

The Farver–Campos Labor Coping Scale as a Replacement for the 10-Point Pain Scale for Labor

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ABSTRACT

The 10-point pain scale was developed to avoid undertreated pain in the hospital setting. Developed in a Veterans Administration hospital for medical–surgical patients in 2003, the 10-point pain scale was adopted in health care as part of the “pain as the fifth vital sign” initiative. The pain scale was implemented in maternity care as part of a general hospital initiative. Assessing coping is more appropriate to the labor process than focusing on pain or its avoidance. The Farver–Campos Labor Coping Scale is evidence-based and promotes vaginal birth and personal labor care by guiding nurses and laboring women through a number of coping options. The scale is an appropriate tool to replace the 10-point pain scale in the maternity care setting.

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HOW THE PAIN SCORE BEGAN

The history of the pain scale began in 1995 when the American Pain Society (APS) established guidelines to improve the treatment of pain (APS, 1999; Max et al., 1995). Their guidelines established that assessing and recording patients’ reports of pain were the necessary first steps. In 1996, the APS introduced the phrase “pain as the fifth vital sign.” The use of this pain score would address widespread concerns that pain was being undertreated in the medical–surgical patient population and establish pain assessment with vital sign checks. In 1998, the Veterans Health Administration began a national strategy to improve pain management for its patients. The “pain as the fifth vital sign” initiative

required the use of a numeric rating scale for all clinical encounters (Cleeland et al., 2003; Veterans Health Administration et al., 2000). The scale is a standardized 10-integer verbal and/or visual analog scale, ranging from 0 = no pain to 10 = worst possible pain, for a patient self-report of pain. This required nursing staff to perform frequent pain assessments in the hope that these frequent assessments would also provide more frequent pain intervention before the patient’s pain became intractable.

In the year 2000, the Joint Commission on Accreditation of Healthcare Organizations introduced standards for pain assessment and management relevant to multiple health-care disciplines and settings and adopted the 10-point

pain scale for use in health-care institutions (Veterans Health Administration et al., 2000). Once studied, however, the use of this pain scale was discovered to make no difference in pain levels as measured before and after its initiation (Mularski et al., 2006). Coincident with the use of the pain scale, there was a widespread increase in opioid use and abuse and a rapid rise in opioid dependency and opioid overdose deaths (Rudd et al., 2016).

The 0–10 Pain Scale Tool Was Shown to Be Ineffective

Mularski et al. (2006) evaluated the effectiveness of the Veterans Health Administration’s “pain as the fifth vital sign” initiative in improving the quality of pain management. They found that the “quality of pain care was unchanged before and after the pain initiative” and concluded that “routinely measuring pain as the fifth vital sign did not increase the quality of pain management.” In fact, patients with high pain scores as documented by the fifth vital sign frequently had inadequate pain management.

Not only was the 10-point pain scale ineffective but the use of the pain score was also correlated with a sharp increase in the use and abuse of opioids and death by opioid overdose (Rudd et al., 2016). Drug overdose deaths nearly tripled during 1999–2014. In 2014, among 47,055 drug overdose deaths, 61% involved an opioid. In fact, the Joint Commission (TJC) withdrew its requirements for pain as the fifth vital sign in the year 2000 due to these concerns (Baker, 2017). The American Medical Association and the American Association of Family Physicians also declared their position that assessing pain as the fifth vital sign should be stopped, linking its practice to the opioid crisis and resultant patient harm (Anson, 2016; Lowes, 2016; Scher et al., 2018).

How the Pain Score Entered the Maternity Care Setting

The 10-point pain scale was mandated to be used in all hospital inpatient units with all vital sign assessments. Since maternity care units reside within a hospital, the use of the pain score was mandated there as well. Although implemented in maternity care as part of a general hospital initiative, it was not intended for the maternity care setting (APS, 1999; Max et al., 1995). The 10-point pain scale was developed in response to the lack

of sufficient pain control in the medical–surgical setting but was adopted by the Board of Registered Nursing (BRN) to assess women’s pain in labor. A birthing unit is unique in that “unlike the pain of injury, labor pain is ‘normal’ and nonpathologic... Despite these differences from pathologic pain...most hospitals continue to use this standard numeric scale for women in labor;” declare the authors of the California Maternal Quality Care Collaborative (CMQCC) toolkit to support vaginal birth and reduce primary cesarean surgeries (Smith et al., 2019). Arguably, general hospital initiatives do not belong in a maternity unit as it is unlike other hospital departments. Hospital initiatives should be filtered before initiation to test their fitness for the maternity care setting.

The Detriments of Using a Pain Score in Labor

The 10-point pain scale has been viewed as more of a barrier than an aid to the appropriate care of the laboring woman (Roberts et al., 2010). In adopting the “pain score” in labor units, the focus became pain and “pain relief,” with subsequent skyrocketing of the use of medicines and medical interventions and an increase in cesarean surgeries and maternal mortality (MacDorman et al., 2016). A study of low risk nulliparous women noted that as medical interventions increased, rates of normal vaginal birth decreased, and they were more likely to have operative births (Dahlen et al., 2012). “Reliance on the numeric pain scale, added to the human desire to eliminate pain in patients and loved ones, has contributed to a singular focus on pharmacologic methods of pain relief in most maternity care centers” (Smith et al., 2019). Focusing on pain in a process where pain is normal is maladaptive for women in labor. Birth is not a medical procedure but primarily a normal healthy process occurring within a generally normal healthy woman (Prosser et al., 2018). Lowe (2002) differentiated “the pain of childbirth from the pain of pathology.” Labor pain differs from acute or chronic pain in that it is an expectation of the process. Increasing intensity and frequency means progress and is a positive sign, not a sign that something is wrong. The 10-point pain scale neither addresses issues of support nor differentiates between the pain of childbirth and that of pathology. Pain assessments address pain as a malady to be treated and diminished; however, pain in labor is a normal part of a healthy process through which the woman copes until it culminates in birth. “Modifiable factors

that have been shown to influence labor pain include the following: environmental conditions, coping strategies, fear, anxiety, expectations about the experience, and, above all, a woman's sense of self-efficacy or confidence in her ability to cope" (Caton et al., 2002). The central question for any woman in labor is not where she is on the pain scale, but rather how can we help her to cope. Labor isn't about having pain but about having a baby. The 10-point pain scale makes it about pain.

Women in labor dislike the pain scale. Making the patient focus on pain rather than the labor process is not perceived as helpful (Gulliver et al., 2008). They feel they have enough of a challenge dealing with pain and do not want their nurses to make them focus on it. "Women planning an unmedicated birth were annoyed at the request for a pain rating...viewing it as an intrusion in their birth plan. They preferred no mention of pain" (Roberts et al., 2010). Women themselves declared pain scores inaccurate for assessing pain in labor as it does not take into account their desire to go through it and environmental factors that enhance coping (Jones et al., 2015).

Many nurses and midwives have expressed dissatisfaction with the pain scale as an assessment tool for laboring women. "Upon being asked to rate their pain, laboring women would voice confusion and annoyance with the request. Nurses also felt that the pain scale was limited in assisting them with options for labor management, whereas the assessment of coping more intuitively and more appropriately encompassed variables such as birthing styles and cultural diversity" (Roberts et al., 2010).

Physicians as well decried the inappropriateness of the numeric pain scale for labor pain assessment, stating "we still have far to go in the development of an effective, patient-centered, reliable measurement tool for the labor pain experience" (Carvalho & Cohen, 2013). They challenged the use of a numeric pain rating score for labor pain and called for improving methods for quantifying it. Having a better measurement tool would improve maternal satisfaction with the labor process and allow providers to assist patients in making decisions for their care, they concluded.

The Point of Labor Patient Care Is to Help the Woman Cope With Labor, Not Eliminate Pain

Labor pain differs from acute or chronic pain in that it is an expectation of the process and normal.

Increasing intensity and frequency often heralds progress and is interpreted as a positive sign rather than a sign that something is wrong. Labor staff support the woman with coping through the labor process. Supportive options for birthing women help them "cope with labor, more than directly affect pain scores," and nonpharmacological methods "help women cope with labor pain rather than directly mitigate the pain" (Bryant & Borders, 2019). "Measuring pain during labor is not as useful as assessing coping and then implementing coping techniques" (Childbirth Professionals, 2022). The role of the labor nurse is to assist the woman by providing support, information, and options that aid her in coping with labor.

Emphasis on Coping by Use of a Coping Scale With Coping Options Is Integral to Birth Philosophy and Care

Assessing coping is more appropriate to the labor process than focusing on pain or its avoidance (Caton et al., 2002; Gulliver et al., 2008; Hodnett, 2002). Not only is a pain scale inappropriate for assessing a women's support needs in labor but also "the use of a coping scale in conjunction with different nonpharmacologic and pharmacologic pain management techniques can help obstetrician-gynecologists and other obstetric care providers tailor interventions to best meet the needs of each woman" (Bryant & Borders, 2019).

The role of the labor nurse is to assist the woman to cope through labor. The experience of going through labor is multifactorial, involving the woman's mind, body, and spirit (Whitburn et al., 2019). Coping as well is multifactorial. Coping options that are a part of the Farver-Campos Labor Coping Scale include physical activities as well as emotional support and guidance. The supportive presence of the labor nurse and other support persons bolster the woman's coping. Continuous emotional support has been shown to lead to shorter labors, reduced need for oxytocin, decreased use of analgesia in labor, fewer operative deliveries, fewer cesarean surgeries, and fewer babies with low 5-minute Apgar scores (Bohren et al., 2017; Sahile et al., 2017). Walking and upright positioning shorten labor, reduce the use of epidural analgesia, and result in fewer cesarean surgeries (Lawrence et al., 2013). Nonpharmacological options not only help with the physical aspect of pain but also provide mental and emotional care.

Education, support, and active options help decrease maternal anxiety, thereby decreasing the perception of pain (Whitburn et al., 2019). Support and active options also help with labor progress. Pain control options need to address the use of both nonpharmacological and pharmacological interventions, their side effects, and effects on labor progress for properly informed decision-making.

In Response to Concerns About the 10-Point Pain Scale, the Farver–Campos Labor Coping Scale Was Developed

The Farver–Campos Labor Coping Scale was developed in 2009 in a small northern California community hospital birthing center by Marie-Celine Farver, staff nurse and policy writer, and Carolyn Joyce Campos, nurse manager. The birthing center was founded on the midwifery model of care. The midwifery model upholds the view of birth as a normal and competent physiological process (Rooks, 1999). Touting the lowest cesarean birth rate in the state (Keehn, 2016), the birthing center attracts women from both northern California and nearby states who are looking for a low-intervention and high-support environment that fosters coping with labor. The unit has a volunteer doula program, birthing tubs, showers in each labor room, and midwifery staff available 24/7. The rooms are comfortable and inviting, with medical supplies available but out of sight. Operating in a collaborative practice model, obstetricians are on call for any complications or the need for a cesarean birth (Shaw-Battista et al., 2011). As a baby-friendly designated hospital, the unit has a high exclusive breastfeeding rate. This fact highlights the relationship between birth interventions and their impact on breastfeeding both directly as well as their impact on the newborn's breastfeeding behaviors (Smith, 2009).

Fueled by a basic dissatisfaction with the view of labor pain as detrimental rather than as part of a competent physiological process, the coping scale's authors brainstormed a way to reframe pain assessment in labor into a positive process that would support women through labor. Its development included the assessment of the basic increments of a woman's coping with labor. The four points in the Farver–Campos Labor Coping Scale are (1) coping without help, (2) coping with labor support, (3) coping with labor pain medications/anesthesia, and (4) not coping (Table 1).

Joint Commission Requirements Are Met by the Farver–Campos Labor Coping Scale

The coping scale was rigorously tested through hospital quality management for compliance with all Joint Commission requirements. Development of the scale involved quality management and risk management and was researched regarding BRN guidelines, Title 22, and Joint Commission Standards. The intention of TJC standard is that a hospital's assessment approaches, including tools, must be appropriate for the patient population. TJC does not dictate the use of the 0–10 pain scale for all patient populations. The intent of the standard was to ensure an appropriate approach to pain management in special populations. Laboring women meet this special population criteria (TJC, 2017).

The Birthing Center manager confirmed with the risk management department that what TJC required was documentation of pain as a fifth vital sign at each time vital signs were recorded for the patient. TJC Element of Performance (EP) requirements for pain assessment (PC.01.02.07) are as follows: EP 1: The hospital conducts a comprehensive pain assessment that is consistent with its scope of care, treatment and services, and the patient's condition. EP 2: The hospital uses methods to assess pain that are consistent with the patient's age, condition, and ability to understand. EP 3: The hospital reassesses and responds to the patient's pain, based on its reassessment criteria. EP 4: The hospital either treats the patient's pain or refers the patient for treatment. The Farver–Campos Labor Coping Scale fulfills these requirements as an assessment of pain that can be used as an alternative to the 0–10 scale if used each time vital signs are taken or a pain measure is used.

Implementing the Farver–Campos Labor Coping Scale on the Maternity Care Unit

The Farver–Campos Labor Coping Scale was implemented into practice in May of 2010. The unit policy addressing the assessment and management of labor pain was updated to include the coping scale, directions for nurses regarding the use of the coping scale and coping options, and guidelines for documentation. Staff were educated regarding the policy change and charting requirements. Nurses received education regarding coping strategies. These educational opportunities included practicing coping options with staff

TABLE 1.

The Farver–Campos Labor Coping Scale With Definitions

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1. Coping without help (unaware, talking, or sleeping through contractions).
 2. Coping with labor support (aware of contractions, using breathing, relaxation, and/or comfort techniques).
 3. Coping with labor pain medications/anesthesia (using pain medication and/or anesthesia interventions).
 4. Not coping (inadequate coping despite interventions).

In labor, assess coping using the Farver–Campos Labor Coping Scale with each vital sign or coping intervention, or less frequently per patient request.

For pain in the postpartum period or pain not related to labor, such as headache, gall bladder pain, and pyelonephritis pain, use the 10-point pain scale.

Chart the coping scale rating.

Determine interventions according to the Farver–Campos Labor Coping Scale rating:

1. Coping without any help: No intervention needed.
2. Coping with labor support: Utilize labor support and nonpharmacological interventions to help the woman as needed/desired (see below).
3. Coping with labor pain medications/anesthesia: Have a collaborative discussion with the woman, family, and provider regarding desired pharmacological interventions.
4. Not coping: Suggest other untried interventions and support the patient in implementing chosen options. If still not coping with supportive options, have a collaborative discussion with the woman, family, and provider regarding interventions available to enable coping. At times, the sensation or appearance of not coping may simply mean birth is imminent.

Labor support interventions

Use any of the following support measures as nonpharmacological methods of pain management:

1. Acupressure.
 2. Ambulation.
 3. Birthing ball (weight limit 300 pounds). Good for sitting and leaning.
 4. Birth sling.
 5. Breathing slow and relaxed or another breathing pattern.
 6. Counter pressure over the back, hips, or knees.
 7. Comfortable upright birth seat (weight limit 265 pounds).
 8. Dim lights. There are a variety of lighting options and battery-powered candles to use.
 9. Distraction strategies.
 10. Frequent position changes.
 11. Heat packs or cold packs.
 12. Keep out of bed as much as possible.
 13. Keep off the monitor as much as possible/utilize intermittent auscultation by doppler.
 14. Massage.
 15. Meditation.
 16. Music.
 17. Peanut ball. Good for positioning in bed.
 18. Positions such as leaning forward, kneeling, hands and knees, and side lying.
 19. Quiet. Keep voices low and use comforting tones.
 20. Rebozo techniques with rebozo or sheet.
 21. Rocking chair.
 22. Shower.
 23. Support people and doulas. Have your own doula or a volunteer doula.
 24. Sterile water injections for back pain (tiny water injections over the lower back).
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(Continued)

TABLE 1.
The Farver–Campos Labor Coping Scale With Definitions (Continued)

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25. TENS unit. Apply the pads over your back.
 26. Tub.
 27. Upright positioning: makes gravity work for you to bring baby down.
 28. Visualization.

Provide training to your nursing staff on providing labor support.

In order to talk about coping, there need to be processes in place for facilitating coping. The following are suggestions for building a culture of supporting coping in the maternity care unit:

1. Provide education regarding the coping scale, assessing coping, and potentiating coping.
2. Provide training in measures to potentiate coping.
3. Practice these measures outside the clinical setting.
4. Provide mentoring: have mentors who are proficient in labor support techniques and work with staff to increase the competence of trainees; this may be a class with a doula, or doula trainer, for instance.

A culture of coping will include attitudes as well as practices in the birthing unit

Coping involves a philosophy of care on the unit, which includes attitudes as well as practices:

1. Respect the woman’s privacy and limit staff entrance into her room to those who are helpful and preferable to her. It’s her room, not yours.
 2. When performing nursing duties, maintain an attitude that honors the woman’s needs and preferences. It’s her birth, not yours.
 3. Do not routinely offer analgesics without maternal request and informed consent.
 4. Have equipment and tools available on the unit for coping techniques.
 5. Consider developing a volunteer doula program.
 6. Have dimmable lights, and battery-operated candles, for dim lighting in labor rooms.
 7. Facilitate the use of music provided by the laboring woman and family.
 8. Consider having midwives and adopting the midwifery model of care. The midwifery model of care approaches birth as a robust physiologic process (Rooks, 1999) and promotes support and coping options to deal with labor pain. The medical model tends to view pain as something to be eliminated or avoided.
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mentors through skills fairs, classes, and informal unit gatherings. Posters containing the Farver–Campos Labor Coping Scale along with a menu of possible coping strategies were posted in every labor room at the birthing center. Women were educated upon admission regarding the coping scale as well as the many options available to assist their coping with labor. They were also given the assurance that staff were there to assist them with coping. Women were informed that they would not be asked for a pain score for normal labor pain. Nurses assessed the laboring woman’s coping using the coping scale and charted their assessment in the electronic record. Assessments were made with each vital sign, with each coping intervention, and within an appropriate time frame after coping interventions to assess their effectiveness. Coping assessments are ongoing because labor is expected to intensify until it culminates and subsides with birth. Specific elements of the use of the Farver–Campos Labor Coping Scale are shown in Table 1. For pain in the postpartum period or pain not

related to labor, such as headache, gallbladder pain, and pyelonephritis pain, the 10-point pain scale continued to be utilized.

Prenatal education included distribution at all associated perinatal clinics of a double-sided document with information regarding the possible effects of medications on labor along with nonpharmacological methods of coping with labor. The document emphasizes many ways to cope with labor that help with labor progress without the deleterious effects of medications or other pharmacological interventions. It is also available on the hospital website. Additionally, a prenatal educational booklet titled “The ABCs of Birth” was developed as a guide for parents to utilize labor coping options. It outlines active and nonpharmacological labor coping and includes a brief discussion of the risks and benefits of pain medications and pharmacological interventions. The booklet is also distributed by the hospital to local prenatal clinics and is available as a downloadable file on the birthing center website.

How the Farver–Campos Labor Coping Scale Was Implemented in Major Hospital Systems

Several months after its initial implementation, a staff nurse in another local hospital system heard of the Farver–Campos Labor Coping Scale. Dissatisfied with the use of a pain scale in her labor unit and fielding complaints from nurses and laboring women alike, she contacted the authors to ask about borrowing the Farver–Campos Labor Coping Scale for use in her hospital. After approval from her hospital's management, staff were educated on its use, and the coping scale replaced the use of the pain scale in their labor and delivery department. Once it was implemented there, it was so favorably received that she contacted the hospital system's administration about rolling it out for their entire 17-hospital maternity network. Staff and physician educational modules were developed, maternity staff were trained, and in 2012, it was incorporated into their electronic health record (EHR). Posters describing the coping scale were posted in each labor room. One hospital affiliate made the coping scale part of their public website as a marketing tool to tell potential patients that they would not be asked for a pain score in labor.

Although used within the authors' hospital birthing center since 2010, the Farver–Campos Labor Coping Scale was not utilized within other system affiliates until 2016. At that time, the hospital system realized the advantages of using a coping scale for labor rather than the pain scale. System management approached the author regarding the use of the Farver–Campos Labor Coping Scale for all 16 of their hospital affiliates with obstetric units. She presented the Farver–Campos Labor Coping Scale to the Clinical Nurse Specialist at the system's main campus and then to the system obstetric practice and EHR committees. Once approved, she developed an online learning module with post-test to train nursing staff. Details regarding documentation were included in the learning module. With the assistance of the marketing department, printed educational documents were developed for patients and medical staff. Tent cards were printed for patient rooms, with an introduction to the coping scale on one side and several coping strategies on the other. The Farver–Campos Labor Coping Scale was then incorporated into the EHR by clinical systems analysts. Labor Care and Labor

Pain Management Policies were updated to include guidance for using the Farver–Campos Labor Coping Scale for labor in place of the 10-point pain scale.

The Farver–Campos Labor Coping Scale Is Appropriate for Utilization in All Labor Units

The Farver–Campos Labor Coping Scale may be used in all labor units with both nonpharmacological and pharmacological options. The task of coping is best promoted by active and nonpharmacological methods that help a woman embrace birth. Realizing that women approach birth with individualized goals regarding the labor experience, nonpharmacological coping options may be utilized for the time they are at home or to cope with labor before the implementation of pharmacological intervention if that is their desire or goal. Most women use nonpharmacological methods for managing labor pain even if ultimately using pharmacological interventions (Kozhimannil et al., 2013). In fact, 90% of women in an Australian study preferred to have continuous labor support to help them cope regardless of their plans regarding pharmacological methods to manage labor pain (Jones et al., 2012). It is therefore imperative for all maternity care units to be prepared to deliver nonpharmacological methods of coping for all laboring women regardless of their intent to use pharmacological pain management. The use of medications or anesthesia in labor is included in the Farver–Campos Labor Coping Scale as its third component.

The Role of the Childbirth Educator Is Crucial in Promoting Labor Coping

Childbirth education is crucial to successful labor coping and improving perinatal outcomes (Gallo et al., 2018). Women who take childbirth classes are less likely to use an epidural and are more likely to have a vaginal birth (Gagnon & Sandall, 2007). Women who view labor pain as purposeful and productive, taking them to a desired end goal (birth), experience it as a transformative life event (Whitburn et al., 2019). Childbirth educators have an opportunity at a pivotal time to bring about this view of labor. Teaching parents a philosophy of coping and viewing labor as a positive and competent process directly affect their experience of birth. Prenatal education significantly enhances a woman's belief that she can cope with labor (AlSomali et al., 2023).

Childbirth educators who incorporate the use of coping strategies in their curriculum equip and empower their students to cope with labor (Brixval et al., 2016). This in turn has been shown to reduce anxiety, pain, and obstetric intervention (Carlsson et al., 2015). Parents who learn, practice, and implement coping options in labor have higher satisfaction with their births (Lally et al., 2008). Labor coping techniques improve women's experience of birth and reduce the use of analgesics (Bohren et al., 2017). Nonpharmacological coping options shorten time in labor and improve perinatal outcomes (Gallo et al., 2018). Prenatal classes provide an important source of information for decision-making in labor and should include the opportunity to practice and master nonpharmacological coping techniques. Childbirth educators who utilize the Farver–Campos Labor Coping Scale in their classes have an effective tool to instruct parents in practical coping options to achieve these outcomes. It includes an extensive menu of evidence-based coping techniques, both mental and physical, that parents and caregivers can utilize.

Implications for Research

We have clear data regarding the use of the pain scale: it is ineffective for reducing pain, it has led to a general increase in opioid use and abuse, and it is inappropriate for labor pain assessment. We have clear data that coping with labor should be assessed rather than pain, that nonpharmacological coping options are desired by women regardless of their chosen pain control method, and that nonpharmacological coping methods result in improved perinatal outcomes and better satisfaction with the birth experience. In addition, there is no evidence of harm when using nonpharmacological coping options (Chaillet et al., 2014). More research is needed however to evaluate patient and nurse satisfaction after implementing the Farver–Campos Labor Coping Scale. This can be accomplished by having hospitals currently using the pain scale in their labor units to switch to the Farver–Campos Labor Coping Scale. These facilities should survey patients prior to implementation to assess satisfaction with being asked for a pain score in labor. They should then survey patients after implementation to assess satisfaction with not being asked a pain score in labor. In addition, these facilities should survey nursing staff post implementation for feedback on using the coping scale versus the pain scale.

Along with the implementation of the Farver–Campos Labor Coping Scale, facilities must also ensure that a robust array of coping options is available to women. This would improve overall care and have financial benefits as well. Data demonstrate improved perinatal outcomes (maternal and neonatal) along with improved patient satisfaction when nonpharmacological coping methods are used. Nonpharmacological methods are also low cost compared to pharmacological interventions, and when utilized, reduce the use of expensive pharmacological interventions. In addition, nonpharmacological coping options reduce cesarean birth rates and thus their associated costs, risks, and lengths of stay (Table 2).

Implications for Practice

The major task of a woman in labor is to cope with labor until it culminates in birth. Using a pain scale decreases labor coping by making the focus on pain. The use of a coping scale increases labor coping by focusing on coping. More than an assessment tool, the Farver–Campos Labor Coping Scale promotes coping by guiding women in the use of coping options and guiding nurses in providing support. The Farver–Campos Labor Coping Scale is an intuitive, concise, and helpful tool to replace the pain scale in the maternity care setting.

Implementation of a labor coping scale is supportive of personal labor care. Horn and D'Angelo used a coping assessment tool in place of the numeric pain scale to guide nursing care in labor. As a result, patient satisfaction scores regarding their care were higher (Horn & D'Angelo, 2017). They concluded that further research should test their coping assessment scale against the 0–10 pain scale and against other pain and/or coping tools in a randomized trial.

Implementation of a labor coping scale promotes vaginal birth by encouraging a philosophy of coping and by offering a variety of coping options. The authors of the CMQCC toolkit “Promoting Vaginal Birth” highlight the need for tools that promote labor coping, including nonpharmacological options (Smith et al., 2019). This has implications for hospitals to change practices and policies. “Changing certain hospital policies, such as instituting a freedom of movement policy, intermittent monitoring for low-risk women, or offering a full array of

TABLE 2.

Reduction in Cesarean Birth Rates by Nonpharmacological Interventions

Study	Nonpharmacological intervention	Outcome
Bell et al., 2017	Movement in labor. Maternal positioning. Birthing balls. Peanut balls.	Reduction in C/S rate from 27.9% to 19.7%.
Ghasemi et al., 2013	Birthing tubs.	The C/S rate laboring on land 16%. The C/S rate laboring in water 5%.
Javernick & Dempsey, 2017	Delay admission until >4 cm dilation. Intermittent auscultation.	Reduction in C/S rate from 28.9% to 12.3%.
McGrath & Kennell, 2008	Doula usage.	C/S rate with no doula care 25%. C/S rate with doula care 13.4%.
Ben Regaya et al., 2010	Ambulation versus bedrest.	C/S rate with bedrest 16%. C/S rate with ambulation 5%.
Sahile et al., 2017	Continuous labor support.	Reduction in C/S rate by 50%.
Souter et al., 2019	Midwifery care.	Reduction in C/S rate by 50%.

Note. C/S = cesarean section.

nonpharmacologic methods to promote comfort and coping may be necessary in order to practice high-quality maternity care.” The document explains that having limited choices to manage pain and improve coping during labor is a barrier to supporting intended vaginal birth. “Often, a variety of pain management methods, both pharmacologic and nonpharmacologic, are necessary to meet the unique needs of each laboring woman” (Smith et al., 2019).

Labor and birth units must provide nonpharmacological coping options and train staff in their use (Simkin et al., 2017). Analgesia and anesthesia can blunt or block labor pain but carry a host of side effects, including prolonged labor and increased risk of operative birth methods. Labor coping strategies, especially nonpharmacological ones, increase labor coping, have no deleterious effects, and have a greater potential to increase labor progress (Gallo et al., 2018). Studies show that a major determinant of a woman’s ability to cope with labor is having continuous support (Van der Gucht & Lewis, 2015). Nursing staff should be enabled to provide bedside labor support. The hospital should consider having other support options such as a volunteer doula service.

Childbirth educators are considered a knowledgeable source by parents. They are sought out for guidance on how to go through labor. Promoting clients’ knowledge and practice with coping skills increases their self-efficacy (El-Kurdy et al., 2017). They can teach parents that labor is a positive process, that labor pain is productive,

and that it leads to their desired end goal, the birth of their baby. Sustaining this view that labor pain is purposeful and productive improves women’s experience of birth and reduces their need for interventions (Whitburn et al., 2019). Describing pain in this way, as “functional discomfort,” promotes coping (Sanders, 2015).

CONCLUSION

Maternal–child units must adopt a labor coping scale in place of a pain scale to better serve women in labor. Adopting an environment of coping with labor decreases suffering and increases women’s sense of control and satisfaction with their births. It is incumbent upon childbirth educators to inform parents-to-be regarding labor coping options and facilitate their practice of these options (Simkin et al., 2017). Having a labor coping scale to replace the numeric pain scale in labor promotes coping and the use of nonpharmacological methods of labor coping. These in turn reduce the use of interventions and the rate of cesarean surgeries.

The Farver–Campos Labor Coping Scale assesses coping rather than pain. Other labor coping scales are lengthy and tedious and require more extensive time and attention. The Farver–Campos Labor Coping Scale with four basic points is succinct.

The Farver–Campos Labor Coping Scale promotes a philosophy of coping with labor by focusing on coping rather than focusing on pain. It both assesses and promotes labor coping by guiding

nurses and laboring women through coping options. Nonpharmacological coping options built into the coping scale promote labor coping without deleterious effects. Labor support is at the heart of nursing care in the labor and birth unit. Assessing and promoting labor coping increases the effectiveness of labor care.

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