

# **Doctor, Nurse, Patient Relationships: Negotiating Roles and Power**

*A Case Study of Decision-Making for C-sections*

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### Abstract

Relationships between doctors, nurses and patients significantly affect patients' overall hospital experience, their health, and life thereafter. Research on these relationships typically focuses on only two of the groups. This study examines the relationships between all three groups simultaneously and asks how each participant in the interaction perceives their own and others' roles. I studied the case of how C-section decisions are made through in-depth qualitative interviews with six obstetricians, five nurses in the OBGYN, and six women who had C-sections. I asked about their roles and interactions, and how they were perceived by others. In cases of disagreement about having a C-section, there tended to be some miscommunication or power struggle making mutual agreement among the participants difficult to achieve. Sometimes, disagreements were not only the result of differing individual opinions, but were influenced by broader, often covert, institutional constraints that shaped the participants' roles and the decisions made. While adding a multi-perspective analysis, I also suggest ways doctors, nurses and patients can interact to make decisions more equally to improve the experience of all persons involved. These results may provide guiding principles for doctors, nurses and patients outside the context of C-sections as well.

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## **Preface**

A few years ago, I was admitted into the hospital and found myself in the position of a patient for the first time. I had heard about the stereotypes that doctors are always busy and have little time for patients, while nurses will be the ones who spend the most time with the patients and try to get to know the individual. For the most part, I found this idea to be true, but upon considering how doctors and nurses both operated within the structure of the hospital and were obligated to adhere to all of its protocols and procedures, I realized that there was more to my relationships with the doctors and nurses than what a patient would ordinarily notice. These overarching structural and organizational factors significantly influenced the work that nurses and doctors performed, and in turn, their relationship with patients. For example, when I required an x-ray at the radiology department, I had to wait several hours without food or drink to have a five-minute procedure performed. Although I was perfectly capable of returning to my hospital room on my own, the medical staff asserted that it was protocol that they have to call for transport to return me to my room in a wheelchair. By that point, I was starving and desperate to get some food and water as soon as possible, but the hospital was busy and I had to wait an additional hour after the procedure in the radiology waiting room to be brought back to my room in a wheelchair, when it made sense for me as a patient to have been allowed to walk back to my room in about two minutes. I understood that the hospital had certain procedures in order to manage the large number of patients and also to protect themselves from injury liability, but it made little sense to me from the patient's perspective.

In addition, as a patient, I was able to spend a significant amount of time with and get to know a lot of the nurses as opposed to the doctors who would hurriedly come in during their rounds and ask the same basic questions. I was actually able to develop a relationship with the

nurses to the point where we were joking around together and having normal conversations that made me feel as though I was just another person rather than being labeled as a patient. Because I was able to develop such a close relationship with the nurses, it made me wonder why the nurses were not further empowered to make medical decisions with the patients as they seem to have more holistic knowledge about the patient as well as sharing the patients' best interests. Through my experience as a patient, I encountered several situations that made me question why the hospital system operated in the way that it did with these seemingly predefined roles for doctors, nurses and patients. These peculiarities that I noticed that seemed counterintuitive to the idea of prioritizing the patients' best interests in terms of comfort and patient-focused care, led me to take an interest in attempting to understand the underlying institutional influences that shaped the relationships that developed between doctors, nurses and patients, particularly in the troublesome constraining ways. As a result, when this opportunity presented itself to allow me to undertake an independent research study, I eagerly focused my interest to understanding the sociological perspective of relationships between doctors, nurses and patients in the context of the hospital as an institution that shapes interactions and roles.

## **Introduction**

Becoming sick is an inevitable part of life, and therefore, most people will engage in an interaction with doctors and nurses as a patient at some point in their lives. This interaction plays a crucial part in determining the quality of care received, patient satisfaction, and overall outcome of the patient's well-being. Particularly in a hospital setting, however, the interaction depends highly upon the institutional power structure that already exists, placing doctors, nurses, and patients in predefined roles. These roles create obstacles for the interaction between doctors, nurses and patients that limit the most effective communication and relationship possible. For example, in negotiating medical decisions, doctors must necessarily consider the potential of legal liabilities and negotiate the interests of insurance companies that have increasingly integrated itself into the health care system in their capacity as medical decision makers, while nurses are more often bound to institutional regulations and protocols, and patients are limited by their lack of familiarity with medical knowledge. This is significant for people as patients because in such a vulnerable condition of being sick and assuming the patient role, patients expect doctors and nurses to perform their functions to the best of their abilities to provide the utmost care, but it is concerning if the nature of the hospital structure presents challenges to this interaction. Considering this, we begin to ask, what can be done to address these limitations of the interaction and relationship between doctors, nurses and patients so that each and every doctor is satisfied with the quality of care they provide, each and every nurse feels sufficiently empowered to meet the needs of patients, and each and every patient ultimately receives the best care possible and ends their illness experience satisfied?

To examine the limitations that exist in effective interaction between doctors, nurses and patients, I will focus on the medical arena of obstetrics, particularly decision-making for

Cesarean sections. Although C-sections is a considerably different set of circumstances from my personal illness experience of becoming a patient that motivated my research interest, it is significant because childbirth is an experience that the majority of women will experience, so similar to illness, it is a means by which a large population of individuals will enter into the patient role and engage in the hospital setting. Additionally, focusing on this specific arena of medicine will allow me to narrow the scope of my research while finding a way to apply the concepts that I learn to other medical fields, especially relationships among all doctor, nurses and patients. C-sections, however, are particularly interesting to consider because of the complexity of the decision involved, often having significant implications for the life of the mother and child. Although some people consider C-sections to be an easy alternative that evades the complications associated with the difficulty of traditional vaginal labor, it is an invasive surgery that has presents the same, if not greater, risks of complications including but to limited to infections and death. Additionally, on a societal level, the increasing rates of women having C-sections as opposed to traditional vaginal birth in the past couple of decades is a growing social and economic concern. C-sections are a social concern because about half of all C-sections performed in the United States today would be considered medically unnecessary, implying that risk of performing the surgery would be greater than that of undergoing a traditional vaginal birth. In economic terms, a C-section is a much more costly surgery than a planned vaginal birth; consequently, the increasing C-section rate translates into the growing cost of health care in the United States. This is attributed to both advancing medical technology making C-sections a viable alternative when doctors and pregnant women encounter problems for a traditional birth. Additionally, as the medical field becomes increasingly entangled with legal and economic influences, medical providers increasingly rely on C-sections as a protective strategy to reduce



their responsibility by being able to make the claim that in making the decision to perform the surgery, they have done the ultimate in providing what they can. Along this framework, patients are persuaded that C-sections are the safer alternative. In analyzing the institutional constraints that shape doctor, nurse, patient relationships in terms of the distribution of power and ways of interacting and communicating, I present an alternative view from the commonly presumed influences of legal liabilities and economic motives to considering how relational perspectives and power dynamics operating within the organizational system of the hospital itself complicates the decisions made regarding C-sections. For these reasons, there are a variety of considerations to take into account and the decision to have a C-section entails significant contributions from doctors, nurses and patients. I am interested in studying the relationship among the three groups, doctors, nurses, and patients, in order to understand the power relationships that exist as a result of the roles and differing, even conflicting, perceptions of doctors, nurses and patients.

In conducting this research project, I seek to answer the questions, “How do doctors, nurses and patients each perceive their relationship and interactions in the context of medical decision-making for C-sections, and in particular, how are these relationships and interactions constrained by the organizational structure of the hospital as an institution?” Furthermore, in my interest of evaluating doctor-nurse-patient relationships in general, I also ask, “How can the concepts highlighted in relationships and interactions between obstetricians, labor and delivery nurses, and women who have had a C-section be applied to suggest ways to improve patient care and satisfaction in a way that benefits all doctors, nurses and patients?” In answering this question, I hope to be able to explain the more subtle obstacles between doctors, nurses and patients that present challenges to effective communication and relationship-building, which ultimately impacts the quality of care provided to patients. In addition, I want to suggest ways to

think about how understanding the dynamics inherent in the hospital as an institution that shape relationships and interactions between doctors, nurses and patients provides the awareness necessary to improve the experience for all people involved in developing and receiving beneficial quality care.

## **Literature Review**

### **C-Sections**

In the United States, the rate of C-sections being performed as opposed to traditional vaginal deliveries had significantly increased in the past couple of decades, although the rate has stabilized, it remains high. According to the National Center for Health Statistics, in 2012, the total number of births was 3,952,841 in the United States, and the C-section birth rate remained at a stable 32.8% since 2010. This is a significant increase from 20.6% in 1996 that increased annually until 2010. (Martin et. al. 2013; 10). The concern over this rate is due in part to the fact that 32.8% is approximately twice the World Health Organization's recommended rate of 15% (Morris 2013; 17). There are five main categories of determining the use of C-sections: fetal compromise, "failure to progress" in labor, repeat C-section, breech, and maternal request (Shoaib et. al.) The rising rate can be attributed to several factors: doctors perform C-sections as an alternative to vaginal delivery in the interest of protecting themselves from liabilities for medical malpractice, making a greater profit, and convenience (Meyer 1997). Meyer also suggests that C-sections are a preferred alternative because women have been gaining more weight during their pregnancy making vaginal delivery difficult, as well as C-sections allowing for older and high risk pregnancies (Meyer 1997). As medical technology advances, making C-sections a more viable option for many people, doctors and insurance companies want to market

C-sections for their profit seeking motive as C-sections can cost nearly twice as much as a vaginal delivery (Meyer 1997). In 2011, on average at a hospital, a planned vaginal birth with no complications costs \$10,657 per birth, while a C-section with no complications costs \$17,859 per birth. As mentioned, with a rate of 32.8%, C-sections are the most common surgery performed in the United States. Since approximately half of those C-sections are considered unnecessary, that translates to approximately \$9.3 billion in excess costs due to performing unnecessary C-sections rather than undergoing a traditional vaginal birth. In terms of the overall health care system, C-sections have done its part in contributing to rising costs, thereby serving as a significant economic topic of interest for the health care debate as well.

C-sections are an interesting and significant topic of study because of the risks and benefits associated with it as an alternative method of birth, as well as the profound consequences that the decision to have the procedure can have on both the woman and the child. Mothers must assess the risks and benefits of the procedures with their doctors in exercising their decision-making. Some of the risks to consider include increased maternal mortality, conditions resulting from complications of C-section such as chronic pelvic pain, as well as concerns over a lack of bonding between the child and mother (Sarda 2011). In addition, particularly for young first-time mothers, their future prospects are also an important consideration because there are risks associated with C-sections, such as placental complications, that make subsequent pregnancies riskier and more difficult (Terhaar 2005). Despite these risks, however, C-section rates remain high in the United States, so it will be of interest to explore the rationale and circumstances behind doctors', nurses', and mothers' reasoning in deciding whether to have a C-section or a traditional vaginal birth.

Additionally, C-sections are strictly regulated by institutional codes due to the unpredictability of birth that makes it such a risky procedure for patients in terms of their health and recovery as well as doctors in terms of their legal liabilities. Theresa Morris, in her recent book analyzing the “C-section epidemic” in America, *Cut It Out*, suggests that one of the major reasons for the increasing rate of C-sections that has not been addressed in most previous literature are due to institutional constraints that become heavy burdens on the doctors who perform the actual surgeries. In particular, she explains doctors’ concerns of facing lawsuits in a case of an unsuccessful C-section; doctors follow institutional policies not necessarily because they believe that it is in the individual patients’ best interest, but rather because in case of liability threats, they can cover up for themselves by claiming to have done nothing wrong in following the standardized procedures of the hospital’s protocols for the C-section (Morris 2013; 55). The concern that this way of handling C-sections as Morris argues, is that lawsuits occur primarily in the case of harm done to the baby; accordingly, doctors will try to do everything possible for the safety of the baby, perhaps at the expense of the mother’s health (Morris 2013; 81). As this example suggests, the organizational influence of the hospital as an institution has profound effects on the way that doctors, and consequently nurses who work with those doctors, provide care for patients and make decisions about C-sections.

### **Doctor-Patient Relationships**

The literature on doctor-patient relationships focuses on the power imbalance with doctors as the authority figures with medical expertise and patients as owning their subjective illness that they must communicate with doctors in order to receive a proper diagnosis and treatment. The unequal power relationship is dependent in part on the different type of expertise

that doctors and patients possess: doctors possess legitimate medical knowledge while patients' expertise is in their illness experience (Gill 1998); however, the effectiveness of this relationship is highly dependent on the patient explanation – doctor response communication, in which the patient provides the doctor with the valuable information that doctors want to know in order to fulfill their role to diagnose and treat (Gill 1998). Parker (2002), who studies the bioethics of doctor-patient relationships, also supports the idea that the doctor-patient relationship is based on information sharing (Parker 2002; 88-9). Although medical knowledge inherently gives doctors more power in the field over patients, it is also suggested that there is an element of mutual dependence in the relationship because while patients seek doctor's medical expertise, doctors also depend on patients being able to share and communicate their illness experience in order for the doctor to be able to carry out his or her function (Gill 1998). In a similar way, Heldal suggests that it may be beneficial to the doctor-patient relationship by empowering patients, thereby creating a relationship based on "trust, honesty, and self-respect," as well as mutual understanding (Heldal 2009). Heldal examines the increasingly "active" and "informed" patient role, in which the patient has a greater degree of control and authority by being informed with advanced medical knowledge, being involved in the treatment, and also having other third party health professionals as allies (Heldal 2009). Ideally, this patient empowerment will be possible without patients "[challenging] medical domination," allowing nurses and doctors to perform their own roles, while acknowledging control for the patient (Heldal 2009). Parker argues that informed consent and the shared decision-making model between patients and doctors was intended as a way to help empower patients in making medical decisions, but there is also the possibility that it reinforces the doctors' authority because the information is disclosed by the expert, who is the doctor (Parker 2002; 94-5). Although doctors still tend to hold a great amount

of authority over the patient with the expert medical knowledge needed to make medical decisions, doctors are unable to exercise that authority without the cooperation of the patient to share information about the illness, thereby providing some sense of control for the patient.

Talcott Parsons' model of the sick role illustrates the roles and responsibilities of the doctor and patient. Firstly, the two rights that the sick person possesses are that they are exempt from any normal social obligations, and that they are not responsible for being sick; secondly, the two responsibilities of the sick person is that they must want to get better, and they must make an effort to seek help from doctors in order to restore their health and leave the sick role (Myers and Grasmick 1990; 159). Myers and Grasmick, applies this concept of the sick role in terms of the pregnant woman and her rights and responsibilities in relation to the doctor. For example, the pregnant woman is responsible for seeking the appropriate medical care, even when she does not need immediate medical attention (Myers and Grasmick 1990; 161-2). This is significant because it highlights the patients' responsibility to seek medical treatment, and the doctor's obligation to provide continuous care until health is restored, which in the case of pregnancies is when the baby is born. Thus, the relationship between doctors and patients is one of mutual responsibility, in which the patients' sick role and doctors' caretaker role are both intended with the goal of eliminating the sick role status. However, the relationship is not mutually equal because the doctors' advanced medical knowledge through years of training, education and experience provides them with expertise and credibility that gives them the authority to make informed decisions in the best interest of the patient.

## **Nurse-Patient Relationships**

Nurses are often able to develop a more personal relation with patients as opposed to doctors. In contrast to the science and technology based medical profession of doctors, nursing is the “expert in caring, humanity, human kindness, empathy” (Määttä 2006). Nurses display more empathy and emotions in their interactions with patients; however, nurses must negotiate the emotional boundary of closeness and distance. Despite the need for nurses to be able to emotionally relate to their patients, being able to maintain a certain distance or detachment from their patients is also considered an important part of the relationship because it allows nurses to keep an objective point-of-view (Määttä 2006). Additionally, this distancing and emphasis on objectivity is seen as a way of maintaining a sense of professionalism in nursing, especially as nursing is trying to gain recognition as a true profession; however, the concept of distancing is not new to nursing as is evidenced by Florence Nightengale’s emphasis on observations of patients’ conditions (Määttä 2006). One way in which nurses balance empathy and distance is by emotionally distancing themselves initially, and engaging in mainly cognitive and physical interactions (Hayward and Tuckey 2011, 1513). This allows nurses to control their own and others’ emotions by expressing an appropriate amount without “losing” themselves by becoming too attached to the patient (Määttä; Hayward and Tuckey 2011, 1514).

A specific case of nurses successfully balancing empathy and distance is in Fegran’s study of nurses’ interaction with parents of babies in the neonatal intensive care unit (NICU). The appropriate amount of emotional support with a professional demeanor allowed parents to feel mutually respected, or as partners, through the difficult experience, thereby increasing their commitment to be involved (Fegran and Helseth 2009). Through a careful balancing of emotional closeness and distance, nurses have a “level of expertise and perceived authority to

choose when and how to emotionally connect to get to know patients on a personal level” (Hayward and Tuckey 2011, 1514). Nurses authority, therefore, stems not from the medical expertise and credibility that doctors have, but rather from their ability to manage emotions.

### **Doctor-Nurse Relationships**

Doctors and nurses occupy different professions and jurisdictions, which is defined by professional boundaries. Differences in their professional identities are present in the language that they use as well as the type of work that they do. From the nurse’s perspective, nurses share atrocity stories as a way to define nursing boundaries (Allen 2001; 95). In the narrative of these stories, nurses use language as a way to isolate and undermine the doctor, by casting the doctor as an outsider and establishing a sense of solidarity among the nurses (Allen 2001; 88). Nurses also challenge their jurisdictional boundaries by asserting their superior holistic knowledge of and relationship with the patient through daily interaction as opposed to the doctors lack of empathy and effective communication with the patients (Allen 2001: 90-1, 94). In practice, on the other hand, professional boundaries are determined by the hierarchical organization of the hospital structure, and nurses find it more difficult to expand their jurisdictional boundaries. For example, in the case of postoperative pain management, or anesthesiology, nurses resist attempting new tasks because they fear the risk of their personal incompetence in a high risk procedure, while anesthesiologists resist new tasks because they are interested in defending their status (Powell and Davies 2012). In this way, nursing lacks full professional autonomy and jurisdiction (Allen 2001, Salhani and Coulter 2009). There are also intraprofessional differences in nurses’ treatment by doctor’s as is demonstrated by Coser’s comparative analysis of nurses in the medical and surgical ward; she found that nurses on the surgical ward were allowed to take



part in important decision-making, while nurses on the medical ward were expected to follow the rules (Coser 1958; 62). The professional boundary between doctors and nurses is largely defined by the limitations of nursing's jurisdiction in addition to developing a shared collective identity distinguished from that of the doctors.

### **Sociological Significance**

Informed by the existing literature, I began my research with the intent to examine the relationships between doctors, nurses and patients as a web of interactions between these three actors. It was my hope that this new perspective would illuminate what occurs in a hospital setting, where patients' experiences are built by one-on-one interactions with nurses or doctors, but by a combination of interactions between all three of these players.

I want to suggest three types of boundaries that exist between the three groups: a boundary of authority between doctors and patients, a boundary of the medical institution between nurses and patients, and a boundary of professions between doctors and nurses. The boundary of authority between doctors and patients focuses on the power imbalance that exists because of the different roles that the doctor and patient each assumes that highlight differences in priorities and knowledge. The boundary of the medical institution is the inherent institutional constraints that medical professionals have to operate under in their efforts to provide care for patients. The boundary of professions between nurses and doctors is the distinction between the profession of doctors and the lack of autonomy of nursing. These three boundaries help explain the limitations of effective interaction and relationship-building, which is related to power dynamics extending beyond the individuals involved to the context in which they develops. Ultimately, the significance of the interactions among the three actors as well as the institutional

context in which these interactions occur and relationships develop connects back to how it affects the quality of patient care. Studying this will be important in helping to build an understanding of how doctors, nurses, and patients relate and interact in order to recognize how power operates in the hospital organization to improve experiences at the personal level.

## **Research Methods**

As described in my preface, my research was motivated by my personal experience as a patient. That experience made me want to learn how patients come to understand their relationships with doctors and nurses, and to explore how those relationships are shaped by the context of the hospital and the history of medical professions. Despite the strictly structured and generally accepted hierarchy within the hospital, however, in practice, health conditions are unpredictable and various contributing factors, such as informed consent, how educated the patient is, whether or not the nurse serves as the voice of the patient, affect how decision-making is determined. Through this research, I aim to answer the question: How do doctors, nurses and patients each perceive their relationships and interactions with each other in the context of medical decision-making for C-sections? In particular, I ask, how are these relationships additionally shaped by institutional constraints?

In order to answer this question, I conducted in-depth qualitative interviews to get the perspectives of doctors, nurses and patients separately. Although I am interested in the relationships and interactions of doctors, nurses and patients in general, I used medical decision-making for C-sections as a case study in order to narrow down my population of interest to specific groups of people in order to make my research feasible. Using data from in-depth interviews with doctors, nurses and patients, I will examine how each of the three groups

understand and perceive their relationships with each other, analyze what factors influence their perceptions, and identify general concepts that can be applied to all doctor-nurse- patient relationships. My ultimate goal with my research is to identify areas of disconnect or misunderstandings between doctors, nurses and patients, in order to be able to suggest ways to improve communication and interaction amongst the three groups so that the caretakers are able to provide the best patient care possible, and all three groups are satisfied with their experience.

### **Sample**

In order to answer this question, I collected and analyzed the stories and experiences of obstetricians, nurses working in the OBGYN, and women who have had a C-section within the past three years. The obstetricians constituted my “doctor” population, the OBGYN nurses constituted my “nurse” population, and the women who have had a recent C-section constituted my “patient” population. I decided to interview these three specific groups of people because of my interest in studying medical decision-making for C-sections.

I conducted in-depth qualitative interviews with six obstetricians (OBs), five nurses, and six patients, for a total of seventeen interviews. I recruited these three groups using several different approaches. I mainly networked through my professor to interview the first couple of OBs since he works in the field and was able to refer me to a three OBs who were interested in participating in my interview. From there, I relied on snowball sampling by asking my interviewees about any other OBs whom they know may also be interested and that I could contact to request meeting for my interview. With the referring person’s permission, I mentioned their name in my effort to recruit the next OB. In recruiting my sample of nurses, I first asked my former professor who had worked in the hospital, who was able to refer me to a

graduate student whom she had worked with previously on a dissertation on C-sections. The graduate student had a friend who worked as a secretary at the UM hospital labor and delivery department, who offered to distribute a recruitment email to nurses working in the OBGYN. Through this approach, I received a fairly large number of potential participants; however, I lost contact with several of them. I sent out reminder emails a few times to each nurse who initially replied, set up interviews with those who maintained contact, and asked the others to refer other potentially interested nurses to contact me before I thanked them for their consideration to be involved. After not being able to recruit enough nurses, I requested for the email to be redistributed, received another round of interested nurses, and was able to conduct interviews with about half of them, bringing my total to five nurses. Finally, for the patient population, I posted fliers at a few childbirth preparation centers, but this method did not work at all. A director at one of the centers offered to include a short message about my research in the monthly e-newsletter that reaches many more women than who actually come to the center. Through this approach, several interested women contacted me, and I was able to arrange interviews with six of them.

The interview location and length varied widely, especially by the population of interest. In general, I interviewed all of the OBs in their offices, the nurses in the main lobby of the hospital, and women at different locations around Ann Arbor, either at public locations or in their homes. With the exception of one nurse and one patient interview, which were conducted by phone, all of my interviews consisted of one-on-one face-to-face interviews. With slight variations, my doctor interviews lasted about thirty minutes (ranging from twenty-five to forty minutes), my nurse interviews lasted about thirty-five minutes (ranging from twenty-five to forty-five minutes), and my patient interviews lasted about fifty minutes (ranging from thirty-

five minutes to over an hour). Additionally, all of the OBs and nurses worked at the UM Hospital (some had worked elsewhere previously as well), and three of the six patients gave birth at the UM Hospital, while the other three gave birth at other southeastern Michigan hospitals.

I did not include any specific demographic limits in recruiting my three populations of interest, because I was interested in getting as wide of a variety of people and experiences as I could. The main factor that I noticed that may affect my data was gender. Four of the OBs were male while two were females, all of the nurses were females, and all of the patients were females as well. On the surface, this may seem like a skewed sample, but it may actually be representative of the actual populations: all patients making C-sections decisions are necessarily women, and according to an OB whom I spoke with, most OBGYN nurses are female, while about half of OBs are male and the other half are female. All of the OBs and nurses identified themselves as white/Caucasian. Four patients identified themselves as white/Caucasian, one as Asian/Pacific Islander, and one as half Hispanic/Latina. All of the OBs were between 30-60 years old with an average of 10-15 years of experience working as an OB. Most of the nurses were between 30-40 years old with 10-20 years of nursing experience in the OBGYN, with one younger nurse between 20-30 years with less than ten years of experience, and one older nurse between 40-50 years old with more than 20 years of experience. All of the patients had completed some college, with three of them having earned a master's degree.

## **Methodology**

I used three different interview guides, one for each group. The questions paralleled each other in terms of the structure, purpose and content, but were framed in a way that was most relevant to each group and correspondingly asked for their relations to the other two groups.

I began with simple factual questions to help set the context of the topic. For nurses and doctors, I asked them about how often they encounter C-sections and what were some of the most common cases. For patients, I asked them about their experience with C-sections and asked them to describe the situation leading up to making the decision. I then asked nurses and doctors about what they perceive the patient feels is the most negative risk and most positive benefit of having a C-section, while I asked patients the difference in how the nurse and doctor explained the risks and benefits to them. The purpose of this combination of questions was to identify any disconnect between patient, nurse and doctor understandings about the factors influencing the decision of whether to have a C-section or not.

In order to gather stories about personal experiences or other actual incidences, I asked the nurse and doctor to describe the most recent situation in which they decided with a patient about whether or not to have a C-section. To continue trying to identify areas of disconnect or misunderstandings, I asked the nurses and doctors to describe a time when they disagreed with a patient about whether or not to have a C-section, specifically focusing on who made the ultimate decision, the interviewees perception of who was satisfied or not with the decision, and the reasoning behind it. For the same purpose, I then asked the doctor to describe a situation in which he or she disagreed with a nurse about whether or not to have a C-section, and for the nurses to similarly describe a situation in which she disagreed with a doctor about whether to have a C-section or not. By comparing these two answers, I intend to discover whether doctors and nurses have a common understanding of each others' views about conducting C-sections under various circumstances, or on the other hand, if they completely lack being able to perceive the situation and reasoning from the other person's role or point-of-view. For the patient, after asking them to describe their C-section experience in detail, including their interactions with

both doctors and nurses, and any other factors or actors involved that influenced their decision, I inquired about what disagreements occurred with doctors and nurses, if any. The purpose of this question was to build a foundation upon which to compare the doctors' and nurses' responses to their perceptions of the causes and reasons for any disagreements, through which I hope to identify topics of concern that must be addressed in order to improve relationships and communication amongst the three groups.

Lastly, I focused on relationships in general, asking doctors to describe their relationship with nurses as well as patients, nurses to describe their relationship with doctors as well as patients, and patients to describe their relationship with nurses as well as doctors. In particular, I highlighted four concepts: the most important aspects of cases of agreement and disagreement, the recurring theme of "healthy mom healthy baby," and limitations to power. I used the answers that I received from each of the three groups in order to compare and contrast their understandings and perceptions of each other. For example, if the nurse described the role of the patient to be a certain way, I compared it to how the doctor describes the role of the patient as well as to how the patient herself perceives her own role. I conducted this cross-comparison and analysis for each of the four concepts for each of the three groups in an attempt to identify where consistencies in perceptions exist, and where disconnect arises.

I analyzed my data by identifying major concepts and trends, as well as repeated key phrases, which I used as a way to categorize and organize answers from each of the groups. I used a coding program, NVivo, to organize my data by initially creating a six-part structure: doctor's perceptions of patients, doctor's perceptions of nurses, nurses' perceptions of doctors, nurses' perceptions of patients, patients' perceptions of doctors, and patients' perceptions of nurses. I then made notes in three memos, doctor's perceptions, nurses' perceptions, and

patients' perceptions based on which groups' interviews I analyzed. This allowed me to keep the views of doctors, nurses and patients separate, while creating categories that applied to all of the three groups. I based my argument on the overarching idea of "healthy mom healthy baby," which served as the dominant medical ideal by which doctors made decision regarding C-sections. In opposition came the viewpoint of some women who argued that their experience depended on much more than physical health and safety. I used this difference in opinions to highlight how agreements or disagreements occur in the decision-making progress, as well as how those limitations to power arises among the relationships between the three groups. Each of the sections includes direct quotes from interviews with doctors, nurses and patients that are meant to represent general patterns from the data. These quotes are identified by pseudonyms, ages and years of experience for medical professionals (except for one nurse who declined to provide such information). Many of these have been edited for the purpose of grammatical correctness and ease of reading, but every conscious effort has been made to preserve the integrity and originally intended significance of the speaker's comments.

Conducting interviews with each of the three populations was a very different experience depending on whom I was interviewing. As a student working on her senior thesis project, my status does not change, but doctors, nurses and patients all assume different positions on the hierarchy. Doctors are generally at the top, with a great amount of authority and autonomy, as was evidenced by the fact that I had to go through most of the OBs' secretaries in order to set up an interview meeting with them; additionally, they told me to come meet them at their office. On the other hand, in recruiting and interviewing nurses, I contacted them directly, often through email, and we negotiated a meeting location and time together. Most often, it was in the main lobby of the hospital because it was a mutually convenient and public location to meet,



especially appropriate considering the topic of my research. My patient population was the most varied, ranging from graduate students to stay-at-home moms, with different degrees of educational attainment. My interaction with the patients was closer to that with the nurses because we arranged most of the meetings in a public location, except two where I was asked to come to their homes. Although I was not aware of it at the time, my conduct may have differed when approaching doctors as opposed to nurses or patients, which may or may not have affected the results of my data in terms of how the participants answered my questions.

## **Results**

### **General Overview**

The medical professionals whom I had spoken to commonly referred to the idea of “healthy mom healthy baby” as a guiding principle that directed the way that they made decisions. The idea is based on a successful birth as defined as a physically healthy and safe mom and baby as the outcome. Some women have challenged this medical ideal by arguing that the experience itself determines the emotional health of the mother in addition to the physical health, and that it has a profound effect on how she enters the next stage of developing a bond with her baby. In several ways, the disagreement over the concepts embedded in this idea shapes the way doctors, nurses and patients develop relationships and perceive each other.

### **Healthy Mom Healthy Baby**

A common phrase that occurred repeatedly among doctors was the goal of having a “healthy mom, healthy baby.” It served as a guiding principle of providing medical care because

the bottom line for the doctor was to have a good outcome: a safe and healthy delivery of a baby and the safety of the pregnant woman. This principle is often used to justify the means of delivering the baby: it should not matter whether the baby was delivered by C-section or vaginally as long as the baby is delivered safely and the mom is also safe. On the surface, this idea seems very reasonable, and even commendable by interpreting its significance as the doctor's best effort to produce a desirable outcome, which is supported by the fact that many moms are usually happy afterwards because they have their child in their hands after nine long months of waiting and several grueling hours of labor; however, some women suggest an alternate idea that a "healthy mom healthy baby" should not be the sole motivating goal because the process of birth involves much more than the physical safety and health of the baby and mother's bodies.

Most often for doctors, the idea of the "healthy mom healthy baby" is brought up in the decision-making phase of the C-section, usually as a means to justify performing the surgery. Doctors claim that in this particular setting of the University of Michigan hospital in Ann Arbor with an above-average college-educated population that tends to have a negative attitude disfavoring C-sections, most women hesitate at the prospect of needing a C-section, often asking for more time to push and try to labor vaginally. Nurses who monitor the patient continuously and spend a much longer time with her than doctors may begin introducing the possibility of a C-section if the nurse notices some of the common problems that complicates the labor such as a poor fetal heart strip or failure to progress after several hours of pushing, which may continue to safely proceed as a vaginal delivery with close supervision and assistance; however, when a doctor begins to suggest it, it often indicates that most other options have not been successful, and the C-section may be the only realistic option left. As Nurse Deb comments,

“[Patients] know there’s one of two ways they have a baby: vaginal or C-section. I would say ninety-nine percent of them say, “I don’t want a C-section.” (female in 30s, 10-20 years as OBGYN nurse)

This nurse makes it clear that there are only two ways to deliver a baby, and patients are well aware of it. If the labor is not successful, the C-section is the only alternative. Even so, as this nurse explains, many women are reluctant to having a C-section, and that is when the doctor utilizes the “healthy mom healthy baby” motto as a persuasion method. This idea is appealing to the patient because it demonstrates that the obstetricians’ goal is a very human one; he or she is interested in the well-being of the patient and the baby in contrast to the stereotyped image of a very methodical and clinically-oriented doctor. It also suggests to the patient that despite the risks of a C-section as a surgery, it is a method that can be safe and produces the desired outcome. In addition to the risks of a C-section, the doctor also often times has to convince the patient that one method is not better than the other as long as the final outcome is a “healthy mom healthy baby.” For example, Doctor Fred explains that:

“whenever I say to the parent, ‘whenever we have a C-section or vaginal delivery, our goal’s a safe baby and a safe mom.’ And sometimes, they have to get there. There’s different pathways to get there ... The prize at the end of the day is your baby. Whether you had ten hours of excruciating pain and grueling pain, and you can look back and enjoy the birth of your child, and it doesn’t make you a better woman or worse woman because you’ve chose to have an epidural.” (male in 40s, 10-20 years as OB)

By referring to the baby as a “prize,” the obstetrician emphasizes that what is most important is the final product and the pathway should have no effect on the woman’s assessment of the experience or herself. Another obstetrician, Doctor Gaby, agrees with that ultimate goal:

“Healthy mom, healthy baby; everybody kept their uteruses, nobody had big blood losses, no wounds open, nobody got pneumonia, nobody got blood clots. And, you know, if some day they have pain at that site, well, certainly a possibility [that] you can have pain at the site, [but] ‘isn’t your little one beautiful?’ [laugh]. I mean, you know, you have to just boil it down to what is the

actual important goal: healthy mom, healthy baby. That is the goal.” (female in 40s, 5-10 years as OB)

Specifically, she suggests that the health of the mom depends on having been able to avoid most major complications of surgery, and that a minor bad experience could be troublesome, but it is nothing compared to knowing that she has her baby delivered and in her possession.

In direct contrast comes the opinion of some women who would argue that although the “healthy mom healthy baby” is an important guiding principle, it should not be the sole consideration. Many of these women reflect upon this idea after a significant amount of time has passed since the birth of their child. On the one hand, some women, like Izzy, seem to be convinced by the doctor’s persuasion:

“how that happens, it doesn’t really matter ... I mean, really like, your goal is the baby... I mean as long as the baby is ok, and the mom is like in an OK position to take care of the baby, then all of the other stuff, it matters in the moment, but, it doesn’t, I mean, when I’m with my son now, when I think about my son, I don’t care that I had a C-section. I mean I care that I have my son.” (30 year old female)

Another woman, Nancy, was also persuaded to agree to a C-section, which was planned due to a medical condition called placenta previa that would make a vaginal delivery risky:

“the baby could have issues, I could bleed out or whatever, and so, [the obstetrician is] like, ‘what are you willing to risk? You’re not willing to risk your life or your child’s life.’ [laughing] So, I’m like, ‘OK. OK. I’ll do it. Let’s have a C-section.’” (female in late 30s)

However, an important consideration is the shift from using the “healthy mom healthy baby” idea as a method of appealing persuasion, to producing the opposite effect by using it as a coercive scare tactic by emphasizing the risks of not having the C-section; understandably for any woman, if the choice is between a potentially risky delivery and a not-as-risky C-section, most women would “choose” the C-section. As a coercive means, though, it depends highly on the way that the doctor presents the risks and benefits.

Despite their different opinions of the “healthy mom healthy baby” concepts and their attitudes toward the C-section in general, what the two previous patients had in common was that they were both diagnosed with a medical condition that complicated their pregnancy and delivery, so a C-section was discussed early during the pregnancy and the decision for it was made after several conversations in which alternatives were discussed and the patient was well informed. Izzy acknowledges this fact:

“I had plenty of time to get used to the idea. I did not have a traumatic birth experience by any stretch of the imagination.”

Unfortunately, for Olivia, such physical and mental preparation was far from the picture: she claimed to have suffered an extremely traumatic experience in which a week or two before her due date, she was stricken with sudden serious stomach pains, went to the hospital to have it checked out, and ended up “trapped” with an IV injected in her arm and being told, “we can get you in for C-section in an hour.” She explains how panicked and scared she felt because she had entered the hospital expecting to have her previous night’s stomach problem checked, but it quickly turned into a slippery slope of one medical intervention after another, which she did not understand the reasons for needing them. Furthermore, she did not perceive the C-section to be a choice for her because firstly, it was introduced to her only an hour beforehand and not as a question but as a statement, and secondly, most of the discussion that actually occurred about the C-section was between the doctors and her family, who in turn were trying to convince her to agree to the C-section.

Due to her traumatic experience with the C-section, she argues that it took her two-and-a-half years to fully recover:

“The physical scar heals in a couple weeks. That was no big deal, but emotionally, it took me a long time to heal, and I feel like it was the hospital that wounded me.” (female in 40s)

Olivia's perspective stands in direct contrast to the doctor's insistence on the primary importance of the "healthy mom healthy baby" idea. Obstetrician Gaby mentioned how asking, "isn't your baby beautiful," puts the woman in the mindset that the child is the only thing that matters, but Olivia had a hard time understanding this because whenever she tried to talk about her dissatisfaction and difficult experience with friends or family, "everyone's saying, 'you have a beautiful baby. Let's stop it. What's your problem?'" She is undoubtedly grateful to have a happy healthy baby boy, but she also realizes that there is something more to birth than just the baby. After those two-and-a-half years of recovery and searching for an explanation, she has reached the conclusion that:

"it was a C-section. ... I never got to mourn the loss of the birth experience. So, it was, it was a loss that I was feeling."

This "birth experience" she mentions involves everything she expected in a vaginal birth that did not happen with this emergency C-section situation. For example, she believes that the experience of childbirth prepares a woman to become a mom by also being a process in which she develops a "coat of armor" that makes her strong and ready to be a mom. Additionally, childbirth is much more than that:

"when you give birth, you not only give [birth to] that moment, you give birth to a baby, you give birth to a mom. It's the birth of a mom, and the hospital should recognize that there are two births there."

What Olivia seems to be alluding to is the idea of birth being more than just producing a baby, as the "healthy mom healthy baby" principle assumes; rather it is about a process of preparation and development, the first stage to the mother-child bond. Not having been able to achieve that, she claims to have felt like a failure, causing her emotional instability and suffering, something much

worse than the scar of a C-section incision. In fact, this seems to suggest that the C-section only fulfills half of the “healthy mom healthy baby” principle:

“we really need, at the hospital, especially with something so emotionally [difficult] as having a baby, they really need to watch out for the mom, because it’s one thing if you have a healthy baby, but if the mom’s not healthy, that just, that doesn’t work.”

Only fulfilling half of it also presents serious consequences after the birth itself. For Olivia, that meant a lack of a bond with her baby:

“I lost those two-and-a-half years with my baby. I could never get that back. But now, I just love him so much. I mean I loved him all the way, but, I always was feeling bad, like, talking to my husband because, it’s not anything about him, he’s perfect. It’s just me trying to figure out my, my brain, you know, my, what’s going on, emotionally. So, feeling guilty that, hopefully, he doesn’t think it’s him. Cause he has nothing to do with it.” (P05)

Without a fully, physically and emotionally, healthy mom, the physically healthy baby as the product of the birth may also suffer. Without a strong bond between the mother and child, the relationship suffers. This poses the question: if the C-section deprives women of the experience of childbirth and all of the constructive processes that come with it, ultimately affecting the mother-child relationship, can doctors really defend the “healthy mom healthy baby” as a guiding principle and meaningful justification for C-sections? How can doctors develop and actually put into practice that idea to include more than just the physical component of a successful surgery?

Perhaps Olivia’s suggestion to have greater concern for the mother’s emotional well-being can provide a hint to resolving this problem, and the nurses may play a larger role. Nurses, in general, are understood to be more emotionally connected to their patients because that is the nature of their role in providing care and also because they spend the most time with patients. Part of their role, as medical professionals, is also to be fully knowledgeable on the clinical side,

and from that perspective, nurses endorse the idea of the “healthy mom healthy baby” in the same way that doctors do. In practice, however, nurses seem to reflect the ability to recognize the woman’s need for something more beyond just the physically healthy baby and body. A major point of contrast between the doctors and nurses that may point to different implementations of the same principle can be seen in the recovery phase. Many patients expressed disappointment because most of the doctors who checked up on them in recovery were not the one who had performed their C-section, whereas patients often expressed relief and gratitude for some nurses who became very friendly and familiar because they have been working together from the beginning of the experience when the patient was admitted until the end when they were ready to go home. Additionally, nurses addressed patient’s concerns about pain management and breastfeeding often times in recovery as well. These can also be ways of fostering the birth experience and preparing to create a mother, in addition to the actual labor of childbirth. If this can bring comfort to women like Olivia, a greater emphasis on nurses’ roles or encouraging doctor’s to approach patient care from a nurses’ perspective in terms of providing emotional support along with clinical expertise, may be able to help make “healthy mom healthy baby” truly significant in every sense of the phrase.

## **Agreement and Disagreement**

In making the decision to have a C-section or not, a discussion ideally occurs between doctors, nurses and patients about the process, the risks, the benefits, and recovery. Each person has his or her opinion that may be in agreement or disagreement. Additionally, there are also cases where an initial disagreement can be resolved. Several common themes characterize both cases of agreement and disagreement, particularly communication and understanding each



other's perspectives. Studying cases of agreement and disagreements provide a context that helps explain relationships between doctors, nurses and patients in their interactions.

## **Agreement**

In most cases, agreement between doctors, nurses and patients on the need for a C-section was the result of effective communication, characterized by distributed information and an effort to understand the reasoning behind each person's opinion. Among all groups in all directions, the most common answer to the most important part of the interaction was communication. We see this in the interaction between doctors and nurses:

Ayui: What do you think is most important part of the doctor-nurse interaction?

Bob: Open communication, and like I said, that it's bidirectional." (male in 30s, 5-10 years as OB)

Ayui: Ok, and what do you believe is the most important part of the doctor-nurse interaction?

Jen: Doctor-nurse interaction?

Ayui: Yeah.

Jen: Oh, definitely communication." (female, identification withheld)

The same is evident in the relationship between patients and doctors, and patients and nurses:

Ayui: Switching over to doctor-patient interactions, can you describe what you believe is the most important part of that relationship?

Ellen: Um, communication." (female in 40s, 10-20 years as OB)

Ayui: So, what do you think is the most important part of this nurse-patient interaction?

Deb: Sit down, face-to-face communication."

Effective communication requires direct interaction, flexibility and openness to listen to and address the other person's questions and concerns, as well as making one's opinions known. Additionally, and related to communication, achieving understanding was another important element in cases of agreement. For example, Izzy, a woman who ultimately required a C-section

due to a breech birth for which all alternative attempts to make a vaginal birth possible failed, recalls a conversation with her obstetrician about conducting the surgery in a specific way:

“one of the things I remember asking her about was if there was a way to do delayed cord clamping after the birth. There’s evidence that it’s better for the baby because there’s a certain amount of blood in the cord, and she said, ‘well, my priority really at that point is getting you stitched back up, and if you wait, it increases the risk of hemorrhage.’ It’s like, ok, I’m a reasonable person, and I don’t really want to hemorrhage on the operating table.”

This case demonstrates how a patient’s personal desire can conflict with medical safety, but if the doctor explains to the patient in an accurate and informative, albeit persuasive, way, the patient is willing to listen and compromise. Another woman, Queen, was determined to have a home birth with the assistance of midwives, but after seventeen hours of unprogressive labor, the midwives began to worry about the health and safety of the baby and Queen, and together, reached the decision to go to the hospital. The hospital staff determined that the labor was not in an emergency state, and allowed her to continue laboring in accordance with her desire.

Ultimately, she spent fifty hours in active labor, with the C-section being the final solution; however, she still insists that if any nurse or doctor was still supportive of a vaginal labor at the fifty hour mark, she would have continued laboring. Evidently, Queen was unbending in her desire for a vaginal birth, but the doctor was able to speak with her in a way that acknowledged her wishes by offering her choices and alternative scenarios while explaining his serious concerns about what could and what should happen, that encouraged Queen to eventually come to terms with the doctor’s recommendations:

“they brought the head of surgery, and I don’t remember what his name is, but the OB surgeon, and [pause], I think he just said that, ‘this is what we have to do.’ He explained to me why we had to do it. They knew, when I came in, that I was coming in from a home birth, that I did not want to be in the hospital. Everyone was very respectful of that. So, I mean, he did say that, ‘we can keep doing this, but it’s probably not gonna go. He’s just not moving. You know, four hours of not getting past phase one is a good indication of either the baby's too big, or

there's something else going on that we can't see' ... I would have never opted into it, but because he approached it with, 'I would do an assisted delivery, or I would do these other things, if we could get you past phase one, but four hours of being at phase one,' in his expert opinion, was not going to produce, a vaginal labor." (P06)

Overall, these two patients responded favorably to my question that asked about how satisfied they were with their experience, and they both commented that they really liked the obstetrician whom they were working with, despite the fact that they both ultimately had a C-section which was not their initial desired intention at all. This suggests that the patient can still come away with a great experience working with the obstetricians and be satisfied with the overall C-section experience if the doctor understands and makes an effort to acknowledge the patient's ideas and desires for birth, even if the outcome is unpredictable and uncontrollable. Additionally, from the doctor's perspective, effective communication makes their job a lot easier to do by allowing them to understand the root of the patient's hesitancy to agree with the doctor's recommendation:

"I'm only as good as the information that you give to me. So, I think that they need to be forthcoming and trustworthy, and about the information they provide me. And they need to be willing to tell me if something is working or not."  
(Doctor Bob)

The doctor can only do so much for a patient if the patient does not express her opinions and desires. The doctor depends on the information that patients provide to them in deciding how to proceed with a medical procedure. Therefore, bidirectional communication is crucial to the doctor-patient interaction because it allows for mutual understanding and possibility of compromise between the doctor's medically safest and necessary judgment and the patient's personal desires.

Doctors and nurses alike also claim that communication is a crucial part of the relationship and interaction. It includes many of the same elements that exist for doctor-patient interactions such as mutual understanding and willingness to voice an opinion as well as listen.

Between doctors and nurses, an additional contributing factor plays an important role: familiarity. A few of the doctors and nurses interviewed have several years, up to thirty years of working in the labor and delivery department, and they commonly expressed the idea that the nurses and doctors they work the most well with, respectively, are the ones with whom they have spent a lot of time working together, have become familiar with, and have built an intuitive relationship with. For example, Doctor Bob explains his idea of a “good nurse”:

“You just know that they’re good nurses, intuition, experience, I mean, some new nurses are great, but they can’t ever substitute experience”

The experience of the nurses who have worked at the hospital for several years with that particular obstetrician allowed them to work effectively with the doctor. Other obstetricians agree that spending a long time working together in the same setting helps foster familiarity and consequently, better communication and interactions as demonstrated in the following cases:

“My MA, I have one of the best MAs I’ve ever worked with. She knows what I routinely forget [laugh]. And she anticipates it [laugh], which isn’t an excuse for me forgetting it, but it definitely makes things flow better in the office. She’s interested. She’s thinking ahead, like, if I put an order in, if I sign it, she can see it, cause she’s paying attention, she sees it, she gets it ready, so by the time I walk out, she’s got the vaccination in her hand! She’s not waiting for me to communicate to her verbally, cause I’ve already communicated in the chart, and she’s paying attention, in the new system, and, god bless her, she doesn’t always wait for me to put in vaginal cultures. She can do it, I sign it, her objective is to provide good efficient care, and she is interested in anything that will help me do that. And part of that is her engaging with me. We work together, she’ll say, ‘I forgot to do that,’ ‘ok, no worries, send it back to me,’ or, ‘I can’t take care of this,’ ‘great, send it to me. How can I help?’ And then she’ll be like, ‘I queued that up for you,’ ‘Wow! Great!’” (Doctor Gaby)

“There’s like a seasoned nurse and a seasoned doctor, we know each other really well. It’s like, we just do it... I know a lot of those nurses, and it’s not the same thing over and over, but it’s similar. We’ve all been here for twelve years. New doctors and new nurses come and go, and maybe they’ve got communication. But, there’s something about this long-term trust, you know, that we just know each other. And so, the communication is there.” (Doctor Carl, 52 year old male, 20-30 years as OB)

The familiarity that the doctor and nurse has been able to develop here makes it easy for them to work together; consequently, they are more often able to come to an agreement because they know how the other person works. Interestingly, Doctor Gaby mentions that their familiarity has reached such a point that they are beyond verbal communication to intuitive communication. In contrast, as Doctor Bob and Doctor Carl explain, there is no problem working with new nurses, but their relationship and communication is just not nearly as developed as the one between nurses and doctors who have worked together for several years.

Nurses with many years of experience agree that familiarity helps establish a more effective relationship with doctors:

“I usually work well with doctors; again, I’m not sure if that’s an experience thing. And I’m not afraid to tell them about what I think about the situation.”  
(Nurse Deb)

“I’ve also been a nurse for a long time, so I’ve developed skills as well to get my needs met for how I am able to get the response I need as well.” (Nurse Jen)

“We’re pretty familiar with each other, so usually, if I’m calling, that’s because something’s going on. I don’t usually just call for a Tylenol. I respect them, and they usually respect me.” (Nurse Katie, female in 50s, 20-30 years as OBGYN nurse)

Nurses Deb, Jen and Katie point to their long years of experience working in labor and delivery with specific doctors as what allows them to have the type of relationship with doctors with whom they feel there is effective communication and respect. The key, however, is that this process of relationship-building happens over time, and involves doctors and nurses both developing the kinds of skills necessary to foster communication.

Finally, although communication between nurses and patient occur more frequently on a daily basis as nurses are the ones who spend the most time caring for the patient directly, there may be reasons to question its significance. Firstly, in terms of the decision-making portion of

the C-section, nurses may be present and may voice an opinion, but the ultimate decision is primarily made between the patient and doctor, as will be explained later in the “Limitations to Power” section. Secondly, as several nurses mentioned, because nurses tend to view their role as being a patient advocate, they mostly serve to ensure that the patient’s desires and needs are being known to the doctor. As a result, they may be acting in ways that do not reflect their own clinical assessment of the situation. In such cases, the nurse is open as a line of communication for the patient, particularly as a pathway to the doctor, but that raises the question of whether they are truly engaged in an effective communication that includes mutual understanding and participation, or are they only relaying messages between doctors and patients?

## **Disagreement**

There are several dimensions that contribute to cases of disagreements between doctors, nurses and patients. In most cases, disagreements between patients and both doctors and nurses tended to be based on patients’ decisions that are in contrast to what caregivers believe to be the medically prudent course of action:

“I don’t usually say, ‘your baby could die if you don’t do this.’ It has happened, where they refused a C-section . . . if they ask me questions about the C-section and stuff, or they’re hesitant, a lot of times, I’ll say, ‘if they’re recommending a cesarean section, there’s a reason, there’s something going on. We can keep going on if you want to, but eventually, the outcome will probably be a cesarean section.’” (Nurse Katie)

Nurse Katie, a nurse with more than a decade of experience, is in agreement with the obstetrician she was working with to encourage a C-section for this patient, but for some personal reason, the patient absolutely refuses the C-section. The nurse and doctor are well aware of the severity of the situation and the grave threat to the baby’s life, but what is less clear is how significantly this information has been communicated to and received by the patient: did the patient not believe

the doctor's expertise, or was there a better way for that information to be communicated to her to have affected her decision in another way? Doctor Carl also dealt with a patient who absolutely refused a C-section, and as was in the case of the incidents Nurse Katie described, the baby unfortunately died as a result. In this situation, however, Doctor Carl strongly asserts that he gave her every piece of convincing evidence that he could use and the patient had comprehended it because at a meeting in which he and the patient documented the case, the patient had been able to clearly articulate all of the risks that Doctor Carl had informed her of.

Patients, on the other hand, in their position as a lay person, often find the language and medical terminology of the doctors difficult to comprehend and agree to. According to Holly, it sometimes felt that the way that doctors explained things to her were done in a way that took advantage of her lack of medical knowledge:

“I'm not a doctor and I don't have medical training, but I didn't agree with certain things that he said to me . . . he used the specific words, like “hemorrhage,” that I was going to be very likely to hemorrhage, and that he wasn't going to wait to cut the umbilical cord, and that at most, he would only give me sixty seconds. He was expecting a lot of blood. So there were certain things that happened prior to the surgery that I didn't agree with, but, I was leaving, my life in his hands, with him being the expert, and without ever having given birth before, I didn't know what I was going into, except a very vague textbook definition of what I had read about C-sections.” (female in early 30s)

Holly explains the difficult position in which she finds herself: as a patient, she relies on the doctor's medical expertise to navigate through the unpredictable process of labor and delivery in the safest and most efficient way possible, however, the goal of efficiency for the doctor resonated with Holly as encouraging a coercive method of persuasion:

“He said ‘not cutting it quickly might actually be detrimental to the baby's health because there would be so much, so much of a blood surge,’ and I, even at that time, I didn't believe that. Simply because the blood that comes from the placenta has been available to the baby that whole time . . . and he had very good bedside manners, and everybody was like very taken with him, it, but I just felt like there are certain language or, vocabulary used to make the process more efficient.”

Specifically, Holly mentioned that the word, “detrimental” that the doctor used, bothered her a lot because she did not understand how trying to allow as much blood from the placenta to be transferred to the baby before the umbilical cord being cut could be hazardous. She interpreted this discussion to have served the purpose of coercing her into agreeing to have the C-section performed, as was the recommendation of the doctor. Although some could argue that Holly may simply not have understood the actual physical mechanisms involved that could make hemorrhaging a serious medical problem, her concerns about the potentially manipulative manner in which the doctor presented the information and tried to convince her is not unfounded:

“He said, ‘no, there’s not a lot of blood.’ Well, when they took out the baby, he cut the cord right away, even though I had specifically, specifically had an entire conversation and I had asked him, ‘can you please wait? Can you please wait?’ He said it was detrimental, but he would wait one minute, sixty seconds. Nope, none of that . . . But just the fact that, we had this whole conversation, he had said, ‘I’ll give you sixty seconds. That’s no problem.’ And then that totally went out the window.”

Holly suggests that the doctor’s underlying purpose in having given her the option to wait sixty seconds for the baby to receive at least some placental blood was only for the purpose of her to consent to the C-section. The doctor may have intentionally neglected his promise preferring the safest approach to not delay the cutting at all or he may have unintentionally forgotten the conversation that may not have had any significance to him from the beginning. Ultimately, though, for the doctor, once the goal to perform a C-section was met, the patient’s wish was of secondary importance to the doctor’s effort to produce a successful physical birth.

On a related note, Olivia’s experience also suggests a coercive nature in the doctor’s methods of persuasion in favor of a C-section against the patient’s desire. Olivia was unexpectedly admitted to the hospital a week before her due date for sudden inexplicable stomach pains and was simply told, “we can get you in for a C-section in an hour.” She was



traumatized, and adamantly against the C-section. Without any prospect of receiving consent from her, the doctors reverted to trying to convince her family members who were present with her. As Olivia recalls:

“I feel like the doctors were convincing my parents and my husband. And then the more I asked, my parents and husband would step up and say, ‘just Olivia, relax.’ It’s like, ‘this is what you have to do.’ So, come to think of it, I think they were talking more to them, and I just signed [the consent form], I didn’t even read any of it. I just saw my husband looking at me, like, ‘you don’t have a choice. The C-section is what we have to do.’”

From her perspective, the doctors were persuading her parents and husband to agree to the C-section so that they would convince her to agree to consenting to it. In this way, doctors blocked off any support in her favor against a C-section. Perhaps if everyone had been accurately informed and agreed that the C-section was the best safest option in the situation, there would be less distress about her experience. As Olivia argues, however, this was not the case. She explains that after they have all had some time to reflect back on the experience months later, the reason for having the C-section was multiple: For Olivia, it was because she was too old (over forty) with a large baby (over nine pounds) that made her birth risky. Her mother claims that a doctor had specifically told her that the baby was in danger because there was a lack of oxygen, and she is not certain of the reasons her husband and her father have. This illustrates a serious problem in the communication between doctors and patients. Part of consent requires that the patient has been informed of the process, risks, and benefits, and that she has also comprehended it. The discordance in the reasons that each of her family members and herself has for the justification of the C-section indicates that the doctors have failed to provide accurate information and justification for the C-section; any or none of the reasons that they were told and believed could have posed a serious risk to the baby. For all Olivia knows, she may have been correct in her own assessment that she did not feel anything problematic after her stomach pains

went away, and the C-section may have been completely unnecessary, becoming a source of suffering and a hindrance to being able to bond with her baby through the process of childbirth rather than as an alternative method intended to preserve the health and safety of the mother and baby. Upon reflection, patients like Holly and Olivia see the source of tension in decision-making of C-section between themselves and their doctors as one of miscommunication, and more specifically, doctors taking advantage of their medical expertise to persuade the patient that their recommendation is the “right” way to do it. On the surface, having the consent form and discussion provides the illusion that the decision-making was a joint effort based on mutual agreement, but a closer examination of the language in relation to each participant’s goals presents a relationship based on inequality. The doctor has years of experience training in the field and versed in the medical language, while a patient has the medical knowledge of a layperson and in order to participate in the decision-making under the circumstances of birth, rely on the information provided by the doctor. In this way, not only is there a difference in education and knowledge, but the inequality is exacerbated by the doctor taking advantage of the patient’s vulnerability by channeling the information in the way that mostly reflects the doctors’ perspective.

Some patients felt that the difference in the type of care different nurses provided, whether they favored or disfavored it, was mainly due to a difference in personalities. As in any human interaction, most of the patients generally found nurses who were positive, cheerful and overall seemed to love their job caring for and helping patients as the ones that they relied on the most and had the most satisfactory experience with:

“I think a lot of times, a lot of them go above and beyond what is expected, it’s just based on personality. There was one nurse, after I was in the recovery room, that we called, “Nurse Ratchet,” because her bedside manner was so rough. She

would come in and slam the door, and like, start yelling . . . I think a lot of it comes down to personality, and what types of roles they want to take on.” (Holly)

“Through all my birthing experiences, I could remember some nurses that I like more than others. And it wasn’t that they treated me bad, or did anything wrong; it’s just their personality was more bubbly and cheery, and they were more, I don’t know, there was just something about some personalities, that you’re drawn to, and so some of the nurses that I enjoyed interacting with felt like they would spend more time and talk to me, and other nurses would just kind of come in and do their job and leave.” (Nancy, female in late 30s)

As these examples demonstrate, patients do not necessarily feel that nurses intentionally provide less-than-ideal care, but the best care largely depends on the nurses’ personal attitudes which can coincide with the patient’s own personality and be very compatible, or generally be an easy person to work with. On the other hand, it may just be in the nurse’s nature to truly sympathize with the patient and provide care beyond what they are required to do within their means. Queen was fortunate enough to have had such an experience with one nurse in recovery:

“I was getting really bad pain, and I wasn’t allowed to get out of bed, which was really frustrating. I couldn’t even you know, go in a wheelchair, or hang my legs over the side, and the nurse that was on said, ‘oh, you know, my nurse friend,’ and I forget in what department, but she wasn’t in labor and delivery, ‘does massages. Let me see if she can come down here on her break.’ And she gave me a massage on my, on the side of my hip, and my back. I was in pain, and for probably half an hour, forty-five minutes, what I’m assuming was her lunch break, she came do that. And I didn’t pay her for it or anything, she just came and did it.”

Both Queen’s nurse and her nurse’s friend recognized the her enormous pain recovering from the C-section, and they offered to provide a service that was neither indicated anywhere as being medically necessary nor within the nurses’ role; they simply thought that that would help bring some comfort to her, and took actions within their abilities.

In contrast, patients view disagreements or a distaste working with a certain nurse as a result of clashing personalities. Queen also has had a less favorable experience working with another nurse:

“All the other nurses I dealt with were very kind, supportive, and at my level of comfort. This nurse just has a completely different personality. It reminded me [laugh], honestly, of a secretary of state worker. I go to secretary state, and I swear to God, I always get the women who hates her job, and says, ‘why are you here?’ and ‘what do you want?’ That’s what I felt like when I was dealing with her. She just hated being at her job, which as a nurse, well you could hate a lot of jobs and still do a good job, but I don’t think you can hate your job and be a nurse [laugh].”

As Queen asserts, nursing is a job that requires a very specific type of personal interaction and relationship development with patients that is difficult to achieve without a sense of willingness to foster that kind of relationship. Nurses like Deb and Katie agree, as two nurses who commented that they love their jobs because it feels like the right type of work for them, and from a patient’s perspective, those would be the nurses that she would want to have care for her.

On the other hand, patients recognize that the personality of individual nurses is not the only factor contributing to cases of disagreement between them, but that there are more hospital-wide sources of discordance. Specifically, nurses in a hospital are working under limiting institutional policies that consequently shape their relationship with patients. In general, patients and nurses alike view the nurses’ care as being more personal than that of the doctors, and although this may be true in everyday practices, patient concerns highlight how some things that the nurses do seem to be based on following standardized procedures that the patients are not necessarily agreeable to. For example, Queen describes the less favorable nurse as not trying to provide suboptimal care or making the patient’s experience more difficult, but rather, they either do not notice due to strict adherence to policies and procedures, or they feel unable to act upon what they believe would be better for the patient due to the constraints they feel as a result of policy requirements:

“it didn’t feel like it was a personal, ‘I want to make you uncomfortable.’ It was just, ‘this is what we have to do, so this is what we’re gonna do,’ and basically, I just needed to man up, and get over the fact that there was going to be fifteen

[laughs] things coming out of me while I was trying to breastfeed. So, I think, she was just, you know, personality, and, just very, ‘this is the policy.’”

“[Nurses] hide behind protocol, they hide behind hours, they hide behind whatever it is they feel they need to hide behind, and they’re a barrier.” (Doctor Gaby)

Again, it is unclear whether nurses use policies as an excuse to forego direct patient desires as Doctor Gaby argues, or the protocols themselves make it difficult for some nurses to overcome them and do what they feel is in the patient’s best interest if it is not part of a standard procedure, but these patients’, and even doctor’s, experiences suggest that a serious obstacle to nurses accommodating to patient needs and desire is due at least in part to the nurses’ perceived constraint of institutional policies.

Disagreements between nurses and doctors reflect difference in expertise. Both doctors and nurses agree that nurses and doctors tend to have a different perspective of medical care in general:

“The medical model of care can view labor and birth as a pathological process, rather than a normal physiological process, so [doctors] can view it for the C-section, even knowing the C-section [rate] is very high in this country, and many cases are not indicated.” (Nurse Jen)

“doctors treat conditions, and nurses treat people” (Nurse Amy)

“Well, you should do this, you think you should do that, you order a medication, [nurses] don’t think it’s the right one, and not from a safety standpoint. It’s different saying this patient’s allergic, obviously you’re gonna agree, but ‘oh, I don’t think you should give her anymore pain medication,’ or, ‘she’s in so much pain,’ it’s like, well if you give her pain medication now, it may delay her delivery.” (Doctor Fred)

Doctors base their care on clinical conditions and medical indications as measured by the various instruments and machines that monitor a patient's conditions, while nurses tend to see the person as a whole, considering her feelings and emotions in addition to assessing their fetal strip or other monitors. Doctors often argue that medicine is and should be objective because treatment

requirements are based on certain measures that indicate a dangerous condition, while nurses may suggest that the grimaced look on a person's face or any perception of discomfort would be enough to suggest providing some sort of treatment. This is not to suggest that nurses are more likely to favor medical interventions, including C-sections, but that they have different perspectives and reasons for doing so. Doctor Ellen has a very unique perspective on relationships expressed in her comment that she does not believe that conflicts exist. She agrees that disagreements can occur:

“Nurses are more focused on the patient's experience and comfort, and doctors are more focused on diagnosis and management. Those two cultures can certainly clash on labor and delivery. And so, for example, a nurse might come and say, ‘this patient is really in pain, really in pain.’ What she's really saying is, ‘could you please,’ to the doctors, ‘could you please do something about their pain?’ What the doctor hears is, ‘she's in pain,’ and the doctor's first thought is not ‘how can I make her pain go away,’ but the doctor's first thought is, ‘gosh, I wonder what's causing her pain. Is this normal or is this something to worry about?’ And so I think that those cultures can clash sometimes. That's been my experience that nurses are more focused on management of symptoms, and doctors are more focused on why someone's having the symptoms”

But what she emphasizes is that even when there is disagreement, it can always be resolved. Considering the issue of inequality mentioned earlier in doctor-patient relationships, I suggest that a similar factor plays a role here. Doctors have greater autonomy and decision-making power than nurses, and historically, nurses have assumed a subordinate position in relation to the doctor. Doctor Ellen may not see conflicts precisely due to her position in the hierarchy. What she perceives as a disagreement that has been resolved, could be that the doctor's opinion tends to dominate anyway. She may even have had to compromise her view somewhat, but how can she really know, as a doctor, whether the nurse is as satisfied with the final decision that they reached as she herself is? Could it be that she does not realize from the nurses' point-of-view that the “agreement” may not actually have been a resolution, but rather a reluctant

acquiescence? Additionally, although Doctor Ellen herself is a female professional, doctors have historically been predominantly male, which reflects a wider social pattern of job segregation with males in traditionally more powerful roles, which may also play a significant part in organizing their relationships with predominantly females nurses.

Disagreements between doctors, nurses and patients occur in various forms from misinformation to a misunderstanding of the other's perspectives to differences in knowledge. Upon deeper investigation, these are further compounded by factors such as positions of the doctor, nurse or patient in relation to the other operating within the specific organizational structure of the hospital, expertise or knowledge of medicine in general, and even age and years of experience. Therefore, conflicts in perspectives and understandings is not based on a clear favor or disfavor for a C-section, but it is confounded by a multitude of variables that have strong influences on the nature of the relationship and how doctors, nurses and patients interact with each other based on those relationships.

## **Limitations to Power**

The hospital is a hierarchically organized institution in which the relationship between doctors and nurses is usually unequal. Doctors are considered to be medical professionals with autonomy and decision-making power, whereas outside of the nurses' circle, nursing is considered to be a semi-profession with substantial institutional limitations to what they can and cannot do as a part of their role. Power, however, works in a variety of complicated and intersecting ways, and the doctors' authority is not without limits either. Doctors are limited by institutional restrictions as are nurses, but a less recognized but quite significant limitation to doctor's power is in their relationship with patients.

Patients, in many ways, may feel a lack of control or power in their situation: they lack the medical knowledge to make decisions on their own, they are usually in a state of vulnerability due to the physical and mental exhaustion of labor, and simply navigating the hospital in terms of both the physical structure and the bureaucratic organization is a challenging task. What they may not realize, however, is the influence they have on the doctor's power due to the nature of the doctor-patient relationship and their relative positions and roles to each other. For C-sections, specifically, this is demonstrated most clearly by the fact that the ultimate decision of whether to have a C-section or not must be made by the woman. Without her consent, a C-section cannot proceed, without legal precedence, no matter how beneficial or crucial the C-section would be in a particular case:

“No doctor can ever do a C-section on a patient who doesn't want one. I mean that's just absolutely clear. Now, that doesn't mean doctors don't try, I've never seen that happen here, but I consult with a group called Natural Advocates for the Pregnant Women, which is an advocacy group for pregnant women just like it sounds, and all the time, I get calls saying, “do you know this patient doesn't want a repeat C-section. Her doctors are all saying she has to have one. They're threatening her ... But, no, I mean there's very clear precedent you can't do that.”  
(Doctor Ellen)

“the autonomy of the mom, allows her to make the final decision, so if she says “no,” then no it is.” (Doctor Matt)

All of the doctors recognize this power of the woman in the decision-making process, although it is less certain whether doctors themselves interpret it to be a limitation to their power. Nurses, on the other hand, do not have the same kind of restraint from the patient for two reasons. Firstly, it is not within the nurses' role to recommend a C-section directly to the patient in the way that doctors do by explaining the risks and benefits; they may provide information about it, but legally, it is not within their jurisdiction. Secondly, one of the claims that nurses make about



their role is to be a patient advocate, suggesting that they view their responsibility is to fulfill the woman's desires:

“I just go with what the patient usually wants, so it's been a rare occasion that you really disagree with the patient” (Nurse Katie)

“we'll do everything we can to meet their goals, but that is not always possible.... And trying to, at the same time to keep in line with their plan as much as possible.” (Nurse Laura, female in 20s, less than 5 years as OBGYN nurse)

“any women that goes for an elective C-section, I never disagree with. I think that's fine. It's your body and it's your baby and if it's the right choice for you, then, good for you.” (Nurse Amy)

These three nurses demonstrate that they believe that they should support the woman's desires for either having the C-section or not, whether they personally agree or disagree; in such cases, if nurses cater to the patient's requests, than there is not conflicting opinion from which patients can exercise a limit on them in the way that they do with doctors.

A possible sign that doctors interpret this as a limitation to their power is reflected in the frustration that doctors feel when there is a conflict of opinions. For example, Doctor Fred tells a story about a woman who was stubbornly insistent on a vaginal birth following the Bradley Method, until it was too late because by the time she consented to the C-section, her baby had died. He reflects on his emotional afterthoughts:

“I wasn't directly caring for her, but [I was] frustrated because it's like, I'm not doing this out of, I don't make any extra money for doing the C-section. I don't get anything extra out of it, so there's no reason for me to tell you to do this, if it doesn't need to be done.”

Doctor Fred is a strong proponent of the “healthy mom healthy baby” principle, and for him, the patient's desire for the vaginal birth for whatever reason, did not allow him to accomplish that goal. For him, and other doctors who experience a failed birth due to a conflict between the doctor's medically-based reasoning necessitating a C-section and the patient's decision against it,

the legally established rule permitting C-sections only with the consent of the woman presents a serious hindrance to the doctor's prescribed goal.

On the other hand, such a limitation does not mean that the doctor silently resigns to the woman's decision. In a variety of ways, they may try to persuade, even coerce, the patient to decide in favor of the doctor's view. Doctor Fred recognizes the potential coercive nature of certain, especially emergency, situations of how doctors' influence the woman's decision:

“when you have to consent in a true emergency, [we ask] “is it ok for us to do the C-section on you? You could get bleeding, infection, lose your uterus, you could die and your baby can die.’ What can they say?” (D04)

At the point of recommending the C-section, the doctor has already evaluated the risks of continuing vaginal labor and undergoing a C-section; undoubtedly, both carries risks, but the point of recommending the C-section indicates that the doctor has determined that the risk of C-section has become less relative to that of continuing labor. Therefore, the C-section potentially presents these complications, but so does the labor and without the guarantee of the baby coming out. Presenting such dire circumstances to the patient, it would be unlikely for the patient to opt to continue with the vaginal labor and present greater risk to herself and her baby. Although the C-section is technically presented as a choice, it asks us to wonder, “is it really a choice?”

Overall, Doctor Matt addresses all of these considerations very concisely:

“the patient has to express that she agrees that we are going to go ahead and do a C-section. Even legal courts will not support us doing a C-section if we think it's better for the baby to overrule the mom's beliefs. The mother here has always the last say. So, as a doctor, you recommend it, and obviously, you can be very strong in that recommendation, and you should try to provide as much information as possible in that short time period so she makes hopefully the right decision, but it is ultimately the patient who needs to say ‘yes’”

He acknowledges the ultimate decision-making power of the patient, and even the legal restriction against the doctor's goal for a “healthy mom, healthy baby,” although the doctor has

varying degrees of how strongly he or she can try to convince the mother in favor of his or her view. He also mentions the “right” decision, however, that still suggests the idea of the doctor as the ultimate medical decision-making authority who knows that there is a “right” answer in medicine.

In addition to this specific type of limitation specific to the doctor, a broader institutional limit is also imposed upon not only doctors in this case, but all medical staff at the hospital, including nurses. For nurses, this limitation comes in two forms. Firstly, embedded in the organizational hierarchy, nurses operate under the authority of the doctor. For example, nurses cannot legally recommend a C-section nor explain the risks and benefits to them because it is not a part of their role, so despite how strongly the nurse feels that a C-section may be necessary for a patient and her baby, she cannot act until the doctor does. They must also wait for the doctor’s approval for other major and even minor medical interventions, such as prescribing pain medications.

Secondly, as many doctors and patient recognize, nurses are required and tend to strictly follow hospital policies and procedures. For example, Doctor Gaby recalls a situation in which she was engaged in an extended argument with a nurse over scheduling an appointment for a patient over the lunch break:

“The nurse called, and we probably had a ten minute conversation about how she didn’t understand the schedule, and she was so fixated on the schedule, I finally said, ‘she’s coming in at this time because you will not work over lunch, and I will! Please! I will see her first over my lunch, and you will see her at one, but I cannot have the patient come in, and be seen at eleven-thirty, and I have to wait an hour, because you’re eating lunch!’ That does not make sense! Enough! We’re all on the same team. You have, a different set of rules. I don’t have to eat my lunch. No one’s protecting my lunch. No one tells me I have to eat. No one. They tell you, you have to eat, or you have to take your lunch, or your union says you have-, well, I didn’t say any of that, but, like, just, it’s better for the patient! Who has time to sit in the office for three hours? Nobody! I don’t have time!

You don't have time! Stop! Sometimes, people get so wrapped up in protocol, and so wrapped up in whatever is the right way to do things."

Although Doctor Gaby recognizes that the nurse is likely constrained by the strict hospital protocols of scheduling, whereas as a doctor, she does not have such constraints but she is also free to have lunch whenever time permits her, she finds that the nurses' strict adherence to the protocol detracts from providing the best patient care possible. What she does not seem to recognize as clearly, however, is how much more imposing procedural constraints are to nurses as opposed to doctors who are recognized to have greater autonomy in their profession.

Additionally, patients recognize and attribute some less-than-satisfactory experiences with nurses to the nurses being constrained under institutional protocols. For example, Holly and Izzy both experienced unexpected check-ups in the middle of the night during recovery, such as being asked to walk at two in the morning or perform certain movements and stretches every certain number of hours after the surgery when all they felt was the need to sleep. According to Holly;

"I think that they get caught up in procedures, and care could have been better. We just felt bothered, more than we felt we needed to, cause it's constant, you know, there's people in the room hourly, and, I feel like that's not necessary."

Both Holly and Izzy followed those instructions believing that those specific evaluations must be done at specific times in order to ensure a proper recovery, yet, they also expressed some skepticism over whether it was necessary at those times, or whether the nurses were too focused on following the procedures exactly, causing them to completely forego consideration of the patients' desires and condition at the specific time. It is interesting to consider this because it seems to be a direct contrast to the common view of the nurse as the one who usually are able to understand the patients' feelings and needs the best, because if they are constantly seen as a bother to the patients, the patient's satisfaction with her experience is decreased.

For doctors, the institutional limits come mostly in terms of legal liability. If something goes wrong, the biggest threat they face is a lawsuit, and procedures are set into place to prevent such issues as much as possible. What is more interesting to consider in the doctor's case is not what those actual mechanisms of constraint are, but to view the doctor's response to dealing with institutional constraints. I argue that the patriarchal relations that they develop with the nurses and patients are the result of doctor's trying to protect themselves in the context of institutional constraints, specifically lawsuits. Many of the doctors interviewed explain the enormous burden of responsibility that they feel with C-sections:

“the physician has the sole responsibility for the patient, as far as, ultimately, if there's something bad that happens” (Doctor Fred)

“And ultimately, the decision for C-section is going to rest with me. I mean, nurses don't do C-sections.” (Doctor Gaby)

They emphasize how the responsibility of the C-section lies with them because the doctor is ultimately the one who actually performs the surgery. Therefore, they feel justified in assuming the leadership role:

“Ultimately, I'm the one who has to do the surgery. So if I feel the surgery is needed, I'd do the same thing. If a nurse said, 'I don't think this woman needs a C-section.' If she's really saying that to me, I have to figure out why. That is the rarer event. It is by far more common that a nurse thinks a patient needs a C-section, and I need to think through why I think it's safe for her to continue to labor.” (Doctor Gaby)

“I know I'm always satisfied [laugh], because ultimately, as the physician or care provider versus the midwife, you write the order so you take on a greater degree of responsibility, so ultimately you're going to get what you want. I think it's important that you try to discuss it, and figure out why you're having a conflict, why is that person disagreeing with you. Like, where does the disagreement lie, and discuss that. But, for instance, if you're talking about the decision to make the C-section, that's my call and that's the patients call, ultimately cause I'm responsible. Because I fall in the sword if I'm wrong.” (Doctor Fred)

In both cases, the doctor speaks in relation to a nurse, and feels that they must assert their assessment over the nurses' suggestion because they have confidence in their knowledge and judgment. Moreover, however, recognizing the responsibility that they have, they speak to having their view implemented (usually in favor of the C-section) because they want to avoid any problems for possible complications of the surgery, and the best way to do that will be to do what they believe is the "right" procedure. In this way, the doctor's patriarchal relation with the nurse, and even the patient if they coercively convince her, can be seen as a kind of protection they provide for themselves. They would be more unlikely to concede to a nurses' opinion because in assuming responsibility for any potential lawsuits or liabilities, one of their main priorities would be to find ways to protect themselves. Doctors consciously do what they believe is "right" based on their clinical expertise as a way to protect themselves, but it also suggests that assuming a patriarchal relation is a necessary consequence.

These limitations to doctors', nurses' and patients' power work in a complex web of interactions, rather than a straightforward top-down hierarchy. Although such ideas about constraints, both between groups and from the overarching institution of the hospital itself, suggest an environment of conflict and power struggle, there have been hints at a more equal relationship. For instance, the ideal of shared decision-making: several doctors explained how the ideal way to discuss and reach a decision about C-section would be in a non-emergency situation in which the conversation includes explaining and understanding the risks and benefits with the patient, any family members or friends, the nurse and any other care providers. This would allow for a mutual understanding and agreement about the circumstances as well as the final decision without the feeling of coercion from patients, lack of involvement by nurses, or inadequacy by doctors. The problem is, however, the unpredictable nature of birth; there is a

very slight chance that such a calm and agreeable situation for decision-making is possible, and unfortunately, these discussions about C-sections do not happen with all women as a potential possibility. But in recognizing the benefits of shared decision-making, it suggests that doctors, nurses and patients are willing to discuss and compromise as long there is good communication and mutual understanding and respect. What needs to be addressed as a major obstacle, aside from the uncontrollable birth, is the hospital-wide institutional constraints because it has been demonstrated that individual doctors, nurses and patients are willing and able to participate in a shared decision.

## **Discussion**

As mentioned above, my initial interest in studying the relationship between doctors, nurses and patients was motivated by my personal experience as a patient. One of my biggest concerns was how differently I developed relations with doctors as opposed to nurses, and how that could have affected the progress of my recovery. According to common belief, doctors are very busy and have limited amounts of time to spend with their patients. Nurses also have a lot of patients to take care of, but due to the nature of the type of work that they do, they are able to spend more time with the patients and consequently develop a more personal relationship with the patient. Accordingly, doctors often focus on treating the patients' conditions based on grounded medical criteria, while nurses have a larger role in emphasizing the patients' overall well-being, such as considering comfort and providing emotional support. In my personal experience, I found this to be true. What I found problematic with this differential relationship was that although I felt more connected to and at ease confiding in the nurses, the doctors were the ones who made the official medical treatment plans and determined my progress for release. Every four or five days, the rounding doctor would change and they each claimed to

have discussed such information with the previous doctor and were aware of the course of action to take; however, the questions they asked me and the way they made decisions made me doubtful of how well the information was communicated between the doctors. I felt that the nurses understood my conditions and progress better than the doctors, leading me to question why nurses were not able to have a greater role in the decision-making aspect of providing care and treatment. What is the significance of clinical expertise in relation to quality of patient care based on taking into account the patients' experience and emotional needs?

Although nurses and doctors work towards a common goal of healing patients, their actual everyday practices and how they interact with each other as well as patients are influenced significantly by their roles and responsibilities, their training and areas of expertise, and how they are limited by the institutional organization of the hospital in terms of its policies and protocols. Doctors, being the medical experts basing their care on measurable and objective medical indications focus on treating conditions and symptoms, potentially at the expense of patients' desires and needs particularly in terms of emotional support. Yet, doctors do not have unrestricted power as demonstrated by the requirement of patient consent to carry through the medical intervention of C-sections. In this light, doctors' assumption of a patriarchal relation to their subordinate nurses and dependent patients can be seen not as an intentional attempt to exercise authority over them, but rather as a protective measure for themselves against the burden of responsibility instilled upon them by the larger institution. Given this responsibility, they tend to do what they believe is "right" for an objectively successful surgery, rather than prioritizing flexible options that incorporate considerations of patient and nurse' ideas of what may be a more whole-person, mind and body, emotional and physical approach to caring for patients.



Nurses, on the other hand, have the clinical training and education, but they also spend a significant amount of time with the patient, inevitably developing a more personal relationship. Nurses, however, like doctors, operate under the constraint influences of the hospital policies and protocols. They are not recognized as having a part in the decision-making role, and so they assume the role of a patient advocate, putting aside their own ideas of what they believe is the "right" decision to support the patient's wishes. As much as they try to cater to the patient's needs and what they understand to be what the patients want, nurses are constrained by having to follow institutional procedures, which is reflected in patients' perceptions of how they see some nurses performing certain actions based on not what would be the most beneficial to the patient, but rather on what seems to be regulated by standards of procedure. Patients are placed in a somewhat ambiguous position; the institution seems to recognize their vulnerability due to the lack of medical knowledge and experience they have as lay persons. This can become a source of problems in their communication with doctors especially in terms of understanding explanations involving specific medical procedures and terminology. On the other hand, they are given some leverage over the doctor with the power to consent. Relationships with nurses provide the emotional and mental support that is lacking from doctor, but has little real influence in the decision-making negotiations.

From this analysis, we can see another dimension of how doctors and nurses work. It is not a straightforward hierarchy with doctors as the ultimate authority figures with autonomy and decision-making power, nurses under them who have to follow doctor's orders and disseminate them to the patient, and patients as passive actors. Rather, the relationships between doctors, nurses and patients is more of a complex web of interactions, shaped in various ways by several factors such as organizational positions, experience, roles, and values. Doctors' authority is

limited by the patients' power to consent, yet they often employ a coercive method of persuasion that seems to take advantage of the patient's lack of medical knowledge. Nurses and doctors share a common goal of a "healthy mom healthy baby," but their emphasis differs, with the doctors primarily focused on physical well-being and evaluating the success of the surgery based on medical indications, while nurses tend to the recovery of the patient as well; in this sense, they provide the opportunity to address the patient's concerns of the "healthy mom healthy baby" principle from their perspective that it is not only about the safe delivery of the baby, but also what comes after a C-section: how is the mother able to transition to motherhood, how she is able to effectively bond with the baby, and how might physical suffering create emotional and mental scars?

An overarching and often restricting influence on the relationships between the three parties is the institutional power of the hospital itself. Doctors and nurses, as employees of the hospital, are constrained by this power, in visible and invisible ways. Most visibly, we see nurses following standard procedures, including, for example, how and when to monitor the progress of labor, to do regular check-ups and to administer tests in recovery. We see doctors doing obligatory rounds and being required to obtain consent before proceeding with a C-section. The powers of the institution are also manifested in invisible ways. Consider, for example, how doctors, nurses, and patients interact with each other. Doctors assume a patriarchal position, even when they claim to treat nurses respectfully and value their (and patient) input, because they carry the burden of responsibility damages resulting from bad outcomes. Consequently, they act according to their own idea of the "right" decision based on their medical expertise. For their part, nurses may get to know their patients personally and attempt to provide care that caters to patient wishes, but they still get wrapped up in protocols and standard procedures that they must

do even if patients do not understand why. Once they come into the hospital, patients also assume a role as a member of the institution, subject to the responsibilities of that role. This including cooperation, even obedience, to doctors' orders, communicating effectively with doctors and nurses, and – in an era of shared-decision-making – being an active participant in the course of their care. In addition, this analysis of the doctors' and nurses' constrained roles under the institution suggest that patients not only are affected by the institution directly under their patient role, but also under another layer of all of the ways in which doctors and nurses interact and provide care for them shaped by those limiting influences. This becomes particularly important to consider because the ultimate goal of all of these relationship-building, interactions and medical care is for the patient's safe recovery and satisfactory experience, which includes not only physical health, but well-being. Under a doubly constraining system of care that serves to emphasize “healthy mom healthy baby” from the medical model of care, the emotional and mental side of health has the potential to be neglected twice over. This seems to be the experience of those women undergoing C-sections that they experienced to be traumatic and damaging to their relationship with their baby, leaving them to feel that recovery was not possible even when the symptoms of pain resided and pondering a long time beyond their C-section of why they felt dissatisfied with their care and overall experience, even when they described many of the actual individual nurses and doctors they worked with to be very caring and helpful people.

The other major goal of undertaking this research was to be able to suggest ways in which patient care can be improved to provide the maximal level of satisfaction for all individuals involved, specifically doctors, nurses and patients. I focused on C-sections in this research because under the limits of time and resources, undertaking a fully-comprehensive

study of all departments of the hospital was not feasible, but C-sections provided me with three specific populations of actors that interact together very closely. Additionally, emphasis on the decision-making aspect of the interaction allows me to consider such interactions and relationships between doctors, nurses and patients in general. Thus, research on C-sections was specific enough to allow me to make a comprehensive analysis of what goes on in these relationships and interactions, while allowing me to broaden these concepts to apply them to doctor-nurse-patient interactions in general, and not only among obstetricians, labor and delivery nurses, and pregnant women. As a word of caution, however, as will be mentioned in my “limitations” section below, this is not a perfect application as additional variables are context-specific to C-sections such as the patient population being only pregnant women. Despite such limitations, the findings discussed in this study will be helpful in suggesting some ways to help improve patient experience and satisfaction in medical care. Furthermore, in contrast to the existing research on doctors, nurses and patients that often look at bidirectional relationships between only two of those groups at a time, these suggestions will be unique and informative because they are composed of perspectives from all three groups, which more accurately reflects reality in that what happens in patient care is not only between the patient and doctor or patient and nurse only, but involves many other actors and variables as well.

The previous research on C-sections often focused on the external influence, such as legal and economic considerations that influence doctors to perform so many C-sections, even when it may not be medically necessary. This research provides an alternate explanation looking into the relationships and interactions among doctors, nurses and patients shaped by the often constraining organizational structure of the hospital, which plays a significant role in how medical decisions are made. Although the interactions and relationships between specific actors

are important, within the institution of the hospital, various actors work simultaneously in a complex web of interactions, illuminating the benefits of the multi-perspective approach undertaken in this research. Understanding doctor-patient, nurse-patient, and doctor-nurse interactions are each important, but it is precisely in examining how doctors, nurses and patients, all act synergistically that we are able to identify some of the more invisible ways in which decision-making occurs.

### **Limitations**

The main constraint on my data is the sample size. Ideally, I would have liked to interview several more doctors, nurses and especially patients, but due to limits on time and recruitment strategies, I could only conduct a limited number of interviews. In particular, I would have liked to interview several more patients, because that was the population from which I was expecting the greatest variety of circumstances and experiences. For example, I was interested in learning about the experiences of women who have had to have a C-section on an emergency basis, as well as semi-planned, completely scheduled, and even those who have just considered to have one, but never actually did. My final sample consisted of women who have had C-sections due to an emergency as well as those who have had it semi-planned, but I was not able to recruit any women who had scheduled their C-section for convenience or others who had only considered and discussed a C-section as a possibility. As a result, my data does not reflect the wide range of circumstances for C-sections that actually exist, and therefore, the generalizations that I make about the patient population may not be representative of all C-section patients, but is rather skewed towards women who have had their C-sections semi-planned or in an emergency. Despite all of these limitations and challenges, small sample

qualitative studies provide a valuable opportunity to understand the specific and personal experiences and knowledge of doctors, nurses and patients in-depth, and help discover concepts and ideas that underlie the dominant discourse in the medical field.

## **Conclusion**

The following are three ways in which patient care can be improved as a compilation of ideas from doctors, nurses and patients. Firstly, in cases where patient desires and indications of the medically safest option conflicts, communication is key. As demonstrated by cases in which there may be initial disagreement, once the doctor is able to explain informatively and honestly of what he or she believes to be the severity of the situation that necessitates a certain medical intervention (or perhaps denying one), patients are more willing to listen and participate in a reasonable shared decision-making process. It is when doctors tend to be coercive or assume a superior role that patients feel the need to be defensive, consequently resulting in miscommunication and unresolved disagreements. In these situations now, nurses are often pushed aside as not being a significant member of this discussion due to their lack of any real decision-making authority, but the valuable personal relationships they are able to develop with the patient as well as the medical knowledge they share with doctors allow them to understand both sides of the conflict better, and can perhaps serve to clarify and enhance communication. Additionally, nurses do have experience and expertise, and they are unlikely to promote their own beliefs over patient desires or medically indicated reasons, so providing them with practical decision-making power may help to make the process more efficient as well as equal.

Secondly, relieving nurses and doctors of institutional pressures will help them provide more efficient care, resulting in improved patient satisfaction as well as doctor and nurse

satisfaction. Some of the major sources of tension between doctors, nurses and patients came from how they felt they had to do things because it is the standard way. In medical care, however, C-sections being a model example, everything is unpredictable and all patient conditions and circumstances are different. In such cases, providing care according to an institutionalized policy is not the most effective or even safest way to treat patients. This is not to suggest that institutional regulations be eliminated because they serve an important purpose of ensuring high quality practices are being implemented, but when it reaches a point where the individuals involved begin to notice those policies and protocols coming to the forefront and becoming more of a hindrance than providing efficient management, the institutional practices themselves should be reevaluated.

Finally, patient care does not end with the completion of a medical intervention; the patient's experience extends far beyond that into the physical recovery, and also to their life. Often, doctors end the relationship with the feeling of accomplishment when a medical procedure is completed and the patient's condition improves. Nurses provide extended care in providing support until the patient is released. Obviously, nurses and doctors have no control in what they can do after the patient leaves the hospital, but what they do before that point has a significant influence on the patient's experience to that point and beyond. Physical scars heal and can be forgotten, but the emotional and mental memories of the experience lasts much longer; if those experiences were traumatizing, it affects patients' perceptions of future interactions with doctors and nurses, whether it is with the same people or different ones at a different hospital or clinic. Therefore, the medical model of "care" and "health" should be extended in clinical practice and medical education to include a greater emphasis on the non-physical side of treatment as well. As C-sections are not only about physical health and safety, it

is also not only about the birth of a child; it is also a birth of a mom. Such an understanding is very complicated and challenging to decipher, but once it is recognized, it is very telling of how doctor-nurse-patient understandings can extend and has the potential of developing into. Although a more “whole-person” approach to medical care has been emphasized in recent years, further progress needs to occur.

These three suggestions are not all-inclusive, nor will it resolve all problems in medical care. My hope through this research is to provide new insight into how relationships, interactions, power, identities, and institutions work and develop upon each other to affect those participants. I came from a patient’s perspective, but I attempted to illuminate ideas to improve patient care and satisfaction with input from doctors and nurses, which in turn will not only benefit the patient’s experience, but make the work of doctors and nurses more effective and rewarding as well. The reasons for having to go to a hospital are stressful enough, and the work of doctors and nurses are not much easier. But healthcare affects each and every person, and doctors and nurses deserve to be recognized for their altruistic work. Yet, their work is far from perfect, and reevaluation and progressive changes must be made from time to time to ensure that medical care continue to meet patient needs and desires as the way that health care works advances to include not only new technologies, but also new ways of doctors, nurses and patients to negotiate continuously developing relationships.



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**Appendix**

**Patient Recruitment Flier**

Are you a woman who has had a baby within the past three years?

Had the doctor or nurse ever recommended that you have the baby by C-section?

What did *you* decide, or did somebody else heavily influence your decision?

Please share your story!



I am interested in studying the doctor-nurse-patient relationship in the case of medical decision-making for C-sections. I would like to interview you to discuss what you thought about the information that was provided to you about the procedure, the relationship you built with the obstetrician and nurses, and what your ultimate decision was.

Ayui Murata will be a senior majoring in sociology at the University of Michigan this coming fall. This research project is a part of her honors thesis.

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C-section Research Interview

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## Pre-Interview Questionnaire (Doctors)

This questionnaire is intended to be completed by the participant prior to the start of the interview. The purpose of this questionnaire is for you to provide some background information about yourself, as well as prepare you for some of the topics that we will discuss. Any information you provide will be kept strictly confidential, and will only be used for the purposes of this study. Please answer the questions to the best of your abilities, but feel free to skip any questions that you prefer not to answer.

What is your age?

- 20-30 years
- 30-40 years
- 40-50 years
- 60 years or older

What is your gender?

- Male
- Female
- Other: \_\_\_\_\_

What is your race/ethnicity?

- Caucasian/white
- African American
- Hispanic/Latina
- Asian/Pacific Islander
- Native American
- Other: \_\_\_\_\_

How long have you been working as an obstetrician?

- 0-5 years
- 5-10 years
- 10-20 years
- 30+ years

How often do you recommend C-sections?

- Never
- \_\_\_\_\_ times per day
- \_\_\_\_\_ times per week
- \_\_\_\_\_ times per month
- \_\_\_\_\_ times per year

How often do you conduct C-sections?

- Never
- \_\_\_\_\_ times per day
- \_\_\_\_\_ times per week

- \_\_\_\_\_ times per month
- \_\_\_\_\_ times per year

What is the most common reason for a woman to have a C-section?

- At a woman's request for scheduling convenience
- Emergency situation necessitates it
- Labor fails to progress
- Safer alternative for a risky pregnancy
- Other: \_\_\_\_\_

What is the least common reason for a woman to have a C-section?

- At a woman's request for scheduling convenience
- Emergency situation necessitates it
- Labor fails to progress
- Safer alternative for a risky pregnancy
- Other: \_\_\_\_\_

## Pre-Interview Questionnaire (Nurse)

This questionnaire is intended to be completed by the participant prior to the start of the interview. The purpose of this questionnaire is for you to provide some background information about yourself, as well as prepare you for some of the topics that we will discuss. Any information you provide will be kept strictly confidential, and will only be used for the purposes of this study. Please answer the questions to the best of your abilities, but feel free to skip any questions that you prefer not to answer.

What is your age?

- 20-30 years
- 31-40 years
- 41-50 years
- 51-60 years
- 61 years or older

What is your gender?

- Male
- Female
- Other: \_\_\_\_\_

What is your race/ethnicity?

- Caucasian/white
- African American
- Hispanic/Latina
- Asian/Pacific Islander
- Native American
- Other: \_\_\_\_\_

How long have you been working in the OBGYN?

- 0-5 years
- 6-10 years
- 11-20 years
- 21-30 years
- 31+ years

How often do you recommend C-sections?

- Never
- \_\_\_\_\_ times per day
- \_\_\_\_\_ times per week
- \_\_\_\_\_ times per month
- \_\_\_\_\_ times per year
- 

How often do you encounter C-sections?

- Never
- \_\_\_\_\_ times per day
- \_\_\_\_\_ times per week
- \_\_\_\_\_ times per month
- \_\_\_\_\_ times per year

What is the most common reason for a woman to have a C-section?

- At a woman's request for scheduling convenience
- Emergency situation necessitates it
- Labor fails to progress
- Safer alternative for a risky pregnancy
- Other: \_\_\_\_\_

What is the least common reason for a woman to have a C-section?

- At a woman's request for scheduling convenience
- Emergency situation necessitates it
- Labor fails to progress
- Safer alternative for a risky pregnancy
- Other: \_\_\_\_\_

## Pre-Interview Questionnaire (Women)

This questionnaire is intended to be completed by the participant prior to the start of the interview. The purpose of this questionnaire is for you to provide some background information about yourself, as well as prepare you for some of the topics that we will discuss. Any information you provide will be kept strictly confidential, and will only be used for the purposes of this study. Please answer the questions to the best of your abilities, but feel free to skip any questions that you prefer not to answer.

What is your age?

- 18 years or younger
- 18-24 years
- 25-30 years
- 30-35 years
- 35-40 years
- 40 years or older

What is your race/ethnicity?

- Caucasian/white
- African American
- Hispanic/Latina
- Asian/Pacific Islander
- Native American
- Other: \_\_\_\_\_

What is your highest level of education?

- High school or equivalent
- Some college
- Associate's Degree
- Bachelor's Degree
- Master's Degree
- Doctoral Degree
- Professional Degree
- Other: \_\_\_\_\_

How many children do you have?

- 0 (expecting)
- 1 (age \_\_\_\_\_)
- 2 (age \_\_\_\_\_, \_\_\_\_\_)
- 3 (age \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_)
- 4 (age \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_)
- 5 (age \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_)
- 6 or more (age \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_)

How many children did you have by C-section, and what number birth was it?



- 0 children by C-section
- 1 child by C-section (birth #\_\_\_\_\_)
- 2 children by C-section (birth #\_\_\_\_\_, #\_\_\_\_\_)
- 3 children by C-section (birth #\_\_\_\_\_, #\_\_\_\_\_, #\_\_\_\_\_)
- 4 children by C-section (birth #\_\_\_\_\_, #\_\_\_\_\_, #\_\_\_\_\_, #\_\_\_\_\_)\_\_\_\_\_)
- 5 children by C-section (birth #\_\_\_\_\_, #\_\_\_\_\_, #\_\_\_\_\_, #\_\_\_\_\_, #\_\_\_\_\_)
- 6 or more children by C-section (birth #\_\_\_\_\_, #\_\_\_\_\_, #\_\_\_\_\_, #\_\_\_\_\_, #\_\_\_\_\_, #\_\_\_\_\_)

Do you expect to have a child by C-section in the future?

- Yes
- No

## **Interview Questions**

The following questions revolve around your experience with the process of making the decision of whether or not to carry out a Cesarean section. I am going to ask about specific situations in which you participated in the decision-making process, and in particular, I am going to focus on what interactions occurred between you and the patient and nurse, as well as the relationship that was built from it. If you do not feel comfortable answering any question, please feel free to let me know, and we can move on to the next question, or you may choose to end the conversation. Also, if you have any questions during our time together, feel free to ask at any time.

### **Questions for the Doctor:**

How long have you worked as an obstetrician?

During your career, how often have you recommended and performed C-sections?

In what cases do you recommend it if at all?

Who usually brings up C-sections initially?

Please describe how you would explain to a patient about the pros and cons of having a C-section.

What do you think the patient feels is the most negative risk of having a C-section?

What do you think the patient feels is the most positive benefit of having a C-section?

Tell me about the most recent situation in which you and a patient reached a decision about having a C-section.

What were the circumstances of the pregnancy that lead to C-sections as an option?

Please describe the process of the decision-making.

Who else was involved? What was the nurses' role?

Did the nurse have an opinion about the C-section?

What was the ultimate decision?

Who made the final decision?

Do you believe that that person should have made the decision? If not, who should have?

\ Were there any other factors that influence the decision?

Does a patient agree to have a C-section, or does she choose to have one?

Can you describe a situation in which you disagreed with a patient about whether to have a C-section or not?

Why was there the disagreement?

Who made the ultimate decision?

In your view, was the patient satisfied with the final decision? Why or why not?

Were you satisfied with the final decision? Why or why not?

Was there any conflict with the nurse? If so, please describe.

Can you describe a situation in which you disagreed with a nurse about whether to have a C-section or not?

Why was there the disagreement?

Who made the ultimate decision?

In your view, was the nurse satisfied with the final decision? Why or why not?

Were you satisfied with the final decision? Why or why not?

Was there any conflict with the nurse? If so, please describe.

What do you believe is the most important part of the doctor-patient interaction?

What do you believe should be the role of the patient? Doctors?

How do you handle cases of disagreement or conflict with your patients?

What obstacles prevent you from providing the best patient care?

What is the greatest obstacle to effective interaction with your patients?

If you could improve one thing about your relationship with patients, what would it be?

What are doctor-nurse relationships like?

Can you provide some specific examples to illustrate that relationship?

Does your attitude about C-sections differ from that of most nurses?

What do you believe is the most important part of the doctor-nurse interaction?

What do you believe should be the role of nurses?

How do you handle cases of disagreement or conflict?

Do you feel that you are able to work well with nurse to provide the best patient care?

Why or why not?

What makes a good nurse?

What is the greatest obstacle to effective interaction with your nurses?

If you could improve one thing about your relationship with nurses, what would it be?

## **Interview Questions**

The following questions revolve around your experience with the process of making the decision of whether or not to carry out a Cesarean section. I am going to ask about specific situations in which you participated in the decision-making process, and in particular, I am going to focus on what interactions occurred between you and the patient and doctor, as well as the relationship that was built from it. If you do not feel comfortable answering any question, please feel free to let me know, and we can move on to the next question, or you may choose to end the conversation. Also, if you have any questions during our time together, feel free to ask at any time.

### **Questions for the Nurse:**

How long have you worked in the OBGYN?

During your career, how often does the topic of C-sections arise in your discussions with patients?

In what cases do you recommend it if at all?

Who usually brings up C-sections initially?

Please describe how you would explain to a patient about the pros and cons of having a C-section.

What do you think the patient feels is the most negative risk of having a C-section?

What do you think the patient feels is the most positive benefit of having a C-section?

Tell me about the most recent situation in which you and a patient reached a decision about having a C-section.

What were the circumstances of the pregnancy that lead to C-sections as an option?

Please describe the process of the decision-making.

Who else was involved? What was the doctors' role?

What was the doctors' opinion about the C-section? Did it conflict?

What was the ultimate decision?

Who made the final decision?

Do you believe that that person should have made the decision? If not, who should have?

\ Were there any other factors that influence the decision?

Does a patient agree to have a C-section, or does she choose to have one?

Can you describe a situation in which you disagreed with a patient about whether to have a C-section or not?

Why was there the disagreement?

Who made the ultimate decision?

In your view, was the patient satisfied with the final decision? Why or why not?

Were you satisfied with the final decision? Why or why not?

Was there any conflict with the doctor? If so, please describe.

Can you describe a situation in which you disagreed with a doctor about whether to have a C-section or not?

Why was there the disagreement?

Who made the ultimate decision?

In your view, was the doctor satisfied with the final decision? Why or why not?

Were you satisfied with the final decision? Why or why not?

Was there any conflict with the patient? If so, please describe.

What is your relationship with patients like?

Can you provide some specific examples to illustrate that relationship?

What do you believe is the most important part of the nurse-patient interaction?

What do you believe should be the role of the patient? Nurses?

How do you handle cases of disagreement or conflict?

What obstacles prevent you from providing the best patient care?

What is the greatest obstacle to effective interaction with your patients?

If you could improve one thing about your relationship with patients, what would it be?

What is your relationship with doctors like?



Can you provide some specific examples to illustrate that relationship?

Do your attitudes about C-sections differ from that of doctors?

What do you believe is the most important part of the doctor-nurse interaction?

What do you believe should be the role of the doctor?

How do you handle cases of disagreement or conflict?

Do you feel that you are able to work well with doctors to provide the best patient care?

Why or why not?

What makes a good doctor?

What do you believe the role of nurses should be in relation to doctors?

Do you consider nursing a profession? Why or why not?

What is the greatest obstacle to effective interaction with doctors?

## **Interview Questions**

The following questions revolve around your experience with the process of making the decision of whether or not to carry out a Cesarean section. I am going to ask about specific situations in which you participated in the decision-making process, and in particular, I am going to focus on what interactions occurred between you and the doctor and nurse, as well as the relationship that was built from it. If you do not feel comfortable answering any question, please feel free to let me know, and we can move on to the next question, or you may choose to end the conversation. Also, if you have any questions during our time together, feel free to ask at any time.

### **Questions for the Patient:**

How many C-sections have you had?

For how many pregnancies was C-sections considered? Who initially suggested you consider a C-section?

If you had a C-section, why did you decide to have one?

If you did not have a C-section, why did you decide not to have one?

Please describe how the doctor explained to you about the pros and cons of having a C-section. What did you think?

Please describe how the nurse explained to you about the pros and cons of having a C-section.

What did you think?

Did it make you feel any differently from how the doctor explained it?

Tell me about the first C-section decision and how you and a doctor/nurse reached a decision about having a C-section or not.

What were the circumstances of the pregnancy that lead to C-section as an option?

Please describe the process of the decision-making.

What other actors were involved? What was the doctors' role? What was the nurses' role?

What was the doctors' opinion about the C-section? Did it conflict?

What was the nurses' opinion? Did it conflict?

What was the ultimate decision?

Who made the final decision?

Do you believe that that person should have made the decision? If not, who should have?

Were there any other factors that influenced the decision?

In general, do you think that a patient agrees to have a C-section, or does she choose to have one? What about in your case?

Did you ever disagree with your doctor about whether to have a C-section or not?

Why was there the disagreement?

Who made the ultimate decision?

In your view, was the doctor satisfied with the final decision? Why or why not?

Were you satisfied with the final decision? Why or why not?

Was there any conflict with the nurse? If so, please describe.

Did you ever disagree with a nurse about whether to have a C-section or not?

Why was there the disagreement?

Who made the ultimate decision?

In your view, was the nurse satisfied with the final decision? Why or why not?

Were you satisfied with the final decision? Why or why not?

Was there any conflict with the doctor? If so, please describe.

What do you believe is the most important part of the nurse-patient interaction?

What do you believe should be the role of nurses? Patients?

How do you handle cases of disagreement?

Do you feel that you received the best patient care? Why or why not?

What is the greatest obstacle to effective interaction with nurses?

If you could improve one thing about your relationship with nurses, what would it be?

What do you believe is the most important part of the doctor-patient interaction?

What do you believe should be the role of the doctor?

How do you handle cases of disagreement?

Do you feel that you received the best patient care? Why or why not?

Do you feel that the doctor listened to you?

How did you feel that the doctor treated you?

What is the greatest obstacle to effective interaction with doctors?

If you could improve one thing about your relationship with doctors, what would it be?

## **Consent to Participate in a Research Study**

### **Power and Boundaries Between Doctors, Nurses and Patients – Interview**

Principal Investigator: Ayui Murata, University of Michigan senior, Department of Sociology

Faculty Advisor: Karin Martin, Ph.D. Department of Sociology, University of Michigan

You are invited to be a part of a research study that examines the relationships and interactions between doctors, nurses and patients in order to highlight patterns of power dynamics and boundaries that exist between the three groups. The purpose of this study is to understand the relationships that are built among doctors, nurses and patients and the challenges that they face in their interactions to provide suggestions of ways to improve their relationships and patient care.

If you agree to be part of the research study, you will be asked to participate in one face-to-face interview at the location of your choice. The interview will last approximately one hour. I would like to audiotape the interview to make sure that our conversation is recorded accurately. The discussion topics include your experience interacting with members of the other two groups (doctors, nurses or patients), specifically in terms of how the decision was made whether or not to conduct a cesarean section. I will also talk about your opinions about what you believe should be the role of the doctor, nurse and patient.

While you may not receive a direct benefit from participating in the study, some people find that having the opportunity to share their stories is a valuable experience. I hope that the findings of this study will contribute to improving relationships between doctors, nurses and patients to promote effective communication and better patient care and satisfaction.

Answering questions or talking about personal experiences, especially concerning the topic of C-sections, can be difficult. Your participation is completely voluntary. You may choose not to answer any question for any reason, and you may choose to end your participation at any time.

I plan to use the results of this study in my thesis, but will not include any information that would identify you. To keep your information safe, the audiotape of your interview will be stored in a locked cabinet

until a written word-for-word copy of the interview has been created. As soon as this process is complete, the tapes will be destroyed. The researchers will enter study data on a computer that is password-protected. To protect confidentiality, your real name will not be used in the written copy of the discussion. I plan to keep this study data for approximately five to ten years for recordkeeping purposes.

There are some reasons why people other than the researchers may need to see information you provided you provided as part of the study. This includes organizations responsible for making sure that the research was conducted safely and properly, including the University of Michigan and government research offices.

If you have any questions about the research, including scheduling of the interview, contact Ayui Murata at 340 Sedgewood Lane, Ann Arbor, MI 48103, (978) 335-3289, [almurata@umich.edu](mailto:almurata@umich.edu). If you have any further questions, you may also contact the faculty advisor, Karin Martin at [kamartin@umich.edu](mailto:kamartin@umich.edu) or (734) 936-0525.

If you have questions about your rights as a research participant, or wish to obtain information, ask questions or discuss any concerns about this study with someone other than the researcher(s), please contact the University of Michigan Health Sciences and Behavioral Sciences Institutional Review Board, 540 E Liberty St., Ste 202, Ann Arbor, MI 48104-2210, (734) 936-0933 [or toll free, (866) 936-0933], [irbhsbs@umich.edu](mailto:irbhsbs@umich.edu).

By signing this document, you are agreeing to be part of the study. Participating in this research is completely voluntary. Even if you decide to participate now, you may change your mind and stop at any time. You will be given a copy of this document for your records and one copy will be kept with the study records. Be sure that questions you have about the study have been answered and that you understand what you are being asked to do. You may contact the researcher if you think of a question later.

I agree to participate in the study.

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Signature

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Date

## Recruitment Scripts

### Email Correspondence with Doctors

Hello Dr. \_\_\_\_\_,

My name is Ayui Murata. I am a senior majoring in sociology in the Honors Program at the University of Michigan. With guidance from Professor Karin Martin and Professor Raymond De Vries, I am working on my Honors Thesis research, which examines the way medical decisions regarding C-sections are shaped by relationships between doctors, nurses and patients. I am interested in studying the organizational and cultural aspects that influence the dynamics of decision-making between these three groups with the goal of finding ways to improve communication and thus the quality of the experience for women and caregivers. I am contacting you because I am interested in arranging a short interview to learn about your experience as a doctor [nurse, new mother] and your interactions with [nurses and patients]. I expect the interview to take no more than 30 minutes of your time. Please contact me if you would like to participate.

### Recruitment Email to Nurses

My name is Ayui Murata. I am a senior majoring in sociology at the University of Michigan. With guidance from Professor Karin Martin and Professor Raymond De Vries, I am working on my Honors Thesis research, which examines the way medical decisions regarding C-sections are shaped by relationships between doctors, nurses and patients. I am interested in studying the organizational and cultural aspects that influence the dynamics of decision-making between these three groups with the goal of finding ways to improve communication and thus the quality of the experience for women and caregivers. I am contacting you because I am interested in arranging a short interview to learn about your experience as a nurse and your interactions with doctors and patients. I expect the interview to take no more than 30 minutes of your time. Please contact me at [almurata@umich.edu](mailto:almurata@umich.edu) if you would like to participate.

### Email Correspondence with Directors of Childbirth Centers

Hello Ms. \_\_\_\_\_,

My name is Ayui Murata. I am a senior majoring in sociology in the College of Literature, Science and the Arts at the University of Michigan. I am a member of the Honors Program in sociology, and am currently working on my thesis research with Professor Karin Martin and Professor Raymond De Vries. It involves studying the relationships, power dynamics and boundaries between doctors, nurses and patients in the context of medical decision-making for



C-sections. Ultimately, I would like to use the data that I collect and my analysis to suggest ways in which to improve communication and relationships between the patients and care providers to provide the best possible experience for all those involved.

I am writing to you because I am interested in recruiting potential participants, and Professor De Vries recommended that I contact you. For my "patient" population, I want to include women who have had or have considered having a C-section within the past three years. I believe that there are many women who fit this description at your program, and I would like to know if you would help me in recruiting potentially interested women. Participation is completely voluntary, and involves one approximately hour long recorded interview. The major benefit for the participant is the uncommon opportunity for the woman to share her pregnancy and childbirth experience, while the risks are minimal, such as the occurrence of uncomfortable emotions due to recalling difficult experiences. I believe that it is important for women to be able to share their birth experience, and extend the research that has been done on this topic.

Please let me know if I can provide you with any more information, and whether you are interested in assisting me with this research.

Thank you very much for your time and consideration.

Sincerely,  
Ayui Murata

### **Recruitment Message in E-Newsletter**

Have you had a cesarean in the past three years?

For her Honors Thesis, Ayui Murata is seeking to interview women who have had or have considered having a C-section within the past three years. Participation involves an hour-long recorded interview. Ayui's goal is to understand existing power dynamics in the interaction between doctors, nurses, and patients in order to suggest ways to improve those relationships. If you are interested in sharing your story or would like further information, please contact Ayui at [almurata@umich.edu](mailto:almurata@umich.edu) or (978) 335-3289 by Friday, Nov 15.