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# Communication Accommodation in Maternity Care: A Qualitative Analysis on how Patient-Provider Communication Affects Labor and Delivery Decisions

Gabriele Cafone  
gabriele.cafone@shu.edu

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**Communication Accommodation in Maternity Care:  
A Qualitative Analysis on how Patient-Provider Communication  
Affects Labor and Delivery Decisions**

**Gabriele Cafone**

**Seton Hall University**

**Thesis Advisor(s):**

**Danielle Catona, PhD**

**Renee Robinson, PhD**

**Submitted in partial fulfillment of the requirements  
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THESIS ADVISER(S)

Adviser:

Danielle Catona, PhD

*Danielle Catona*

1-15-18

Name (printed)

Signature

Date

Adviser:

Renee Robinson, PhD

*Renee Robinson*

1-18-18

Name (printed)

Signature

Date

Adviser:

Name (printed)

Signature

Date

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## Abstract

**Background.** Over 4.3 million mothers and newborns receive maternity care in the United States each year (Sakala & Corry, 2008). Childbirth is the leading reason for hospitalization yearly in the United States, with 23% of all individuals discharged from hospitals being either a mother or a newborn. The most common operating room procedure is cesarean section, and six of the fifteen most commonly performed hospital procedures are associated with childbirth (Sakala & Corry, 2008). Women may be led to believe that these medical interventions during labor and delivery are necessary without ever being properly educated, resulting in an intervention filled experience that places unnecessary risks on both mother and baby (Lothian, 2012).

While extensive research has proven the benefits of an intervention-free birth for low risk pregnancies, the rates for these interventions continues to rise. According to the Centers for Disease Control and Prevention (2014), cesarean sections in low risk pregnancies in the United States rose from 18.4% in 1997 to 32.7% in 2013. Federal regulations and guidelines state that every woman has the right to make maternity care decisions based on accurate up-to-date information (Goldberg, 2009).

Prior to giving birth, expecting mothers should be given the ability to make decisions regarding which interventions, if any, will be administered during the progression of labor. Despite the research that supports both shared decision-making and informed decision-making models, women undergoing maternity care are often uninformed, leaving them unable to make proper decisions. This misinformation leads to maternity patients agreeing with practitioners' predetermined decisions and not being active decision-makers in their own care (Stevens & Miller, 2012). A possible reason for expecting mothers not taking an active role in their decision-making may be a direct result of providers under-accommodating expressed patients' needs relaying labor and delivery-related information.

**Method.** Semi-structured interviews were conducted with three mothers who gave birth to their first child within the past two years. Interviewees were recruited by a maternity nurse affiliated with a private university. Mothers had varied labor experiences but all delivered via cesarean section. Interview questions explored the lived experience of labor and delivery and how provider communication affected mothers' decisions to receive or not receive a medical intervention.

**Results.** A qualitative analysis using the constant comparison method revealed five themes related to labor and delivery decision-making: (1) reason for C-section/lack of decision-making, (2) provider's description of risks/benefits, (3) delivery day communication, (4), pre-delivery day communication, and (5) overall provider satisfaction.

**Discussion.** It was discovered that the participants in this research were not as involved in their decision-making as is recommended by the shared decision-making model. However, despite not being the final decision maker participants were satisfied overall with their provider. The results may inform medical education training for providers in maternity care, as well as patient education materials for expecting mothers. Additional research in this area is needed to further determine the affect patient-provider communication has on maternity care decision-making.

*Keywords:* communication accommodation, patient-provider communication, maternity care, decision making

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**Chapter 1: Introduction and Statement of the Problem**

Over 4.3 million mothers and newborns receive maternity care in the United States each year (Sakala & Corry, 2008). Childbirth is the leading reason for hospitalization yearly in the United States, with 23% of all individuals discharged from hospitals being either a mother or a newborn. The most common operating room procedure is cesarean section, and six of the fifteen most commonly performed hospital procedures are associated with childbirth (Sakala & Corry, 2008). With a vast number of hospital patients being mothers and newborns, it is imperative that mothers are aware of any procedures or interventions they are receiving while under the care of their main healthcare provider.

Expecting mothers are a special population that deserve medical treatment that best suits their care needs. This population of patients is cared for prenatally and during labor and delivery by a variety of health care professionals, including but not limited to, physicians and midwives. When preparing to give birth, expecting mothers rely on their health care provider as a main informant (Lothian, 2014b). Mothers should be educated by their provider about risks and recommendations based on clinical evidence, as well as different birthing procedures and interventions that may occur during the labor and delivery progression (Lothian, 2007a). Expecting mothers becoming educated can allow them to become more active in making decisions regarding the care they are receiving. However, current evidence suggests that health care providers may not be communicating care options that support patient involvement in decision-making (Stevens & Miller, 2012).

During labor and delivery expecting mothers may often be told by their health care providers that a medical intervention is necessary without disclosing the possible consequences and risks of these interventions (Jansen, Gibson, Bowles Carson, & Leach, 2013). Many maternity practices that were originally developed to address specific issues during childbirth are now being used routinely (Sakala & Corry, 2008). Women may be led to believe that these medical interventions during labor and delivery are necessary without ever being properly educated, resulting in an intervention filled experience that places unnecessary risks on both mother and baby (Lothian, 2012).

While extensive research has proven the benefits of an intervention-free birth for low risk pregnancies, the rates for these interventions continues to rise. For example, according to the Centers for Disease Control and Prevention (CDC) (2014), cesarean sections in low risk pregnancies in the United States rose from 18.4% in 1997 to 32.7% in 2013. Federal regulations and guidelines state that every woman has the right to make maternity care decisions based on accurate up-to-date information (Goldberg, 2009). Women rely on health care providers to supply them with unbiased information that allows them to make decisions regarding prenatal care, specifically with regard to decisions pertaining to medical interventions during labor and delivery. Shockingly, women are misinformed regarding these interventions and often times they are not given accurate information that would allow them to make informed decisions when it comes to interventions. For example, a national study reported that 60% of women surveyed wrongly believed that macrosomia (a baby whose weight exceeds 8lb 13oz) is an appropriate indication of induction and 30% of women wrongly believed that induction decreases their chance of having a cesarean section (Amis, 2007).



Communication between the health care provider and the patient may be ineffective which could be a factor in the increase in interventions during labor and delivery. The purpose of medical communication is to allow patients and their care providers to promote the exchange of information between the provider and the patient (Ong, De Haes, Hoos, & Lammes, 1995). Exchanging information should provide women with the opportunity to become active decision-makers. Expecting mothers should be given the chance to become informed as well as the ability to weigh intervention options prior to the labor and delivery experience (Saka & Corry, 2008). As patients, expecting mothers need to know and understand the procedures that are offered and their risks and complications (Ong et al., 1995).

Throughout the patient-provider relationship, quality communication is essential to assure functionality and understanding. When discussing patient-provider communication a variety of theories can be applied to this relationship. Bylund, Peterson, & Cameron (2013) note goals-plans-action theory, uncertainty reeducation theory, and action assembly theory as some of the interpersonal communication theories that may specifically affect health communication. While said theories may relate to the patient-provider relationship directly, for the purpose of this research the Communication Accommodation Theory (CAT) will be investigated. CAT suggests that individuals alter their communication techniques depending on who the individual is they are communicating with (Bylund, Peterson, & Cameron, 2013; Giles, 2008). Many women may be intimidated by healthcare providers because of their use of jargon, their perceived social power (health care providers know more than patients), and in some cases, mother's lack of experience with the topic being discussed (first time mothers). When analyzing CAT it is also important to remember that providers and patients may be under accommodative, as well, meaning, they may not attend or listen to the other's needs and have their own egocentric

agendas on which they are focused (Giles, 2008). The inability to accommodate communication may result in health care providers giving biased information to patients regardless of how the patient communicates during appointments.

In the patient-provider relationship CAT allows the ability to predict and explain nonverbal and verbal modifications that providers and patients make when communicating with each other (Bylund et al., 2013). Specifically, in the expecting mother-health care provider relationship it may help to determine why some mothers are more involved in decision-making and why others are less active. Mothers and providers may change their communicative behaviors (accommodation), they may change how they speak or their non-verbal behaviors (convergence), they may accentuate or match the others' communicative behaviors (divergence), or they may persist in their own communication style despite what the other person is portraying (maintenance) (Giles & Ogay, 2007). Situations that do not reflect appropriate accommodation may lead to miscommunications between provider and patient, which can result in an incorrect understanding of medical interventions or the incorrect assumption that the patient is unable to be an active decision-maker in the labor and delivery process.

If women were more involved in their labor and delivery decisions there would be an increase in satisfaction in care and patient confidence and a decrease in unnecessary labor and delivery medical interventions (Goldberg, 2009). However, women are often convinced to make uninformed decisions or no real decisions at all when it comes to their birthing options. This lack of knowledge and active decision-making allows for medical interventions to be given without mothers knowing exactly what is happening or why it is happening until after the baby is born.

**Trends in Interventions During Labor and Delivery.** Despite evidence-based labor and delivery methods indicating that interventions should be avoided unless medically necessary,

mothers reported experiencing a wide range of routine interventions during the birthing process (Amis, 2007; Jou, Kozhimannil, Johnson, & Sakala, 2015; Lothian, 2014a, 2014b; Sakala & Corry, 2008). Specifically, in the United States interventions are common practice during maternity care (Lothian, 2007b). According to a national survey 62% of mothers had an IV, 67% had an epidural (Lothian, 2014b), 31% were given Pitocin to speed up their labors, 27% had their membranes artificially ruptured, 17% had an episiotomy, 31% had a cesarean (Lothian, 2007a), and 89% used electronic fetal monitoring with 66% being continuous (Lothian, 2014b). With medical interventions routinely occurring mothers are still not being properly informed by their health care providers of complications and risks associated with these procedures. Research has noted that all (78-81%) or most (17-19%) of potential complications associated with interventions should be disclosed. However, most mothers were poorly informed regarding complications of labor induction and the risks associated with cesarean sections (Declercq, Sakala, Corry, & Applebaum, 2007).

### **Purpose of This Study**

Given the information shared previously, this study seeks to examine how communication accommodation effects patient's labor and delivery decision-making. This study looks to analyze accommodation in communication among both the patient and the provider in the maternity care setting. In some cases expecting mothers do not make any decisions at all or their decisions are based on their provider's opinions only. This study seeks to examine how expecting mothers feel their health care provider communicated options to them so that they could be active in their labor and delivery birth plans, most importantly the decision to receive interventions.

The study of patient-provider communication in the expecting mother-provider relationship is complex because the mother is accepting care not only for herself but for her unborn child, as well. It is essential that communication between the provider and mother be two way, fluid, and informative. Among inter-personal relationships the patient-provider relationship is complex because it often involves interactions between individuals who are in non-equal positions, is non-voluntary, contains vitally important information, and is often emotionally laden (Ong et al., 1995).

Communication between the providers and their patients becomes even more important as a result of patient-centered care becoming a focus among health care providers (Jenerette & Mayer, 2016). It is essential for maternity care providers to recognize and find ways to engage their focus on the patient (Heatley, Watson, Gallois, & Miller, 2015). Communication between the provider and the patient provides information for care, including risks and concerns. During labor and delivery women may not know what to expect, and receiving information from their provider that explains possible outcomes to different interventions is imperative to assure the mother knows what could happen to not only her but her baby as well. When patients understand their health care provider they are more likely to understand treatment options and modify their behavior accordingly (Travaline, Ruchinskas, & D'Alonzo 2005). Therefore when communicating, the provider needs to make sure the patient understands what is conveyed to them. The research question this study focuses on and how it relates to patient-provider communication will be discussed throughout the next section and the chapters that follow.

### **Patient-Provider Communication Affecting Decision-Making**

This research will aim to understand patient-provider communication in the context of maternity care. It will attempt to answer the question:

Do health care providers influence expecting mothers' labor and delivery decisions, specifically decisions as they relate to medical interventions, based on how they accommodate, under accommodate, or over accommodate their communication?

In order to determine if expecting mothers are involved in the decision to have a medical intervention during labor and delivery semi-structured one-on-one interviews were given to judge the parallel between provider and patient communication styles as they relate to CAT. The theory that both patients and providers alter their communication techniques depending on each other will also be investigated. In the next chapter the literature will be reviewed in the following sections: birthing trends, the Listening to Mother's survey series, patient-provider communication, patient decision making, and CAT as a theory related to patient-provider communication.

## Chapter 2: Literature Review

### Birth Trends

Giving birth for the first time can be an experience filled with joy, happiness, anxiety, and fear all in one. The process of giving birth for the first time also throws an expecting mother into a situation of uncertainty (Maimburg Damkjær, Væth, & Dahlen, 2016). It is recommended that new mothers research on their own, join support groups, take childbirth education courses, talk with family and friends, or consult their health care providers for advice and information on what to expect when giving birth. Mothers who have previously given birth may also use past experiences to help guide their decision-making and shape their birthing experience for the second time and beyond.

According to the CDC (2014), in 2014 in the United States alone, 3,988,076 babies were born, making for a large population of women experiencing labor and delivery. Although most childbearing women in the United States are healthy and at low risk for complications, national surveys reveal that essentially all US women experience high rates of interventions with risks of adverse effects (Sakala & Corry, 2008). Possible adverse effects of these interventions include chronic post-surgical pain (Jin, Peng, Chen, Zhang, Ren, Qin, & Min, 2016), blood clots (Blondin, Casini, Hoppe, Boehlen, Righini, & Smith, 2016), infection (Bodner, Wierrani, Grunberger, & Bodner-Adler, 2011), and fever (Bodner et al., 2011; Segal, 2010). Specifically, cesarean surgeries can result in increased pain, bladder, and bowel injuries (Herbruck, 2008), as well as maternal sepsis (van Dillen, Zwart, Schute, & van Roosmalen, 2010). The use of these interventions can turn the process of giving birth from a normal physiological experience to a medical or surgical procedure (Jansen et al., 2013). The American College of Obstetrics and Gynecologists (n.d.) also notes that interventions should not be given or offered for provider

convenience and that providers should be up to date on all current guidelines regarding potential complications and risks during labor and delivery.

In the present paper, the role patient-provider communication plays in the decision-making process for expecting mothers during labor and delivery and the use of medical interventions will be investigated. The researcher intends to discover if the communication exchanged between the patient and the provider ultimately affects expecting mothers' ability to make decisions regarding their choice for medical interventions. The following review of research aims to examine the medical support for a natural birth, the patient-provider relationship, the degree to which the patient makes decisions regarding her perinatal healthcare, and the role communication accommodation plays in the patient-provider relationship.

### **National Survey Results About Maternity Care**

Research within maternity care has been conducted in order to help improve perinatal care for expecting mothers. National surveys (*Listening to Mothers I, II, & III*) within the United States have taken the initiative to survey women who have given birth. These surveys help compare actual experiences of childbearing women to their childbirth preferences. The surveys took place in 2002, 2006, and 2013 with follow up surveys being conducted in 2006 and early 2013.

*Listening to Mothers I* surveyed 1,600 women (Declercq, Sakala, Corry, Applebaum, & Risher, 2002), *Listening to Mothers II* surveyed 1,573 women (Declercq et al., 2007), and *Listening to Mothers III* surveyed 2,400 women (Declercq, Sakala, Corry, Applebaum, & Herrlich, 2013a).

These surveys have provided the baseline for a variety of maternity care research studies and journal articles written in the United States and all over the world (see, Attanasio, McPherson, & Kozhumannil, 2013; Jou et al., & Lothian 2007a, 2014b).

Specifically, in *Listening to Mothers III*, the labor and delivery experience and medical interventions were reviewed (Declercq et al., 2013a). Medical interventions play a large role in the labor and delivery process and experience. Webster's Medical Dictionary (2016) defines the term *intervention* as "the act or fact or a means of interfering with the outcome or course especially of a condition or process." Interventions have become a common part of low-risk labor and delivery and the *Listening to Mothers* reports discovered that medical interventions during labor and delivery were experienced by most mothers (Declercq et al., 2013).

Medical interventions becoming a mainstreamed part of low-risk labor and delivery and evidenced-based care was highlighted in *Listening to Mothers III*, the most recent Listening to Mothers survey. *Evidence-based care* is defined by Lamaze International (2016) as "using the best research about the effects of specific procedures, drugs, tests, and treatments, to help guide decision making." Lamaze International lists six healthy birth practices as the gold standard for maternity care based on evidence-based care research. These birth practices highlight the importance of minimizing interventions unless medically necessary. The *Listening to Mothers* research found that 59% of mothers agreed with the statement, "Giving birth is a process that should not be interfered with unless medically necessary" (Declercq et al., 2013b p. 16). However, some mothers still felt pressured by providers to accept an intervention, with the research showing 25% had labor induced and 25% had a cesarean section as a result of this pressure (Declercq et al., 2013a). In addition to feeling pressured 63% of women who had a primary cesarean indicated that their provider was the final decision maker (Declercq et al., 2013b).

In *Listening to Mothers II* it was disclosed that most mothers (78%-81%) felt that all possible intervention complications should be disclosed; however, whether or not the participants



experienced certain interventions most had an incorrect understanding or were not sure about the complications associated with the side effects of labor induction, epidural anesthesia (commonly referred to as epidural), and cesarean (Declercq et al., 2007). Despite five years passing in between surveys, *Listening to Mothers III* concluded that misinformation was still an issue among expecting mothers. This survey also noted that when asked questions regarding cesarean and induction the majority of mothers did not provide a correct response, indicating they were either misinformed or unsure of the risks and complications associated with these interventions (Declercq et al., 2013b).

Despite mothers indicating they were not sure of the risks and complications associated with medical interventions or what was occurring during procedures they did feel confident and comfortable in their relationship with their provider. *Listening to Mothers III: New Mothers Speak Out* noted 89% of women agreed with the statement “I was confident I could tell my maternity care provider concerns I had even when he or she did not ask” (Declercq et al., 2013b p. 7). The next section describes additional research on patient-provider communication.

### **Patient-Provider Communication and Patient-Centered Care**

**Provider role.** The Institute of Medicine (2013) defines *patient-centered care* as “Providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions (Drenkard, 2013).” Recent health care reforms have aimed to achieve better patient-centered care outcomes by increasing patient engagement (Jenerett & Mayer, 2016; Kozhimannil, Attanasio, Yang, Avery, & Declercq, 2015; Mira, Guilabert, Perez-Jover, & Lorenzo, 2012). Patient engagement can be improved by providers asking questions, developing relationships, and by creating an atmosphere that supports the patients’ involvement in care (Scharf & Street, 1992; Street & Millay, 2001). The

research also stresses the importance of clinicians taking the patients values, preferences, and life circumstances into account and forming collaborative discussions to formulate care plans (Kozhimannil et al., 2015).

Patient-centered communication is another important aspect of patient-centered care. Patient-provider communication is one of the most important aspects of the patient-provider relationship (Travaline et al., 2005). Communication that focuses on the patient recommends that providers seek to understand the patient's perspective (Ledford, Villagran, Kreps, Zhao, McHorney, Weathers, & Keefe, 2010).

Research that has been done on the difference in communication based on the provider lists empathetic communication style, provider willingness to respond to questions, and allowing enough time to discuss the women's concerns as some of the main components to successful maternity care communication plans (Kozhimannil et al., 2015). The midwifery model of care as noted by the American College of Nurse-Midwives (n.d.) lists four components of care that reflect these components. This model offers patients (1) continuous and compassionate partnership, (2) acknowledgement of life experiences and knowledge, (3) individualized methods of care, and (4) therapeutic use of human support and skillful communication. Patients who utilized a midwife for their maternity care were often satisfied with the supportive nature of the relationship the midwife provided. These women reported fewer communication problems than women who had care from other types of providers (Kozhimannil et al., 2015). Specifically, many patients have difficulties asking their health care provider questions but when researching midwifery care and communication it was discovered that only 14% of women held back questions from their provider (Kozhimannil et al., 2015; Mira et al., 2012).

However, specifically in the United States, research has lacked in studying how patient-provider communication effects expecting mothers' satisfaction with care based on their maternity care provider (physician or midwife). The reason communication with provider care research has lacked in the United States could be a direct result of the number of patients that utilize midwifery care. In 2014 of the 3.98 million births only 8% utilized a midwife as their primary prenatal provider (American College of Nurse-Midwives, 2014).

Research that was conducted in Canada discovered the level of satisfaction with midwives was much higher than patients who used another health care provider (Coughlin & Jung, 2005). Conducting more research in this area within the United States would prove to be beneficial when studying patient-provider communication in the maternity care setting. The role the patient plays in the patient-provider relationship will be discussed in the next section.

**Patient role.** It is imperative that the maternity care team as a whole collaborate and encourage active participation by the patient (Heatley et al., 2015). Positive birthing experiences have been related to the improved communication between women and their providers (Attanasio et al., 2014). While researchers have emphasized the positive outcomes associated with effective communication, the recent emphasis on the importance of patient-centered care highlights the importance of a patient's participation in her health care choices (Heatley et al., 2015; Jenerett & Mayer, 2016; Kozhimannil et al., 2015). Active patient communication offers the provider the opportunity to understand the patients' needs and perspectives, in turn allowing for care to be more centered on the patient (Heatley et al., 2015). In the patient-provider relationship each party should equally contribute to the communication efforts. In order for patients to participate in medical consultations, they must be able to express their concerns

(Street & Millay, 2001). Patients who participate in care are associated with high levels of communication satisfaction (Ledford et al., 2010).

When communication satisfaction is present the patient is more likely to engage actively with the provider. Patients who are more active and involved experience improved health outcomes and quality of care (Cegala, Chisolm, & Nwomeh, 2012; Ledford et al., 2010; Street & Millay, 2001). These patients also receive more information and support from providers which allows them to have a better understanding of treatment options (Street, Gordon, Ward, Krupat, & Kravitz, 2005). In addition, patients who take a more active role in their care are often more satisfied with the care they receive (Street et al., 2005). Providers are also more patient-centered and informative when they are interacting with high participation patients (Cegala et al., 2012). Research has been conducted to see why some patients are more involved than others and it was discovered that active patients' providers used partnership-building and supportive talk to engage the relationship (Street et al., 2005).

**Patient-provider relationship.** Effective communication and mutual trust can help to minimize or prevent conflicts during the birthing process (Debaets, 2016). Lefiman, Sinatra, and Huberty (2014) conducted research in the area of patient-provider communication as it related to health behavior changes during pregnancy. The study indicated that trust and rapport are important aspects in the patient- provider relationship as it pertains to communication. Additionally, patients found their prenatal visits to be opportunities to receive information from their providers regarding health behavior changes. As discovered in the research, one of the main underlying reasons that health care providers often missed opportunities to communicate information was a lack of training (Leifman et al., 2014). Baker and Watson (2015) note that the

value of effective communication skills and training between the patient and provider helps to create a positive health care experience.

Patient-provider communication is extremely important for any clinical encounter to be successful. Patients and providers use verbal communication to create pathways to healthy outcomes. Quality healthcare is often based on effective patient-provider communication that is patient-centered, informative, and promotes trust and confidence (Ahmed & Bates, 2016). The role effective patient-provider communication plays in decision-making will be discussed in the next section.

### **Patient Involvement in Decision-Making**

Another important aspect of patient-provider communication is the patient's involvement in decision-making. A variety of different decision-making models can be applied to the health care field. Research has been conducted on medical interventions and new mothers perceptions of decision making. When deciding on a cesarean birth or a vaginal birth mothers indicate that interaction with providers plays an important role in their decision-making (Goodall, McVittie, & Magill, 2009). Additional research found that only about half of women who had planned cesareans felt fully informed and only 25% knew exactly what was happening during the procedure beforehand (Blüm, Stammler-Safer, Reitingner, Resch, Naderier, Leithner, 2012).

**Paternalistic decision-making model and informed consent.** The paternalistic decision-making model, which can be defined as, the doctor making all of the care decisions with the patient's adherence to the care plan selected, is the most traditional model of care (Mira et al., 2012). Prior to the 1980s this model of care was widely used within the patient-provider relationship (Ballard-Reisch, 1990). However, with the creation of the doctrine of informed consent in 1982, this model of care has slowly been phased out. Informed consent protects

patients' rights to consent or refuse medical treatments, procedures, or interventions based on potential complications or risks and benefits (Goldberg, 2009). The American College of Obstetricians and Gynecologists (2015) lists comprehension, adequate information, and freedom of choice as essential components of informed consent in maternity care.

Patients desire to know what medical treatments and prescriptions they are receiving noted the failure in the traditional paternalistic model of care (President's Commission, 1982). Ballard-Reisch (1990) also states that due to patient's not agreeing with providers or not receiving desired information, care plans are not effectively executed with the patient being unwilling to conform to a plan they do not agree with or feel informed about. According to the President's Commission (1982) on informed consent shared medical decision-making encourages more open communication between the patient and provider, increasing the quality of care. In the health-care setting the paternalistic model of care is often ineffective and does not meet the needs of patients in a health care setting (Ballard-Reisch, 1990).

**Shared decision-making model.** The second decision-making model, known as the shared decision-making model, can be identified as having four necessary characteristics. Charles, Gafni, and Whelan (1997) list those characteristics as: (1) at a minimum, both the physician and patient are involved in the treatment decision-making process, (2) both the physician and patient share information with each other, (3) both the physician and the patient take steps to participate with the decision-making process by expressing treatment preferences, and (4) a treatment decision is made and both the physician and patient agree on the treatment to implement. With the focus shifting towards the shared decision-making model patients have been encouraged to become more active in making decisions regarding their care (Goldberg & Shorten, 2014; Mira et al., 2012; Ong et al., 1995). Patients' positive experiences in labor and

delivery are often related to shared decision-making (Attanasio et al., 2014). Declercq et al., (2007), found that when it came to induction and cesarean sections decisions were shared with the provider or were made by the patients on their own. However, mothers noted, 80% of the time for induction and 72% of the time for a cesarean, that the doctor recommended the intervention first for one reason or another.

An example of an effective way to encourage shared decision-making was investigated in Australia. Stevens, Thompson, Kruske, Watson, and Miller (2016) specifically looked at the utilization of patient decision aids to increase patients' involvement in the decision-making process. Stevens and colleagues (2016) define *decision aids* as "tools (e.g., audio booklets, pamphlets, video/computer-based programs, web-based tools) designed to improve decision-making processes and outcomes for patients across a variety of health care domains (pg. 30)." While Street (2007) notes that the goal of a decision aid is "to help patients (and clinicians) make informed, preference-sensitive medical decisions: informed in that the decision is grounded in the best available clinical evidence and preference sensitive in that the decision is consisted with the patient's values (pg. 550)." Decision aids can allow women to intake an abundance of information, support the women's involvement in decisions, and deliver important information parallel with the health care provider. While the conclusion of this research was positive more studies and reviews need to be conducted to analyze the real effect that decision aids have on increasing patients' participation in the decision-making process.

Jenerette and Mayer (2016) developed a conceptual framework for patient-centered communication and decision-making for cancer patients that can also be utilized in the maternity care context. This framework outlines six core functions of communication that include exchanging information as being an important part of decision-making. These functions include:

(1) fostering patient-provider healing relationships, (2) exchanging information, (3) responding to emotions, (4) managing uncertainty, (5) making decisions, and (6) enabling self-management. These core functions can allow expecting mothers to feel they have developed a meaningful relationship with their provider which in turn results in an increase in communication. When patients increase their communication with their provider both parties can discuss treatment options which ultimately involves the patient in decision-making.

**Informed decision-making model.** In the third decision-making model providers fostering the patient-provider relationship can allow patients to engage on a more active level (Jenerette & Mayer, 2016). Patients making a majority of the decisions in the patient-provider relationship are engaging in what is known as the informed decision-making model. Within the informed decision-making model patients take on a greater portion of the decision making responsibility (Stevens & Miller, 2012). Communication between provider and patient proves to be an important part of patient decision- making. Providers can facilitate effective patient involvement by how they communicate the patients' options. Communicating quality, unbiased information relevant to the care options, and actively supporting and assisting patients' preferred level of involvement are some of the ways in which patients who wish to make informed decisions can be supported (Stevens & Miller, 2012). Educational tools may be helpful in patients defining their priorities to their providers. These decision support tools may help patients engage in a more informed decision-making approach (Kaimal & Kuppermann, 2012).

Despite the research that supports both shared decision-making and informed decision-making models, women undergoing maternity care are often uninformed, leaving them unable to make proper decisions. This misinformation leads to maternity patients agreeing with practitioners' predetermined decisions and not being active decision-makers in their own care



(Stevens & Miller, 2012). A study conducted by Goldberg and Shorten (2014) revealed that when it came to receiving an epidural, patients and providers perceived the amount of decision-making made by the patient differently. This lack of consistency indicated that providers were not properly educated in including patients in the decision to receive an epidural and often left them receiving this intervention without proper information. As a result of this research Goldberg and Shorten (2014) recommend childbirth educators as advocates and valuable resources for expecting mothers regarding decision-making prior to the labor and delivery experience.

Many women want to be involved in their pregnancy-related decisions. However, women receiving maternity care often felt coerced into treatment options that were their doctor's preference and found it difficult to express their own preferences if they did not agree with the provider (Stevens & Miller, 2012). The provider may offer education and guidance to help the patient understand recommendations which in turn can help eliminate passive patient communication (Kaimal & Kupperman, 2012).

Regardless of what decision-making model is utilized in the patient-provider relationship, both expecting mother and provider should communicate the patient's desired amount of involvement in making maternity care decisions. The provider and the patient should agree on the patient's preferences for participation in making decisions related to care since some patients like being responsible for all choices and others prefer not to be the sole decision-maker (Charles et al., 1997). Providers should be encouraged to support women who face decisions regarding interventions and patients should be encouraged to take responsibility for their labor and delivery birth plans (Goldberg & Shorten, 2014). CAT and the role it plays in patient-provider communication and decision-making will be discussed in the next section.

### **Communication Accommodation Theory**

When studying how the patient-provider communication relationship affects decision-making and medical interventions, CAT can be used to measure the effect this communication has on patient outcomes. CAT focuses on ways communication is modified as a result of communication with another person (Bylund et al., 2012). CAT provides a wide range framework to predict and explain adjustments individuals make to create, maintain, or decrease social distance (Giles & Ogay, 2007). CAT initially emerged as a sociopsychology account of how dialect and words change depending on to whom we are speaking (Giles & Powesland, 1975). Accommodation can have multiple meanings in different theoretical areas; however, CAT accommodation is a process concerned with how individuals reduce and magnify communicative differences (Giles, 2008). Within the patient-provider context accommodation can be made in either an upward convergence or a downward convergence. *Upward convergence* is a patient accepting and conforming to the provider's communicative styles if they reflect medical jargon or a prestigious accent and downward convergence is the provider replacing the jargon and inserting lay words and explanations to match the patient (Giles, 2008).

The social stereotypes in the patient-provider relationship may lead to faulty expectations about the other's competence in the conversation (Giles, 2008). For instance, a provider may assume a patient does not understand what is being said and may over accommodate his or her communication style. While this may be beneficial in cases where the patient really is confused, in cases where the patient is informed and understands this over accommodation may be seen as demeaning.

Quality communication between patient and provider is vital and if ineffective may impede a provider's ability to deliver quality patient outcomes (Watson & Gallois, 1999). According to

CAT communication is influenced by the features of the situation and socio-historical context in which the situation is embedded (Giles & Orgay, 2008). With past provider practices revolving around the paternalistic model of care (patient has little say in care decisions) and the provider making all of the health care decisions for the patient (Mira et al., 2012; Ong et al., 1995), patients may believe the context of their relationship is one where the doctor makes the decisions and controls the accommodation. However, research studies have shown that doctors who utilize CAT strategies, including the use of accommodating behaviors (patients who feel listened to, patients who feel able to ask questions, and patients who feel that their provider gave time to make sure they understood their health information), provided their patients with a more positive health care experience (Baker & Watson, 2015).

Also present within CAT is individuals' tendencies to be non-accommodative. *Non-accommodative communication* can be defined as when a patient or provider does not accommodate communication styles appropriately (Baker & Watson, 2015). Non-accommodative behaviors can occur for a variety of reasons. Baker and Watson (2015) note that often times individuals engaged in interpersonal communication are not aware of their tones or use of language and are often unwilling to adjust due to social power, roles, and status. For example, if an expecting mother is speaking to her provider using language that does not include medical terminology the provider should return communication in the same fashion. However, in the non-accommodative setting, people do not attend or listen to others' needs, resulting in egotistic agendas being carried out via this communication (Giles, 2008). While the importance of quality communication is stressed, research suggests that providers often adapt non-accommodative communication patterns, including the use of medical jargon that they fail to explain to patients (Thomas, Hariharan, Rana, Swain, & Andrew, 2014). This lack of explanation

can lead patients to feel confused, uninformed, and unsure about the medical procedures or complications they may have or could experience. Qualitative research conducted has shown that patients rated unsatisfactory interactions with providers who were less likely to attend to the relationship and emotional needs of the patient (Watson & Gallois, 1999).

**Limitations and strengths of the theory.** CAT has an explanation that covers significant ground that can be generalized to apply to a variety of different areas of communication research. CAT is utilized in interpersonal communication, intergroup communication, health communication, and cross gender communication. The theory's ability to go beyond a single instance and cover a range of events gives the theory strong theoretical scope (Littlejohn & Foss, 2005). In addition, West and Turner (2007) note that "there is no doubt that the theory is heuristic and has lasting scholastic value" (p. 547).

CAT has proven to be a valuable resource when studying human interactions. However, CAT does have limitations. There is little understanding regarding which communication features will be accommodated during an interaction. It is also important to note that non-accommodative patterns and whether they are consciously or subconsciously used has yet to be studied (Giles, 2008).

## **Conclusion**

In conclusion, with a significant amount of the patients receiving health care being expecting mothers (Sakala & Corry, 2008) the relationship providers have with these patients needs to be one that reflects their preferences for care. With medical interventions being a common aspect of the labor and delivery process it is essential that all potential risks and complications related to

these procedures are communicated and disclosed to the patient (Amis, 2007; Goldberg, 2009; Jou et al., 2015; Lothian, 2014a, 2014b; Ong et al., 1995; Sakala & Corry, 2008;).

Patient-provider communication should be patient-centered and reflect the patient's values, preferences, and life circumstances (Kozhimannil et al., 2015). However, patients who are not active in the patient-provider relationship may not receive satisfactory care or the necessary information required to make a decision (Ledford et al, 2010). Active patients are more likely to receive useful information and support from their health care providers (Cegala et al., 2011; Street et al., 2005) which results in a higher level of communication satisfaction (Ledford et al., 2010).

In relation to medical interventions during labor and delivery, providers should aim to include their patients in the decision-making process. The shared decision-making model reflects patient-centered communication and patient-centered care and encourages patients to be included in the decision-making process resulting in a more positive labor and delivery experience (Attanasio et al., 2014; Goldeberg & Shorten, 2014; Mira et al., 2012; Ong et al., 1995). Providers may use a variety of techniques, including decision aids, to inform and include patients so that they may participate in the decision-making process (Kaimal & Kupperman, 2012; Stevens et al., 2016).

Providers who accommodate their communication techniques provide a better opportunity for patients to become involved in the shared decision-making process. Understanding if provider's accommodation affects expecting mothers' ability to make informed decisions based on evidence is an area that has not been studied. If mothers are more aware of the potential risks and complications associated with an invention filled birth will they still decide to have these procedures regularly? It will benefit maternity care to discover how providers communication

techniques effects mothers' involvement in their labor and delivery choices and birthing procedures.

The research conducted for this paper will explore if patient-provider communication in the maternity care setting and expecting mothers ability to be included in decision-making is affected by communication accommodation. The methods used to conduct the research discussed in this paper will be introduced in the next chapter with the results revealed in later chapters.

### **Chapter 3: Methods**

#### **Research Question**

To fully understand how patient-provider communication effects patient's decision-making when it comes to medical interventions during labor and delivery the experience of labor and delivery was analyzed through a qualitative data analysis grouping participant's responses into themes and subthemes from one-on-one semi-structured interviews.

The research question this study aims to answer is:

Do health care providers influence expecting mothers' labor and delivery decisions, specifically decisions as they relate to medical interventions, based on how they accommodate, under accommodate, or over accommodate their communication?

Semi-structured interviews were an appropriate method of research to answer this question because the researcher will had the ability to measure the participant's labor and delivery experience through a set of pre-established questions. In addition to the interviews the thorough literature review in chapter two was integrated as a part of the research findings and was a valuable guide to making this research more meaningful (Humble & Cross, 2010; Lopez & Willis, 2004).

#### **Data Collection**

One on one semi-structured interviews were conducted to gather data. Before data collection began the researcher received approval from Seton Hall University's Institutional Review Board (IRB). In order to protect the participants of this research anonymity was assured by assigning each participant a number. At no time during the study was a participants name used. Participants were made aware of their anonymity and confidentiality by signing an

informed consent which was approved prior by IRB. All participants signed and agreed to the terms outlined in the informed consent document and understood the benefits and risks of participating in this study. The interviews were audio recorded and as noted by Lindolf and Taylor (2011) were given in protected time and in a protected place. Lindolf and Taylor (2011) define a *protected time* as when the participant is not distracted by other appointments or calendar items and a *protected place* is defined as a comfortable and confidential space where privacy is respected and distractions are limited or non-existent. The protected place was a comfortable location selected by the participant. The protected time was a one hour time slot selected by the participant. Each person was interviewed one time with no follow up meeting.

Interview questions were formatted as noted by Kvale (1996). The interview protocol included introduction questions, follow-up questions, probing questions, specifying questions, indirect questions, structuring questions, and interpreting questions. Interview questions were carefully selected to promote open-ended answers. Questions included discussing the mothers' relationship with their provider, how they felt their provider relayed information to them, what their birth plan was prior to the labor and delivery experience, and if they felt comfortable asking their provider questions related to medical interventions. Questions that are respondent in nature help to elicit these responses (Lindolf & Taylor, 2011). A list of the questions may be found in Appendix A.

## **Participants**

The participants varied in age, baby birth weight, and amount of time between due date and birth date. All participants utilized an Obstetrician/Gynecologist (OBYGN) as their maternity care provider, delivered in a hospital, delivered a boy, and delivered via a C-section. In addition, each new mother had delivered within the past 6 months providing a recent recall on



the labor and delivery/maternity care experience. Each participant's delivery resulted in a C-section for a different reason, however, each participant was told that a C-section was the only option of delivery available to them. Participant's maternity care providers were all part of a practice that had 2 or more doctors on staff and all of the women were required to meet with each of their practices doctor's. While each of the participants were satisfied with the overall communication received from their provider areas of potential improvement and under-accommodation were present in pre-delivery appointments as well as on delivery day itself.

The participants all fulfilled the purposeful sample that was sought out by the researcher. *Purposeful sampling* is often used in qualitative research to identify and select information-rich instances related to a phenomenon of interest (Palinkas, Horwitz, Green, Wisdom, Duan, and Hoagwood, 2016). For this study the purposeful sample was necessary to compare and contrast different labor and delivery experiences. The purposeful sample for this research was based on the following criteria: (1) one woman had given birth via a semi-planned cesarean section, (2) one woman had been induced, and (3) one woman had given birth via a cesarean section that was decided on the day of delivery. The researcher initially was seeking a sample that included a woman who experienced a natural non-surgical birth, however, no such participants could be recruited. The researcher had access to this purposeful sample by working with a well-respected child birth educator and nursing Professor who has conducted significant amounts of research on the labor and delivery experience. The child birth educator sent a solicitation email to a qualified list of potential participants and provided the researchers information. Interested participants contacted the researcher to inquire further about the research opportunity and to ask any questions. Networking between potential participants also helped to fulfill the sample. Once the sample was fulfilled no more participants were recruited.

Participants who experienced the same phenomenon but in a different way gave the researcher the ability to highlight the differences in decision-making, patient-provider communication, and the use of medical interventions during this shared significant life experience.

### **Data Analysis**

Glesne and Peshkin (1992) state that “data analysis is the process of organizing and sorting data in light of increasingly sophisticated judgements and interpretations (Glesne & Peshkin, 1992, p. 130).” The researcher analyzed data using the four general stages of qualitative data analysis and data preparation outlined by Ruona (2015) and further supported by the work of Pietkiewicz and Smith (2012). Analysis begins with data preparation. The researcher transcribed the 12-25 minute interviews, edited, and formatted the data to reach desired conclusions. Ruona (2015) lists the importance of beginning data analysis as soon as the first interview is complete so that further questions can be added and a reflection of the process can be completed throughout. The researcher transcribed each interview within 24 hours of conducting it for better efficiency and recall. Transcriptions were familiarized by reading, rereading, listening to the audio tape, making notes, and gaining a general sense of the data as a whole. During this stage the researcher began to see what patterns emerged from the themes discovered. Next, coding of this information began. Lines from the transcribed interview were broken into significant statements. These statements were explanations that reflect the patients experience with their provider. Once the statements were established they were broken into themes. Having identified common themes throughout the transcription united the phenomenon of giving birth and allowed the researcher the ability to separate and identify additional subcategories. After deciding which themes and subthemes emerged from the transcription, the researcher coded the data using

Microsoft Word and created tables as recommended by Ruona (2015). Tables are organized by theme, question, participant, line number, data, and notes (Ruona, 2015). Separating the data into an organized table allowed the researcher to better analyze and organize the data. The data was written in a narrative form to better summarize findings. Consistencies or inconsistencies with other research and literature was included and compared. This process was completed for each participant and an exhaustive description tying together each of the themes was established and written. The findings from the data collected and the semi-structured interviews will be revealed in the next chapter.

## Chapter 4: Findings

After the interviews were transcribed they were coded and analyzed by the same researcher and grouped into themes and subthemes. The data presented the following five consistent main themes: (1) reason for the C-section/lack of decision making, (2) provider's description of risks/benefits, (3) delivery day communication, (4) pre-delivery communication, and (5) overall provider satisfaction. The four sub-themes that emerged under delivery day communication were (1) confidence in delivery day doctor, (2) comfort with the delivery day doctor, (3) positive reinforcement (non-verbal and verbal) on delivery day, and (4) explanation of delivery day procedures. The four sub-themes that developed under pre-delivery day communication were (1) visiting different doctors, (2) differences in doctor's communication within the same practice, (3) ability to ask questions during appointments, and (4) trust and confidence established with their doctor's. before delivery day Data was grouped into these themes and sub-themes by common word choices used by the participants and stories and instances offered as answers to similar questions.

In the next section each theme and sub-theme will be broken down to connect the participant's maternity care and labor and delivery experience and how their provider's communication negatively or positively affected their ability to make decisions regarding their care.

### **Reason for a C-section/Lack of Decision**

Prior to labor and delivery participants 1 and 3 noted that they preferred a natural birth.

Participant 1 stated "The plan was to go natural, they induced me on my due date which was exactly 40 weeks." While Participant 3 noted

My original birth plan was to go natural, like no epidural, and see where that takes me. Like I wasn't opposed to getting an epidural if I felt I needed one at the time but I wasn't going in like planning to have one. I was pretty much open to anything except having a C-section originally.

Participant 1 said she originally did want a C-section but as her pregnancy progressed she desired a natural birth more.

As it got closer I wanted to go natural because I thought that would be less painful and I started to think about the actual operating situation. They always say natural is the way to go. I guess because of the risk factor, like having a C-section would be and just like going under and the whole process.

Participant 2 did not really have a birth plan due to her baby being in a footling breech position. Footling breech is described as the feet being delivered first. Prior to the delivery Participant 2 was set to have an appointment to discuss options other than a C-section. However, due to the baby arriving 3 weeks pre-term that appointment never occurred and a C-section was her only delivery option because the baby was still breech.

They said it was either a C-section or trying something called version which is them putting their hands on my stomach and trying to twist him to try and get him to go head first...we did not get that far. Our appointment was for Thursday to talk about each option and he decided to come earlier than that so I only had one choice at that point.

While each of the participant's reasons varied for why they encountered a C-section their providers did note that a C-section was their only option, taking away the ability for the new mothers to make any decision regarding their labor and delivery method. Participant 1 noted

At the 23rd hour I developed a high fever and an infection and within 20 minutes of the fever and my body reacting terribly I was in the operating room to have a C-section. She (provider) said basically there was no other option, the most important thing is we get the baby out as soon as possible because with your fever and with your infection.

It is also important to note that Participant 1 had additional interventions prior to the C-section and that could have caused her fever. She recalls,

Unexplained fever and infection...could have been from the catheter, could have been from the epidural...my body could of just, it could have been anything. I could not go to the bathroom... it could have been anything, I would not know because I had no idea.

Participant 2 remembered her provider explaining the need for a C-section due to her baby's breech position,

I did not really have options. The appointment that was supposed to be on Thursday they were going to explain the risks and things with the C-section and version because those were my only options at that point...they said they do not deliver feet first.

Participant 3 recalled her last ultrasound appointment and the realization she was going to have a C-section.

When we went to our last ultra sound appointment I was in labor and didn't realize it and then they told me that I had to go for like not an emergency C-section but like a you have no choice other than having a C-section C-section because my fluid was low and he was measuring really big so I was like kind of in labor but not totally.

Despite her high desire to have a natural birth Participant 3 was left with no decision other than a C-section as she describes her provider telling her, “He basically said like this is it there is no choice here to be made this is what it’s going to be.” She continued “I would have been a high risk natural delivery um so the doctor said that I could try but he wasn’t going to be the one to do the delivery if I chose to um just because it was so high risk.”

Throughout her pregnancy Participant 3 was active with her provider regarding her original plan but felt that in the end the doctor’s decision was most likely the best one due to her circumstances.

I mean up until then um I kind of always asked like what are the chances I am going to have a C-section how does it look? Does it look like I can go natural and they always said yes everything looks fine you look healthy and your active so it shouldn’t be a problem but then I guess when it came down to it all those things were out of there and my control.

### **Description of risks/benefits**

While the Participants were each told a C-section was their only choice for delivery they were not completely informed on the risks and benefits associated with the procedure other than it was what the doctor recommended and said had to happen. Participant 1 originally asked her provider questions regarding the risks of a C-section because that was what she originally thought she wanted as her birth method. When the researcher asked her if risks and benefits were explained she replied,

They did because I asked... I only asked because I just wanted one because when you think about giving birth you're like having to push this big baby out, but when the time comes it could be minutes of having the baby vs the whole getting over the C-section.

While risks were explained as a result of the participants questions prior to delivery day there was not much time for the doctors to relay any information on delivery day due to the participants fever and infection. "There was no time to ask about the procedure they just said this is what we are going to have to do."

Participant 2 arrived at the hospital after her water broke and she was 4cm dilated indicating labor had begun, leaving no time on delivery day to discuss the risks and benefits associated with the procedure. While an appointment was set for later in the week to discuss the C-section and version the information was never relayed due to the pre-term birth. She describes "They did not really explain that much because I did not really have options...on the appointment that was supposed to be on Thursday they were going to explain the risks and things with the C-section." Despite not being informed of the risks of a C-section she was informed of the risks associated with a breech birth and why a C-section was the safest option.

They said they do not do feet first birth for reasons for him and safety. The umbilical cord could be wrapped and all that so they explained why I was going to have a C-section and why it would be the safest option and why they just don't deliver feet first.

Participant 3 described why she was told she needed to have a C-section as well but only on the day of the delivery.

So basically he said that because of the measurements and the fluid there is basically an algorithm that they use or something and he showed me the chart of what a normal



delivery would be and how a low risk and a high risk and I was like right in the middle of like the high risk area.

Participant 3 had only planned on having a natural birth so during her appointments she did not ask her provider about risks and benefits associated with a C-section. As a result of her not asking questions the information was never completely relayed, which was a similar situation to Participant 1 who only received this information after asking. Participant 3 recalled “It wasn’t something I had explored much or asked him much about before then because I was just hoping not to have one.”

Each participant became aware that a C-section would be the method of birth on the day of delivery, with the exception of Participant 2 who was aware that a C-section was a likely option for her. While Participant 1 and Participant 3 were planning for a natural birth their providers should have explained the risks and complications associated with both delivery methods without the patient having to prompt them for this information. It is imperative that new mothers be educated by their providers on what could happen during both a natural delivery and a C-section just in case one is needed. Being informed allows mothers to make educated decisions and to be active in decision-making during labor and delivery.

### **Delivery Day Communication**

*Confidence in Delivery Day Doctor.* While each Participant’s doctor was a part of a group, they were all familiar with each of the doctor’s within the practice. Participant’s 1 and 2 specifically indicated that they were confident with their delivery day doctor and were happy with who ended up being on call for their deliveries.

Participant 1 said “I felt thank God it was her. I was happy it was her because she had that like confident tough like. I just knew once he was out she had control and everything would be fine.”

Participant 2 stated,

After the C-section I was very impressed with the doctor because she was younger so I was a little nervous umm but no she was really great and did amazing and I’m actually happy she was the one on call that night.

Both participants noted confidence through saying they were happy with the doctor who was on call. The participant’s views on confidence are discussed further in the pre-delivery day theme. Noting happiness at seeing your preferred doctor also gave the participants a sense of comfort which will be discussed in the next sub-theme.

*Comfort with Delivery Day Doctor.* Each participant felt comfortable with their delivery day doctor as a result of confidence in the doctor’s knowledge, reassuring communication, and trust in the doctor’s abilities. Participant 1 was especially grateful to her delivery day doctor as a result of her medical emergency during labor and delivery. She also indicated her comfort was a result of the doctor’s knowledge.

I was really comfortable with how much she knew, she was just extremely bright, you just got that from talking to her, you know doctors are smart but she was exceptional. She’s very serious about her work and I remember in the room while the C-section was going on she was just commanding every aspect of the whole room and I felt like she was just running that room and making sure that everyone was doing their part and I knew it was an hour long and it was just a life-saving moment. She just had no problem running.

As the participant recalled her doctor taking command she expressed gratitude indicating that her doctor's confidence and stern communication made her feel confident the doctor knew what she was doing and talking about in a time of crisis. This serious verbal and non-verbal communication put the participant at ease.

Participant 2 indicated comfort through her doctor's reassuring communication and felt that her worries and concerns prior to the C-section were listened to which in turn made her feel relaxed on delivery day. She noted, "Yes definitely (felt listened too and worries and concerns were listened too), they you know reassured me." Participant 3 expressed that her trust made her feel comfortable with the decision the doctor made for her to have a C-section despite it not being what she wanted.

I feel like I'm comfortable enough with him and I trust him enough that even though it wasn't what I wanted like I mean I wasn't going to go against him the thought didn't even cross my mind to find another doctor and have a natural delivery because if he is telling me this is what I need to do then it is what I need to do.

Each participant indicating their comfort with their delivery day doctor is a positive sign that trust, confidence in knowledge, and reassuring communication can all play a role in making a new mother feel less nervous about giving birth.

*Positive reinforcement (verbal and non-verbal).* Throughout labor and delivery the participants noted that the positive reinforcement they received gave them confidence and left them feeling at ease. Participant 1 noted "I like that when it came time when I was in the hospital and she was like this is what we are doing and it's going to be fine and she made it better by calming the situation down."

Participant 2 remembered, “She was like rubbing my back saying it will be ok, you’ll be ok, you’ll be fine, this is what’s happening...they were very reassuring.”

Participant 3 recalled,

Initially I was totally freaked out because I didn’t want that at all like the recovery and everything was just not what I was prepared for and um but once I got to the hospital the nurses explained everything and the doctor explained everything and the anesthesiologist came in and explained everything and I talked to like my friends who have been through it then I was ok.

While Participant 1 and 3 felt that verbal communication helped to relax them in a stressful situation Participant 2 noted non-verbal back rubbing as something her doctor did to relax and reassure her. The use of positive reinforcement in all 3 situations gave the participants confidence that everything was going to be ok and allowed them to continue feeling confident in their doctor’s and the situation as it was unfolding.

*Explanation of Procedures.* Before a C-section begins patients may not know what to expect during the procedure itself. Especially for a new mother this is the first time she will have been experiencing surgery to deliver a baby. All 3 participants noted that their providers or some other medical professional explained to them what was going to happen during the procedure.

However, when asked to recall an instance of when their doctor told them what was happening Participant 1 noted she was unsure of what actually happened and Participant 3 stated that a variety of medical professionals told her what was occurring.

Participant 1 stated,

Then they said this is what we are going to do...you know what's funny, I don't remember exactly what went down but they pretty much break your water and they put this thing inside of you to track how far you are dilated. I am not sure what they used to induce me it's all a blur. It could have been a shot.

Participant 3 described,

Um so basically the anesthesiologist is the one that came in and explained most of it because he was the one who was going to be doing the spinal tap. Um so he told me you know that I would be, they would bring me into the room, the nurse was going to stand in front of me, I was going to have to lean over, he would do that, and told me all that and how long it was going to be and everything and when the doctor came in he kind of talked me through as he was doing everything. Um so I mean they told me enough but they didn't tell me too much where then I would be totally freaked out and the nurses they reassured me along the way too.

Participant 2 was able to recall the doctor's explanations due to the usage of comparing the pain and feelings to other situations. She also indicated that the medical professionals were using medical jargon but only when speaking to each other. When they spoke to her she said they explained what it was they were doing in terms she would understand.

Participant 2 said

During the C-section they just said you know you're going to feel pressure here, pressure there, um you know they compared the feel of the epidural... it's going to feel like a bee stung you, it's just going to burn a little. When they spoke to each other they used

medical terms but when they talked to me they used simpler terms and kind of explained what it was.

### **Pre-Delivery Communication**

*Visiting Different Doctors.* Prior to delivery day the participants met with and had communications with a variety of doctor's as a result of each mother having a doctor that was part of a practice. Practices ranged from 2-4 doctors.

Participant 1 noted her team was made of 4 doctors and continued,

The doctor I had was a team of doctor's. There were four of them and prior leading up to the delivery they required I visited all the doctor's so I was comfortable with all of them.

The team of them they were incredibly smart and knowing them I trusted all 4 of them.

Participant 2 remembered,

“There's a group of 3 of them so they kind of rotate so I did see all three and I did see this one quite a few times recently (delivery day doctor)”

*Difference in doctor's communication within the same practice.* As a result of visiting different doctors the participants had different feelings about their communication experiences within the practice.

Participant 1 recalled personalities,

You know I can remember the personalities of the doctors and there was one doctor in particular, who actually ended up delivering me, who was very tough but she was very bright. When she said things you just had this feeling that she was very pressed for time so I would go do my own research when she talked to me and I would look things up on

my own and then there were a couple of doctors that were so nice and that you could ask them anything and you felt comfortable asking them anything and it was no problem and they would sit there and talk to you and answer any questions.

Participant 3 noted extensively the difference between the two doctors in her practice. As a result of the practice being smaller than Participant 1 and Participant 2's she was able to see both doctor's extensively.

Participant 3 reflected,

The doctor that did the delivery he's really good at explaining things. Like he'll tell you in a way that you can understand it even if you have no idea like no medical background at all. The other doctor in the practice he's a little bit more like oh well everything will be fine, you don't need to know about that, you don't need to worry about that. He doesn't really explain it unless you push him too. Um so the doctor that did the delivery is really good at explaining things pretty easily and if there was ever anything I was unsure about he clarified it when I asked him.

Differing personalities and how they meshed with her personality was another reason why Participant 3 felt more comfortable with one doctor over the other. She also noted instances where the doctor's differing communication made her feel either reassured or not as comfortable. She ultimately felt more comfortable with one doctor over the other due to the differences in communication. The ability for one doctor to make her feel more assured and to explain different risks and go into detail about certain things made her feel more confident. Participant 3 expressed,

He was a little bit more reassuring the other doctor was kind of just like any question that I asked or any concern I had he was oh you're pregnant there is nothing you can do about it, or oh its fine or yeah its great ... he was never concerned about anything like he was never gave me any sort of like oh well you can do this but you should do that...or like everything for him was like oh its fine its fine... he was just too easy going for me I think...where the other doctor would kind of tell me well you can do this but there is these risks associated with it...he explained things more.. I mean I know they would both be prepared if there was something some sort of emergency...but I feel I would do better if he was the one in the situation.

*Ability to ask questions during appointments.* Participant 2 specifically indicated that her doctor's ability to answer all of her questions and the time it took them to answer made her feel confident in what they knew. She specifically noted: "They knew every answer to every question that I had for them." In addition to increasing her confidence she recalled an instance where she was feeling nervous about a situation and called her doctor to ask about her worries. Her doctor's provided her with reassurance by answering her questions and spending time discussing her concerns with her.

In the beginning I had bloodwork done and it came back with something low pap a levels of course I googled and found like the worst things ever and we ended up calling the doctor and you know he actually gave us a call back and stayed on the phone with us for awhile...and was kind of like no you know it's not a big deal and then the next appointment he kind of explained what it was and reassured us its usually fine it's just something they test for now and it affects very few people.



Participant 3 was also able to recall an instance when her doctor was able to answer questions about concerns she was having.

Yes definitely (listened to questions)...yeah so um a couple things like with working out my mom was concerned that I was working out to much so she was like talk to the doctor about it so I asked him my husband asked him and he explained that as long as I was doing these things beforehand and I felt good while I was doing it then it was ok and safe but if there was ever a point where I felt like I couldn't do it anymore or I was in pain or something felt not right then I needed to stop... and then also there were some times when I would research things online and I would like come in and ask him and oh I read this article about (example of a rare occurrence)... and he would laugh at me and tell me that I need to stop researching on the internet and give me like the real statistics.

Participant 1 felt hesitant and intimidated by one of the doctor's in her practice. Despite this eventually being the doctor she noted she was satisfied with during delivery she did indicate she did not feel completely comfortable asking her questions during appointments. Participant 1 recalled "She was willing to answer questions but I was a little more intimated by her."

*Trust and confidence established before delivery.* Participants 2 and 3 established trust and confidence with the doctor's in their practice prior to delivery day. They indicated comfort when going to appointments and excitement to receive check-ups. The friendly demeanor of the office staff as well as the doctor's welcoming attitudes made the pre delivery experience pleasant.

Participant 2 stated,

Umm just that everyone was really friendly and welcoming and you know if we had any questions they would answer them right away and they seemed very on top of their stuff

and like they knew you know what they were doing and everything about what we had to ask.

She continued, “They you know reassured me... I am a big baby soo I was nervous about everything and you know the doctors were all actually really good” Participant 3 noted the amount of time her doctor’s spent with her combined with the ability to have her questions answered helped to establish a relationship with her doctor’s. She stated

When I did have a list of questions he did answer them for me...and even if he was about to walk out the door and I was like oh I have one more thing he would come back and sit down and it wasn’t like he was rushing me out of there.

### **Overall provider satisfaction**

All 3 participants indicated overall satisfaction with their providers and how they communicated. However, Participant 1 mostly recalled additional hospital staff and the facility as part of her satisfaction and Participant 3 noted that she felt she may not have had all of the information she wanted about her situation before delivery day.

Participant 1 remembered,

Overall what I remember most was the hospital was amazing...regular hospital staff was the most amazing experience they were round the clock there to take care of you.

Looking back all I think about are those nurses and how amazing they were. They were like the most caring group of people and they were not fake about it. Almost like you knew that’s a really good job to have and they only hire the best, that’s how I felt and I remember leaving the hospital and I wrote a separate note reviewing them saying how it was the best hospital.

Participant 2 felt “Umm very satisfied they were great”

Participant 3 verbalized her satisfaction but also an additional expectation that was not reached,

I'd say I was pretty close to as satisfied as I could be...aside from discussing all the possible scenarios prior to labor and delivery which you know there's so many things that could of happened where I don't know if that's a realistic expectation um but other than that I think I was pretty satisfied...(on being pretty satisfied) um I think just like maybe if he had said to me you know I know you have your heart set on a regular delivery but there is a chance that there could be a C-section and if there is and if he had just addressed it a little bit and reassured me about it but I feel like that's maybe playing devil's advocate which he probably doesn't want to do. I knew it was a possibility (having a C-section), I mean I knew it was always a possibility, but there were no red flags along the way I never thought there would ever be any reason I would have to have one.

The participant's experiences, how they affected their ability to make decisions during labor and delivery, and how that compares to previous research as well as limitations and future research areas will be discussed in the Discussion section.

## **Chapter 5: Discussion**

The intention of this study was to attempt to determine if communication accommodation in the patient-provider relationship affects expecting mother's ability to make decisions regarding interventions during labor and delivery. Three women elected to be interviewed who matched the purposeful sample. Interview sessions were recorded and data was analyzed. As a result of the data analysis process five main themes emerged, (1) reason for the C-section/lack of decision making, (2) provider's description of risks/benefits, (3) delivery day communication, (4) pre-delivery communication, and (5) overall provider satisfaction. Within the theme of delivery-day communication four sub-themes emerged, (1) confidence in delivery day doctor, (2) comfort with the delivery day doctor, (3) positive reinforcement (non-verbal and verbal) on delivery day, and (4) explanation of procedures. Within the pre-delivery day communication theme four sub-themes were also established, (1) visiting different doctor's, (2) differences in doctor's communication within the same practice, (3) ability to ask questions during appointments, and (4) trust and confidence established with their doctor's. Participants also described how they felt going into delivery day, what their original birth plans were, and how their labor and delivery experiences played out.

### **Participants Decision-Making**

Current research has found that 25% of women who had a planned C-section knew exactly what was happening during the procedure beforehand (Blüm et al., 2012). The participants in this study suggested that while they were being told what was happening during the procedure they were unaware or had not had the time to discuss the procedures or the risks and complications before the procedure actually began. This information indicated that the participants were not as active in their decision-making as is recommended.

The traditional decision-making model, the paternalistic decision-making model, indicates that the provider suggests the treatment and plan of action and the patient obliges. Patients desire to know what medical treatments they are receiving noted the failure in the paternalistic model of care (President's Commission, 1982), however, participants in this study were ultimately told by their provider that a C-section was their only option for labor and delivery. While all 3 participants arrived at a C-section differently, they were all told this was the only method available for them to give birth. The lack in options despite different circumstances among participants suggests that no decisions were made by the patients, which ultimately is the paternalistic model of care.

Patients have been encouraged to be more active in making decisions regarding their care and this model of decision-making, known as shared decision-making, should be the standard (Goldberg & Shorten, 2014; Mira et al., 2012; Ong et al., 1995). According to Charles, Gafni, and Whelan (1997) there are 4 characteristics that define a shared-decision making model. (1) at a minimum, both the physician and patient are involved in the treatment decision-making process, (2) both the physician and patient share information with each other, (3) both the physician and the patient take steps to participate with the decision-making process by expressing treatment preferences, and (4) a treatment decision is made and both the physician and patient agree on the treatment to implement. All 4 of these characteristics were not initiated or implemented in the participants interactions with their provider prior to a C-section being decided on. While the participants felt they were able to share information with their delivery day doctor and Participants 1 and 2 felt they could express their preferences to their provider, ultimately, the decision to deliver via C-section was made by the provider for reasons given to the patient. These results are consistent with Declercq et al., 2007, who noted that the women

they surveyed felt that 72% of the time the doctor recommended a C-section first for one reason or another.

While the provider's communication plays an important role in the ability to make decisions shared it is also imperative for the patient to remain active in the relationship as well. When patients are active in their communication with their provider both patient and provider can discuss treatment options which ultimately involves the patient in decisions (Jenerette & Mayer, 2016). It is important to note that Participant 1 was active in asking her provider questions regarding a C-section procedure. This active communication allowed for information on risks and benefits and what the procedure is to be explained to her prior to delivery day. Had she not engaged in active question asking it is possible the provider would not have volunteered this information. Participant 3, who was planning a natural birth, did not engage in a lot of conversation on this topic and therefore was not fully aware of the risks and benefits of a C-section and felt that she could have been more informed on the procedure. She felt if she had asked the provider questions he would have answered them but she was not planning on this delivery method so it did not seem necessary. It is both the provider and the patient's responsibility for communication to remain two way so that the decisions can be effectively shared.

### **Communication Accommodation**

Social stereotypes in the patient-provider relationship is often a reason for miscommunication (Giles, 2008). As a result of this stereo type accommodation, convergence, divergence, and maintenance often taken place while the patient and provider communicate with one another. Upward convergence was present in each participant's experience. Each participant conducted external research even after meeting with their provider. This could indicate that while

they felt comfortable asking questions of the provider if something was said in an appointment that they wanted more information on they felt it was easier to look it up themselves rather than to actually ask. While this can be seen as a negative and an under-accommodative communication trait, participants also felt that their provider did not use any medical jargon when speaking with them. The willingness of the participants provider's to use language that was easy to understand demonstrates that downward convergence was also present in their communication relationships. With both under accommodation and convergence present in the communication relationships in this study more research on accommodation is needed to gain further insight on convergence and under accommodation in the relationship.

It is also important to note that the patient's did not feel their providers were non-accommodative. However, non-accommodation is not just the use of medical jargon or words the patient may not understand. Baker and Watson (2015), state that often times individuals engaged in interpersonal communication do not realize they are not accommodating their communication, whether it is due to status, social power, or relationship roles. The participants in this research noted that when their provider told them something they believed and trusted it due to their strong communication delivery. While provider's communicating confidently is not a negative aspect in the communication exchange between patient and provider it could affect how the patient views their options or how the patient ultimately makes decisions. In this case the participants did not make any decision regarding their birth method and the doctor's suggestions were carried out.

In each instance the participants trusted their providers due to the context of their relationship and their confident communication. Participant 2 noted she trusted and was confident in her providers because of how quickly they answered her questions and how they

were always sure of the answers they were providing her. Participant 1 also felt confidence in her provider based on how they answered questions and how they spoke confidently. Being confident in the provider made the participants feel reassured and comfortable agreeing with their provider's decision to give them a C-section.

### **Theoretical Implications**

The results of this research can be applied to CAT and help further inform the theory by giving patients and providers alike relevant information as to how communication accommodation in maternity care can affect how expecting mothers understand and use the information given to them by their providers. While CAT suggests that communication techniques may be altered depending on who an individual is communicating with (Bylund et al., 2013; Giles, 2008), this research suggests that further data needs to be collected in the maternity care setting to determine if expecting mothers do alter their communication while in appointments or on delivery day with their providers. While this research offered a valuable insight on expecting mothers lived experience of receiving maternity care and labor and delivery the insight of the provider is also necessary to gauge the level of accommodation that occurred on both sides of the relationship. Based on the data collected from the 3 participants in this research convergence, divergence, and communication maintenance were unable to be completely measured. However, it can be assumed based on the data collected that patients exhibited convergence and maintenance during their communication experience. These conclusions can be made as a result of the participants each feeling they could ask questions in terms that were comfortable for them (convergence) and that they spoke openly with their delivery day providers about feeling nervous and unsure (maintenance). Further research should be conducted to continue contributing to CAT and the patient-provider communication context



as well as the maternity care context. It is the conclusion of this research that accommodation does occur but that further observations should be made from both the patient's experience and the provider's experience as well as throughout the duration of care.

### **Practical Implications**

This research was consistent with the findings in *Listening to Mothers II* and *Listening to Mothers III: New Mother's Speak Out*. *Listening to Mothers II* noted that 78%-81% of mothers felt that all possible intervention complications should be disclosed (Declercq et al., 2007). However, the mothers surveyed in *Listening to Mother II* were not sure of all the risks and complications associated with common interventions. Similarly, the mothers interviewed for this research noted that due to their delivery day circumstances not all risks of a C-section were indicated to them. This disconnect notes that further communication training should be implemented and that a strategic communication plan throughout the maternity care experience should be executed.

It is also important to note that consistent with previous research is the idea that while mothers were not sure of risks and complications associated with these procedures they did feel confident and comfortable with their providers (Declercq et al., 2013b). As noted in the main themes and sub themes that emerged from this research, trust and confidence was established prior to delivery and all participants felt comfortable with their delivery day doctor. Providers can further this trust and comfort by offering detailed explanations of procedures, noting risks and complications prior to delivery day, and by providing patients with memorable decision-aids to help them understand what is being discussed.

Childbirth education classes also provide a valuable forum for mothers to learn and become familiar with childbirth, labor and delivery, and the maternity care experience. Goldberg and Shorten (2014) recommend childbirth education as a resource for patients. The participants in this study did not participate in formal extensive childbirth education classes and therefore were limited in the information they received. As a way to improve this lack of education maternity care providers can recommended or refer their patients to childbirth education classes as a way to improve the patients knowledge on procedures, interventions, and the labor and delivery process. Kamil and Kupperman (2012) suggest that the provider offering this education and guidance can help the patient improve understanding which can help to eliminate passive patient communication. The data from this research supports this claim and extensive childbirth education classes is a recommendation for expecting mothers receiving maternity care.

### **Limitations**

This research has certain limitations. The research is limited to women who have given birth within the past year and were considered low risk. Women who delivered multiples or a still born were excluded from selection. The research is qualitative in nature and therefore only studies a select number of participants who fit the criteria of the purposeful sample.

The research focuses uniquely on medical interventions and not any other aspects of labor and delivery. While interventions play a large role in the labor and delivery experience and outcomes they are not the only important aspect of the process. It is also important to note that in some cases women may have experienced a planned or unplanned cesarean section. The research does not take into account the difference between each procedure and is solely focusing on the fact that the procedure was done. The interview questions reflect the desire to know about the experience of having the cesarean and how the mother arrived at the decision to have a cesarean.

Lastly, communication is analyzed with the women's main health care provider only. The researcher does not take into account patients use of a doula, their individual support system, their interaction with nurses, or any additional research that might have been done by the patient regarding medical interventions prior to labor and delivery. All participants had an OBGYN as their maternity care provider and communication between other health care providers was not analyzed or available.

Extensive research has been done on medical interventions and their effectiveness in labor and delivery, as well as the risks and complications associated with these interventions. Research has also been conducted on patient-provider communication, women's satisfaction with their health care providers as it relates to their maternal care, and the overall birthing process. Research has also been conducted concerning CAT and patient-provider communication. However, there is no research related to CAT effecting women's decisions when it comes to medical interventions during labor and delivery.

### **Directions for Future Research**

Future studies in maternity care and patient-provider communication can be beneficial for multiple reasons. Originally this research aimed to obtain a participant who had given birth naturally, however, no such participant ever presented themselves. Including a mother who has experienced an intervention free birth will be helpful in comparing and contrasting further the communication techniques utilized by other providers. All of the participants in this current research utilized an OBGYN as their provider, including a midwife in the sample may also prove to be beneficial as they often have different foundations of care.

Another direction this research can take that will provide new insight on patient-provider communication in this care context is to interview women who have given birth before.

Understanding how experience can factor into mother's communication with their provider and how that experience affects their involvement in decision-making would be a way to extend this research further.

While this research provided an in depth look at the experience of labor and delivery and patient-provider communication and decision-making in maternity care it only judged the patients point of view. Observing the provider and patient together and interviewing both the provider and the patient will afford the opportunity for this meaningful research to study and analyze all angles of the patient-provider relationship in maternity care and can further offer practical and theoretical implications.

The topic of maternity care and patient-provider communication in maternity care and how it affects decision-making is an understudied area of health communication. There are multiple facets of research that can be conducted to extend this relevant and necessary research. While this research named a few areas that can be further investigated, bringing to light the increase in C-sections and intervention filled births as listed in this study needs to be talked about further to understand why this increase is happening and what role patient-provider communication plays in this facet.

### **Research Question Being Answered**

This study aimed to answer the question:

Do health care providers influence expecting mothers' labor and delivery decisions, specifically decisions as they relate to medical interventions, based on how they accommodate, under accommodate, or over accommodate their communication?

Based on the data obtained from semi-structured one-on-one interviews with 3 new mothers and the extensive literature review and research that was conducted to formulate this research project it is determined that future research needs to be conducted to definitively answer this question completely.

With medical interventions being a common aspect of the childbirth process and the idea that all potential risks and complications should be disclosed to patients (Amis, 2007; Goldeberg, 2009; Jou et al., 2015; Lothian, 2014a, 2014b; Ong et al., 1995; Sakala & Corry, 2008), it was discovered the participants in this research were not completely as informed prior to delivery day as they should have been. Additionally, with the adoption of informed consent and the suggestions that the paternalistic model of care is being phased out, it was also determined that the provider was the final decision-maker in each participants case for a C-section being performed, which indicates that the paternalistic model of decision-making is still being utilized.

The patients overall satisfaction of care and communication with their provider could have been a direct result of each participant delivering a healthy baby under their provider's care. While communication factors may not have been overall satisfactory each participant was ultimately happy with the end result because of the successful delivery of their first child. However, it is important to note that the patients did feel comfortable and trusted their providers which is a testament to the relationship that was built prior to delivery day and to the fact that the providers at times did accommodate their communication.

In conclusion, maternity care and patient-provider communication is an understudied field and more research needs to be conducted to fully understand if patient-provider communication actually affects expecting mother's ability to make decisions when it comes to interventions during labor and delivery. However, this research provides a good starting point for future study considerations.

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## Appendix A

1. Tell me about your original birth plan.  
Follow up: If the participant's actual delivery strayed from the plan. Why was that?
2. Describe how your health care provider explained the potential risks and complications associated with C-section, induction, and epidural.
3. How satisfied were you with your health care provider's explanation of potential risks and complications?
4. Based on your health care provider's explanation, how confident were you about what was going to happen during labor and delivery?
5. Describe your health care provider's ability/willingness to explain medical terms. Please provide a particular instance when your provider either did or did not explain a term you were unsure of.
6. How comfortable were you asking your health care provider questions regarding potential interventions during the labor and delivery experience?  
Follow up: What about your provider made you feel comfortable/uncomfortable to ask questions?
7. How would you describe your health care provider's willingness to listen to your questions, worries, and feelings about giving birth for the first time?  
Follow-up: Please provide a particular instance when your provider seemed willing or unwilling to listen to your concerns.
8. Describe a time, if any, where you felt reluctant/had reservations to meet with your provider prior to labor and delivery.
9. Overall, how satisfied were you with the care and communication your provider gave you before and during your labor and delivery experience? Please provide a particular instance that sums up your overall level of satisfaction.



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**Informed Consent Form for Communication Research**  
Seton Hall University College of Communication and the Arts

**Principle Investigator:** Gabriele Cafone  
Seton Hall University  
College of Communication and the Arts  
Strategic Communication  
400 South Orange Ave  
South Orange, NJ 07079

**Purpose of the Study:** Thank you for taking the time to complete this study and participate in research. I am trying to learn more about how health care providers (doctor or midwife) communicate labor and delivery options to their patients. Your insight on how your health care provider communicated information to you is deeply appreciated as I complete my project.

**Duration/Time:** It will take 45 minutes to an hour to complete. It will only take one session to complete this project.

**Procedures to be followed:** You will be asked 9 open-ended questions about your maternity care experience. The face-to-face interviews will be audio recorded and will take place in a convenient, public location for you.

**Instruments to be used:** The 9 open-ended questions ask you to describe your birth plan, your health care provider's description of labor and delivery options, and your satisfaction with your health care provider's communication. You can answer them honestly and to the best of your ability and memory. Your answers will be audio recorded and transcribed.

**Voluntary Participation:** Your decision to be in this research is voluntary. You can stop at any time. You do not have to answer questions you do not want to answer. Refusal to take part in or withdrawing from this study will involve no penalty or loss of benefits you would receive otherwise.

**Statement of Anonymity:** Your participation in this study is anonymous. You will be assigned a number, which I put on your audio recording and transcript. After the study is complete, neither your name nor any other identifying information will be associated with the audio recording or the transcript.

**Statement of Confidentiality:** Your participation in this research is confidential. Data will be stored electronically on a USB memory device and locked in a filing cabinet at Seton Hall University in the Arts and Sciences Building Room 219. Only the investigator and her research advisor will be permitted to listen to the audio recordings and/or read the transcripts. In the event of a publication or presentation resulting from this research, no personally identifiable information will be shared.

**Records:** All data will only be available to the investigator and her research advisor. This information will remain on a USB memory device in a locked filing cabinet at Seton Hall University in the Arts and Sciences Building Room 219 for up to 3 years after project completion.



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**Discomforts and Risks:** There are no risks in participating in this research beyond those experienced in everyday life. Some of the questions are personal and might cause discomfort. You may experience temporary discomfort with talking into a tape recorder if you have never done so before.

**Benefits:** You might learn more about patient-provider communication by participating in this study. You may have a better understanding and reflection on the process of communicating with a health care provider in potential future pregnancies. This research might provide a better understanding of how providers communicate labor and delivery options to their patients and could assist future first time mothers with their own patient-provider communication efforts.

**Alternative Procedures:** There is no alternative procedures in this research project.

**Right to Ask Questions:** Please contact Gabriele Cafone at (973) 641-6682 or her research advisor, Dr. Danielle Catona, at 973-313-6007 with questions, complaints, or concerns about this research. You can also call this number if you feel this study has harmed you. Questions about your rights as a research participant may be directed to Seton Hall University's Institutional Review Board (973) 313-6314.

You must be 18 years of age or older to consent to take part in this research study. If you agree to take part in this research study and the information outlined above, please sign your name and indicate the date below.

You will be given a copy of this consent form for your records.

\_\_\_\_\_  
 Participant Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Principal Investigator

\_\_\_\_\_  
 Date

**Seton Hall University  
 Institutional Review Board**

**FEB 22 2017**

**Approval Date**

**Expiration Date**

**FEB 22 2018**



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Audio Recording Addendum

I understand that this study involves the audio recording of the interview. After the study is complete, neither my name nor any other identifying information will be associated with the audio recording or the corresponding transcript. I will be assigned a number, which will be put on my audio recording and corresponding transcript. Only the investigator and her research advisor will be permitted to listen to the recordings and/or read the transcripts.

I understand that the recordings will be transcribed by the investigator and erased once the transcriptions are checked for accuracy. Transcripts may be reproduced in whole or in part for use in presentations or written products that result from this study. Neither my name nor any other identifying information (such as my voice) will be used in presentations or in written products resulting from the study. Transcripts will remain on a USB memory device in a locked filing cabinet at Seton Hall University in the Arts and Sciences Building Room 219 for up to 3 years after project completion.

Please check one of each pair of options.

- A.  I consent to have my interview taped.  
 I do not consent to have my interview taped.
- B.  I consent to have my interview transcribed into written form.  
 I do not consent to have my interview transcribed.
- C.  I consent to the use of the written transcription in presentations and written products resulting from the study, provided that neither my name nor other identifying information will be associated with the transcript.
- I do not consent to the use of my written transcription in presentations or written products resulting from the study.

\_\_\_\_\_  
 Participant Signature

\_\_\_\_\_  
 Date

I hereby agree to abide by the participant's above instructions.

\_\_\_\_\_  
 Principal Investigator

\_\_\_\_\_  
 Date

**Seton Hall University**  
**Institutional Review Board**

**FEB 22 2017**

**Approval Date**

**Expiration Date**

**FEB 22 2018**

Graduate Communication Programs  
 400 South Orange Avenue • South Orange, NJ 07079 • Tel: 973.761.9490 • Fax: 973.761.9234 • [www.shu.edu](http://www.shu.edu)



February 22, 2017

Gabriele Cafone

Dear Ms. Cafone,

The Seton Hall University Institutional Review Board has reviewed and approved as submitted under expedited review your research proposal entitled "Communication Accommodation in Maternity Care: A Qualitative Analysis on how Patient-Provider Communication Affects Labor and Delivery Decisions". The IRB reserves the right to recall the proposal at any time for full review.

Enclosed for your records are the signed Request for Approval form and the stamped original Consent Form. Make copies only of this stamped Consent Form.

The Institutional Review Board approval of your research is valid for a one-year period from the date of this letter. During this time, any changes to the research protocol must be reviewed and approved by the IRB prior to their implementation.

According to federal regulations, continuing review of already approved research is mandated to take place at least 12 months after this initial approval. You will receive communication from the IRB Office for this several months before the anniversary date of your initial approval.

Thank you for your cooperation.

*In harmony with federal regulations, none of the investigators or research staff involved in the study took part in the final decision.*

Sincerely,

Mary F. Ruzicka, Ph.D.

Professor

Director, Institutional Review Board

cc: Dr. Danielle Catona

**Office of Institutional Review Board**

Presidents Hall • 400 South Orange Avenue • South Orange, New Jersey 07079 • Tel: 973.313.6314 • Fax: 973.275.2361 • [www.shu.edu](http://www.shu.edu)