COMMENTARY

Beyond the Nursery: Postnatal Care in the 21st Century

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Postnatal care has been one of the great public health successes of the past century. In 1910, most infants were born at home, and perinatal mortality was high; 1 in 10 US infants died before their first birthday.[1] By 1960, the large majority of US births occurred in a hospital, where infants received multiple effective preventive interventions that led to a steep decrease in mortality rates. At that time, newborn preventive interventions were typically provided in a room called the "nursery," where infants were lined up in row after row, and nurses moved from infant to infant to deliver care; mothers were housed on the postpartum ward, where they recovered from the birth process by resting quietly in bed.

Things have changed for the better in the 21st century: the number, scope, and effectiveness of postnatal preventive interventions has continued to expand, whereas infant mortality has continued to decline. We have learned that the cohousing of infants and mothers leads to better health outcomes, and providers have therefore adopted new patterns of care.[2,3] The preventive services previously located in the nursery now occur in a room shared between the mother and infant, and the big nursery room has gradually emptied as mothers and infants have begun to "room in." This change has been facilitated by advocacy from programs such as the Baby Friendly Hospital Initiative[4] and by mounting evidence that rooming-in with mothers improves not only breastfeeding but also infant temperature regulation and glycemic control.[5–7]

Difficulties with the transition to extrauterine life remain common, of course, and the evidence that these transitions are ameliorated when newborns are in close proximity to their mothers[8] has impelled pediatric clinical staff to deliver a higher level of acuity of care in the room shared by the mother and infant than formerly. For example, intravenous antibiotics or observation and management of narcotic abstinence syndrome may require acute inpatient management but may no longer be an indication to remove the infant from the room shared with the mother.[9,10] This new emphasis on maintaining rooming in for infants requiring antibiotics, phototherapy, or management of other acute illnesses demands increasing expertise from physicians and nurses caring for such infants. Newborn care providers also now need enhanced expertise to provide maternal education about important care practices such as effective breastfeeding techniques, safe sleep position, tobacco exposure avoidance, and infant safety, which require reinforcement multiple times a day when mother and infant are rooming-in.

As the level of care provided in the shared mother-infant room has increased, and the nursery room itself has emptied, the term "well newborn nursery" has stuck and is still used to describe the doctors and nurses providing

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postnatal care; the room shared by the infant and mother is still often described as the postpartum room. Use of this antiquated terminology seems to lead to 2 areas of misunderstanding. First, the empty nursery room may suggest that modern medicine has made the care previously provided in the nursery obsolete. Such an observation would of course be erroneous; routine postnatal care has indeed shifted in location but has grown in importance. Second, the empty nursery room may suggest that the newborns rooming-in with mothers are well, whereas in fact, the medical staff is often exerting extensive effort to maintain a newborn's physical proximity to his or her mother when inpatient treatments such as intravenous therapy are required. For these reasons, the time has come to revise the nomenclature of this field.

We propose a sunsetting of the terms nursery and well newborn unit, because they no longer sufficiently describe the location of or the care provided to newborns who are rooming-in. As an alternative, we would like to propose the terms "mother-infant unit" or "postnatal unit" to describe the location of newborns who do not require intensive care. We additionally propose the term "newborn medicine provider" to describe those who provide routine postnatal care to newborns and the term "procedure room" to describe the location where infants stay separately from their mothers when continuous observation is required. We believe such nomenclature provides a more accurate description of current postnatal care, in keeping with the responsibility of newborn medicine providers to improve the evidence base for cost-effective care for the vast majority of US births.

Over the coming years, it is highly likely we will see even greater advances in the routine postnatal care of newborns. Retaining the term nursery risks the false connotation of antiquated images, even of an empty room, and may denigrate an important area of hospital medicine. In contrast, using terminology parallel with obstetrics, such as postnatal unit and mother-infant room, may help clarify the role of the clinical staff and of the location formerly called the nursery, and it may underscore the fundamental importance of postnatal care for promoting population health.

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