**Influence of Provider Communication on Women’s Delivery Expectations and Birth Experience Appraisal: A Qualitative Study**

Christy J.W. Ledford, PhD; Mollie Rose Canzona, PhD; Jasmyne J. Womack, MPH; Joshua A. Hodge, MD

**BACKGROUND AND OBJECTIVES:** Although current research suggests that patient-provider prenatal communication and expectation-setting affects women’s outcomes, more needs to be understood about the kinds of communication experiences that shape women’s expectations, the nature of expectations that women hold, and how those expectations influence their appraisal of labor and delivery. The goal of this study is to draw connections between provider communication, birth experience expectations, and birth experience appraisals.

**METHODS:** Recently delivered mothers (n=36) were recruited at a mid-Atlantic community hospital. Using a grounded theory approach, interviews were systematically analyzed to uncover how participants perceived provider communication during their prenatal care, how participants described their expectations of the birth experience, and how expectations affected appraisals of the experience.

**RESULTS:** Mothers recognize providers’ use of patient-centered communication in messages of empowerment, emotional support, explanation, decision making, and elicitation. Findings posit that it is the inflexibility or flexibility of expectations that may determine mothers’ appraisals of the birth experience.

**CONCLUSIONS:** Mothers continue to rely on providers as partners in health care. Through patient-centered communication, providers can help mothers develop flexible expectations of the birth experience, which in turn can result in positive appraisals of delivery.

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A mong a variety of social and environmental factors that influence women’s expectations of childbirth, prenatal care providers play a significant role in preparing women for the complexities of birth and delivery. Poor prenatal communication has been connected to adverse events and psychological distress, especially when births do not go as planned. Effective communication has been shown to positively impact patients’ physiological status, psychological distress, pain control, satisfaction, and information comprehension.

One element of effective patient-provider prenatal care related to expectations is the process of shared decision-making about the birth process. When patients are not involved in decisions about delivery, it can lead to feelings of frustration, confusion, and lack of control.

This collaborative work in prenatal care is especially salient because when women’s expectations are violated and their delivery experiences are poor, it can negatively impact the health outcomes of mothers and their children.

Women have expectations about a range of issues related to birth. When women’s expectations are not met, they are more likely to be unsatisfied with their delivery. When women’s expectations about epidural uptake are violated, their birth appraisals are negative. Also, women who have unplanned surgical delivery report significantly poorer childbirth appraisals than women.
In addition, we aim to answer two additional questions to draw the connections among the patient perceptions.

RQ4: How does provider communication influence women's expectations for childbirth?

RQ5: How do expectations for childbirth affect mothers' appraisal of the birth experience?

Methods

Using a grounded theory approach, interviews with recently delivered mothers were systematically analyzed to uncover how participants perceived prenatal communication, how participants described their expectations of the birth experience, and how expectations affected appraisals of the experience.

Upon approval by the local Institutional Review Board, purposive sampling began with mothers of children delivered within 6 months at a mid-Atlantic community hospital. Mothers were approached in the Family Health Clinic and Women's Health Clinic following their postpartum appointments. Interviews were conducted in person using an open-ended, semi-structured interview guide between June 2014 and January 2015 (Interview guide available from the corresponding author on request). Three research assistants (including the second and third author) trained in qualitative methodology and interviewing conducted the interviews, which occurred in patient rooms or education areas at the hospital. Each interview was audio recorded and transcribed. The 36 interviews resulted in 7 hours, 29 minutes, and 4 seconds of audio for transcription.

For analysis, we defined prenatal communication by time and sender. Prenatal communication included messages received during pregnancy but prior to triage for delivery. Provider communication included messages from all health professionals in the hospital system, including (but not limited to) obstetricians, family physicians, midwives, nurses, and allied health professionals.

Potential themes and emergent codes were examined as theoretical sampling continued to include more recently delivered mothers. Transcripts were carefully reviewed several times to build an interpretative framework for qualitative analysis. The analytic approach included both answering a priori research questions and searching for emergent themes. Each interview transcript was discussed among the researchers to glean information about potential themes. Through this iterative process, as the team analyzed interview data, we modified the interview guide to elicit data more narrowly focused on the research question.

Investigators conducted an open coding process and analyzed transcripts line-by-line and recorded themes as they emerged. Axial coding then related subcategories and further developed categories. Emerging themes were informed by existing communication theory. During analysis, the prenatal interpersonal processes of care (PIPC) emerged as a framework that fit the provider communication data. Interpersonal processes of care is the concept of “how” care is provided rather than what care is provided. They are conceptualized as the social and psychological aspects of provider interactions with patients. The PIPC definitions of empowerment, explanation, emotional support, decision making, and elicitation were matched to emerging themes. During axial coding, researchers identified causal conditions that influenced predictors of resulting communication behaviors. The constant comparative method was used to saturate categories. In final analysis, researchers generated the emergent themes into integrated patterns.

Since the first author participated in data analysis in this qualitative research, personal biases, experiences, and assumptions of the researcher must be considered. A mother to three children, she has personally experienced prenatal communication, birth expectations, and the resulting appraisal. Although as a
researcher, she sought to bracket her own experiences, the lens created by those delivery experiences impacted analysis of the data. Our team research process, from interview guide design through data collection through data analysis included team reflexivity, which allowed the team to share common ground, foster dialogue, and develop a shared understanding of the data and emerging themes.31

As a validation strategy, data analysis included searching for disconfirming cases.32 Second, member checks were not available since we had not collected personal health identifiers from participants; alternately, three recently delivered mothers who were not part of the sample reviewed the results section as a peer check, supporting content validity.34 The women confirmed results accurately reflect their perspectives regarding prenatal communication, birth expectations, and delivery experience. They emphasized the role prior birth experience (their own or family members’ birth experiences) played in shaping expectations for their most recent delivery.

Results

Of the 50 women approached, 36 completed the interview (72% response rate). Table 1 presents sample demographics. Birth experiences represented in this data included cases complicated by gestational diabetes, pre-eclampsia, eclampsia, fetal heart rate decelerations, and cases requiring induction and emergency C-section. Table 1 presents participant characteristics.

For research question 1, six themes describing providers’ prenatal communication emerged. Table 2 presents these six themes, along with their countertypes. Five themes aligned with the prenatal interpersonal processes of care: empowerment or self-care, explanation of processes of care, emotional support and respectfulness, patient-centered decision making, and elicitation of and responsiveness to patient problems and concerns. The sixth theme was the continuity of the provider. Although not a communicative action, mothers described continuity as having a direct bearing on communication, recognizing particularly that a lack of continuity created a repeated need for building rapport and gathering basic information. These themes were categorized as patient-centered (presence of communication behavior) or absent (countertype or absence of communication behavior).

Across these six communication contents/themes, timing and mode shaped provider communication. Mothers described the timing of messages as critical to establishing expectations.

I didn’t realize that some of the other drugs that they could give you in lieu of that were actually worse for you because of going into your bloodstream, like IV [intravenous] and things like that, so the epidural really was the best option. That might have been helpful to know beforehand because I definitely... I thought I was gonna be able to take stuff that was a little less, um, strong, and not quite as paralyzing, but definitely needed that in the end.” (32-year-old mother of two)

Mothers also elucidated that messages were most effective when presented face-to-face.

They gave me a sheet of paper and expected me to go over it, but it would have been nice if they had gone over exactly what their methods are and then I could have discussed maybe a more natural route. (mother of three)

The biomedical nature of delivery prompted mothers to appreciate not just hearing about the tools of delivery but seeing them and understanding their role prior to the inpatient experience.

Cause I know at the 3rd week they had the tools and stuff that could go with labor. It’d be easy to just throw in a quick like, hey, this is the balloon that they might use for an induction... Like it’s just weird, I didn’t see a balloon coming. (mother of one)

For research question 2, data analysis focused on mothers’ descriptions of their expectations for childbirth. Three themes emerged

Table 1: Sample Characteristics

<table>
<thead>
<tr>
<th>Category</th>
<th>n=36</th>
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<tr>
<td>Age of mother at interview</td>
<td>29.47 (SD 4.51)</td>
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<tr>
<td>Race/ethnicity</td>
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<tr>
<td>White</td>
<td>25 (69.4%)</td>
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<tr>
<td>Non-white</td>
<td>11 (30.6%)</td>
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<tr>
<td>Mode of delivery</td>
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<tr>
<td>C-section</td>
<td>5 (13.9%)</td>
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<td>Vaginal (induction)</td>
<td>11 (30.6%)</td>
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<tr>
<td>Vaginal (spontaneous)</td>
<td>20 (55.6%)</td>
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<tr>
<td>Gravida (number of pregnancies)</td>
<td>2.36 (SD 1.27)</td>
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<tr>
<td>Gestational age at delivery (weeks)</td>
<td>39.45 (SD 1.65)</td>
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<td>Time since delivery at interview (age of baby in weeks)</td>
<td>5.52 (SD 5.13)</td>
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### Table 2: Emerging Provider Communication Themes

<table>
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<tr>
<th>Theme</th>
<th>Definition</th>
<th>Example From Data</th>
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| **Continuity**   | Patient-centered: Patient describes repeated appointments with same provider | • It’s really personal when you’re seeing one doctor and, you know, you don’t have to keep telling your life story over and over and over to every single doctor. (24-year-old mother of two)  
• I mean, he’s great. He’s my PCM (primary care manager) and he took care of the whole pregnancy…He really did a great job. (37-year-old mother of two) |
|                  | Absent: Discontinuity, mothers describe series of appointments with different providers | • I didn’t really have a set provider. I was just seen by like whoever was available…and with having different providers every time, I feel like I didn’t really get to know my doctor. (22-year-old mother of two)  
• I’ve seen several different people. They kept telling me that that’s how it is everywhere…it seems like they don’t care about what’s going on with you. (24-year-old mother of two) |
| **Explanation**  | Patient-centered: Patients report that providers explained procedures and provided information throughout the pregnancy. | • I was very well informed every step of the way, every little thing. I knew about everything. They didn’t keep me in the dark. Even the possibilities, like everything. (24-year-old mother of two)  
• I mean I felt like I was pretty informed either by my midwife or doctor, because I was going to be induced. I knew a lot about it. I was prepared ahead of time regarding what it was going to look like. (mother of one) |
|                  | Absent: Mothers tell how they were missing information that the provider should have explained to them. | • Maybe kind of going over induction with me more. That would have been helpful. I didn’t know I had to be induced, and there was no telling but you know after my forty week visit…it would have been nice if they had gone over exactly what their methods are and then I could have discussed maybe a more natural route. (mother of three)  
• The induction tools I guess. Those weren’t really covered too much beforehand. And like they had covered vacuums and forceps and things like that, but they didn’t really cover in any of the classes beforehand like what might happen with induction. So like I didn’t know about the balloons and like that stuff. (mother of one) |
| **Empowerment**  | Patient-centered: Patients recount instances of providers giving the patient information that helps them enact self-care behavior. | • They were telling me like where the resources were and things like that and then they basically would just tell me to check for the week coming up and if I needed put any questions in there (patient diary). (mother of one) |
|                  | Absent: Patients talk about how they did not have the information they needed to self-care. | • I wish they would have said was to give you a warning about retained placenta, and just in case it happens, that way you know the warning signs well in advance. (mother of two) |
| **Elicits information** | Patient-centered: Patients describe providers who asked for patient perspective and information | • She (provider) brought it (birth plan) up and I was like, oh, I don’t have one yet so she sent me home to think about it…When I came in for a visit and she asked me. (34-year-old mother of one)  
• He asked if I wanted more information a couple of times and I said no, I think we’re good to go with this particular experience. (mother of three) |
|                  | Absent: Mothers describe providers who do not ask for the patient’s perspective. | • I wish they had really asked more about my birth plan. They didn’t ask for it ’til it kind of got time to have the baby, but I wish they had kind of asked for it right off the bat, you know, to find out what I wanted so they could more cater to my needs. (mother of three)  
• I wish for my appointments I had before they would just talk, like ask me more…like how are you doing. (34-year-old mother of two) |

(continued on next page)
as descriptive of mothers’ expectations of childbirth. Across the focus of individual expectations, mothers described birth expectations that were classified as: general, flexible, or fixed. Mothers with a general expectation approached delivery with a general idea of how the process will occur. For example, a first-time mother said:

I can’t really say that I knew exactly what was gonna happen but you have a good general idea.

Mothers with flexible expectations identified specific desires regarding birth, such as delivery mode or anesthesia preferences but discussed it using language that demonstrated an understanding that medical decision making may override desires. Flexible does not mean passive or submissive. These women still made tough decisions but felt they were prepared for decisions they may have had to make.

I’m kind of more like if the doctors say I need something, then I’d rather do that than stick to this plan that might not work. So that’s basically my birth plan, but I did not want a C-section. (33-year-old mother of two)

And I told them you do what you have to do to make sure my baby comes out healthy. And you know, they warned me about the forceps and stuff, which I really was hoping they wouldn’t have to be used, and thank God it didn’t. (mother of two)

Mothers with fixed expectations presented specific, focused birth plans in unwavering language. These fixed plans most often included expectations regarding mode of delivery and pain management.

I also was very adamant on having a natural vaginal birth without any epidural, which is also why I did a class on it. (mother of one)

That particular midwife looked at my birth plan, pulled out a red pen and started just crossing things off. Like no, you have to have an IV. (26-year-old mother of two)

For research question 2, data analysis focused on mothers’ appraisal of their inpatient birth experience. Three themes of appraisal emerged from the data: positive, neutral, and negative. In positive appraisals, patients recounted the birth experience positively, using affective and/or cognitive language. A mother of two recounted:

They (labor and delivery team) were pretty great at care and

<table>
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<tr>
<th>Emotional support</th>
<th>Patient-centered: Mothers describe providers who supported them and their partners emotionally.</th>
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<td>• We bonded ‘cause she reassured me, you know, we’re gonna get through this and we’re gonna, you know make it work. (24-year-old mother of two)</td>
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<td>• I had to go the emergency room once with this pregnancy… he called later to find out how the appointment had gone and if I needed to come in extra, so just that type of concern was really special and unique in this pregnancy. (mother of three)</td>
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<td>• They wouldn’t let the dads be involved which I didn’t like ‘cause he’s my partner. (26-year-old mother of two)</td>
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<td>Absent: Mothers describe providers who did not consider their support system and emotional needs.</td>
<td>• They would give me enough information or help me understand and get me the right person so that I could make a good decision. (mother of one)</td>
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<td>• We discussed like who would be there and things like that. And the doctor asked do we want the baby right away versus do we want the baby after it’s been cleaned so just ins and outs of what I wanted at delivery. (31-year-old mother of six)</td>
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<th>Decision making</th>
<th>Patient-centered: Patients discuss inclusion in decision making processes.</th>
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<td>• He [the doctor] told me that he would just want me to wait… He wanted me to wait ‘til that next Thursday, ‘til I was like 41 and 6 days and so I was like no, I’m not waiting any longer. And I had already talked to the other doctors at labor and delivery, so they were the ones that actually put me down to be induced for my induction, not my actual doctor. (mother of three)</td>
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<td>Absent: Mothers describe how they are not included in medical decisions.</td>
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everything so I was pretty well happy about that care and the provider.

Another first-time mother said:

I would say overall it was a good experience. Um, the actual labor, delivery process was long, and it wasn’t easy but you know it came out well. But I would characterize it as overall positive.

In neutral appraisals, patients described birth experience without valence, assigning no psychological value to the experience. A second-time mother simply described:

It was a completely different birth experience.

Another example was the use of the colloquialism, “fine.” A mother of three stated:

It was just something I had to go through I think to fully understand. And it was perfectly fine. Like everything went just as expected.

In negative appraisals, patients used affective and/or cognitive statements to describe the birth experience negatively. These descriptions were decidedly negatively valenced, including descriptions of anger or fear and even threats of administrative action.

It was just horrible. I felt like nobody listened to me, nobody really cared about my desires... They (labor and delivery team) were just more about meeting their own needs and putting what they needed to put in the computer at the time. They just wanted to make sure they weren’t going to get in trouble by whoever is looking over them. (mother of three)

I haven’t gone to patient advocacy yet… The whole pregnancy experience…it hasn’t been good at all. (24-year-old mother of two)

The emerging model, which describes the connections explored in research questions 4 and 5, included three stages in the communicative processes of birth experience: (1) prenatal communication, (2) expression of expectations, and (3) appraisal of delivery experience. Patient-centered prenatal communication linked to all three types of expectations. However, absent communication linked only to general or fixed expectations. Moreover, mothers identified a complex information environment, in which providers are only one of many voices throughout prenatal care. Three factors in the information environment influenced mothers’ expectations: prior birth experience, social norms, and information sources outside of the clinical structure.

Mothers who had prior birth experiences talked about how those pregnancies and deliveries influenced their current expectations.

I had one [birth plan] the first time and there was really no point. Because you know they didn’t even look at it when I gave it to them, and being a first time mom you think...nothing goes how you plan it so it didn’t matter. (34-year-old mother of two)

Going into labor, delivering two weeks early because I went late with my last one, and I had never really gone early, so that was the most unexpected. (37-year-old mother of five)

We learned our lesson from the first birth, to stay at home as long as possible, because otherwise they will force things on you that you don’t want. So I almost delivered him on the side of the road because we stayed at home. (26-year-old mother of two)

Second, social norms also influenced mother expectations:

They say the second time around it’s supposed to be a little easier. Things are supposed to progress faster. Things were a lot slower and harder this time so I was surprised by that. I think I had trusted everyone’s opinions but they were wrong. (24-year-old mother of one)

One mother cited social norms including family stories:

How quickly it went [was unexpected]. I was always told by the third one, each labor goes by a little faster, [by my] mom who has three kids…my grandma who had five kids. (27-year-old mother of three)

Third, mothers also sought out information from sources independent of the health care system, including birth classes, websites, books, interpersonal relationships, and mobile applications. One mother cited the negative impact of the Internet on birth expectations, ‘The Internet is scary. It tells you crazy stuff’ (mother of two)

Although these descriptions of the information environment influenced mothers’ expectations, these filters did not change the connection between prenatal provider communication and expectations, which linked absent provider communication to only general or fixed expectations. It is possible that the absence of quality provider communication is what prompted mothers to continue with general or fixed expectations.

In connecting birth expectations to appraisals, general expectations were linked to positive, neutral, and negative appraisals. Fixed expectations also connected to all three types. However, flexible expectations connected only positive appraisals.

When mothers had a fixed or general expectation, mothers described expectations as supported or violated in contrast with mothers who had flexible expectations, which were only supported. Topically, expectations of delivery mode, pain management, and length of labor were all discussed in terms of violation or support. As an example, expectations of natural childbirth were violated. These mothers who had been
insistent in prenatal communication about natural or vaginal birth were not prepared for the possibility or process of C-section.

You come in I mean thinking natural, natural, natural and all of a sudden it’s like, wait, wait, what’s going on. All of a sudden I’m learning not. I’m under stress. I’m in pain. Maybe I could have at least mentally prepared myself for this prior to. (34-year-old mother of one)

Expectations of the process and efficacy of pain management during delivery were also a common theme of violation.

And then I asked for the epidural but I had to wait...'cause they thought I would have the baby by then. By like the two hours that it like wears off. But it didn’t, so by that time it had worn off and the pains were like a lot worse...and the anesthesiologist, she wanted to make sure that I wasn’t ready to have the baby, so she didn’t want to give me the second shot again until a little later. (22-year-old mother of two)

However, some mothers described violations that were favorable. These events contrasted what the mothers had expected, but the contrast was better than what the mothers had expected. In cases where expectations were favorably violated, mothers described the violation as a surprise.

This one actually went a little bit faster than we expected ‘cause when we went in she was like four centimeters dilation and then we went off to the cafeteria to get food and came back and the baby was comin’ out. You know, I was like wow. (31-year-old mother of two)

It just says baby straight to chest, but I didn’t realize I would be able to sit there with her for an hour. She was like on me for an hour. So it came as a shock, but then it was like this was great! So it would be nice to go into it knowing. (mother of three)

Despite expectations, experiences during the birth process were filtered through the mother’s perception of the final baby outcome in appraisal. For example, when mothers recognized that expectations were violated, a healthy baby outcome justified that violation.

I wasn’t too happy with it (having a C-section), but as long as the baby was going to be okay I didn’t care... If I had a choice, I wouldn’t have a C-section. But of course I didn’t have a choice. Like I said, as long as he was gonna be okay, I didn’t care. (30-year-old mother of one)

It was constricting his umbilical cord when I contracted. That was something new for me, but the nurse was able to take care of him...But once they like were able to put fluid back into me, it stopped constricting his cord, so everything after that was fine. (37-year-old mother of five)

In this emerging model, unfavorable violations of expectations connected to negative appraisal. One disconfirming case was identified. In this case, the mother’s positive appraisal was not a result of prenatal communication but the quality of the inpatient hospital experience.

Yeah, they know what they’re doing and they’re great. They made me feel so comfortable, like I’ve been going here for years. So yeah, I definitely want to have all of my kids at this hospital. (mother of one).

This mother identified more recent communicative behaviors as influencing her appraisal.

Discussion
This research connects the quality of providers’ prenatal communication to birth experience expectations and then to birth experience appraisal.

Findings here can influence how providers are trained to communicate with mothers during their prenatal care. Providers can create flexible expectations for delivery as a strategy of influencing appraisal.

Previous research has shown that low expectations (contrasted to high expectations) of childbirth are related to negative psychological outcomes for mothers. Other than high versus low expectations, our findings posit that it is the inflexibility or flexibility of expectations that may determine potentially negative psychological outcomes. In our study, flexible expectations were associated with positive appraisal of the birth experience, whereas fixed and general expectations could lead to negative evaluations. Psychologically, when mothers accept the possibility of the unexpected and understand that expectations may not be met in childbirth, they may be building protective factors for coping with the complexities of birth and delivery.

The emerging model here does not attempt to create a path for all occurrences in the delivery process. However, in its parsimony, it confirms the need for flexible, educational, transparent prenatal communication. Mothers repeatedly identified gaps in information provision regarding unexpected events, such as C-sections and failed epidurals. We recognize that providers cannot prepare mothers for all possible outcomes in the uncertain delivery environment. However, we propose that there is a difference between unexpected and improbable. Across 2009–2013, 32% of babies were delivered via C-section,34 which shows that the probability of C-section is considerable, regardless of the expectations of the mother or the care team. This warrants at least a general discussion of the reasons for, the process of, and the implications of C-section with all pregnant mothers.

In this group of mothers, the only consistent set of expectations that connected to positive appraisal was flexible expectations, which only consistently followed patient-centered
communication. This finding prompts us to recommend flexible expectations as a goal of prenatal expectation and delivery readiness. This goal should be attained through patient and provider education. Mothers identified the importance of early communication in prenatal care and the use of multiple modes of communication, specifically a preference for face-to-face communication and demonstration of the biomedical tools. The data here present rich narratives for inclusion in provider and prenatal education. Charon25 said the study of patient narratives facilitates empathy, reflection, and open communication among providers. The narratives collected can be used to inform efforts aimed at helping providers understand expectant mother’s social context, specific childbirth concerns and expectations, and to work collaboratively to create flexible plans that honor patients’ psychosocial needs and protect their physical health.

The interview methodology used did not include direct observation of prenatal communication or the birth experience. Although researchers read the patient narratives to check for accuracy in medical retelling, we acknowledge that mothers may be misinterpreting or editing stories in retrospect.

Two sample characteristics regarding delivery mode must also be considered when reading these results. First, this sample included no mothers who had a scheduled, planned C-section. Second, the sample of mothers interviewed here represents a smaller proportion of C-sections than the general population. Both of these factors affect the context in which to interpret results. Lastly, qualitative analysis relies on thematic saturation.36 However, some of the saturation we achieved in our study could be explained by its single-site nature.

In the complex information environment of prenatal care, mothers continue to rely on providers as partners in health care and communication. Although providers may not have system power to influence their continuity of care, providers can use patient-centered communication through messages of empowerment, emotional support, explanation, decision making, and elicitation. Through this patient-centered communication, providers can help mothers develop flexible expectations for their birth experience, which in turn can result in positive appraisals of delivery.

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