OBSTETRIC PROCEDURES AND CHILBIRTH:

EDUCATED WOMEN'S PERCEPTIONS OF PATIENT AUTONOMY

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DEDICATION

For my six daughters, Victoria, Alisha, Hailey, Piper, Lorelei, and Rowan. Although you are each unique in personality, you share one common thread; you are all strong and independent. My hope is that you never lose that quality and that you always maintain your autonomy.

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ABSTRACT

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Research suggests that women who are subjected to an increased use of obstetric interventions and standard procedures may have a diminished perception of their decision-making ability during childbirth. To identify the extent to which women believed they maintained their decision-making power in childbirth, female students at Texas Woman's University, who have given birth, were surveyed through an online questionnaire containing closed-ended and open-ended questions, designed to measure perceptions of autonomy, and were analyzed for themes pertaining to autonomy and consent. The main finding of this study is that there is a discrepancy between what women report (diminished autonomy) and what they assert (a perception of satisfaction with their medical care). The results of this study point to the existence of an "ideology" of expert authority that is operative in the obstetric practice in the United States. These results are analyzed through theories of hegemony, hygienic regime, embodiment, and metaphysical violence.

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CHAPTER I

INTRODUCTION

PURPOSE OF THE STUDY

The purpose of this study is to examine the way in which educated women, who receive obstetric intervention during pregnancy and childbirth, understand their ability to make decisions regarding their care, their body, and their child. Innovations in medicine have significantly improved fetal and maternal mortality rates, and have assisted in achieving greater positive birth outcomes throughout the United States and the world, based on available data (Centers for Disease Control and Prevention [CDC] 1999; Kukla and Wayne 2016). Yet, within the last two decades, maternal mortality rates in the United States have begun to rise for reasons not yet clear (CDC 2016). Additionally, despite advancements in medicine and medical practices, many women are beginning to speak out about their birth experiences, noting increases in the use of obstetric interventions, and expressing feelings that their autonomy, or decision-making abilities, was diminished during childbirth (Pascucci 2015). In these instances, a perceived decreased sense of autonomy results due to suspected encroaching policies and procedures set in motion by hospitals and medical staff. Policies and procedures that limit, or even prohibit women from making certain decisions about their own care abound in the United States, despite the bioethical premise that "law and ethics of medicine are dominated by one paradigm – the autonomy of the patient" (Stirrat and Gill 2005:127). Not only do obstetric interventions have the potential to encroach upon the decision-making ability of

a laboring woman, but they may also contribute to negative pregnancy outcomes (Shabot 2015). Even the use of simple devices such as electronic fetal monitors, (external devices used to record fetal heartbeats) have led to the need for further interventions and more C-sections (Shennan 2003:607). However, there is no evidence that the use of these devices contributes to healthier birth outcomes (Shennan 2003:607). In fact, Rowlands (2012) states that unplanned C-sections, and "forceps-assisted vaginal deliveries" increase a woman's risk of "poorer health and wellbeing" following childbirth.

Current theoretically grounded research on women's perceived levels of autonomy after receiving obstetric intervention is limited. The extant literature addresses perceptions of the childbirth experience and mode of delivery (Bryanton et al. 2008), childbirth "embodiment" (Walsh 2010), and qualitative research on post-traumatic stress disorder (PTSD) (Beck 2004). The literature that does exist concerning woman's autonomy and childbirth outcomes focuses on developing countries (Osamor and Grady 2016; KC and Neupane 2016). The concept of autonomy or the decision-making ability of women in childbirth seems to be largely ignored in the United States in the literature. This study aims to address this neglected area.

This thesis shows that a decrease in decision-making ability is based on restrictions placed on pregnant and laboring women through the use of such procedures as mandatory external fetal monitoring, prohibiting laboring women to consume food or water, prohibiting "trial of labor after cesarean section" or (TOLAC), artificial rupture of membranes (breaking water), mandatory vaginal cervical exams, mandatory episiotomy,

and assisted delivery, to name a few. Understanding a woman's perceived level of patient autonomy when faced with interventions is important for not only the mental and physical wellbeing of women and their children but also for establishing policy and procedures with regard to maternity care.

Through the utilization of exploratory research methods, including a questionnaire with both closed and open-ended questions, completed by educated women who have given birth, this study gained insight into these lived experiences. Pregnancy and childbirth is not simply a biological process, which can be regulated and controlled with medical technology. Every childbirth experience is as unique, and idiosyncratic as the woman involved. In order to achieve the highest standard in medical care, improve birth and health outcomes, and reduce inequality in maternity care, it is of paramount importance to incorporate the perceptions of the woman's experience in scientific research on pregnancy and childbirth.

This thesis addresses both perceived and actual levels of autonomy among women in childbirth. Parous (those who have given birth), and pregnant women have the utmost interest in the outcome of their labor and delivery experience (Malacrida and Boulton 2013), yet their voices seem to be underrepresented in modern research, and possibly throughout their own labor and delivery experience. It is often argued that doctors and medical professionals with greater medical expertise should override women's decisions during childbirth in an effort to promote the welfare of the unborn child (Flannigan 2016; Paltrow and Flavin 2013). However, Molyneaux (2009) posits that individuals generally

know what is in their best interest, and what will negatively affect their wellbeing, and for this reason, it is important to consider the individual's autonomy.

SIGNIFICANCE OF THE STUDY

This thesis is the first exploration of parous, educated U.S. women's perceptions of autonomy in childbirth. The study examines the impact of obstetric practices on public health, human rights, and equality for women. This research also assists in formulating hypotheses and developing research questions for future studies. It also explores whether laboring women believe that they were stripped of their autonomy and had limited input into procedures performed on their bodies. Examination of women's perceived levels of autonomy may lead to further research that could facilitate greater communication and understanding between medical personnel and patients and thereby, potentially strengthen and balance the patient-doctor relationship. A greater understanding of a woman's perception of her decision-making abilities in childbirth, could increase positive birth outcomes, and decrease PTSD and other negative pregnancy outcomes (Osamor and Grady 2016).

This study contributes to the current literature on the impact of obstetric intervention during childbirth and its effects on women; an area in which very little research currently exists (Walsh 2010). As previously noted, much of the current literature and scientific research addresses technology and biology or focuses on developing countries. Research, which addresses women's perceived levels of patient autonomy in childbirth may contribute to progress in obstetric care. Policies, practices,

and innovations in technology can be drastically improved if the women who are subjected to them are afforded a greater opportunity to provide their input and insights. This thesis can be considered as a first step in that direction.

PLAN OF WORK

Chapter Two covers prior research on obstetric interventions during childbirth and theories of metaphysical violence, embodiment, ideology, hegemony, and hygienic regime. Chapter Three describes the methods, data, and data analysis of the study. Chapter Four discusses primary findings. Chapter Five summarizes the findings and discusses theoretical implications, limitations, and recommendations for future research.

CHAPTER II

REVIEW OF THE LITERATURE

This chapter begins with a review of current literature regarding the effects of obstetric procedures and interventions on laboring women. This exposition is followed by an overview of theories concerning metaphysical violence, embodiment, and ideology, hegemony, and hygienic regime. Finally, research questions are introduced.

OBSTETRIC INTERVENTIONS

Despite high levels of obstetric procedures in the United States, it has been suggested that "the recent increase in operative intervention has not been associated with improved" childbirth outcomes (Shennan 2003). Furthermore, it is noted that the increase in cesarean section rates "and other obstetric interventions" is a cause for concern. Green et al. (2007) and Shennan (2003) proposed that although elective C-sections are considered safer than those that are unplanned, they may double a woman's risk of death in labor and delivery (606). The phrase "elective cesarean" suggests that the decision to have a cesarean section is a result of a choice, independent from any existing or emergent danger to the mother or infant. However, it has been argued that many women are manipulated or coerced into consenting to such procedures, which would contradict the perception of patient autonomy. Molyneux posited, that when ideas are "introduced by coercion or oppression" patients are no longer independent, and their autonomy has been violated (Molyneux 2009). Much of the research in this field (Sheenan 2003; Beck 2015) tends to assume a medical or psychological standpoint

regarding obstetric procedures and resulting perceptions of autonomy. However, there is limited literature grounded within sociology or sociological theory on this topic.

Current literature suggests that women who receive high levels of obstetric intervention tend to experience a perceived decrease in their level of decision-making and control over their own bodies. Beck (2004) noted that these interventions, in addition to feelings of helplessness and poor quality of care often lead to symptoms of PTSD following labor and delivery (222). Women have reported feelings such as abandonment, loneliness, being "betrayed," feeling "raped," loss of "dignity," being "treated like nothing," and "terrified" (Beck 2015). Additionally, the research proposes that listening to women is paramount for making progress in maternity care (Murphy et al. 2003).

METAPHYSICAL VIOLENCE

The routine and ever-increasing medicalization of childbirth directly affects the laboring woman according to Allison B. Wolf. Utilizing the concept of "metaphysical violence," Wolf illustrated how common procedures in childbirth, which have become routinized within the medical community, in fact, constitute violent acts against women. According to Wolf, medicalized childbirth is a "system of childbirth that requires medical intervention and management at each stage of pregnancy and labor, *regardless* of the woman's individual risk;" and that it "denies that the woman is a unique self" (2013:7). Since this system is ingrained in our society, medicalization of childbirth is rarely questioned, because it is deemed normal in an institution which functions according to an established protocol (Wolf 2013).

Metaphysical violence, according to Wolf, is “violence aimed at the very being of its victims,” and can eliminate their “self or identity-constituting aspects,” repudiate their legitimacy as a distinctive “entity,” and interfere with their ability to develop themselves (2013). Accordingly, metaphysical violence can diminish a person’s agency and cause “physical or mental injury” (Wolf 2013). In her analysis, Wolf illustrated how various routine procedures, such as mandatory vaginal cervical exams, continuous electronic fetal monitoring, and repeated suggestions of epidural injections to laboring women amounts to metaphysical violence against them. For example, Wolf argued that vaginal cervical exams are “dehumanizing” in that they relegate a woman to a mere “vessel that can be manipulated and handled according to the dictates of others” and that it allows repeated physical violations to the laboring “woman’s body without provocation” (2013). Furthermore, this practice calls into question women’s assertion that they are actually in labor and reinforces the notion that “medical authorities” must confirm their claims before they are deemed true (Wolf 2013). According to Wolf, this strips the laboring women of their ability to know the authority they possess, and as such, it constitutes an assault on their most fundamental existential rights (2013).

This form of violence against women remains implicit and is often undetected within the context of the normal day-to-day workings of maternity care because it differs from outright physical assault and its effects are often internalized or dismissed. In fact, most women do not experience symptoms of metaphysical violence, such as post-traumatic stress disorder, and those who do feel these effects, do not always understand the root of their symptoms (Wolf 2013). However, Wolf argued that “perceiving violence

is not required for the violence to exist," and understanding how these violations occur is paramount to repairing any damage to the self that may result (2013).

EMBODIMENT

The idea of embodiment stems from the phenomenological theory of Edmund Husserl, which was later elaborated on by Heidegger and Merleau-Ponty (Behnke n.d.). Husserl's philosophy was adopted by Alfred Schutz in a sociological context and is currently enjoying a renewed revival within sociology particularly in the sociology of the body (Behnke n.d.; Shilling 2001). The notion of embodiment integrates - rather than differentiating - the psychological and physical into one. Thus, our lived experiences (including physical and emotional sensations, and our interactions and experiences with other lived bodies), are seen as continually transforming our being (Behnke n.d.). Husserl proposed that "the lived body is a lived center of experience," and our bodies are not merely vehicles that *transport us* through life, but *they are us;* (Behnke n.d.). According to Husserl, investigations involving the body must consider both the subjective and intersubjective experiences of the individual (Behnke n.d.).

Classical sociological theory has traditionally focused on "structural considerations over experiential and agentic considerations" (Shilling 2001) to account for social phenomena. However, Chris Shilling (2001) posited that traditional theories can work in tandem with body theories such as embodiment. For example, Shilling (2001) noted that both Durkheim and Simmel investigate the "human experience," which include emotions, interactions, and energies, and the ways in which this experience acts and is acted upon within society. These are the same premises that exist within the theory of

embodiment (Shilling 2001). Although it appears that Durkheim and Simmel differ in their views on "social life," according to Shilling, in actuality they are united "in their treatment of embodied experience" as vital for the formation of society (2001).

There is a specific body of literature that addresses the sociological concept of "the natural body strand" of "embodiment" as it relates to childbirth (Walsh 2010). The notion of natural body strand is an examination of "embodiment" from the perspective of both naturalism and social constructionism. It highlights the differentiation of male and female autonomy based on the premise that the female body was viewed as faulty, capricious, and likened to a machine in need of regulation and control. This view would contribute to the rationalization for the medicalization of childbirth.

The 1970s produced a feminist resistance to this idea. The pendulum swung in the opposite direction and fueled the natural childbirth movement. Walsh argues that the aforementioned ideology is not much better, because it reinforces gender constructs, and creates an essentialist dichotomy (2010). This standpoint causes "disappointment and distress" when expectations of birth are not met, and adherents of opposite views remain isolated from each other and deprived of collaboration, causing "occupational stress" (Walsh 2010). Walsh encouraged cooperation and urges "obstetricians and midwives to understand 'team' as including the woman." He noted that themes of "poor communication and diminished agency" are common throughout women's stories of their traumatic birth experiences (2010).

Finally, Walsh posited that the lack of research into maternity care in academia "has had negative consequences for consumers and professionals alike" (2010). A

phenomenological inquiry, in connection with a quantitative analysis of maternity care, may prove more effective in understanding issues surrounding childbirth. Walsh notes that this approach is currently emerging in areas of neuroscience as clinical researchers are transcending the "mind/body duality," and since this concept is especially applicable to childbirth, research in this area should thrive as well (Walsh 2010).

IDEOLOGY, HEGEMONY, AND HYGIENIC REGIME

Ideology is defined as a "set of beliefs and values" that justify power structures within society (Marger 2014:222). Marx argued that subordinate groups tend to willingly accept the dictates of those in authority even when it is not necessarily in their best interest to do so (Marger 2014:224). This is connected to the Marxist notion of "false consciousness" (Marger 2014:224). Similarly, Gramsci, a neo-Marxist theorist, argued that "hegemony" is a subtle process by which the subjugated "consent to their own domination" (Calhoun et al. 2012:226). This submission becomes "embedded" in normal day-to-day workings, and acquires the status of "common sense" and is rarely questioned (Calhoun et al. 2012:226). Foucault proposed that there exists a "regime of truth" (Dillon 2014:375); "the systematic, authoritarian, and controlling ways in which" society establishes and accepts particular beliefs as true (Dillon 2014:376). Foucault argued that these "institutional regimes" shape and direct our knowledge and are "coerce[d] and power-ridden" (Dillon 2014:376). This study proposes that obstetric care in the United States today exemplifies an ideology, a hegemonic order, and a "hygienic regime" whereby women are subtly compelled into believing (and willingly accept) that they must submit to medical authorities and their policies and practices during childbirth.

RESEARCH QUESTIONS

This study addressed the following questions:

1. How do women feel about their decision-making power during pregnancy and childbirth?
2. Under what conditions, if any, were procedures done without the woman's consent?

CHAPTER III

METHODS

This study gathered quantitative and qualitative data from educated parous women on perceived levels of their decision-making ability during pregnancy and childbirth. Data are based on responses of women in this study concerning the actual and perceived level of autonomy during pregnancy and childbirth. Through a questionnaire pertaining to procedures that were offered to, prohibited for, or performed on women during pregnancy, this research gathered information about the use of obstetric intervention and women's perceived levels of autonomy.

SAMPLE

A purposive sampling method for this study was utilized because this was an exploratory study that examined a specialized population of women who have experienced childbirth (Neuman 2015:274). Exploratory studies tend to have smaller sample sizes because the topic is either new or under-researched, and the purpose of the study is to glean enough information to provide a starting point for future in-depth studies (Neuman 2015:38). Parous women students at Texas Woman's University were recruited to participate in a study of their childbirth experience. A request to participate in this research, along with a link to the questionnaire designed for this study was sent to all female TWU students through email following Institution Review Board (IRB) approval. A sufficient number of qualified respondents were obtained, so a follow-up email invitation to participate was not necessary. The questionnaire garnered 176 completed

responses, and data entry and analysis began immediately. Although exploratory research tends to utilize a smaller sample size, and the data gathered is not generalizable, it is hoped that the information obtained through this sample will assist in providing a basis for future research.

DATA AND DATA COLLECTION

Since this study sought to examine educated women's perceptions of their own personal experiences, qualitative research data collection obtained through a questionnaire was deemed appropriate. The findings were analyzed for themes and attitudes pertaining to patient autonomy, both perceived and actual. IRB approval was sought and granted at Texas Woman's University. The questionnaire was designed for the purpose of this research and was administered through PsychData. Those who chose to participate clicked the link in their email and it directed them to PsychData. The first page was a consent form explaining the study. Those who wished to participate in the study clicked 'Yes' at the bottom of the consent form. Clicking 'Yes' indicated their consent and took them directly to the questionnaire.

The questionnaire contained seven closed-ended, general demographic questions such as age, age at childbirth discussed in the interview, race/ethnicity, religion, and household income. Twelve closed-ended questions, which were adapted from "The Health Care Climate Questionnaire" (PAS 2018), were included to measure perceptions of autonomy. All other closed-ended questions were conceived by the researcher. Also included were five open-ended questions that addressed the woman's perception of her childbirth experience, which, if any, types of interventions were implemented, and the

outcome of the birth in question. Finally, women had the opportunity to provide a detailed account of their individual birth experience. Participation required a maximum of 45 minutes to complete the questionnaire. Once the questionnaire was complete and the survey closed, the data were downloaded from PsychData for analysis.

DATA ANALYSIS

Descriptive statistics including frequency distributions were used to analyze responses to closed-ended questions. The results are presented in Chapter Four. Qualitative data was collected from the questionnaire and downloaded into SPSS for analysis. Data collected was first coded through open coding in order to identify common themes and patterns, and then consolidated into groups (Neuman 2015:481). The initial codes were organized to identify associations or new categories through axial coding, followed by a comparison and elaboration of specific themes and attitudes through selective coding (Neuman 2015:482). A multiple stage process of coding allowed fluidity for themes to emerge, and concepts to be identified, well defined and analyzed (Neuman 2015:480).

CHAPTER IV

FINDINGS AND DISCUSSION

This chapter presents the results of this exploratory study into educated women's perceptions of autonomy in childbirth. The first sections describe the characteristics of the participants. The second section discusses the procedures and interventions that are addressed in the questionnaire and subsequent findings. The third section addresses the research questions that were articulated before. Finally, the fourth section provides the analysis of responses to open-ended questions.

CHARACTERISTICS OF PARTICIPANTS

Table 1 shows that the majority of participants in this study were over 25 years old (69%), white (64%), married (69%) graduate students (59%) with a family income over $60,000 (61%), and claim to have a religion (73%).

Table 1. Characteristics of Participants

Characteristics	N	%
Age at most recent birth		
Over 25	122	69
Race/Ethnicity		
White	113	64
Black	26	15
Hispanic/Latino	19	11
Other	18	10
Marital Status		
Married	122	69
Divorced/separated	25	14
Never married	29	17
Family income		
$60,000 or more	107	61
Classification		
Graduate student	104	59
Religious	129	73

PROCEDURES AND INTERVENTIONS

Women who are admitted to labor and delivery units in U.S. hospitals are often subjected to a number of procedures and interventions. This study found that nearly 8 out of 10 women surveyed (75%) stated that they had no choice when it came to routine hospital procedures and practices (Table 2). They include:

- Staying in bed (in the supine position).
- Restriction of food and water.
- Electronic fetal monitoring (EFM). This device is strapped around the laboring woman's abdomen to record fetal heartrates.
- Cervical examination (CE). This examination requires the care providers to insert their fingers into the laboring woman's vagina to measure how much her cervix has dilated.

Other non-routine, yet somewhat common procedures and practices that women experience during labor and delivery include:

- Internal fetal monitoring (IFM). This device is inserted into the laboring woman's vagina and attached to the head of the fetus.
- Episiotomy, in which the woman's vagina is cut at the perineum to enlarge the opening and make more room for the baby's head to emerge.
- Forceps or vacuum assistance. This procedure requires the use of forceps or vacuum suction to pull the baby out from the birth canal.
- Cesarean section (C-section). This surgical procedure involves removing the baby through an incision made in the woman's abdomen.

Generally, one of the first things to occur when a woman in labor is admitted to the hospital is to have her lie in bed, and unless she needs to use the restroom, she remains there until her child is born. However, laboring in this position is not an evidence-based practice and can, in fact, lead to "adverse effects" such as "supine hypotension," slow fetal heart rate, difficult birth (including inadequate contractions, slow dilation, and longer labors), and can increase the need for a C-section (American College of Obstetrics and Gynecologists [ACOG] 2017; Jansen et. al 2013). In light of this realization, the ACOG recommends that most laboring women should not be restricted to bed and should be given the choice of the positions with which they are most comfortable (ACOG 2017). Positions that increase comfort for laboring women could include standing, walking, swaying, or squatting, which require unrestricted mobility. Yet the majority of participants in this study (65%) reported that they were required to remain in bed for the duration of their labor and delivery (Table 2).

Restricting women from eating food or drinking water during labor, in case they will require a Cesarean section (C-section), is a common practice in most hospital obstetric units. This restriction stems from the belief that women may aspirate if anesthesia is administered in the event a C-section is required (Tillett and Hill 2016). However, current research claims that this policy is no longer warranted and recommends that healthy women eat a light meal during labor (Tillett and Hill 2016). However, nearly 8 out of 10 participants in this study reported that they were not allowed to eat food or drink water during labor and delivery (Table 2).

Continuous EFM is another standard procedure in most hospitals in the United States. During labor and delivery, monitors are secured around the laboring woman's abdomen to monitor fetal heart rates and contractions. This monitoring device significantly restricts movement for the laboring woman and consequently has been shown to lead to the need for further interventions and an "increase in cesarean deliveries" (ACOG 2017). Research suggests that laboring women should be monitored intermittently rather than continuously, to allow freedom of movement and promote better birth outcomes (ACOG 2017). However, the majority of participants (79%) were required to have monitors continuously strapped to their abdomen (EFM) during labor and delivery, in spite of these recommendations (Table 2).

It is not surprising that 81% of participants reported that they were required to have CEs during labor and delivery because this is the most common method used by care providers to determine the progress of labor (Table 2). However, cervical exams are not reliable predictors of the timing of delivery and can have negative consequences (Downe et al. 2012). For example, there is no way to predict when or to which degree a woman's cervix will open during labor and care providers can often misdiagnose a woman having a slow labor (Downe et al. 2012). This can lead to increased anxiety in laboring women and subsequent interventions such as the administration of labor-inducing medications and C-sections (Downe et al. 2012). Additionally, too many cervical exams, especially after a woman's water breaks, can increase the risk of infection to the mother or her baby. For this reason, the World Health Organization (WHO) recommends that cervical exams occur every four hours, with no

more than seven exams during labor (WHO 2015). Women, however, can refuse cervical exams (ACOG 2016) although many are not aware of their options or they are told that they cannot refuse.

Although only 27 percent of respondents reported that they were required to have an episiotomy, it is worth noting (Table 2) that the routine use of episiotomy has not been shown to improve birth outcomes, and has, in fact, led to adverse outcomes for the woman including "anal sphincter dysfunction and dyspareunia" (difficult or painful sexual intercourse) (ACOG 2016). The ACOG (2016) has recommended against the routine use of episiotomy and suggests that care providers instead use alternative measures first. Current episiotomy rates in the United States are approximately 12 percent (ACOG 2016) which is significantly lower than the rate of occurrence found among women in this study.

Finally, this study found that 33 percent of respondents were required to have a C-section to deliver their child (Table 2). This rate is somewhat higher than the current national average rate of 31.9 percent. Furthermore, the increased use of the C-section method of delivery in the United States today is concerning (Green et al. 2007) and the World Health Organization notes that C-section rates above 10-15 percent are "not associated with reductions in maternal and newborn mortality rates (Betran et al. 2015).

Table 2. Percentage of Participants Who Experienced Common Hospital Procedures

Procedure	Yes		No	
	N	%	N	%
Routine hospital procedures				
Remain in bed	114	65	62	35
No food or water	138	78	38	21
Electronic fetal monitoring	139	79	37	21
Cervical examination	142	81	34	19
Non-routine procedures				
Internal fetal monitoring	28	16	148	84
Episiotomy	48	27	128	73
Forceps or vacuum assistance	21	12	155	88
Cesarean Section	58	33	118	67

RESEARCH QUESTION ONE

To examine how women feel about their decision-making power in childbirth, participants were asked specific questions related to their childbirth experience. These questions were meant to elicit perceptions of patient autonomy in two core areas; communication, and decision-making. The participants' responses to Likert scale questions were combined to produce three levels for each area; High, Low, and Neutral. The corresponding levels of communication and decision-making were then combined to produce an overall level of perceived autonomy. The level of autonomy categories of High, Low, and Neutral represent levels of perceived autonomy or decision-making ability. Responses to open-ended questions were analyzed separately and were not included in the measurement section.

Communication

For women to be able to make informed decisions, and to have their decisions respected, it is not enough for women to simply feel comfortable communicating with their provider, but they must also feel understood and supported. Similarly, providers should educate women in their care about pregnancy, labor, and delivery. Further, they must seek to understand their patient's needs and desires. Effective communication allows for a balanced provider/patient relationship, improves mutual trust, and can contribute to better birth outcomes (Walsh 2010).

While 75 percent of respondents reported high levels of overall communication between themselves and their care provider, three areas of interest indicate a likely provider/patient communication imbalance. Table 3 shows that over 70 percent of respondents reported high scores in all areas but one. When asked if their care provider understood their perspective, only 57 percent of participants believed this to be true. Interestingly, a higher percentage of women (81%) reported that their provider encouraged them to ask questions, and 87 percent of participants reported that their provider fully answered their questions. This indicates that providers are willing to offer information. However, our results indicate that they may be less likely to understand the perspective of the person receiving the information. Understanding how a woman perceives her childbirth experience can aide care providers in making recommendations while respecting their patient's autonomy.

Table 3. Closed-ended Survey Questions Regarding Communication

Question	Yes		No		Neutral	
	N	%	N	%	N	%
Care provider understood the respondent's thought process	126	70	35	20	15	10
Able to be open and honest with care provider	135	76	21	12	20	12
Care provider listened to respondent	130	74	21	12	25	14
Respondent was able to share feelings with care provider	134	77	24	13	18	10
Care provider understood the respondent's perspective	102	57	26	15	48	28
Respondent was encouraged by care provider to ask questions	140	81	23	12	13	7
Care provider fully answered questions	150	87	12	7	14	6
Care provider insured that the respondent understood about her pregnancy	135	78	24	13	17	9
Total Average		75		13		12

Decision-making

Table 4 reports participants' perceptions of their level of decision-making ability. The majority of participants reported feeling a high level of decision-making ability (70%), which included having choices (71%), not feeling forced to do things (79%), and feeling included in decisions (80%). However, fewer women believed that they felt a sense of choice and freedom during labor (60%), or that their care provider showed confidence in their decision-making ability (63%).

Table 4. Closed-ended Survey Questions Regarding Decision-Making

Question	Yes		No		Neutral	
	N	%	N	%	N	%
Felt a sense of choice and freedom during labor and delivery	103	60	42	22	31	18
Felt that care provider offered choices and options during labor and delivery	126	71	36	21	14	8
Felt that care provider showed confidence in respondent's decision-making ability	110	63	31	18	35	19
Most of the things the respondent did they felt they had to do	56	33	92	51	28	16
Decisions were a reflection of what respondent really wanted	122	69	25	14	29	17
Felt excluded from decisions about their care	21	12	140	80	15	8
Respondent felt forced to do many things	23	14	135	79	18	7
Trusted their care provider	184	84	13	7	15	9
Total Average		70		17		13

Autonomy and Satisfaction

Combing the levels of communication and decision-making produced an overall measurement of autonomy with three categories, high, low, and neutral. The results show that the majority of women (72%) who participated in this research maintained a perception of high levels of autonomy throughout their childbirth experience.

Overall satisfaction with the respondent's childbirth experience was measured based on responses to Likert scale items in the questionnaire. To maintain uniformity with previous measurements in this study, the categories were condensed to produce

three levels of satisfaction, High, Low, and Neutral. This survey found that 7 out of 10 women had a high level of satisfaction in their childbirth experience. Conversely, 1 out of 4 women reported low levels of satisfaction during their childbirth experience.

RESEARCH QUESTION TWO

Consent

Overall, the majority of women reported that they consented to the procedures listed in Table 5 during their labor and delivery experience. The most salient finding in this area concerns women who received an episiotomy. As previously noted, an episiotomy is an invasive procedure in which the care provider cuts the woman's vagina to make more room to deliver the baby. As mentioned above, episiotomies are often judged unnecessary and can result in long-term and sometimes permanent damage to the woman's vagina, which can affect her quality of life (ACOG 2016). Of the respondents who were required to undergo this procedure, 40 percent reported that an episiotomy was performed without their consent.

Table 5. Procedures where consent was granted/not granted

Procedure	Yes		No	
	N	%	N	%
Electronic fetal monitoring	104	78	30	22
Internal fetal monitoring	27	89	13	11
Cervical examination	128	93	11	7
Episiotomy	27	60	21	40
Forceps or vacuum assistance	15	78	7	22

Open-ended Responses

Through analysis of the open-ended comments, three themes emerged; communication, decision-making, and consent. Comments pertaining to communication included comments about the care providers and what they did or did not do to increase effective communication during labor and delivery. Examples include providing education and information, listening (or not listening) to the laboring woman, the level of confidence the provider showed in the laboring woman's abilities and decisions, and the way in which care providers communicated and worked with each other.

Interestingly, almost half of the respondents (42%) used language that contradicts the notion of autonomy. Phrases such as "I was allowed to," "they let me," (positive context) or conversely "I wasn't allowed," "I couldn't," or "they wouldn't allow me" (negative context) were common among responses to open-ended questions regarding decision-making. Even when stated in a positive context, the word "allowed" implies permission. Although women may have been pleased that they were given permission, this contradicts autonomous decision-making, which is independent of any outside authorization.

In terms of consent, some women explained instances in which they gave their consent to certain procedures. However, others explicitly stated either that they did not consent to procedures, or implicitly stated consent was not granted. For example, in many instances women stated that they felt "pushed," "forced," "pressured," "bullied," "pestered," or "worn down" to submit to procedures. Some women reported that they were given medication that they did not want, were physically placed into

uncomfortable positions that were “best for the doctor,” had their water broken by care providers, or were subjected to an episiotomy against their wishes.

CHAPTER V
CONCLUSION

Section One summarizes key findings of this research. Section Two addresses theoretical implications. Finally, this chapter discusses the limitations of this study and provides recommendations for future research.

SUMMARY

To the best of my knowledge, this thesis is the first sociological exploration into educated women's perceptions of autonomy in childbirth in the United States. To identify the extent to which women believed they maintained their decision-making power in childbirth, I surveyed female students at Texas Woman's University, who have previously given birth. I gathered data through an online questionnaire containing closed-ended questions, designed to measure perceptions of autonomy and open-ended questions, which were later analyzed for themes pertaining to autonomy and consent. Two primary questions were addressed in this study.

Research Question One

As previously stated, maternal mortality rates in the United States are on the rise (CDC 2016) despite technological advancements in obstetric practices. At the same time, women are speaking out about their birth experiences, and many have expressed feelings that their decision-making abilities were encroached upon during childbirth (Pascucci 2015). As a result, the first question addressed in this thesis was "How do women feel about their decision-making power in childbirth?"

An examination of two core areas, communication, and decision-making, revealed that the majority of women surveyed (72%) perceived that they maintained autonomy during labor and delivery. Similarly, 7 out of 10 participants reported that they were satisfied with their childbirth experience. Yet, analysis of common interventions and procedures revealed that nearly 8 out of 10 women stated that they were required to submit to standard protocols and procedures during labor and delivery - many of which are against the recommendation of the American Academy of Obstetrics and Gynecology (ACOG 2016; 2017). Although women reported higher levels of autonomy in childbirth when responding to Likert scale items in the questionnaire, their words told a different story. Analysis of the open-ended questions revealed that women might not actually possess the level of autonomy that they perceive. For example, many women (42%) used phrases such as "I was allowed to," "they let me," (positive context) or conversely "I wasn't allowed," "I couldn't," or "they wouldn't allow me" (negative context). When an individual's decisions are curtailed, or they are given "permission" to make certain decisions one can argue that their autonomy has been diminished.

Concerning the area of communication, approximately 7 out of 10 women reported that they could be open and honest with their care provider and that they felt heard. Moreover, 8 out of 10 women stated that their care provider encouraged them to ask questions and in turn answered their questions fully. However, fewer women (57%) reported that their provider understood their perspective, which indicates a likely provider/patient communication imbalance that has a potential to contribute to negative birth outcomes (Walsh 2010). As noted in Chapter 2, "poor communication and

diminished agency" are common themes found in women's stories of their traumatic birth experiences (Walsh 2010).

Likewise, nearly 8 out of 10 women reported that they did not feel forced to do things and they felt included in decisions regarding their care. Yet, only 6 out of 10 women stated that their care provider showed confidence in their abilities and that they felt a sense of choice and freedom during labor. These discordant findings indicate that although women felt *included* in decisions, they may have also felt that there were not enough choices presented to them.

Research Question Two

The second question addressed in this thesis was "under what conditions, if any, were procedures done without the woman's consent?" Women were surveyed about various procedures, including electronic fetal monitoring, internal fetal monitoring cervical examination, episiotomy, and forceps or vacuum assistance in childbirth. In all categories regarding procedures, at least some women reported that they did not give consent before they were performed. However, the most salient finding concerns women who underwent an episiotomy, an invasive procedure that is often deemed unnecessary, and can have permanent negative effects on women (ACOG 2016). Our results indicate that 4 out of 10 women in this study who received an episiotomy claimed that it was performed without their consent.

The analysis of open-ended questions revealed that although consent was often present, many women might have been coerced into submission. For example, women stated that they felt "pushed," "forced," "pressured," "bullied," "pestered," or "worn

down" to submit to procedures. As discussed in Chapter 2, coercion or persistent pressure violate autonomy and infringe on an individual's independence (Molyneux 2009). When people are manipulated into consenting to procedures their agreement is no longer autonomous, and genuine consent ceases to exist.

THEORETICAL IMPLICATIONS

The main finding of this survey is that there is a discrepancy between what women report (diminished autonomy) and what they describe (a perception of significant satisfaction with their medical care). How are we to reconcile the two?

The results of this study point to the existence of an "ideology" (as defined in Chapter 2) that is operative in the obstetric practice in the United States. This amounts to a "hygienic regime" (Dillon 2014:376) in which women are restricted from decision-making, coerced into consent, or subjected to "metaphysical violence" while at the same time, perceive that they are satisfied with their childbirth experience. This is reminiscent of what Antonio Gramsci called "hegemony" (Calhoun et al. 2012) practiced in an institution in which medical professionals wield authority and control over women in one of their most vulnerable states – during the act of giving birth. Thus, women are subjected to authoritative control in the name of medical wisdom, accepted obstetric practices, and professional expertise. Women may even embrace the hegemonic dictates of this hygienic regime, in which acts of violence occur during childbirth, but are not viewed as such.

Medical professionals who assert power and control over women's bodies generally do so unknowingly and unintentionally. Most believe that they are acting in the

woman's (and ultimately, the infant's) best interest and as such believe that their actions are objectively justified. Likewise, women submit to this system, often without question because of 1) the belief that medical professionals possess superior knowledge and skills, 2) they have been conditioned to accept standard practices and procedures in maternal care as necessary and benevolent, and 3) they are unaware that these practices can be challenged and their autonomy can extend into the labor and delivery room. In this hygienic hegemonic regime, the outcome of a successful birth effectively erases any negative experiences that result, (either during labor and delivery or long after the childbirth experience).

Theories of embodiment and metaphysical violence can also explain how women are affected during labor and beyond. They offer insight into the encroachment of patient's autonomy in the maternal healthcare system. Although the aforementioned theories provide adequate explanations about the effects of this ideology and the way it operates, they are not sufficient in identifying and naming the phenomenon. Therefore, I propose the term *Obstetriarchy* as a theoretical locus and synthesis of the above theories and findings.

LIMITATIONS AND RECOMMENDATIONS FOR FUTURE RESEARCH

Limitations

This research is exploratory in nature and, as a result, is not readily generalizable to a larger population. Additionally, this research was limited to educated female parous students of Texas Woman's University and is not inclusive of underlying variables. This study focused on educated women's perceptions of autonomy and obstetric intervention

in childbirth. However, there are other socioeconomic or sociocultural factors such as ethnicity that could contribute to a sense of a loss of decision-making ability. Additional qualitative or quantitative research into this subject would be appropriate for the identification and analysis of these variables for future work.

Recommendations

Further exploration into the notion of obsteriarchy is warranted, especially considering current research that supports a return to a less medicalized approach to childbirth (Woog 2017). To understand processes that have contributed to the development and acceptance of the current ideology regarding childbirth, future research could analyze this phenomenon from a historical and comparative perspective. Examining these historical processes in comparison to other societies may help to identify when and where shifts in childbirth views and approaches have occurred. Addressing these issues may broaden the frame in which obstetriarchy is further explored. Additionally, future research must examine the impact of class and racial inequality on this phenomenon. Finally, the future examination of the race and gender of the medical provider may uncover patterns and practices of obstetriarchy.

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APPENDIX A

IRB Approval

Institutional Review Board
Office of Research and Sponsored Programs
P.O. Box 425619, Denton, TX 76204-5619
940-898-3378
email: IRB@twu.edu
http://www.twu.edu/irb.html

DATE: January 16, 2018

TO: Ms. Tanya Faglie
Sociology & Social Work

FROM: Institutional Review Board (IRB) - Denton

Re: Approval for Obstetric Intervention, Childbirth, and Educated Women's Perceptions of Patient Autonomy (Protocol #: 19809)

The above referenced study has been reviewed and approved by the Denton IRB (operating under FWA00000178) on 1/8/2018 using an expedited review procedure. This approval is valid for one year and expires on 1/8/2019. The IRB will send an email notification 45 days prior to the expiration date with instructions to extend or close the study. It is your responsibility to request an extension for the study if it is not yet complete, to close the protocol file when the study is complete, and to make certain that the study is not conducted beyond the expiration date.

If applicable, agency approval letters must be submitted to the IRB upon receipt prior to any data collection at that agency. A request to close this study must be filed with the Institutional Review Board at the completion of the study. Because you do not utilize a signed consent form for your study, the filing of signatures of subjects with the IRB is not required.

Any modifications to this study must be submitted for review to the IRB using the Modification Request Form. Additionally, the IRB must be notified immediately of any adverse events or unanticipated problems. All forms are located on the IRB website. If you have any questions, please contact the TWU IRB.

cc. Dr. Celia Lo, Sociology & Social Work
Dr. Mahmoud Sadri, Sociology & Social Work
Graduate School

APPENDIX B

Prospectus Cover Sheet

TEXAS WOMAN'S UNIVERSITY-GRADUATE SCHOOL
PROSPECTUS COVER SHEET

Department/College/School of Sociology and Social Work

Prospectus for ☐ Dissertation ☒ Thesis

This prospectus proposed by Tanya Faglie 0849937 tfaglie@twu.edu
(Student Name) (ID#) (TWU Secure Email Address)

and entitled: [Title]

"Obstetric Intervention, Childbirth, and Educated Women's Perception of Patient Autonomy"

has been read and approved by the members of her/his Research Committee.
This research (Check One)

☒ Involves human subjects or use of animals.
(Attach IRB or IACUC approval letter and written approval letters from external agencies where data will be collected, if applicable.)

☐ Does not involve either human subjects or use of animals.

Both the student and faculty mentor must provide evidence of completion of all required modules of the Responsible Conduct in Research (RCR) Training in accordance with TWU policy 5.11.

For Graduate School Use Only	
PROSPECTUS	
Original Signatures	
Unconditional Admission	
Approved Degree Program	
Admission to Candidacy	
Institution/Agency Approval	
Human Subjects Approval	
Animal Use Approval	
RCR Training Confirmation	
Dean Approval:	Date:
Letter Sent:	

☒ RCR completion certificates for student and faculty mentor are attached.

Research Committee (Original Signatures Required):

Major Professor [Signature] [Date] Sep 22. 2017
[Type Name] Mahmoud Sadri, PhD.

Member [Signature] [Date] 9-22-17
[Type Name] James Williams, PhD.

Member [Signature] [Date] 9-22-17
[Type Name] Luis Espinoza, PhD.

Member [Signature] [Date]
[Type Name]

Member [Signature] [Date]
[if appropriate] [Type Name]

Chair/Director/Associate Dean [Signature] [Date] 9/26/17
[Type Name] Celia Lo, PhD.

In accordance with Leg. HB 1922, an individual is entitled to: request to be informed about the information collected about them; receive and review their information; and correct any incorrect information.

APPENDIX C

Consent to Participate

TEXAS WOMAN'S UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH

Title: "Obstetric Intervention, Childbirth, and Educated Women's Perception of Patient Autonomy"

Investigators: Tanya Faglie, BS……tfaglie@twu.edu 940/898-2833
Advisor: Mahmoud Sadri, PhD……..…...…msadri@twu.edu 940/898-2061

Explanation and Purpose of the Research

You are being asked to participate in a research study at Texas Woman's University. The purpose of this research is to examine educated women's perception of autonomy in childbirth
for my Master's thesis. You have been asked to participate in this study because you are a current student at TWU.

Description of Procedures

As a participant in this study you will be asked to spend a maximum of 45 minutes of your time responding to an online questionnaire about your most recent childbirth experience. The questionnaire will ask you about your feelings during childbirth, procedures performed, and general demographic information. Some of these questions can be emotionally sensitive. Additionally, you will be allowed to provide a detailed account of your most recent childbirth experience if you choose to do so. In order to be a participant in this study, you must be at least 18 years of age or older, female, a student at TWU, and have given birth at least once.

Potential Risks

The questionnaire will ask you about your most recent childbirth experience. A possible risk in this study is emotional discomfort which may occur as a result of the questions you are asked. If you experience a negative emotional response or become upset, you may stop answering questions at any time and end your participation in this study. If you feel you need to talk to a professional about your discomfort, the researcher has provided you with a list of resources.

An additional risk is loss of confidentiality. Confidentiality will be protected to the extent that is allowed by law. The results of the study will be reported in scientific magazines or journals but your real name or any identifying information will not be included. There is

a potential risk of loss of confidentiality in all email, downloading, and internet transactions.

A final risk is a loss of time. Your participation will require a maximum of 30 minutes of your time. Although you will not receive monetary compensation, your participation will help further research in the area of women's experiences during childbirth. The researchers have tried to minimize your time commitment by providing an online questionnaire with as few questions as possible.

The researchers will try to prevent any problem that could happen because of this research. You should let the researchers know at once if there is a problem and they will help you. However, TWU does not provide medical services or financial assistance for injuries that might happen because you are taking part in this research.

If you have any emotional issues or feelings of distress that arise during your participation in this study, please contact the TWU Counseling Center at 940-898-3801 or go to their office at **West Jones Hall.** The TWU Counseling Center offers individual therapy, group therapy, couples counseling, and other mental health services. Students are allowed 12 sessions for therapy each academic year as well as the initial intake interview. The TWU Counseling Center does their best to match patients with a therapist that can help with their particular issues. Additionally, you may locate a therapist through the APA Therapist Locator website: http://locator.apa.org/

If you do not feel comfortable contacting the TWU Counseling Center or an APA therapist, please contact the TWU Student Health Services at 940-898-3826. They are located in the lower southeast corner of Hubbard Hall on Administration Drive across from the Administrative Conference Tower building.

If you have any mental health issues that the TWU Counseling Center is not equipped to deal feel free to contact Denton County Mental Health Mental Center at 940-381-5000.

If you have any other questions or concerns regarding other agency referrals please contact me at (940) 898-2833 or tfaglie@twu.edu.

Participation and Benefits

Your involvement in this study is completely voluntary and you may withdraw from the study at any time. If you would like to know the results of the study, you may provide a valid email address and we will e-mail them to you.

Questions Regarding the Study

If you have any questions about the research study you may contact the principal researcher at tfaglie@twu or 940-898-2833. If you have any questions about your rights as a participant in this research or the way this study has been conducted, you may contact Texas Woman's University Office of Research and Sponsored Programs at 940-898-3378 or via e-mail at IRB@twu.edu.

Participant's signature _____ Date _____

*****If you want to know the results of the study, please provide a valid email address below.

E-mail: _____

APPENDIX D

Referral List

Referral List

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If you have any other questions or concerns regarding other agency referrals please contact me at (940) 898-2833 or tfaglie@twu.edu.

Sincerely,

Tanya Faglie
Texas Woman's University
Denton, TX

APPENDIX E

Questionnaire

Women's Autonomy in Labor and Delivery Survey

TEXAS WOMAN'S UNIVERSITY

CONSENT TO PARTICIPATE IN RESEARCH

Title: "Obstetric Intervention, Childbirth, and Educated Women's Perception of Patient Autonomy"

Investigators: Tanya Faglie, BS……tfaglie@twu.edu 940/898-2833

Advisor: Mahmoud Sadri, PhD……..…...…msadri@twu.edu 940/898-2061

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Potential Risks

The questionnaire will ask you about your most recent childbirth experience. A possible risk in this study is emotional discomfort which may occur as a result of the questions you are asked. If you experience a negative emotional response or become upset, you may stop answering questions at any time and end your participation in this study. If you feel you need to talk to a professional about your discomfort, the researcher has provided you with a list of resources.

An additional risk is loss of confidentiality. Confidentiality will be protected to the extent that is allowed by law. The results of the study will be reported in scientific magazines or journals but your real name or any identifying information will not be included. There is a potential risk of loss of confidentiality in all email, downloading, and internet transactions.

A final risk is a loss of time. Your participation will require a maximum of 30 minutes of your time for which you will not be compensated. Although you will not receive monetary compensation, your participation will help further research in the area of women's experiences during childbirth. The researchers have tried to minimize your time commitment by providing an online questionnaire with as few questions as possible.

The researchers will try to prevent any problem that could happen because of this research. You should let the researchers know at once if there is a problem and they will help you. However, TWU does not provide medical services or financial assistance for injuries that might happen because you are taking part in this research.

If you have any emotional issues or feelings of distress that arise during your participation in this study, please contact the TWU Counseling Center at 940-898-3801 or go to their office at **West Jones Hall.** The TWU Counseling Center offers individual therapy, group therapy, couples counseling, and other mental health services. Students are allowed 12 sessions for therapy each academic year as well as the initial intake interview. The TWU Counseling Center does their best to match patients with a therapist that can help with their particular issues. Additionally, you may locate a therapist through the APA Therapist Locator website: http://locator.apa.org/

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If you have any other questions or concerns regarding other agency referrals please contact me at (940) 898-2833 or tfaglie@twu.edu.

Participation and Benefits

Your involvement in this study is completely voluntary and you may withdraw from the study at any time. If you would like to know the results of the study, you may provide a valid email address and we will e-mail them to you.

Questions Regarding the Study

If you have any questions about the research study you may contact the principal researcher at tfaglie@twu or 940-898-2833. If you have any questions about your rights as a participant in this research or the way this study has been conducted, you may contact Texas Woman's University Office of Research and Sponsored Programs at 940-898-3378 or via e-mail at IRB@twu.edu.

1)
*If you want to know the results of the study, please provide a valid email address below.

E-mail:

Selecting 'Yes' below will indicate your consent to participate in this study, and will allow you to proceed to the questionnaire.

***2)** Do you agree to participate in this study?

--Select-- **Agree**
- Yes [Value=1]

——————————————————Page Break——————————————————

Please answer the following background questions that cover the history of your most recent childbirth experience.

***3)**
At what age did you deliver your most recent child?

If you have had more than one child please list all the ages you were when you gave birth.

		Age
4)	Child 2	
5)	Child 3	
6)	Child 4	

***7)**
Who attended the birth of your most recent child?

Doctor/Obstetrician Midwife Other (please specify)
[Value=1] [Value=2] [Value=3]
Other:

***8)**
Did you have a support person during your most recent birth?

Partner/Spouse Doula Other (please specify)
[Value=1] [Value=2] [Value=3]
Other:

9)
If you had a support person present when you gave birth, did your support person make decisions for you during labor and delivery?

Yes No
[Value=1] [Value=2]

Please think about your physician or care provider (midwife, nurse, etc) during your most recent birth and answer the questions below.

Please rate each question on the following 5-point scale about your most recent childbirth.

		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
***10)**	I felt that my physician or care provider has provided me choices and options during labor and delivery.	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]
***11)**	I felt my physician or care provider could relate to me or understood my thought processes during labor and delivery.	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]

*12)	I was able to be open with my physician or care provider during labor and delivery.	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]
*13)	My physician or care provider conveyed confidence in my ability to make changes to my choices during labor and delivery.	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]
*14)	My physician or care provider made sure I really understood about my pregnancy and what I need to do during my pregnancy, labor, and delivery.	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]
*15)	My physician or care provider encouraged me to ask questions at anytime throughout my pregnancy, labor or delivery.	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]
*16)	I felt I could trust in my physician or care provider.	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]
*17)	My physician or care provider answered my questions fully and carefully.	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]
*18)	My physician/care provider listened to how I would like to do things.	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]
*19)	I feel that my physician or care provider cared about me as a person.	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]
*20)	I didn't feel very good about the way my physician or care provider talked to me.	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]
*21)	My physician or care provider tried to understand how I saw things before suggesting a new way to do things.	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]
*22)	I felt able to share my feelings with my physician or care provider.	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]

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Part 2: Interventions During Your Most Recent Labor and Delivery

***23)**
Were you prevented from eating food or drinking water during labor and delivery?

Yes No
[Value=1] [Value=2]

***24)**
Were you required to remain in bed during labor and delivery?

Yes No
[Value=1] [Value=2]

***25)**

Were you required to have continuous fetal monitoring, that is did you have sensors strapped to your belly to monitor your baby's heart rate?

Yes No
[Value=1] [Value=2]

26)
If you answered no to question 25 please skip to question 28.
Did your healthcare provider/doctor explain what they were doing?

Yes No
[Value=1] [Value=2]

27)
Did you give consent for continuous fetal monitoring?

Yes No
[Value=1] [Value=2]

***28)**
Were you required to have an internal fetal monitor, that is did your provider insert a monitor into your vagina and attach it to your baby's head to monitor its heart rate?

Yes No
[Value=1] [Value=2]

29)
If you answered no to question 28 please skip to question 31.
Did your provider explain the procedure for internal fetal monitoring?

Yes No
[Value=1] [Value=2]

30)
Did you give consent for internal fetal monitoring?

Yes No
[Value=1] [Value=2]

***31)**
Were you required to have vaginal cervical checks to see how far you were dilated?

Yes No
[Value=1] [Value=2]

32)
If you answered no to question 31 please skip to question 34.
Did your provider inform you before beginning the vaginal cervical check?

Yes No
[Value=1] [Value=2]

33)
Did you give consent for your healthcare provider to check for dilation?

Yes No
[Value=1] [Value=2]

***34)**

Were you required to have an episiotomy, that is did your healthcare provider cut your vagina to make more room for the baby's head?

Yes No
[Value=1] [Value=2]

35)

If you answered no to question 34 please skip to question 37.
Did your healthcare provider inform you before beginning the episiotomy?

Yes No
[Value=1] [Value=2]

36)

Did you give consent for your provider to cut your vagina?

Yes No
[Value=1] [Value=2]

***37)**

Did your healthcare provider use forceps or a vacuum on your baby to help get its head out?

Yes No
[Value=1] [Value=2]

38)

If you answered no to question 37 please skip to question 40.
Did your provider explain what they were doing before beginning the use of forceps or vacuum?

Yes No
[Value=1] [Value=2]

39)

Did you give consent for forceps or vacuum assisted delivery?

Yes No
[Value=1] [Value=2]

***40)**

Were any of your children delivered by cesarean section (C-section), that is, did they cut your belly open to take the baby out?

Yes No
[Value=1] [Value=2]

41)

If you answered no to question 40 please skip to question 44.
If any of your children were delivered by cesarean section (C-section), when was the decision made to have the cesarean section?

Before labor pains started [Value=1] After labor pains started [Value=2] Other (please specify) [Value=3]

Other:

42)
If yes, which pregnancy (first, second, third, etc.)?

43)
If you had a prior C-section, were you prevented from attempting a vaginal birth?

Yes [Value=1] No [Value=2]

***44)**
Were any other procedures performed on you and/or your child? Please explain your answer.

(1000 characters remaining)

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Part 3: Feelings During Labor and Delivery

Please think about the experiences you had during your most recent labor and delivery. Indicate with a number between 1 and 5 your agreement with each of the statements below.

Not true at all **Completely true**

1 2 3 4 5

		1	2	3	4	5
***45)**	I felt a sense of choice and freedom.	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]
***46)**	I felt disappointed with my childbirth experience.	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]
***47)**	I felt that people who are important to me were cold and distant towards me.	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]
***48)**	Most of the things I did felt like "I had to".	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]

*49)	I felt confident that I could do things well.	[Value=1][Value=2][Value=3][Value=4][Value=5]
*50)	I felt that my decisions reflected what I really wanted.	[Value=1][Value=2][Value=3][Value=4][Value=5]
*51)	I felt connected with people who care for me, and for whom I care.	[Value=1][Value=2][Value=3][Value=4][Value=5]
*52)	I felt excluded from decisions about my care.	[Value=1][Value=2][Value=3][Value=4][Value=5]
*53)	I felt forced to do many things I didn't choose to do.	[Value=1][Value=2][Value=3][Value=4][Value=5]

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Part 4: Overall Labor and Delivery Experience

***54)**
Before the birth of your child or children, where did you plan to labor and deliver?

A hospital [Value=1] Home [Value=2] Birthing Center [Value=3] Other (please specify) [Value=4]
Other:

***55)**
Where did you give birth during your most recent pregnancy?

A hospital [Value=1] Home [Value=2] Birthing Center [Value=3] Other (please specify) [Value=4]
Other:

***56)**
Did you have a choice as to where you could labor and deliver your child or children? Please explain your answer.

(1000 characters remaining)

***57)**
Did you feel like your most recent labor was managed properly by the doctors and nurses? Please explain your answer.

(1000 characters remaining)

***58)**

Did you feel like you were given all the options during your most recent pregnancy, labor, and delivery? Please explain your answer.

(1000 characters remaining)

***59)**

Overall, how would you describe your most recent birth experience?

Poorly [Value=1] Okay [Value=2] Neutral [Value=3] Good [Value=4] Excellent [Value=5]

60)

If you would like, please provide a detailed account of your most recent birth experience. For example, would you like to provide additional information about your answers, feelings you experienced, or procedures not mentioned in this questionnaire?

(28000 characters remaining)

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To help me better understand your responses, please answer the following demographic questions:

***61)**
What is your age?

***62)**
What is your race/ethnicity?

White [Value=7] Black or African American [Value=3] Hispanic or Latino [Value=4] American Indian or Alaskan Native [Value=1] Asian [Value=2] Multiracial [Value=5] Native Hawaiian or Other Pacific Islander [Value=6] Other (please specify) [Value=8]

***63)**
What is your marital status?

Married [Value=1] Divorced [Value=2] Separated [Value=3] Widowed [Value=4] Never Married [Value=5]

*64)
What is your household income?

Under $10,000 [Value=1] $10,000 - $19,999 [Value=2] $20,000 - $29,999 [Value=3] $30,000 - $39,999 [Value=4] $40,000 - $49,999 [Value=5] $50,000 - $59,999 [Value=6] $60,000 - $69,999 [Value=7] $70,000 or higher [Value=8]

*65)
What is your present religion, if any?

Protestant [Value=1] Roman Catholic [Value=2] Orthodox such as Greek or Russian Orthodox [Value=3] Jewish [Value=4] Muslim [Value=5] Buddhist [Value=6] Hindu [Value=7] Atheist [Value=8] Agnostic [Value=9] Something Else [Value=10] Nothing in Particular [Value=11]

*66)
What is your highest level of education?

High school diploma/GED [Value=1] Some College [Value=2] Bachelor's degree [Value=3] Master's degree [Value=4]

*67)
What is your current classification at TWU?

Freshman [Value=1] Sophomore [Value=2] Junior [Value=3] Senior [Value=4] Master's student [Value=5] PhD student [Value=6] PhD candidate [Value=7]

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Women's Autonomy in Labor and Delivery Survey

THANK YOU FOR YOUR HELP WITH THIS STUDY!