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UNIVERSITY OF ALBERTA

WOMEN'S PERCEPTIONS OF COLLABORATIVE DECISION MAKING REGARDING THEIR LABOUR AND DELIVERY EXPERIENCE

BY

WANDA ANNETTE MERTICK 

A THESIS
SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF NURSING

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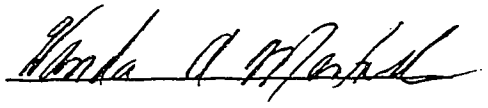

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Date: June 13, 1991

Abstract

The purpose of this study is to examine women's perceptions of collaborative decision making regarding their labour and delivery experiences. Collaborative decision making was analyzed by asking postpartum women what they had wanted to have a say in during their labour and delivery experience and in what they perceived themselves as having had a say. A taped interview and card-sort was conducted on a convenience sample of 30 women who had normal pregnancies and vaginal deliveries. It was found that more than 50% of the women wanted a say in 11 of 17 items. Using Chi-squared techniques (1 d.f.) to determine significant differences between women who wanted a say and had a say and women who wanted a say but did not have a say, women were found to have a say in: the presence of chosen persons during labour and delivery, the administration of pain medications, freedom to move, privacy, to breastfeed within the first hour of delivery, vaginal exams, and an "others" category. Using the Pearson's correlation coefficient, with significance at $p < .05$, satisfaction with decision making was found to increase as the congruency between wanting a say and having a say increased. Satisfaction with the childbirth experience was found to increase as satisfaction with decision making increased. Length of labour decreased as satisfaction with both decision making and the childbirth experience increased. Differences were found between multigravidae and primigravidae women. The primigravidae group revealed a positive correlation between satisfaction with the childbirth experience and satisfaction with decision making; and a negative correlation between satisfaction with decision making and length of labour. With the multigravidae group, a significant positive correlation was found between congruency and satisfaction with decision making; and a negative correlation between congruency and length of

labour. Strategies are suggested for health care professionals to help improve women's opportunity for collaborative decision making in labour and delivery.

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Women's Perceptions of Collaborative Decision Making Regarding Their Labour and Delivery Experience

Over half a century ago, women feared for their lives in childbirth (Burchell & Gunn, 1980). Medical and societal advances such as the discovery of antibiotics and their use in health care, improved nutrition, and sanitation helped to practically eliminate a woman's chance of dying in childbirth. With the mother's life basically secure, focus turned to fetal and neonatal well-being, and advances in these fields also reduced neonatal mortality rates. Once safety for both mother and baby became relatively assured, it was natural for the focus to shift again. This new focus centred on the psychosocial aspects of childbearing and a quest for the attainment of joy and beauty in the woman's transformation to motherhood. Birth became viewed as a "significant life experience" rather than a mere "medical occurrence" (Burchell & Gunn, 1980, p.251)

The shift to the psychosocial aspects of childbearing coincided with the consumer and woman's movement in society. The consumer movement demanded more equality and individual autonomy in all aspects of life, including health care (Brody, 1980). Scepticism of those in power led to an unwillingness to delegate exclusive power to physicians (Banta & Marinoff, 1975) and so cries for patient autonomy and patient rights led to the push for shared power, mutual participation and collaborative decision making in health care.

The consumer movement set the standards: "Patients in any health care setting retain their legal rights as human beings; they maintain their right to the whole truth, the right to privacy and personal dignity and the right to self-determination" (Trandel-Korenchuk, 1982, p. 46).

The woman's movement, along with consumerism, made this health care reform particularly relevant to the field of obstetrics. Because the prerequisite for safety in obstetrics was met, the experience could now be evaluated and strategies to improve the childbirth experience identified. One strategy that appears significant with respect to the childbirth experience is the labouring woman's perception of collaboration in decision making about her care.

Statement of the Problem

We know through many lay-writings and opinion articles what items women are reported as wanting to have a say in during their labour and delivery experience. Little formal research has been done in this area, however, leading one to wonder if the opinions expressed in the literature truly reflect what women want. Further, if women want certain items, are they given the opportunity to obtain those items during their childbirth experience?

Purpose of the Study

The purpose of this study is to examine women's perceptions of collaborative decision making during their labour and delivery experience. One way of looking at this issue is to examine what women want to have a say in during labour and delivery and to compare those wants with what they perceive themselves as getting to have a say in during labour and delivery. Another component necessary in the analysis of collaborative decision making in labour and delivery is to assess whether women's satisfaction with their childbirth experience is related to their perceived participation in making decisions about their care. The questions formulated to guide this research are:

1. What do women want to have a say in during their labour and delivery experience?

2. What do women perceive themselves as having a say in during their labour and delivery experience?
3. Is satisfaction with their labour and delivery experience and/or length of labour related to: a) the congruency between wanting a say and having a say and/or b) the incongruency between wanting a say and not having a say?

Theoretical Framework

Kim (1983) cites evidence for increased participation in decision making as being associated with the following: (a) an increase in individuals' good feelings and behaviours in industry settings; (b) an increased productivity, satisfaction, positive attitude and responsiveness to innovations; (c) a decrease in feelings of powerlessness; and (d) an improved sense of well-being. The effects of collaboration in decision making on individuals are seen as positive. Kim views participation in decision making as congruent with the concept of adulthood in that independence, autonomy, and self-regulation are enhanced. Having a say in decisions during labour and delivery should then likewise enhance independence, autonomy, and self-regulation in labouring women. Consequently, the use of a theoretical framework which deals with collaboration in decision making would be most appropriate to this study, the aim of which is to examine women's perceptions of their collaboration in decision making in labour and delivery.

The source of the theoretical framework for this study is Kim's "Theoretical Framework for Collaborative Decision Making in Nursing Practice" (1983). A diagram of the framework may be found in Appendix A. This framework was chosen because in it are identified factors that affect the occurrence of collaborative decision making in health care situations (for example, client

attitudes towards participating in health care decisions). Also identified are measurable outcomes for the client when collaborative decision making occurs (for example, satisfaction). This framework is designed so the user can study certain aspects of collaboration in decision making without testing the entire model.

Assumptions Within the Framework

1. In nursing care situations many different types of nursing care decisions are made for clients that influence their health in various ways.
2. Clients have resources to be active participants in making such decisions and this participation may affect outcomes of nursing care (Kim, 1983, p. 271).

Definitions within the Framework

Decision making. An act of selecting a choice among two or more possible alternatives for a prospective action is the definition of decision making. Decision making is a conscious, deliberate action and there have to be potentially realizable alternatives as choices. A decision is always aimed towards the future, no matter how short the time-frame between the action of making a choice and realizing the choice (Kim, 1983)

Collaboration. As defined by Kim (1983, p. 276), collaboration is "a process in which two or more individuals work together for the attainment of a goal; a process by which a joint influence on an action is produced".

Collaborative decision making. Collaborative decision making is defined as "an act of selecting a choice among two or more possible alternatives for a prospective action by a group on individuals (two or more parties) mutually influencing the decision" (Kim, 1983, p. 276).

Nature of decision. According to Kim (1983) , the nature of decision can be defined in terms of the extensiveness, attainability, and affective meanings of the decisions. Extensiveness refers to situations around which collaboration in decision making occurs. Attainability refers to the frequency of collaboration in decision making. Affective meanings refer to what it means to the persons involved to collaborate in decision making.

The purpose of this study is to examine women's perceptions of collaborative decision making during their labour and delivery experiences. Kim's work (1983) provides the framework for the collection and labelling of the data obtained in this study. In this study, collaborative decision making is operationally defined as having a say: women will be asked about those items in which they had wanted to have a say in during labour and delivery and whether they perceived themselves as having had a say. The extensiveness of the decisions will be assessed by the situations or issues in which women wanted a say. Attainability will be assessed by the perception of the women of having had a say in the items in which they wanted a say. The affective meanings will be assessed by asking the women to identify the importance of having a say with respect to the items about which they wanted a say. Satisfaction will be the main client outcome addressed in this study: each woman's satisfaction with her collaboration in decision making during labour and delivery and her satisfaction with the childbirth experience as a whole will be assessed. Thus Kim's "Theoretical Framework for Collaborative Decision Making in Nursing Practice" (1983) provides an excellent framework for collecting and categorizing data in this study.

Review of the Literature

Literature on decision making during labour and delivery has been organized to encompass four main themes: (a) the issue of control; (b) the situations or issues that women want during their labour and delivery experience; (c) actual collaboration in decision making during labour and delivery; and (d) identification of factors which can limit a woman's involvement in decision making during labour and delivery. Each of these themes and the subsections pertinent to each are discussed in turn.

The Issue of Control

The first theme discussed is the issue of control. In looking at control, three subsections are: the effects on a person of maintenance or loss of control of one's body, the definition of control in relation to labour and delivery, and the examination of research on the concept of control in the labour and delivery setting.

The Effects on a Person of Maintenance or Loss of Control of One's Body

In the health care literature, many benefits are reported to be associated with a high level of patient participation in decision making. Sense of control over one's body and one's self is maintained or increased with participation in medical decision making (Brody, 1980; Burchell & Gunn, 1980; Speedling & Rose, 1985). With this maintenance or enhancement of sense of control comes an increase in self-reliance (Brody, 1980), maintenance of or increase in self-esteem (Brody, 1980; Moughton, 1982) and a decreased likelihood of fostering dependency. Furthermore, increased dialogue with health care professionals as a result of participation in decision making will "diminish the tendency of physicians to view their patients as objects to be manipulated" (Brody,

1980, p. 721), improve the quality of data collection (Brody, 1980), enhance the quality of decisions made and the care provided (Brody, 1980; Speedling & Rose, 1985), decrease the gap between patient expectation and medical capabilities (Brody, 1980), increase satisfaction with the care provided (Brody, 1980), and increase compliance with treatment regimes (Moughton, 1982; Rothert & Talarczyk, 1987).

Rubin (1968) writes that loss of control of oneself leads to shame, which is defined as "the personal private judgement of failure, passed on self by self" (p. 23) (emphasis in original). Having one's shame viewed by others amplifies the feelings within the person. Thus support for the benefits of patients maintaining control in the health care system is apparent.

Helping women maintain control in labour and delivery is a positive goal to be obtained. With respect to the physiology of labour, fighting for control or being in an argument over choices surrounding childbirth experiences can cause anxiety and fear. These feelings can raise the mother's catecholamine levels to the point of interfering with labour (Shearer, B., 1984). Indeed, documented decreases in uterine blood flow and placental perfusion in sheep in response to catecholamines (Cunningham, MacDonald, & Gant, 1989) lends credence to the belief that anxiety, fear, pain, anaesthesia, anything which elevates circulating catecholamine levels, will decrease blood flow to the uterus and inhibit effective contractions. Ineffective contractions consequent slow the progress of labour. Allowing women to participate in care decisions to the extent they desire will theoretically maintain or enhance the progress of labour. But what does control mean to a woman experiencing labour and delivery?

The Definition of Control in Relation to Labour and

Delivery

Willmuth (1975) studied the written responses to a questionnaire regarding childbirth experiences of 145 women who attended prepared childbirth classes. In the analysis it was found that the major factor associated with a positive, favourable childbirth experience outcome was the woman's perception of her ability to succeed in maintaining control during labour and delivery. To maintain control meant a number of things to the women in the study. Occasionally, the phrase meant the ability to control the perception of pain; to not be overwhelmed by pain. Secondly, and more commonly, maintaining control meant to be in charge of one's emotions and actions; to not be debilitated by fear, and to behave appropriately and with dignity.

The third meaning of control identified by these women was the one most frequently cited and most relevant to this study. The meaning of control was described as the ability to have a sense of control in the interpersonal relationships with the staff (Willmuth, 1975). Women perceived themselves in control if they felt they were active participants in labour and delivery rather than passive recipients of care. Being active participants meant that the women felt they were able to continue to influence decisions during labour and delivery. They were able to "'have a say in things'" (p.140). This sense of being in control seemed most closely related to the women's satisfaction with their childbirth experiences.

In determining women's perceptions of their labour experiences, Butani and Hodnett (1980) used the model of control developed by Tiffany, Shonty, and Wall (1969) to identify the needs of a labouring woman. Butani and Hodnett (1980) postulate that a labouring woman experiences control in terms of :

1. The forces of labour originating within her,
2. The breathing techniques and other coping mechanisms she utilizes in attempting to control these forces,
3. The control of environmental influences, such as intravenous Oxytocin, conduction anaesthesia, and hospital routines, and
4. The control she exerts over the environment in which she labours, including participation in decision making about the conduct of her labour (p. 74).

Using these postulations of control as experienced by labouring women, Butani and Hodnett (1980) interviewed 50 women (29 primiparous women and 21 multiparous) to determine the women's subjective experience of labour and delivery. "Pain" and "loss of control" were the most frequently cited unpleasant aspects of the labour experience. One aspect of control was related to subjects' concerns about participation in decision making. The authors stressed that not all women expressed a desire to be in control, thus the authors advocated individual assessment of each woman's desires in labour and delivery.

Control may also be defined in terms of mastery. Shainess (1963) wrote that a woman's sense of mastery over her childbirth experience in terms of ego, identity, or self-esteem will shape her acceptance of her child. The author went on to say that by having the woman participate in her childbirth experience will probably help her feel more useful and more in control of her experience, and thus the woman would experience a greater sense of self-esteem. Thus the idea of mastery can be considered in relation to control of the labour and delivery experience.

Humenick and Bugen (1981) defined their concept of

mastery of childbirth as being made up of active participation in decision making, self-reliance, self-control, independence, and an internal locus of control. In working with 33 primiparous women who attended Lamaze childbirth preparation, the authors found that a woman's perception of active participation during the childbirth experience was associated with a rating of increased self-esteem. The authors suggested that mastery, therefore, may be the key to childbirth satisfaction as opposed to the belief of many authors that pain management is the key.

Review of the literature of the definition of control regarding labour and delivery illustrates that control may have many components, one being participation in decision making. Participation in decision making, or active participation during childbirth as it is sometimes called, is used as the definition of control in labour and delivery for this study. The following review of the research in labour and delivery is guided by the definition of control as participation in decision making.

The Research in Labour and Delivery

Besides the study by Humenick and Bugen (1981), there are other studies to support the concept that being in control or being an active participant with respect to decision making is related to satisfaction with the childbirth experience. Davenport-Slack and Boylan (1974) interviewed 75 private patients in their third trimester, during labour, and within 18 hours of delivery. One scale used to analyze the childbirth experience was an attitudinal block of questions, one component being who should be responsible for medication decisions. This the authors broadly generalized to reflect the attitude towards who should be in control of the childbirth experience. The analysis of the responses led the

authors to conclude "that women who desire to and are given the opportunity to play an active, participatory role in childbirth have far more satisfying experiences than women who expect to rely on drugs and doctors" (p. 222).

Highley and Mercer (1978) presented a case study of a 41-year old primiparous patient who experienced labour and delivery in a hospital setting. Comments by the patient illustrate that taking part in making decisions was central to the patient's maintenance of cognitive control (as opposed to the physiologic control) of labour. Taking part in making decisions helped the patient strengthen her self-esteem and bolster her self-confidence which then led to the ability to retain control over the pain of the physiological aspect of labour. Although interpretation from a case study can supply useful information, results can not be generalized; thus caution is advised in using the information from this study. However, the information in this case study is consistent with the findings reported in other studies.

Chute (1985) used a convenience sample of 33 primiparous women to compare differences between the 15 women who chose nurse-midwifery services and the 18 women who chose traditional physician services for labour and delivery. The author found those women in the nurse-midwifery group expected to be and actually were significantly more able to be greater participants in their labour and delivery experience than those in the physician group. The nurse-midwifery group also ranked themselves higher in importance for contributing to the satisfaction of the experience and that they themselves controlled the quality of the experience. Analysis of these results supports the notion that being in control of the experience and being an active participant are

closely related to satisfaction with the childbirth experience.

Littlefield and Adams (1987) examined characteristics of 21 women who chose an alternative birthing centre and 78 who chose a hospital setting. The alternative group was older and contained a higher percentage of multiparous women. Both groups were found to have high scores on the health locus of control scale, but the conventional group scored higher on the "powerful others" scale, indicating a greater reliance on health care providers and health care institutions. The alternative group experienced greater participation during their labour and delivery experience and although both groups were satisfied with the nursing care, there was a greater sense of satisfaction in the alternative group.

In order to understand components of women's satisfaction with obstetrical care, Seguin, Therrien, Champagne, and Larouche (1989) sent questionnaires to women who had had live births. The authors received 938 questionnaires which reflected a 52% response rate. Through analysis of the responses, the authors identified that participation in the decision making process was one of five dimensions to satisfaction. The authors found that participation in decision making was the first component of satisfaction with medical care for women who had a vaginal delivery. Some factors not associated with any level of satisfaction were income, parity, education, prior desire to participate in decisions surrounding childbirth, prenatal information about birth, attendance at prenatal classes, and interventions during labour and delivery (such as induction/augmentation of labour, fetal monitoring, episiotomy, forceps). The authors identified that it is not only a minority of well-educated women who are affected by participation in decision making and the

frequency of explanations received, since education level contributed minimally to the variation of satisfaction with medical services (p. 113). Thus support is strengthened for the idea of maintaining control (as defined by participation in decision making) as important for satisfaction with childbirth experiences.

In examining the expectations of 61 multiparous women in regard to involvement of the labour and delivery nurse, Mackey and Lock (1989) found that women varied in the amount of nurse involvement expected and amount of participation in decision making expected. Most women who expected limited nurse involvement (13 of 17) expected the nurses to respect their decisions on how labour would be managed and to allow the women to be in control of their labour. All women in this group saw themselves as able to manage labour on their own without a nurse's help.

The moderate involvement group emphasized the importance of managing the labour along with the nurse, but this group varied with respect to their amount of involvement in decision making (Mackey & Lock, 1989). Of the moderate involvement group, three of 22 said they would decide how to conduct themselves in labour, and nine of the group felt they would rely on the nurse to make the decisions. The other 10 women did not mention decision making. It is clear from this study that women vary in their expectations of and preferences for participation in decision making. This supports the idea that each woman must be allowed to choose for herself the amount of collaboration in decision making.

Further evidence for the existence of this desire for control of the childbirth experience and for an active role in decision making is found in the literature examining the reasons underlying women's decisions for choosing home births. Many authors researching home

births found that the desire to maintain control over the childbirth experience and the desire to be an active participant in the experience was a major factor in choosing home birth over hospital or alternative birthing centres (Conklin & Simmons, 1979; McClain, 1983; Schiff & LaFerla, 1985).

On review of the research on control during labour and delivery, it is clear that some women do want to maintain an active role in participating in decision making. Support is evident for the idea that satisfaction is related to participation in decision making. However, the body of literature just reviewed has not specifically addressed the issues about which women want to have a say during their childbirth experience. The next section in the literature review will focus on this topic.

Women's Preferences During Labour and Delivery

The second theme addressed encompasses the situations or issues that women want during their labour and delivery experience. Included in this theme are those things which women see as options in labour and delivery care, as well as those things in which women are specifically reported as wanting a say.

In discussing collaborative decision making in labour and delivery, it is important to identify those things about which women want some choice. In the lay literature, labour and delivery options have been identified. According to the various authors, women experiencing normal labour and delivery should be able to participate in decisions about the following: anaesthesia/medications, shave preps, enemas, fetal monitoring, intravenous, food and fluids in labour, mobility in labour, preferred companion during labour and delivery, vaginal exams, spontaneous rather than artificial rupture of the membranes, spontaneous labour,

presence of hospital personnel, position changes in bed, when and how to push, position for delivery, episiotomy, time of cutting of the cord, skin-to-skin contact with the infant after delivery, and babe to breast if breast-feeding within the first hour after delivery (see for example Balaskas, 1984; Carty & Tier, 1989; Hilligweg, 1982; Jennings, 1982; Kitzinger, 1985; Safran, 1979; Simkin & Reinke, 1980; Snell, 1983).

The conclusions of most of the articles reviewed in the lay literature are not supported with research. However, some researchers have actively researched and quantified choices women want during their labour and delivery experiences.

Scaer and Korte (1978) conducted telephone interviews with 210 randomly chosen women who had had a live birth in a specific time period, 230 LaLeche League members who had had a live birth, and 205 women who had attended prenatal classes. Some options to which 50% or more of the random sample gave a response of "very important" or "strongly agree" were the presence of the father of the baby in both the labour and delivery rooms, unrestricted visiting by the father and siblings of the baby after the birth, an opportunity to initiate breast-feeding within the first hour, and recovery of mother and baby together. Other options cited as important for the labour and delivery experience were use of the mother's body to warm the baby rather than a nursery warmer, Leboyer birth, nourishing liquids during labour, effort to avoid an episiotomy, and alternatives in delivery position.

Birch (1982) interviewed 30 women on their second to fourth postpartum day to identify some aspects of labour they had wanted some say in and those in which they had some say. The three most important items for these women to have a say in were pain medication, privacy (being

left alone, alone with husband, alone with husband and baby, and draping/covering during procedures, exams and delivery), and partner's presence during the administration of epidural anaesthesia. One hundred percent of the women who said they wanted a say in pain medication had a say, 77% who wanted a say in privacy had a say, and 50% who wanted a say in their partner's presence during the epidural had a say. Further, 93% of the women who wanted a say in the presence of hospital personnel did not have a say, 82% of the women who wanted a say about fetal monitoring did not have a say, and 63% of the women who wanted a say about internal exams and 63% of the women who wanted a say about the position for delivery did not get a say. Other items that were considered important were walking during the labour, food and fluids during labour, position at delivery, and whether or not to have an enema.

As the discrepancy increased between what the women wanted and what they received, satisfaction in the primiparous women decreased significantly (Birch, 1982). In multiparous women, such a statistical relationship did not exist. The author also looked at effects on length of labour with respect to the congruity or incongruity between wants and reality and found that more congruence was associated with an increase in the length of labour in the multiparous women although this finding may be the result of the effect of an outlying point on the statistical analysis. Increased incongruity (discrepancy between what they wanted and what they had a say in) was not associated with longer labours. Age and education level appeared related to congruity, meaning older and more educated women reported more congruence. With respect to satisfaction, more than 70% of the women rated their satisfaction as a four or five on a five-point Likert scale, and no one expressed total dissatisfaction

with the experience or amount of say they had.

To determine satisfaction with maternity care, Sullivan and Beeman (1982) developed and sent questionnaires to women who had had a live birth. The authors received a 52% response rate which provided them with 1900 questionnaires to analyze. Within this questionnaire was a series of questions related to whether or not the women had wanted certain procedures and if they had had them. Those items with the greatest discrepancies between what women wanted and what they perceived as getting were: choice of atmosphere (62% wanted and did not get), freedom to move around (27% wanted but did not get), fetal monitoring (26% did not want but got), and family member present (22% wanted and did not get).

These authors found that "many women offering highly negative comments still checked 'satisfactory' in response to the question evaluating overall labour and delivery care" (Sullivan & Beeman, 1982, p. 325). They concluded that there is a reluctance in women who have given birth to criticize caretakers and thus the analysis of the distinction between being "very satisfied" and "satisfied" with the labour and delivery experience is necessary to identify dissatisfaction. Thus in this proposed study, "very satisfied" and "somewhat satisfied" will be regarded as distinct categories, and "somewhat satisfied" will be considered to be a measure of dissatisfaction.

Cranley, Hedahl, and Pegg (1983) looked at participation in decision making around certain items in assessing women's perception of vaginal (40 women) and Caesarean (39 emergency, 43 planned) delivery experiences. Subjects indicated on a questionnaire which of the identified items on a "decision participation scale" were important to them, as well as their success

in participating in making decisions about them. Some examples of items identified by the authors were choice in anaesthesia, support person at delivery, mirror available for viewing the birth, breastfeeding shortly after delivery, and having one nurse only assigned to each woman. The women who experienced vaginal delivery had significantly higher mean decision making participation scores than both the Caesarean groups, but no correlation was found between these scores and their perception of the birth experience. A point of interest is that a number of women indicated that they were unaware that they could request anaesthesia, their husband's presence, and to see and touch their infants although these were three areas rated as most important for a good experience.

Field (1985) interviewed 24 women who had delivered in a birthing room and 24 women who had delivered in a delivery room to determine their reactions to their labour and delivery and postpartum care. Specific to labour and delivery, one question that was asked was "Did you have a say in the care you received?"; if the woman responded "yes": "In what way?" was asked; if "no": "Was this what you wanted?" (p. 41). Although an attempt was made in this study to examine women's participation in having a say during labour and delivery, few pertinent results regarding this issue were presented by the author. The researcher found multiparous women felt they had a say with respect to medication administration and the need for an enema. Other factors such as ambulation during labour and choosing positions in bed during labour were spoken about positively by the women, but nothing is documented regarding participation in decisions about these issues. A few negative comments about fetal monitoring and intravenouses were recorded but the women stated they felt their doctors had given them adequate

explanation as to their need. A few women were reported as feeling they had received inadequate explanation regarding augmentation of labour (five of 44) and these women were less satisfied with their care. Satisfaction with participation in decision making was not addressed.

Finally, Jacoby (1987) randomly sampled women who had registered a live birth in one particular month in 1984 and sent them questionnaires approximately four months after delivery to determine their preferences for and satisfaction with the current maternity system. The 1920 respondents were asked if prior to their labour and delivery experiences they had wanted or not wanted a certain procedure to be done. Sixty percent of the women had hoped prior to labour and delivery that a shave prep would not be done or necessary, 63% felt that way regarding an enema, 72% regarding an epidural, 55% towards other anaesthetics, 72% regarding artificial rupture of the membranes (ARM), 83% induction by drugs, and 70% regarding episiotomy. Despite these findings, it was found that 81% of the women reported that during the actual labour and delivery experience they had wanted and received a shave prep, 81% wanted and received an enema, 66% an epidural, 80% other anaesthetic, 78% ARM, 59% induction by drugs, and 58% wanted and received an episiotomy. These inconsistencies in responses by the women could reflect the changes in preferences regarding their experience as they lived it. Things they had not particularly wanted prior to their labour and delivery (ie. medication) may at the actual time of labour and delivery have become quite desirable. The responses could also reflect some "rationalization" of the experience so the women could live with what had happened to them.

Those women who admitted not wanting these procedures during the actual labour and delivery but

received them anyway were 31% in the shave prep group, 28% in the enema group, 11% epidural, 53% other anaesthetic, 59% ARM, 23% induction by drugs, and 39% episiotomy (Jacoby, 1987). Thus there is a large number of women whose preferences were not met.

Other aspects, termed "social aspects" (Jacoby, 1987), such as the ability to move freely, having the father present during labour and during delivery, and holding the baby immediately after birth, showed more congruence between what the women wanted and what they received. Seventy-two percent of the women who wanted to move freely about were able to, 96% who wanted the father of the baby present for the labour had him present, 88% who wanted the father of the baby present at the delivery had him present, and 86% who wanted to hold their baby were able to do so. Regarding fetal monitoring, 76% of all the women were monitored. Forty-five percent of these women were "pleased" that they were monitored, 44% did not want to be monitored, and 14% "didn't mind" being monitored.

Overall, 61% of the respondents said their labour was managed as they liked, 33% "in some ways, but not in others", and 6% not at all as they liked (Jacoby, 1987). Those who reported having their labour managed as they liked showed significantly fewer procedures being done than the other women. Those who reported positive social aspects were more likely to say the labour was managed as they liked.

Jacoby (1987) found overall satisfaction to be high but women who experienced procedures which they preferred not to have were least likely to say their labour was managed as they had liked. The author concluded that women's views of their management were clearly related to the procedures experienced and that women tended to prefer noninterventionist labours.

Review of the research regarding women's preferences for labour and delivery has enabled the identification of a number of issues and items. It was shown that satisfaction with labour and delivery experiences increases with an increase in the congruency between what women want and what they receive. An important factor in whether women receive their preferences during labour and delivery is collaboration in decision making.

Collaborative Decision Making During Labour and Delivery

While Birch (1982) and Jacoby (1987) found that some preferences were honoured during labour and delivery, there were still many women who did not receive what they wanted. Shaw (1974) in her comparative analysis of maternity care in several urban hospitals found through participant observation that women played little part in the decisions made regarding their intrapartum care. Danziger (1978) wrote about women's avoidance of conflict during their prenatal care, and found during an ethnographic study of two maternity wards that neither the staff nor the patients requested large amounts of patient input into the decision making process (1979).

Hanvey (1988), in discussing the Canadian Medical Association's report on an obstetrical care survey carried out in 1987, outlined some beliefs and concerns cited by the CMA which manifested the "perceived dissatisfaction" with obstetric care in Canada at the time of the survey:

1. That there is excessive medical intervention in hospital-based reproductive care.
2. That many hospital facilities provide a sterile and rule-encrusted environment for childbirth.
3. That there is not enough emphasis on the psychosocial aspects of the birth experience, and that few choices are available regarding

alternative approaches to childbirth.

4. That patients do not participate fully in decision-making about childbirth.
5. That little has been done in recent years to allay these concerns. (Hanvey, 1988, p. 483).

Although the Canadian Medical Association (1987) concluded that "it is apparent that having a choice about a procedure or preference honoured was more important to the women than whether certain procedures were actually performed" (p. 25), it is not evident from the survey how this conclusion was obtained. The only indication of choice for the women was a question about preferred position for labour and delivery: only 26% of the women responding were given a choice (Hanvey, 1988). Little support is shown for women having a say in actual practice in labour and delivery.

Finally, Taylor, Pickens and Geden (1989) videotaped male and female physicians and nurse practitioners during 127 actual interactions with patients. Shared decision making behaviours/statements were found only 8.8% of the time with the male physician group, 21.1% of the time with the female physicians, 4.5% with the male nurse-practitioners, and 10% with the female nurse-practitioners. Consequently, little opportunity for collaborative decision making presented itself during these interactions. Although generalizing these data to a labour and delivery setting is not feasible, the data do raise questions in a reader's mind regarding what actually occurs regarding participation in decision making in health care settings, including labour and delivery.

Factors that Limit Collaborative Decision Making in Labour and Delivery

One factor that limits participation in collaborative decision making is the hospital as an

institution. Being a large institution which serves many individuals, a hospital requires rules to maintain its internal organization and functioning (Ladd, 1985). It is not dependent on satisfying the self-perceived needs of individual clients. Within the hospital, the rules or policies and procedures of the labour and delivery unit may also constrain the expression of individual preferences.

Physicians and nurses in labour and delivery are trained to believe in helping people. This is a positive orientation which can be associated with willingness to have women collaborate in decisions regarding their care during their childbirth experiences. But conflict can arise due to the other training of physicians and nurses which directs them to make autonomous decisions based on their special knowledge (McKay, 1988). In other words, having the woman collaborate in making decisions may conflict with the idea of "we know best".

Conflict can also arise when physicians and/or nurses believe that attempts by expectant mothers to share in the decision making regarding their care indicate a lack of trust in the care providers (McKay, 1988; Richards, 1982). In other words, some health care practitioners may see a patient's wishes as a personal insult or threat, although the intent of the patient could have been merely a defining of the woman's perspective, wants, and perhaps, needs.

Finally, there is the view by some health care practitioners that safety is the underlying issue; that something may go "wrong" at any time, that pregnancy, labour and delivery can not be considered normal prospectively but only retrospectively at the six-week check-up. "Implicitly or explicitly, the maternity system regards emotional comfort and satisfaction as secondary to <u>the</u> important issue of safety (or, more

accurately, interventions that are believed to influence the perinatal mortality rate)" (Richards, 1982, p. 256) (emphasis in original). It is implied that alternatives suggested by patients, or their desire to be the ultimate decision maker over their own care in order to obtain their optimum childbirth experience, is somehow a disregard for safety. As mentioned earlier, safety is the prerequisite for the opportunity to seek a meaningful and satisfying childbirth experience. From the literature, it can be seen that the things that are identified as important for women to have a say in are not life-threatening, immoral, or illegal.

Thus it can be seen that the institution, the labour and delivery unit, and the beliefs and attitudes of the health care practitioner can affect the attainability and the extensiveness of women's participation in decision making during labour and delivery.

Summary of the Literature

Review of the literature encompassed four main areas: the issue of control, women's preferences for labour and delivery, collaboration in decision making during labour and delivery, and factors that limit collaborative decision making during labour and delivery. One important aspect of control is participation in decision making. Participation in decision making was shown to be valuable in that a sense of loss of control was diminished, self-esteem and self-respect were enhanced, and with respect to the physiology of labour, progress of labour was promoted. Participation in decision making was associated with satisfaction with the childbirth experience.

Review of the research revealed that participation in decision making is important to women during childbirth and that women vary with respect to the amount of involvement desired in decision making. Women's

preferences for labour and delivery experiences were identified, as was the extent to which women's preferences were considered during their experience. It was shown that many women did not receive attention to their preferences.

Birch (1982), Chute (1985), Cranley, Hedahl and Pegg (1983), Field (1985), and Littlefield and Adams (1987) examined women's participation in decision making during labour and delivery. However, only Birch (1982) attempted to look at what women wanted to have a say in during labour and delivery as well as in what they perceived themselves as having had a say. Further, each study was conducted using various strategies for data collection thus inhibiting standardization and comparison of results. Reliability and validity of the methods were not always identified by the authors.

Therefore it is necessary that further evaluation be done on what women want to have a say in during labour and delivery and on women's perceptions of having had a say during labour and delivery. Ongoing assessment of these issues is important to be in tune with what the women of today want. Further testing of a relationship between participation in decision making and satisfaction with the childbirth experience and length of labour is also warranted. The present study is a modified replication of Birch's (1982) work. Replication will serve to corroborate and validate the particular findings of that earlier study.

The purpose of this study is to look at what women in a labour and delivery unit in a hospital want to have a say in, what they had a say in , and how satisfied they were with their level of participation in decision making and with their childbirth experience. A relationship between participation in decision making and length of labour will also be examined.

Method

Design

The design of this study is a correlational descriptive survey design (Brink & Wood, 1988), retrospective in nature, and is a modified replication of the study by Birch (1982). In examining women's collaborative decision making experiences in labour and delivery, the relationship between women wanting a say and their perception of having had a say is assessed. The relationship between the congruency of a woman's wishes regarding certain issues in labour and delivery (having a say in those things a woman wants a say) and the woman's satisfaction with her participation in decision making and her satisfaction with her overall childbirth experience is also examined.

The demographic (independent) variables are age, parity (number of births), years of education, income, race, marital status, and attendance at prenatal classes. These variables are generally assumed to influence participation in decision making during labour and delivery, however little support for these assumptions is found in the research literature. Therefore, the relevance of these variables will be interesting to note in the study results.

The dependent variables are those items in which women are interested in having a say, as identified in the literature and from clinical experience. The items specifically addressed in this study are:

1. Spontaneous or induced labour,
2. Perineal shave prep,
3. Enema,
4. Medications to relieve pain during labour including narcotic analgesics, Entonox (nitrous oxide), and epidurals,
5. Freedom to move during labour,

6. Food/fluids during labour,
7. Intravenous,
8. Presence of chosen persons during labour and delivery,
9. Presence of hospital personnel,
10. Frequency and timing of vaginal exams,
11. Position for delivery,
12. Spontaneous or forceps/vacuum extraction delivery,
13. Episiotomy,
14. Breastfeed baby within the first hour (if the woman is breastfeeding),
15. Privacy (being alone as desired, alone with significant other(s), alone with baby, and the draping of one's person, and
16. Fetal monitoring.

Outcome measures will be the subjects' rated level of satisfaction with participation in decision making and their satisfaction with the overall birthing experience, as measured on a five-point Likert scale (ranging from very unsatisfied to very satisfied) and length of labour.

Although difficulty in adequately measuring women's satisfaction with childbirth experiences has been documented in the literature (Lumley, 1985; Oakley, 1985; Shearer, 1983), it is also suggested that the method of assessment (a questionnaire or an interview) also affects the responses given, with more honesty obtained in an interview format (Lumley, 1985; Oakley, 1985). Because an interview assessment of satisfaction has been chosen for this study (although subjects will be asked to rate their level on a scale), it is expected that some subjects will qualify the data which will enrich the understanding of subtleties among the levels of satisfaction.

Length of labour will also be examined as an outcome

measure as it is hypothesized that increased participation in decision making will enhance the woman's sense of control and thus reduce the anxiety and fear which can cause increased levels of circulating catecholamines and thus decrease the length of labour.

A pilot study was conducted with one woman who met the inclusion criteria. Based on the evaluation of that interview, no changes were necessary regarding the interview format. Interviewing for the study then proceeded.

Setting

The setting of this study was the postpartum unit of a large teaching hospital in an urban area. The interviews took place at the convenience of the woman with privacy ensured.

Sample

The sample for this study was a convenience sample (Brink & Wood, 1988) of women who fit the inclusion criteria and who consented to participate. All subjects were given an information sheet about the study (see Appendix B) by the unit supervisor or shift nurse and the subjects informed the nurse of their wish to participate. The researcher was informed by the nurses on the postpartum units of interested women, and the researcher then approached the potential subject to arrange a convenient time for the interview and to obtain consent.

Women were added to the study as they consented to participate until the number of interviews that could be coded reached 30. This number permits the use of parametric statistical analysis.

The hospital review committee believed it necessary to obtain consent from physicians prior to accessing patients. Therefore physicians who delivered women at the study hospital were sent a package containing a letter of introduction, a summary of the proposal, the

information and consent forms that were to be given to the women, and a consent form to be signed by the physicians if they did not consent to their patients being approached (see Appendix C for the letter of introduction and the letter of consent). Only one physician denied access to his/her patients.

Criteria for inclusion were: women who read, write, and speak English; a pregnancy uncomplicated by medical or obstetrical complications (ie. a "normal" pregnancy); and a vaginal delivery with a healthy outcome for mother and baby. Onset of labour could be spontaneous or induced and delivery spontaneous or assisted with forceps or a vacuum extractor (as in these circumstances women could still have the opportunity to collaborate in decision making).

In order to minimize confounding variables, women who had Caesarean deliveries, women who became ill after delivery (eg. elevated blood pressure, infection) or women who had ill newborns or newborns requiring Neonatal Intensive Care, were excluded from this study.

Method of Data Collection

Data were collected through the use of a semi-structured interview. A semi-structured interview permits flexibility in elaborating on women's answers while providing a standard framework for consistency and simplification of analysis. An interview also permits elaboration and clarification of responses by either the subject or the researcher.

For those women who met the criteria and were interested in participating in the study, the researcher asked each woman to set a convenient time for the interview. All interviews occurred at this first meeting. The interviews usually took place on the subject's second postpartum day, and occasionally on the third. The timing of the interviews shortly after

delivery was important as during this time women often review their labour and delivery experiences to come to terms with the events of that time (Affonso, 1977). The researcher wore street clothes and her Master's of Nursing student name-tag to emphasize that the researcher was not conducting the study for the hospital, nurses, or physicians. A portable tape-recorder and flat microphone were used to tape the interviews.

During the interview, a card-sort or Q sort (Nunnally, 1967) was conducted by the woman. Each card showed one of the researcher's 16 identified items. Any additional items identified by the woman during the interview were written individually on extra cards. The woman then rated the issues or items which she had identified in one of three categories: "highly important", "moderately important", and "somewhat important" to have a say. Those things most important to women were identified as was their order of importance.

The researcher then asked the woman to describe her satisfaction with the amount of say she had during her labour and delivery experience. Satisfaction was rated on a scale from 1 to 5, with 1 being very dissatisfied and 5 being very satisfied. The same procedure took place regarding satisfaction with the overall childbirth experience.

Finally, the researcher asked the woman her age, parity, years of education, race, income, marital status, and whether or not she had attended prenatal classes during any of her pregnancies. After these questions were answered, the researcher asked the woman if she had anything more to add. The researcher then noticeably turned the tape-recorder off and thanked the subject for her time and information.

Information regarding the length of labour was obtained from the woman's chart and by so doing an

attempt was made to clinically separate the actual length of labour (contractions accompanied by progressive cervical dilatation or effacement) from any false labour (contractions with no accompanying cervical changes). For a detailed outline of the interview, please refer to Appendix E.

Reliability and Validity

Reliability refers to "the consistency, stability, and repeatability of a data collection instrument" (Brink & Wood, 1988). One method to ensure that the interview in this present study is reliable is to use both interview and card-sort. The card-sort strengthens the assertion of the women regarding the importance of certain items to them. It is hoped the women were honest and expressed their true feelings on the matter and did not give a socially desirable response.

Reliability of the interviewer in categorizing the data to "wanted a say" or "did not want a say" and measuring the importance of certain items was obtained with the assistance of two maternal-child clinicians who each reviewed two tapes and completed the categorization of the data. Correlation between the researcher and the reviewers was found to be .94. The subjects' interviews in which discrepancies were found were replayed by the researcher in order to discern the woman's responses. In four of the six discrepancies, the women themselves labelled the item as "that's the [want a say] pile". For the other two discrepancies, the tone of the interview and the woman's voice tones helped discriminate between wanting a say or not wanting a say, and between had a say and did not have a say. The women's responses were then coded accordingly.

Validity reflects the extent to which that which is attempted to be measured is truly measured. Face validity is the asking of the apparent "right" questions

to obtain the relevant information (Brink & Wood, 1988). This study included a pilot study to ensure that the questions asked were clear, sensible, and appropriate to the purpose. In other words, the questions asked during the interview elicited information regarding: what women want a say in during labour and delivery, what women have a say in during labour and delivery, and their satisfaction with decision making and with the childbirth experience.

Content validity was met by having an expert in the field review the items and the questions to be asked to ensure accuracy and adequacy of the items (Brink & Wood, 1988).

Ethical Considerations

The protection of human rights is essential for the conduct of research. This study first accessed the potential subjects for both the pilot study and the full study through the postpartum unit manager or shift nurse via an information sheet regarding the purpose of the study, the procedure involved, risks to the subjects, and assurance of confidentiality (see Appendix B). This method of access to subjects helped ensure voluntary consent of participants as the researcher herself was not initially involved. Voluntary participation was reinforced to each subject by the researcher during the review of the consent form (see Appendix D for Informed Consent form). Participants were assured that they were free to participate or not, that if they did participate they did not have to answer any question they chose not to, and that they could drop out of the study at any time without consequence. The women were assured that participation or not, their care by physicians, nurses, and others would not be affected. The participant was told she could expect the interview to take approximately 30 minutes, depending on the amount of information

offered by the subject. There was no anticipated risk to the participant who agreed to take part in the study. If however, participants revealed harmful or threatening information towards themselves or towards others, the researcher would discuss this with the woman at the conclusion of the interview. Subjects were informed that the researcher, by law, cannot keep such information secret and that the researcher would discuss the information with the appropriate health care personnel. No such situation arose.

There were no direct benefits for the participants, except that by participating in the study the women were given the opportunity to review their labour and delivery experiences, thus possibly providing a vehicle for helping them come to terms with those events. Certainly, results from this study may help health care practitioners become more aware of what women want to have a say in during labour and delivery. Health care personnel may be encouraged to implement some of these findings in practice.

Confidentiality was ensured by locking the signed consent forms in a cabinet, excluding any references to a particular woman that may enable others to identify her, using numbers and letters as opposed to names when coding the data, locking the tapes when not being analyzed, and destroying the tapes at the completion of the study. Verbatim information was transcribed from the tapes to provide qualitative information in order to enrich the data analysis, but these transcriptions were coded to ensure confidentiality. The coded data, the transcribed information, and the consent forms will be kept locked in a file for five years, then destroyed.

Prior to commencement of the interview, a written consent form was reviewed with the woman and an opportunity provided for questions (see Appendix D for

Informed Consent form). Participants received a copy of the consent. Those subjects who wished to receive a summary of the results signed a detachable section at the bottom of the consent form.

Data Analysis and Results

The following chapter, which addresses data analysis and results is divided into seven sections. First addressed is the sampling of the women participating in the study. The characteristics of the women are then described along with significant correlations that appear in regard to the independent variables ($p < .05$). The section following identifies the items about which women wanted a say. The importance of having a say with respect to each item is then identified. Analysis to determine whether or not women had a say in the items they identified is presented. The sixth section deals with statistically significant correlations ($p < .05$) among all the variables: the demographic characteristics of the women, congruency between wanting a say and having a say, satisfaction with decision making, satisfaction with the childbirth experience, and length of labour. The final section contains additional qualitative analyses that are not specifically related to the research questions.

Sampling of the Women

The sample of women for this study is a convenience sample. During the study, 37 women were interviewed. One woman was in the pilot study and her interview is not incorporated into the interviews analyzed. Due to mechanical problems with the tape-recorder, four interviews could not be coded. Another interview was disqualified because questions of satisfaction were omitted. Finally, during the course of an interview, one interviewee revealed that her baby was delivered in a breech position. As this situation is considered "high-risk", this interview also had to be excluded from the study. Consequently, 30 interviews were coded.

Characteristics of the Subjects

Age

Age is an important demographic characteristic to examine in order to compare the study group with the general population. The percentage of subjects in the present study in each age group is depicted in Figure 1, as well as the percentages for women in Alberta and Canada.

The mean age of the subjects in this present study was 27.27 years. Approximately 7% of the women were 19 years of age or less. The largest frequency, 37%, was found in the 25-29 years of age range, and almost 17% of the sample were in the 35 years or greater age group. Compared with Statistics Canada (1990) information, the study sample under-represents women in the age group 30-34. Over-representation exists with the 20-24 and 35-44 age groups. However, an over-all comparison shows only a small difference between the study sample and the results from Statistics Canada (1990). With respect to statistically significant correlations, age was found to be positively correlated with parity, education, income, and the congruency between wanting a say and having a say. A statistically significant negative correlation existed between age and attendance of prenatal classes.

Parity

Parity has been found to be related to satisfaction with decision making and satisfaction with the childbirth experience (Birch, 1982). It is important to see whether parity similarly affects the results of this present study. Of all the women interviewed, 63% were multigravidae and 37% were primigravidae. Statistically significant positive correlations were found between parity and age, and parity and education.

Education

Education is an important demographic characteristic in order to be able to compare the results of this study with women of similar educational backgrounds. It is

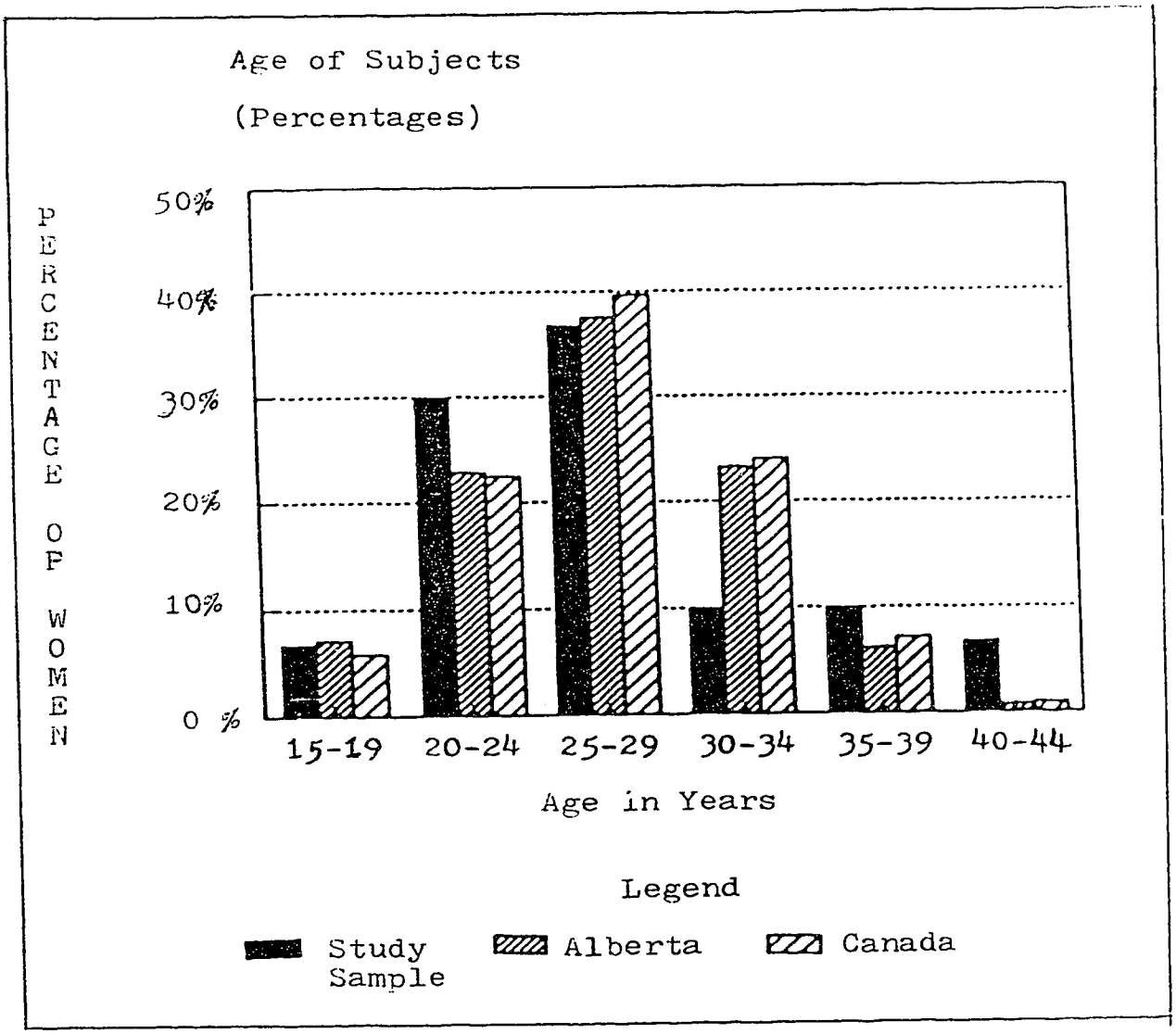
Age of Subjects
(Percentages)
PERCENTAGE OF WOMEN
50%
40%
30%
20%
10%
0 %
15-19
20-24
25-29
30-34
35-39
40-44
Age in Years
Legend
Study Sample
Alberta
Canada

Figure 1

also interesting to see if education is related to the outcome variables, although no study to date has shown such a relationship to exist. The frequencies of the type of education for the study sample
are shown in Figure 2.

The mean number of years of education for the subjects interviewed is 14.72 years, and approximately 53% of the sample possessed at least a college education. Census or Vital Statistics information is not available to compare the study population with the general population, however an average of 14.72 years of education is higher than the purported education of Albertans and Canadians.

Statistically significant positive correlations were found to exist between education and parity, and education and income. A statistically significant negative correlation was found between education and the attendance of prenatal classes.

Income

It is important to know the family's economic status as income may play a role in the congruency between wanting a say and getting a say. It is also important to know family income in order to compare findings with women of similar economic backgrounds. The percentages of women from the study and from Statistics Canada figures in the different income groups are shown in Figure 3.

Approximately 57% of the women stated they made a combined income of at least $35,000, and almost 27% of those women stated their family income to be greater than $60,000. Twenty percent of the women in the study chose to not answer the question. These findings are high compared to Statistics Canada (1989) results for those income ranges. Compared to the Statistics Canada figures, the study sample under-represents women in the

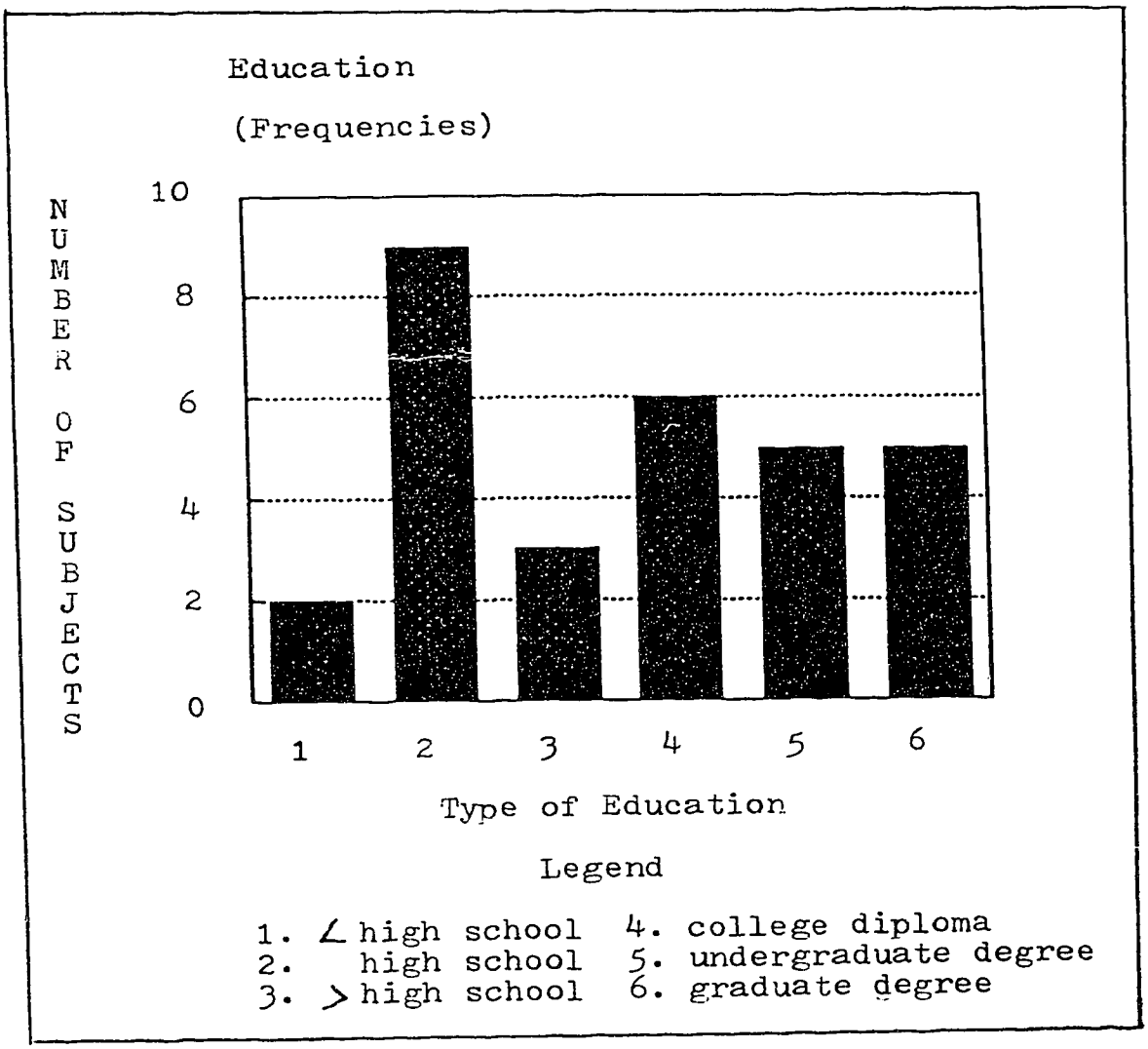
Education
(Frequencies)
NUMBER OF SUBJECTS
10
8
6
4
2
0
1
2
3
4
5
6
Type of Education
Legend
1. < high school
2. high school
3. > high school
4. college diploma
5. undergraduate degree
6. graduate degree

Figure 2

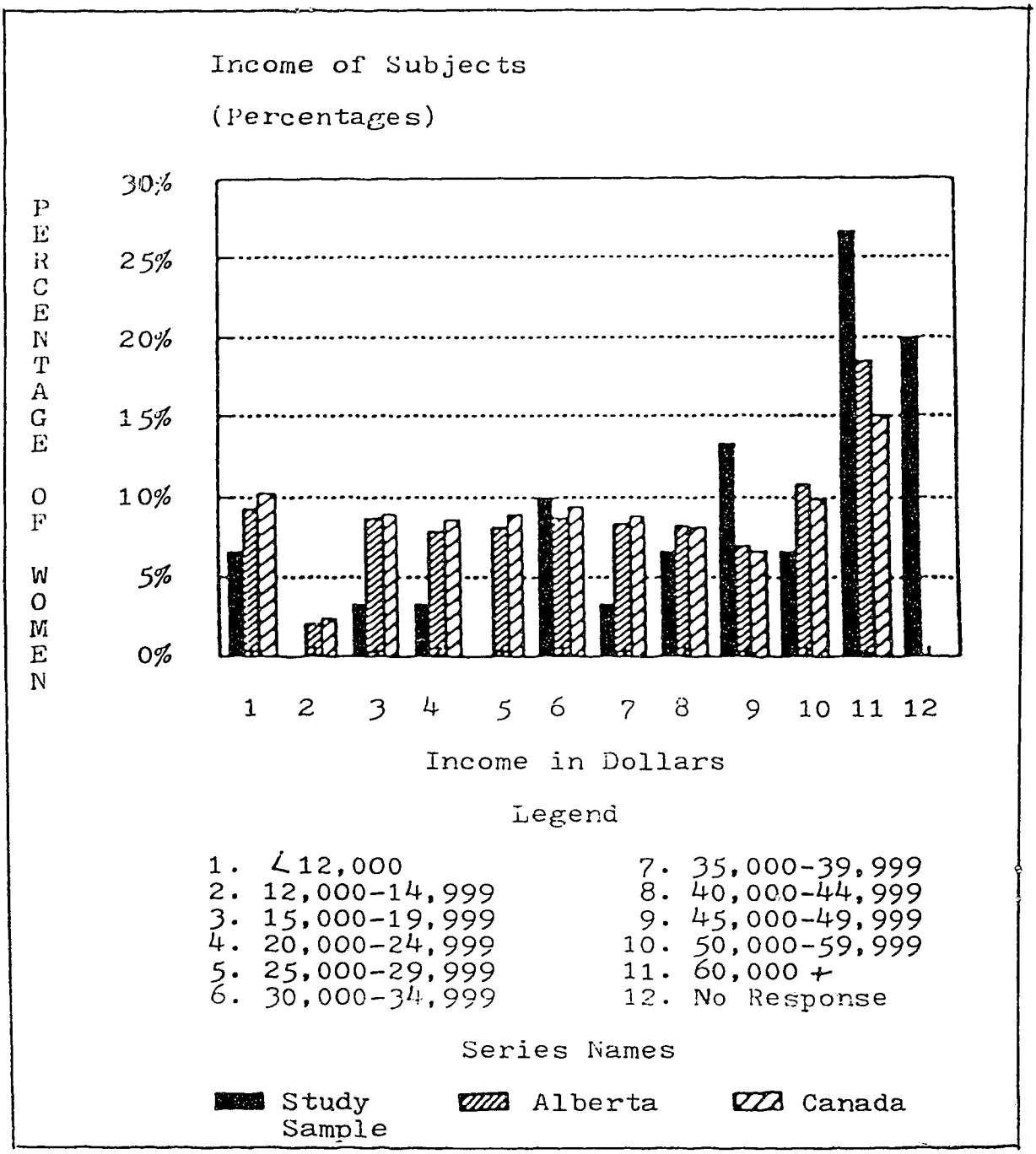
Income of Subjects
(Percentages)
PERCENTAGE OF WOMEN
30%
25%
20%
15%
10%
5%
0%
1 2 3 4 5 6 7 8 9 10 11 12
Income in Dollars
Legend
1. ∠12,000
2. 12,000-14,999
3. 15,000-19,999
4. 20,000-24,999
5. 25,000-29,999
6. 30,000-34,999
7. 35,000-39,999
8. 40,000-44,999
9. 45,000-49,999
10. 50,000-59,999
11. 60,000 +
12. No Response
Series Names
Study Sample
Alberta
Canada

Figure 3

< $24,999 group.

Statistically significant positive correlations were found to exist between income and age, and income and education. A negative correlation was found between income and attendance at prenatal classes.

Prenatal Classes

Prenatal classes may influence women's behaviours during labour and delivery, as well as affecting their expectations of the labour and delivery experience because one aim of prenatal classes is to educate women and couples for active participation in childbirth (Walker & Erdman, 1984). Attendance at prenatal classes has been associated with a positive attitude toward the childbirth experience post delivery (Cogan, 1980). Therefore, it is interesting to see if attendance at prenatal classes is related to congruency, satisfaction with decision making, and satisfaction with the childbirth experience. Furthermore, Coussens and Coussens (1984) found in a review of the literature that attendance at prenatal classes is associated with decreased length of labour.

Of all the subjects in the study, approximately 83% had attended prenatal classes with the recent pregnancy or a previous one. Those women who did not attend any prenatal classes comprised almost 17% of the women.

A statistically significant positive correlation was found between the attendance at prenatal classes and marital status. Statistically significant negative correlations were found between the attendance at prenatal classes and age, education, and income.

Race

Twenty-seven of the 30 subjects were Caucasian. Two women were Native Canadians, and one woman was East Indian. The high percentage of Caucasian women in the present study is comparable to other studies. There was

no significant relationship between race and any other variable.

Marital Status

Marital status may have an impact on what women want a say in during labour and delivery, what they have a say in, and the outcome measures of satisfaction.

Eighty percent of the subjects were married, 10% were in stable common-law relationships, and 10% of the women were single and keeping their baby. Statistics Canada (1990) reveals that approximately 20% of women giving birth in Canada and almost 18% of women giving birth in Alberta are single. Married women comprise just over 78% of women giving birth in Canada and almost 78% of the women giving birth in Alberta. Comparison of the proportions of marital status and women giving birth shows the study sample to be representative of the married population and under-representative of the single population. The other marital status categories for Statistics Canada were divorced, widowed, and no response. It is not known how women in stable common-law relationships answered the question, so it is possible that they said they were single, thus augmenting the results found in Statistics Canada. It is also equally possible that women in common-law relationships labelled themselves as married, in which case the results for the married category for Statistics Canada could be inflated. Consequently, comparison between the study sample characteristics of marital status and the Statistics Canada results is limited.

The only statistically significant correlation with marital status was a positive correlation with attendance at prenatal classes.

Items About Which Women Want a Say

Examining the items in which women want a say during labour and delivery addresses the extensiveness of

collaborative decision making in labour and delivery. Women identified anywhere from five to sixteen items about which they wanted some say. The mean number of items cited by the women was 10.2, the mode was 12 and the median was 11. Twenty-six of the 30 women wanted a say in eight or more items. Shown in Table 1 are the items and the number of women who wanted a say and whether those women who wanted a say had a say. Reported in Table 2 are the number of women who did not want a say with respect to each item.

Presence of Chosen Persons

In the interviews coded, all the women wanted a say in who they wanted present during their labour and delivery experience. Most women defined their chosen person as their husband, common-law husband, or boyfriend. One woman had her mother present as her chosen person; one had a good friend. Two women also had good friends along with their "significant other". Some women did mention the desire to have their other child/children present,or a special friend to share in the event, but felt that their husband was the only person allowed to attend the birth. Feeling that these other people were not allowed did not upset these women as having their one significant other present satisfied their needs.

Pain Medications

All the women interviewed wanted a say in the administration of pain medications. Women wanted a say as to whether or not medication was given, the type of pain medication given, and the timing of the administration of the medication.

One woman said:

> I had a say in what I could take. Like they kept asking me if I wanted to take drugs at 12 o'clock, and I just started labour, and I said "No", so I

Table 1

Categorizing Frequencies of Items and Wanted a Say

Item	Wanted a Say N (%)	Wanted a Say and Had a Say N (%)	Wanted But Did Not Have a Say N (%)
1. Presence of Chosen Persons	30 (100)	29 (96.67)	1 (3.33)
2. Pain Medications	30 (100)	27 (90)	3 (10)
3. Freedom to Move	29 (96.67)	26 (86.67)	3 (10)
4. Presence of Hospital Personnel	23 (76.67)	16 (53.33)	7 (23.33)
5. Privacy	22 (73.33)	20 (66.67)	2 (6.67)
6. Breastfeed Within the First hour	21 (87.5)	17 (70.83)	4 (16.67)
7. Fetal Monitoring	20 (66.67)	12 (40)	8 (26.67)
8. Food/Fluids	20 (66.67)	10 (33.33	10 (33.33)
9. Position for Delivery	19 (63.33)	13 (43.33)	6 (20)
10. Vaginal Exams	19 (63.33)	14 (46.67)	5 (16.67)
11. Enema	18 (85.71)	13 (61.9)	5 (23.81)
12. Intravenous	12 (52.17)	7 (30.43)	5 (21.74)
13. Spontaneous Versus Induced Labour	11 (84.61)	7 (53.85)	4 (30.77)
14. Episiotomy	10 (35.71)	1 (3.57)	9 (32.14)
15. Shave Prep	10 (58.52)	8 (47.06)	2 (11.76)
16. Others	8 (100)	7 (87.5)	1 (12.5)
17. Spontaneous Versus Assisted Delivery	4 (36.36)	3 (27.27)	1 (9.09)

Note: Percentages were calculated using all the women who wanted a say (Table 1) as well as those who did not want a say (Table 2).

Table 2

Categorizing Frequencies of Items and Not Wanted a Say

Item	Not Wanted N (%)	Not Wanted But Had a Say N (%)	Not Wanted And Not Had N (%)
1. Presence of Chosen Persons	0	0	0
2. Pain Medications	0	0	0
3. Freedom to Move	1 (3.33)	0	1 (3.33)
4. Presence of Hospital Personnel	7 (23.33)	0	7 (23.33)
5. Privacy	8 (26.67)	0	8 (26.67)
6. Breastfeed Within the First Hour	3 (12.5)	2 (8.33)	1 (4.17)
7. Fetal Monitoring	10 (33.33)	0	10 (33.33)
8. Food/Fluids	10 (33.33)	1 (3.33)	9 (30)
9. Position for Delivery	11 (36.67)	0	11 (36.67)
10. Vaginal Exams	11 (36.67)	0	11 (36.67)
11. Enema	3 (14.29)	0	3 (14.29)
12. Intravenous	11 (47.83)	0	11 (47.83)
13. Spontaneous Versus Induced Labour	2 (15.38)	0	2 (15.38)
14. Episiotomy	18 (64.29)	0	18 (64.29)
15. Shave Prep	7 (41.18)	0	7 (41.18)
16. Others	0	0	0
17. Spontaneous Versus Assisted Delivery	7 (63.64)	0	7 (63.64)

Note: Percentages were calculated using all the women who wanted a say (Table 1) as well as all those who did not want a say (Table 2).

had an option to say "No", that I didn't want any drugs. I tried to hold it out as long, as much as I could.

This woman saw a choice being offered and her power to control what happened.

However, another woman said:

> Yes [I had a say], but towards the end, they were starting to make decisions for me, and then they realized that maybe they should be asking me, and they did, and I, then I made the decision which wasto not have [pain medication]. They were starting to decide for me what I should have, where, and even the attending physician was starting to decide. They thought I should have an epidural which was probably the last thing on Earth I needed at that point. And, um, then they were getting into the Demerol, and all that kind of stuff. My other two deliveries I never had drugs either. It was just that I was tired, and that's, I still knew what I was doing.

One woman felt she was given a choice about pain medication, but felt "pressured" to take it:

> I felt, like, it's not fair to say they didn't give me the choice. I, like I told you, I just felt disappointed, that I felt a pressure the way things were asked. Like I told you, well, things were getting ready before I even said "yes". And that's, I think, when I think about that, then I think "Well maybe that was pressure". Like a brain-wash. "Why should you feel pain things when an epidural is available?" and all this. And when you are in pain, then it's terrible, like "That's true". But when you're not in pain you think, you think "No, I don't want those things, it's a risk." So it's not fair to say I didn't have a say, but I had it on pressure. And I chose something that I had to choose, I guess.

Freedom to Move

Twenty-nine women said they wanted a say in their freedom to move. These women wanted to be able to choose to walk or rest, or assume any position they wanted to help cope with their labour. If restricted to their bed, for example because of an epidural block, most women wanted a say in their positioning.

Presence of Hospital Personnel

Twenty-three women said they wanted a say in the hospital personnel present during their labour and delivery. Two women mentioned they wanted a say in changing nurses should the one assigned to them be incompatible with themselves. Most women said they wanted a say in the number of people in the room, and some of these women said they were satisfied with a number of people in the room as long as they knew the people or the role they played. Others, however, said they definitely did not want a lot of people around.

For example, one woman said:

> Yeah, I didn't want any students. If they were there, I didn't want them to take any action. Uh, because I just didn't think they were qualified.... Those who were important to be there should be there.... Yeah, it is [important], because if there's someone, and you're wondering who that person is standing there, you know, you don't want 12 people looking at you. It, it's important, I mean, it's your body and um, whatever. You like to know what that person's doing, what kind of role do they play.

Privacy

Twenty-two women said they wanted a say about being left alone or not being left alone before or after the delivery.

One woman said:

> When I was very close to the end of my labour, and I was in a lot of pain, and there was nobody there. There was my husband and I, and a student nurse who wasn't even on duty, and I think there should have been somebody there. 'Cause it turned out that about 15 minutes after the nurse got back I had the baby. It would have been nice to be told how to relax, and, 'cause I was getting really bad pains at that time, and I wasn't sure how to get myself out of the pain. And when she came back in, it was so easy after that, that I thought "Where was she half an hour ago when I was in agony?"

Breastfeeding Within the First Hour of Delivery

Of the 24 women breastfeeding, 21 wanted a say in whether or not they breastfed within the first hour of delivery.

Fetal Monitoring

Twenty women wanted a say with respect to some aspect of fetal monitoring, such as continuous versus intermittent monitoring, the frequency and timing of monitoring with the electric fetal monitor, having the monitor belts removed when up walking, and having an external versus internal electrode for monitoring the baby's heartrate.

Food and Fluids

Twenty women wanted a say in issues related to eating and drinking during their labour. A few women mentioned the desire to eat something light, like toast. Most women wanted to drink juice or water as opposed to the ice chips offered by the hospital. Some women, however, felt ice chips were satisfactory.

Position for Delivery

Nineteen women wanted a say in the position assumed for delivery. One woman said she wanted to squat and one woman wanted to deliver on her side. The other women wanted a say with respect to the degree of uprightness when sitting and pushing in order to achieve a comfortable position.

Vaginal Exams

Nineteen women wanted a say with respect to the timing and frequency of vaginal exams. Two women wanted a say with respect to who performed the exams. One wanted either her nurse or physician to do the vaginal exams, as the nurse and physician disagreed frequently.

Enema

Eighteen women wanted a say about having or not having an enema. Women chose to have an enema for fear of "soiling" themselves during the delivery, and

therefore an enema would provide a "clean" environment into which their baby would be born. Others felt an enema would help labour progress faster. Other women were simply constipated and required some relief.

Women whc did not want an enema said their bowels were functioning well, or they felt an enema was an invasive procedure.

Intravenous

Twelve women wanted a say as to whether or not they received an intravenous, the site of the IV, or how often someone could try to establish the IV.

Spontaneous versus Induced Labour

Of the 13 women having an induced labour, 11 women wanted a say as to how the induction was commenced (IV or tablets) or the timing of the induction.

Episiotomy

Of the 28 women responding to this item, 10 women wanted a say. Of those 10 women wanting a say, some women wanted an episiotomy performed, others did not.

Shave Prep

Seventeen women responded to this item, and 10 women wanted a say. Not one woman of the women who wanted a say wanted a shave prep to be done.

Others

This category includes "choice of hospital", "choice of physician", "artificial rupture of the membranes", "having a mirror in which to view the birth", "holding the baby", "having a Labour-Delivery-Recovery room", and the "choice of going home when in early labour". Two women identified "choice of hospital" as an item about which they wanted a say. Individual women chose one of the other six items identified in this category.

Spontaneous versus Assisted Delivery

Eleven women had an assisted delivery. Four of these 11 women wanted a say as to whether or not an

assisted delivery was done, or when it was done.

Importance of Having a Say with Respect to Each Item

The importance of having a say is the affective meaning of collaborative decision making according to Kim's (1983) framework. Shown in Table 3 are the items and the order of importance.

The women ranked from 2 to 10 items as very important to have a say. An average of 5.3 items were placed in the very important rank by each woman. The modes are 4 and 6, and the median is 5. The women had identified an average of 10.2 items in which they wanted a say, and the average number of items that were very important to have a say was 5.3. Therefore, it appears that approximately half the items women wanted a say in were also very important for the women to have a say in.

All the women in this study wanted a say in the presence of chosen persons and in the administration of pain medications. Twenty-six women said it was very important to have a say in the presence of chosen persons, and 20 said it was very important to have a say in the administration of pain medications. Freedom to move was ranked third in the ranking, very important to have a say. Freedom to move also had the highest frequency in the ranking, moderately important to have a say.

There is strong similarity between the items women ranked as very important to have a say and the ordering of the items with respect to the number of women who wanted a say. For example, presence of chosen persons, pain medications, and freedom to move were the items most women ranked as very important, as well as the items that held the three largest numbers of women who wanted a say.

Items About Which Women Had a Say

Applying the framework of Kim (1983), the attainability of collaborative decision making in labour

Table 3

Items with Respect to Identified Importance

Item	Very Important To Have a Say N (%)	Moderately Important to Have a Say N (%)	Somewhat Important to Have a Say N (%)
1. Presence of Chosen Persons	26 (86.67%)	3 (10)	1 (3.33)
2. Pain Medications	20 (66.67)	8 (26.67)	2 (6.67)
3. Freedom to Move	19 (65.52)	13 (44.83)	2 (6.67)
4. Privacy	12 (54.55)	6 (27.27)	4 (18.18)
5. Presence of Hospital Personnel	11 (47.83)	9 (39.13)	3 (13.04)
6. Position for Delivery	11 (57.89)	7 (36.84)	1 (5.26)
7. Breastfeed Within the First Hour	11 (52.38)	5 (23.81)	5 (23.81)
8. Fetal Monitoring	10 (50)	6 (30)	4 (20)
9. Vaginal Exams	9 (47.37)	5 (26.32)	5 (26.32)
10. Enema	6 (31.58)	5 (26.32)	8 (42.11)
11. Others	6 (75)	2 (25)	---
12. Food/ Fluids	5 (25)	8 (40)	7 (35)
13. Episiotomy	5 (45.45)	2 (18.18)	4 (36.36)
14. Spontaneous Versus Induced Labour	5 (45.45)	2 (18.18)	4 (36.36)
15. Shave Prep	3 (27.27)	---	8 (72.72)
16. Spontaneous Versus Assisted Delivery	3 (75)	1 (25)	---
17. Intravenous	1 (8.33)	5 (41.67)	6 (50)

and delivery is addressed by discovering the items about which women had a say. In order to determine whether or not women had some say in the items about which they wanted a say, it is necessary to consider the difference between the proportions of women who wanted a say and had a say, and the proportions of women who wanted a say but did not have a say.

The attainability of the items for the women who wanted a say with respect to each item are first presented in this section on the items about which women had a say. Presented next are the qualitative descriptors of the women who did not have a say in the items about which they wanted a say.

The Attainability of the Items

A Chi-squared between two groups (Marascuilo & McSweeney, 1977) was performed on the proportions of women who wanted a say and had a say and those women who wanted a say but did not have a say in order to determine whether or not a significant difference exists between the two groups. Shown in Table 4 are the significant and non-significant proportions of women who wanted a say and had a say, and the proportions of women who wanted a say but did not have a say with respect to each item.

Using Chi-squared techniques, a statistically significant difference was obtained for the items: presence of chosen persons, pain medications, freedom to move, privacy, breastfeed within the first hour, vaginal exams, episiotomy, and the others category. Therefore, women who wanted a say in the items that were statistically significant, except for episiotomy, had a say. Because the proportion of women who did not have a say was significantly greater than those women who had a say for an episiotomy, one can interpret that for this item, the women who wanted a say regarding an episiotomy did not have a say.

Table 4

Proportions of Women Who Wanted a Say and Had a Say, and Wanted a Say But Did Not Have a Say According to Chi-Squared Significance (for alpha=.05 and d.f.=1)

Item	Wanted a Say And Had a Say %	Wanted a Say But Did Not Have a say %
	Significant	
1. Presence of Chosen Persons	96.67	3.33
2. Pain Medications	90.00	10.00
3. Freedom to Move	89.66	10.34
4. Privacy	90.91	9.09
5. Breastfeed Within the First Hour	80.95	19.05
6. Vaginal Exams	73.68	26.32
7. Episiotomy	10.00	90.00
8. Others	87.50	12.50
	Non-Significant	
1. Presence of Hospital Personnel	69.57	30.43
2. Fetal Monitoring	60.00	40.00
3. Food/Fluids	50.00	50.00
4. Position for Delivery	68.42	31.58
5. Enema	72.22	27.78
6. Intravenous	58.33	41.67
7. Spontaneous versus Induced Labour	63.64	36.36
8. Shave Prep[a]	80.00	20.00
9. Spontaneous versus Assisted Delivery[b]	75.00	25.00

[a]Total N=10, therefore the difference between the proportions of 8 women having a say and 2 women not having a say is not significant.
[b]Total N=4, therefore the difference between the proportions of 3 of women having a say and 1 woman not having a say is not significant.

No statistically significant difference was obtained between the women who wanted a say and had a say, and the women who wanted a say but did not have a say in: the presence of hospital personnel, fetal monitoring, food and fluids, position for delivery, enema, intravenous, spontaneous versus induced labour, shave prep, and spontaneous versus assisted delivery.

Qualitative Information

Verbatim transcriptions of the women's comments regarding not having a say in the items about which they want a say will aid understanding of the reasons women do not have a say.

Thirty women wanted a say in who accompanied them during their labour and delivery experience, and only one woman said she did not have a say. This one woman said:

> [My husband] got booted out for a little while. It was during the night when labour was progressing rather slowly. I was still having contractions. He was sharing the bed with me, 'cause of course he was exhausted too, and there were two other women sharing the room, and both of them were in labour. And the nurse said, "Well, everbody's sleeping" which was farthest from the truth, and asked him to leave. An hour later I went out looking for him. I wasn't too pleased with that. I mean, God, it's your labour, you should be able to do what you want to do, within reason.

Obviously this woman felt it reasonable that her husband be with her throughout her labour, during the night, with other labouring women in the room. The nurse, however, appeared to see the situation in a different light.

Thirty women also wanted a say with respect to the administration of pain medications. Twenty-seven women felt they had some say, and three felt they did not have a say. One of the women who said she did not have a say in pain medications identified a lack of communication between herself and the nurse:

> I asked for some pain medication, and when I came in they put me on the baby monitor, and the monitor didn't work, so I sat, in that, prep room for about an hour, while the strip was running. And they came in and said, "You're just experiencing Braxton-Hicks, you can go home." I thought, "What's wrong with this nurse?" So I, so she came in and re-adjusted [the monitor], and said "Go walking for awhile", and I was, I went from 3 centimetres to 7, then directly to 10, so this was fast. But she, the nurse, gave me the Demerol after, I mean, he was being born, and she gave me (pause). I mean, I was kind of disappointed [because of] the lack of communication. I can't really say that they did a bad job or whatever, it's just that I, I found that a little more communication between everybody would help a lot, you know.

This woman said it was very important to have a say in pain medications, and rated her satisfaction with decision making as a 2.5 because of this lack of communication.

The second woman who said she didn't have a say in the administration of pain medications but thought it very important to have a say, said:

> They gave me an epidural, which was great, and it lasted through my major contractions, but then the one thing they did, is they let it go, the epidural ran out, and I was in pain. And that's, that was during the time when they were putting the vacuum and the forceps and everything, and nobody saw that I was in pain until one of the nurses suggested "Give her some gas", I don't know what it's called, but the gas mask or whatever, to try to relax me. And, uh, it was too late as far as I was concerned. The pain was so great that nothing over-, no medication then and there could have overcame it. Like, they weren't thinking of me after that point, after that the epidural ran out. So, I wish I had, I tried to ask for it but I didn't get it.

This particular woman had a very negative birthing experience and rated both her satisfaction with decision making and her satisfaction with the over-all childbirth experience as 1, very dissatisfied.

The third woman who had wanted a say in the

administration of pain medications but felt she had no say stated "I wanted a say, but they just handed me the mask (Entonox). Everything went too fast." She had wanted a say in the type of pain medication but felt she did not have a say. Having a say in pain medication was of moderate importance for her.

Twenty-nine women said they wanted a say with respect to freedom to move, and 26 perceived themselves as having a say, while three women said they did not have a say. One of the three women simply said she did not have a say, and did not elaborate as to in what way she did not have a say. Another of the three women said:

> Um, I didn't want to get up and move, and they wanted me to. So I got up twice after they induced me. The first time I wanted to try it, the second time they wanted me to get up and I feel like I was being told to. So, I would have liked a say in that.

For the first and second woman cited as not having a say in freedom to move, both women rated freedom to move as moderately important to have a say.

The third woman who wanted a say in freedom to move but felt she had no say said the nurses would not let her remain in bed even though she found the contractions painful when she walked. This woman rated freedom to move as very important in having a say.

Women in this study also had a say with respect to privacy. Twenty-two women said they wanted a say in privacy, and 20 women said they had a say. One of the women who said she did not have a say had been in a room with other labouring women for most of her labour, and was moved to a birthing room only in time to have her baby. She also felt that she and her husband were "rushed out" of the birthing room with her baby and so did not have the opportunity to spend time with her baby. The other woman who said she did not have a say with

respect to privacy was strongly influenced by her negative feelings towards the presence of a student:

> Well, when I actually went into labour, um, I didn't know that there was going to be an intern present that was going to deliver my baby and not my doctor. Because I was going to my doctor for nine months, or whatever, eight months, and thinking that I would be delivering with him, made me feel comfortable. All of a sudden, when I see this other man, when [sic] I've never laid eyes on before during my pregnancy, and he's digging his fingers in me, did not make me feel comfortable. And I didn't know whether I could say anything or not. I didn't know if I had any right to say anything that I want, I didn't want him present, or I didn't want him delivering my baby. And, um, nobody listened to me, like when I said I was in pain, or I didn't like what he was doing.... It was just the intern that was the big, (pause). Like I was introduced to him in the beginning, you know, "Here he's the student that's going to be around while everybody's doing the delivery", fine, stand there, don't touch me. But I did not know that he was going to be present and doing the delivery. Like, it could have been told to me when I was first induced like "Point A", when I first saw him or whatever, but it wasn't.

Twenty-one women wanted a say in breastfeeding within the first hour and 17 women felt they had some say. Those women who felt they did not have a say said: they weren't asked whether or not they wanted to breastfeed or that the baby was taken to the nursery before they had a chance to attempt to breastfeed.

Nineteen women wanted a say with respect to vaginal exams, and 14 women said they had a say. One woman who felt she did not have a say did not want the "intern" to perform the exams:

> You know, it would be that my own doctor would examine me, leave, and then this guy would come up, poke his fingers in, examine me, and leave. Like I didn't need anybody else poking around in there, like, honestly... I didn't want him in the first place or anything, it just made me more tense and that's probably what caused a heavier labour or whatever, 'cause I wasn't relaxed and um, things of

> that nature... And they weren't telling me what was going on, like how much further it's going to be, how far the head is. They just told me to push, and nothing, and it was between them.

The last item in which women were found to have a say when they wanted a say was in relation to the others category. Eight women wanted a say with respect to the various items within this category and seven women said they had a say. This category tends to reflect things that the women have a great deal of control over, such as the choice of hospital and the choice of physician. The only aspect of the others category that was not congruent with having a say was having a mirror in which to view the birth. It was moderately important for this woman to have a say in having a mirror.

A significant difference between wanting a say and having a say also existed for having an episiotomy. Only one woman who wanted a say said she had a say. The other nine women did not have a say when they wanted one. Most of these women found they received an episiotomy when they did not want one. One woman said she had discussed not having an episiotomy with her doctor and she/he agreed to make an attempt to avoid one. However, this woman's labour progressed very quickly and her physician missed the delivery. Consequently the resident on-call did the delivery and cut the episiotomy "without even waiting to see [if I really needed one]".

Another woman who said she had no say said:

> They let me rip. (The intern) let me rip. I wish I could have had an episiotomy but nobody, no one, nobody listened, that's the thing. Like, they just let it happen.

The Outcome Variables

The client outcome variables for collaborative decision making in this study are satisfaction with decision making, satisfaction with the childbirth experience, and length of labour. Shown in Figure 4 are

the ratings of satisfaction with decision making and satisfaction with the childbirth experience by the women in the study. The satisfaction scale ranged from 1 to 5, with 1 being very dissatisfied and 5 being very satisfied. A rating of 2 is somewhat dissatisfied, 4 is somewhat satisfied, and a rating of 3 denotes neither satisfaction nor dissatisfaction.

Satisfaction with Decision Making

Approximately 37% of the women ranked their satisfaction as a 5, very satisfied with the decision making during labour and delivery. A total of 80% of the women in the study ranked their satisfaction with decision making as a 4 or greater, meaning that 80% of the women were at least very satisfied or somewhat satisfied with the decision making they experienced during labour and delivery.

According to Sullivan and Beeman (1982), it is important to distinguish between those women responding as very satisfied from those who respond as somewhat satisfied in order to identify dissatisfaction during childbirth. These authors found that "many women offering highly negative comments still checked 'satisfactory' in response to the question evaluating overall labour and delivery care" (p. 325). They concluded that there is a reluctance in women who have given birth to criticize caretakers and thus the analysis of the distinction between being "very satisfied" and "satisfied" with the labour and delivery experience is necessary to identify dissatisfaction. In considering the women in this particular study, it is found that just over 63% of the women rated their satisfaction with decision making during labour and delivery as less than a 5. Therefore, 63% of the women were less than "very satisfied" with decision making during their labour and delivery experience. One woman rated her satisfaction

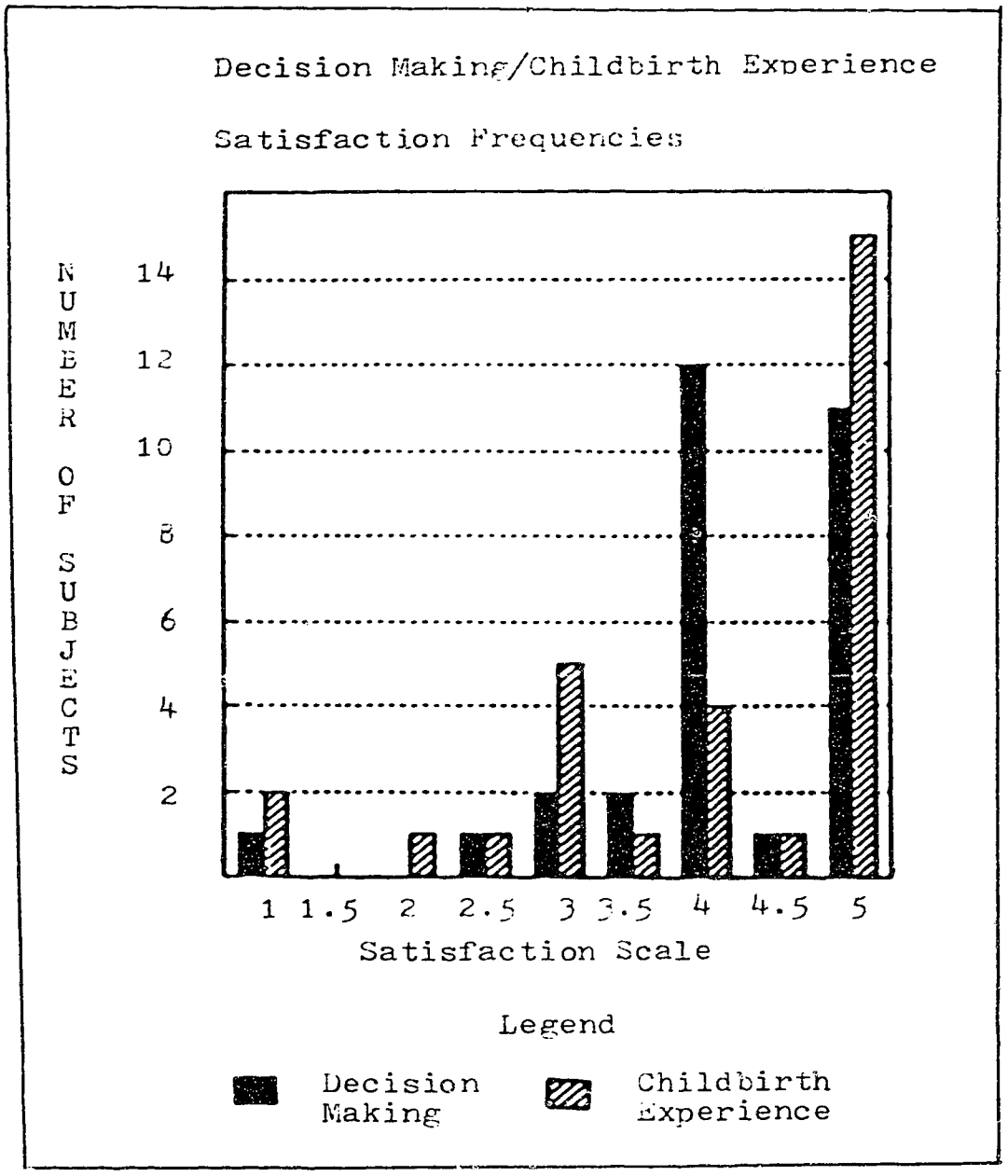
Decision Making/Childbirth Experience
Satisfaction Frequencies
NUMBER OF SUBJECTS
14
12
10
8
6
4
2
1 1.5 2 2.5 3 3.5 4 4.5 5
Satisfaction Scale
Legend
Decision Making
Childbirth Experience

Figure 4

with decision making as a 1, one woman rated her satisfaction as 2.5, and two women rated their satisfaction with decision making as 3.

Satisfaction with the Childbirth Experience

Fifty percent of the women in this study rated their satisfaction with their over-all childbirth experience as 5, very satisfied. Approximately 67% of the women rated their satisfaction as 4 or greater, making 67% of the women at least very satisfied or somewhat satisfied. However, looking at the total number of women who rated their satisfaction as less than 5, 50% of the women were less than "very satisfied" with their childbirth experiences.

Two women rated their satisfaction with their over-all childbirth experience as one, very dissatisfied. One who so rated her satisfaction was the same who rated her satisfaction with decision making as one. The second woman had rated her satisfaction with decision making as three. One woman rated her satisfaction with the over-all childbirth experience as a two, another as a 2.5, and five women rated their experience as 3.

Length of Labour

The mean length of labour was 5 hours, 27 minutes, with the shortest length of labour being 1 hour 4 minutes, and the longest being 17 hours 4 minutes. Approximately 43% of the women had labours lasting less than 4 hours, 40% of the women had labours lasting at least 4 hours but less than 8 hours, almost 7% women had labours lasting 8 to 12 hours, and 10% had labours lasting more than 12 hours. The length of labour of the women participating in the study is depicted in Figure 5.

Correlations Among the Variables

A Pearson's correlation coefficient (r) was obtained among the demographic variables of the subjects, the number of items about which each woman wanted a say, each

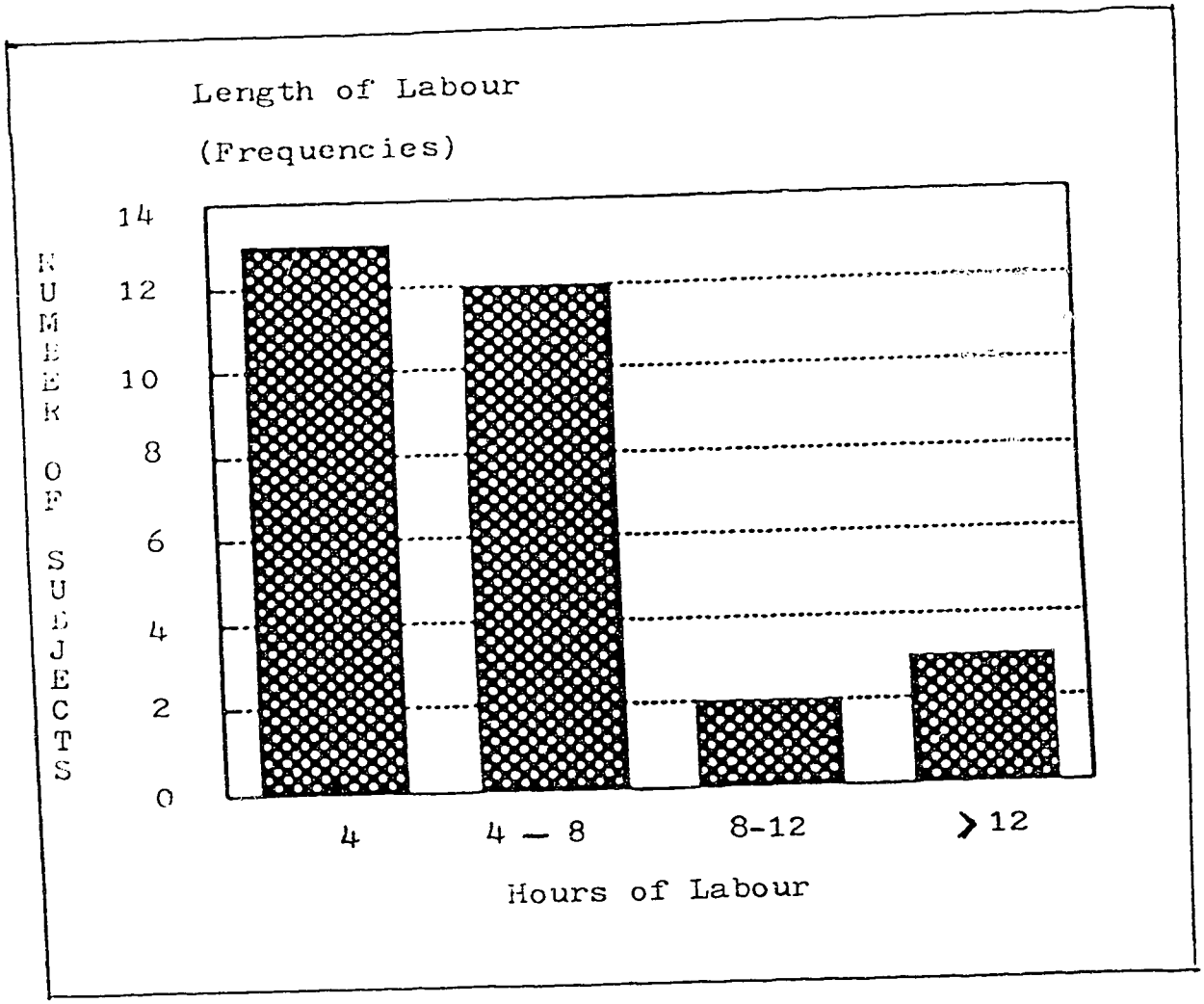
Length of Labour
(Frequencies)
NUMBER OF SUBJECTS
14
12
10
8
6
4
2
0
4
4 — 8
8-12
> 12
Hours of Labour

Figure 5

woman's congruency score, satisfaction with the amount of decision making during labour and delivery, satisfaction with the childbirth experience, and length of labour. The congruency score was calculated by dividing the number of items about which women perceived themselves as having a say by the total number of items about which they had wanted a say. The Statistical Package for the Social Sciences, version X computer program (SPSSx) was used to run the Pearson's correlation program. Shown in Table 5 are the significant correlations obtained for the entire 30 subjects. The number of items for each woman wanting a say was not correlated with any other variable.

Reviewing the satisfaction scores of the women, it has been shown that one woman rated her satisfaction with decision making as one, and two women rated their satisfaction with the over-all childbirth experience as one. The majority of women rated their satisfaction as three or greater, so it is possible that these two women could skew the data. Therefore, a second program was run that did not include any information from these two women to obtain Pearson's correlation coefficients for the variables: congruency score, satisfaction with decision making, satisfaction with the over-all childbirth experience, and length of labour.

Statistically significant correlations were obtained between congruency and satisfaction with decision making ($r = .5144$), and congruency and length of labour ($r = -.4159$). The former correlation existed within the group of 30 subjects, the latter did not. The significant relationship between congruency and length of labour may have been masked by the outliers in the group of 30 subjects. However, even without the outliers, a significant correlation was obtained between congruency and satisfaction with decision making.

Birch (1982) found a difference between

Table 5

Significant Correlations ($p < .05$) Among the Variables

	Variables	Correlation
1.	Age with Education	0.7220
2.	Satisfaction with Decision Making with Satisfaction with the Childbirth Experience[a]	0.5663
3.	Congruency with Satisfaction with Decision Making[b,c]	0.5621
4.	Length of Labour with Satisfaction with the Childbirth Experience	- 0.5236
5.	Length of Labour with Satisfaction with Decision Making[a]	- 0.4539
6.	Education with Prenatal Classes	- 0.4461
7.	Income with Prenatal Classes	- 0.4459
8.	Age with Income	0.4293
9.	Age with Parity	0.4149
10.	Age with Congruency	0.4032
11.	Marital Status with Prenatal Classes	0.4000
12.	Parity with Education	0.3708
13.	Age with Prenatal Classes	- 0.3700
14.	Education with Income	0.3622

[a]In the primigravidae group these correlations were significant as well.
[b]In the multigravidae group this correlation was significant as well.
[c]In the group without the outliers this correlation was significant as well.

primigravidae and multigravidae with respect to the correlations obtained with the outcome variables. Therefore, programs were run to see if parity influenced the correlation scores with the outcome variables. With the primigravidae, a significant correlation was obtained between satisfaction with decision making and satisfaction with the childbirth experience (r= .7580) and between satisfaction with decision making and length of labour (r= -0.6001). These correlations were also significant within the group of 30 women. However, as the primigravidae group includes the two outliers, the results found in the group of 30 women could be due to the presence of the outliers. Support for this hypothesis is attained by the fact that such correlations were not found to exist in the program without the outliers.

With the multigravidae group, significant correlations were found to exist between congruency and satisfaction with decision making (r= .5645) and between congruency and length of labour (r= -.6100). Congruency and satisfaction with decision making was also shown to be significantly correlated with the entire group of subjects and the group without the outliers. The primigravidae group did not have a significant correlation between congruency and satisfaction with decision making. It is possible that the lack of a relationship between congruency and satisfaction with decision making in the primigravidae group was due to the outlying points within the primigravidae group.

Length of labour and satisfaction with the over-all childbirth experience was shown as significantly negatively correlated with the entire 30 subjects. Breaking the 30 subjects into primigravidae, multigravidae, and a third group lacking the two the outliers, it is interesting that none of these groups

showed a significant correlation. Therefore, it is possible that, when doing calculations with the entire 30 subjects, the outliers skewed the results to reflect a significant negative correlation.

Length of labour and satisfaction with decision making were significantly negatively correlated in the entire group of subjects. Only in the primigravidae group was the correlation significant in the further tests. The primigravidae group could therefore also have affected the over-all group results earlier identified.

One other result of interest is the fact that length of labour was found to be significantly negatively correlated with congruency for multigravidae and for the group without the outliers, but within the entire 30 subjects no such correlation was found to exist. Perhaps the primigravidae group, which included both the outlying subjects, then masked this correlation from showing in the calculations run with the 30 subjects.

Additional Qualitative Analyses

In this final section, the focus is on qualitative information obtained from the women interviewed that is not directly associated with the study questions. The areas addressed in this section are the women's definitions of satisfaction and the case studies of the two women who were very dissatisfied with their childbirth experiences.

Definition of Satisfaction with Decision Making

Those who ranked their satisfaction as a 5, very satisfied, said: "I was very, very, very, very pleased", "Very good", or "Very satisfied"

A rating of 4.5 brought the comment "It was fairly pleasant and a lot of my decisions were respected. But it really bothered me that I had an episiotomy and that my doctor didn't make this delivery."

A rating of 4 elicited comments such as "Very good",

"Very satisfied", "Exceedingly [satisfied]". Although these women said they were very satisfied with decision making, these women must have thought something more was needed in order to give their satisfaction with decision making a true 5, very satisfied.

Other women who rated satisfaction with decision making as 4 said that most of their choices/decisions were respected, but not all of them. One woman said, "They took my pain away", and no pain may have meant her decisions were honoured. Another woman stated that "Just the student there really bothered me", and another said "I was very satisfied except for the epidural wore off before the forceps were applied...the ending was kind of brutal".

And finally, one woman said "[I was] pretty satisfied, if you think of what you had a say in 20 years ago!" Thus women ranged from feeling very satisfied, to wanting to have more say in some things, to comparisons with the past.

A rating of 3.5 elicited the responses "there was no time to say anything...but they need to trust the judgement of the mother", and "During the labour [I was] reasonably satisfied. During the delivery, the hospital staff and doctor decided for me, and they should have listened to my husband. Over-all, I was very satisfied."

A rating of 3: "I never, I didn't really have a say", and "I felt a pressure the way things were asked."

For the rating of 2.5, the woman was influenced by the lack of communication surrounding her desires and the accomplishing of those wishes.

Finally, the woman who rated her satisfaction with decision making as 1 said, "I felt I had no say. I didn't know I was allowed to say anything, that I had the right".

<u>Definition of Satisfaction with the Childbirth Experience</u>

Women who rated their satisfaction with their childbirth experience as 5 said they were "very, very satisfied", "it was great", "I liked it". Two women related this experience to a previous one: one woman felt this childbirth was "a piece of cake" compared with the first labour, and the other woman said "it was exactly like the first." One woman felt pride in herself: "I never thought I'd be able to do it." Another said "I'd do it again. You block out everything that happened to you. It was great."

Another response for a rating of 5 was "I was really scared and the staff helped me a lot." This woman felt that the staff helped make her childbirth experience very satisfying.

One woman said "I wish I wouldn't have had the epidural. I would have liked to have a normal labour." These feelings of not having had a normal labour did not influence this woman's rating of satisfaction.

"It was hell and it hurt. I'm satisfied 'cause I got a beautiful baby out of it." This particular women, then, looked at the end, rather than the means, when rating her satisfaction.

Finally, one woman simply stated "Can't think of anything I'd have differently." Perhaps because she felt she couldn't ask for anything better, she rated her satisfaction as 5.

One woman rated her satisfaction as 4.5. She made no comment to qualify her rating.

One woman who rated her satisfaction with the childbirth experience as a 4 said she was "very satisfied". This is similar to women's responses of satisfaction with decision making rated as 4. Another woman said "If there was no pain, a 5."

One woman who rated her satisfaction with the hospital childbirth experience as 3.5 had gone home when

in early labour. She said "At home, you have all the freedom in the world. Not in the hospital."

Women who rated satisfaction with their childbirth experience as 3 said: "It was a miracle, fantastic." "It was an easy pregnancy. Hard labour." "It was quite different from what we expected." "They had a hard time getting the epidural in. [There was] bleeding and a wet tap. That was upsetting."

The woman who rated her satisfaction as 2.5 stated "[It was] not my ideal." The woman who rated her satisfaction as 2 said "Compared to the last one it was hell. It wasn't anything anyone did or didn't do."

One woman who rated her satisfaction with the childbirth experience as 1 stated she was "really disappointed, surprised and shocked", felt she had lost control of herself during her labour, felt she was a "wimp", and felt "pressure" to make choices the staff wanted.

The other woman who rated her satisfaction as 1 said:

> [It was] hell. No, I'm completely serious. Like, it could have been, it could have been something else, like it could have been much better than it was. From the amount that I hear from the other nurses, and I've become anaemic because of it, and all this kind of stuff like all these complications, and you know, having to stay here longer than I actually have to and all that kind of stuff. So it's very, number one, very dissatisfied.

Interestingly, a woman who rated her satisfaction with the childbirth experience as 5 described it as "hell", as did the woman who rated her satisfaction as 2, and one of the women who rated her satisfaction as 1.

Summary of Definitions of Satisfaction

When reading the comments made by women in describing their satisfaction levels (and the women described their satisfaction before they rated it on the

scale), it becomes very clear that what makes childbirth satisfying for one woman does not make it satisfying for another. This is not surprising as women also differ in their expectations of labour and delivery and even in their responses to labour.

Some women rated their satisfaction with decision making and with the childbirth experience as a 4 even though they described their satisfaction as "very satisfying". It would be interesting to discover what it would require to enable them to rank a "very satisfying" as 5.

The Case Studies

Although only two women rated their satisfaction with the childbirth experience as 1, very dissatisfied, it is important to determine what made their experiences so negative. Learning what made negative childbirth experiences for these two women may increase understanding and aid in the prevention of similar experiences from occurring.

The first woman said:

> When the nurses will [sic] see me progressing and, you know, feeling weaker, she would ask, she would give me the opportunity to make the choice. She would say "Would you like to have this or that", and then because you have the choice, it makes you feel like, well, maybe I was wrong [to not want pain medications]. I didn't know what it was to have the baby, so that I will put on doubts, so that everything would be welcomed to save my pain. I was really, really against epidural or something, and I finished by having one, which didn't work, and then I thought, they, well, you know. It makes me feel pretty bad because I thought, "Well, why did I risk something?" I, I felt like I lost control or something. The idea that you have choice, but you don't have the mind to think like when you don't, when you're not in pain, you know what I mean? So I was disappointed. I should have talked to the nurses beforehand and say "I don't want this at all. Don't even think about asking me." But when it was time, it was like "please give it to me", like I was a totally different

person. But after all, when the baby is out and everything, it was like, whatever, I was just s happy that I was safe and the baby's safe, you kn what I mean? Like, I don't, I can't say that I mad or anything, I thought that everything was do for good result.

So, like I, I, I feel like I failed. I feel like I wasn't good or there's something, I lost control somewhere. But the result makes me feel like, well, maybe I didn't have a choice. Maybe, maybe that's, I didn't know what I was talking about before, and everything when I was through all this pain. And then I just reversed completely, like "Give me anything. Do something."... Like, afterall, I feel like "Where did I lose my mind?"

So when the [contractions became stronger], like, I lost control, and I had prenatal classes and I was trying to do my breathing, and, and, and nothing. Like the pain. I, I felt like I was a wimp. Like, I wasn't strong enough... I feel like, I should have toughed [sic] my mind for, I wasn't expecting this kind of pain, and I guess I just panicked, or....

It's just that as long as the mom takes her responsibility, like. I, I feel like it's bad, all this intervention, because I thought that's not what I was expecting. But I know that I made the decision. If somebody would have made the decision for me, well, maybe I would be mad... But that would be easy, I could be mad at them, not at me. But I rather to take [sic] my responsibility you know what I mean? So....

I, like I told you, I just felt disappointed, that I felt a pressure the way things were asked. Like I told you, well, things were getting ready before I even said "Yes". And that's, I think, when I think about that, then I think, well maybe that was pressure. Like a brain-wash.

(Describe for me your satisfaction with your childbirth experience). Really disappointed, like, really surprised and shocked, and I thought I would never have a baby again. I, I didn't expect that, all those interventions. Like I said I'm disappointed that, I don't know if it's of myself or. I think I'll need time to get through this again and again and again, and then maybe say I did the right choice [sic]. So maybe, they shouldn't

> have pressured me, maybe, there's a lot of "maybe" around it. But I would say I'm really disappointed.

This woman felt like she lost control of herself when trying to cope with the labour. She felt pressured by the staff to make certain choices, and perceived this to be "brain-washing". Although she is happy that both she and her baby came through the experience safely, it is clear that safety is not the essential component of satisfaction for this woman. She feels that, somehow, she failed, was a "wimp", and wonders who that person was going through labour. Furthermore, and more importantly, she says "I think I will need time to get through this again and again and again, and then maybe say I did the right choice [sic]." It is clear that this woman will need time to sort out and come to terms with her feelings about her experience.

The second woman repeatedly states that "nobody listened" to her, that she didn't know she could have a say, that she didn't know that she had a right to say what she wanted:

> I just didn't know what I could say you know, or if I had a right to tell him to leave, or whatever. Like sure I understand they have to learn somehow, and all that kind of stuff, but, when uh, you see a patient lying there, like I was just pleading, like I'm not asking nobody to feel sorry for me, but it was just getting way out of hand, like nobody was listening to me, nobody....
>
> Yes [it was important to have a say in whether I had an assisted delivery]. If they did it, cause both things were done wrong, the vacuum was put on the wrong area of the baby's head, and the forceps were put on the wrong area of the baby's head. And if I knew what was going to happen, like I wouldn't have let them, but you know, but nobody told me they were, whatever. Nobody, like they just used it, and like telling you they're going to use it, not asking you if they can use it. 'Cause I was fully dilated, but the head was still high, so any person in their right mind should have done a C-

> section, but they stuck the vacuum in, stuck the vacuum in wrong, put the forceps in, put the forceps in wrong....
>
> (Describe for me your satisfaction with the decision making you had in labour and delivery.) Well, I feel I had no say, in. But I didn't know I was allowed to say anything, that was the one important thing, like I didn't know I had the right to speak up and say something. Because in a way I was scared if I did yell out at my doctor that, you know, even though, I know [my doctor] wouldn't do anything to hurt me on purpose, but, I didn't want to risk it. Like, it's like, it's happening, it's going, let them do what they want, it's, it's, it has to be over with, whatever, but. That's about it, I guess.

This woman obviously felt powerless, "I didn't know I had the right to speak up and say something", and reinforcement of not having a right to say something occurred whenever she attempted to say something ("pleading") and "nobody listened". She also expresses a fear that, perhaps, the attending physician would "hurt" her for expressing her feelings. Feeling powerless to express contrary feelings or opinions can be a common occurrence when feeling that you depend upon someone for your safety, and the safety of your baby.

From reading the statements of the two women who had very dissatisfying childbirth experiences, it is clear that their expectations or beliefs of what should happen during childbirth were not met. Both women felt they were not in control of the situation and felt that they did not receive assistance in meeting their expectations.

Summary of Results

Comparing the demographic results of this study with Statistics Canada for both Canada and Alberta, the subjects in this study overrepresent the age groups 20-24, 35-39, and 40-44; and overrepresent the family income groups of > $35,000, especially in the $45,000-49,999 and to $60,000+ groups. Underrepresented are

single women bearing children, the age group 30-34, and the lower income families who earn less than $24,999 per year.

It is shown that more than 50% of the women responding to each item want a say in all items except two, those two being episiotomy and spontaneous versus assisted delivery.

A Chi-squared test (Marascuilo & McSweeney, 1977) was calculated for each item with respect to the women who wanted a say. A statistical difference was obtained between those women who had a say and those who did not have a say for the items: presence of chosen persons, pain medications, freedom to move, privacy, breastfeed within the first hour, vaginal exams, episiotomy, and the category others.

It was found that just over 80% if the women rated their satisfaction with decision making as a 4 or greater on the 5-point satisfaction scale. However, in considering dissatisfaction as ratings of less than 5 (very satisfied), 63% of the women in this study rated their satisfaction with decision making as less than "very satisfied". Regarding satisfaction with the childbirth experience, approximately 67% of the women rated their satisfaction as 4 (at least somewhat satisfied) or greater. Yet 50% of the women rated their satisfaction as less than 5, very satisfied. Therefore, 50% of the women were less than "very satisfied" with their childbirth experience.

Fourteen statistically significant correlations were found among certain variables when including all 30 subjects. Significant correlations involving the outcome measurements of satisfaction and length of labour were: a positive correlation between satisfaction with decision making and satisfaction with the childbirth experience, a positive correlation between congruency and

satisfaction with decision making, a negative correlation between length of labour and satisfaction with the childbirth experience, and a negative correlation between length of labour and satisfaction with decision making. Three additional statistical programs were run to check for the influence of the outlying data points and parity on the correlations observed when incorporating all 30 subjects. Some interesting patterns emerged from these programs. The program without the outliers showed a positive correlation between congruency and satisfaction with decision making, and a negative correlation between congruency and length of labour. The primigravidae group showed satisfaction with decision making positively correlated with satisfaction with the childbirth experience, and a negative correlation between satisfaction with decision making and length of labour. The multigravidae group showed a positive correlation between congruency and satisfaction with decision making, and a negative correlation between congruency and length of labour.

Having presented the results of data analysis, it is important to now discuss the possible relationships among the findings and speculate as to their cause.

Discussion

This chapter is divided into six sections. First, the demographic characteristics of the study sample are discussed with respect to the relationships amongst them and with respect to the implications of the characteristics on the results of the data analyses. The second section addresses the research question, "What do women want a say in during their labour and delivery experience?". Also discussed in the second section is the importance to the women of having a say.

Discussed in the third section is the research question, "What do women perceive themselves as having had a say in during their labour and delivery experience?" Addressed in the forth section is the third research question, which pertains to whether or not satisfaction and/or length of labour is related to the congruency between wanting a say and having a say, or not wanting a say and not having a say, and/or the incongruency between wanting a say and not having a say, or not wanting a say but having a say.

The fifth section identifies the implications of the findings of this study for nursing, and the final section addresses the limitations of the research and suggestions for further study.

The Demographic Characteristics of the Study Sample

The sample group is somewhat older, better educated, and financially better-off than the general population of women giving birth. Therefore, the application of the findings of the study must be limited to groups with similar demographic characteristics.

Age

The sample in this study was similar to the Canadian and Albertan statistics for women giving birth aged 15-19 and 25-29. The sample in this study underrepresents women in the age group 30-34, and overrepresents women

aged 20-24, 35-39, and 40-44. The underrepresentation of women in the younger age group of 20-24, and the overrepresentation of women in the older age groups (35-39, 40-44) limit the transference of the results to the general population.

Birch (1982) found the average age for her sample to be 29.0 years. The largest age group in her sample was the 25-29 group, and Birch had no women participate who were less than 20 years of age, and no one over 40. The average age in this present study is 27.27 years, slightly lower than Birch's findings. The largest group in this present study, and also in Alberta and Canada, was the 25-29 age group, as found in Birch's study.

In this present study, age was found to be positively correlated with congruency. The older the woman, the more likely she is to have a say in the things about which she wants a say. This finding could be related to experience that often comes with age, leading to an increased awareness of what one wants as well as what one is most likely to have. In other words, it is possible that older women ask for what they know they can have in labour and delivery. It is also possible that older women are more assertive and so are better able to ensure that they do, in fact, have what they want during their labour and delivery experiences.

Parity

Approximately 63% of the women in this present study were multigravidae, and almost 37% were primigravidae. Birch (1982) found 57% of her sample to be multigravidae and 43% primigravidae. Again, the findings of the two studies are similar.

In this present study, parity was positively associated with both age and education in the correlational analyses. These findings will be discussed later in this section. Differences were found between

the multigravidae and the primigravidae groups with correlational analyses. These results will be discussed in the fourth section of this chapter.

Education

The mean number of years of education for this study sample is 14.72. Birch (1982) found her sample to have an average education of 13.9 years. Thus the two studies have had well-educated women take part. Although no relationship was found between education and satisfaction or between education and length of labour, it is possible that education could have a less overt effect on the results. In other words, although no statistically significant correlations were found between education and the outcome variables, education may more subtly influence the decisions the women make. However, it is also possible that education does not significantly affect women's satisfaction or their length of labour. Birch (1982) also found no significant correlation between education and the outcome variables.

Income

The women in this study tend to be well-off financially. No correlations were found to exist between income and any outcome variable. Income, as with education, may play a more subtle role in the decisions women make.

Marital Status

Eighty percent of the women in this study are married, and this proportion is similar to those found throughout Canada and Alberta. Marital status was found to be positively correlated with attendance at prenatal classes, which would support popular opinion that prenatal classes attract traditional families.

Prenatal Classes

In this study, 83% of the women had attended prenatal classes during the present or a previous

pregnancy. With such a large representation, it is interesting that the only positive correlation with attendance at prenatal classes is marital status. The negative relationships found between prenatal classes and education and income will be discussed below. No relationship was found to support reports of attendance at prenatal classes associated with decreased length of labour.

Correlations Among the Demographic Variables

In the correlational analyses, age, parity, education and income all seem inter-related. Age is positively correlated with education, income, and parity. Education is likewise positively correlated with age, parity, and income. These relationships make sense as with increased age, chances of a higher education exist, as does the opportunity to be in a secure job and a higher income bracket. The chance of having a second or third child when older is also more likely. With increased education comes access to better-paying jobs, thus the correlation between education and income, and with increased education comes also increased age and a greater chance of being multigravid.

It is interesting that age, education, and income are all negatively correlated with the attendance at any prenatal classes. The popular opinion is that the better educated and financially better-off people attend prenatal classes. This study's results suggest that perhaps the middle to lower-income people are now attending. However, decreased attendance by these better educated, better-off, older women may reflect that they have greater access to information outside prenatal classes and a better understanding of where to look and what to look for regarding obstetrical information. Thus these women may not feel a need for prenatal classes.

In the present study, no significant relationships

were found between age, education, income, and the attendance at prenatal classes, and the outcome variables. Interestingly, Sequin et al. (1989) also found no association between parity, education, income, or prenatal classes and satisfaction with maternity care.

Research Question #1: What do Women Want to Have a Say in During Their Labour and Delivery Experience?

The items about which women want a say in during labour and delivery help to identify the extensiveness of collaborative decision making in this setting. In this study, 11 of the 17 items were identified by more than 50% of all the women as wanting a say. When calculating percentages according to the number of women responding to each question, this study revealed 15 of the 17 items as having more than 50% of the women responding as wanting a say. Not one woman in this study said she did not want a say in anything. In comparison, Birch (1982) found seven items in which at least 50% of all the women wanted a say, and nine items with greater than 50% of the respondents wanting a say. The findings in this present study suggest that women want a say in their labour and delivery experience moreso than women of 9 years ago. The extensiveness of collaboration in decision making in labour and delivery is wide.

In the present study, 30 women wanted a say with respect to the presence of chosen persons, 30 women wanted a say in the administration of pain medications, and 29 women wanted a say in freedom to move. In comparison, Birch (1982) found 29 of the 30 women in her sample to want a say in the administration of pain medications, 24 women to want a say in having their partner present during the administration of epidural anaesthesia, and 19 women to want a say in freedom to move. Therefore, in this study, more women were found to want a say in the items.

Thus it is seen that the women in this study did get a say in a number of issues. These results differ from the results of Shaw (1974), Danziger (1979), Hanvey (1988), and Taylor, Pickens and Geden (1989), who found their subjects to not request a large amount of collaboration in decision making.

It is clear that not all women want a say in everything, all the time, but it does appear that all women want a say in something. Butani and Hodnett (1988) and Mackey and Lock (1989) also found that women vary with respect to wanting a say.

The items in which more than half of the women said they wanted a say are: presence of chosen persons, pain medications, freedom to move, the presence of hospital personnel, privacy, to breastfeed within the first hour, fetal monitoring, food or fluids, position for delivery, vaginal exams, and an enema. These items could be classed as "non-medical" items: items in which a physician's order is not necessarily required; and if an order is required, the woman's preferences are often taken into account during a normal labour and delivery.

The [illegible] in which less than half of the women said they want[illegible] say are: intravenous, spontaneous versus induced labour, episiotomy, shave prep, others, and spontaneous versus assisted delivery. Except for the others category, the items in this group can be labelled "medical" items. The women themselves frequently identified these items as "a doctor's decision", and therefore many women did not particularly want a say in these items.

Importance of Having a Say

In ordering importance, Birch (1982), in her study, had women rank the items from "most important" to "least important". Then Birch took the top three items identified by each woman and labelled those as "very

important to have a say". The items ranked by women as fourth to sixth were labelled by Birch as "moderately important". All other items ranked by the women were labelled as "somewhat important". Such external labelling does not necessarily reflect the labelling the women themselves would have applied. In the present study, women themselves placed the items in one of the three ratings, and thus women could express their own concepts of very important to somewhat important.

The items in which all, or the majority of the women said they wanted a say were also the largest frequencies in the very important to have a say ranking. Similarly, the items in which fewer women said they wanted a say were lower in the very important to have a say ranking. Most of the items that women identified as less important to have a say were the items classed above as "medical decisions". Therefore, fewer than half of the women wanted a say, and having a say was not very important to them if they wanted a say.

Research Question #2: What do Women Perceive Themselves as Having a Say in During Their Labour and Delivery Experience?

Having a say in the items in which one wants a say reflects the attainability of collaborative decision making during the labour and delivery experience. Items that showed a significant Chi-squared between the proportions of women who wanted a say and had a say and the women who wanted a say but did not have a say were: the presence of chosen persons, pain medications, freedom to move, privacy, breastfeed within the first hour, vaginal exams, and others. For these items, the women did indeed have a say. These items can be described as attainable. Not having a say with respect to an episiotomy was also significant with respect to statistical analyses; therefore having a say in an

episiotomy was not attainable.

The items that showed no difference between the proportions of women who wanted a say and had a say, and women who wanted a say but did not have a say were: presence of hospital personnel, fetal monitoring, food and fluids, position for delivery, enema, intravenous, spontaneous versus induced labour, shave prep, and spontaneous versus assisted delivery. Most of these items fall in the previously defined "medical" category.

In total, 7 of the 17 items were found to be attainable, and 1 of the 17 was definitely unattainable. Nine of the 17 items can not be said to be attainable.

Jacoby (1987) found women wanted and received the opportunity to move freely, to have the father of the baby present during labour and delivery, and to hold the baby. Freedom to move and the presence of the chosen persons in this study were congruent with women's wants.

Jacoby (1987) found that some women did not want but received shave prep, enema, epidural, other anaesthetic, artificial rupture of the membranes, induction of labour, episiotomy, and fetal monitoring. These results are similar to the "no difference" items listed above.

According to Scaer and Korte (1978) at least 50% of their sample said having the father present and breastfeeding within the first hour were very important. Having food and fluids during labour, not having an episiotomy, and having a choice in delivery position were also important to their study sample.

Cranley, Hedahl, and Pegg (198[illegible] found women in their study wanted to make decisions [illegible]out anaesthesia, their choice of support person, havi[illegible] mirror in which to view the birth, to breastfeed wit[illegible] the first hour, and choice in the nurse.

Field (1985) found multigravidae to want a say with

respect to medications and enemas.

These findings from other studies are supported by the findings from this present study.

Research Question #3: Is Satisfaction with Women's Labour and Delivery Experience and/or Length of Labour Related to the Congruency or Incongruency Between Wanting a Say and Having a Say?

This study question was addressed by running a Pearson's correlation (Marascuilo & McSweeney, 1977) among the demographic variables, the number of items in which women wanted a say, the congruency (ratio) between wanting a say and having a say, satisfaction with decision making, satisfaction with the childbirth experience, and length of labour. In this section, the significant correlations found with respect to congruency, satisfaction, and length of labour are discussed.

Congruency

Congruency was found to be positively correlated with age and with satisfaction with decision making. The relationship of congruency with age has been addressed in a previous section. That congruency was found to be positively correlated with satisfaction with decision making during labour and delivery helps support that wanting a say and having a say reflects satisfaction with decision making. Thus support is achieved for the concept that "having a say" is important in order to be satisfied with decision making during childbirth. Support is also given in that in the program without the two outliers, congruency was still positively associated with satisfaction with decision making. It is very possible then that during labour and delivery, the more one has a say in what one wants a say, the more satisfied one will be in the decision making experienced.

Congruency was found to be negatively correlated

with length of labour with the multigravidae; in other words, the length of labour decreased as congruency between wanting a say and having a say increased. Therefore, it appears that for the multigravidae group, the more one has a say in what one wants a say, the more likely it is that the length of labour will decrease. Length of labour may be affected because multigravidae who see themselves as getting a say in what they want may then relax more and labour progression is promoted.

That congruency was not associated with a decreased length of labour in the primigravidae group is interesting. This finding may relate to the fact that primigravidae women do not know what to expect of their first labour and delivery experience and they may be more willing to accede to the advice of health care professionals. Primigravidae women may have a greater tolerance for incongruency.

Satisfaction

Satisfaction with decision making during the childbirth experience and satisfaction with the over-all childbirth experience are client outcome measures that are important in the analysis of collaborative decision making. Satisfaction with the childbirth experience was found to increase as satisfaction with decision making also increased. It is possible that an increase in the amount of decision making or the quality of the decision making during childbirth helps influence satisfaction with the childbirth experience as a whole. It follows, then, that decision making during childbirth could be an important aspect of satisfaction with the childbirth experience. Thus the findings of Davenport-Slack and Boylan (1974), Willmuth (1975), Chute (1985), Littlefield and Adams (1987), and Seguin et al. (1989) are supported; that a positive relationship exists between having a say and satisfaction with the childbirth experience.

Alternatively, it is also possible to view satisfaction with decision making as increasing as satisfaction with the childbirth experience increases. In other words, as one feels increased satisfaction with the childbirth experience, for whatever reason, one could then look favourably on the decision making aspects during labour and delivery regardless of what really happened.

The comments of the women themselves support either interpretation of the correlation between satisfaction with decision making and satisfaction with the childbirth experience. For example, one woman said, "I feel I had no say" and felt her childbirth experience to be very dissatisfying. Satisfaction with decision making may have influenced satisfaction with the childbirth experience for this particular woman. Another woman said, "Things went so fast that I didn't really have a say... [The childbirth experience] was great!" The concept of the childbirth experience may have influenced satisfaction with decision making for this particular woman. Clearly the relationship between satisfaction with decision making and satisfaction with the childbirth experience needs to be examined more fully.

The primigravidae group showed a positive correlation between satisfaction with decision making and satisfaction with the childbirth experience, whereas the multigravidae group showed only congruency associated with satisfaction with decision making. It is possible that the multigravidae women are more concrete in their thinking, having experienced childbirth before. In other words, multigravidae may make a mental note of whether or not they have a say in what they want a say. A more accepting attitude may be the reason the multigravidae women did not show a relationship between satisfaction with decision making and satisfaction with the childbirth

experience. With the primigravidae women, it is possible that their expectations of labour and delivery are different and that collaborative decision making may be considered a more integral part of their childbirth experience.

Birch (1982) found satisfaction with the childbirth experience to increase as satisfaction with decision making increased for the entire group and for the multigravidae women. It is interesting that in the present study, it is both the group including the entire sample and the primigravidae group who exhibit this relationship. The difference between the two study results may be due to sample differences as well as due to a difference that occurred over the time from Birch's study to the present time.

Jacoby (1987) found 61% of her sample to find labour managed as they liked, 33% found labour managed as they liked in some ways but not in others, and 6% found their labours managed not at all as they liked. The results of this present study reveal less satisfaction with women's childbirth experience, possibly due to the satisfaction scale used as well as to the attention given to considering those women who were not very satisfied as somewhat "dissatisfied". Also, women giving birth in today's society may have felt comfortable in expressing their dissatisfaction at this time. Also, an interview format may have permitted an openness for women to express their dissatisfaction.

Length of Labour

Length of labour is another client outcome measure important in analyzing collaborative decision making during the labour and delivery experience. The length of labour of the women in this study was found to be negatively correlated with both satisfaction with decision making and satisfaction with the childbirth

experience. In other words, labour was shorter when women expressed more satisfaction with the amount of say they had as well as when women expressed more satisfaction with their childbirth experiences. These findings lend support for the idea that increased satisfaction with decision making and with the childbirth experience reflect women having a say in what they want a say. This increased control over their childbirth experiences could decrease anxiety, thus helping promote greater relaxation and consequently shorter labours. The finding that length of labour decreases as satisfaction increases supports the postulation of B. Shearer (1984) that increased control leads to decreased anxiety levels, decreased circulating catecholamine levels, and thus a decrease in the length of labour.

Alternatively, the correlations between length of labour and satisfaction could mean that satisfaction with decision making and satisfaction with the childbirth experience are influenced by the length of labour, rather than length of labour influencing satisfaction. In cases when the length of labour influences satisfaction then, the shorter the labour, the more likely women are to be pleased with the say they had, and pleased with the overall childbirth experience. Certainly, as the length of labour increases, the more likely it is that a woman may experience decreased opportunity for decision making. Furthermore, as length of labour increases, satisfaction with the say one has and satisfaction with the childbirth experience could decrease because of tiredness, anxiety, worry, and fear. Birch (1982) also found length of labour to decrease as satisfaction with the childbirth experience increased for her entire group of subjects as well as for the multigravidae group. However, the multigravidae group also showed the length of labour to increase as congruency increased. Birch attributed this

finding to an outlying point in the multigravidae group.

Birch (1982) also found length of labour to increase as satisfaction with decision making increased for the primigravidae group. "It has been suggested that some primiparous mothers feel that their labour must be of a certain length in order that they may fully experience it and therefore be satisfied" (p. 90). Also, it is possible that if labour is short there may be less time in which to make decisions, and therefore the primiparous mothers may feel "cheated" (p. 90).

In the present study, length of labour decreased as satisfaction with decision making increased within the primigravida group, but neither the primigravidae, multigravidae, nor the group without the outliers showed a negative correlation between length of labour and satisfaction with the childbirth experience. Obviously only the entire 30 subjects showed this significant correlation to exist, but what influenced the correlation is unknown.

Implications for Nursing

In reviewing the comments made by women with very dissatisfying childbirth experiences, one speculates about what can be done by health care professionals to avoid such devastating experiences?

Health care professionals need to actively seek understanding of what women want during their labour and delivery experiences and what is most important to them. With this knowledge, health care professionals will then be able to avoid the feelings women express of being "pressured" to make a choice. Women and their partners can be encouraged to express their thoughts and feelings about what they want during labour, and about what is important to them. And, health care professionals need to listen. The idea of a "birth plan" has received negative press from some individuals in the medical

profession (Richards, 1982), however a birth plan which involves mutual planning may have allowed these particular women the opportunity to clearly express their wants and needs to the health care professionals assisting them during labour and delivery.

Furthermore, active listening skills employed by health care professionals help women to perceive that "someone is listening". Women may not be able to have all their preferences met in all circumstances, but they can know that someone hears them, and that someone will try to help them achieve what is important to them. Women and their partners can be helped to learn how to be assertive and how to collaborate in decision making in order to facilitate achieving their goals during their childbirth experience.

Finally, women should be informed of their rights during the childbirth experience. Health care professionals must keep women informed of their rights.

Limitations and Suggestions for Further Research

There are several limitations to this study. First, the population is somewhat older, better-educated and financially better-off than the general population of women giving birth, and so the results of this study can be applied only to similar populations. However, it is noted that most of the other studies conducted with respect to decision making also have similar samples, hence results from this present study can be compared with previous findings. Perhaps younger, less educated and lower income women would respond differently to the study questions.

The sample is a convenience sample of 30 women. With the sample size of 30, parametric statistical analyses may be conducted. However, as occurred in this study, outlying points may skew data results and further statistical analysis was required. A larger sample size

would decrease the likelihood of outlying data points that skew the data and make the results suspect.

The responses women made to the questions asked during the interviews are certainly subjective and reflect only their feelings and perceptions, at the time. It is possible for a woman to indicate that she did not have a say with respect to an item and yet she may have, in fact, had a say. However, it is the perception of what happened that women take home with them, and if a woman believes that something did or did not happen, that is what is incorporated into her reality.

This study was conducted retrospectively, and so the results are clearly affected by the memory of the women interviewed. Also, because only one interview was conducted, after the delivery, changes in wanting a say that may have occurred from before childbirth, during childbirth, to after childbirth are not identified, unless a woman so specified. It would be interesting to explore what women want to have a say in before childbirth and discover how they feel about wanting a say after childbirth.

Difficulty with accurately measuring satisfaction has been discussed previously. Difficulty exists in developing a standard measuring tool, the timing of the questioning, and the method of questioning. The present study allowed women to describe their satisfaction prior to rating it. As illustrated by the varied comments relating to the levels of satisfaction ratings, support is given for the difficulty in creating a standard measurement. There are obviously many dimensions to satisfaction, and there may even be many levels of conscious and sub-conscious thought processes involved. For this study, the measurements of satisfaction may have been influenced by women's emotional states at the time of the interview and with responding according to how

they thought the researcher wanted them to reply. However, the fact remains that a few women did express extreme dissatisfaction, and were equally capable of describing great satisfaction.

Further research obviously is needed to fully examine the concept of satisfaction. To better understand what makes up satisfaction for women during childbirth, women who have had a baby could be interviewed over the period of a year. Such a study would illustrate any changes over time as well as the components of satisfaction with the childbirth experience.

Finally, it would be very interesting to follow women who have had extremely negative childbirth experiences to see how the experience affects them over time. What really does happen to women who, for example, feel powerless during childbirth, who felt no one listened to them, and who felt they were "wimps" because they somehow lost control.

Conclusion

The purpose of this study was to examine women's perceptions of collaboration in decision making during labour and delivery. The questions formulated to guide the research were:

1. What do women want to have a say in during their labour and delivery experience?
2. What do women perceive themselves as having a say in during their labour and delivery experience?
3. Is satisfaction with their labour and delivery experience and/or length of labour related to: a) the congruency between wanting a say and having a say, and/or b) the incongruency between wanting a say and not having a say?

The first question deals with the extensiveness of collaborative decision making during the labour and delivery experience. In this study, over 50% of the women interviewed wanted a say with respect to 11 of the 17 items. If one looks at the number of women responding to each item rather than the number of women out of 30 who responded to each item, it is found that more than 50% of the women responding to each item wanted a say in 15 of the 17 items. Therefore, that women want a say in many items is apparent, but each woman varies with respect to the number of items about which she wants a say.

The second question addresses the attainability of collaborative decision making during labour and delivery. Using Chi-squared techniques, it is found that women had a say in: the presence of chosen persons, pain medications, freedom to move, privacy, breastfeed within the first hour, vaginal exams, and the others category. Women did not have a say with respect to episiotomy.

The importance of having a say is the affective

meaning of collaborative decision making in labour and delivery. The presence of chosen persons, pain medications, freedom to move, privacy, the presence of hospital personnel, and position for delivery were the six top-ranking items in the very important to have a say rating. Therefore, it was very important for women to have a say in the things about which they wanted a say.

The third question addresses the client outcomes of collaborative decision making during labour and delivery. Approximately 37% of all the women said they were very satisfied with the decision making they had during labour and delivery, but 63% of all the women were less than very satisfied. There is a need for health care personnel to enhance women's experiences of decision making during labour and delivery.

Fifty percent of all the women were very satisfied with their childbirth experience as a whole. However, 50% of the women were less than very satisfied with their over-all childbirth experience. Measures must be taken in ensuring that women's birthing experiences are very satisfying to them; for we don't know what happens to women and their families when women have had dissatisfying childbirth experiences.

The length of labour was the last client outcome to be addressed. It is found that length of labour decreases significantly as satisfaction with decision making and satisfaction with the childbirth experience increase. Therefore, a further incentive is given for assisting women to achieve satisfying decision making and childbirth experiences in labour and delivery.

It is concluded, based on the results of this study, that women do want a say in their labour and delivery experiences, that women vary with respect to the things they want a say about, and that it is important for women to have a say in their chosen items. The length of

labour is found to decrease as satisfaction with decision making and satisfaction with the childbirth experience increase. Furthermore, women's satisfaction with the decision making they had and their satisfaction with their over-all childbirth experience is connected to their perceptions of and feelings about collaborative decision making during their labour and delivery experience.

It is important that nurses and other health care professionals acknowledge the wants and needs of women in labour in order to help women experience a satisfying childbirth experience. Understanding what women want a say in during labour and delivery, and what they perceive as having a say in, can help health care professionals become more in tune with what women of today want.

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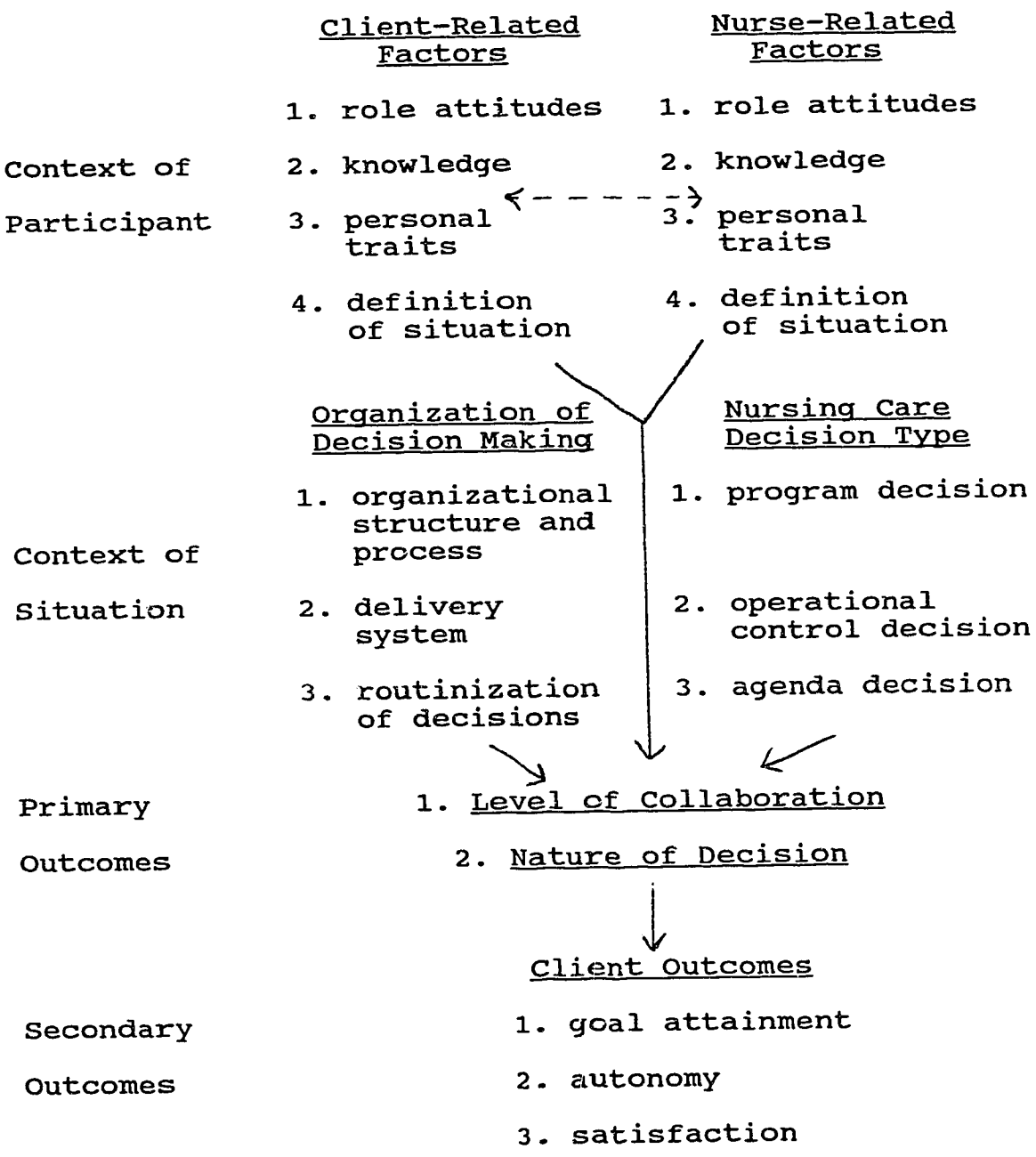

Appendix B

Information Sheet

To potential participants:

I am a Master's of Nursing student with the University of Alberta. I am asking women who have just had a baby to take part in a study called "Women's Perceptions of Collaborative Decision Making Regarding Their Labour and Delivery Experience". I am interested in finding out about what choices you wanted during labour and delivery, and what happened.

If you might be interested in taking part in this study you can let your nurse know and I will come talk with you either in the morning (after 10) or afternoon (after 1:30). At that time I will tell you more about my study and answer any questions you may have. You can choose to participate or not after I have explained the study.

If you choose to be in the study, I will tape record an interview so I don't have to worry about trying to write down everything you tell me. I will ask you about what choices you wanted during your labour and delivery and whether or not you were able to have these choices. Part of the interview will include you sorting cards, on which I will have written those things you tell me about, in levels of importance to you. This interview will take from 15 to 45 minutes, depending on how much you have to tell me. The interview will take place in private in your room or a quiet room.

The things you tell me will be part of what a number of other women tell me (your name will not be given), and it is expected that all this may help nurses and doctors understand what choices women want in labour and delivery. It will also show them what choices women are actually making in labour and delivery.

Thank you for your time.

Wanda A. Mertick, RN, BScN

Appendix C

Physician Consent Package

Wanda A. Mertick
11415 78 Ave.,
Edmonton, Alberta
T6G 0N2
(403) 436-9699

July 10, 1990

Dr. _____
(Address)

Dear Dr. _____:

I am a Master's of Nursing candidate at the University of Alberta and my thesis proposal involves finding out what women want to have a say in, and what they get to have a say in, during their labour and delivery experiences. I am also interested in their level of satisfaction with the amount of say they had as well as their satisfaction with the overall childbirth experience. I am writing to all the Obstetricians who deliver at the _____ Hospital on the recommendation of Dr. _____, Chairman of the OBS/GYN Department, to receive permission to interview patients for my research on the postpartum units.

For information regarding my research, please find enclosed an outline of my proposal, an information sheet I will give to potential participants, and a list of the items I intend to ask the participants about.

If you **DO NOT** want your patients to be considered as potential participants for this research, please inform me by either:

1. telephoning me at my home,
2. speaking to me on the L&D unit at the hospital, or
3. returning the enclosed form in the stamped, addressed envelope provided.

If I do not hear from you by **JULY 20th, 1990**, it will be understood that I may interview your patients for my research. Feel free to contact me if you have any questions or concerns.

Thank you for your time and consideration of my request.

Sincerely,

Wanda A. Mertick
MN Candidate,
Faculty of Nursing,
University of Alberta

Appendix C (Cont'd)

Letter of **Refusal** of Patient Participation

To: Wanda A. Mertick
MN Candidate,
Faculty of Nursing,
University of Alberta

From: Dr. _____

Re: Proposal: Women's Perceptions of Collaborative Decision Making Regarding Their Labour and Delivery Experience

I, _____, DO NOT wish my patients to be considered as potential participants for the proposed research of "Women's Perceptions of Collaborative Decision Making Regarding Their Labour and Delivery Experience".

Appendix D

Informed Consent

Title of Research: Women's Perceptions of Collaborative Decision Making Regarding Their Labour and Delivery Experience.

Researcher
Wanda Mertick, MN Student
Faculty of Nursing
University of Alberta

Phone: 436-9699

Advisor
Dr. D. Forrest
Faculty of Nursing
University of Alberta
Phone: 492-5924

Purpose of the Study:

The purpose of this study is to find out what choices women want while in labour and delivery. Another purpose is to find out how satisfied you were with the amount of involvement you had in having a say in making these choices.

Procedure:

You will have one interview in the hospital two to four days after your baby is born. This interview will take about 15 to 45 minutes of your time. You will be asked during the interview to show with some cards which things in labour and delivery were most important to you to have a say. You will be asked to say how satisfied you were with the amount of involvement you had by choosing a number from one to five. All interviews will be tape recorded so the information you give the researcher can be reviewed at a later time. Your chart will be looked at to find out how long your labour was.

Risks:

You may not directly benefit from this study. Results from this study may help nurses and doctors understand what choices women want during labour and delivery. This in turn may help improve the care nurses and doctors give women in labour.

Voluntary Participation:

You do not have to be in this study if you do not want to be. If you choose to take part in this study, you may still drop out at any time by telling the researcher or your nurse. You will not have to tell anyone why you decided to drop out. You do not have to answer any question during the interview if you don't want to. Taking part in this study or dropping out of this study will not affect your care in hospital.

Confidentiality:

Your name will not appear in this study. The tape of the interview will belong to the researcher, and your name and any identifying material will be erased. The tape and this form will be kept in a locked cabinet. The tape will be destroyed at the end of this study. The transcribed information will be kept on file for five years and then destroyed. Your name will not appear in any reports of this study, articles of this study, or talks of this study.

If you have any questions or concerns about this study at any time, you may call the researcher, Wanda Mertick, or her advisor, Dr. D. Forrest.

Consent:

I, _____, have read this information and agree to be in the study called "Women's Perceptions of Collaborative Decision Making Regarding Their Labour and Delivery Experience". I have had a chance to ask questions about this study and my part in it. All my questions have been answered at this time. I have been given a copy of this consent form.

_____

Signature of Participant Date

_____

Signature of Researcher Date

If you wish to receive a summary of the study when it is finished, please fill in the next section:

Name: _____

Address: _____

_____

_____

Appendix E

The Interview

(Following Outline by Birch, 1982)

1. The interview will commence (after receiving written consent) with an open-ended statement asking the women to recall the events of labour and delivery in which they wanted some say. Birch found that this type of opening helped put the subjects at ease, was a stimulus for conversation, and identified those things uppermost in the woman's mind.
2. For those things mentioned in which she wanted some say, the woman will be asked if she had a say, and if it was important to her to have a say.
3. After identifying her own items, the subject will be taken through the researcher's list of items that were not identified by the woman and be asked if she had wanted a say and if she had some say, and how important having a say was to her. Some items may not be applicable to all women, for example a woman may have been allowed to deliver spontaneously with no thoughts of having an assisted delivery. These questions, when applicable, will be asked for each item prior to advancing to the next item.
4. The researcher's items will be on cards and those items mentioned by the woman that are not included on this list will be written on cards and added to the collection. For example, although the researcher's list appears comprehensive, a woman may say she wanted to have a Leboyer birth (have her baby bathed immediately after birth). "Leboyer birth" would then be written on a new card.
5. Using the woman's identified list of things in which she had wanted a say (excluding all the cards on which are written those things in which she did not want a say), the woman will be asked to place those cards with the identified items written on them in any of three identified piles. The three piles will be labelled as "highly important to have a say", "moderately important to have a say" and "somewhat important to have a say". Included in the cards for sorting will be any additional items the woman may have identified as important in having a say (see #4 above).

6. The woman may add any forgotten items at this time.
7. The woman will be asked to describe her satisfaction with the amount of say she had during her labour and delivery experience. This will elicit qualitative descriptors of satisfaction.
8. She will then be asked to rate her level of satisfaction with the amount of say she had on a scale of one to five, with "one" meaning "very dissatisfied" and "five" meaning "very satisfied".
9. The woman will then be asked to describe her satisfaction with her overall childbirth experience.
10. She will then be asked to rate her satisfaction with her overall childbirth experience using the same one-to-five scale identified above.
11. As a "relevance check" (Birch, 1982, p. 22) the mother will be asked to recall what she found most satisfying and least satisfying about her labour and delivery experience.
12. Independent variables will be asked (age, parity, years of education, race, income, marital status, and attendance at prenatal classes).
13. Length of labour will be obtained from the chart.