and that they may have to think about it" (Smith, 2005, p. 151). The extended definition of work shines the light on what people do that will often go unrecognized or missed in the everyday use of the word (Smith & Griffith, 2022). Work defined in this way speaks to the complex, intricate, and sophisticated nature of nurses' work, the behaviors involved in accomplishing nurses' work, and illustrates the knowledge, skills, and experiences involved in performing specific forms of nurses' work.

People, (nurses) are often not aware how social institutions, their organization, power structures, and practices, influence everyday work (Campbell & Gregor, 2008). Carrying out IE research enables researchers to learn, to see, to hear, and to understand what people are doing in their everyday lives. Researchers can then begin to assemble how

separate everyday occurrences are coordinated by external forces.

Smith (2005) coined these more powerful social relations “ruling relations” (p. 10); an extraordinary, yet ordinary, set of complex relations that are textually mediated and connect people across space and time. IE researchers uncover and explain how ruling relations regulate, organize, and coordinate people’s behaviors; and often beyond conscious awareness (Rankin, 2014). IE researchers delve into peoples’ knowledge and everyday work looking and listening for traces of ruling relations to explain what is happening to people and why it happens as it does (Smith, 2005).

Ruling relations are not explicit; rather they are subtly produced through texts, especially when texts are linked to the social organization of power (Campbell & Gregor, 2008). Texts can be written, oral, or visual, and examples include film, newspapers, policies, reports, computer programs, social media, patient chart forms and other institutional documents, to name a few. IE researchers pay close attention to the dominant ideological discourses that are often embedded in texts, which play a major role in shaping institutional culture, values, and agendas (DeVault & McCoy, 2006). Texts are also easily replicable and can be mass produced for wide distribution through a health care institution, for example. Mass production allows for standardization and for centralized ruling relations to coordinate multiple settings because the same texts are activated by users in diverse local settings (DeVault & McCoy, 2006).

Data Collection Methods

All data were generated by Kelly in 2019 through semi-structured interviews with informants,³ participant observations, and retrieval and review of forms and relevant documents. Informant interviews took place in person, audiotaped of 60 to 90 minutes in length, transcribed, de-identified to maintain anonymity, and protect confidentiality. Interview questions were asked to understand the particular standpoint (i.e., the views) of nurses’ everyday fetal surveillance experiences. Questions were formulated for the purpose of understanding how informants know/learned fetal surveillance work, what they consider when making decisions related to fetal surveillance work, and what documents inform their fetal surveillance work. The questions assisted with the goal of understanding how things (i.e., fetal health surveillance) “happen” on the labor and delivery unit. Following initial interviews, each informant was contacted for a second brief interview to clarify or follow-up on certain points that were made in either the original interviews, during participant observations, or collect additional information. All follow-up interviews were completed by Kelly.

Participant observations involved shadowing three nurses while they worked 12 hour day shifts, totaling 23 observational hours, other face-to-face interviews with two additional labor and delivery nurse informants, and retrieval and review

of documents the informants used and spoke of in their interviews related to their fetal health surveillance work.

It must be noted that the number of informants in IE research is not specified; instead, the focus is on acquiring enough participants to represent a varied range of experiences within the institution in order to expose ruling discourses across different times and places (DeVault & McCoy, 2006). To achieve these diverse experiences, informant criteria for the study required that they were registered nurses (RNs) who worked at the bedside in the labor and delivery unit. Informants varied in age and work experience. Two were relatively new nurses having 1 to 3 years work experience, two were seasoned nurses whose careers spanned more than 30 years, and one informant worked for 8 years as a labor and delivery nurse. Once recurring behaviors and similar use of words began to surface in the nurses’ day-to-day fetal surveillance work and during interviews, we determined we had recruited enough nurse informants ($n=5$) in order for us to begin to see patterns and trace how this work was being socially organized and generalized across different times and locations (Smith, 2005). Ethics approval for the study was obtained from both the Newfoundland and Labrador Health Research Ethics Board⁴ and the regional health authority⁵ Research Proposal Approval Committee.⁶ Written consent was obtained from all informants including verbal consent from women in labor during participant observations.

Data Analysis

Data collection and data analysis occur simultaneously during an IE study (Campbell & Gregor, 2008). Data analysis entails iterative reading and re-reading of data collected from interviews, field notes, and key documents. Kelly immersed herself in the data, beginning with examination of field notes obtained from participant observations.

Interview transcripts were read, re-read, and indexed; relevant documents routinely used by nurses were analyzed; and observations of participants’ activities and interactions (e.g., with other nurses, physicians, and patients) were made and examined. Once patterns and connections began to emerge in the analysis, we started to link pieces of the data together by using analysis techniques unique to IE, including indexing, mapping, and writing accounts. These techniques assist IE researchers to “weave the analysis together to show how ruling relations work as generalizing practices and unfold in similar ways for variously located people across different sites and times and in different situations” (Rankin, 2017, p. 8).

An Ethnographic Account of Fetal Health Surveillance

The following is the ethnographic account of Kelly’s participant observation in a tertiary care labor and delivery unit. Kelly shadowed Barb,⁷ who considered herself an

experienced labor and delivery nurse, during 12-hour day shift as she cared for Susan who was having her first baby. Barb's practice behaviors and experience was found to be a good exemplar of the fetal surveillance work of other nurses on the unit. It also made apparent the disjuncture between what is *supposed* to happen related to nurses' work and what Kelly witnessed was *actually happening* during the care of laboring women. It is important to note the authors had no intention to judge or to criticize any of the participants' nursing care. The purpose of this ethnographic account is to demonstrate how the laboring nursing care provided by Barb and other nurses, is unknowingly influenced by ruling relations.

Barb was assigned to care for Susan, a woman with no known health issues, having her first baby, during the day shift. Susan was admitted during the night shift. The account started as Barb begins her 12-hour day shift. Barb provided a brief outline of Susan's obstetrical history as she flipped through Susan's chart. She quickly explained that Susan was in a birthing room and was attached to CEFM. She explained, "The night nurse thought she heard a deceleration" and therefore applied the CEFM for an assessment tracing. Barb stated she was waiting for the obstetrical resident to reassess Susan "for pit."⁸ While Barb waited for the resident to appear she stood by the nursing desk and casually chatted with her nursing colleague. A short time later, the on-call resident arrived at the nursing station and Barb reported what had occurred with Susan during the early morning hours.

Barb and the resident discussed both the details of the questionable fetal heart rate deceleration heard by the night nurse as well as the plan for Susan's care in the desk area. Kelly noticed a large bulletin board with the label "Graph Discussion Board," directly opposite the nursing station. Displayed were numerous examples of fetal heart rate tracings which were enlarged to direct readers' attention to particular elements of the graphic printout, indicating various descriptions and classifications. Kelly asked herself when did fetal health surveillance become so technologically focused, requiring such displays of tracings to be hung on the walls of the unit? Kelly also noted a lack of posters or display material outlining physical comfort measures that support and provide active nursing care to women during labor. For instance, there was an absence of any evidence-based non-pharmacological *nursing* actions that demonstrated nurses assisting women with rocking, swaying, breathing, using a birthing ball, position changes, massage, or the use of hydrotherapy. As their conversation continued, Barb and the obstetrical resident discussed how to "get her into labor." Based on both Barb's and the resident's experience, both seemed to believe the use of intravenous oxytocin to be the best route as Susan had been "tightening for days," was "contracting too much for misoprostol,"⁹ but was not yet in established labor. While the plan of care was being decided, Susan remained in the birthing room out of sight from where we (Barb, the resident, and Kelly) were located.

Barb and the obstetrical resident finished their discussion and Barb headed for the birthing room. She greeted Susan and her partner for the first time, repeatedly glanced at the CEFM graphic printout strip and declared it a "beautiful graph, a normal graph." Kelly introduced herself as "the researcher" who Barb had described would be joining her during the shift. Within minutes the obstetrical resident entered the birthing room and her eyes immediately focused on the CEFM as she began to explain to Susan the need for intravenous oxytocin to strengthen her contractions. Susan and her partner listened attentively to the resident as Barb gathered supplies and prepared the oxytocin infusion. There was no explanation by the resident as to how the decision to start oxytocin was made, however Susan accepted the plan for oxytocin without question. The resident wrote in Susan's patient chart and exited the birthing room once the documentation was complete.

Barb assured Susan and her partner that she would be "watching the baby the entire time" by way of the CEFM tracing. Barb also asked about Susan's plan for pain medication. Susan said she did not have a specific pain plan and preferred to "see how it goes." As a prenatal instructor and a labor and delivery nurse, Kelly was puzzled why Susan was not presented with information about CEFM, especially given the use of CEFM requires that women be restricted to the birthing bed and as such are prevented from using upright positions, movements (e.g., swaying back and forth, rocking, or bouncing on birthing ball), or other measures and supports (e.g., position changes) known to aid the progress of labor. Kelly was also curious whether Susan had attended prenatal classes and, if so, did she recall ways to cope in labor? Kelly *knows* the prenatal curriculum regarding non-pharmacological coping techniques such as movement, hydrotherapy, massage, position changes, to name a few. Yet, none of these methods were mentioned or offered to Susan. As Barb prepared the oxytocin infusion she communicated a list of pain medication and pain relief options that were available and used frequently on the unit. Barb reassured Susan that they could "chat about it as your labor moves along." Barb's first response was to describe pharmacological interventions without mentioning or considering the use of non-pharmacological, supportive measures. *How* did this information come to be Barb's initial response to Susan?

Shortly after the oxytocin started infusing, Barb suggested to Susan's partner that it was a "good time to go for an hour" as the "baby won't be coming too fast." Her partner agreed and stated he would return soon. At this point Barb switched the transducers to telemetry¹⁰ and disconnected the EFM machine from the wall, pushing it out to the busy nursing station while Susan was left walking about in the birthing room alone. Barb described to Kelly how she "needs to watch the baby constantly" and how, at this point, "you're feeling almost like you're a hindrance in the room, she isn't uncomfortable, and she doesn't need me in the room." Barb organized a place to sit in the nursing station with the EFM

machine next to her so that she could focus on documenting her fetal heart rate interpretation, classification, and the uterine contraction pattern every 15 minutes.

Barb remained at the nursing station for several hours and returned to Susan's birthing room only to increase the oxytocin infusion rate, to monitor Susan's vital signs, to readjust the CEFM, or to accompany the resident or obstetrician when they assessed Susan's progress. While at the nursing station, Barb spent the majority of her time focused on interpreting and classifying the CEFM graphic printout and documenting her assessments in the partogram flowsheet.¹¹ At times, the EFM machine sounded an alarm when the fetal heart failed to make contact with the ultrasound transducer or showed a slower heart rate than what was produced previously. Barb pressed the "silence" key, and waited, to see if she needed to return to Susan's birthing room and readjust the transducer. Barb explained to Kelly how the loss of contact and lower heart rate is likely due to Susan walking around and how the monitor often picks up the maternal pulse due to the position of the mother.

During her time at the nursing station Barb also took her breaks as instructed, updated Susan's progress on the inpatient white board,¹² and reported on Susan's labor progress with the patient care coordinator and the obstetrical resident. For example, at one point Barb suggested to the resident that Susan may benefit from an internal exam to assess for the presence of forewaters.¹³ Following further discussion, the resident agreed with Barb's suggestion and conducted the internal exam and artificially ruptured Susan's remaining amniotic fluid sac.

Barb continued sitting at the nursing station with the EFM machine and returned to Susan's room when she determined Susan was "getting uncomfortable" with her contractions. Barb determined Susan's comfort level by returning to the birthing room to "check on her" a few times while watching the CEFM tracing. One of these "check ins" caused Barb to push the EFM machine back into the birthing room. Barb explained, "the patient wants something and is getting uncomfortable."

When Barb returned to the birthing room Susan was sitting in a rocking chair using deep breathing exercises as she experienced a contraction. Her partner was sitting near her. Barb returned the EFM machine to its original spot, near the birthing bed, and then situated herself in a chair next to the EFM machine. From the chair, Barb described to Susan in detail how to "relax" during contractions. Barb did not actively (i.e., verbally or physically) support Susan through the contractions. "Support" can be seen when there is a focus on Susan's discomforts of labor, talking Susan through her contractions, or provision of reassurance and encouragement (Bohren et al., 2017; Hodnett et al., 2013; Sosa et al., 2012). There was no physical touch and very little, if any, positive coaching or feedback.

Susan began to appear more uncomfortable and tense with her contractions, stating, "This is a bad one." Barb

remained seated with her back to Susan and continued with her assessment of the CEFM graphic printout and did not appear to pay attention to Susan's remark. There was no verbal acknowledgment from Barb in response to Susan's description of the contraction, nor did she turn to look at Susan and assess how Susan was coping and breathing through the difficult contraction. There was no indication that Barb actually heard Susan say how intense she found the contraction. Barb's focus remained on the CEFM graphic printout, watching and then recording her tracing interpretations on the partogram flowsheet, and commenting in the progress notes.

Susan, again, became even more uncomfortable and Barb decided to perform a vaginal exam to assess the labor progress. While Barb instructed Susan to lie on her back, the contractions continued and Susan appeared even more uncomfortable as Barb performed the internal exam, especially when Barb struggled to palpate Susan's cervix. The EFM machine then lost contact with the fetal heart and Barb quickly readjusted the ultrasound transducer to regain contact. Barb quickly stated, "Let's do the morphine" without any other discussion with Susan about pain management strategies. Susan agreed and Barb immediately left the birthing room to prepare the morphine injection. At this point, Susan's partner assisted Susan to stand and accompanied her to the bathroom.

Findings

The discoveries presented below show how nurses' fetal health surveillance work is organized by dominant ideological discourses. From there, we explicate what *actually happens* when labor and delivery nurses conduct this work.

Boss Texts

Our analysis of participant observations, interview transcripts, and document analysis uncovered that nurses' fetal health surveillance work is socially organized by biomedical and medical-legal ruling discourses. These discourses infiltrate documents (texts) that nurses are mandated to use, through an interconnected textual pathway beginning with a "boss text" (Smith & Turner, 2014, p.10). Boss texts are regulatory or higher order texts that regulate, govern, and standardize subordinate level texts within organizations (Doll & Walby, 2019; Smith, 2006). Our findings revealed that many SOGC clinical practice guidelines (e.g., *Fetal Health Surveillance Intrapartum Consensus Guideline*, 2020; *Induction of Labour*, 2013; *Management of Spontaneous Labour at Term in Healthy Women*, 2016) are the boss texts that govern the management of intrapartum care, fetal health surveillance, and are foundational to organizational texts discovered in our study. In fact, the SOGC clinical practice guidelines hierarchically orders organizational unit policies, standards, and patient chart forms (e.g., the partogram

flowsheet) that are routinely used by nurses during the care of laboring women. Further investigation revealed the majority of these boss texts (clinical practice guidelines) are developed from and reflect current clinical and scientific data obtained through Cochrane reviews, meta-analyses, and randomized controlled trials (Blake & Green, 2019). These guidelines are written mainly by physicians and at times, nurses, are considered to be the evidence-based standards and methods of accountability for the provision of intrapartum quality care. This discovery was significant given the fact that the majority of the SOGC clinical practice guidelines informs many of the unit policies and patient chart documents which are routinely activated by nurses.

The Partogram Flowsheet

Our analysis suggests that much of what guided Barb's practice interventions and fetal health surveillance work and decisions was the discourse embedded within the partogram flowsheet. From the moment women are admitted to the labor and delivery unit and deemed to be in labor, nurses record their assessments and interventions on the partogram flowsheet.

The partogram flowsheet which was first developed in 1954 by Emmanuel Friedman (an obstetrician and professor at Harvard Medical School) is designed to primarily collect biophysical data providing a graphic chronological representation of women's labor and birth (Friedman, 1954). The graphic timeline was used to determine normal labor progress and to highlight abnormal (slower) progress (Groeschel & Glover, 2001; Lavender et al., 2013). The partogram has evolved to become a tool that is not only employed to record biophysical data but also biomedical interventions related to both fetal heart rate assessments and labor progress. The partogram flowsheet is now a standardized, replicable tool that is used by most tertiary care centers. The partogram flowsheet sanctioned by the regional health authority reflects the national SOGC's *Fetal Health Surveillance* (Dore & Ehman, 2020) clinical practice guidelines and institutionally endorsed unit policies and procedures.

This unit's partogram flowsheet is arranged as a pamphlet. When one opens it, the date and time, maternal vital signs, biophysical information about labor (cervical assessments, contraction patterns, and fetal heart data and classifications) is recorded by nurses on the left page. This means, women's labor experiences become very quickly reduced to a set of numbers. Nurses can avail of progress notes to record women's thoughts, feelings, and other laboring activities (e.g., walking, or using the shower) however, most chose not to so. This nurse informant explains:

I mean the only thing that's in it [progress note] that's different is how mom's doing like mental wise kind of thing. Like for example, in my progress note I would write patient received for care at 7:30, settled in birthing room number 2, resting

comfortably in semi-Fowlers, connected to EFM and toco, baseline fetal heart rate which is in here [partogram] but I've just been taught that that's what you write in your progress note. Or, she's uncomfortable with her epidural then I'd be writing it in here [progress note] because you can't really write that anywhere here [partogram] (Nurse Informant)

On the right, nurses record biomedical interventions such as medications (oral, intravenous and epidural) with limited space to record comfort measures thus demonstrating they are not prioritized. Columns on the flowsheet were found to be presented in order of importance, starting with maternal vital signs, and then, high priority is given to fetal health surveillance, uterine activity, and medical interventions. In fact, a total of five columns are dedicated to fetal health surveillance and four are devoted to details of uterine activity.

There is only one area on the partogram flowsheet pertaining to comfort and supportive measures that are so essential to positive labor progress and birth outcomes (Bohren et al., 2017; Hodnett et al., 2013). These essential nursing interventions are ranked lower in significance than fetal heart rate, biophysical measures, and biomedical interventions as there are far fewer columns (more than nine for biomedical data versus one for comfort measures). There are five columns for all biomedical interventions, with the final column which is labelled as supportive measures (with a predetermined coding system developed by the institution). The 11 coded measures include positioning, linen change, back rubs, assistance to the washroom, and, or checking an intravenous site. Missing from these coded measures are several nursing practice measures such as encouraging the use of a birthing ball or rocking chair, the use of touch, the application of hot and cold therapy, hydrotherapy, and position change (Barrett & Stark, 2010; Edmonds & Jones, 2013). Barb does refer to these nursing measures as being essential to her nursing care but only if women are classified as healthy and without risk factors. Barb explains: "They are contracting regularly. They haven't needed anything for pain. They've had different positions. They've been in the shower. I'm doing intermittent auscultation because they are low risk."

Nowhere on the flowsheet are these and other nursing practices reflected or recorded. Holistic care practices that provide laboring women with constant support, encouragement, reassurance, and reinforcement, and a calm relaxed atmosphere within the birthing room, are invisible as they are not documented.

Unit Policies

The unit policies, that the nurse informants told us were always used, specifically reference the national SOGC fetal health surveillance clinical practice guidelines. For example, in terms of fetal health surveillance, intermittent auscultation (IA) of the fetal heart rate is designated to be used for all low-risk laboring women and CEFM is the recommended choice for high-risk laboring women. That is, CEFM

is recommended when perinatal risk factors are present [maternal, fetal, or both] or when there is an increased risk for an adverse perinatal outcome (Dore & Ehman, 2020). In the unit policy, details are clearly outlined for both IA and EFM in terms of the equipment, frequency of fetal heart rate assessment and recording during each stage of labor, and how to interpret assessment findings. In particular, the EFM policy provides detailed step-by-step instructions for use of CEFM. Nurses are expected to assess the baseline, variability, periodic and episodic changes, uterine activity, and classify the tracing as either normal, atypical, or abnormal every 15 to 30 minutes during the first stage of labor (Regional Health Authority Electronic Fetal Monitoring Policy), which is also stated in the SOGC (Dore & Ehman, 2020) clinical practice guideline for fetal health surveillance.

The IA policy provides similar step-by-step instructions; however, this method of assessment requires a different skill-set and approach to interpreting the fetal heart rate. Although IA is the recommended method during low-risk labor, IA is an intricate skill and requires nurses to obtain a baseline by listening and counting the fetal heart rate for 1 minute without a contraction and while the baby is inactive (Dore & Ehman, 2020). Nurses must then determine whether the fetal heart is beating within normal baseline range and if the rhythm is regular or irregular. While the IA technique requires practice and repetition before the nurse is considered competent in the execution of the skill, nurses interviewed reported receiving very little training and practice in the art of IA. Our data revealed during the 9-hour unit orientation session, 4 hours were devoted to fetal health surveillance and focused on interpreting and classifying CEFM tracings with little reference to IA. Similarly, the MORE^{OB14} workshop on fetal health surveillance provided little practice related to IA. Workshop itinerary indicated content was devoted to interpreting and classifying fetal monitoring strips. One nurse informant explained how she learned fetal health surveillance:

“So, she was a very experienced nurse, I followed her. We were laboring patients and looking at graphs, and looking at graphs, and looking at graphs and through that I learned about fetal monitoring essentially. Then we did our orientation, classroom orientation, learned some from that we just looked at graphs. We went through the norms. We looked at graphs and pointed out different things for example, what’s the baseline? What would you say the baseline is? Is this decel, is it an acceleration? Is this normal? (Nurse Informant)

The Use of Risk Discourses to Institute the CEFM

Philosophical approaches to childbirth influence how health care providers intervene and provide care for laboring women (Heelan-Francher & Edmonds, 2021; Liva et al., 2012; Reime et al, 2004; Stark et al., 2016). Risk surveillance begins as soon as pregnancy is confirmed. For example, women who are 35 years and older are immediately sent

for a barrage of tests including blood work, ultrasounds, and/or amniocentesis to rule out certain genetic conditions. During the second and third trimesters, women are monitored closely for development of high-risk pregnancy conditions (e.g., gestational diabetes, pre-eclampsia). The tertiary care center within which this IE exploration took place offers care for women experiencing either low or high-risk pregnancies including triage, and labor and delivery services for the entire province. Within the labor and delivery unit, women receive obstetrical care during prenatal, intrapartum, and postpartum periods from either obstetricians or family medicine physicians. While these groups of physicians can assist with deliveries, their skills are different. Obstetricians are considered *high-risk* specialists who receive advanced education and training related to conditions unique to women’s reproductive system and complex pregnancies (Royal College of Physicians and Surgeons, 2019). Family medicine physicians provide prenatal, intrapartum, postpartum, and newborn care for low-risk women and will consult with or refer to obstetricians if women develop complications or risk factors during pregnancy and, or, the intrapartum period (Royal College of Physicians and Surgeons, 2019). There are 14 obstetricians and 7 family medicine physicians on staff at this tertiary care center. Most of the laboring patients on the unit are cared for by obstetricians, obstetrical residents, and medical students whether or not they are considered low- or high-risk. Currently, no midwives provide obstetrical care within this regional health authority.

We discovered how the obstetrical team activated some risk discourses that were used to institute the CEFM. In addition to the partogram flowsheet, the SOGC *Management of Spontaneous Labor at Term in Healthy Women* (Lee et al., 2016) and the SOGC (2008) *Policy Statement on Normal Birth* were the organizational texts that played key roles in the obstetrical team’s approach and planning of Susan’s care during her intrapartum hospital stay. Upon admission to the unit, despite being assigned a *low-risk* status with no foreseen complications, a subtle shift occurred in Susan’s risk assessment. Based on the definition of active labor in the SOGC (Lee et al., 2016) *Management of Spontaneous Labor at Term in Healthy Women*, Susan was in the first stage of labor (i.e., having regular uterine contractions with cervical dilation) and in the latent (early) phase (i.e., the presence of uterine activity) with some progress in cervical dilation (i.e., 0–3 cm). However, Susan was deemed by both Barb and the obstetrical resident, not in active labor, she was less than 4 cm dilated, she had spontaneous rupture of membranes, and a possible fetal heart rate deceleration was recorded. She was then assigned an *at-risk* status and prescribed intravenous oxytocin because she was “contracting too much but not in established labor.”

According to the SOGC (2008) *Joint Policy Statement on Normal Birth* a birth is considered *normal* if the baby was delivered vaginally, in the vertex (cephalic) position between 37 and 42 completed weeks gestation, and was not assisted

by forceps, vacuum, or cesarean section. Normal birth is defined in relation to how *the baby delivers*, with no apparent consideration of the woman's birthing *experience*. Even if there are complications of pregnancy (e.g., hypertension, gestational diabetes), or medical interventions during labor and birth (e.g., induction, CEFM, regional anesthesia), if the *baby delivers* vaginally and spontaneously, the birth is considered *normal*. Further, according to the normal birth policy statement, women's risk assessment *continues* throughout the entire labor and birth process because "complications can occur" at any point during the intrapartum period that require interventions. It is not surprising, then, that several informants in our study believed most women require technological interventions like CEFM because "the majority of laboring women" admitted to the labor and delivery unit have co-morbidities which puts them *at risk*. One nurse informant commented, "So, moms are now older having babies, so with that comes older maternal diseases. Obesity is a big thing, high blood pressure and diabetes." Another explained, "Our population is becoming more and more unhealthy. So we are going toward where we are putting a lot of people on the monitor." The nurses "knew" such risk factors increase the potential for adverse perinatal outcomes and therefore indicated that their population of laboring women "required" CEFM, regardless of their risk assessment.

The Friedman Curve "Clock" Approach

Expectations for the duration of the active phase of labor along with the rates of cervical dilation, primarily stem from research published by Friedman beginning in the 1950s (Neal et al., 2010). Labor progress of an individual patient is plotted on the graph for comparison with the norm (i.e., 0.5–0.7 cm dilation per hour in first-time mothers). Any deviation from the Friedman curve could be indicative of dystocia¹⁵ and warrants close assessment. Although it is not explicit that the unit's partogram relies on the Friedman curve, there was an underlying urgency to "make contractions stronger" because Susan was "only 1 cm with this amount of contractions." This is a significant finding. As described by the nurse informants above, women who give birth today are generally older with co-morbidities but are being compared to an *outdated normal*—this is problematic. Further, approximately 90% of women, like Susan, who are at term with spontaneous rupture of membranes will go into labor on their own within 24 hours of rupture (Middleton et al., 2017). Based on this information, we were puzzled by the obstetrical team rushing to "get her into labor."

Our data revealed that the obstetrical team acted on labor progress cues not from Susan, but more from indications from the Friedman curve "clock" approach. Susan's cervix had not dilated beyond the 1 cm following admission during the night. According to the SOGC *Induction of Labor* guideline (Leduc et al., 2013), it would have been "risky" to wait and allow Susan's innate biological mechanisms to begin

and to establish labor spontaneously due to the risk of chorioamnionitis.¹⁶ Susan was contracting with ruptured membranes but was determined by the team not to be in active labor. She therefore required intervention with oxytocin to prevent the development of chorioamnionitis. Once oxytocin is instituted, nurses must also commence the use of the CEFM as stipulated in both the SOGC *Induction of Labor* guideline (Leduc et al., 2013) and the Regional Health Authority (2016) unit induction policy. Chorioamnionitis occurs in 1% to 13% of term pregnancies (Spensard et al., 2019) and is often associated with membrane rupture, multiple vaginal exams, prolonged labor, and the use of internal fetal heartbeat monitoring devices like CEFM (Petruskavich, 2017). The obstetrical resident indicated there had been a "few cases of chorio in the past" justifying their decision to prescribe oxytocin for Susan. Kelly's field notes confirm how Barb reminded the obstetrical resident that Susan may have the presence of forewaters. Barb explained, "When pitting someone who is not in labor, from my experience, I know that forewaters can prevent people from going into labor. Once they are broken, they kick into labor. I will get the resident to assess." Kelly's field notes also indicate Susan had at least two vaginal exams to determine the presence of forewaters and to assess cervical dilation during the early (latent) stage of labor. We discovered that the obstetrical team responsible for Susan's plan of care deferred to the Friedman curve clock as an indication of Susan's progress and to the SOGC induction clinical practice guideline rather than waiting for Susan's physiological capacity to progress to active labor. Similarly, other nurse informants believe birth through the biomedical approach *should* be the routine practice to assist with women's labor progress. This nurse informant explains: "I find obstetricians like they're realistic, they want to get the show on the road. They want to progress their [women] labour, just realistic things. Whereas family medicine kind of like lets them [women] do what they want. They [women] don't want their cervix checked for 12 hours then fine. And sometimes too, we have a patient that who probably could have been delivered, they [family medicine physicians] don't want to intervene." (Nurse Informant). This plan of care which includes the use of medical interventions (i.e., rupturing forewaters, the use of oxytocin) strongly reflects the deep-rooted biomedical discourse activated by Barb and the obstetrical resident. The SOGC clinical practice guidelines are subordinating Barb's, and other nurses', own nursing practice and knowledge of normal labor progress.

The Work of Safeguarding the Fetus

Our data revealed nurses spent an exorbitant amount of time working to safe guard the fetus during women's labor experiences. In Susan's case, this began shortly after admission to the labor and delivery unit. Although she was considered not to be at risk for any anticipated complications, according to the unit IA policy and SOGC *Fetal Health Surveillance*

clinical practice guideline (Dore & Ehman, 2020), Susan's fetus, *should* have been assessed through IA. Consistent with Kelly's field notes, Barb reported that the night nurse bypassed what is written in the IA policy which states the registered nurse *should* reassess the fetal heartbeat again following the next contraction. Instead, the night nurse immediately chose to use CEFM and activate the EFM unit policy by attaching Susan to the EFM machine. The night nurse documented her concern in the progress notes related to possibly hearing a deceleration, and the subsequent actions taken. Barb explained, "I've heard this a lot. 'I want to know what that baby is doing in there. If I don't put them on the monitor and just do intermittent auscultation, I don't know.' [Nurses] want clear-cut evidence on paper of what that baby's doing. They [nurses] want more information." Another informant agreed "I'm [afraid] I am going to miss something with respect to the fetal heart. I'm going to miss a deceleration or I'm going to miss that it's gone down and stayed down for a long time. It [fetal heart] could go down and stay down for 10 minutes. How would you know unless [women] are on the monitor?"

Similarly, Barb's focused attention on the EFM machine demonstrated that she was fulfilling her nursing responsibility to record what is considered institutionally important during labor and the birthing process. Despite the SOGC *Fetal Health Surveillance* (Dore & Ehman, 2020) clinical practice guidelines, the Canadian Association of Perinatal and Women's Health Nurses (CAPWHN, 2018) *Perinatal Nursing Standards in Canada*, and the unit policy for 1:1 labor support which all maintain that women in active labor *should* receive continuous labor support, the configuration of the partogram flowsheet reveals the profound emphasis on the institutionally sanctioned biophysical data related to fetal well-being along with technological interventions and medications.

Instead, nurses like Barb, are not providing holistic 1:1 nursing care because they are so focused on interpreting CEFM graphic printouts, and instead are *nursing the tracing*. Barb was observed managing the CEFM from afar, completely removed from the birthing room and therefore unable to assess the physical and individual psychosocial care needs of Susan. Many of the nurse informants also reported on the importance of monitoring the fetus. For example, this informant articulated "fetal monitoring is such an important aspect. It's 95% of my job to make sure that baby stays safe and 5% is mom." Another indicated: "Now the patient needs me, and I have to say, I'm sorry you're just going to have to wait a minute, I have to look at this 30-minute graph so I can qualify it" (Nurse Informant). One other informant commented:

Until they're in active labor and uncomfortable, you're not necessarily constantly with them. I mean I've had patients before who've wanted me to walk around with them which you can't really do, because you got to sit with your monitor. And once you explain to them, they understand and they usually have two support people with them anyway. But once they ask for pain medication, then I'm kind of like 'okay, maybe I should be

in the room with them,' and if anything goes wrong on the graph, I'm in the room to intervene. (Nurse Informant)

According to Kelly's field notes, when Susan's labor accelerated, possibly resulting from the oxytocin infusion, the fetus began demonstrating signs of possible fetal distress on the graphic printout. Barb instructed Susan to return to her bed and lie on her side. Barb commented, "Three complicated variables puts you in the category of an abnormal fetal heart tracing. You go from a normal tracing to boom, boom, boom. Something is going on. I need the resident." Barb had to respond to the abnormal tracing with intrauterine resuscitation as directed by the SOGC *Fetal Health Surveillance* guidelines and the unit policy on the use of EFM. This meant instructing Susan to return to the birthing bed and position herself on her side (Dore & Ehman, 2020), followed by Barb notifying the resident or obstetrician of the abnormal tracing (Regional Health Authority EFM Policy, 2011). According to Kelly's field notes Barb did not assist Susan with getting comfortable by repositioning with pillows. The fetus, again, was the sole focus of Barb's care. Very little to no consideration was given to how repositioning to the bed and moving her from side to side impacted on Susan, a woman in labor. This approach to detecting possible fetal distress is also supported by other nurse informants. "Now if I hear it [fetal heart] kind of start to go down I'm like, 'Okay mom, let's go on your left side' and if that doesn't work I'll *flip* them to the right side." One other informant explains, "we do resuscitation on baby so that would be *flipping* mom from side to side, giving mom IV fluids, turning off the oxytocin."

Absence of Collaborative Decision Making

The *Client and Family-Centered Care* (CFCC) philosophy for the regional health authority (2020) and the PHAC (2017) *Family Centered Maternity and Newborn Care in Canada* guidelines are texts that state information sharing, participation, and partnership between patients (women and their families) and their health care provider (nurses) should result in collaborative health care decision-making. According to the regional health authority's *Annual Performance Report* for 2017 to 2018, one of the organizational priorities is achieving quality and safety through caring and compassionate hospital services founded on the CFCC philosophy (Regional Health Authority, 2017-2018). Additionally, the CFCC philosophy is endorsed in nursing programs in the province during classroom theory, required readings, and clinical rotation. The CFCC is promoted as a best practice approach by both CAPWHN's (2018) *Perinatal Nursing Standards in Canada* and PHAC (2017) *Family Centered Maternity and Newborn Care in Canada* guideline and each laud its importance when caring for laboring women and their families. However, none of my study informants spoke of the CFCC philosophy or described how they integrate the philosophy within their practice. Similarly, none of the nurse

informants spoke about or referred to how CAPWHN's (2018) *Perinatal Nursing Standards in Canada* informs their nursing care. Susan's care did not reflect any of these guidelines.

There is also a significant lack of documentation reflecting Susan's initial plans, requests, wishes, or any discussion between Barb and Susan regarding the risks associated with the use of CEFM. At no time during the participant observation did Kelly witness Susan being informed about how the CEFM could put her at risk for having an instrumental and or surgical birth (Alfirevic et al., 2017; Devane et al., 2017; Paterno et al., 2016; Small et al., 2020). Nor was Susan presented with how both types of births increase risks to women (Curtin et al., 2015; Jansen et al., 2013; Karlström et al., 2013; O'Mahony et al., 2010; Sandall et al., 2018) and/or their newborns (Jansen et al., 2013; Karlström et al., 2013; Neu & Rushing, 2011; O'Mahony et al., 2010). How was Susan able to make an informed decision regarding the method for monitoring her baby if she was not provided with this vital information?

In addition, notably absent in the ethnographic account was also the lack of detailed explanation provided to Susan about the obstetrical team's interventions. For example, the pros and cons associated with the plan for pain management. Kelly observed the resident ask Barb, "What are you doing for pain?" It was unclear as to whom the resident directed her question. Without an answer from Susan or Barb, the resident quickly stated to Barb, "Give an epidural now, turn off the pit to give baby a break." Barb repositioned Susan to her side while the CEFM traced the baby's heartbeat and then Barb left the birthing room to prepare for an epidural. At this point, it became very clear that Susan is very much viewed as a vessel and not as a holistic person. Instead, the well-being of the fetus takes priority over the health of Susan. Later when asked about the decision to give Susan an epidural, Barb stated, "I think the patient really wanted an epidural anyway and it may have been a little early for her but we needed the fetal heart to come back. If it doesn't come back, [we] go down the hall [OR]."

However, according to Kelly's observations and field notes, neither the resident nor the nurse asked Susan if this was what she preferred, nor did they communicate the consequences of having an epidural in labor. This is of relevance as epidurals are not without complications to both women (Anim-Somuah et al., 2018) and their neonates (Salameh et al., 2020). Knowing this vital information would have allowed Susan and her partner to make informed decisions both as a patient and as a mother. This is significant as both Barb and the resident are questioning Susan's judgment as a mother.

According to the CNPS (1994) patients require enough information about risks and should be explained to the patient to obtain informed consent. Information detailing the ramifications of refusing treatment and an explanation of possible alternatives, should also be included. Susan was not

permitted to collaborate with Barb in deciding on the method for monitoring her fetus or her preferred choice of pain relief. She was also not provided with alternate non-pharmacological pain relief options (e.g., upright positioning, repositioning, hydrotherapy). It is evident the focus of care is on the fetus. Barb and the resident are doing what they think is in the best interest of the fetus versus trusting Susan's decision making as a mother. This goes against the regional health authority's *Client and Family Centered Care Philosophy* (Regional Health Authority, 2020). The biomedical discourse dominates Barb's nursing practice and as a result, Susan, the laboring woman, a human being, disappears and instead is reduced to a vessel to transport her newborn.

The Work of Documentation

Documentation is a nursing action that produces a written and/or electronic account of relevant client data, nursing clinical decisions and interventions, and the clients' responses in a health record (Potter et al., 2017). The requirement for documentation is also part of the College of Registered Nurses of Newfoundland and Labrador (CRNNL, 2019) *Standards of Practice for RNs and NPs*, and the Canadian Nurses Association (CNA, 2017) *Code of Ethics for Registered Nurses*. According to the CRNNL (2021) *Documentation Principles* documentation establishes accountability, promotes quality nursing care, facilitates communication between the healthcare team, outlines the plan of care, and communicates the contribution of nursing to health care. The SOGC *Fetal Health Surveillance* (Dore & Ehman, 2020) guideline outlines specific recommendations related to frequency of assessment and documentation for the fetal heart. The structure of both the unit EFM policy and the partogram flowsheet reflects the SOGC's guideline recommendation for frequency of documentation. When women are in active phase of labor, nurses must record detailed fetal heart findings every 15 minutes and classify the CEFM tracing every 30 minutes. Once women progress to active second stage or situations turn urgent, assessment and documentation are suggested to be completed more frequently (i.e., every 5 minutes when IA is used or every 15 minutes when CEFM is in place). For such situations, the guideline suggests narrative notes should also be included outlining health team communication, interventions, patient concerns, requests, and details of the situation (Dore & Ehman, 2020).

We uncovered that the major concern for all of our nurse informants was their fear of professional discipline, losing their licenses to practice and, or, their jobs, and being named in civil lawsuits. Many informants described documentation in the labor and delivery unit as "the bane of my existence," and "very painful" but also spoke of its professional significance. "I document everything," "if you didn't write it, it never happened kind of thing," "to cover my ass," and that "my documentation is all I have to cover me legally if something occurs." For example, one informant explained what

happens when patients refuse any sort of fetal monitoring. “There’s nothing you can do if they [patients] refuse it [fetal monitoring]. There’s just documentation, documentation, documentation. You let the doctor know. You let the PCC know. You let everyone know that we’re not monitoring this woman. She’s refusing.” (Nurse Informant). Again, evident in this quote is how nurses appear to question women’s ability to make decisions as mothers.

All of the nurse informants spoke of a case on their labor and delivery unit in which a significant adverse event occurred and “destroyed the morale on the unit.” One nurse informant stated, “We haven’t rebounded from it even though it’s been a number of years.” According to several nurses’ descriptions, a patient had suffered an obstetrical trauma and the baby died. Shortly after the event the two nurses involved were suspended from their jobs for 1 month, were reported to the professional practice team, and a formal complaint was made to the province’s licensing body by the regional health authority. According to our informants the two nurses never worked again in labor and delivery. Many of our study informants commented how easily the same thing could have happened to them and how shocked they were when they learned of the “punishments” their co-workers had received. They claimed that “everyone was freaking out”; there was “fear of liability”; and, “you need to make sure you kind of cover your butt because there have been lawsuits.” Since this case occurred, all of our nurse informants sounded distressed, tormented, and fearful due to how this adverse event had been handled by the institution and because of the discipline their colleagues had received. As a result of this situation, several of the nurse informants believed “that the only thing that is really going to get me in trouble is a fetal heart” and reported how they now “document a lot.” What the nurse informants describe above involves documenting more out of fear, rather than recording their nursing care and interventions. This behavior goes against the intent of documentation and is problematic for patient safety, quality care, and team communication. Over documentation takes nurses’ time, attention, and focus away from the laboring women.

Continuing Education

Several informants spoke of the mandatory education nursing staff must complete once they are hired to work in the unit. All registered nurses working within the unit and physicians who provide obstetrical care are required by the regional health authority to complete the Canadian Perinatal Program Coalition’s (2009) *Fundamentals of Fetal Health Surveillance* offered through a western Canadian university. This is an online, 8-hour course consisting of a manual, an exam, and a certificate of completion. The SOGC *Fetal Health Surveillance* guideline underpins and informs the curriculum (Blake & Green, 2019). Course content is focused on participants understanding fetal and utero-placental physiology in relation to alterations in fetal heartbeat patterns.

The overall goal is to improve awareness, recognition, and response when fetal compromise is suspected. This education program appears to be very similar to the two chapters on fetal health surveillance included within the MORE^{OB} program that nursing staff must also participate in. Labor and delivery nurses who work in this unit are required to complete this fetal health surveillance course every 2 years. This recommendation is in keeping with recent SOGC guidelines (Dore & Ehman, 2020) and is endorsed by the Canadian Association of Midwives (CAM) and the Canadian Association of Perinatal and Women’s Health Nurses (CAPWHN). The SOGC recommends an 8-hour, interdisciplinary, fetal health surveillance workshop within 30 days of finishing the online course. The unit currently has seven trained fetal health surveillance instructors (who are also labor and delivery nurses), ready to offer the educational sessions when needed. Sessions include interpreting and classifying CEFM tracings by applying the theory from the online course. The above educational training programs are thought to assist with organization and teamwork, communication, emergency responses, and eliminate a culture of blame in hospitals (Reszel et al., 2019).

Despite the belief that fetal health surveillance education assists with the health care team working as a cohesive group and abolishing blame within hospital settings, several senior nurse informants reported how having the extra education subjugated their experiential nursing knowledge regarding what they *know* about women’s labor and fetal monitoring, caused lengthy deliberations and disagreements when classifying fetal heart tracings, and created ineffective team work, and blame. This nurse informant explains:

All this emphasis on fetal monitoring and the workshops, and the online courses and the SOGC guidelines ad nauseum. . . I find even me, after all these years and my abilities, I have to neglect my patient to a certain extent in order to stop and classify my graph because I have to. . . because before when I looked at a graph and said, ‘oh that’s just a normal pushing graph, of course there are variables of course there are decelerations, of course there is. The patient is pushing this is normal’. But now I have to stop and I have to stare at it and say, ‘do I have complicated variables of which there are about 7 definitions. Do I have persistent tachycardia over so many minutes, and is my graph atypical or is it abnormal?’, because now I have to stop and go out and get the doctor and say ‘Look, I’m not worried about this graph at all, but now it’s abnormal and you have to come in and look at it.’” (Nurse Informant)

Similarly, another informant recounts a situation when her experiential knowledge was subordinated by the attending physician and in doing so, she was reported to the nurse manager:

“The obstetrician comes in and has a look and loses her mind—‘it’s showing lates!’ . . . I said, ‘Yeah, I don’t really know about that. Excellent variability, baby is really active like I can hear the

baby move. She's not contracting frequently but I can't turn up the pit because she [the woman] can't deal with this'. So anyway, I turned off the pit. Anyway, as soon as the pit stopped all of these things went away but anyway, she [the woman] was sectioned by now. So, it was a big hoopla, big hoopla, lost her [the obstetrician] mind. I was called in to [Manager's] office about the fact that [the obstetrician believed] I did not recognize these things".

Further, several other informants described how the additional fetal health surveillance education created situations in which health team members cannot agree on the interpretation and classification of fetal heart tracings as explained by these informants. "Even though to me the definitions are reasonably clear the resident can come and look at it and say, I don't agree with you." Or, "I can look at a graph because studies have shown that they have given graphs to maternal fetal people and they have interpreted the graph, given the graph 6 months later and they interpret it completely differently. Fetal monitoring is so subjective." Several other informants spoke how learning to classify fetal heart strips can be, at times, challenging as described by this nurse informant: "All the guidelines have changed for fetal monitoring which is a good thing, really hard to learn but it was a good thing because the criteria, there's a lot of criteria now and there's a lot for a nurse to do when choosing exactly what this graph is and how you should classify it."

Despite the required fetal surveillance education and the new SOGC classification guidelines, Kelly's field notes reflect instances when classifying fetal heart strips took prolonged periods of time as nurses had difficulty deciphering what was showing on the fetal heart tracing. These situations often resulted in the nurse comparing definitions provided by the SOGC, consulting with other nurse colleagues and physicians, reach a conclusion and then, the process begins all over again.

Discussion

The nurses in this IE study perpetuated dominant biomedical and medical-legal discourses by how they talked about, described, viewed, and approached childbirth and how they provided care for laboring women. We illuminate that the approaches and interventions to managing labor that Kelly witnessed during participant observation of Barb and Susan, are derived from the obstetrical *biomedical and medical-legal discourses* that have filtered down through a series of textual pathways and ultimately become the taken-for-granted competency of nurses, like Barb, who do their work as is expected. Any laboring women opposing the use of biomedical interventions are glossed over or explained, colloquially, as "better for you and, or your baby"; "get the show on the road"; or, "ARM,¹⁷ pit, get it over with," as reported by several nurse informants.

We discovered that Barb's practice decisions and behaviors during fetal health surveillance were largely regulated

by organizational texts, namely the partogram flowsheet. Barb's routine engagement with the institutionally sanctioned partogram flowsheet and other organizational texts (e.g., unit policies) influenced Barb's dedicated time and attention to technical tasks, to the collection of biophysical data, and to the promotion of biomedical interventions; and thereby, overlooking the supportive measures critical to the care of laboring women which is also contrary to what the regional health authority states is happening. Nurses are mandated to complete the partogram flowsheet to record fetal well-being assessments during labor and when the textual format for documentation directs nurses to focus primarily on biophysical dimensions. The partogram flowsheet has pre-established elements that take priority over supportive measures that would be more in keeping with psychosocial and emotional dimensions and nursing holistic care practice standards. Nurses were observed distancing themselves (both physically and emotionally) from laboring women because they were so focused on interpreting CEFM graphic printouts. Moreover, Barb was observed managing the CEFM from afar, completely removed from the birthing room and therefore unable to assess the physical and psychosocial care needs of laboring women (Susan) or provide any interventions to meet identified individual needs.

The partogram flowsheet is an *organizational text* because it informs how intrapartum nursing care happens on the unit and is the manifestation of the application of the *boss texts*—the SOGC clinical practice guidelines and unit policies. Once activated (e.g., as nurses enter flowsheet data), organizational texts are structured in a manner to collect information that the organization deems vital and central to describing what occurs during inpatient health care stays: in this case, the labor and delivery experience.

However, the data collected for the partogram flowsheet reflected Barb's nursing care as structured by the *partogram* and what was being constructed through Barb's completion of the partogram was an authorized description or *documentary reality* of what could be said, for example, about Susan's labor as it related to her baby's heart rate, uterine activity, and the impacts those contractions may have had on the fetus. We show how Susan's *actual* labor experience and how she dealt with each contraction and her labor as a whole was not reported, became lost, or was considered insignificant. Susan, the person in labor, was not at the center of this experience; rather, she became represented through the *institutional textual account* vis-a-vis the labor record—the partogram flowsheet.

This institutional textual account of Susan's intrapartum experience serves a significant institutional purpose. According to Accreditation Canada, Healthcare Insurance Reciprocal of Canada (HIROC), the Canadian Medical Protective Agency (CMPA) Salus Global (2016), and the CNPS (2002), obstetrics is well established and well known as a high-risk practice domain with malpractice or negligence lawsuits being quite common, particularly in relation

to fetal health surveillance during labor. HIROC provides insurance for health care institutions and is also focused on safety in health care. HIROC highlights patient safety knowledge from insurance claims and makes this knowledge available to health care institutions and practitioners (Accreditation Canada, HIROC, CMPA, & Salus Global Corporation, 2016) through the development of a list of the top leading risks of the costliest claims within hospitals. These risks are published in *Risk Reference Sheets* and are available on the HIROC website. Through the *Risk Reference Sheets*, HIROC offers mitigation strategies to reduce the general risk of patient safety events and makes recommendations to regional health authorities to put in place patient safety measures that reduce adverse events from occurring in labor and delivery. The top five obstetrical risks are also among the top 30 of all risks within acute care organizations (Accreditation Canada, HIROC, CMPA, & Salus Global Corporation, 2016). Out of the five obstetrical risks, three are directly related to fetal health surveillance—*Failure to Monitor or Document Fetal Status*, *Failure to Communicate Fetal Status*, and *Failure to Interpret and Respond to Abnormal Fetal Status*. It makes sense then that the majority of birth trauma cases that lead to medical malpractice claims are generally not related to birth injuries the mother experiences; instead, the cases are pursued when the baby suffers a brain injury (Miller, 2017). When adverse outcomes occur during childbirth specifically as it relates to the baby, patients are encouraged to sue due to the financial burden placed on the family and the costs involved in care needs (Rokosh, 2020). Lawyers involved in birth injury cases typically sue for liability and damages, and include pain and suffering, loss of income, and costs of care needs. These cases can result in multimillion-dollar settlements due to the life-long expenses required to care for the child (Rokosh, 2020).

Knowing that biomedical and medical-legal discourses infiltrating the forms and policies that labor and delivery nurses use regularly in their everyday work, nurses are not so much focused on meeting holistic care needs because they must spend an inordinate amount of time and effort on technological interventions (e.g., the CEFM) and documentation. Nurses are not meeting the holistic care needs of laboring women because childbirth has become a risk adverse event within the hospital institution. Health care providers are under constant pressure that a patient safety incident may occur that will result in legal action which could affect the institution's reputation with important organizations such as HIROC, or professional regulator bodies and within the community. Lawsuits also have financial implications for the facility and regional health authorities. Ensuring the safe birth of the baby through advances in technological surveillance and medical interventions take priority. Nurses are mandated to complete the partogram flowsheet to record fetal well-being assessments during labor and are required to focus primarily on biophysical dimensions that take priority over supportive measures (e.g., one-to-one labor support)

that would be more in keeping with psychosocial and emotional dimensions and nursing holistic care practice standards. Nurses' time and attention is focused on interpreting the CEFM and documenting findings. Nurses' (like Barb) own nursing knowledge is being subordinated by the biomedical and medical-legal discourses through their activation of texts like the partogram flowsheet.

While documentation of nursing care constitutes a significant practice standard (CNPS, 2020; CRNNL, 2021), we explicated how the nurses whom Kelly interviewed recognized the importance of documentation not insofar as fulfilling standards but to "cover" themselves if an adverse event arises. Nurses' vigilance is justified, though, as the patient chart is a legal record that should accurately reflect the assessments, interventions, patient responses, information shared, and patient care decisions (Barry & Kerr, 2019). However, the nurse informants described how they witnessed colleagues being disciplined as a result of a patient safety incident on the unit several years ago. During legal proceedings the patient's chart and documentation were presented as evidence to determine whether the nurses in question met the standards of what a prudent nurse would do in the provision of reasonable care. It was determined that some nurses had not provided care reflective of a prudent nurse in accordance with unit policies, guidelines, and the CRNNL (2019) *Standards of Practice for Nurses and Nurse Practitioners*. The event and disciplinary action that followed continue to instill considerable fear and apprehension in the unit's nursing staff.

Findings from this study indicate that nurses work under a cloud of fear and anxiety and are *afraid* to activate the IA policy when caring for women in labor, even if women are assigned a low-risk status. When the night nurse indicated that she "thought she had heard a deceleration" after applying IA to assess the fetal heartbeat, she chose to "err on the side of caution" and immediately switched to the use of the CEFM. Are nurses so fearful of missing something or making a mistake that they *invent* situations or activate risk discourses to "allow" them to apply CEFM? The night nurse had *thought* she heard a deceleration which justified activation of the EFM policy. The night nurse no longer trusted her sense of hearing, clinical knowledge, or professional judgment because it was safer to "cover your bum" despite the known risks of CEFM for women in low-risk labor. Borg (2003) writes how nurses *believe* IA unlike the EFM policy, would not stand up in a legal defense as there is no hard documentary or graphic evidence of what was heard by the nurse. Consequently, they think the decision to activate the EFM policy provides security believing that the paper tracing generated by the CEFM is hard evidence of prudent care provided.

Strengths and Limitations

This study was conducted through the use of a rigorous qualitative methodology to produce findings. We ensured

methodological congruence between the theoretical underpinnings and the research design as outlined by Smith (2005). We adhered to several methodological principles, including, maintaining nurses' standpoint and remaining grounded in the data through an iterative approach during data collection and analysis. We met regularly as a committee to verify Kelly's emerging findings. A reflexive journal was also maintained by Kelly as data were collected and analyzed. This journal was especially important because as a labor and delivery nurse, Kelly approached the study as an insider with embodied knowledge of the practice area. In light of this, a researcher with embodied knowledge is also a ruling relation. The reflexive journal assisted with not subordinating the informants' experiences with those of Kelly's.

The goal of IE is not to create knowledge that is generalizable. Instead, the goal is to describe the social organization of a particular problematic at a certain place and a specific time (Smith, 2005). The findings were gathered from a single tertiary care labor and delivery unit that references the SOGC clinical practice guidelines as the boss texts to inform other unit texts specific to conducting fetal health surveillance. Generalizing our findings to other sites is not possible. However, given that the SOGC is a national specialty organization whose goal is to promote excellence in the practice of obstetrics and gynecology, to advance the health of women, and is considered to be the national leader in offering evidence-based clinical practice guidelines (Blake & Green, 2019), it is reasonable to suspect that similar behaviors are ongoing with other tertiary care centers across Canada. Further investigation is warranted to examine the how the ruling relations are influencing the everyday work of nurses in other settings.

Conclusion and Recommendations

Nurse informants indicated that the SOGC clinical practice guidelines and unit policies are their main references and sources of knowledge to inform how they carry out fetal health surveillance. Future research to test amendments to certain texts such as the partogram flowsheet in terms of contributing to improvements in holistic and person-centered care and supportive measures in labor and delivery would be a significant research pursuit. Additionally, an investigation exploring the texts childbearing women draw on to help prepare them for childbirth is required. Finally, involving women as active partners in the research process through Participatory Action Research could be an appropriate research approach to address the lack of person-centered care and collaborative decision making that is common place during the intrapartum period.

We showed in our study that institutional interests are infiltrating nurses' work. As a result, labor and delivery nurses are unintentionally activating the dominant biomedical and medical-legal discourses as they care for laboring

women. Nurses are being pulled to place laboring women onto the CEFM in case they don't have time, skills, confidence, or support to conduct IA. The superiority of the technology (CEFM) takes precedence over "old fashioned" hands on assessment. This activation functions to subjugate nurses' professional standpoint (Campbell, 2001). These powerful regimes overrule nurses' professional judgement, standardize care across large populations, and improve hospital efficiencies. Shining the spotlight on nurses' fetal surveillance work, as we have done, enables labor and delivery nurses to challenge, disrupt, and ultimately transform their nursing care in ways that will better serve themselves and the women for whom they care.


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Notes

1. Continuous electronic fetal monitoring will be represented as CEFM throughout this manuscript and refers to the continued use of the electronic fetal monitor machine.
2. Standpoint refers to the particular knowledge individuals have based on their social locations in the world (Smith, 2005).
3. Participants in IE studies are referred to as informants.
4. Reference Number 2019.030 approval date March 10, 2019
5. Name withheld to protect anonymity
6. Reference Number 2019.030 approval date April 10, 2019
7. Identifying details have been changed and pseudonyms used to protect confidentiality.
8. "Pit" refers to Pitocin. This synthetic intravenous oxytocin is used to stimulate regular labor contractions.
9. Misoprostil is a cervical ripening agent that acts to soften, dilate, and thin (efface) the cervix. It also stimulates uterine contractions.
10. Telemetry allows monitoring and transmission of the fetal heartbeat and contraction patterns to the EFM machine but does not require the woman to be attached to the EFM.
11. The partogram flowsheet is part of the patient chart in which labor and delivery nurses record women's labor progress and fetal well-being assessments.
12. This white board is located in the nursing station and contains the initials and labor progress of all in-patients.
13. Forewaters are the portion of the amniotic fluid sac presenting in front of the fetal head.

14. MORE^{OB} refers to Managing Obstetrical Risks Efficiently. It is a performance improvement program marketed to create a culture of patient safety within obstetrical units. This tertiary unit “bought” the MORE^{OB} program. All nurses are expected to participate.
15. Dystocia refers to delayed or arrested progress in labor.
16. Chorioamnionitis is a bacterial infection of the amniotic cavity and is usually diagnosed through clinical findings of maternal fever, maternal and fetal tachycardia, uterine tenderness, and foul odor of amniotic fluid (Petruskavich, 2017).
17. ARM refers to artificial rupture of membranes.

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