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## THE ROLE OF THE MESSAGE CONVERGENCE FRAMEWORK IN OBSTETRICIANS' CLINICAL AND COMMUNICATIVE PRACTICES

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THE ROLE OF THE MESSAGE CONVERGENCE FRAMEWORK IN  
OBSTETRICIANS' CLINICAL AND COMMUNICATIVE PRACTICES

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DISSERTATION

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A dissertation submitted in partial fulfillment of the  
requirements for the degree of Doctor of Philosophy in the  
College of Communication and Information  
at the University of Kentucky

By  
Kathryn E. Anthony

Lexington, Kentucky

Director: Dr. Timothy Sellnow, Professor of Communication

Lexington, Kentucky

2013

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## ABSTRACT OF DISSERTATION

### THE ROLE OF THE MESSAGE CONVERGENCE FRAMEWORK IN OBSTETRICIANS' CLINICAL AND COMMUNICATIVE PRACTICES

Over the past few years, the rate of elective interventions in pregnancy in the United States, including elective inductions of labor and elective cesarean deliveries, has increased dramatically. While scholars attribute some of the increase in elective interventions to the female patients who request elective procedures from obstetricians, some literature contradicts that notion and suggests physicians are actually the primary perpetrators of the growth in elective procedures. Although pregnant women may seek elective interventions because of desired convenience, physicians can also claim the benefit of convenience in scheduling deliveries. In addition, elective procedures provide physicians greater monetary compensation than labor and deliveries which evolve without intervention. The current dissertation investigates the communicative role of obstetricians in women's delivery decisions through in-depth interviews with obstetricians practicing in the state of Kentucky ( $N=28$ ). Guided by the framework of Message Convergence, the study assesses how obstetricians manage uncertainty surrounding patient care and make clinical decisions in the midst of either unclear evidence or competing messages. The study also reveals the ways that physicians utilize their medical expertise to engage in decision-making with patients. In addition, specific scenarios of decision-making regarding delivery are discussed, including patients' requests and physicians' provisions of requests; patients' requests and physicians' refusals of requests; and physicians' recommendations for treatment and patients' refusals of recommendations for treatment. Finally, the internal tensions and conflicts experienced by physicians in the decision-making process with patients are also examined.

KEYWORDS: message convergence, patient-provider communication, health communication, medical decision-making, risk communication

Kathryn E. Anthony

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THE ROLE OF THE MESSAGE CONVERGENCE FRAMEWORK IN  
OBSTETRICIANS' CLINICAL AND COMMUNICATIVE PRACTICES

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## DEDICATION

For my parents, Debbie and Darrell Anthony, who have always believed in my academic endeavors. Thank you for your sacrifices that afforded me many opportunities. I love you.

## ACKNOWLEDGMENTS

The completion of this dissertation would have been impossible without the help and support of several important people. I would like to first thank Dr. Timothy Sellnow for being a wonderful mentor and friend over the last five and a half years. I have gleaned much from your excellent instruction, and I look forward to many more years of learning from you. I would also like to thank the members of my doctoral committee including Dean Dan O’Hair, Dr. Elisia Cohen, and Dr. Deborah Crooks for their thoughtful input throughout the entire dissertation process. Further, this dissertation would not have been possible without the willingness of obstetricians throughout the state of Kentucky to discuss many concerns and struggles in their professional lives.

I would like to thank Julie Lasslo for her encouragement during my graduate school career. I will forever be thankful for your friendship and steadfast support in my professional and personal life. I would also like to thank my mother, Debbie Anthony, for her very thorough edits of the current document. Finally, I want to thank my professors at the University of Kentucky College of Communication and Information for affording me with many opportunities over the years. I hope to continue to make you proud as I embark on the next chapter of my academic career.



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## **CHAPTER ONE: INTRODUCTION**

While the phrase “Mother knows best” may be a well-known cultural platitude, in the field of obstetrics, this sentiment has lost much ground in the context of allowing Mother Nature to take her course and allow a woman’s labor to begin naturally. Currently, the total annual number of elective interventions in pregnancy has been steadily rising for the past several years. Not only have rates of elective labor more than doubled from 1990 to 2009, but one in every five deliveries performed today is the result of elective intervention (Tam, Conte, Schuler, Malang, & Roque, 2012). The rates of cesarean deliveries have also increased dramatically from 5.8% in 1970 to 32.3% in 2008 (Blanchette, 2011). While not all of the cesarean deliveries reported were elective, Martin et al. (2009) attribute about 15% of all cesarean deliveries to be elective rather than necessary. Elective interventions may be defined as non-medically necessary interventions or interruptions into a woman’s pregnancy. Understandably, many members of the medical community have expressed concerns over the alarming increase in the number of these procedures. First, elective interventions of labor have been found to introduce additional risks to both mothers and babies (Tam et al., 2012). Second, elective interventions are far more costly to the healthcare system than is expectant management of pregnancy, or waiting for labor to begin on its own without external influences (Clark et al., 2009). The following sections provide discussions on elective interventions in pregnancy, including an in-depth look at the risks and benefits. Specifically, the discussion will focus on elective inductions of labor and elective cesarean deliveries.

### **Elective Inductions of Labor**

Tam et al. (2012) defined elective inductions of labor as “the process of

artificially initiating labor for the purpose of fetal and placental delivery” (p. 407). The scholars argued that successful elective inductions are those which result in a vaginal delivery. Moore and Rayburn (2006) claimed that elective inductions of labor are the most common practices in obstetrics. Elective inductions are characterized as procedures that are not medically necessary interventions into the labor and delivery process.

Many medical experts are wary of elective inductions of labor because the procedures may introduce additional risks to mothers and their babies because, in specific instances, pharmacological agents used to begin labor contribute to the complications surrounding excessive activity in the uterus and abnormal fetal heart rates (Simpson & James, 2008). Elective inductions can also be dangerous for mothers because artificially induced deliveries are often more complicated than spontaneous deliveries. Some complications associated with elective inductions include unnecessary stress on the uterus and the fetus (Lothian, 2006). Further, elective inductions have been associated with longer delivery experiences, especially when the cervix has not fully ripened. As a result, many scholars claim that elective, unnecessary inductions in nulliparous women, or women carrying a first child, significantly increase their risks for having cesarean deliveries (Clark et al., 2009). Cesarean deliveries, if unplanned, can be extremely undesirable because “cesarean birth after labor is associated with increased maternal and neonatal morbidity and mortality, as well as an increase in inpatient length of stay and healthcare costs” (Simpson & Newman, 2010, p. 189).

Elective inductions not only pose unnecessary delivery complications for mothers and babies, but, as noted, can be quite costly. Simpson (2010) revealed that childbirth accounts for the majority of hospital admissions in the United States. When elective

inductions fail, women must endure cesarean deliveries instead, and the cost incurred to the healthcare system for cesarean deliveries is double that of naturally occurring, vaginal births (Agency for Healthcare Research and Quality, 2006). Some medical institutions have tried to reduce the number of unnecessary, elective inductions by implementing protocol requiring physicians to complete extensive paperwork in order to request inductions before 41 weeks (Durham et al., 2008).

Further, a distinction should be made between elective inductions of labor at 39 weeks and beyond when pregnancies are considered full-term and elective inductions performed before 39 weeks. The latter are labeled late pre-term births, and unlike information regarding elective inductions at term, research clearly reveals that elective inductions before 39 weeks do not promote neonatal health. The American College of Obstetricians and Gynecologists (ACOG) asserts that 40 weeks is the preferred amount of time for full-length pregnancy (Ashton, 2010), and that patients should wait until at least 39 to 40 weeks before scheduling inductions of labor. Babies born before 37 weeks are considered to be pre-term, and pre-term birth is often accompanied by physical and psychological development impairment and is also the primary cause of neo-natal deaths in the United States (Buus-Frank, 2005). A primary focus of the current study involves understanding the communicative environment surrounding elective interventions at term. Elective inductions before 39 weeks will also be addressed.

Current scholarship reveals that many pregnant women request elective inductions from their providers not only for reasons of convenience, but also because they experience heightened discomfort at the end of pregnancy (Tillett, 2007). However, Tillett (2007) asserted that women who request inductions for the sake of convenience

must not fully understand the risks that accompany their requests. Budin (2012) aptly stated that “an often overlooked drawback of elective induction of labor or scheduled cesarean surgery is that although the mother may be ready to give birth, the baby may not be fully ready” (p. 199).

Rayburn and Zhang (2002) stated that white women receive inductions more frequently than women from other racial groups. Additionally, the researchers revealed that women with higher levels of formal education also induce their deliveries at a higher rate than women with less formal education. The scholars’ conclusions intimated a relationship between socio-economic status and elective pregnancy interventions.

The Agency for Healthcare Research and Quality (AHRQ) (2009) identified specific reasons that women may pursue elective inductions from their providers. It noted that women may opt for elective inductions because they may be experiencing a great deal of physical discomfort during the last portion of their pregnancies; they may desire that certain family members attend the birth and scheduling the birth would make that easier; and also, employment obligations and concerns over making it to the hospital in time might all be contributing factors for expectant women wanting to be in control of the time of birth. Conversely, AHRQ also highlighted reasons women may be opposed to receiving elective inductions of labor. It found that most women desire to start labor without medicinal influence; they may fear their babies might be born prematurely because of uncertainty surrounding due dates; they may fear that elective inductions might be far more painful than spontaneous births; and finally, they may worry the risks associated with elective inductions of labor have not been adequately studied and that many potential risks to both mothers and babies are still yet unidentified.



## **Elective Cesarean Deliveries**

In addition to the increasing number of elective inductions, Collard, Diallo, Habinsky, Hentschell, and Vezeau (2008) revealed that although cesarean sections were performed primarily for medical emergencies several decades ago, the procedure is commonly done today based on the requests of patients. Currently, cesarean sections being performed in the United States is at the highest rate ever. Although cesarean deliveries are often necessary when babies are breech or there are other labor complications, cesarean deliveries often result in higher rates of maternal and neonatal morbidity and mortality for babies in a cephalic (head-down) presentation (Villar et al., 2007). The authors discussed other risks associated with cesarean deliveries including prolonged recovery time, increased risks for infection, increased risks for hospital re-admission, and delayed contact between mothers and babies.

Despite potential risks associated with elective cesarean deliveries, Collard et al. (2008) discovered that similar to elective inductions of labor, patients may request elective cesarean deliveries based on scheduling conveniences. In addition to calendar conveniences afforded by cesarean sections, women may also seek elective cesarean sections based on their fears of either pelvic organ prolapse or urinary and anal incontinence.

Bettes (2007) et al. surveyed American obstetricians to assess their perceptions of cesarean deliveries based on maternal requests. Of the 1,063 obstetricians surveyed, 92% claimed their practices had no rules in place for responding to such inquiries. Of the 8% who claimed they had established regulations for responding to such requests, 72% responded that they try to honor the requests of mothers as long as the mothers sign

waivers of informed consent. The remaining physicians admitted they typically refused to grant such patient requests.

Both elective inductions of labor and elective cesarean deliveries contribute to unnatural interruptions of pregnancy, according to Lothian. She argued, "For both mothers and babies, it is safe and wise to wait patiently until labor begins on its own" (2006, p. 43). However, because obstetricians play such a pivotal role in women's decision-making, the following section examines the influence of obstetricians on elective interventions.

### **Physicians and Elective Procedures in Pregnancy**

Although much literature suggests that pregnant women are primarily responsible for requesting elective interventions for delivery, other literature exists which reveals that physicians may also be responsible for suggesting or recommending elective interventions of labor to their patients. In her research, Lothian (2006) revealed various motivations for physicians making such recommendations. Benefits of elective interventions often include increased compensation, ease of scheduling deliveries, and decreased patient care time (Lothian, 2006). Because many pregnant women cite their providers as the most influential voices in their delivery decisions and because many patients view their providers as the foremost experts on health-related subjects (Beisecker, 1990) recommendations from physicians for such procedures can prove extremely influential for patients. Because the roles of the providers are so influential for women's delivery decisions, the ways in which physicians counsel their patients about elective interventions should provide a clear explanation about the reasons leading to the dramatic increase in elective interventions in the United States.

Although some studies reflect the experiences of pregnant women engaged in making delivery decisions (Tillet, 2007; Vos, Anthony, & O'Hair, in press), the self-perceived roles of obstetricians are vastly underrepresented in the literature because of the paucity of information concerning the true communicative roles of physicians in women's delivery decisions.

Moore and Lowe (2012) conducted a comprehensive synthesis of the scholarship focused on elective inductions and revealed that specific reasons compel patients and physicians alike to pursue elective inductions of labor. The scholars revealed that pregnant patients pursued elective inductions out of a sense of convenience, and also because often busy mothers-to-be desired the ability to schedule the labor and birth of their babies. According to the researchers, many women who opted for the convenience aspect of elective inductions were simply unaware or misinformed of the risks associated with the procedure. Finally, the literature review uncovered a substantial number of articles that indicated women were pressured from healthcare providers, including physicians and nurses, to request elective inductions.

In addition to investigating the experiences of patients, Moore and Lowe (2012) revealed that medical providers may have encouraged their patients to pursue elective inductions out of a sense of convenience in scheduling the delivery of births around their own schedules and planned absences. The study by Moore and Lowe (2012) yielded some other interesting findings regarding physicians who recommend elective inductions. The literature review highlighted several articles that documented a lack of knowledge even by some physicians concerning the risks associated with elective inductions. Financial incentive was also seen as an important reason many physicians recommend

elective inductions to their patients. And lastly, the study showed that fear associated with malpractice suits is a significant reason that physicians sometimes order early inductions.

Simpson and Newman (2010) collected survey data with pregnant and post-partum women to assess the role of providers in their decisions surrounding elective inductions. The scholars stated that of the sample of women who opted for elective inductions, 75% did so because they claimed their physicians suggested and even encouraged them to pursue elective inductions. Particularly, some women felt compelled to pursue elective inductions when physicians commented their babies were too big or when physicians told them they were either due now or were currently overdue. The scholars argued that their study offers an empirical contradiction to the long-held belief that physicians merely grant elective inductions at the behest of their patients. Instead they claimed that physicians may be initiating the process of elective induction by encouraging patients to pursue it. In reiterating the powerful influence of physicians over patients' decisions, Simpson and Newman stated, "When the option for elective induction was offered by their physicians, women were significantly more likely to choose elective induction than when the option was not offered" (2010, p. 193).

Further, Simpson (2010) articulated that physicians who enable pregnant patients to pursue elective inductions for the sake of convenience operate in direct contradiction to the paramount medical goal of patient safety. Specifically, she explained, "There is likely no other area of medicine in which potentially dangerous medications are given to hasten completion of a physiological process that would, if left on its own, usually be accomplished without incurring the risk of drug administration" (p. 45). Similarly,

Oshiro, Henry, Wilson, Ware-Branch, and Varner (2009) argued that babies who, as a result of the nature of the elective induction, are admitted to the NICU because of complications, are never cared for in the NICU by the providers who advised or performed the elective inductions. As a result, the scholars argued that “there is a lack of awareness for any individual practitioner of the consequences of his or her actions” (p. 808). Additionally, the scholars stated that “Over time, as each individual obstetrician does not see harm from delivering patients slightly early, there is a migration to an unsafe practice,” also referred to as “the normalization of deviance” (p. 808).

In an effort to reduce the overall number of elective interventions in pregnancy, patient education initiatives have been designed to teach women the risks associated with elective inductions. Particularly surrounding elective inductions before 39 weeks, which ACOG and other organizations have deemed as poor medical practice (Ashton, 2010), Simpson and Newman (2010) argued that patient education may be an effective means for reducing the number of elective inductions among first-time mothers. For example, the Association of Women’s Health, Neonatal, and Obstetric Nurses developed the educational guide, “40 Weeks to Go to the Full 40.” The initiative educates pregnant women by providing them important information concerning the necessity of getting to 40 weeks, including, “Birth a brainier baby; at 35 weeks your baby’s brain is only 2/3 the size it will be at term” and “Give baby’s development the benefit of time since you may not know exactly when you got pregnant” (p. 352). And even though technically ACOG only discourages elective inductions before 39 weeks, Simpson and Newman (2010) encourage women to complete a pregnancy of 40 weeks rather than simply 39 weeks.

Because voices of the providers are often so integral to women's delivery decisions (Lothian, 2006) and because when faced with potentially risky decisions, women typically ask their physicians, "What would you do?" (Tillett, 2010), further research needs to be conducted with physicians to fully assess their roles in women's delivery decisions. Because literature regarding elective decisions reveals the presence of risks for both elective procedures and for expectant management of labor, research surrounding the ways physicians make sense of diverse messages in healthcare is essential to understand the ways physicians counsel patients. Simpson (2011) advocated specifically for interventions with medical physicians because of their influence over women's delivery decisions.

Despite the abundance of literature which focuses on the experiences of pregnant patients, little research has considered the role of physicians from an empirical standpoint. Although many opinion pieces about physicians have been written, limited research has attempted to capture the communicative experiences of obstetricians and their delivery decisions with patients. The concerns over elective interventions in pregnancy clearly necessitate a thorough examination of medical providers. Physicians often assume specific roles with their patients as they aid them in critical decision-making regarding elective interventions.

The overall objective of the current study is twofold. First, through the lens of the message convergence framework, the study investigates the ways in which obstetricians make sense of potentially conflicting arguments when treating patients. Second, the current study is designed to promote understanding of the perceived roles of obstetricians as they engage in shared decision-making with their pregnant patients regarding elective

interventions; in addition, it seeks to promote a thorough understanding of the somewhat complex dialogue between the two parties when they consider elective interventions. The following chapter is an examination and an in-depth review of the literature for the proposed study.

## CHAPTER TWO: LITERATURE REVIEW

Life is filled with uncertainty, and particularly within the context of health, uncertainty is pervasive (Brashers, 2001). Uncertainties in health often emerge when details “are ambiguous, complex, unpredictable, or probabilistic; when information is unavailable or inconsistent; and when people feel insecure in their own state of knowledge or the state of knowledge in general” (Brashers, 2001, p. 478). Babrow and Mattson (2003) claimed uncertainty is central to the experience of illness. They state, “Given its pervasiveness, it is not surprising that uncertainty is the locus for much of the tension between the realms of communication and the body, scientific and humanistic assumptions and aspirations, and idiosyncrasy and commonality” (p. 44). Further, Brashers et al. (2003) argued that when individuals experience either acute or chronic illness, uncertainty is a stressor that can impair one’s quality of life.

The experience of uncertainty in health communication has been considered in many health contexts, including the experience of individuals living with HIV/AIDS (Brashers, Neidig, & Goldsmith, 2004); the experience of individuals who receive organ transplants (Martin, Stone, Scott, & Brashers, 2010); the uncertainty of individuals living with spinal cord injuries (Parrot, Stewart, & Cairns, 2000); and the uncertainty associated with self-breast exams (Kline & Babrow, 2000). In summary, the uncertainty factor inherent in health issues has been well documented in the illness literature (Babrow, Kasch, & Ford, 1998).

However, uncertainty in the context of health can be present in more than an illness experience. Although not considered an illness or pathological experience, pregnancy is, in fact, a unique state of health often accompanied by the experience of



uncertainty. The following section discusses ways in which uncertainty has been conceptualized for pregnant women and their medical providers in the scholarly literature.

### **Uncertainty and Birth**

The process of human reproduction and pregnancy is often replete with a sense of uncertainty for both women and their medical providers (Matthias & Babrow, 2007; Matthias, 2010). Pregnancy is a unique period in the life of the mother. According to Matthias (2009), “Being pregnant is not a typical or usual circumstance, nor is it a pathological state of illness” (p. 60). Danziger (1986) reported that pregnancy is a period rife with ambiguity and uncertainty for the mother. For many pregnant women, sources of uncertainty arise from various considerations not only present in the process of pregnancy (i.e., whether or not they would miscarry, whether or not they would remain healthy throughout the pregnancy), but also in the unknowns regarding the health of their unborn babies (Melender & Lauri, 1999). Matthias (2009) argued that because so much emphasis is placed on having healthy babies, any potential threats to the health of unborn babies intensify the experience of uncertainty for expectant mothers.

In an effort to reduce anxiety of the unknown, women are more likely to seek social support from their friends and family during pregnancy (Tarkka & Paunonen, 1996). The scholars revealed that words of affirmation from family members and friends and emotional support enables pregnant women to cope with the uncertainty inherent in pregnancy. Additionally, Melender and Lauri (2002) revealed that while the potential fear of pregnancy problems and complications threaten women’s perceived security during the pregnancy process, social support from family, friends, spouse, or intimate partner,

and supportive communication from medical physicians enable women to manage perceived threats to their sense of security while pregnant.

Although pregnancy creates much uncertainty for women, it also produces similar feelings for obstetricians. Within the United States, women typically seek prenatal care from obstetricians, turning to a traditionally biomedical standard of care (Matthias & Babrow, 2007). Nussbaum, Ragan, and Whaley (2003) explained that not only are pregnant women placed in a “sick role” by their providers, but medical providers often view pregnancy as a condition that necessitates medical treatment. They argued the medical establishment has “medicalized” the natural, reproductive experiences of a woman’s body, resulting in the “performance of frequently unnecessary surgeries," (p. 193) including hysterectomies and cesarean deliveries.

Because many scholars perceive the process of birth as being medicalized, they believe that obstetricians are quick to promote medical interventions among their pregnant patients. Matthias (2010) argued that physicians view pregnancy as a risky phenomenon that necessitates medical intervention because even the healthiest of pregnant women are placed into “low risk” groups rather than “no risk” groups. Further, Rothman (1991) revealed that many obstetricians believe the voice and expertise of medical physicians should have the greatest influence over patient pregnancy and delivery. Rothman states, “It is the skill and techniques of the physician, and not the interdependent emotional relationship with the woman that are believed to determine the outcome of a birth” (1991, p. 61).

Literature reveals that patients and physicians alike experience uncertainty related to the pregnancy process and delivery decisions. The feelings of insecurity, however, are

often heightened by the various interpretations and arguments which are present in elective interventions of pregnancy (i.e., elective inductions, cesarean sections).

Given the differing interpretations of elective interventions in pregnancy which will be discussed later in this chapter, the following section introduces the theoretical framework of message convergence. Based on the early argumentation writings of Perelman and Olbrechts-Tyteca (1969), Sellnow, Ulmer, Seeger, and Littlefield (2009) proposed the framework as a lens sense-making for competing and interacting arguments when perceptions of risk and uncertainty are present.

### **Message Convergence**

The uncertainty inherent in health decision-making, and particularly pregnancy, inevitably gives rise to competing messages of explanation provided by distinct sources (Coombs, 2012) Competing messages resulting from various interpretations of risk situations may actually increase uncertainty (Sellnow et al., 2009). Because it is unreasonable to assume that one argument will be accepted fully by an individual while another will be merely ignored, the various messages are said to converge as individuals “make sense of the issue by observing ways in which the arguments interact” (Sellnow et al., 2009, p. 12). The message convergence framework offers an explanation for how audiences seek to resolve potential confusion created by multiple messages.

Perelman and Olbrechts-Tyteca (1969) observed that arguments on a given topic are “in constant interaction at more than one level” (p. 460). This interaction results from differing views related to both the context of the discussion and content of the arguments. Perelman and Olbrechts-Tyteca identified four levels of interaction: interaction between various arguments put forward by separate sources; interaction between the arguments

and the overall argumentative situation; interaction between the arguments and their conclusions; and interactions between arguments occurring in the discourse and those that are about the discourse (p. 460). The interaction is extended in two ways. First, closer scrutiny of the arguments put forth may intensify the interaction. Second, the interaction expands by “giving consideration to an increasing number of spontaneous arguments having the discourse as their subject” (p. 460). This consideration of spontaneous arguments has previously been studied within the context of crisis communication because crises are characterized by a high degree of threat, surprise, and short response time (Anthony & Sellnow, 2011; Seeger, Sellnow, & Ulmer, 2003). Thus, crisis responders must resolve dangerous situations with limited information and time. As a result, the discourse surrounding crisis events tends to evolve spontaneously as more or better information becomes available (Tompkins, 2005; Weick, 1995). Competing arguments over how the crisis occurred and who is responsible are also typical in the latter stages of crises (Coombs, 2012).

However, the message convergence framework is equally fitting for assessing uncertainty within the health communication context. Brashers (2001) articulated that the management of uncertainty of health is often a complicated endeavor, especially because individuals may either avoid information or seek information from various sources, and these sources may reveal inconsistent or contradictory information surrounding health concerns (Brashers et al., 2000). Martin, Stone, Scott, and Brashers (2010) revealed the nature of competing arguments concerning the risks and benefits that accompany complex decisions surrounding organ transplants. Similarly, Brashers et al. (2003) discussed how individuals diagnosed with HIV or AIDS must contend with conflicting

information surrounding different types of treatment for managing their illnesses.

Conflicting arguments and perspectives abound in the health context.

To resolve the complex intersection of messages, Perelman and Olbrechts-Tyteca (1969) explained that observers seek to identify areas of convergence among the various arguments. They explained that opposing arguments are best understood systematically because the argumentative situation “shifts each moment as argumentation proceeds” (p. 460). As competing or distinct arguments interact, the strength and weakness of the claims are assessed by those engaged in discourse about the issue.

Thus, individuals typically cannot conclude that one party’s argument is absolutely correct. Instead, as arguments interact in the system of discourse, there are typically some degrees of convergence among the claims. Perelman and Olbrechts-Tyteca (1969) explained that convergence occurs when “several distinct arguments lead to a single conclusion” (p. 471). The “strength” of converging arguments is “almost always recognized” because the “likelihood that several entirely erroneous arguments would reach the same result is very small” (p. 471). Three central propositions can be gleaned from Perelman and Obrechts-Tyteca’s discussion of message convergence. Each of these propositions is summarized in the following section:

### **Central Propositions**

Perelman and Olbrechts-Tyteca (1969) specified that the source plays a role in the audiences’ assessment of the argument’s strengths or weaknesses. In considering different sources, Brashers, Goldsmith, and Hsieh (2002) found that in the context of illness and health concerns, individuals often seek information from family members, friends, and healthcare providers regarding their symptoms and uncertainty. Case,

Andrews, Johnson, and Allard (2005) revealed that people often seek health information from family members who have experienced a similar illness. Further, Brashers, Hsieh, Neidig, and Reynolds (2006) revealed that HIV patients perceive their medical providers to be extremely credible sources if providers display knowledge, engage in effective interpersonal communication behaviors that reduce the stigma surrounding their disease, and discuss advances in treatment surrounding the disease.

Additionally, individuals may engage in information-seeking from mediated sources including television programs, newspapers, and magazine articles that contain pertinent health information (Cutilli, 2010). The internet also provides individuals a myriad of information-seeking opportunities, including online support groups and illness or behavior specific sites (Bell, Orrange, & Kravitz, 2011).

Once individuals encounter the information, Perelman and Olbrechts-Tyteca (1969) argued that “in advance, or after delivery, the effect of some arguments can be played down” by the audience if the content is attributed to “factors inherent in the person or speaker” (p. 467). For example, sources that consistently provide a “harsh appraisal” of an issue can create an impression of bias that lessens the perceived strength of their claims (p. 467). In other words, consumers often engage in an informal dialogue about whom and what to believe.

When two opposing sides of an issue offer conflicting arguments, as is often the case with different approaches to healthcare and treatment, there is rarely a complete distinction between them. Perelman and Olbrechts-Tyteca (1969) noted, “if several distinct arguments lead to a single conclusion [convergence], be it general or partial, final or provisional, the value attributed to the conclusion and to each separate argument will

be augmented” (p. 471). The fact that individuals or institutions seemingly in opposition to one another agree on some premise makes that agreement especially noteworthy for stakeholders. This notion that message convergence from distinct sources contributes to persuasiveness is summarized in Perelman and Olbrechts-Tyteca’s first proposition:

*Proposition 1: Convergence in the claims made by distinct sources, be it partial or complete, increases the strength of those claims.*

Previous research in crisis communication has established the perceived proximity to a crisis by an audience makes that audience more likely to take protective action (Sellnow et al., 2009). Conversely, if an audience does not perceive that risk is in close proximity, it is unlikely to follow the advice provided for self-protection. In terms of health decisions, several health communication theories have utilized the construct of perceived susceptibility, or an individual’s “beliefs about the likelihood of getting a disease or condition” (Champion & Skinner, 2008, p. 47). For example, a woman usually believes there must be a distinct possibility that she could develop cervical cancer before she decides to obtain the HPV vaccine. Also, the construct of perceived severity, or the “feelings of seriousness of contracting an illness or leaving it untreated” also affects how threatening an individual actually perceives a health risk. Additionally, an individual’s perceived susceptibility, or perceived personal significance in relation to the health concern, and perceived severity of the health issue dictate whether or not the individual will even pay attention to messages surrounding the health risks (Witte, 1992; Griffin, Dunwoody, & Neuwirth, 1999). Case, Andrews, Johnson, and Allard (2005) argued that, “the concept of salience implies that information is not only perceived to be relevant to a need, but that it is also applicable to a person's concerns. Thus, salience is the key

motivator in deciding to look for information” (p. 358). Perelman and Olbrechts-Tyteca’s (1969) second proposition concurs with these findings. They explained, “sometimes the convergence will be considered irrelevant because the hearer does not attach the same importance to the system as does the speaker, or because the convergence is regarded as without significance” (p. 472). Thus, the second proposition states:

*Proposition 2: The more significant the points of convergence are to the audience, the stronger the claims.*

As the swirl of interacting arguments spontaneously expands during a situation marked by uncertainty, perceived convergence may evolve. Observers will continue to recognize and consider new claims that may or may not support the convergence perceived earlier in the situation. Perelman and Olbrechts-Tyteca (1969) explained this ongoing interpretation as a manifestation of the nonformal context in which public debate or discussion occurs. They stated, “In a nonformal system, an affirmation of convergence is one that can always be challenged, as it depends on the interpretation given to the arguments” (p. 471).

Thus, as discussions of a contested issue evolve, the strength of converging arguments may change. Perelman and Olbrechts-Tyteca (1969) offered three means by which convergence may or may not foster trust in an audience: compatibility versus incompatibility; contrived versus genuine; and coherence versus incoherence. First, convergence initially emerges from perceived compatibility of some claims shared by distinct parties. As arguments evolve, this perceived compatibility might be diminished. As a result, Perelman and Olbrechts-Tyteca noted, “the convergence between arguments may cease to carry weight if the result arrived at by the reasoning shows up elsewhere



some incompatibility which makes it unacceptable” (p. 472). Second, the persuasiveness of convergence rests with its spontaneous and genuine alignment of claims over the lifecycle of a debate. If at any time the convergence is seen as contrived, its persuasiveness is lost. Perelman and Olbrechts-Tyteca summarized this reaction by explaining, “convergence also can cause mistrust: It may be feared that the new elements were arranged specifically in order to bring about the convergence” (p. 473). Third, the “nonformal” system out of which message convergence emerges is imperfect (p. 471). Thus, observers expect some degree of ongoing disagreement. The implicit uncertainty of health situations makes such disagreements even more likely; therefore, complete convergence is likely to foster distrust. Perelman and Olbrechts-Tyteca summarized this phenomenon by explaining, “because of the distrust felt for excessive coherence, a certain measure of incoherence is taken as a sign of sincerity and seriousness” (p. 473). Any of these conditions identified by Perelman and Olbrechts-Tyteca can make message convergence fleeting. This continuous interpretation process leads to the third proposition:

*Proposition 3: The strength of convergence may be modified as a result of a reflection about this very convergence.*

Message convergence can be clearly understood when assessing the experience of coastal residents in the wake of Hurricane Katrina. Anthony and Sellnow (2011) revealed that when employing message convergence to assess the information seeking patterns of individuals along the Mississippi Coast, the scholars found that message convergence revealed a clear preference for local media in the wake and aftermath of Hurricane Katrina because of the public’s perception that local media exhibited pro-social

intentions. Conversely, the scholars discovered that divergence occurred for local residents when seeking information from national sources, who they believed simply reported over-sensationalized news repeatedly.

In summary, the message convergence framework illustrates the function of message convergence for audiences who observe competing arguments, and the convergence is seen as a potentially persuasive condition arising from the interaction of those arguments. The process begins with the distinction of various sources participating in the public debate, advances to an assessment of those sources, and then evolves to the recognition of message convergence, if such convergence occurs in discourse.

### **Message Convergence and Different Ways of Knowing**

Scholarship in medical anthropology reveals that various sources of knowledge and ways of knowing can exist surrounding one's health, and especially surrounding pregnancy and birth. The presence of different sources of knowledge from an anthropological perspective provides support for the theoretical framework of message convergence. Schoenberg and Drew (2002) acknowledged that differing belief systems concerning health exist, and these systems constantly interact to produce ways in which people act in response to their health-related uncertainty. The scholars state, "instead of focusing on a polarized view of lay belief versus biomedical knowledge, an expanded vision must examine the interplay of seemingly divergent foundations of knowledge and how both guide everyday decisions of knowledge" (p. 471). Similarly, Bibeau (1997) claimed that medical anthropologists are acutely aware that when designing interventions, they must contend with the reality that "people already have a wealth of

local knowledge and that the recommended behaviors must compete with a vast array of representations of what is considered ‘good health’ (p. 250).”

In literature which examines pregnancy and birth, Obermeyer (2000) revealed that Moroccan women must make sense of competing arguments surrounding maternal care both during and following delivery. These divergent, yet interacting, voices of health arise from a Western, biomedical model and a knowledge system that is traditional to the Moroccan people. Obermeyer (2000) discussed that in seeking delivery and post-delivery care, Moroccan women do not wholly accept one knowledge system over the other. Instead, the women “combine elements of two systems in accordance to their particular situations and the means at their disposal” (p. 196).

Similarly, Miller (2011) considered the various sources of maternal knowledge in relation to infant health in Kenya. Women in the region have access to both traditional approaches to health and Western options for care. When assessing the women’s knowledge, she found that many of the women exhibited an overlap in traditional and Western understandings of infant health, and the health knowledge advocated by some of the women was a distinct convergence of the two knowledge systems. Miller concluded the systems of knowledge appear to complement each other because the women most knowledgeable about traditional medicine were also extremely well- informed and understanding of Western medicine. In the case of infant health, the domains of knowledge did not appear to exist in contradiction. Additionally, Tanner et al. (2011) argued that mothers with strong understandings of ethnomedical knowledge and Western medical knowledge were able to better protect their children from contracting hookworm, or Helminth infections. A convergence of multiple understandings of knowing may

contribute to overall good health because the most prominent argument should emerge from the interacting sources of knowledge.

Alternatively, an anthropological perspective can highlight the ways that one system of knowledge can become dominant and subsume another, stagnating and suppressing the natural interaction of arguments. Kaufert and O'Neil (1990) described the process of the medicalization of birth among the Inuit people living in Ottawa, Canada. Traditional rituals surrounding birth were conducted by the elders and were attended by midwives. Each birth was understood as a unique and symbolic occurrence. However, traditional understandings of birth were discarded when the Canadian government mandated a specific type of care that women must receive during delivery. Additionally, the documentation of Inuit births by the government became a source of control for biomedical institutions. The authoritative knowledge of the Canadian government overshadowed the local understandings about birth among the Inuit, medicalizing the process of birth.

Most of the aforementioned literature has focused on the ways that messages interact for medical patients and individuals experiencing illness. However, the following sections assess the ways in which the process of message convergence occurs among medical providers who must prescribe care or treatment to patients in the presence of conflicting information or sources.

### **Message Convergence among Medical Providers**

Much literature exists which assesses the role of convergence among stakeholders in an environmental crisis (Anthony & Sellnow, 2011), stakeholders of a terrorist hoax (Sellnow, Littlefield, Vidoloff, & Webb, 2009) and medical patients who must manage

interacting arguments to determine their most appropriate path to managing risks surrounding the Human-Papillomavirus (HPV) (Head, 2013). Ultimately, most of the existing studies incorporating message convergence have been employed as a means for environmental stakeholders and medical patients to make sense of their uncertain physical or healthcare environments through managing interacting arguments from diverse sources, including medical experts, friends, family, and mediated sources (Mishel, 2007).

However, message convergence as a theoretical framework has not been employed to assess the ways that medical physicians, who are typically perceived as having the most credible and authoritative voices within medicine, make sense of competing messages when they must decide on the most appropriate clinical care for their patients. Specifically in the context of elective interventions, information concerning the potential health risks which may experienced by women and their babies as a result of elective procedures varies dramatically from one source to the next. In such situations, physicians must make sense of these varied and often conflicting sources.

### **Arguments Surrounding Elective Delivery Interventions in Pregnancy**

The current dissertation investigates the ways in which medical practitioners make sense of competing messages from various, and often disparate, sources concerning the risks associated with elective inductions of labor and scheduled cesarean deliveries for women and their babies. Within the field of obstetrics, multiple arguments exists in the area of elective procedures in pregnancy. Some obstetricians strongly disapprove the notion of interrupting the natural process of pregnancy with unnecessary interventions. For instance, Akinsipe, Villalobos, and Ridley (2012) argued there are many risks

implicit in elective delivery procedures, including a mother's heightened risks for undergoing a cesarean delivery as a result of an elective induction. However, despite the risks, the scholars claimed the number of elective inductions performed by physicians is steadily increasing every year.

Alternatively, some medical practitioners advise that elective inductions present no greater risks for mothers and their babies than spontaneous deliveries. For instance, Caughey et al. (2009) conducted a systematic review of randomized controlled trials comparing cases of expectant labor management and elective inductions, and he argued that women who expectantly manage their delivery may actually be at heightened risks for undergoing cesarean deliveries as compared to those women who scheduled elective inductions. However, Keirse (2010) objected to the empirical validity of Caughey et al.'s (2009) findings based on the poor quality of the eight studies in their review and also based on the seemingly unclear nature in which they operationalized completely elective inductions versus inductions that are requested based on medical concerns. Finally, Stock et al. (2012) conducted a retroactive cohort study incorporating birth data in Scotland from 1981 to 2007 of elective inductions of labor which included women who reached at least 37 weeks gestation. The scholars argued that elective inductions of labor do not statistically increase the probability that women will have cesarean deliveries.

In considering elective cesarean sections, some medical practitioners advocate for the continued practice and implementation of elective abdominal deliveries, while other physicians argue against such procedures because they promote unnecessary risks to women and babies. Singer (2004) claimed that women who undergo cesarean deliveries experience a reduction in the risk of pelvic organ prolapse and urinary incontinence

resulting from vaginal deliveries. Alternatively, Solheim et al. (2011) found that elective cesarean deliveries increase risks of maternal and neonatal morbidity and mortality. Further, the scholars argued that elective cesarean deliveries can complicate future pregnancies by increasing women's risks for placenta accreta, a potentially fatal condition in which the placenta attaches abnormally to the uterine wall. Finally, scholars at the National Institutes of Health State of Science conference (2006) were unable to issue a definitive opinion statement concerning cesarean delivery on maternal request because "there is very little consensus regarding the risks and benefits of cesarean delivery on maternal request, and very little strong data on which to base decisions" (Bettes et al., 2007, p. 58)

Because of the presence of contradictory evidence present in medical journals examining outcomes associated with elective pregnancy interventions, namely elective inductions of labor and scheduled cesarean deliveries, the following sections will consider the literature surrounding physician uncertainty and literature surrounding the physician evidence uptake decisions, or decisions to change clinical practice based on the presentation of research based clinical guidelines.

### **Physician Uncertainty**

A body of literature has documented the experience of physician uncertainty. Medical physicians, who must regularly make decisions concerning patient care and treatment often experience uncertainty through such decision-making. In a seminal piece concerning physician uncertainty, Fox (1957) claimed that physicians experience uncertainty for various reasons, including an insufficient mastery of medical knowledge, insufficient or limited availability of medical knowledge, and the inability to decipher the

shortcomings or limitations in medical knowledge from one's own limited understanding of the knowledge. Fox's seminal piece advocated a scathing perspective of medical education as a process that creates uncertainty in burgeoning physicians, yet provides physicians no mechanisms or strategies for managing their uncertainties.

Similarly, Beresford (1991) examined the sources of uncertainty that affect medical practitioners and described how physicians experience technical, personal, and contextual sources of uncertainty. Technical sources of uncertainty may emerge from a physician's uncertainty in current medical knowledge. Also, because medical technology and research often far outpace the rate of adoption of new medical research, uncertainty can emerge as physicians are unsure concerning the most effective form of treatment. Personal sources of uncertainty may arise from physicians having an insufficient amount of information regarding a certain patient, or from physicians who become too involved in the care of a particular patient, resulting in the physician questioning his or her treatment plan for the patient. Finally, conceptual sources of uncertainty may result from the application of previous patient experiences to those of current patients or from the multiple aspects of patients' health that may need treatment. Hall (2002) argued that such a classification of various sources of uncertainty reveals that uncertainty management for physicians is far more complex than previously understood. Further, she argues that classification diminishes the notion physicians merely need additional information to manage their uncertainty.

Similar to the experience of patients and uncertainty, physicians who experience high levels of uncertainty while treating patients also experience much discomfort resulting from the uncertainty (Fox, 1957; Rizzo, 1993). Beyond the experience of



discomfort over the appraisal of uncertainty, physicians are often extremely reluctant to disclose their uncertainty (Katz, 1984; Fox, 1957). Katz (1984) concluded that physicians may be reluctant to admit any presence of uncertainty because they do not want their expertise to be questioned by patients or their colleagues. However, regardless of the physicians' need to maintain or save face in the medical encounter, Henry (2006) indicated that physicians ethically must disclose the experience of uncertainty when trying to make a medical decision or diagnosis. Eddy and Billings (1988) discussed the physicians' reluctance to disclose uncertainty resulting in poor medical care. When uncertain medical providers make clinical decisions "on a logic that does not use information on the magnitude of their benefit and harm...the logic appears to be that a practice will be considered appropriate if it might have benefit" (p. 271).

Rather than seek additional information, Hall (2002) indicated that when faced with uncertainty, physicians may base many of their healthcare decisions on their own intuition, which emerges from the personal decision rules of individual physicians and may be dangerous for patients. She stated, "Physicians' intuitive decisions made under conditions of uncertainty are also prone to well-documented errors and biases. These errors and biases are often related to the use of heuristics or 'rules of thumb'" (p. 217).

Further, physician uncertainty has been directly linked to unnecessary treatment and care in the medical field (Leape, 1989). Katz (1984) acknowledged that in the face of uncertainty, physicians have a "propensity to resolve uncertainty and ambiguity through action rather than through inaction" (p. 22). Hall (2002) articulated that selecting to act in the presence of medical uncertainty may result in "increased hospital admissions and may be a cause of excessive ordering of tests" (p. 218). Physician uncertainty may lead to

unnecessary medical attention or treatment for the patient, and Rizzo (1993) lamented that “practitioners who have embraced the ‘when in doubt, treat’ approach to clinical decision-making perceive little need for better evidence” (p. 1453).

In assessing physician uncertainty in the context of prenatal care, Matthias (2009) investigated the ways in which women and their medical providers must confront and manage the uncertainties inherent in pregnancy. The scholar observed and compared the experiences between women who sought care and treatment from obstetricians and women who sought care and treatment from midwives. She concluded that women who seek prenatal counseling from an obstetrician are, as a whole, more likely to be advised or encouraged to schedule a cesarean delivery because the procedure enables both the physician and the women to reduce their uncertainty surrounding the risky and unpredictable nature of birth.

Conversely, Matthias (2009) claimed that women who sought prenatal counseling from midwives decided they would simply manage their uncertainty rather than trying to control the process of birth. Midwives differ substantially in their philosophy surrounding birth than do many obstetricians. Rather than control the uncertainty surrounding birth, midwives believe they should intervene as little as possible in the birthing process because despite feelings of uncertainty, Mother Nature knows best. These two types of providers of prenatal care obviously maintain very different approaches to managing uncertainty.

In examining physician uncertainty in approaches to patient care, the following section considers clinical practice recommendations and the concerns and barriers to provider uptake and adherence to such recommendations.

## **Physician Evidence-based Medicine Uptake**

The literature regarding physician uncertainty is intimately connected to the literature surrounding evidence-based practice, and the uncertainty of certain evidence-based recommendations can serve as a barrier for physician behavior change (Pathman, Konrad, Freed, Freeman, & Koch, 1996). The medical community is intimately acquainted with the disconnect present between evidence-based medical recommendations published in scholarly journals and the actual practices of physicians who treat patients daily. Some scholars argue that research-based recommendations are simply insufficient to change physician behavior, despite the potential for better patient outcomes (Glasziou & Haynes, 2005). In an effort to understand more fully the process of physician adoption of evidence-based research, Pathman et al. (1996) articulated that traditional ways of understanding physician adherence to medicine position the physicians as medical professionals who synthesizes new clinical information proposed by medical research entities, and yet their behavior in practice does not reflect the medical recommendations. However, this model of evidence-based practice uptake is far too simplistic. Pathman et al. (1996) discussed how physicians' adoption of clinical recommendations is not only dependent upon physicians passing through the stages of adoption, including pre-awareness, awareness, agreement, adoption, and adherence, but is also dependent upon existing physician beliefs, their prior experience treating patients, and their personal characteristics.

Several scholars have attempted to assess the reasons or barriers that may inhibit physicians from adhering to clinical-based recommendations. Freeman and Sweeney (2001) investigated physician reticence and hesitance to implement evidence-based practice recommendations made by major medical associations into their daily practices.

Through focus groups with physicians, the scholars explained that physicians do experience barriers of implementing evidence-based practice. One major barrier is the physicians' previous experiences as medical professionals. If something in their medical backgrounds persuaded the physicians not to act in accordance with the medical recommendation, then they will not comply with the evidence-based practice. Additionally, sometimes physicians' relationships with patients may play a major role in whether or not the physicians decide to adhere to the recommended clinical guidelines. Physicians articulated that even if the evidence is strong, they evaluate the treatment for individual patients in the context of the patient's health and needs.

Similarly, Cabana et al. (1999) revealed other barriers physicians encounter when implementing evidence-based practice. The scholars acknowledged a lack of awareness of evidence-based interventions as a prominent reason for the lack of implementation from physicians. Second, the scholars discussed a lack of familiarity with certain recommendations as preventing the physician uptake of evidence-based recommendations. Third, the lack of agreement surrounding the evidence backing a clinical recommendation is noted as another barrier. Finally, the perceived lack of self-efficacy in implementing the recommendation was found to be a final barrier to implementing evidence-based practice.

In a recent systematic review, Wallace, Nwosu, and Clark (2012) considered the barriers experienced by medical decision-makers in implementing research based-evidence. Similar to the findings of Cabana et al. (1999), the scholars cited a lack of knowledge of research-based practice as a major barrier. Further, a lack of familiarity with the recommendations was also identified as a medical decision-making barrier.

Beyond knowledge and familiarity, a lack of motivation toward the recommendation was found to be as high as 10% among some physicians. The researchers found that provider perceptions concerning the lack of utility of research-based evidence were as high as 95% in some cases. Finally, the scholars highlighted external barriers, including lack of resources and lack of time, for implementing research-based recommendations.

The literature reveals that physicians may not adhere to recommended practice guidelines because they are uncertain about the recommendations. An application of the theoretical framework of message convergence may reveal the ways that physicians make sense of clinical recommendations from clinical research entities.

### **Physician Information Seeking**

Further complicating concerns surrounding physician uptake of recommendations are medical provider patterns of information seeking. Younger (2010) advised that when seeking information, physicians will first ask a close colleague not only out of a sense of trust, but also because physicians discuss a lack of time and a perceived lack of information in medical databases as deterrents for searching for information through those databases. Additionally, according to Hider, Griffin, Walker, and Coughlan (2009), physicians overwhelmingly reported seeking medical information more frequently from Google than any other online source. Of their sample, 86.1% of physicians claimed to search for medical information at least once a month from Google while 81 % of their sample reported seeking information once a month from PubMed or Ovid MEDLINE. Additionally, from a sample of physicians and nurses, the scholars revealed that people consistently rated Google as the most valuable online source.

Hughes, Joshi, Lemonde, and Wareham (2009) revealed that junior physicians regularly employ “Web 2.0,” or “a second generation of web-based tools” that includes social networking sites and wikis like Wikipedia for information-seeking purposes. The scholars disclosed that junior physicians appreciate the ease of information-seeking through such sources, but they often wonder about the credibility of the information found on these sites. The scholars concluded that junior physicians attempt to confirm the information found on these sources with other websites to enhance the credibility of the information.

By examining the various bodies of literature dealing with physician uncertainty, barriers and concerns regarding the uptake of evidence-based recommendations, and the methods of information-seeking of medical providers, it is apparent that uncertainty is not only an ever present and familiar experience for physicians, but physicians are bound by their own limited resources of knowledge and time. Such constraints or barriers seem to only increase the experience of uncertainty, not ameliorate it. Further complicating the uncertainty of the physicians are the multiple arguments involved in elective procedures in pregnancy. Not only do physicians experience barriers when trying to decide effective methods of treatment, but they also must face competing opinions and arguments during elective pregnancy interventions.

The theoretical framework of message convergence may provide much insight into the process of ways physicians interpret interacting arguments and information about patient care. The current literature addresses physician barriers to integrating clinical guidelines into their practices, and considerations of physician uncertainty. Because of these complexities, the resulting research question is posed:

RQ1: How does the process of message convergence manifest among obstetricians who make sense of competing medical literature when advising patients?

### **Physician as “Conduit of Convergence”**

A continuing look at how message convergence influences physicians in their medical practices yields interesting observations and findings. Mathews and Pronovost (2008) argued that “physicians are often the purveyors of information to help patients make informed decisions about their care” (p. 2914). Because physicians are medical experts who study medical literature and make sense of competing messages when necessary, physicians should be considered conduits of message convergence. Once obstetricians recognize a convergence of arguments, it then becomes their job to relay the information to patients. Therefore, when physicians make sense of conflicting medical literature, they must begin to function as “conduits of convergence” during medical consultations with their patients. Further, when patients are uncertain and overwhelmed by large amounts of medical information, physicians are obligated to help them make reasonable and informed decisions by clarifying confusing information (Matthews & Pronovost, 2008; Krumholz, 2010). Physicians are positioned uniquely as medical experts who not only must make sense of competing messages, but who must also counsel patients, provide assistance when information is confusing, and correct patients when their understanding of certain medical concerns is incorrect. Understanding the ways in which obstetricians counsel patients regarding confusing information can extend the theory of message convergence by revealing its effect on patient-provider medical

encounters. In an effort to extend the current theoretical framework, the following question is posed:

RQ2: How do physicians function as conduits of convergence within the medical encounter?

### **Medical Encounter Models**

As previously mentioned, convergence theory has only recently been applied to interactive decision-making in medical encounters. Consequently, this dissertation contributes to the development of the message convergence theory by focusing more directly on medical encounters. Within the field of medicine, several models have indicated specific medical encounters between patients and their medical providers. The most prevalent and potentially the least advisable model is the “biomedical” model or the paternalistic model of medicine (Roter & McNeilis, 2003; Sparks & Villagran, 2010). In this approach to healthcare, medical providers rely heavily on scientific and medical evidence when they view patients as compositions of cells rather than individuals with unique needs and concerns. The input of patients is typically absent, and the medical physicians are entrusted to act in the best interests of patients. In considering the power dynamics of this model, “the patient and physician are often on so unequal a footing that the patient is unable to shape the relationship to the same degree as the physician” (Roter & McNeilis, 2003 p. 123). Patients are view as passive recipients of healthcare rather than active participants, and they are often unaware of any alternative for participation in medical encounters.

Equally as undesirable as the biomedical model of medicine is the consumerist model of medicine (Roter & McNeilis, 2003). According to Sparks and Villagran, (2010),



“consumerism in health care implies that well-informed patients are best equipped to decide among treatment options and that control over decisions should lie solely with the patient” (p. 58). The physicians are viewed as accommodating and unquestioning of their patients’ demands and wishes for treatment. Patients, in this model, enjoy power over physicians, and the model is typified as a “market transaction” in which patients seek care based on their own values. The overarching concern of this model is the passive role of physicians, who could provide much needed input and information concerning treatments and care to their patients. In contrast to the biomedical model, the medical providers’ voices are lost in the consumerism model.

However, because of the implicit shortcomings of the previous two models, a major ideological shift has been afoot in the medical community in recent decades. Increasingly, patients are encouraged to take a meaningful role in their own healthcare decisions (Coulter, 1999). Because the “disease focused” or biomedical model of medicine is becoming further antiquated and because physicians are less likely to be positioned as the ultimate authority in an individual’s medical decisions, the medical model of mutuality (Roter & McNeilis, 2003) or shared decision-making has emerged, and it not only values but encourages the inclusion of the patients’ voices and concerns about their healthcare (Stewart, 2001). Additionally, although physicians are encouraged to act as counselors or advisors, the decisions made within the medical encounter should ultimately be co-created with patients.

### **Patient-Provider Communication**

In considering the communication of patients who must make delivery decisions for themselves and their babies, scholarship documenting patient-provider

communication during medical encounters reveal that female patients may have different experiences than their male counterparts. Through a meta-analytic review, Hall, Roter, and Katz (1988) discussed how gender significantly affects patient-provider interaction. Their research revealed that both male and female physicians tend to give more information to female patients over male patients. Gabbard-Alley (1995) claimed that female patients are not only more likely than male patients to visit the doctor when they are ill, but they are also more likely to engage in verbal communication within the medical interaction. Women are also more likely to ask questions of their medical providers and, as a result, perceive they are engaging in shared decision-making. (Arora & McHorney, 2000).

Conversely, gender differences exist in the ways physicians approach communication with their female patients. Scholarship affirms the notion that physicians tend to engage in more supportive communication behaviors with female patients than with male (Weisman & Teitelbaum, 1989). Stewart (1984) revealed that not only were female patients far more open in expressing their feelings to physicians concerning health concerns than male patients, but physicians themselves tended to be more open when interacting with female patients and attempted to elicit expressions of feelings from their female patients. Further, Waitzkin (1985) not only claimed that women typically received more time during medical encounters than male patients, but that information provided by physicians was presented in a more comprehensible manner to female patients. However, scholars acknowledged that although female patients appear to receive certain types of special privileges within medical encounters, female patients are typically less

satisfied than their male counterparts with patient-provider communication (Hall & Dornan, 1990).

Beyond gender differences, scholars have also found that patients who are formally educated are more likely than patients who are not to voice their opinions to their healthcare providers. Scholars argue that the reality exists because patients who have been formally educated are more likely to value the interaction with their healthcare providers and are more likely to feel empowered to speak up. Formally educated patients also tend to exhibit stronger health literacy and verbal expression skills over less educated patients (Street, Gordon, & Haidet, 2007). Interestingly, educated female patients are also more likely to request elective inductions than their less educated pregnant counterparts (Rayburn and Zhang, 2002).

### **Shared Decision-making Model**

Within the shared-decision-making model, or the mutuality model of medicine, physicians are encouraged to provide “patient-centered care.” Lambert et al. (1997) articulated the patient-centered care movement encapsulates seven primary dimensions that include, “respect for patients’ values, preferences, and needs; coordination and integration of care; information, communication, and education, physical comfort, emotional support, and alleviation of fear and anxiety; involvement of family and friends; and transition and continuity” (p. 28). The scholars claimed that patient-provider communication is at the core of patient-centered care, and that patient-centered research within patient-provider communication emphasizes, “patient involvement, mutual participation in decision-making, interpersonal relationships, and trust” (p. 28). Roter and Hall (1993) articulated that in general, physician-patient communication has taken on

two forms. The first is classified as “patient-centered,” and it is the form in which providers ask questions frequently of patients and encourages patient participation in the medical consultation. Alternatively, the second communication style may be viewed as more “physician-centered.” Communication that is “physician-centered” in nature is marked by close-ended questions and typically promotes the discursive control by physicians and greatly diminishes patient participation.

Similarly, McCormack et al. (2011) conducted a systematic review of published articles and research in an effort to integrate the somewhat diverse literature surrounding patient-centered care. The scholars uncovered six general domains for understanding patient-centered care. The first domain, entitled exchanging information, is marked by physicians exploring patient informational needs and quest of knowledge by patients; the second domain consists of practices for promoting the relational aspect of the patient-provider interaction; the third domain addresses the aspect of recognizing and responding to the emotions of the patients; the fourth domain pertains to uncertainty maintenance within the medical experience; the fifth domain explores decision-making functions; and finally, the sixth domain identifies and addresses the patients’ self-management of health.

In stressing the necessity of shared decision-making within the medical encounter, Matthias, Salyers, and Frankel, (in press) stated, “Policy makers promote shared decision-making because of its potential to increase use of beneficial treatment options, decrease utilization of treatment options without clear benefits, decrease variations in health care delivery, and promote patients’ involvement in their own health” (para 2). Additionally, shared decision-making is critically important not only because of the ethical implications of patients being informed of all of the various treatment options and

their accompanying risks, but once the medical treatment has been provided to the patient, patients are the ones who must live with the risks and side-effects of the treatment. Shared decision-making is essential in the medical encounter (Montori, Gafni, & Charles, 2006).

Matthias, Salyers, and Frankel, (in press) discussed four habits that physicians should adhere to for ensuring the creation of an environment that favors shared decision-making. The scholars argued that physicians must “invest in the beginning” by establishing rapport with the patients and by eliciting the patients’ concerns. Second, the physicians should “elicit the patients’ perspective” by assessing the ways that the treatment could affect patients’ lives and by identifying the requests of patients. Third, physicians must “demonstrate empathy” by acknowledging patient concerns through both verbal and nonverbal displays of empathy and by responding to patient emotions. Finally, physicians should “invest in the end” by providing information to patients and by sharing in planning and decision-making with patients. These behaviors should promote shared decision-making from the providers within the medical encounter.

Within the shared-decision-making model of healthcare, patient participation has emerged as one of the most important aspects of the medical encounter concerning patient health outcomes. Street (1991) articulated that for patients to fully participate in a medical encounter, they must be able to express their beliefs, concerns, and hopes for the consultation with their medical providers. Roter (1977) indicated that patients who participated in the medical encounter were typically more satisfied with their perceived healthcare. Street and Millay (2001) defined patient participation as “the extent to which patients produce verbal responses that have the potential to significantly influence the

content and structure of the interaction as well as the health care provider's beliefs and behaviors" (p. 62). Patient participation within the medical consultation is assessed by both the frequency of the interaction of the patient with the provider and the type of interaction that the patient engages in with the provider. Street and Millay (2001) stated that consistent with existing research, patients overall participate far less in patient-physician interactions than do medical providers. In fact, the scholars revealed that patient communication typically only accounts for about 25% of the communication within the medical encounter. Thus, patients must be persistent in their communication efforts and providers must be vigilant to elicit desired patient responses within the medical encounter.

Partnership building is another component of patient participation in medical consultation. Street and Millay (2001) stated that partnership building is defined as "communicative acts that encourage patients to discuss their opinions, express feelings, ask questions, and participate in decision-making" (p. 66). The scholars revealed that participation building not only provides patients a voice within the medical encounter, but partnership building also yields greater health outcomes for patients who believe they are participating actively in their own healthcare. Arora and McHorney (2000) claimed that while some less educated patients may take a more passive role in their healthcare, other more educated patients preferred to be more active by asking more questions and by readily voicing their opinions and concerns.

In shared decision-making during medical encounters, Heisler, Bouknight, Hayward, Smith, and Kerr (2002) explained that patient perceptions of the physicians' communicative style is directly related to patient self-management of an illness. The

scholars argued that the more capable the physician was in facilitating participatory decision-making by providing patients with sufficient information, asking questions of patients, and including patients in medical decision-making, the more likely patients were to perceive higher levels of self-maintenance for their illnesses.

In cases of medical encounters during pregnancy, Matthias (2010) investigated the willingness of obstetricians to engage in shared decision-making with their pregnant patients. She revealed that although providers appeared to be forthcoming in wanting women to participate in decisions about their health, the providers often used language laden with power dynamics during medical encounters with patients. The use of certain word choices and specific language may contribute to perceived intimidation by physicians and could reveal that providers may be less than willing to acquiesce much of the decision-making responsibility to their patients. Matthias (2010) explained that midwives are far more likely to engage female patients in medical decision-making than are physicians.

### **Power Dynamics and Decision-Making**

In perfect enactments of shared decision-making, patients and providers should exert equal amounts of influence over the interactions and should be able to have their desires, concerns, and fears considered equally. However, given that power imbalances exist inherently within medical encounters, the potential for decision-making to either be inequitable, or the potential for attempts at shared decision-making to result in power struggles is likely. According to Beisecker (1990), power is defined as “the probability that persons within a social relationship will be able to carry out their will despite resistance” (p. 105). Additionally, because physicians perform procedures or provide

treatment needed by patients, Beisecker claimed that physicians actually maintain legitimate, referent, and expert power in the medical consultation. Especially in the context of information-providing, physicians can maintain much power through refusing to provide complete information to patients.

Many medical professionals are keenly aware of the potential for such drastic power dynamics within medical encounters (Mostow et al., 2010). Some communication training programs for medical students and residents encourage providers to consider the power dynamics present in encounters by paying attention to both verbal and nonverbal communication from patients and by eliciting input from patients. Providers are encouraged to not talk over the patients, but to be sensitive to their desires and concerns.

In terms of patient power displays, Beisecker (1990) stated that more educated patients are typically more likely than less educated patients to formally resist or challenge physicians' suggestions for treatment. Many patients resist by refusing to adhere to recommended treatment by physicians (Tarn et al., 2008). Additionally, patients do not always voice their concerns or frustrations directly toward the physicians who are providing care. When they do, however, patients rarely match physicians' level of assertiveness, pitch, or volume (Stimson, 1974).

Although power favoring the physicians within the medical encounter is often the norm, not all medical encounters reveal an asymmetrical power dynamic that favors the physicians. Also, patients may sometimes actively resist the advice of their providers. Stivers (2005) found that when considering their children's diagnosis and treatment by physicians, parents may engage in active, overt participation with physicians, regardless of whether or not the medical physicians implicitly invite the parents to engage in



decision-making. And at times, parents are quick to voice their disagreement with the diagnosis or with the course of the treatment directed by the providers.

Similarly, there are times in patient-provider encounters when patients attempt to dictate their own medical care, and often providers feel pressured to respond to such requests because of the threat of legal recourse that could result. Real, Bramson, and Poole (2009) discussed the sources of identity construction for medical providers. While the scholars noted that many physicians construct their professional identities in light of the helping and healing relational nature of medicine, others may position the patients as opponents. The scholars articulated the importance of medical providers resisting the temptation to view patients as opponents, especially in light of potential litigation and malpractice suits that may result from patient-provider communication. Because of their previous clinical experiences, some physicians have admitted they must be guarded against patients who have the capacity to potentially harm their practices. The fear of litigation and malpractice is very real for many physicians who must treat patients with caution given the litigious environment surrounding the medical field. Obstetrics and gynecology are notoriously known as litigious disciplines in medicine (Tussing & Wojtowycz, 1997).

Although physicians may become frustrated or apprehensive when patients choose to take decidedly active roles in their own medical care, patients are, nonetheless, well within their rights to do so because of understood autonomy. Patient autonomy, or the right of patients to make independent medical decisions and request and/or refuse medical treatment, must be respected by attending physicians (Entwistle, Carter, Cribb, & McCaffery, 2010). Quill and Brody (1996) claimed that physicians can enhance patient

autonomy as they “engage in open dialogue, inform patients about therapeutic possibilities and their odds for success, explore both the patients’ values and their own, and then offer recommendations that consider both sets of values and experiences” (p. 765). Further, the scholars argued that the model of enhanced autonomy empowers patients to make their own decisions because “accepting the physician's power to offer recommendations—while obligating the physician to fully understand the patient's reasoning when those recommendations are rejected—enhances rather than reduces the patient's power and competence” (p. 765).

Implicit in misperceptions about patient autonomy is the assumption that patients are unable to make informed decisions for their healthcare. Discussions of patient autonomy certainly must be accompanied by a consideration of patient informed consent. According to Krumholz (2010), when patients are considering elective procedures, they need to be educated about the potential risks and benefits in order to make fully informed medical decisions. The scholar claimed physicians must discuss “risks, benefits, alternatives, experience, and cost—providing the minimal information patients require to make challenging decisions and to facilitate meaningful discussion with physicians” (p. 1190). Physicians must fulfill a moral obligation by supplying patients with substantive information regarding elective interventions and risks and benefits of alternative procedures so that patients might participate in informed decision-making.

Vos, Anthony, and O’Hair (in press) presented narratives from both pregnant and post-partum women regarding the nature of decision-making with physicians. In reflecting on their experiences, the patients pointed out the existence of both provider-favoring and patient-favoring power imbalances. Some women argued they had

demanded their providers induce them early because they were uncomfortable or simply because they wanted the convenience of an early induction. Although some providers eventually acquiesced and granted some elective inductions, other women reported that despite their demands, they were encouraged by their obstetricians to wait for labor to begin naturally. Alternatively, Vos et al. (in press) reported that some women were actually encouraged by their providers to pursue elective inductions.

Patient education programs and pregnancy centering classes have actively encouraged pregnant patients to resist physicians' suggestions to induce labor early because of conveniences accrued by the procedure (Simpson, 2012). On the other hand, scholarship has documented the experiences of obstetricians who feel pressured by their patients to perform elective interventions in pregnancy. Patient demands often result in physicians fearing the legal repercussions that could occur (Moore & Lowe, 2012). The final component of the current study is to assess the perceptions of physicians concerning the nature of decision-making with patients, particularly decision-making regarding elective interventions. In light of the scholarship which focuses on decision-making dynamics between patients and their providers, the following research question is posed:

RQ3: What is the physician-perceived nature of decision-making with patients surrounding delivery decisions?

### **Summary**

The current literature review considers the theoretical applicability of message convergence, not only in the experience of health and uncertainty, but specifically in understanding the ways in which medical providers make sense of competing messages. Many competing messages exist because of complex risks inherent in elective

interventions in labor, including elective inductions and scheduled cesarean deliveries. An explication of the scholarship surrounding physician uncertainty, evidence-based recommendations, and physician information-seeking has been provided. Additionally, the literature review provided an overview of the various models of medicine in patient-provider encounters, shared decision-making, and patient provider communication. The exhaustive examination reveals an assessment of the actual communication that occurs in medical interactions in which women and doctors determine delivery decisions. The following chapter discusses the methodological approach of the current study.

## CHAPTER THREE: METHODS

This chapter details a study design which addresses the communicative role of medical physicians who a.) make sense of a large body of medical information in an effort to counsel their patients and b.) engage in decision-making with their patients surrounding delivery decisions. Little research has been conducted to examine the ways that physicians understand the risks surrounding health concerns when multiple and often competing sources are present. Additionally, few studies have considered the actual voices of medical providers, not reports from patients or opinion pieces, concerning their perceived communicative role in engaging in decision-making with their patients' delivery decisions. Given the formative nature of the current study, a qualitative inquiry of the perceived communicative role of physicians is appropriate. The current study proposes three research questions:

RQ1: How does the process of message convergence manifest among obstetricians who must make sense of competing medical literature when advising patients?

RQ2: How do physicians function as conduits of convergence within the medical encounter?

RQ3: What is the physician-perceived nature of decision-making with patients surrounding delivery decisions?

The first research question stems directly from message convergence theory by assessing the degree to which message convergence plays a role in the way obstetricians make sense of multiple arguments in medicine. The second and third research questions expand the message convergence theory as it has been applied in the past to consider the role of

physicians as conduits of convergence who must present their opinions of the best medical practices offered to patients. Further, the current study contributes to understanding the perceptions of physicians concerning decision-making with patients regarding delivery. Thus, the current dissertation is a formative inquiry concerning the communicative role of medical providers involved in counseling expectant patients and their collaboration with them regarding delivery decisions.

### **The Interpretive Paradigm**

The three research questions introduced are examined from an interpretive perspective. Lincoln and Guba (1985) offered several characteristics of an interpretive inquiry that differentiate interpretive work from the positivist and post-positivist traditions. First, the scholars indicated that in terms of an ontological approach to inquiry, multiple realities exist and can be observed through an interpretive inquiry. Second, they claimed the researcher and those that she chooses to study are mutually influenced by the other. Third, interpretive inquiry is not intended to produce generalizable results in the sense of a positivist understanding of the word. Rather, a qualitative inquiry reveals truth(s) about the scene being considered. Fourth, unlike the inquiries of positivists and post-positivists, the intention of the interpretive inquiry is never to establish causal relationships. Finally, the scholars stated that inquiry in the interpretive paradigm is value-laden by its very nature. Inquiry is influenced by the values of the researcher, of the paradigm, of the theoretical underpinnings, and of the values of the scene being investigated.

## **Qualitative Interviews with Obstetricians**

The current study consists of in-depth interviews with obstetricians ( $N=28$ ) concerning their roles in women's delivery decisions. The focus on the roles of physicians in the decision-making process with their patients is being examined because historically, it has not been adequately investigated. According to Lindlof and Taylor (2011), qualitative interviews provide six advantages to scholars. First, they allow the researcher to understand the social actor's experience, knowledge, and worldviews. Second, in-depth interviews allow the researcher to elicit the specific language choices and forms from the interviewees. Third, in-depth interviews enable the scholar to gather information about things or processes that cannot be observed effectively by other means (i.e., through a survey). Fourth, in-depth interviews allow the scholar to inquire about the past with the participants. Fifth, in-depth interviews provide the scholar with the opportunity to ask participants to verify, validate, or comment on information obtained from other sources. Finally, qualitative interviews enable the development of efficiency with data collection because of the purposive sampling strategy that many scholars employ (Lincoln & Guba, 1985).

Lindlof and Taylor's (2011) guidelines for conducting informant interviews guided the investigation surrounding the role of physicians in women's delivery decisions. The scholars indicate that informant interviews "inform the researcher about the scene- the scene's history, customs, and rituals; the local 'lingo;' the identities and actions of the key players and so forth" (p. 177). Further, Lincoln and Guba (1985) explained how in-depth interviews are helpful for "obtaining the then and now constructions of persons, events, activities, organizations, feelings, motivations, claims,

concerns, and other entities” (p. 268). The nature of the proposed study is to assess not only the ways medical providers make sense of competing claims of information, but also the ways they counsel their patients. An inquiry firmly situated in the interpretive paradigm can help provide the researcher with descriptive data and is especially meaningful for formative research (Lindlof & Taylor, 2011). Thus, qualitative interviews were conducted and are appropriate and essential for a study of this nature.

### **Participants**

For the current study, 28 obstetricians within the state of Kentucky were interviewed regarding their communicative role within women’s delivery decisions. The sample consisted of 14 male physicians and 14 female physicians. Of the 28 physicians interviewed, four were Caucasian doctors, two African American doctors, one Indian American doctor, and one Hispanic doctor. Among the participants, years of practice in the field of obstetrics ranged from 3 to 47 years with a mean of 17.89 years. Additionally, of the sample, 11 physicians reported to be in private practice, 10 providers reported to be hospital-employed obstetricians, and 7 physicians reported to be maternal-fetal medicine specialists or high-risk perinatologists. The interviewees indicated they practiced medicine in various regions across the state of Kentucky. The majority of the participants currently practice in the Lexington, KY and Louisville, KY areas, and the remaining physicians in the sample practice medicine in Ashland, Florence, Frankfort, Morehead, and Paducah, KY.

The inclusion criteria for the study specified that physicians must currently practice or have practiced in the last 12 months within the state of Kentucky. Since hospital and medical records within the Commonwealth indicate the number of elective



inductions of labor and scheduled cesarean deliveries are much higher than the national average (March of Dimes, 2012), Kentucky proved to be a fertile landscape for causal investigation. Currently, the state of Kentucky has been assigned a grade of “D” from the March of Dimes because of excessive elective inductions of labor and scheduled cesarean deliveries. For this reason, the sample consists solely of obstetricians who currently practice medicine within the state of Kentucky in an effort to better understand the communicative role of the obstetricians and the influence they wield with their patients.

### **Recruitment Procedures**

Once approval from University of Kentucky Institutional Review Board was received, recruitment letters were faxed or emailed to obstetricians across the state of Kentucky. The researcher compiled a list of private physician offices throughout the selected counties as well as a list of clinical physicians at community and research hospitals. The researcher then identified potential research participants through purposive sampling methods, or a “deliberate, purposeful, strategic sample” in which respondents are non-randomly selected on the basis of a particular characteristic” (Frey, Botan, & Kreps, 2000, p. 132). Additionally, once a physician took part in the current study, the researcher requested that the participant refer her to other obstetricians who might also be willing to participate. Therefore, snowball sampling was also employed.

Table 3.1

<i>Participant Characteristics</i>					
Participant	Sex	City	Type of Practice	Race	Years of Practice
Physician 1	Female	Frankfort	Private Practice	Caucasian	20
Physician 2	Male	Lexington	Private Practice	Caucasian	30
Physician 3	Male	Lexington	Private Practice	Caucasian	23
Physician 4	Male	Louisville	Hospital MFM	Caucasian	30
Physician 5	Male	Louisville	Hospital Generalist	Caucasian	32

Table 3.1 (continued)

Physician 6	Male	Louisville	Hospital MFM	Caucasian	21
Physician 7	Female	Lexington	Private Practice	African American	3
Physician 8	Female	Lexington	Hospital Generalist	Caucasian	3
Physician 9	Male	Lexington	Hospital Generalist	Caucasian	4
Physician 10	Female	Louisville	Hospital Generalist	Caucasian	9
Physician 11	Male	Florence	Hospital MFM	Caucasian	24
Physician 12	Female	Lexington	Private Practice	Caucasian	12
Physician 13	Female	Lexington	Private Practice	Caucasian	15
Physician 14	Male	Paducah	Private Practice	Hispanic	23
Physician 15	Female	Ashland	Private Practice	Asian American	15
Physician 16	Female	Lexington	Hospital Generalist	Caucasian	23
Physician 17	Female	Louisville	Hospital Generalist	Caucasian	28
Physician 18	Female	Lexington	Hospital MFM	Caucasian	8
Physician 19	Male	Louisville	Hospital Generalist	Caucasian	47
Physician 20	Male	Louisville	Hospital MFM	African American	25
Physician 21	Female	Florence	Hospital MFM	Caucasian	11
Physician 22	Female	Lexington	Private Practice	Caucasian	16
Physician 23	Female	Lexington	Hospital Generalist	Caucasian	5
Physician 24	Male	Ashland	Private Practice	Caucasian	14
Physician 25	Male	Ashland	Private Practice	Caucasian	12
Physician 26	Male	Florence	Hospital Generalist	Caucasian	25
Physician 27	Female	Morehead	Hospital Generalist	Caucasian	5
Physician 28	Male	Lexington	Hospital MFM	Caucasian	18

### Data Collection Procedures

The majority of the interviews were conducted in-person ( $N=19$ ), and all in-person interviews occurred in physician offices. The remaining interviews ( $N=9$ ) were conducted over the telephone at the convenience of the physician. The interviews lasted approximately 33 minutes on average, and the interviews yielded 310 pages of transcripts. Once physicians consented to participate in the study, the researcher asked permission of each one to digitally record the audio of the interview. Then the researcher employed a semi-structured interview guide (Appendix A) for assessing the communicative experience of the provider. However, the guide was established flexible

so the interviewer and the interviewee were free to pursue additional topics that emerged within the interview (McCracken, 1988). The semi-structured interview guide was developed based on the propositions derived from the theoretical framework of message convergence, the literature surrounding elective procedures associated with labor and delivery, and the scholarship regarding shared decision-making and relational dynamics between physicians and their patients. The semi-structured interview guide was vetted by several health communication scholars and by an ACOG certified obstetrician.

Once the interviews began, the researcher was keenly aware to the ways in which participants responded to the semi-structured interview guide. Based on the emergent design of the study (Morrow, 2005), the researcher amended the interview guide as the interviews proceeded in an effort to be sensitive to the voices of the participants and the data. When physicians were asked specifics about the ways in which they make sense of information surrounding the treatment of their patients, they consistently referred to a higher-level of data. When asked about elective inductions and elective cesarean deliveries, they often claimed that their answer would ultimately depend on each individual patient. Thus, they tended to answer in more general terms.

### **Data Analysis Procedures**

The interview transcripts were audio recorded and were transcribed verbatim. The interview transcripts with physicians were evaluated using an “an etic analytic view” (Lindlof & Taylor, 2011). Lindlof and Taylor explained that an etic analytic view allows the researcher to evaluate qualitative data “through the conceptual categories provided by our disciplinary knowledge and theory” (p. 95). Two coders examined the data using a “template approach” interpreting the transcripts, while “remaining open to new

constructs, contradictions, and negative cases” (Iverson & McPhee, 2008, p. 181). The template was guided by the propositions of Message Convergence Theory and extant literature surrounding medical decision-making between patients and physicians.

For the data analysis procedures, both coders first read all of the transcripts in their entirety to become familiar with the data. Lindlof and Taylor (2011) argued that a “systematic” analysis of qualitative data begins with the development of categories and a coding scheme for the data. Lindlof and Taylor differentiated between category and code by arguing that a code serves to “characterize the individual elements constituting a category” while a category is “devised as to enable the researcher to define and explain the underlying meanings of these elements” (p. 248). In order to provide guidelines that encourage consistent coding of the transcripts, the methodological recommendations of Saldaña (2009) and Glaser and Strauss (1967) were observed. According to Saldaña (2009), “A code is most often a word or short phrase that symbolically assigns a summative, salient, essence-capturing and evocative attribute for a portion of language based-data” (p. 3). Saldaña argued that coding is not a precise science, but rather is an interpretive act. Coding not only reduces data, but condenses it as well.

After becoming familiar with the transcripts, the coders met to determine the provisional codes that would be employed in the data analysis. Saldaña (2009) claimed provisional coding is “appropriate for qualitative studies that build on or corroborate previous research or investigations” (p. 121). He claims that provisional codes should be developed from “preparatory investigative matters” including literature reviews, research questions, existing scholarly findings, and researcher hunches. In the current study, the two coders discussed and agreed upon a “lean list” of provisional codes. Although

provisional coding is deductive in nature, in maintaining the “template approach” to coding, the coders also remained open to constructs that emerged inductively from the data analysis that were not previously identified as a provisional code. The coders then coded the data according to the established provisional codes while simultaneously engaging in open-coding for emergent categories.

Once the first cycle of coding was complete, the coders met again to discuss the categories derived from provisional coding and to discuss the second round of coding. Lindlof and Taylor (2011) recommended that once researchers have coded the data during the initial cycle of coding (provisional coding), researchers must then conduct a second cycle of coding in which the data are integrated into greater themes. Lindlof and Taylor (2011) recommended axial coding as an approach to the second cycle of coding for integrating the data. According to Saldaña (2009), axial coding enables the scholar "to reassemble the data that were split or fractured during the initial coding process" (p. 159). In other words, axial coding is employed to “bring previously separate categories together under an overarching theory or principle of integration” (Lindlof & Taylor, 2011, p. 252). Therefore, based on the categories they agreed upon during the provisional coding, the coders engaged in axial coding to organize the categories into collapsed themes. During this coding phase, the coders “examined each construct –again by a constant reference to the incidents that make up the construct- and try to tease out the key variations” (p. 252). Any disagreement in collapsing the themes was resolved through discussion between the coders.

Finally, the primary researcher organized themes and quotations into a manuscript. The second coder assessed the structure of the current study. Any

disagreements in the presentation of themes or quotations were resolved through discussion.

### **Data Interpretation**

Lindlof and Taylor (2011) argued that in the interpretation phase of data analysis, theory plays a major role in constructing and finalizing the researcher’s interpretation.

They articulate that theory enables scholars to “create and validate claims” (p. 267).

Similarly, Alasuutari (1996) stated:

Being theoretically informed means that one is reflexive toward the deceptively self-evident reality one faces in and through the data, able to toy with different perspectives to it, and that one is open to new insights about everyday life and society. (p. 375)

While interpreting the data of the current study, a constant and continual reference to theoretical propositions of Message Convergence and emergent theory was considered.

The researcher strove to ensure that current theoretical propositions guided the analysis while paying close attention to any additional phenomena that emerge from the

“template” approach to the data (Iverson & McPhee, 2008). The researcher also identified and presented several negative case analyses in chapter 5.

Table 3.2

*Qualitative Thematic Categories*

Category	Thematic Category	Key Terms	Characteristic Quotations
RQ1: How does the process of message convergence manifest among obstetricians who must make sense of competing medical literature when advising patients?			
Proposition One	Managing Competing Arguments in Medicine	Collegial physicians, ask for assistance	I’ve got very good partners, so we tend to work collaboratively. So if there’s an obscure medical issue or something that’s outside of our usual protocol, we will email and get a team vote.

Table 3.2 (continued)

Proposition Two	Overlapping Messages and Convergence	Expert opinion, consensus, overlap of messages	When multiple sources recommend the same plan of action, it lends credence to its selection.
Proposition Two	Participatory Convergence	Physician uncertainty, patient preferences, patient as source	With all of my years of experience, and my gut feeling and science, I don't know which way is the best way to go. So it's whichever one you [the patient] feel best about."
Proposition Three	The Nature of Convergence over Time in Medicine	Reconsider, re-evaluate established convergence	That has certainly happened in the past in medicine where people have all gone down the same road by consensus and that road has been wrong. So we need to be careful.
RQ2: How do physicians function as conduits of convergence within the medical encounter?			
Conduits of Convergence	Correct Misinformation Patient Counseling	Incorrect information, online sources Education, health literacy	There's lots of stuff on the Internet, but as you know you've got to be careful. So it is dispelling myths, I think is what pre-natal care could do. It's also a time where you can capture women to teach about health in general because, as you know, health literacy is very poor.
RQ3: What is the physician-perceived nature of decision-making with patients surrounding delivery decisions?			
Scenario One	Patient requests for elective interventions and physician acquiescence	Patient autonomy, control, consumerism, informed consent	That discussion would often involve the risk of either route. My personal approach would be to emphasize that this is one of the few situations in medicine where it is truly the patient's choice. You pay your dollar and you take your choice. Which risks do you want to take on and which risks don't you want to take on?
Scenario Two	Patient request and physician refusal: Requests that harm	Bad medicine, selfish patients, Uncomfortable, tired patients	Hey, you're asking me to put myself at risk for being thrown off the medical staff if I do what you want me to do. I can't do it
Scenario Three	Patient refusal of provider recommendations: Physician frustration	Frustration, discomfort, feeling helpless	I told her, ' I really don't feel comfortable with this. But that's fine.' It is fine. She chose another avenue. I have to live and practice what my ethical standards are

## Conclusion

In summary, the current study involves an interpretive investigation to understand the ways in which physicians make sense of multiple arguments when managing patient care. Further, the current dissertation also reveals a significant awareness in the medical community of the perceived communicative role of obstetricians in the formation of

delivery decisions with their patients. Responses garnered from in-depth, semi-structured interviews promote an understanding of the ways in which physicians make sense of the risks surrounding delivery decisions and the resulting rationale they use to counsel their patients. Data analysis techniques adhered to establish approaches to qualitative inquiry.



## **CHAPTER FOUR: MESSAGE CONVERGENCE AND MEDICINE**

The objective of the current qualitative research is to obtain the voices and experiences of medical providers who must consider patient care through managing medical guidelines and recommendations. This chapter explores themes and key findings that emerged as a result of participant responses to a standardized interview protocol based on the propositions established by Perelman and Olbrechts-Tyteca (1969). Each physician was assigned an identification number, not only to protect the anonymity of the participants, but also to establish that all the voices of the participants have been included in the analysis. The chapter examines the ways that physicians manage large amounts of information and multiple sources to provide care to their patients. Specifically, the chapter provides examples of applications of propositions of the message convergence theoretical framework through medical decision-making by physicians.

This chapter explores the themes revealed within the data based on the propositions of the message convergence framework as advocated by Perelman and Olbrechts-Tyteca (1969). The themes discussed within this chapter include Level A evidence-based recommendations and message dominance, the frustrations by obstetricians concerning the “gray areas” of obstetrics in which evidence-based recommendations do not exist, physician strategies for managing competing messages in “gray areas” of obstetrics, and the role of collegial physicians in helping sort and interpret competing messages. Further, message convergence among physicians is discussed both at the organizational level in terms of “expert consensus” and also at the individual level. The disintegration of convergence, or the third proposition of message convergence is also considered in the context of physician discussions of changes in recommended

practice over the years. Finally, the results section of the chapter concludes with a discussion of the proposed term of “participatory convergence,” or message convergence that occurs when obstetricians consider the desires of their patients to help confirm or disconfirm potential treatment routes. The chapter concludes with a thorough examination of the results.

### **Evidence-Based Medicine and Clinical Practice**

When asked about the ways that providers make decisions concerning patient care, the resounding answer from the obstetricians focused unequivocally on evidence-based medicine. Across the interviews, the physicians argued that evidence-based medicine equips physicians with the data necessary for assessing patient needs and for making research-based healthcare recommendations. Physician 9 stated that evidence-based practice “means that when there is evidence, that you’re using that evidence to sort of give recommendations.” Similarly, Physician 5 stated that evidence-based medicine requires physicians to “analyze the evidence with specific issues, and use that evidence to guide the decisions and recommendations we make in clinical practice.” The physicians overwhelmingly reported that evidence-based medicine provides them with research-based recommendations that promote the most effective clinical practices possible. The physicians articulated that they can proceed with “certainty” and “confidence” when extensive research, specifically double-blind experimental trials, has provided data that reveals empirically the best approach, either from a patient health or cost perspective, for providing care.

**Levels of evidence.** Physicians noted that there are three levels of evidence-based medicine. Level A evidence, which is typified by double-blind experimental trials, is

considered the most methodologically rigorous studies, yielding the most robust and compelling evidence. Beyond Level A evidence, Levels B and C, which the physicians described as cohort studies and retrospective studies, are not considered as rigorous and thus not as convincing as Level A evidence. In the absence of Level A data, physicians report that Level B and Level C evidence are still useful in providing data to the providers, but Level B and Level C evidence by no means carry the clinical practice weight of Level A evidence. Physician 23 clearly made this point as he expressed his thoughts:

Evidence-based means making our medical decisions based on what the medical literature supports as level 1, level 2, and level 3. We would like to base our decisions on not necessarily retrospective trials, but prospective randomized trials that provide us the best information about the treatment and outcome.

Similarly, Physician 21 claimed that in order to provide the best possible care for her patients, she must make sense of varying levels of evidence-based medicine. She stated:

Understanding where the evidence came from and how it was conducted, where the conclusions of a study came from, and how they were arrived at, seeing if my patient fits into the category or fits enough that I can, in terms of my medical knowledge, draw the same conclusion.

Several physicians voiced their belief that simply because published evidence exists concerning certain medical topics, obstetricians should be wary and approach lower levels of evidence with caution. They warned that some study results may not necessarily yield the best course of action for their patients. Physician 8 discussed her ideas on moderately trustworthy evidence:

I think you have to be really careful about that because especially in pregnancy, there are not a lot of randomized control trials and there's not a lot of intervention studies because of safety concerns. A lot of information that you get is from retrospective cohort studies. And so I think you can use that evidence. You can use the conclusions. You just have to be aware that because it's not like mechanism studies where they're drawing a distinct line from A to B to C. They're making associations and you have to decide if your patient fits into those categories.

Published data enables the providers to make sense of certain scenarios. However, Level A evidence is considered most rigorous, and as the physicians reported, it weighs more heavily in their medical decision-making than do the other levels of evidence.

**Standard of care.** Beyond enabling physicians to make strong, data-based recommendations of care for their patients, evidence-based medicine is considered the paragon for good practice, or the standard of care, that physicians should follow. Within their own personal practices, the physicians expressed the belief that evidence-based medicine guides them in decision-making so they are able to make the most appropriate and ethical recommendations to their patients. Physician 2 claimed that practicing evidence-based medicine means, "Practicing medicine in the confines of what's acceptable, proven, and ethical." Similarly, Physician 2 acknowledged that evidence-based medicine serves as a "good base" for making medical decisions, and although she may need to tweak the specifications of the recommendations to treat her individual patients, evidence-based medicine provides the basis for the standard of care so that physicians are able to work from a similar foundation. She argued that evidence-based

medicine, “is the establishment of this home protocol of good medicine, and if you go outside of that, for goodness sakes, have a good reason. Don’t go ‘willy nilly’ and do what you want. Have a good reason.” Thus, she claimed that not only does evidence-based medicine provide a sense for the physicians of what is “good medicine,” but evidence-based medicine should also constrain individuals from practicing medicine without good justification.

Physician 12 also reported that evidence-based guidelines not only help her manage uncertainty when practicing medicine, but they ensure that physicians practice according to the standard of care established within the medical profession. Evidence-based medicine enables practitioners to align their practice in accordance with the precedents established by other providers, rather than doing something completely unsupported. Although there are times when evidence-based medicine does not exist for certain concerns or topics, Physician 12 said that when it is available, the evidence-based medicine guidelines are helpful in promoting and maintaining consistency in obstetrical care:

I would say that they [evidence based medicine guidelines] do help you manage uncertainty...It gives you a nice backbone so you’re not doing something crazy and wrong. You know, I want to have other people backing me up with the appropriate management and appropriate care.

The medical providers acknowledged that not only does evidence-based medicine enable them to practice medicine with confidence based on rigorous empirical testing, the guidelines also equip physicians with the knowledge of practices that are considered the standard of care within obstetrics. The providers also stated their appreciation for the

guidelines which establish the boundaries of what is acceptable and ethical versus practices that are not considered appropriate.

**Evidence-based medicine: What it is not.** Alternatively, Physician 3 discussed both what evidence-based medicine is and what it is not by claiming, “We don’t do things based on anecdotal evidence. We don’t prescribe medications or do procedures until there’s adequate [experimental] trials that have been done to prove that it is valid.” In addition, Physician 10 expressed her perception of the confines of evidence-based medicine: “Treatment decisions made on the basis of data. Not my personal experience, not expert opinions, but data that objectively show the outcome of an intervention of the risks and benefits of an intervention.” Additionally, Physician 22 stated that evidence-based medicine “means that you don’t do something based on the way you were trained, what the resident above you did. You do it based on what has been studied in the literature, peer reviewed journals, testing, one method versus another and which one has turned out to be best.” The physicians pointed out that evidence-based practice is not based upon a provider’s past experiences, training, or anecdotal evidence, but upon evidence that is derived from rigorous scientific inquiry.

### **Evidence-Based Medicine and Message Dominance**

In the context of message convergence, evidence-based medicine that is deemed Level A evidence, appears to function in a manner of dominance. Once Level A evidence has been published and researchers agree that the study is reliable and valid, practicing providers will then have reliable guidelines to follow and employ in their practices.

Physician 6 explained how such standards emerge:

Well, when it becomes clear that one way is the best way then everybody does that and that becomes the standard of care. This is when something becomes the safest and has the best outcomes and least risk then that becomes the standard of care once enough evidence-based medicine, or once enough evidence is accumulated regarding a certain topic.

As Physician 6 explained, once enough evidence is accumulated on a topic that reveals that one method or mode of practice is better than another, then that becomes the standard for the field. And as long as evidence-based recommendations exist for a certain concern or question within obstetrics, providers tend not to seek additional evidence or explore other modes of seeking information. Physician 19 argued that once strong data and evidence necessitate guideline changes, he believes that individuals must comply and change their practices, regardless of the ways they have practiced in the past. He claimed:

I think it's helpful because the information when you're practicing, you do things a certain way, because that's the way you're taught or that's the way you've learned; that's the way previous information has led you. If there's some situation, there's new evidence; it's going to alter your practice based on the new evidence.

Similarly, Physician 20 articulated his belief that evidence-based medicine is good, nearly irrefutable science that justifies a particular course of action. He said "evidence-based practice means that the treatment, the prescribed treatment, is based upon good science. So there have been studies of a sufficient level to justify the treatment." Thus a sufficient level of research and inquiry have lead physicians to determine clearly that one approach to treatment is superior to another.

Additionally, Physician 15 discussed evidence-based medicine as guidelines that have been based on data. He claimed that once medical scholars have concluded that one method of treatment is superior based on robust data, then evidence-based guidelines emerge. He stated:

Evidence-based practice is when we have done research and the research has said this is the way we should do because they have calculated the data and concluded that this is the way it should go, the management; it is called evidence-based practice.

When evidence-based recommendations are published that are based on the highest level of scientific inquiry, the physicians argued that the evidence reveals unquestionably that one method of treatment is superior to another.

Evidence-based medicine functions as message dominance in the framework of message convergence. Evidence-based medicine is advocated by governing medical bodies, including ACOG and the Society of Maternal-Fetal Medicine (SMFM) as being the unequivocal paragon of medical treatment based on the data and scientific method employed to reach the results. When such guidelines are recommended, other arguments seem to carry little weight against the recommendations based on Level A evidence.

### **Making Sense of Medicine in the Absence of Evidence-Based Recommendations**

Despite the desire of the physicians to be as evidence-based as they possibly can, the physicians articulated that within the field of obstetrics, as compared to other fields of medicine, many issues exist surrounding procedures and interventions for which evidence-based medicine is unavailable. Providers acknowledge that this lack of evidence-based recommendations in obstetrics is due in part to either the fact that



research has not been conducted, or because the research is too risky to conduct when the necessary subjects are pregnant women. Whatever the reasons for the lack of credible research and evidence-based recommendations, the physicians agreed that there are many “gray” areas in obstetrics. Further, several physicians acknowledged that “gray areas,” present multiple arguments concerning how to treat patients. For instance, Physician 10 explains, “For obstetrics, there are a lot of situations where there is never going to be evidence about the problem in front of you.” Also, several physicians revealed their sentiments surrounding an obvious lack of evidence-based recommendations in the field of obstetrics. For example, Physician 24 stated:

Unfortunately in the practice of obstetrics there isn’t a whole lot of evidence-based practice because clinical research in pregnant women is a very difficult task. Finding ways to have control groups and intervention groups in obstetrics is difficult. I don’t know if it is liability issues, but nobody seems to want to perform double-blinded placebo trials looking at pregnant women.

Physician 24 argued that the nature of the field makes conducting clinical trials on pregnant patients difficult because of the inherent legal concerns associated with caring for and possibly harming pregnant patients or their babies. In the absence of these clinical trials, Level A evidence is unobtainable.

Physician 27 agreed that the absence of evidence-based medicine is “unfortunate.” Specifically, Physician 27 discussed the absence of evidence-based medicine in some areas of obstetrics, and the ways that providers must practice medicine in the absence of these recommendations:

You can't enroll pregnant people in a lot of studies because the IRB's won't approve those because they're a vulnerable population and then there's like a lot of legal aspects of maternal versus fetal health. So, unfortunately a lot of the information we use in obstetrics is expert-based instead of actual randomized control trials.

Additionally, Physician 17 discussed the difficulties of trying to base her clinical practice on evidence-based medicine recommendations when such guidelines are missing from the literature. She stated:

Unfortunately, there are a fair number of areas in obstetrics where there is no evidence yet, where those studies have not been done, which makes it hard to practice totally evidence-based medicine.

Not only does this provider acknowledge that the field of obstetrics has a number of areas in which there are no evidence-based practice guidelines, she claimed that the absence of the guidelines makes it impossible for providers to be completely evidence-based.

Similarly, Physician 22 also discussed the lack of evidence-based guidelines within the field of obstetrics. She stated:

There are a lot of things that we do that are not evidence-based medicine. There's a lot, especially in obstetrics because people have been delivering babies without any medicine, and then we [obstetricians] come into the picture. Most of the things that we did to begin with were not evidence-based, but were anecdotal. This is what works so we keep doing it. There's still hundreds of things that haven't been studied, but we still do them anyway.

Physician 22 acknowledged that beyond the risk of subjecting pregnant patients to medical trials, there are simply areas in obstetrics where practices have been performed routinely and consistently for years without evidence-based medicine to justify the practice. Therefore, practicing complete evidence-based medicine may never come to fruition within the area of obstetrics.

**Being careful with Level A evidence.** In the midst of the discussions that positioned Level A evidence as the paragon for the standard of care for obstetricians, Physician 26, a seasoned maternal-fetal medicine specialist stated that even in the presence of the strongest evidence, physicians still must be able to interpret the data and assess whether or not it is applicable to the individual patient. He said:

If you rely entirely on subjectivism or if you relied entirely on strict guidelines, you might miss the boat with an individual patient. Because when you deal with a patient, it is too granular rather than categorical. And with evidence-based medicine, it's very categorical, so you've got to make sure the patient that you're dealing with or the situation or circumstance you're dealing with actually fits the category.

Although the providers described evidence-based medicine as the gold standard for treating patients, Physician 26 explained that even when evidence is available, providers must be careful and thorough to assess whether or not their patients fit into the categories specified by the research. And in the situations where a patient does not fit well into the evidence-based research, the provider must then seek alternative methods for treating the patient. Physician 12 confirmed this point as she pointed out that there are times when her patients don't necessarily fit well into the narrow confines of the Level A evidence and

recommendations that result from that evidence. In those cases, she is simply unable to practice strict evidence-based medicine. She stated:

Not every patient fits into the “definitely do this, definitely do that” camp. And I just have to use my instincts on which argument I think I should go with based on this patient’s personality, this person’s physical exams, this patient’s lab data; then I’m probably going to go with this camp and do this. I guess I use my gut instinct. I depend on that in times of conflicting information. I make a decision and I go with it. If I’m wrong, I’m wrong.

Physician 12 articulated that in the midst of uncertain situations, she relies on her “gut instinct” to help her make difficult decisions, particularly when her patients don’t fit within the parameters of evidence-based recommendations.

When the clinicians pointed out that there are few clear, evidence-based recommendations for certain areas in obstetrics, the providers claimed that in those situations, they rely heavily on expert consensus or committee opinion that is backed by either ACOG or SMFM. The following section examines in depth the reliance of physicians on committee opinion and expert opinion when data from extremely robust clinical trials is unavailable.

### **The Importance of Multiple Sources when Managing “Gray Areas” in Medicine**

When questioned about the ways they manage the “gray areas” of obstetrics, or the areas of the discipline that are void of practice guidelines, the physicians reported that they have several strategies for handling such situations. First, the physicians revealed that they typically seek information from multiple sources when trying to make sense of the best way to treat patients in the absence of recommended guidelines or when patient

comorbidities exist. The physicians articulated that seeking out multiple sources ensured they would obtain a more comprehensive understanding of the situation. They also emphasized in their responses that employing only one source for seeking medical information could prove to be insufficient. In fact, one university physician said the danger in using one source is that, even in medicine, the source could be wrong. He stated:

My dad, who is a doctor, was addressed by then editor of the New England Journal of Medicine who said, “We have a pretty good journal. The problem is that 50% of what we publish in our journal is wrong. The problem is that we don’t know which 50%.” So there is no one source of truth, unfortunately, in our business... If you read the sources closely, they aren’t all saying precisely the same thing.

Other physicians acknowledged that medical literature doesn’t always say the same things, despite the presence of evidence-based guidelines. As a result, collecting information from multiple sources enables doctors to make sense of potentially interacting messages within the literature. For example, one private practice physician claimed that looking for information from multiple sources is incredibly helpful because:

Sometimes there’s not always a consensus in the literature. There may be one study pushing for vaginal birth after cesarean and one study that says we should do the repeat section. I also think that having other colleagues, high-risk colleagues, and getting their opinion is really helpful.

Beyond acknowledging that there is not always a consensus in the published medical literature, Physician 11 acknowledged that obtaining multiple sources helps manage the biases that are implicit within the literature. He stated:

The challenge of trying to say that there is any one source [that is correct] is that most of the sources have an established bias, so you can't really trust one source because they're going to present the picture the way they want, and you need to use multiple sources so you're not led down the wrong path. For example, a lot of people want to use ACOG as their kind of go-to reference, but the problem is that ACOG is designed to set the minimum or the basic standard that would be acceptable to anyone in the country. But I don't plan on working at the minimum level of acceptable management. So I can't really use them as my end all, be all.

The provider acknowledged that limiting information to one source in medicine is simply unrealistic. The implicit biases among sources necessitates that providers observe multiple sources to ensure that the full understanding of the situation is conveyed.

Therefore, in the context of considering the ways that obstetricians make decisions and make sense of medical information both in the presence and absence of evidence-based recommendations, the following sections explore the presence of the propositions of the theoretical framework of message convergence. The propositions will be assessed in the ways that providers make sense of medical literature in the face of uncertain situations, and particularly, in the context of gray areas of obstetrical practice.

### **Proposition 1: Managing Competing Arguments in Medicine**

Upon acknowledging the field of obstetrics is replete with “gray areas” of research, or areas in which there is no Level A evidenced-based medicine to guide

physicians, the providers discussed ways in which they “make sense” of situations marked by uncertainty.

**Collegial physicians.** The most prominent strategy reportedly employed by physicians in the pursuit to make sense of competing claims is to seek the expertise of their colleagues in order to assess whether or not the information they have read or obtained is viable. Beyond their immediate colleagues or practice partners, the physicians reported that they seek advice from specialists within the field to obtain their opinions. For example, Physician 20 noted that he navigates unfamiliar medical scenarios by seeking information from published literature and by seeking help from both his colleagues and specialists within the field. He stated:

After I glean some basic information, sometimes it is just a condition that’s unusual that I’ve seen before, but there’s plenty of data out there that is going to be good enough. But if not, or if the data are conflicting, then the next thing I arm myself with is to talk to my colleagues to find out if they have any personal experience or any opinions as I start to formulate my plan. And if that’s not very helpful, and there happens to be some sort of thought leader in the nation or in the area, and it is controversial, or I just don’t know what to do, I will either email or try to call an outside physician.

In the absence of evidence-based medicine guidelines and expert opinion statements, many physicians collectively conveyed a course of action in which they make sense of uncertain situations replete with multiple arguments by seeking advice and help from fellow physicians. In fact, Physician 18 aptly stated that her mantra is to “talk to people who have more experience than I do and try to figure out what’s the best thing for the

patient.” Physician 11 reflected a similar course of action when he described the role that other members of his practice play in his decision-making. He stated:

I’ve got very good partners, so we tend to work collaboratively. So if there’s an obscure medical issue or something that’s outside of our usual protocol, we will email and get a team vote. And we include our fellows in that team vote.

In the presence of an obscure case, or one that is beyond the protocol, the physicians sometimes email their vote in terms of a potential treatment option for a patient.

Physician 16 stated:

So anytime you have a complex case, you’re going to get some competing recommendations and just understand that this is all Level C evidence, this is all experience and opinion, so you do your best, I guess. You try to do your best. But consults [with other specialists] are one of the ways that we handle that type of situation. And I usually figure it out over time.

Additionally, Physician 25 said he also reaches out to his partners in his medical practice and also approaches high risk perinatologists for help when he is unsure how to treat a patient. He explained that this is a fairly common practice for providing his patients the best care possible when evidence-based guidelines are unavailable. He explained:

There are three or four perinatologists that I would call or text in a moment’s notice and get some advice on what to do. And even being in practice now, since 1997, those times that we have to consult perinatologists, you know, are fewer and fewer as you develop more experience; but they’re still not infrequent that you call, and it’s not always the perinatologists, it might be one of my partners



that I would say, “What do you think about this? This is what I think I would do, but does this sound reasonable? Or would you do this?”

Therefore, the providers agreed that when they are trying to treat patients or cases that may be unfamiliar to them, they seek information from sources they trust. Not surprisingly, the doctors noted that the sources they tend to trust the most are colleagues, whether immediate partners or high-risk colleagues, who can provide information and help either confirm or disconfirm other sources or recommendations under consideration.

### **Proposition 2: Overlapping Messages and Convergence**

The second proposition of message convergence claims that “the more significant the points of convergence are to the audience, the stronger the claims.” The decision-making processes described by obstetricians, specifically the process of message convergence, both at the organizational and individual level, are examined.

**“Consensus of experts:” Convergence at the organizational level.** Providers argued that evidence-based guidelines and guidelines based on Level A evidence do not always exist in the field of obstetrics as compared to other areas of medicine because of the peculiar nature of obstetrics. They suggested that certain areas have not been thoroughly studied, nor has the necessary data been obtained to establish such guidelines because of the potential risks to mothers and babies. The obstetricians agreed that when evidence-based medicine is lacking or unavailable, they turn to experts in the field who offer consensus or expert opinion statements based on available peer-reviewed data, published medical commentaries, and personal medical experience. Physician 12 expressed in detail the purpose of expert consensus statements and how they serve obstetricians in their daily practice. She explained:

So ACOG puts out every year, if you're an ACOG member, they put out every year this compendium of their latest committee opinions, their actual data.

There's a committee opinion which is just what we have decided as a consensus on what we believe. There's a committee opinion statement on women and alcohol and other topics.

ACOG, based on a group of highly-specialized and trained physicians who are charged with the task of analyzing all of the available information and evidence, determines what the individuals in the field should believe based on analysis of the data. ACOG and other organizations including SMFM, entrust a group of leading specialists on whatever the specific topic may be, and the providers issue an expert consensus that defines the treatment that appears to be most efficacious for members of the obstetrics field to follow.

Because there are some areas in obstetrics in which some Level A evidence-based recommendations do not exist, physicians rely heavily on the expert opinion or expert consensus statements that are issued by the governing bodies within ACOG. Physician 5 cited the reliance on expert consensus by the profession:

We try to make most of the things that we do, at least as evidenced-based as possible. But there are some things that we do that are not evidence-based. They are based upon, what's the old story? Good ole' boys sitting around the table? You know, it's based upon a consensus of experts because there is no randomized clinical trial that is going to prove to be evidence-based.

Although the obstetricians described their distinct preference as always practicing according to the highest level of evidence, it is not always feasible. Therefore, the

providers look to the consensus of experts in their field for guidance and clarification in how they should proceed.

Physician 4 argued that in the absence of evidence-based medicine, multiple arguments emerge and interact from distinct sources. However, expert consensus issued from governing medical bodies provide physicians some help in deciphering conflicting options within various arguments. He claimed, “People can quote just about whatever they want from certain parts of a medical issue or the support, just about anything they can dream up, but there are expert consensus statements that help prevent that.” When expert consensus statements are available concerning a certain topic, providers report that these statements help them to make informed and meaningful decisions, even in the absence of Level A evidence. Additionally, expert consensus statements help prevent the loose application of medical data and findings so that proper standard practice of care is maintained within obstetrics. When several medical experts agree on a certain best practice and release an expert consensus, the obstetricians in the current study reported that they are more likely to follow that recommendation than arguments not advocated by a group of obstetrical experts. Similarly, Physician 18 acknowledged that when available, medical providers should manage their practices according to expert opinion. She stated:

Unfortunately in OB, we don't have a lot of evidence-based recommendations. We have some, but because people don't like to experiment on pregnant women and babies; there's a lot of gray areas in OB where we actually have to go by expert opinion. It's frustrating because we all like protocols and algorithms but there aren't necessarily some [protocols] for every situation.

As previously discussed, the distinct preference of providers for approaching the everyday practice of medicine is to allow evidence-based medicine to guide their practice. However, expert opinion or consensus is helpful to physicians in making sense of their daily practice when no Level A guidelines are available. Physician 2 described how ACOG committee opinions are agreed upon and the utility they offer to his daily practice of medicine, especially when he encounters patients with concerns or issues that are not routine. He stated:

I'm going to pull up ACOG and see what the recent current opinion is. The current opinion is a bunch of physicians that are gifted and voted on and respected in our field to give us current opinions on topics like antiphospholipid syndrome....So you put credence in the good studies, peer review journals and authorities who create the ACOG opinion. ACOG not will not come out and endorse anything unless it's been looked at, studied, peer-reviewed et cetera, et cetera. They're not going to endorse it.

Finally, Physician 10 articulated that when ACOG issues a consensus statement for other obstetricians to follow, the providers should abide by the standard ACOG has established.

Well, so if ACOG has come out and said something in a committee opinion or a practice bulletin, then I think we are responsible for following that. And usually, you know, if it's appropriate to give leeway, they give leeway. So if they have taken a stand on something, then, we need to.

According to Physician 10, when ACOG has released an expert consensus or opinion statement, physicians should adhere to it. It is accepted practice that providers rely heavily on ACOG recommendations because ACOG is one of the leading clinical

organizations in the country surrounding obstetrics, and because obstetrical experts have sifted through the published data on the topic and have made a decision based on their analysis of the literature and upon their expertise and knowledge. Thus, as organizations such as ACOG submit expert consensus statements and committee opinion statements concerning the status of certain topics or concerns in obstetrics, their committee consensus appears to mirror Perelman and Obrechts-Tyteca's (1969) understanding of convergence.

The providers discussed in detail the importance of committee opinions and consensus statements for reaching consensus at the organizational and national level. However, when Level A evidence or consensus statements do not exist for certain scenarios, or when patients do not fit cleanly into the parameters of the evidence or committee opinions, providers must make sense of potentially competing recommendations for treating patients. The following section discusses the process of message convergence for medical providers at the individual level.

**Convergence at the individual level.** Almost all of the physicians interviewed discussed the need to seek information from multiple sources so they are not led astray by using information from a source that is eventually proven incorrect. Evidence of message convergence emerged as physicians discussed the need to engage in information-seeking to see if particular recommendations or plans of treatment are consistent across multiple sources. Physicians also specifically discussed the ways in which overlapping messages, or sources that reveal similar arguments, are helpful in discerning the ways they should practice medicine either in the absence of practice guidelines or when new practice guidelines are revealed for certain medical concerns. Physician 4 echoed this sentiment

when he discussed the introduction of new practice guidelines into obstetrics. He said that if new guidelines are introduced, he wants to hear the benefits of such an addendum to his practice endorsed by many sources rather than simply one. He stated:

Most of us in clinical practice spend our lives battling the post hoc ergo propter hoc fallacy. In other words, after the fact, therefore, because of the fact. And I need to have more evidence than just one, especially if it is an earth-shattering change in practice. I'd like to have it confirmed by many researchers.

The physician clearly stated that if he is considering a major change in his clinical practice, he must hear the information from more than one source. In fact, he stated that only when he hears a similar argument or recommendation emerge from multiple sources can he act with confidence or certainty that the recommendation will be beneficial for his patients. Additionally, Physician 15 notes that she looks for an answer from a “combination” of sources, which includes the voices of her fellow physicians as well as the peer reviewed literature from the ACOG compendium when making decisions for her patients within the gray areas of obstetrics. She stated:

I believe in my gut. So I ask the maternal-fetal medicine specialists if I have a difficult case. I go to the ACOG compendium to see what they recommend, then I ask my senior partners what they have done in their experience, what is the outcome? So then I make a decision based on my judgment and based on the combination of similar recommendations I get from sources I trust and then I make a plan for them [the patient] the best that I can do.

According to Physician 17, when sources seem to say similar things, the strength of that argument is increased for her. She stated, “When multiple sources recommend the same

plan of action, it lends credence to its selection.” In other words, the argument seems more credible to her when she finds that it is advocated by distinct sources. Similarly, Physician 9 mentioned ways in which overlapping messages, or finding similar arguments from multiple sources, helps him discern the medical strategy he should take:

When I encounter situations where there are no evidence-based guidelines, I tend to form a plan of care based on experience, judgment, and extrapolation of other known data. If there are expert opinions or other position statements for the specific situation that agree with my thoughts, then I feel more confident carrying out the treatment plan.

The provider continued his discourse on the importance of messages that overlap when he is attempting to make sound medical decisions. He stated, “It [overlapping messages] helps me feel confident that there is a reasonable chance the sources are based in sound reason/logic if they reach the same conclusion based on a review of the available evidence and clinical experience.”

A similar opinion regarding the role of overlapping arguments from multiple sources when trying to find the best plan of treatment for patients was offered by Physician 5. He stated, “Overlapping messages from multiple sources verify and clarify a particular management approach and provide a firm basis for the recommendations that are made to the patient.” Physicians responded that they are more confident and more willing to continue with that plan of action when they see a similar argument conveyed across multiple sources.

Physician 27 acknowledged that when a number of sources agree on a certain topic, it is easier for her to pursue that recommendation with confidence and suggest an

appropriate course of action to her patients. When she sees the recommendation across several sources rather than just one, she believes that it will be more efficacious and more persuasive for her patients than other recommendations that are not consistently advocated by multiple sources. She claimed:

I mean, it's reassuring to know that it would note [the study] that 3 out of 3 sources instead of 1 out of 1, you know, are recommending or voting for whatever plan. Sometimes it helps to be able to tell the patient that not all I teach you is the national OBGYN society.... [not only is] this is their favorite plan, but also some specialist that's in Lexington and my partner here in town. I try to reassure them that a lot of people are behind this action plan.

Physician 27 recognized that she is more willing to endorse a plan in which multiple sources have advanced the specific healthcare recommendation. Further, she conveyed that she feels more confident in making a recommendation to her patients if the proposed plan of action is not just endorsed by the national college of obstetrics and gynecology, but if there are other distinct sources, including a local specialist and fellow practitioner, that endorse the same plan of action.

Physician 10 indicated that if ACOG issues a practice statement, various sources will promote the recommendation because of the influence of ACOG. However, she claimed that if she runs across other sources that echo or merely repeat ACOG's findings, she would not be as persuaded if she encountered multiple sources that independently confirm the ACOG recommendation. She claimed that she is far more persuaded and comforted when independent sources reach a similar conclusion, and it appears to her that



the recommended course of action is one worth taking with her patient population. She stated:

If ACOG makes a statement based on expert opinion which stops short of giving a guideline, their statement might be echoed in all kinds of places, which sounds like a bunch of sources agreeing with each other when really they are just repeating the same initial message. I'd have to look at the source of the different messages. If they were each independently derived, it would be comforting to see that they agreed with each other.

Therefore, in line with the second proposition of Message Convergence, the medical providers acknowledged that as multiple and distinct sources reveal a similar argument surrounding a course of action, they are more likely to follow the recommendations they perceive to be initiated, at least in part, by multiple sources. However, there may be times when providers seek the presence of overlapping messages among their patients. The following section discusses in depth the idea of participatory convergence.

### **Participatory Convergence**

Although the physicians discussed in depth the ways they seek information when they are unfamiliar with a certain area of medicine and the ways they strive to manage conflicting information pertaining to a certain topic, some physicians claimed that in certain situations, there was simply not enough valid research to make a strong recommendation to their patients. Across the spectrum of interviews, obstetricians cited the fact that there are certain “gray areas” for which there seems to exist no single answer because of a lack of research conducted on the topic. However, the physicians acknowledged that in those circumstances where evidence-based medicine is unavailable,

or when evidence is available but of questionable validity, the obstetricians said their interactions and consultations with patients differ from other interactions when viable Level A evidence is available. When physicians are unable or unwilling to make strong recommendations for patient care either because of the lack of research or expert opinion surrounding a topic, several providers articulated that in these circumstances, the opinions of patients are highly valued. Providers, in fact, rely on patient input in helping to make decisions for which there are no clear answers. This engagement of thought between physicians and patients can be labeled as “participatory convergence.” When providers have difficulty making definitive recommendations, they may seek to include their patients’ help in determining treatment options based on what will be most beneficial to the patient. Physician 10 revealed the presence of participatory convergence by sharing her philosophy of including patients in helping make sense of competing recommendations surrounding medical care. She said, “And then, if it really seems to be a tossup where there’s not plusses and minuses of this way, or plusses and minuses of that way, then the patient needs to tell me what they think about it too.” In the preceding statement, the obstetrician revealed that at times when messages are conflicting, and the strongest argument has not yet emerged either because a lack of research or expert opinion, she relies on the input of her patients. The opinion of the patient enters the interaction of arguments as another, viable source that may confirm, or converge, with one of the possible courses of action. This interaction enables the physician and patient to make a choice among competing options. When the patient herself helps make an informed decision and thus voices a preference for one particular option regarding her care, participatory convergence can occur. Both the obstetrician and the patient can

contribute jointly in making informed decisions and will hopefully opt for the best mode of treatment.

Physician 17 espoused a similar sentiment as Physician 10 concerning the participatory role of patients in helping promote convergence when there are not enough expert opinions available, and a substantial evidence base is lacking. She stated:

I may go to my patient and say, “Some people say that this is the better way, some people say that this is the better way. What do you think fits better for you?” if I don’t have strong feelings. Sometimes, the patient comes back and says, “You’re my doctor. What do you think is right?” So we try to look at both sides and see what works best for the patient.

Physician 17 acknowledged that at times when there seems to be no clear answers, or at least an answer for which she does not have “strong feelings,” she will present the varying arguments to her patients. Through this interaction, the patient actually aids the physician in the decision-making process for obtaining the best and most appropriate course of treatment among competing options. Essentially, through communication, the patient and the physician promote convergence among the conflicting or competing options. Physician 21 also espoused the value of presenting conflicting arguments to patients for their consideration. In examining two or three research studies which did not possess the quality of evidence she needed to make the most informed decision, she claimed:

If they have equal quality, either strong or weak, I generally tell the patients that the particular question has yet to be answered because there is conflicting information that is published on the topic. And if I think there is not really good

evidence either way, I usually tell them, “It’s okay either way, and I can’t make a strong recommendation either way.” So then I will ask them for their opinion on the situation, and I will usually follow up by asking, “Would you like to know what I would do in your shoes?”

By asking the patient for input in the choice of treatment desired, the physician is able to put the patient in the center of the decision-making process. At the same time, the physician is able to offer his or her opinion on treatment options.

Additionally, Physician 20 stated that when certain scenarios are presented to him for which he is unable to make a recommendation, he reported that he also looks to the patient for her input. He claimed:

Occasionally, I’ve been in a situation where I’ve said, “You know what? This is kind of a tough situation and I see that there are three ways that we can go with this...So there have been times where I’ve said, “Well, which one is better? Honestly, I don’t know. With all of my years of experience, and my gut feeling and science, I don’t know which way is the best way to go. So it’s whichever one you [the patient] feel best about.” And that’s about the best way I can say it, and of course I lay out the risks and benefits.

Again, the physician discussed the way that he reconciles competing approaches to care by relying on the opinion of the patient in question. Despite the years of experience of the physician, he articulated that he looks to his patients to essentially help promote convergence in situations where there seems to be no clear superior option. Physician 27 expressed the fact that she also seeks the opinion of her patients when no one option seems to be clearly the best. She stated, “When I have legitimate, various options that are

all equally safe and effective, then I'll let the patient decide.” Thus, by allowing the patients to enter the conversation of care and aid the physician in determining the best trajectory of care, the physicians are seeking to achieve convergence through patient participation.

### **Proposition Three: The Nature of Convergence over Time in Medicine**

The third proposition of the message convergence framework, or the notion that the strength of convergence may be modified as a result of the reflection upon the existing convergence, also seemed to be apparent in some of the interviews. The obstetricians pointed out that expert opinion serves as the “convergence” arrived upon by various experts within the field based on their thorough review of the literature. However, despite the efforts of the most advanced and talented medical experts, there are times when physicians must return to the drawing board, so to speak, when evidence-based guidelines or expert opinions appear to have been disproven. Often through the emergence of new data, medical experts may realize there are better ways for approaching or managing patient care. Physician 26 interjected in his responses that despite the efforts of good physicians and medical researchers, there are times when individuals establish standards and guidelines that must later be rescinded. He explained the situation in the following statement:

I'm sure back before Columbus sailed to America, whatever their equivalent of peer-reviewed best scientific minds said the world was flat. And, you know, we certainly have seen things in medicine that we thought were true that were made based on the best logic that we could come up with that subsequently weren't

right. People are so desperate, which is good. We're all so desperate to seek knowledge that sometimes we go down blind pathways.

Physician 26 argued that even in the medical field, physicians want answers for the questions surrounding how to best care for their patients. Unfortunately, there are times when the answers or solutions agreed upon by the medical community are revealed to be either inaccurate or insufficient upon further reflection and assessment of the particular clinical practice. Similarly, Physician 28 also mentioned that even some of the greatest minds in the field of obstetrics have reached consensus on a particular method of treatment and later realized the consensus of clinicians was incorrect for treating patients. He claimed:

It is better to have more people coming up with guidelines or plans than it is to have just one person coming up with them. And that's why the decisions that we talked about before require consensus. Now hopefully we're not so off-base that everybody misses an important element, but that has certainly happened in the past in medicine where people have all gone down the same road by consensus and that road has been wrong. So we need to be careful.

The physicians agreed that some consensus statements endorsed by their governing medical organizations were later deemed to be incorrect, resulting in the reassessment of appropriate patient care and treatment.

Further, some of the obstetricians pointed out that even once guidelines are issued from entities like ACOG, so much time has lapsed that data on which the guidelines are based is somewhat outdated. Once certain guidelines are published, other studies have been conducted that yield data that run counter to the published guidelines. Physician 20

discussed his concern with the sometimes out dated nature of recommended guidelines. He stated, “Now the tricky thing is that sometimes the documents or guidelines are written and they are two or three years old and there’s emerging evidence. I’ll fill that in by talking to the patients about new evidence.” Similarly, Physician 25 described how quickly guidelines may become outdated before they are published. He claimed, “However, some of those things [evidence based recommendations] are, by the time they hit print, they may be a year or two old in terms of some recommendations.” Even obstetrical recommendations agreed upon by influential researchers and physicians may have to be revisited and changed in the midst of emergent evidence.

Finally, proposition three of message convergence is evident in the presence of discussions surrounding the biases that may exist among some of the organizations that propose certain guidelines and recommendations for practicing medicine. Physician 20 stated that although it does not occur frequently, there are times when he believes certain guidelines have been established based on lackluster evidence because of an agenda that an organization or entity may be advancing. He explained:

There are times when, not often, when I think the evidence is wrong when I look at the studies that push a particular policy, and I’ll look at it and I’ll say, “You know what? This is a major study that’s really determining these recommendations.” And it’s only one study and I have some trouble with this study. I have some concerns.

Even in the field of obstetrics, consensus measures that may have been previously decided upon may be reconsidered or retracted in the presence of more recent data that necessitates a change in the current recommendations.

Physicians described information-seeking and decision-making processes that closely reflect the crux of the message convergence framework. In the midst of uncertainty, obstetricians report that they seek information from multiple sources in an effort to assess the prominent arguments surrounding medical recommendations. Further, the providers state that when an argument is consistent across multiple sources, or when they perceive there are overlapping arguments from distinct sources, they are not only more likely to proceed with the recommendations, but they feel more assured that the recommendations are legitimate. Finally, the providers acknowledged there are times when medical recommendations that initially emerge within the field of obstetrics must be revised or rejected because the initial message convergence was revealed as inaccurate. Physicians stated that, at times, an initial convergence must be reconsidered either because additional data was produced that revealed the perceived convergence as incorrect, or because certain recommendations or guidelines later revealed bias in practice that was not determined by sufficient evidence. Comments gleaned from interviews with various obstetricians confirmed the notion that propositions of message convergence hold true not only in specialized communicative applications, but also in the practice of medicine.

### **Summary of Message Convergence and Medicine**

This chapter has considered the role of the message convergence framework among obstetricians who make medical decisions, amidst often competing arguments and claims, for providing care for pregnant patients. When discussing the treatment of patients, obstetricians expressed their reliance on evidence-based medicine, and specifically, Level A evidence-based guidelines. The obstetricians said their reliance on



Level A evidence is based on the rigorous clinical trials and methodology from which Level A evidence is obtained. Although the physicians acknowledged their consideration of the findings of Level B and Level C evidence-based guidelines in the absence of Level A evidence, the obstetricians also acknowledged their wary attitude toward the lower levels of evidence. Because the physicians positioned Level A evidence-based recommendations as the paragon of evidence-based guidelines, the prevailing reliance on this evidence among the obstetricians is manifested as message dominance. Once ACOG or other governing bodies declare evidence-based guidelines to be Level A caliber, the guidelines function as the dominant argument in that area of medicine. Ultimately, Level A evidence-based guidelines are viewed as the most appropriate method of treatment or the primary approach to treatment.

However, despite the high position for Level A evidence based-guidelines, the obstetricians stated that, much to their chagrin, few Level A evidence-based guidelines exists in obstetrics compared to other areas of medicine because of the inherent risks posed to pregnant women and their babies. As obstetricians generally strive to avoid imposing additional risks to patients and their babies, the doctors reflected on the many “gray areas” of obstetrics in which there are no evidence-based recommendations based on random-controlled trials. The physicians revealed that gray areas can be frustrating for them as they must sift through various alternatives and competing arguments surrounding the options for care when evidence-based guidelines of Level A caliber are unavailable.

The presence of the three propositions of the message convergence framework was evident among the interviews with the obstetricians. First, in the context of proposition one, the obstetricians stated that when making sense of diverse options for

managing patient care, they often seek advice and expertise from fellow physicians. The obstetricians explained how seeking advice from partner physicians or specialists helps them manage and make sense of competing messages.

Second, the presence of proposition two was revealed as the physicians acknowledged when diverse arguments from multiple sources overlap in certain medical concerns, they often experience message convergence both at the organizational and individual levels. In terms of convergence at the organizational level, the physicians acknowledged that, in the absence of adequate evidence-based practice guidelines, ACOG will issue “expert consensus” statements for guiding the medical practice of obstetricians. Although the expert consensus statements are subject to change from time to time, ACOG issues the statements based on the thorough review of medical literature and available data surrounding the specific medical concern. Therefore, prominent ACOG members are essentially making sense of interacting messages and arguments and searching for the most viable argument. Once the ACOG members have decided upon the most promising course of action, it is then recommended to other practicing obstetricians. Based on national recommendations and guidelines, convergence at the organizational level occurs.

Further, the obstetricians discussed ways in which they engage in convergence at the individual level. The physicians described situations when treating patients, especially high-risk or those with multiple co-morbidities, in which they seek the assistance of their fellow physicians for clarification or help. The doctors described reaching out to their partners and to perinatologists, or high-risk specialists, for clarification when they perceive there are multiple options available for treating patients. When the physicians

are faced with considering alternative and potentially competing recommendations for patient care, they revealed how they rely heavily on their medical colleagues. Thus, convergence at the individual level for obstetricians often occurs when they reach out to fellow colleagues for help and advice.

Proposition three was also evident in the physician interviews as the obstetricians discussed that over time, expert consensus statements advocated by ACOG often must be revised, either because newer evidence necessitates revisions of outdated guidelines, or because original consensus statements were laden with biases from either individual researchers or governing bodies pushing for certain obstetrical policies. The physicians agreed that within the medical community, the convergence of arguments is constantly being revisited and reconsidered.

Finally, the chapter discusses participatory convergence and the role patients play in the message convergence process. When multiple options are available for treating patients and no one option emerges as the most effective or beneficial choice, the obstetricians revealed they sometimes solicit the feelings and desires of patients to help determine if one method or treatment option is more desirable than another. The process of participatory convergence is not meant to imply that physicians only seek the input of their patients in extremely complicated situations. Certainly many physicians indicated they welcome patient participation in decision-making whenever possible. However, in rare or unique cases when physicians do not feel as though they can make strong, indisputable medical recommendations to their patients, the obstetricians admit they consider the preferences and concerns of patients as important sources and legitimate arguments in the environment of interacting messages. Therefore, the preferences of

patients often help physicians make sense of complicated message environments regarding specific medical procedures and treatment options.

The following chapter examines many facets of physician and patient decision-making. The role of physicians as conduits of convergence in shared decision-making with patients is explored thoroughly. Also, the chapter discusses the complexities of decision-making that physicians must address and manage in their practices. Finally, several scenarios detailing decision-making with patients are defined and explained.

## **CHAPTER 5 RESULTS: CONDUITS OF CONVERGENCE AND SHARED DECISION-MAKING**

The objective of the current chapter is to foster understanding of the obstetricians who function as conduits of convergence while engaging in medical encounters with their patients. As discussed in chapter 4, the self-proclaimed role of obstetricians is to stay abreast of current medical trends and evidence-based recommendations in an effort to provide the best medical care to their patients during pregnancy. Because of their positions as conduits of convergence, the physicians indicated they believe strongly in their responsibility to educate and counsel their patients. The physicians also agreed that the patients and physicians should participate in shared decision-making.

This chapter examines themes and key findings that emerged as a result of participant responses to a standardized interview protocol based on the shared decision-making literature. Specifically, this chapter considers the physician perceptions of challenges surrounding shared decision-making in prenatal care, particularly when the desires of the patient and those of the physician diverge or conflict. The obstetricians insisted they must manage multiple considerations simultaneously, including their understanding of the best method of care for their patients while managing the need to respect patient autonomy. The chapter considers three complex scenarios surrounding medical decision-making between physicians and their patients in prenatal care. The three scenarios for prenatal decision-making between physicians and patients include patient requests for elective procedures and physician granting of patient requests based on patient autonomy, physician refusal of patient requests for elective procedures based on the potential harm inflicted on the mother and her baby, and the final scenario reveals the patient refusal of physician recommendations for care.

## **Obstetricians as Conduits of Convergence**

The obstetricians discussed how they strive to provide the best medical care to their patients by staying up-to-date on evidence-based medicine. They also pointed out that people expect them to be responsible for not only counseling their patients during the prenatal encounter, but also supplying them with valid advice and correct information when patients enter medical encounters with misinformation. The physicians revealed they believe their patients to be well-educated, but they also discussed the pervasive “pregnancy myths” that are circulated both by social systems and perpetuated by online websites. For instance, Physician 16 described that often she has to correct the misinformation that her patients receive from friends, family, and popular culture sources surrounding pregnancy and labor and delivery. She described her medical encounters with her patients by stating they often revolve around dispelling myths and incorrect beliefs they encounter from other sources. She said:

And so often women will say, “My mom told me this, my aunt told me this, or my friends tell me this.” It really should be a time for dispelling many of those myths. They’re hard to do so in a short visit, right? And I think this is where pre-natal care could do so much more. It’s designed more for keeping women safe physically than it is designed for education. So the education piece is very dependent on the system that you put into place.

The obstetrician revealed her belief that the time within the medical encounters between providers and their patients should not only be used to ensure that both the mothers and babies are safe, but the obstetricians also need to take advantage of that time to ensure that patients are receiving correct information. Incorrect myths surrounding pregnancy,

specifically surrounding delivery timelines, should be corrected or dispelled for patients.

She continued to say:

There's lots of stuff on the Internet, but as you know you've got to be careful. So it is dispelling myths, I think is what pre-natal care could do. It's also a time where you can capture women to teach about health in general because, as you know, health literacy is very poor.

Other obstetricians also argued that social forces can influence a pregnant woman's perception of her pregnancy process. Family members and friends can potentially provide a pregnant woman with unrealistic expectations surrounding her final weeks and delivery. Physician 13 claimed that imposed assumptions and expectations are often incorrect. She stated:

People will always have an opinion on whether a pregnant woman is too small or too big, and it's completely irrelevant to what she is. So, I think maybe you have a family member or a close friend telling you how huge you are, 'You can't possibly go another week', or 'I'm sure you're going to have that baby tomorrow; look at you.' Giving them some sort of expectation that's not realistic.

Implicit within the discussion of the incorrect assumptions and assertions about the size of a pregnant patient, the physician continued to explain how she functions as a conduit of convergence when she attempts to correct any anecdotal assumptions or expectations that her patients may have as a result of external social influences.

Beyond the influences of a woman's social group surrounding delivery myths, providers acknowledged that it can be problematic when patients search for pregnancy information online. Because of the sheer amount of information about labor and delivery

that is available online, and because many providers fear that a great deal of that information is incorrect, providers acknowledged that they often must be on the defensive to help protect their patients by correcting any misinformation and misunderstandings they have surrounding pregnancy. Physician 23 indicated she is sometimes “leery” when patients approach their prenatal care interaction with the obstetrician with research they have obtained on the Internet because of the questionable quality of the information. She claimed:

I get a little leery when patients come in saying that they’ve done this research on the Internet because I know what’s out there. Sometimes I do it for fun, like what is out there on this topic, and it can be a little frightening sometimes what comes up.

The physician acknowledged that she sometimes searches for topics that her patients search for simply to see what information exists. And she claims that the information she finds concerning pregnancy online can be a bit scary. Physician 4 discussed that sometimes his patients are confused by the massive amounts of information surrounding pregnancy available online. He suggested that the amount of information available online can overwhelm his patients, and that is why he tries to discuss the information with his patients because much of it can be inaccurate or misleading. He stated:

In this day and age, there’s so much written that most of the time, the patient is confused mostly by like Googling the whole thing. You get 36 pages of potential information, some of it good, some of it bad. So we really go over what she’s read because most of the patients have a preformed idea of what’s going on and what they’d like to do.



Physician 4 revealed that he strives to counsel his patients so that they will understand which online information sources are accurate and which ones are not.

Similarly, Physician 21 acknowledged that her patients often approach the medical encounter with their biases and opinions, but she claimed that before she discusses a certain topic with a patient, she proactively researches the concern of the patient so that she can grasp the existing arguments, biases, and assumptions that are circulated online. She claimed:

The first thing I do if I know the patient has a question and she's come to my office for that question, I usually Google it, because I know if they've come with a question, almost everybody had already Googled it. So I want to know what supporting biases my patient is coming in with their question.

Physician 21 revealed that she searches online for information about patient questions and concerns in an effort to understand the biases of the online sources and, when necessary, to dispel the biases and assumptions that may be incorrect.

Therefore, the physicians function as conduits of convergence in that they strive to correct the incorrect assumptions and information their patients encounter online and espouse within the prenatal consultation. The obstetricians revealed they try to grasp and then dispel the misunderstandings and misinformation their patients have surrounding pregnancy. Although the providers acknowledged that many of their patients are very well-educated about many topics surrounding pregnancy, there are still times when the medical providers feel it necessary to educate and correct the incorrect assumptions of their patients.

Specifically, the obstetricians stated they must often counsel women who espouse incorrect assumptions surrounding labor and delivery. Many of the physicians mentioned the fact their patients nearing the end of their pregnancies requested to be induced well before their due dates because of a variety of reasons, including discomfort and a sense of wanting to meet their babies. However, Physician 21 said that mothers who request to be delivered before 39 weeks simply don't understand the heightened risk for prematurity and the complications associated with prematurity. She claimed that if mothers were more versed in the potential complications associated with prematurity, they would be far less likely to request such procedures. She stated:

And in the general community of pregnant women most of them are generally not well versed on medicine, certainly not very well versed on neonatal medicine, and most of them wanting to be delivered before their due date are influenced by their discomfort and their lack of knowledge of how bad the complications can be if their baby is born before it's mature enough. I think if most women knew that babies can have really serious prematurity complications when they're born before 39 weeks, there would be fewer women who would ask to be delivered early. Obviously no mother wants to hurt her baby, so there's just sort of a lack of general knowledge in the community of the seriousness of complications related to prematurity that can happen even after 37 weeks.

When women are unaware of the potential risks associated with prematurity and early elective delivery, the physicians must function as conduits of convergence to educate the patients on the literature surrounding the perils of early, elective inductions. Physician 13 discussed her perception of the lack of knowledge surrounding the potentially poor health

outcomes for babies delivered electively before mothers have reached full-term pregnancy, and she noted the arguments and rationale shared by mothers who request to be delivered early. She stated:

Yes, they'll tell me 'I delivered my last child at 36 weeks and he did just fine.' Or, 'I'm not even sure that due date is correct. I know when I had intercourse. I know when I conceived and your due date is 3 or 4 days off.' You know, it's built into the statistics but still. It's usually about they go back to, 'My due date wasn't right' or 'My last baby was fine and it was delivered early.' You get away with it most of the time, prematurity, 36 is no big deal, but that's probably their experience, they're an "n" of one.

The physician revealed that her patients, at times, rely on anecdotal evidence or their own pregnancy experiences when trying to schedule the delivery of their babies. When patients rely on anecdotal evidence to guide their decision-making, physicians must serve as conduits of convergence to combat the misunderstandings surrounding delivery timing.

The physicians function as conduits of convergence during prenatal counseling for educating their patients and for clarifying misinformation surrounding pregnancy. Additionally, the interviews with the providers revealed that the physicians also function as conduits of convergence during decision-making with patients. The following section discusses the complexities of medical decision-making between patients and obstetricians.

## **“Lord Knows We’re a Society of Getting What We Want:” The Complex Web of Medical Decision-Making**

When discussing shared decision-making with patients, particularly in the realm of delivery decisions, the obstetricians articulated that shared decision-making is one of the most prominent aspects of their practices. The physicians were insistent that shared decision-making with patients is paramount to providing meaningful care in obstetrics. Across the board, the providers agreed that the mother should be the dominant influence in decision-making concerning her body and her baby. Providers acknowledged further that patients perceive far better health outcomes when they are given a significant amount of control over the decision-making processes.

In agreement with much of the literature on shared decision-making between patients and their providers, the providers claimed their primary responsibility is to advise patients about medical literature and its accuracy in order to ensure their patients are equipped with the information necessary to make an informed decision concerning their healthcare. For instance, Physician 3 stated, “My job as a physician is to be compassionate and caring, to be up-to-date on everything I can be, and provide them [patients] with the best information I can and then let them make their decision.” Physician 3 and Physician 6 espoused similar views concerning shared decision-making. Provider 6 claimed, “Every decision is a shared decision between the physician and the patient. The physician's obligation is to help the patient understand the alternatives and the risks thereof; and the patient then chooses what she wants.” Similarly, Provider 4 described his role as being primarily to inform and advise his patients on the medical

literature and evidence-based medicine. Further, he claimed that he tries not to get in the way of patient decision- making. He stated:

My role as a physician is to make sure that all of my patients have as much information as they can in order to make an informed decision about their care. If patients ask me my opinion, I will give that to them, but I always clarify that by saying I don't walk in your shoes, and so you have to make this decision based on your own beliefs, your own knowledge, your family, et cetera.

Like Physician 4, Physician 2 recognizes the utmost importance in allowing mothers to have a strong voice in their pregnancy experiences. He revealed his view of patient participation in shared decision-making is one that affords patients much autonomy. He stated:

Current trends are that the patient herself is in the cockpit. It's a natural process. So I talk to them about you know—we give them options and we—it is a shared decision. I have some patients that say, 'Hey, I'm a woman of the 21<sup>st</sup> century. I can't sleep; get this [pregnancy] over with.' And other women say, 'I want to be natural. I want to experience the natural [labor] process to the best of my ability.'

Beyond simply acknowledging a willingness to engage in shared decision- making with patients during their pregnancies and delivery decisions, Physician 27 described in specific terms the accommodations she is willing to engage in with her patients during labor and delivery. She stated:

I tend to be very flexible. You know, we have some people come up with birth plans; and you can do anything from no medication whatsoever to a little bit of local anesthesia at the time of the delivery, IV narcotics, epidural anesthesia,

intrafetal anesthesia- those are all reasonable options and they can use whatever they want if they're just for general comfort measures: heating pads, the whirlpool, sitting on the birthing ball, different positions in the bed, and I'm obviously willing to participate in all of those.

Therefore, the physicians routinely reveal a willingness to engage in shared decision-making in different scenarios during their patients' pregnancies. In fact, during the interviews, as the conversations began, the providers explained that shared decision-making with their patients is one of the most important aspects of their practices.

In an effort to allow the mother to have the "say so" that she desires over her pregnancy, obstetricians described the obvious conflict they experience between wanting to allow their patients a great deal of autonomy and decision-making privileges within the pregnancy process and the best course of care they deem necessary, even though the physicians' protocol may not appear to be the most desirable in the patients' eyes. In particular, Physician 17 described her concerns over this perceived tension:

Patients will come in saying, 'I want my labor to be as natural as possible,' which, I think is a very reasonable goal. Pregnancy is not an illness, it's a natural thing. I try to, when there aren't medical indications pushing me one way or another, to let my patients have some control over what they want to happen and how they want it to happen. But I also encourage them that there has to be some flexibility because there's so many unknowns going into the labor process. I can't tell them exactly what's going to happen, how they'll respond to pain. I can't predict ahead of time that they will definitely not have to have a cesarean delivery.

The provider acknowledged she would like to allow her patients the opportunity to have a substantial amount of control over their pregnancy and delivery decisions. However, she also claimed that her patients must be flexible in their desires and requests because the pregnancy and delivery experience can be fraught with uncertainty for both providers and patients.

Providers pointed out that even during low-risk pregnancies, they strive to establish strong relationships with their patients so that a strong bond of trust will be forged, and thus physician recommendations will more likely be accepted by the patients. Despite the ways physicians emphasized shared decision-making as one of the cornerstones of their medical practices, decision-making within obstetrics, particularly surrounding delivery decisions, is truly a complex and difficult process. Although the physicians claimed they were typically very willing and eager to pursue shared decision-making with their patients, they cited various scenarios in which shared decision-making did not always result in successful shared decisions between provider and patient. Throughout the interviews, the physicians discussed various instances in which they and their patients collaborated to make important delivery decisions. Some of these collaborations were quite successful while others proved to be problematic. In the current chapter, the scenarios are presented as distinct decision-making patterns that occur within prenatal consultation.

In the first scenario, the physicians described situations in which their patients often make requests for care during their pregnancies. If physicians believe that patient requests do not expose patients to a greater level of harm, then the physicians will likely accept the requests; thus shared decision-making is achieved. However, this scenario is

often fraught with frustration for the providers as they must manage the sometimes conflicting tension of respecting patient autonomy while adhering to their own convictions surrounding the practice of good medicine. The providers discussed that there are times in which patients request certain procedures in their pregnancies or deliveries that providers believe to be inferior methods of treatment to those which the provider would normally proscribe. Patient requests for treatment often result in internal tension and struggle for obstetricians because most want to respect patient autonomy, but they also realize they must practice “good medicine,” even if it inconveniences the patient.

In the second scenario, patients make requests during their pregnancies that are completely at odds with what the physicians consider to be good medicine or the standard of care by which they must abide. In those situations, regardless of the patients’ desires, obstetricians will resist based on their belief that the patient request is counter to healthy pregnancy.

In the final scenario, obstetricians recommend care to their patients based on the course of the pregnancy. Given the uncertainties that may arise during pregnancy, providers recommend various courses of action they deem to be most appropriate as the pregnancy progresses. However, there are times when patients, based on their perceived patient autonomy, refuse certain medical recommendations made by their physicians. When patients refuse the recommendations of physicians, especially when the obstetrician perceives the recommended care is necessary for the health of mothers and the babies, shared decision- making is not achieved. Further, the providers stated they often experience anxiety and discomfort when patients refuse recommended medical care.



The current chapter discusses the different scenarios which highlight patient request/physician request versus patient refusal/physician refusal and considers the internal tensions and conflicts experienced by the obstetricians as they attempt to provide the best patient care possible. The following section discusses the decision-making scenario surrounding patient requests and physician acquiescence based on perceived patient autonomy.

### **Patient Requests for Elective Interventions and Physician Acquiescence**

With few exceptions, most obstetricians interviewed were adamant in their beliefs that optimal outcomes in pregnancy are directly correlated with as few interventions as possible. In other words, the obstetricians said the best outcomes for women and their babies result from allowing spontaneous delivery to begin. Physician 16 articulated this point by stating, “There’s a reason why we do the things we do; so I feel like my job is to keep my hands off unless there is something going on and only to intervene when necessary.” Similarly, Physician 10 revealed that waiting for spontaneous labor to begin for low-risk mothers is usually her preferred decision. She claimed, “And generally, I think, what’s best for the mom and baby is if labor comes spontaneously, which means that I have to sit back.” Physician 20 echoed the sentiment of Physician 10 when he stated:

This is a natural process that works pretty well if we don’t get in Mother Nature’s way and really I see my job as if you have medical problems that we know can be a bad influence, helping you mitigate those risks going in. But another big part of my job is to not get into Mother Nature’s way.

The understanding that the physicians should not intervene in the natural process of pregnancy unless absolutely necessary was also espoused by Physician 23, who claimed, “I will fall pretty squarely for the most part that without an indication, it is better for them [patients] to wait for natural labor.” Thus, the notion that allowing Mother Nature the opportunity to run her course uninhibited by unnecessary interventions as the proper course of action was conveyed by most of the physicians.

Although nearly all of the physicians revealed their beliefs that pregnancy is best managed when they do not tamper with the natural processes, the obstetricians admitted they do not have the ultimate authority concerning patient choice for managing pregnancy and delivery. The physicians pointed out that the American College of Obstetricians and Gynecologists maintains a firm position statement that physicians should strive to honor the requests of their patients, giving them autonomy in making decisions, unless the requests of the patients directly violate established standards of ethical medicine. Further, the physicians revealed they believe that eliciting patient participation within the medical encounter promotes a meaningful communicative healthcare experience for both patients and physicians. This generally held belief is why physicians are encouraged by ACOG to constantly encourage patient participation in the prenatal medical encounter and also, when possible, honor patient requests for prenatal care when such requests do not interfere with providing appropriate care.

**Patient-desired interventions.** Although the physicians agreed their clinical preferences are that their patients wait expectantly for labor to begin, they also reported that, notwithstanding, patients often request elective interventions concerning both mode and timing of the delivery, even though they have been encouraged otherwise.

Conversations surrounding the mode of delivery focus on the risks and benefits of cesarean deliveries versus vaginal deliveries. Patient requests surrounding mode of delivery include requests for either a primary (first time mother) or a multiparous (repeat delivery) elective cesarean section. Additionally, conversations between the physicians and patients surrounding the timing of delivery focus on whether the patients desire to expectantly manage their pregnancies and wait for spontaneous delivery to begin or whether they desire to schedule the delivery at 39 weeks or beyond. When patients desire to schedule their deliveries, they request an elective induction of labor at 39 weeks or beyond.

While the obstetricians noted that many of their patients desire to have a natural labor process without imposing their desires on Mother Nature, the physicians revealed that more commonly, patients make requests for elective procedures surrounding the mode of timing of delivery. Physician 28 conveyed his feelings about his patient population and their seeming disinterest in waiting patiently for spontaneous labor to commence. He stated:

I think most women are not, at least not expressed to me, interested in staying pregnant to allow their cervix to ripen; and if that is going to be a process that makes their labor progress easier and have a higher chance of success, that's, they don't tend to want to wait as often for that process.

Other physicians also revealed that routinely, patients request elective procedures toward the end of their pregnancies. Some obstetricians revealed that discussions surrounding inductions of labor or the timing of delivery, are the most common conversations they have toward the end of a patient's pregnancy. Physician 9 claimed, "I would say that

most of my patients ask for inductions of labor. I'd say 80% of them." Similarly, Physician 16 claimed, "So probably the single most decision-making between a physician and the patient is whether to induce labor." Therefore, obstetricians are often faced with the sometimes difficult task of managing patient requests for elective procedures for both the mode of delivery and the timing of delivery with their patients. Further, although the physicians believe that for low-risk mothers, waiting expectantly for labor to begin spontaneously is the best approach to care, the obstetricians must still navigate patient requests, however unnecessary, while continuing to provide appropriate and ethical care. The following section introduces the tensions the providers reported between patient requests and the physician perception of appropriate medical care.

### **Physician Tensions: Patient Requests versus "Good Medicine"**

Although the obstetricians in the sample discussed how they were eager to engage in shared decision-making with their patients, the providers also reported that they have distinct clinical preferences when advising and treating patients. As discussed in chapter four, the obstetricians claimed they prefer to practice as much evidence-based medicine as possible in their medical practices. When Level A evidence-based medicine is unavailable, the physicians claimed they closely review the available published data and expert opinion statements to make the most informed decisions possible. The physicians reported they attend to multiple sources in an effort to counsel their patients according to the highest standard of care available.

The physicians revealed that they have established an understanding of what they perceive to be the most appropriate standard of care for their patients. However, the physicians reported that their pregnant patients also have distinct preferences concerning

their prenatal care and their delivery plans. The obstetricians admitted that, at times, the requests and desires of the patients do not necessarily coincide with the physicians' understanding of superior medical care. The doctors discussed the fact that there are times when patient requests for medical care do not align with specific protocols that obstetricians believe to be sound medical care. And although there are certain patient requests that do not directly contradict expert consensus statements or evidence-based medicine guidelines, some patient requests for healthcare present an internal tension for physicians. The doctors contend they must strike a delicate balance between granting patient requests that do not directly conflict with the ACOG standard of care, thereby honoring patient autonomy, and still provide the most beneficial care to mothers and their babies. Physician 9 discussed in depth the tension that he experiences when patients request procedures that he believes to be less than ideal healthcare preferences. Although he believes at times, that he and his patients have conflicting goals surrounding their healthcare, he often feels compelled to grant their requests based on ACOG's recommendation to respect the autonomy of the patient. He stated:

That's been hard for me to balance. You want them to be pleased with their care, but you also want to do the right thing for them; and sometimes, we don't have those same goals...They just want to be happy and get done what they want, and it's sort of an interesting dynamic of medicine I didn't really think about or know about when I was going through a medical school.

The difficulty in balancing seemingly different medical goals of patients and their physicians was also described by Physician 20. He discussed the difficulty he experiences when he perceives that patient requests can position the provider in a struggle between

wanting to both respect patient autonomy while providing patients appropriate medical care. He claimed, “Sometimes good medicine can conflict with patient desire.” The physicians revealed that unless requests of patients result in direct contradiction of standard of care, the providers are strongly encouraged to allow the patients to exert limited influence over their medical care and acquiesce to requests of patients based on patient autonomy.

If patients make requests for elective procedures or interventions during their pregnancies, physicians must thoroughly counsel patients through the process of “informed consent.” Based on patient requests, physicians must counsel their patients surrounding the risks and benefits of their choices versus other options of care. Once patients have been thoroughly counseled and still decide to pursue desired interventions, physicians are encouraged to proceed with the care by ACOG. Physicians are charged with determining if women have been well-counseled and are willing to accept the risks associated with their choices.

In discussing her struggle with the conflict of managing patient requests and autonomy and providing excellent medical care, Physician 27 stated her perception of the role of patient autonomy and patient decision- making in the current medical landscape. Although she ultimately acknowledged that patients should be allowed to make their own healthcare decisions if they have been properly counseled concerning the risks and benefits of the decisions, she also believes that patients are not always necessarily capable of making the best, most informed decisions because many hold preconceived ideas about pregnancy. She claimed:

Medicine in the United States [is] very much into individual rights and individual decision-making, so I think pretty much across the board in medicine there are those that push for autonomy-letting the patients make their own decisions. I think there are downsides. Obviously, the patient did not go to medical school, and despite the fact that we give them informed consent, I think there's a limit to how much people can actually understand about what we're talking about. But I think as long as you present them with all of the options and they're allowed to ask questions, they are allowed to make their own decisions about their healthcare.

Physician 23 expressed a similar opinion concerning current healthcare trends and patient autonomy. She argued that even within the last few decades, patients have been provided far more power and autonomy in their healthcare decisions than patients have been afforded in the past. And while greater patient autonomy is a good thing, according to Physician 23, she pointed out that physicians today are instructed to grant certain patient requests that physicians were not expected to grant in recent decades. She stated:

I've not even been in medicine that long, but I feel like there's been a shift in the short time that I've been in it toward even more power toward the patient per se. There's even more of an emphasis in making sure they're engaged in that decision. There's been a swing during my time in this field even to like if a woman wanted a primary c-section by choice, that certainly you have a very in-depth conversation about the risks and benefits of the decision, but that she can make that decision, and that wasn't true for most physicians in years past.

Given the current shift toward patient autonomy, she acknowledged that if patients desire even a primary cesarean section, then usually they are granted the procedure. Further, she

believes that physicians find themselves at the mercy of their patients' desires and wishes more now than in the past. The following sections describe the providers' perceptions of granting patient autonomy surrounding both elective cesarean deliveries and elective inductions at 39 weeks and beyond.

**Patient autonomy and elective cesarean delivery.** Throughout the interviews, the physicians revealed their inclinations to honor patient requests for elective cesarean delivery despite their clinical preferences, and noted the fact they are highly influenced by the ACOG position statement surrounding patient autonomy. ACOG recommends that obstetricians be willing to grant patient requests for "reasonable" elective procedures, including elective cesarean deliveries on request, as long as the physicians have thoroughly counseled the patients surrounding the risks and benefits of the elective medical intervention as opposed to expectantly managing pregnancy. If patients still desire the elective intervention after having been thoroughly counseled by their physicians about risks and potentially poor outcomes, then patients should be granted their requests on the basis that they understand and accept the potential risks associated with their decisions. And in light of the ACOG recommendation, the providers acknowledged that patients do have the right to request certain procedures. However, despite their stated desire to respect patient autonomy, many of the obstetricians voiced displeasure over granting patient requests for procedures they deem to be unnecessary and counterproductive.

Concerning elective cesarean deliveries, the obstetricians acknowledged that sometimes they are necessary when either the mother or baby is at risk for harm. They admitted there are specific medical emergencies in which mothers and babies have better



chances and potential outcomes when the babies are delivered immediately by cesarean sections. Further, there are also certain situations in which cesarean deliveries are safer for mothers, potentially if the babies are breach or if the mothers have had several cesarean deliveries in the past. However, the obstetricians pointed out that elective cesarean deliveries introduce the mothers to higher levels of risk for infection and problems for future pregnancies than do vaginal deliveries. Further, the physicians described the benefits of vaginal deliveries for babies, particularly because vaginal births help dispel fluid in the baby's lungs that must be dispelled immediately when the baby is born.

However, the obstetricians, despite their preferences for vaginal delivery due to lower levels of risk, stated they will provide elective cesarean deliveries for their patients on request. Because of the ACOG position statement surrounding elective cesarean deliveries and patient autonomy, Physician 4 acknowledged that patient request for elective cesarean deliveries is one of the few areas in obstetrics in which there is little resistance. He stated:

That discussion would often involve the risk of either route. My personal approach would be to emphasize that this is one of the few situations in medicine where it is truly the patient's choice. You pay your dollar and you take your choice. Which risks do you want to take on and which risks don't you want to take on?

The provider indicated that being able to decide between a cesarean delivery and a vaginal one has truly become an issue of patient choice. Based on extensive counseling

by their obstetricians, patients must decide which risks they are willing and unwilling to accept.

Physician 5 described his understanding of the extent of patient autonomy to choose the type of delivery desired. He claimed that because patients have so much autonomy and freedom in other areas of healthcare, he believes it is unreasonable for him to refuse to give patients elective cesarean delivery if they are well-counseled on the risks of the procedure. However, he maintains that patients must understand the risks involved with the desired procedures. He stated:

Now I realize that women can make a choice about the veins in their legs, the size of their breasts, the shape of their nose, whether they have permanent eye makeup on. So, they can have a cesarean section [on request] but they have to do it with informed consent. And informed consent means they have to understand that there are risks, that there are risks that may be greater than they would have if they deliver vaginally. And if you choose to have a cesarean section, then fine, I'll be happy to do that on a scheduled basis.

The physician noted that he often grants his patients cesarean deliveries on request because in other areas of healthcare, women are provided the freedom to choose methods of treatment and make decisions about other elective procedures for their bodies. However, he acknowledged there are greater risks in abdominal deliveries than in vaginal ones. He stated further that if patients hope to have more children, they are potentially creating problems for the future. He claimed:

But that's not a good precedent to set, because then she's what I refer to as an obstetrical cripple for the rest of her life, because so few people will allow her to

try to deliver vaginally in the future and there are so many greater risks associated with women who have one or multiple cesarean sections with regard to placenta accreta and uterine rupture and some of the other very serious complications of pregnancy.

Similar to Physician 5, Physician 6 echoed his sentiments concerning elective cesarean deliveries. He claimed that because patients are afforded a great deal of medical autonomy in approaching other elective, non-medically necessary procedures, he has no reason to refuse their requests. Although he said he feels that elective cesarean deliveries are not necessarily the most appropriate medical decisions, he believes that patients have the right to choose. He stated:

If a woman wants to have a cesarean delivery rather than vaginal delivery, I think that's a reasonable request. And if somebody wants some sort of plastic surgery type procedure for whatever reason, they can have that and cesarean section is not so far away. So a cesarean section upon maternal request is available. If somebody wants a primary section in the first delivery, that's their choice. They need to understand the risk or the benefits versus vaginal delivery. A cesarean delivery has various complications, but a woman that completely understands those various complications I think it's their right to choose a cesarean delivery.

The physician acknowledged that although there are greater complications inherent within an elective cesarean delivery than a spontaneous vaginal delivery, he will grant the requests of his patients if he perceives they are properly counseled on the potential risks of cesarean delivery versus vaginal delivery. Similarly, although Physician 4 revealed that women are empowered by ACOG to opt for an elective primary cesarean section, he

admitted his resistance for providing a procedure he believes to be less than beneficial for his patients. Although he will provide an elective primary cesarean delivery to patients who request the procedure, he claims he will not provide it based on particular dates or for sheer convenience. He stated:

I mean, if she has researched it, has heard all of the data, and still feels the right thing for her is a primary elective cesarean section, then yes, I will provide it for her, but not on her calendar.

The physician explained that although he is willing to perform cesarean sections based on patient requests, he is unwilling to provide such procedures based on patients' calendars because so many obstetrical procedures are performed out of simple convenience for the mother without proper consideration of the possible consequences.

Just as Physician 6 indicated, other physicians also noted there is a distinct difference in a patient who desires to schedule a repeat cesarean delivery and a patient who requests to schedule a primary cesarean delivery for her first pregnancy. Physician 17 emphasized her perceptions surrounding requests for primary elective cesarean sections, or cesarean sections performed on first-time mothers. She claimed that although she does not believe these types of procedures may be in the best interest of the mothers or babies, she will still grant the requests of patients because of the autonomy of patients to make informed decisions. She stated:

An elective primary section... I really try to discourage that because it is a surgery that, although it's simple and we've done it time and time again, it does carry more risks for the patient in terms of blood loss, infection, possible clots. Ultimately though, it is the patient's decision.

Although the physician openly admits that she discourages her patients from requesting primary cesarean sections because all unnecessary risks and potential complications are greatly decreased by having vaginal deliveries, the provider explained she will still grant a primary cesarean delivery if patients continue to request the procedure. Similarly, Physician 20 emphasized that although he practices medicine according to the ACOG position statement, he tries to dissuade his patients who indicate they are interested in having a primary cesarean delivery. He stated:

The American College of OBGYN says, and ethics experts say that patient autonomy should be respected; so we counsel about the advantages and disadvantage of c-section versus vaginal delivery, and ultimately let them know that it's their decision. Whatever decision they finally make, fine with me. I won't hold it against them if they make one decision or another, but my job is to be sure that they understand what options are available, what the advantages and disadvantages and alternatives are, and whatever decision they make I will respect. But for the primary c-section, if I don't feel that their level of risk is such that a primary c-section is the best way to go, then I will express that.

Thus, the physician explained how he is compelled to respect the autonomy of patients and grant their requests if he has fully discussed the risks and benefits of the requested procedure. However, he revealed that he will tell his patients if he believes their choices can potentially complicate otherwise low risk pregnancies.

**Fear of natural birth.** Several of the physicians revealed that, while some patients do request elective cesarean deliveries because of the convenience afforded them in scheduling their cesarean sections, as a whole, women tend to be fearful of vaginal

deliveries. And many of the requests they receive for elective cesarean deliveries are born out of such fear. Physician 28 described his experiences with patients who, motivated by the fear of vaginal delivery, request elective cesarean sections. Despite his best efforts, if those patients are counseled to understand the risks of cesarean delivery and still desire to pursue that route, then he grants them a cesarean delivery on request. He stated:

However, there's still some patients that have persistent fears and concerns and then the question is whether or not they can justifiably, despite discussion and informed consent, decide to still undergo a cesarean section. And those patients even after they've gone through the process and still are insistent upon that method of delivery are granted that as an option.

The physician wondered if patients who have been thoroughly counseled about the risks of cesarean delivery as opposed to vaginal would willingly put themselves at increased risks for complications. However, he claimed that if they choose to, they are granted their delivery requests.

Similarly, Physician 25 articulated his beliefs about the motivations for requesting elective primary cesarean sections. He too believes that many of his patients request such procedures based on fear of having a vaginal deliveries. He stated, "I think fear is a common reason that they, and lack of information, so, you know, we try to provide them with as much information as they need." And despite his belief that patient requests for cesarean deliveries are driven by fear or lack of information, he claimed that as long as patients have been thoroughly counseled surrounding the risks of such a procedure, "I have no problem with doing that as long as you're willing to undergo the potential greater risks of the c-section over the vaginal route of delivery." Physician 21 also claimed that

she tries to educate those patients who request elective cesarean sections because they are afraid of vaginal labor. Not only does she perceive fear to be an unreasonable criterion for requesting cesarean delivery, but she emphasized that the outcomes are simply better for babies who are delivered by vaginal procedure. She claimed:

If it's her first baby, and she wants to have a cesarean because she's afraid of the pain of labor and that's her reason, then I generally try to dissuade them from having a primary elective cesarean. It certainly is not beneficial to the baby to have an unlabored primary cesarean; and actually some studies have shown that babies don't do as well if they're born by cesarean as opposed to vaginal birth if they haven't had labor. However, if they push it farther and they want more information and they say, "I don't care, I still want a primary cesarean," there is room, ethically and medically, to provide that for a patient.

Despite the physician's concerns that a cesarean delivery is not beneficial to the baby if the mother could attempt a vaginal birth, the provider concedes that ultimately, there is justification to grant a mother her request based upon thorough counseling of the patient and her autonomy. However, the provider is clear that such a request is not the most beneficial path for delivery.

**Physician as gatekeeper: Physician autonomy.** Most of the obstetricians revealed they believe that elective cesarean deliveries, and particularly primary elective cesarean deliveries, are not the most ideal delivery plans for low-risk patients. However, the physicians conceded that, because of patient autonomy, they feel compelled to grant the requests of patients. However, some physicians appealed more heavily to their right of physician autonomy to distinguish between good versus mediocre medical care than a

reliance on patient autonomy. Some providers revealed that they had not performed primary elective cesarean deliveries in the past because either they do not offer such procedures in their practices or because after extensive patient counseling concerning the risks of such a procedure, their patients no longer desired an elective primary cesarean delivery. Physician 19 said that because he perceives the unnecessary procedure to be detrimental for first time mothers, he does not provide them with the option of primary cesarean section unless they have specifically brought it up in the patient-provider interaction. He stated:

As far as elective c-sections, unless the patient has a medical reason, I don't bring it up; I don't include it in my list of things. If the patient brings it up and they are interested in a primary c-section, I basically explain the downstream risks of having a c-section when you don't have to. That's fine, that's their choice, and if they understand the problems that can come from the surgery, I document that in my chart just so that they know that certain things can happen in an operative procedure.

Physician 18 said she believes primary elective cesarean deliveries are an unwise choice and that she does not offer them to her low- risk patients. She stated:

I have had patients who have come in requesting a primary cesarean, and I would say I don't know that I've ever done one truly just for elective. I have had patients who've had some sort of rectal surgery or something and they didn't want to ruin that, and that makes perfect sense to me; I am all for that, I understand that; but I don't think I've ever done one just because the patient didn't want to go through labor. I think it's a bad decision. It's a really bad decision.



Similarly, Physician 10 also explained that she has also never performed a purely elective primary cesarean delivery. Although she claimed that if patients were absolutely adamant about the procedure after having been counseled thoroughly, she would have to honor patient autonomy. Still, she steadfastly believes that vaginal deliveries are simply better for mothers and their babies. She stated:

I actually have not done, I don't think ever, a purely elective section just because the patient didn't want to have a vaginal delivery. I've had that conversation with patients a couple of times, and I really believe that for a low-risk patient, the best thing for her and her baby is vaginal delivery. And I do think if a patient has really been counseled and she really sticks to her guns and says that's exactly what she wants, I think patients have autonomy. I've just haven't had anybody who didn't change their mind after we talked about it for a while.

Not only are primary elective cesarean deliveries not the delivery option of choice for obstetricians, but the physicians contend that some patients are simply better candidates than others for the procedure. And because not all women are good candidates for the procedure, the physicians believe they have a responsibility to select carefully the patients who are good candidates. Physician 23 articulated this point well when she claimed:

And part, I think for the primary C-section, you have to choose a patient well and make sure that they understand, that they've thought about not just the risks of the immediate surgery, but more so the risks down the road. If somebody wants a large family, then each time they have that c-section, their risks increases

dramatically. So, not every patient when they think of that first section, is thinking that far down the road.

Although the physician revealed that she would provide the procedure for a patient, she also said that the patient has to be a good candidate for the procedure. She also acknowledged that she helps determine whether or not a patient is, in fact, a proper candidate for the procedure.

**Physician as gatekeeper: Determining candidacy for inductions.** Beyond patient requests for elective or scheduled cesarean sections, the physicians discussed how they frequently receive requests from patients for elective inductions at term. According to ACOG, women between the gestational ages of 39 and 41 weeks are considered to be full-term. Thus, once women approach 39 weeks, the physicians stated they begin receiving numerous requests for elective inductions. Unlike reasons given for requested cesarean sections, the physicians reported that most of the patients making the requests for elective inductions are simply tired of being pregnant and are uncomfortable. However, just because women have reached 39 weeks gestation does not mean they are good candidates for elective inductions. According to physicians, ideal candidates for elective induction have not only just reached an appropriate gestational age, but also have favorable cervixes. The physicians described favorable cervixes by employing certain terms including “soft,” “open,” “short,” and “thin.” In other words, the physicians said that if women have favorable cervixes and request elective inductions, then inductions will typically result in successful vaginal deliveries.

In addition, physicians discussed how not all women are good candidates for elective inductions even once they have reached full-term. If a woman’s cervix is

unfavorable, which the obstetricians described as “hard”, “closed”, “long”, and “thick”, a woman is simply not a good candidate for an elective induction. Unfortunately, elective inductions performed on women whose cervixes are unfavorable result in elevated rates of cesarean sections. Further, the ACOG recommendations surrounding patient autonomy and elective inductions are not as directive as those surrounding elective cesarean deliveries. Therefore, providers are charged with identifying and determining candidacy for patients who request elective inductions. Although many of the physicians maintain that patients are welcomed to request elective inductions at 39 weeks and 0 days, the physicians also suggested that not all women are ideal candidates at that gestational period because their cervixes are not yet favorable. The physicians would rather not induce women whose cervixes are unfavorable simply because the women feel they are ready to deliver. The physicians’ concern is that such a procedure dramatically increases the chances for having cesarean delivery.

In terms of determining candidacy, Physician 7 said that although she makes strong recommendations to her patients to wait until their cervixes are favorable, she claimed that the decision to induce or not induce is ultimately the choice of the patients, even if their choice directly contradicts what she knows to be good medical care. She stated:

I tell them that in those situations that my medical recommendation would be to just wait until they go into spontaneous labor. That way, the risk for cesarean decreases dramatically. But it’s still their decision whether or not they want to be induced at 39 weeks or whether they want to wait until spontaneous labor begins.

Therefore, Physician 7 revealed she ultimately gives her patients the decision of whether or not to pursue elective induction. Similarly, Physician 22 stated that although she is willing to induce her patients at 39 weeks, she is hesitant to do so when their cervixes are unfavorable. She understands that if she induces patients whose bodies are not ready for such a procedure, she is greatly increasing the chances that the procedure will result in cesarean section. She stated:

Well, yeah, if you ask me, 'Am I okay to induce at 39 weeks?' The answer is, 'Yes.' Now, if the patient says, 'Please, please, please induce me,' and I check her and her cervix is long and thick and closed and made out of concrete, I'm going to say, 'Do you really want to do this?'

However, not all the physicians interviewed espoused similar views concerning patient autonomy and elective inductions after 39 weeks. Several claimed they believe that when a patient has an unfavorable cervix, they are less inclined to honor the request for patient autonomy. For instance, Physician 9 declared patient requests for elective inductions to be unreasonable when the patients' cervixes are not ready. He stated:

If you've given your patients' numbers, like if I induce you right now, even at 39 weeks and this is your first child, your cervix is closed and thick, you have a 50% chance of C-section. I mean that's quite-it's unreasonable to me.

Similarly, Physician 10 said that as a clinician, a major component of her patient care is to educate patients of the perils of certain decisions they may desire to pursue. She stated that if patients' cervixes are unfavorable, then the women are significantly increasing the chances that induction will result in cesarean section. She claimed:

They have a strong desire for medical interventions with their delivery and their cervix is long and closed; it's really counter to what they're looking for to induce them at 39 weeks and zero days. And I have to help them weigh, you know, the risks and the benefits of slightly decreasing the risk for still birth, versus increasing possibility of the risk of her C-section... Somebody whose cervix is long and closed, I think, my job is to educate them that they're really upping their risks for a section if they proceed.

The obstetrician maintained her job is to educate her patients when their desired procedures run counter to having a potentially low-complication vaginal deliveries because the elective induction poses a greater risk that patients will have to undergo cesarean deliveries if the elective inductions fail.

Physician 16 discussed that in general, regardless of a patient's Bishop Score, (the measurement that helps physicians determine whether or not a patient's cervix is favorable) she simply believes that patients who choose elective inductions are simply not fully aware of the realities surrounding the procedure. She mentioned she was even unsure if she believed that the decision to opt for an elective induction should be afforded patients because of the heightened risks associated with cesarean deliveries after failed attempts for vaginal deliveries. She stated:

This is a common, common discussion. Some doctors think that it's really her decision, pure and simple. I don't quite feel that way. I feel like she needs to be educated really about what induction means and her risks for increased fail for vaginal delivery.

She continued her discussion surrounding her personal convictions about why patients demand elective inductions and the fact that elective inductions are far more complicated procedures than patients perceive. Although many patients believe they will be able to deliver on the same day that they are induced, the obstetrician claimed this belief is simply untrue. She stated:

I probably do it every week for a medical indication, but to do it for convenience? There is the great question of autonomy, right? Autonomy versus harm. I certainly have brought women in to induce, but I don't do so lightly. I'll be honest with you. So this is that art of shared decision- making, but so often they [patients] don't quite understand what it entails. If you sign somebody up for an induction and they think they're coming in, they're going to have their baby in the next 12 hours, it ain't so. It can take 36, 48, sometimes 3 days to get somebody into labor. So I sit and explain. It's not easy.

The physician believes that patients are not fully aware of the ramifications and complications elective inductions can create. She claimed that she does not conduct elective inductions lightly. In fact, she stated that only if patients were very knowledgeable and well- counseled on the topic would she consider providing them the procedures. Therefore, the physicians revealed that with requested elective inductions, the ACOG recommendations for respecting patient autonomy are not as directive as they are when patients request elective primary or elective repeat cesarean sections. In fact, according to the physicians, ACOG charges them to help patients make reasonable decisions surrounding elective inductions. Some physicians espoused the belief that once the patients reach 39 weeks they should have the ability to choose whether or not to be

induced, while other physicians indicated they believe the patients' cervixes need to be favorable. They also contend that patients need to be thoroughly counseled concerning the risks of imposing labor if the cervix is unfavorable. It is obvious that physicians must serve as gatekeepers in helping to determine whether or not patients are good candidates for such procedures.

**Physician endorsement of elective inductions at 39 weeks.** Although the majority of the physicians in the sample espoused the view that they were unwilling to rush Mother Nature even once a woman reaches 39 weeks, two physicians admitted that, in reality, they are more than willing to offer elective inductions to their patients if they perceive their patients will have successful vaginal deliveries. If they believe that their patients can deliver vaginally and avoid unwanted cesarean sections, two physicians revealed they would happily schedule elective inductions and even offer them to their patients for the convenience of the patients and themselves. For example, Physician 22 said that with every patient reaching 40 weeks, she offers the option to induce. She stated:

Well pretty much every patient that I deliver I offer inductions. I mean, I'm very... open to letting them choose an induction; probably just about every patient that I see, there is some kind of shared decision-making at least on that point and what I do is I just, as their due dates approach, usually it's the 39<sup>th</sup> week, I tell them, 'Your due date's coming up next week, are you interested in having a light at the end of the tunnel?' is my classic line that I use. Do you want a day where you say, 'if I'm still pregnant on this day, I would like to be induced?'

Physician 22 also revealed a bit later in the interview that her nickname is the “induction queen” because patients know that once they reach a certain gestational age, they have the choice to opt for an elective induction. Physician 25 also explained his position that he will absolutely schedule elective inductions for his patients, both for his convenience and for the convenience of the patients, if he believes they can have successful vaginal deliveries. He related a specific story of inducing a patient who was almost 40 weeks gestation so that he could attend his daughter’s championship softball game. He claimed:

So, yes, there are reasons that we would do that for convenience of our schedule and likewise, convenience of their schedule, too... My daughter plays in the championship softball game tonight. The lady that I just delivered, the 10 pounder, at 10:00 this morning, had I waited her out she may have, her water broke and she may have come into labor, you know, at 5:00 tonight and I miss my daughter’s game. But I knew if I brought her in this morning and started inducing her labor and broke her water that we would probably have a baby before noon.

Therefore, although the majority of the physicians discussed how they were rarely enthusiastic about performing a requested elective induction of labor at 39 weeks, two physicians admitted that elective inductions are as equally convenient for them as they are for their patients. The physicians revealed that if they believed they could successfully induce and deliver patients, they were willing to do so for the convenience of all parties involved. Although respecting patient autonomy is not a mandate by ACOG, the providers discussed how they are encouraged to grant patient requests for two reasons. First, the providers argued that patient autonomy is a major concern of ACOG in that the organization wants to ensure women feel as though they are engaged in their own



healthcare. Second, there are major legal concerns for providers when they refuse to provide care for their patients and something goes amiss in patient pregnancies. The following section discusses the tension and conflict that physicians reportedly experience between granting reasonable patient requests and the concern over legal repercussions.

### **Granting Reasonable Requests versus Risks of Legal Repercussions**

Physicians discussed the very real tensions they face in the context of patient autonomy. On one hand, and especially in the context of legal concerns and malpractice suits, providers are encouraged to respect the autonomy of patients and their requests. Alternatively, within the context of prenatal care, physicians reported that patients frequently request procedures that are outside the bounds of what is considered to be standard care, particularly, procedures that could be damaging to both mothers and babies. For instance, the providers reported that women often request to be induced before 39 weeks, or they request to be induced after 39 weeks even when they have unfavorable cervixes.

The legal concerns for providers seem to emerge from one of two areas. First, physicians fear that if they do not honor the requests of patients and something unforeseen occurs in the pregnancies that could have been ameliorated had the physician listened to the requests, then they may find themselves in trouble legally. Physician 4 articulated this concern when he stated:

I do insist on giving them my interpretation of literature, but in this day and age with the number of lawsuits in medicine, it is foolish to say, ‘I won’t do that for you or I won’t let you do it.’ Now I may say, ‘I won’t do that for you, but I’ll find someone who will,’ but I’ve not chosen to take that path.

When clear evidence-based practice guidelines are established within the literature and are advocated by ACOG, physicians feel empowered through their own personal physician autonomy to refuse patients' requests that could be potentially harmful to mothers and babies. However, if evidence-based practice guidelines do not directly reveal that a particular procedure is inherently dangerous for mothers and their babies, ACOG admonishes obstetricians to respect patient requests by acknowledging patient autonomy and honoring their healthcare desires. Physician 23 addressed this point directly when she claimed:

I think it's probably granting patient autonomy. Realizing that we shouldn't be quite so paternalistic, and I think part of it is certainly pushed by medical legal. You know either not granting a patient's wish when there's not like a [an identified harm]...it's different if you have a very identified harm that something is going to cause. If you can grant someone's wish with the relatively equal risk benefit ratio, is it wrong in that regard to ignore them? We've had that fear driven into us that if you say no and if something goes wrong with what you didn't let them have, then are you really sunk?

Provider 8 espoused a similar concern. She described that she often considers the future outcomes of patient pregnancy according to the legal ramifications she could face. She stated:

The medical legal concern comes in some of those where if there's a situation and if I don't deliver them, [on request] and they have a bad outcome and a baby is harmed or they have stillbirth, like if I, if I or somebody else were reviewing this case from a medical and legal perspective, would I have avoided this by

delivering them? And usually, if the answer is yes, then that sort of makes my decision.

Finally, Physician 6 acknowledged that although patients have much autonomy, he may be unable to provide care for patients, especially if they choose some type of alternative delivery that is more in the realm of midwifery care, such as home birth. Although he respects the autonomy of patients, there are certain types of deliveries that for legal reasons, he is unable to provide. He stated:

I have to respect the patient's opinion and she has autonomy, so she can do what she wishes. But as for myself, I need to help the patient understand what is the usual choice and what are the alternatives and if she chooses the path that is different, sometimes in some situations, I might not be able to provide care for her; somebody else might need to provide care for her potentially.

Therefore the physicians argued that unless patient requests directly interfere with what ACOG and other entities recommend, they should be willing to help their patients pursue the delivery options they choose. However, obstetricians struggle with the tension of believing they know the more suitable route of care for their patients because they are trained medical professionals.

Although physicians are encouraged to grant patient requests for interventions that do not directly conflict with the standards of care established by ACOG, there are also patient requests that physicians simply cannot grant because they directly contradict widely accepted standards of care. The following section discusses the physicians' rejection of patient requests that pose those contradictions.

### **Patient Request and Physician Refusal: Requests that Harm**

Although the obstetricians discussed in depth the importance of respecting patient autonomy in delivery plans, the providers also described how patients have, at times, requested procedures that could potentially jeopardize the health and well-being of their babies. In other words, the risks of patient requests far outweigh any potential benefits gained by the desired intervention because research has revealed that at times, desired interventions may likely engender harm to babies. In those moments, the physicians believe they are well within their rights to refuse the autonomy of the patients, both because of the risk of the requests and because of the potential legal repercussions that could result. Further, they believe educating patients on the problematic nature of certain requests is essential.

**Requests for elective inductions before 39 weeks.** Although providers are often willing to honor patient requests for elective inductions of labor after a due date has passed, the obstetricians reported they are unwilling to grant requests for purely elective inductions of labor before 39 weeks. In light of recently emerging data that suggests delivery before 39 weeks often results in greater morbidity for babies, coupled with the national “Healthy Babies Are Worth the Wait” campaign by the March of Dimes, and the subsequent implementation of “hard stop” policies in hospitals across the nation, the providers emphasized they are not at liberty to induce patients before 39 weeks for purely elective procedures, and not unless induction is absolutely necessary.

The obstetricians discussed how pregnant patients may be motivated to request induction procedures for an array of reasons, such as patients being uncomfortable in the final weeks of pregnancy, being tired of the pregnancy, and wanting to exert a certain

level of control over the process. The providers articulated they would refuse such requests because late pre-term elective inductions often render poor health outcomes and are inconsistent with evidence-based recommendation guidelines. The providers are well aware of risks inherent in such procedures, including the risk of prematurity, which results in higher rates of infant admission into the neonatal intensive care unit (NICU), and other major concerns of infant morbidity and even infant mortality. Physician 8 pointed out that when patients request elective inductions of labor before 39 weeks, she does recognize the patient has a certain level of autonomy to request procedures. However, she also indicated that as a provider, she too is afforded autonomy as a physician in deciding which procedures to grant based on their potential benefits or potential harm to the mother or baby. In discussing her refusal of requests for elective inductions before 39 weeks, she stated:

This is my medical opinion, and you are more than free to go to a different doctor or go to a different hospital. But I also have autonomy as physician. I don't think this is the right thing to do and, I understand how you, how you feel but you know, I have to stand by what, what I think is, is right for you and your baby.

The provider recognizes that she must do what she deems correct, even if that means denying patient autonomy because of risks to both mothers and babies. Provider 3 claimed that over the years, he has had patients threaten to leave his practice if he refused to deliver their babies before 39 weeks. He stated:

You need to seek the best medical care for yourself. You know, I am not the best doctor for everybody. I am the best doctor for my patients because I know the literature; I know what's best, and I am going to provide that for them. But if you

don't agree with that, you need to feel free. No hard feelings...If we are not in agreement, then you need to do what's best for you. I've never felt that I need to cling to patients.

The provider acknowledged that if patients were persistent in demanding delivery of their babies before 39 weeks, he was unwilling to compromise his medical practice for such behavior. He noted he always instructs patients to make the best choices for themselves, even if it means finding a provider that would induce them electively before 39 weeks.

Similarly, Physician 6 discussed how, he too, is morally obligated as an obstetrician to provide the best care to his patients. He claimed that he cannot and will not risk harming his patients, even if they request procedures that they think will make their pregnancies and deliveries easier. He claimed:

If somebody says, you know, 'Here shoot me with this gun, I want you to shoot me,' physicians cannot harm. 'First do no harm.' That's the way it is. We cannot harm our patients even if patients request things that are going to harm them. So that's kind of the way it is with delivery prior to 39 weeks unless there's some medical indication associated with harm and the physician cannot harm the patient even if the patient is informed about all this stuff.

Physician 6 stated that even if the patient has been appropriately counseled and is fully aware of the potential risks involved in delivering electively before 39 weeks, he will not grant such a request based on his conviction that physicians must practice good medicine that does not create additional risks of harming patients, even if patients are willing to take those risks.

Additionally, physicians reported they are not basing their decisions to reject such requests solely on possible poor outcomes for mothers and their babies. Because of the recent Healthy Babies are Worth the Wait campaign highlighting the poor outcomes for mothers and their babies and because of the added burden of costs to the healthcare system when elective inductions before 39 weeks result in a great number of admissions to the NICU, the doctors reported that hospitals have become increasingly intolerant of elective, unnecessary procedures. In discussing the strict policies of ACOG against such procedures, Physician 4 claimed that he refuses to allow elective inductions before 39 weeks because conducting such procedures could jeopardize his livelihood. He stated: “Hey, you’re asking me to put myself at risk for being thrown off the medical staff if I do what you want me to do. I can’t do it.” In addition, other providers reported to be unwavering in their refusal to provide elective inductions before 39 weeks on request. The providers explained that engaging in such clinical behavior could not only potentially compromise the health of the baby, but could also result in professional repercussions for their practices.

Physicians not only reported they were unwilling to comply with requests for pre-term elective inductions, but many providers also discussed the communicative strategies they employed to help women complete full-term pregnancies. Those strategies are discussed in the following section.

### **Completing a Full-Term Pregnancy: Patient-Provider Communication Strategies**

In discussing patient requests for elective inductions before 39 weeks of gestation, the providers articulated that often women who request elective inductions before 39 weeks are operating either out of a sense of fear, anecdotal evidence, or a previous

experience in which they categorize their understanding of pregnancy through an “n of one.” In other words, patients sometimes base their understanding of elective inductions before 39 weeks on the story of a friend or family member who delivered a baby electively before 39 weeks and had “fine” outcomes. Therefore, the physicians know they must engage in pre-natal education within the medical encounter to act as amplifiers of convergence to the women surrounding the risks of prematurity associated with elective inductions before 39 weeks.

In discussing the communicative strategies employed by physicians to ensure their pregnant patients understand the importance of carrying their babies to 39 weeks, physicians described the conversations they have with patients to relay the importance of continuing a pregnancy to term. These communicative strategies are discussed below.

**Acknowledging the “miseries of pregnancy.”** In an effort to encourage their patients to complete full-term pregnancies, many of the providers indicated they begin to engage in supportive communication with their patients. Across the board, the physicians acknowledged that toward the end of their pregnancies, patients usually report they experience some physical discomfort as they near their due dates. The physicians believe that physical discomfort experienced by patients undoubtedly contributes to the number of requests from patients for late pre-term elective inductions. For instance, Physician 12 revealed that patients are often surprised by the discomfort they experience toward the end of pregnancy, and she claims that patients frequently ask to be delivered because of that discomfort. She stated, “It’s uncomfortable being pregnant, so I don’t think a lot of people anticipate having another human being inside their body is uncomfortable. And so they are shocked when they are uncomfortable.” Later, she claimed, “You can’t tap



everybody and deliver them at 36 weeks because they're uncomfortable."

In an effort to help their patients complete full-term pregnancies, the providers revealed they try to combat, as one provider coined, the "miseries of pregnancy." In an effort to acknowledge the discomfort of her patients while encouraging them to continue their pregnancies, Physician 1 revealed the strategies she employs when counseling her patients:

So, I think part of it is making them understand that third trimester pregnancy is uncomfortable and your back is going hurt and your feet are going to swell. So, trying to help them to understand what normal symptoms of pregnancy are is a lot less frightening for them. So, I think that's important. It's trying to look at the pregnancy through their eyes.

The provider discussed how she both acknowledges patient discomfort during the final weeks of pregnancy and also helps patients understand the discomforts that are expected during the third trimester. She claims that this enables her to understand better her patients' concerns through their eyes. Additionally, Physician 13 described the ways she acknowledges to patients that she is aware of their discomfort. She also claimed that she attempts to utilize humor with her patients during those moments. She stated:

I try to bring a little humor into it and say, my belief is the reason God made pregnancy to be 40 weeks long to make labor look like a good way out. It is miserable, it's miserable for everybody; and when you come and shut the door, it's easy to let your guard down and share with me how miserable you are and you keep a strong face out there, but so is every other woman in the waiting room.

Similarly, Physician 23 acknowledged that especially for women who report to be completely miserable and uncomfortable, providing them with emotional support is an important strategy in helping them reach full-term. She stated:

I acknowledge the fact that it is uncomfortable. To be realistic and to say, 'I get it. I know that you're uncomfortable, but you're really doing great things for your baby by staying pregnant. We know that the baby, even in these last few days, is developing a lot of their brain, their lungs and that these last few days can still really mean a lot for your baby.'

Although most of the physicians reported they refuse to conduct elective inductions before 39 weeks simply because patients were experiencing discomfort, the providers also recognized the importance of helping patients get to term by acknowledging their symptoms and explaining how many patients typically experience this discomfort at the end of pregnancy.

Although nearly every physician articulated the importance of acknowledging patient discomfort in an effort to help them complete full-term pregnancies, some of the doctors also reported they encourage their patients to complete full-term pregnancies by reminding them that the duration of pregnancy has relatively firm time constraints, and that whether they believe it or not, pregnancy will ultimately come to an end. Physician 12 expressed this sentiment when she tells her patients the following, "There's no evidence that you shouldn't just wait until they come out. That's what I tell people. You won't be pregnant forever, and they will come out when they're ready to come out." Similarly Physician 13 stated, "I tell them it's completely natural and normal, and I have been there; but this is a matter of days, it's not a matter of life and death; it's a matter of

days.” Thus, reminding the patients that their pregnancies will not last forever helps equip them with the emotional support they need in understanding there is an end in sight.

While some of the providers discussed the direct communicative strategies they employ with patients to encourage them to stay pregnant longer, Physician 20 discussed how he does his best to speak with the spouses to help them create a plan to enable the patients to complete longer pregnancies. By trying to help lighten patient load at home, spouses can be of great assistance in enabling the pregnancy to continue to term.

According to Physician 20:

If the spouse is there I'll try to get some sense if there's home responsibilities or duties that I could relieve them of. If they're still working, how about 3 or 4 days off work or a week off work or starting disability, which I don't do lightly, but if it's a matter of, 'I want to deliver at 37 ½ weeks,' and they're really sort of adamant then I'm willing to try pretty much anything that's reasonable to get the baby some additional time.

The provider acknowledged he will try to do whatever he can for the mother, including trying to plan ways to lighten her load at home in an effort to buy the baby additional time in the womb. He stated that babies at 37 or 38 weeks simply need more gestational time, especially if the mothers and babies face no medical complications from the pregnancy. Physician 7 claimed that she engages in the same strategy when trying to help her patients get to term. She claimed:

It's really uncomfortable to be nine months pregnant and-- but unfortunately discomfort is not an indication for delivery ensue, I just try and provide the

medical perspective in understanding about, you know, what the reasons are and see if we can sort of find a compromise or if they can, you know, change family plans or whatever.

Although many of the providers reported employing supportive messages that acknowledge the discomforts of pregnancy, some providers revealed they employed less than supportive communicative messages when trying to get their patients to complete full-term pregnancies. The following section examines some of the less supportive strategies some providers reported employing with their uncomfortable or impatient patients.

**“Selfish patients.”** Although many of the physicians acknowledged they attempt to provide encouraging messages of support or high-person-centered communication for their patients in the final weeks of their pregnancies, some of the strategies reportedly employed by these physicians to encourage pregnancy continuance to full-term were marked by low person-centered communication. Rather than legitimize the discomfort experienced by patients in their messages, some of the providers instead engaged in a rather scathing criticism of patients’ intentions to induce early. For instance, Physician 2 commented that when his patients request inductions before 39 weeks, he questions their concern and intentions concerning the well-being of their babies. He stated:

So I say, this is a bad picture. ‘Do you care at all about this baby?’ If a patient pushes me, I get right down, factual and frank with them and say, ‘If you care about this child, you’re not going to play that game.’ Because I’ve got ways of helping them...I can get them through whatever; but most people who push that

[inductions before 39 weeks] are really self-centered individuals. They don't really have their baby's interest at heart.

The provider articulated that when patients request elective inductions before 39 weeks and are insistent about receiving late-preterm inductions, he tends to question whether they are more concerned about good outcomes for their babies or for themselves.

Physician 11 articulated a similar strategy when communicating with patients who request elective inductions prior to 39 weeks. Although he acknowledged that most of his patients between 36 and 39 weeks are "hurt, they're tired of it, they feel miserable, and they're tired of getting up to pee 300 times a night." He admits that he is "pretty good at providing guilt" when his patients request elective inductions before 39 weeks. In discussing a persuasive strategy he may use to encourage his patients to make it further in their pregnancies, he described a hypothetical example with a patient:

So the momma comes in and says, 'I'm miserable and I'm 37 weeks so surely I just need to get the baby out.' So I say, 'Well, it's nice that you're selfish enough that you're willing to put your baby at risk just for your comfort.'

The physician described how he attempts to engender guilt in the minds of the pregnant women in an effort to encourage them to carry to full-term. Similarly, Physician 27 revealed her own frustrations with patients who request to be induced based on their level of discomfort toward the end of pregnancy. She claimed:

I get frustrated very much with a lot of our patients who request delivery before 39 weeks because they're uncomfortable, because their pelvic bones hurt, or their abdomen hurts, or their feet are swollen. It frustrates me. It seems to me that they are thinking more about themselves than the baby, or the idea of having a baby

premature with premature complications is not as important to them as their own immediate comfort.

The provider said she perceives that patients are more concerned with their physical well-being or comfort than being concerned with the well-being of their babies when they request to be induced before 39 weeks. She later stated, “You just have to be patient with people and try and provide them as much education as possible;” however, her interview also revealed that she, along with other physicians, become frustrated when mothers seem to espouse a greater concern for themselves than for the health of their babies.

Although the physicians reported they personally refuse to deliver patients electively before 39 weeks on the grounds that such procedures would potentially harm the babies, the physicians are also ethically and legally prohibited from such behavior. Many hospitals across the country have implemented hard stop policies and regulations intended to prevent any elective deliveries before 39 weeks. And within the interviews, the physicians discussed in-depth their perceptions of hospital hard stops in restricting purely elective preterm deliveries. The following section discusses physician perceptions of hospital hard stop policies and the effectiveness of those policies.

### **Hospital Hard Stops: Physician Perceptions**

Many of the obstetricians acknowledged their discussions with patients surrounding elective pre-term deliveries aren't nearly as tense or as involved as they used to be because of the hard stop rule that many hospitals within the state of Kentucky have initiated. The hard stop rule refers to the hospital policy that no elective inductions, or non-medically indicated inductions, may be performed before 39 weeks. And for many hospitals, if the physicians are found to have delivered their patients electively before 39

weeks, the physicians are subject to reprimand before the ethics board of their respective hospitals. Further, if the physicians continue to violate the policy, they may be faced with losing their right to practice medicine in that hospital.

**Hard stops: Convincing patients.** Several providers talked about the influence of the hard stop on their everyday interactions with patients who may request early elective inductions. Physician 12 claimed that the hard stop rule in her hospital forbidding physicians from performing elective, non-medically indicated procedures before 39 weeks is liberating to her. She stated:

It's called a hard stop and a lot of hospitals are moving to this hard stop. I actually love it because it's liberating because I'm not the bad guy anymore. I get to be, 'Well the hospital will not let me do it at 36 weeks. I'm sorry.'...I really don't think that there's anything bad about the hard stop. I think it's really good. I love it.

Similarly, Physician 18 indicated that she liked the hospital hard stop rule because it made her life easier when talking to patients who were requesting to be delivered before 39 weeks. She stated, "and the fact that it was a hard stop made it easier because I could always say, 'It's our protocol, sorry.'" Physician 13 also claimed that because of the hard stop policy, "I don't have a lot of difficulty getting people to term." Additionally, Physician 23 discussed whether patients are reticent to listen to the data she provides them concerning the undesirable outcomes of elective inductions before 39 weeks. She argued the hard stop rule is always helpful. She stated, "But we do at least have something else to fall back on, which is the hard stop. If there's not a medical indication, we're not going to induce you." Physician 28 expressed his viewpoint that the hard stop

is intended to help take some of the pressure off of the providers, especially when women request elective inductions before 39 weeks that would result in less than ideal outcomes for mothers and babies. He claimed:

We're attempting to take some of these processes out of the hands of the practitioners because patients are frequently insisting on wanting to be delivered as soon as possible because of their discomfort...so the way we try to work around those kinds of things is to create a hard stop. Right now we have a hard stop for time frames for inductions and making sure that earlier inductions have medical indications.

The physician acknowledged and praised the fact that the hard stop rule helps take the option to induce out of the hands of the providers. The hard stop has proven to be effective because if providers are now forbidden to engage in early elective interventions with patients, then patients, in turn, request non-medically indicated inductions less frequently than they did previously.

**Hard stops: Physicians convincing themselves.** Similarly, Physician 22 agreed how the hard stop is not only meaningful for curtailing patient requests for inductions before 39 weeks, but is also helpful to providers. Although it may be convenient to deliver patients at 38 weeks and 5 days if it's a Friday afternoon, the providers agreed the hard stop reminds them they must be accountable for their actions. She stated:

ACOG took that data and ran with it and have now come out with a public statement [hard stop], which has been adopted by most hospitals, including mine, that we do not deliver below 39 weeks. I'm on the peer review committee, so it's really embarrassing to have to yell at yourself in the meeting for inducing



somebody. So it doesn't mean it can't be done, but you better have a darn good reason and the reason needs to be on this list [medically necessary]; it's approved by the hospital, by my committee.

Similarly, Physician 5 discussed how the hard stop rule has been implemented in many hospitals across the country thanks to the efforts of the March of Dimes. ACOG has also been instrumental in managing patient requests for early non-medical inductions. The provider also acknowledged that the hard stop rule serves to remind him personally of the importance of ensuring his patients complete full-term pregnancies. He stated:

The College [ACOG] has always been clear with regard to the 39 weeks...but it becomes a relatively slippery slope, I have to admit that occasionally myself, 38 and 6 is on Friday, what's between Friday and Saturday? It's hard to convince myself that it makes a huge difference. So, how do I convince the patient that she should wait until Monday for 39 and 2? But it's also an example for the residents. So, I think that's sort of how we start to approach it.

Similarly, Physician 16 revealed that she appreciates the hard stop rule because it sends a clear message to providers about the perils of inducing labor before 39 weeks. Even though she believes there is little difference between a baby born just shy of 39 weeks and a baby born right at 39 weeks, she had this to say, "So I feel like this 39 week rule is a hard stop because it sends a very strong message. But do I understand that a baby born at 38 [weeks] and 5 [days] is going to be okay. I do." According to the physician, the hard stop is essential because it sends a strong message to both patients and providers regarding the risky nature of elective late preterm inductions.

The physicians revealed that a hospital hard stop is beneficial for them in a two-fold manner. First, the hard stop prevents the providers from feeling as though they are the “bad guys” when patients request elective, pre-term inductions. Second, the hospital hard stop serves to remind the providers the importance of their clinical behaviors. The physicians discussed how delivering patients at 39 weeks, or full-term, is distinctly different from delivering patients at an earlier gestational age for no apparent reason and potentially inviting rather than preventing harm to both mothers and babies.

The current study has considered several decision-making scenarios, including patient requests and physician acquiescence based on patient autonomy and patient requests and physician refusal based on the direct contradiction of the patients’ request to good medical care. The final decision-making scenario espoused by the obstetricians revolves around a situation in which physicians may recommend treatment to their patients and the patients in return, may refuse the recommended care. The following section examines the frustrations, discomfort, and conflict experienced by physicians in this decision-making scenario.

### **Patient Refusal of Provider Recommendations: Physician Frustration**

The final scenario of patient-provider decision-making in obstetrics focuses on physicians' recommendations of treatment and patients’ refusals of the treatment. The physicians discussed that, although patients are well within their rights to resist or refuse medical recommendations, physicians are often frustrated when patients refuse treatment or refuse to follow their recommendations. Physician 22 revealed that she becomes frustrated when patients refuse her recommendations surrounding prenatal care and delivery decisions. She claimed:

I'm always shocked at how people come to us for advice, and this is what we are, we are glorified consultants, and so what we do is we give medical advice. The truth is that they don't have to take it, but I'm also completely shocked that they would be paying me over and over again, and yet when I give them advice, they say, 'No thanks, I am going to do something completely opposite.' Why are you paying me for advice?

Beyond the frustrations that clinicians expressed when they discuss the fact that patients often decide against their medical recommendations, obstetricians reported there are also times when patients' refusal of care potentially jeopardizes either the health of babies or mothers. In these situations, the physicians reported experiencing great discomfort and worry.

Physician 1 discussed a situation in which she worried about a patient who refused medical intervention when she was 42, almost 43 weeks. The physician was gravely concerned because the statistical likelihood of a woman having a stillbirth increases significantly after 42 weeks gestation. The physician recounted a scenario she witnessed in medical school of a patient, whose refusal of a medical intervention to induce her pregnancy resulted in a still birth at 43 weeks. In her own practice, the provider recounts the distress she endured when one of her patients refused her medical recommendations:

I had a patient that did not want to be induced and was getting close to 43 weeks. I was personally and professionally terrified because the only experience I had with 43 weeks was a dead baby. I probably lost five years of my life [worrying].

She finally went into labor at about 42 weeks and 2 days. But she was railing against the medical establishment and their interventions.

Because of her previous experiences, the refusal of the patient to accept medical intervention greatly concerned and worried the physician, who feared that she would have to deliver yet another dead baby. This physician and others explicitly stated that, contrary to popular belief, they do not recommend medical interventions simply for the sake of performing medical interventions. The providers indicated, however, that when mothers or babies are at heightened risks for poor health outcomes, they will encourage certain interventions for the health and well-being of both. When the patients refuse the recommendations of physicians, especially those interventions deemed necessary for preventing devastating health outcomes, the obstetricians reported they frequently experience discomfort and anxiety over the potential outcomes of the pregnancies. Physician 5 described an experience with a patient who needed a c-section because her baby was under a great amount of stress. He recounted his conversation with her in the following manner:

I'm concerned about the health and well-being of your baby. This is not about me trying to do a cesarean section that doesn't need to be done. I'm concerned about it and this is the right thing to do for your baby. I can't force you to sign a consent document, and I can't strap you to the table. But about every half an hour, I'll come back in [delivery room] and make a new recommendation to you. You can continue to refuse, and I will continue to document that you've refused.

When women refuse the medical advice and care advocated by their providers, physicians report they have little recourse other than asking patients to sign legal

informed consent documents in which they acknowledge they are refusing the care advocated by their physicians. However, while the patients' signatures provide certain legal protection to the providers, physicians report they still experience discomfort when patients do not comply with standard of care recommendations.

Similar to the experiences of the other physicians, Physician 2 remembered a time when he strongly encouraged a patient to schedule an induction of labor because she was approaching 42 weeks gestation. He became concerned because of the increased rate for still births at 42 weeks and beyond. The physician recounted the conversation he had with the patient:

I told her, 'I really don't feel comfortable with this. But that's fine.' It is fine. She chose another avenue. I have to live and practice what my ethical standards are. So I said, 'There is an issue here. I don't feel comfortable with this....so I'm just going to document informed consent. You do what you want to do.'

Although the physician reported that he was uncomfortable with the scenario, he had to respect the autonomy of his patient, and as a result, was only able to document the patient's informed consent. Physician 9 detailed a similar situation in which he strongly recommended a mother deliver her baby through cesarean delivery because of unforeseen health complications that developed during pregnancy. However, despite his best efforts, the patient still refused his recommendation. The provider stated:

If there's definite evidence that something is either harmful or beneficial to them, at least my thought is, I need to tell them that, but let them make their ultimate decision. I mean, we've had other scenarios in labor here where we would recommend a C-section because the baby's heart rate had been down for an

extended period of time and we felt that we needed to emergently deliver the baby and the mom refused the C-section. That's her prerogative.

The provider stated that although he has an obligation to educate his patients about the risks and benefits of certain decisions, he is unable to force patients to accept his recommended interventions because patients have the legal right to refuse them, even if the physician deems the recommendations as life-saving.

In a more complex scenario, Physician 22 described an interaction she had with a patient who, at 32 weeks, refused to allow the provider to deliver her baby. Despite all of the indications for delivery, even in the face of major prematurity concerns, the patient refused to allow the provider to deliver her baby by a C-section. The provider recalls the moments following the mother's refusal of a potentially life-saving cesarean section:

And so I watched the heart rate monitor go lower and lower until the baby died and I pitted out a breach. Saddest thing I've ever seen. I cried and cried and cried for hours. But that's the line of patient autonomy. How do I cross that? I mean, I can't do a C-section on somebody who doesn't want it. That's assault. So my only choice is to get a judge's order, and when I've got a dying baby, I don't have time.

This provider's narrative highlights the full-range of emotions that may be experienced by physicians. Particularly within the context of pregnancy, providers acknowledge they are often overtly criticized for public perception surrounding seemingly unnecessary medical interventions. Doctors believe when there are times they can provide life-saving procedures or interventions that will positively impact the health of either mothers or babies and yet are unable to do so, they express feelings akin to powerlessness. They are

unable to force care upon their patients, and even if they could, they would be denying them their rights to patient autonomy.

Physician 16 expressed a similar situation in which she recommended a high-risk mother to stay in the hospital to be monitored because of various co-morbidities she had including serious hypertension and gestational diabetes; however, the patient refused to be hospitalized for monitoring. The situation was further complicated because the patient lived two hours away from the hospital. The physician recounted how she felt both conflicted over how to provide appropriate care for the expectant mother and anxious concerning the potential outcomes the woman might experience because of her refusal to be monitored. The physician stated:

But I worry sick about her out there; but yet, should I have taken her baby out at 32 weeks? Which is to me significant prematurity. If she abrupts, I'm going to think I should have, right? But those are very competing outcomes, which I have a very hard time knowing what the percent is. I think less than 1% that she'll do that. But I tell you if something happens, we're all going to feel terrible.

Despite the recommendation from the physician that the patient remain in the hospital for fear something tragic could happen to her and or the baby, the patient refused the recommendation. As a result, the provider experienced tension and stress over whether or not she should have delivered a 32 week baby or continue to expectantly manage the woman's pregnancy despite the many indications for delivery.

Similarly, Physician 27 claimed there have been times in her medical practice in which she strongly recommended medical interventions either for the sake of the mothers or babies, and the recommendations were rejected. When patients refuse recommended

medical interventions, she argued she has no choice but to require them to sign a document of informed consent, or a document that describes how the patient has been thoroughly counseled by the provider but is refusing recommendations for medical care. However, she claimed that despite the desires of physicians, she or any other obstetrician cannot force procedures upon patients. She claimed:

They'll sign a kind of consent form that says that it is the physician's recommendation that we do such and such and that you are declining it, and that you understand that the risks could lead up to fetal death or even maternal death. Once they sign the form we just continue on with their plan of care. We tend to have them sign paperwork for our legal protection, but ultimately we're not going to force anyone to have a procedure against their will.

During the course of the interviews, the physicians strongly expressed their unwillingness to impose their medical recommendations on patients. And even if the physicians were afforded such opportunities, they recognized the importance of patient autonomy in their plans of treatment. However, when patients refuse physician recommendations, the doctors report experiencing much anxiety and frustration over patient decisions. And while patients are well within their rights in refusing to accept recommended procedures from physicians, the providers expressed confidence in the decisions and recommendations they make as trained medical professionals.

### **Summary**

This chapter has identified the physicians as conduits of convergence within medical decision-making encounters with their patients. The physicians, who are well-versed in medical literature and recommendations, indicated how they strive to



thoroughly educate patients in prenatal medical encounters. Within that realm, the doctors described how they often must correct pregnancy beliefs that patients espouse, many of which arise, they believe, from various social influences and from pervasive pregnancy myths. Further, the physicians discussed how they specifically address incorrect perceptions held by their patients surrounding early pre-term birth and patient requests for elective inductions before 39 weeks.

The chapter also highlights various decision- making scenarios that the physicians who function as conduits of convergence experience with their patients. The first scenario focused on patient requests and physician acquiescence to those requests based on patient autonomy. According to ACOG, patients should be allowed autonomy, when possible, in their prenatal care. More specifically, if the desires of the patients do not conflict with the proscribed standard of care, or with standards the providers consider to be good medicine,” ACOG encourages physicians to grant patients’ requests as long as they do not circumvent what physicians consider to be good medicine and as long as physicians have thoroughly counseled patients regarding risks and benefits of medical options. Particularly surrounding elective primary and elective multiparous cesarean sections, physicians are strongly encouraged to afford their patients autonomy.

Physicians are strongly encouraged to supply their patients with a high level of autonomy, particularly when it involves elective primary and elective multiparous cesarean sections. However, there are times when physicians disagree with certain patient requests because they believe those requests are born out of a sense of fear or uncertainty; thus, they believe that granting such requests would be tantamount to providing care that is less than ideal for both mothers and babies. The physicians were quick to point out the

seriousness of the tension they experienced over granting patient requests even though the provider understands fully that patients' choices may not be ideal.

The physicians also described a decision-making scenario in which patients make requests of their obstetricians, but the physicians, in turn, reject those requests based on their own professional autonomy and their belief the requests appear to be in direct contradiction to what is considered to be good medicine. When patients request elective inductions before 39 weeks, the physicians indicated they are particularly adamant about not granting those requests because of the preponderance of the literature warning of the dangers of inductions of labor at such early stages. Also, not only did the physicians note how granting such requests could endanger their medical practices, but they discussed the communicative strategies they employ in order to help foster patient understanding of the risks to mothers and babies when patients do not complete full-term pregnancies. In addition to discussing their personal viewpoints concerning patient requests for early inductions, the physicians explained their positive perceptions and support of hospital hard stops which are designed to prevent early elective inductions.

Finally, the obstetricians discussed a unique decision-making scenario in which the physicians recommend certain procedures to their patients, but the patients decide to reject the recommendations. The physicians explained that although public perception of obstetricians is that they sometimes are notorious for recommending and providing unnecessary medical interventions, there are, in fact, times in interventions during pregnancies are medically necessary and warranted. The physicians claimed that decision-making in their medical practices is not always easy, and they contend they experience both frustration and heightened discomfort when patients reject their

recommendations. According to the physicians, when women are counseled by their obstetricians throughout the duration of their pregnancies, they should be more trusting of and willing to accept the advice of their doctors who are highly-trained medical professionals. The physicians are quick to admit, however, that this is unfortunately not always the case.

## CHAPTER SIX: CONCLUSIONS AND IMPLICATIONS

The current chapter reviews the findings and presents conclusions surrounding the communicative role of the obstetricians in women's delivery decisions. The study positioned obstetricians as conduits of convergence who must make sense of uncertain communicative health environments when providing care for patients. The study also considered roles of obstetricians as conduits of convergence who must help patients engage in delivery decisions. Finally, the current study considered the scenarios of decision-making with patients as espoused by the physicians. The tensions expressed by obstetricians in delivery decision-making with their patients include patient requests and physician refusal, patient request and physician acquiescence, and physician recommendation and patient refusal.

The chapter presents the overarching study conclusions as guided by the following research questions:

*RQ1: How does the process of message convergence manifest among obstetricians who must make sense of competing medical literature when advising patients?*

*RQ2: How do physicians function as conduits of convergence within the medical encounter?*

*RQ3: What is the physician-perceived nature of decision-making with patients surrounding delivery decisions?*

### Message Convergence and Medicine

The study examined the framework of message convergence among obstetricians who must make sense of diverse arguments and often competing messages in order to

make sound recommendations for patient care. Sellnow et al., (2009) proposed the message convergence framework as a mechanism for understanding the ways that people make sense of competing messages and multiple arguments in a complex communication environment. In an effort to more comprehensively understand the ways in which medical physicians make sense of competing arguments when making recommendations for patient care, the following research question was posed: *How does the process of message convergence manifest among obstetricians who must make sense of competing medical literature when advising patients?* In-depth interviews with obstetricians revealed ways in which the message convergence framework functions among obstetricians. The findings of message convergence and obstetricians are discussed in the following section:

### **Message Dominance and the Medical Landscape**

Within the interviews, the physicians' remarks often substantiated the findings of Sellnow et al. (2009) when they argued that the process of message convergence is distinct from message dominance, or the state in which "an industry or government agency imposes a dominating presence in the public discussion or risk" (p. 15) by denying individuals access to information. Scholars conceptualize message dominance as a situation in which one major argument is advanced by a certain entity that overpowers and essentially refuses the admittance of additional/alternative messages into the risk communication message interaction. As a result, when one message is advanced by an entity that functions as a gatekeeper forbidding the consideration of other messages, message dominance is undoubtedly undesired.

However, message dominance may function much differently in the field of medicine. Rather than refusing the presence of other messages, evidence-based clinical recommendations are established on the most methodologically rigorous experimental designs which produce data that empirically reveals the risks and benefits of certain medical procedures or practices. Thus, when medical governing bodies, such as ACOG, promote one method or procedure as the most acceptable method of clinical practice, the organization is doing so based on the most reliable and sophisticated data available.

Depending upon the context, message dominance is not necessarily a dismal commentary on the dismissal of plausible arguments that are denied their rightful place in the risk communication forum. Instead, message dominance in the field of medicine, and more specifically within obstetrics, reveals that certain governing bodies within medicine have developed medical guidelines and recommendations on the best available data possible. And in doing so, medical governing bodies, including ACOG, establish standards for optimal clinical practice. In fact, deviating from the standards without legitimate reasons would be tantamount to deviating from the standard of care with which all obstetricians are charged and required to follow. The examination of individual physician practices and established medical protocol exhibits that message dominance functions differently in a medical environment than it does in other arenas.

### **Expert Consensus as Message Convergence**

The physicians reported that in the absence of Level A evidence, which is based on rigorous methodological designs which are utilized to create explicit evidence-based recommendations, obstetricians must rely heavily on expert consensus for establishing medical judgments. The providers stated that there are many gray areas within obstetrics

where evidence-based recommendations either do not currently exist or situations in which evidence-based recommendations may never exist because of the risks involved with subjecting pregnant women and their babies to certain clinical trials. Therefore, expert consensus provides obstetricians a high level of confidence when determining the appropriate treatment for their patients.

**Convergence at the organizational level.** When governing medical bodies, including ACOG, issue expert consensus statements, the organizational members responsible for creating guidelines in obstetrics experience message convergence as they sift through diverse and, at times, competing arguments in published scholarship. Expert consensus is desired when robust and rigorous clinical trials are unavailable for establishing evidence-based guidelines. As the providers in the current study agreed, expert consensus or current expert opinion statements are developed when leading physicians employ their expertise and clinical knowledge when reviewing competing data, opinions, and claims for managing certain concerns in obstetrics. The act of developing and reaching expert consensus not only serves as a best practices approach for continuity in providing the best obstetrical care across the country, but the development of expert consensus for obstetrical practitioners reveals that message convergence is occurring by leading physicians in the field who set the standards of medicine and practice for other physicians. Governing bodies, such as ACOG, regularly release committee opinion or expert consensus articles on a variety of topics so physicians might understand their stance on various issues based on their assessment of the literature.

**Convergence at the individual level.** Despite the best efforts of the governing bodies of medicine for issuing committee opinion and expert consensus statements, there

are still concerns providers may encounter, especially when patients have several co-morbidities that may be complicated for providers to treat when no expert opinions exist. During those situations, physicians must sort through competing claims for managing either unique cases or high-risk patients. Providers stated that when they need to make sense of competing claims, they seek a wide variety of sources for clarification. Not only do they report conducting an initial online search to obtain a knowledge base for a topic, but the providers also described how they seek help and opinions from other providers who possess differing areas of expertise or who have more experience practicing in the field.

Once the providers seek information from multiple sources to assess various arguments that may often contradict one another, they must then determine which methods to recommend to their patients based not only on the patients' input and specific medical needs, but also on the knowledge base and experience of the attending physician and of other physicians from whom advice was solicited. The physicians articulated that when they perceived an argument or message for pursuing a certain method of treatment was consistent across multiple sources, the overlapping messages appeared to validate the recommended treatment. In other words, the physicians were convinced the chosen course of treatment was appropriate when they found it present among several distinct sources. The finding that medical providers not only look to multiple sources for overlapping arguments, but that they also are more persuaded and feel more confident to proceed with the treatment method that becomes most salient through message convergence is significant. Current analysis indicates the way healthcare providers make sense of competing claims is consistent with the theory of message convergence.



Previous studies have only considered interacting arguments and message convergence among lay individuals. However, the current analysis reveals the process of sorting conflicting messages and sources while looking for similarity and overlap is consistent among highly-trained and specialized medical physicians. The analysis suggests the process of message convergence is not only the decision-making process employed by lay individuals, but is also utilized by highly trained and knowledgeable physicians who reportedly engage in sorting through interacting messages to assess the most salient argument, or the argument that appears to be overlapping through multiple sources.

### **The Disintegration of Perceived Convergence**

Beyond revealing that propositions of the framework of message convergence ring true among medical providers when they are looking to make sense of voluminous research and information, the current analysis also reveals that physicians must keep a watchful eye on the recommendations or expert consensus statements that are issued for the field. Because consistent with other message convergence studies, the strength of certain claims of convergence must be constantly assessed and considered in light of more recent information. The physicians noted there have been times in medicine when later research studies or additional evidence revealed initial recommendations to be incorrect.

Other providers commented that because ACOG and other organizations are slow to publish their compendium, data is often outdated by the time the providers receive it. Because of this, obstetricians must consider more recent, published scholarship not contained within the ACOG document. Although the physicians noted that ACOG appears to be vigilant in trying to ensure physicians keep updated with the most recent

research, the updates can quickly become obsolete when new evidence is introduced. Although not always successful at being timely, the organization strives to systematically update its recommendations and guidelines through current opinion statements, according to physicians.

Finally, some providers acknowledged they must be extremely careful when practicing by evidence or guidelines, especially if they suspect a potential for bias either in the data of published studies or by the agencies advocating for a certain guideline based upon medical research.

### **Participatory Convergence**

Another interesting finding from the current analysis focuses on the concept of participatory convergence. Several physicians pointed out circumstances in which either evidence-based recommendations or expert opinions do not exist for treating certain patients with multiple co-morbidities. Situations exist when particular patients do not fit well into the confines proscribed by the recommendation or consensus. Although there are multiple choices from which the providers can select a treatment option, most reported they look to their patients for their opinions concerning treatment. The significance of this finding illustrates that in seeking overlapping messages from sources concerning the appropriate methods for treatment, providers often rely on and put much stock into patient input. They look to their patients to engage in interacting messages by encouraging them to voice specific preferences concerning their medical treatment. Ultimately, the discourse between providers and patients reveal that patients can and do play a critical role in helping the provider sort through competing messages when determining the most appropriate and effective method of patient care.

## **Perceived Role of Physicians as Conduits of Convergence**

The current study was conducted to enhance understanding surrounding the perceived communicative role of obstetricians as conduits of convergence with their patients. In an effort to promote understanding of the influence of the message convergence framework on physician interaction with patients, the following research question was posed: *How do physicians function as conduits of convergence within the medical encounter?* The obstetricians reported that sometimes their patients experience a wealth of misinformation about pregnancy, specifically surrounding delivery. Although the physicians acknowledged that even though many of their patients are well-educated about pregnancy and childbirth, as physicians they frequently must debunk misinformation because their patients often hear erroneous details and may also be overwhelmed by the sheer amount of pregnancy information in circulation. The obstetricians stated how addressing online information can be particularly challenging because patients often bring a great deal of it to the medical encounter. Physicians even report searching for certain topics or concerns online to determine what information patients may be encountering in their research.

By helping patients make sense of multiple arguments and interacting messages, the physicians function as conduits of convergence. Given their medical expertise and experience sifting through multiple arguments and myriad sources in medicine, physicians function as conduits of convergence by clarifying information for their patients.

## Perceived Communicative Role in Decision-Making

The current study also sought to create understanding of the perceived role of obstetricians in decision-making with their patients. To that end, the following question was posed: *What is the physician-perceived nature of decision-making with patients surrounding delivery decisions?* Within the prenatal encounter, the physicians perceived their role as not only educating their patients concerning delivery, but also correcting obstetrical misinformation the patients may have previously received.

### Scenarios of Decision-Making

*What is the physician-perceived nature of decision-making between obstetricians and patients surrounding delivery decisions?* The physicians discussed three distinct scenarios of decision-making with their patients regarding delivery decisions. The following sections contain in-depth discussions of the three physician-perceived scenarios of shared decision-making.

**Patient request and physician acceptance.** Because the obstetricians perceive they practice medicine in an environment dictated by medical consumerism, the physicians described a frequently occurring scenario in which patients request elective procedures from their physicians regarding labor and delivery. Although the obstetricians acknowledged their distinct clinical preference is to not interfere with Mother Nature, they also revealed that when patients make requests for elective procedures that do not contradict established medical guidelines, the physicians are usually inclined to grant their requests if possible. Although there are times when patients request elective procedures that physicians consider as average or mediocre approaches to care, the physicians revealed how they are strongly encouraged by ACOG to grant such requests.

Granting patient requests promotes patient autonomy and encourages patients to participate in their own care and pregnancy experience. Additionally, given the litigious nature of the current medical landscape, denying patients their requests could be legally risky for physicians. By honoring the requests of patients, the physicians are recognizing the importance of patient autonomy and are also protecting themselves legally.

**Patient request and physician refusal.** The physicians also discussed scenarios in which patients request elective procedures that directly conflict with the physicians' understanding of "good medicine." In other words, patients sometimes request elective procedures that physicians believe directly contradict evidence-based guidelines.

In particular, some obstetricians discussed the fact that patients may request elective inductions before 39 weeks either because of perceived convenience or because they are simply uncomfortable during the final stages of their pregnancies. The obstetricians stated that persuasive communicative strategies that encourage patients to complete full-term pregnancies must be implemented. Such strategies include acknowledging the miseries of pregnancy and encouraging the patients by reminding them their pregnancies are temporary and will not last forever. The physicians stated the importance of their rights to refuse patients' requests for elective inductions before 39 weeks because the procedure is unnecessary and risky. According to the physicians, they are also forbidden by ACOG and many hospitals from performing such procedures. Violating the restrictions on late pre-term births could jeopardize the medical practices of obstetricians.

**Physician recommendation and patient refusal.** The obstetricians also revealed decision-making narratives with patients in which the physicians recommended medical

interventions or treatments to patients during pregnancy. The physicians revealed they often make recommendations for important medical interventions when they perceive their patients to be at heightened risk for harm.

However, the physicians also noted that despite their years of medical experience and expertise, patients at times refuse to heed their expert advice. Although the patients have the right to refuse any and all treatment, the doctors expressed frustration and discomfort whenever patients do, in fact, refuse their recommendations. Some obstetricians revealed they have experienced anxiety and discomfort while worrying about patients who refuse to receive what they deem as essential medical care.

### **Implications**

The current study has several implications regarding the application of the message convergence framework among obstetricians who counsel and aid their patients in decision-making. The following section contains an in-depth discussion of the implications.

#### **Message Convergence**

The analysis of the current study reveals that message convergence continues to function and maintain its predictive properties when applied within a healthcare environment. While previous research employing message convergence has focused primarily on arguments that emerge from various organizations in the midst of a crisis and necessitate immediate decision-making from stakeholders, the current dissertation positions the message convergence framework in an environment free of temporal timelines. The messages surrounding women's delivery decisions, and particularly elective procedures for women, have developed over decades. This implication affirms

and resonates with the findings of Head (2013), who applied the message convergence framework to understand the message environment of the HPV vaccine. Head argues that messages pertaining to young women's decisions about certain vaccines have developed over many years and will continue to develop. Also, similar to Head (2013), the current study employed the message convergence in a health communication setting rather than a crisis communication situation. Therefore, the current study also reveals the message convergence framework is applicable in health communication message environments without temporal restrictions.

Further, the current study applied the message convergence framework within a novel group of participants: medical physicians. Previous research involving message convergence has assessed the experience of uncertain communication environments and decision-making processes among lay stakeholders in the midst of a crisis. However, the current study utilized the message convergence framework to generate greater understanding of decision-making processes of obstetricians who counsel and provide care for patients. Particularly when physicians experience uncertainty or when multiple options exist for treating patients, physicians must make sense of an environment with often interacting arguments. When faced with various options for patient care, the physicians chose decision-making strategies consistent with the propositions of message convergence. In other words, the physicians discussed the convincing nature of messages whose core arguments overlap. The obstetricians believed the overlapping messages enable them to make confident decisions for patient care in the midst of either conflicting arguments or in the absence of rigorous evidence to aid them in their decisions. Further, the physicians also acknowledged that the strength of the perceived message convergence

is continually re-evaluated in medicine. In other words, the argument that emerges as the most valid and promising may later need to be revisited because of more recent findings and newer research in the field of medicine.

The finding that the framework of message convergence appears to function in the same manner among lay stakeholders and medical patients as it does among highly trained medical professionals bolsters the viability and practical application of the message convergence framework. Regardless of an individual's level of education and profession, the message convergence framework functions consistently among persons operating in communicative environments marked by multiple messages and conflicting arguments. Therefore, the propositions of message convergence perform similarly among diverse samples of people.

Finally, the current study provides a unique departure from traditional applications of the message convergence framework. Sellnow et al. (2009) clearly distinguished between message convergence and message dominance, and the latter is cited as undesirable because the interaction of arguments is stunted. The scholars conceptualized message dominance as “detrimental to the risk communication process” because “no party has the right to dominate and exclude the concerns of another” (p. 15).

However, in the context of physicians making sense of competing messages in medicine, evidence-based medicine, and particularly that of Level A caliber, performs similarly to message dominance. Specifically, evidence-based guidelines function as the most dominant and salient arguments because they are advocated to physicians by medical governing bodies including ACOG. Medical organizations strongly encourage physician adherence to evidence-based guidelines because evidence-based



recommendations are established only after extensive and sophisticated research has been conducted. When medical organizations promote evidence-based guidelines, they are giving preference to one perspective, thereby advocating for a dominant message or argument. Yet in the medical field, when governing bodies strongly encourage physicians to adhere to evidence-based recommendations for the sake of providing a high standard of care to patients, message dominance should be welcomed as a positive force rather than one that inhibits the natural interaction of arguments. The current study provides an extension of the message convergence framework by positioning message dominance as a positive and desirable condition instead of one that should be avoided.

### **Conduits of Convergence**

The finding that obstetricians function as conduits of convergence for their patients is significant not just in obstetrics, but for other areas of medicine. Because patients now have instant access to health information at the click of a button, physicians are not only responsible for educating patients within the medical encounter, but they also are charged with correcting misinformation or myths adopted by their patients. The significance of physicians serving as conduits of convergence is that the physicians are important and credible voices in the sea of many messages and arguments about patient health. Physicians not only have the opportunity, through patient counseling and education, to equip patients with the knowledge they need during their pregnancies, but they also are afforded the opportunity to dispel myths and anecdotal information women may have obtained online or from family and friends. Therefore, obstetricians should proactively inquire into their patients' understanding of health information because the physicians may have to correct and educate their patients.

## **Perceived Communicative Role in Decision-Making**

The current study also has very interesting implications for patient-physician communication. The interviews with obstetricians concerning their perceived communicative role in patient decision-making yielded results that differ greatly from long-standing narratives regarding pregnant patients and their obstetricians. First, many studies (Simpson & Newman, 2010) identify physicians as agents of persuasion and manipulation who encourage and even coerce their patients into unwanted and unnecessary elective delivery procedures. Physicians are blamed for increasingly high cesarean delivery rates and for elevated numbers of elective inductions, particularly including those before 39 weeks gestation.

However, the obstetricians in the current study revealed a very different version of the role of the physician in women's delivery decisions. The physicians insisted they do not promote or encourage their patients to engage in unnecessary elective medical interventions. Instead, they argued that patients request elective procedures on their own and without the input of the physicians. However, due to ACOG recommendations for patient autonomy, as well as their own fears of legal consequences, the physicians perceive they are sometimes at the mercy of the patients and their requests. The obstetricians explained that despite their own preferences not to tamper with Mother Nature, especially with elective interventions, they are personally committed to honor and respect the autonomy of their patients. Therefore, the physicians felt that, at times, their medical autonomy was usurped by conditions that necessitated the need to promote patient autonomy.

The stark difference between the self-perceived account of the physician role and the perception of the physician as presented by pregnant and post-partum patients in

current scholarship suggests significant misunderstandings between patients and their physicians. In the current study, physicians expressed how they believe they are genuinely trying to offer the very best care to those they treat, but also expressed an awareness that some individuals mistrust them and do not believe their primary concern is for their patients. However, often accounts of physicians in the literature describe them as more concerned with their own schedules and conveniences than with the well-being of their patients. The obviously differing portrayals of physicians reveal a need for improved patient-provider communication. Patients need to be fully convinced of the good intentions of their physicians in order for them to have faith and trust in them.

In terms of decision-making, current literature has also examined the willingness of obstetricians for engaging in shared decision-making as compared to other medical providers. For instance, Matthias (2010) argues that obstetricians are less likely than other medical providers, particularly midwives, to engage in shared decision-making with their pregnant patients. However, her argument tends to be too simplistic for grasping the dynamic of patient-provider decision-making and communication. While Matthias claims that midwives are far more patient-centered in their approach to care than obstetricians, the reality in shared decision-making with patients is far more nuanced.

The physicians in the current study acknowledged time and again the complications they must face when striking a balance between respecting patient autonomy and maintaining their perceived physician autonomy. The physicians in the current study acknowledged when established clinical guidelines are published by the American College of Obstetrics and Gynecology warning against specific medical

practices, then obstetricians will definitely refrain from granting patient requests for those procedures for fear they will harm the mother and the baby. Also, physicians admit they would be fearful of practicing outside the realm of the recommended standard of care. Alternatively, obstetricians must manage with great finesse the simultaneous and often conflicting struggles of patient autonomy versus evidence-based medicine and the tension between patient autonomy and physician autonomy. Further, the providers must also reconcile concerns of patient autonomy and informed consent when providers advise certain medical recommendations for their patients, and the patients subsequently refuse them.

### **Patient Refusal of Recommendations**

The obstetricians reported they experienced situations in which patients resisted their recommendations for necessary medical care. Physicians consistently stated that while they would never force undesired care upon their patients, they frequently experienced frustration associated with patient refusal of necessary medical recommendations. The obstetricians credited the behavior of their non-compliant patients to patient-empowerment movements within the medical community. The physicians recognized that patients are well within their rights to resist recommended care, but by the same token, physicians sometimes perceive patient refusal of physician recommendations to be emotionally and professionally taxing, especially if the physicians believe that refusal of care could result in harm to the mother or baby.

The obstetricians reported experiencing feelings of distress and helplessness when patients refuse their medical interventions. They also claimed that patient refusal of recommended treatment destroys the bond of patient-provider trust that may have

developed over many months. Physicians admitted they have become actually surprised when patients are so eager to refuse their professional medical recommendations.

Because some voices in the birthing community position physicians as antagonists to patients having natural deliveries, (Simpson & Newman, 2010) the physicians sometimes perceive that women feel empowered to resist elective, non-medical recommendations. The obstetricians, however, also report having been horrified when patients resist essential medically-necessary recommendations. For instance, there have been cases when physicians recommend cesarean sections to their patients because of medically necessary reasons, and patients resist because they distrust the intentions of the physician. Although physicians revealed that such refusals may not be a common occurrence, the refusals are certainly serious and occur far more frequently than they would prefer.

These disturbing findings reveal a need for greater patient-provider communication to improve the level of trust between patients and their obstetricians. Many birthing programs coach patients to ask physicians questions about the necessity of their actions and encourage patients to refuse medical care if they are not thoroughly convinced of the necessity of the procedures. Further, a distinction needs to be made between non-medical, elective procedures that physicians suggest and the potentially life-saving, necessary interventions physicians recommend. Glantz (2012) argues that obstetricians must improve their efforts in educating patients on the differences of elective interventions and medically necessary interventions. While patients should be trained to ask physicians hard questions and to be cautiously suspicious of physician

recommendations of elective procedures, patients should also be encouraged to trust their obstetricians even if doing so means altering the mother's birth plan.

### **Organizational Constraints**

The physicians also discussed the various organizational constraints they experience when engaging in decision-making with their patients. The obstetricians first discussed the hospital enforced hard-stop programs intended to reduce the overall number of elective pre-term births. They noted that the hard-stop rule prevents the practice of elective inductions before 39 weeks gestation. For the most part, the obstetricians reported their approval of the hard-stop initiatives because of the frequent pressure they receive from their patients who request elective inductions. According to physicians, the initiatives serve to keep them accountable when considering pre-term cesarean sections. They also pointed out that defying the policies could lead to severe repercussions on their medical careers.

Further, the physicians discussed the tension they experience between managing the prescribed level of patient autonomy, as advocated by ACOG, while also balancing their own need for autonomy. Several of the physicians described the tension between their autonomy to practice as medical professionals and the autonomy of the patients to participate in decisions regarding their care. Many physicians admitted, however, that earlier in their careers, they did not foresee that the conflict might emerge as an integral consideration. The frustration experienced by physicians was evident when they discussed perceived tension between physician autonomy and patient autonomy. They recognized the importance of honoring the autonomy of the patient, but also emphasized that they were the individuals with medical degrees and experience, not the patients.

Other physicians described how modern obstetrics and medicine in general are defined by an atmosphere of consumerism. Many physicians claimed that as medical students, they did not expect to deal with such opinionated patients in their practices. Because of the frustrations experienced by the physicians, efforts must be made to assist them in navigating decision-making with patients, especially when they perceive their autonomy may be in jeopardy. Yoon, Rasinski, and Curlin (2010) revealed in their research that dissatisfaction and burnout rates are extremely high among American obstetricians, with over 60 percent annually reported to have difficulties in decision-making with patients. Given the high burnout rates, teaching obstetricians how to communicatively manage demanding patients may help increase their levels of physician satisfaction and perceived autonomy in practicing medicine.

### **Patient-Provider Communication**

The physicians discussed the communicative tactics employed to help their patients complete full-term pregnancies. Many physicians reported that at different times, they utilize humor, empathy, and encouragement with their patients in order to establish a greater rapport and influence. Some recalled urging the women to complete full-term pregnancies and forego requests for late-preterm elective inductions by acknowledging to the women how difficult pregnancy really is. Along with acknowledgement, physicians would then encourage the women by praising them for continuing their pregnancies.

However, not all of the physicians reported being totally supportive of their patients. Some of the providers acknowledged they have told patients their requests are selfish, especially when patients request elective inductions before 39 weeks. Extensive

literature details the adverse outcomes associated with elective inductions before 39 weeks, so when patients continue to seek elective inductions before that time, it is likely a result of being misinformed, being very uncomfortable during the last weeks of pregnancy , or sometimes the requests are even made for scheduling convenience. However, given the perceived power difference between patients and their obstetricians, handling patients so harshly by the physicians is not an ideal way for engaging in positive communication with them (Beisecker, 1990). Physicians should do everything they can to demonstrate empathy for their patients, many of whom are very uncomfortable toward the end of their pregnancies (Vos, Anthony, & O’Hair, in press). Despite the less than ideal nature of the requests, physicians should encourage and empower their patients rather than resorting to assigning guilt and issuing insults. Gallagher and Levinson (2013) advocate for greater communication training for physicians who are less than collegial with their patients. They point out that patients who feel humiliated or mistreated by their physicians are likely to file grievances against the physicians. Strategies for showing support and empathy should be emphasized and consistently reinforced to medical students, residents, and even current physicians so that patients might feel encouraged rather than discouraged and even humiliated when dealing with their physicians.

### **“Healthy Babies Are Worth the Wait”**

Before the March of Dimes campaign, the numbers of late pre-term births were steadily on the rise. Patients and physicians were both partially to blame for the increasing number of elective deliveries before 39 weeks. However, in terms of the current study, the physicians interviewed reported being vehemently opposed to elective late pre-term inductions. The physicians also mentioned the “Healthy Babies are Worth



the Wait” campaign, attributing the implementation of hospital hard-stops to the increase in awareness by both the medical community and the general public to the data indicating the poor health outcomes associated with elective inductions before 39 weeks. The physicians indicated their belief that the March of Dimes campaign has been effective in informing women of the risks associated with elective late pre-term inductions.

The following section discusses in detail certain limitations inherent in the current study.

### **Limitations**

One limitation of the current study is the reliance on self-reporting by the physicians in understanding the decision-making scenarios within the medical encounter. Particularly in the area of decision-making with patients, the current study includes only the perceptions of physicians regarding their interactions with patients. Although the physicians in the sample expressed similar accounts of their interactions with patients, their reflections differ greatly from studies which focus primarily on the perceptions of patients regarding medical decision-making with obstetricians. Therefore, the lack of the presence of patient perspective is a limitation of the current study.

The second limitation of the current study surrounds potentially sensitive topics discussed by the physicians. Specific questions in the study probed the motivations and the behaviors of physicians, and as a result, the obstetricians may have been less than willing to speak freely about the intentions of their actions. A prime example of this would be the topic of elective inductions before 39 weeks. The physicians in the study reported to be vehemently opposed to the practice, yet much scholarly literature surrounding elective inductions reveals a different narrative. Statistically, several

members of the sample have most likely engaged in this questionable practice either in the past or recently. However, the physicians may have perceived that either their medical reputations or practices could be jeopardized if they answered all questions with complete honesty. Thus, the social desirability bias may have played a role in why some doctors may not have been quite so forthcoming in their responses.

The third limitation of the current study is the absence of empirical data to confirm the self-reported elective intervention records of the obstetricians. Although the majority of the physicians claimed they rarely perform elective interventions during pregnancy, their accounts do not necessarily reflect the available data for the state of Kentucky. However, without the records of the physicians interviewed, there is no way to confirm if the physicians were accurately reporting their elective intervention numbers to the researcher.

The fourth limitation of the current study is the inclusion of both generalist obstetricians and Maternal-Fetal-Medicine specialists in the same analysis. Although the physicians seemed to answer the questions in a similar manner, the inclusion of the specialists in the study could have potentially affected the results of the study and the subsequent analysis as the population of high-risk patients differs substantially from low-risk patients.

### **Future Research**

Future research should consider the perceptual differences of physicians and their patients. Much scholarly literature positions obstetricians as healthcare professionals who either strategically or forcefully persuade patients into unnecessary elective procedures that benefit both schedule and compensation of physicians. However, the physicians

reported a very different version of the narrative of decision-making in delivery decisions. Future research should closely follow patient-physician dyads in order to include the perceptions of both the physicians and patients. Particularly in discussions of elective inductions before 39 weeks, the voices of both patients and physicians should be provided. The reporting of those dual voices may in fact reveal a different dynamic in decisions regarding elective inductions. In addition, assessing the perceived decision-making by capturing the perceptions of the medical encounter immediately following an interaction would undoubtedly provide a more comprehensive picture of the perceptions of the patients and physicians.

Future research should also consider the process of message convergence for both medical physicians and patients in other areas of medicine where competing messages and arguments compose the communication environment. As the obstetricians in the current study discussed, evidence-based guidelines are essential for guiding physicians in their medical practices. While the obstetricians in the current study lamented that there are often fewer high-caliber evidence-based practice recommendations, this is not true of all areas of medicine. For instance, in recent years in the area of cancer screening and prevention, dramatic changes have been instituted in evidence-based recommendations for screenings of both prostate and breast cancer. For example, the guidelines for prostate cancer screening were changed three times in a decade- in 2002, 2008, and again in 2011. Message convergence could be used to understand the ways in which physicians and patients make sense of these dramatic changes and could also help capture the experience of patients who must advocate for their own healthcare. Further, this application might enable scholars to gain a better understanding of how physicians make

decisions about changes in their medical practices regarding the updated recommendations for screening for prostate cancer (Barry, Denberg, Owens, & Shekelle, 2013). Future studies should continue to employ the message convergence framework in the health communication context to promote an understanding of how both patients and their healthcare providers make sense of competing claims and diverse arguments. Additionally, the current analysis guided by the message convergence framework reveals the need to conduct health communication campaigns surrounding the proposed changes for breast cancer and prostate cancer screenings so that both physicians and patients are aware of the recommended changes to the screenings.

### **Practical Applications**

One practical application of the current dissertation is that the study establishes a need for a communicative intervention with physicians surrounding decision-making with patients. Particularly concerning the third decision-making scenario in which obstetricians perceived a sense of disregard or refusal from patients surrounding timely medical recommendations, a communication intervention with physicians and patients could ameliorate some of the tensions expressed by obstetricians in decision-making. Patients, although taught in birthing and centering classes to be skeptical when physicians propose changes to established birthing plans, should be taught to ask specific questions to physicians concerning the medically necessary nature of the proposed intervention or changes to a birth plan. Alternatively, physicians should be encouraged to patiently describe the medical necessity of the proposed intervention to the patient. Such an intervention would better equip physicians to have conversations with patients toward the end of pregnancy regarding medically necessary interventions in pregnancy.

## **Conclusion**

The current study carefully examined the communicative role of obstetricians in women's delivery decisions. Guided by the framework of Message Convergence, the study considered the ways obstetricians make sense of diverse sources of information to help guide them in caring for their patients and making clinical treatment decisions. Further, the study considered the ways obstetricians function as conduits of convergence for their patients. Finally, the study presented and analyzed various scenarios of decision-making between obstetricians and their patients.

## **APPENDIX A: Provider Interview Questions**

### **Demographics:**

1. How long have you been practicing medicine?
2. Are you a private practice physician, a hospitalist, or a Maternal-Fetal Medicine specialist?
3. To which racial group do you belong?

### **Message Convergence/Sources**

4. How do you typically stay “up-to-date” on clinical guidelines and recommendations?
5. Where do you obtain your information surrounding medical research? Scholarly journals? Peers? Conferences? Online databases?
6. Is there a benefit of using multiple sources of information for information seeking?
7. Are there sources of information that you tend to trust more than others? Tend to distrust?
8. When you encounter contradicting information in the field of medicine, what do you do to sort out the differences concerning the conflicting information?
9. Can you tell me what the term evidence-based medicine means to you?
10. Is evidence-based medicine important to your practice?
11. What are some of the evidence based practices recommendations in the medical community surrounding elective inductions of labor?
12. What are some of the medical arguments in the medical community surrounding elective inductions of labor? Elective cesarean deliveries?
13. What are your personal opinions of the benefits associated with inducing labor at 39 weeks? At 40 weeks? At 41 weeks?
14. What is your perception as a provider surrounding the risks of elective inductions of labor before full term, or 39 weeks?
15. What is your opinion concerning the outcome associated with elective inductions before 39 weeks in relation to the outcomes associated with spontaneous birth?

### **Patient-Provider Communication**

16. Can you describe a typical medical encounter with a patient about delivery? How do you talk with patients about her delivery?
17. What are some of the uncertainties your patients face about delivery?
18. What are some of the uncertainties you face regarding delivery?
19. Shared decision making is defined as defined as “clinicians and patients making decisions together using the best available evidence. In partnership with their clinician, patients are encouraged to consider available screening, treatment, or management options and the likely benefits and harms of each, to communicate their preferences, and help select the course of action that best fits these.” Can you tell me a story in which you engaged in shared decision making with your patients surrounding delivery decisions?
20. What is your opinion of “shared-decision making” with patients?

21. Do you think that shared decision making between patients and physicians is important for effective patient-centered care?
22. How do you encourage shared decision making when discussing delivery decisions with your patients?
23. How do you present delivery options to your patients?
24. How do you advise your patients that seek early, elective inductions before 39 weeks? Between 39 and 41 weeks?
25. What are the reasons that women request scheduled cesarean sections?
26. What are the reasons that women request elective inductions of labor?
27. What are the benefits/risks that you present to you patients who are seeking an elective inductions? Scheduled cesarean sections?

**Power Dynamics**

28. Do you ever feel pressured by a patient seeking an elective induction of labor or a scheduled cesarean delivery?
29. How do you advise your patients who are considering elective inductions of labor?
30. How do you counsel patients that request an early induction before 39 weeks? What are some of the reasons that your patients request elective inductions before 39 weeks?
31. Have you ever employed the March of Dimes Brain Card to educate women about the perils of early term birth?
32. Have women ever resisted your instruction because of their hope to have a natural delivery?

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## Vita

Kathryn E. Anthony

### **Education**

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M.A., Communication, University of Kentucky (2010)

B.A., Communication, University of Southern Mississippi (2008)

### **Professional Academic Appointments**

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2013-present      **Assistant Professor**  
Communication Studies Program, Columbia College

2008-2013      **Graduate Teaching Assistant**  
Department of Communication, University of Kentucky

### **Awards and Honors**

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#### University of Kentucky

Michael Carozza Fellowship for Excellence in Health Communication, Fall 2013

Top Paper Award, Kenneth Burke Interest Group, Eastern Communication Association, April 2013

Top Paper Award, Applied Division, National Communication Association, November 2012

Risk Sciences Fellow, Division of Risk Sciences, 2011 & 2012

Graduate Fellowship Award, Delta Gamma National Fraternity, 2008

#### University of Southern Mississippi

Don George Award for Academic Excellence, Department of Speech Communication, University of Southern Mississippi, 2007 & 2008

## **Refereed Publications**

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Vos, S. C., Anthony, K. E., O'Hair, D. H. (in press). Getting to 40 weeks: Constructing the certainty of women's due dates. *Health Communication*.

Anthony, K. E., Sellnow, T. L., & Millner, A. G. (2013). Message convergence as a message-centered approach to analyzing and improving risk communication. *Journal of Applied Communication Research*, 41(4), 1-19.

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